

Dr. Toriello - Defendant - Direct

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1 THE COURT: On the record.

2 Counsel, are you ready to proceed?

3 MR. GREENBERG: Yes, I am, your Honor.

4 MR. HARTLEIN: Yes, I am, your Honor.

5 THE COURT: Please bring in the jury.

6 COURT OFFICER: Jury entering.

7 (Whereupon, the jury entered the courtroom.)

8 THE COURT: You may be seated. Good

9 afternoon, members of the jury. Welcome back.

10 Hopefully you had a good few days off. We will now

11 proceed. Counsel.

12 MR. HARTLEIN: Yes, I call Dr. Toriello.

13 (Whereupon, the witness takes the witness

14 stand.)

15 THE CLERK: Raise your right hand.

16 E D W A R D A. T O R I E L L O , called as a witness by

17 and on behalf of the Defendant having been first duly sworn,

18 was examined and testified as follows:

19 THE CLERK: You may be seated. State your

20 name, please.

21 THE WITNESS: Edward Toriello,

22 T-O-R-I-E-L-L-O, 78-15 Elliot Avenue, Middle

23 Village, New York 11379.

24 THE CLERK: Thank you.

25 THE WITNESS: You're welcome.

Direct (by Mr. Hartlein) [445]

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1 THE COURT: Counsel, you may inquire.

2 MR. HARTLEIN: Thank you, Judge.

3 DIRECT EXAMINATION

4 BY MR. HARTLEIN:

5 Q. Good afternoon, Doctor.

6 A. Good afternoon.

7 Q. What is your occupation?

8 A. I'm an orthopedic surgeon.

9 Q. And where did you -- give us an outline of your  
10 medical education.

11 A. I graduated from Brooklyn College. Went to medical  
12 school and graduated from State University of New York at  
13 Buffalo. I then went and did a residency program in  
14 orthopedic surgery for five years and finished that at  
15 Downstate Medical Center here in Brooklyn. And since 1985  
16 I've been in private practice for orthopedic surgery.

17 Q. Where is your private practice?

18 A. In Middle Village.

19 Q. And how long -- when did you say you started that  
20 again?

21 A. Well, I started private practice in 1985.

22 Q. And you treat patients for orthopedics?

23 A. Yes.

24 Q. And have you done surgery in the past?

25 A. Yes.

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1 Q. What's board certification?

2 A. Board certification is a voluntary process that an  
3 individual who successfully completes a residency program  
4 puts themselves through. It's a two step process. The first  
5 step is taking and passing successfully a written  
6 examination, then several years later one is then permitted  
7 to sit for the second part which is an oral examination. The  
8 oral examination is when four or five other orthopedic  
9 surgeons who are already board certified, sit on one side of  
10 the table and ask you questions about your practice and about  
11 orthopedic surgery. If you pass both parts of that process  
12 then you are deemed board certified. I've sat on both sides  
13 of that table. I've been a candidate, but I've also been an  
14 examiner for the board as well. Board certification doesn't  
15 last forever, it lasts for ten years and then one must  
16 recertify. So I certified for the first time in 1988, I  
17 recertified in 1998 and then I just recently recertified  
18 again.

19 Q. Okay. Do you have any professional appointments,  
20 hospitals?

21 A. Yes.

22 Q. Where do you practice?

23 A. Wycoff Heights Medical Center and St. John's Queens  
24 Hospital on Queens Boulevard.

25 Q. Now, are you a member of any professional

1 societies?

2 A. Yes.

3 Q. What are they?

4 A. I'm a member of the Board of Directors of the New  
5 York State Society of Orthopedic Surgeons, I'm past treasurer  
6 of the American Academy of Orthopedic Surgeons, I'm past  
7 president of Brooklyn Orthopedic Surgery, past president of  
8 the Wycoff Heights Medical Staff Society. I've been a member  
9 of the Board of Directors of Kings County Medical Society. I  
10 am a member of Eastern Orthopedic Association and I've been  
11 invited in and have become a member of the American  
12 Orthopedic Association as well.

13 Q. At some point in time were you asked to do an  
14 examination on behalf of the defendant of Raymond Hammond?

15 A. Yes.

16 Q. And when was that? Let me first ask you, did you  
17 make a report based upon that examination?

18 A. Yes.

19 Q. Do you have that report with you here today?

20 A. Yes, I do.

21 Q. If you need to refer to that, Doctor, please do to  
22 refresh your recollection. Your fee here for your time today  
23 is \$5,000, is that correct?

24 A. Yes.

25 Q. When did you examine Mr. Hammond?

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1 A. On December 11, 2006.

2 Q. And did he tell you, give you any history of his  
3 injuries?

4 A. Yes.

5 Q. What were they?

6 A. He told me he was struck by a car and had injured  
7 his neck, his lower back and his right leg.

8 Q. And what complaints did he make to you at that  
9 point in time?

10 A. In December of 2006 he complained of decreased  
11 function of his right hand and a right foot drop.

12 Q. At that point what was his height and weight?

13 A. He told me he was 5'9, 170 pounds, right-handed  
14 gentleman.

15 Q. Did he appear to be in any pain or any acute pain  
16 at the point in time when you examined him?

17 A. No.

18 Q. Do you have a set procedure with regards to how you  
19 examine a patient, an orthopedic examination?

20 A. Yes, sir.

21 Q. By the way, what is the study of orthopedics, what  
22 is that area of medicine?

23 A. Orthopedic surgery is the area of medicine that  
24 individuals specialize in to treat problems with your muscles  
25 and bones. It's both to treat problems that occurs in

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1 relation to injury, problems that occur in relation to  
2 wearing them out, degenerative things such as arthritis and  
3 we're also involved in attempting to avoid problems with your  
4 bones such as osteoporosis.

5 Q. And where did you start your examination of Mr.  
6 Hammond, what part of his body?

7 A. His neck.

8 Q. And what tests did you give to him for his neck?

9 A. I observed his neck and his upper extremities, that  
10 is his arms. Because your neck contains the nerves that go  
11 to your arms and so I looked at the top part of his body and  
12 found that his right hand was held in a position we call a  
13 benediction sign, which is much like the Pope when the Pope  
14 gives you a blessing, but his hand was being held in this  
15 position. I noted that he had weakness in grip and pinch  
16 strength. That is when I asked him to grab my fingers and  
17 make the benediction sign and keep his fingers pinched, when  
18 I tried to open them up he had weakness. He had numbness  
19 along the outside part of his hand. He had atrophy of the  
20 muscles in his forearm, not his hand, but his forearm had  
21 muscle atrophy.

22 Q. What is atrophy, Doctor?

23 A. Well, atrophy is the opposite of what happens to  
24 your muscles when you work out. If people work out they get,  
25 muscles get big, the opposite happens if you don't use your

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1 muscles quite so much, they get smaller and we say they  
2 atrophy. So muscles that are atrophied indicate that an  
3 individual is not using those muscles for one reason or  
4 another for a significant period of time. It wouldn't happen  
5 overnight. It would take a while for it to happen. He had  
6 atrophy of muscles in his right forearm. I asked him to look  
7 all the way up to the ceiling, look all the way down, touch  
8 his chin to chest, chin to shoulders, ears to shoulders and  
9 found that he had normal motion of his neck. That's the test  
10 of range of motion of the neck. His motion was normal and  
11 pain free. He had no atrophy of spasm of muscle of his neck.  
12 I found that his reflexes were normal as well in his arms.

13 Q. Okay. Do you have any -- what are motor nerves?

14 A. Motor nerves are the nerves that go to your muscles  
15 and make your muscles contract and so therefore your hands  
16 other parts of your body do things. There are related  
17 sensory nerves, sensory nerves that are nerves that are just  
18 there to feel things.

19 Q. How were his reflexes at least in his cervical  
20 area?

21 A. His reflexes were fine.

22 Q. Okay. Did you then move onto his right shoulder?

23 A. Yes.

24 Q. Did you conduct an examination?

25 A. Yes.

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1 Q. And what did that examination show?

2 A. Well, Mr. Hammond while standing I asked him to  
3 hold his arms down at his side and bring his arms up over his  
4 head, to bring his two thumbs together in front of him and  
5 bring them over his head to touch his hands to the back of  
6 his head, to the back of his back, and this test the motion  
7 in his shoulder was normal and pain free. He had no evidence  
8 of any bruising, no evidence of inflammation or swelling of  
9 his shoulder, no tenderness when I pressed on the shoulders.  
10 He had no weakness of the muscle of his shoulders, they were  
11 good and strong and normal. He had no instability of his  
12 shoulder. In other words, his shoulder didn't come out of  
13 place and no evidence of the impingement of arthritis in the  
14 shoulder.

15 Q. What's impingement sign?

16 A. Impingement sign is a test that we do to see if  
17 someone has arthritis in their shoulder. It's done by asking  
18 someone to bring their arm straight up in front of them as  
19 high as they can and then turning the thumb down internally  
20 rotating the shoulder. What happens is positive impingement  
21 sign would cause pain right in the front part of the shoulder  
22 and that occurs because the muscles, the rotator cuff gets  
23 caught or impingement upon between two bones that ordinarily  
24 wouldn't happen if you don't have the arthritis.

25 Q. What's a frozen shoulder if you've ever heard that

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1 term?

2 A. Frozen shoulder is a term, it's really a lay term.  
3 We don't use it in medicine too much, but what it indicates  
4 is it's a shoulder that doesn't move very much. So it's not  
5 that it's cold, it's really that it's not like it's in ice  
6 it's frozen. So that's what a frozen shoulder is.

7 Q. At least at this point in time when you examined  
8 him, Mr. Hammond, December 11, 2006, was there any indication  
9 of frozen shoulder at that point?

10 A. No, not at all.

11 Q. Did you examine his left shoulder?

12 A. Yes.

13 Q. What were your findings there?

14 A. The examination of the left shoulder was completely  
15 the same as the right shoulder, that is completely within  
16 normal limits.

17 Q. Now, you then went down and did an examination of  
18 his right wrist and hand, is that correct?

19 A. And his elbow and wrist and hand, yes.

20 Q. And what were your findings there for the right  
21 elbow and left elbow?

22 A. The elbow examination was completely normal. He  
23 had normal range of motion and no evidence of any problems  
24 with either elbow.

25 Q. Okay. How about then you looked at his right wrist

1 and hand?

2 A. That's correct.

3 Q. Was there any swelling in the right wrist or hand?

4 A. No.

5 Q. What's dorsiflexion?

6 A. That's bringing the wrist back towards the  
7 shoulder.

8 Q. Did you conduct range of motion test of the right  
9 wrist and hand?

10 A. Yes.

11 Q. And what's the difference between active and  
12 passive range of motion testing?

13 A. Active is motion that an individual is able to do  
14 on their own. Passive is motion that I'm able to do for that  
15 individual. So I would take their arm or shoulder or hand  
16 and move it myself so that I would be able to tell if there  
17 is at least suppleness or motion in the joints even if that  
18 person's not able to do it themselves.

19 Q. When you activated the range of motion in Mr.  
20 Hammond's right wrist and hand, do you recall whether it was  
21 active or passive range of motion that you were doing at that  
22 point?

23 A. It was passive. He wasn't really able to do much.

24 Q. Just describe how you would do the passive range of  
25 motion?

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1           A.    I would just take Mr. Hammond's hand and bring it  
2 back as far as I could, bring it forward as far as I could  
3 and to the sides as much as I could. That would test the  
4 range of motion of his wrist. Then the fingers I would bring  
5 each finger down and see just how much motion they had in the  
6 finger, passively, not on his own.

7           Q.    Okay. So passively at least was there any problems  
8 with the actual muscles in his hand or wrist?

9           A.    The muscles in his hand were fine.

10          Q.    Is there a reasonable cause why then he can't  
11 totally use his hand as you've described before, it's held in  
12 a benediction sign?

13          A.    Yes.

14          Q.    What is that?

15          A.    Well, of the muscles that control the fingers  
16 moving up and down or actually in your forearm, so his  
17 forearm muscles were the ones that were really effected.  
18 That's what kept his hands from moving quite so well.

19          Q.    That was right arm where you saw atrophy in his  
20 right forearm, is that correct?

21          A.    That's correct.

22          Q.    And could a spinal -- spinal cord contusion be a  
23 cause ultimately of a right forearm atrophy or problem with  
24 the right forearm muscles?

25          A.    Well, I'm not a neurologist, so I would have to

1 defer to a neurologist, but I could say a problem with the  
2 nerve could cause atrophy in a forearm. That's why the  
3 answer to that question is yes.

4 Q. Okay. How about his left wrist and hand, did you  
5 test that?

6 A. Yes.

7 Q. And what were your findings there?

8 A. The left wrist and hand examination was completely  
9 within normal limits.

10 Q. At least on the left side of Mr. Hammond's body can  
11 we say that there were no findings of any limitations in the  
12 testing, left shoulder, left arm, the left wrist?

13 A. All that was normal, yes.

14 Q. Now, then you tested his -- what's a lumbosacral  
15 spine?

16 A. That's the lower portion of your back. Your back  
17 has three areas, the neck area which is the cervical spine,  
18 the chest area which is the thoracic spine and then the lower  
19 area which is the lumbosacral spine.

20 Q. And what did your examination reveal at least in  
21 terms of that part of the examination?

22 A. Well, once again, I looked at his lower back, but I  
23 also looked at his legs because the nerves from your lower  
24 back at this time go to your legs and so I checked both  
25 areas. And what I found was that Mr. Hammond had what we

1 call right foot drop, meaning that his foot was down and he  
2 couldn't bring it up himself. He also had weakness of the  
3 muscles that would make his right foot go up which was the  
4 reason why his right foot wasn't going up. He had a decrease  
5 in the sensation. He had numbness on the back or the top  
6 part of his foot. The motion of the lumbosacral spine was  
7 normal, that is when I asked him to bend forward he was able  
8 to bend forward all the way down, bend to the side, bend all  
9 the way back, slide and rotate both ways. That was all  
10 normal. He had no spasm of the muscles in the back of his  
11 back. No loss of the normal curvature of the back. His  
12 reflexes in his legs were normal. I did a straight leg  
13 raising test which is a test that we do to see if a person  
14 has sciatica which is the big nerve that comes out of your  
15 back, the sciatic nerve, again, that test was normal. He did  
16 not have a problem with the sciatic nerve. He had normal  
17 circulation to his legs. He had atrophy of the muscles of  
18 his calf, his right calf and he did walk with a limp on his  
19 right side.

20 Q. What's the significance of atrophy in the right  
21 calf muscles in terms of a right foot drop?

22 A. The --

23 Q. Let me go back. What did you mean by right foot  
24 drop?

25 A. Well, like I said, if you want to you can make all

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1 your toes kind of go up toward the ceiling as we're sitting  
2 here right now and you can make your foot also go up to the  
3 ceiling while we're sitting here right now. It's under your  
4 control to do. A person with a foot drop is unable to do  
5 that. They can do it one side that's normal, but the other  
6 side they can't bring their foot up. So that's what a right  
7 foot drop is.

8 Q. And what's the significance of -- what muscles are  
9 usually involved in someone having a right foot drop, the  
10 muscle in the foot or ankle or some other place?

11 A. Actually it's the muscles in your calf control your  
12 foot going up and down, so that's why Mr. Hammond has atrophy  
13 of the muscles in his calf because they're not working  
14 properly.

15 Q. And you indicated he walked with a limp, is that  
16 correct?

17 A. That's correct.

18 Q. And would -- what's a foot splint?

19 A. Sorry, what?

20 Q. A splint, a foot splint?

21 A. A foot splint is an appliance that we as  
22 orthopedists would prescribe for an individual who has a foot  
23 drop and what a foot splint would do would keep the person's  
24 foot up. Would keep your foot up because you don't have  
25 muscles to do that. And the reason to do that is to allow an

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1 individual to walk better. Because if your foot is hanging  
2 down as you can imagine, when you take a step, when you swing  
3 your leg through to get it to the next step ordinarily you  
4 would lift your foot up and go down and do that, right, but  
5 if you can't lift your foot up, then your toes are going to  
6 scrape along the floor. Then what you have to do either you  
7 have to bring your foot out or lift your foot way up. You  
8 have to do something so you don't keep tripping over your  
9 toes. If you have the appliance -- it's actually called  
10 ankle foot orthosis, but it's a foot splint. It keeps the  
11 foot up. As a result you are able to move your foot forward  
12 without having it drop down and it would help.

13 Q. Would it help someone who is walking with a foot  
14 drop?

15 A. That's what it's designed to do, yeah.

16 Q. What are deep tendon reflexes in someone's leg?

17 A. Well, deep tendon reflexes, those are the tests we  
18 do with a reflex hammer when you hit various parts of your  
19 body and jump around a little bit. So it's an involuntary  
20 test and what we're doing is testing the nerves that are  
21 going from your leg or arm to the spinal cord and then back  
22 out. It doesn't go -- those impulses don't go up to your  
23 brain. It's just a fast impulse through the spine and back  
24 out again.

25 Q. And were his reflexes normal in the lumbosacral

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1 spine area?

2 A. Yes.

3 Q. And how about did you do range of motion testing  
4 for his back?

5 A. Yes.

6 Q. And was that within normal limits the actual range  
7 of motion?

8 A. Yes.

9 Q. You tested then his right knee and left knee?

10 A. Yes.

11 Q. And what were your findings there?

12 A. The knee examinations were completely normal, that  
13 is the range of motion of both knees was within normal limits  
14 and there was no swelling, inflammation, no tenderness, no  
15 problems with any of the ligaments and the cartilage in the  
16 knee also seemed to be just fine.

17 Q. Now, his actual right ankle and foot again was that  
18 when you did range of motion tests for that, was that active  
19 or passive testing to your recollection?

20 A. Passive testing for dorsiflexion going up.

21 Q. At least under passive movement, what kind of range  
22 of motion did he have?

23 A. He had a normal. In other words, I was able to  
24 pull his foot up into a normal position. He was able to  
25 maintain it, but I was able to bring it up so it was normal.

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1 Q. How about his left ankle, foot, did you find any  
2 problems there?

3 A. The left ankle and foot was completely within  
4 normal limits.

5 Q. What was at the end of your examination, what was  
6 your impression of your medical impression of Mr. Hammond's  
7 injuries?

8 A. My impression from an orthopedic standpoint was  
9 that he had a resolved cervical hyperextension injury,  
10 resolved low back strain and resolved right leg contusion.  
11 He had no evidence of significant orthopedic abnormality, but  
12 he did have --

13 Q. How about neurologically at least you can tell from  
14 your examination?

15 A. Right, my opinion was that he had a significant  
16 neurologic abnormality from the injuries that he sustained in  
17 the accident in February of 2004.

18 Q. That would be the foot drop and the hand having  
19 been held in the benediction sign, is that right?

20 A. Right.

21 Q. And your opinion, are those injuries permanent?

22 A. Yes.

23 Q. Is there any chance of them improving over the  
24 course of time at least from what you have seen?

25 A. Once again, I'm not a neurologist, but from my

## Cross (by Mr. Greenberg) [461]

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1 knowledge it's probably little, if any, chance that they will  
2 improve.

3 MR. HARTLEIN: Thank you, Doctor.

4 THE COURT: You may cross-examine.

5 CROSS-EXAMINATION

6 BY MR. GREENBERG:

7 Q. Good afternoon, my name is Barry Greenberg, I  
8 represent Raymond Hammond. I have very few questions to ask  
9 you. Thank you for being so thorough with your exam and  
10 report. Now, at the time of your examination you had a  
11 history that the accident happened on February 4, 2004?

12 A. Yes, that's what he told me.

13 Q. And am I correct then at the time of your exam it's  
14 two years and eight months later, a little more than that?

15 A. Yes.

16 Q. Okay. And you had -- so whatever problems he had  
17 during the first two years and let's say four, five, six,  
18 seven, eight months, it was before your visit. If they did  
19 resolve, you wouldn't know anything about what he went  
20 through during that time period?

21 A. With the exception of what I learned from the  
22 hospital records at Jamaica. I did not have any other  
23 records between those two times.

24 Q. That was going to be my next question. You had an  
25 opportunity to review the Queens Jamaica Hospital record?

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1 A. Yes.

2 Q. That was an admission for three and a half months?

3 A. I believe so. I believe so.

4 Q. February 4, '04 to May 14, '04, about three and a  
5 half months?

6 A. Sure.

7 Q. And in the hospital record was there any indication  
8 he broke any bones at all?

9 A. To my knowledge, no. I didn't memorize the  
10 records, but to my knowledge I don't recall any bones being  
11 broken, no.

12 Q. And your history he didn't indicate that he broke  
13 any bones?

14 A. That's correct.

15 Q. So from an orthopedic standpoint there was nothing  
16 to look into as far as fractures or any problems of bones, am  
17 I correct?

18 A. That's correct.

19 Q. And in his history and your review of the Jamaica  
20 Hospital record, you also I believe in your report stated  
21 that he had a collapsed lung and needed surgery placement of  
22 a Greenfield filter in his body?

23 A. He had several things occur during that time and  
24 two of the things was a problem with his lung and need for a  
25 Greenfield filter to be inserted, yes.