UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X
TAMAR TCHELIDZE,

PLAINTIFF,

-against-

Index No:
10 CV 4158

THE TJX COMPANIES, INC. d/b/a T.J. MAXX and MARMAXX OPERATING CORP.,

DEFENDANTS.
----------X

DATE: January 20, 2012

TIME: 11:00 a.m.

DEPOSITION of a Non-Party Witness, SEBASTIAN LATTUGA, taken by the Defendants, pursuant to an Order, held at the offices of Wingate, Russoti & Shapiro, LLP, 420 Lexington Avenue, New York, New York 10170, before Marleine Lamey, a Notary Public of the State of New York.

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

WINGATE, RUSSOTI & SHAPIRO, LLP
Attorneys for the Plaintiff
TAMAR TCHELIDZE
420 Lexington Avenue
New York, New York 10170
BY: JOSEPH STODUTO, ESQ.

CERUSI & SPRING, ESQS.
Attorneys for the Defendants
THE TJX COMPANIES, INC. d/b/a T.J. MAXX
and MARMAXX OPERATING CORP.,
One North Lexington Avenue
White Plains, New York 10601
BY: THOMAS F. CERUSI, ESQ.
File #: 100.7746-10

* * *

Lattuga

S E B A S T I A N L A T T U G A, called as a witness, having been first duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

MR. CERUSI: I am just going to request on the record a copy of Dr. Lattuga's file. I am missing two additional visits from the records that were provided with the expert disclosure. I am missing the September 16, 2011 and the December 16, 2011 visits but I would also request a complete copy of that and I just ask that I be provided by next Friday since next Friday is the date for the completion of all discovery.

MR. STODUTO: Off the record.

(Whereupon, a discussion was held off the record.)

EXAMINATION BY

MR. CERUSI:

Q. Please state your name for the

record.

A. Sebastian Lattuga.

Q. What is your current home address?

A. 78 Laight Street, New York, New York 10013.

Q. Good morning, Dr. Lattuga.

A. Good morning.

Q. My name is Tom Cerusi. I am with the law firm of Cerusi & Spring and I represent the defendants in this case. I am going to be asking you some questions this morning concerning your involvement in the treatment of Tamar Tchelidze who you performed surgery on back in May of 2010. If at any time you do not understand my questions, let me know and I will rephrase them for you in a way that you will understand them. I just ask that you keep your voice up and answer all questions verbally, okay with you?

A. Yes.

Q. Other than Sebastian Lattuga are you known by any other names?

A. No.

Q. The address you gave us that is your residence?

A. Yes.

Q. How long have you resided there?

A. Three years.

Q. Where did you reside before then?

A. 125 Prince Street.

Q. In New York City?

A. Yes.

Q. How long did you reside there?

A. Approximately three years.

Q. Your date of birth, Doctor?

A. 8/3/63.

Q. Where did you obtain your undergraduate degree?

A. St. John's University.

Q. What years were you at St. John's?

A. 1985.

Q. That is when you graduated?

A. Yes.

Q. When did you start there?

A. 198 -- I guess it would be three.

Q. Where were you before that?

A. Manhattan College.

Q. Was that from 1981?

A. Yes.

Q. Why did you transfer to St. John's?

A. Just to be closer to home.

Q. Where did you go to medical school?

A. SUNY Stony Brook School of Medicine.

Q. Where was that located?

A. Stony Brook, New York.

Q. Long Island?

A. Yes.

Q. For what years were you there?

A. 1985 to 1989.

Q. Did you do an internship?

A. Yes.

Q. Where was that?

A. Mount Sinai.

Q. In Manhattan?

A. Yes.

Q. What years were you there?

A. 1989 to 1991.

Q. What was your focus during your internship?

A. It was a preliminary year in general surgery and research in orthopedics. It was tied to my, you know, tied to my orthopedic residency program.

Q. That was my next program, did you do a residency?

A. At Stony Brook. I returned to SUNY Stony Brook orthopedic residency program 1991 to 1995.

Q. In addition to general surgery did your residency have any specific field or concentration?

A. My residency was in orthopedic surgery. General surgery applied to my internship year.

Q. Any fellowships?

A. Fellowship in adult and pediatric spinal surgery through 1997 at

the University of Miami, Jackson Memorial Medical Center.

Q. What did you do after that?

A. I went to private practice and I have been in private practice ever since.

Q. Private practice in New York State?

A. Yes.

Q. Tell me where you first were employed after you finished your fellowship down in Miami?

A. Well, I joined a group at the time in Rockville Centre, Long Island.

Q. What was the name of that?

A. Orlin & Cohen Orthopedic Associates.

Q. What years were you there?

A. I was there from 1998 through 2003 or 4.

Q. Are you still there?

A. No. Then I left the group in --

Q. Why did you leave there?

A. I went into my own practice.

Q. Have you been in your own practice since 2003, 2004?

A. Yes.

Q. What is the name of your practice?

A. New York Spine Specialists.

Q. Is that a practice that you're in with other physicians?

A. No, but I, I mean, now I have a physician employee but.

Q. So, is it fair to say that when you first started there you were a sole practitioner in that position?

A. Yes.

Q. Back in 2003, 2004 how many offices did you have for your practice?

A. One.

Q. How many do you have now?

A. I have five offices now.

Q. Is there a main office?

A. Lake Success.

Q. Now, the offices that you have are those offices for meeting patients?

A. Yes.

Lattuga

Q. Do you perform surgery in any of your offices?

A. No.

Q. Are you affiliated with any hospitals currently?

A. Yes, North Shore Franklin Hospital.

Q. How long have you been affiliated there?

A. Since 2004.

Q. Is that the only hospital where you are affiliated now?

A. Yes.

Q. Have you been affiliated at other hospitals since you have been in private practice?

A. Yes.

Q. What were those?

A. Mercy, South Nassau Community Hospital.

Q. Where is Mercy Hospital?

A. It's in Rockville Centre.

Q. South Community Hospital?

A. It's in Oceanside. Briefly I

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was on staff at Winthrop in North Shore Manhasset as well.

Q. Winthrop University?

A. Yes.

Q. Why did you leave Mercy?

A. I was offered the position of chief of spine surgery and chief of spine development for the North Shore Hospital system, so I was recruited to a different hospital system.

Q. Is that the position that you currently hold at North Shore Franklin Hospital?

A. Yes.

Q. How long have you held the position of chief of spinal surgery?

A. Since that time, 2004 or 5.

Q. What about South Nassau Community Hospital, the same thing?

A. Well, both of those hospitals when I went to Franklin, I resigned my privileges to those other hospitals.

Q. Is that the same with Winthrop and North Shore?

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A. I was briefly on staff. I resigned because I focused my energies into one setting.

Q. Is North Shore Franklin Hospital where you perform any surgeries that you conduct on your patients?

A. Yes.

Q. Can you break down your time for me between your offices as far as visiting, having patients in your office, and surgery and hospital rounds?

A. I operate every Tuesday and Wednesday.

Q. Full days?

A. Yeah. I am generally in the hospital every morning. It depends on the time of my arrival varies on how much work I am anticipating and then --

Q. When you say every morning, approximately how many hours in the morning?

A. Approximately an hour.

Q. Then in your offices?

A. Then I divide the remaining

Mondays, Thursdays and Fridays between the various offices.

Q. Are you in more than one office on a Monday?

A. Sometimes, yes.

Q. Is that the same for Thursday and Friday?

A. Correct.

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

A. Yes.

Q. Are you board certified?

A. Yes, sir.

Q. When did you first become licensed?

A. 1991.

Q. When did you first become board certified?

A. 1998.

Q. Has your license remained consistently in effect since 1991?

A. My license is in good standing and always has been, has not been subject

Lattuga

to disciplinary review.

Q. So, the answer is yes?

A. Yes.

Q. You have been consistently board certified since 1998?

A. Yes. I recertified in 2008.

Q. You're board certified in orthopedic surgery?

A. Yes, sir.

Q. Any subspecialty to that that you're board certified in?

A. No.

Q. I think you already answered my question, has your license to practice medicine ever been suspended?

A. No.

Q. Revoked?

A. No.

Q. Have you ever been censored?

A. No.

Q. I just want to have your CV marked.

(Whereupon, CV was marked as Defendant's Exhibit A for

Identification as of this date by the court reporter.)

Q. Doctor, I would like to show what you has been marked as Defendant's Exhibit A and that is a document provided to me by Mr. Stoduto. Is that your up-to-date curriculum vitae? Take a look at it.

A. Yes, sir.

Q. What is Long Island Day Op Center in Mineola?

A. That was an ambulatory -- that is an ambulatory center in which I was affiliated also briefly but I am no longer affiliated with them.

Q. Everything else that is on Exhibit A is in line with what you previously testified to as far as your education?

A. Yes.

Q. Before today have you ever testified in a litigated matter where there is a lawsuit pending?

A. Yes.

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Q. Approximately how many times?

MR. STODUTO: You mean at depositions, in court, all together, can you be more specific?

Q. Deposition, let's start with that, how many times?

A. Including Workers' Comp depositions or not?

Q. No, let's talk about non-Workers' Comp forums?

A. I would say about 20 times over the course of 15 years.

Q. Do you keep a list of the depositions that you have testified in?

A. No.

Q. Now, when you say over the past 15 years, is that from approximately 1996?

A. 1998 from when I went into practice --

Q. Did you ever give --

A. -- to date.

Q. Did you ever give any depositions before you went into private practice?

Lattuga

A. No.

Q. Now, what about during trial, how many times have you testified in the past 15 years in a litigated matter at trial?

A. I would say about 15 times.

Q. Let's take the 20 depositions that you have given, can you break down what the percentage would be for plaintiff or defendant as best you can?

A. Well, it would be mostly -- with respect to my testimony it would be either for the plaintiff or I would be the defendant in a medical malpractice action to be candid.

Q. Well, we'll put the medical malpractice on the side for a second, just in litigated matters where you have either been an expert witness or a treating physician, how many in cases in that respect?

A. Just for deposition?

Q. Just for deposition first.

A. I don't have -- it would be a

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guess but to give you an estimate it would be under five as a deposition.

Q. Five percent?

A. Under five times, let's say, of the 20 times that I was deposed.

Q. Well, what were the other 15 for?

A. It would either be some of them, let's say, another five or six I was a defendant in a malpractice action.

Q. What would the other say five be?

A. I don't know. I would put two on one and two on the other. Again, I don't keep a list, I am trying to give you an estimate.

Q. What about trial, again, with medical malpractice aside, in the trial testimonies you have given what percentage has been for the plaintiff and what has been for the defendant?

A. It's been for the plaintiff I would say exclusively.

Q. When was the last time you

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testified at trial?

A. About two months ago.

Q. Where was that?

A. I believe it's Queens County.

Q. Were you testifying as a treating physician?

A. Treating physician.

Q. Now, percentage-wise that you have testified at trial whether plaintiff or defendant percentage-wise as an expert witness or as a treating physician.

A. It's been exclusively as a treating physician.

Q. You have never been retained as an expert by the plaintiff where you have not treated the plaintiff?

A. Never.

Q. That is the same with this case?

A. I was a treating physician, yes.

Q. I asked you about your deposition. Do you keep any list or record of your trial testimonies that you have

Lattuga

given over the past 15 years?

A. No.

Q. Why is that?

A. There is no reason.

Q. Let's take the past three years, what percentage of your income has been derived from testifying in litigated matters?

A. Less than one percent.

Q. Have you ever testified in a case where the law firm of Wingate, Russoti & Shapiro was involved, this firm?

A. No.

Q. Have you ever worked on any cases with them?

MR. STODUTO: Can you define what you mean by worked on any cases?

Q. Have you ever consulted with them on any cases?

A. No.

Q. Have you ever worked on a case with Mr. Stoduto before?

A. Again, I don't work, you know, I am, essentially, a treating physician so.

Lattuga

Q. Have you ever consulted in a case where Mr. Stoduto was the plaintiff's lawyer before this one?

A. I don't understand the question.

Q. Have you ever consulted on any litigated matter where Mr. Stoduto represented the patient that you were involved with before this case?

A. Again, I believe I answered that question but I don't have any consulting arrangement or prior experience directly with this attorney firm or any attorney firm.

Q. How many times have you testified at trial in 2011, last year?

A. It's generally it's about once or twice a year I would say over the last five years would be the average number of testimonies.

Q. Did you do anything in preparation for this deposition?

A. I reviewed my chart.

Q. Did you speak to anyone?

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A. Other than the attorney briefly prior to this the answer is no.

Q. The attorney you're referring to is Mr. Stoduto?

A. Yes.

Q. When did you speak to him?

A. Approximately five minutes before we entered the room.

Q. What is your compensation for testifying at deposition?

A. Six hundred dollars an hour.

Q. When was the last time you gave a deposition before today?

A. Sometime last year. I don't have a specific recollection of the date.

Q. What were the circumstances where you testified, in other words, what was the case about, were you a treating physician, something else?

A. You reminded me, I was subpoenaed by defense -- a defense firm as -- subpoenaed as a practicing physician in Nassau County and they wanted to know my knowledge of MRI and I have no ownership or

interest in MRI whatsoever and how patients obtain MRI's in Nassau County and their ease of obtaining MRI's in Nassau County, so I was deposed in that action I guess as a witness.

Q. Was that --

A. It was a federal case.

Q. Was it a medical malpractice case?

A. No, no, it was some kind of -- it was a class action suit by physicians against an insurance company and they dragged me into it.

Q. Now, Doctor, are you familiar with an individual by the name of Tamar Tchelidze?

A. Yes, sir.

Q. Did there come a time when Ms. Tchelidze came under your care?

A. Yes, sir.

Q. Do you know how that occurred, in other words, how she got to you, was she referred to you or something else?

A. She was referred to me.

Q. How was she referred to you?

A. By her physical therapist I believe.

Q. Who was that?

A. May I review the chart, sir?

Q. Sure.

A. I don't have that. I don't have the name. I have a Dr. Winiarsky as a referring physician in a document that is filled out by the patient.

Q. That is part of your file?

A. Yes, sir.

MR. CERUSI: We're going to mark the doctor's file.

Q. Doctor, we're going to mark your file as an exhibit today and I have asked Mr. Stoduto to provide me a copy but we would ask that you, which I am sure you will, maintain the original as you have been doing; is that all right with you?

A. Yes, sir.

MR. CERUSI: Can we mark that, please?

(Whereupon, chart was marked as

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Defendant's Exhibit B for Identification as of this date by the court reporter.)

Q. Doctor, your file which you brought with you today has been marked as Defendant's Exhibit B for this deposition. Is that your complete file pertaining to your care and treatment of the plaintiff in this case, Tamar Tchelidze?

A. As far as I know, yes.

Q. Has anything been removed from that file before testifying here today?

A. Not that I am aware of.

Q. Do you know if anything is missing from that file?

A. Not that I am aware of.

Q. There are some materials located on the left side which are not hole punched as the rest of the file is. They are records from Beth Israel Medical Center. Do you see those?

A. Yes, sir.

Q. When did those come into your possession?

Lattuga

A. I am not sure.

Q. Were you provided with them today?

A. No, prior to today.

Q. Last week?

A. The chart was prepared in my office. I don't know when it was.

Q. Well, do you know if Mr. Stoduto's office had provided you with copies of those records?

A. I am not aware, sir.

Q. There are also some X-rays that were taken after Ms. Tchelidze's surgery, are those also part of your file?

A. Yes, sir.

MR. CERUSI: Why don't we mark those too.

(Whereupon, X-rays were marked as Defendant's Exhibit C for Identification as of this date by the court reporter.)

Q. Now, I think you mentioned earlier there was a questionnaire that Ms. Tchelidze had filled out when she initially

came to see you?

A. Yes.

Q. Is that a procedure or practice that you follow in your private practice?

A. Yes, sir.

Q. What is the purpose of a patient filling out a questionnaire at the initial consultation?

A. The main purpose is so that I can get a lot of information that I would ordinarily have to ask the patient for and if they fill out the paper, then I am able to glean very quickly the essential information that I need to help me formulate an opinion about what the circumstances are revolving around the patient's illness.

Q. So, that is something that you do with all patients that come to your office?

A. Yes.

Q. How does it work, when they come in before you see them, are they provided with that blank document?

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A. Yes.

Q. You rely on them to fill it out as accurately as possible; is that correct, sir?

A. Yes, sir.

Q. Do you know if the first time that Ms. Tchelidze had come into your office whether she was alone or with someone else?

A. I don't recall.

Q. If you could just take a look at the questionnaire, Doctor, I just have a couple of questions for you about that.

A. Sure.

Q. Is there any information contained on that questionnaire which indicates the circumstances which brought her to your office, in other words, did she have an accident, did something happen?

A. Only that it says type of accident, work injury, car accident, personal injury.

Q. What does she have checked there?

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A. Personal injury.

Q. Do you know the circumstances of how she sustained that injury?

A. Yes.

Q. How do you know that?

A. From my review of the records.

Q. What records?

A. There is an emergency room record from her admission to the ER subsequent to her injury.

Q. Well, did you have those ER records when you first looked at that questionnaire?

A. No.

Q. Can we agree that that is something that was provided for you some time later?

A. Yes, sir.

Q. As you sit here today you don't know when those records were provided?

A. That's correct.

Q. Were they provided to you in 2012?

A. I don't know when it was

provided to me, sir.

Q. Do you know if you were provided with those records for that purpose of knowing the circumstances of Ms. Tchelidze's accident?

A. I don't know why I was provided the records, sir.

Q. Other than those records do you have any other records in your file which pertain to treatment that was rendered to Ms. Tchelidze before you initially saw her?

A. This is -- as far as I know, this is the complete record.

Q. So, you were not provided with anything else before your treatment of her?

A. Again, as far as I know, this is the complete record.

Q. Do you know what doctors she saw before she came to see you?

A. Other than Winiarsky's name because it's present in my file, I don't really know.

Q. Do you know Dr. Winiarsky?

A. No.

Lattuga

Q. Other than Dr. Winiarsky do you know any doctors or facilities where she sought treatment before you saw her?

A. I mean, not specifically. I mean, there might be like a therapy record here and I might recognize the name. Do you want me to look for that? Other than that the answer would be no.

Q. The records that were provided to you in this case can we agree that those records start with her initial treatment on July 17, 2009 at Beth Israel Medical Center?

A. Correct, that is the earliest document, dated document, I believe. Let me double check a second. Yes, that is the earliest record that I have.

Q. Did you ever speak with any doctors or facilities that she went to before you initially saw her?

A. No, sir.

Q. Now, the first time you saw Ms. Tchelidze that was in April of 2010?

A. Yes, sir.

Lattuga

Q. Can we agree that that was approximately nine months after her accident?

A. Sure.

Q. Yes.

A. Yes.

Q. Now, other than the questionnaire that Ms. Tchelidze filled out at the initial consultation did either you or anyone from your staff take any additional information regarding a history from her?

A. No.

Q. Is that something that normally occurs in your practice, you rely solely on the questionnaire for a medical history?

A. Not necessarily, I mean, certainly it's a foundation for it. We may clarify that during our initial visit or on a subsequent visit we may get further information about the mechanism of the injury as it pertains to the care of the patient.

Q. Do you know if you did that in

this case when you first saw Ms. Tchelidze, did you take additional history, did you elicit additional injury regarding the injuries sustained in July of 2009?

A. I do not have any independent recollection. My records would reflect what my testimony would be with respect to each encounter.

Q. Other than her indicating personal injury on the initial questionnaire did you have any information about how she was injured before she saw you?

A. I mean --

Q. That you recall.

A. No, no.

Q. When you first saw her in April of 2010, did you know the mechanism of the injury, in other words, what exactly happened?

A. Again, I don't have an independent recollection of what occurred on that day.

Q. Now, let's look at the first

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consultation for April 30, 2010. Her complaints at that time were neck and back pain, upper and lower extremity radiation, correct?

A. Yes, sir.

Q. What do you mean by upper and lower extremity radiation?

A. Upper and lower extremity radiation refers to the patient's complaint of pain that is -- that radiates, that gives from the patient's perspective the sensation that it begins in one area of the arm or leg and moves to another area of the arm or leg. That is a very, very common complaint in patients with spine-related conditions. It's actually called radicular pain or radiating pain is a common complaint that patients make.

Q. Where was the radiation in the upper extremity, in other words, where was it going?

A. I did not specify.

Q. What about the lower extremity?

A. I didn't specify.

Lattuga

Q. Now, where it says history of present illness, again, on the initial visit it indicates patient is a 52-year-old female involved in a motor vehicle accident on 7/11/09, sustaining injury to the neck and back as a result. Where did you get the information regarding that it was a motor vehicle accident?

A. Again, I don't have an independent recollection but that is not what occurred but that is what is on the narrative for that date.

Q. Why is it on the narrative?

A. Transcription error.

Q. Well, how were these reports prepared? Are they dictated by you?

A. Yes.

Q. Then someone types them?

A. Yes.

Q. So, are you saying that it was a typographical error or an error in how it was dictated?

A. Again, I don't recall and I wouldn't because I don't have an

independent recollection but it doesn't correspond with the mechanism as I understand it today.

Q. What do you mean by that?

A. Well, after having reviewed the chart and all of the records I am aware currently that the patient -- that it was not a motor vehicle accident.

Q. The chart that you're referring to specifically are those Beth Israel records?

A. As well as the history that the patient fills out. I mean, I was just refreshed by -- my testimony is refreshed by the record.

Q. Well, in her questionnaire didn't she just indicate that it just said personal injury?

A. Yes.

Q. And then it had a date?

A. Yes.

Q. It didn't say anything about motor vehicle accident, right?

A. It doesn't say motor vehicle

Lattuga

accident, correct.

Q. It doesn't say anything about falling down in a store, right?

A. No, it does not.

Q. So, can we agree, Doctor, that the only document in your entire file before you which references the mechanic of this injury is referenced in the Beth Israel medical report?

A. Correct.

Q. Which you were not provided with when you initially saw the patient, correct?

A. I don't believe I had that document at the time.

Q. What are you referring to with regard to conservative treatment that she had?

A. In general and specifically in this case it would be physical therapy, massage, warm packs, exercise, acupuncture, what we term modalities of treatment associated with physical therapy, she had medicines like Tylenol with Codeine and

different attempts with medical management, she had what is called an epidural steroid injection which are -- which is an invasive procedure where medicine is introduced into the spine.

Q. Well, let me ask you, how do you know all of that?

A. That is on the history and physical that we have her fill out, it's circled by her.

Q. Can I see that?

A. It's this part all here, all of this would give you that information.

Q. Did you ever confirm that she, in fact, had those things done before she saw you?

A. Yes.

Q. How did you do that?

A. Well, it's my custom and practice to speak to the patient directly while reviewing this history and physical and so I like to make confirmation of the facts with respect to specifically her treatment and her symptoms.

Q. So, is it fair to say that you rely on Ms. Tchelidze to give you accurate information with regard to what treatment she had before she saw you?

A. Yes.

Q. Is there anything else that you base your answer on other than the questionnaire filled out by Ms. Tchelidze or any conversations that you may have had with her?

A. No, not in this particular case.

Q. You never spoke to any other doctor she saw before, right?

A. No.

Q. Before you saw her?

A. No.

Q. You never spoke to anyone at Beth Israel, right?

A. No.

Q. You never spoke to anyone who gave her physical therapy, acupuncture or any epidural injections, right?

A. No, I did not speak with.

Lattuga

Q. Now, her complaints at the time of the first visit were neck and back pain, upper and lower radiation with numbness, tingling and dysesthesia?

A. Yes.

Q. Did she have any complaints relating to her head?

A. Again, which was contained in my narrative would be the extent of my ability to testify in terms of recollection, so I don't see that word head here.

Q. Do you recall any complaints with regard to her right arm?

A. Other than the reference to upper extremity radiation, I don't have -- and other than -- other than that reference to upper extremity radiation there is no, the words right arm, do not appear on my narrative and also I would, just to make it clear, generally this consultation is from a spine perspective, so if a patient might have a concomitant knee injury or elbow or shoulder injury, it wouldn't necessarily

end up in my narrative even if it was significant.

Q. Have you seen any reference to any injuries into the head or right arm or any portions of the body other than the spine that is mentioned in your chart, your entire chart, that is in front of you?

A. Well, including or excluding the Beth Israel?

Q. Excluding the Beth Israel records?

A. No.

Q. Can we agree, Doctor, at the time you performed your surgery on Ms. Tchelidze in May of 2010 that you did not have the Beth Israel emergency room records?

A. I couldn't say that. Again, my answer to the question is I don't know when I received this document.

Q. Now, the symptoms that she told you were made worse and interfered with her daily activities were those things that she articulated to you?

Lattuga

A. Yes, sir.

Q. It says patient denies any other trauma, the trauma you're referring to is the incident of July 11, '09, right?

A. Yes.

Q. As far as past medical history she indicated that she had no prior injuries to her neck or back before the date of this accident; is that fair to say?

A. Yes, sir.

Q. Is that something that is important to you and that you rely upon in treating a patient and giving a diagnosis to a patient, in other words, getting an accurate medical history from them?

A. Yes. An accurate medical history is an important part of to helping create a diagnosis.

Q. Do you know Dr. Steven Horowitz?

A. No.

Q. Do you know anyone at Brooklyn Premiere Orthopedics?

A. No, sir, I mean, you have to

mention the names individually but I don't have an inmate knowledge of who or members of that organization.

Q. How about Boris Tsatkis do you know who he is?

A. I mean, I don't recognize the name.

Q. Serge Kianovski do you know who he is?

A. No, sir.

Q. Did she bring any records or any films with her during the first consultation?

A. I believe she brought the MRI films.

Q. How do you know that?

A. It is my custom and practice to review the MRI film prior to arranging for surgery.

Q. Well, did you keep those films?

A. I don't have them, no.

Q. So, that was something that she brought to you and you let her take back with her?

Lattuga

A. Yes, sir.

Q. Is there anything in your report here that indicates that you reviewed those films?

A. There is nothing in my report that signifies that I reviewed the film.

Q. In fact, the diagnostic imaging which is referred to on the second page of your 4/30/10 visit refers to the MRI report of July 31, '09, right?

A. Yes.

Q. So, that is what you reviewed on that day, right?

A. I reviewed the report but I probably, and that is the best, most accurate answer I can give you, would have reviewed the MRI on that date as well.

Q. But you did not note the MRI review?

A. Right.

Q. Is it your testimony, Doctor, before you performed surgery on May 12, 2010 that you had, in fact, reviewed the MRI that was taken in July of 2009?

Lattuga

A. Yes, sir.

Q. Is there any documentation in your file which indicates your findings or confirms your review of that film before you performed surgery on her?

A. I would say yes based on my diagnosis of herniated disk of the lumbar spine. In those circumstances where I don't have definitive evidence of a herniated disk I generally wouldn't write that as my diagnosis until I was sure or I felt as sure as I could be. In this case the diagnosis is lumbar sprain, lumbar spine radiculopathy, sprain and H & P, so as this narrative represents the sum and substance of my thoughts on that day. The fact that I wrote herniated disk which is H & P signifies to me that I had an opportunity to review that MRI on that date and felt comfortable at that point proceeding and recommending surgery.

Q. Can we agree, Doctor, that the MRI report that you referenced in your April 30, 2010 office note does not

indicate a finding of a herniated disk?

A. That's correct.

Q. So, can we agree that your reading of the MRI was different than the radiologist who prepared the MRI report?

A. To a certain extent, yes.

Q. Did you also find that there were degenerative changes at L4-L5 and L5-S1 upon your reading of the MRI film?

A. Yes.

Q. How do you know that?

A. That is consistent with -- that is consistent with the information I have intraoperatively and consistent with, you know, obviously in preparation of this I reviewed my X-rays, et cetera, I had an opportunity to review what some of the findings were at the time and so there are degenerative changes presents in her spine at the time of surgery.

Q. Degenerative changes, just so we're clear, those are changes that occur over a period of time, correct, to a person's spine?

A. To a certain extent, yes.

Q. What do you mean to a certain extent?

A. Well, they are the consequence of some process, age related, you know, wear and tear, age-related changes to the spine.

Q. Would you agree with me that to have degenerative changes at L4-L5 and L5-S1 for a 52-year-old female would not be an uncommon thing?

A. It's something we find often.

Q. It also says in the MRI report there is a suspected ulnar fissure at L4-L5, what does that mean?

A. That is -- what -- it's annular fissure and, essentially, that is a tear in the cover of the intervertebral disk, specifically the portion called the annulus which is the outer cover or analogy would be the rind, like the rind of an orange, and that tear, fissure, he is using the word fissure, as he characterizes it, but that is an injury. It's considered

traumatic, acute injury, to the annulus and it's a finding that he is making, an observation that he is making, by reviewing the MRI.

Q. Is a fissure something that can occur as a result of degenerative changes?

A. It can but there are other more likely mechanisms for it to occur.

Q. But, again, he does not note or suspect that there is a herniated disk in his interpretation and when I say his, the radiologist, who wrote the report, he doesn't mention or indicate a finding of a herniated disk, right?

A. He doesn't mention that, no.

Q. Is it fair to say he also doesn't mention whether or not there is any compression on any nerve roots, correct?

A. That's correct.

Q. Upon your review as best you can recall of the MRI do you recall seeing any evidence of nerve root compression on any of the findings that you saw on the MRI?

Lattuga

A. I mean, I don't use those words in my narrative, you know, so I don't want to opine on what I was thinking at the time if it didn't reflect in my note. You know, having said that I do mention a herniated disk and the word radiculopathy which is consistent with some sort of neural irritation as well as, you know, the remainder of the physical exam but I don't use those words impingement in my narrative on that date.

Q. Or nerve root compression?

A. Or nerve root compression on that date. I do in a subsequent, in the OR record, but not on that date.

Q. Now, the lumbar spine radiculopathy that you referred to what is the basis for your opinion with regard to that diagnosis, again, back on April 30, 2010?

A. The basis of that opinion are, essentially, the following: The patient's complaint of pain in her leg, the patient's abnormal neurological exam, specifically a

weak EHL muscle, patient's decreased sensation in the L5 distribution and the presence of asymmetrical reflexes in the lower extremities all are consistent with the word radiculopathy in this case, in this case a lumbar radiculopathy, in the L45 distribution.

Q. Is that something that you're reading off your report?

A. Not verbatim but I was referring to the neurological abnormalities that were documented in the narrative on that date which reflect my exam of the patient and to answer your question with respect to how I came about in making a diagnosis of radiculopathy as they represent the components of the physical exam which would reflect the status of the L4-5 nerve.

Q. Can I just see what you're referring to?

A. That is this part here.

Q. Doctor, we seem to have a different second page to the April 30th

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report.

A. Would you like to compare it?

MR. STODUTO: Do you want me to make a copy of this page?

A. Look at the bottom. It might be before we had an opportunity to proofread it.

Q. This is what I was provided by your lawyer in your expert disclosure, so we'll compare them.

MR. CERUSI: Can you make a copy of that and a clean copy of what you have?

MR. STODUTO: Sure.

Just for the record, the copy that I have and the one I provided you says dictated and not proofread, the one he has here in his chart says proofread.

MR. STODUTO: Well, that is fine but that is not the one you provided us but we'll talk about that a bit.

(Whereupon, a recess was

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taken.)

(Whereupon, second page of report was marked as Defendant's Exhibit D for Identification as of this date by the court reporter.)

(Whereupon, second page of report was marked as Defendant's Exhibit E for Identification as of this date by the court reporter.)

Q. Dr. Lattuga, did you take any films yourself at that first visit for consultation?

A. No, sir.

Q. I would like to show you what we have marked as Defendant's Exhibits D and E for Identification and D is a copy of the second page of your report which was provided to me by counsel and then Exhibit E is a copy of the second page of your report which is contained within your file, so since you have a copy of Exhibit E in front of you, I am just going to give you Exhibit D and we'll kind of just talk about those. First of all, take a look at that.

Lattuga

I want you to take a look at that and compare it to Defendant's Exhibit E which is the second page in your file.

A. Okay.

Q. Now, you talked about your diagnosis of radiculopathy sprain and herniated disk during your initial consultation with Ms. Tchelidze as being based upon your review of the MRI and/or the MRI report but also the neurological examination which you conducted, correct?

A. Yes, sir, yes, sir.

Q. Have you ever seen what has been marked as Defendant's Exhibit D, in other words, that version of the report?

A. I don't recall; however, this is sometimes what comes out in my narratives when we don't get all of the information down on the initial dictation, so then this is presented to me and I have an opportunity to reconstruct that.

Q. Do you know why we were provided with Defendant's Exhibit D as opposed to the copy of the report that is

contained in your file?

A. I mean, I don't know how you get your records so but, obviously, these documents for many reasons go out and that is why, unfortunately, we have to write dictated but not proofread. They go out before we have a chance to review them for billing purposes, for requests for records. Rather than hold them up we just send them out to be as compliant as possible and at some point I have an opportunity to review the document. Generally it's contemporaneous, let's say within a week or within a day, several days or within a week or so, and then I have an opportunity to make the corrections but you could see normal/abnormal, this also suggests that these things haven't been -- that the transcriptionist wasn't able to either hear the transcription accurately or there was a space, for example, in the tape or she wasn't sure.

Q. Well, I was provided with a copy of this by Mr. Stoduto's office in

September of last year, so can we agree that the corrected version of that report would have been taken care of before September of last year?

A. I mean, I would believe so but, again, I don't have a --

Q. As you sit here today you don't know when Defendant's Exhibit E, the version that you have currently in your file, was actually done and placed into your file?

A. No, sir.

Q. Now, let's look at Defendant's Exhibit D which is the one that is not in your file, it's the one, again, as Mr. Stoduto indicated indicates on the bottom dictated but not proofread, do you see the information contained under the neurological heading which is toward the top of that page?

A. Yes, sir.

Q. It indicates that patient has normal coordination and normal gait, correct?

Lattuga

A. Yes.

Q. That is consistent with what you have in your report contained in your file, Defendant's Exhibit E, right?

A. Correct.

Q. Then it also says patient ambulates with a cane/walker, again, Defendant's Exhibit D, right?

A. That is what it says, sir, yes.

Q. Now, Defendant's Exhibit E, the one in your file, indicates that she had a cane, right?

A. Yes, sir.

Q. As you sit here today do you know whether she had a cane or a walker?

A. She had a cane.

Q. Do you know who prescribed the cane for her?

A. No, sir.

Q. Now, is it your position that that is a typographical error in Defendant's Exhibit D?

A. No. It's an incomplete record.

Q. Listed under that you have

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motor strength exam, correct?

A. Yes, sir.

Q. Looking at your file copy, Defendant's E, it says motor strength is abnormal, EHL, 4/5, what does EHL mean?

A. Extensor hallucis longus.

Q. That is at level L4-L5?

A. No, no, it's a motor strength grade testing with five over five would be normal and four out of five would be one power below normal.

Q. How do you test motor strength?

A. You grasp the limb or position yourself so that you have the ability to apply a resistance across the muscle and then you ask the patient to maximally contract that muscle and then you provide the resistance across that and so, you know, obviously, we do this all day long so we get a sense for what would be normal and you get that sense from your experience and there is also a bilaterality to it and you compare one side to the other and then you give a grade based upon your experience of

what you think it is.

Q. The motor strength you are referring to in Defendant's Exhibit E is which side or is it both?

A. It's bilateral and this is the leg now because EHR refers to a leg muscle, so it's both sides.

Q. Would you agree you rely on the patient to cooperate with regard to that exam?

A. Yes.

Q. Would you call that exam an objective test or a subjective test or both?

A. It's predominantly an objective test with a subjective component, that is how I would like to characterize it.

Q. What is the subjective --

A. The patient has to participate. The patient has the ability to influence the exam. There are things that we do as part of the exam to mitigate against, you know, false, you know, participation but that is why I say it's primarily objective,

you can get a good sense, but there is a subjective component and that can influence it to a certain extent.

Q. Looking at Defendant's Exhibit D which is the dictated but not proofread copy of the second page that one has a little different test result on it, correct?

A. No, it's incomplete. That normal/abnormal in this format means the transcriptionist had no data to fill in, so she wrote normal/abnormal meaning provide me with this information or there is insufficient information for me to create the transcript instead of leaving it blank.

Q. It says incomplete test result contained on Defendant's Exhibit D, correct?

A. Correct.

Q. Is it your position that that is a transcription error?

A. It's just -- there isn't enough information for -- instead of putting a blank she will put abnormal/normal, on the

next line there is XXX instead of putting something in or leaving it blank, that is to remind the reader which would be the doctors to put something, you know, fill out, complete that portion of the narrative.

Q. Well, let's look at the next line, again, referring first to the one in your file, Defendant's Exhibit E, sensation is decreased in the L5 nerve root distribution, now, what do you mean by that?

A. Again, that is a predominantly objective test with a subjective component in which the doctor in this case me places his hands on the patient and uses an instrument to assess sensation as part of the exam, we generally only put the pertinent findings, so the permanent finding in this case was there was decreased sensation in the L5 nerve root distribution.

Q. How did you do the test?

A. It's done with my neurological

hammer which is usually what I use is a large instrument with a sharp point on one side and a dull point on the other side, so what I do is I stroke the patient, I stroke the patients, in this case I am stroking her legs in a determine MA TOEM NAL distribution, you go down the leg, do you feel this, do you feel that, does it feel the same, sharp or dull, do you feel this, do you feel that, sharp or dull and you will go down and at some point sometimes and in this particular case the patient says that feels different, it doesn't quite feel sharp, I can't tell the difference between sharp or dull, so we try to get a sense, compare one side to the other, and then compared to normal areas that there is a difference in the sensation and because it's so variable I don't really -- all I like to document is that there is just a decreased sensation.

Q. So, again, it's a test that you rely on the patient to cooperate with and give you accurate information, correct?

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A. Yes, sir.

Q. Now, looking at Defendant's Exhibit D which, again, is the dictated but not proofread report which is the copy I have it says sensation is normal/abnormal/decreased in the XXX nerve root distributions. Would you agree with me that that is an incomplete test result listed there?

A. It's an incomplete documentation of that event.

Q. Now, the last one that we have under neurological looking at the one in your file, Defendant's Exhibit E, is inflammation of the reflexes are asymmetrical, what does that mean?

A. Again, we test -- reflexes we like to test side to side as well as across multiple distributions, so patients tend to respond similarly into the upper and lower extremity symmetrically is what we consider normal. Asymmetrical reflexes suggest a problem with that nerve root and are consistent with the radiculopathy.

Lattuga

Q. Tell us how you do that test?

A. It's the famous neurological hammer and the knee jumps tests. It's not only the knee jump, however, there are other reflexes and so we test all of the reflexes and we use, I use, my summary analysis in response to all of my reflexes from top to bottom before I make an assessment whether it's asymmetric or symmetrical and in this case I found that although I don't specify which reflex in this case because I am writing the note for myself to read it suggests to me those reflexes in this distribution are asymmetrical.

Q. That is another test that you rely on the patient for cooperation, correct?

A. Yeah. It's, again, they are all predominantly objective tests; however, again, there is a subjective component.

Q. Now, looking, comparing Defendant's Exhibit E and Defendant's D, can we agree that the remainder of the

report is the same?

A. Yes, sir.

Q. Now, after your impression or your plan where you indicate lumbar spine radiculopathy, sprain and herniated disk did you have a discussion with Ms. Tchelidze regarding the options that she had for treatment?

A. Yes, sir.

Q. What options were discussed both surgically and nonsurgically?

A. Obviously, the discussion I had is specific to this patient in this circumstance and so this is a patient that I discussed the following options, number one, continuing to live in pain, engaging in no treatment, this is my custom and practice, and so -- so one option is to do nothing, live in pain, live in pain, live with disability, and, again, I am not suggesting that is a good option but, again, you need to discuss what all of the options are, live with neurological deficit and then explain all of the implications,

I'm not going to go down that, but there is an implication to not treating it; the second option is to continue into what we call palliative interventions which include more physical therapy, epidural injections, narcotics, again, again, I am not necessarily recommending that but I need to convey to the patient that there are other choices that she can make but there are consequences, and I am not going to discuss what all of the many consequences or positive consequences are in that circumstance; and the third option would be surgery and I went and discussed, you know, surgery or the implications, what they are, the benefits as well as the risks and that is the conversation that I had with the patient on that day.

Q. Did you discuss various surgical procedures?

A. I don't have an independent recollection but in general it's not my custom and practice to give patients the choice of what operation to have because

really, essentially, that is a technical exercise by the surgeon to accomplish a goal. There are certain circumstances where a patient may have some options meaning less invasive or more invasive but really the ultimate judge of that of what is the best thing for the patient would be the surgeon because the patient doesn't have experience between doing an open surgery versus a microsurgery versus anterior fusion versus lumbar fusion, he has to rely on the expertise and experience of the surgeon just to give you the background of that answer. I generally don't do that, I don't make any mention, and if I did, I would have made a mention that I explained this operation versus that operation. I do make note here that I explained, I was recommending a spinal fusion and that would refer to what would be my custom and practice at this juncture of my career of what that would mean in terms of what operation I would choose.

Q. Why did you not suggest a

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procedure such as a discectomy?

A. Because the patient had considerable back pain as part of her pathology, so a discectomy is really the wrong surgery for low back pain, that is the first thing; the second thing is the other issue which is the main thing which is, you know, borne out on my operative report is patients that have traumatic injuries like these develop what is called instability. The primary reason why people get low back pain is not because they have a herniated disk, it's because the herniated disk or the traumatic event in certain circumstances creates instability and instability means that the back is weak and it moves too much. Because you asked me the question I'm going to answer it, if you just go in and do a discectomy, a microdiscectomy or an open discectomy, what you're doing, actually, is further destabilizing that segment. If you include the trauma to the muscle and the ligaments that it takes to do the operation, the back

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is weaker than what it was before, so most of the history of all of why people think spine surgery fails is because people always did discectomies where they should have done fusions. Really that is really the gold standard, so in this case given my experience, obviously, and my opinion with regard to that, I am giving you my opinion, that I felt that if you just did a discectomy, which I do discectomies, so that is part of my surgical armamentarium, I would be making the patient worse, so I chose the operation that I thought would yield the highest success rate in this circumstance.

Q. Do you have an opinion as to whether or not Ms. Tchelidze would have required surgery in the future in any event had she not been involved in the accident and, again, my question is based upon the degenerative changes which you saw at L4-L5 and L5-S1?

A. There is no way of knowing that answer; however, surgery in the general

population is under two percent, so if you look statistically at the amount of patients that have spine surgery for strictly degenerative reasons as a percentage of, let's say, the national cohort of 220 million people it's under two percent, so I can't answer it specifically based upon her X-rays and MRI's but in general the risk of needing an operation for degenerative changes is under two percent.

Q. Now, this was your first and only consultation that you had with her before you performed the surgery, right?

A. Yes, sir.

Q. Now, the surgery that you performed on May 12, 2010 that was based upon your examination of Ms. Tchelidze, right?

A. That is correct.

Q. That was also based upon your review of diagnostic studies?

A. Yes, sir.

Q. I apologize if I asked you

this, Doctor, did you take X-rays at the first visit?

A. No, I didn't.

Q. Did you review any X-rays that she may have had with her?

A. I don't recall.

Q. Did you take any X-rays after the first consultation but before you performed the surgery?

A. No, sir.

Q. The initial MRI's that you reviewed they were from July of 2009?

A. Yes, sir.

Q. Did you take any MRI's between April 30, 2010 and May 12, 2010 when you performed the surgeries?

A. I have no record of that.

Q. Well, let me ask you this, if you had taken MRI's or had them done, would they not be part of your file?

A. It's possible the patient could have gone -- I mean, I don't believe that to be the case is the answer but it's possible I could have given them an MRI,

bring the new MRI on the date of surgery, they show up, I look at it, I give it back, because I am at surgery I don't grab the report and stick it in the chart. I am not saying that happened. Again, I am trying to give you an honest answer about how you might have another report out there but I am not aware of one.

Q. Do you have any diagnostic testing facility in any of your offices?

A. Other than X-ray, no.

Q. Now, I just want to take you back to the first page of your first consultation. You also performed a musculoskeletal examination?

A. Yes, sir.

Q. Let's start with the cervical, how do you perform that, how is that exam conducted?

A. It's conducted with the patient either standing or sitting, depending on the level of comfort. With respect to the neck, for example, I place my -- I stand at the patient's side and I ask them to move

their head in the following planes, I say, I ask the patient to look up as far as they can go, I actually place my hands on the patient's chin and I ask them to go back as far as they can go and tell me when it begins to hurt and tell me, I also ask them to flex their neck, bring their chin to their chest, similarly make that assessment and I ask them to turn left and right with their head and then I make an assessment based upon what the normal values are and I list the normals there.

For the lumbar spine generally the patient is standing, that is the easiest way to do that. I ask the patient to bend forward, I ask the patient to bend back, I ask the patient to twist left and right. We use what is called a goniometer and it's just an angulum measuring device and that helps us to come up with, you know, as best as possible a degree, a specific numeric value for the degree of motion that they have.

Q. Those are also tests where you

rely on the patient to cooperate with you?

A. Yes.

Q. You indicated in both records of D and E where at the top it says the right and left upper and lower extremities are not within normal limits on inspection as described below, what do you mean by that as described below, what are you referring to?

A. I am referring to the neurological abnormalities.

Q. Now, the next time you saw Ms. Tchelidze you performed the surgery, correct?

A. Yes, sir.

Q. That was at Franklin North Shore Medical Center?

A. Yes, sir.

Q. Is that an outpatient procedure or inpatient?

A. Inpatient.

Q. How long was she in the hospital, do you know?

A. Not specifically but usually

it's two to four days.

Q. How long did that procedure last?

A. I don't have the operative record but in general it's about two hours, I am sorry, in this case it was six hours, there you go.

Q. Is that on the operative summary that you have?

A. Yes. It says six hours.

Q. The pre-op diagnosis was herniated disk with radiculopathy and herniated disk instability. We already talked about the radiculopathy. Where did you come up with the diagnosis of the herniated disk instability?

A. I alluded to it before in my discussion of why I chose certain operations, so instability is you base that diagnosis on both the clinical history of how, when and why they get their pain, it's based on the MRI review and those two factors can help you to assess the diagnosis of instability but just to add

it's very, very common to have instability with a herniated disk. I mean, there are circumstances where you don't have it but it's, you know, it's part and parcel of a herniated disk. It's almost always there and you need to be mindful of it as part of what you're making your diagnosis.

Q. Can a herniated disk instability also be related to degenerative changes?

A. Herniated disks -- well, the short answer is yes, it's possible for that to occur in the absence of trauma.

Q. Now, you performed all of the procedures listed on the first page of the operative report?

A. Yes, sir.

Q. Then your findings following the operation were instability, foraminal stenosis with severe nerve compression, what is the basis for that finding?

A. It's just your intraoperative observation.

Q. What about where it indicates

the traumatically-induced disk, what is the basis for that finding?

A. Typically during surgery you're able to see, for example, someone can have -- I have to use a comparison and that would make it easier to explain what a traumatically induced is. For example, calcified disk, sometimes you will go into surgery and you will actually go to grab the disk with a pituitary rongeur and you go to grab it and it's actually hard as a rock, it becomes calcified. Calcified disks are very common in the elderly, it's something we see, not necessarily in this case, and it's part of spinal surgery and calcified disk are considered to be a degenerative condition. The opposite of that is a traumatic disk where you find the disk material you retrieve is soft and the analogy I like to make is like crab meat or the lobster claw and that is the consistency, it's more hydrated, it's soft and so it's more consistent with a fresh, young, you know, sorry, young disk of

herniation.

Q. Is that noted anywhere in the operative report, your finding of this soft or noncalcified disk?

A. The way I, again, these operative reports are for me to remind me what happened. When I say the word traumatically-induced disk, that is what I am describing. I don't really make that -- I am using a more colloquial description here for the purposes of non-physicians present but, you know, if I was speaking to doctors, I would say it was a well hydrated disk that I removed.

Q. Did you mention that anywhere in your operative report?

A. My custom and practice is to list it in the beginning.

Q. That is listed under your findings?

A. Right.

Q. Not specifically listed what you observed in the body of the report, correct?

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A. Again, yes is the answer to your question.

Q. There were no signs of residual free fragments, right?

A. That's correct.

Q. What about nerve compression?

A. Well, again, I like to put the note right on the front page because I personally don't want to review. If I am going to my operative record subsequent to surgery, I don't want to have to thumb through my own record to find out what happened, I like to go to the front page, the first page, to see what happened during the surgery. It's my way of, again, reminding myself on a subsequent date what happened during the surgery. That is the purpose of the operative record for my perspective.

Q. What does stenosis means?

A. It's narrowing, that is all it means, so one of the things that I found, and it's consistent with instability, when you get instability, you get collapse, the

vertebrae begins to collapse and the foramen, from which foraminal is derived, the foramen is the tunnel through which the nerve root travels as it exits the spinal canal was narrowed and that narrowing caused severe nerve compression in addition and that's sort of a separate finding in addition to the hydrated disk that I found.

Q. Stenosis can that be a degenerative condition?

A. Yes.

Q. In fact, the narrowing of the spine that is something that could occur over a period of time, correct?

A. Yes. The spinal stenosis can also be a degenerative phenomena, yes.

Q. What is the purpose of taking X-rays after you perform a procedure such as this?

A. During surgery or in the office after?

Q. Well, what did you do in this case?

A. I do it during surgery, you

know, we use fluoroscopy during surgery, it's a realtime image --

Q. The X-rays we have here --

A. -- that is in the office.

Q. -- Defendant's Exhibit C those were X-rays taken after the surgery?

A. After the surgery.

Q. Do you recall what those X-rays read?

A. I did look at them right before. I mean, I looked at those X-rays, to answer your question, that is still open, because I think it will answer your question, is that we do this reconstructive procedure and a grafting procedure. Even though the word says fusion, I don't do the fusion, God does the fusion, that takes time, it has to heal over time, like a fractured bone it has to heal, it fuses together over time. My only ability to assess that fusion is an X-ray post-operatively and we take X-rays serially post-operatively until I feel comfortable that the vertebrae fused

together. That is the purpose of those X-rays.

Q. What did your review of those X-rays show? The X-rays were taken approximately eight days later.

A. I mean, this one, I mean, this particular X-ray that I have is just showing that, you know, it's my custom and practice a week after surgery to get a post-operative X-ray. The purpose of that X-ray I am not anticipating it to be fused but I am just want to confirm that there has been no displacement of the hardware, you know, and we put materials in the spine to help it to fuse and I want to make sure that it hasn't displaced, so the initial X-ray is to make sure that nothing untoward has occurred in the immediate post-operative period and that is, indeed, what, you know, that this demonstrates. Further, of course, as I described before, further down the line, six weeks, two months, six months, nine months, those X-rays if we obtain them would be for me to