SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY - CIVIL TERM - PART 5

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CHRISTOPHER MILLER

PLAINTIFF ,

-against-

JETBLUE AIRWAYS CORPORATION and TURNER CONSTRUCTION CORP.

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Index No. 111750/06
TRIAL

80 Centre Street
New York, New York
September 22, 2008

B E F O R E:

HONORABLE EILEEN RAKOWER, Justice, and a jury

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

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Direct - Toulipoulos - Borowick

THE COURT: Counsel call your next witness.

MR.BOROWICK: Yes, the Plaintiff calls Dr. Steven Toulipoulos.

D O C T O R S T E V E N T O U L I P O U L O S,

Witness, called on behalf of Plaintiff, having first been duly sworn, took the witness stand and testified as follows:

THE COURT CLERK: State your name and spell your name.

THE WITNESS: Steven Touliopoulos, T-O-U-L-I-O-P-O-U-L-O-S, first name Steven with a V.

THE COURT CLERK: And what is your business address?

THE WITNESS: 23-1831st Street, Astoria, New York 11005.

MR. BOROWICK: May I, Judge?

THE COURT: Yes, you may.

DIRECT EXAMINATION

BY MR. BOROWICK:

Q Dr. Touliopoulos, I'm going to ask you to keep your voice up so we can keep the airconditioner on and direct your remarks to the jury.

What is your occupation?

A I'm an orthopedic surgeon.

Q What does it mean to be an orthopedic surgeon?

A It's a specialty in medicine that studies problems with bones and muscles and joints.

Q It's a little hard to hear you back here, so as well, I'm projecting. If you could keep your voice up it will work well.

A It's a specialty in medicine that specializes in disorders of bones, joints and muscles.

Q And are you licensed to practice medicine?

A Yes, I am.

Q And where are you licensed?

A I'm licensed in New York State and Connecticut, also.

Q And what background education do you have that permits you to get a license to practice medicine?

A Well, you have to finish an accredited medical school and take a three part examination.

Q Okay, and what is your educational background?

A I have a bachelor's degree in chemical engineering from Columbia University. I have a

master's degree in bioengineering from Columbia, I went to medical school and SUNY Downstate and I stayed there to do my residency in orthopedics and I did a sport medicine fellowship at Lenox Hill Hospital in New York City.

Q Doctor, are you board certified in your field?

A Yes.

Q And canyo u explain to the jury what it means to be board certified in orthopedic surgery?

A You have to finish an accredited orthopedic residency program and then pass a two-part examination.

Q Are you presently in private practice?

A Yes, I am.

Q Describe for the jury what your private practice includes.

A I have a general practice in orthopedics. I treat, of course, sports injuries, but also traumatic injuries. I take calls at several emergency rooms.

Q Do you have a particular specialty?

A Again, I have a fellowship in sports medicine and athletic trauma.

Q Do you do spine surgery?

A I do not.

Q Are there doctors in your practice that specialize in spine surgery?

A Yes, there is.

Q Now, have you ever operated on a knee?

A Yes.

Q Approximately how many times?

A I would have to say --

Q You don't have to give me an exact. Is it tens, hundreds or thousands?

A Approximately a couple thousand.

Q And what about feet?

A Yes.

Q How many?

A Feet, probably several hundred.

Q What about hands?

A Probably also several hundred.

Q Now, have you and I met before?

A Yes.

Q And have I called you as a witness when my client is also one of your patients?

A Yes, I have.

Q When you come to Court as a witness, when one of your patients has had a trauma injury and has gone to Court, do you charge a fee for your time?

A Yes, I do.

Q Are you charging a fee for your time, here, today?

A Yes, I am.

Q Tell the jury, when did you first become familiar with Chris Miller?

A I became familiar with him while I was at St. Vincent's Hospital. He was transferred there from another institution.

Q And do you know how he came to be transferred?

A I don't know, I do not know the particulars, no.

Q And was he someone who had a congenital condition, a traumatic condition or otherwise?

A He had a traumatic condition.

Q Do you treat both types?

A Yes.

Q Is there difference in the way in the way you treat congenital or traumatic condition?

A Congenital is something that you are basically born with and traumatic is as a result of an accident.

A traumatic injury is something that's treated more acutely.

Q I want you to assume that he went to Jamaica Hospital from his accident scene and he -- I'm looking now at Exhibit 23 in evidence, and Jamaica Hospital, he reported or they reported that he was a twenty-nine year old male construction worker, that he fell and landed on his feet with an unknown loss of consciousness, that his complaints at the hospital included left wrist, bilateral ankles and low back pain. They did a lot of tests, films on him, exams on him and ultimately put him on morphine and planned to operate on him.

At some point he or his family made a decision to transfer out of Jamaica Hospital and go to St. Vincent's.

Do you know where St. Vincent's Medical Center is?

A Yes.

Q Are you affiliated with that Medical Center?

A Yes, I am.

Q What is your position at St. Vincent's?

A I'm on staff, there.

Q And for how long have you been on staff, there?

A Since I believe, '97.

Q Are your partners on staff, there?

A The -- some of them are, yes.

Q Do you know a Dr. Andrew Merola?

A Yes, I do.

Q What is his specialty?

A Spine surgery.

Q Do you know Dr. Papathomas?

A Yes.

Q How do you pronounce that?

A Papathomas.

Q Papathomas. And what does she do?

A She's a podiatrist.

Q Now, when you first met Chris Miller, the week of his accident, what was his condition when you first saw him?

A You know, he had a significant trauma. He had multiple fractures, fractures of his right foot and also left foot. He had a dislocation of his left wrist. Soon thereafter we also discovered he had a fracture of his left knee and fracture of his lower back.

Q Have you, since becoming his doctor, have you had an opportunity to review the Jamaica Hospital records and the films that were taken of him at Jamaica Hospital?

A Yes, I have.

Q And when you said --

MR.BOROWICK: Strike that.

Q When was the last time that you treated Chris Miller?

A I don't have the exact date, but I think it was within the last month or two.

Q So you're still his treating doctor?

A Yes, I am.

Q And over the two years that you have treated him, would you say that he was compliant or non-compliant?

A He's been compliant.

Q Cooperative or non-cooperative?

A He's been cooperative.

Q Have you ever found him to be a malingerer?

A Never.

Q What is a malingerer?

A Somebody that doesn't really want to get better, somebody that maybe exaggerates their injuries.

Q Has he ever been someone whose complaints were out of whack, much greater than what you found his objective findings to be?

A No.

Q Have they ever been less or understated from what his physical findings would be?

A He is usually very stoic, not somebody who -- that likes to complain about pain, although you can tell he is in pain.

I frequently see him grimace in pain when he's moving on and off the table.

Q Now, during that first exam, after you examined him and had a chance to give him a physical, did you come to a conclusion about his injuries?

A Yes.

Q And did you do tests yourself, that even though there were films that were existent from Jamaica Hospital, did you do your own tests?

A Yes, we did.

Q And I'm going to ask you, with the Court's permission, I'm going to ask you to step down and give us a little bit of background using this exhibit, which is Exhibit 10.

Would you describe for the jury --

MR.BOROWICK: Actually, if we can put that off.

Q Would you describe and explain to the jury the variety and extent of the injuries that you

found?

THE WITNESS: May I step down?

THE COURT: Yes.

THE WITNESS: Thank you.

(Witness steps down.)

Q Okay, this is -- okay, do you have a pointer?

A He sustained multiple injuries.

Q I'm just going to ask you to shift it around a bit so everybody here can see.

THE COURT: But it is important for the Reporter to be able to see the speaker, so do you need to reposition?

(Pause.)

THE COURT: Can everyone see.

THE JURORS: Yes.

THE COURT: All right.

A He sustained multiple injuries very frequently found with people that fall, especially when they land on their feet. There's kind of an axle force going up the body resulting in fractures of the heels.

We call that bone the calcaneus, which is the heel bone.

Q Let me just stop you for a second.

We have some models, here, if it would help you to explain in three dimension as you're going through the charts, that would be great.

A Again, this is the calcaneus. It's in the base of the heel area of the foot and on the right side, the base of the bone is shattered, it's cracked like an egg into dozens of pieces.

On the left side, fortunately, it cracked but didn't really move, so we were able to treat that without surgery.

Q How did you treat it?

A We treated it with just a soft dressing, soft cast.

Q Now, would you explain using the model, explain the dynamics, the mechanics of the foot?

A Yes, the foot is, basically it's multiple bones in the foot. This is the ankle joint and right below is the foot and the subtalar joint is the joint that kind of combines the ankle and the foot joints together, and that was -- this joint here was affected by the fracture, because the fracture entered the joint.

Q What's the significance of a fracture entering a joint?

A Whenever there's a fracture that involves

the joint there is damage to the cartilage and that predisposes people to get arthritis later on in life.

Q You mentioned a subtalar joint.

What is a subtalar joint and what is the importance in the mechanics?

A Basically, the subtalar joint -- I'm just going to pull this apart --is the joint between the talus and the calcaneus, and this joint, this bone was fractured and the fracture went into, you can see here, into the joint.

That's the joint that moves as you walk, so that injury to that joint will affect the way you walk.

Q When a fracture like that occurs and splinters it into dozens of pieces, is it just bone that's affected?

A Well, it's everything. This is a --this is significant trauma, so, the bone is affected, the cartilage is affected and everything surrounding the injured bone, whether it's the skin, soft tissues, tendon, ligament, muscles are also affected.

Q How is bone --how is bone vascularized? In other words, how does blood supply the bone?

A Well, there are blood vessels that enter the bone, there are holes in the bone where our

branches of our arteris go into the bone and they feed the bone, and those can also be disrupted with trauma.

Q What about nerves?

A There are nerves, again, throughout the skin and the soft tissues and the covering of a bone and that's something that's also injured in this kind of trauma.

Q All right, in his particular case, with his particular foot injury, were those affected?

A Yes.

Q Tell the jury, if you can, what is proprioception and how is it involved in weight bearing joints like the foot?

A Proprioception is knowing where your joint is without actually looking at it.

So, if someone were to move my finger with my eyes closed, I would kind of know my finger is moving.

Propioception kind of tells you what position your joints are in and it's very important during the lower extremities when walking.

Q How is that affected in Chris' case?

A Again, about the nerve injuries and associated muscle trauma and atrophy that affect proprioception.

Q Now, getting back to the exhibit, you've told us about the foot injury on the right side, on the left side. Go up the line.

A Yes, so, again, this is a diagram of the injuries.

Coming up to the left knee, he had a fracture of the knee. We call that a plateau fracture, a tibial plateau is the upper part of the knee -- let me see if I can use this.

This is a plastic model of the knee, it's the kneecap, shinbone, and thigh bone and he broke the upper part of the shinbone, the tibia and that was kind of crushed and pushed in from this accident.

Q Did the fracture go into the joint?

A Yes, it did.

Q Again, now, with regard to the knee, tell us the significance of the fracture into his knee joint.

A Well, it's also significant for the same reasons.

You have, whenever there is cracks in the cartilage, it never heals, with normal cartilage it heals, with scar tissues so that it's predisposed to arthritis later on in life.

Q All right, we'll get to it later but

there's a little label on the right shin that says RSD.

Tell us just as a preliminary -- we'll get into that a little later-- what is that?

A RSD is short for reflex sympathetic distrophy and it's a condition where the nerves become hyperactive. So the nerves are the sympathetic nerves and there's kind of reflex arc where the pain causes more activity in the nerves and that causes more pain, and this becomes a cycle that's very hard to break.

And the symptoms are extreme pain, swelling, redness, stiffness and so forth.

Q And hypersensitivity, is there a connection between a fracture like he had in his heel and hypersensitivity and this RSD that you have described?

A Well, the more significant the trauma the more likely one is to get RSD.

Q Now, before we get past the right leg, was there any injury to the ankle itself on the right side?

A He had ankle pain. There were no fractures in the ankle joint but we later found out his ankle was very loose, his ligaments were stretched out.

Q How did you find out?

A It's a clinical examination, we do it in the office by kind of pulling on the joints.

Let me show it on the diagram. We perform a couple of tests, we pull the ankle forward and where we pull the ankle and kind of test the ligaments in the ankle.

Q What did you find.

A That the ankle joint was loose.

Q Is that something that you operated on?

A It's something that we have operated on, yes.

Q Is that something that requires surgery?

A It's something that would require surgery.

The problems right now is the RSD and also, the fact that he still has problems with his left knee and his wrist.

But, the operating on the RSD can have certain risks that they may aggravate the RSD so it's something that we want to wait it out and see.

Q Okay, now going up and off the legs, the next thing seems to be indicated is the wrist.

A Yes.

Q The left wrist, tell us what happened to

his left wrist?

A He had a very complicated injury it's called perilunate dislocation.

Q If you would just give us some basic anatomy of the wrist?

A The wrist is made up of eight very small bones and whenever we move our wrists these little bones kind of grind over each other. It's a very fine machine, and what's holding the bones together are these very small ligaments.

When he fell, the force caused the bones to kind of spread open and the ligaments to tear.

Q And is that a painful injury?

A It's very painful.

Q The heel fracture on both sides are those painful injuries?

A Very painful.

Q The knee fracture into the joint, is that a painful injury?

A It's also very painful.

Q How was he medicated at St. Vincent's during the four weeks that he was there?

A He was, I believe receiving narcotic medication. I believe morphine was some of the medications he was receiving.

Q Was that enough to -- I mean can medication cure him?

A No, it helps take the edge off the pain. Obviously, with these multiple injuries, even high doses of narcotic medication are not always successful in reducing pain.

Q Now, the diagram indicates certain spinal injuries of the lumbar spine, the cervical spine, but there's a fracture at L-1, a complex fracture, is that-- that's not your specialty, is it.

A That's not my specialty.

Q So then we'll leave it for Dr. Merola.

You can take that down and I ask you to replace it with this one.

(Witness complies.)

MR.BOROWICK: I'm talking about now Exhibit 3 in evidence.

Q Now, when you came to start treating Chris Miller, and you found these conditions to be present, was there a plan?

In other words, what were you going to address first, what were you going to do?

A There was a plan, obviously, we had Dr. Merola get involved with the spine injury right from the get go. And the issues with the extremities

were addressed in the stage fashion.

Q What factors and considerations were there for what to address first?

A Usually swelling. He had significant swelling of his right foot and his ankle and if you operate too early on a swollen foot you would have trouble closing the skin afterwards. So you really have to wait for the swelling to go down and that can take sometimes, one, to two, even three weeks to happen.

The left wrist was more amenable to surgical intervention at an early stage.

Q Tell us what you did.

A We made an incision to examine the small bones in the back of the wrist and we went through or between the tendons and through the capsule to expose the carpus.

The carpus is the eight small bones of the wrist. And we found that the bones were split apart, that there was damage to the cartilage as we said in the knee and the foot, there was also damage to the cartilage in the wrist. That holds the same kind of prognosis.

We removed the loose pieces of chip in the wrist, kind of put the bones back together again,

put multiple pins in -- that diagram, that's a real x-ray of the case -- to hold the bones in place and then we, as best we could, we sutured the ligaments tears.

Q Are those pins exiting the skin?

A Yes, they are.

Q And how does that resolve?

A We pull them out, usually in the office.

Q How long before you pull them out?

A You know, around three months, plus or minus.

Q And did that surgery remedy his wrist problems?

A Well, the wrist, I guess the wrist is very fine machine, and once you rip it apart like this it's never going to work the same.

With surgery, we hope it kind of restores anatomy to regain some motion and some strength, but, you never really regain your full motion, full strength. And considering that the extent of his injury with the bone chips, there's a high likelihood of the bone to develop arthritis.

Q Now, what was his post-op care for the left wrist?

A He was placed into a splint for a couple

of months.

Q Was there any medication or physical therapy while he waited for his knee surgery at St. Vincent's?

A He -- there was minimal therapy that we could do because of his multiple injuries.

For the hand, it's really immobilized for a prolonged period of time in the splint.

Q Now, when you say immobilized, when he became-- when the pins were taken out and he would move his hand either up or down, what do they call it palmar?

A Palmar flexion in the direction of the palm and dorsi flexion which is bringing the wrist back.

Q And when he would do that, did he experience any pain?

A Yes, he did.

Q And what would be painful about that kind of movement after his bones have healed?

A Well, because of scar tissue, because of the damage to the cartilage, because of residual swelling and stiffness, there's going to be pain for an extended period of time.

Q And at some point -- let's move onto the

foot.

Did there come a time during that hospitalization when you addressed his foot fracture?

A Yes.

MR.BOROWICK: I'm now putting up Exhibit 4.

Q I'm going to ask you to take us through his foot fracture and what you did.

A We made an incision on the outside of his foot. We call this a hockey stick incision because it looks like a hockey stick.

And we actually lift this skin up to expose the outside of the calcaneus, the heel bone and what we found was a very, very badly crushed bone, we call that comminutia when it's in many pieces and we piece them together the best we could.

We couldn't get it back together the way it was before it broke because it was just kind of crushed, and there was a lot of damage to the area below the joint. We put the plate on, the multiple screws and filled in the holes with bone graft.

Q Where did you get the bone graft from?

A We got it from parts of his own foot but also from a cadaver.

Q Is that surgery done under general

anesthesia?

A Yes.

Q And was it successful?

A Well, successful in that we were able to kind of restore the general anatomy of the foot. Before the surgery his foot was kind of blown out, it was very wide in which case it would be hard for him to put a shoe on.

We were able to make it narrow -- this is a view from the bottom -- so that he could wear a shoe more comfortably. We were able to make it a little higher so he's not as short as he would have been without the surgery, but, as far as the joint goes, you know it was fairly crushed and we knew from the get go this was something that was going to give him problems in the future.

Q While you were in there, wouldn't it have been easy enough to address the ankle?

A No, no, because, you know, with all the swelling you really want to do as minimum amount of surgery as possible.

Something like a ligament problem in an ankle is elective surgery that doesn't need to be done right away and there's no need to be increasing his surgical time, increasing the complication rate by

doing everything at one time.

Q Were you able to eyeball, actually see the damage to the cartilage?

A Yes.

Q And what did you see?

A There was a lot of cracks in the cartilage and something-- some areas where we just couldn't piece it back together again.

Q What is it called when you have cracks in the cartilage that are permanently damaged?

A Again, multiple fractures, we call that comminutia. And the comminutia involves the articular cartilage and bone beneath the cartilage that helps.

Q What is comminuted malacia?

A That's when a cartilage start to wear.

Q Now, when the crackled cartilage, when you remove pieces of that, when you observed the other pieces, was there any point at which it was while he was not weight bearing where there was bone on bone?

A You mean initially after his accident?

Q Initially after the accident.

A Well, there's still cartilage on the other side on the talus, but there are parts on the calcaneus where there's no cartilage covering it.

Q Now, what happens when there's bone on

bone and it starts out with cartilage on cartilage and one side of that is stripped of its cartilage.

A Well, it's a progressive process. Cartilage is something that we walk on. It happens to lubricate the joint and reduces friction.

So, without cartilage -- I said knee, but whatever joint it is, whether the it's a subtalar joint or any other part of the body will wear at an accelerated rate.

Q All right, let me just ask you to assume that Mr. Miller never had any problem with his right or left foot, no fractures, no arthritis, no surgeries, is there anything in your analysis of his condition and treatment over the years that you have treated him that would suggest other than this fall was the cause of his foot problem?

A There are no other conditions that would sway me from saying this was the cause of his condition.

Q Same question with regard to the wrist.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not other than this fall, there's any other cause for his injury?

A My opinion is that there's no other

cause.

Q Okay. Now, if I'm just going to ask you to describe, because I saw them in the hospital records, and I want to ask you what they mean.

There was, with regard to the arm and the wrist injury, atrophy. What exactly is that and why did it happen?

A Atrophy is when the muscles get thin and it's usually from disuse.

So, you can imagine that once you're in a cast or you have a fracture and you're not moving the joint anymore, the muscles don't get used and start to get very weak.

Atrophy can happen within a few days but can progress over weeks and months.

Q Did he have it?

A Yes.

Q Osteopenia, what is that?

A Osteopenia, like the way the muscle gets weakened and skinny when not being used, the bone also weakens and loses calcium when not being used, and I could tell that on the x-ray because it gets to be really washed out.

Q Carpal instability and ruptured ligament?

A That's what we found in the surgery as a

result of his accident.

Q Now, with regard to the left hand, in addition to the wrist injuries, there was something in the record about a crush injury and contracture, and I think it was about the fifth digit.

What happened?

A Well, after an accident, you can get swelling and stiffness and that's kind of the way your body wants to heal itself.

The down side is you can get contracture where it just doesn't want to move anymore and that can significantly affect the function.

Q With regard to his wrist, over the last two years since two years and three months, have you continued to treat his wrist, examine it, make findings?

A Yes.

Q How has his wrist been over the last two years?

A His wrist has has progressed getting more pain and stiffness and which is not unexpected, and we discussed additional surgery for his wrist.

Q Let's talk about the progression of the symptoms.

Firstly pain; what have you noticed about

his complaints of pain in the wrist when you examined him?

A He's had more pain in the wrist and has had less function of the hand, and this concurs with the x-rays that we've taken that show that he's developing arthritis.

Q Have you continued to take x-rays over time?

A Yes.

Q Of his wrist?

A Yes.

Q And you just mentioned, I had asked you about pain but you included something about function.

Tell us about how you test function and what those tests of Mr. Miller have shown.

A Function is basically how good you can use your body part, and to have good function you need good strength, good motion, and sensation.

Q Okay, with regard to his wrist, how is his motion?

A He has significant restriction of motion.

Q And those other things you mentioned?

A Also associated weakness.

Q That accounts for the atrophy?

A The atrophy and weakness go hand in hand

together, yes.

Q Hand in hand -- sorry.

Okay, based on your surgery two years ago, the injury, what your findings have been over the last two years, did you have an opinion with a reasonable degree of medical certainty what his wrists future is going to look like?

A He's getting more and more arthritis and that's resulting in more pain, stiffness and weakness. It's come to the point where he needs additional surgery.

The surgery that we recommended was a wrist fusion, and what that is is we actually make those eight bones one bone and we fuse --

Q Go ahead, I'm sorry.

A I'll probably show it better on an x-ray but we fuse the bones together so the wrist no longer moves.

The down side is, of course, the wrist doesn't move anymore. The upside is, without motion you have usually no pain.

That's what we've recommended for his wrist.

Q I'm pulling out two x-rays that you have provided, which is Exhibit 20 and Exhibit 19.

If you don't mind, if he we can just figure out a way

A This is one of the x-rays.

Q Just try to step back so that you're not blocking the jurors.

A This is one of the x-rays soon after the surgery showing the multiple pins, these are again, through the skin to be removed later in the office.

This is the primary bones that are affected in this location although all the bones are to some degree, and showing that we've restored the anatomy.

However, if you look at a more recent x-ray, he's developing what we call a slack wrist. So this is a well known complication of a perfect lunate dislocation where the bones are separating, getting arthritis in this joint, there is very little cartilage there and the cartilage is actually coming down because these bones are separating.

So, this is leading to and this is a progressive problem, so this, over time is getting more and more symptoms and for these reasons we have recommended the additional surgery.

Q I'm sorry if I missed it. What is the additional surgery?

A It would be a fusion. So, we would basically open the back of the wrist, the incision would be from here to here and we would kind of scrape whatever cartilage is left off the bone surfaces so they would fuse.

We pack all the areas between the bone with bone graft and put a plate on. It would span the radius to the metacarpal bone. It would hold the wrist still so the fusion will heal.

Q Does that plate ever come out?

A There is a good chance that it will come out because it's right at the skin, and will likely bother him in the future.

Q When it comes out, how will that wrist be positioned?

A Once the wrist actually fuses, the plate is no longer necessary, and it can be removed.

The wrist, again, will not have any motion so he will not be able to flex or extend, or he will have very limited rotation, also.

Hopefully he may be able to maintain his finger function.

Q Isn't there something that goes through the wrist and carpal bone called carpal tunnel?

A Yes.

Q Explain that and whether or not it's involved in any of the considerations for his wrist treatment.

A Yes, we diagnosed the patient with carpal tunnel syndrome.

This is something that I'm sure many of you have heard about. It can be a condition that happens after repetitive use of the hand, however in this instance it's a result of trauma. It's a known complication of a bad wrist injury to develop carpal tunnel syndrome.

Sometimes the symptoms are noticed right away, sometimes it occurs months and years later.

Q While you're up there, so that you don't have to keep going up and back, I'll take the wrist ones and let's jump back to the foot.

Show us what those x-rays depict.

A This is an x-ray of the right foot, and again, this is soon after the surgery with the plate and screws in place.

You can still see the amount of damage where he had the fracture, and again, this is a view from the bottom of the foot.

You can see all the lines here where the fractures are going all the way. This is the joint

here, the subtalar joint, this is the fracture going right into the joint.

Then more recently was --

Q Keep your voice up.

A More recently, we are seeing the osteopenia, the bone is losing its calcium, he's getting arthritis in the subtalar joint.

Q What's the impact of -- well, is the osteopenia, is it reversible --

A Well --

Q --in him?

A The osteopenia, there is two reasons. One is disuse,with respect to his ankle and foot, one is disuse because he has pain whenever he puts his foot down and the other is RSD, and RSD is known to cause osteopenia.

You know, if he has a fusion and he has some improvement in his pain and is able to walk a little bit more on the foot, his osteopenia may improve but never completely reverse.

Q And has he regained any function in his foot as a result of the work that you did?

A Well, he's able to put some weight down of very limited, and I would say that the goal of initial surgery was to prepare him for the fusion in

the future, but if you don't restore his bone stock and create a normal looking foot, it's hard to fuse it later.

So we didn't have great expectations with the first surgery, but we were able, in kind of restoring the bone and kind of the way it was before it broke and he's ready for a fusion.

Q How much function has returned?

A Again, you know he's got limited motion, swelling, stiffness.

Q What's his pain level scale of one to ten?

A It's pretty high. I don't recall off the top of my head. I would have to look at my records, but it's pretty high.

Q Is there any correlation with the amount of use that he put his feet to, and the amount of pain?

A Yeah, the more he stands or the more he walks, the more pain he's going to have and I recall he told me he has trouble walking within a few blocks.

Also just sitting down is causing blood to rush to his foot which increases swelling and pain.

Q So, if he can't walk for or stand long or sit long, what's the answer for him?

A Well, unfortunately there's no good answer. This is what we try to resolve in surgery. We try to get things as best we can with what we have to work with.

RSD is a chronic pain condition, therefore we expect him to have chronic pain.

We're hoping that with a fusion some of his subtalar pain will get better and maybe make him walk a little bit better. I don't expect him to ever walk without a limp.

Q Will he ever be able to squat?

A No.

Q Will he ever be able to walk stairs comfortably?

A Not comfortably, no.

Q It's his right foot; will he ever be able to drive like a normal person drives?

A Like a normal person, no.

Q Is the fusion that you're going to do on his foot, will that fuse his ankle as well or will it just fuse his lower foot?

A It's just going to fuse the lower foot which is the subtalar joint. The joint --he will still have -- he will still have issues with the ankle rolling because of it's instability.

Q How will this fusion affect his osteopenia?

A Well, again, the -- if the pain improves and he's able to put a little more weight down it may help his osteopenia, again, although it will always be there to a certain degree. On the flip side, though, whenever you fuse a joint, no matter what part of the body it is, the joints that are not fused that are beside it get overworked.

So, the joints in the midfoot are going to get overworked and will likely give him problems later on in life.

Q What -- is there a correlation between the use of his foot and the development of arthritis?

A Well, the more he walks on this foot, the more wear he will have and the more fast the arthritis will progress.

Q Now he didn't have any other injuries to the other foot or knee, would the limp that you said he's going to have forever, would that affect his -- the other joints in his body or in his spine?

A It may, yes.

Q And why is that?

A Whenever you walk off kilter, that's going to-- it increases stress on other parts of the

body.

In other words, it's -- and in a situation like this, it's very common to see patients develop pain in the left knee and he already has issues in his left knee from the left hip, sometimes same side, increase back pain and again he already has issues in his back from the accident.

Q All right, so, now, after the fusion of his foot and after the fusion of his wrist, let's talk about the other leg.

How is his right -- how is his left foot?

A His left foot fortunately, has healed fairly well. I don't think he has that many symptoms in his left heal at the present time.

Q All right, let's talk about his left knee.

You mentioned before that the tibial fracture -- before we get there, I want you to explain and take us through this RSD thing because ultimately I'm going to ask you whether or not it's going to be with him for the rest of his life. If you could just step down and maybe --

By the way while you were treating him, did you notice anything in any of the MRI films that suggested or confirmed the existence of RSD?

A Yes.

Q And what did you notice?

A The bone scan and MRI both confirmed.

Q Well, with regard to the MRI, what about an MRI film was there, that confirmed the existence of RSD?

A It revealed abnormal uptake in the joint around the injured area and foot, consistent with an RSD.

Q Now, you said something about a bone scan.

Did you cause a bone scan to be done?

A Yes.

Q Take that and approach the jury if you would and just explain what that shows --

A This is the result of a bone scan and what a bone scan is, is that the body is injected with a technician 99, which is our radioactive ion, and that binds to the blood and then it goes to where the blood goes in the body.

There are different phases of the bone scan, early and late, and there's a scanner that's used to scan the body to find out where the reactive ion end up going to.

And here is a bone scan of his right foot

and also his left foot. And you can see that the uptake there is in all the bones.

So, when you have an RSD it doesn't affect just the bone that was injured, it affects all the bones in the area. So you can see that the small bones are affected, the ankle is affected, and of course, the area of the injury is affected and again this is just a different illustration of the same problem.

You can see in the other foot where he had a calcaneus fracture, there's no uptake, there or minimal because it's healed and there's no RSD, there.

Q Now, would you explain to us, using the exhibit, how the mechanism of pain from the regional complex occurs?

A First thing is there's initial trauma to the area, whether it's the foot or elbow or shoulder or hand. It can happen in almost any part of the body.

That triggers pain response from the brain which affects the spinal cord and the nerves of the spinal cord, especially the sympathetic nerves.

Q Excuse me one second. Does RSD happen in every injury?

A No, it does not.

Q In this case, did he develop any RSD from his left foot?

A No, he did not.

Q Left knee?

A No.

Q Left wrist?

A No.

Q Spinal injuries?

A No, he did not.

Q Please, go on.

A The sympathetic nerves are responsible for restriction of the blood vessels coolness and warmth of the foot and causes swelling and stiffness, again causes burning and swelling which triggers additional pain and that goes back around.

So there's a cycle here; once created it can be very, very difficult to break.

Q And in -- I mean, in different patients that have RSD, is it always the same level of pain?

A There are, different patients have different clinical pictures. There is no cure for RSD.

There is some treatments and he has received some of them, including medications and injection treatment to help kind of contain it but

once you have it you can't cure it.

Q What injection treatments has he gotten?

A He received some foot injections.

Q And did they give him any significant relief?

A At best I think it was only for a couple of days.

Q And with regard to the level of his pain from just from the RSD, forget the arthritic problems, et cetera, can you categorize or quantify that level of pain from the RSD?

A Oh, it's severe, severe pain.

Q Does the medication take the edge off that?

A There are different medications: Pain medication, injection treatments, but, these are all palliative, they are not curative. And.

The issue is that he needs additional surgery, and we're at the point now where there's a chance that he may worsen because surgery can sometimes trigger RSD, but we're at the point now where he has so much pain from arthritis, I think it's worth while to attempt any additional surgery.

Q The RSD, you mentioned, you showed us on one of the foot x-rays that the bones were kind of

mottled.

What are the symptoms besides these objective tests that you have done the MRI and bone scan, what symptoms have you found clinically to support the diagnosis of RSD?

A Again, he has significant pain. He has swelling, he has stiffness. At times, I believe the foot was warm. Again, it changes in temperature, results of another sign of RSD, and again the osteopenia is the radiographic center of RSD.

Q Now, has the temperature of the foot -- has it ever been discolored?

A I believe I've seen some when I was reviewing the chart, yes.

Q In addition to -- with regard to discoloration and temperature changes, cool or hot or whatever, do those -- are those always present in a patient that has RSD? Would they be consistently there, day after day, after day, or do they come and go?

A There's no consistent picture. With some may cases, redness, coolness, some may have neither, some may have hair loss or overgrow hair and sometimes it may be present one day and other days may not be present.

So these signs may not be present during the entire course or may vary from day to day.

Q You can take that one down.

(Witness complies.)

Q Dr. Toulipoulos, why did you wait on the knee surgery until this year?

A Well, he had multiple injuries and this had to be thought out really well, and obviously, he had a back fracture, he needed back surgery for a disproblem and obviously we had to wait for his back to get better because it's hard to rehab if you have back pain and sciatica.

Q If he had these back problems and sciatica rehab, how did he heal from the heel and knee fractures?

A It's very restrictive, and part of the problem is that you treat one problem but the other problems are still there, and, you know, -- we can fix his foot with a fusion, but it will put more weight on his left knee. So it's like a circle, where one problem will aggravate the other problem. Especially with knee surgery, though, you need to be able to bend your knee and your hip and for those reasons, more so than the foot or the wrist, I think it was prudent to wait.

Q Did you coordinate it with Dr. Merola as to who would get to operate again first, would it be the knee or the back?

A Yes, we had --there were many occasions where we saw the patient together. We were in the same office the same day and saw him together and we kind of planned out the procedures.

Q And ultimately after the back surgery, did you do the knee surgery?

A Yes.

Q And would you take us through the knee surgery that you did on Chris Miller?

If you need a model, here it is.

A What we found after the fractured heel, so basically he had a fracture that we said did not need surgery and that healed. But, very commonly with a fracture, you can tear up the soft tissues in the knee, meaning the meniscus, cartilage and the ligaments. And the patient had ongoing symptoms of his knee buckling and giving out. This actually resulted in falling several times because his knee kept giving out.

That was one of the first clues that his ACL, his anterior crucial ligament was not working. That was confirmed on examination. He had positive

tests in the office that showed that he had a loose ACL, when we did various testing the Lachman and pivot shift test.

So, we again, we indicated him for surgery. We feared that if he kept falling down he would do further injury to his body and that's something that he really didn't need.

So, we eventually performed a knee arthroscopy and reconstruction.

What we found was that he did have some damage to the cartilage which was consistent with his injury.

In other words he fractured his lateral plateau and this area he had damaged cartilage. I believe it was grade three.

And zero is no damage and four is the worse, so he had pretty advanced damage when we went in there.

He had a loose ACL that we cleaned and we reconstructed with a cadaver ligament.

So, basically --

Q Cadaver meaning a dead body?

A Yes, it's a dead person, someone that's passed away that's donated their body parts and we used an Achilles tendon, this area here, from a dead

person to reconstruct his ligament.

To do that, we make an incision here, we make holes in the bones here and here with a drill and then we pass through the ligament in the knee and hold it with a couple of screws.

Q Did you do that with open surgery or was that arthroscopic?

A Arthroscopic assisted, meaning that most of the surgery is through the camera, however we have to make a small incision in order to pass the graft.

Q How did that surgery work out?

A Initially, he was improved, he had better stability.

There was an additional injury to the knee, and now we believe there's a recurrent injury to his ligament.

Q Over the course of -- by the way, in that joint are there proprioceptors, as well?

A Yes.

Q And given his, the buckling can you say with a reasonable degree of medical certainty as to whether or not those have been affected?

A Propioceptor is affected, it's one of the things that we have that helps control buckling.

Q Because of the damage that you saw, even

though you reconstructed the ACL, the damage to the cartilage, is that permanent?

A That's permanent.

Q Is there any way to repair that?

A No, there's not.

Q What is the functional effect of the damaged cartilage in the knee?

A The prognosis is that as time goes by, that cartilage will wear progressively over months and years.

With an ACL that works, you can slow down this arthritic process, but you can't stop it. Without an ACL your knee will buckle and the bones will slip and every time that happens it just causes more grinding wear of the cartilage.

Q Be you you gave him a new ACL with that graft, so, it should have been fine; right?

A Like I said, initially it was, but then there was an incident.

Q How do you explain the incident -- well, what was the incident, when was the incident and how do you explain the incident?

A He was on steps, he was using a brace and I believe he also had a cane at the time and his knee gave out and he twisted it.

Obviously, the causes are residual weakness of the knee, the problems that he has bearing weight with his right foot, it hurts, so he has to put his weight on his left side, and the difficulty using his hand to use a cane or handrail.

Q Now, with regard to the knee, even after the ACL reconstruction, having these problems, can you give the jury a sense of what his prognosis is with regard to the knee?

A His prognosis is it's guarded because we're looking at an additional surgery now.

Because of his right foot problem and his back problem and the stresses that it's going to put on his knee, I'm not quite sure how successful additional surgery will be.

I think it's worth one more time to help regain the stability and slow down the arthritis.

But, because of his underlying damage to the cartilage, this is an injury as years go by will give him more symptoms.

Q Now, have you done any recent films of the knee?

A I believe I have.

Q And would you show us what you did, when you did it and what it shows?

A I believe this was July of this year.

THE COURT: What film are we looking at?

MR.BOROWICK: It may be on the other side.

Exhibit 22.

THE COURT: Thank you.

Q First explain to us what an MRI is and what we're, looking at?

A It's a machine that uses magnets to spin the kind of protons in the body and to give back a signal inside our body. So it does not use radiation or x-rays, like a regular x-ray does.

Q Please, I'm missing half of what you said. Keep your voice up.

A Okay, so this is an MRI of the left knee and you can see that all this white signal here is injury to his ACL we call that mesocoelia ligaments.

And also on examination he also again had laxity of his ACL, ACL looseness is a clinical diagnosis, which means make the diagnosis based on physical examination.

An MRI may not show it and therefore what the patient tells you, what you see when you examine the patient is sometimes more important than an MRI.

Q Does that show any degenerative condition

ongoing?

A I do see some abnormal signal, again, in the lateral tibial plateau.

Q Using Exhibit 8, would you show us using Exhibit 8 what you've described as the prognosis for his knee?

A Arthritis has different symptoms and different signs and early on it's sometimes very hard to see on a regular x-ray.

Q Could you just rotate that a little bit?

(Witness complies.)

Q That's good.

A Therefore, the arthroscopy in which you're looking at, the cartilage is the best test.

As time goes by, patients have conditions like spurring of the bone, it kind of wears itself off and that sometimes one of the earlier signs of arthritis they can also develop spurs which are bumps on the bones that kind of develop because of the mechanics of the knee. And again, this all results from the loss of cartilage. As that wears out, the body responds by making the spurs and trying to kind of stabilize the knee on its own.

Q Okay, you can put that down, and resume your seat.

(Witness complies.)

MR.BOROWICK: Let me just take this down.

Q Dr. Toulipoulos, in the last month or two months or as of the last visit that he made to your office, tell us what, bring us up-to-date, in how he's doing.

A Again, he has --

Q You have to keep your voice up.

A He has recurrent left knee symptoms. His knee is buckling again; it's very painful, it's getting swollen and stiff. He has ongoing progressive pain in his foot, he's got an ankle that rolls.

He's got increasing pain and stiffness in his left wrist.

Q Now, over the course of the two plus years that you have been treating him, has he ever exhibited any type of emotional reaction to his multiple disabilities?

A Yes, he has.

Q Tell us about that.

A Well, initially in the hospital, he was having nightmares. Whenever he would wake up at night he would feel that he was falling again and we actually called for a psychiatric consult while he was in the hospital.

As time went by, I believe within a year or so later he was developing a depression that I had recommended that he follow up with a psychiatrist, again.

Q Did you actually write him a script?

A I believe I did, yes.

Q Do you know whether or not he is or has seen a psychiatrist?

A I believe he has.

Q A few more questions.

As part of your practice dealing with sports, the related injuries and other traumatic injuries, are you called upon on a regular basis to assess a person's ability, physical ability, medical condition to return to work either at their career, or at other work?

A Yes.

Q And over the course of time, have you had patients that could go back to work in doing what they were doing?

A Yes.

Q How about patients who couldn't go back to doing what they were doing, but could go back to doing other things?

A Yes.

Q Do you have an opinion, with a reasonable degree of medical certainty as to whether or not Chris Miller will ever return to any manual labor construction job?

A It's my opinion that he will never be able to perform any sort of manual labor construction work.

Q Do you have an opinion in the real world, as to whether or not Chris Miller will ever be able to compete for a full-time job at anything?

MR.KAMINSKY: Objection.

THE COURT: I'll allow it.

Go ahead.

A My opinion is that he will not be able to.

Q Why?

A He has chronic pain that's lasted for a couple of years, his conditions have worsened and not improving. He requires narcotic medications, those are medications that make people drowsy and sedate them. He has pain management control issues and I'm not even referring to his back problem, but I'm just referring to his extremity injuries.

Q You've mentioned a number of procedures that he will require, at least with regard to his

extremities. You said a wrist fusion, a foot fusion, ankle surgery, further knee reconstruction, and forget the spinal stuff.

Those things cost money, don't they?

A Yes.

Q And let me ask you whether or not in connection with this litigation, I've asked you to confer with a life care planner who puts together a medical picture of costs in the future for litigation.

Did you do that?

A Yes, I did.

Q Let me ask you, when is your best estimate that he will need the foot fusion?

A Well, the goal right now is to address his knee, first. It's, I think, important to give him at least one good leg to stand on so that he can recuperate from his other injuries.

Because the ankle injury is fairly complicated with RSD and arthritis, I believe that the knee should be carried out very soon and then once he's recovered from the knee, in six months to a year maybe the right foot fusion.

Q When do you believe he will need the wrist fusion?

A The wrist fusion, again, because he's

going to need crutches after either his knee or foot surgery, I believe the wrist surgery is best deferred until after his knee and after his foot surgeries.

Q How about his -- well, if you defer it to after the foot or knee surgery then when he does that rehab for his foot and his knee, get back up, weight bearing and uses the crutches, what's he going to do with that hand on a crutch?

A It's going to be painful, it's going to be painful.

The options are, you know, there's a risk of doing the wrist fusion and then having him use crutches and have the surgery fail, but like I said earlier, there's no good answer. No matter how you look at it it's what will give him less pain, not what will give him no pain.

Q After you do the foot fusion and ankle and the wrist -- I'm sorry you do the foot, ankle and knee, then you do the wrist, what's his future look like after those surgeries?

A Again, he's going to have a wrist that is going to be fused. We're hoping that that will help a lot with his pain. It all depends on the success of the surgery. He will have loss of motion of the wrist, residual motions of his hand including weakness

and stiffness. He has the carpal tunnel that we may also address at the time of his wrist fusion.

With his foot, again, we're hoping that at least in the subtalar joint it will be able to relieve some of the pain, but again, the RSD is still going to be there.

We're hoping that it will not be aggregated by the surgery, although that's a chance that everyone will have to understand and be willing to take.

He will still have the ankle that rolls and it's loose.

Q He's thirty-one years old, now, with a life expectancy of something like forty-six or forty-seven years.

Do you have an opinion with a reasonable degree of medical certainty of how self-sufficient he will be in thirty years?

MR.KAMINSKY: Objection.

THE COURT: Overruled.

Answer, doctor.

A Again, with respect to the knee, I believe thirty years from now he's going to have significant arthritis, that more than likely will require additional procedures. That will give him

stiffness and weakness and difficulty walking.

If his foot fusion is successful, hopefully that will alleviate some of his foot pain, but as I said earlier that will increase chance of getting arthritis in the adjoining joints, that will happen over thirty years and he will have arthritis in the small bones of his foot because of the way he walks.

Again, his wrist, after fusion and after carpal tunnel surgery, hopefully, that will be something that will be successful in relieving his pain and hopefully, will be able to stabilize his symptoms.

Q Do you have an opinion with a reasonable degree of medical certainty as to whether or not when he gets into his fifties, sixties and seventies, he will require a home health assistant?

MR.KAMINSKY: Objection.

THE COURT: Overruled.

A Yeah, my opinion is that he will need one.

Q Why?

A Because he's going to have-- even at the present time he has difficulty walking five blocks, difficulty negotiating steps. You can imagine how he

will be thirty years from now. Even the simplest activities of daily living are going to be restricted and he's going to need help to carry these out.

Q I want you to assume that he's a father of five, he had been an active coach, coached three of his kids in different sports, he enjoyed sports himself, he was a responsible homeowner who took care of his house, helped with chores, took care of the outside and inside.

Are those activities or are those activities that he will ever be able to participate in meaningfully, again?

A Not in any meaningful way, no.

Q I want you to assume that since the accident and during some of the rehab he's been able to go to one of his kid's games and keep score in the dug out.

Is that something he can do?

A Good bless him, that's something he can do. Obviously he's not going to be able to walk around the field and give instruction to the kids, but sitting for period of time is okay to do, yes.

Q Do you encourage your patients to find things that they enjoy and do them?

A Yes, I do.

Cross - touliopoulos - Kaminsky

MR.BOROWICK: I have nothing further.

THE COURT: Do you need a break?

MR. KAMINSKY: May I proceed?

THE COURT: Yes.

CROSS EXAMINATION

BY MR. KAMINSKY:

Q Good morning, Doctor. My name is Alan Kaminsky I'm the attorney for the defendants, okay?

A Good morning.

Q You and I have obviously never met before; true?

A I don't believe so.

Q Just bear with me, I'm a little sad today because I was at the Yankee game last night and it was very emotional.

I don't have a lot of questions for you and I'll tell you why: We don't dispute the orthopedic injuries that were suffered by Mr. Miller. There's no dispute about the ankle fracture, there's no dispute about the calcaneal fracture, there's no dispute about the wrist, there's no dispute about the knee, and in fact he has had surgery.

MR.BOROWICK: I'm sorry, Judge I'm going to object.

THE COURT: Please ask questions.

Q He's had surgery for --

THE COURT: Questions, please, not speeches.

Q Is it true he's had surgery for all of those injuries?

A He has had surgery for most of his injuries.

Q And you've gone through that with the x-ray films and discussed that; correct?

A Correct.

Q So, let's put the orthopedic injuries aside.

And that's your specialty; is that correct?

A Yes.

Q By the way, is it fair for me to say to the jury, we heard your credentials, we've heard how many times you've done surgeries, were those surgeries successful?

A Again --

Q Just if you can answer yes or no?

A That's not a yes or no.

Q Then I'll accept that, okay.

He tolerated the surgical procedures well?

A Yes, he did.

Q Now, currently, he is at home, he's self sufficient; correct?

A He's at home. He's living with his wife and children, yes.

Q And he dresses himself?

A (No response.)

Q Yes?

A I believe he does.

Q And he takes care of his daily needs; correct?

A Again, he has significant restrictions in terms of how far he can walk, but there are some activities he can do, yes.

Q But he takes care of himself; he bathes himself, he feeds himself, he dresses himself, the day-to-day things that a person has to do, he's capable of doing them; true?

A To the best of his ability.

Q To-- anyone to the best of their ability.

But my question is, he does them on his own; is that true?

A Yes.

Q And as far as driving is concerned, if a modification to accommodate his foot is needed he

would be able to drive; correct?

A If there was a modification, so there is no need to use his right foot, and modification for his loss of his wrist and hand use, I believe he may be able to drive again.

You would have to ask Merola about his back issue, though.

Q Okay, that's fine.

Now, when he had this trauma, we can agree that these were fairly serious injuries; correct?

A That is correct.

Q Over the course of time, though, obviously, the condition of his heel is better today than it was when he fell; correct?

A Better than day one, I would have to say, yes.

Q And same thing for his wrist; true?

A That is correct; yes.

Q And the same thing for his knee?

A That is correct.

Q Okay, so, if you take him from where he was at the time of the occurrence and go over the past two years, and if you look at the hospital records and the treatment records, there has been improvement;

true?

A There are --

Q If you can answer my question yes or no I would appreciate it. If you can't, just say you can't.

A Initially I would say --

Q Let me rephrase the question.

If you can answer it yes or no, please do, if you can't, please say you can't.

A I would have trouble answering that yes or no.

Q Okay, that's fine.

Do you have file material with you?

A Um --

Q Did you bring anything with you to Court, today.

A I brought x-rays and copy of some of my office notes.

Q May I see your office notes, please?

THE COURT: Would you like to take a break?

MR.KAMINSKY: You know, I'm going to try to finish the doctor before lunch.

THE COURT: Great.

Q By the way you told us you're being

compensated. What is the amount of compensation Mr. Borowick is paying you?

A It's five hundred dollars an hour.

Q Is there a minimum?

A No.

Q What do you expect your compensation to be for your testifying in Court?

A Again, dependses on how long I'm here, but approximately between six and eighth thousand.

Q Six and eight thousand?

A Yes.

Q If I make you come back after lunch will it be eight to ten thousand?

A It will be more --

Q It's a joke.

A Okay.

MR.KAMINSKY: May I approach, Your Honor?

THE COURT: Yes.

Q How much does --how much did the knee surgery cost?

MR.BOROWICK: Objection.

THE COURT: Overruled.

MR.BOROWICK: May we approach?

THE COURT: Yes.

(Whereupon, an off the record discussion

was held at the bench.)

MR.KAMINSKY: I'll ask the question differently so we can avoid approaching.

MR.BOROWICK: I don't mind approaching.

MR.KAMINSKY: I'm trying to save time so I'll ask the question differently, so there's no need to object.

If you want to approach, we will.

(Whereupon, an off the record discussion was held at the bench.)

(Record resumed.)

Q The surgery that you did for his knee?

A Yes.

Q You said that that was modified arthroscopic surgery?

A Assisted, yes.

Q Arthroscopic assisted surgery is usually done on an outpatient basis; is that correct?

A That's correct.

Q So, this was done an an outpatient surgery?

A Yes.

Q He went in in the morning and left in the afternoon; is that correct?

A I believe so, yes.

Q That's the type of surgery, when we hear the term arthroscopic surgery, that's what the athletes get for their knee; correct?

A Usually, yes.

Q What is your charge for doing an arthroscopic surgery?

A It depends on the procedures performed.

Q What would be your charge for the type of surgery done to Mr. Miller?

A I would have to give you an estimate because I don't know the exact numbers.

Q Not a guess; I want an educated estimate.

A It would probably be six thousand, five, six thousand dollars.

Q So, it cost more for you to come to Court and testify than for you to do the surgery, roughly?

A The --

Q Just yes or no.

A It's about the same numbers, yes.

Q Okay, and let's see, he also had the wrist surgery?

A That is correct.

Q What was the --what would be the typical cost of the wrist surgery?

A That would be more of a guess than an

estimate.

Q Okay, I don't want you to guess, okay.

Now, a couple of things I want to go over briefly.

I want to go over his stay at St. Vincent's, okay. I'm just going to read some comments from the St. Vincent's -- first of all he was in Jamaica before he made it over to St. Vincent's; correct?

A That's correct.

Q Let's just talk about his condition when he arrived at Jamaica Hospital.

Do you know what an Assessment indicator is, in functional screen?

A A functional assessment indicator?

Q Yes.

A There are different types, but every hospital has their own.

Q Well, they gave him a score of twelve, which means that he was not in great shape, but he wasn't in dire straits.

Can we agree with that?

A It depends on the scale system.

Are you talking about the Glass Glaucoma scale?

Q No, I'm not talking about the Glass Glaucoma scale.

I might as well show you.

MR.KAMINSKY: May I?

THE COURT: Yes.

(Handing.)

Q On the bottom left.

(Witness looking at document)

Q If you use that scale, and that's just a very brief cursory assessment of his condition, and using layman's term would basically a score of twelve means he has a serious injury but he's not in dire situation?

A He's not critical, that's correct.

Q Well, he checked himself out of Jamaica against the hospital's advice and he ended up at your hospital; correct?

A Yes.

Q Now, while he was at Jamaica, they did some CAT scans and they did a bunch of x-rays; is that true?

A I believe so, yes.

Q And the CAT scan that was done at Jamaica showed that he had an acute comminuted right calcaneal fracture; correct?

A Correct.

Q And they did a CAT scan of the left wrist, carpal instability; correct?

A Correct.

Q They did a CAT scan of the thoracic spine.

Can you just show the jury on your body when the thoracic spine is?

A It's not so easy. I can show on her body. Don't move.

It's the area between the neck and spine, it's from here to down here.

Q So, when he landed, it's fair to say he landed, as I properly described, he landed pretty much in a vertical position, that put force throughout his body; correct?

A That's correct.

Q Now, the CAT scan taken at Jamaica Hospital on the day of the occurrence in the emergency room of his thoracic spine there's no fracture or bone destruction, disc spaces are adequate and the impression was there's no significant abnormality of his thoracic spine; true?

A I don't recall, but if that's what you're reading, I would have to agree with it, yes.

Q So, we know there were no injuries to the thoracic area of the spine?

A That's correct.

Q The lumbar spine, it said that there's a mild depression which showed an L-1 complex deformity.

And the lumbar, I'll use mine.

MR.BOROWICK: Excuse me, Judge, this witness is not being offered with regard to the spine, at all. We'll bring in the spine surgeon.

MR.KAMINSKY: I'll move on, okay. I'll move on.

Q Now, the cervical spine, that's the neck; correct?

A That's correct.

Q They did a CAT scan of the cervical spine and that showed that there's no fracture of the cervical spine?

A I believe so.

Q They also, I guess to play it safe, took a CAT scan of his pelvic region; correct?

A I believe so.

Q And that was negative, everything was fine?

A I believe so.

Q They took a CAT scan of his right leg and

that showed that there were no abnormalities; correct?

A I have no recollection, but if you're reading that, I would have to agree with you, yes.

Q They took a CAT scan of his chest and it showed know abnormalities; correct?

A If --

Q Do you want to see it?

A If you're reading from the reports.

Q I am.

A Then I will agree with it.

Q Would you accept my saying that I am reading from the records?

A I would.

Q Thank you. The Cat scan of the pelvis showed there's no abnormality and the fact that there's no abnormalities are all good things; true?

A I would say yes.

Q They did a CAT scan of the abdomen and there are no significant findings related to either lung base, compression, and when I say impression of the CAT scan, that's radiologist's impression of the reading of the films?

A Correct.

Q No offense, but you're not a radiologist; correct?

A That's correct.

Q Do you often rely on the findings of radiologists?

A I do, especially when it's not an orthopedic report.

Q As far as the CAT scan of the abdomen, the impression of the radiologist, Dr. Aieoli, whoever he is, no significant findings pertaining to the abdomen and the pelvis.

Now, this is important, they also did a CAT scan of his head; true?

A I believe so.

Q And it showed that there's no intra-cranial hemorrhage, no mass, no extra axial collection is noted, no indication of acute or remote, non hematophagic infarction, if I'm saying that correctly?

MR.BOROWICK: Judge, we're not claiming any brain injury.

THE COURT: Thank you, Counsel.

MR.KAMINSKY: I understand, but I want to point this out, if you don't mind.

MR.BOROWICK: It's not part of this case.

THE COURT: Thank you, Counsel.

MR.KAMINSKY: May I continue, Judge?

THE COURT: Please.

Q The impression, normal CAT scan of the head, okay, you're aware of that; true?

A If that's what you're reading, yes.

Q Now, the CAT scan of the cervical spine, okay, "Overall cervical alignment is normal. More careful inspection suggests either that these are old or that the appearance is related to ligament calcification. No adjacent soft tissue abnormalities noted, also speaking against any acute injury."

So, to the extent that there was any problem with the cervical spine, in layman's terms, they are suggesting that there may have been a pre-existing condition?

A (No response.)

Q Yes or no?

A I'm not sure what they're suggesting, honestly.

Q Okay.

The thoracic spine, no significant abnormalities?

A Again, that's what you said earlier, yes.

Q "Left ankle, okay oblique and lateral projections show the bony structures to be unremarkable. No evidence of fracture or dislocation

is seen. The joint spaces are well maintained and the surrounding soft tissue injuries are within normal limits."

So, those are good findings; is that correct?

A That is correct.

Q And the impression is no evidence of fracture or dislocation, so, as far as his left ankle, everything was normal; correct?

A That's correct.

Q Now, they did his wrists and they found no evidence of acute fracture and dislocation.

They did find an acute right calcaneal fracture, as you discussed at length, the right leg was found to be normal and CAT scan of the left wrist, which you spoke about showed carpal instability.

Do you remember speaking about that?

A Yes.

Q Okay, now, let's get to St. Vincent's Hospital and move this along.

When he arrived at St. Vincent's Hospital they did an examination, they said he was a construction worker.

Now, they asked him to review his symptoms and St. Vincent's has a system where if they

write, "N C", that means non-contributory; is that correct.

A Usually, yes.

Q So, in general, pulmonary, ear nose and throat, cardiovascular, neurological, these were all non-contributing, meaning there were no issues concerning those aspects of his physical condition; true?

A I don't have the chart in front of me, but if that's what you're reading, I would have to agree, yes.

Q Now, they also take a social and family history and he said he smokes one pack of cigarettes a day for ten years.

What are the effects on a person, as far as their lungs and potential life expectancy of smoking a pack of cigarettes a day for ten years?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A As an orthopedic surgeon, I think I would be least likely to answer that question.

Q As a doctor, would you agree with me, smoking a pack of cigarettes a day for ten years is not something you advise him to do?

A We advise them not to smoke.

Q Why is that?

A There are adverse effects.

Q And those adverse effects demonstrate them, how?

A From an orthopedic point of view it affects the circulation to the extremities.

Q So, if he was twenty-nine when this happened and he said he smoked a pack of cigarettes a day for ten years, is it a good idea for a person at age nineteen to smoke a pack of cigarettes a day for ten years to age twenty-nine; just yes or no?

A I would recommend not smoking, so I would say it's not healthy.

Q Now, I'm going to take you through some more of the St. Vincent's medical records.

When he arrived there they did a musculoskeletal examination and he was right upper extremities, painless from shoulder, elbow, wrist, fingers, no gross deformities. Left upper extremety, painless, full range of motion, painless, full range of motion. Shoulder, elbow, right lower extremity, painless, full range of motion. Hip, knee, leg, left lower extremety, full range of motion. Hip, knees, tender with an infusion. He had a black and blue, he had injuries to his heel, tenderness to his heel and

he was alert A O times three.

What does that mean when you see that in the medical records?

A Alert and oriented times three.

Q Basically means if you're talking to somebody he knows where they are?

A Person, place and time, yeah.

Q Okay. Now, let's go to the different -- I just want to get a sense of, because -- would you agree with me that when he was in St. Vincent's, recovering from his injuries and undergoing surgery and things like that, he was in pain; correct?

A That's correct.

Q And you use, as most hospitals do, a pain scale and nurses or who ever is seeing the person at the time will say, describe your pain on a scale from one to ten, with ten being the worse; correct?

A Correct.

Q And have you had a chance to read the history of the progress notes from St. Vincent's Catholic Medical Center?

A I have reviewed them.

Q And there were times when he said his pain was a six out of ten; correct?

A I believe so.

Q And there were times when he said his pain was a one or a two out of ten; correct?

A Again, you're reading that, I would trust you to read correctly but again --

Q Most people don't trust lawyers, so I appreciate that very much, but I'm just reading from the records that are in evidence, okay.

A Again, that wouldn't surprise me if he's on high narcotic medications.

Q Absolutely, he's receiving OxyContin, so obviously, these injuries would cause significant pain; correct?

A That is correct.

Q But, these medications were masking the pain?

A They were helping with the level of pain, yes.

Q So, my question is, I'm trying to give the jury a sense of his condition and the pain that he was actually in, whether he was actually experiencing pain or the pain was masked by these medications.

When he's asked to describe his pain, he often says two out of ten, it may be because he was on the medication, but that was also the level of pain he described himself in --

MR.BOROWICK: Objection.

Q --at various times?

MR.BOROWICK: Objection, Counsel is talking about often.

THE COURT: Let me just remind you, ladies and gentlemen, that Counsel is referring to a document that's in evidence, and that is anything that is in evidence will be available to you during deliberations.

Q Now, also, one of the things the nurses do when they come in and check on a patient, they say what are your complaints, the patient will say I'm in pain, I want medication or whatever the complaints may be?

A Yes.

Q And if they have no complaints, they will say no complaints; right?

A That may be an effect of the medication, but, yes.

Q So, for instance, July 17th, '06, when the nurse comes in and says, "How do you feel?" He says, "I have no complaints this morning", okay, I'm just taking some things out of the medical records, I'm sure Mr. Borowick will take out other things. 7/17, here, he says his pain is a four out of ten,

okay.

On 7/17 at 11:15 in the morning he says, P S, pain scale, right, he says three out of ten.

On 7/18, in the morning he has no complaints.

On 7/18, that evening, he has no complaints.

On 7/19, at 11:30 a.m. patient reports pain scale zero to three.

7/21, lower leg extremety, he's in a spling, he has good capillary refill, and sensation is intact.

Just so the jury understands what that means, good capillary refill means that the blood is flowing properly throughout his body; is that correct?

A We kind of pinch the toes, and we wait and see how long it takes to turn from white to pink.

Q So, if I go like this with my finger, and the pressure is going to make it white, but if I have good capillary refill, it's going to come back to pink?

A Usually within a couple of seconds it should turn pink again.

Q And good capillary refill is an indication that the blood is flowing the way it's

designed to flow?

A Usually, yes.

Q Again that's a good thing; is that correct?

A That's correct.

Q And, "Low extremety, all sensation is intact, meaning if you touch him, he's going to feel what he's supposed to feel?

A Again, that's a good sign, yes.

Q 7/21, another note at 10:00 a.m., no new complaints of pain, and it says progress noted toward S T Gs.

Is it fair of me to say that the nurse or the doctor that made that notation say that the Plaintiff is progressing towards his short term goals?

A It's making progress considering his injuries.

Q Listen, I'm not asking you guys to do miracles.

When a person comes into a hospital they set short term goals for him and long term goals for him, just like you've done?

A That is correct, yes.

Q So, here in the hospital, they set short term goals for him, they wanted to stabilize him, make

him better and wanted to be able for him to go home.

I would imagine were some of his short term goals?

A That is correct.

Q So, on 7/21, the note says, "Progress noted towards short term goals", so at this point I can't recall exactly what date he transferred to your hospital. Do you remember the date?

A I don't remember the date.

Q Let me see if I can find it.

(Pause.)

Q Looks like 7/13, okay.

So, by 7/21, they're writing down that he's making progress towards short term goals.

Had he had any surgery by then?

A I don't believe he has.

Q Okay. Now, you mentioned, a question in response to question from Mr. Borowick that he had a psychiatric consultation while he was in the hospital. I want to read from that, if I may?

A Sure.

Q Because, as I pointed out, my clients don't dispute the orthopedic injuries, okay, we do dispute --

MR.BOROWICK: Objection, Judge.

MR.KAMINSKY: Withdrawn.

Q I'm going to read from the psychiatric consultation: "He denies dreams of falling. He denies nightmares. "

Now, if this says he denies nightmares, is that consistent or inconsistent with what you testified to?

A I believe I testified that he had dreams of falling.

Q Okay, well let me read from the --

A But I'm not sure if that was in the hospital or afterwardses.

Q Let's read from the psychiatric consultation, okay.

"He denies actual dreams of falling, he denies nightmares, he denies flashbacks, he denies that he has been feeling anxious, generally. Overall mood has been good. He has had normal sleep. He denies --", I can't read that word. He denies --

MR.KAMINSKY: May I approach?

Q Can you help me with this symbol, here?

A Sure, I'll try to.

(Witness reading document.)

Q Is that --oh, history of?

A Yes.

Q "He denies history of recent auditory and halucinatory and suicidal illutation. He has a history of alcoholism as a teenager. He denies history of illegal drugs, except marijuana as teenager."

And then the doctor says he recommends, "No psychotherapy is indicated at this time."

Now, according to the psychiatric consultation, given his physical condition, especially, that's a pretty good psychiatric consultation; is it not?

MR.BOROWICK: Objection.

THE COURT: Overruled.

MR.BOROWICK: Your Honor, this witness is not offered as a psychiatrist.

THE COURT: This witness recommended the psychiatric consultation so he's perfectly capable of answering that question.

Thank you.

Q Just yes or no.

A Can you ask that question again, please?

Q I'll be happy to ask it again.

Especially given his physical condition, okay, what I just read to you, that is a pretty favorable psychiatric evaluation; is it not?

A From the parts you read to me, I would

say yes.

A Okay.

Q Now, let's go to the next date, 7/21; "Reports a pain scale of three out of ten."

Again, on 7/22, they write, "The right leg extremity capillary refill is brisk. Left extremity capillary refill is brisk."

Again, those are good things?

A Yes.

Q 7/22 at night, He's resting comfortably at this time and his friends are visiting at bedside.

7/24, patient reports pain of seven of ten before medication and the pain has decreased to a four of ten by noon and continues to decrease because of his medication.

Now, on 7/25, he's starting to be able to transfer himself out of his bed onto a chair; is that correct?

A If that's what you're reading I would have to agree, yes.

Q OOB means out of bed?

A Yes.

Q With an arrow pointing to a chair?

A Onto a chair, yes.

Q So, the first week he's there he's

confined to bed rest and now he's making that progress to the short term goals, able to get out of bed and make it to a chair.

Now, on 7/27 he's complaining of pain of a six out of ten and the nurses or whoever basically conclude it's because of the position he was lying, so they repositioned him and the pain is now a three out of ten, okay.

Let's see, on 7/27 he reports pain decreased to four out of ten.

On 7/28, pain is three out of ten.

On 8/4, patient now reports relief. Pain is two out of ten, no other complaints.

8/4, patient has no complaints.

On 8/6, the patient says, "I'm ready to go home", and orders are obtained to send him home.

And an orthopedic clearance is given on 8/8.

Now, on 7/21, they do a consultation and one of the things you do in a consultation, you ask a person about their past medical history; is that correct?

A That's correct.

Q Because when you're treating a person, you want to know his entire medical situation, because

there may be things that would affect the way you treat him; true?

A There may be, yes.

Q So, for instance, if a person has pancreatitis, secondary to alcohol abuse, that's something you want to know about; true?

A It could be, yes.

Q And are you aware that Mr. Miller told the hospital that he "drank a lot in his teens", could not quantify the amount. He had pancreatitis ten years ago. He says he has stopped drinking a week before the accident because he felt that his pancreatitis was returning.

Now, pancreatitides is painful; is it not?

A You know, it can be.

Q And pancreatitides is due to alcohol abuse; correct?

A That's one cause of pancreatitides.

Q Well, I want you to assume that Mr. Miller told his treating physicians-- and by the way often times when a person is talking to their physicians it's in their best interest to tell them the truth because they are the ones that are going to take care of them?

A That is correct.

Q And so, when he told his doctor that he had pancreatitis secondary to alcohol ten years ago because he was drinking a lot in his teens, when he was nineteen, and he kept drinking heavily up until allegedly, a week to be --

MR.BOROWICK: Objection, objection.

THE COURT: Sustained.

MR.BOROWICK: This is outrageous.

THE COURT: Thank you, Counsel. Just objection is enough.

Sustained.

Q I'll read to you from the hospital records. "Substance abuse--"

MR.BOROWICK: Objection.

It's already been read and Counsel knows what he's doing.

THE COURT: Thanks, Counsel, you can sit down, too.

Save the summation for summations and just ask him his questions.

Q Okay. You said it could be attributable to drinking?

MR.BOROWICK: Objection.

THE COURT: Overruled.

Q Does the patient himself attribute it to his drinking?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A From what you're reading it seems he is.

Q Would you like -- have you seen this part?

A I probably have, but I don't recall.

Q All right, let me show it to you.

(Handing.)

MR.BOROWICK: May we approach while he reads it?

THE COURT: Yes.

(Whereupon, an off the record discussion was held at the bench.)

(Record resumed.)

THE COURT: Can we take the jury out for a moment, please?

THE COURT OFFICER: All rise, jury exiting.

(Whereupon, the jurors are exiting the Courtroom.)

THE COURT: Doctor, you can step out.

THE WITNESS: All right.

(Witness excused.)

Cross - touliopoulos - Kaminsky

THE COURT: Feel free to make your record, Counsel.

MR.BOROWICK: Judge, what Mr. Kaminsky is doing and not even subtly, he is injecting something into the case which has no relevance number one, pancreatitis, number one, but what he's doing is he's -- even in his last question he says, "And he continued to drink heavily up until a week before the accident", which isn't in any record.

THE COURT: I have not read the record. To the extent that it does not say "heavily", that will be the only thing that I can see was objectionable about what Counsel was saying.

MR.BOROWICK: What he's injecting is making this proximate cause of the accident. There's no indication of anything, that alcohol had anything to do with the accident.

THE COURT: This jury is going to be called upon to determine a life expectancy and working life expectancy of Plaintiff and they are entitled to hear what is already going to be before them in the juryroom, which are records that are in evidence.

MR.BOROWICK: And there is going to be no

opinion given by any expert about life expectancy, period, not about smoking a pack a day, not about pancreatitis as a youngster, none of it.

THE COURT: But the jury is permitted to use their own opinion about what they have heard about Plaintiff, what they have heard about Plaintiff's life, what they have heard about how the Plaintiff's health was in determining whether they accept a statistical life expectancy.

MR.BOROWICK: That is true, but what is pancreatitis -- but he brought it up and I didn't object to it. But now what he's doing is he's bringing it close to the day of the accident, almost to the day of the accident, bringing it in so that there's some kind of attachment to maybe the accident happened as a result of alcohol.

MR.KAMINSKY: Absolutely not.

MR.BOROWICK: That is the connection by harping --

MR.KAMINSKY: Absolutely not.

MR.BOROWICK: If it's just as the Judge has suggested, that they should know that he had pancreatitis --

THE COURT: All right, thanks, gentlemen.

As I read the record, and you can show me if there's a different place for this, it says, "Pancreatitis ten years ago. Patient stopped drinking alcohol in early July, 2006, as he felt that his pancreatitis was returning."

MR.KAMINSKY: Which is a week before the occurrence.

MR.BOROWICK: Where does it say he was drinking heavily up until just before the accident?

THE COURT: It says, "could not quantify."

MR.KAMINSKY: Okay.

THE COURT: Counsel is correct to object to places where you characterize what you are reading as opposed to simply reading, and I will sustain objections in that vein.

MR.KAMINSKY: Okay.

THE COURT: As I read the document that you were reading from, it does not say anything about heavy drinking. It does not qualify when he stopped drinking in terms of the accident.

MR.KAMINSKY: There's a specific reference in the record.

THE COURT: And therefore -- if you can show it to me, you can read it, if it's not in

the records your characterizations will stop.

MR.BOROWICK: How about the prejudice of him making some connection to the day of the accident that my client was in some way contributory to the accident without saying it, he's just bringing --

THE COURT: There's no prejudice to the extent that liability is not before this jury.

MR.BOROWICK: There is, though, because liability isn't before this jury and Counsel is making that suggestion to try to put off some kind of notion into that juryroom.

THE COURT: I disagree.

MR.KAMINSKY: Judge, on that page, somewhere, it does say a week before the accident.

MR.KAMINSKY: What was the date of the-- here we go, Judge: "Has a history of alcohol abuse as a teen. Last drink 7/6", a week before the accident.

MR.BOROWICK: Last drank, oh, my God.

Judge, it sounds like my client is a raving drunk a week before the accident.

THE COURT: Counsel, there's notation in those documents that they should monitor for

alcohol withdrawal during this stay in the hospital.

MR.BOROWICK: Which means what? So they --

THE COURT: Which means they thought something was connected to that.

MR.BOROWICK: How do we know that's what they thought?

THE COURT: We don't know and that's why I'm going to restrict Counsel simply to what's written and not characterize.

MR.BOROWICK: I'm going to ask for a direction to the jury that alcohol had nothing to do with this accident.

THE COURT: I'm happy to say that, not in those terms, but I'm happy to say that there's no indication that alcohol had anything to do with this accident, nor is the happening of the accident an issue before them.

Liability has already been determined and they are only to determine the damages.

MR.BOROWICK: Saying that there's no indication that alcohol had anything to do with this accident is kind of milk toast compared to what they need to hear.

THE COURT: If you two can agree on different language I'm happy to say something other than that.

MR.BOROWICK: I just said something and he said there's no objection to that.

THE COURT: Write it out, Counsel.

MR.BOROWICK: I said that you should understand that alcohol had nothing to do with this accident.

MR.KAMINSKY: I agree.

THE COURT: Okay.

Bring them in.

THE COURT: Counsel, you can stop as close to one o'clock as you want, and we'll stop at one o'clock.

MR.KAMINSKY: Okay.

(Witness resumes the stand.)

THE COURT OFFICER: All rise, the jury is entering the Courtroom.

(Whereupon, the jurors are entering the Courtroom.)

THE COURT: All right, please sit down.

Ladies and gentlemen, I instruct you, alcohol had nothing to do with the happening of this accident, and I remind you you are here to

determine damages, only, not liability. Liability has already been determined.

Please continue.

MR.KAMINSKY: Thank you, Judge.

Q Now, concerning the consultation notes that I was just in the middle of showing you, "Pancreatitis secondary to alcohol use and then it's asked about substance abuse and it says alcohol, 'drank a lot in teens.' Could not quantify. Pancreatitis ten years ago. Patient stopped drinking alcohol in early July 2006 as he felt that his pancreatitis was returning."

Now, does that suggest to you that his pancreatitis, you said one of the causes of the alcohol abuse, does that suggest to you that according to the Plaintiff himself, he suffered pancreatitis from alcohol abuse?

A (No response.)

Q Just if you can answer that question?

A I can't answer that question.

Q You can't or you don't want to?

A I don't have the information to answer that question.

Q What more information do you need to make that determination, other than the quotes from the

Plaintiff himself, that he had pancreatitis and felt it coming back because of his alcohol abuse, what other information do you need?

A You would need some sort of radiographic study; CAT scan or MRI to see if the inflammation is contained.

Q If he says he feels it returning, could that be because he feels the pain and symptoms associated with it?

A You can, but you can't make the determination without blood tests and radiographic study.

Q Let's talk about the blood tests, then, that at your hospital, one of the things they were doing was monitoring for signs signs of alcohol withdrawal due to patient's history.

Can I show you this?

A Sure.

Q Tell the jury if I read that correctly?

(Witness reading document.)

A You read that correctly, yes.

Q What does it mean to be monitoring the patient for signs of alcohol withdrawal?

A Well, there are certain signs of alcohol withdrawal and a patient could get fidgety, anxious,

they could have trouble resting and sleeping.

Q So, there's another note here which I'm going to read to you: "Patient has a history of alcohol abuse as a teen. Last drink was 7/4/06."

The accident happened 7/11/06, so, according to these notes the Plaintiff says his last drink of alcohol was exactly a week before; is that true?

A Yes.

Q Now, as far as the consultation that was done after the psychiatric examination that we discussed, psychiatry was called on 7/21/06. "Currently is not having flashbacks, is not having dreams of the event, he is not hypervigilant. He is not startled to response, he is not having any difficulty falling back asleep and no psychotropic medications are needed."

Psychotropic medications would be medication for psychiatric disorders; correct?

A That's correct.

Q Now, they did an impression of the Plaintiff from a psychological standpoint and it says axis one.

What is Axis one?

A It's been a few years since I was in

medical school.

MR.BOROWICK: Excuse me, Judge, I'm going to object.

This is psychiatric testimony, we both have a psychiatrist who is going to testify. He's not a psychiatrist.

THE COURT: Thank you.

You can answer the question.

A It's -- I can't give you a definite answer, it's what the psychiatrist used to make the diagnosis.

Q And their diagnosis was alcohol abuse versus dependence, did you see that in the record?

A I reviewed the records, yes.

Q Now, I asked you if you recommend to your patients that they smoke a pack of cigarettes a day.

Do you recommend that your patients abuse alcohol?

A No, I do not.

Q That's because of adverse health effects; correct?

A That's correct.

Q Now, pancreatitis in addition to -- it's painful; right?

A That's correct.

Q How does the pain from pancreatitis manifest itself in a person?

A Usually, it's flank pain, mostly, and it's a deep pain in the gut that you feel.

Q Could it be debilitating?

A Oh, at certain stages it can be very painful, yes.

Q Can be very painful?

A Yes.

Q And could, yes or no, can you tell us smoking a pack of cigarettes a day, for ten years, is that something that can shorten a person's life expectancy; just yes or no?

MR.BOROWICK: Objection.

THE COURT: Overruled.

Q Just yes or no?

A I would say it can.

Q Okay, thank you.

And just again, yes or no, abusing alcohol from the age of nineteen to twenty-nine, to the point where you develop pancreatitis, to the point where you feel the pancreatitis returning within a week of this occurrence, is drinking that amount of alcohol, and I'm going to give you a quote. "Drank a lot in teens", could not quantify, okay.

Is drinking to that extent that can cause -- what's the pancreas, by the way?

A The pancreas is an organ that makes enzymes to help us digest what we eat and also makes insulin.

Q Is it a vital organ?

A Yes, it's vital, yes.

Q And could a person developing pancreatitis because of alcohol abuse, is that something that could cause a shortened life expectancy?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A If --

Q Just yes or no?

A If he has --

Q Sir, listen to my question.

A I can't answer that question.

Q You can't say whether or not -- you can't say whether or not abusing alcohol can have an adverse effect on a person's life expectancy?

A You say --

Q Can you answer that question?

A If he --

Q Yes or no?

A If he abuses it chronically over a long period of time, it can, yes.

Q Would ten years qualify as a long period of time considering he started at nineteen and was twenty-nine when he was still doing it?

A You say he abused it as a teenager.

Q Well, he was re-developing pancreatitis shortly before the occurrence.

MR.BOROWICK: Objection:

THE COURT: Sustained.

Q Okay, let's move on.

Can a diagnosis of alcohol abuse made by your hospital -- is alcohol abuse in and of itself something that can shorten a person's life expectancy, yes or no?

MR.BOROWICK: Objection.

THE COURT: Overruled.

You can answer that question, please.

A The chronic alcohol use abuse, chronic over a period of time can.

Q In addition to shortening a person's life expectancy, can pancreatitis, alcohol abuse, smoking a pack of cigarettes a day for ten years, are those the type of things that can also shorten a person's work life expectancy?

MR.BOROWICK: Objection.

Q Yes or no?

THE COURT: Overruled.

You can answer that question.

A Well --

Q Sir, stop, stop.

A If you --

Q Where did you go to college, again?

MR.BOROWICK: Judge, it's argumentative.

THE COURT: Overruled.

You can answer that.

A Columbia.

Q You know what yes or no means, I would imagine?

A Yes, I do.

Q So, my question to you is, can those things affect a person's work life expectancy; yes or no?

A If you say can, I would say yes.

Q Thank you.

THE COURT: Counsel, it's a few minutes before one, shall we break?

MR.KAMINSKY: Let's break.

THE COURT: Very good.

Don't talk about the case amongst

yourselves or anybody else.

See you back at 2:15. Please be back on time.

THE COURT OFFICER: All rise.

(Whereupon, the jurors are exiting the Courtroom.)

(Witness excused.)

(Whereupon, the Court takes a luncheon recess.)

* * *

(P. M. S E S S I O N).

(Witness resumes the stand.)

THE COURT OFFICER: All rise, jury is entering.

(Whereupon, the jurors are entering the Courtroom.)

THE COURT: All right, please sit down and let's continue.

MR.KAMINSKY: Thank you, Judge.

Q Welcome back, Doctor.

I want to show you some pictures. I want you to assume that Plaintiff's Exhibit 14 and 15 are photographs that the Plaintiff exchanged during the course of discovery, okay?

A Yes.

Q And for the record, those are photographs of Mr. Miller when he was in the hospital; right?

A This is a hospital picture. This I'm not sure where that is. There's a TV in the room.

Q Okay, can we agree this picture was taken in the hospital?

A Yes.

Q It's in evidence, this is Plaintiff's Exhibit 14, all bandaged up, there.

Do you know who took this picture?

A No, I don't.

Q Isn't it unusual to take a picture of a person a day or two after an accident while they're in the hospital?

A Um --

Q Just yes or no?

A I wouldn't say it's unusual.

Q Do you know if an attorney took this picture or why this picture was even taken?

A I don't know who took it and why.

Q Well, you didn't direct the photo to be taken, did you?

A No, I did not.

Q And these illustrated charts, I mean, this isn't pretty stuff to look at. I mean this is

what surgery is; right?

A I'm sorry, your question was?

Q This is not pretty stuff, this is what surgery is?

A It's an illustration of an operation, yes.

Q And how many surgeries have you done?

A Knee surgeries?

Q Knee surgeries.

A I would say over my career a couple of thousand.

Q And that's what they look like; is that correct?

A That's correct.

Q I'm not going to go over all the other charts, but that's what surgery is, you open somebody up; right?

A That's correct.

Q And tell me, the thousands of people that you have done knee surgery on, how many of them returned to work in some capacity?

MR. BOROWICK: Objection.

THE COURT: Overruled.

Q Do you have any way of knowing?

A I don't know the exact number. Some do

and some don't.

Q And of the people that you do wrist surgery on, some return to work, some don't?

A That's correct.

Q People that you do foot surgery on, some return to work, some don't?

A That's correct.

Q Do you keep any sort of statistics as to the percentage who return to work that aren't in lawsuits compared to the percentage who return who don't return to work, who are in lawsuits?

A I don't keep statistics on patients and lawsuits, so I wouldn't be able to answer that.

Q You know what secondary gain is?

A Yes.

Q Tell the jury what secondary gain is?

A It's when somebody can stand to gain from an injury, I guess.

Q In other words, if someone can return to work in some capacity, but they don't because they're involved in a lawsuit and they have a claim for loss of earnings, that could be a form of secondary gain; true?

A I believe so, yes.

Q Now, and again, keeping in mind, I'm not

disputing his --

MR.BOROWICK: Objection, Judge.

THE COURT: Save it for summations.

Q From a neurological standpoint, there's no injury to his thought process or ability to communicate?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A Well, he's on narcotic medication which can alter your --

Q I'll accept that, but he's had no injury that affects his ability to communicate or speak; correct?

A When he's not on medication he will be able to speak.

Q All the testing from the various doctors and all the records in, hospital records and everything else all show that he did not suffer any injuries to his head or to his cognitive abilities; true?

A As far as I can see there was no injury to the head; that's correct.

Q Okay. And are you aware that he uses a computer several hours a day?

A I'm not aware of that.

Q Well, would it surprise you if he's capable of sitting and using a computer several hours a day?

A Well --

Q Yes or no?

A That wouldn't surprise me.

Q And as far as this life care plan that you are a part of, let me see if I understand this.

You're the treating doctor, and you meet with Mr. Borowick?

A I met with him to discuss this case last week, yes.

Q Where did that meeting take place?

A In my office.

Q And how long did that meeting take place?

A An hour to two hours.

Q One to two hours?

A (No response.)

Q Was that complimentary or did you charge him for that?

A That's included in my hourly fee.

Q That's part part of your hourly fee?

A Yes.

Q During that one to two hours, did he indicate to you the types of questions he would be

asking you?

A Um --

Q Generally speaking?

A He was more or less asking me medical questions. He had questions about the injuries and the prognosis and so forth.

Q Did he show you the charts?

A He showed me the charts and made sure that I was okay with them.

Q He did show you the charts?

A Yes.

Q And is it then that you discussed this life care plan or was that a different time?

A I believe it was at an earlier time.

Q So you met with him prior to this?

A I spoke with the life care planner about the involvement.

Q Who was the life care planner that you spoke with?

A I don't know if I can recall the name-- Boyle, I believe.

Q I'm sorry?

A I can't recall the name exactly, I'm not sure.

Q Barbara Scheffer?

A No, I --

Q Barry Root?

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

Q Is it in your notes anywhere?

A Probably not.

Q Is it in a file that you kept somewhere?

A Probably not.

Q Did you have any other materials pertaining to this case other than what you brought to Court today?

A I brought my office notes.

Q Did do you have anything else?

A No.

Q Do you have anything else?

A X-rays.

Q Any correspondences, any handwritten notes, phone conversations written down?

A No handwritten notes, and no phone conversations, no.

Q Okay. And the life care plan, is it fair for me to say that by far, the single biggest component of that life care plan is the claim that he needs home health assistance?

A I'm not sure if that's the --

Q Yes or no?

A I'm not sure if that's the biggest.

Q Had you ever seen the plan that's been drawn up and provided to me?

A I've seen it, yes.

Q Would you agree with me that the biggest care of the life care plan is the cost of either his being admitted into a residence, assisted facility or someone coming to his house to provide home health care?

A If you tell me it is I would tend to believe you. I don't remember the specifics.

Q That's fine.

And obviously, if he doesn't need that, that would be crossed off the cost of the plan?

A If he would not need it, it would not be in the plan, yes.

Q Has he had any home health care up until today.

A I believe he did.

Q You believe he did?

A Yes.

Q Who is the person that provided him the home health care?

A Upon his discharge from the hospital.

Q For how long?

A The exact time of the duration, I'm not sure.

Q Does he have home health assistance today?

A I don't believe he does.

Q And in your notes which you were good enough to let me look at at lunch time, when he first came to you-- I'm going to give you your file back.

When he first came to you, he was confined to a wheelchair was he not?

A I believe so, yes.

Q For a couple of visits?

A Yes.

Q And then didn't he progress from a wheelchair to cane or crutches?

A Yes.

Q And then did he progress from crutches or cane to ambulating on his own?

A Yes.

Q And he continues to ambulate on his own?

A I believe so.

Q You believe so or you know?

A I can look at my last records and let you know.

Q Go ahead. When was the last time you saw

him?

A June 16, 2008. And I have that he had a significant limp, but was not using a brace or cane.

Q So, in the beginning, is it fair for you to say that you would see him on a weekly basis?

A It would have been more frequent, yes.

Q And over the course of time it would be bi-weekly basis or monthly basis?

A The visits would extend themselves, yes.

Q You just told us now, that the last time you saw him was in June, three months ago?

A I believe so.

Q Do you have an appointment to see him in October or November, or is he going to call you as needed?

A I'll look in my records.

Q Sure.

(Witness looking in the records.)

A The exact time of the next visit I don't have listed, but I do know that he is an ongoing patient in our office.

Q He's a patient of your office but the last time you saw him was three months ago and you have no idea when you're going to see him again?

A I would imagine in the near future, but I

don't remember the exact date; that is correct.

Q Now, if he were in any sort of the excruciating pain or had any emergency over the last three months or so, he could have called you; true?

A He --

Q Yes or no?

A He could have called me or another doctor, yes.

Q And there is nothing in your file to suggest that he did?

A That's correct.

Q Now, I just want to go back to this issue of pancreatitis and ask you if you would agree or disagree with the following statements:

Pancreatitis is inflammation of the pancreas often due to gallstones or alcohol abuse?

A I would say yes.

Q And the most common symptom of pancreatitis is abdominal pain?

A I believe so, yes.

Q Pancreatitis can lead to a number of serious complications; they include infection.

A When the pancreas is damaged it sometimes becomes infected with bacteria from the small intestine.

Q Pancreatitis infections can be fatal. Do you agree with that?

A I agree with that.

Q Abscess, collection of pus that develops in or around the pancreas, treatment involves drainage by catheter or surgery.

Do you agree with that?

A Yes.

Q Would you agree that pancreatitis can cause respiratory failures, chemical changes can occur as a result of pancreatitis, can impact lung function. This could result in hypoxia, a condition in which the level of oxygen in the blood becomes dangerously low.

Would you agree with that?

A I believe that is correct, also.

Q Now, if a person has pancreatitis, is it helpful or --

MR.KAMINSKY: Withdrawn.

Q Is it an additional complicating factor to that person's lungs that they smoke a pack of cigarettes a day?

A I --

Q Or you can't answer?

A If the person has acute active pancreatitis, I would say smoking is not a good idea.

Q Do you agree that pancreatitis can also cause kidney failure?

A In extreme cases, yes.

Q And also shock that can be life threatening?

A That is correct.

Q Would you agree that excessive alcohol consumption causes seventy percent of chronic cases which often develop between the ages of thirty and forty.

Do you believe that?

A Unfortunately, I'm not well enough versed in pancreatitis to answer that question.

Q All right. Would you agree or disagree with the following statement: Damage from alcohol abuse may not appear for many years, and then a person may have a sudden attack of pancreatitis. In up to sevent percent of adult patients, chronic pancreatitis appears to be caused by alcoholism.

This form is more common in men than in women and often develops between the age of thirty and forty.

A Again, I'm not well enough versed to answer that question.

Q Okay, that's fine.

Concerning the life care plan, inpatient rehabilitation -- no, I'm sorry that's not what I'm looking for.

(Pause.)

Q Many home health aides and a driver, 14,600 a year and then when he becomes sixty-one years old, that rises to $29,000 a year, then when he becomes seventy-one years old, that rises to $87,000 a year.

Is that part of what you helped the life care planner to prepare?

A If you're reading from that, I would say yes.

Q Again, if he doesn't need that, we can cross that off?

A Obviously, yes.

Q Just like all the things that are on here: Total left knee replacement for $40,000.

Is he scheduled to have a total knee replacement?

A Scheduled for it at the present time, no.

Q So if he doesn't have that we can cross off $40,000; right?

A Hypothetically, if he doesn't have it, that's correct.

Q What percentage of people that have arthroscopic surgery to their knee end up having a total knee replacement?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A This is not just an arthroscopy, he had a fracture. So if you look at this patient in particular and his young age --

Q Just try and answer the question.

MR.BOROWICK: The witness is in the middle of an answer.

THE COURT: You will have an opportunity to redirect.

If you can answer the question as it's posed, do it.

A There's a high likelihood that he will be required --

Q If you can't give us a percentage, don't give us a percentage.

Do you know what the total cost of all the Plaintiff's surgeries and all the Plaintiff's physical therapy and all the Plaintiff's hospitalization and all the Plaintiff's medicines and all the Plaintiff's anesthesia, all the Plaintiff's visits to doctors such as yourself, do you know what

the total cost of all those visits, all that medical treatment had been since the day of this accident up until today?

A The exact number, I don't know.

Q Can you give us --

MR.BOROWICK: Objection.

Q --an educated --

MR.BOROWICK: The life care planner is going to be here tomorrow.

THE COURT: But the witness did say that he spoke to the life care planner and helped in the report.

MR.BOROWICK: For his specialty.

THE COURT: So, to the extent-- I don't have the report in front of me and I don't know the extent of what his help was, this is proper questioning.

MR.BOROWICK: He's not just asking about just him, he's asking about every doctor, every therapy and every item in that plan.

THE COURT: You can answer the question.

Q Doctor, do you know?

A Can you repeat the question?

Q I'd be happy to.

Could you give the jury your

understanding of what the total costs from the day of the accident up until today have been for all the surgeries?

You saw the charts on for all the hospitals that we've seen the records on, for all the medications that we've heard about, physical therapy that's been discussed every possible bit of medical treatment that the Plaintiff has received from the date of occurrence up until today.

Do you know how much that comes up to?

A I don't know.

Q You have no idea, at all?

A I probably couldn't even guess. The reason is I don't know what the hospital budgets are.

Q That's fine, if you don't know, you don't know.

Now, when he was at St. Vincent's, they did radiological examinations just like they did at Jamaica; correct?

A Many were similar, yes.

Q I'm sorry?

A Many of them were similar, yes.

Q And what does it mean that during the course of a film, that there's mild degenerative disease involving L-1, S-1, as well as T-11, T-12?

MR.BOROWICK: Objection.

THE COURT: Overruled.

While I know this is not the doctor's specialty, you can address it and redirect and with your other witnesseses.

Q What is degenerative disease?

A It's wear and tear on the disc.

Q And degenerative, what does degenerative mean?

Does it mean the fact it's the opposite of traumatic; correct?

MR.BOROWICK: Objection.

May we approach, Judge?

THE COURT: I believe you went through congenital versus traumatic with this witness so I don't see why we want do that.

MR.BOROWICK: As a general category, may I approach? I don't want to do this out loud, unless you want me to.

Counsel will ask this witness about neurological, spinal surgery, about psychiatric and life care planning, then he'll ask the witness with the life care planning and psychiatrist.

THE COURT: Thank you, Counsel. Please

sit down.

MR.BOROWICK: That's what is happening.

Q Doctor, I want you to understand that under our rules of practice I'm allowed to cross examine you, okay?

A Yes.

Q Can you tell the jury degenerative means?

A Degenerative is a process in life where things can wear a little bit.

Q So, for instance, if somebody is a construction worker, lifting heavy objects over the course of years, bending and using his back and things like that, you could expect to see some degenerative changes; true?

A I don't know if you would expect, but you could.

Q And that's what we see on some of these films; correct?

A On the report that you just read me, yes.

Q Now, there's no question that the injuries that you operated on were because of trauma, because of the accident?

A That's correct.

Q But, the films show other things that aren't necessarily related to the accident; true?

A I would say to a minor degree, yes.

Q Okay. And now, if I told you that the total medical expenses that the Plaintiff has incurred today, for every drop of medical care, surgery -- I'm not going to go over the whole list -- as of today is $112,559.88, would that surprise you?

A Again, if that's what it is, then that's what it is.

Q So, all the surgeries we heard about, everything we've done all that comes up to $115,000?

A I'm taking your word for that.

Q Now, do you have any idea what the life care plan is projecting his total cost to be for the future?

A I can review the records but I don't recall.

Q Well, if I told you --

MR.BOROWICK: Objection, objection, Judge.

THE COURT: Come up.

(Whereupon, an off the record discussion was held at the bench.)

(Record resumed.)

A You can answer the question, Doctor.

A I don't recall what the number was.

Q But you were a big part of it; right?

A In my portion, yes.

Q Who else was involved, if you know?

A I don't know who the other treating doctors are.

Q Concerning the person's ability to go back to work, have you ever seen patients go back to work that are confined to a wheelchair?

A In my personal experience, I would say no, but it is possible.

Q Have you ever seen people go back to work who are paralyzed?

A Yes, there are patients that are, yes.

Q Are there patients who go back to work who suffer from brain injuries?

A That's correct.

Q Are there patients who go back to work who are blind?

A I believe so, yes.

Q So, in this case, we're talking about a fracture to a person's heel, albeit a bad fracture. We're talking about a fracture to a person's wrist, we're talking about a fracture that you had to put pins in and those pins were taken out?

A That is correct.

Q By the way, I'm not going to go through all your notes, but all your notes, at no time whatsoever did he suffer from any infection or anything like that?

A That's correct.

Q And you were pleased with the surgery, were you not, that you performed on him?

A Again, is he better than he was before, yes.

Q And that's the point of your doing the surgery?

A To make him as best as possible.

Q Correct, and granted he's --no one is saying there's going to be climbing on top of Yankee stadium installing a roof, but that's the sole issue in the case.

The issue is you have done what you can to make him better and you are satisfied with your work, are you not?

A (No response.)

Q I asked a convoluted question.

Did you do good work?

A I'm satisfied with my work but not with the outcome.

Q And there's still room for improvement;

correct.

A He needs additional surgery, that's correct.

Q And the purpose of that additional surgery would be to make him better or you wouldn't be doing that surgery?

A That is correct.

Q Okay, and are there people who go back to work that have fused wrists?

A Some people do, yes.

Q Are there people who go back to work who have fused ankles?

A Depending on the job description, it's possible, yes.

Q Would Mr. Miller be a candidate -- do you know what VESTED is?

A I don't recall, no.

Q Do you know if the State of New York provides free rehabilitation counseling for people to return them to the work force?

A I know that there's consult for that, yes.

Q Have any of your patients, to your knowledge, ever sought out that counsel?

A I believe so.

Q Have any of those patients that have sought out this one hundred percent free training and counseling offered by the State of New York to people who suffer different injuries, do you know if any of them have been satisfactorily retrained to return to the work force in some other capacity than what they previously did?

A Some of them have been, yes.

Q Okay, people that used to do physical labor have been retrained to do sedentary type work?

A Some, yes.

Q But in order for that to happen they have to be willing to go for the treatment, be able to go for the counseling, be able to perform it; correct?

A You have to be capable of performing it.

Q Do you know if any of the training is available at home?

A That, I would not know.

Q Do you know if any of the training -- for instance, do you know if you can get a GED by studying on the computer?

A That I don't know, either.

Q Do you know if all these services are provided free?

A I would believe they would be.

Q They are free.

Do you know if Mr. Miller has ever made an attempt while this lawsuit is pending to pursue such counseling, do you know?

A I do not know.

Q Yes or no -- you do not know?

A (No response.)

Q You said you encourage your patients to do as much as they can?

A That's correct.

Q And that's with physical therapy. And you want them to resume as much of, for a lack of better word, as much of a normal life as they're capable of securing; is that correct?

A That's correct.

Q Would you encourage Mr. Miller to seek such counseling if such counseling were available to him and if he could do it; yes or no?

A At this point he's not --

Q My question is, if he could do it.

A If he was a medical candidate, I would encourage him.

Q You would.

And he's now --we're only two years after the accident; right?

A It is two years, yes.

Q So, from the date of the accident, from this and this and this, would you say he has, and as evidenced by your own office notes, would you agree with me that over the course of the last two years, his overall condition is better today than it was two years ago?

A That is correct.

MR.KAMINSKY: Nothing further. Thank you, Doctor.

THE COURT: Redirect?

RE DIRECT EXAMINATION

BY MR. BOROWICK:

Q Dr. Toulipoulos, I'm sorry, but I have to clear up some of the things that were raised.

Counsel just brought up vocational and educational service offered free by the New York State Department of Education.

What he said is they have been training for free and I want to ask you this question; if their prerequisite is that you must be physically able and medically cleared to go through a four day a week program and then accept a full-time job, would you say, given those criteria, would you say that my client is retrainable at the present time?

A I would say no.

Q Based on your treatment of the whole person, not just his foot, not just his ankle, not just his knee, not just his hand, but the whole person, including the medication that you give, would you say that in reasonable likelihood, within a reasonable degree of medical certainty, will he ever be able to participate in a program like that, forgetting even his educational status, to obtain a compete tive forty-hour a week job?

A I would say no.

Q Given what you told this jury about his prognosis, regarding each and every one of the injuries for which you've treated him; his foot, bad getting worse, better than the day of the accident as Mr. Kaminsky hilights, better than the day of the accident but getting worse, his ankle , bad, getting worse, his knee gotten better, gotten bad again, to worse --

MR.KAMINSKY: Objection to the form.

THE COURT: I'll allow that.

Go ahead.

Q --heading toward arthritis at the knee and foot?

A Correct.

Q Wrist, better, now bad, getting worse, still on narcotic medication?

A Yes.

Q And over the course of the last two years sinking into a depression for which he's medicated, is this a person, within a reasonable degree of medical certainty, that is ever going to be ready to get out of the house and go to a job every day?

A No.

Q Well, Counsel pointed out that people in wheelchairs wheel out and go to a job. People who are paralyzed wheel out and go to a job, people with brain injuries get up and go get a job.

Are those people necessarily in chronic pain, medicated with narcotics on a regular basis, waiting for surgeries on multiple limbs and spinal portions?

A No, they are not.

Q So, there are plenty of people with mild traumatic brain injuries who can physically go to work without pain; right?

A That is correct.

Q If we get past that, we scratched through the surface of those notions that it is just a guy who has a couple of orthopedic injuries, when you look at

your patient as a whole person with all of these things, all of these problems affecting all of the other problems, is there any reason to believe that he will get better and be a whole person again?

A No, if you --

Q I'm sorry?

A If you look at the entire person, the multiple injuries, the multiple extremities that are affected and also the fact that he hurt his back very significantly, and the need for ongoing pain medication on a chronic basis and the fact that he has RSD of his right lower extremety, these are chronic conditions, and I cannot foresee him ever returning to the work force.

Q I want you to assume that somebody is going to suggest that he can be a clerical worker in an office or he can be an architect, just get a degree, go to college, get more training, go work in an office. But you said he can't squat?

A That is correct.

Q He can't bend, he can't lift. Could he do any of those jobs?

A No.

Q And in a competitive job market where lots of people are competing for those jobs, competing

against people who are not under narcotic medication, do you think he would be competitive for any of those jobs?

MR.KAMINSKY: Objection.

THE COURT: I'll allow that.

A No, he would not.

Q Counsel asked you if your surgeries were successful and you were satisfied with your work and you just interjected before he stopped you, you said I'm satisfied with the work, but not with the result.

How could you be satisfied with the work you're a doctor, board certified, orthopedic surgeon, how can you be satisfied with your own work but not with the result?

A Well, with what we had to work with, I don't think anybody could have made it much better.

You know, we're hoping that he would not need a fusion so soon in his wrist and ankle. The fact that he's progressed from arthritis so early in this course --

Q So, hope, whatever hope is, is a wonderful thing but here is reality, Mr. Miller's reality means, at least insofar as these other surgeries are concerned and his overall condition, hope is a wonderful, thing but it ain't his reality?

A That's correct.

MR.KAMINSKY: Objection.

THE COURT: The answer stands.

Q Counsel kept asking you about this life care plan that you offered your own expertise into, with regard to the orthopedic injuries, and he said, well, if he doesn't need anymore surgeries, if all those surgeries don't happen, then that life care plan has too much money in it.

If it's not needed, then he shouldn't have it, we can agree with that; right?

A That is correct.

Q Your expert opinion as his treating surgeon, whose been inside his foot, ankle, knee, wrist -- forget the spine -- is it your opinion that those surgeries, some of them are needed right now and others are going to happen in the future?

A That is correct.

Q And let me ask you about those surgeries.

With regard to the knee jury and the second surgery that you want to do, now, is that second surgery, a reconstruction or a scope?

A A scope with a reconstruction.

Q With a reconstruction.

And do you foresee whether or not he will

ever need a TKR?

A TKR is a total knee replacement. My opinion is that he will.

The fact that he is only around thirty years of age, he's got grade three out of grade four cartilage damage on his knee that was fractured and that this is a progressive problem that over many years will develop into a more and more arthritis.

Q When do you foresee-- he's now thirty, when do you foresee, if he continues to try his best to use his limbs, to get up, to get up and be mobile, when do you anticipate that he will need a total knee replacement?

A I would say it would be in the next ten to twenty years.

Q Let's average it, fifteen years. He's now forty -five, how long do the total knee replacements last?

A About fifteen to twenty years.

Q So if he's forty-five he goes to sixty and needs another one, at seventy-five and needs another one.

Sir, would you tell us whether or not you hope he doesn't need them?

A I hope he doesn't need them but the

reality is that he will.

Q Mr. Kaminsky pointed out that my client didn't have a brain injury, that he didn't have a pelvic jury.

Well, I want to add to that; he didn't have a jaw injury, he didn't hurt his ear, he didn't hurt his shoulder, he didn't hurt his tailbone, anything else.

So given all of those things, I'm going to ask you to consider all the injuries he had; the chronic pain, the RSD, the medications, the fact that's got discs -- you know what I'm going to leave that out, that's for tomorrow -- fractures in both legs, in the middle of his back, whether or not he has a brain injury, whether or not he has a pelvic injury, is that determinative as to whether or not a person can go back to work?

A No, it is not.

Q Counsel also brought up, and I think I was trying to time it, there was at least twenty-five minutes about pancreatitis, because there was a note in one of the hospital records that he had had pancreatitis as a youngster, as a nineteen year old and that he had some pain that he thought might be pancreatitis on the 4th of July, during a barbecue.

Redirect - Touliopooulos - Borowick

I want you to assume that in the hospital records --

MR.KAMINSKY: Mischaracterization, Your Honor, it's not --

THE COURT: I don't remember anything about a barbecue.

MR.BOROWICK: It's coming this afternoon, subject to connection, I promise.

THE COURT: Okay, go ahead.

Q I want you to assume that no where in the Jamaica Hospital record or St. Vincent's Hospital record, is there any indication of alcohol on breath, in blood.

MR.KAMINSKY: Judge, we've agreed -- objection.

THE COURT: I'm going to let him ask his question.

MR.KAMINSKY: Okay.

Q No pancreatitis diagnosis, no films, no workup, no x-rays, no CAT scans, no MRIs. Looking at the pancreas, no diagnosis, no delirium, tremors from alcohol withdrawal, no treatment for alcohol withdrawal, no medication -- I think it's called an abuse?

A Yes.

Q No medication given by reason of the fact that my client said that he had had a drink a week after which happened to be July 4th.

Does pancreatitis enter into this guy's medical picture?

A No. In fact, I believe he read a CAT scan of the pelvis which was negative, so if he had pancreatitis, it would have shown up on the CAT scan of the abdomen.

Q So, what about this smoking thing. Did anything about the smoking cause or contribute to any of his medical conditions for which you and the other doctors who are trying to treat him for?

A No, there's no connection.

Q Sometimes-- we know smoking is a bad thing and sometimes it shortens people's lives.

Do you know any folks that are seventy-five and smoking?

A I know a lot of Veterans that I have treated that are.

Q So, can you say with a reasonable degree of certainty, can you say that my client, your patient, is going to have a shorter life because of his smoking habit?

A No, I can't say that.

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Q Did you see anything in any of the records or during any of your examinations or interactions with Chris Miller that would indicate that he had any prior disability relating to work, at all?

A No.

Q I want you to assume that he had worked over 1700 hours a year, over 2000 hours in the year before the accident, he had no physical limitations he was a young foreman.

MR.KAMINSKY: Objection.

THE COURT: I'm going to allow it, I'm going to let Counsel do this.

Go ahead.

Q I want you to assume that was his real profile.

Other than this accident, pancreatitis, smoking, any of that, have anything to do with his disability from employment?

A No.

Q Now Counsel picked through some of these records and said, well, look he was doing pretty well. He actually had no problem emotionally, no problem from a psychiatric point of view and he even went to something called Axis one, and I'm not going to ask

you about psychiatric illness except to ask you whether or not your patient who you had been treating since the week after the accident, did he develop the depression that you diagnosed him with, and gave him a prescription to see a psychiatrist with, did he develop that immediately?

A That was something that was progressive.

Q And when a person has the kind of disabilities and injuries that require seriatim, surgery, rehab, surgery, rehab, progress, regression, how does that on a person's emotional health?

A Oh, you can imagine it's very depressing, especially for a young construction worker who has been healthy his whole life.

Q Counsel read from July 18th, I'm going to read from July 17th just for fun.

Patient's complaint of pain, right lower extremity with pain scale seven to eight of ten, requesting pain medication almost every four hours with breakthrough pain.

Does that sound like somebody who is comfortable?

A No.

Q Okay. Now, there were times when he was given significant medications, and the reaction was

going from two of ten at his best, to ten of ten at it's worse.

Ten of ten is pretty bad; right?

A It's as bad as it gets.

Q And the medications that he is given were Dilaudid, Oxycontin and at times morphine and Percocet.

Is that something that would take ten of ten and make it two of ten?

A Yes, if there was a very potent narcotic medication.

Q And if you wanted to continue to take these potent medications, what do you sacrifice in clarity of thought?

A It makes you dazed, it makes you lethargic, tired and sleepy.

Q Now, I just read from the medical record of the hospital that you're associated with, for a patient that you were treating during the entirety of that admission.

I read two pages out of it and I only pulled those two pages as a balance.

If one wanted to get the whole picture of that month that you treated him or three weeks that you treated him, what would the whole picture be,

without picking apart the record?

A The whole picture or the big picture is that he had multiple fractures, severe pain at times that was not controllable and required extended hospitalization among procedures and still has significant issues of pain which require further treatment.

MR.BOROWICK: I have nothing further.

RECROSS EXAMINATION

BY MR.KAMINSKY:

Q There's no two ways about it, I mean Mr. Miller was a mess after this accident; right?

A Yes, he was.

Q And when he spent those three, four weeks in the hospital, that was not a pleasant experience?

A No.

Q True?

A No, it was not.

Q And the fact is he required medication to control his pain, but the medication largely did it's job and it controlled his pain while he was in the hospital; true?

A I would say not always, because --

Q Not always?

A Because there was breakthrough pain that

he just reported.

Q I agree with you.

The point I was making was just to try to show his condition in the hospital, that's all. I'm not negating what he went through, okay and I'm not suggesting --

THE COURT: Question, please.

MR.KAMINSKY: Yes.

Q We can all agree, can we not, that his alcohol abuse and his smoking of cigarettes had nothing to do with his fractures; true?

A That is correct.

Q Counsel said he knows people that are seventy-five years old that smoke cigarettes.

You can't say if his life is going to be shorter or longer because he smokes cigarettes, but if you were to bet, would you bet that the smoking cigarettes would lengthen his life or shorten his life?

A Well, smoking is not a good thing, and if you smoke enough, it tends not to be good for your life span.

Q So, you're not going to put your money down on Mr. Borowick suggesting that it might lenghthen his life?

Re recross - Touliopoulos - Kaminsky

MR.BOROWICK: What? I didn't say that, Judge.

THE COURT: Is that an objection?

MR.BOROWICK: Yes.

THE COURT: Sustained.

MR.BOROWICK: I could barely hear it but it sounded objectionable.

Q Let's talk about the pancreatitis, just another thirty seconds.

MR. KAMINSKY: Did I use that much time?

MR.BOROWICK: It was twenty-five minutes.

Q Then we can go for another twenty-five seconds, okay.

Pancreatitis can show up ten years down the road; can it not?

A Well, again, I'm not an expert but I believe it can, yes.

Q So, the fact that he had it and the fact that he may not be suffering from it today does not mean that ten years from now, he won't develop an acute case of it; true?

A There's a small possibility, yes.

Q And as far as his need for psychiatric consultation, who gave him the name of the psychiatrist to see, you or his lawyers?

A I don't recall.

Q What if I told you it was his lawyers, would that surprise you?

A It wouldn't, because sometimes --

Q It doesn't surprise you?

A No.

Q Do you generally like having your patients referred to medical providers by lawyers?

Is that something you think is a good idea, bad idea, or you don't care?

A As long as it's a competent physician, I'm happy that they get treatment.

Q Do you know the extent of the so-called psychiatric treatment Plaintiff has received in this case?

A I do not know the full extent.

Q I'm sorry.

A I do not know the full extent.

Q What if I told you it was about two visits, would that surprise you?

A I'm not sure if he's being treated and if the treatment is successful, it wouldn't surprise me.

Q So it's been about two visits, okay to someone referred to by the attorneys.

You said that his medications make him

Re recross - Touliopoulos - Kaminsky

tired, sleepy, cloudy thought.

Are you aware that he's been administered, during the course of this procedure, all sorts of psychiatric tests and he's never demonstrated any cloudiness of thought or any problems with his memories or problems with his cognitive abilities?

Are you aware of that?

MR.BOROWICK: Objection.

MR.KAMINSKY: Sustained.

MR.KAMINSKY: I have nothing further, thank you.

THE COURT: Anything?

MR.BOROWICK: No.

THE COURT: You can step down, thank you, Doctor.

(Excused excused.)

MR.KAMINSKY: Doctor, have a nice afternoon.

THE WITNESS: You too, thank you.

THE COURT: Mr. Borowick?

MR.BOROWICK: Yes, Mrs. Miller.

D E B O R A H M I L L E R, Witness, called on behalf of Plaintiff, having first been duly sworn, took the witness stand and testified as follows: