

Jayaram - direct - Turkewitz

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

2 (In open court; jury not present.)

3 THE COURT: Are we ready?

4 MR. TURKEWITZ: Yes, your Honor.

5 THE COURT: Ask the jury to come in, please.

6 (Jury present.)

7 THE COURT: It strikes me, it may well be you folks
8 might be more comfortable if you sat in the second row, too,
9 since we have lost our Juror No. Two.

10 MR. TURKEWITZ: The plaintiff calls Dr. Nadubeethi
11 Jayaram.

12 N A D U B E E T H I J A Y A R A M,

13 having been duly sworn, was examined and
14 testified as follows:

15 THE CLERK: State your name and spell it, please.

16 THE WITNESS: Nadubeethi, N A D U B E E T H I, last
17 name is Jayaram, J A Y A R A M.

18 THE COURT: Keep your voice up, please.

19 DIRECT EXAMINATION

20 BY MR. TURKEWITZ:

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

23 A Yes, sir.

24 Q And is your practice orthopedics?

25 A Yes, sir.

1 Q And do you know Oliver Tookes by virtue of having treated
2 him for a fractured ankle and fractured wrist?

3 A Yes, sir.

4 Q Would you please tell the members of the jury about your
5 medical education and background?

6 A I graduated from Bangalore Medical College in Bangalore
7 City in India in 1973, and after that I completed a qualifying
8 examination to get to the United States and to do a residency
9 program in general surgery.

10 After passing the qualifying exam in 1975, I started
11 immediately a residency program in general surgery at
12 Downstate Medical Center in Brooklyn, and I completed that in
13 1982. Then I did one year of vascular surgery in Lutheran
14 Medical Center in Brooklyn. Following that, I was selected
15 for an orthopedic residency program in Downstate Medical
16 Center, Brooklyn, and I completed the orthopedic residency
17 training program in 1985.

18 Following that, I was selected to be on the faculty
19 in Downstate Medical Center for two years. In 1987, I went
20 for a fellowship in hand and microsurgery at the University of
21 Birmingham for one year. I returned to New York City and
22 joined a private practice called Richmond Orthopedic
23 Associates on Staten Island from 1988.

24 Q Have you been at Richmond Orthopedic Associates from 1988
25 until the present?

1 A Yes, sir.

2 Q Are you board certified in any medical specialties?

3 A I am board certified in orthopedic surgery, and also
4 recently, my last recertification was in the year 2003.

5 Q So, you have been certified and recertified?

6 A Yes, sir.

7 Q Could you explain to the members of the jury what that
8 means to be certified in a medical specialty?

9 A Certification in any specialty means you have to go
10 through a qualified and prescribed residency program. A
11 residency program would be hands-on training in an approved --
12 usually, it's a university center, for a period of anywhere
13 from three to five years.

14 Q When for the first time did you meet Oliver Tookes?

15 A I have to go through the chart.

16 Q By the way, you saw him at Staten Island University
17 Hospital, or was it Richmond University Hospital?

18 A St. Vincent's Medical Center. The name has been changed
19 recently to Richmond University Medical Center.

20 Q Would you like to have the St. Vincent's medical records
21 with you to assist you while you testify?

22 A Yes, sir.

23 Q Anytime while I'm asking you questions, if you would like
24 to refer to your medical records or to the St. Vincent's
25 records, please feel free to do so.

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1 A Yes, sir.

2 Q So, did Oliver Tookes come to St. Vincent's on the
3 evening of May 18, 2007?

4 A Yes, sir.

5 Q You were working that evening there?

6 A I was on call for the department of orthopedics at St.
7 Vincent's Medical Center on that date.

8 Q You came to see him to find out what had happened?

9 A Yes.

10 Q Can you tell the members of the jury what it is you
11 learned when you first met Mr. Tookes?

12 A I'm going through the chart here to highlight my
13 emergency room notes.

14 Q By the way, have you had an opportunity before today to
15 do this?

16 A I did not have access to these records, because
17 everything has gone electronic. I didn't have access to
18 these.

19 Q You just showed up at the courthouse about fifteen
20 minutes ago.

21 A I'm sorry. I apologize. I was a little bit late because
22 of the traffic.

23 (Pause.)

24 A Yes, sir. I found it.

25 Q All right?

1 What did you learn about Mr. Tookes and the
2 accident.

3 A This emergency note has been written by me in my
4 handwriting, and I saw him -- he was admitted to the trauma
5 service. Normally, what happens is, when a patient is
6 admitted to a hospital, there's usually a trauma service which
7 is controlled by a qualified general surgeon who is called the
8 trauma leader, and he delegates out all the injuries to the
9 subspecialty. So, initially, the patient was admitted to the
10 trauma service under a doctor by the name of Dr. Jung, and he
11 requested an orthopedic consultation for the injuries to the
12 bones on Mr. Tookes.

13 And I was summoned to the emergency room, and this
14 is my finding. He was fifty-eight years old at that time. He
15 was admitted to the trauma service for management of any
16 multiple injuries that may exist, but I saw him in orthopedic
17 consultation. He gave a history of falling through a grate
18 from a height of approximately twelve feet, and sustained an
19 injury to his left ankle and left wrist.

20 I examined the patient. He had a deformity of the
21 ankle, which was obvious, and he had clinical signs.
22 "Clinical signs" means, by looking at him, there was a
23 deformity of the ankle which resembled a dislocation of the
24 ankle. It was an open fracture. "Open fracture" means --
25 people call it a compound fracture. We no longer use that

1 term "compound fracture." We use the term "open fracture."
2 "Open fracture" means if the injury is severe, and due to the
3 force, the skin also rips at the area of the fracture site,
4 which he had a big opening over the fracture site. That means
5 you can see the bone poking through the wound.

6 It was a Grade 3 open fracture. "Grade 3" means it's
7 the more severe form of an open fracture. Grade 1 is a small
8 wound measuring approximately a half inch or, in our
9 terminology, we use centimeters, the metric system, we say it
10 is one to two centimeters is a Grade 1 open fracture. More
11 than two centimeters, we call it a Grade 2 open fracture.
12 Anything which has a wide open wound and the bone exposed to
13 all the dirt that may be around is called a Grade 3 open
14 fracture.

15 He did have a Grade 3 open fracture. The wound was
16 more than two centimeters. It was in fact more than that,
17 because you could easily see the broken bone through that.

18 An x-ray of the ankle was done and to see what the
19 bones looked like, and he had what's called a bimanular
20 fracture. "Bi" means two. There was a fracture of the tibia.
21 That is 1.

22 Number 2 was the fibula. That's the companion bone
23 of the leg at the level of the ankle. That's the smaller
24 bone. That's called the fibula. That was also broken.

25 The tibia was the open fracture.

1 The fibula was a closed fracture.

2 And he also had evidence of, on the x-rays, an
3 increased space between the two bones at the level of the
4 ankle. What it means is, when there's increased space between
5 the two bones, the ligaments, the ligaments of the ankle, are
6 completely torn. Normally, the bones are held together by the
7 ligaments for the ankle function, normally. If the bones are
8 separated, that means the ligament is completely torn, and
9 it's a much higher grade of a fracture of the ankle, which he
10 did have.

11 Q Which he did or did not?

12 A Which he did have.

13 When you see something like that, we usually reduce
14 it. "Reduce" means we want to restore as normally an anatomy
15 or position of the bone as possible as soon as possible,
16 because when you see something like this, there can be
17 injuries to the blood vessels, and a continuing abnormal
18 position of these bones will compromise the circulation and
19 damage the skin, blood flow, and multiple other problems can
20 arise. We usually reduce it. "Reduce it" means bring it back
21 to as close to normal position as possible, which we did, and
22 put a splint on after cleaning the wound in the emergency
23 room.

24 The next thing we focused on was his left wrist. He
25 was complaining of pain in the left wrist around in the

1 radius.

2 The radius is the longer bone of the wrist. The
3 other bone, which is next to it, which is the ulna.

4 He had a fracture of the radius, which is the bigger
5 bone of the wrist, and the bone was interarticular, which
6 means it's going into the joint and it was displaced.

7 "Displaced" means it was not in good contact after it broke.
8 There was a step, like that. It was unstable. "Unstable"
9 means we need to restore it to a good position, usually by
10 surgery, and stabilize it. "Stabilize" means we either have
11 either a cast or put screws and a plate or connecting pins.
12 It's called an external fixator. That, we usually decide in
13 the operating room, what's the optimal procedure to be done.

14 After reviewing all this, his injuries were
15 discussed with the patient, consent was obtained, and he was
16 also informed that within injuries like this, because of the
17 nature of the fracture both in the ankle and the wrist, since
18 the fracture was -- in the ankle was Grade 3 and going into
19 the joint, also, and being opened there and exposed to all the
20 dirt, infection would be -- the chance of infection would be
21 extremely high, because all the dirt and bacteria would have
22 already gotten in there before he came to the hospital. In
23 spite of doing the best we can in the hospital, he can still
24 get infected.

25 Number two, he can develop arthritis from the

1 severity of the fracture.

2 Q What's arthritis?

3 A Arthritis is damage to the cartilage, and the cartilage
4 wears out because of the damage at the time of the injury. As
5 the cartilage starts wearing out, it thins out and the bone
6 gets exposed, and bone can rub on its neighboring bone which
7 forms the joint, and cause continuous pain.

8 He had, as I'm going to use the term, chronic
9 arthritis. That's what developed. It refers to arthritis
10 following fractures.

11 Q Eventually, that's what he ended up with?

12 A That's correct.

13 He was also informed that the fracture can develop
14 delayed union. "Delayed union" means if the fracture is badly
15 displaced, which he had, the blood flow to the bone would have
16 been disturbed. It would have been decreased significantly.
17 For any bone to heal or any tissue in the body to heal, you
18 need good blood flow, even a cut in the skin. For you to heal
19 properly, you need good blood flow. Diabetics don't heal,
20 because they don't have good flow into the skin or whatever it
21 is. Something similar happens in bad injuries. All the
22 tissues, or the envelope of tissue which carries the blood
23 flow and cap capillaries to the bones, gets stripped off at
24 the time of a serious fracture. Grade 3 open fractures,
25 usually, when we examine them in the operating room, the

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1 tissues are indeed stripped off. When we took him to the
2 operating room, he had that. "Delayed union," that means a
3 fracture which would not heal at the usual time is to be
4 anticipated. Normally, fractures heal in around six weeks'
5 time, in most healthy individuals, but in open fractures or in
6 the presence of infection, the healing of the bone will be
7 delayed significantly. It can go on for several months.

8 So, all this was discussed with him and then consent
9 was obtained.

10 I'm finished with my emergency room encounter.

11 Q Did you plan for surgery the next morning?

12 A Yes.

13 Q I have some --

14 A "Next morning" means he came in the night; that is -- I
15 don't have the exact time, 5-18, in the night.

16 Q 5-18 means May 18?

17 A Yes.

18 Q He came in sometime late at night?

19 A Correct.

20 And my note was, at 6:00 a.m. on 5-19-07, he came
21 pretty early in the morning to see this patient and plan on
22 the surgery. He was put on the fast track to be taken to the
23 operating room.

24 Q Okay?

25 Now, you performed surgery on him that day --

1 A That is correct.

2 Q -- May 19, the day after the accident?

3 A That is correct. It's not really a day. A day would be
4 twenty-four hours. We don't wait twenty-four hours. We do it
5 much earlier than that, as soon as we can.

6 Q The next day on the calendar?

7 A On the calendar. I think it was within a few hours,
8 maybe six or seven hours, we did the surgery, after the
9 injury. After he came in.

10 Q I had sent you some medical illustrations?

11 A Yes, sir.

12 Q What I would like you to do -- if you come down here, I
13 have enlargements of the medical illustrations.

14 MR. TURKEWITZ: These are enlargements of
15 Plaintiff's Exhibit 8.

16 Q And we'll start with the wrist. The wrist was the lesser
17 of the two injuries?

18 A That's correct. First, I would like to focus on the
19 x-ray of the wrist.

20 Q I'm not sure all the jurors can see.

21 A Tell me if you can't see. I can help you with that.

22 Okay.

23 Q Why don't you show us what was observed on x-ray, because
24 you were giving some description up there, but this gives a
25 visual. After that, we'll go to how it is you fixed it.

1 A Yes, sir.

2 Q Okay.

3 A This is the left wrist, and the wrist is like this here.
4 The x-ray has been done of the wrist like that. This is the
5 radius. On the side of the thumb is -- this is the thumb,
6 this is the radius, this is the ulna. If you notice, the
7 radius is broken here. The ulna seems to be intact here.
8 There may be a small chip there, which there is a small clip
9 of bone there, which is not very significant.

10 But the significant part of the fracture is the
11 radius. We call it the distal radius. "Distal" means further
12 away from the trunk. This is called distal radius. That's
13 the terminology we use in orthopedics, and it's an
14 interarticular fracture.

15 These are the cracks going into the joint. If you
16 carefully look at this, this is not very clear here, but here,
17 it becomes a little bit more clear, but the actual x-ray shows
18 the cracks going into the joint like this.

19 Anyone have questions? Okay.

20 This is the second crack going in there.

21 And the third crack going in there.

22 And there are the smaller pieces there.

23 What this indicates is, it's an interarticular
24 fracture, that means it's going into the joint, damaging the
25 cartilage. Cartilage you don't see on x-rays. Cartilage does

1 not contain calcium, so it will not appear on the x-rays.
2 Only the bone appears on the x-rays. You need calcium, which
3 makes it radiopaque. "Radiopaque" means for it to be -- for
4 it to be able to be reflected by the x-rays, so you see that.
5 But whenever you see this, we look for how much displacement
6 is there. Displacement is this way inside the joint. You can
7 see that there's a step here inside the joint. That is
8 significant. When there is a step like that, we know for sure
9 there is damage to the cartilage, and we anticipate possible
10 arthritis in the future.

11 A fair number of patients do well, a fair number of
12 them do not do well, depending upon the force with which they
13 fell. That's the other factor that we have to consider.

14 If he fell from a height of like ten, twelve feet,
15 it's a significant force. People develop major injuries after
16 a height of approximately six feet by statistics. If you
17 climb a ladder, you should always be careful that you don't
18 fall from a ladder more than six feet. If you fall, you are
19 guaranteed to have major injuries. If you fell from ten feet
20 or twelve feet, guaranteed to have major injuries.

21 We always see major injuries to the hip, the wrist
22 or the ankle. We see this combination all the time. The
23 force with which they fall from a height of ten to twelve feet
24 is a lot of force. Force gets concentrated on a tiny little
25 joint like the wrist, if you fell on the wrist. Or the ankle,

1 the ankle joint is a tiny joint, and the force will actually
2 punch into the joint. Usually, the normal reflex is, people
3 fall, to try to protect themselves, with their hands spread
4 out like that, and the force goes this way and punches
5 everything into the wrist. That means it can cave in there,
6 and that is the caved-in portion there.

7 Q How did you go about repairing or fixing the wrist?

8 A Okay. When you have a situation like this, we like to
9 restore as good anatomy as possible or as good a joint as
10 possible, and reestablish the length of the bone here. So, it
11 becomes short here. We like to push it up or pull it up and
12 hold it in place, so that it will heal in as normal position
13 as possible, and that's what we did in this patient. We took
14 him to the operating room, and under anesthesia, we pulled on
15 it, pushed on the small fragments to restore the anatomy of
16 the joint, so that it will become level.

17 Q I'm not sure all the jurors can see.

18 A This is how we started. If you notice, there's a little
19 caved-in portion. This fragment is down this way, and this is
20 spread out this way a little bit. So, we closed the gaps,
21 pulled this up, held it in place with what's called an
22 external fixator. An external fixator is --

23 Q Maybe standing over here, it would be easier.

24 A Good.

25 An "external fixator" means we put pins like about

1 four to five inches away from the fracture. This is about
2 like three millimeters in diameter. And usually, you need two
3 pins on this bone on this side of the fracture, another two
4 pins own this side of the fracture. That is, it's going into
5 the bone of the index finger here. That's called the
6 metacarpal. We connected with clamps and rods, like this.
7 Then my assistant pulls on it, we check with the x-ray in the
8 operating room, make sure it's in a good position, and tighten
9 up all the clamps here, so this will remain like this. That's
10 called an external fixator.

11 Q The external fixator is getting drilled into the bone?

12 A That's correct.

13 Q All right?

14 Let's move on to the ankle. This is for the surgery
15 the following morning. It was all done in one surgery.

16 A Yes. Yes.

17 Q Can you show you the members of the jury the preoperative
18 condition of the ankle?

19 A This is the x-ray of the ankle. When we examined him,
20 all this was sticking out. The ankle was blown up, black and
21 blue, and you could see this part of the bone sticking out of
22 the wound there. The laceration was here, like this. This
23 part of the bone was sticking out.

24 This bone belongs here. This part should be really
25 sitting on top of this bone called the talus. Here, you see

1 two fractures. One is the tibia here, this break here.

2 Q The tibia is the bigger of the two?

3 A The tibia is the bigger of the bones.

4 This is the fibula. The smaller, skinny bone is the
5 fibula, and there's also a break here. Both of them should be
6 together and should sit right on top of the talus there.

7 And there's an increased space between this bone and
8 this bone. What it means is, the ligament which connects
9 these two bones and holds it together is completely torn. So,
10 we need that ligament for you not to develop arthritis in the
11 future. It's a very important point there. Okay.

12 (Continued on next page.)

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1 CONTINUED DIRECT EXAMINATION

2 BY MR. TURKEWITZ:

3 A (Continuing) This diagram will show you, also help you
4 understand what it looked like when we opened up the wound,
5 this part sticking out, the laceration here, you see the
6 fracture, the jagged edge. This is another fragment, whitish
7 area, double density, bone sitting right there on top of the
8 bone, the fragment is there. That's why it's much wider.

9 This is the fibula. This is the fracture. This
10 part, the fibula moves along this way along with the tibia,
11 both have moved off this way.

12 This is called the Talus, the keystone of the ankle,
13 didn't see much damage to this one.

14 Q That's what the tibia and fibula is supposed to be next
15 to?

16 A That's correct.

17 This is the picture of the x-ray after we did the
18 surgery. We got as good anatomy as possible for this patient.

19 Before I take the next step, I want to emphasize
20 that is intra-articular fracture, going right into the joint
21 in the weight bearing of the tibia. This is the portion,
22 going right through there. You see that? This is the joint
23 between the talus and the tibia. This is the joint, the dark
24 space is the joint and this part of the bone has moved off the
25 joint here. That means there's significant cartilage damage,

1 the white portion is the cartilage which you don't see on the
2 x-rays, but it's actually tissue there which lubricates the
3 joint, pushes on the joint, prevent pains when the ankle
4 moves. That's damaged there.

5 This is the x-ray of the ankle after we restored the
6 normal anatomy here. This is the fracture here, there's a
7 piece here which you don't see here, we put back together with
8 two screws. This part has been held with these screws here,
9 this one and this one here. Then this fibula has been brought
10 together, held together with the pin.

11 Q In order to put Mr. Tookes's ankle together, there are
12 four screws and a long pin?

13 A That's correct. Before I finish here, on top of this, we
14 have the bone poking through the skin. There's a vein, the
15 saphenous vein and the nerve, and that carries the sensation
16 in this part, this portion of the foot. You have the feeling
17 due to the presence of this. If this is cut, you lose the
18 feeling in this part of the foot. Later you can also develop
19 problems due to the nerve, neuroma, means damaged, doesn't
20 heal right, forms a very sensitive ending like a live wire
21 sitting there, you feel like electric shocks.

22 Q Is that like a sensation I get at the dentist when he
23 hits a nerve?

24 A I don't go to the dentist too much.

25 Q Never mind.

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1 A Root canal, I'm sorry.

2 Q Let's keep going.

3 A It's like electric shock, what you feel, strong electric
4 shock.

5 Q The saphenous nerve was injured?

6 A Yes.

7 Q How is it injured?

8 A This sharp edge had ripped it off.

9 Q Cut it?

10 A Right.

11 Q After this combination surgery was done, Mr. Tookes
12 stayed at the hospital for a week or so?

13 A That is correct.

14 Q Then he got sent off, you sent him off to rehabilitation?

15 A Correct.

16 Q Why?

17 A Normally we don't keep patients in the hospital too long.
18 Since it was an open fracture, contamination of the wounds
19 with dirt and other things, he was in the hospital for
20 antibiotic therapy, intravenous to prevent infection, usually
21 keep anywhere from four to five days. At the end of that
22 period, if the wound looks clean, we send him either home or
23 if they need to go to short term rehabilitation facility, we
24 do that.

25 Q Should I assume he was on pain medication while he was at

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1 the hospital?

2 A Yes, sir.

3 Q What was your objective? He got sent off to Clove Lakes,
4 right?

5 A Yes.

6 Q What was your objection in sending him off to Clove
7 Lakes? What is it he would actually do there or learn to do
8 there or redo?

9 A This patient has a serious injury to the ankle. He has
10 injury to the wrist. For you to walk, you need too good arms
11 to use the crutches or a walker. You can't put obviously any
12 weight on the ankle. If you do put weight on the ankle
13 everything will fall apart, what we do, screws will break, the
14 fracture will move out of place. He's not allowed to put any
15 weight on the leg. He's unable to walk with one arm for
16 support, one leg for support, impossible. You need two arms,
17 use the crutches to carry the body weight, to limp on one good
18 leg. Here, we didn't have the luxury of sending him home
19 since his left wrist was also broken. We had to place him in
20 rehabilitation facility so at least something would heal here.
21 Usually we're waiting for the wrist to heal so he could put
22 weight on it, able to go home.

23 Q The first thing was just to lay there, wait for the wrist
24 at least, the bones to knit together?

25 A That is correct. While he's waiting, he also gets range

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1 of motion, means keep all the joints moving, make sure he
2 doesn't develop clots in the legs. If you lay in bed, you
3 could develop clots in the leg.

4 Q Did Mr. Tookes return to the hospital about a week or two
5 later?

6 A Yes, sir.

7 Q Was that because he needed some drainage done?

8 A Before he came to the hospital, he was seen by me in the
9 office. He had an infection in the wound. It was a little
10 bit reddish, small amount of pus present, didn't want to take
11 any chances. Let's take the patient to the hospital, clean it
12 out again, make sure the infection doesn't go deep. He was
13 readmitted. I'll proceed as you ask the question.

14 Q The second surgery he had on the ankle?

15 A Came back to the operating room, aggressive with the
16 treatment to wash it out, not sit with antibiotics, clean it
17 out, open the wound partially, drained everything and
18 continued the antibiotics.

19 Q Sent him back to Clove Lakes?

20 A That's correct.

21 Q Going back to Clove Lakes, what was the plan when you
22 were sending him back now for the second time after the ankle
23 had been drained?

24 A Continue the intravenous antibiotics, because he had an
25 infection. Number two, continue these physical therapy for

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1 the other parts of the body, keep up the strength of the leg,
2 keep up the strength, including the left leg, the knee, all
3 the muscles in his thighs, right leg, right arm, shoulders
4 from freezing, all the things that are essential so we keep
5 him in good shape when he's ready to walk, he should be able
6 to walk as best as he can, not feel very weak.

7 Q After he was in Clove Lakes for six weeks or so, he went
8 back out to his home in Pennsylvania?

9 A That's correct.

10 Q You continued to be his doctor?

11 A Yes, sir.

12 Q Did there come a time when you had to operate on him a
13 third time?

14 A Yes, sir.

15 Q What was that for?

16 A I'll have to look at the chart.

17 Q Please.

18 (Pause.)

19 A Can I bring the chart?

20 Q Absolutely. We'll make room for you.

21 A I'll bring the other chart. Excuse me.

22 (Pause.)

23 THE COURT: What's your question?

24 MR. TURKEWITZ: He's finding his notes for surgery
25 number three.

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1 A I'll briefly mention what led to the next surgery.

2 Q Yes.

3 A During the course of is the follow-up, he started having
4 pain, tingling in the ankle. He was complaining of a
5 sensation of burning sensation, pain and numbness, a
6 combination that you feel in a nerve injury. In the
7 distribution of the saphenous nerve, the long nerve that
8 passes, comes down this way and goes to the middle segment of
9 the foot, this much of the foot. The sensation is carried by
10 this much of the foot in the middle.

11 When I examined him, he had tenderness, means when
12 you touch it or tap on it, he had excruciating pain, feeling
13 electric shock, like feeling on the side of the damage to the
14 nerve. That indicates he has developed a neuroma, means the
15 cut ends of the nerve, it forms like a bulb-like appearance,
16 becomes very sensitive, like a live wire sitting close to the
17 scar, called a neuroma. I informed him on 8-15-07 he has
18 developed a neuroma. This has to be explored, means you open
19 up that area, limited area, look for the neuroma, if he indeed
20 has a neuroma, we have to treat it, otherwise you'll have such
21 severe pain from the neuroma, it could keep him awake in the
22 middle of night, the sheets you wrap yourself in sleep, it
23 wakes you up, feels like electric shock. It's an
24 uncomfortable feeling. If you wear a high top boot or socks,
25 it drops on it, you feel pain. The pain can be triggered by

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1 anyone touching it or bumping into someone, you feel it like a
2 shock, which he did indeed have.

3 Q That's from the end of the nerve getting encapsulated in
4 the scar, going into the scar?

5 A Contents of the nerve do develop neuromas. Some people
6 have a lot of pain from neuromas, some people do not develop
7 too much pain. Those who develop a lots of pain from the
8 neuroma will need intervention.

9 Q That's what happened with Oliver?

10 A Yes.

11 Q Did you operate on him for the third time on
12 September 13th, 2007?

13 A Of that is correct.

14 Q That was --

15 A In 2007.

16 Q How did you solve the problem with respect to the
17 electric shocks that he was getting from the saphenous nerve
18 being touched?

19 A We operate on neuromas, we do it under local anesthesia.
20 We want the patient to be awake. We want to find out the
21 exact location of the damage to the nerve, that means to zoom
22 in on that area, expose that area. Once we find the neuroma,
23 the recommended thing currently in standard textbooks to bury
24 deep inside the tissues. You can remove the swollen portion,
25 it will form another neuroma. You bore deep into the tissue,

1 away from all kinds of contact. One of the recommendations,
2 there's a nice big bone there, you burn the hole in the bone,
3 break inside the bone. That's what we did so that problem is
4 away from everything.

5 Q After you did that third surgery, you continued to be
6 Oliver's treating orthopedist, right?

7 A Sorry?

8 Q After that third surgery in September of 2007, you
9 continued to be his treating orthopedist?

10 A Right.

11 Q There came a point where he asked you for permission to
12 go back to work?

13 A Yes, he was very enthusiastic to return to his previous
14 work. He expressed that. Most of the time he came to the
15 office for follow-up he wants to return to work as soon as
16 possible.

17 Q What did you tell him?

18 A I had to wait, naturally, for the fracture to heal so he
19 wouldn't get into trouble. I want him to be relatively pain
20 free, be able to handle his work.

21 Q Eventually did you give him permission to go back to work
22 beginning in 2008?

23 A Yes.

24 Q He went to work on light duty, right?

25 A That is correct.

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1 Q Did there come a time after about a year when Mr. Tookes
2 was experiencing problems again?

3 A Yes, sir.

4 Q What kind of problems?

5 A Started complaining of pain in the ankle which is
6 gradually increasing. It was the kind of pain he had, a
7 different character to it. It was so more like arthritic
8 pain, not neuroma pain anymore, pain in the joint, moving the
9 joint up and down caused more pain. He was developing
10 stiffness, related to moving the ankle up and down was
11 decreasing and walking for any minimal distance brought on
12 pain in the ankle joint.

13 Q You knew he did a lot of walking as part of his job?

14 A That's correct.

15 Q What happened?

16 A Of course, we repeated the x-ray to see if he was
17 developing arthritis. We were anticipating arthritis in a bad
18 fracture like this. We did do the x-ray, the space between
19 the tibia and the talus had decreased significantly there.
20 That means the cartilage was wearing out due to the original
21 injury.

22 Q The cartilage sits on the end of the bones, makes them
23 work smoothly together?

24 A That is correct, cartilage is like a cushion which is
25 like a cap at the ends of the bones on both sides of the joint

SS

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1 so that there's a cap on the bone on this side, a cap on the
2 bone on that side. Bone never comes in direct contact to each
3 other, always cartilage on this side and that side, acting as
4 a buffer and cushion between these two bones. That's the way
5 it happens, no pain, good lubrication going on. The cartilage
6 was damaged here, eventually it wore out completely and he
7 developed what's called traumatic arthritis which is due to
8 the injury.

9 Q That's because now you had bone on bone because the
10 cartilage was gone?

11 A Yes, sir.

12 Q You recommended a fourth surgery for him?

13 A Yes, sir.

14 Q What kind of surgery was that?

15 A His ability to walk decreased to such a great extent that
16 we had to restore his ability to walk again without
17 significant pain. One of the recommended procedures most of
18 the time is called ankle fusion. Fusion means joining
19 together. Here in this case we joined two bones together so
20 there won't be any bone rubbing on bone. When we do that, the
21 motion in the ankle is completely eliminated. It's going to
22 lose some, gain some here, going to lose the motion, gain the
23 loss of pain. That was our goal.

24 Q The joint is eliminated?

25 A Joint is eliminated in that area.

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1 Q I'm going to show you a third blowup. There's another
2 enlargement of part of Plaintiff's Exhibit 8. Does this show
3 the fourth surgery that you did on Mr. Tookes's ankle with
4 respect to fusing it together?

5 A Yes, sir.

6 Q Can you show the members of the jury the before and after
7 and what you did and how you did it?

8 A I'll take one step back to make this more clear to you.
9 Please pay attention to the ankle joint space between the
10 tibia and talus, nice and smooth. It's uniform appearance
11 here.

12 This is when he came just before the surgery
13 September 13th '07 before this x-ray was done. You notice
14 what's happening here? The space is getting -- this is an
15 enlargement. You really can't compare this to this because
16 this is much more enlarged here. It's a smaller picture here.
17 Please don't factor this into your thinking here.

18 This much space in here, this space should be like
19 that (indicating), normal space.

20 Q Your body might be blocking part of it.

21 THE COURT: Let me make sure I'm keeping my record
22 straight. What are the exhibit numbers here?

23 MR. TURKEWITZ: Plaintiff's Exhibit 8, three
24 enlargements.

25 THE COURT: Move it along. The doctor is getting

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1 too elaborate under the circumstances. This is the last one?

2 MR. TURKEWITZ: The fourth surgery.

3 THE COURT: The last one?

4 MR. TURKEWITZ: Yes.

5 THE COURT: You can come back, sit down here.

6 You've explained it all. You want to sum up what you have
7 concluded from that, you can do that, but take your seat
8 again.

9 MR. TURKEWITZ: Can't he go through the fusion?

10 THE COURT: I don't think it's necessary.

11 THE WITNESS: Just one minute?

12 THE COURT: Try to do it. We're extending this
13 thing unreasonably now.

14 A The space narrowing down, this area is called cystic
15 changes for the arthritis, clearly arthritis going on.

16 This is the operation we did after we took all the
17 screws out. All this was removed (indicating) and we put more
18 screws from here in this direction. After we leveled this
19 out, we put bone graft from the hip, the pelvic bone, the
20 standard bone graft is taken. The healing potential is
21 greatest when you take, use the pelvis as the donor site, a
22 lot of stem cells, you heard about that, that helps in the
23 healing process. We took the bone marrow from there, filled
24 up this area after scraping it, put the screws here from this
25 bone into the talus like this in different directions to hold

1 it rigidly in place so that it would knit together.

2 Q Is this the bone graft in here?

3 A That is correct.

4 THE COURT: You've explained all your four
5 surgeries. Come back and sit down.

6 THE WITNESS: Yes, sir.

7 MR. TURKEWITZ: I want him to describe the current
8 condition, if I could have him come down, show how he's
9 limited? . I need Mr. Tookes.

10 THE COURT: When is the last time you examined him,
11 doctor? I take it, it was recent?

12 THE WITNESS: Last year, sir, last December.

13 THE COURT: You examined him last September.

14 Mr. Tookes, come up here.

15 What was his condition as of last September?

16 THE WITNESS: A permanent limp.

17 THE COURT: He's walking right now. That's what
18 you mean by a permanent limp?

19 THE WITNESS: Yes, sir. He was complaining of pain
20 in the joints below the ankle joint, continued swelling of the
21 ankle and leg, continuing pain in the ankle region below the
22 level of the fusion and stiffness in his left wrist.

23 THE COURT: Do you need Mr. Tookes to stand here
24 for demonstrative reasons? Otherwise he can return to the
25 seat.

1 MR. TURKEWITZ: If the doctor believes he could use
2 demonstrations, with respect to his wrist and ankle.

3 THE COURT: I'll let you do a few.

4 A When you do a fusion, there's more stress passes through
5 the adjacent joints of the foot. There are joints below the
6 ankle joint and the forces are transmitted to the next joint.

7 THE COURT: You don't have to go into that
8 elaboration. He has problems bending?

9 THE WITNESS: Yes, sir. I'll explain why he has the
10 pain.

11 THE COURT: Go ahead, explain to the jury. We know
12 what his condition is, have lots of testimony.

13 THE WITNESS: Stand on your toe, left side, not able
14 to stand on his toe like normal people can. Try to move the
15 ankle. Hardly can move that, minimal motion in the ankle when
16 he does that. It is coming from the joints below the ankle
17 joint, the tiny joints next to that. Because of the stress
18 going through that, he's developing arthritis in those joints.
19 He started having pain there.

20 THE COURT: Anything else?

21 THE WITNESS: The wrist motion has decreased,
22 residual stiffness of the wrist.

23 THE COURT: Hard to bend over, is that what you're
24 saying?

25 THE WITNESS: The wrist.

1 THE COURT: Show that.

2 THE WITNESS: Move the wrist, come back to the other
3 side. Lean back. You'll lose your balance. Let me take your
4 cane. Move the wrist together, down.

5 THE COURT: As far as he could go, consistent with
6 your examination?

7 THE WITNESS: Yes, sir.

8 THE COURT: Mr. Tookes, you can return to your
9 seat.

10 Q Last question. What does his future hold with respect to
11 the wrist and ankle?

12 A The wrist, still has continued decrease in the range of
13 motion of the wrist. He doesn't have too much pain in the
14 wrist, has some discomfort, not too much pain, but there is
15 stiffness. He would not have the same dexterity as a normal
16 wrist.

17 Q That's permanent?

18 A Yes.

19 THE COURT: Wouldn't get better?

20 THE WITNESS: Won't get better, permanent condition.

21 THE COURT: Can it get any worse?

22 THE WITNESS: Probably not.

23 A Number two, the ankle, in the ankle, yes, it can get
24 worse. The reason it can get worse is normally when you have
25 injuries, multiple joints, several joints below the ankle, the

1 weight is transmitted, that means passes through the ankle
2 joint to the next joint, onto the next joint. The ankle takes
3 the initial brunt of the forces when you walk, jump. It
4 handles the initial force there. In this case the ankle joint
5 is no longer there. The forces are being transmitted right to
6 the bones into the next joint.

7 THE COURT: What do you think is going to happen?

8 THE WITNESS: Arthritis in the adjacent joint.

9 THE COURT: What will happen?

10 THE WITNESS: That would limit his walking, continue
11 to cause pain or increasing pain, his ability to walk
12 distances, progress will decrease.

13 THE COURT: Continue to walk with the cane?

14 THE WITNESS: Yes.

15 THE COURT: Any other apparatus to get around in
16 the future in your opinion?

17 THE WITNESS: An ankle brace might help, sometimes
18 more surgery, the next joint fusion would help, this brings up
19 a whole new avenue here.

20 THE COURT: You know he's not in for a happy time?

21 THE WITNESS: That's correct.

22 THE COURT: Let's take a recess, then
23 cross-examination. Fifteen minutes.

24 (Jury leaves courtroom.)

25 (Continues on next page.)

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1 (Court resumed)

2 THE COURT: Bring in the jury.

3 (Jury now present)

4 (Witness resumed the stand)

5 THE CLERK: You all may be seated.

6 THE COURT: All right.

7 CROSS-EXAMINATION

8 BY MS. DANELLI:

9 MS. DANELLI: Thank you, Your Honor.

10 Q Good afternoon, Doctor.

11 A Good afternoon.

12 Q Can you just tell us, Mr. Tookes never developed an
13 infection in his wrist, did he?

14 A No.

15 Q Okay. And the third surgery that you conducted on the
16 infection in Mr. Tookes' leg, was that a surgery that required
17 him to remain in the hospital, or did he leave the facility
18 where the surgery was performed the same day?

19 A For the neuroma?

20 Q Yes.

21 A No, he didn't have to stay in the hospital. It was also
22 done with local anesthesia.

23 Q And so that meant that he was awake during the procedure?

24 A Semi awake.

25 Q You talked a little bit about the force -- you used the

1 word force and about how that interplayed in terms of bringing
2 about the injury. Was that the only thing that's relevant in
3 terms of force the height from which he fell, or is there also
4 the factor of his weight and the type of surface on which he
5 landed?

6 A This patient, if I recall, he was not this heavy before.
7 Because of his inability to walk, to do normal exercise he
8 has gained weight after the fact. He sustained this injury
9 and his capacity to walk has decreased and his ability to
10 exercise has decreased a lot, so he did gain weight.

11 Q Do you remember what his weight was on May 18th of 2007?

12 A I do not.

13 Q Do you recall him being around 260 pounds or so?

14 A He was 200 or little bit more. I don't know the exact
15 figure.

16 Q Irrespective of whether or not you recall right now
17 whether his weight was 260 or not, would his weight as well as
18 the surface upon which he landed have an impact on the nature
19 of the injury that he sustained if he landed -- if his body
20 landed on the parts that were injured?

21 A The average patient that we see is usually 200 pounds --
22 the average patient is on the heavier side of 200 pounds or
23 maybe more. Yes, weight can play a role, yes.

24 Q Would you consider the operative procedures that you
25 conducted on Mr. Tookes to be successful?

1 A Partial success.

2 Q Okay. So tell us which ones you think are partial. The
3 wrist, the ankle, the first ankle surgery, the nerve surgery,
4 or the joint fusion?

5 A I will take one step back here. The surgery was
6 successful to the text that we were able to restore the level
7 of the join to a smooth appearance on visual examination at
8 the time of surgery.

9 Q Which joint are we referring to, wrist or ankle?

10 A The ankle. The wrist also was the same.

11 Q Did Mr. Tookes, after you performed the neuroma surgery,
12 did he ever develop another neuroma?

13 A He did not develop any shooting pains, shocks following
14 the neuroma surgery.

15 Q And since the last time -- at the last date that you had
16 contact with him, which was approximately a year ago, did he
17 complain of any such sensations?

18 A According to my notes, he doesn't mention any neuroma
19 related pain.

20 Q What impact, if any, does the fact that Mr. Tookes was a
21 smoker prior to the accident and up until this point in time
22 have on his ability to heal?

23 A The smoke can delay the healing of the fracture, yes, but
24 it does not cause arthritis.

25 Q Do you know how many packs of cigarettes Mr. Tookes

1 smoked prior to this surgery?

2 A I don't recall. All I know, he was a smoker, yes.

3 Q Now, Mr. Tookes, he testified and told us that he has
4 what is known as osteoarthritis, is that something different
5 from traumatic arthritis that you discussed?

6 A No. Traumatic arthritis is a form of osteoarthritis but
7 there's a specific cause here from the injury.

8 Q And is it your opinion that the only reason he developed
9 the osteoarthritis is the injury, and his weight has nothing
10 to do with this?

11 A If his weight had something to do with it or other
12 reasons, he would have developed arthritis in the other ankle,
13 too. He has no problem with the other ankle, even though he
14 is putting extra weight on the other ankle. So his other
15 ankle is in good shape, able to withstand his present weight,
16 so I don't think it has any major contribution here.

17 Q He does not have arthritis in the wrist, does he -- in
18 the left wrist?

19 A He has some discomfort, but it doesn't look like he has
20 arthritis, but he can develop arthritis over a period of time.

21 Q And has he lost any -- withdrawn.

22 Did he lose all motion or just some motion in the
23 left ankle?

24 A He has lost all motion in the ankle joint.

25 Q Is that as a result of the joint fusion surgery?

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1 A I will take one step back. Following an ankle fracture
2 even if successful --

3 THE COURT: Mike, is the sound system on because he
4 is acting as if it is. He's, like, reaching close to the
5 microphone. So let's take a moment one way or the other,
6 either with or without the sound the system. Step back. Sit
7 back and now say something.

8 THE WITNESS: Okay.

9 THE COURT: Say: Hello, Judge Block.

10 THE WITNESS: Hello, Judge Block.

11 THE COURT: We will do it that way. Go ahead.

12 A Sorry. Could you repeat the question please.

13 MS. DANELLI: Could you read it back.

14 (Read record)

15 A Yes, I'll continue.

16 Even after successful ankle surgery, which looks
17 perfect on x ray, they do lose certain motion following the
18 injury itself. It is in the nature of the injury. There is
19 some loss of motion on a permanent basis, and if they do
20 develop arthritis and it is complete loss of fusion -- some
21 loss of motion at the ankle joint.

22 Q Are you the physician who recommended that -- withdrawn?

23 Did you ever tell Mr. Tookes that he could not
24 return to work?

25 A I did send him back to work, and he went on limited duty.

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1 He tried hard. He was very enthusiastic in giving it a try to
2 go back to work. He tried really hard.

3 Q Are you the physician who recommended him to work light
4 duty or was that -- was that a determination that was made by
5 Mr. Tookes' employer?

6 MR. TURKEWITZ: Objection as to form.

7 THE COURT: Well, I think you can answer the
8 question.

9 A Yes.

10 THE COURT: He doesn't know if it was made by -- do
11 you have some knowledge on the issue?

12 THE WITNESS: This patient certainly was not ready to
13 return to his full duty because of the seriousness of the
14 injury.

15 THE COURT: Did you make the recommendation to him?

16 THE WITNESS: Yes. I asked him to start limited duty
17 first, and see how it goes.

18 THE COURT: What did you tell him that he could do?
19 Limited duty meaning what?

20 THE WITNESS: I would normally have told him not to
21 do heavy living activities, climbing too many stairs, walking
22 long distances.

23 THE COURT: So you thought he could do some light
24 work?

25 THE WITNESS: Light work, correct.

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1 Q Did there come any point in time when you lifted that
2 restriction and told him that he could do any additional type
3 of work or resume the full duties that he was doing as a
4 gardener?

5 A I don't recall he reached a stage where he could go back
6 to full duty.

7 Q Okay. Did you ever tell him that he couldn't do any type
8 of work -- not the work that he did as a gardener but any work
9 at all?

10 A I don't recall, but I usually tell them if there's any
11 sedentary work not involving use of the leg and the left arm,
12 to explore that possibility. I usually tell them, but I don't
13 recall. I don't have it on record, if you look for it on the
14 record.

15 MS. DANELLI: Thank you.

16 I have no further questions.

17 THE COURT: All right. Anything else?

18 REDIRECT EXAMINATION.

19 BY MR. TURKEWITZ:

20 Q Did you consider Mr. Tookes to be permanently disabled?

21 A Yes.

22 Q As a result of the accident?

23 A Yes, sir.

24 THE COURT: All right.

25 You may step down. Thank you, very much.