1 smoke, it surely will not work.
2 Keep on smoking and then keep on smoking and come
3 to court and say that second surgery there is Mr. Nelson's
4 client's fault. I had the first one. You listen to what I
5 talk about during this case, listen to what I say about the
6 first one. First one clearly from the accident. You will
7 see that. I told you that in jury selection. But to come
8 into court and say the doctor tells me a dozen times don't
9 smoke, don't smoke. The doctor tells me the operation
10 surely will not work, don't do it and then come to court and
11 say by the way pay me. I want Mr. Nelson's client's money
12 for the second surgery because it is her fault. It is not
13 my fault that I didn't stop smoking, it is her fault, pay
14 me.
15 That is what you are going to hear and you are
16 going to hear it from the doctor's own words. Thank you for
17 your time.
18 THE COURT: All right, thank you.
19 Mr. Block, call your first witness.
20 MR. BLOCK: With permission I call Dr. Hecht.
21 Let's see his own words.
22 Thank you, Doctor.
23 (Whereupon, the witness took the witness stand.)
24 (Whereupon, the witness was sworn in by the clerk
25 of the court.)

1 THE CLERK: Give us your name and office address.
2 THE WITNESS: Andrew Hecht, 80 98th Street, 9th
3 Floor, New York, New York 10029.
4 THE CLERK: Thank you. Please be seated.
5 THE COURT: Counsel, proceed.
6 MR. BLOCK: Thank you, Your Honor.
7 DIRECT EXAMINATION BY
8 MR. BLOCK:
9 Q Doctor, keep your voice up so all the jurors can hear.
10 You brought your office records with you today?
11 A I did.
12 Q Before you start just give the jury three minutes of
13 your educational background and qualifications and what makes
14 you qualified to be an orthopedic spinal surgeon.
15 A I did my undergraduate training at Brown University in
16 Rhode Island. I did my medical school at Harvard Medical School
17 in Boston. I did my residency in orthopedic surgery at Harvard
18 combined orthopedic program at the Massachusetts General
19 Hospital. I did a spine fellowship at Emory University. I then
20 rejoined the faculty at the Massachusetts General and Harvard
21 for several years and brought up by Mount Sinai to head up their
22 spine program. I have been in practice about ten years.
23 Q Doctor, did there come a time that you began to treat
24 Suzanne Kusulas?
25 A Yes.

1 Q I just want to go back for a second. In the opening
2 statements you heard myself and counsel, counsel said the first
3 surgery is caused from the car accident. I will jump right to
4 the point. Do you agree or disagree?
5 A Yes.
6 Q Any question about that?
7 A No.
8 Q We will talk about that first surgery. Can you tell us
9 would she have needed a second surgery if the car didn't hit her
10 from the rear causing her to have a first surgery?
11 A I am sorry.
12 Q Would she need a second surgery if there wasn't a need
13 for the first surgery?
14 A No.
15 Q Let's talk about it. She comes to you when for the
16 first time?
17 A September 12, 2007.
18 Q When she comes to you in September of 2007, does she
19 give you a history?
20 A Yes.
21 Q Tell the jury what a history is before you tell them
22 what this history is.
23 A Every physician when meeting a patient we try to get a
24 history in your own words about what is going on with your pain
25 or clinical complaint. And we try to hear about the types of

1 symptoms that you have and what makes it better and what makes
2 it worse, sort of where you have been with your clinical
3 problem.
4 Q If you need to you can clearly refer to your notes with
5 the court's permission. The notes are evidence by the way as an
6 exhibit. If you need to read off of them you can.
7 Tell us what history Mr. Kusulas gave to you?
8 A That she was a belted passenger in a rear end motor
9 vehicle accident and she started developing having never had
10 previous history of any neck pain or arm pain, that she started,
11 that her clinical complaints followed as a direct result of this
12 accident.
13 Q Did she have any treatment before she came to you?
14 A She saw some other doctors and whose names I don't have
15 in my chart.
16 Q If you look -- I am --
17 A She had some therapy, trigger point injections,
18 medications but I can't tell you the names of those doctors.
19 Q I see a doctor of 9/12/07, Dr. Brisson.
20 A Dr. Brisson is another surgeon she saw.
21 Q Doctor, what is the significance to you as an
22 orthopedic spinal surgeon the fact someone 40 years of age comes
23 to you with no prior history of neck complaints, meaning no
24 history that predates the auto accident of February 23, '06?
25 A This is a new problem and the close proximity of the

1 onset of her symptoms to her accident is very indicative these
2 symptoms were as a result of the accident.
3 Q I want you to assume Miss Kusulas was a belted
4 passenger hit in the rear as she told you and she was taken by
5 ambulance to Methodist Hospital, assume that.
6 A Yes.
7 Q Complaining of neck pain, they are in evidence.
8 A Yes.
9 Q She started treating with Dr. Vitale, records are in
10 evidence as Exhibit Number 11 and she has neck pain. He sends
11 her out for an MRI of her cervical spine. Can you assume that?
12 A Yes.
13 Q By the way, Exhibit 4 in evidence is an MRI of her
14 cervical spine, correct?
15 A Yes.
16 Q All have her name, date, etc.?
17 A Yes.
18 Q Is the black and white portion just an enlargement of
19 the actual films?
20 A Apparently so.
21 Q And then there is a medical illustration next to it,
22 correct?
23 A Yes.
24 Q I will ask you if you can get off of your seat and on
25 your feet. I want you to demonstrate the anatomy to the jury.

1 I will hand you a model of the spine and ask you to please
2 demonstrate to the jury what we are looking at.
3 A Okay, all patients I see I explain the normal. In our
4 neck we have seven cervical vertebrae. The cervical spine is
5 just adjacent to your skull. The skull sits right on top of the
6 cervical spine and you have seven cervical vertebrae. Below
7 that you have thorax and lumbar. We will focus here on the
8 cervical spine.
9 It affords you a great deal of motion. You can do
10 things with your neck that you really can't do with say your mid
11 portion of your spine, your thoracic spine. It allows you to
12 rotate a great deal. Rotation is a side to side motion, a
13 flexion extension motion, up and down, main motions of our neck.
14 Tilt, that is uncomfortable with our spine. When you look at
15 motion in the neck it is very important the majority of your
16 neck motion of your rotation and your flexion extension comes
17 from the top of the neck with your skull C-1 and C-2. Each
18 other level, the other levels contract relatively equally to the
19 motion. Each other motion is about ten to fifteen percent
20 contribution to the overall range of motion.
21 Now in between each bone sits a disc. A disc is sort
22 of like a shock absorbing cushion to help us dissipate forces on
23 the neck. Inside of the disc think of it like -- a simple way
24 to think of it is like a doughnut. The doughnut which is
25 embolus and the yellow outside is called the nucleolus. All of

1 us have these up and down to help us move and dissipate forces
2 that load on the spine.
3 Behind the discs and bones sit nerves. The main
4 highway of nerves is the spinal cord, gives off exit ramps.
5 When you have problems with your discs you can get compression
6 of the main nerves, the spinal cord, and sometimes you can get
7 compression of the nerve roots themselves. Okay.
8 Q Is that bad having compression of the spinal cord?
9 A It can give you significant amounts of pain, sometimes
10 numbness and sometimes weakness.
11 Q With everything we just talked about let's look at her
12 MRI.
13 MR. BLOCK: May I grab the easel?
14 THE COURT: Sure.
15 Q I will go back and forth.
16 MR. BLOCK: For the record we are talking about
17 Exhibit 4.
18 A This first view here we are looking at the spine from
19 the side. So what the MRI has done is taking slices of the
20 person like this and we are looking from the side.
21 This is the front, this is actually the angle of the
22 jaw. Somewhere in here is her tongue. This is the front of the
23 spine here. Here is those nerves I was telling you about. Here
24 is the back of the spine. These little bones here are those
25 little knobs on the back and here is the skin.

1 So here is your brain here and here is your spinal cord
2 coming down. The spinal cord travels in a tube filled with
3 fluid, spinal fluid. That is what this white side is, spinal
4 fluid. Within that tube is the spinal cord. What is happening
5 here are the bones, in between these little things here these
6 are the discs. If you see here take this one, a normal disc
7 relatively normal disc, not entirely normal. Showing you here
8 it ends at the back. It respects the boundaries of the bone.
9 Now if you come down here, you don't have to take my
10 word for it, this is C-2, C-3, this is C-5 and this is C-6, you
11 see two herniations where the jelly has come out of the doughnut
12 and pushing on the nerves.
13 Q To the right is the blowup of the actual film?
14 A Yes, we are zooming down the picture showing again the
15 side of the herniation and you can see how you don't see any of
16 that white fluid.
17 It is not going to be as illustrative as this, but
18 again here is your spinal cord and here is that white fluid
19 around it. You can see here how you don't have that so well.
20 There is pressure on the spinal cord and the nerves. This and
21 this is a color illustration of what we just talked about. So
22 remember that jelly doughnut, of the jelly coming out of the
23 doughnut pushing on the nerves and this is just showing again
24 that section where those axial cuts or the roll of salami cuts.
25 Q Doctor, when Miss Kusulas comes with an MRI of 2/26

1 following a 2/26 accident, does she show signs of normal age
2 related wear and tear for a 40 year old or degenerative?
3 A She has two herniated discs which we don't see in
4 everybody and she has, you can see that she has some age related
5 things which are related to the loss of water content in the
6 disc. The disc has water. You need to lose a fraction of the
7 water for the MRI to start to become a little darker, less than
8 ten percent of the water of your disc. But you notice the
9 height of the disc is preserved at every level. But what is
10 impressive is here are the two large herniations she has in her
11 neck.
12 Q Within a reasonable degree of medical certainty what
13 was the cause of those two herniations?
14 A Her motor vehicle accident.
15 Q While you are standing up can you go on to demonstrate
16 what you did next. I have MRI --
17 A She had a lot of arm pain.
18 Q Can you explain to the jury why she had arm pain?
19 A When the disc pushes on the nerves it can send pain
20 down your arm.
21 Q Looking at Exhibit 5A in evidence.
22 A If you remember looking at discs the way we treat
23 cervical herniations is lower disc herniations because here we
24 are working around the spinal cord and it is very different than
25 when you are working nerve roots in the lumbar spine. The

1 majority of these operations we take pressure off the nerves we
2 do from the front because we can't move the spinal cord around,
3 we have to work around it so to speak. So what we do is come in
4 the front of the cervical spine and we take the discs out under
5 with the use of a microscope. We take them out and in its place
6 we put in a piece of bone and this bone is from a cadaver, it is
7 called allograft. It is freeze dried piece of bone that serves
8 as a scaffold. A scaffold means there is nothing in it, there
9 is collagen in there and the bone. Your bone cells will come
10 from either end and incorporate into the bone to make it become
11 one bone.
12 The goal of the surgery is to make her C-4, C-5 and C-6
13 bone one bone, but most importantly take the pressure off the
14 nerves first. After we put those pieces of bone in to protect
15 her further we add a special kind of a plate to help increase
16 the chances of her fusion. When you look at people who have
17 this operation without a plate and with a plate the people with
18 the plate do much better than those without the plate. That is
19 why we used a plate.
20 Q Doctor, this is the post operative x-rays of January
21 28th of '08.
22 A This is showing you --
23 Q That is Exhibit 5B, as in boy, in evidence.
24 A This is showing you a post operative x-ray. Again you
25 see the plate is on the spine, the bone grafts are inside

1 between the bones and this is an x-ray showing a view from the
2 front and then a view from the side. What we like to see is the
3 bones to incorporate. That is for your bones to grow into the
4 allo. If you look closely you see the x-ray showing the bone
5 has not grown in on this x-ray.
6 Q I want to slow you down. You yourself cut open Miss
7 Kusulas' neck and went into her spine?
8 A Yes.
9 Q With your own eyes saw the pathology?
10 A Yes.
11 Q Can you tell the jury what you found intraoperatively
12 as far as the pathology?
13 A She had exactly what we thought. The MRI was pretty
14 specific. Two herniated discs causing compression of the
15 nerves. We removed them, placed the cervical plate, gave her a
16 collar. She is in the hospital a day or so, went home.
17 Q Let's back you up. Before the surgery, did you discuss
18 with Miss Kusulas the risks of doing an ACD?
19 A Yes.
20 Q What are the risks that you discussed with her or any
21 other patient?
22 A We try to discuss every risk that is possible. We also
23 give you a booklet regarding the operation that also reinforces
24 or discusses the risks and shows you pictures again. What are
25 the big risks? Infection, bleeding, injuries to nerves, spinal

1 fluid leaks. We talked about having a hoarseness, having
2 trouble swallowing, having a sore throat. We talked about not
3 fusing. Even in the norm, a person who doesn't smoke there is a
4 risk of developing a nonunion when you do two levels of fusion
5 with allograft of about 15 percent. We talked about developing
6 when you have a fusion but developing something that is adjacent
7 segment degeneration. What does that mean? Pretend for a
8 minute you had your knee fused instead of having a knee
9 replacement. How much more difficult would it be to ~~work~~ walk, how
10 much more work would your hip and ankle have to do in order to
11 walk? A lot more than that.
12 Remember how I was telling you how the neck moves.
13 Just below is holding the bones together have to work harder.
14 And when structure have to work harder the components of that
15 jelly doughnut start to wear out and you can develop either
16 degeneration above the fusion or below a fusion or develop a
17 herniation above or below a fusion.
18 Q By the way, Doctor, when you saw Miss Kusulas and were
19 explaining the risks to her and saw her for the first time, did
20 she advise you she was smoking one pack per day for the past 15
21 years as in evidence in your records?
22 A Well, I have to look at my records.
23 Q I will show you a copy of 9/12/07 report. Is that
24 correct?
25 A Correct.

1 Q Was she trying to hide something from you?
2 A No.
3 Q Did you discuss with her the need to wean down or stop
4 smoking?
5 A Every patient who is going to have a fusion procedure,
6 a fusion means bones growing together. What is it about smoking
7 that will interfere with this process? Smoking, the nicotine
8 within a cigarette, nicotine with a patch, gum, anything with
9 nicotine tells the bone cell to stop making bone or it slows it
10 down significantly. There are times where people do fuse if
11 they do smoke but it increases the risk of not fusing if you do
12 smoke.
13 Q How much does it increase that risk?
14 A Depending upon the levels for a one-level operation the
15 difference is minimal. But at a two level operation it
16 approaches 10 percent. Out of three levels even higher. At a
17 two-level operation it increases the risk you already have.
18 Q Doctor, did you prescribe her medication for her to
19 stop smoking?
20 A I believe we did.
21 Q Chantix was provided. Did she follow up?
22 A We tried whatever possible. Even though I am a spine
23 surgeon for this particular reason we spent a lot of time
24 explaining about nicotine usage. We were worried about the
25 complications trying to give her the best successful outcome.

1 She weaned down her nicotine usage with the medication.
2 Q She didn't fuse?
3 A She didn't fuse.
4 Q Nicotine is an addictive substance, correct?
5 A Yes.
6 Q Let's go on to the post fusion or post surgical period
7 of February of '09. She is coming back on a regular basis?
8 A Yes.
9 Q And following your advice?
10 A Yes.
11 Q And you ordered a CAT scan, correct, February 17, '09?
12 A Yes.
13 Q In evidence as Exhibit 7. What does a CAT scan show?
14 A A CAT scan, remember we looked at the MRI it showed us
15 the bones, spinal cord, discs, a CAT scan is specifically to
16 look at bone. It doesn't show you the nerves and all the other
17 stuff. It is really to highlight the bone. We get a CAT scan
18 in a particular case and try to judge the incorporation of the
19 bone, the fusion.
20 Remember she had those phases. You can see here. Look
21 at the top surface of this graph. That is what a fusion looks
22 like. You can see the bone in growing into the bone and you can
23 see it growing completely here. Here you don't see the fusion
24 so well. She was just about completely fused at this level but
25 not so much at this level. The bone didn't grow. What happens

1 is fibrous tissue gets in there instead of bone and that could
2 be a source of ongoing pain.
3 In addition if you look at this you can start to see
4 already starting to see at the level below the fusion. Remember
5 we talked about that adjacent segment degeneration. What
6 happens when you fuse your knee and hip and ankle have to work
7 harder. This level is already starting to work harder. How so,
8 you are starting to see a formation of a spur, starting to see
9 degeneration here, the thickness of the disc starting to
10 diminish.
11 Q Why is it she was able to develop a fusion here but not
12 at 5, 6?
13 A I don't know.
14 Q It just happens?
15 A Talk to mother nature, I don't know.
16 Q Did you order an MRI in April of '09 before you did the
17 second surgery?
18 A Yes.
19 Q I will hand you what is part of Exhibit 28?
20 A The first MRI I don't think anybody can see from back
21 there but we will do our best. Remember we talked about here
22 you can see the MRI in little more detail. It is the actual MRI
23 itself. Here you can see again, here is that angle of the jaw,
24 here is the tongue, here is the front, here is the back.
25 MR. BLOCK: Your Honor, can we take that off the

1 wall at all?

2 THE COURT: No.

3 A Here is the spinal cord coming down. Here is the
4 fluid. This is where we operated here. You see there is no
5 longer any disc herniations, those have been removed. What has
6 happened is she is starting to develop generation here at the
7 level below. There is a herniation here at 6, 7. In addition
8 in comparison to the previous MRI she is starting to develop
9 this white stuff here in the bone which is reactive changes to
10 the increased work and degeneration that is going on at the
11 level below the fusion.

12 So there is two problems here now. One, she didn't
13 fuse one level and, two, because of the increased work that is
14 going on by the level below. She has developed a new herniation
15 and degeneration here.

16 Q Doctor, I want to slow you down for a second. I want
17 you to look at Exhibit 22 in evidence which is the first MRI
18 report, the one you demonstrated earlier.

19 I want you to demonstrate the changes that occurred to
20 Suzanne's neck from the April of '06 MRI following the accident
21 to the one you did in April of '09 before the second surgery.

22 A Remember we talked about the original jelly doughnuts?
23 Here are those degenerations and this is below where we operate,
24 C-6, 7. Here you can see fluid around it. No problem, and it
25 is nice and thick. You don't see that big support. And look at

1 the height of it.

2 Now if you go back over here you can see that the

3 height of it is lower. We now see this white change in the bone

4 which we don't see over there. It is very hard for you to see.

5 You can see this is lower. There is a reactive change on both

6 sides of the bone and there is now a herniation here below the

7 fusion.

8 So let me sum up here. On the basis of this MRI which

9 was obtained prior to the second surgery why did we get this

10 MRI. I know she didn't fuse one level. I got this MRI not to

11 tell me about the fusion, I got the MRI to tell me about any

12 other level that she might have had a problem with because when

13 we talked about her original surgery what did we counsel her

14 about. We counseled her about the risk of developing a

15 systematic adjacent segment problem which is about almost three

16 percent per year.

17 Q Do you have an opinion within a reasonable degree of

18 medical certainty whether she did develop the adjacent segmental

19 problem?

20 A She developed a degeneration and herniation.

21 Q Can you tell us within a reasonable degree of medical

22 certainty.

23 The cause of that adjacent segmental herniation was?

24 A As a result of the first fusion.

25 Q And the first fusion is caused by the --

1 A Car accident.

2 Q The car accident is responsible for the new herniated

3 disc?

4 A Her accident is responsible for the first surgery and

5 the new herniation is a result of the first surgery. Whether

6 she was fused or not you can have a systematic herniation at the

7 level below.

8 Q Before you went in to operate on her again was she

9 making complaints of pain?

10 A Yes.

11 Q Did you ultimately go in and operate on her?

12 A Simply the presence of a nonunion or lack of fusion

13 doesn't necessitate another operation without pain. You need

14 the pain too. So if somebody has a nonunion or lack of fusion

15 not all of them have symptoms. It is the combination of the

16 nonunion and the pain that makes you have another operation.

17 Q Doctor, can you step down and if I can ask you, are you

18 done with those films, Doctor?

19 A Yes.

20 Q Did there come a time that you had a discussion with

21 Suzanne about going in and reoperating on her neck?

22 A Yes.

23 Q And did you take her into the operating room?

24 A Yes.

25 Q When?

1 A 5/12/2009.
2 Q And what type of procedure did you do?
3 A Due to the fact she had a nonunion, what do we do to
4 make this thing heal. What we do is we provide additional
5 fixation, more screws and rods to further mobilize the cervical
6 spine. So that was what we do was put these little screws and
7 we put in a rod connecting it and we put the bone graft from her
8 pelvis this time. No more cadaver bone. And then we also
9 extended it down one additional level because as you saw she had
10 herniated discs and disc degeneration below the fusion. We
11 didn't want to leave that behind because she had a problem now.
12 The cost of going in to fix the nonunion and she has neck pain I
13 don't want to leave it there and her still have neck pain.
14 Q Doctor, after doing the second surgery, did you take
15 post surgical films?
16 A Yes.
17 Q And can you show us what those post surgical films look
18 like, Exhibit Number 8 in evidence?
19 A Here you can see color diagram of the operation from --
20 here is where we added these additional supportive screws and
21 rods to tension the back side as it has been fixed on the front
22 side. We extended the fusion down, this little segment of rod
23 is there to fuse this level too. The one below the fusion which
24 we just talked about. And because we really, she already has
25 this nonunion we are going to use bone we took from her pelvis

1 and when she is laying there we open up this segment right here,
2 take out the bone inside and transport it all the way up here to
3 help her fuse. It is at this time that will give her a better
4 chance.
5 If you look at her x-rays now you can see how there is
6 no lines here. And we now have a fusion. We fused 4, 5 and 6
7 and now 7.
8 Q Doctor, are the metal plates, screws and rods that we
9 see on Exhibit 8 still in Susie's neck?
10 A Yes.
11 Q Will they be there for the rest of her life?
12 A Yes.
13 Q Doctor, with those plates, screws and rods does she now
14 have full range of motion?
15 A No.
16 Q Why not?
17 A Remember how we talked about range of motion, we talked
18 about how does the neck move. Neck moves by the two bones at
19 the top, the skull, C-1 and C-2, 50 percent. Rotation up and
20 down. The other ones C-2,3, C-3,4, C-4,5, C-6,7, we just lost
21 three. We just lost, C-4,5, C-5,6 and C-6,7. It is
22 physiologically impossible when you have a plate on the front of
23 your neck and screws and rods on the back of your neck to have
24 normal range of motion. She will have some range of motion
25 because the top is still there, the C-1 and the C-2, C-2 and the

1 C-3, and the C-3 and 4. What about the three we just used were
2 titanium screws and rods. Now that vertebrae that used to move
3 independently with a four move with the five and the five move
4 with the six and the six move with the seven. They all used to
5 move separately. Then they become one mega vertebra. Now they
6 are now joined together. How could someone move normally with
7 full range of motion if all those bones are now fused together?
8 Q What is the percentage of loss of range of motion she
9 has now?
10 A Remember we talked about 50 percent of the motion is up
11 here. She has lost somewhere around 35 to 40 percent of the
12 motion.
13 Q Is that a permanent loss of use of that portion of her
14 neck?
15 A That is forever, permanent.
16 Q And, Doctor, within a reasonable degree of medical
17 certainty what was the cause of the need for both surgeries and
18 all the herniated discs?
19 A Her original accident.
20 Q You can resume the stand.
21 Are you still seeing Suzanne Kusulas?
22 A Yes.
23 Q And, Doctor, are you seeing her because she has what?
24 A She continues to have neck pain.
25 Q How do you --

1 A Last time I saw her was December 19, 2011 where she had
2 very minimal pain and numbness in her hand and we referred her
3 to see a hand surgeon due to her symptoms of Carpel Tunnel.
4 Q And, Doctor, how does she have pain after you fused
5 her?
6 A Most of the complaints after the surgery have been
7 about over the last several visits numbness and tingling in her
8 hand. She complained of neck stiffness, no arm pain.
9 Q That is after you took the discs off the cord, correct?
10 A Correct.
11 Q Mr. Nelson is a fine lawyer, got up here in front of
12 this jury during his opening statement and blamed Suzanne
13 Kusulas for the need for the second surgery. Do you have an
14 opinion within a reasonable degree of medical certainty what the
15 reason for the second surgery was?
16 A Suzanne Kusulas' second surgery was a result of two
17 facts. One, the nonunion, and number two, we saw that
18 herniation and degeneration below the original fusion. Anyone
19 whether they smoke or don't smoke has a risk of developing a
20 nonunion or lack of fusion. The more levels you do the more
21 that risk goes up. You have a one-level fusion that risks four,
22 five percent, a two-level fusion it is 15 percent, a three-level
23 fusion it jumps up 30, 40 percent. It is not nothing, it is
24 significant. The nicotine uses increases that risk. Not with
25 the one level, but with the two, three and four-level fusion.

1 There were two reasons why we went back on Mrs. Kusulas. One is
2 the nonunion and then we extended the fusion down because of the
3 new herniation and advanced degeneration below the fusion.
4 Q Doctor, throughout the course of treating Miss Kusulas
5 in your records I see you prescribed things like Percocet,
6 correct?
7 A Yes.
8 Q What does Percocet do?
9 A It is a pain medication.
10 Q I see you prescribe physical therapy. Is that
11 something you would prescribe for a patient who is like Mrs.
12 Kusulas with multi level disc herniations and surgery?
13 A Yes.
14 Q I also note in your records, Doctor, you were very
15 diligent by telling Miss Kusulas you need to stop smoking,
16 correct?
17 A Yes, we try to give everybody the maximum best chance
18 of having success, that is why we do what we do. We want to
19 make you go from no pain -- having pain to no pain and give you
20 everything we possibly can to maximum that probability.
21 Q And, Doctor, just so we are a hundred percent clear, if
22 Miss Kusulas was not involved in this car accident and she
23 continued smoking would she need to have surgery?
24 A No.
25 Q If she was not involved in this car accident would she

1 need surgery two?

2 A What.

3 Q If she was not involved in a car accident would she

4 need surgery two?

5 A No.

6 Q Whether she smoked or didn't smoke did the adjacent

7 level of degenerative changes or the pathology, the disc

8 herniation, did it have anything to do with her smoking?

9 A No.

10 Q As you sit here now, let's look to the future, she is

11 46 years of age. What is going to happen to the levels above

12 and the level or levels below this massive fusion in your

13 opinion?

14 A So this is the world's opinion, this is what the

15 medical literature speaks. People have followed people over

16 time looking at what happens to discs above and below fusions.

17 There is a risk of about 2.9 percent per year of developing

18 degeneration above or below a fusion. We don't know how to stop

19 it. We don't know how to prevent it. We don't have that

20 technology whether it is implants or biology or injections or

21 special medications at this point to prevent that. So we are --

22 this is the known risk of anybody who has a spinal fusion in the

23 cervical spine, what those risks are and what we tell every

24 patient when they are going to have.

25 You are making a train getting rid of your arm pain and

1 the weakness or numbness you may or may not have to have a
2 fusion but the down stream risks of the fusion is you may or may
3 not develop adjacent segment degeneration at some point in your
4 life.
5 Q And in this case we know for a second she did develop
6 segment degeneration?
7 A Correct.
8 Q We know she developed it rather quickly?
9 A Correct.
10 Q You showed us it was in the 2009 MRI but not in '06?
11 A Correct.
12 Q In a period of three years from the time of the
13 accident she developed it, but in a period of one and a half
14 years from the time of the first surgery she developed that
15 adjacent segment degeneration, correct?
16 A Correct.
17 Q Doctor, is Miss Kusulas at risk for needing further
18 spinal surgeries?
19 A Yes.
20 Q And, Doctor, in terms of conservative modalities short
21 of surgery, is it fair to say someone like Miss Kusulas if she
22 has pain should have the same level of modalities before, during
23 and after your surgery?
24 A Yes.
25 Q Doctor, just tell us so we get an idea, if you had to

1 go back in for a private patient that came to you and they said,
2 Doctor, I now have a neck that looks like Miss Kusulas' neck and
3 I have developed adjacent segmental degenerative changes and I
4 need a surgery. Can you tell the jury in dollars and cents
5 surgical fees to your office, anesthesia fees as well as
6 hospital and hardware fees would be?
7 A I am not a medical economist so it would be thousands
8 and thousands of dollars.
9 Q In terms of what do you mean by thousands?
10 A Tens of thousands of dollars, 50,000, 80,000, the
11 hospital fee, the anesthesiologist, the surgeons, the therapy
12 after.
13 THE COURT: Counsel, come up a second.
14 (Whereupon, a discussion was held off the record.)
15 Q Doctor, I want you to help us just one more time with
16 talking about the fact that was caused by this accident. Is it
17 similar to like a snowball, once it starts going down hill it
18 picks up momentum and speed and size and isn't something you can
19 change or stop, arthritis? Tell us what goes on from the
20 accident going forward.
21 A I am not sure what the question is.
22 Q Doctor, the changes to Miss Kusulas' spine resulting
23 from this accident, what does that mean throughout the course of
24 her life?
25 A She had surgery, she had -- we finally obtained the

1 fusion. Her arm pain is gone. She has some Carpel Tunnel
2 syndrome in her hand. She is at risk of developing problems
3 above and below where she had her fusion and those can manifest
4 themselves as neck pain related to degeneration of the doughnut
5 above or below or manifest themselves as herniation which she
6 can get arm pain at some point or she may need further
7 treatment.
8 Q Doctor, is it fair to say that I have never called upon
9 your services as an expert in the past, correct?
10 A Yes.
11 Q And fair to say that your office is, you are being
12 compensated for your time away from your office or your
13 practice?
14 A Yes.
15 Q I want to ask you a couple of last questions. Doctor,
16 what is the difference between -- are you board certified?
17 A Yes.
18 Q Are you board certified for spinal surgery?
19 A No, only orthopedic surgery.
20 Q Doctor, what is the difference between a spinal surgeon
21 such as yourself and a general orthopedic surgeon?
22 A So spinal surgeon is someone who is either -- you go
23 to medical school, do a residency, a residency is either to
24 become a spinal surgeon or you do either an orthopedic surgery
25 or neuro surgery. And when you finish your residency you do

1 something called a fellowship. And a fellowship is a one to two
2 years where you get all of your training, not the knee
3 replacements or ligaments or hand surgery but just to practice
4 in spine surgery. You become a fellowship trained spine
5 surgeon. My practice is nothing but spine surgery. One hundred
6 percent dedicated to the taking care of patients with spine
7 problems and researching these types of problems in an academic
8 medical center.
9 Q Doctor, I want you to assume Miss Kusulas was examined
10 by the defendant's neurologist, a Dr. Salen Sobin on January 12,
11 2009. Can you assume that?
12 A Sure.
13 Q And I want you to assume that Dr. Sobin opined that she
14 has chronic cervical pain, that is after the first surgery but
15 before the second surgery. Would you agree with that?
16 A She had neck pain.
17 Q Doctor, I want you to assume that the same doctor in
18 August of 2010 reexamined her, that is after both of your
19 surgeries, correct?
20 A Yes.
21 Q And this time this doctor says that she has normal
22 range of motion of her cervical spine. Is that -- do you have
23 an opinion within a reasonable degree of medical certainty
24 whether or not that opinion is valid?
25 A It is physiologically impossible.

1 Q I want you to assume that the defendants had Miss
2 Kusulas examined by Allen Zimmerman, a regular orthopedic
3 surgeon.
4 A Yes.
5 Q That examination took place August 5, 2010 after both
6 of your spine surgeries. Can you assume that?
7 A Yes.
8 Q And once again with the exception of extension which he
9 gives us 35 degrees normal being 45 to 60, all of the
10 plaintiff's range of motion were normal. Do you have an opinion
11 as to a reasonable degree of medical certainty whether or not
12 that is accurate?
13 A It is not accurate.
14 Q Why?
15 A Because she has two titanium rods spanning form C-4 to
16 C-7 and a cervical plate. Range of motion -- what contracts to
17 range of motion in that, she has three segments that are no
18 longer contracting so it is not physiologically possible to have
19 that.
20 Q Lastly that same doctor, the general orthopedic surgeon
21 has a diagnosis of surgical injury post surgery resolved.
22 A I am not familiar with any of those terminologies,
23 those are nebulous terms and don't reflect a diagnosis of any
24 kind.
25 MR. BLOCK: Thank you very much. I have no further

1 questions.

2 MR. NELSON: Judge, can we step up.

3 THE COURT: Come up.

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

5 THE COURT: Ladies and gentlemen, we will take a

6 believe recess. Don't discuss the case.

7 (Whereupon, the jury exited the courtroom.)

8 (Whereupon, a brief recess is taken.)

9 THE CLERK: All jurors present.

10 Doctor, you are still under oath.

11 CROSS-EXAMINATION BY

12 MR. NELSON:

13 Q Good morning, Doctor.

14 A Good morning.

15 Q Doctor, you mentioned earlier that people who have

16 surgery like this are at risk for future complications.

17 A Yes.

18 Q Not everyone who HAS this type of surgery ends up

19 having these complications, that is not a hundred percent thing,

20 is it?

21 A Yes.

22 Q Yes, it is not?

23 A Yes, it is not.

24 Q And it is not possible to tell between two different

25 individuals who is going to be the one, five, ten, fifteen years

1 in the future who is going to have the complications?
2 A Correct.
3 Q So you are not claiming here today that you are
4 predicting this for this particular woman, correct, because you
5 can't tell?
6 MR. BLOCK: Objection, Your Honor. He testified
7 within a reasonable degree of medical certainty.
8 THE COURT: I will sustain that as to form. You
9 can question the doctor as to a reasonable degree of medical
10 certainty.
11 MR. NELSON: I will adopt your question.
12 Q To a reasonable degree of medical certainty, as you sit
13 here today can you tell that particular person is going to have
14 these complications?
15 A I can give her probabilities.
16 Q Within a reasonable degree?
17 A With a reason degree of certainty she has a 2.9 percent
18 year risk system at degeneration, that is what the world's
19 literature speaks.
20 Q My question is this: Doctor, can you say within a
21 reasonable degree of medical certainty that these are going to
22 be the one that has the complications, not 2.9, reasonable
23 degree as to her?
24 A I don't understand the question.
25 MR. BLOCK: Objection, Judge.

1 THE COURT: Move on to something else.
2 Q The hand problems you discussed earlier, that is not
3 related to the neck?
4 A No.
5 Q It is a Carpel Tunnel problem, correct?
6 A Yes.
7 Q Yes, it is not related?
8 A Yes, it is not related to the neck.
9 Q Thank you. Doctor, what future monitoring is this lady
10 going to require?
11 A She will need periodic evaluations from physicians to
12 treat her ongoing symptoms.
13 Q Okay. How many of those evaluations -- withdrawn.
14 By what specialties?
15 A It could be various specialties, it could be evaluating
16 and treating her at this point.
17 Q Let's take on a yearly basis. How many evaluations is
18 she going to require in a year?
19 A It depends how bad her symptoms are.
20 Q As you are sitting here right now you can't tell me in
21 the future for her lifetime she will need X evaluations a year?
22 A No.
23 Q How about other modalities of treatment, can you tell
24 me? Is she going to need injections?
25 A Possibly.

1 Q Not possibly, Doctor, with a reasonable degree of
2 medical certainty as you sit in that chair now can you tell me
3 if she is going to need injections for the rest of her life?
4 A My answer is the same, I am a physician, not a -- I
5 don't have a crystal ball, I can only estimate based upon the
6 experiences of the world's literature and my practice what
7 happens with people who have this problem. So with a reasonable
8 degree of medical certainty there is a significant probability
9 that she is going to need follow-up care and treatment.
10 Q Specifically with respect to injections, can you tell
11 me how many in a year she is --
12 A It is going to depend on what her clinical symptoms and
13 complaints are during that time.
14 Q Can we agree that right now you can't tell me in five
15 years how many injections she is going to need that year? If
16 you don't know her symptoms five years from now you can't tell
17 me?
18 A I don't know.
19 Q Okay. Is she going to need physical therapy in the
20 future?
21 A It is a very high probability.
22 Q Let's go back once again. You are sitting in a chair
23 now and let's go five years into the future. From where you sit
24 right now can you tell me within a reasonable degree of medical
25 certainty that she is going to need physical therapy five years

1 from now?

2 A I think it is more than likely.

3 Q With a reasonable degree of medical certainty?

4 A Yes.

5 MR. BLOCK: Objection.

6 THE COURT: He is testifying with a reasonable

7 degree of medical certainty it is more than likely.

8 Q Five years from now, Doctor, as you sit there how many

9 physical therapy visits a year is she going to need?

10 MR. BLOCK: He is not a physiatrist, he is a spine

11 surgeon.

12 THE COURT: Are you able to answer that question,

13 Doctor?

14 THE WITNESS: No.

15 THE COURT: No? Thank you.

16 Q Doctor, would physical therapy be one of the modalities

17 that would treat a person postsurgically in a situation like

18 this?

19 A Yes.

20 Q But you can't tell me if she is going to need the

21 physical therapy five years from now?

22 MR. BLOCK: Judge, four times asked and answered.

23 THE COURT: I will sustain the objection.

24 Q Doctor, you are aware of the phrase disc desiccation?

25 A Yes.

1 Q And disc desiccation is where a disc starts to dry out,
2 starts to lose its moisture contact?
3 A Yes.
4 Q Has it been demonstrated by studies that cigarette
5 smoking increases disc desiccation?
6 A Yes.
7 Q So your statement earlier to the effect that the
8 smoking had absolutely nothing to do with the desiccation of
9 that disc was not entirely accurate if she was smoking at the
10 time?
11 A Nicotine does not lead to the rapid desiccation of a
12 disc, it leads to over many, or a prolonged period of time, so
13 it is a variable that is not good for a disc. However in the
14 with the rapidity of what she developed degeneration below her
15 fusion that is very unlikely to be the source of that problem.
16 Q Is 15 years a long period of time?
17 A I have an MRI from 2006. Whatever the first MRI is
18 that shows a relatively healthy disc, then I have an MRI from
19 before her second surgery that she is having rapid progression
20 of her degeneration and herniation. Not only did she have
21 degeneration, she also had a disc herniation at that level.
22 Q Doctor, is the method you used in your surgery called
23 allograft?
24 A Yes.
25 Q Is there a method known as autograft?

1 A Yes.

2 Q With respect to the allograft method, which is the one
3 that you used, would you agree with me that good medical
4 practice is that you don't even use that particular technique
5 with a person who smokes?

6 A With someone we believe --

7 MR. BLOCK: Judge, I have an objection. Unless I
8 am hearing that there is a dispersion being made and a claim
9 being made against this doctor for medical malpractice, what
10 in the world is he asking this question for.

11 MR. NELSON: Judge, can we step up?

12 THE COURT: I will allow it right now, this is
13 cross. But let's get to the point.

14 Do you understand the question.

15 Q I didn't hear your answer.

16 A You are answering --

17 THE COURT: I don't believe there was an answer.
18 You can answer the question.

19 A With someone who we believe is going to stop smoking as
20 a result of the surgery, which we thought Mrs. Kusulas was, we
21 had this conversation autograft versus allograft we thought she
22 would stop smoking as a result of the surgery. We were
23 confident as many patients who have surgery would stop smoking.
24 We elected to use allograft. The difference between autograft
25 and allograft even -- whether you use autograft or allograft

1 there is a risk of nonunion and once you get one level, two
2 levels, three levels or four levels.
3 Q Doctor, would you agree with me that the, that the
4 allograft method, which is the one you used, is so greatly
5 affected by cigarette smoking that if a person told you I am not
6 going to quit smoking it would be bad medical practice to do
7 that?
8 A For a one-level fusion the differences have been shown
9 to be the same. For a two-level fusion --
10 MR. BLOCK: Can we let the doctor finish his
11 answer?
12 THE COURT: Let him finish.
13 A For a two-level fusion if we were a hundred percent
14 convinced someone was going to continue smoking I would not
15 offered Mrs. Kusulas allograft. We were pretty confident she
16 was going to be off of the nicotine. And early in the post
17 operative she wasn't and resumed smoking. When we talked with
18 her prior to surgery, even on the morning of surgery that we
19 were pretty confident she was going to stop smoking.
20 Q I want to read something, Doctor, and this is contained
21 within Exhibit 14 in evidence which is your notes as received by
22 the court system. I want to know if you recognize these words.
23 "Mrs. Kusulas has been a three pack a day smoker who has weaned
24 down to several cigarettes a day --
25 A Which page are you reading from?

1 Q I am reading from --

2 MR. NELSON: Judge, can this be handed up to the

3 witness so he can see what it is?

4 THE COURT: For the record which exhibit are you

5 reading from, counsel, Plaintiff's Exhibit number?

6 MR. NELSON: 14.

7 A I have it. Go ahead.

8 THE COURT: The doctor has it. It is on the

9 operative report from the first surgery.

10 Q -- who has been weaned down to several cigarettes a day

11 is currently off of nicotine. We have worked with her over

12 this. We discussed with her the pros and cons of autograft

13 versus allograft. We had an extensive discussion with her

14 preoperatively regarding the need to use autograft versus

15 allograft depending upon her smoking status. She strongly

16 understands that she will have a higher risk of nonunion if we

17 use allograft if she continues to smoke. She assures us she

18 will not smoke and smoking in light of her need for surgery and

19 the adverse effects of nicotine on a fusion. She understands

20 this and she strongly prefers to use autograft. I explained to

21 her that we would only use if she continued to stop smoking and

22 she agrees and consents to this."

23 Are those your words, Doctor?

24 A Yes.

25 Q Doctor, do you have in your records your report of

1 September 12th of 2007?
2 A Yes.
3 Q Turning to the third page about seven lines up from the
4 bottom. "In the mean time Dr. Hecht did have a frank discussion
5 with her that surgery with regards to fusion will not have a
6 significant success rate which she is continued smoking one and
7 a half packs of cigarettes a day."
8 Are those your words?
9 A These are in my notes, yes.
10 Q You prescribed Chantix?
11 A Yes.
12 Q Is that a medication to help a person stop smoking?
13 A Yes.
14 Q Do you have your report of October 10, 2007?
15 A Yes.
16 Q At the bottom of the first page the section entitled
17 plan: "At this point in time Mrs. Kusulas is going to have
18 surgery. She will be undergoing a C-4,5 and C-5,6 anterior
19 cervical surgery with allograft or autograft, an
20 instrumentation. I discussed with her the need to get off
21 nicotine. She is making straight drives. We will do her
22 medical clearance at Mount Sinai at her request. In addition it
23 was explained to her if she continues to smoke she will most
24 likely need an anterior, posterior spinal fusion. She
25 understands this."

1 Are those your words, Doctor?
2 A Yes.
3 Q And that anterior spinal fusion that she will most
4 likely need if she continues to smoke, that is the second
5 operation you performed on her, right?
6 A This is prior to the first operation this note.
7 Q The anterior, posterior spinal fusion that you are
8 saying in this report she is most likely going to need if she
9 continues to smoke, that is the second surgery that you
10 ultimately performed?
11 A We did a posterior surgery the second time.
12 Q Now, Doctor, when you keep medical records it is
13 important that they be complete and accurate, correct?
14 A Yes.
15 Q And that is for a variety of reasons, one of them among
16 many is that physicians sometimes get sued and the complete
17 records to document what occurred?
18 A My records are kept accurate to help take care of
19 patients period.
20 Q The next reason is because it is good for patient care,
21 correct?
22 A No, number one, the number three reasons for the
23 records are automatically related to taking care of patients.
24 Q Okay. And that is your practice, correct?
25 A Yes.

1 Q And they are accurate and complete?

2 A To the best of my knowledge.

3 Q And if something significant occurs between you and a

4 patient relative to their treatment and their recuperation you

5 make sure it is in the records, right?

6 A Yes.

7 Q Okay. In your record of October 7, 2007, the one we

8 just talked about.

9 A October 10, 2007?

10 Q Yes.

11 A Yes.

12 Q Is there any indication that Mrs. Kusulas asked to

13 discuss with you methods of quitting smoking?

14 A I don't know what you are asking.

15 Q Do you have anything your notes that indicates that

16 Mrs. Kusulas said to you, Doctor, I need to talk about various

17 ways that I can quit smoking?

18 A I am a spinal surgeon so I am not sure what you are

19 asking. She said she cut back her smoking from a pack and a

20 half to half pack a day and she was taking Chantix.

21 Q Did you ask if hypnosis would help her?

22 A Once again I am a spinal surgeon.

23 Q Can you give me a yes or no?

24 A No, I did not discuss hypnosis with her.

25 Q Is there anything in any of your notes that you visited

1 with this lady where you had a discussion at her request to
2 discuss any way of her possibly quitting smoking, anything in
3 your notes?
4 A I think we have just been through this multiple times.
5 We tried to get her to stop smoking and actually gave her the
6 medication which had the highest degree of ethicacy to stop her
7 from smoking in order to help her to do so.
8 Q Subsequent to you finding out despite you gave her that
9 medication with a high degree of ethicacy she continued to
10 smoke. Was there any conversation with you or her with further
11 efforts, anything in your records to that effect?
12 A No.
13 Q Your report of January 28, 2008?
14 A Yes.
15 Q In the history section, "she does note that she has
16 been smoking intermittently over the last several months' time,
17 had a two, three-week period of consistent smoking. Over the
18 last few weeks she stopped again."
19 Are those your words?
20 A Everything that is in my notes are my words.
21 Q "We have offered her repeat prescription for Chantix
22 which she has declined." That is the medicine you were talking
23 about before, correct?
24 A Yes.
25 Q "She feels she is not going to be smoking anymore."

1 Do you have your report of 2/25/2008 which is the next
2 visit right after the one we just discussed?
3 A Yes.
4 Q In the history section, "she continues to
5 intermittently smoke. She has over the last one week's time she
6 cut back significantly, however, I could smell the nicotine on
7 her today."
8 Is that an accurate record made by you?
9 A Yes.
10 Q Going to, Doctor, the same report of February 25, 2008,
11 first sentence, "I explained to her again in detail that if she
12 continues to use nicotine she will never heal this fusion."
13 Did you do that, did you tell her that?
14 A Everything in this note, yes, is my words and I told
15 her.
16 Q Do you have a report of March 24, 2008?
17 A Yes.
18 Q In the plan section, "in addition she has assured me
19 she has finally stopped smoking. I explained to her this is
20 five months post operatively. This may be too little too late
21 and she might depending on the status of her fusion may require
22 a posterior fusion if she fails to fuse."
23 Those are your words, correct?
24 A Yes.
25 Q Now, Doctor, relative to the second surgery, looking at

1 your notes as Mrs. Kusulas in between the second surgery, had
2 she stopped smoking?
3 A She told me she stopped smoking.
4 Q And to the extent that your records reflect it, can you
5 tell if after the surgery she continued to stay off nicotine?
6 A To the best of our knowledge.
7 Q And the second operation that she had she did achieve a
8 fusion, right?
9 A Yes.
10 Q Doctor, did you ever read the records of Dr. Brisson?
11 A No.
12 Q Those records are in evidence as Exhibit 13 and Dr.
13 Brisson has a report of April 11, 2007 where at the bottom
14 paragraph it is saying he says, "we discussed smoking cessation
15 two weeks minimum prior to surgery and six months following the
16 surgery." Would that seem reasonable to you?
17 A Yes.
18 Q Doctor, when was the last time you saw Miss Kusulas?
19 A December 19, 2011.
20 Q As of that time, how was she? What did you write?
21 A Doing well and mostly she had been complaining on and
22 off symptoms of numbness in her hand and she always complained
23 of a little stiffness in her neck.
24 Q As of that visit, the last one that you saw her, and
25 those were complaints you examined her on too?

1 A Yes.

2 Q Based upon your examination and her complaints at that

3 last visit, was she a patient who was unable to run?

4 A We didn't have her run in the office.

5 Q You would have to have her run, Doctor, in order -- you

6 can't tell --

7 A We didn't ask her --

8 Q My question is your examination, Doctor --

9 A It is not something we routinely whether the patient is

10 able to run.

11 Q Doctor, my question is from your examination did you

12 see anything that would prevent her from running?

13 A No.

14 Q Did you see anything that would prevent her from

15 skiing?

16 A Yes.

17 Q Did you see anything that would prevent her from riding

18 a bicycle?

19 A Possibly.

20 MR. NELSON: I have no more questions, Your Honor.

21 MR. BLOCK: I have just a few.

22 RE-DIRECT EXAMINATION BY

23 MR. BLOCK:

24 Q Doctor, are you a hypnotist?

25 A No.

1 Q Can you tell the jury why it is that you didn't
2 hypnotize or discuss hypnotic therapy with Mrs. Kusulas?
3 A I am not familiar with clinical effects getting someone
4 to stop smoking. We tried to give her her best chance of
5 getting off of nicotine.
6 Q When you went to Harvard Medical School and did your
7 clinics at Boston, they didn't teach you hypnotics?
8 A No.
9 Q Did you prescribe the Chantix to Miss Kusulas?
10 A Yes.
11 Q Did she take it?
12 A Yes.
13 Q Did she make straight drives to trying to stop smoking?
14 A That was supposed to be significant strides, but, yes.
15 Q Significant strides?
16 A Yes.
17 Q Want to make sure we are clear.
18 Counsel asked you a question about 15 years and you
19 answered there was a date on the first MRI and there was
20 significant adjacent segmental degenerative changes and disc
21 herniation. My question to you is between April of 2006 and
22 April of 2009 how many years is that.
23 A Three.
24 Q Just so we are a hundred percent clear, Doctor, because
25 it sounds like a whole lot is now Mrs. Kusulas's fault. She was

1 a habitual smoker?

2 MR. NELSON: Objection.

3 THE COURT: I will sustain that.

4 MR. BLOCK: May I ask a question?

5 THE COURT: Rephrase.

6 Q Doctor, the fact that Ms. Kusulas was a habitual smoker

7 for 15 years before the accident and attempted tod wean herself

8 off of nicotine, did that cause the need for the second surgery?

9 A No.

10 Q Did that cause the need in and of itself for the second

11 surgery?

12 A The nicotine increases the likelihood of developing a

13 nonunion which is present in all of us whether we smoke or don't

14 smoke, but she also developed adjacent segmental disc herniation

15 and degeneration as a result of the first surgery.

16 Q We do know she is one of the people that did develop

17 the segmental --

18 A Yes.

19 Q The goal of the first surgery was to obviously create a

20 solid bone structure --

21 MR. NELSON: Object.

22 THE COURT: I will sustain it as to form.

23 Q The goal, if she fused in the first surgery?

24 A Yes.

25 Q Right?

1 A Yes.
2 Q Would she be in the same situation she is in now? She
3 now has a solid fusion, correct?
4 A She has a solid fusion.
5 Q She still has pain?
6 A I haven't seen her since December.
7 Q If she came up and testified that she was taking
8 Percocets, pain patches and she needs pain medications,
9 indications of pain?
10 A Those are indications of pain.
11 Q And with or without the second surgery she would still
12 be in the same condition she is in now, correct?
13 A Possibly.
14 MR. BLOCK: Thank you.
15 THE COURT: Anything?
16 MR. NELSON: No, Judge.
17 THE COURT: Thank you, Doctor. You can step down.
18 (Whereupon, the witness exited the courtroom.)
19 THE COURT: Mr. Block, call your next witness.
20 MR. BLOCK: Sure, I call Suzanne Kusulas.
21 (Whereupon, the witness is sworn in by the clerk of
22 the court.)
23 THE CLERK: Give your name and address for the
24 record.
25 THE WITNESS: Suzanne Kusulas, K-U-S-U-L-A-S, 135