

1 Lee - Direct - Plaintiff

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

3 COURT OFFICER: Come to order.

4 THE COURT: Are we ready?

5 MR. SIRIGNANO: Yes.

6 THE COURT: Bring in the jury.

7 (Jury enters courtroom.)

8 THE COURT: Remain seated, everybody. Good
9 afternoon. We are back on the Plaintiff's case.
10 We heard a witness this morning for the defense
11 and that was Dr. Fisher, radiologist. And now we
12 are moving back to the plaintiff and he will now
13 call an expert witness. Counsel?

14 MR. SIRIGNANO: Dr. Thomas Lee, your Honor.

15 T H O M A S L E E, called as a witness on behalf of the
16 Plaintiff, having been duly sworn, testified as follows:

17 THE COURT: Be seated, please and give us
18 your full name.

19 THE WITNESS: Thomas T. Lee, L E E.

20 THE COURT: Is the last name?

21 Your professional address, sir?

22 THE WITNESS: 150 White Plains Road, Suite
23 110, Tarrytown, New York, 10591.

24 THE COURT: Your witness, please.

25 MR. SIRIGNANO: Thank you, your Honor.

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2 DIRECT EXAMINATION

3 BY MR. SIRIGNANO:

4 Q Good afternoon, Dr. Lee. Are you a physician duly
5 licensed to practice medicine in the State of New York?

6 A Yes, I am.

7 Q For how many years have you been so licensed?

8 A 14 plus years.

9 Q Are you licensed in any other states in the United
10 States?

11 A California.

12 Q Do you also hold a DEA, a drug enforcement agency
13 narcotic prescription license?

14 A Yes, I do.

15 Q What is the purpose of that licensure? What does
16 that allow you to do?

17 A It allows you to prescribe class substances such
18 as narcotic pain killers, sedatives and so on.

19 Q Doctor, would you tell the jury where you had your
20 medical studies?

21 A I went to UCLA Medical School, Los Angeles
22 California.

23 Q What year did you graduate from UCLA?

24 A 1993.

25 Q Did you do any post medical school graduate

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2 studies?

3 A I completed my neurosurgery residency at
4 University of Miami spanning 1993 through 1999.

5 Q What does that mean that you did a residency in
6 neurosurgery?

7 A That means that you start your first year in
8 general surgery rotations through different subspecialties
9 or general surgery. Then the following five years were
10 focused on the clinical diagnosis and operative treatment
11 of neurosurgical diseases.

12 Q So early in your career you made a decision to
13 specialize in neurosurgery?

14 A Yes.

15 Q Tell the jury please what neurosurgery specialty
16 is? What does it involve?

17 A Neurosurgery treats diseases of the brain, spinal
18 cord, spinal column and peripheral nerves.

19 Q Do you have any academic positions?

20 A Yes.

21 Q Please tell the jury about those?

22 A I'm an assistant clinical professor at both New
23 York Medical College affiliated with Westchester Medical
24 Center and Mt. Sinai school of medicine.

25 Q What are your duties and responsibilities in terms

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2 of being an assistant professor?

3 A Department neurosurgery conferences, teaching
4 residents how to operate; that's my primary duties.

5 Q So you are involved in the education and
6 advancement of the skills of the next generation of
7 neurosurgeons?

8 A I like to think of it that way.

9 Q Very good. Are you board certified in any
10 specialty?

11 A Yes.

12 Q Which specialty are you board certified in?

13 A Neurological surgery.

14 Q Please explain to the jury what that means, what
15 that distinction of being board certified means? How do
16 you get there and what does it mean?

17 A Board certification requires completion of the
18 American graduate medical education certified residency
19 training program, the passage of both oral and written
20 neurosurgery board examinations, logging and approval of
21 your case load during your residency as well as for nine
22 months after the completion of your residency the
23 completion of your records.

24 And on top of that obviously there is a usual
25 continuing medical education requirement.

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2 Q Is there a peer review that's part of your
3 election or attainment of that certification?

4 A The American board of neurological surgery is the
5 body that governs all diplomates of the specialty and
6 that's the only one in the states.

7 Q Are all neurosurgeons in New York board certified?

8 A No.

9 Q So it is an additional distinction?

10 A Yes.

11 Q Have you received any other honors or awards, in
12 particular the Best Doctors in New York Metropolitan Area
13 for the past four years?

14 A Yes.

15 Q And have you been designated as one of the top
16 doctors in the past three years by Westchester Magazine?

17 A Yes.

18 Q Where do you spend your time? Where is your
19 private practice located?

20 A My office is in Tarrytown. I do procedures and
21 operation in Westchester County and at Mt. Sinai.

22 Q Do you see patients in your office?

23 A Yes.

24 Q Do you perform surgeries at various hospitals?

25 A Yes.

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2 Q In the area?

3 A Yes.

4 Q Which hospitals do you have admitting privileges
5 at?

6 A Westchester Medical Center, Phelps Memorial, St.
7 Johns Riverside, Lawrence Hospital and then, of course, Mt.
8 Sinai.

9 Q Am I correct that you have written publications,
10 either journals or book chapters on traumatic injuries to
11 the cervical spine, is that correct?

12 A I have.

13 Q Is that a part of your practice on a regular basis
14 treating patients with cervical spine traumatic injuries?

15 A Very common.

16 Q Just briefly explain to the jury what it means
17 traumatic injury versus other spinal injuries?

18 A Well injuries could either be traumatic or could
19 be long term degenerative process. Traumatic injury
20 generally infers that there are traumatic forces from
21 falls, accidents, either automobile related or not.

22 I mean, it runs the gamut or just falls down the
23 stairs or even from standing high because sometimes it can
24 pose significant injury on a spine.

25 Q I dont want to take you through all your

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2 publications or writings. Would you tell the jury what
3 your private practice consists of? What type of patients
4 do you treat, what type of procedures do you do on a
5 regular basis?

6 A I do 89% spinal surgery entailing endoscopic
7 minimally invasive spinal surgery all the way up to spinal
8 reconstruction for deformities. That's about 89 percent of
9 my practice. I do still do brain tumor operations.

10 Q How much of your time is spent being dragged into
11 court by annoying lawyers like me?

12 A Very little, thankfully.

13 Q Good. Is this, how many times have you testified
14 in courts here in New York?

15 A Five, ten times.

16 Q Were they mostly for your patients, patients you
17 were treating?

18 A Mostly.

19 Q Okay. The cases where you weren't the treating
20 neurosurgeon, which side are you asked to testify for?

21 A I have been asked by the State of New York to
22 testify as an independent medical examiner. I -- when I'm
23 asked in that field in the case where my opinion is
24 valuable, I undertake the effort to do it.

25 Q So you have testified for the State of New York as

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2 a defendant?

3 A Yes.

4 Q State being sued?

5 A Yes.

6 Q Very good. Now, doctor, Vincent Taurone, we call
7 him Vinnie in this courtroom was one of your patients,
8 correct?

9 A Yes.

10 Q You are here today because I asked you to come and
11 give testimony about your care and treatment of Vinnie?

12 A Yes.

13 Q You told me that you would do that. But if you
14 can't be in your office seeing your patients or in the OR
15 performing surgeries that you would need to be compensated
16 for your time away from your office and patients, correct?

17 A Correct.

18 Q Can you tell the jury what your standard fee is to
19 take an afternoon from your busy life and practice to come
20 to court?

21 A I charge an hourly fee of \$2,000 an hour.

22 Q Before coming this afternoon, you and I met at
23 your office to discuss Vinnie's case, correct?

24 A Yes.

25 Q And you charged a fee for that time as well,

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1
2 correct?

3 A That's correct.

4 Q Fair enough. Doctor, let's get to it. You first
5 came to treat Vinnie by way of a referral from another
6 physician, is that correct?

7 A Yes.

8 Q Do you happen to remember offhand which of
9 Vinnie's doctor's sent him over to you?

10 A That would have been a Dr. David Dickoff.

11 Q And have you worked with Dr. Dickoff on other
12 patients as well over the years?

13 A Yes.

14 Q When Vinnie first came to see you, of course, it
15 is prior to October of 2009 when you performed your first
16 surgery, did you perform an examination?

17 A Yes, I did.

18 Q I believe that was May the 8. Am I getting the
19 date right of 2009?

20 A That is correct.

21 Q All right. Tell the jury briefly Vinnie's
22 condition when he first appeared and presented in your
23 office upon a referral from Dr. Dickoff?

24 A Well Vinnie has prior to coming to me been treated
25 extensively already for his past issues with neck pain,

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2 pain radiating down to the arm, weakness, numbness and he
3 was also under the management of a neurologist at the time.

4 He has been living with symptoms, but his symptoms
5 have been worsening which is why his neurologist referred
6 him for a surgical opinion at that time.

7 Q Neurologists don't do surgery on the spine,
8 correct or anywhere else?

9 A I hope not.

10 Q Did you have the benefit of any radiographic
11 studies that had been done before Vinnie walked into your
12 office that first time in May of 2009?

13 A Yes. Vinnie has brought along a couple MRIs done
14 in 2009 and one from two years prior.

15 Q 2007?

16 A Yes.

17 Q Very good. You reviewed those as part of your
18 work up and evaluation?

19 A Yes.

20 Q Doctor, did you reach a conclusion either at that
21 visit or subsequently about what the best course of
22 treatment would be for Vinnie?

23 A Based on the examination of the patient having
24 weakness at that time on initial evaluation, MRI showing
25 arthritic changes, yes, but also degenerative disk problem

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2 as well as spinal cord having been bruised in the past on
3 those MRI examination. My recommendation is that he
4 considers undergoing surgical treatment to take the
5 pressure off the spinal cord and to reconstruct the spine
6 at those two levels C5-6 and C6-7.

7 Q What do you mean by take the compression off his
8 spinal cord?

9 A Well he had disk problems on both MRI from 2007
10 and nine. On the more recent MRI he had developed swelling
11 inside the spinal cord or scarring inside the spinal cord.
12 It is impossible to tell. Based on those and his physical
13 examination findings because of the pressure which has
14 caused the scarring and the swelling, it would be
15 reasonable to remove the pressure so the spinal cord has a
16 chance to heal and the nerves.

17 Q Doctor, am I correct that you probably in the
18 course of your career have performed both anterior
19 procedures and posterior procedures. Would you tell the
20 jury -- of course this was an anterior procedure on October
21 12; explain the difference to the jury?

22 A The anterior procedure put it simply is to address
23 pathology at the front of the neck pressing on the nerves
24 and the spinal cord from the front. The posterior
25 procedures are performed from the back of the neck to

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2 address pressure on the spinal cord and nerves on the back
3 of the neck. So sometimes there is instances where you may
4 need to go in stages to address the problem sequentially.

5 But most of the time you want to give that one
6 approach a chance to work first going from the aspect where
7 the spinal cord nerves are most compressed in order to see
8 the patient can improve adequately from that procedure.

9 So in this case the pressure is mostly from the
10 front of the spinal cord; hence, the recommendation for an
11 anterior which is front of the neck procedure.

12 Q Very good. So on October 12, 2009 you performed
13 an anterior procedure, correct?

14 A Yes.

15 Q Would you tell the jury what procedure you
16 performed on Vinnie?

17 A Vinnie had about a two inch incision near his skin
18 crease in the front of the neck on the left side. He had
19 spinal cord margin during the surgery. That's a routine
20 for me. We approached the spine from the front of the neck
21 after pushing the esophagus and trachea to one side and the
22 carotid sheaths which is our arteries and veins the big
23 ones that go into the head to the other side that creates
24 the corridor to the spine.

25 After retractors are placed, the bone spurs get

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2 removed from the front of the spine. The disk space gets
3 entered and the disk material are removed with either a
4 mechanical drill or a hand held instrument.

5 And that portion of the procedure is done under
6 the microscope because of the delicate nature of what is
7 involved beneath. After that more of the bone gets removed
8 all the way back through the spinal cord, and the nerves
9 where the spinal cord and nerves are visualized and there
10 the pressure gets taken off of them and the space gets
11 distracted.

12 After the space gets distracted at those two
13 spaces, a space -- bone spacer, cortical bone spacer which
14 is a machine, bone device gets placed into the space to
15 support the space so the space will not collapse.

16 Q That's where the disk used to be and you removed?

17 A Correct. And then secure these devices in place
18 and allow them to heal which does take time. Immediate
19 stability is afforded by plate and screw system which spans
20 C5-6 and C-7.

21 Q Before you affixed the plate with screws, do you
22 do any preparation work on the vertebrae where you are
23 going to be screwing the plate to?

24 A Well you will see many post-operative x-rays where
25 the plate does not sit flat on the spine, and the reason is

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2 that it is difficult to smooth out the anterior which is
3 the front surface of the spine completely because those
4 bone spurs would have grown over the years.

5 So it does take some time to smooth them out and
6 contour them and sculpture them rather in a way that the
7 plate can sit snugly so that it does not pinch the
8 esophagus right in front of it.

9 Q And then how many screws did you place in Vinnie's
10 neck on October 12, 09?

11 A There were two at C-5, one at C-6 in the center
12 and two at C-7.

13 Q They go right into the bony material of the
14 vertebrae?

15 A Yes.

16 Q And what next did you do during that surgery?

17 A Well you make sure there is no injury to the
18 esophagus and the trachea medially, meaning to the middle
19 and laterally to the outside. You make sure there is no
20 injury to the carotid arteries, the jugular vein and the
21 vagal nerves.

22 Those are the prominent structures in the area you
23 want to protect, as well as the pharyngeal nerve which
24 controls your voice box. People can lose their voice
25 completely after surgery if you don't look out for it. So

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2 those are the things you inspect, make sure there is no
3 bleeding in the site. You lock the plate and screw system
4 with a locking mechanism. That generally prevents the
5 screws from backing out, and then you put some material in
6 there to reduce the amount of scarring that then you close
7 the surgical plane by layers.

8 Q And was any bone grafting material inserted into
9 Vinnie at that time or October the 12?

10 MS. TAYLOR: Objection, your Honor.

11 Continues leading.

12 THE COURT: Well I'm going to allow some
13 leading in order to bring out specific medical
14 testimony. If you don't allow leading it becomes
15 often a speech that goes on and on. So I do allow
16 some. Overruled.

17 A He does have bone implants in the disk space at
18 C5-6 and C6-7. Those are from donated bone from the bone
19 bank rather than his own hip bone.

20 Q Okay. Doctor, a defense radiologist this morning
21 said that looking at films after your first surgery he saw
22 there were still osteophytes in and around the plate. Can
23 you address that issue?

24 A Sure. In doing surgery you can do too little or
25 you can do too much. You had to take the underlying

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2 protoplasm of the patient you are treating into significant
3 consideration. That would actually dictate what you need
4 to do. The case in point is that Mr. Taurone has
5 relatively softer bone consistency through wear and tear in
6 life. He's a smoker. He has developed lot of bone spurs
7 anteriorly. We had already shaven a lot of the bone
8 anteriorly in order to place the plate down flush with the
9 spine such that it would not be a problem with him having
10 swelling difficulties after surgery and the plate being too
11 protruded.

12 On the back end of the spine where the nerve and
13 spinal cords are compressed you remove the disk, you remove
14 the bone spurs that you reasonably can and should. If you
15 were to remove more bone spurs that generally would entail
16 you removing more of the vertebra at the same time. And
17 somebody who was relatively soft bone if you remove that
18 much bone from the vertebral body those, the rest of the
19 bone won't be able to hold the screws at all.

20 So you really need to pick your battles and draw a
21 line where how much you should do under the circumstances.

22 Q So you made a judgment call as a based upon your
23 skill and experience as to how much of the spurring you
24 would shave off?

25 A That's the decision I make every day, yes.

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2 condition such that you gave him a date some 18 days out to
3 come back?

4 MS. TAYLOR: Objection, your Honor. Leading.

5 THE COURT: I'm overruling on that.

6 Overruled.

7 A Yes.

8 Q Is that typically normal period for your first
9 post-op visit with this type of a surgical patient?

10 A Yes, about two to three weeks post-op initially.

11 Q When you saw him on October 30, how was he doing?

12 A He was doing pretty well.

13 Q What do you mean by that in terms of his
14 neurological function, his pain levels, et cetera?

15 A I think by then he had shown some noticeable
16 improvement of his strength in the arms compared to his
17 condition just before surgery. He had shown some
18 improvement of his pain pattern. And he did not appear to
19 have any side effects from the initial procedure.

20 If you are going to have any problems from a
21 surgery usually you find out almost right away if there was
22 an issue and there did not appear to be those issues. And
23 his neck pain was also improved also.

24 Q At that point in time let's just take that
25 snapshot of October 30 based on your surgery which you saw

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2 and did during the surgery and based on your first post-op
3 visit evaluation and examination of Vinnie, what was your
4 prognosis for him going forward?

5 A If the gentleman can heal a fusion procedure I
6 generally tell my patients that you can expect to do fairly
7 well. Prognosis is fair, not perfect. Anybody who has a
8 condition that requires surgery is not going to be perfect
9 like they are 16 years old again. So they may I have some
10 intermittent neck discomfort, some stiffness, but what they
11 feel then a couple weeks after surgery will get even better
12 still somewhat until the fusion bone union takes place
13 about anywhere from six to 12 months.

14 Some people it takes longer. But in that general
15 time frame.

16 Q After the fusion, after fusion had taken place
17 after whatever period of time did you have a reasonable
18 expectation that he might be able to return to some kind of
19 gainful employment?

20 A It is possible.

21 Q Doctor, when did you first hear that he had been a
22 passenger, front seat passenger in a rear end accident on
23 the Saw Mill Parkway?

24 A I believe it was slight short of four weeks after
25 surgery I was called by the emergency room.

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2 Q And what was your initial reaction to getting that
3 news being his treating surgeon?

4 A One is most vulnerable before the fusion is healed
5 completely so if you are going to sustain another injury,
6 that's compounded a healing process, it would be when those
7 first generally within the first three months. But
8 potentially up to six months after until the fusion started
9 really to take hold.

10 Q So he was particularly or especially vulnerable at
11 that point in time, November the 9?

12 MS. TAYLOR: Objection, your Honor.

13 THE COURT: That is leading.

14 Q Doctor, what can you tell the jury about his
15 vulnerability to a traumatic either new injury or
16 exacerbation of his prior condition?

17 A I can't put a number on it, but it is clearly more
18 vulnerable than the average folks who have not had the
19 surgery.

20 Q Doctor, given the nature of this rear end accident
21 and the fact that the van was lifted and propelled some 36
22 or 38 feet forward, what is the consequence of that on
23 these particular cervical disk levels at the C5-6 C6-7
24 levels? What's the significance of that?

25 A Generally in that type of injury mechanism you

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2 sustain a flexion extension type injury to the cervical
3 spine.

4 THE COURT: Flex what?

5 THE WITNESS: Flexion meaning going forward,
6 extension meaning going back in your neck. Many
7 people experience a whiplashes and this will be a
8 gradation of degree of such injuries. First upon
9 stoppage of the vehicle you lunge forward and then
10 after the vehicle comes to a stop, your neck
11 swings backwards.

12 Being that the lower cervical spine at the
13 lowest level in the cervical spine or your neck it
14 carries all the weight of the head and the neck.
15 He also has the highest degree of movement being
16 at the base of the neck at the bottom of the neck
17 because that is the fulcrum of movement. It has
18 the longest lever arm.

19 So the most amount of stress is exposed to
20 the lower spine versus the upper spine when your
21 relatively big head swings forward and back.

22 Q Doctor, you saw Vinnie at St. John's Hospital soon
23 after he was taken there by his friend, Mr. Forese?

24 A Correct.

25 Q And did you examine him?

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2 A Yes, I did.

3 Q What were your clinical findings upon examination?

4 A I found that he had some recurrence of his right
5 arm and hand weakness.

6 Q What is that indicative of?

7 A That indicated that something has occurred in a
8 similar distribution as this prior problem that was
9 surgically addressed because these were the same areas
10 where he was weak before surgery and were no longer as weak
11 after.

12 Q Any other clinical findings?

13 A He also has numbness. He did not have very good
14 reflexes but that's an ongoing issue.

15 THE COURT: Numbness where?

16 THE WITNESS: In his right arm.

17 A He also has a lot of muscle spasm and very very
18 limited range of motion in his neck.

19 Q Okay, tell the jury about muscle spasm as you
20 diagnosed it at that time. What does that mean?

21 A Generally after an injury or generally an acute
22 injury, your muscle tenses up as if as a splint to hold
23 your spine in place so it does not shift or move. That is
24 the natural body physiological response to prevent further
25 injury to the level that was irritated or injured.

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2 Q That's an involuntary response by the body?

3 A It is an involuntary response by the body.

4 Q Based upon those clinical findings --

5 MR. SIRIGNANO: Oh, withdrawn.

6 Q What about his pain? Were you able to determine
7 whether he was in pain at that time when you first saw him?

8 A He has complained of more pain again upon the
9 readmission to the hospital about four weeks after the
10 initial procedure.

11 Q Based upon your examination, your clinical
12 findings at St. John's Riverside Hospital on November the 9
13 into November the 10 of 2009, do you have an opinion with a
14 reasonable degree of medical certainty whether Vinnie
15 Taurone sustained an injury in that motor vehicle accident?

16 A I can opine that with a reasonable degree of
17 medical certainty, yes.

18 Q What injuries did he sustain as of that time; what
19 do you believe to be his injuries or diagnose to be his
20 injuries?

21 A I believe that he has neck pain and once again
22 cervical radiculopathy in his right arm, meaning pinched
23 nerve in the neck causing arm symptoms including weakness,
24 numbness and tingling.

25 Q And that pinched nerve was not an issue when you

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2 discharged him from the hospital after his October 12
3 surgery?

4 MS. TAYLOR: Objection, leading.

5 THE COURT: I didn't hear it. Could you read
6 it back.

7 (Requested portion was read by reporter.)

8 Q Is that correct?

9 THE COURT: I will allow that one.

10 A Mr. Taurone by the time of discharge a few days
11 after surgery has done very well, was better strength,
12 better sensation and less pain in the arm and neck. So I
13 do not believe it to be a significant contributor at that
14 time in terms of the neck causing his problem.

15 Q Doctor, jumping ahead a little bit here but you
16 continued to treat and care for Vinnie into 2010. Did you
17 ever see him again regain the progress that you had seen
18 just before the November accident?

19 A I'm not sure I understood, get you.

20 Q Let me take you through it step by step then, no
21 problem. Did you admit Vinnie to the hospital after his
22 accident?

23 A He was admitted by his medical physician who then
24 consulted me.

25 Q You concurred with that admission?

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2 A Yes.

3 Q Why was it a hospital admission needed after this
4 motor vehicle accident?

5 A He had significant pain and he was not able to
6 take enough medication to medicate himself and be
7 alleviated of the symptoms at home. Therefore he was
8 admitted both to complete radiographic studies, meaning CAT
9 scan and x-rays and whatever have you as well as to receive
10 enough pain medications to control his pain.

11 Q Doctor, was this admission, this hospitalization
12 for some six days immediately after the car accident
13 causally related to the car accident in your opinion?

14 A Yes.

15 Q In terms of radio graphic studies did you want to
16 get an MRI?

17 THE COURT: Can you try to ask some questions
18 without so much leading.

19 MR. SIRIGNANO: I'm just trying to move it
20 along, judge.

21 THE COURT: I know.

22 MR. SIRIGNANO: Thank you.

23 Q Doctor, what diagnostic studies did you want to
24 have following this motor vehicle accident?

25 A Regular x-rays of the cervical spine, CAT scan of

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2 the neck, MRI of the neck if the symptoms persisted.

3 Q Were you able to get an MRI of his neck at the
4 hospital while he was in patient?

5 A It was done as outpatient. I generally wait after
6 initial injury a couple weeks to see if further medical
7 treatment will improve it to a degree that MRI will not be
8 needed. So he had a CAT scan and x-rays only while
9 hospitalized.

10 Q He was discharged after some six days in November,
11 correct?

12 A Yes.

13 Q And he continued to follow with you?

14 A Yes.

15 Q When did you next see him in your office, doctor?

16 A I believe I saw him in the hospital again.

17 Q Okay. I would suggest a date, but I will get
18 yelled at.

19 A Yes, I believe I saw him in the hospital on the 19
20 of November again.

21 Q All right and what was the reason that you saw him
22 in the hospital?

23 A He had reportedly had a fall at home and he also
24 had some neck pain and because of his history of neck
25 surgery I was consulted once again by his medical doctor.

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2 Q Okay. Was he discharged shortly after that
3 admission?

4 A He was treated for about two days and discharged.

5 Q Doctor, given your intimate knowledge of Vinnie's
6 condition and cervical problems and the motor vehicle
7 accident, the surgery, all of that; is it uncommon that he
8 would be unsteady on his feet and his legs would give way
9 while he's at home at this stage in his recovery?

10 A That's not uncommon, plus he has another incident
11 right after surgery. If everything is a smooth recovery
12 there would be lower likelihood of that occurring.

13 Q Then you see him again in your office after that,
14 correct?

15 A Yes, I did.

16 Q And I believe you see him twice in your office
17 before there is a second surgery, is that about right?

18 A That is correct.

19 Q Tell the jury how we get to the decision to re --
20 essentially redo everything you had done on October the 12?

21 A By then incidentally we did try to get MRI of
22 Vinnie when he was hospitalized a second time figuring it
23 would be easier for him not to have to run around. But he
24 wasn't able to tolerate a closed MRI which is the only
25 option the hospital had so he wasn't able to do that

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2 because of some claustrophobia. Now by then into November
3 into December he has had a repeat CAT scan. He has had a
4 new MRI and the MRI has shown one there is the possibility
5 of recurrent disk herniation at those levels; two, there is
6 some swelling within the vertebral body of C 5-6 and 7.

7 So there is further injury to the vertebra. And
8 on the CAT scan on the most recent CAT scan it had shown
9 that number one the C-6 vertebra is somewhat compressed in
10 height compared to the immediate CAT scan after surgery
11 which is post-op date number one or two of his initial
12 operation.

13 And another notable finding is that the plate and
14 screw system in his neck has pulled out on the bottom. And
15 if these implant systems are going to fail it generally
16 fails on the bottom because there is higher level of
17 momentum like how we described earlier with the flexion
18 extension type injury, more poses are imposed upon the
19 bottom.

20 So you can see on the CAT scan images that the
21 bottom of the plate has been lifted off the vertebra and
22 the screws on the bottom has backed out.

23 Q Doctor, those two findings in your diagnosis, do
24 you have an opinion with a reasonable degree of medical
25 certainty whether those injuries were causally -- were

1 Lee - Direct - Plaintiff

2 caused by the motor vehicle accident of November 9?

3 A These implants before I answer that, these
4 implants are very strong. Some people perform surgeries
5 without putting these implants, the more old fashioned
6 surgeons if you will. They put in the implants in the
7 space without putting plates, screws or anything else to
8 stabilize the construct.

9 In order for this early out after surgery months
10 or month or two out for the plate and screws to be pulled
11 out there has to be significant forces imposed upon the
12 spine for this to occur.

13 Q And?

14 A So --

15 Q The car accident of November 9, is that
16 significant force so as to dislodge the work you had done
17 on October the 12?

18 A Yes.

19 Q Doctor --

20 THE COURT: I'm going to take a minute and
21 just -- I know it is after lunch and this is kind
22 of long testimony, but we have to wake up. A
23 couple of us are dosing off I'm afraid and that is
24 not fair to either side. So we are all going to
25 stand up. Stand up.

1 Lee - Direct - Plaintiff

2 (Jurors stretch and stand.)

3 THE COURT: Move your arms, move your legs.
4 Again I appreciate everyone's attentiveness. It
5 is after lunch, but I have to make sure that
6 everybody hears the relevant testimony.

7 And I know if you were either the defendant
8 or the plaintiff you would want that, all right?
9 Everybody, okay? Everybody feel -- anybody feel
10 that they just can't do this?

11 A JUROR: Water.

12 THE COURT: Can you give them a cup of water?
13 Do you want to take a break and get some water?

14 A JUROR: Yes, please.

15 THE COURT: Let's take a five minute break,
16 five, ten minutes, you go back and just refresh
17 yourself, all right.

18 (Jury exits courtroom.)

19 THE COURT: You can step down, doctor.

20 THE WITNESS: May I leave the chart here?

21 THE COURT: Sure.

22 (Witness exits courtroom.)

23 MR. SIRIGNANO: Sorry, your Honor.

24 THE COURT: I was just talking to our court
25 officer who told me about the sleepiness issues

1 Lee - Direct - Plaintiff

2 that we are having. She pointed out that number
3 two to whom we have discussed previously was
4 asleep earlier in the morning and now we see that
5 the older gentleman who I forget the number of
6 him, it could be number 6.

7 COURT OFFICER: Five.

8 MR. SIRIGNANO: Number five.

9 COURT OFFICER: Four or five.

10 THE COURT: I watched him during his
11 testimony and I think he has been nodding off.

12 MR. SIRIGNANO: I appreciate you taking --

13 THE COURT: This is important testimony. We
14 have two alternates who seem to be awake during
15 the entire time and I have been watching them. So
16 you do whatever you want. Everybody can say their
17 opinion, but this is testimony that is requires
18 some attention. So you are on. What do you think
19 counsel Mr. Sirignano?

20 MR. SIRIGNANO: I have to speak to my client,
21 judge, but I'm not inclined at this moment to
22 disrupt the jury. I think and maybe I should take
23 responsibility for not being a more exciting guy.
24 My wife tells me that I'm not an exciting guy all
25 the time. I will try to keep the level up.

1 Lee - Direct - Plaintiff

2 THE COURT: It is not your function to
3 entertain them. It is your function to elicit
4 testimony favorable to your client. That's what
5 do you think --

6 MR. SIRIGNANO: Well, before I turn it over
7 to Joanne, perhaps we could again ask them
8 generally if any of them are having a real problem
9 following this testimony and whether we should
10 give some serious consideration to addressing that
11 if it is going to be a continuing problem and let
12 the jurors speak for themselves.

13 THE COURT: I would do whatever counsel
14 agrees to. However, it is my opinion after being
15 a judge for many years that no one is going to
16 admit in front of others that they are having
17 trouble getting the testimony. It is a very
18 sensitive thing and you know what do you think Ms.
19 Taylor?

20 MS. TAYLOR: I agree with Mr. Sirignano. I
21 think you know without more at least hearing from
22 the jurors I think there needs to be -- they need
23 to make a statement notwithstanding your Honor you
24 probably are right that they are going to deny it,
25 but I think we should at least let them be heard

1 Lee - Direct - Plaintiff

2 as to what -- it could be just a matter of just
3 closing their eyes. I certainly didn't see it
4 when --

5 THE COURT: I don't think it is just that.
6 If that was it -- I have one on previous trial who
7 liked to close her eyes and she was very into it
8 very sharp and that was fine. But okay, do you
9 want me to bring them out and question them.

10 THE COURT: Yes.

11 MS. TAYLOR: Yes.

12 MR. SIRIGNANO: Yes.

13 THE COURT: Number two.

14 (Whereupon, a sworn juror enters courtroom.)

15 THE COURT: Hello, how are you Mr. Smith?

16 A JUROR: Okay.

17 THE COURT: I notice that and again we are
18 not just picking on you this time, this is long
19 testimony and I know after lunch a lot of people
20 get drowsy. I notice that you have been nodding
21 on and off. Are you okay?

22 A JUROR: Yeah, yeah, I didn't think I was.

23 THE COURT: It is all right. Now the only
24 reason I'm asking is because this is medical
25 testimony and it will probably have to come under

1 Lee - Direct - Plaintiff
2 some discussion in some detail during
3 deliberations. If somebody has not heard it, you
4 know, it is going to be very difficult thing to
5 deliberate. That's why I mention that. Okay. So
6 if you at any time feel hey you know you have been
7 a little tired lately and I can certainly
8 sympathize with anybody who feels that way. Let
9 us know.

10 A JUROR: I'm okay.

11 THE COURT: You are okay?

12 A JUROR: Yes.

13 THE COURT: Let me speak to is it Mr. --

14 COURT OFFICER: I will get him by the visual.

15 THE COURT: Counsel, I didn't really ask you
16 if you had any questions. I'm sorry.

17 MR. SIRIGNANO: No I don't have any.

18 MS. TAYLOR: No.

19 MR. SIRIGNANO: I think it is Best handled by
20 the court.

21 (Whereupon, a sworn juror enters courtroom.)

22 THE COURT: Hi, how are you. You are
23 Mr. Tabow?

24 THE WITNESS: Schulman.

25 MS. TAYLOR: Excuse me, your Honor, should

1 Lee - Direct - Plaintiff

2 the witness be here?

3 THE COURT: No, wait outside, sir. We will
4 just be a few minutes.

5 (Witness exits courtroom.)

6 COURT OFFICER: Sir, have a seat.

7 THE COURT: I notice during this afternoon
8 and it is not too surprising frankly that a number
9 of jurors are closing their eyes. I thought I saw
10 you nodding off. Frankly, I could care less under
11 ordinary circumstances if anybody you know is very
12 tired.

13 But my concern has to be that you as a juror
14 you know hear all of the medical testimony. This
15 case requires jurors to really hear and take in
16 medical testimony. It is the essence of the case.
17 And it will probably be discussed in some detail
18 during deliberations.

19 If you didn't hear it because maybe you
20 drifted off, we really have to know and I'm not
21 picking on you, not picking.

22 A JUROR: Do you want me to say something?

23 THE COURT: Sure.

24 A JUROR: I'm having a little bit difficulty
25 hearing you.

1 Lee - Direct - Plaintiff

2 THE COURT: Okay.

3 A JUROR: I'm okay with the two lawyers and
4 the -- well most of the other people who have been
5 brought in to testify. That's the only -- that's
6 really the main thing.

7 Now I have to say this the first day I was
8 here last week the judge at the front of the room
9 a man who was talking to the group of about 30 of
10 us I was going like this because I couldn't make
11 out anything he was saying.

12 THE COURT: Right.

13 A JUROR: And he accused me of being a little
14 bit hard of hearing and asked me to take a seat
15 further up -- closer to the front. And discovered
16 that there was one other person in the room who
17 was also having difficulty hearing him. Now I
18 have to say this that for normal every day living
19 my hearing is perfectly adequate. I don't have
20 any problem.

21 However, I have a little bit of difficulty
22 occasionally with hearing you and that original
23 judge who interviewed the group of people I was
24 with. And I think that that's when I start to
25 lose it. You know I didn't really have very much

1 Lee - Direct - Plaintiff

2 for lunch. I don't think the lunch was a big
3 issue. And I don't think -- I don't think I dozed
4 off, but you know maybe.

5 THE COURT: Isn't that an accusation because
6 I am at times I have been a judge you have to
7 fight off drowsiness. How about this doctor who's
8 testifying? We don't have microphones. Can you
9 hear me now?

10 THE WITNESS: Yeah now I'm not having any
11 trouble, but.

12 THE COURT: So we don't have them and some
13 people they can't hear my voice because it is soft
14 or maybe the doctor's voice may be soft. You know
15 or sometimes they have accents and it is
16 difficult.

17 A JUROR: Well Dr. Lee is a little bit more
18 difficult for me to hear but actually the only two
19 people I have had any real difficulty with hearing
20 are the two judges, yourself and the original
21 judge the first day.

22 THE COURT: All right, that is important to
23 me not because of vanity, it's not important that
24 way but you have to be able to hear a charge and
25 the instructions of the court. You must be able

1 Lee - Direct - Plaintiff

2 to hear that. We do have some devices I think in
3 the court house that work to make things louder
4 and I think that might be helpful, but I can never
5 guarantee anything.

6 A JUROR: Well, I don't have -- I'm not a
7 really hard of hearing type of person. I think it
8 is a borderline thing and you know I have never
9 felt I had to get a hearing aid because.

10 THE COURT: I'm not saying you do. But
11 sometimes because either the acoustics of this
12 courtroom it is hard to hear. I'm telling you
13 that I have had witnesses sitting right next to me
14 and their faces towards the jury and they have a
15 soft voice and I can't hear them. I just can't.

16 A JUROR: I have already been accused of that
17 by a judge the first day being of being a little
18 bit hard of hearing.

19 THE COURT: I'm not accusing you of anything.
20 I'm just trying to make sure that you can hear.
21 Let me ask if the lawyers have any questions. Do
22 you have any questions Mr. Sirignano.

23 MR. SIRIGNANO: I would just ask if you can
24 hear Dr. Lee today.

25 A JUROR: I can hear him, but his accent is a

1 Lee - Direct - Plaintiff

2 little more difficult but he's not a problem.

3 MR. SIRIGNANO: Okay.

4 A JUROR: As I said there is only two people
5 I have had difficulty hearing since last week
6 since I have been coming down here and they are
7 both have been judges. I'm sorry to have to tell
8 you that.

9 THE COURT: That's okay. Except for the
10 charge and some instructions what I say is not
11 really anything in the case. What the witnesses
12 say is important and why I'm asking is because you
13 are going to hear differences between doctors in
14 their description of the medical injury or what is
15 alleged to be a medical injury. Can you hear me?
16 And some of it is --

17 A JUROR: Yeah.

18 THE COURT: -- requires close listening in my
19 opinion, all right. And if you miss it, you know,
20 you could end up giving the wrong verdict and
21 that's all I care about.

22 A JUROR: Let me say this then that I have
23 some academic background in anatomy and anatomy so
24 I you know I don't think I have a real difficulty
25 but I have to admit though that Dr. Lee is not

1 Lee - Direct - Plaintiff

2 quite as clear as the previous witnesses. I'm not
3 saying I'm having any real difficulty hearing and
4 understanding him but he's getting toward my
5 borderline hearing.

6 THE COURT: Let me ask Ms. Taylor, do you
7 have any questions of this juror, Mr. Schulman.

8 MS. TAYLOR: Mr. Schulman, did you hear all
9 the testimony from yesterday?

10 A JUROR: Yeah I haven't had any problems
11 with the witnesses. As I said the only two people
12 I have had real difficulty hearing --

13 THE COURT: Now now, let's not repeat it.

14 A JUROR: -- were the judges.

15 THE COURT: And you can't hear everything
16 that this doctor says because it is difficult.

17 A JUROR: It is not a question of hearing. I
18 think he is, he has a little bit just a tiny drop
19 of an accent maybe the slightest bit and it is
20 getting very highly technical.

21 THE COURT: Exactly. It is. That's why I'm
22 concerned and those technical questions are
23 probably going to decide the case. So I just feel
24 I have to ask. I'm not making a decision. I will
25 let the lawyers ask another question.

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Lee - Direct - Plaintiff

MR. SIRIGNANO: Your Honor, I would ask him if he would like to maybe temporarily move closer to the witness stand for the rest of the day to see if that helps. Is --

MS. TAYLOR: I wouldn't object to that. I think that's a reasonable solution.

MR. SIRIGNANO: If you are comfortable and wish to do that.

A JUROR: I could change places with one of the people over there. But then they would be facing the other way. I haven't had any real difficulty. I don't know what to tell you.

THE COURT: Well I have a grasp of what you are saying. We are going let you go back there and we are going to discuss it.

A JUROR: Okay.

THE COURT: Then we will let you know what's going on.

(Whereupon, juror exits courtroom.)

MR. SIRIGNANO: I'm not going to ask that any of the jurors be removed. I will ask Dr. Lee to keep his voice up.

THE COURT: You know something? I mean I speak for myself I have allergies so it is

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Lee - Direct - Plaintiff

difficult sometimes for me to speak louder than I do. That is not always so easy for people. I know for myself I can speak so loud and not any more. We do have devices. He doesn't appear to be very interested in that and I can't impose that on somebody.

But and again it is up to counsel. But as he points out this technical material that I don't think he's hearing or can't seem to comprehend. It is your case, both of you. So I will do whatever you want.

What do you want do?

MR. SIRIGNANO: I think Ms. Taylor and I are of one mind. Let's keep going and I will try to keep the volume up.

MS. TAYLOR: I agree.

THE COURT: I don't think you can ask the doctor to shout.

MR. SIRIGNANO: Well I can ask the doctor to face the jury more because he's -- and that might help project his voice.

(Court officer confers with Court.)

THE COURT: She is suggesting we have an afternoon break.

1 Lee - Direct - Plaintiff

2 MR. SIRIGNANO: We have to get this doctor
3 finished.

4 THE COURT: I made my record. You can do
5 whatever you want.

6 MR. SIRIGNANO: Thank you.

7 COURT OFFICER: Bring everyone or just the
8 juror.

9 THE COURT: Bring him in, I will tell him.
10 (Whereupon, juror enters courtroom.)

11 THE COURT: All right, the decision is you
12 are going to stay, but I would like you to take
13 the number one seat.

14 A JUROR: Which one is that?

15 THE COURT: She will tell you. The officer
16 will tell you so you will be facing that doctor.

17 A JUROR: Oh, him, yes.

18 THE COURT: Okay.

19 A JUROR: Some of the those people were there
20 at the first date, meeting when the judge told me
21 that he thinks I'm hard of hearing.

22 THE COURT: I didn't --

23 A JUROR: I want you to know that it was
24 already a public thing and people here no it.

25 MR. SIRIGNANO: Can we bring the jury out and

1 Lee - Direct - Plaintiff

2 get the doctor back on the stand?

3 THE COURT: Yes. Bring him in.

4 A JUROR: I violated -- I'm sorry.

5 THE COURT: I just have a seat, please.

6 A JUROR: Here?

7 THE COURT: We had a discussion which was not
8 in public it was just the parties to this lawsuit
9 as you know. And to go back and to give a long
10 explanation and make it a special inquiry is
11 probably not a good idea. You did it. I heard
12 you. It is finished, all right.

13 A JUROR: Okay.

14 THE COURT: You are going to sit in the
15 number one seat.

16 A JUROR: Thank you, very much.

17 THE COURT: That's it. End of story. All
18 right bring the jurors in.

19 (Jury enters courtroom.)

20 THE COURT: We are going to continue now. I
21 have to be sure the jurors this is testimony as
22 one person put is it kind of technical, that's
23 one. But your verdict is going to require you to
24 discuss certain things that are going into
25 evidence.

1 Lee - Direct - Plaintiff

2 And if anybody hasn't heard it or dozed off,
3 I don't really, it doesn't matter to me. We can
4 fix that, but you are going to not understand what
5 other people are talking about when you have
6 deliberations and that can be very frustrating for
7 everybody, all right.

8 That's all I'm saying. So if you have any
9 problem staying Awake, you are human beings, we
10 are all human, that's okay. What I don't want is
11 you to hide it and say I was awake the whole time
12 when you weren't.

13 I don't want that. I have been very clear.
14 All right, let's go. The doctor is now on the
15 stand. You are still under oath, doctor.
16 Understood and agreed?

17 THE WITNESS: Yes.

18 THE COURT: Let's continue.

19 MR. SIRIGNANO: Can I have the last question
20 read back? I just lost my train of thought.

21 THE COURT: Okay.

22 (Requested portion was read by reporter.)

23 DIRECT EXAMINATION (Continued)

24 BY MR. SIRIGNANO:

25 Q Dr. Lee, we are going to ask you to keep your

1 Lee - Direct - Plaintiff

2 voice up and I take responsibility, maybe I'm not the most
3 exciting guy in the world and we have people dozing off on
4 us. If you can maybe turn and look at the jury so your
5 voice projects a little better into the box that might be
6 helpful. I will keep my voice up and try to be more
7 exciting and let's get through this.

8 So, doctor a decision was made to do what's known
9 as a revision surgery on January the 6, 2010, correct?

10 A Yes.

11 Q What was the need for that surgery? What was
12 Vinnie's condition that lead you to recommend that surgery
13 and in fact perform it?

14 A There are two parts to the decision. The first
15 part is the fact that he had developed these symptoms again
16 in his neck and his arms all referable to the problem he
17 has in the neck.

18 The second part is a combination of the CAT scan,
19 x-rays and MRI findings showing that the implant is not
20 holding him and the fusion has not yet taken place.

21 Q Doctor, did you in terms of those radiographic
22 studies, did you review the films themselves or did you
23 review the reports made by the radiologists at St. John's
24 and elsewhere or both?

25 A Both.

1 Lee - Direct - Plaintiff

2 Q Before you went back in and reopened Vinnie's neck
3 under general anesthesia on January the 6, you were
4 confident that this surgery was necessary?

5 MS. TAYLOR: Objection, your Honor. Leading.

6 Q Were you confident that this surgery was
7 necessary?

8 THE COURT: I will allow it.

9 A Yes.

10 Q Doctor, tell the jury what you had to do under
11 general anesthesia on Vinnie on January the 6?

12 THE COURT: January 6, 2010.

13 MR. SIRIGNANO: Yes, Judge.

14 A We positioned the patient, put on the traction
15 like we do with the first operation. We reopen the
16 previously open incision and go through some of the scar
17 tissues. Scar tissues are common in patients who had prior
18 surgeries.

19 So through the scar tissue, dissect the different
20 plains out. Approach the spine similar to what we did
21 previously. Now there is more scar tissue making the
22 approach somewhat more hazardous and that's the nature of
23 revision surgery. That's why nobody wants to do them
24 unless they have to do them.

25 There is the slight added advantage that this time

1 Lee - Direct - Plaintiff

2 there is actually a plating system there that's actually a
3 road map. So we expose the plate, remove the scar tissue
4 from the plate, identify the plate on the bottom to be
5 separated from the vertebra as the CAT scan has already
6 identified on the preoperative imaging study.

7 Q Let me stop you right there. Before you took out
8 a single screw, did you visually confirm that that plate
9 had been backed off from where you had planted it on
10 October the 12?

11 A It is shown exactly as the CAT scan has indicated
12 before surgery and it is about a few millimeters off the
13 bottom of the vertebral body which is C-7.

14 Q You saw that with your trained eyes?

15 A Actually we put it on the microscope. It is
16 magnified about ten times, so.

17 Q All right. Continue.

18 A We dislodged the mechanism where the screws are
19 locked to the plate, removed the screws. All five of them.
20 Removed the plate from underneath on the top where the scar
21 tissue adhering to the plate. We then proceeded to remove
22 and literally had to drill out the previously inserted
23 implants because the bone had started to heal.
24 Unfortunately by then it is not enough healing to hold the
25 spine.

1 Lee - Direct - Plaintiff

2 So those implants were removed with a combination
3 of drills and additional disk material on the sides were
4 removed. The space were retracted open to allow us to get
5 back to the spinal cord again after removing the scar
6 tissues.

7 Again the nerve roots both sides were visualized.
8 The spinal cords were once again visualized. So under
9 additional traction, larger implants were placed into the
10 disk space this time around to further distract the spine.
11 And a new longer and bigger screws and bigger plate were
12 used because once you have put in screws into a bone, the
13 bone has become fairly soft in the area.

14 There is a void of bone there. So you need either
15 longer screws or bigger screws or both in this case were
16 both so that's why it was what was done and the screws were
17 engaged, locked at closure was done similar prior to just
18 as the prior surgery did.

19 Q How long was Vinnie under general anesthesia
20 during the surgery?

21 A About anywhere between three to four hours, three
22 and a half hours or so.

23 Q It is a complex surgery, fair to say?

24 A Revision surgery is always complex by definition.

25 Q Certainly from your perspective his treating

1 Lee - Direct - Plaintiff

2 neurosurgeon less than ideally you had to do this revision
3 surgery?

4 MS. TAYLOR: Objection.

5 THE COURT: That is leading.

6 Q Doctor, would you tell the jury why this is not an
7 ideal situation for you as a neurosurgeon?

8 MS. TAYLOR: Objection, leading, your Honor.
9 It assumes that it is.

10 THE COURT: No this one isn't leading. The
11 other one was.

12 THE WITNESS: As a surgeon if there is a
13 condition you need to operate on. You hope that
14 one procedure would do it and your patient will go
15 back their marry way and carry on with their life.
16 It is not desirable or generally recommended
17 barring situations such as this where revision
18 surgery is done this soon out.

19 Q Doctor, when you reopened his neck I believe you
20 said cut away the scar tissue to expose the plate, if you
21 had seen that plate in exactly perfect position and the
22 screws exactly perfect condition that you had put them in
23 October 12, would you have removed the plate and screws?

24 A I would not have, but that was not my expectation
25 or finding.

1 Lee - Direct - Plaintiff

2 Q Doctor, you told the jury that after your October
3 12 surgery up to that 28 day before the accident you gave
4 Vinnie a fair prognosis. After having to take out all that
5 hardware and those prosthetic devices and redo the whole
6 surgery, what was your prognosis for Vinnie after January 6
7 surgery 2010?

8 A For revision procedure the success rate of
9 procedure automatically drops for any surgeon it is between
10 ten to 20 percent at least.

11 THE COURT: I don't understand that. Any
12 surgery is ten to 20 percent?

13 THE WITNESS: Less adaptation of the first
14 operation even if it is identical or nearly
15 identical operation. I would have given Vinnie a
16 poor to at best fair chance of recovery.

17 Q Doctor, do you have an opinion with a reasonable
18 degree of medical and neurological certainty that this
19 January 10 -- January 6, 2010 surgery was necessitated,
20 caused by the motor vehicle accident on November the 9?

21 A Yes, I am.

22 Q What is your opinion?

23 A That my opinion is that it was reasonable with
24 reasonable degree of medical certainty that the accident
25 has precipitated the events leading up to the surgery.

1 Lee - Direct - Plaintiff

2 Q And what does this revision surgery mean? What
3 did it mean for Vinnie's recovery in terms of time and
4 success?

5 A Recovery times are generally longer and the
6 success rates are generally lower. So if the first time
7 fusion would have expected to heal in 6 to 12 month. This
8 time you would expect it to take 6 to 9 to or 18 months to
9 two years to heal this fusion.

10 Q Did you prescribe any medications for pain or
11 otherwise for Vinnie following his January 6, 2010 surgery?

12 A Yes.

13 Q Please tell the jury what regimen you had him on
14 during the rest of his hospitalization and then upon
15 discharge?

16 A Vinnie was given ten milligram Percocet which is
17 Oxycodone a narcotic pain killer. And ten milligram
18 Percocet is the highest dosage of the three dosage of
19 Percocet. He was prescribed muscle relaxant. That was
20 Soma. That's for his muscle stiffness and spasm. He was
21 also on a flexor patch, anti-inflammatory patch of his
22 neck. And at a different point in time he was on Ucinta
23 which is another narcotic pain killer.

24 Q You followed him post-operatively for some period
25 of time thereafter, correct?

1 Lee - Direct - Plaintiff

2 A Yes.

3 Q Would you describe his status during your
4 post-operative examinations?

5 A After the second operation he again showed some
6 improvement of his right arm weakness as well as numbness.
7 However, he still has some residual tingling and numbness
8 of his right arm and hand. He also has some, he also has
9 problem with neck muscle spasms and stiffness after the
10 second operation.

11 Q In terms of his pain what was the status of his
12 neck pain?

13 A His arm improved much more than the neck this time
14 around.

15 Q When did you last see him?

16 A I believe it was February the 12, 2010.

17 Q What was the status last time you saw him as a
18 treating physician?

19 A Improved, not normal.

20 Q What was your prognosis for him as of that time?

21 A Fair to poor as I stated earlier.

22 Q Doctor, do you have an opinion to a reasonable
23 degree of medical certainty as to whether as a result of
24 the November nine 2009 accident Vinne Taurone has
25 permanently lost the use of a body, organ, member, function

1 Lee - Cross - Defendant

2 or system?

3 A Yes. He has lost neurological function.

4 Q And do you have an opinion to a reasonable degree
5 of medical certainty as to whether as a result of the
6 November 9, 2009 accident Mr. Taurone sustained a
7 significant limitation of use of a body, function, or
8 system?

9 A Yes.

10 Q And lastly do you have an opinion to a reasonable
11 degree of medical certainty as to whether as a result of
12 the November 9, 2009 accident Vinne Taurone sustained a
13 permanent, consequential limitation of a body, organ or
14 member?

15 A Yes.

16 MR. SIRIGNANO: Thank you very much, doctor.

17 No further questions.

18 THE COURT: Cross-examination.

19 MS. TAYLOR: Thank you, your Honor.

20 CROSS-EXAMINATION

21 BY MS. TAYLOR:

22 Q Good afternoon, Dr. Lee.

23 A Good afternoon.

24 Q When Mr. Sirignano asked you whether you had met
25 with him before testifying today you said yes, isn't that

Lee - Cross - Defendant

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24
25

right?

A Yes.

Q Did you discuss any of your testimony here today?

A He had asked my opinions as he had earlier today,
yes.

Q Did you discuss any of the documents that you
previously testified to during that meeting with Mr.
Sirignano?

A What do you mean by discuss? Any document.

Q Did you talk about any of the reports and what the
contents were?

A Yes.

Q Before appearing here? Your answer was yes?

A Yes.

Q Now doctor, as part of your CV, your curriculum
vitae and also your testimony on direct you said that you
are a clinical assistant professor both at New York Medical
College and at Mt. Sinai university, is that right?

A That's correct.

Q Do you teach residents or interns as part of that
function?

A Residents, yes.

Q As part of your teaching assignment at New York
Medical College and Mt. Sinai university do you teach your

1 Lee - Cross - Defendant

2 residents proper record keeping?

3 A Um --

4 Q And reports?

5 A I try to go over with them what the format of what
6 I would expect as an attending physician, yes.

7 Q Is accuracy of a report considered something
8 that's important that you would teach your students?

9 A We do our best, yes.

10 Q But it is an important component accuracy, is that
11 right?

12 A Yes.

13 Q Now I want to just draw your attention first let's
14 go back to the films that you saw in April, 2007, doctor.
15 I believe it was an MRI?

16 A Okay.

17 Q You had an opportunity to review that April 13,
18 2007 MRI before you did the October 12 surgery?

19 A Yes.

20 Q It indicates in that report that there was
21 spondylitic change at C-5 C-6, doesn't it, doctor?

22 A Yes, it did.

23 Q The MRI also indicated that there was posterior,
24 meaning back osteophyte bulging, isn't that correct?

25 A Yes.

1 Lee - Cross - Defendant

2 Q In fact the report indicates that there was
3 prominent spondylitic changes with posterior bulging, is
4 that right?

5 A Yes.

6 Q Let's go to April 22, 2009 MRI. That was in the
7 same year that you did the October, 2009 surgery, right?

8 A Correct.

9 Q Again in that MRI dated April 22, 2009 the MRI
10 also showed diffuse spondylitic changes between the levels
11 of C-3 through C-7, is that correct?

12 A Yes.

13 Q And diffuse, doesn't it mean that it is on several
14 levels of the spine, doctor? Would I be correct in
15 describing it that way?

16 A Diffuse could be either a multiple levels or
17 multiple parts of the spine, same.

18 Q All right. Also the April 22, 2009 MRI indicated
19 that there was cord malacia, didn't it?

20 A Myelomalacia. It should have been myelomalacia.
21 That's their typo, yes.

22 Q But that is, would that be correct to say that's a
23 disorder of the spinal cord?

24 A It is a radiographic finding on the MRI
25 specifically of spinal cord scarring from prior injury,

Lee - Cross - Defendant

1
2 yes.

3 Q So before you did the October 12 surgery there was
4 already scarring on the spinal cord, right?

5 A Yes.

6 Q Now there were a series of consultations and
7 reports that you yourself did starting with May of 2009.
8 Do you recall that report, doctor?

9 A I'm looking at it. I don't recall on specifics,
10 no.

11 Q All right. And when you did your report on May 8,
12 2009, you also found that multi level spondylosis, didn't
13 you?

14 A Yes, I did note that.

15 Q And you also noted that there was severe spinal
16 stenosis which would be impingement on the spinal canal,
17 didn't you?

18 A Yes, I did.

19 Q In fact you described in your May 8, 2009 report
20 that there was severe spinal stenosis at C5-6 and C6-7,
21 isn't that correct?

22 A That is correct.

23 Q You also indicated in that report that there was
24 degenerative bulges that impinged on the cord, didn't you,
25 doctor?

Lee - Cross - Defendant

1
2 A Yes.

3 Q Also in that report you noted that there were
4 osteophytes and spinal cord stenosis as well?

5 A You cannot have spinal cord stenosis.

6 Q I'm sorry spinal stenosis?

7 A Yes.

8 Q Now let's go to your October 12, 2009 operative
9 report. Do you have that with you, doctor? Do you have
10 that report?

11 A Yes.

12 Q You described the operation that you performed on
13 Mr. Taurone, right?

14 A Yes.

15 Q And you indicated that you did an anterior
16 cervical discectomy of C-5 through 6 and C-6 through 7?

17 A Yes.

18 Q Now discectomy would mean that you took out the
19 disk, is that correct?

20 A Yes.

21 Q Do you recall whether you completely removed the
22 disk, doctor?

23 A Nobody removes the disk completely.

24 Q But did you remove most of the disk?

25 A That is the goal, yes.

Lee - Cross - Defendant

1
2 Q You also have a heading on that report of post
3 operative diagnosis and have one, two, three items. Do you
4 see that?

5 A Yes.

6 Q Now post-operative diagnosis would mean what you
7 saw or found after you did the surgery, isn't that correct
8 or when you were doing the surgery; would that be fair to
9 say?

10 A Yes.

11 Q Okay and you also saw on that October 12, 2009
12 surgery you saw there was degeneration and disk protrusion
13 into the spinal cord with impingement?

14 A Yes.

15 Q And you determined that there was cervical
16 myeloradiculopathy, is that correct?

17 A That was a clinical diagnosis.

18 Q Well clinical is there any difference you say
19 clinical as opposed to something else?

20 A A clinical diagnosis is when patient presents with
21 systems. You describe the symptoms, make the diagnosis
22 based on all the available testing and examination. That
23 is clinical diagnosis. Radiographic diagnosis meaning
24 merely referring to what x-ray whatever it shows. It does
25 not take into account the clinical status of the patient.

1 Lee - Cross - Defendant

2 Q But the disk protrusion and the spinal cord
3 impingement would be something that you would see when you
4 went in and did the operation, is that right?

5 A Yes.

6 Q You also found on that operative record one of
7 your findings that there was extensive spondylosis from C-4
8 to C-7?

9 A Yes.

10 THE COURT: Once again could we define that
11 spondylosis?

12 MS. TAYLOR: She is addressing you, doctor,
13 not me.

14 THE WITNESS: You asked the question.
15 Spondylosis are arthritic changes of the spine
16 generally occurring at where the joints and where
17 bone come close to bone. Therefore you have two
18 vertebra close to each other because the disks
19 have degenerated.

20 They are very close to each other. They can
21 form bony ridges between them. That's one place
22 where spondylosis can form. Second place
23 spondylosis can form are joints, where the joints
24 keep on rubbing each other, two sides of the joint
25 and the joint becomes hypertrophy or becomes very

1 Lee - Cross - Defendant

2 large; that's another form of spondylosis. You
3 see these on x-rays as overgrowth of the bone in
4 general.

5 Q And that spondylosis you described that as
6 arthritic; did you use that term, doctor?

7 A Could be arthritic by cause, yes.

8 Q And that would be a chronic long standing
9 condition, wouldn't it?

10 A Yes.

11 Q You also made a finding that there was severe
12 degenerative disk disease and again the spinal cord
13 impingement at C5-6 and C6-7; was that your finding as
14 well?

15 A That was my finding, yes.

16 Q On October 16, doctor, you also did a consultation
17 note?

18 A October 16?

19 Q Yes.

20 A I wouldn't, it wouldn't be me. That would be two,
21 four days after the surgery. I would not do a
22 consultation.

23 Q I stand corrected. Do you have as part of your
24 record a consultation note of a Dr. Steven Franciscone?
25 Would that be part of your record?

1 Lee - Cross - Defendant

2 A That's the hospital record, not my office record.

3 Q Did you ever review that before you did the --

4 MS. TAYLOR: Withdrawn.

5 Q Did you ever review that at any time after you did
6 the surgery on October 12, 2009?

7 A During -- sometime during the hospitalization.

8 Q Do you have an independent recollection of what
9 Dr. Franciscone's findings were?

10 A I do not recall specifically.

11 Q Would it surprise you if Dr. Franciscone indicated
12 as of October 16 that there was bilateral shoulder pain?

13 MR. SIRIGNANO: Objection.

14 THE COURT: Well isn't it in evidence?

15 MS. TAYLOR: Yes, your Honor.

16 MR. SIRIGNANO: The hospital chart is in
17 evidence. But I think the question is improper
18 would it surprise him.

19 THE COURT: Well I think first of all he has
20 to be shown the consult record to review it for a
21 minute or two and then ask him the question.

22 MS. TAYLOR: All right. I will withdraw that
23 right now, doctor.

24 Q You had a report dated October 30, 2009. You have
25 that with you, don't you?

1 Lee - Cross - Defendant

2 A October the 30?

3 Q Yes?

4 A Yes, I do.

5 Q You had some recommendations for Mr. Taurone that
6 you noted in that post-operative visit, isn't that right?

7 A Yes.

8 Q And what is a bone growth stimulator, Dr. Lee?

9 A A bone growth stimulator is used to hopefully
10 accelerate bone formation for spinal fusion or bone
11 fracture.

12 Q That was one of the devices that you recommended
13 that Mr. Taurone use after that October 12 surgery, didn't
14 you?

15 A Yes.

16 Q According to your note it indicates that you
17 recommended four hours a day for at least three months,
18 isn't it a fact?

19 A Yes.

20 Q You also made a notation about your encouraging
21 Mr. Taurone to stop smoking completely?

22 A Yes.

23 Q Now it is true that smoking could inhibit some of
24 the growth of the bone after you did that October 12, 2009
25 surgery, isn't that a fact?

1 Lee - Cross - Defendant

2 A Yes.

3 Q And you recommended that Mr. Taurone use that bone
4 growth stimulator for four hours a day because in your best
5 medical judgment that would help stimulate the growth after
6 that surgery, isn't that correct?

7 A Yes.

8 Q Doctor, if there were testimony that Mr. Taurone
9 only used it one hour a day, would that have an effect on
10 the stimulation of the bone growth?

11 MR. SIRIGNANO: Objection. I don't believe
12 that's the state of the record.

13 MS. TAYLOR: Your Honor, there was direct
14 testimony from the plaintiff.

15 THE COURT: Well.

16 MR. SIRIGNANO: The jury will decide --

17 THE COURT: That's right.

18 MR. SIRIGNANO: -- what they heard.

19 THE COURT: So the question would be if he
20 testified to that what would you think of that,
21 something to that affect.

22 MS. TAYLOR: Thank you, your Honor. With the
23 court's aid I will rephrase that question.

24 Q If there were testimony that Mr. Taurone only used
25 the bone growth stimulator for one hour a day and did not,

1 Lee - Cross - Defendant

2 was not compliant with the neck collar, would that be
3 significant in terms of affecting the fusion surgery you
4 had done in October?

5 A It could.

6 Q In fact it could slow down that process, couldn't
7 it, doctor?

8 A It could.

9 Q Now as far as the fusion surgery itself, isn't it
10 true that it could take a minimum four to six months for
11 even the healing process to begin?

12 A It is possible it could take that long, yes.

13 Q So from October 12, 2009 to January 6, 2010, is it
14 fair to say that there was actually no beginning healing
15 process after that surgery?

16 A There was little evidence on the CAT scan that he
17 has healed yet.

18 Q Doctor, I believe you testified on direct you said
19 that a few days after the surgery meaning the October 2009
20 surgery Mr. Taurone was doing well. Do you recall saying
21 that?

22 A Yes.

23 Q Were you aware, doctor, that Mr. Taurone presented
24 to St. John's Riverside Hospital on October 26, 2009
25 complaining of neck pain?

1 Lee - Cross - Defendant

2 A Yes.

3 Q You were aware of that. Did you see Mr. Taurone
4 during that October 26 hospital visit?

5 A No.

6 Q Did you request any CT scans at that time on that
7 October 26 visit?

8 A No.

9 Q November 10, 2009 you have come to learn was --
10 withdrawn. You have come to learn that November 9, 2009
11 Mr. Taurone was involved in a motor vehicle accident, isn't
12 that correct?

13 A That's correct.

14 Q You described motor vehicle accident as a
15 traumatic incident. Did I get that right, doctor?

16 A Yes.

17 Q Would it be -- isn't it also accurate to say that
18 a fall is a traumatic incident?

19 A Yes.

20 Q Were you --

21 MS. TAYLOR: Withdrawn. I will withdraw
22 that.

23 Q November 10, 2009 there was a CT cervical spine
24 done by a Dr. Elizabeth Dubovsky, were you aware of that,
25 doctor?

Lee - Cross - Defendant

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A Yes.

Q Did you have an opportunity to review that November 10, 2009 C T review before you did your January 6, 2010 surgery?

A Yes.

Q That November 10, 2009 scan indicated that there was no evidence of any fracture, doesn't it?

A That's what the report states.

Q Right. Also well the report states that you review that report, didn't you?

A Yes.

Q And you didn't have any reason to question that report, did you?

A I always question the report because a report is merely somebody else reading the scan.

Q Right, but you are not a radiologist, are you, Dr. Lee?

A Oh, I look at more CAT scan and MRI of the neck than any average radiologist would look at.

Q That was not my question. You were not trained or licensed as a radiologist, are you, Dr. Lee?

A No.

Q And that report by Dr. Dubovsky also indicated that there was no subluxation. What is that, doctor?

1 Lee - Cross - Defendant

2 A Subluxation means that one part of the spine did
3 not perch inappropriately on the other part of the spine by
4 going forward or going backwards.

5 Q So in layperson's terms if I get you correctly
6 that would mean that the vertebra were in good alignment,
7 would that be fair to say?

8 A No, it just means that I think that my report and
9 my interpretation would have said that there is reversal of
10 the lordosis, the natural curvature of the spine is
11 lordotic. And he has lost lordosis once again. Now that
12 is not normal alignment. The perch, I forgot the phrase
13 you used -- what's the phrase that --

14 Q Subluxation.

15 A Subluxation merely means that one part of the
16 spine has jumped in front or fell behind the other part
17 only related to a particular level. I'm talking about
18 overall alignment of the spine versus that, yes.

19 Q This report saying there was no subluxation?

20 A Right.

21 Q That would show that there was no as you described
22 it movement on one vertebrae in front of the other, isn't
23 that correct?

24 A Correct.

25 Q The report also indicates that it was a status

Lee - Cross - Defendant

1
2 posterior fusion C-4 - C-6 with retained hardware. Do you
3 see that, doctor?

4 A I have to go to that.

5 Q That's November two, 2009 C T can?

6 A Yes.

7 Q Doctor, have you seen that phrasing before
8 retained hardware?

9 A Sometimes.

10 Q Did you interpret that to mean that the hardware
11 that you had implanted on October 12, 2009 was in the
12 position that you had placed it?

13 A For me that actually means that there is hardware
14 there from before; that's all it means.

15 Q Well, if there had not been hardware in the place
16 that you had put it, would you expect it to be in that CT
17 scan report?

18 A That is exactly what I'm saying that why a surgeon
19 is the one better at reading the films because the
20 radiologist has no clinical history and they do not pay
21 attention to some of the subtle details between the scans
22 which were apparent there.

23 Q But a radiologist is a trained physician who looks
24 at the films and interprets just what's there, not with any
25 other influence or any other medical information, isn't

1 Lee - Cross - Defendant

2 that correct?

3 A Those are good influences I must say, but I guess
4 the answer is correct.

5 Q Well the report doesn't say that it was not
6 retained or out of place hardware, does it?

7 A It did not say that, no.

8 Q The report also indicated that there was dis --
9 diffuse spondylosis on multiple levels and moderate canal
10 and foraminal stenosis, didn't it, doctor?

11 A Yes.

12 Q There was also a November 10, 2009 I guess that is
13 a head scan it looks like; do you see that?

14 MR. SIRIGNANO: I'm sorry what was the date?

15 MS. TAYLOR: November 10, 2009, same date.

16 Q Did you see C T of the head, did you see that,
17 doctor?

18 A I had looked at it but it is not in my records,
19 no. These are office records once again, not hospital
20 records.

21 Q Okay. Do you have any independent recollection of
22 what that report showed?

23 A Just from my dictation and my recording that there
24 was no abnormality or bleeding of any kind.

25 Q And no injury to the head, isn't that correct?

1 Lee - Cross - Defendant

2 A There was no injury to the head or brain.

3 Q Let's go to I believe it is your yes, your
4 November 10, 2009 consultation note. Do you see that?

5 A Okay.

6 Q That was one day after the motor vehicle on
7 November 9, 2009, right?

8 A Yes.

9 Q Now I direct your attention to page two of your
10 own consultation note, Dr. Lee. It looks like under the
11 heading physical examination and before impression, do you
12 see that on page two?

13 A Yep.

14 Q And it says CT scan of the brain is normal. CT
15 scan of the cervical spine demonstrates intact hardware
16 from C-5 to C-7. There is extensive spondylosis
17 throughout. There is reversal of normal cervical lordosis.
18 Isn't that what you said one day after this accident,
19 doctor?

20 A Yes.

21 Q Regarding the intact hardware?

22 A That's one day after, yes.

23 Q Now there was also a consultation note by a Dr.
24 Mark Weigle, W E I G L E. Do you have that record with
25 you, doctor?

1 Lee - Cross - Defendant

2 A That's hospital record once again.

3 Q Do you recall reviewing a consultation note of Dr.
4 Weigle?

5 A Vaguely, not the content of it, no.

6 Q There was also the November 18 C T of the cervical
7 spine. Do you have that?

8 A I do not have that in my record. It was a
9 hospital CAT scan ordered at the hospital by a different
10 physician I would not have that. I do not have the CAT
11 scan.

12 MS. TAYLOR: I believe that's in evidence
13 counsel the November 18 records.

14 MR. SIRIGNANO: Here. It has come unbound.

15 Q I'm going to show you doctor what has been marked
16 as defendant's exhibit E and ask you to take a look at
17 that?

18 A Okay.

19 Q That is a CT of the cervical spine done on
20 November 18, 2009, isn't that right?

21 A Yes.

22 Q It said that the patient fell yesterday, doesn't
23 it?

24 A Yes.

25 Q Under history. Were you aware that Mr. Taurone

1 Lee - Cross - Defendant

2 fell on November 17, 2009?

3 A I was informed of that, yes.

4 Q When were you informed about that?

5 A The day after that, actually the next morning I
6 saw him I believe.

7 Q Also as part of the November 18 record is an -- I
8 will show you page two of 8 of the emergency medical
9 department chart of that same admission. Again that's
10 defendant's exhibit E. If you look on the bottom of that
11 report, doctor?

12 A Yep.

13 Q Does it give you the presenting history that Mr.
14 Taurone gave to the hospital on that admission?

15 MR. SIRIGNANO: Page two of eight?

16 MS. TAYLOR: Yes, two of eight on the bottom.

17 A That's what it says, yes.

18 Q Do you see where it says that states fell
19 yesterday lost balance and landed on back?

20 A Yes.

21 Q Complains of increased pain to upper back area.
22 Do you see that?

23 A Yes.

24 Q And it there is, indicates states numbness in
25 right hand and leg since yesterday which would be November

1 Lee - Cross - Defendant

2 17, 2009. Do you see that, doctor?

3 A That's what it says.

4 Q Okay. Also you see a November 19, 2009
5 consultation note, is that part of your file there, doctor?

6 A It is.

7 Q I draw your attention to page 1 the last paragraph
8 of your report and again this is November 19, 2009, your
9 consultation note with sentence beginning at that point:
10 An x-ray and CT scan of the cervical spine demonstrated
11 unchanged alignment of the cervical spine as well as the
12 spinal implants.

13 Do you recall making that notation in your
14 consultation note dated November 19, 2009 which was about
15 ten days after the motor vehicle accident?

16 A That is what's in the record, yes.

17 Q Well you made this record, didn't you, doctor,
18 this is your report, isn't it?

19 A I did say that, yes.

20 Q It is signed by you, isn't it?

21 A I should have signed, yes.

22 Q Also on page two of that same report and second
23 paragraph it says he was discharged a couple of days ago
24 for outpatient physical therapy and outpatient MRI but two
25 days ago he tripped and fell backward and hit his shoulder.

1 Lee - Cross - Defendant

2 Do you see that in your report, doctor?

3 A Yes.

4 Q It also indicates that he was readmitted through
5 the emergency room yesterday evening. That's in that
6 report as well, right?

7 A Yes.

8 Q You also in the last two sentences of that
9 paragraph state he has not been compliant with the external
10 bone growth stimulator. He was put in a cervical collar
11 combo and was not compliant with the collar overnight by
12 report. That's what you stated in your November 19, 2009
13 report, isn't it?

14 A That's what it says.

15 Q That was important to you as his treating surgeon
16 that he be compliant with the collar and also the bone
17 growth stimulator; isn't that fair to say, doctor?

18 A That is my prescription, yes.

19 Q You also indicate when he was in the hospital on
20 November 18 that Mr. Taurone he has taken off his cervical
21 collar on his own accord and left the collar at the
22 bedside. You noted that as well in this November 19
23 report, didn't you?

24 A I did.

25 Q Page three of that same consultation note I refer

1 Lee - Cross - Defendant

2 you to the radiologic studies heading. Do you see that?

3 A Yes.

4 Q It says that x-ray the cervical spine demonstrates
5 kyphotic deformity in the mid and lower cervical spine
6 possibly secondary to paraspinal muscle spasms. There
7 appear to be a wedge deformity of the C-6 vertebra, is that
8 right?

9 A Yes.

10 Q You said that there is slight separation from the
11 C-7 vertebral body inferiorly. The inner body implants
12 appear to be intact. So at that time when you saw him when
13 you made your note on November 19, the implants were
14 intact, weren't they, doctor?

15 A I had suspected based on the x-ray that there was
16 some early separation, some early wedging of the vertebra.

17 Q We went through your reports from the beginning,
18 doctor and up until November 19, 2009 after the motor
19 vehicle accident you put in your report that the implants
20 were intact, didn't you?

21 A Yes, I did.

22 Q And you also went on in the second paragraph after
23 of the radiologic heading you said CT scan of the cervical
24 spine while compared from the CT scan from one week earlier
25 does not demonstrate significant difference. There is

1 Lee - Cross - Defendant

2 extensive spondylosis throughout. The inner body implants
3 as well as the anterior cervical fixation systems appear to
4 be intact contrary to the suggestion by the cervical spine
5 x-rays. Do you recall making that notation in this record?

6 A Yes.

7 Q So the CT scan from a week before the November 18
8 admission while compared to the scan for that November 18
9 admission did not support your suspicion of a wedge at the
10 C-6 level, did it?

11 A The CT scan does not support it first of all one
12 has to recognize that CT scans are done supine, meaning on
13 your back.

14 THE COURT: Supine.

15 THE WITNESS: Meaning on your back.

16 A X-rays are generally done with you upright. So
17 there is dynamic differences in the spine when you are up
18 versus when you are down. So if the C T shows the plate to
19 have started to separate away from the vertebral body,
20 sometimes the initial, an early CAT scan will not show
21 that.

22 And in a traumatic situation that's why you need
23 serial scan and serial x-rays because fracture does get to
24 become more pronounced as time goes on. Fracture is not a
25 static process. Fracture is a dynamic process, meaning

1 Lee - Cross - Defendant

2 that you compress the vertebra slightly but a few weeks
3 later you look at another x-ray it is decreased by a lot.
4 So all the forces and the inner working of vertebra is not
5 going to show on one x-ray, one CAT scan per se.

6 That's why you need these things in series
7 watching them after a traumatic event to see if they do not
8 progress or progress. That's when you are then ascertain
9 that it has not caused more longer term problem.

10 Q Well you didn't order any additional CT scans
11 between November 9 to January 6, 2010 when you did the
12 surgery, did you, doctor?

13 A If not ordered by me, they were ordered by another
14 physician. We have a team of physicians taking care of
15 him, so.

16 Q But there is no CT scan --

17 MS. TAYLOR: Withdrawn.

18 Q There is no diagnostic supporting your suspicion
19 of that C-6 compression fracture; is there, doctor?

20 A I think later on if you look at the MRI report it
21 then demonstrates that there was more than the C-6
22 compression fracture, but in fact there is C-5 C-6 and C-7.
23 Different tests have different sensitivity levels.

24 And if you look at the MRI images and even this
25 time radiologist picking up on the report.

1 Lee - Cross - Defendant

2 Q Well let's --

3 A Excuse me.

4 Q I'm sorry.

5 A It does demonstrate that there are swelling inside
6 the vertebral body and one does not develop swelling
7 without some sort of trauma or tumor.

8 Q But you didn't include the word swelling in your
9 report of November 19, 2009 or your?

10 A That's not the MRI. That's the CAT scan. I
11 cannot see --

12 Q I'm not talking about the test. I'm talking about
13 swelling. There is nothing, there is no term of swelling
14 in your own report dated November 19, 2009; is there?

15 A I'm certain that I referred to it at some point in
16 my records somewhere when I saw him the MRI.

17 Q I'm asking about the November 19, 2009 report,
18 doctor?

19 A Perhaps not in that time because the MRI wasn't
20 done yet.

21 MS. TAYLOR: Thank you.

22 THE COURT: You know what? You have to wait
23 for him to finish his answer before cutting him
24 off.

25 MS. TAYLOR: I'm sorry. I'm sorry, Dr. Lee.

1 Lee - Cross - Defendant

2 I apologize.

3 Q My question was there was no use of the term
4 swelling in the November 19, 2009 report, is there?

5 A Not on that report, correct.

6 Q You referenced the MRI. That MRI was done on
7 December 15, 2009, wasn't it?

8 A Yes.

9 Q Now there is nothing on the MRI of December 15,
10 2009 that indicates any swelling on the C-5 C-6 levels of
11 the spine, is it?

12 A Actually if you read the test it does say that
13 there is diffuse decreased signal intensity from bone
14 marrow on T1 way to image also increasing though at C-4 to
15 C-7.

16 Q That's the signal in the spinal cord, that's not
17 the swelling, is it of the tissue of the muscle?

18 A No that's the vertebra. They are talking about
19 the vertebra.

20 Q But the swelling that you said indicates an
21 indicia of trauma, that would be the swelling to the muscle
22 or ligaments around that area, wouldn't it?

23 A No, the bone.

24 Q Oh, the bone, okay. Does it say it in this
25 December 15, 2009 that there was swelling of the bone?

1 Lee - Cross - Defendant

2 A It does say that within the findings under the
3 paragraph.

4 Q Which page is that, doctor?

5 A Swelling on the MRI shows a T1 decrease signal and
6 increase signal. That is exactly how they describe it.

7 THE COURT: What's T1?

8 THE WITNESS: T1, these are proton spins.
9 Now we are going to get into areas you don't want
10 to hear.

11 THE COURT: Proton what.

12 THE WITNESS: Proton spin sequence of the MRI
13 examination. So these are the changing in the
14 magnetic field of the MRI machine that creates
15 signals. Now a normal signal of the spine on it
16 one would be gray. And abnormal signal on T1
17 would either be dark, meaning swelling of the bone
18 marrow which is what's happening here and which is
19 exactly what's reported here.

20 Q But that was after the November 9, 2009 motor
21 vehicle accident and after the November 18, 2009 admission
22 for Mr. Taurone's fall, wasn't it?

23 A That's correct this is the first MRI, yes.

24 Q Let's go to your November 24 report. Actually it
25 is a follow-up visit. Do you see that, doctor?

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2 A Yes.

3 Q I direct your attention to the heading impression.

4 Number one you indicate status post anterior cervical
5 decompression and fusion with instrumentation, C-5 C 7.

6 MR. SIRIGNANO: Your Honor, I'm going to
7 object. This is his office chart which is not in
8 evidence. This is not part of the hospital chart.
9 This is an office note and I object to the witness
10 being asked to testify about a document that's not
11 in evidence.

12 Or I object to counsel reading it to the jury
13 when it is not in evidence.

14 MS. TAYLOR: I will rephrase the question,
15 your Honor.

16 Q Do you recall making a notation regarding the
17 anterior cervical fusion?

18 THE COURT: Well if it is not in evidence you
19 can't ask it that way either because you are
20 referring to the body of the evidentiary exhibit.
21 Now do you want to put it in evidence?

22 MS. TAYLOR: That would be fine with me. I
23 thought it was.

24 THE COURT: All right.

25 Q Doctor, do you have the --

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2 THE COURT: Do you want to say anything, Mr.
3 Sirignano?

4 MR. SIRIGNANO: Is it now being offered?

5 THE COURT: I don't know.

6 MR. SIRIGNANO: I don't think there has been
7 a foundation laid for it to go into evidence.

8 MS. TAYLOR: Well I will establish that.

9 Q Doctor, you have all of your consultation and
10 follow-up visit reports for Mr. Taurone?

11 A I do.

12 Q Do you have that with you, doctor?

13 A Yes, I do.

14 MR. SIRIGNANO: Your Honor, I think -- I
15 object to just one part of his office chart going
16 in. I think if one is going to go in.

17 THE COURT: The whole thing.

18 MR. SIRIGNANO: The whole chart.

19 THE COURT: The whole thing can go in. She
20 just wants one page. You can then offer the whole
21 thing.

22 MR. SIRIGNANO: Okay. With that --

23 THE COURT: I don't think one page is going
24 to go in. The whole thing has to go in.

25 MR. SIRIGNANO: With that stipulation, I have

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2 no objection to the whole thing going in.

3 THE COURT: All right.

4 Q Dr. Lee you have your full chart and record for
5 your treatment for Mr. Taurone?

6 A I do.

7 Q Okay, it includes all of the reports and
8 consultation and follow-up notes that we previously
9 discussed?

10 A Not the hospital generated reports.

11 Q No, but just your notes as well, okay. Did you
12 make those notations as part of your practice in terms of
13 treating Mr. Taurone as part of your practice as a treating
14 physician?

15 A Yes.

16 Q Do you as a matter of course part of regular part
17 of your practice make notations for patients that you
18 treat?

19 A Yes.

20 Q Is the November 24, 2009 follow-up office visit
21 report part of that record?

22 A Yes.

23 MS. TAYLOR: Your Honor, I would ask that it
24 be offered.

25 MR. SIRIGNANO: Your Honor, I stipulated to

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2 the entire chart going in, the office chart going
3 in.

4 MS. TAYLOR: That's fine.

5 MR. SIRIGNANO: Subject frankly to a
6 redaction which we would have to do outside of the
7 jury.

8 MS. TAYLOR: That's fine.

9 THE COURT: What do you want it in as.

10 MR. SIRIGNANO: That would be defendant's.

11 THE COURT: Defendant's G, Dr. Lee's office
12 chart. Defendant's G. The entire chart.

13 (Defendant's exhibit G marked received in
14 evidence.)

15 Q Now, Dr. Lee, I draw your attention to that
16 impression on your November 24, 2009 report.

17 A Yes.

18 Q Item number one. You made a notation as to your
19 impression regarding the fusion instrumentation, didn't
20 you?

21 A Yes.

22 Q Nowhere in that report does it indicate that there
23 was any dislocation or elevation of either the plate or the
24 fusion hardware, isn't that right?

25 A I think the test did reference that my impression

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2 that there is slight wedge deformity of the C-6 vertebra.

3 Q Well your impression in the middle of the page
4 one, two, three and four. Specifically item number one.
5 There is no indication, is there of any defect or any
6 dislocation of either the screws or the plate from the
7 surgery that you did on October 12, 2009 is there, doctor?

8 A Not on the CAT scan as obviously but a fracture
9 was there at C-6.

10 Q You also indicated in the recommendations section
11 of that report that you might need to do the -- might need
12 to do the fusion surgery with new implants. Do you see
13 that?

14 A I do.

15 Q That was because you considered doing another
16 surgery because the vertebral body showed progressive
17 deformity, isn't that correct?

18 A It did.

19 Q And that progressive deformity was because of the
20 underlying degeneration, wasn't it, doctor?

21 A Deformity means the compression fracture that's
22 not a degeneration.

23 Q Well a fracture is not progressive, is it?

24 A As I testified earlier that when you have
25 developed a fracture initially you can have minimal

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2 depression of the bone. As time goes on the depression
3 over the ensuing weeks to months can actually progress
4 because the underlying bone structure is damaged. So you
5 actually see more and more deformity of the spine, more and
6 more deformity of the implant.

7 And in somebody with persistent symptoms, your
8 index of suspicion have to be very very high to continue
9 watching these findings. And they do unfortunately
10 continue to get worse as time goes on. I don't consider
11 that degenerative. I consider it part of a traumatic
12 process carrying on forward until the fracture settles in
13 about six, eight months.

14 Q Isn't it fair to say or isn't it accurate to say
15 that an x-ray would actually show you would be the best
16 tool to show you whether there was a fracture, isn't that
17 correct?

18 A X-rays is not the best test for a fracture per se.

19 Q Well a CT scan or an x-ray would show a fracture,
20 wouldn't it?

21 A A more subtle fracture such as this are best
22 detected actually on the MRI examination because it shows
23 the bone to have abnormal signals on the MRI sequences
24 which is what's shown here.

25 Q When you did the original surgery on October 12,

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2 2009, I thought you said on direct that you tried to remove
3 the spurs or the osteophytes, is that correct?

4 A Yes.

5 Q But I believe in your own words you said that you
6 can't always do it completely because it is kind of a
7 judgment thing you have to make as a doctor, right?

8 A Based on the bone consistency, yes.

9 Q Isn't it a fact that when you went in to do the
10 revision surgery on January 6, 2010 there were remaining
11 osteophytes at C-5 C-6, weren't there?

12 A There were some osteophytes, yes.

13 Q And osteophytes can cause pain, can't they,
14 doctor?

15 A They could.

16 Q And osteophytes can also cause numbness in the arm
17 or the hand, can't they, doctor?

18 A They could.

19 Q Again you had a follow-up visit on December 22,
20 2009?

21 A Yes.

22 Q And a follow-up a post-operative visit on February
23 12, 2010?

24 A Yes.

25 Q And you made impressions or there is a heading on

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2 those reports under impression on both of those reports,
3 isn't there, doctor?

4 A Yes.

5 Q In neither of those reports December 22, 2009 or
6 on -- I'm sorry December 22, 2009, there is no indication
7 of any dislocation or elevation of the screws or the
8 hardware, is there?

9 A On December -- on January the 22 he already had
10 the revision surgery, so.

11 Q I stand corrected. December 22, 2009, there is no
12 indication of any defect or dislocation of the screws or
13 the hardware in that report, is there?

14 A I did not go over the CAT scan or x-ray findings.
15 Those are just the MRI findings, so --

16 Q But this is your report?

17 A Right.

18 Q That you authored, isn't that correct?

19 A Yes, it is.

20 Q And there is no indication in your own report on
21 December 22, 2009 of any dislocation, elevation or anything
22 of the plate or the screws that you had implanted in
23 October, is there?

24 A No, only on my note from November 19.

25 THE COURT: Only on your what?

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2 THE WITNESS: Only on my hospital record from
3 the 19.

4 THE COURT: I can't hear it. Only on your
5 hospital record.

6 THE WITNESS: On November 19.

7 THE COURT: On November 19.

8 THE WITNESS: Not on the subsequent records.

9 Q On January 6, 2010 you did an operative report?

10 A Yes.

11 Q And you had -- you made a preoperative diagnosis
12 which means you diagnosed Mr. Taurone before you did the
13 surgery; would that be fair to say?

14 A Yes.

15 Q And your pre o diagnosis was recurrent cervical
16 myeloradiculopathy, wasn't it?

17 A Yes.

18 Q You also indicated that there was a history of
19 anterior cervical decompression and fusion at C-5 and C-7,
20 right?

21 A Yes.

22 Q You also on that same operative report had a
23 post-operative, in other words a diagnosis after you did
24 the surgery?

25 A Yes.

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2 Q And your post-op diagnosis was again recurrent
3 cervical myeloradiculopathy and the cervical decompression
4 and fusion, isn't that right?

5 A Yes.

6 THE COURT: Could you please define the first
7 diagnosis which is recurrent cervical myel
8 something.

9 THE WITNESS: Okay.

10 THE COURT: What is it. Say it again and
11 what is it?

12 THE WITNESS: Recurrent as you know is
13 something that has returned. Cervical is neck.
14 Myeloradiculopathy meaning problems with the
15 spinal cord and the cervical, the neck nerve roots
16 and the resulting clinical symptoms from them.

17 THE COURT: Radiculopathy is referred pain to
18 the limbs.

19 THE WITNESS: Weakness, numbness, pain,
20 tingling of the arms.

21 Q And isn't it true, doctor, that myeloradiculopathy
22 could be caused by the osteophytes?

23 A Could, yes.

24 Q And isn't it also true that the myeloradiculopathy
25 could be caused by the underlying degenerative disk disease

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2 that Mr. Taurone had going back to April, 2007?

3 A It could.

4 MS. TAYLOR: Thank you. I'm almost done,
5 doctor. I have a few more questions and I thank
6 you for your forbearance.

7 Q Doctor, did you ever use the term re collapse of
8 the disk space when you were either examining or Mr.
9 Taurone himself or any films or CAT scans? Did you ever
10 use that term?

11 A I believe it is in the report somewhere.

12 Q That re collapse of the cervical of the disk
13 space, that could be caused by degenerative disk disease as
14 well, couldn't it?

15 A Degenerative process to collapse the space will
16 take months to years. And I'm talking about not just one
17 month or two month, it is a long, prolonged process just
18 like any of the rest of the degeneration takes that long.

19 Q As you testified earlier as of April, 2007, there
20 was evidence on an MRI that Mr. Taurone had underlying
21 spondylosis and degenerative and spinal changes, correct?

22 A That is not correct. I think that's all
23 preoperative changes. I'm referring to the disk space
24 height after he was reconstructed immediately
25 post-operatively from the immediate post-operative CAT scan

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2 to subsequent imagining CAT scans as was operative finding
3 that the space them self had collapsed again.

4 Q So you are talking about that collapse after the
5 January 6, 2010 surgery?

6 A No. I'm talking about collapse that has occurred
7 between those two surgery dates.

8 Q And that could be caused by --

9 THE COURT: I don't like the word could,
10 because could have, would have, should have are
11 not --

12 MS. TAYLOR: All right, judge.

13 THE COURT: No, I'm talking, please.
14 Courtesy.

15 MS. TAYLOR: I apologize, your Honor.

16 THE COURT: It has to be asked can you tell
17 us with a reasonable degree of medical certainty
18 whether whatever it is. Otherwise it is not
19 competent evidence. Could, maybe, possibility is
20 not competent medical evidence.

21 MS. TAYLOR: I will rephrase it, your Honor.

22 Q Doctor, can you state within a reasonable degree
23 of medical certainty whether Mr. Taurone's underlying
24 disease might have caused or is likely to have caused the
25 collapse between the disks?