Dr. Kolb

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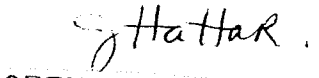


**EXHIBIT F TO SMODISH AFFIRMATION -**
**EXCERPTS OF TRANSCRIPT OF PROCEEDINGS [121-191]**



SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS CIVIL TERM: PART 43

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JOHN BUTLER,

PLAINTIFF,

INDEX #
28259/99
Trial

-against-

VICTORIA WYNTER,

DEFENDANT.

----------X

Supreme Courthouse
360 Adams Street
Brooklyn, New York 11201
April 8, 2002

B E F O R E:

THE HONORABLE MURIEL HUBSHER,
Justice of the Supreme Court
(and a jury)

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

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SUSAN K. YOUNG
Senior Court Reporter

sky

-Proceedings-

(The following is an excerpt of the proceedings, transcribed as requested.)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

COURT OFFICER: Please be seated.

THE COURT: Hope you had a wonderful weekend. We're about to continue. We just barely started the openings and the trial will continue as I described it to you in the earlier part.

The same procedures follow, same set of rules, so I don't have to tell you or introduce you because now you're all professionals.

Do we have a witness that you wish to call to the stand?

MS. NEUMUNZ: Yes, your Honor.

Your Honor, the plaintiff would like to call Dr. Thomas Kolb to the stand.

But prior to that, your Honor, the plaintiff makes a motion to put into evidence the subpoenaed hospital record from Kings County Hospital as well as Caledonian Hospital and corresponding X-rays, your Honor.

THE COURT: Do we have those records?

Show them to defendant's attorney. Subject to redaction, of course.

-Proceedings-

MS. NEUMUNZ: Yes, your Honor.

THE COURT: Plaintiff's Exhibit 1 and 2.

Make Kings County number one.

MS. SMODISH: No objection to the record, subject to redaction.

I do have an issue, Judge. I don't believe that it's proper. We've had no foundation for a doctor to testify. This is the first witness --

MS. NEUMUNZ: It's subject to connection.

THE COURT: What is he --

MS. SMODISH: I mean, he hasn't -- this is not an examining physician.

THE COURT: No, I'm sorry. Approach.

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

THE COURT: I misunderstood. I thought you were not noticed of his appearance.

MS. SMODISH: No, no.

THE COURT: I misunderstood.

Exhibit 1 and 2 are in evidence subject to redaction.

That means that we will take out from it anything that doesn't apply to this particular instance.

(Whereupon, Plaintiff's Exhibits 1 and 2 were received in evidence.)

-Proceedings-

THE COURT: We are now having who?

MS. NEUMUNZ: The radiologist, Dr. Thomas Kolb, your Honor.

THE COURT: T-H-O-M-A-S. What's the --

MS. NEUMUNZ: K-O-L-B.

THE COURT: A doctor normally does not testify first. As it turns out, we are taking the doctor out of turn because of his particular commitment prior to this and therefore, while it is not the usual thing to hear the doctor before you hear about the injuries as such, we're going to do that for this particular case.

You may call your witness.

MS. NEUMUNZ: Thank you, your Honor.

Dr. Kolb.

(Whereupon, the witness takes the stand.)

DR. T H O M A S K O L B,

Having been called as a witness by and on behalf of the Plaintiff after having been first duly sworn, testified as follows:

THE CLERK: Have a seat and state your name and address for the record, please.

THE WITNESS: Thomas Kolb, K-O-L-B, 222 East 68th Street, New York, New York.

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MS. NEUMUNZ:

Q. Doctor, good afternoon. I'm going to ask you to keep your voice up because we have this ventilation system that makes it kind of difficult and all the jurors have to hear, okay?

A. Yes, I hear.

Q. Doctor, are you licensed to practice medicine in the State of New York?

A. I am.

Q. Why don't you tell the jurors when you were so licensed?

A. I was so licensed in 1983.

Q. Why don't you tell us a little bit about your education, your medical background, things of that sort.

A. I went to college here in New York at Queens College from 1976 to 1979.

I then attended Downstate Medical School in Brooklyn from 1979 through 1983, graduated with an M.D. degree.

From '83 through '86 I was first an intern and then a resident in pediatrics at Albert Einstein College of Medicine in the Bronx, and then I became board certified in pediatrics.

From 1986 through 1990 I was a resident in

diagnostic radiology at Columbia Presbyterian Medical Center in Manhattan and again became board certified in diagnostic radiology in 1990.

From 1990 through current, through now, I've been in the practice of diagnostic radiology.

Q. And first off, can you just tell us briefly what radiology is.

A. Radiology is the study where we're able to look within the body, to look for what is normal, what is abnormal with only very minimal invasiveness. So we have many tests such as X-rays, CAT scans, MRI scans, ultrasound where we can look inside the body and determine if there's a problem or if there isn't a problem.

Q. What is board certification?

A. Board certification, first you have to complete the required study. For example, do your internship, do your residency and then after that's done, you take a written examination and if you pass the written examination, you then take an oral examination and you have to pass that as well. If you pass both, you become a diplomate of the board of that specialty.

So in my case I was board certified in both pediatrics and in radiology.

Q. And can you tell me, Doctor, are you affiliated with any universities, any teaching staff or --

A. Yes, I'm an assistant clinical professor of radiology at Columbia Presbyterian Medical Center or Columbia University College of Physicians and Surgeons in New York.

Q. And, Doctor, outside of your current practice do you publish -- have you published articles in radiology magazines, spoken at all, lectured?

A. Yes. I published one of the first studies on MRI of the heart back in 1988 and research was done in 1988, 1989 and I recently published articles on breast cancer detector which I specialize in as well and I've popularized the use of breast ultrasound to diagnose breast cancer.

Q. And currently would you just tell the jurors what your current practice consists of.

A. I'm in private practice. Large part of my practice deals with breast cancer diagnosis and the other part of my practice deals with orthopedic radiology, MRI of the bones and joints.

Q. And with respect to being here today with us in court, are you being compensated for your time?

A. Yes, I am.

Q. What is that compensation?

A. Five thousand dollars.

Q. And, Doctor, have you been qualified in the courts of the State of New York to testify as an expert in radiology before today?

A. Yes, I have.

Q. And approximately how many times?

A. About five times. Roughly give or take about five times a year for the past maybe six or seven years.

Q. Did there come a time when you were asked to review the MRI films on a John Butler?

A. Yes.

Q. Do you need your report to refresh your recollection?

A. That will be fine.

MS. NEUMUNZ: May I approach the witness, your Honor?

(Handing.)

Q. And, Doctor -- well, when was that?

A. I looked at the films on November 8, 2001.

Q. Doctor, could you just tell -- what type of films were there?

A. These were MRI scans of the neck, the cervical spine.

Q. And what is an MRI?

A. An MRI is a test where we use magnetic waves and it's controlled by a computer. You may have heard or seen the machine. It's a large machine and actually what you don't see is when you lie down in the machine, there's a magnet that surrounds you and there's a very powerful

computer that can manipulate the magnetic waves that come out of that magnet and those waves are actually pulsed into your body and you don't feel anything, it's completely painless.

And your body reacts to having those magnetic waves come into your body. And the way your body reacts, the computer can actually listen to those reactions, it can see those reactions. There's -- it's the way the crotons within our atoms in the cells of our body react.

But in any case, the computer can take this activity in our body and actually show it as a picture of the inside of our body. It's a very highly specialized and a very sensitive test for looking through different areas of abnormality within specific areas of the body.

Q. Doctor, in your practice can you tell the jurors approximately how many times a year you review MRI films?

A. I would have to estimate maybe between one or two thousand, roughly, a year, per year.

Q. And for how many years has that been, Doctor?

A. Oh, ten years.

Q. Now, with respect to the cervical spine, Doctor, before we get to the MRIs, could you just explain to the jury a little bit about the anatomy. And I'm going to ask you --

MS. NEUMUNZ: Your Honor, could I have something just marked for identification as an exhibit?

THE COURT: Sure.

(Whereupon, Plaintiff's Exhibit 3 was marked for identification.)

MS. NEUMUNZ: Your Honor, with the Court's permission can the doctor refer to the exhibit of the spine?

THE COURT: That's the spine?

MS. NEUMUNZ: Yes, your Honor.

THE COURT: Sure.

He needs this to help him explain to the jury I assume?

MS. NEUMUNZ: Yes, I apologize, your Honor.

Q. Doctor, is that anatomically correct?

A. Yes.

Q. Would that assist you in discussing the MRIs with the jury?

A. Yes.

THE COURT: Any objection?

MS. SMODISH: No objection.

A. This is a model of our spine. We all have the same spine, we all have the same number of bones and so on. And we divide the spine up into basically four major segments. For the purposes of what we're going to talk about for the study that I interpreted, we're looking at the neck which is the top of the spine, what we call the cervical spine.

There are other parts to the spine. Thoracic,

lumbar and lower. But we're looking up here.

The anatomy in general is the same throughout the spine. So what we have are bones in our neck and each one of us has seven bones and so that we all know what we're talking about, we label these bones 1 through 7 or C for cervical, because it's the neck, C1, C2, C3 through C7.

So we each have seven bones. In between the bones so that the bones don't knock together when we jump up and down are what we call disks and we've all heard about disks in the back of the neck and their function is to be a shock absorber. They're like gelatinous structures that are tough on the outside and jelly-like in the center so that they cushion the shock of us walking around or jumping around or moving. They're like little springs basically.

Now, the bones of the spine actually go all the way around to the back, okay. We see the front of the bone here. This is the front of this model, the patient. The back, we have these protrusions. But in between the circle of bone is the spinal cord and it starts at the bottom of the brain which would be here and it comes down and you can see this yellow structure goes all the way down, which is the spinal cord.

Now, in order for us to move, for us to feel things, to feel pain, differences between hot and cold, we have to have nerves that go to our entire body and all the

nerves start from the spinal cord.

Now, in order for these nerves to get to different parts of the body, they have to get out of the spinal column or the spinal cord and get to where they're going. The way they do that is that there are holes between each bone and there's a hole on the right side for nerves going to the right and there are holes on the left side for the nerves that go to the left and they are all symmetrical. And these holes are called neuroforamina.

Foramen is just a fancy medical way of saying a hole. Neuro, nerves. The nerves go through the hole.

Now, we talked about the disks that are in between the bones. The reason why when we jump up and down the disks don't just spurt out is because they're held in place and they're held in place by three very tough coverings. There's a covering which is called a ligament which runs from the top of the spine down to the bottom in the front of the spine and there's a ligament on the back of these bones.

So there's a ligament, a very tough covering, fibrous covering, which is plastered against the bones in front and the back so that the disks don't spurt out front and back, they are held in place.

The front ligament is called the anterior or front. Longitudinal for long ligament and the back is called

posterior for back, longitudinal, long ligament. So we have a anterior ligament, posterior ligament that holds it in place. But in order for the disk not to spurt out the sides, there's another tough covering and that's called an annulus.

They are all fancy medical words, but the point is that there is a covering that circles around each level where there's a disk. So there's a covering, let's see, this is two, three, four, let's see, between the fifth and the sixth bone there's a covering called the annulus that goes circumferentially around the disk in addition to the coverings in front and the coverings in back. So those ligaments hold everything in place.

Why is that important. Because if there is a problem with the ligaments or the annulus, this disk can move out from its normal space. It's normally confined to the edge of the bone and stops because there is an annulus, there is a ligament that are very tightly covered, that are very tightly covering the bone. And so that stops the disk from going beyond the bone. Just like in this model, the disk gets to the edge of the bone, the front and stops. And if you can see into the back, the disk would come to the edge of the bone and stop. If there is a tear in one of these coverings, the disk can then move or herniate or push out into a place that it shouldn't be because it's going through a hole in the ligament, or the annulus. It's torn.

The problem with a disk going where it shouldn't be is that this spine is pretty much anatomically correct. It is anatomically correct. There is very -- so your spine, my spine, it all pretty much looks exactly like this. There's very little space between the end of the bone and the spinal cord and the end of the bone and the nerves which come off the spinal cord.

So if a disk were to herniate through a torn covering and go into an area that it shouldn't be, it can push on an important structure.

We talked about the nerves that go to all parts of the body and the nerves are responsible for pain. Whether we can move or not, whether we have motion, whether we can feel the difference between hot and cold, whether we can feel vibrations and all that is controlled by the nerves. So that if something's pushing on the nerve, you could have a problem with feeling or doing.

So that's pretty much all you really need to know about the anatomy of the spine.

Q. Doctor, I'm just going to stop you there.

For purposes of an axial view I'm going to just show you what I have here and ask whether or not this would assist you just so that the jurors can see, again, a sliced section.

Would that assist you as far as looking into

the spinal cord?

A. Sure.

MS. NEUMUNZ: Your Honor, can I just have that just as an exhibit?

(Whereupon, Plaintiff's Exhibit 4 was marked for identification.)

Q. If you could just explain so that the jurors can understand the position of the spinal cord within the spine.

A. This is a model of a spine. Mine should be so easy. And this is a disk, which is jelly and springy and it goes in between two bones. So that it's like a little shock absorber.

Now, I told you that this is the spinal cord coming down. Right now we're looking at it as though we cut this and look inside this way. The spinal cord comes down and at each level through a hole a nerve comes out and this would be the top, like that and there would be a hole where the nerve comes out on the right side and the left side. The spinal cord in the middle.

If there were a disk herniation, the disk wouldn't look like that. The white is the tough outer part of the disk and the pink is the jelly part of the disk. It would look like that. The disk material has herniated out through the covering that is holding it in place and now it is outside of the disk and pushing out. And what would

happen then, if you had a disk that was herniated, you would then have just for the purposes of demonstration, you would have a disk in a place that it shouldn't be pushing on a nerve or even worse, the spinal cord, if there was a disk herniation.

So that just is to explain a problem. This is a problem disk.

THE COURT: Are you going to show that?

MS. NEUMUNZ: Yes, your Honor.

THE COURT: You need a box.

MS. NEUMUNZ: Your Honor, may I have these marked?

THE COURT: What are they, blow-ups of what?

MS. NEUMUNZ: Blow-ups of the MRI that were read by this doctor of John Butler. They are inscribed so and I'll have the doctor talk about them.

THE COURT: Certain areas.

MS. NEUMUNZ: Yes.

THE COURT: Okay, please mark it now for identification only.

THE COURT: Did you mark the MRIs? You want them all in the envelope?

MS. NEUMUNZ: Yes.

(Whereupon, Plaintiff's Exhibits 5, 6 and 7 were marked for identification.)

THE COURT: And 7 is the MRI.

Without objection; is that correct?

MS. SMODISH: Just so we're on the same page, what is 5, your Honor?

THE COURT: 5 is the blow-up.

THE CLERK: 5 and 6 are the two blow-ups.

THE COURT: Is that an authentic blow-up?

MS. NEUMUNZ: Yes, yes, yes. It's an exact duplication, just enlarged for the jury to see.

MS. SMODISH: Let me see the blow-up.

THE COURT: Which frame is that? Which one?

THE WITNESS: The blow-up? Number 5 is Slices No. 4 and 5, T1. 4 and 5, T1.

THE COURT: And 6?

THE WITNESS: 6 is Slice No. 5, T2 sagittal.

THE COURT: Why don't we -- that's only in as ID. You want to put them into evidence after he reads the MRI, then please compare the two.

MS. NEUMUNZ: Okay, thank you.

THE COURT: So we make sure that everything -- because I think that would be most efficient.

MS. NEUMUNZ: Okay, thank you, your Honor.

Q. Doctor, could you just tell us what you have.

I believe you have what's been marked for identification the films of John Butler and just if you could

just tell us what you see there.

A. This is an MRI scan of the neck on this patient and the way we look at things in this particular scan is from the side. So we're all looking at side views.

Now, when you look at the side view of the model, you are kind of blocked, you only see the right side or the left side, you can't really see the middle. But on the MRI we can take little thin slices going from right to left or left to right and pull them out and look at them.

So that we can -- what I'm now showing you, each one of these little boxes is an MRI scan going from one side of the patient to the other side of the patient. In this case from the right to the left.

And we have ten pictures on this slice, on this piece of film. The first picture starts all the way off on one side. The last picture goes all the way to the other side and in between we see the inside of the spine and the bones.

Now, if we go to the middle pictures, you'll see the middle, the spinal cord. We'll also see the middle part of the disks and the middle part of the bones. That's straight down the center. So if you direct your attention to the middle row of pictures, you will see -- for example, let's take the very middle, this one, No. 5, you will see gray squares and each one of these gray squares is one of

these bones which we call vertebral bodies and each one has a number.

We number them really from 2 through 7. 1 is a special case. So the top square here is 2 and then 3, 4, 5, 6 and 7 until we get to the next part of the spine, which we are not going to really deal with today.

In between these bones are gray objects, gray, and these gray objects here are the disks. In between the bones are the disks.

Now, this is the front of the patient here and this is the back of the patient here. So in the front of the patient are these bones with the disks and right behind the bones and the disks is the spinal cord and here's the bottom of the brain. And this gray stripe coming down is the spinal cord and around the gray stripe it's white and we can manipulate what's black and what's white by telling the computer how we want those magnetic waves to go in the body.

In this particular instance we've told the computer to show us everything that's watery, everything that has water in it to be white and things that don't have a lot of water in it to be black. So the spinal cord is kind of watery so it's gray. Around the spinal cord is a white stripe in the front and the back and that's because that is the cerebral spinal fluid.

We've all heard about spinal taps. You put a

needle in and take fluid out. Well, there's the spinal fluid and we can see the spinal fluid.

Now, I told you that each one of these disks in between the bones can only go to the edge of the bone and must stop if everything is okay. However, if there is an abnormality of one of the coverings of the disks, then the disk can punch through or herniate through and push into a place where it shouldn't be pushing.

And you will see that there are two levels and I'm going to show you more pictures and there are blow-ups so that you can see it because these pictures are very small, there are two levels where the disk pushes beyond the bone and they are between the fifth bone and the sixth bone which is C5 and 6 and between the sixth bone and seventh bone which is C6-7. And in both of those cases at C5-6 there's a little pushing back on the spinal fluid and at C6-7 there's a very big push back from the disk. And as I'll show you, it pushes directly not just on the spinal fluid around the spinal cord but it pushes directly on the spinal cord itself.

So we can make -- as I told you, we can make the white and black the way we wanted to make the white and black. So if we look at these which are called T1 sagittal images, again we're looking from the side, but in this case we want water to be black. So the spinal fluid is dark. Whereas the spinal cord is, you know, has some water in it

but not as much as the fluid. That remains gray. And you can see here between 6 and 7 there's a large herniation and we'll show you blow-ups, I think we have to do that, that's actually pushing on the spinal cord.

Let me put a little arrow on it. It's not coming out very well, but we'll show you blow-ups. I think we can show you blow-ups.

Q. Doctor, any preference?

A. No.

Q. Should we go to the little and then big or the big and then little?

A. Doesn't make a difference.

Now, we're looking on this one which is number --

MS. NEUMUNZ: Number 6.

A. Number six. This is the center cut that I showed you on small pictures. It's the same thing, it's just blown up because it's impossible for everyone to see.

Q. Doctor, does that correspond with one of the MRI films?

A. Yes. It's Slice No. 5.

Q. Is that an exact enlargement of Slice No. 5?

A. Yes.

MS. NEUMUNZ: Your Honor, I move to put Exhibit No. 6 into evidence.

THE COURT: Any objection?

MS. SMODISH: No.

(Whereupon, Plaintiff's Exhibit 6 was received in evidence.)

A. I mean this is -- I think you can see this pretty easily. I'm just going to number the bones here. 3 -- 2, 3, 4, 5, 6, 7, 1.

So I've just numbered the bones and you can see that here the disk is -- you can see the white stripe. The white stripe is the fluid that surrounds the spinal cord which is the middle and you'll see at this level 5-6 that this disk, the darkish area in between bones 5 and 6. So the disk in between 5 and 6 pushes on the white stripe and it makes it gray.

So the white stripe is now starting to be lost there. Meaning that the disk has pushed out or herniated out and is pushing on the spinal fluid. At 6-7 it becomes very obvious what's happened. This whole big glob of disk, and you can compare it to normal, between 2-3, 3-4, 4-5, 7-1, you'll see there's a huge glob of disk that's pushing out and that's a big herniation with the disk herniating through the coverings. You don't see spinal fluid but it directly pushes on or impinges on the spinal cord itself.

Q. Now, at that level, Doctor, what is in the spinal cord at that level?

A. Nerves. The spinal cord is made up of nerves and at every level the nerves come off, the nerves come out of the holes in each side. So between 5-6 the nerve will come out, between 6 and 7 a nerve will come out to the right and the left and at every level the nerves comes out.

Q. And, Doctor, the configuration of this looks like it's actually even going down. Can you explain what that is?

A. Well, the herniation is really so large that it just doesn't have any room anymore to go straight back because the spinal cord is there and being hit and so it's going, pushing back to the spinal cord and part of it is actually coming down along the front of the spinal cord. It's just running out of room. This is -- from here to here is one centimeter. This is basically just about a little bit less than half an inch. From this line to this line is a little less than half an inch. You can see the room here between the back of the bone and the spinal cord normally is maybe an eighth of an inch. Very, very tiny. And this is a rather large herniation that pushes on the cord because there's no more room left so the disk material is coming down as well.

If we look at No. 5 which are Slices 4 and 5 and in this one the spinal fluid is dark instead of white, again you can see the disk herniation very well here. And you can see the spinal cord is going down, down, down and you

can see that it's being deviated or pushed back at the C6 level and you can see the disk material inside there and again you can see at 5-6 there's also a nubbing of disk material being pushed back as well.

So the bottom line is that -- and again you can see here very nicely the spinal cord is being pushed back here, herniation at 6-7 and at 5-6.

So you can see very nicely there's a large -- as herniations go this is very easy to see -- large herniation pushing out of its normal space onto the spinal -- area of the spinal fluid and directly upon the spinal cord.

Q. And, Doctor, before I ask you about the significance of a herniation in someone the age of -- how old -- 26, male 26.

Can we just go back to the larger blow-up or enlargement and can you just comment to the jury about in general the appearance of the spine.

A. Well, the other finding on this study is that this is an abnormal curve of the cervical spine. The normal curve of the cervical spine is like this. In other words, the front of the spine is more forward than the back, okay. When we stand straight up, the normal curve is the opposite of this. It's actually like that. The top of the neck, top of the cervical spine is towards the back. The bottom is a little bit towards the back and the middle is curved towards

the front.

This patient has a reversal of the normal curvature of the spine, of the cervical spine. So that's the other finding here. The remainder of the disks are normal. Each of the disks has the same height as the other disks.

Q. And what is the significance of the same height?

A. Well, as I told you, as the -- the function of the disks are to be shock absorbers and they're gelatinous and they are contained. Once a disk is ruptured out or herniated out, it starts drying out. So we would expect disks at some point to start losing some of its water and then what happens is after they dry out, they start because there's a lot of -- they become more brittle when they dry out, they become more brittle and they lose their height.

In other words, they get thinner. They're not as thick and as plump and as like a spring as they were. They get narrower because we always put pressure on our spine up and down and when it starts becoming more brittle, they become narrower. It loses its height.

When disks lose their height, the bones that are on either side of the disk come closer together.

When bones come together, the body doesn't like that because bone on bone is not a good thing. That's why we have -- many areas of our body have structures like cartilage or disks that separate our bones but when the bones

come together, there's an unnatural force that's exerted on the bones that the bones have to respond to. And the way they respond are by forming bone spurs.

Bone spurs are a response of bones getting too close together being not in balance with each other and in order to try -- for the body to try to keep its integrity, to keep its structure in place, it forms what are called osteophytes or what we know as bone spurs.

So in this particular case, this spine has not done that yet because the disk -- and you can actually take a ruler and measure them -- every disk in the cervical spine are of the same height. They haven't yet become brittle enough to have lost their height. And the spine as of yet has not formed any bone spurs.

Q. What would that indicate to you, Doctor, I mean as far as actually maybe the age of the herniation?

A. Well, it indicates that the herniation is relatively recent meaning that the body, that the disk -- if you measure the disk from here to here and the disk between 6 and 7, you measure the disk between 5 and 6, measure the disk between 4 and 5, measure the disk between 3 and 4, you will come up with the same measurement, the same height. So this has not gotten to the point yet.

Yes, it's pushing on the spinal cord and it's pushing on the nerves that are in the spinal cord, but it

hasn't gone to the point yet where it has degenerated such that the disk has lost its height so that the bones are on bone yet, whenever this was done in 1999, in December 1999.

Q. Doctor, I'd like you to assume that -- and subject to connection -- that in July of 1999 John Butler was taking a shower in his bath, obviously in his bathroom and without warning a ceiling collapsed on his head, it hit directly on top of his head, he was thrown back, he tried to catch himself with his wrist and he fell out of the tub, there was cement, there was plaster, there was wood contained in that ceiling and thereafter, he was taken to the emergency room where he complained of severe pain in his neck as well as in his back and that was in July of 1999, would that correspond -- and after continued complaints, he ended up having an MRI six months later.

I need to know within a reasonable degree of medical certainty as to whether or not that which you've noticed -- which you've identified here, the herniation, that that accident was a competent producing cause of the herniation.

A. Yes, absolutely.

Q. Now, Doctor, does that also, the six-month time span, span from the time of the accident to the MRI, does that also correspond with your findings here with respect to the fact that there's no arthritic changes, that the disk

heights are normal except for the fact that there's a very large herniation there?

A. Yes, it does.

Q. Now, Doctor, I have a few other questions I'm going to just ask.

Doctor, with respect to a normal 26-year-old man, can you tell the jurors, a herniation such as that, what is that caused by?

THE COURT: What is what? What was the question?

MS. NEUMUNZ: What is it caused by, a herniation.

THE COURT: What is it caused by?

Q. A herniation in a 26-year-old male, without any prior symptoms of any injury, pain, disability with respect to his neck, who undergoes an accident wherein a ceiling falls on the top of his head, Doctor, within a reasonable degree of medical certainty would that herniation be caused by that accident?

MS. SMODISH: Objection. He just testified to that.

MS. NEUMUNZ: You know what, your Honor, I'm actually rephrasing it because I didn't put in the other question with respect to the prior -- no prior injuries, no prior complaints.

THE COURT: Was it caused by trauma is what she's asking.

THE WITNESS: Given what she's saying, yes, absolutely.

Q. Now, Doctor, what is the consequence to a spine of a 26-year-old after a trauma such as what I've described to you and the resulting herniation? Could you just tell the jurors within a reasonable degree of medical certainty what happens.

A. Well, once a disk is herniated and the ligament is torn, that ligament doesn't heal and you can expect these disks to get brittle. As I said, it's certainly reasonable, reasonable to expect these disks to get brittle, lose their height and eventually form arthritic changes in the spine. I mean, that's not even talking about the fact that there's a disk herniation pushing right on the spinal cord. If that pressure is continual, then the changes within the spinal cord itself can be permanent as well, but this is -- this is permanent.

The ligament is not going to heal and a patient who has these findings is in general more likely to --

MS. SMODISH: Objection.

A. -- to degenerate.

Q. Within a reasonable degree of medical certainty,

Doctor?

A. Yes.

THE COURT: I will allow that.

Q. Doctor, a herniation that compresses on the spinal cord, is that a competent producing cause of pain?

A. It can be.

Q. Doctor, I want you to -- withdrawn.

Doctor, a herniation, what happens to the annulus as a result of the herniation?

A. It's torn.

Q. Is that a competent producing cause of pain, Doctor?

A. It can be.

Q. Okay, Doctor, I want you to assume that my client after being hit on the top of the head as a result of the ceiling falling down and going to the emergency room was complaining of severe pain in his neck and that this -- prior to this he had no other complaints of pain and following continued complaints of pain he was sent for the MRI.

I need to know within a reasonable degree of medical certainty as to whether or not that pain that he was experiencing is related to the herniation that you've told us about in the MRI.

A. Yes, given that, just to repeat what you said, that he had no symptoms at all, he had no pain at all, he had some

type of event happen to him, a trauma happen to him after which he had pain and an MRI showing a large herniation, yes, it's medically reasonable and likely that the herniation was caused by a trauma and the pain is caused by a trauma, just to repeat what you are saying.

Q. And, Doctor, with respect to the herniation itself, the annulus, that's a permanent tear in the annulus; is that correct?

A. Yeah, a tear is a tear.

Q. And, Doctor, with respect to the herniation and the escaping of the nucleus pulposus, the gel-like substance, is that a permanent condition?

A. Is that a permanent condition?

Q. Yes.

A. Yes, once the disk is herniated, it's herniated.

Q. Doctor, and what, if anything, can be done to correct a herniation such as that?

A. Well, to correct it? A patient can have surgery and take the disk out.

Q. It doesn't go away.

A. A herniation is a herniation.

Q. Doctor, could you tell us within a reasonable degree of medical certainty as to what happens to the body when there's a compression, a continual compression on the spinal cord at a level C5, C6?

A. Well, it's --

Q. Excuse me, I misspoke, C6, C7.

A. Well, constant pressure on the spinal cord can cause changes in the cord itself. The cord itself can become fluid filled or can be what we call edematous and it can be irritated by the constant pushing by the structure on it. It could swell and cause the nerves to be pushed on further. The cord itself can degenerate and form a fluid-filled sack in the middle of it.

So there are a few things that can happen to the cord that can be problematic.

Q. Doctor, I want you to assume subject to connection that my client's going to testify that after he had the severe pain, finally went for the MRI, that he began to develop symptoms in his shoulders and down -- that were pain, burning, stabbing and tingling sensation into his bicep and down into his hand.

I need to know within a reasonable degree of medical certainty as to whether or not that corresponds with the herniation and the injury that you've told us about.

A. Well, you have to look at a chart, a dermatome chart and to look at the nerves that come out of the spine to see what conforms to the patient's pain.

Q. Doctor, would this help the jury?

A. I don't know what it is.

Q. With respect to the dermatome? Oh, I'm sorry.

A. Yes.

MS. NEUMUNZ: Your Honor, can I have something marked for identification?

THE COURT: Well, we're certainly getting a lot of displays here today. That is, according to my figure, 8, correct?

THE CLERK: Yes.

(Whereupon, Plaintiff's Exhibit 8 was marked for identification.)

THE COURT: Exhibit 8, and that is a visual of what?

MS. NEUMUNZ: The dermatomes of the spinal system, your Honor.

Q. Just if you could just relate to the jury about the spinal system and the dermatomes.

THE COURT: No objection?

MS. SMODISH: No objection.

A. This is a chart of the nerves. Remember we gave numbers to each one of the levels where the nerves came out. So these are the actual places where the nerves go. For example, C3, the third cervical nerve goes to the front of the neck here on the top. Whereas C6, the sixth nerve that comes out the left side, the right side, goes down the outside of the arm here. C7, the seventh nerve is -- there's

actually an eighth. I don't want to get into it. It could be confusing. But C7 goes to the outside two fingers here, C8 goes to the inside two fingers. So you can see where all the nerves travel.

This is the front of the patient, the back of the patient. So the back of the arm. C7, C8 go all the way down the back. C6 goes down the side. C5 goes down the front. So you have 5, 6, 7, 8. Just a representation of all the nerves.

Q. And, Doctor, with respect to dermatomes, so that the jury can understand, when there's disruption at one level here, what occurs? Is there a corresponding pain or -- with respect to --

A. Well, if a nerve is pushed on or if the spinal cord is pushed on, that contains nerves and a nerve or a group of nerves can be effected or affected by whatever is being pushed, by whatever is pushing it and so the nerve can swell and you can have pain, you can have tingling, you can have difficulty in moving. You can have difficulty in discerning hot from cold, vibrations and all of that. So if there is an injury that involves a nerve, we would expect there to be some symptom that the patient complains of corresponding to which nerve it is.

So if the patient says I have a pain right there, we would look at C5 and C6 to see if there's a problem

with those nerves.

Q. Thank you, Doctor.

I'll move on to the Caledonian Hospital records.

Doctor, I want you to just assume that my client two days after going to the hospital and as a matter of fact, having an X-ray taken of his spine --

MS. NEUMUNZ: Your Honor, I believe these have been moved into evidence.

Q. I'm just going to show you.

MS. SMODISH: Wait a minute. You said Caledonian.

MS. NEUMUNZ: I'm sorry, Kings County.

Q. Initially seeing the Kings County Hospital and the X-ray of the cervical spine was taken at Kings County, Doctor. Actually, you can read from that report.

MS. SMODISH: Excuse me, he can't read from the report. It's not in evidence. If he's relying on it --

THE COURT: The whole chart is in evidence.

MS. NEUMUNZ: The whole chart is in evidence.

Q. Doctor, can you --

A. On these films the vertebral bodies of the cervical spine C1 through C7 are visualized. There is no evidence of acute fracture or subluxation. The predense space appears

within normal limits. The visualized vertebral bodies alignment is within normal limits. The prevertebral retropharyngeal soft tissue appears within normal limits. Impression, no evidence of acute fracture.

Q. What does that indicate to you, Doctor?

A. It indicates to me that they read the spine as being completely normal.

Q. Now, we'll move on to the Caledonian hospital. I want you to assume subject to connection --

A. But that's an X-ray.

Q. Yes, an X-ray. And, Doctor, with respect to an X-ray, what can you visualize on an X-ray that's different on an MRI?

A. Well, X-rays -- MRIs are different. X-rays you can see the bones and you can see the space between the bones but you can't see the disks. So if there were to be a disk herniation, you would not see it on an X-ray. What you would see is that the spaces in between the disks are maintained or not maintained.

In other words, whether they would lose their height like we talked about. You would see if there was a fracture or not.

You would see arthritis on an X-ray, which we talked about a little bit.

You would see bone spurs, which is that

arthritic condition that where bones come together too close they form spurs. You would see that on an X-ray, too.

Q. Was any of that found by the radiologist at Kings County Hospital?

A. No. He read it as totally normal notwithstanding his inability or her inability to see the disks. Everything else, there was no arthritis, no narrowing of the disk spaces, no fracture, nothing else, nothing was found.

Q. But a disk could not be viewed on an X-ray is what you are telling us?

A. Right. That's why we do the MRI scans so that you can actually see the disk.

Q. Okay, Doctor, I'm going to go to Caledonian and --

THE COURT: May the doctor return to the stand?

MS. NEUMUNZ: Actually, I have an X-ray for the doctor so I'd like him to --

THE COURT: What is this X-ray?

MS. NEUMUNZ: This is X-ray of the left wrist which was misidentified as the right wrist but the doctor can -- it's in the hospital records that they misidentified it.

Q. But, Doctor, could you approach --

THE COURT: You looked at the X-ray?

MS. SMODISH: No.

THE COURT: Please look at the X-ray, see if the name is there.

MS. NEUMUNZ: This was subpoenaed, your Honor.

MS. SMODISH: My only objection -- Judge, I do have an objection.

THE COURT: Pardon me?

MS. SMODISH: I do have an objection.

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

Q. Just tell us what we're looking at.

A. This is a regular X-ray of the wrist and as I told you, with X-rays you can only see the bones. You can't see the structures in between the bones. We know they are there but you can't see them, just a space. This is the end of the forearm and you have two bones in the forearm, radius and ulnar, and these are the bones in the hand and in between the hand and the wrist there are actually eight bones.

These are these bones superimposed upon one another here. These are three separate views, 1, 2, 3. And the finding on this film is that there are two of the bones, there's this bone here, this curvalinear-shape bone which is the scaphoid. And then the next bone next to it underneath here is the lunate. There are eight bones and those are two of the bones, scaphoids and lunates, and they have a very

tough ligament also that holds the two bones together, the scapho-lunate ligament. And if that's torn, the scaphoid and the lunate, instead of being together separates and we call that a dislocation of the scaphoid. The scaphoid is dislocated because the ligament's torn. You can't see the ligaments here like you can see in an MRI but you know that it's happened because there's a space in between the two bones that shouldn't be there. There is not a fracture. This is a tearing of a ligament and scaphoid being dislocated and that's the finding on this film.

Q. Doctor, I just want you to assume for purposes that subject to connection my client's going to testify that two days before the X-ray was taken after the ceiling fell he fell back with his left wrist -- actually I'd like you to explain that to the jury -- but, left wrist on the faucet and then fell out of the tub and while he didn't complain about it because of his pain in his neck the first day, two days later he goes to Caledonian Hospital, has swelling and the complaints of pain in his left wrist, I need to know whether or not that injury was a competent producing cause of the findings that you found, the dislocation in the wrist?

A. Yeah. Again if the patient had no pain at all, no symptoms at all, had a trauma and two days later has an x-ray showing a dislocation of the scaphoid, it's reasonable within medical certainty to link up that the pain that's happening

is because of the dislocation which was because of the trauma.

Q. All right. Doctor, and the rupture of the scaphoid lunate ligament, is that a permanent condition?

A. Yes, once it's torn, it's torn, again.

Q. And is that rupture of the ligament, a dislocation of the wrist, is that a competent producing cause of pain?

A. It can be.

Q. And what is the future consequences of a dislocation in the wrist?

A. Well, again, the scaphoid is now in an abnormal position so the balance of the bones are off and so the body will try to compensate for that and because of that there's possibility of accelerated arthritis at that spot.

Q. All right, Doctor, I don't think I have anything more for you.

Just one other question, subject to connection.

John Butler in addition to having pain through his left arm also has sometimes difficulty in grasping with full strength on his left wrist. What, if any, structures can be compromised by a dislocation of the wrist such as you described?

A. Well, the structures in the neighborhood of this dislocation are -- there's a ligament, there's a piece of

cartilage actually. Let me show you here. That can be pulled off and you can't see it, you can only see it on an MRI, you can't see it on an x-ray that is between this bone, the ulnar and the bones here. In that space is cartilage that can be damaged and there's also tendons.

The reason we can go like this or go like that is because we have tendons in the front which are the flexor tendons and tendons in the back which pull down so that allows us to go back up, the extensor tendons. And tendons can be damaged as well. There are -- again, it's a very tight small space so those are possibilities of things that could have been damaged as well.

Q. And, Doctor, I'm just going to show you just for the purposes of marking this to show the jurors where the dislocation occurs. This is an enlargement of the X-ray we've been looking at?

A. Yes, this is abnormal. See that space between this bone and this bone, the gray area here, there should be no gray area. This gray area means that this bone, the scaphoid has now twisted up or dislocated. This ligament is torn. So like in the spine, we can look at normal versus abnormal, the abnormal just jumps out at you. In the wrist -- we don't have the other wrist, we only have one wrist to look at. This is an abnormal finding here. It's called the Terry Thomas sign because of the wide space between his front teeth

when this was first described many, many years ago before I was doing this.

Q. Really?

A. Yes, it's called the Terry Thomas sign and there's a space between the scaphoid and the lunate, the David Letterman sign for today.

Q. If you could just circle that for us, Doctor.

A. (Witness complies).

Q. And just so you -- is this the right or the left, because --

A. Well, it's marked right.

Q. And in reviewing the Caledonian Hospital records and looking at the X-ray --

A. Well, you can pull it out.

Q. Okay.

A. It says on the top, wrist left. And then it says the examination requested is X-ray examination of the left wrist with a clinical history of trauma. Note is made that the submitted three views of the wrist are labeled right. So that whoever read this said that there was a mistake in the labeling of the films.

Q. And, Doctor, with respect to the --

A. They are calling this three projections of the wrist, one, two, three, are labeled right, reveal apparent posterior dislocation of the carpal lunate. And we talked

about this is the scaphoid and this is the lunate. So there's a subluxation of the scaphoid and the lunate is being pulled away to the back. This is the lunate here.

Q. And that's of the left.

A. Right. So their impression was apparent posterior dislocation of the lunate. Orthopedic consultation is strongly recommended. You know this is usually a scaphoid dislocation but both bones appear to be in abnormal position because of the tear of the ligament so notwithstanding me saying there was a scaphoid dislocation and them saying it's a lunate dislocation, I do not disagree with this report. I think both bones are pulled apart and are in abnormal position.

Q. Thank you, Doctor.

MS. NEUMUNZ: Your Honor, I have nothing further.

THE COURT: Your turn, Counselor.

MS. SMODISH: Can we take a few minutes?

THE COURT: Yes, you may. If you want to look at the exhibit, you may do so. Let's take a little break.

(Whereupon, the jury exits the courtroom.)

(Whereupon, a recess was taken.)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

COURT OFFICER: Please be seated.

THE COURT: Counsel, you may proceed.

Ms. Smodish.

MS. SMODISH: Thank you, your Honor.

CROSS-EXAMINATION

BY MS. SMODISH:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. My name is Susan Smodish and of course I represent the defendant in this case.

You and I have never met, would that be fair to say?

A. Not that I recall.

Q. Now, I have your resume, Doctor, that was provided by plaintiff's counsel.

MS. SMODISH: May I approach the witness, your Honor?

(Handing.)

Q. I'd like to hand it to you and just ask you to review it briefly.

A. Yes.

Q. Your resume, your curriculum vitae I think would be the proper word.

A. Yes.

Q. Does that consist -- I'm sorry, have you reviewed

it?

A. Yes.

Q. Does it consist of four pages?

A. Yes.

Q. And is that your complete curriculum vitae?

A. No, it is not.

Q. It is not.

A. It's an old one. Very old.

Q. But that is the one that was provided to my office, so that's the one I'm working with.

A. Okay.

Q. On that resume there's nothing there that indicates that you have a teaching position; is that correct?

A. Yes, this may have been ten years old for all I know.

THE COURT: In the future, Doctor, I suggest that when you do send them out, you update. It's difficult for defense counsel to read the future if it's not on there.

THE WITNESS: Very much agreed.

MS. NEUMUNZ: I think it was the law firm's fault. They had something old. I apologize.

THE COURT: Whatever it is, I don't care but that puts defense counsel at a disadvantage.

Go ahead.

Q. I don't recall or -- I was taking notes as you testified before regarding your qualifications. I don't recall if you said that you were affiliated with any hospitals at the present time. Is that incorrect?

A. I'm a clinical assistant professor of radiology at Columbia Presbyterian Medical Center. That's a teaching position.

Q. You have a teaching position?

A. I teach there, that's correct.

Q. Are you an attending physician at any hospital?

A. I teach there.

Q. Right. Okay.

So you have a private practice; is that correct?

A. Yes.

Q. And you're on the Upper East Side; is that correct?

A. Yes.

Q. Do hospitals refer patients to you?

A. Yes.

Q. Okay.

A. All the time. Well, hospitals are buildings. You mean doctors who --

Q. Well, the doctors that examine and treat people within hospitals, do they refer patients to you?

A. Yes.

Q. Just tell me, you said you teach radiology. When did you begin your teaching position?

A. Probably in 1997, '96 or '97.

Q. And you've continuously been teaching at Columbia Presbyterian?

A. Yeah, my position's been continuous.

Q. What are your office hours?

A. Office sees patients from eight, between eight and 8:30 till about five. Sometimes I finish at seven, but the last patients are seen at five.

Q. And you yourself see patients, would that be fair to say?

A. I do see patients.

Q. Do you see patients beginning at eight o'clock in the morning and finishing up six or seven at night?

A. 8:30 to five and depending on how busy, could be longer than that, yes.

Q. How many days a week?

A. Five days a week.

Q. What equipment do you have in your office? Do you have an MRI?

A. MRI's on 77th Street. We can't physically fit the MRI into our office that we see patients in on 68th Street, so --

Q. What do you have in that office at 68th Street?

A. In 68th Street?

Q. Yes.

A. Bone density, we have mammography, we have ultrasound, we have fluoroscopy, we have X-rays, that's it.

MS. NEUMUNZ: Just note my objection as to relevancy here, your Honor.

Q. Do you personally, Doctor --

THE COURT: I'll allow it.

Q. -- perform the tests or do you have technicians that perform testing in your offices?

A. Some tests I do myself, some tests the tech does.

Q. Can you tell us which tests you perform personally?

A. All I perform are the ultrasound personally.

Q. What about MRIs, are the MRIs done in the 77th Street facility?

A. Yes.

Q. Do you perform the MRIs?

A. No, a technologist pushes the buttons for it.

Q. Do you read and interpret the results of those MRIs?

A. Yes.

Q. Then do you discuss them with your patients?

A. It depends. On the MRI, most of the time the physician gets the report who sent the patients and the physician who sent the patients will discuss the results with

the patient. Mammograms, ultrasounds, chest X-rays I discuss with the patients personally. CAT scans, MRIs generally the clinician discusses the results with the patient.

Q. You said you perform ultrasounds yourself; is that correct?

A. Yes.

Q. What about mammograms, do you perform those?

A. Well, again, the technologist pushes the button. I'm there on site responsible and I talk to each woman that comes through.

Q. Does your office perform biopsies?

A. I do.

Q. And do you personally do that?

A. Personally.

Q. How much of your practice would you say relates to cancer screening as you mentioned?

A. The majority.

Q. The majority.

A. Yeah.

Q. More than 50 percent?

A. Yes.

Q. How much more than 50 percent?

A. I can't estimate. It would be hard for me to estimate. Certainly the majority.

Q. In addition to your seeing patients and conducting

ultrasound tests and reviewing the results and preparing reports with regard to your findings, do you also have a portion of your practice that you devote to consulting on personal injury cases such as this one?

A. Minuscule.

Q. When you say minuscule --

A. I'd say less than one percent.

Q. But you do have a portion of your practice that is devoted to that; is that correct?

A. Yeah. Yes, you can say it's devoted, yeah.

Q. Within the past year, how often would you say you've consulted on a personal injury case such as this one?

A. Seven times.

Q. And you have a private practice.

You have a partner; is that correct?

A. Yes.

Q. And that's Dr. Lichi (phonetic)?

A. Yes.

Q. Does he also act as a consultant on cases such as this one?

A. Yes.

Q. Within the past year from today going back, how many times have you testified in court?

A. Again, I'd have to guess. I'd say the average is five times it could be in one year. Maybe three times one

year, eight times. But give or take one or two times. Somewhere between five times, six times. Every year varies.

Q. Over the last couple of years would you say you've consulted primarily on behalf of plaintiffs in personal injury cases?

A. No, absolutely over the last two years I would say definitely defense. I do much of the defense work for breast cancer, for failure to diagnose breast cancer and the vast majority of all the consults I do right now for legal purposes are defense.

Q. What about on the orthopedic side in a case such as this?

A. Orthopedic side would be 80 percent plaintiff, 20 percent defense roughly, give or take 20 percent.

Q. Is that a choice on your part?

MS. NEUMUNZ: Objection.

A. Is it a choice?

Q. Yes.

MS. NEUMUNZ: Objection.

THE COURT: Counselor, I'll sustain that objection. I don't know how -- I don't understand the question. In other words, he refuses to take defendants or refuses to take plaintiffs? These are patients I assume, Counselor. Get on another line of questioning.

MS. SMODISH: Okay.

Q. Well, Doctor, attorneys approach you to consult on their cases, would that be fair to say?

A. Attorneys do.

MS. NEUMUNZ: Objection.

Q. Pardon?

A. I'm sorry?

MS. NEUMUNZ: Asked and answered.

MS. SMODISH: I didn't ask that question.

THE COURT: I don't believe so. Go ahead and ask it again.

Q. Has it happened, Doctor, that attorneys with personal injury cases have sent records to you, films to you and asked you to review them?

A. Yes.

Q. And would you say that most of those in the last couple of years have been plaintiffs or defendants or can you not say?

A. Just as --

THE COURT: That is asked and answered. He told you most of them on orthopedic is plaintiff. Now, go on.

MS. SMODISH: Okay.

Q. Now, in your practice, Doctor, have you ever seen MRI films and MRI films of the cervical spine depicting chronic hypertrophic degenerative arthritis?

A. Yes.

Q. You've seen that. Okay.

What does the word hypertrophic mean?

MS. NEUMUNZ: Objection to relevancy. I've never --

THE COURT: Subject to connection.

MS. SMODISH: Subject to connection, please.

Q. What does the word hypertrophic mean?

A. Hypertrophy means exuberant growth.

Q. Exuberant growth of what?

A. Depends what you are talking about. Cells can be hypertrophied.

Q. With respect to the cervical spine could it mean exuberant growth of bone?

A. Yes.

Q. Could it -- withdrawn.

And the word degenerative, what does that mean?

A. It means that over time there are changes that occur to a structure or something that minimizes its function in general.

Q. And arthritis, what is the medical meaning of the word arthritis?

A. Arthritis by definition is an inflammation, actually, of the joint. But there are different types of

arthritis.

Q. Well, let's talk about degenerative arthritis.

Can you explain to the jury what that is?

A. Arthritis, as we talked about before, there are different manifestations of it. One manifestation we talked of are bone spurs. Bones can actually form spurs. Arthritis can include narrowing of the joint spaces of any part of the body, of the knee, the elbow, the spine. Those are common manifestations of arthritis.

Q. Would it be fair to say, Doctor, that arthritis generally develops over some period of time?

A. Yes.

Q. It doesn't develop overnight.

A. Correct.

Q. What would be some findings that you might expect to see on MRI films that would indicate the presence of degenerative arthritis?

MS. NEUMUNZ: Objection to form, your Honor. We have MRIs here if she wants to be specific. I'm going to object to the generality of it.

THE COURT: She's laying a foundation. I'll allow it.

A. What are the -- as I said, you can have spurs, you can have loss of height of the disks. Those are two conditions that -- those are important things actually that

could predispose the patient to having symptoms. So those are two important things to mention.

Q. Bone spurs and loss of height in the disks?

A. Right.

Q. And backing up, what would be the cause of loss of height in disks?

A. Again, the disks becoming brittle.

Q. Well --

THE COURT: We are talking about arthritis. Is that labeled as part of arthritis?

THE WITNESS: Yes, it can be.

Q. Well, I think you told us on your direct examination, Doctor, that the disks themselves, the interior part, the nucleus pulposus, that's a jelly-like substance; is that fair to say?

A. That's correct.

Q. Let me move on to something else here.

You said that bone spurs are a sign. What are bone spurs?

A. Well, we talked about how the bones can actually grow to try to rebalance out the spine once the bones are in an abnormal alignment. Bones are actually living things, they're not dead and so bones, when they are in an abnormal alignment, the bones will actually realize that there's an abnormal stress and will form a -- like a structure which is

a spur in order to realign themselves. It's like if a bridge was falling down, you may put a strut in or something to hold the bridge up from one side and that's the body's attempt to realign back to normal.

Q. You could call it a projection, a bone projection?

A. A piece of bone that comes out, is out of line would be a structure that's out of balance.

Q. Doctor, at any point before you testified today, did you review the report of Dr. James in particular regarding his review of the MRI of Mr. Butler's cervical spine?

A. Not before today.

MS. SMODISH: May I approach the witness, your Honor?

(Handing.)

Q. Just review that to yourself, please.

A. (Witness complies.)

Q. Have you had a chance to review that?

A. Yes.

MS. SMODISH: May I approach the witness again?

(Handing).

Q. In your practice, Doctor, have you ever seen bone spurs form on the top, the anterior portion of the spine?

A. Yes.

Q. And have you seen posterior bone spurs?

A. Yes.

Q. Now, is it your testimony, Doctor, that this MRI and the MRI that you reviewed that you had up on the easel in the shadow box before does not indicate the presence of any bone spurs in Mr. Butler's cervical spine?

A. Absolutely correct.

Q. Did the MRIs that you reviewed, that you reviewed for the jury here before show any desiccated disks?

A. The disks are desiccated.

Q. And let's see if we can put that up there.

What does a desiccated disk look like?

A. A desiccated disk looks like --

Q. Could you come and we'll use -- let me ask you this:

This enlargement here that we marked, I'm not sure what exhibit it is, the enlargement, does this show desiccated disks?

A. Yes.

Q. Let me put it on the easel and let me ask you to come up, with the Court's permission, and point out the desiccated disks.

(Whereupon, the witness approaches the easel.)

A. Remember we talked about everything in this picture that was white has a lot of water in it. And these disks

here are less white than the disks further down. So these disks have begun to start the early process of drying out.

In other words, we talked about the process of arthritis, we talked about how disks can first dry out and become brittle, second, lose height and then finally because they've lost height, the bones get closer together, can form spurs.

Well, the earliest manifestation of that is happening in that example this disk, this disk are less white than these disks. So the disks are just starting to become very brittle.

Q. And these disks here, down here below, 7, C6-7 and C7-T1 are white.

A. Yes.

Q. They show up as white, which means that there is more water content in them; is that fair to say?

A. Correct.

Q. You could step back to the stand. Thank you.

(Whereupon, the witness returns to the stand.)

Q. Is desiccated disks also something that we would expect to find in a person with arthritis, Doctor?

A. Desiccation can be the very early sign of something drying out, which is what desiccation means, the disks drying out. So it's the first and earliest sign.

Q. And over the long term as water is lost and the

disk dries out, what are the anatomical consequences of that process?

A. Over time because those disks have been damaged and are drying out now the disks are becoming more brittle and with time they may start losing height and if that happens then spurs or osteophytes can form.

Q. And with respect to movement, does that have any impact on a person's ability to move through the cervical spine?

A. Well, once the cervical spine -- again, once you lose that shock absorbing properties of the disks, you then can have a problem with arthritis and arthritis means that there can be problems with pain and movement.

Q. Is there restriction of movement?

A. There can be both pain and/or problem with movement once arthritis develops.

Q. And, Doctor, would it be fair to say that this is a natural process that happens in virtually all of us as we age?

A. Yeah, the important word of course is aging, as we get older.

Q. As we get older, would you expect to find it?

A. As we get older, yeah, well, there's a continuum. So it's highly unlikely to find it in the 20s, less unlikely but still unlikely in the 30s, more likely in the forties,

more likely than that in the 50s, 60s and 70s, so that an 80-year-old person is more likely to have arthritis than a 20-year-old person.

Q. But you did tell us we do see it on Mr. Butler's MRI.

A. Oh, it's a grossly abnormal MRI. It's a big herniation there as well, yeah. There's abnormal findings in that MRI.

Q. And there's remarkable disk desiccation on there; would that be fair to say?

A. I don't know. You wouldn't use remarkable for dessication. I would say that there's early desiccation of the disks. There's no structural abnormalities in those disks that are dessicated other than the herniation that we talked about.

Q. But you would not expect to find that in a person that was age 26, would that be fair to say?

A. It's unlikely to find findings of even early arthritis in a normal healthy 26-year-old than in a normal healthy 46-year-old or 66-year-old unless something's happened in the 26-year-old.

Q. Now, I think you told us the spinal column supports the body; is that correct?

A. No. Okay, that's fair. That's fine.

Q. I'm not a doctor. I'm just, you know --

A. Yeah, okay. It supports the body.

Q. If you disagree with me, tell me.

A. No, I'll agree.

Q. Well, it helps us to stand upright, does it not?

A. Yes.

Q. Are there any activities that you are aware of that might serve to accelerate the aging process? Withdrawn.

One of the problems we have is that over time as you get older, there's wear and tear on the spine just by activities of daily living; is that correct?

A. Yeah, as we get older there is more wear and tear on the spine that accumulates.

Q. And are there any activities or physical activities that you know of that might accelerate the process?

A. I can't be specific about activities that accelerate it because the person who does the activities may be in great shape with strong muscles as opposed to someone who's in terrible shape doing the same activity or even a lesser activity and so the lesser activity may predispose to a problem whereas the more strenuous activity may not. So there's a lot of variables here that can answer that.

Q. What about, you told us in a herniation the material, the nucleus pulposus is actually coming out of the disk; is that correct?

A. Yes.

Q. And that comes out through a tear in what we call the annulus fibrosis, right?

A. Yes.

Q. What is the annulus fibrosis composed of?

A. It's a fibrous structure.

Q. Sort of like a tire?

A. It's a fibrous structure that goes around the vertebral body and it closes the disk.

Q. And that's subject to wear and tear as we get older; is that correct?

A. It's no different than any other part of the body.

Q. No, but just as any other part of the body.

A. As any other part of body.

Q. Would it be fair to say that someone who leads a -- who has a job that requires them to move furniture and boxes and also someone who has a hobby of weightlifting, would that put unusual stress on the spine?

A. Well, like I said, there's other variables to take into account, so I can't say yes or no. I can't answer yes or no.

Q. The MRI that we have that you reviewed, Mr. Butler's MRI, do you know when that was taken?

If you need to refer to your report --

A. December 20, 1999.

Q. So the MRI shows the condition of Mr. Butler's

cervical spine as of that date.

A. That day.

Q. Correct?

A. Yes.

Q. Would it be fair to say, Doctor, that the herniations that you have described at C5-6 and C6-7 could have occurred on the day before?

A. Of course.

Q. Would it be fair to say they could have occurred on November 1st?

A. Could have occurred at any time before the date of the exam.

Q. Any time.

A. Could have occurred five minutes before as well. Well, less likely. The answer to your question is it's unlikely to have occurred a day before because of the associated desiccation in a young person who hadn't complained of any complaints before a trauma. So it's highly unlikely for that scenario to be correct.

Q. But it is possible.

A. Anything is possible. It's highly unlikely.

Q. And you told us that it does show the desiccation of the disks. You said there's no bone spurs, right?

A. Right.

Q. Would you say that the desiccated disks indicate a

weak -- a general weakening of the cervical spine?

A. The desiccated disks indicate a very early sign that the disks are becoming brittle.

Q. What about the herniation? You indicated that it's out of place because the ligaments were not holding it in place; is that correct?

A. They are torn. The ligaments are torn.

Q. Well, we can't see them on the MRI, can we?

A. But we know they are torn because of the position of the disks, that's correct.

Q. Would you agree with me given what we saw on the MRI of Mr. Butler that it is not possible to say with a reasonable degree of medical certainty that the herniated disks that we see on the film were not -- is it possible to say that they were caused by the accident of July 5, 1999; yes or no, Doctor?

A. I disagree with you. In other words, within reasonable --

Q. No, that's all.

A. -- degree of medical certainty as I was asked. I gave the answer to reasonable degree of medical certainty.

Q. But it's not possible to say that they were caused --

A. Possible could be anything.

Q. Doctor, people get arthritis without having trauma

such as that sustained in a car accident or a fall; is that correct? Is that fair to say?

A. Absolutely correct.

Q. It's something that happens as we age?

A. As we age.

Q. Without any trauma?

A. Right.

Q. And would you agree with me that not everyone as they age gets arthritic changes?

A. There's a continuum. Some to a lessor degree, some to a greater degree.

Q. I think you've told us before that Mr. Butler has the possibility of accelerated arthritis?

A. Yes.

Q. I think that's the term you used.

A. Yes.

Q. We are now a couple of years after -- a couple of years post-accident.

Would you agree with me, Doctor, that given what you just said that not everybody gets arthritis and arthritis sometimes develops in the absence of any trauma that it is mere speculation that Mr. Butler will get accelerated arthritis as a result of the accident of July 5, 1999, yes or no?

A. Well, I don't know how you want to define

speculation. What I did say is that it's possible -- I did say that he is definitely predisposed to having accelerated arthritis because of a rather large herniation at C6-7 and that's exactly what I said and what I repeated.

I wouldn't use the term speculation. I would say he was definitely predisposed to developing it. Whether he does or he doesn't will be his individual case.

Q. There's no way to know as we are sitting here today whether that will happen; is that correct?

MS. NEUMUNZ: Objection to form.

A. No, I'm saying it's predisposed.

Q. And, Doctor, one other thing. I think you told us ligaments in the wrist were torn?

A. Yes.

Q. A ligament?

A. Yes.

Q. Ligaments can be repaired, can they not?

A. Surgically repaired?

Q. Yes.

A. Yes.

MS. SMODISH: Thank you. No further questions.

REDIRECT EXAMINATION

BY MS. NEUMUNZ:

Q. Doctor, can you just tell us, what is the

relationship between trauma and in this case trauma where a ceiling falls down directly on the top of the head with the impact going through the cervical spine before it reaches the other part of the spine and desiccation? Can you tell the jurors what that relationship is?

A. Well, as I said, desiccation is a very early sign of disks becoming brittle. In a patient -- I think I said this. In a patient who is young, otherwise healthy, it's less likely to find drying out of the disks than in someone who is older and healthy.

When someone suffers some trauma and clearly there is evidence here of a trauma large enough to, within medical certainty in my opinion, to have caused a relatively large herniation that pushes on the spinal cord, when that happens, the disks become damaged. When those disks become damaged, they are then predisposed as we see here to start having very early signs of arthritis, which is drying out.

The disks have not changed in height, the bones have not gotten any closer to each other yet, if they ever will. But they haven't right now. And so therefore, as well, there are no spurs, no osteophytes, no other signs of arthritis in the spine now. So the desiccation, within a reasonable degree of medical certainty in this case would appear to be because of the trauma.

Q. And, Doctor, when you've been asked questions about

arthritis and expecting to get it when someone ages, are we talking about a 26-year-old or some other age? When someone ages, when do you normally expect to see the arthritic changes?

A. As I've said, when you age you're more likely to have arthritic changes. It's more likely for a 60-year-old or a 40-year-old to have arthritic changes than a 25-year-old.

You want to look at it the other way around, it's much less likely or highly unlikely for a 25-year-old to have arthritis when compared to an older person.

MS. NEUMUNZ: Thank you, Doctor.

THE COURT: Anything else?

MS. SMODISH: Nothing.

THE COURT: Doctor, thank you. You're excused.

(Whereupon, the witness is excused.)

THE COURT: Do you have another -- it's five o'clock. Come up for scheduling, please.

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

THE COURT: I think we have accomplished a good deal today. It gives you a lot to think about.

It is a fascinating area and I've heard it before, obviously, the situation about spines as this is

what this case is about in damages and it is interesting.

As I told you, being on a jury is a fascinating experience. Not only because you are here but because it is also a learning experience in many, many ways.

The obvious learning experience is to learn how juries and lawsuits work, but in addition, you're getting an education as well. That always is helpful. We will come back -- Tuesday I have all my motions. We will come back on Wednesday morning and I expect that we are scheduling morning and afternoon of testimony and then we'll go on.

Just in case anybody wants to know, on Thursday we're scheduling from twelve o'clock on and Friday from twelve o'clock on. The morning I am using for my guardianship hearings. I'm trying to get it so there is some continuity.

Have a very good evening.

JUROR: What time Wednesday?

THE COURT: Wednesday, not tomorrow but Wednesday, I'm sorry. Wednesday at ten o'clock, our normal time.

Thank you very much. Have a good evening. Don't talk about it, don't open up your own medical

office tonight.

(Whereupon, the jury exits the courtroom.)

(Whereupon, the matter is adjourned to Wednesday, April 10, 2002 at ten a.m.)

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