

1 A F T E R N O O N S E S S I O N

2 (Admelinda Rubio relieves Nadonna  
3 Ferguson.)

4 THE CLERK: You are reminded you are still  
5 under oath.

6 THE COURT: Go ahead.

7 CONTINUED DIRECT EXAMINATION

8 BY MR. SCHWITZER:

9 Q. I believe when we left off, I was at your  
10 medical records, January 26, 2009.

11 A. Yes.

12 Q. Now January 26, 2009, backing up, doctor. As  
13 of that time, he had undergone those three injections  
14 with Dr. Kaisman?

15 A. Yes.

16 Q. Could you tell us, could you read for us your  
17 followup visit?

18 A. Mr. Gustavo returns to the office today. He  
19 has had a full course of conservative care and  
20 management including injection treatments as  
21 administered by Dr. Kaisman.

22 They have not helped. He has severe pain in  
23 the lower extremities which is what was accompanied to  
24 the office by family members who help him with his  
25 ability to commute.

1           He cannot bend, lift, twist, push, pull,  
2   stoop, or crawl and he cannot assume upright posture  
3   without reproducing pain into the legs. He walks with  
4   antalgic and kyphotic gate. He has severely restricted  
5   lumbar and lumbosacral range of motion. He has reversal  
6   of lumbar lordosis upon ascent. He has positive  
7   Phalen's maneuver, positive straight leg raise on the  
8   right side at 50 degrees and on the left side at 40  
9   degrees.

10        Q.     That's what you told us. It should be 90 when  
11   it is normal?

12        A.     Yes.

13        Q.     Please continue.

14        A.     He has loss quadriceps and achilles tendon  
15   reflexes and has decreased sensation contractile  
16   sensation in the L-4 through S-1 dermatomes. He is  
17   unable to heel or toe raise on either the right or left  
18   sides.

19        Q.     What is loss of quadricep and achilles tendon  
20   reflex?

21        A.     Those are the reflexes when you tap on the  
22   tendon, the knee jerk reflex or the ankle jerk reflex.

23        Q.     If somebody is fine, what should happen when  
24   you do that?

25        A.     The knee will extend or the ankle and foot

1 will dorsiflex.

2 Q. Is that when you use a rubber hammer?

3 A. Yes.

4 Q. And involuntarily my leg will move?

5 A. Yes.

6 Q. Did it move in his case?

7 A. No. No motion.

8 Q. What was the significance of that?

9 A. There is a problem with reflex arc or the  
10 nerves that control the reflex arc that go down the into  
11 the legs.

12 Q. The last line?

13 A. He was unable to heel to toe raise on either  
14 right or left side.

15 Q. What is the significance of that?

16 A. That's the weakness in being able to dorsiflex  
17 your foot and ankle, plantar flex, your foot or ankle.

18 Q. You next see him March 30, 2009. He can't  
19 ambulate. He has antalgic, or kyphotic gait pattern,  
20 correct?

21 A. Yes.

22 Q. Still unable to heel or toe stand.

23 A. Yes.

24 Q. Moving ahead to June 1, 2009, now. Would you  
25 read that followup visit for us, please?

1           A.       Returns to the office today, continues to have  
2       significant and severe mechanical axial lower back pain.

3           Q.       What is severe mechanical axial?

4           A.       Pain in the lower back aggravated with motion.  
5       Rated as ten out of ten on a ten scale with bilateral  
6       lower extremity radiating pain rated as 8 out of 9 on 0  
7       to ten scale.

8           Q.       Was that the time, was he on prescription pain  
9       medication?

10          A.       Yes.

11          Q.       Please continue.

12          A.       Repetitive motion exacerbate the pain as does  
13       bending, lifting, twisting, pushing, pulling, stooping,  
14       crawling and or sitting and standing for prolonged  
15       periods of time. Bowel movements exacerbate the pain,  
16       particularly pain into the lower extremities.

17          Q.       What is -- number one, did you perform  
18       physical exam?

19          A.       Yes.

20          Q.       What did that reveal?

21          A.       Antalgic and kyphotic gait pattern.

22          Q.       You told us before what antalgic was. That is  
23       somewhat of a limp?

24          A.       Yes.

25          Q.       Kyphotic is the spine you told us about?

1           A.       Yes.

2           Q.       Did you categorize in your record the type of  
3 antalgic kyphotic pattern you saw, did you label it?

4           A.       When you say did I label it?

5           Q.       Well, you have terms like minimal, moderate,  
6 severe. Do you label things?

7           A.       Yes.

8           Q.       How did you label it on that day?

9           A.       Severely antalgic and kyphotic.

10          Q.       As a result of that severely antalgic kyphotic  
11 gait pattern, what, if anything, happened on that day as  
12 far as getting on and off the table?

13          A.       Required assistance on and off the exam table.

14          Q.       On that particular day, did you have to do  
15 anything to assist him?

16          A.       I had to help him take his clothes off for the  
17 exam.

18          Q.       He was unable to do that?

19          A.       Correct.

20          Q.       What did you find that day as far as spasm?

21          A.       Palpable spasm and tenderness in the lower  
22 back area.

23          Q.       Now, turning ahead to July 13, 2009, on the  
24 followup visit?

25          A.       Yes.

1 Q. Can you read what it says, Gustavo?

2 A. Gustavo continues to remain symptomatic with  
3 severe and unremitting back pain and bilateral lower  
4 extremity pain unresolved with conservative care and  
5 management getting worse over time.

6 Q. What does that mean?

7 A. That means he is getting worse.

8 Q. Did you indicate who he came to the office  
9 with?

10 A. Came in with his wife.

11 Q. What did your exam reveal?

12 A. Once again had the kyphotic and antalgic gait.  
13 He utilized a cane, he required assistance on and off  
14 the exam table. He had palpable spasm and tenderness in  
15 his lower back. He had decreases in the L-4/L-5 and S-1  
16 sensation of the lower extremities and could not heal  
17 heel or toe raise right or left sides, continued to have  
18 positive spinal Phalen's maneuver.

19 Q. He comes to you on October 12, 2009, correct?

20 A. Yes.

21 Q. What is his pain rated on on that day?

22 A. Ten out of ten.

23 Q. What does he tell you as far as his good days  
24 and bad days, what does he say to you?

25 A. He said he has mild good days but bad days are

1       worsened and bad days outnumber good days.

2           Q.       He comes back to you on November 9, 2009,  
3       correct?

4           A.       Yes.

5           Q.       At that time, did you have any conversation  
6       with him about the need for him to have more surgery?

7           A.       Yes.

8           Q.       Did you do that in English or with the help of  
9       a translator?

10          A.       Although I speak Spanish, I also had Sarah  
11       there who works in our office to help with any other  
12       questions he may have had.

13          Q.       You speak Spanish as well?

14          A.       Yes.

15          Q.       And at some point, did you make a request for  
16       further surgery?

17          A.       Yes.

18          Q.       Prior to you being allowed to do that surgery,  
19       do you know whether Mr. Tapia had to undergo some type  
20       of independent exam?

21          A.       Yes.

22          Q.       Do you know who performed that exam?

23          A.       Yes.

24          Q.       Who was that?

25          A.       That is a physician that the employer uses in

1 order to review treatment.

2 MR. BRODY: Objection. I thought he asked  
3 him for a name.

4 THE COURT: Just tell us a name, if you  
5 know.

6 A. I don't recall the name of the examiner off  
7 the top of my head.

8 THE COURT: If there are no records in  
9 evidence about any of this, then you cannot ask any  
10 questions about it.

11 Q. Doctor, whatever the name of the doctor and I  
12 am going to move ahead, did you review that doctor's  
13 report and findings?

14 MR. DEMERS: Objection.

15 THE COURT: He can answer yes or no.  
16 That's an innocuous question.

17 A. Yes, they send us those questions as part of  
18 the treatment for Mr. Tapia.

19 Q. Was the surgery performed eventually  
20 authorized?

21 A. Yes.

22 Q. Going ahead.

23 The first time he came to you after the  
24 surgery was January 18, 2010?

25 A. Yes.



1           Q.       What I would like you to do at this time,  
2 first of all, is take the shadowbox and put this film  
3 up.

4                   MR. SCHWITZER:   This would be MRI of the  
5 lumbar spine, taken at Doshe Diagnostics, dated  
6 9/18/08.

7           Q.       For the record, and so counsel can have an  
8 idea, is there a notation as to which particular film  
9 that is in addition to the MRI of 9/18/08?

10          A.       Yes.

11          Q.       What is that?

12          A.       It is Doshe diagnostic.

13          Q.       So that if someone wanted to know specifically  
14 what cut that was, is there a designation there as to a  
15 number on the film in any way?

16          A.       This is a, this is a T-2 sagittal image and it  
17 is 7 out of 15.

18          Q.       Doctor, did you -- by the way, how is it that  
19 Mr. Tapia came to go to Doshe diagnostic?

20          A.       I sent him for the MRI.

21          Q.       You told him he needed MRI?

22          A.       Yes.

23          Q.       You did not say go here, go there?

24          A.       No, I send him for an MRI, that's a process  
25 that requires MRI.

1 Q. Moving ahead. Can you tell us what that film  
2 as of September '08, approximately 16 months after this  
3 accident shows?

4 A. This film sideview, lower back MRI are  
5 looking at the bones once again, and the discs in  
6 between the bones and the spinal canal that contains the  
7 nerves, the fracture site is up at the top of the film.  
8 You can see that as triangular wedge up on the top as  
9 part of the film. What we are looking at here, we are  
10 looking at the disc in the lower -- as part of the back.

11 Q. Why are we still looking on September 18, '08  
12 that even after the surgery, this is still wedged and  
13 collapsed?

14 A. That's the fracture site, that's the fracture  
15 area, that's the position that the fracture has remained  
16 in after the injury.

17 Q. So there was no way to bring the height back  
18 up to where it was before?

19 A. Correct. With the procedure that was done,  
20 this is still in kyphotic or anterior angulated aspect.

21 Q. Please continue?

22 A. So, we are looking at the area where the discs  
23 are and they are in between each of the bones and we are  
24 looking at the spinal canal which is the thick bright  
25 line behind the vertebral bodies or to the right of this

1 image. The gray lines, within that spinal canal area  
2 are the nerve roots that travel down into the legs.

3 And we can see that at L-3/L-4, there is some  
4 bulging of disc material at L-4/L-5, there is a central  
5 herniation of disc material in the canal beyond the  
6 confines of the vertebral bodies. And L-5/S-1, there is  
7 some disc material inside the spinal canal, beyond the  
8 confines of the vertebral bodies.

9 Q. Has this film that was done in '08 of those  
10 lower levels, as opposed to the original film that we  
11 went through earlier a little bit of the MRI in '07, are  
12 there differences to your knowledge?

13 A. Yes.

14 Q. What are they?

15 A. Couple of differences: Number one, what we  
16 had previously seen as an annular tear at L-4/L-5  
17 segment which is that area where we saw a bright signal  
18 on the back side of the disc, we no longer see that  
19 because the acute or abrupt onset tear that filled up  
20 with fluid, that fluid has disappeared or resorbed so  
21 that is no longer there.

22 You start to see disc material protruding into  
23 the canal so there is a central herniation at L-4/L-5.  
24 At L-5/S-1, we see herniation in the canal area in the  
25 area where the nerve roots go down into the legs.

1           Q.       Now, doctor, without doing an MRI of me, Mr.  
2       Brody, Mr. Demers, his honor or whoever else in this  
3       courtroom, would you have an opinion without looking at  
4       a film as to whether us here at a certain age would have  
5       certain bulges and certain herniations?

6           A.       Yes. As time goes on, as part of the natural  
7       course of degeneration, we are going to have disc  
8       changes which can include bulges or herniations.

9           Q.       Can you tell the jury the difference between  
10      having herniation or bulge that is symptomatic versus  
11      one asymptomatic?

12          A.       Sure. That's one word that describes a  
13      constellation or a group of problems that a patient may  
14      have, so symptomatic means that it is producing symptoms  
15      for a patient.

16                 When these things produce symptoms, they  
17      produce symptoms of radiating pain, pain traveling down  
18      into the extremities and to the feet and legs, combined  
19      with sensation problems or problems with their  
20      activities in daily living or problems with lower back  
21      range of motion, etc. These issues can be symptomatic  
22      or asymptomatic depending on whether or not the nerves  
23      are irritated or not.

24          Q.       Without you asking me or these gentlemen of  
25      the jury a question, have you ever had any back pain in

1 your life --

2 MR. BRODY: Objection.

3 Q. Without asking me whether I had any back pain,  
4 would you know whether someone has at one time or  
5 another encountered some type of back pain?

6 MR. BRODY: Objection.

7 MR. SCHWITZER: I will move on.

8 Q. Is there a difference between musculoskeletal  
9 pain and the pain you observed on the film which leads  
10 to radiating pain down the legs?

11 MR. DEMERS: Objection.

12 MR. BRODY: Objection.

13 THE COURT: There is no pain on the film.

14 Q. Fine I will withdraw the question.

15 Can you tell us the difference between the  
16 average musculoskeletal pain someone may encounter versus  
17 conditions that would occur as a result of what you are  
18 seeing on that film as far as the ideation?

19 MR. DEMERS: Objection.

20 MR. BRODY: Objection.

21 THE COURT: I will allow it.

22 A. Typical lower back pain or typical lower back  
23 symptoms can come and go. You can have some good days,  
24 bad days. There can be periods where you have an  
25 exacerbation of your pain and then the pain goes away

1       versus symptomatic herniations or nerve root irritations  
2       that over the course of time or the clinical course of a  
3       patient progress and continue to cause problems that  
4       require care and management and treatment.

5           Q.       The pain that he had, can you describe what it  
6       was?

7                   MR. BRODY:   Objection.

8                   MR. DEMERS:   Objection.

9                   THE COURT:   Go ahead.   Do you know?

10          A.       Mr. Tapia's pain, over the course of time,  
11       since the fracture was constant, involved lower back,  
12       involved radiation, involved positive provocative signs  
13       like straight leg raising, phalen's, failed long course  
14       of treatment which included modifying activities, taking  
15       medications and series of three epidural injections.  
16       That's persistent, progressive pain.

17          Q.       At some point you perform surgery, correct?

18          A.       Yes.

19          Q.       That was back on January 12, 2010?

20          A.       Yes.

21          Q.       Do you have the St. Vincent's record?

22          A.       I do not have that here.

23          Q.       Please put down the shadowbox.

24                   Do you have a copy of St. Vincent's?

25          A.       No.

1 THE CLERK: Plaintiff's 45.

2 Q. Doctor, turning to page 9. Whose handwriting  
3 is that?

4 A. That's my handwriting.

5 Q. What do you have as chief complaint?

6 A. Two year history of progressive S-1 pain,  
7 right side worse than left, history of prior spinal  
8 fusion, secondary to fracture.

9 Q. What do you have under medical history?

10 A. Past medical history, denies significant  
11 except for hypertension and capital DM diabetes  
12 mellitus.

13 Q. Turning to page 10, whose handwriting is that?

14 A. That's my handwriting.

15 Q. Was that musculoskeletal exam?

16 A. Yes.

17 Q. What did that reveal?

18 A. Spinal range of motion, 0 degrees at which  
19 gave positive spinal phalen's test. That's zero degrees  
20 extension of lumbar spine.

21 Q. What does that mean spinal range of motion,  
22 was at zero degrees?

23 A. If you bend him back, lower back beyond 0  
24 degrees, that produces palpable spasm in the lower back  
25 with radiating pain to the legs.

1 Q. The zero extension?

2 A. That's zero extension.

3 Q. Next?

4 A. Positive straight leg raise, right lower  
5 extremity at 30 degrees.

6 Q. Now, doctor, when you straight leg raise, you  
7 told us before, normal is 90.

8 Can you explain to the jury what it means that  
9 if someone has SLR at 30?

10 A. 30 is significant in terms of nerve root  
11 irritation, it means you are irritating the nerve root  
12 at a lesser angle of knee extension.

13 Q. How significant was it that he was at 30?

14 A. Very significant.

15 Q. Can you quantify -- you do surgery, you ended  
16 up doing surgery?

17 A. Yes, that's bad enough to require operation.  
18 30 degrees is very painful.

19 Q. Did you find anything else?

20 A. And there was right lower extremity atrophy 4  
21 centimeters when compared to the left-lower extremity  
22 around the gastroc soleus.

23 Q. Why are you looking for atrophy?

24 A. So we have baseline understanding of what the  
25 muscle bulk is in the lower extremities pre-op.



1 Q. Is atrophy objective?

2 A. Yes.

3 Q. What is atrophy?

4 A. Atrophy means shrinkage when you are comparing  
5 shrinkage, when you are comparing one side to the other.

6 Q. Turning to page 14. What is that?

7 A. It's an admission, physical assessment.

8 Q. Was that done by you or someone else?

9 A. Someone else.

10 Q. Next to musculoskeletal what is written in?

11 A. It says pain when walking, worse in the right  
12 leg.

13 Q. Before the words when walking, what does it  
14 say? Can you read that?

15 A. Loses balance when walking.

16 Q. Now, doctor, you know that Mr. Tapia uses a  
17 cane?

18 A. Yes.

19 Q. Do you have an opinion with reasonable degree  
20 of medical certainty as to whether he uses the cane  
21 because he like canes and it makes him more comfortable  
22 or is there a medical reason that requires him to use a  
23 cane?

24 MR. BRODY: Objection.

25 MR. DEMERS: Objection.

1 THE COURT: Did you prescribe the cane,  
2 why is he using a cane, let's move this along.

3 Go ahead you. Can answer the question.

4 A. He requires the cane so he does not fall over.

5 Q. Now, doctor, turning to page 22.

6 Do you have that?

7 A. Yes.

8 Q. What is that?

9 A. That's the physical therapy evaluation in the  
10 hospital.

11 Q. Was that done by you or somebody else?

12 A. Somebody else.

13 Q. What did that indicate on strength?

14 A. It indicates right versus left leg weakness  
15 Grade 4 over 5.

16 Q. What is the significance of that?

17 A. It means weakness in the leg.

18 Q. Doctor, on page 24, you have that?

19 A. Yes.

20 Q. In addition to whatever meds he was receiving,  
21 was he receiving anything for any other condition in  
22 addition to pain meds?

23 A. In addition to his pain medications, he was  
24 also on finger stick coverage for his diabetes.

25 Q. Turning to page 25. Under nursing?

1           A.       Yes.

2           Q.       It says patient remains -- can you read what  
3 it says?

4           A.       Patient remains on PCA, patient controlled  
5 analgesia, that's a device that the patient controls to  
6 administer pain medication, which in this case is  
7 dilaudid for pain control.

8           Q.       What is that?

9           A.       That is a morphine derivative, intervenous  
10 morphine used post-operatively, used to control pain.

11          Q.       What I would like to do is have you go through  
12 your surgery.

13                   These have been previously marked as  
14 Plaintiff's 7, 8, 9 in evidence, and I would like you to  
15 come down and we will do what we did the last time.

16                   Using plaintiff's 24 and 25, whichever one you  
17 want me to put up first.

18                   What I would like you to do is walk us through  
19 that surgery of what you did and why.

20          A.       This is my operative report for the surgery.  
21 That was on January 12 of 2010 and my pre-operative  
22 diagnosis is herniated nucleus pulposus, L-5/S-1 severe  
23 bilateral neural foraminal nerve root compression.  
24 Progressive, severe right lower extremity radiculopathy  
25 with weakness and atrophy of the right lower extremity,

1 primarily S-1 myotome.

2 Q. Can you tell us in English what you said?

3 A. Real bad lower back. Pain add weakness,  
4 radiating down the right greater than the left leg.

5 Q. Please continue.

6 A. The operation I did, was a decompression, I  
7 took the pressure of the nerve roots at L-4, L-5/S-1, I  
8 did a transforaminal decompression which means I went  
9 across the neural foramen. I did radical discectomy,  
10 which means I removed the entire disc. I replaced that  
11 disc with biomechanical device, basically, carbon fiber  
12 shin that recreates disc height space, stimulates  
13 effusion between the bones.

14 Q. Why are you doing that?

15 A. I am reconstructing the L-5/S-1 junction,  
16 that's the junction between L-5 and the pelvis. The  
17 reason I am reconstructing that junction, that's where  
18 the majority of his clinical deterioration occurred S-1  
19 nerve root. I am also decompressing the nerve roots  
20 above that area to take pressure off of those nerves, in  
21 addition to the biomechanical device, I used rods,  
22 screws as well.

23 Q. Tell us why?

24 A. The illustration on your right is a  
25 description of the first as part of the operation, which

1 is finding the bones, doing an incision in the lower  
2 back, where you move the muscle out of the way, expose  
3 the bones and then start to take the pressure off the  
4 nerves in the same way we saw the pressure taken off the  
5 nerves where that fracture site was previously. Only  
6 this is being done to the lower part of the back. It is  
7 being done between L-5/S-1 and also between L-4 and L-5.

8 This also involves a removal of the entire  
9 disc L-5/S-1 to remove the herniation in the canal, add  
10 disc in between the bones so that we can then do what is  
11 known as interbody fusion.

12 Interbody fusion simply means you are fusing  
13 in between the vertebral bodies by placement of this  
14 caged device, which is made out of carbon fiber mesh.  
15 And in addition to fusing in between the vertebral  
16 bodies, we are also doing standard posterior fusion with  
17 the rods and screws.

18 Q. How significant a surgery is this?

19 MR. BRODY: Objection to form.

20 Q. How extensive a surgery is this?

21 A. That's a rather extensive surgery in terms of  
22 once again you are totally removing a disc, you are  
23 moving nerves out of the way, you are doing a  
24 replacement with biomechanical device and you are  
25 inserting rods and screws and doing a posterior fusion

1 as well.

2 Q. Now earlier on, when Dr. Betchen last saw  
3 Mr. Tapia, in addition to the L-1 collapse, I don't  
4 remember, do you remember what level she said there was  
5 instability?

6 A. She said instability at L-3/L-4 site.

7 Q. Do you do anything regarding that?

8 A. No.

9 Q. Are you done with the surgery for a moment?

10 A. Yes.

11 Q. In Dr. Betchen's records, when she last saw  
12 him in March -- sorry when she saw him at the end of  
13 March and the last time in May, she recommended surgery  
14 which she discussed with him and it is in her record to  
15 extend the instrumentation, if I am quoting you  
16 correctly.

17 MR. BRODY: Objection.

18 MR. DEMERS: Objection. She did not  
19 recommend it.

20 MR. SCHWITZER: I will rephrase the  
21 question. One moment.

22 Q. This is March 31, 2008. Mr. Tapia has  
23 pseudo-arthritis, has not fused and has increased  
24 kyphosis. He is to come back and see me after he has a  
25 CAT scan to discuss the possibility of further operation

1 to keep him from kyphosing more.

2 On May 5, the last time she sees him, plane  
3 fields were done after his previous visit that showed  
4 further kyphosis and collapse at L-1 with some signs of  
5 instability at L-3/L-4. If this continues to progress,  
6 you told us earlier, if this continues to progress and  
7 to kyphosis and collapse, is that correct?

8 A. Yes.

9 Q. If this continues to progress then I would  
10 strongly recommend that he have another operation to  
11 extend his instrumentation and assess the fusion.

12 Now my question to you is: The surgery that  
13 you did, which was the surgery she had discussed with  
14 Dr. Tapia was not at that time to extend the  
15 instrumentation?

16 MR. BRODY: Objection. The surgery is  
17 different than what she discussed with him.

18 MR. SCHWITZER: I will ask it differently.  
19 Is the surgery that you did different than the  
20 surgery Dr. Betchen discussed back --

21 THE COURT: Recommended. Go ahead.

22 Q. Back in May of 2008 with Mr. Tapia?

23 A. Yes.

24 Q. Turning to your informed consent of the  
25 surgery you did, I would like you to read it to the jury

1 please. This is back on January 12, 2010.

2 A. I sat down with Gustavo and had a lengthy and  
3 detailed conversation outlining his treatment options  
4 and alternatives, his surgical options and alternatives,  
5 the surgical procedure and type, the realistic goals and  
6 expectations therein including the fact revision  
7 surgical intervention in the form of a long  
8 thoracospinal and thoracopelvic fusion will be required  
9 and indicated in the future.

10 Q. In this procedure you just read to us, you  
11 said he is going to require in the future. Is that --  
12 do you have an opinion to a reasonable degree of medical  
13 certainty as to whether that was Dr. Betchen was talking  
14 about as far as extending the instrumentation?

15 A. Yes.

16 Q. Was it the same, is that what we are talking  
17 about?

18 A. Yes.

19 Q. Why is it, doctor, that you, in 2010, did not  
20 do that procedure but performed a different one?

21 MR. BRODY: Objection.

22 THE COURT: I will allow it.

23 A. The reason is over my course of treatment of  
24 Mr. Tapia, his lower back symptoms and his leg symptoms  
25 pre-dominated the instability at the fracture site.



1 Most of those symptoms if not all of those symptoms were  
2 going down into the lower extremity nerve roots, lower  
3 extremity nerve roots as I wrote in my physical history  
4 section for admission into the hospital.

5 The right leg weakness he was having and the  
6 radiating pain down the right worse than left leg was  
7 mostly due to the lower portion of the spine becoming  
8 problematic; more so, than just the fracture site.

9 So, what Gustavo has is not a curable problem.  
10 it is a manageable problem. When you have to manage the  
11 problem based on what is happening in the patient  
12 clinically, clinical deterioration, lower portion of the  
13 spine necessitated fixing that segment to prevent those  
14 nerves from getting worse while preserving as much  
15 motion as possible above that area to avoid having to do  
16 a major thoracopelvic fusion in a relatively young  
17 adult.

18 Doing thoracopelvic fusion would involve  
19 having to remove all of the old implants, and then  
20 inserting rods and screws above the level of the prior  
21 fusion and then into the pelvis. So you basically  
22 remove all of the motion of the thoracic and lumbar  
23 spine and down to the pelvic area as well, which, in  
24 relatively young adult, carries with it significant  
25 post-operative consequences in terms of restricted range

1 of motion, having to walk in a completely different way  
2 because your pelvis can no longer accommodate tilt after  
3 you lock it in place.

4 Q. Let me stop you for a moment.

5 Explain to us, in layman's terms, why you did  
6 what you did and had the delay in doing this revision  
7 surgery?

8 MR. BRODY: Objection.

9 MR. DEMERS: Objection.

10 THE COURT: He testified to what he did.

11 Q. Let me ask you this question so we are clear:  
12 The need for the surgery you performed on 1/12/2010, is  
13 that as a result of -- do you have opinion with a  
14 reasonable degree of medical certainty whether that was  
15 as a result of what happened to him, the original burst  
16 fracture, added trauma of falling on his buttocks or was  
17 that from some unrelated condition.

18 MR. BRODY: Objection.

19 THE COURT: I will allow it.

20 A. As a result of the original trauma.

21 Q. Why do you say that?

22 A. Several reasons. Number one, not only are we  
23 dealing with subadjacent post-traumatic kyphosis  
24 breakdown but we also have the annular tear and  
25 herniation from L-4 to S-1 which now becomes symptomatic

1 to the point where it causes nerve problems that need to  
2 be addressed.

3 Q. What was the reason you did not do anything at  
4 this level. What level is this?

5 A. What I did, I did surgery L-5/S-1. I left the  
6 L-4 /L-5 segment free to move. I left the L-3/L-4  
7 segment free to move so he could still have some ability  
8 to accommodate his spine and his pelvis without locking  
9 everything together at the same time --

10 Q. Do you have an opinion with reasonable degree  
11 of medical certainty as to whether in the lumbar spine  
12 medically as to whether certain portions of the lumbar  
13 spine carry a heavier load than other levels if you  
14 understand the question?

15 A. -- there are certain portions of the lumbar  
16 spine that are more, have more stress on them than other  
17 segments of the lumbar spine. One of those segments is  
18 L-5/S-1 because it is the junction between the spine and  
19 pelvis, followed by L-4/L-5 and L-3/L-4 less so.

20 Q. Now, you ordered some films, correct?

21 A. Yes.

22 Q. This would be post-operative films of November  
23 20, 2012, exhibit 26 and then number 27 would also show  
24 what was done here. Are there any findings as to what  
25 you see going on now after both these surgeries?

1           A.       Yes.

2                   This shows the original fracture implants and  
3 instrumentation with the area of the fracture, which is  
4 still wedged. It shows the fusion of the L-5/S-1  
5 segment and the intervening two segments, L-3/L-4 and  
6 L-4/L-5 show decreases in disc space height; more so, at  
7 L-3/L-4, L-4/L-5, both these sections have decreased  
8 height in their disc spaces.

9           Q.       Doctor, this revision surgery that you had  
10 been trying to delay, do you have an opinion with  
11 reasonable medical degree of medical certainty as we sit  
12 here in court as to one whether Mr. Tapia is going to  
13 have to have that surgery?

14                   MR. BRODY:   Objection.

15                   MR. DEMERS:   Objection.

16                   THE COURT:    I will allow it.

17           A.       Yes.

18           Q.       Number one, what is your opinion, with a  
19 reasonable degree of medical certainty whether he has to  
20 have it and two, how long will it be before you will not  
21 be able to put this off any more?

22                   MR. DEMERS:   May we approach?

23                   THE COURT:    The question is when we need  
24 the surgery.

25                   MR. SCHWITZER:  Yes.

1 THE COURT: Okay. Go ahead.

2 A. Within the next five years.

3 Q. Can you explain to us when you do that  
4 surgery, what you are going to have to do?

5 A. Sure.

6 MR. DEMERS: Objection. May we have side  
7 bar?

8 MR. BRODY: Objection.

9 THE COURT: Go ahead.

10 A. What you need to do in order to eventually  
11 revise it and extend fusion is you need to first remove  
12 the implants from the prior two fusions. And then, you  
13 need to reconstruct above the level of the prior fusion,  
14 the prior fusion went from T-11 down to L-3, thoracic  
15 spine.

16 Most of the kyphosis in the thoracic spine is  
17 around the, if you look at it, 10, 9, 8, 7, it is around  
18 T-7/T-8 where most of that apex of that curvature is you  
19 have to come above that curvature, we generally come up  
20 to the T-4 or T-5 area on top to be able to capture the  
21 upper portion of the thoracic spine, then you need to  
22 come down into the pelvis to be able to capture the  
23 pelvis to include it as part of your fusion because  
24 otherwise what you have is a very long lever arm  
25 connected to the sacrum only through the L-5/S-1

1 section.

2 To decrease the chance of non-union or  
3 psuedo-arthrosis as well as to recreate sagittal  
4 balance, you need to be able to lock yourself down to the  
5 pelvis as well that would involve a revision from the  
6 upper portion of the thoracic spine down into the  
7 pelvis.

8 Q. Now, doctor, is the objective of this to make  
9 him pain-free; what is the objective to a reasonable  
10 degree of medical certainty?

11 A. The purpose of doing that revision surgery is  
12 to prevent these segments from breaking down to the  
13 point where they will start to cause the problem with  
14 the nerves that are behind those segments, so you want  
15 to stabilize the spine to prevent these areas from  
16 causing damage to these nerve roots that are adjacent to  
17 those segments.

18 The surgery does not alleviate the pain or the  
19 symptoms from the back pain. Axial pain we talk about,  
20 as pain limited to the back area but it provides an  
21 environment, stable environment that prevents further  
22 nerve root damage.

23 Q. Doctor, do you have an opinion with reasonable  
24 degree of medical certainty, I am not going to repeat  
25 everything, he can not do as far as activities of daily

1 living, crawling, sitting, standing, you went through  
2 the whole litany, do you have an opinion to a reasonable  
3 degree of medical certainty what will happen to his  
4 activities of daily living after you do this surgery?

5 MR. BRODY: Objection.

6 MR. DEMERS: Objection.

7 THE COURT: What's the question?

8 Q. As far as his activities as daily living with  
9 reasonable degree of medical certainty how will this  
10 impact his activities of daily living once he does this  
11 surgery?

12 THE COURT: Post-surgery?

13 MR. SCHWITZER: Yes.

14 THE COURT: Go ahead.

15 MR. DEMERS: Objection. It is  
16 speculative.

17 THE COURT: If it is speculative, he will  
18 tell us.

19 A. The reason I am prolonging here for as long as  
20 I can prolong it, it significantly increases your  
21 mobility because you are locking the pelvis into the  
22 rest of the spine. Oftentimes these patients have  
23 pretty restrict gait and ambulation tolerance. And  
24 oftentimes, you have to prescribe assisted devices for  
25 them to help them with their gait and ambulation.

1           Q.     Do you have an opinion within reasonable  
2     degree of medical certainty as we are here right now,  
3     this is his one and only time to be in court as far as  
4     his ability to ambulate in the future after the surgery,  
5     what is going to happen to, with a reasonable degree of  
6     medical certainty, to Mr. Tapia?

7                     MR. BRODY:   Objection.

8                     MR. DEMERS:   Objection.

9                     THE COURT:    I will allow it.

10          A.     It will be decreased where we have to use  
11     motorized scooter, wheelchair device, something like  
12     that.

13          Q.     Do you have an opinion with reasonable degree  
14     of medical certainty as to what the cost of that  
15     surgery is going to be?

16          A.     Yes.

17          Q.     What will that be?

18          A.     The cost of that type of revision surgery,  
19     which would include hospitalization, implants, surgeons,  
20     anesthesia, rehab, etc., hospital stay, would be 175  
21     thousand dollars.

22          Q.     Do you have an opinion with reasonable degree  
23     of medical certainty as to whether Gustavo Tapia will  
24     need to continue to see you on some basis from now up to  
25     the surgery and from the surgery forward?



1 A. Yes.

2 Q. What is your opinion?

3 A. That he will continue to need to see me for  
4 surgical followups.

5 Q. What before the surgery, how often does he  
6 need to see you?

7 A. Biennial basis.

8 Q. What does that mean, twice a year?

9 A. Yes.

10 Q. After the surgery, will he still need to see  
11 you twice a year?

12 A. Yes.

13 Q. At the present time, what do you charge for an  
14 office visit?

15 A. Follow up visits are 175.

16 Q. In addition to the surgery and followup office  
17 visits, will you also be asking him to undergo any type  
18 of diagnostic testing?

19 A. Yes.

20 Q. What would that be?

21 A. We look at MRI, we usually get MRI's.

22 Q. How often would you want to do that?

23 A. Reasonably, once every couple of years.

24 Q. Now, doctor, at the present time, you are  
25 familiar that he is treating with Dr. Gary Thomas?

1 A. Yes.

2 Q. Who is Dr. Thomas?

3 A. Pain management treatment.

4 Q. Do you know him?

5 A. Yes.

6 Q. Do you do referral work back and forth with  
7 him as well as Dr. Kaisman?

8 A. Yes.

9 Q. And other doctors?

10 A. Yes.

11 Q. Only if you know, do you know why Dr. Kaisman  
12 who is a pain management doctor, why he stopped treating  
13 him at some point?

14 A. Yes.

15 Q. Do you know the reason Dr. Kaisman stopped  
16 treating him and referred him to Dr. Thomas?

17 MR. DEMERS: Objection.

18 MR. BRODY: Objection.

19 THE COURT: He answered yes. What's your  
20 reason?

21 Q. Is this based on conversation?

22 A. It is based on their practice.

23 THE COURT: Go ahead.

24 A. Dr. Kaisman does acute pain and Dr. Thomas  
25 does acute and long-term pain.

1 Q. What do you mean acute versus long term?

2 A. Acute pain management is pain management that  
3 is much more oriented toward injections and procedures.  
4 Long term pain management does not only injections and  
5 procedures but also manages pain on long term basis so  
6 it could also involve things such as spinal cord  
7 stimulators and/or medication pumps, so Thomas's  
8 practice does those type of things where Kaisman  
9 practice does not.

10 Q. Now, doctor, turning to your records, February  
11 1, 2010.

12 Do you have that?

13 A. Yes.

14 Q. What do you note for his gait?

15 A. Antalgic and kyphotic.

16 Q. Continue reading.

17 A. It requires assistance on and off examination  
18 table, consistent with his pre-operative status.

19 Q. As far as the right lower extremity,  
20 neurological status, what did you indicate?

21 A. It remained stable, approximately Grade 3/4  
22 over 5 weakness.

23 Q. What else did you note?

24 A. Atrophy right lower extremity when compared to  
25 left side.

1           Q.     What did you note about the radicular symptoms  
2     at that time?

3           A.     I said his radicular complaints and symptoms  
4     had been ameliorated post-surgical.

5           Q.     In addition to your surgery of Mr. Tapia, did  
6     you recommend that he undergo physical therapy?

7           A.     Yes.

8           Q.     At the present time, do you know whether he is  
9     undergoing physical therapy?

10          A.     Yes.

11          Q.     Is he?

12          A.     Yes.

13          Q.     Why do you want him to have some degree of  
14     physical therapy?

15          A.     Physical therapy is good basically on what we  
16     call maintenance basis.

17          Q.     What does that mean?

18          A.     It means it maintains mobility of your joints,  
19     flexibility and as much strength as possible to prevent  
20     retrogression or back-sliding in your condition.

21          Q.     The surgery you did, the one in 2010?

22          A.     Yes.

23          Q.     Was that to get rid of his pain?

24          A.     That was to prevent the nerves from continuing  
25     to get worse over time.

1           Q.       When you did the procedure, was that something  
2       you said to Mr. Tapia, I am planning on you being pain  
3       free after this surgery?

4           A.       No.

5           Q.       Can you explain to the jury why you knew he  
6       would not and what you were doing?

7           A.       Sure.   Spinal surgery, particularly when you  
8       are doing a reconstruction and fusion is very good at  
9       protecting and decompressing the nerve roots and  
10       maintaining as much nerve function as you can into the  
11       legs and feet.

12                   In this case, it is a lot less helpful in  
13       terms, helpful in terms of making the pain in your back  
14       go away because there are multiple factors that cause  
15       pain in the back.   So, it is not only a disc or a nerve  
16       root that is involved but there are multiple issues, in  
17       balance muscles, tendons and other joints in your spine  
18       that had increased load and increased stress, so there  
19       is a multiple reason for back pain to occur and exist  
20       and surgery only addresses very specifically nerve root  
21       damage and nerve root issues, in the specific area that  
22       you are operating on.   It does not fix all of the  
23       problems.

24           Q.       When he came back to you in June of 2010,  
25       doctor, you have that?

1           A.       Yes.

2           Q.       On your physical exam, what did you note as  
3 far as range of motion and compare them to what you  
4 would consider normal/average?

5           A.       So, his ranges of motion were extension of  
6 zero degrees, we talked about extension. You should be  
7 able to extend your spine, lower back to 30, 35 degrees  
8 at least. Flexion to 30 degrees. We are talking about  
9 at least 90 degrees forward flexion. Right lateral  
10 bending was 20. Left lateral bending was ten.

11                   Once again, we are looking into 45 degree area  
12 for those and rotations were on right side at ten, and  
13 on the left side at five.

14                   Once again, you want to be able to rotate your  
15 spine at least to be able to see over your hips, you are  
16 talking at least 60 degrees to 70 degrees rotations  
17 minimum.

18           Q.       Did he still have spasm?

19           A.       Yes.

20           Q.       Doctor, you continue to see him, correct?

21           A.       Yes.

22           Q.       And you saw him -- I am not going to go  
23 through every note -- july 26, you saw him. You saw him  
24 on October 18, 2010?

25           A.       Yes.

1           Q.     And, on that followup visit of October 18,  
2     2010, which is approximately ten months after his  
3     surgery, what did you note as far as the first  
4     paragraph?

5           A.     Mr. Tapia returns to the office today, status  
6     post-decompression and reconstruction of lumbar spine.  
7     Continues to suffer from chronic residual permanent  
8     sequelae of injury sustained, utilizes cane to ambulate.  
9     Requires assistance with activities of daily living,  
10    able to perform some hygiene maneuvers and can robe and  
11    disrobe himself but does require assistance,  
12    particularly, robing/disrobing. Repetitive motion  
13    produces severe pain.

14          Q.     Did you refer him out to someone under the  
15    plan?

16          A.     Yes.

17          Q.     Who was that?

18          A.     A physiatrist by the name of Dr. Schwartz.

19          Q.     For what purpose did you send him to?

20          A.     Have him look at him from therapy point of  
21    view, see if could he make recommendations for us as far  
22    as long-term physical treatment.

23          Q.     Did you have an opinion with reasonable degree  
24    of medical certainty and did you note the level of his  
25    disability at that time?

1 A. Yes.

2 Q. What was it?

3 A. I had him 100 percent total.

4 Q. Going back to the surgery of January 2010, did  
5 you prescribe something for Mr. Tapia to help him with  
6 the healing process?

7 A. Yes.

8 Q. What was that?

9 A. Bone growth stimulator.

10 Q. Did you bring that with you today?

11 A. Yes.

12 Q. Could you please show it to us, what it is,  
13 the purpose of it?

14 A. A bone growth stimulator.

15 MR. DEMERS: Objection.

16 THE COURT: Overruled.

17 A. It is an electrical device that you wear, like  
18 a little belt over the area where the fusion is so it  
19 straps on. It is powered by batteries and you turn it  
20 on. It causes a, it sets up electrical field that then  
21 stimulates bone cells to fuse or to heal. It is what we  
22 call an adjunct to the fusion process. It decreases the  
23 pseudo-arthritis rate, the rate of non-healing. It  
24 increases fusion rate or rate of healing.

25 Q. You next saw him on July 20, 2012, correct?



1           A.       Yes.

2           Q.       The last time you saw him, prior to coming in  
3 today, would that have been December 14, 2012?

4           A.       Yes.

5           Q.       So let's go to the very last time you saw him.  
6 Can you read and tell us what you noted?

7           A.       Mr. Tapia returns to the office today, he is  
8 accompanied by his family members. He continues to have  
9 mechanical axial neck pain as well as lower back pain.  
10 He modifies his activities to include the avoidance of  
11 repetitive motion to the neck and back, remains on  
12 medication, had multiple injury which required surgical  
13 intervention, particularly surgical intervention to the  
14 lumbar spine in the form of decompressed lumbar  
15 laminectomy and lumbar spinal fusion undertaken  
16 principally to prevent further neurological  
17 deterioration, secondary to high grade nerve root  
18 impingement and damage to both L-4/L-5 and L-5/S-1  
19 segments.

20          Q.       Please continue.

21          A.       Mr. Tapia continues to demonstrate antalgic  
22 and kyphosis during gait and ambulation with spasm and  
23 tenderness present in the neck and lower back areas,  
24 continues to require assistance on and off the  
25 examination table, because of difficulty in rotating

1 spine.

2 Q. I want you to go down to where it starts with  
3 lumbar spinal extension.

4 A. Approximately 0-5 degrees. Spasm and  
5 tenderness present and palpable beyond those ranges of  
6 motion. Flexion is approximately 35-40 degrees. Right  
7 lateral bending 20 degrees. Left lateral bending 20  
8 degrees, right lateral rotation 20 degrees. Left  
9 lateral rotation 20 degrees.

10 Q. Do you have an opinion with reasonable degree  
11 of medical certainty as to whether the accident of  
12 5/26/07 was the competent producing cause of the burst  
13 fracture at L-1, the fracture at T-12, the fracture at  
14 L-2, the annular tear at the lower lumbar spine at  
15 L-3/L-4, the impingement at L-5/S-1 the need for surgery  
16 with Dr. Betchen performed at Maimonides Hospital, the  
17 need for your surgery in January 12, 2010 and the need  
18 for the future surgery for the revision and extension of  
19 the instrumentation that you have testified earlier will  
20 occur within five years, do you have an opinion as to  
21 whether they are causally related to the accident of May  
22 26, 2007?

23 MR. BRODY: Objection.

24 MR. DEMERS: Objection.

25 THE COURT: Overruled. Go ahead.

1 A. Yes.

2 Q. Yes what?

3 A. Yes, that the accident was the principal  
4 responsible cause for the injuries outlined above.

5 Q. Doctor, do you have an opinion with reasonable  
6 degree of medical certainty and you indicated that  
7 Mr. Tapia is on medications, as to whether Mr. Tapia  
8 will require pain medications, muscle relaxants and  
9 other medications in regard to the injuries he sustained  
10 on May 26, 2007?

11 A. Yes.

12 Q. What is your opinion?

13 A. That he will continue to require those  
14 medications.

15 Q. Do you have an opinion with reasonable degree  
16 of medical certainty as to whether Mr. Tapia will  
17 require a life-time of pain management care?

18 A. Yes.

19 Q. What is your opinion --

20 MR. BRODY: Objection.

21 THE COURT: I will allow it.

22 A. That he will continue to require lifetime pain  
23 management.

24 Q. As you know, one of the questions is this:  
25 When you say the word "prognosis", can you tell the jury

1     what that means?

2           A.     Prognosis is what you foresee in the future  
3     with respect to how a patient is going to do.

4           Q.     Doctor, do you have an opinion with reasonable  
5     degree of medical certainty as to what the prognosis is  
6     for Mr. Tapia as a result of the accident, May 26, 2007.

7                   MR. BRODY:   I object.   That's the second  
8     question and it requires a third question.

9                   THE COURT:   We will get to that too.

10          A.     Yes.

11          Q.     What is your opinion?

12          A.     That the prognosis overall is poor.

13          Q.     Why?

14          A.     Because he is going to require revision  
15     surgery with locking down of pelvis, decrease in  
16     function over the course of time.

17                   MR. SCHWITZER:   I have nothing further.

18                   THE COURT:   Go ahead counsel.   You can  
19     start.

20     CROSS EXAMINATION

21     BY MR. BRODY:

22           Q.     There came a time on November 23, 2012 that  
23     you were wrote a lengthy report to Mr. Schwitzer, is  
24     that correct?

25          A.     Yes.

1           Q.     You basically, you paste a lot of stuff from  
2     your prior reports and added a few comments along the  
3     way?

4           A.     Yes.

5           Q.     How many times is the word "diabetes" in that  
6     report?

7           A.     I don't know. I don't think it is in there  
8     that often.

9           Q.     Would zero be okay?

10          A.     Yes.

11          Q.     How many times did you use the word  
12     "wheelchair" in your report. You want to tell the  
13     lawyer what is going to happen to his client so he can  
14     present it to the defendant so we all know what it is  
15     you are going to come in and tell the jury.

16                 How many times in that report did you mention  
17     that Mr. Tapia will need a wheelchair in the future?

18          A.     I did not put it in that report.

19          Q.     You did not put it any report?

20          A.     No.

21          Q.     You did not make any mention of him needing  
22     some motorized cart to get him around, did you?

23          A.     No.

24          Q.     The last time you saw him, you did not tell  
25     him that he would need surgery in five years, did you?

1           A.       No.

2           Q.       In fact you said that if you start to get  
3       radicular pain again in the future, it is possible you  
4       might need revision surgery, isn't that what you put in  
5       your report?

6           A.       Yes.

7           Q.       Today, he definitely needs it in five years,  
8       then he has to be in a wheelchair and motorized device  
9       because we have jurors here who will award him damages?

10          A.       No, not because there are jurors here who will  
11       award him damages.

12                   I was asked a temporal relation to when he  
13       will require the revision surgery.

14          Q.       A temporal relation would mean that he would  
15       absolutely need it in the future but you wrote  
16       "possible"?

17                   MR. SCHWITZER:  Objection.

18                   THE COURT:  Go ahead.

19                   MR. SCHWITZER:  I would like to offer Dr.  
20       Merola's report in evidence.

21                   MR. BRODY:  I have no problem.

22                   THE COURT:  Go ahead.

23          Q.       Let's see if we can get the words correctly.  
24       December 4, 2012.  That's in evidence.

25                   Doctor did you use these words --

1                   MR. SCHWITZER: One moment. He crossed  
2                   him on the narrative report now he wants to cross  
3                   him on a record.

4                   Q.       December 4, 2012?

5                   MR. SCHWITZER: The narrative report is in  
6                   evidence.

7                   THE COURT: Go ahead.

8                   Q.       Did you say doctor the possibility of  
9                   recurrent neurogenic or radicular symptoms would require  
10                  revision surgery in the future?

11                  A.       Yes.

12                  Q.       That means if those radicular symptoms do not  
13                  come back he does not need the surgery?

14                  A.       That's offering him the hope of possibly not  
15                  having to have future surgery, yes.

16                  Q.       When you spoke to him in your office, you  
17                  talked in the positive but when you speak to the jury  
18                  today, he is going to have to have the surgery in five  
19                  years or less, correct?

20                  A.       I am here to tell the jury the facts. In my  
21                  office, I am not there to discourage hope in my patient.

22                  Q.       You are here to tell the jury the facts. How  
23                  often do you tell the juries the facts?

24                  A.       Always.

25                  Q.       How many times a year?

1           A.       Three to four.

2           Q.       How many times have you been cross examined by  
3 Alan Kaminsky?

4           A.       You told me five times today but I would not  
5 be able to give that you number otherwise.

6           Q.       Doctor, you actually testified before Judge  
7 Vaughn before, didn't you?

8           A.       Yes, I have had the pleasure.

9           Q.       How many other times in the past 12 months  
10 have you testified?

11          A.       In the past 12 months, maybe once but I cannot  
12 recall the last time I testified.

13          Q.       How many times have you testified for Sax and  
14 Sax?

15          A.       In 16 years of practice, I have been in the  
16 courtroom about three to four times a year. That's  
17 three to four, times 16.

18          Q.       You testified about 50 times?

19          A.       I guess that's three to four times over 16  
20 years, yes.

21          Q.       Is that referring there to times when you were  
22 testifying for patients in accident cases, correct?

23          A.       Treating for patients.

24          Q.       In each of those cases, did you testify that  
25 the patient was 100 percent disabled?



1           A.     I don't recall specifically every testimony,  
2     no.

3           Q.     Let's go over your background if I can.  
4     Counsel asked you something about being board certified,  
5     is that correct?

6           A.     Yes.

7           Q.     By how many boards are you certified?

8           A.     I am certified by the American Board of  
9     Orthopedic Surgery, charter member of spinal board. The  
10    spine board is not accepted by the overall board body  
11    for the country so I don't generally list that when we  
12    are discussing board certification.

13          Q.     In the past, you mentioned when you testified,  
14    isn't that correct?

15          A.     I think I mentioned it sometimes. One of the  
16    reasons I am charter member of that spine board.

17          Q.     Now, doctor, let's talk first -- let me ask  
18    you this: Before you came to court, had you looked at  
19    Maimonides Hospital MRI's?

20          A.     Yes.

21          Q.     When?

22          A.     When you wrote the narrative.

23          Q.     You looked at the films?

24          A.     Correct.

25          Q.     Can you tell me what in the narrative the

1 findings are of those films?

2 A. I mentioned I reviewed the records from  
3 Maimonides Hospital.

4 Q. You did not mention anything about any of the  
5 findings in any of the films, did you?

6 A. I think when I reviewed the medical records, I  
7 don't think that I listed all of the findings of all of  
8 the tests I had done so I think my narrative report  
9 might have been 30, 40 pages.

10 Q. Aren't they fairly significant findings in  
11 that MRI as they relate to care and treatment of  
12 Mr. Tapia?

13 A. There are, yes.

14 Q. You did not think it was important to list  
15 what you found on the film?

16 A. No, it is part of the overall impression in  
17 the narrative.

18 Q. What was that that you were reading in front  
19 of you, you had some records, what are those?

20 A. These are my office records.

21 Q. Those are not all of your office records?

22 A. Those are my treatment records for Mr. Tapia,  
23 correct, those are all of my notes.

24 Q. When a law firm sends you an authorization,  
25 asks for all of your medical records, do you send all of

1 your medical records?

2 A. The office sends out the medical records, yes.

3 Q. When you sent your records out to Mr. Demer's  
4 firm or my firm, did you not send copies of Dr.  
5 Kaisman's records, did you?

6 MR. SCHWITZER: Objection.

7 A. My office would have sent those records out.  
8 So whatever you received, you would have received from  
9 my office staff.

10 Q. If I did not get Dr. Kaisman's records, does  
11 that mean you did not have them in your office records?

12 A. No.

13 Q. It just means you did not send them to us?

14 A. When we receive an authorization through HIPAA  
15 health insurance, you are requesting patient records for  
16 my treatment. Dr. Kaisman's records would be coming  
17 from Dr. Kaisman's office.

18 Q. Is your office policy to send only your record  
19 but you may have other records contained within the  
20 file?

21 A. I think the request is for my treatment  
22 records of the patient.

23 Q. Are you certain that you got Dr. Kaisman's  
24 records in this case?

25 A. I had seen Dr. Kaisman's records.

1 Q. When?

2 A. When I was treating the patient. In fact  
3 Mr. Tapia would come in with the records, the films that  
4 we reviewed have St. Vincent's sticker which I use  
5 during surgery.

6 Q. The films you review, doctor, did you compare  
7 your films with the films that Dr. Kaisman sent to you?

8 A. I actually had Dr. Kaisman's films, because  
9 that particular folder that we have here, I actually use  
10 those as part of the operative procedure along with the  
11 MRI that I sent them to at Doshe.

12 Q. Dr. Kaisman's notes say he sent Mr. Tapia with  
13 x-ray but does not say anything about the records?

14 A. Kaisman would have sent the records as well,  
15 correct.

16 Q. So you knew -- withdrawn.

17 Did you ever review any records of Mr. Tapia,  
18 prior to the accident?

19 A. Yes, I did review some records from his  
20 primary care physician, prior to the accident.

21 Q. When did you review those?

22 A. I reviewed those at the time of the narrative,  
23 I believe.

24 Q. Then why didn't you include them in the list  
25 of the records that you said that you reviewed in your

1 narrative report?

2 A. It should have been. I recall reviewing Dr.  
3 Kaisman records.

4 Q. What do they say?

5 A. Primary care physician.

6 Q. Yes?

7 A. Treatment records regarding medical problems  
8 and some issues with back pain and prior problem he had  
9 with one of his fingers.

10 Q. Let's start with back pain, what do the  
11 records indicate about back pain?

12 A. We have to look at the records specifically  
13 because I don't have them memorized.

14 Q. If he had back pain before the accident, would  
15 it be important to know what was causing it?

16 A. If he had persistent deteriorating back pain  
17 over the course of time and had prior treatment  
18 including MRI epidural injection prior to the accident.

19 Q. He was getting anti-inflammatories?

20 A. So do many construction workers and laborers.

21 Q. Why is that?

22 A. They are subject to musculoskeletal symptoms  
23 from the work they do.

24 Q. Do they start to develop wear and tear in the  
25 spine?

1           A.       As we all do, yes.

2           Q.       I understand we all develop wear and tear in  
3 the spine. You made sure the jury understands that but  
4 do people who do manual labor tend to incur more wear  
5 and tear in the spine than others?

6           A.       Yes.

7           Q.       People who develop wear and tear in the spine  
8 that can cause discs to desiccate, correct?

9           A.       Yes.

10          Q.       What is disc desiccation?

11          A.       Desiccation is a term that means drying up of  
12 or loss of water.

13          Q.       When disc desiccate, they shrink, correct?

14          A.       The disc can shrink, when it is desiccated,  
15 yes.

16          Q.       As the disc shrinks when it is desiccating, it  
17 creates a gap between the squares as you referred to  
18 them, correct?

19          A.       Actually, as it is shrinking the gap is  
20 closing because it is shrinking.

21          Q.       The canal and I think you often refer to those  
22 squares as or those areas as the house starts to get  
23 smaller and smaller, correct?

24          A.       The room in the house starts to get smaller,  
25 yes.

1 Q. As it gets smaller, it can impinge on the  
2 nerves, can't it?

3 A. Yes.

4 Q. Do they have a term for what it is when the  
5 room is getting smaller?

6 A. There are multiple terms.

7 Q. How is the term "stenosis"?

8 A. That's an excellent term that describes  
9 narrowing.

10 Q. Let's talk for a second. Do you have the  
11 Coney Island Hospital. It was deemed -- marked into  
12 evidence. Do you have that handy?

13 A. I no longer have it in front of me.

14 Q. I would like to show you page 115 out of the  
15 Coney Island Hospital record.

16 What is that?

17 A. This is lumbar spine radiology results.

18 Q. When is that taken?

19 A. This is 26 May, 2007.

20 Q. When is that in relation to the accident?

21 A. This is at the time of the accident.

22 Q. That's the same day, right?

23 A. Correct.

24 Q. That x-ray says that he has a fracture at L-1,  
25 correct?

1 A. Yes.

2 Q. What else does it say?

3 A. It says evidence of compression fracture L-1,  
4 vertebral body with mild retropulsion into the spinal  
5 canal.

6 Q. What does it say above that?

7 A. It says degenerative disc disease L-5/S-1  
8 level.

9 Q. For an x-ray taken the day of the accident to  
10 show disc degeneration at L-5/S-1, that disc disease had  
11 to pre-exist before the accident?

12 A. Yes.

13 Q. What disc disease did it show?

14 A. Degenerative disc disease.

15 Q. You are an orthopedic surgeon, correct?

16 A. Yes.

17 Q. You know there is a case going on here,  
18 correct?

19 A. Yes.

20 Q. You know that lawyers like me kind of get a  
21 little knitpicky when we start throwing medical terms  
22 such as the accident caused something, around?

23 A. Yes.

24 MR. SCHWITZER: Objection.

25 THE COURT: He answered the question. Go



1 ahead.

2 Q. So, I am sure before you came here today you  
3 anticipated I was going to ask you what x-ray showed?

4 MR. SCHWITZER: Objection.

5 THE COURT: Sustained.

6 Q. What did the x-ray show, doctor?

7 A. It shows the L-1 burst fracture, retropulsion  
8 of bone into the canal and degenerative disc disease at  
9 L-5/S-1.

10 Q. Did it show stenosis, did it show neural  
11 foraminal narrowing, it shows osteophyte complex, what  
12 did it show?

13 A. It does not say, it says degenerative disc  
14 disease.

15 Q. Didn't you look at that film to see what  
16 pre-existing conditions Mr. Tapia had on the day of the  
17 accident?

18 A. Yes.

19 Q. What did the film show when you looked at it?

20 A. You would like me to describe the film for  
21 you?

22 Q. Yes.

23 A. It shows a degeneration of L-5/S-1 disc with  
24 something known as MACNAB traction spurs on the anterior  
25 aspect of L-5/S-1 segment with disc desiccation.

1 Q. Did it also show facetar arthritis?

2 A. Facetar arthritis, fair to say.

3 Q. Do you ever mention in your any of your  
4 reports that Mr. Tapia suffered facet joint pain?

5 A. Do I mention that he suffered from facetar  
6 joint pain in my treatment records, I don't think I  
7 referred to that.

8 Q. Are you aware in every single one of Dr.  
9 Thomas records, he refers to Mr. Tapia as suffering from  
10 facet joint pain?

11 A. Yes. There is a good reason for that.

12 Q. I am sure there is. That facet joint pain has  
13 nothing to do with the accident?

14 A. It has everything to do with the accident.

15 Q. He had the facet joint arthritis and arthrosis  
16 before the accident, correct?

17 A. Correct.

18 Q. Let's go over the MRI for a minute on the  
19 report of the lumbar spine taken two days after the  
20 accident. That's exhibit 29 and 30.

21 Doctor L-1/L-2 was where the fracture was?

22 A. L-1/L-2 is the disc below the fracture.

23 Q. Above it would be T-11 --

24 A. T-12/L-1.

25 Q. At L-1/L-2 he had central canal stenosis,

1 correct?

2 A. Yes.

3 Q. What is that?

4 A. Narrowing of central canal.

5 Q. If someone has central canal stenosis, what  
6 would that look like on one of these pictures?

7 A. This is a little tough to look at because you  
8 are not looking --

9 MR. SCHWITZER: Sorry. For the record,  
10 exhibit number?

11 MR. BRODY: 19.

12 Q. We are now looking at number 13.

13 A. Sideview x-ray lumbar spine. We are looking  
14 at the vertebral bodies to the right of the x-ray. We  
15 are looking at the spine process to the left of the  
16 x-ray.

17 Spinal canal is the canal going down the  
18 middle of the hole in your spinal canal, where the  
19 spinal cord and the nerve roots are. That hole should  
20 be large enough to accommodate your middle finger, so it  
21 should be that much around. And stenosis, basically,  
22 means instead of the canal being large enough to  
23 accommodate the diameter of the middle finger, the  
24 diameter of that area is smaller or stenotic.

25 On the x-ray, that is happening because this

1 is the canal area, where I am pointing to with my finger  
2 behind the vertebral body, there is bone and disc  
3 material in the canal zone. So by definition that takes  
4 up room or volume in the canal and it has to narrow that  
5 canal.

6 Q. That can cause nerve root injury?

7 A. Yes.

8 Q. That can cause pain?

9 A. Yes.

10 Q. That condition existed before the accident,  
11 correct?

12 A. Not in the area of the fracture.

13 Q. So the MRI is incorrect when it says central  
14 canal stenosis?

15 A. No, it is not wrong. It is giving you the  
16 anatomical description of central canal stenosis  
17 occurring at L-1/L-2 segment because there is protusion  
18 of disc and bone into the spinal canal from the  
19 fracture.

20 Q. It is still showing core compression and canal  
21 stenosis?

22 A. It is showing stenosis with compression of the  
23 lower spinal cord.

24 Q. At L-2/L-3, that's the disc below?

25 A. Yes.

1 Q. It says circumferential disc bulge?

2 A. Yes.

3 Q. It says the central canal patented?

4 A. No stenosis of central canal at L-2, L-3.

5 Q. That disc was the disc with the most water in  
6 it in his spine at time of the accident.

7 A. That disc had the same amount of water in it  
8 as the lower thoracic disc did. That disc signal is  
9 comparable to those other disc signals.

10 Q. L-3/L-4 circumferential disc bulge, what is  
11 that?

12 A. That is symmetrical protusion of the disc,  
13 going outside the confines of the vertebral body.

14 Q. By definition, disc bulge is something that is  
15 either congenital or degenerative as opposed to  
16 traumatic?

17 A. Congenital means you are born with it. I  
18 would describe a bulge, you could describe it as being  
19 physiological which bulge can exist in the normal state.

20 Q. It says there are central canal and lateral  
21 recess stenosis. What is lateral recessed stenosis?

22 A. Lateral recess are the areas, we are looking  
23 at number 19, this is an illustration of the spine. The  
24 lateral recesses are these things that appear to look  
25 like ears or the neural foramen. That is loss also

1 known the lateral recesses or the areas where the nerve  
2 roots exit.

3 Q. If they have stenosis, it means those places  
4 where the nerve roots were existing, back two days after  
5 the accident, those had already begun to narrow,  
6 correct?

7 A. That means there was a narrowing of those  
8 areas, correct.

9 Q. At L-3/L-4 it says non-compressive which means  
10 it is not significantly closed in the neural foramenal  
11 area to be causing impingement, at least on the film?

12 A. At least by description of the film, yes.

13 Q. Doctor, I think you said earlier that the film  
14 is taken laying down, correct?

15 A. Yes.

16 Q. So there is less pressure on the spine when  
17 the film is taken then for example if Mr. Tapia was  
18 standing, correct?

19 A. I don't think pressure is exactly the term I  
20 would use. I would say the spine -- it depends on what  
21 as part of the spine you are looking at. If you are  
22 looking at the lumbar spine -- if you are lying down,  
23 the force of gravity is going to extend the thoracic  
24 spine, it is going to flatten out the lumbar spine and  
25 it is going to flatten out the cervical spine by force

1 of gravity. When you are lying down supine in MRI  
2 machine, there is some affect of that position in terms  
3 of altering the position of the vertebral bodies.

4 Q. You used an expression earlier that sometimes  
5 pain comes and goes?

6 A. Yes.

7 Q. Isn't it true that even in patients with  
8 herniated disc, some times they are symptomatic but  
9 sometimes they are not?

10 A. Depends on the herniation.

11 Q. Depends on how much it is compressing and  
12 irritating the nerve?

13 A. Yes.

14 Q. Depends how active they have been for a period  
15 of time?

16 A. Yes.

17 Q. The mere fact that somebody has herniated disc  
18 does not mean it is causing pain, does it?

19 A. Correct.

20 Q. Let's move to L-4, 5, here it says disc  
21 desiccation with broad based posterior disc bulge?

22 A. Yes.

23 Q. The disc is dry?

24 A. Yes.

25 Q. It has this broad based bulge, it does not say

1     herniation, correct?

2             A.     Correct.

3             Q.     It has the annular tear which you told the  
4     jury about before, correct?

5             A.     Yes.

6             Q.     Bilateral facet arthrosis, that's what we  
7     talked about earlier?

8             A.     Yes.

9             Q.     There is moderate central canal and lateral  
10    recessed stenosis, we talked about that too, correct?

11            A.     Yes.

12            Q.     Now let's go to L-5/S-1, it says disc  
13    desiccation narrowing with the prominent circumferential  
14    disc bulge. Do you see that?

15            A.     Yes.

16            Q.     It says severe neural foraminal stenosis?

17            A.     Yes.

18            Q.     With impingement on the right and probably on  
19    the left, correct?

20            A.     Yes.

21            Q.     Doctor, the condition depicted on this MRI,  
22    two days after the accident, can that condition cause  
23    radiculopathy?

24            A.     That condition can cause a radiculopathy, yes.

25            Q.     According to you, based upon your review of



1 this gentleman's history, he was not experiencing any  
2 radiculopathy prior to the date of this accident, is  
3 that right?

4 A. He did not have significant, severe or  
5 progressive pain radiating into the lower extremity,  
6 correct.

7 Q. He did have some weakness in his leg, correct?

8 MR. SCHWITZER: I ask if we are done with  
9 the diagrams, can the doctor sit down.

10 MR. BRODY: We are done with this one for  
11 a moment.

12 Q. Dr. Bass reported he was having some leg  
13 weakness, correct?

14 A. I have to review the record to see where he  
15 put that in.

16 Q. I want you to assume that Dr. Bass is coming  
17 and we will put his record into evidence. I want you to  
18 assume that he described the patient having lower back  
19 pain with weakness. That would be enough to tell you  
20 what was causing his leg weakness, correct?

21 A. Correct.

22 Q. Dr. Bass did not have the ability to review  
23 the MRI two days after his accident, a year and-a-half  
24 before his accident, correct?

25 A. Correct.

1           Q.       When someone has L-5/S-1 stenosis impinging  
2       upon the nerve, does the pain just show up one day badly  
3       or does it increase gradually over time?

4           A.       Degenerative conditions increase gradually  
5       over time.

6           Q.       What effect would things like Naprosyn have on  
7       a person who has canal stenosis?

8           A.       It depends on what you are giving them. The  
9       Naprosyn for, whether or not the stenosis is  
10      symptomatic, anatomically. The Naprosyn is not doing  
11      anything to change the stenosis.

12          Q.       It is anti-inflammatory designed to slow down  
13      the inflammation?

14          A.       The stenosis does not cause inflammation.  
15      Stenosis is only a term that means a narrowing of, so  
16      the anti-inflammatory decreases inflammation in a body  
17      part that is symptomatic; for example, lower back pain,  
18      because of an inflammatory reaction can be painful, the  
19      anti-inflammatory ameliorates the inflammatory reaction  
20      that is causing the lower back pain.

21          Q.       A person who has L-4/L-5 facet arthrosis,  
22      where would that cause them pain?

23          A.       Facet pain is persistent lower back pain.  
24      That is generally referred in the lower back area then  
25      down into the buttock.

1 Q. Isn't that exactly the type of pain that Dr.  
2 Kaisman was reporting that Mr. Tapia was experiencing  
3 when he referred him to you?

4 A. In addition to the lower back symptoms, he  
5 also had right lower extremity radiating symptoms.

6 Q. You reported that?

7 A. No, I think that's in Dr. Kaisman's notes as  
8 well.

9 Q. Doctor, let's go to the record of October 25,  
10 2007 for the moment.

11 Have you ever seen that record before?

12 A. Yes.

13 Q. Do you see any mention of any foot or lower  
14 extremity weakness in that record?

15 A. No.

16 Q. Let's go to December 28, 2007, do you see any  
17 mention of it in the record?

18 A. December 20, 2007.

19 Q. December 28.

20 A. I have 20 on here.

21 Q. December 20.

22 Do you see anything in there about lower  
23 extremity, pain, weakness?

24 A. No.

25 Q. Isn't it a fact that every time Mr. Tapia went

1 to Dr. Kaisman, he had normal motor strength in his  
2 lower extremities?

3 A. Early on, those are the 2007 records, yes.

4 Q. Let's take a look at June 26 and August 21 of  
5 2008.

6 Do you ever remember seeing a record of Dr.  
7 Kaisman where the plaintiff did not have normal motor  
8 strength?

9 A. I recall the reference that he made to right  
10 lower extremity symptoms and straight leg raising as  
11 well.

12 Q. So, your answer, since I asked you a question  
13 about motor strength and you answered with somebody else  
14 you said he always reported normal motor strength,  
15 correct?

16 A. At least for me, yes.

17 Q. Counsel asked you over and over about March  
18 31, 2008 report of Dr. Betchen where she looked at an  
19 x-ray and said gee it does not look like I am getting a  
20 lot of fusion here, I better send him for a CAT scan,  
21 correct?

22 A. Yes.

23 Q. He did not ask you for the CAT scan, he went  
24 for a CAT scan?

25 A. Yes.

1 Q. The scat CAT scan showed that he had  
2 instrumentation in good place?

3 A. Yes.

4 Q. It actually showed that he was starting to  
5 fuse, correct?

6 A. Yes.

7 Q. So Dr. Betchen instead of saying you need  
8 surgery, I recommend that you have surgery, you say if  
9 kyphosis continues to progress, that's not what she  
10 says, then I would recommend he have another operation  
11 to extend his instrumentation, correct?

12 A. Yes.

13 Q. That was in 2008, he had an MRI in 2009, an  
14 x-ray in 2012, correct?

15 A. Yes.

16 Q. Those are the two films that you testified  
17 from today?

18 A. Yes.

19 Q. There has been no change in that  
20 instrumentation, has there?

21 A. In the instrumentation, no.

22 Q. It is stable and intact?

23 A. Yes.

24 Q. It is doing its job?

25 A. Yes.

1           Q.       In fact, when the plaintiff goes to Dr.  
2       Thomas, Dr. Thomas identifies him as having pain from  
3       L-3 to S-1 but plaintiff is not demonstrating any pain  
4       or spasm above that level, is he?

5           A.       Correct.

6           Q.       So really doctor, right now, it would not make  
7       sense to revise a procedure that is working, would it?

8           A.       That's why I have not done it, correct.

9           Q.       I want to go back earlier on, so this  
10      gentleman goes to the hospital and he has degenerative  
11      disc disease at L-5/S-1 that can be competent producing  
12      cause of radiculopathy down his leg, correct?

13          A.       It can be, yes.

14          Q.       He has diabetes, is that correct?

15          A.       Yes.

16          Q.       What is diabetes mellitus?

17          A.       There are two types of diabetes. It depends  
18      on which type we are talking about.

19                 In general diabetes, it refers to abnormal  
20      increase in your blood sugar because your body does not  
21      have an ability to properly store and process the sugar  
22      that you take in when you are eating.

23          Q.       And is that the type of diabetes mellitus the  
24      plaintiff had?

25          A.       That's a general description of diabetes. As

1 I said, there are two types. One is insulin dependent  
2 diabetes and the other is non-insulin dependent.

3 Mr. Tapia has non-insulin diabetes.

4 Q. Mr. Tapia is Type 2 diabetic?

5 A. That's another way of saying that, yes.

6 Q. Can diabetes affect the nervous system?

7 A. It can, yes.

8 Q. Can it cause radiculopathy?

9 A. In general, diabetes does not cause  
10 radiculopathy, it causes poly-neuropathy.

11 Q. Have you ever testified that diabetes can  
12 cause and or contribute to radiculopathy?

13 A. Diabetes can contribute to radiculopathy  
14 depending upon whether or not you had the ravishes of  
15 diabetes that also contributed to poly-neuropathy and  
16 other organ system changes over a long period of time.

17 MR. SCHWITZER: May we come up?

18 THE COURT: Come up.

19 (Discussion held off the record.)

20 THE COURT: Go ahead.

21 Q. Have you testified in a case, Passlalaqua  
22 versus Keyspan and Motorola.

23 Page 76: Diabetes is contributory to  
24 radiculopathy, it contributes to just about every  
25 process in your body inflammation, pain. Was that your

1 testimony?

2 A. Yes.

3 Q. In fact did you further go on to say with my  
4 favorite word in it, page 69 diabetes is co-morbidity.  
5 Diabetics can suffer from poly neuropathy is that  
6 correct?

7 A. Yes.

8 Q. In a person who has, what you have described  
9 as L-5/S-1 radicular pain, can diabetes contribute to  
10 that radiculopathy?

11 A. It can, yes.

12 Q. In fact -- let's go back a second. L-5/S-1  
13 radicular pain, is that impingement on L-5/S-1 nerve  
14 root?

15 A. There are multiple reasons why you could have  
16 L-5/S-1 radicular pain. Impingement is one of them.

17 Q. Diabetic poly-neuropathy is one of them?

18 A. No diabetic poly-neuropathy refers to a  
19 condition whereby patients oftentimes, poorly controlled  
20 diabetics suffer from a problem with multiple nerves,  
21 usually, in the peripheral extremities, usually  
22 distribution in the knees and/or below, usually  
23 presenting with burning dysesthesia.

24 Poly means many. Neuropathy means problem  
25 with nerves. A poly neuropathy or diabetic neuropathy



1 refers to a problem with many of the nerves because it  
2 is a generalized condition that affects particularly  
3 nerves in the periphery of your feet and below your  
4 knees. Often times occurs in particularly type one  
5 diabetics who are poorly controlled with respect to  
6 sugar control.

7 Q. How control was Mr. Tapia?

8 A. Pretty well controlled, if you look at his  
9 blood values.

10 Q. If I look at his blood values where?

11 A. If you look at his blood values in any of the  
12 blood tests that were done in the hospital.

13 Q. Which hospital?

14 A. St. Vincent's Hospital, you look at his finger  
15 stick, or the blood value at Maimonides. Mr. Tapia is  
16 not insulin dependent. He is on medications for the  
17 diabetes but he does not take insulin for the diabetes.

18 Q. Do you know if he was missing a lot of his  
19 appointments before he had his accidents?

20 A. I saw he missed some of his appointments.

21 Q. Did you see anything else in the records -- I  
22 will not get into the specifics now that will not be  
23 indicated with a person with elevated blood sugar  
24 levels?

25 MR. SCHWITZER: Objection to form.

1 THE COURT: Sustained.

2 Q. Did you see anything else in Dr. Bass record  
3 that was contra-indicated for people with blood sugar  
4 levels?

5 A. I am not sure I know what you mean by that.

6 Q. Doctor, when Mr. Tapia went to Maimonides  
7 Hospital and they did this MRI, they found that he had  
8 an L-1 burst fracture to non-displaced, two  
9 non-displaced thoracic and one at low lumbar spine and  
10 lumbar non-displaced fracture of the level below the  
11 burst fracture?

12 A. Say that again.

13 Q. The MRI shows L-1 burst fracture, correct?

14 A. Yes.

15 Q. They found based upon x-rays other tests, T-12  
16 non-displaced fracture and L-2 non-displaced fracture,  
17 correct?

18 A. T-12, yes in L-2 anterior portion of that L-2  
19 that was fractured.

20 Q. Non-displaced?

21 A. Yes.

22 Q. There is fracture line there?

23 A. Yes?

24 Q. They found significant disc degenerative  
25 disease at L-5/S-1?

1 A. Yes.

2 Q. Did you ever note any where in your records  
3 two days before the accident he had significant disc  
4 degenerative discs at L-5/S-1?

5 A. In my treatment records?

6 Q. Yes any where?

7 A. No.

8 Q. Counsel asked you in that last question about  
9 causal relation. He listed 20 things. Do you remember  
10 that?

11 A. Yes.

12 Q. Did you listen to things that he listed that  
13 you said were causally related to the accident?

14 A. Yes.

15 Q. Carefully?

16 A. Yes.

17 Q. One of the things he said was annular tear at  
18 L-3/4?

19 A. Yes.

20 Q. Wasn't the anterior tear at L-4/5?

21 A. Yes.

22 Q. Was the L-3/4 tear causally related to the  
23 accident, there was none at that point?

24 A. L-4/5.

25 Q. The tear from L-5 to S-1 but there was no tear

1 from L-4 to S-1, correct?

2 A. No.

3 MR. SCHWITZER: I ask it is the jury's  
4 recollection.

5 THE COURT: It is always the jury's  
6 recollection.

7 Q. Let's talk about these discs for a second.  
8 L-5/S1 the disc back on the inside?

9 A. Yes.

10 Q. Are you aware that a radiologist is going to  
11 come in and testify in this case that a vacuum  
12 disc --

13 MR. SCHWITZER: Objection.

14 THE COURT: Sustained.

15 Q. Did you review Dr. Fischer's report?

16 A. No.

17 Q. Are you a radiologist?

18 A. No.

19 Q. What is a vacuum disc?

20 A. A vacuum disc is a description of a disc space  
21 that has very dark space that has very dark core or dark  
22 center to it.

23 Q. That dark core or dark center is caused by  
24 gas, correct?

25 A. It has the same consistencies as gas but I

1 don't know whether it is or not unless you open up the  
2 disc and go into its core.

3 Q. At some point you did do that?

4 A. I did that, yes.

5 Q. Was it a black disc?

6 A. When you are looking at it, it does not appear  
7 to be black, it shows up black in the MRI.

8 Q. It had the consistency of vacuum disc?

9 A. No, there was disc material in there. I  
10 removed that material and sent it to pathology.

11 Q. Can you take a look at St. Vincent's hospital  
12 record and show me the pathology report.

13 A. I don't see the path report in the chart.

14 Q. There is no evidence that you sent anything to  
15 the pathology department, is there?

16 A. Everything we remove during the operation,  
17 particularly discs, are sent as a standard to pathology.

18 Q. You wrote your operative report that you  
19 removed disc material from this patient?

20 A. Correct.

21 Q. But you did not describe the disc material  
22 that you removed anywhere in your report, did you?

23 A. No, I was too busy doing the operation.

24 Q. You have written many operative reports and in  
25 many of them you describe the disc material you remove,

1 don't you?

2 A. Sometimes yes.

3 Q. It is important when you are removing healthy  
4 disc tissue that is spongy, it is easily removed but  
5 when you are removing hard disc material, it is much  
6 more difficult to remove, isn't it?

7 A. It can be but it depends on the specific case.  
8 I don't recall any specific difficulties with this  
9 particular procedure.

10 Q. You would not know because you did not write  
11 it in your report?

12 A. If had been particularly difficult, I would  
13 have noted it.

14 Q. Let me ask you this: Counsel asks some  
15 nebulous questions about you getting authority going  
16 forward with treatment, do you recall that?

17 A. Yes.

18 Q. Isn't it true that if you did not report that  
19 the conditions at L-5/S-1 were causally related to the  
20 accident, you would not get paid for the procedure?

21 MR. SCHWITZER: Objection.

22 THE COURT: Sustained.

23 Q. Doctor, when you reported to whomever you  
24 reported to the conditions that you were going to  
25 operate on, did you mention the words "stenosis"?

1           A.     I don't --

2           Q.     Yes or no -- did you mention the word  
3     "stenosis"?

4           A.     Well it is -- when you mention, when we  
5     request authorization for the surgery it is not only  
6     based on my records it is based on all of the patients  
7     treatment records. It is not me saying this is what I  
8     want to do and why I want to do the review of patient's  
9     treatment.

10          Q.     Your records are in front of you?

11          A.     Yes.

12          Q.     You sent a copy to have somebody authorize  
13     treatment?

14          A.     As part of his treatment record, yes.

15          Q.     No where in any of your records does it use  
16     the word stenosis, does it?

17          A.     No.

18          Q.     It does not say he has neural foraminal  
19     narrowing, does it?

20          A.     No, because --

21          Q.     I did not ask you why. You have your own  
22     reason why.

23                     MR. SCHWITZER: Objection.

24          Q.     You don't mention it any where?

25          A.     Correct.

1 Q. You don't mention that he had any degenerative  
2 disc disease in any of your records, do you?

3 A. Correct.

4 Q. That is because if you wrote that he was  
5 suffering from degenerative disc disease that you were  
6 treating, you would not get paid.

7 MR. SCHWITZER: Objection.

8 THE COURT: Sustained.

9 Q. Doctor the disc desiccation that appears on  
10 this 5/28/2007 MRI, that was not caused by the accident,  
11 was it?

12 A. No.

13 Q. Doctor, you said there was a difference  
14 between the CAT scan taken in 2008 and the MRI taken in  
15 2007, is that correct?

16 A. I think one of the things I said CAT scans and  
17 MRI look at things in different ways.

18 Q. Let me rephrase it.

19 Were you shown the Doshe diagnostic, correct?

20 A. Yes.

21 Q. You looked at this MRI from Maimonides  
22 Hospital, correct?

23 A. Yes.

24 Q. They show the same herniated disc at L-4  
25 L-5/S-1?



1           A.       Yes, they show the disc degeneration.

2                   THE COURT:   We have to break.   Return  
3 promptly at 9:30.

4                   Do not discuss the case, do not form any  
5 opinion.

6                   Have a pleasant evening.   See you tomorrow  
7 at 9:30.

8                   (Jury exits courtroom.)

9

10                               \*           \*           \*           \*           \*

11                   The foregoing is hereby certified to be a  
12 true and accurate transcript of the proceedings as  
13 transcribed from the stenographic notes.

14

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17

ADMELINDA J. RUBIO, RPR

18

Senior Court Reporter

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NADONNA FERGUSON

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Senior Court Reporter

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