2003 WL 25545922 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Bronx County

Alonso HERNANDEZ, Plaintiff(s),

v.

151 SULLIVAN TENANT CORP., Jumbo Construction Corp., and Total Structural Concepts, Defendant(s).

No. 21483-99.
November 20, 2003.

(Transcript of Dr. Thomas Kolb)

Name of Expert: Thomas M. **Kolb**, M.D.
Area of Expertise: Medical & Surgical >> Radiology
Area of Expertise: Medical & Surgical >> Pediatrics
Representing: Plaintiff
Jurisdiction: Bronx County, New York

Appearances:

Gorayeb & Associates, P.C., Attorneys for Plaintiff, Church Street, New York, New York 10007, By: Christopher J. Gorayeb Esq., of Counsel.

Decicco, Gibbons & McNamara, P.C., Attorneys for Defendant Sullivan, East 38th Street, New York, New York 10016, By: Daniel J. McNamara, Esq., of Counsel.

Milber, Makris, Plousadis & Seiden, Attorneys for Defendant Total Structure, 108 Corporate Park Drive suite 200, white Plains, New York 10604, By: James Plousadis, Esq., of Counsel.

Rende, Ryan & Downes, LLP, Attorneys for Defendant Jumbo, 202 Mamaroneck Avenue, White Plains, New York 10601, By: Michael F. Grady, Esq., of Counsel.

Before: Hon. Anne E. Targum, Justice.

CAREY ANN ROSENBLATT, CSR, RPR, RMR Official Court Reporter

(whereupon, the jury enters the courtroom.)

THE COURT: You may be seated, ladies and gentlemen.

You may call your first witness.

MR. GORAYEB: Plaintiff calls Dr. Thomas Kolb to the stand.

THOMAS KOLB, having been first duly sworn by the clerk of the court, was examined and testified as follows:

COURT CLERK: Please state your name.

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THE WITNESS: Thomas Kolb, K-O-L-B, MD.

COURT CLERK: And your address?

THE WITNESS: 222 East 68th Street, New York, New York 10025 -- 10021, excuse me.

THE COURT: You may proceed, counsel.

DIRECT EXAMINATION

BY MR. GORAYEB:

Q. Dr. Kolb, are you a physician licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. would you please tell the court and the jury what your specialty is?

A. Diagnostic radiology.

Q. what does diagnostic radiology mean in layman's terms?

A. The discipline of looking into the body using tests that are generally noninvasive like x-rays, MRI scans, CAT scans ultrasound, and to detect whether there is an abnormality or not an abnormality and if there is an abnormality to determine the extent of it and determine what, to help the clinician as to determine what plan of treatment would be necessary.

Q. Doctor Kolb, would you please explain to the jury where you went to school and what your professional background is?

A. I went to college, Queens College City of New York graduated in 1979, went to medical school in Brooklyn, Downstate medical center from 1979 through 1983. From 1983 through 1986 I did an internship and residency in pediatrics at the Albert Einstein College of medicine here in the Bronx. I then went back and did a second four-year residency from 1986 to 1990 and diagnostic radiology at Columbia Presbyterian medical center in Manhattan. That ended in 1990. I became board certified in both pediatrics in 1986 and in diagnostic radiology in 1990 and since 1990 to the present, I have been in practice of diagnostic radiology.

Q. And, Dr. Kolb, what particular areas of diagnostic radiology do you specialize in'?

A. I specialize in two areas, one is bone and joint, musculoskeletal bone and joint radiology, x-rays of the spine, joints.

Much of my time is also spent in diagnosis of breast cancer and I do a large amount of work in mammography, breast ultrasound and breast biopsies and I spend a lot of amount of time doing that as well.

Q. Dr. Kolb, have you published any articles or given any speeches or lectured in those subjects?

A. Yes. I published papers. One of the earliest papers on MRIS which we may talk about which is MRI scans and magnetic resonance imagining scans, that particular paper was of the heart but more recently I have published papers and one of my major 1.8 focuses is on breast cancer detection and I have published papers on detecting breast cancer, utilizing ultrasound, screening breast ultrasound, finding breast cancers even when the mammogram is normal and even when the physical examination is normal and that is, has been I think an important contribution.

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I think you asked lectures. I lecture throughout the country. I am on the staff of Columbia Presbyterian Medical Center, actually Columbia University College of Physicians and Surgeons I am an assistant clinical professor of radiology. It is a teaching position where I teach the residents and young physicians.

And I lecture throughout the country in teaching physicians about various aspects of imagining or radiology. They are usually national courses held around the country.

The last one I taught in was in Pittsburgh in August. I have taught in the major radiology conference which is held once a year in Chicago and so on.

So I have taught extensively throughout the country.

Q. Dr. Kolb, at the request of may office, did you review certain x-rays, CAT scans and MRIs of Mr. Hernandez?

A. Yes, I have.

Q. And this afternoon did you have an opportunity to look at them and organize them for the jury?

A. Yes, I certainly did.

Q. Doctor, would you please begin with the films -- withdrawn.

By the way, were those films blown up?

A. Yes.

Q. Are the blow-ups an accurate representation of the actual films?

A. They are enlargements that were made of the actual films.

Q. And, Doctor, I would ask you to begin with what was marked into evidence as Plaintiff's 1-A through J and 1-AA through FF which depict Mr. Hernandez's left arm and explain to the jury what the findings are.

A. Sure.

MR. McNAMARA: with the Court's permission may we move over here?

THE COURT: Yes, you may.

Please identify what exhibit the doctor is using.

Q. Dr. Kolb, as your Honor indicated would you please tell us what exhibit that is and then describe for the jury what it depicts.

A. This is labeled 1-A and what it depicts is the arm of this patient, Mr. Hernandez, and the arm is a single bone, it is called the humoris and it goes down from the shoulder to the elbow.

The arm is what -- we call the entire limb the arm, but really what we are looking at is the single bone of the upper arm that is the humoris.

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Up top is the shoulder, down here is the elbow. Below the elbow there are two bones but we are looking at the single bone from the shoulder to the elbow and the elbow is here.

It is pretty obvious what we are looking at here is a break, a fracture, a complete fracture, complete break of this bone.

This bone should be one single continuous bone. It should look just like it looks from up here from the top to the middle here. The entire bone should look like that.

What should happen is there has been a complete fracture through the entire bone and one part of the bone, the part that is furthest away from the shoulder has moved forward and this one has moved back.

?? we can take pictures of various angles and then in order for us to understand what is going on in the body, we are all three-dimensional people but these pictures are only two dimensional so we take pictures from different angles and we can see here on 1-B, again we are looking at the same part of the body and you can see the fracture here and not only is it more forward, but it is also overlapping.

In other words, the bottom of this bone should really be connected to the top of this bone with no break at all.

Not only is the bone forward, but there is also overlap of the two pieces and whoever treats this has to take that into account in planning their treatment of this fracture.

Q. Doctor, let me interrupt. What is indicated up towards the top of the shoulder? what is that in the picture?

A. Someone has put a marker here to mark the picture and the level where the picture is. Something lying across.

This may also be an EKG lead if the patient was in extreme -- if the patient has had problems and they were worried about some cardiac problem they would put leads on the patient and this may be a wire from the lead or it could be a marker. But it doesn't relate to the fracture.

Q. Go ahead.

A. what happened next on 1-C at the time of the injury is that now we see that the arm is encased here. Now we see the arm has an incasement around it and that is a splint in order to immobilize the arm.

The arm has been pulled, the humoris has been pulled. So now the fracture lines up a little better. You can see it is obviously a complete fracture.

Not only is it a complete fracture, but there are multiple fractures at that one site. what do I mean by that? It is not just a clean break. You can see here there is a piece of bone, a triangular piece of bone that is separate from the other pieces of bone here and you can see lines going in here.

So there are multiple fracture lines and multiple pieces of bone in this particular fracture.

Q. Why, Doctor, are multiple fractures seen?

A. It is going to be where the fractures are and what the fragment fractures are pushing on.

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When we look at x-rays as opposed to other tests we are talking about, x-rays tell the difference between things that are hard and soft. x-rays are an excellent test of bone because bones are hard but there are arteries, there are veins, there are nerves, there are muscles, there are tendons, there are ligaments and those are all softer structures and you can't tell the difference between all those different structures.

All you see is bone and stuff around it which is softer, so while it is a relatively crude test compared to what other tests we have that we will talk about, it does show the bones very well.

So if there is a piece of bone pushing out it could be pushing on a structure that is important like a nerve or and artery or a vein, and the treating physician or the surgeon would have to know about this and wants to know about it before they would go in and fix it.

So they would like to know if there are extra pieces of bone, multiple fractures in one place and like to know how the bone was aligned.

The bone has to be put back into -- not normal, but as normal an alignment as possible in order for it to try to heal itself.

If you left it like on 1-B, if you left it like this, the pieces of bone would try to fuse together like this and you would have one big mass of bone here and that would be bad.

So what happened is that they pulled the bones apart, they pulled the arm, the elbow down and the shoulder up and they are trying to line the bones up a little better this way and you will see ultimately what they did if they go on to -- they took the patient to the operating room and on No. 1-E -- just to give you an idea of the progression of what happened when you have a fracture like this -- this is a little bit of a different looking picture.

This was taken from floroscopy which is also an x-ray, same thing, but the surgeon can actually look at the image from the inside the body in real time.

In other words, if the surgeon would put his hand in here he would see his own fingers and then they take pictures so there is a permanent record of it.

Here is the fracture. You can see it is quite separated here and now there is an object, a black object that runs completely across.

Q. Doctor, where is the top of the arm in the picture?

A. The shoulder is here (indicating) and the elbow is down here and the break that we talked about here is obviously in the middle.

What has happened is they have taken a metal like nail and they have put it through both, through the center of the bone. The bone is this long piece of bone and they have taken a nail and put it through the top of the bone, through the bottom of the bone, and then expand it across the fracture because what they would like to do is keep the fracture as close, the fracture fragments as close together as possible so that it starts healing so they have intervened, taken the patient to the operating room, put in a device, a fixation device to fix the fracture.

That is the first thing that happened here. and if we look at pictures, what it looks like after the patient comes out of the operating room, if you look at 1-G, this is what it looks like on an x-ray.

And you will see here is the shoulder on 1-G, here is the elbow, here is the nail I told you about that they put across it.

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Don't worry, one is black and one is white. They can manipulate that. The point is here is the humoris, here is the fracture, here is the piece of bone that we talked about.

Now, when they manipulated the bone this fragment has moved and that is an important thing to know in terms of healing, in terms of causing problems down the line, because it could push on structures that are important.

Q. Doctor, you say that fragment has moved. Is that piece of bone connected to anything in that picture?

A. No, this is now in free movement. we talked about how there are multiple fractures. There are not multiple fractures going clean across.

The bone is broken in many places. what has happened here, this is actually a free piece of bone here. It has broken off the major fracture site and is now separated from the fracture.

There is another little piece up here that is also separate and these things are all important as things evolve in crying to fix the damage here, the fracture here.

So this is what it looks like after they took him to the operating room and they tried their bast that they could to bring the fragments together and then there are a series of pictures that were taken along the line to see if there was. any healing.

Here on 1-H again a very similar looking picture, shoulder, elbow, fracture. Fragment is still here even though the picture is very dark you can still see it and the nail is here and you can also see that they have put in stents beyond the bone.

In other words, they have to slip it in somewhere. They had to make a hole in the bone down here in order to slide it up the bone to get across the fracture, so they had -- that is how surgeons intervene, they have to make a hole in the bottom of the bone in order to attempt to bring the fracture fragments close enough to together to start some healing. This is very early on.

Q. Please go on to the next film.

A. Now, we have -- over time what has happened is this is one of the last pictures that we have here on 1-L.

Q. Doctor, is that dated, can you see a date on that?

A. I have to go to the original x-ray. 11-9-1999. November 9th, 1999.

Q. Go ahead.

1-L we see things have changed a little bit. we still see this nail going through the bone, but there is a lot of extra bone there and that is the body's attempt to heal a fracture.

The bone is actually a living substance. It is not like a skeleton. we take that out and look at that, you can wrap on it. This is trying to heal itself and the body has told the bones to form more bone because it wants to span the gaps so bone fills in and you heal a fracture and that is how fractures heal.

So in this case there is a lot of new bone here. You can see the whole triangular area wasn't here before but at the site of the fracture there is no new bone going across.

The body's attempt to heal fractures. As we said, there were a few fractures. The body is starting to heal. That is on the side but not the major area.

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It could be these fragments are too far apart. For whatever reason it is not healing well enough.

So what happened was they took the patient and they decided that they would, the clinicians treating him decided and this film is from November 2030, November 2000 -- I am sorry, September, 9-2000, which is a year later, they decided they are going to have to be a little more aggressive and they took out that nail and they put in a big, thick rod in an attempt to bring those two bones together and make it heal and this is flipped over from the way it was so that triangular piece is still here and you can see extra bone coming in but still a very wide gap at the fracture site.

So the body is attempting to heal this but it is not healing well enough yet. so this patient was taken back to the operating room, the nail was taken out and this rod was inserted in order to try to promote this to heal.

Q. Doctor, what are those round circles at the bottom of the rod?

A. In order to keep the rod in place, they actually have screws. This here is a screw. I will show you a little bit so it is easy to see.

In 1-N which is also this September 2000, there is a screw here. Now, you could also see the screw is broken here but there is a screw going through from the lower part of the humoris from the bone that is fractured, the elbow is on the bottom the shoulder on top and the screw comes through there.

So they put the rods in and then they put screws in to hold the rod in position and you look, for example, at the next one which is 1-0, this is -- I am sorry, the one I just showed you, 1-N was September 2000.

If you go back when they put the rod in in January of 2000, here is what I mean by the screws. They put the rod in, there is a screw on the bottom and there is a screw on the top here and this is the picture they took just as they put it in because you see the staples in the skin up here?

They opened up the patient and in order to close the skin after they put the rod in, they put staples on the skin to bring it together.

So this is a picture taken just after the rod was placed.

Q. Doctor Kolb, in that photograph does it appear the screws are not yet broken?

A. Right. That is not correct. The screw here looks intact so there is a screw here and screw here holding it in place.

And you see also the screw extends beyond the margin of the bone here into the soft tissues that we talked about; muscles, other arteries, and so on.

There is another screw up here across the top and you can see the top of the rod goes to the very edge of the bone as well around and may or may not be an issue as this that may touch the tendon and this is where the rotator cuff in our shoulder comes in.

So there is a rod now in place with screws on the top -- a screw on the top and a screw on the bottom holding everything in place and they are hoping that this will allow the fracture to heal by doing that manipulation.

But, it didn't do what the doctors would have liked it to have done and many pictures were taken of this fracture, for example, if you looked at September 2000 already and then finally, here, in early of 2003, and just before that, they took out that big rod that I just showed you, they took that out because it wasn't healing.

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So that is the rod that was in in 1-M, they took that out. It is gone. But what they did put in, they put in a third separate device, surgical device in order to try to fix the fracture.

The surgeon went in and put two metal plates across the fracture here with many, many screws holding it in place.

Q. Doctor, what exhibit is that?

A. Sorry, 1-Z, and that is, from this picture is from August 2003, relatively recent picture where there are now two metal plates, one here and one here with many screws, 1, 2, 3, 4, 5, 6, 7. At least 7 screws.

More than that because there was screws coming this way as well, holding the plates in position, crossing the fracture in an attempt again to get the body to heal the fracture.

But you can see the fracture is still not healed. There is still a space between it. It should heal up and look like regular bone if it would be a completely successful fix, but it isn't.

One other thing you can notice is if you go back to the earlier pictures versus the later pictures you see the bone has become thinner and that is because since there is a fracture there the patient doesn't use their arm or their left arm as much as they would use the right arm.

Because of that disuse, the nonuse of the arm and you could most likely take pictures of the remainder of the forearm, the wrist and the hand, calcium starts leaving the bone because you are not using it and you become demineralized, you lose the mineral from your bones.

The bones become very fragile and that is what happened here on these pictures as well.

And basically that was the final device that was put in and that is a pretty current picture.

Q. what is the latest film that you have of this arm?

A. I think it is 2003 one that you have up. I will just tell you, for example, that was already in, what you are looking at on 1-DD.

You see those two plates are in there just like what I showed you, that is November 2001. November 2001.

So I have taken you to the end.

Q. Dr. Kolb, if you would, pull the film out from November 2001 and compare that film of November 2001. What exhibit is that?

A. That is No. 1-DD.

Q. Comparing 1-DD to 1-Z, do you see evidence that in 1-Z which was taken in August of 2003, that the fracture has healed?

A. No. There is no significant change in the appearance of the fracture.

well, there is a little bit more bone but it has not gone across the fracture site.

In other words, it hasn't healed the fracture together. This picture on your right, 1-DD is November 2001 and then we skip to August 2003.

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So that is one year and nine months later. So there is one year and nine months in between these two pictures and about five years from the original injury and there is still a line going through the fracture site, so there is certainly incomplete healing of the fracture at the most recent data available.

Q. Is there a medical term for that where the bones have not yet joined together?

A. Nonunion or malunion. Nonunion is where the bones have not joined together. Incomplete union which are incompletely healed. There is to be -- or nonunion where the bones are not together at all.

Q. In your opinion what is that?

A. I think there is incomplete healing, incomplete union, I think there is new bone. It is many years after the trauma. I don't know how much more this patient can repair himself. I don't know how much more this bone can repair itself.

We are looking at films already a year and nine months apart but certainly it is incompletely fixed many years after the trauma. There is no question about that.

Q. Are there any other films that you would like to look at referring his arm?

A. Definitely not.

Q. What part of the body would you like to go to next?

A. The spine?

Q. Okay. I thick those have been marked as Plaintiff's 2-A through M.

Dr. Kolb, referring to what is in evidence as Plaintiff's 2--A through M, would you tell us what those photographs are and what body part they depict?

A. We are going to be looking at CAT scans, MRI scans and x-rays of this patient's back, centered in the lower back, the mid back and the lower back.

Q. which exhibit?

A. 2-A is a CAT scan of this patient's back through a particular level. when the patient came in they centered upon a portion of the back to focus closely on if there was an abnormality, and this was -- 2-A is part of a CAT scan of the back and what we are looking at here, each one of these pictures is a separate image. Each square.

So there is 20 pictures on this one sheet and the reason there are 20 pictures is because this is a little bit more sophisticated way of using x-rays and we can actually take pictures of parts of the body as opposed to taking pictures of the regular x-rays of the arm and what we have done here is we have taken pictures starting with the head, the upper portion of the spine.

We want to look at going down to the lower portion and we took 20 pictures on this sheet and every time a picture was taken they pull it out, pull it up to look at.

In order to save sheets of film they put 20 pictures on one piece of film.

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Now, just for some anatomy here so we are all oriented, there are bones in our back and each part of our back is separated so that we understand what we are talking about.

The different sections of our back are the upper spine which is called the cervical spine, then there is the mid back, thoracic spine, or T spine, and then there is the lower back which is the lumbar spine and there are 12 bones in the thoracic spine. Male, female, short, tall, 12 bones in there, and in the lower back we all have five bones.

When I look at a bone and I want to say something about it, in order for you to know, for you to be looking at the same bone, every bone has a layer and a number, so if I am looking at T-12, that means I am looking at the 12th bone in the thoracic spine.

If I am looking at L-1, I am looking at the first bone of the lumbar spine. So all the doctors are on the same page when we talk to each other.

So here this is and I know because there are other parts of the study and they did a view, they looked at the view, they knew where they were taking pictures and I will show you that in another way in a minute.

We are looking at L-1, the first bone in the lumbar spine, and that is this here with all these lines going through that and we will talk about that in a second. So somebody already has marked it when they read it. It is very faint, but L-1.

Q. Doctor, would you tell us -- L-1, where is that in the back, in the mid to lower back, it is around here where I am pointing in the mid to lower back, but let's not look at L-1 yet.

There is an abnormality there. Let's look at what normal looks like.

L-2, what has been labeled L-2. Now, this round structure here is the front of the bone and the bones are called vertebral bodies or vertebra so we have -- we are looking at the L-2 vertebra and the bone has two parts to it.

The bone has a front part to it here, a back part to it here, and there are joints in the bone. The reason there are joints is so that we can move around.

There are joints in between the bones, above and below it, and there are also joints between the front, from the front of the bone to the back of the bone and that lets us have motion in our back.

So you can see here that this is what a normal bone looks like. This is L-2, the L-2 vertebra. Just going to write L-2 here.

MR. GORAYEB: Your Honor, would you inquire if all the jurors can see it down this end?

THE COURT: Can all the jurors see this exhibit?

A JUROR: Yes.

THE COURT: No problem. Thank you.

A. If we go down a little further, you will see L-3 again. A round structure here.

In between this gray area here are the disk. In other words, we have bones in our back and when we jump up and down we don't want the bones to bump together.

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We have shock absorbers called disk. You may have heard of disk problems in the back and that is what the disks are. They sit in between the bones.

The problem here is again a pretty obvious one. Like in the break of the arm, there are multiple lines going through the L-1 vertebral body here.

It should look exactly like that. That is normal and you can see here there are many, many lines going through it.

There are multiple fractures to the point where this is called a burst fracture of the vertebral body, the bone has exploded out and so that there are many, many many fractures -in the bone and that is what it is called in medical terms it is called the burst fracture. It is burst.

The patient suffered some type of trauma in that it burst this bone.

Now, a bone can burst in many areas. The right side, the left side, and towards the back and even further down in the next bone there is a fracture in the back of the bone.

Now, the reason why this is important and why burst fractures are very important to know about, is because we talked about the bones here, this is normal as we talked about or at least the front of the bone is normal. The back is not.

But you see there is a circle here and the circle here is the spinal canal and in the spinal canal there is a spinal cord.

The spinal cord starts in our brain, comes down the spine. Nerves have to come out so we can move, we can feel, we can feel pain, we can feel touch.

Nerves have too much go to every part of our body. The way the nerve?? get to our arms or get to our legs is from the spinal cord.

There are holes in the bones that are supposed to be there on each side of the opine and those have a special name called a foramina which is the Latin word for a hole.

So the spinal cord comes down and the nerve that is supposed to go out to your shoulder or to your pinky or to your thigh, comes out, comes down and goes out that hole and goes to where it is supposed to go.

And that happens between each bone that I told you about, the 7 spinal bones, the 12 thoracic, the five lumber, and each one in between L-1 and 2, in between 2-3 and 3-4, there are holes in the left side and right side where the nerves come out.

So all of these nerves start from the spinal cord. The spinal cord starts from the brain. This circle here is the spinal canal.

Inside this circle is the spinal cord and it is in a sack because there is fluid around the spinal cord.

You may have heard of a spinal tap. You put a needle into the back and draw out liquid from the spine. That -is where all this -is.

When you put the needle in, you put it in between the bones in the back. So this area here is a very important area because most of the nerves that go out towards the rest of our body are in the spinal cord obviously.

Well, if you look at this picture and you look at these pictures above it, you will see there is a very important thing happening. Not only is there a fracture, but we talked before about how fracture fragments can push on things that are important.

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The fracture fragments are now occupying the spinal canal, meaning they are pushing on it in a serious way, causing an effect on this spinal cord.

This is a burst fracture whose fragments have been pushed back through and pushing on the spinal cord directly.

If I wanted to show you this more graphically to show you the extent of this fracture, we can look at a picture that they took later on -- here, August 9th. I think this one is No. 2--A, is a 7-1999 CAT scan.

Two days later they took an MRI scan of the back and that is labeled 2-B and that is 9-1999, and now we are looking at it from the side.

I am standing this way and you are looking at all the bones in the back.

Q. Could I ask you to bring the tripod this way a little bit.

Now, this is an MRI, this is 2-B, an MRI of the lumbar spine, and I told you that the bones, there are bones and there are disks in between the bones. All of these squares here are bones and these white football shaped structures are disk.

Now, look at each of these bones and you will see they are square. we look at them a different way. we look at them this way and it is like we are cutting a loaf of bread on the CAT scan.

Now we are looking at it straight from the side and you see they are all square and I am telling you this is the fifth lumbar vertebra, this is L-5 right here, No. 5.

This is four, this is three, looks identical. Five, four, three and two are all square and identical looking but what happens here when we get to one? It is collapsed, it is flattened, it is burst.

We saw it on the CAT scan. This is a different way of looking at it. But what else is happening here? Look at image number five on Exhibit 2-B.

I told you that the spinal cord comes down behind the bones here so here are the bones and now we are looking at the upper bones of the thoracic spine.

Here is T-12, T-1, T-10 again. They are all squares because they are not fractured.

The one that is fractured is L-1.

Let's trace the spinal cord down. The brain is up here, the legs are down here. These gray lines coming down are the part, are the spinal cord, is the spinal cord, and the white around it is the fluid that I told you about and you see the space of the spinal cord is from the back of this bone here to the front of this bone here so it goes across that far.

That is, that is the width of the spinal cord and it is the same up here, the same here, the same here, the same here.

Let's go down to the bottom and you will see where the spinal cord ends. It gives off roots but the width of the spinal canal is about the same as we go up.

What happens here at the site of the fracture, you will see that it is narrowed down from this. where I am drawing another line here at L--3 it is narrowed down to this and you can actually see this is a ruler.

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This is put on the film so you can actually measure real distances and the distance between this line and that line is one centimeter which is a little less than half an inch.

So if you measure the width of the normal spinal canal, it is a little less than half an inch we that is all we got there but we all have pretty much the same amount of space and it is a half an inch above and below, and right at the fracture you can see it is narrowed down from here to here maybe a millimeter, two millimeters.

In other words, the fracture has pushed back and is squashing the spinal cord and that causes symptoms that this patient obviously has whether we have pain, immobility, unable to move, unable to feel things below the level of this fracture.

In other words, if nerves from here would go to his body and his legs, he would have problems with those areas of his body.

He wouldn't necessarily have a problem to his ear or to his right shoulder because the fracture here is occurring at a site which is where nerves go to his lower body and his legs.

So here you can see pretty graphically how squashed the spinal cord is by this fracture. This is a pretty heavy duty fracture. As fractures go.

Q. Dr. Kolb, that fracture and that squashing of the spinal cord, is that at the L-1 level?

A. Yes As we counted we said L-5, L-4, L-3, L-2 and L-1. The L-1 body has burst and the fracture fragments from the back of the body are pushing back directly on the spinal cord narrowing the canal severely.

There is almost no space left there at all. So as I said, looking at this picture you would expect a patient like this to have significant medical findings to his lower body and legs.

And those are the major findings here. The disks are involved which we can get to, but there are multiple areas of fractures as I have told you before and I am not going to burden you with every single one of them, but that is the major finding.

Q. Dr. Kolb, would you go on to a later film and show us what the doctors at St. Vincent did to treat the fracture of the spine.

A. well, what they did is, again very much like the humoris, like the arm, this is No. 2-D, it is sideways because it is 2-D, very similar to the picture we saw when they put the nail through the arm.

What they did was they went in, these are retractors, the surgeon is in there now and these are retractors.

Q. What do retractors do?

A. They pull apart muscles and soft tissue so the surgeon can see what they are doing. The surgeon has drilled holes in the spine in order to fix something.

Again, they had to drill holes in another part of the body and they had to pull apart the bones.

That compression fracture had to be pulled apart so that there could be space made again by the spinal cord.

They went in and put in screws in parts of the bone above and below the fracture and then they put rods in, these metal rods in, putting these screws and pulling it apart.

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They put traction on the fracture. They pulled everything apart. You can see here, for example, on a CAT scan labeled 2-E on August 20, 1999, here is a similar picture to what I showed you before, but two things are now in this picture that weren't there before.

The screws are now there, you can see the screw going through the level above the fracture, T-12, even though that wasn't -- there were smaller fractures in T-12, they had to drill through both on the right side and the left side and put screws in and below the fracture they also had to put screws in and they put those rods in that I told you about.

The other screws are below here. Then they also put in some cement to fill in the gap of the fractures to help it heal and stabilize it and they put in material and that is the white material that was in there before.

So in an attempt to pull the fracture fragments apart, in an attempt to heal it they put in metal-like devices and they also put in some cement or some graft material to try to get this patient to heal this fracture.

Q. what do you mean graft material?

A. They could either take shavings from other parts of the body, bone from other parts of the body like the crest of bone that you feel on your hip and they can take shavings of that and put it in in an attempt to heal or sometimes they use cement, not originally part of your body, just to put the whole thing together.

So that is that they attempt to do to fix the fracture site.

Now, even after they fixed it there are still pieces of bone that are going into the spinal canal, number one.

Q. At what level?

A. At -- from T-12 now through L--2. Since they tried to fix it, the fracture fragments that have been there before have been cleaned up a little bit but there are still fracture fragments still there but since they also fixed it and put in the cement.

There are also areas of T-12 and L-2 which are -- the fract are which is there now shows the spinal canal pushing on the fracture that weren't there before, so in an attempt to fix, in an attempt to fix the fracture, there was, there are new substances present, either fracture fragments or the graft material or cement that are now pushing on the spinal canal

They also took out the back of the bones. Remember we looked at the one before, there was a front and a back.

If you have look here, a front and back if you look at the level of fracture there is just a big hole there now. They took out all the bones behind the fracture to give the spinal cord more room, not to breathe but give it to room to open up the space again.

So those bones are now gone. The surgeons have taken those bones out. That is a laminectomy. They took the lamin out. Those bones are gone.

They have done a lot of things to this back to try to fix it.

Q . Dr. Kolb, you are saying that despite the physicians having taken out the back of the bone, that there is still bone pushing into the spinal canal?

A. Yes. The original bone from the fracture, there is still shards of bone that remain that are pushing in and also there is material that the surgeons put in.

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When they put it in it can't be in exactly the right place all the time. we are -- they are working very, very small areas and putting cement or graft in and pieces of that are pushing on the spinal canal as well.

Part of it was from -- the fractured part of it was the attempt to heal the fracture but in any case it is pushing on the spinal canal and it also may have an effect on what the nerves do, in other words, moving, inability to move or problems with sensation and so on.

So that is something more you would want to know when you are looking at CAT scans or MRIs of the back after a patient has had surgery.

Q. Dr. Kolb, are there other films later on that show any changes or progression in the condition of Mr. Hernandez's back?

A. Let me just show you what I mean when I say try to fix it with the graft material. Here is what he looks like -in December 1999. No. 2-I. Here are the screws going through.

This was -- this is the fracture site. Remember it was all collapsed? well, they have put the cement in or graft material in and they have tried to expand it back our.

They have put traction on the back. These rods here can be adjusted and they have made it so they are pulling that way, opposite each other just like in the fracture of the arm so that they are trying to build this back up.

You can seen see on this picture here pieces of bone or cement that are still overlying the spinal canal that shouldn't be there at any other level. You can also see the hole also I talked about where the nerves come out of the foramina.

Those are the holes between the bones so between five and four and four and three, and three and two, they look pretty similar.

Look what happens between two and one, the hole is almost gone occupied by either fracture fragments or metalic devices meaning the things they use to fix the fracture and so on.

So the holes here that the nerves come through not only is the spinal cord pushed on, but the holes where the nerves come off the spinal cord and come out are compromised. They are smaller than they should be.

So that is what his back looks like now and these things stay in full-time. These things generally don't come out. They usually just stay in forever.

Q. If you would, Doctor, go to the latest films that you have and tell us what if any changes have occurred in his back.

A. The latest plain film I have is similar looking to this and that is 2-H and that is dated January 2000.

Again you can see the screws here, here, here, here and rods going up and down and traction devices across here.

If you could also notice on these picture we will talk about in a minute, the bones are the ribs and they are fractured here and we will talk about that in a minute too.

There is so much trauma to this area that the bones adjacent to the spine were broken as well.

Q. what is the date of that film?

A. The date of this film is January 2000.

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Q. January 2000. And does it appear that the fractures of the rib -- what side of the body is that, left or right?

A. I have to look at the original.

Q. hat --

A. That would be the right side.

Q. And as of January 2000, does it appear that those right rib fractures healed?

A. They certainly have not healed. Again we see the crack going through here. when a bone heals you should see a contiguous, you shouldn't see the crack going through. It is at best incompletely healed.

There is no sign of healing on the x-ray and we will talk about the bones a little more on the bone scan as well.

I have to decompress this easel.

So we have looked at CAT scans and plain films of the back and looked at the fracture and see how they tried to fix it, but there are still elements pushing on the spinal canal even after trying to fix it.

Number 2-C is an MRI of the back and the date of this is March 25, 2000.

And here again are the bones that we are used to looking at, the squares, but then we get into an area that is all black and we can't make it out and that is because they put metal into the back and an MRI is a magnetic test. When an MRI comes in contact with metal you don't get a good imagine.

So they will never be able to look at his back very well using an MRI scan. It is difficult to imagine his back. More difficult now because the surgeon has been in there.

We talked about the disk before, we talked about the disks or the structures in the back. Those little shock absorbers and the little oblong areas of the disks.

The disks are gelatinous and like shock absorbers. unless they are held in place they would be like tooth paste and squirt out.

There are ligaments that are in the front of the spine and the back of the spine that hold it in place. If there were to be a tear in one of the ligaments holding it in place then the disk would move into an abnormal position. Two things can happen. Either the ligaments can partially tear and the disk will push out or it car completely tear and the disk can go completely through.

Now, the ligaments run right behind these bones here, so we know there is a disk problem or not a problem if the disk is in an abnormal position and an abnormal position means that if the disk is past the edge of the bone we know there is a tear on the ligament.

And if you look at the disk here lying at 5-1 and look at here which is 2-3, you will see -- hold on, let me just check if I have all the films here, you will see here at these two levels between the third and fourth and the fourth and fifth bone the disks are coming out here behind the bone more than they are at the level above it, 2-3 where it stops at the bone or 5-1 and that means there is at least a partial tear if not a complete tear meaning the patient has a disk bulge or what I think is a disk herniation.

In other words, the disk has pushed through not surprising in a patient that has had such severe trauma to the spine just above it.

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So in addition to the fracture and in addition to the compromise of pushing on the spinal cord, in addition to the way that they fixed the fracture of the spine, there are also disk abnormalities and the reason we talk about those is that they also push on the spinal canal or it can push out on the foramina as well.

It is important to know about those as well for anyone who is treating the patient.

THE COURT: what exhibit is that, Doctor?

THE WITNESS: 2-C and that was March 25, 2000.

THE COURT: Thank you.

Q. Doctor, I want you to assume during the trial we are going to hear that the surgeons at St. Vincent's Hospital who operated upon Mr. Hernandez found that the muscles of the, running along the spine in the area of L-1 were macerated and that the epispinal and interspinal ligaments were completely ruptured.

Would those conditions contribute to the disk abnormalities that you just described for the jury?

A. Look, it certainly weakened the spine and this ligament here is called the postexterior longitudinale ligament. Everything has a fancy medical name.

So the postexterior longitudinale ligament is partially torn and the inability of the area right above it or the trauma itself directly from the trauma could have torn this ligament coming down which has allowed the disks to either severely bulge or herniate from their normal site.

Q. Has the instability of the spine caused any changes at the T-12 or T-11 levels?

A. well, we talked about how you can't see anything, how this patient has been fixed and has all these metal-like rods in his back, and on 2-J you see it again, it was put in by the surgeon and again you can see many, many fractures here, here, here, here of the ribs which we will talk about, but your -- the answer to your question is we can see a lot of the damage in what I have already shown on the CAT scans, but not after the patient has been fixed with an MRI.

That is why they did CAT scans after they have been fixed to look at the fracture sites of T-12, L-1, but looking at the other levels, the lower levels further down, that is what they are looking at with these CAT scans L-3, 4, 5, so they are taking a dual approach because the patient was severely injured to the point of having hardware put in his back which limits some of the testing that can be done as well.

So they are using multiple tests to look at everything.

Q. Dr. Kolb, any films of the spine that you want to show the jury?

A. No, I think we have shown it.

MR. GORAYEB: Your Honor, this would be a good point to take a five-minute break.

THE COURT: We may. Thank you.

Jurors, you can go back to the jury room.

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(whereupon, a short recess was taken.)

(Whereupon, the sworn Jury entered the courtroom)

THE COURT: You may proceed.

Q Dr. Kolb, will you refer to the next set of films and tell the a Jury what area of the body they concern and what they show?

A The next part of the body to look at is the head, the brain. And Number 3B is a CAT scan of the head dated August 6th, 1999. Again, we're looking at a CAT scan of the head here. And you can see actually the patient's eyes here. And here, and a little white dot right in there is the lens in the eye actually, inside the eye.

Q Doctor, tell us what exhibit that is?

A It's 3B.

Q And it's dated 8/6/99?

A Yes.

Q Go ahead.

A And you can see that, actually, the left eye is pushed out further than the right eye is. And that's because there are fractures in the bones here, at the base of the eye and the fat. And, that's behind the eye and the eyeball itself is pushed out abnormally. And that's a significant finding. But, they could see that by looking at the patient. But, the fractures though that are present in these thin bones of the sinuses, it cannot: be seen just by looking at the patient. You can also see, if you look at the eyes, that here is the right eye, and here is the left eye. But, behind the right eye and it's black. That's because there is fat there. There should be fat and nothing else. Behind the left eye, there is an area of light. That's blood, the white. That's blood. From the trauma, there is blood now behind the eye, pushing the eye forward. And so, that's one major finding on the CAT scan. There were fractures in some of the sinus bones. There is hemorrhage or blood in the socket, the eyeball socket, and the left eyeball is being pushed forward abnormally. And you see it on all these pictures. The nerve, the optic nerve and the muscles that control, moving the eye right here are right here. This line here is one of the muscles that's closest to the nose. There is another muscle away from them, and right in the middle here, there is a little line that's the optic nerve, that allows us to see. All the information that goes into this eyeball goes to that nerve and goes to your our brait so that we can see. So, you see a lot of hemorrhage of blood around the nerve that goes to the eye. If the patient would have been examined for symptoms or abnormalities pertaining to the eye. So, that's one finding on a CAT scan.

Another finding which is very important is, so here is the brain and this white stripe around this, this thick white stripe is the skull, is the bone. Inside the skull, is the brain. Now, the brain has spinal fluid in it, in the system called ventricles. And in any case, there are spaces in the brain. There is fluid, just like we talked about in the back, there is fluid around the spinal cord, there is fluid in and around the brain as well. And the brain should be symmetrical. The right should look just like the left.. These dark spaces here are part of the ventricles. They all have very fancy names, but the point is here, if you look at the right space here, this is the right side, the R, versus the left side here, you'll see there is a difference in size. In other words, the right-sided ventricle that holds fluid in the brain is bigger than the left. And the reason for that, many times, and the most common reason for that in a patient who has had a trauma is that part of the brain is now swollen due to the trauma.

And so, when part of the brain as well as, in this case, the left side, it pushes onto the fluid. And since the fluid is easily, is more easy to move than the brain itself, the cavity in which the fluid is held gets smaller.

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In other words, you are putting pressure on it. It's like if you had two balloons, you have one balloon on the right side that has liquid in it, a balloon on the left side has liquid in it, and you put your fist into the balloon on the left side, take a picture of the inside of the balloon, and there is going to be less space in that balloon. It's going to be smaller. It's a mass effect, the pushing on it and that's because the brain on the left side has swollen.

And that's what causes this disparity. And that's a very important finding, because obviously, there is a lot of important things in the brain, that goes without saying, and if there is an injury affecting this part of the brain, it may manifest either at the moment of the injury. In other words, you may have problems with the patient doing things with the opposite side of his body, because, we don't want to go into it now, but the fibers in the brain crisscross, so there would be problems on the right side of his body as well, not just the left side. But, also it may manifest as something down the road as being a problem. And in fact, in this patient, this patient had an MRI scan. of the brain, which is Number 3A.

Q Excuse me?

A Number 3A. There is an MRI of the brain. It looks a little different. Now, the spaces with the fluid that I showed you before are white instead of black. We can control what we want to make white or black, so you don't have the worry about the coloring of it. But, you can see, remember I showed you the right side or the left side, you can see it got more back to normal. You see it's not as pronounced as it was before. In this MRI of the brain, there are little white dots here. You see the liquid here is all white. And there are a lot of squiggly lines and that's all normal. What isn't normal is that inside the brain it should be all gray. Completely gray. Just like any other part of the brain. But, as you go up towards the top, there are little white dots in the brain. And there are a number of reasons for having white dots like that in the brain. And the most common reason is because there's been a trauma or some abnormality to small arteries and veins. And when there is a trauma to the brain, if the head is hit, the brain is depressed you hit it against the skull, the brain itself inside the head goes against the skull and then bounces off the skull, inside and that can cause a tearing of arteries and veins, little tiny arteries and veins, which causes swelling.

Now, CAT scans can't see these little white dots like this, because it's a different test than an MRI. MRIs can. So, what we have here is, at the time of injury, swelling of the brain, that showed up as pushing in of the left-sided ventricle and later on, a year later or some time later, three-quarters of a year later, these abnormal white dots there, which is a sign of small vessel, small vessel disease.

In any case, what this adds up to is that the clinician, whoever is taking care of this patient, has to be aware that there may be long term effects, or that the patient may manifest abnormalities anywhere from headaches to blurry vision, to abnormality in moving things that these parts of the brain send the nerves to go and do. So, those are the abnormalities on the CAT scan of the head -- on the MRI of the head that were done at the time of injury and after the time of injury.

Q Thank you, Doctor. Will you lease finish up with the last set of films that we have?

A There are two other things that we are going the look at relatively quickly, and one is, this is a chest X-ray on the patient and that is Number 4A. And you see this is a very abnormal looking chest X-ray. Half the chest is white. Half the chest is black. And, the reason for that is the lung here has collapsed and is now all white and there is abnormal and there is abnormal air.

Q What exhibit is that?

A That's Number 4A. There is actually what's called pneumothorax or collapsed lung on the left side there. So, everything has shifted over to the other side. If you look at a CAT scan, you'll see it very easily. These are very, very abnormal pictures, which is Number 4B. Here is the lung here. Here is the lung here and there is a black space here. And that is what's called the pneumothorax or collapsed lung. It's air outside the lung collapsing the lung, making it a difficult to breathe.

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What has to be done in this case is that a chest tube has to be inserted and the air has to be sucked out. If you look at this CAT scan, you'll also see that there is liquid and collapse of the bottom parts of both lungs in the right and the left. It's not uncommon in a trauma as severe as this to have findings like this. The lung has partially collapsed on both sides. Besides having this abnormal air, outside the lung, collapsing it, there is also an internal collapse of the lung and there is liquid or fluid called the effusion in the lungs. Chest tubes have to be put in, the liquid has to be drawn out, so that the lung can be expanded so this patient can breathe again.

These are all very acute things. We look at things down the line. The fracture is healing, but this is all stuff that has to be fixed just like the back, immediately, in order for this patient to continue on living. So, that is our glimpse. This patient had, many, many, many chest x-rays. This is a glimpse of what happened to his chest when he got injured and the patient did have chest tubes put in, in order to resolve that pneumothorax, the air, in order to re-expand the lungs, in order to take the fluid out that accumulated in the lungs.

And when you have a trauma to the chest, back like this, it's not, this is ?? severe but you do see this in the emergency room. This is not so atypical. So, that's the ??est on this patient and like I said, there is a whole series of many, many, many chest x-rays that the patient took, even many a day while he was acutely being treated with chest tubes to stabilize breathing. The patient also had a tube put down the trachea in order to breathe for the patient while the chest was being stabilized.

Q What is that, Doctor, that next film?

A This one here, this is a bone scan. And this is number 5, Exhibit Number 5.

Q What is the date?

A The date is September 1, 1999. About two months after injury.

Q One month?

A One month after injury. Less than a month after injury and what we're seeing here is a skeleton. And the point of this test is that any area that has an abnormality of bone. we inject you with dye. The dye goes to the abnormal bone. And when it goes to the abnormal bone, it gets blacker on this picture than it should be. For example, we talked about a fractured humerus that was quite a big fracture that we saw. Here's the patient's right arm here. You can hardly see it. Here's the patient's left arm and there is a big black spot right there. You see the right arm here, this is the right arm. Patient has flipped, here's the right arm. You can almost make our the entire arm and here's the left arm. You see a big black spot there. They put the nail in. Remember, they fixed it so they themselves, the doctors, made a hole there and there was abnormal activity here, and they put the nail in and that's what it looked like when there is a fracture of the bone.

And you see many other areas, some of which we talked about, some of which we didn't, that was fractured. We talked about the rib fractures for example on the right side. You see these dots here, ninth, tenth, eleventh, twelve ribs, all these black dots, those are all fractures. That's on the right side. On the left side, there are fractures of mid ribs in the back, two ribs are fractured here in the back.

Q That's on the left side?

A That's on the left side.

Q And that's where the lung was collapsed?

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A That's right. On the same side. We would literally have to spend six hours going through all the films to point out every single abnormality. So, exactly, it's on the left side, on the side that the lung was collapsed and there are fractures and there are pictures that show the ribs pushing into the lung which may have actually made it collapse. In other words, the rib fractured and pushed into the lung, collapsed it just like a balloon, blew out. The lung just blew out. So, that's what it looks like on a bone scan.

Then, there are areas we talked about of the spine, how there are areas on the spine that are blacker than other areas, that's because of the fractures in the spine. And also a little white area in the spine here, that's because the surgeon went in and took bone out and put the metal, and since the metal doesn't pick up any of the dye, it looks like white on these pictures. So, there are changes from fractures of the spine and plus areas that the surgeons fixed.

Any in any case, there are multiple areas of fracture in the body here, that we just talked about and we went over. And, we just went over abnormalities of the chest were quite severe, and short term and long term abnormalities of the brain as well.

Q Dr. Kolb, thank you. Please take the stand for a second.

(Whereupon, the witness resumed the witness stand)

THE COURT: Cross-examination.

MR. GORAYEB : Just a couple of more questions and then I'm going to sit down.

THE COURT: You may.

Q D?? Kolb, I want you to assume that prior to August 6th of 1993, Alonso Hernandez was a healthy 44-year old Hispanic man who had no history of any medical problem and never received treatment of any kind. Had no problem with his back, with his arm, with any part of his skeleton. That on August 6th, 1999, while working for Jumbo Construction, he fell approximately five stories from a roof landing on the sidewalk ridge; that he was removed by ambulance to St. Vincent's Hospital where he underwent the treatment that you have described for us.

Do you have an opinion, Doctor, with a reasonable degree of medical certainty as to whether the fracture of his left humerus that you have just described for the Jury was caused by that fall of August 6th, 1939?

A Absolutely, it absolutely was.

Q And, Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the conditions which you have described for us as seen in the latest films are permanent in nature?

A Absolutely, as we have shown.

Q Doctor, do you have an opinion, assuming the same hypothetical, as to whether the fractures of the spine and the damage to the tissues and nerves of the spine that you described for us and to the Jury, were caused by the fall of August 6th, 1999

A Yes, of course they were.

Q And do you have an opinion, Doctor, as to whether those conditions are permanent?

A Yes, they are, as I've shown this afternoon.

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Q And, Doctor, referring to the brain, CAT scan and MRI, do you have an opinion as to whether the swelling of the ventricles and the white dots that you described for the Jury were caused by the fall of approximately five stories on the date of accident?

A Yes.

Q And do you have an opinion, Doctor, as to whether those conditions are permanent in nature?

A Yes.

Q And what is your opinion?

A That they are, the MRI months and months later was an abnormal MRI, and so the answer to the question is yes.

Q And Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the fractures of the thorax and of the ribs and the collapsed lung were causally related or caused by the fall of August 6th, 1999?

A Yes, yes.

Q And, your opinion is?

A That they were caused by the fall, of course.

Q And your opinion as to whether those fractures and those conditions, other than the collapsed lung, are permanent in nature?

A As we've shown, to the extent that I've shown here this morning, yes, they are.

Q And Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the fractures of the, of the, of the skull and around the orbit of the eye were caused by the fall of August 6th, 1999?

A Yes, it certainly was.

Q And do you have an opinion, Doctor, as to whether any conditions related to those fractures which may still exist are permanent in nature?

A They may be.

Q Doctor, Dr. Kolb. have you been asked by my firm, by myself or other attorneys to work with us to review films for other individuals represented by us?

A Yes, I have.

Q And have you on occasion come into Court to explain those conditions to other juries?

A Yes.

Q And, Doctor, Dr. Kolb, are you being compensated for your time today?

A Yes.

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Q And at what rate are you being compensated?

A Five thousand dollars.

MR. GORAYEB: Thank you, your Honor. Thank you, Dr. Kolb. Nothing further.

THE COURT: Cross-examination. Mr. McNamara.

MR. MCNAMARA: Just very briefly.

CROSS EXAMINATION

BY MR. MCNAMARA:

Q Dr. Kolb, would I be correct that you never yourself treated Alonso Hernandez?

A Absolutely correct.

Q And would I be correct in this particular case you were asked by Mr. Gorayeb or someone from his firm, to review diagnostic tests to come here before the Jury and tell us about your interpretation of those films?

A Yes, absolutely correct.

MR. MCNAMARA: Thank you.

THE COURT: All right. Mr. Plousadis.

MR. PLOUSADIS: No questions.

THE COURT: Mr. Gra??

MR. GRADY: Just one or two questions.

CROSS--EXAMINATION

BY MR. GRADY:

Q Good afternoon. The major part of your practice is mammograms, and breast lesions?

A Yes, the majority of my time is breast cancer diagnosis.

Q On direct examination, you said a diagnostic radiologist's main function is to help a clinician, is that correct?

A Yes.

Q You didn't ever see this patient at St. Vincent's Hospital or Cabrini Medical Center, would that be fair?

A Absolutely correct.

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Q The first time that you've reviewed the films of Mr. Hernandez were this past September, 2003, would that also be correct?

A Yes.

Q I see that you authored about twenty-one different reports, dated between September 22, 23 and -- 23, 24 and 25. Would that be fair?

A Yes.

Q Those twenty-one reports, all of them are addressed to Mr. Gorayeb's office?

A Yes.

Q So, would it be fair to say the purpose of the review of those films were to testify at trial here today?

A If it would come to that, so then, yeah, it would be fair to say that. Yes.

Q Now, Doctor, you've testified before in court, would that be fair?

A Yes. Absolutely.

Q Approximately how many times have you testified, Doctor?

A I've testified approximately six times per year.

Q Ckay. I see?

A On the average.

Q My research indicated you testified maybe thirty-five times, would that be fair?

A Yes, over about an eight to ten year period, I would say that that's correct.

Q 99 percent of those or plaintiffs, would that also be fair?

A No, I wouldn't say that. I think that it's majority plaintiffs and, the other, the minority defense. Ones that have come to trial have been that percentage, that's correct.

Q And have you previously reviewed cases with Mr. Gorayeb?

A Yes, absolutely.

Q Have you testified for Mr. Gorayeb before?

A Yes, I have.

Q Did you testify last year for him, before Judge Gammerman in a case?

A I can't tell you the name of the Judge, but I certainly did testify for him or for the patient last year.

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Q Did you testify just last month for Mr. Gorayeb in a case in Manhattan?

A I definitely testified recently. I don't know if it was last month or the month before, but I definitely testified recently.

Q And the office sent you films and you never actually treated the patient in the hospital?

A I can't tell you if be sent me the films or if it was films that I've read because doctors sent them in to be treated.

Q In a case you testified last month, the films that you reviewed, were they Doctor Kaplan's films, some of them?

A I can't tell you who the exact Doctor was.

MR. GRADY: I have no further questions, your Honor. Thank you.

THE COURT: Anything further?

MR. GORAYEB: Nothing further, thank you,

THE COURT: All right

(Whereupon, the Witness was excused from the Witness Stand)

THE COURT: Thank you very much, Doctor.

THE WITNESS : Thank you.

(Whereupon, the Witness was excused from the Witness Stand)

THE COURT: Anything further for today?

MR. GORAYEB: Not for this afternoon

THE COURT: All right. I want to direct the Jury to report back, to the Jury room at 10 a. m. tomorrow. Thank you very much. Have a good evening.

(Whereupon, the sworn Jury exited the courtroom)

(Whereupon, this case was in recess, and was adjourned until November 21, 2003)

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