SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

----------X

BRIAN L. DURLACH,

PLAINTIFF,

-against-

Index No.
0602430/2016

THOMAS F. SCHADE,

DEFENDANT.

----------X

DATE: September 13, 2021
TIME: 2:07 p.m.

VIDEOTAPED DEPOSITION of a Non-Party Expert Witness, ALEXANDRE de MOURA, M.D., taken by the Respective parties, held at the offices of New York Spine Institute, 761 Merrick Avenue, Westbury, New York 11590, before Francine Delfino, a Notary Public of the State of New York.

A P P E A R A N C E S:

LAW OFFICE OF GREGORY A. GOODMAN, P.C.
Attorney for the Plaintiff
- BRIAN L. DURLACH -
380 N. Broadway, Suite 305
Jericho, New York 11753
BY: JASON TENENBAUM, ESQ.
BY: GREGORY A. GOODMAN, ESQ.

SCAHILL LAW GROUP
Attorneys for the Defendant
- THOMAS F. SCHADE -
1065 Stewart Avenue, Suite 210
Bethpage, New York 11714
BY: FRANCIS J. SCAHILL, ESQ.

ALSO PRESENT: Brian Durlach

Marco Sozio, Videographer
MARK DAVID VIDEO PRODUCTIONS

* * *

221. UNIFORM RULES FOR THE CONDUCT OF DEPOSITIONS

221.1 Objections at Depositions

(a) Objections in general. No objections shall be made at a deposition except those which, pursuant to subdivision (b), (c) or (d) of Rule 3115 of the Civil Practice Law and Rules, would be waived if not interposed, and except in compliance with subdivision (e) of such rule. All objections made at a deposition shall be noted by the officer before whom the deposition is taken, and the answer shall be given and the deposition shall proceed subject to the objections and to the right of a person to apply for appropriate relief pursuant to Article 31 of the CPLR.

(b) Speaking objections restricted. Every objection raised during a deposition shall be stated succinctly and framed so as not to suggest an answer to the deponent and, at the request of the questioning attorney, shall include a clear statement as to any defect in form or other basis of error or irregularity. Except to the extent permitted by CPLR Rule 3115 or by this rule, during the course of the examination persons in attendance shall not make statements or comments that interfere with the questioning.

221.2 Refusal to answer when objection is made. A deponent shall answer all questions at a deposition, except (i) to preserve a privilege or right of confidentiality, (ii) to enforce a limitation set forth in an order of the court, or (iii) when the question is plainly improper and would, if answered, cause significant prejudice to any person. An attorney shall not direct a deponent not to answer except as provided in CPLR Rule 3115 or this subdivision. Any refusal to answer or direction not to answer shall be accompanied by a succinct and clear statement of the basis therefor. If the deponent does not answer a question, the examining party shall have the right to complete the remainder of the deposition.

221. UNIFORM RULES FOR THE CONDUCT OF DEPOSITIONS

221.3 Communication with the deponent

An attorney shall not interrupt the deposition for the purpose of communicating with the deponent unless all parties consent or the communication is made for the purpose of determining whether the question should not be answered on the grounds set forth in section 221.2 of these rules and, in such event, the reason for the communication shall be stated for the record succinctly and clearly.

IT IS FURTHER STIPULATED AND AGREED that the transcript may be signed before any Notary Public with the same force and effect as if signed before a clerk or a Judge of the court.

IT IS FURTHER STIPULATED AND AGREED that the examination before trial may be utilized for all purposes as provided by the CPLR.

IT IS FURTHER STIPULATED AND AGREED that all rights provided to all parties by the CPLR cannot be deemed waived and the appropriate sections of the CPLR shall be controlling with respect hereto.

IT IS FURTHER STIPULATED AND AGREED by and between the attorneys for the respective parties hereto that a copy of this examination shall be furnished, without charge, to the attorneys representing the witness testifying herein.

A. De MOURA, M.D.

THE VIDEOGRAPHER: Good afternoon, we are going on the record at 2:07 p.m. on September 13, 2021. Please note that the microphones are sensitive and may pick up whispering, private conversation and cellular interference. Please turn off all cell phones or place them away from the microphones as they do interfere with the deposition audio. Audio and video recording will continue to take place unless all parties agree to go off the record. This is Media Unit 1, the video recorded deposition of Dr. Alexandre de Moura, taken by counsel for the Plaintiff in the matter of Durlach, Brian L. versus Schade, Thomas F, filed in the New York State Supreme Court, Suffolk County, index number 0602430/2016. This deposition is being held at the New York Spine Institute, Dr. Alexandre de Moura's office, 761 Merrick Avenue, Westbury, New York

A. De MOURA, M.D.

11590. My name is Marco Sozio from the firm Veritext and I am the videographer. The court reporter is Francine Delfino from the firm Veritext New York. I am not authorized to administer an oath, I am not related to any party in this action, nor am I financially interested in the outcome. Counsel will now state their appearances and affiliations for the record. If there are any objections to the proceeding please state them at the time of your appearance beginning with the noticing attorney.

MR. GOODMAN: Good afternoon, my name is Gregory Goodman from the Law Office of Gregory A. Goodman, P.C., I am the attorney for Plaintiff, Brian Durlach.

MR. TENENBAUM: Good afternoon, my name is Jason Tenenbaum with the Law Office of Gregory A. Goodman, for the Plaintiff Brian Durlach.

A. De MOURA, M.D.

MR. SCAHILL: For the Defendant, Frank Scahill, Scahill Law Group.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

ALEXANDRE de MOURA, M.D., called as a witness, having been first duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

DIRECT EXAMINATION BY

MR. TENENBAUM:

Q. Please state your name for the record.

A. Alexandre de Moura.

Q. What is your address?

A. 761 Merrick Avenue, Westbury, New York 11590.

MR. TENENBAUM: Before we start I want to note for the record that my client Brian Durlach is present and sitting to my right.

Q. Good afternoon, Doctor. My

A. De MOURA, M.D.

name is Jason Tenenbaum, I represent Brian Durlach with respect to a personal injury matter that has been brought against Thomas Schade. I'm sure you have sat through depositions before, just a couple rules I have to put on the record. First please wait until I finish my question before you answer, okay?

A. Okay.

Q. Second keep your voice up so the court reporter can take down what you say and the videographer can videotape what you are saying, okay?

A. Okay.

Q. If you don't understand any question I'm asking for any reason whatsoever just let me know and I will rephrase the question as many times as possible until you understand what it is I'm asking, okay?

A. Okay.

Q. Need a break at any point just let us know, you just have to answer the question before we take a break, all right?

A. De MOURA, M.D.

A. Okay.

Q. Doctor, are you duly licensed in the State of New York to practice medicine?

A. Yes, I am, since 1996.

Q. What's your specialty, Doctor?

A. Spine surgery.

Q. Where are you currently employed?

A. Self-employed, Director of New York Spine Institute.

Q. How long have you been the Director of New York Spine Institute?

A. Greater than ten years.

Q. Before your position as the Director of New York Spine Institute where were you?

A. I was in private practice.

Q. From when? When did you begin private practice?

A. I believe in 1996.

Q. Doctor, where did you go to undergrad?

A. I went to George Washington

A. De MOURA, M.D.

University in Washington D.C., I subsequently went to medical school at the Chicago Medical School in Chicago, I performed my orthopedic residency at Temple University in Philadelphia, and I performed my spine fellowship in orthopedic neurological spinal surgery at NYU.

Q. Doctor, when did you graduate undergrad?

A. 1984.

Q. When did you finish medical school?

A. 1990.

Q. You indicated you are Board Certified, correct?

A. That's correct.

Q. What are you Board Certified in?

A. Orthopedic surgery.

Q. When did receive your Board Certification, Doctor?

A. I believe on or about 1997.

Q. For the jury can you tell us what a Board Certification is?

A. De MOURA, M.D.

A. Once you go to medical school you then subsequently pick a specialty, I chose orthopedic surgery, which is surgery of the bones and muscle of the body. You go through one year general surgery training followed by four years of orthopedic residency. Basically you are an apprentice, you're learning how to become an orthopedic surgeon and then I did one year of specialization in the spine from the neck to the low back. And once you finish your residency you take part one of your Board. The Board is a written examination where you answer multiple choice questions to verify you have the book knowledge of what you learned. Subsequent to that you take part two, which approximately two years later after you have been in practice, you have been treating patients on your own, these are now your own patients, and you comprise a list of approximately twenty surgeries that you have performed you submit them to the Board in Chicago, the American Board of

A. De MOURA, M.D.

Orthopedic Surgery, you travel to Chicago where you have approximately four to six other surgeons that are your peers, they will ask you any question they want on the cases you have presented to them and you will justify the reasoning, the way you did it and the outcome of the surgery that you performed. If they feel you are competent and you are performing surgery to a National standard they then will pass you and you now become Board Certified. Every ten years recertification process takes place, I passed the Board three times.

Q. Doctor, you mentioned previously that you had a fellowship, I believe, at NYU?

A. That's correct.

Q. Can you tell the jury what a fellowship is?

A. Well, as I stated, the fellowship is one added year following orthopedic residency, so to recap you do four years of college, you do four years of medical school, you do five years of

orthopedic training and then you do one added year of spine surgery, now you should be an expert in what you are doing and I chose to specialize in spine surgery.

Q. Doctor, are you involved with any research?

A. Yes, as I said I am the Director of New York Spine Institute, we have a robust research department headed by Dr. Peter Passias. I am an assistant clinical professor of orthopedic surgery at NYU School of Medicine.

Q. How long have you been an assistant clinical professor of NYU School of Medicine?

A. I think since 2000.

Q. Do you have any current hospital affiliations, Doctor?

A. Yes, I'm affiliated with NYU Langone Medical Center, I'm the Chief of Orthopedic Surgery at Mercy Medical Center and the Catholic Health System. I have privileges at Mercy, St. Francis, NYU and Hudson Regional in New Jersey.

A. De MOURA, M.D.

Q. Doctor, do you have any licenses to practice medicine?

A. I'm licensed to practice medicine in the State of New York, New Jersey and Florida.

Q. Doctor, do you have experience with disk issues?

A. Yes.

Q. Can you tell us what your experience is?

A. With disk issues?

Q. Yes. Do you want me to rephrase the question?

A. That's kind of broad-ended.

Q. Do you have any experience with treating herniations and bulges?

A. Yes.

Q. Can you tell us what your experience is?

A. My experience is that I'm a surgeon, people usually present to me when they've had failure of treating their neck or back issues either through physical therapy, pain management, things of that

A. De MOURA, M.D.

nature, they then present to me to find out if surgery is a possibility. I would say the majority of patients that I treat don't require surgery. The small amount that ultimately require surgery, I will determine what type of procedure is recommended. So I have an extensive history of treating and helping people that have disk herniations throughout the spine.

Q. What's the percentage of patients that see you that undergo any type of surgical procedure, Doctor?

A. I would say about five percent.

Q. So out of every one hundred patients you see only five undergo a surgical procedure?

A. That's correct.

Q. Doctor, if you were not present here testifying what would you be doing?

A. I would either be in surgery or seeing patients in the office.

Q. Doctor, what's the difference between a clinician and a hired witness? Do you understand the question?

A. De MOURA, M.D.

A. Well, I'm a clinician so I can state that I'm a person who treats patients, I'm actively treating patients that have problems with the spine and that's what a clinician is.

Q. Doctor, prior to today have you ever met myself or Mr. Goodman?

A. No.

Q. What are some things you do outside of the practice of medicine?

A. Can you be more specific?

Q. Well, you indicated -- what I wanted to know is can you tell us some of the research that you do outside of when you're being a clinician?

A. I've done research regarding the lumbar spine, different treatments for different ailments, and that's in my CV.

Q. Doctor, has a court of competent jurisdiction ever deemed you an expert in the field of orthopedics?

A. I believe so.

Q. To be a little more specific, have New York State courts deemed you an

expert?

A. I believe so.

Q. How about Federal courts within the State of New York, have they deemed you an expert?

A. Yes.

Q. Can you approximate ballpark figure how many times you have been deemed an expert by either a New York court or Federal court?

A. I don't recall. I don't keep track.

Q. Doctor, you treat patients that have been involved in motor vehicle accidents, correct?

A. That's one facet of my practice.

Q. What's the percentage of patients that you treat who are involved in motor vehicle accidents?

A. I don't keep track but I think approximately thirty percent are patients that have been involved in motor vehicle accidents, another thirty percent in work-

A. De MOURA, M.D.

type injuries, and thirty percent living their normal lives that are patient referrals.

Q. Doctor, have you ever treated patients who have had injuries to their spinal cord?

A. Yes.

Q. Have you treated patients who have had what we previously discussed as herniations?

A. Yes.

Q. And you have treated patients who have suffered bulges?

A. Yes.

Q. And you performed surgeries on the spine, correct?

A. Correct.

Q. Doctor, in the last year how many spinal surgeries have you performed?

A. For 2020?

Q. Yes, year 2020.

A. Anywhere -- 300, about 300 surgeries I think.

Q. How about in the last five

A. De MOURA, M.D.

years, approximately how many spinal surgeries have you performed, Doctor?

A. It would be that times five.

Q. About fifteen hundred?

A. Yes.

Q. Doctor, what's the difference between a general orthopedist and an orthopedic surgeon?

A. They're one in the same.

Q. Are there orthopedists that don't perform surgery, Doctor?

A. That's possible.

Q. Doctor, before we discuss the facts of this actual case will you promise us that all the opinions that you give us will be within a reasonable degree of medical certainty?

A. Yes.

Q. Are you aware of a patient, the gentleman sitting to my right, named Brian Durlach?

A. Yes.

Q. Doctor, you have your notes with you today?

A. De MOURA, M.D.

A. Yes.

Q. When did you first become acquainted with Brian?

A. The patient was initially seen in my office on June 12, 2017.

Q. Approximately how many times have you seen Brian?

A. He has been seen approximately eight times in the office. He was seen by my approximately four times.

Q. What is a doctor-patient relationship?

A. Relationship that's developed when the patient comes to you for help, you give the patient advice as to how you can treat him and that in and of itself develops a relationship.

Q. Is there any significant regarding a doctor-patient relationship?

A. It's significant because I'm actually treating the patient, I'm hearing firsthand what ails him, what types of symptoms he's having, I'm able to examine him, find out deeper regarding how his body

A. De MOURA, M.D.

is reacting to his injury, reviewing his records, studies, et cetera.

Q. Do you have a doctor-patient relationship with Brian?

A. Yes, I do.

Q. By the way, does a defense examiner in the course of litigation have a doctor-patient relationship with a patient?

MR. SCAHILL: Objection.

MR. TENENBAUM: You can answer.

A. Whether they develop a relationship I can't attest to that, but it would be -- it would seem to me that it would be a fleeting point in time where that doctor has encountered the patient.

Q. Doctor, besides your own records did you review anything else prior to your testimony today?

A. I reviewed medical records from my database along with MRI reports that the patient has undergone since the injury.

Q. Doctor, in the course of your treatment of Brian, New York Spine Institute actually took MRIs of Brian,

A. De MOURA, M.D.

correct?

A. I believe so.

Q. And you yourself actually read the MRI films, correct?

A. Yes, I read the films.

Q. Doctor, what services did you perform upon Brian?

A. Well, I'm a spinal surgeon and I saw the patient for the first time back in June of 2017, subsequently returned to my office multiple occasions, ultimately I did recommend spinal surgery to the lumbar spine, I also referred to him my associate Dr. Peter Passias who would be treating him if he decides to undergo surgery.

Q. Doctor, prior to going through your treatment notes we want to discuss basic anatomy here, can you tell the jury what a vertebrae is?

A. The spine is broken up into three major sections, the neck, which is the cervical spine, the mid portion, which is the thoracic spine where the rib cage is attached to, and the lumbar spine, which

makes the lower back, and then also the sacral and coccyx which comprise the tailbone. The vertebrae are little bony segments that makeup the spine, and they are segments because if it was one piece of bone you would have a very stiff spine and would have decreased motion. So from an evolutionary standpoint we have developed vertebrae that support the skeleton and in and of it itself also protects the neuro elements which originate from the brain and send signals to the spinal cord and nerves throughout the body.

Q. Can you tell the jury what a disk is?

A. The disk is a little segment, a shock absorber between the vertebrae that allows the vertebrae to move. We can see here, for example, this vertebral segment here, which this moves, that's what the disk allows the spine to do. These cubes are the vertebrae themselves and the disk, as I said, allows motion. But this is also a soft structure. I can give you an

A. De MOURA, M.D.

analogy of a jelly donut. If you go to Dunkin' Donuts and buy a jelly donut you know if you squeeze it jelly can squirt out, we call that a herniation in the human body. When that material pops out, if it's in the wrong area it can cause pain in and of itself, it can also affect the nerves in the area that can give you something called sciatica which would be pain, numbness, tingling radiating in the legs.

Q. Doctor, what is a disk bulge?

A. So a disk bulge is when the outer portion of the disk, if this is the sidewall of the disk, just imagine if we start -- imagine it's a tire and you start letting air out of the tire, the disk face starts to collapse, the wall of the disk or the tire starts to bulge, we call this a bulge.

Q. You discussed the term "herniation", can you tell us what that is specifically?

A. Herniation is when that portion of the internal area of the disk pops

through the disk like the jelly coming out of the donut, we call that a herniation.

Q. How would you differentiate between a bulge and a herniation?

A. A bulge can be considered -- for example, imagine a tire on your car, most tires are steel belted so they have steel belts that go around the perimeter of the tire, if you developed fraying of the steel belts you start developing a bubble on the tire or a blip, so I would call that a bulge, ultimately once the tire blows out, you have a blowout, that's what I would call a herniation.

Q. Doctor, can a trauma cause a bulge?

A. A trauma could cause a bulge, yes.

Q. Could a trauma cause a herniation, Doctor?

A. Yes.

Q. Could degenerative causes be related to a bulge or herniation?

A. They could.

A. De MOURA, M.D.

Q. Doctor, two of the terms may or may not use symptomatic or asymptomatic, can you define those for us?

A. Symptomatic means you're feeling something, you're feeling pain. Asymptomatic means you're not feeling anything, nothing is affecting you.

Q. Doctor, what's the process of diagnosing a disk or nerve injury?

A. Well, the best way to diagnose a disk injury is to visualize it. That can be done two ways, one is with an MRI study, that's the gold standard, to actually look inside the human body and see what the disk looks like, and the other way is to see it during surgery.

Q. Briefly, can you tell us what is a history?

A. A history is a series of events that have happened in the past and that's usually spoken from the patient to the doctor to give the doctor some information as to what the patient has experienced in the past and why he is here in the present

A. De MOURA, M.D.

seeing the doctor.

Q. And in your treatment of a patient what is the importance of a history?

A. In the patient-doctor relationship it's important to get a history from the patient as the patient is giving you information regarding what has transpired in the past.

Q. How does a history affect your examinations of a patient?

A. Well, the history allows me to focus in on certain areas of the body that the patient is complaining of pain, neurological deficit, numbness, tingling, et cetera, so that allows me to focus in as a spinal surgeon as what might be causing those symptoms.

Q. I want you to assume, doctor, that someone comes to see you after a motor vehicle accident and I want you to assume that the person is making a complaint of neck and back pain to you that have occurred after a motor vehicle accident,

A. De MOURA, M.D.

can you tell us how the examination would take place?

A. The examination would take place regarding the areas of the body that are hurting him. For example, I'm not going to be examining the patient's heart or breathing because that's not my area of specialty and that is a separate field of orthopedic surgery, for example. So I would focus in on the neck and back if the patient is having neck and back symptoms, I would focus in on his arms and legs to see if he is having affects of the nerve where he might be developing numbness, tingling or weakness. If he has normal sensation in his hands, legs or feet, if he has normal reflexes, if he has normal strength. Those are the things that you could normally assess from a musculoskeletal examination.

Q. Are you also looking for radiculopathy, Doctor?

A. Radiculopathy is just a fancy term for sciatica, or pain and numbness that travels down your arms and legs, so

A. De MOURA, M.D.

yes, that would be something important to look at to see why the patient is having these symptoms traveling in the legs to see if there's evidence of decreased sensation, weakness and if they're originating from let's say an MRI that shows where damage has occurred to the spine itself.

Q. So radiculopathies are caused by, as you just stated, damage to the spine, Doctor?

A. Yes.

Q. What are some of the tests you perform for neck and back, for neck and back suspected injury, Doctor?

A. Well, first thing is to look at the patient to see how they're standing, if they're hunched over, if they're crooked. Second you can touch the patient, see if they're painful when you touch them, see if there's evidenced spasm, something they cannot control. You can also try to assess whether they have good sensation. You can determine whether they can tell, for example, the blunt head of a safety pin

A. De MOURA, M.D.

versus a pin prick, that would give you indication as to sensation, and then you can test for muscle strength to see if there's weakness in the specific muscle groups that are affected by potential damage at those levels in the spine.

Q. Does your examination contain what we call an objective component?

A. Yes.

Q. Can you tell the jury what an objective component is?

A. Objective is something that the patient can't control, for example a muscle spasm, you can't control a muscle spasm. It's just a tense muscle in and of itself. And a subjective complaint or assessment, for example if you test muscle strength that could be a subjective component to that, for example.

Q. What's the process that you use to come up with a diagnosis?

A. It's a compilation of putting all the pieces together, what the patient has endured in the accident, how he has

A. De MOURA, M.D.

been treated, what findings I find on physical examination, what the MRIs or X-ray studies can show, putting all those pieces together can give me a clue and a better insight as to what the injury the patient has endured and is dealing with.

Q. What you just told us, Doctor, is that the standard in the community in which you practice for how an orthopedic surgeon comes up with a diagnosis?

A. Yes.

Q. Can you test, Doctor, whether complaints of symptoms are consistent with reported history?

A. Can I test for it?

Q. Yes, can you test for it.

A. As I stated, putting all the pieces together in and of itself attest that when we have these pieces come together you have a better picture in its totality as to what the patient is enduring.

Q. Doctor, you have been tasked numerous times in determining whether an

A. De MOURA, M.D.

injury is related to a traumatic event in your career, correct?

A. Correct.

Q. Can you tell us approximately how many times you have done this?

A. I don't keep track of the amount of times I've testified. I don't make a living out of testifying. I would say probably a handful a year that I would have to testify for a patient of mine that has sustained a traumatic injury and then I have to testify on their behalf.

Q. Doctor, in determining whether an injury is related to a motor vehicle accident has anyone ever suggested that you look at the actual cars involved in the accident?

MR. SCAHILL: Objection.

MR. TENENBAUM: Can you answer.

A. Yes.

Q. Doctor, how do you determine whether or not a neck or back injury is related to a motor vehicle accident?

A. Well, as I stated earlier, I

put the pieces of the puzzle together. I take into account the patient's history of the accident, how he has been treated, what the studies have shown that, for example, an MRI study that he had after the accident, how he presents to me with his clinical findings that include muscle weakness, decreased range of motion, tenderness, decreased sensation, et cetera.

Q. By the way, have you ever worked with a biomechanical engineer to determine whether a traumatic impact caused an injury?

A. Yes.

Q. Doctor, let's discuss Mr. Durlach. How did you learn of him?

A. That I don't recall. The patient came to me, as I stated, back in June of 2017.

Q. I want to discuss the initial evaluation on that date. What complaints did Brian make to you?

A. The patient presented to my office with a chief complaint of neck and

A. De MOURA, M.D.

back pain. He had cervical and lumbar radiculopathy. That's where the patient has numbness or tingling in his hands or radiating down his legs, sciatic-type symptoms.

Q. And you are aware that he was involved in an April 15, 2015 motor vehicle accident, Doctor?

A. Yes, sir.

Q. So when you first saw him it was approximately two years after the accident?

A. That's correct.

Q. You also, and I see in your report here there is a thing called "history of present illness", can you tell us what that is?

A. That's the history that patient has told me regarding his development of his symptoms from the accident of April 2015.

Q. Was there anything significant in the history of present illness that was discussed with you at that examination,

A. De MOURA, M.D.

Doctor?

A. What is significant is that he was involved in the accident on April 15, 2015. He was a driver in an automobile that was struck by another automobile. He also denied any prior motor vehicle accident history. Also of importance is he never had neck or back problems before this accident. So I believe those are all significant things to note in the history.

Q. Doctor, when you saw Brian that initial time were you presented with an MRI report?

A. Yes.

Q. Can you tell us what you learned from that, Doctor?

A. The MRI showed a disk herniation at the L-4, 5 level.

Q. At that visit that Brian had with you did he discuss with you his prior treatment, that's the treatment he had before he saw you after the accident?

A. Yes, it's my understanding that the patient had physical therapy before

A. De MOURA, M.D.

along with injections that unfortunately did not help him.

Q. Looking on the second page of your report here, Doctor, you performed what is called a neurological exam, correct?

A. Yes.

Q. Can you tell the jury what the neurological exam consists of?

A. The brain controls the body and it's connected to the body via the spinal cord and the nerves, so a neurological examination is when the doctor is trying to assess if the nerves, spinal cord and brain is functioning normally.

Q. Let's talk about your neurological exam. I see a notation for the upper extremities. Do you see that, Doctor?

A. Yes.

Q. Can you tell the jury what you found in terms of that examination?

A. The examination showed that he had some weakness in the left muscles that

A. De MOURA, M.D.

raised the wrist and also the biceps which is the arm muscle.

Q. What's the significance of that finding, Doctor?

A. That something is pinching the nerve in the neck which is causing him to have the symptoms in the upper extremity itself.

Q. Would that be consistent with a bulge, herniation or something else in the neck, Doctor?

A. Yes.

Q. You also performed a neurological exam lower extremities, do you see that?

A. Yes.

Q. Can you tell the jury what was consistent about that examination?

A. This examination also showed that he had weakness in the lower extremities regarding the ankle, he had absent reflexes and that would indicate that the nerves that travel to the lower extremities were also affected.

A. De MOURA, M.D.

Q. Would that be consistent with some type of bulge or herniation or some other issue in the vertebral column that Brian sustained, Doctor?

A. Yes.

Q. Underneath that you did an examination of the, it says, "neck and cervical spine", do you see that?

A. Yes.

Q. I will read this with you. Your first line says that Brian, who is to my right, was viewed in excessive discomfort, do you see that?

A. Yes.

Q. From your vantage point in putting together a chart what does excessive discomfort mean?

A. How the patient moves about. They might wince or have difficulty in moving in the exam room. Those are little clues that I pick up on that allow me to assess if the patient is having discomfort.

Q. Those are things you visualized during the physical examination, right,

A. De MOURA, M.D.

Doctor?

A. That's correct.

Q. Doctor, your second line indicates there was evidence of bilateral paraspinal musculature spasms, do you see that?

A. Yes.

Q. What is a spasm?

A. That's when the muscle contracts and stays contracted and that in and of itself is painful.

Q. A spasm, is that I think we previously said an objective finding?

A. That's correct. Something a patient cannot control.

Q. You determine a spasm how?

A. By touching you can feel how one side is supple and the other side is tense and rigid.

Q. Your next notation you indicated there was painful range of motion, correct?

A. Yes.

Q. Can you tell us what a painful

range of motion is?

A. As the patient goes through the motion he states that it hurts him.

Q. And then you noted tenderness to palpation, what's that, Doctor?

A. When you touch the muscle you elicit a painful response from the patient.

Q. And then you also performed range of motion studies, right? Would you call them studies, Doctor, that you performed?

A. Yes, I assess the range of motion and I know what the normal basic range of motion is, move your neck forward, back, turn and then you compare it to what the patient can do in front of you. The patient indeed did have limited range of motion.

Q. I will go through this, Doctor. Your first line indicates flexion, can you tell the jury what flexion is?

A. Flexion is when you bend your neck downwards.

Q. What is the American Medical

A. De MOURA, M.D.

Association note as normal for flexion?

A. Normal is close to about 50 degrees.

Q. And you found what?

A. About 20 degrees.

Q. Can you tell the jury what extension is?

A. When you put the neck backwards.

Q. What would the normal value for that be?

A. About 60 degrees and the patient had 10 degrees.

Q. I see a term here called "right rotation".

A. Right rotation is about 80 degrees, you turn your neck to the side, and the patient had limited motion of approximately 10 degrees, so he was very rigid throughout, and also in flexion, which is putting the neck down, in extension and rotation.

Q. So 80 is normal and you found 10 degrees, Doctor?

A. De MOURA, M.D.

A. Yes.

Q. What about right bending?

A. Once again 45 is normal, the patient exhibited about 10 degrees.

Q. Doctor, you indicated you used a goniometer when performing an examination, right?

A. Yes.

Q. Can you tell the jury what a goniometer is?

A. A goniometer is a little device we use to try to assess the motion, the range that the patient is moving his neck and we are able to quantify it with a numerical value.

Q. Doctor, you also performed a range of motion examination on the lumbar spine, correct?

A. Yes, that would prove that he was having spasms in the lower back and as a result his motion was limited. For example, bending forward to flexion is about 90 degrees normal, the patient was measured to be about 20 degrees.

A. De MOURA, M.D.

Extension, going backwards, is about 60 degrees normal, patient could only do about 10 degrees, rotation and bending also significantly reduced.

Q. Following this examination, your review of the MRIs, there's an assessment here, correct?

A. Yes.

Q. What was your assessment after the initial evaluation which was about two years after the accident?

A. My assessment states, "the patient is status post blunt trauma from a motor vehicle accident resulting in severe neck and back pain along with a cervical and lumbar radiculopathy".

Q. And you came up with a treatments plan, is that correct?

A. Yes, I thought that he was a candidate for possible neck surgery at that time and I would like to see him back with the actual MRI for my review.

Q. Doctor, you wouldn't actually perform a surgery until you reviewed the

A. De MOURA, M.D.

MRIs, correct?

A. Correct.

Q. And by review I mean looking at films, right?

A. That's right.

Q. There's a discussion here, can you tell us what your discussion says there?

A. My discussion states that I felt the patient's symptoms were related to this accident and that his prognosis, how he was going to do in the future, was not going to be good.

Q. So, Doctor, did you come up with a working diagnosis as to Brian?

A. My diagnose is that the patient had a lumbar disk herniation and he had cervical and lumbar radiculopathy.

Q. You mentioned I see in your report it's called ACDF surgery, right?

A. Yes.

Q. What is ACDF surgery?

A. Anterior cervical diskectomy and fusion.

A. De MOURA, M.D.

Q. We will discuss that a little later, Doctor.

I want to go to the next visit if I may, Doctor, which is August 17, 2017. Do you see that?

A. Yes.

Q. And for purposes of completeness here was there anything different that you evaluated or observed in the next visit that you did not find in the prior visit?

A. I don't believe so. His symptoms were unchanged.

Q. I did note here that you did discuss -- actually, it wasn't you, it was your PA Karen Brauer wrote down the medications that Brian was on.

A. Okay.

Q. Would Brian taking medications impact your examination in any way?

A. They could.

Q. But even with noting that Brian did take the medications, your examination again or the examination of your physician

A. De MOURA, M.D.

assistant was roughly the same as the prior one, correct?

A. Yes.

Q. The next visit you see was September 7, 2017, correct?

A. Yes.

Q. This differs because I see there is a notation called "MRI review", correct?

A. Correct.

Q. Can you tell us what an MRI review is, Doctor?

A. That's where I actually look at the MRI films, the studies, to see exactly what is going on.

Q. And that MRI, can you tell us where that was taken?

A. I think the MRI was...

Q. Was it August 2017, Doctor, that you took the MRI?

A. I don't have the actual report.

Q. October 27, 2017.

A. I take you by your word.

Q. It's not my word, I'm looking

A. De MOURA, M.D.

at your August 7, 2018 report where Dr. Passias analyzed an October 27, 2017 MRI and a more recent one.

Let's go back. Doctor, looking where it says "radiology" when you reviewed that MRI film that was taken in August 2017, can you tell us what that showed?

A. The MRI showed there was a disk herniation at L-4, 5 and the patient was also showing signs of damage at the L-3, 4 level.

Q. What was the significance of you visualizing those findings, Doctor?

A. I could see what was causing the patient to have the symptoms related to the damage in the lower back area.

Q. Based upon actually reviewing the MRIs what was your treatment plan?

A. My treatment plan was that the patient was a surgical candidate but I felt he would require surgery in the lower back to open up the spinal canal, take the disk out that was causing the pain and subsequently free up the nerve and

stabilize that segment so he wouldn't have the friction and compression that he was undergoing.

Q. So at this point it was your belief that Brian required both cervical and lumbar surgical procedures, Doctor?

A. Yes, his symptoms were more low back at that time so I focused on the lower back because that's what was going to require surgery.

Q. I want you to now look at June 7. I think that's your next exam was June 7, 2018, Doctor?

A. Yes.

Q. That's actually with you?

A. Correct.

Q. And again can you just walk us through what, if any, changes there were between this exam and the prior two or three that we discussed?

A. Well, as we know, earlier he was having neck and back symptoms but now his symptoms were primarily focussed in the low back area radiating into his legs and

A. De MOURA, M.D.

at this point I felt surgery was necessary and I recommended he see my associate Dr. Peter Passias for a lumbar procedure.

Q. So at this point Brian was one the 5 percent of your patients who you believe required surgery?

A. That's correct.

Q. I want to look at the treatment plan here if I may, Doctor, on the June 7, 2018 exam.

A. Okay.

Q. The first line says, "at this point the Plaintiff will require decompressive lumbar laminectomy L-4, L-5 with pedical screw instrumentation and diskectomy". Do you see that?

A. Yes.

Q. There's something else here, Doctor. You indicated that the patient would see Dr. Passias for a transverse lumbar interbody fusion procedure?

A. Yes.

Q. Is that different from the lumbar laminectomy that you recommended,

A. De MOURA, M.D.

Doctor?

A. Well, that's more a component of the surgery in its totality.

Q. And then I think you had one final visit with Brian, is that correct? Actually, no, sorry, there was another visit November 6, 2018, do you see that?

A. That was by Dr. Passias.

Q. Looks like Dr. Passias did another what is called an MRI review?

A. Yes.

Q. By the way, Doctor, I'm looking at History of Present Illness, do you see that?

A. For the November note?

Q. November note, yes, can you look at that with me.

A. Yes.

Q. So it says here at the first line, "patient was in severe pain"?

A. Yes.

Q. That hasn't changed has it?

A. No.

Q. And it says he continues to

A. De MOURA, M.D.

report lower back pain central that radiates outward, correct?

A. Correct.

Q. That's that radiation we were discussing?

A. Yes.

Q. The next sentence he reports severe lower back pain and bilateral anterior thigh pain. What's the significance of that, Doctor?

A. Well, the thigh is the area of the L-3, 4 level, so it looks like the level above the herniation is starting to be affected which can give that patient symptoms into the thigh area.

Q. So by November 6, 2018, Doctor, it was the L-3, L-4 and L-4, L-5 levels that were having issues?

A. That's correct.

Q. The next sentence it says he, meaning Brian, "is noticing right lower extremity pain in the medial thigh calf knee to the ankle", do see that?

A. Yes.

A. De MOURA, M.D.

Q. What's the significance of that, Doctor?

A. That the sciatica is getting worse.

Q. Meaning the radiculopathy?

A. Correct.

Q. And then bilateral leg pain, what's the significance of that, Doctor?

A. Both legs are being affected by the damage of the disk at the L-4, 5 level.

Q. I want to go to the next couple statements, it says, "Brian states a few months ago he was in the bathroom, his legs gave out and he fell." Do you see that?

A. Yes.

Q. And then it states that, "he is unable to sleep due to pain." Do you see that?

A. Yes.

Q. By the way, are those all consistent with the last six visits that your office had with Brian?

A. Yes.

Q. And then it says, "he feels

A. De MOURA, M.D.

back and leg pain worsens with laying supine."

A. That's correct.

Q. Why would that happen?

A. I guess he is putting more pressure on his spine when he is in that position.

Q. It says, "Brian reported intermittent numbness and tingling into his legs."

A. That's correct.

Q. Is that the sciatica and radiculopathy that we discussed, Doctor?

A. Yes.

Q. And then it says, "reports significant limitations with walking and standing", right?

A. Yes.

Q. And that's consistent with the last six visits, the clinical presentation he has given to you, Doctor?

A. Yes.

Q. And then he states, "unable to walk greater than fifty feet", is that

A. De MOURA, M.D.

consistent, Doctor?

A. Yes, it is.

Q. How about sexual impotency, Doctor, is that also caused by a neck or back injury?

A. It can be.

Q. Underneath it there is a note, it says, "physical therapy, epidural injections and injections and diagnostic imaging are commenced and the patient received to date". Do you see that?

A. Yes.

Q. And this is essentially what the patient is telling you he has done, correct?

A. Correct.

Q. And he indicates to you right here, I believe it's the fifth line here, that the ESIs, which are the epidural steroid injections, are no longer helpful, is that correct?

A. That's correct.

Q. Why would that be, Doctor?

A. The canal is very tight, it

A. De MOURA, M.D.

needs to have the area open to give more room for the nerves.

Q. It also indicates here that the OxyContin of which he discussed with your office a few visits prior was not helpful. Do you see that?

A. That's correct.

Q. I just want to discuss the actual MRI review that your office performed. Do you see that there, Doctor?

A. Yes.

Q. Can you just tell us what the MRI review showed?

A. MRI of the lumbar spine shows L-3, 4 and L-4, 5 disk herniations deforming the thecal sack causing central spinal stenosis in conjunction with the [inaudible] and ligamentous hypertrophy changes.

Q. Spinal stenosis, is that a degenerative finding, Doctor?

A. Yes.

Q. Let's assume Brian was involved in a motor vehicle accident on April 15,

A. De MOURA, M.D.

2015, let's assume that Brian sustained herniations in his neck and back due to the motor vehicle accident on April 15, 2015, let's now assume that more than three years have lapsed since that motor vehicle accident. Doctor, could you tell us whether or not the herniations and symptoms can form stenosis?

A. They could, yes.

Q. Again your treatment plan at this point was the surgeries, right?

A. That's correct.

Q. One more visit, Doctor, and that was actually a recent one about three months ago, do you see that?

A. Yes.

Q. What did your office find on that one, Doctor?

A. Once again, his symptoms continue to remain the same. He still deals was daily back pain and sciatic type symptoms in the lower extremities. At this point the patient has underlying medical conditions. Surgery, as I stated, is an

A. De MOURA, M.D.

option but he would need to be cleared for surgery from a medical point of view, specifically his heart condition.

Q. You did at some point learn that Brian had a heart condition, correct?

A. Yes.

Q. And it would not be reasonably prudent to perform a lumbar surgery without clearance concerning the cardiac issue?

A. Correct.

Q. I want to talk about the two proposed surgeries now, Doctor. Prior to your office proposing the surgeries were the risks and benefits discussed with Brian?

A. Yes.

Q. I want to start with the cervical surgery, that being in the neck. Can you tell this jury what the risks and benefits of that is?

A. Well, the risks of surgery are usually bleeding infection, they're usually pretty minimal, less than three percent. The benefits outweigh the risks for the

majority of these types of surgeries. So the patient who has failed conservative treatment continues to have ongoing severe pain, surgery is a good option.

Q. Some of the risks, Doctor, are those related to the anesthesia?

A. Yes.

Q. Could those be death?

A. Yes.

Q. Could those be -- could some of the risks include paralysis, Doctor?

A. That would be a risk of surgery itself. In the neck it could eventually have paralysis. In the low back you can have some damage to the nerves themselves with no paralysis.

Q. And prior to performing the surgery you would obtain what's called informed consent, right.

A. Yes.

Q. What is informed consent, Doctor?

A. You tell the patient the risks and the benefits, explain what the surgery

A. De MOURA, M.D.

is, whether the patient can continue to live with his symptoms or he's reached the end and now he's willing to undergo surgery.

Q. The cervical procedure we discussed, Doctor, would that be performed for instance in an outpatient surgical center or is that something that is performed in a hospital?

A. Majority of all of these surgeries are done in the hospital.

Q. Can you tell this jury, when you state the majority of the surgeries you've performed, can you tell us why they're performed in a hospital?

A. You have backup from other departments in the hospital if anything goes wrong. You can have major vascular injury. A hospital is more well-equipped than a surgical center in the majority of cases. Some surgical cases can be done along with lumbar. When you have a surgery where a fusion and you're completely removing the disk, those types of surgeries

A. De MOURA, M.D.

are done in the hospital.

Q. Are those outpatient or inpatient procedures nowadays, Doctor?

A. Inpatient.

Q. What's the normal inpatient time with the cervical procedure that you discussed?

A. Well, a one-level surgical fusion diskectomy, that patient can go home the same day. The majority often do. If you do multiple levels they usually stay overnight. Lumbar, traditionally those cases are bigger and the patient is in the hospital a couple days.

Q. So a lumbar surgery always has to be performed in a hospital because there's an inpatient stay, correct?

A. Yes.

Q. I don't have model of this, Doctor, but could you -- let me ask you this: We have various models on your desk and one that I brought, would any of these that you have here assist us in at least pointing out the areas where the cervical

A. De MOURA, M.D.

surgery that you proposed to perform, would any of them assist us in visualizing that for us?

A. Can we zoom in on this?

Q. That one, Doctor?

A. Yes.

Q. What you are holding, Doctor, can you tell the jury what that is?

A. This is a model of the cervical spine, little vertebrae in the neck.

Q. That's anatomically correct, right, Doctor?

A. Yes.

Q. And that will assist or aid the jury in understanding the cervical surgery that you proposed to perform, correct?

A. Yes. As I discussed earlier, we have the vertebrae, then we have the disks that allow motion but can be damaged. When the disk is damaged we have to remove that. Once we remove it then we perform the surgery such as we see here. Here we can see the disks have been removed, the little spacers have been put in. The

A. De MOURA, M.D.

spacers occupy the space where the disk used to be. And in and of themselves they allow the bones to go through that which is what we call a fusion when the bones come together. The plate and tiny little screws just holds everything still which gives the bones a better chance to then grow together to create the fusion.

Q. You mentioned the term "spacer". Would that be the product or the material that would replace the area where the disk was?

A. Yes. That's what I stated, yes.

Q. What's a spacer made of?

A. It could be made out of bone or could be made out of different metallic products to act or mimic what bone would look like so that the bone cells can grow through it, like a scaffold.

Q. And by fusing you're taking the two vertebrae and you're essentially putting them together through the spacer?

A. Yes.

A. De MOURA, M.D.

Q. And pardon me if I missed it but how does fusing the vertebrae together assist a patient who has pain in the cervical spine?

A. By removing the disk that's been damaged you are removing the pain generator. When that disk is removed if you didn't putting in anything in its place the two bones would rub against one another and that would cause friction and pain. In order to stop that we put the spacer in which, one, holds the space open for the nerve to exit the spine normally and at the same time the bones are able to grow through the spacer to make the bones come together which is what we call a fusion and once the fusion has taken place you don't have that friction that could also cause pain.

Q. Two things you discussed there. You mentioned the term "pain generator" and then you indicated that a herniated disk is consistent with that, is that correct?

A. That's correct.

A. De MOURA, M.D.

Q. Why is a herniated disk a pain generator, Doctor?

A. Because if you imagine the jelly donut scenario, there's really no area in the body where you don't little nerve endings, and image nerve endings going into the jelly donut, if the jelly itself is not contained in the center portion and starts to come out through the perimeter of the donut, when that material comes out, which is the herniation, that stimulates the nerve endings which in and of itself can cause mechanical back pain. So that's what is generating the pain that causes the symptoms the patient is having. The jelly itself then comes out, which is the herniation. If that is in the area that also secretes chemicals which can cause irritation of the nerves both chemically and physically.

Q. So the goal then is to remove the jelly and remove the pain generator?

A. Exactly.

Q. In terms of the cervical

A. De MOURA, M.D.

procedure, what's it technically called, what the formal name for the procedure that you want to perform on Brian?

A. Anterior cervical diskectomy and fusion.

Q. When you perform that procedure could you take us through how it's performed, Doctor. A patient will come to the hospital, correct?

A. Yes.

Q. What happens after a patient enters the hospital?

A. They go to the operating room, they're put asleep, we then prepare the area, drape it sterilely and then perform the surgery, in the neck we make a one-inch incision on the front of the neck, I then have to go in through the front of the spine where I'm going to remove the disk. You need to go between the food pipe, the esophagus, you have major blood vessels, carotid arteries, trachea and windpipe, you need to expose all of those out of the way so you can get to the front of the spine.

A. De MOURA, M.D.

You subsequently remove the disk, which I stated earlier is the pain generator, then replace it with a spacer and a plate that locks everything together which allows the bones to grow together.

Q. Let's take that step by step, Doctor. Patient, how is the patient lying in the hospital, is it neck down or neck up or in a chair?

A. Face up.

Q. And you and your assistant will take a scalpel and cut open the neck, is that correct?

A. That I would do, not my assistant.

Q. How large is that incision on the front of the neck?

A. About an inch.

Q. After you open up the neck what do you do next, Doctor?

A. I stated this, counselor. I told, you have to go down into the spine, remove the blood vessels, the food pipe, the wind pipe, everything out of your way,

A. De MOURA, M.D.

go into the spine, cut out the disk, prepare the bone for the spacer and then put the plate with the teeny screws in there to lock the two bones together.

Q. How long would this procedure take?

A. It takes me about an hour, hour and a half.

Q. While the procedure is be being done in the patient intubated?

A. The patient intubated and asleep.

Q. After that surgery is performed is there usually any scarring or disfigurement on the anterior portion of the patient's neck?

A. Yes, they will have a permanent scar in that area.

Q. And depending on the patient it can keloid?

A. Yes.

Q. After you perform the surgery what happens to the patient's neck?

A. Then the patient goes to the

A. De MOURA, M.D.

recovery room, they will be evaluated, make sure they're breathing well, swallowing well, and if they're ready some of those patients will go home, some will stay home for observation and go home the next day.

Q. What's the recovery time for the cervical procedure you discussed, Doctor?

A. Ten days for the wound to heal. Light activities within ten days. Heavy lifting six to eight weeks. Physical therapy around six to eight weeks. Takes about a full three or four months for the bones to fuse and then there shouldn't be any limitation for that area.

Q. So it takes four months for the patient to heal from surgery, the anterior cervical fusion, Doctor?

A. Completely, yes.

Q. During those four months does the patient evaluate with you?

A. Yes.

Q. How often would a patient see you during that full four months while he

A. De MOURA, M.D.

or she is healing from the procedure that you performed?

A. The patient comes back in two weeks for a wound check, six weeks we start physical therapy, every three months up to one year with X-rays to make sure everything is healing well.

Q. So the follow-up time is actually one year following the procedure?

A. Yes.

Q. Do patients ever develop complications from these procedures, Doctor?

A. Yes.

Q. Tell us some of the complications a patient could endure from the anterior cervical fusion that you discussed?

A. A patient can develop infection, they can develop bleeding, they may have to go back to the operating room to remove any blood clots that can develop. They have develop numbness in the facial area, drooping of the eyelid, tingling,

raspness of the voice, worse scenario would be paralysis after surgery. And death in certain cases.

Q. Doctor, after you perform an anterior cervical disk fusion does that procedure ever cause any other instability in the cervical vertebral column?

A. It doesn't cause instability but there's always a potential that an adjacent level could degenerate with time.

Q. How long would that degeneration take as a result?

A. Usually every ten to fifteen years there's a thirty percent chance that the adjacent level can degenerate.

Q. And if that adjacent area degenerates that could be a possibility for future surgery, Doctor?

A. That's correct.

Q. And that's in about thirty percent of the cases that you perform this procedure?

A. Yes.

Q. Let's talk about the lumbar

A. De MOURA, M.D.

procedure now, Doctor. Do you have an anatomical model on your desk that could assist us in discussing that?

A. Yes.

Q. Doctor, what you are showing us now, is that an anatomically correct replication of the lumbar spine?

A. Yes.

Q. Will that assist the jury and the Court in discussing the proposed procedure that you previously testified to?

A. Yes.

Q. Doctor, can you tell us, first of all, what's the formal name of the procedure that would perform about the lumbar spine?

A. So I think the proposed surgery for this patient would be a lumbar laminectomy with an interbody fusion. So the patient would be lying down in the operating room. This is the front of the spine that is facing downwards on the table. This is the lamina which is the roof the spinal canal. You can see right

here if you look through the middle, this is the roof just as we have a roof on the building. And if the canal is narrowed or being pinched by the disk inside of it we can do a laminectomy which removing the roof of the spinal canal. We can see this model here, there's bone up here, down in this area there's no bone, a laminectomy has taken place. Depending how much bone is removed, if you have inside of your house right now or in the courtroom, when you take off the roof of the space you're in, that in and of itself can give room, but sometimes you have to take some pieces of the wall out to make even more room to, for example, get out through the doorway. By taking more of that out, the structure of the building you're in can be weakened and as a result you need to fortify it. That's why we put screws in here. These screws hold the spine still. The interbody fusion is when we put a cage into the front of the disk and that's supporting the front of the spine, and just like the neck

A. De MOURA, M.D.

surgery that little cage allows the bones to grow together. So the surgery is basically opening up the spinal canal, the laminectomy, the screws are put in to reinforce the spine and make it stronger and allow the bones to ultimately grow together like I described the fusion of the neck.

Q. Doctor, that procedure, is that performed anteriorly or posteriorly?

A. As I just stated, it's done posterior, the patient is face-down on the table.

Q. To discuss a little bit here, there is an incision that's made around the back, right?

A. Yes.

Q. How large is that incision, Doctor?

A. Three to four inches.

Q. That's a vertical or horizontal incision?

A. Vertical.

Q. At that point is when you

perform the procedure, you open up the skin, Doctor, is that what you do after you cut?

A. Yes.

Q. And you cut the muscle that's there?

A. Yes.

Q. And then the first thing you would do is you cut the lamina, would that be a fair statement, Doctor?

A. Yes.

Q. And then you discussed a cage, and I just kind of missed that, is that like the interbody fusion that we discussed, is that the cage, Doctor?

A. Exactly. That's the same principle.

Q. And then the goal of that is to fuse the bones together?

A. Yes.

Q. Again, Doctor, how long would that procedure take?

A. Couple hours.

Q. Couple meaning more than two?

A. De MOURA, M.D.

A. Two to three hours.

Q. That's always performed in a hospital, correct?

A. Yes.

Q. While that procedure is being performed it's done under anesthesia, correct?

A. Correct.

Q. The patient is intubated, correct?

A. Correct.

Q. When a fusion is done are there also consistent nerve SSEP testing, Doctor, that's performed?

A. Yes.

Q. So that's a significant surgery, correct?

A. Yes.

Q. What happens in the two to three hours, the surgery is completed, what happens next?

A. The patient goes to recovery. He can stay in the hospital two or three days, then they go home. Low back

surgeries are bigger because the bones are bigger, deeper in the body. Once again, start physical therapy, four to six weeks afterwards see the Doctor about two weeks after the surgery, usually about six months for the bones to fuse and ultimately plateau one year.

Q. Because those are larger surgeries, Doctor, are the risks greater on the lumbar surgery as opposed to the cervical surgery?

A. No.

Q. Same risks?

A. Yes.

Q. Those are the risks that you discussed earlier, paralysis, death, infection, et cetera?

A. Yes.

Q. I want to go back. So, Doctor, how long would it take to heal from this procedure, is that six weeks?

A. I just stated, counsel. Two weeks to see them back in the office, six weeks start physical therapy, six weeks

A. De MOURA, M.D.

[sic] for the fusion, plateau one year after surgery.

Q. So the patient would be under your care for a year?

A. Yes.

Q. Doctor, what are the benefits of the surgery in terms of the patient's pain?

A. I tell all my patients, I'm not God so you might get a hundred percent recovery but majority of the patients are eighty to ninety percent better, there's five percent that stay the same, five percent that can actually get worse. The benefits of the surgery are to remove what is compressing the spine causing the pain, removing the pain generator, freeing up the nerve so that that neurological symptoms of numbness, tingling and weakness in the legs or arms would improve.

Q. You used the term "improve", does that mean that the patient would have some residual pain and some weakness even if the surgery is successful?

A. De MOURA, M.D.

A. It's possible.

Q. After a surgery is performed what would a patient's prognosis be? I ask that because I saw that you indicated that Brian's prognosis is fair. Do you see that in your report?

A. Yes.

Q. Generally after the surgery is performed what would your prognosis be?

A. My prognosis is hopefully he would be better.

Q. Be better?

A. Yes.

Q. But you couldn't guarantee he would be back to his pre-accident state, correct?

A. Correct.

Q. What are the costs of the surgeries that you discussed?

A. Based on what?

Q. Based on a cash value. If someone were to pay cash for the surgery, Doctor, how much would they cost?

MR. SCAHILL: Objection.

A. De MOURA, M.D.

MR. TENENBAUM: You can answer.

A. Based on the Fair Health Database as mandated by former Governor Cuomo, the out-of-network rate for surgery of this magnitude for a lower back can be $300,000 to half million dollars, for the cervical it can be $100,000 to $200,000.

Q. When you mentioned the Fair Health Data Base, can you tell us what that is?

A. Those are rates that are mandated by the insurance industry by the State to determine what the fair rate for a medical procedure in the State of New York and that's taken as the benchmark for what the fee is and then certain insurance companies will determine what percentage of that they will pay to have these surgeries for the people they cover.

Q. So going back again, for someone who is not covered the numbers are what the database says, Doctor?

MR. SCAHILL: Objection.

A. That's correct.

A. De MOURA, M.D.

Q. What type of rehabilitative services would Brian require if he had both these surgeries?

A. The patient would require physical therapy at a rate of three times a week up to six to eight weeks after surgery, systematically one to two weeks throughout the year. Pain management can be also be necessary to follow up a pain doctor for medications. As I stated, thirty percent of the time the patient will require further surgery at a ten to fifteen year rate. That's pretty much it.

Q. Doctor, in reviewing your records, I just want to go back here, the first time that you discussed Brian's use of any medication was I want to say August 17, 2017?

A. I believe so.

Q. Can you tell us what you learned about the medications Brian was taking on that date, on that visit that you your office performed?

A. The patient was taking a

A. De MOURA, M.D.

steroid pack back in August of 2017. That was to diminish inflammation. He was on Cyclobenzaprine which is a muscle relaxer and there was Percocet given to control pain.

Q. Percocet is an opioid, correct, Doctor?

A. Correct.

Q. In looking at your records, Doctor, you never inquired from Brian whether or not he took any opioids prior to the April 15, 2015 motor vehicle accident, correct?

A. I think one of the notes indicates that he had taken some medication.

Q. I want you to assume that Brian has used opioids for at least since 2005, which would be about twelve years before your 2017 encounters. I want you to assume that Brian was prescribed and did take opioids from another health care practitioner due to the motor vehicle accident of April 15, 2015, okay?

A. De MOURA, M.D.

A. Okay.

Q. And I also want you to assume that there's been testimony that the amount of opioids Brian has taken from at least 2005 up until even today was within the limits that were set by various governmental standards, okay?

A. Okay.

Q. Based on those assumptions, Doctor, can you tell us whether any of your opinions that you gave today would change?

A. No.

Q. Can you tell us why?

A. Because we have a particular date and time that the patient had a traumatic injury, he sustained injury to the neck and back region, he denies any evidence of those symptoms, specifically neck or back symptoms, or symptoms in the arms or legs, so the point and time of the accident of April 2015 I feel within a reasonable degree of medical certainty is what caused the patient to develop his symptoms irregardless of what medications

A. De MOURA, M.D.

he could have been taking prior.

MR. TENENBAUM: Let's take our break now.

THE VIDEOGRAPHER: This is the end of Media Unit 1, we are now off the record for a 3:24 p.m. for break.

(Whereupon, a short recess was taken.)

THE VIDEOGRAPHER: This the beginning of Media Unit 2, we are now on the record at 3:30 p.m.

Q. Doctor, before I go to the next section, I have two questions for you. Upon your review of the records did you learn that Brian was a cigarette smoker?

A. Yes.

Q. Can you tell us what, if any, affect smoking cigarettes would have on Brian's lumbar cervical spine?

A. Cigarette smoke doesn't cause traumatic disk herniation.

Q. The other issue is that according to your initial note Brian was five foot-eleven and 240 pounds, do you see

that?

A. Yes.

Q. And that would be overweight, correct?

A. Yes.

Q. What effect, if any, would Brian's body habitus that you documented in your report have on Brian's cervical or lumbar condition?

A. His body habitus is not what caused his injury.

Q. I will ask you a hypothetical question and I will just ask you to assume that the facts that I am going to present here are true and then we will ask you for your opinion, all right, Doctor?

A. Yes.

Q. So Doctor, I want you to assume that Brian was a driver of a vehicle stopped at a traffic light on April 15, 2015. I want you to assume that Brian's vehicle was completely stopped with his right foot on the break. I want you to assume that Brian was struck from behind

while his vehicle was stopped. I want you to assume Brian was seat belted. I want you to assume that Brian's body moved forward and back in a whiplash-type motion. I want you to assume that Brian's shoulder and elbow hit the window after the accident. I want you to assume that the car, despite having some minor bumper damage, had ripples in its roof that were not present before the accident. I want you to assume that Brian did not go to the hospital because it was tax day, April 15, and he had an important client meeting. I want you to assume that Brian did go to work but his boss sent him home after one hour due to his pain. I want you to assume that Brian's primary care physician who is Dr. Rizzo would not see him because it was car accident related. I want you to assume that Brian woke up the next day with radiating pain in his neck, back and shoulders. I want you to assume that Brian finally saw a physician because the pain would not go away. I want you to assume

A. De MOURA, M.D.

that Brian was diagnosed with acute herniations in his cervical and lumbar spine. I want you to assume that Brian had eleven epidural injections but, as you noted in your notes, it did not alleviate his pain. I want you to assume that Brian failed conservative therapy. I want you to assume that Brian came to you with debilitating radiating neck pain and back pain. I want you to assume that Brian never injured his neck or back prior to the April 15, 2015 accident. I want you to assume that Brian was never in a prior motor vehicle accident and I want you to assume that Brian saw you due to the debilitating pain. Okay, Doctor? You have those assumptions in your mind?

A. I do.

MR. SCAHILL: Note my objection.

Q. Doctor, with someone who has your experience and training in performing surgeries to the spine, do you have an opinion within a reasonable degree of

medical certainty and orthopedic certainty about whether the April 15, 2015 motor vehicle accident was a substantial factor causing injury to Brian's neck and back, that being his lumbar and cervical spine?

MR. SCAHILL: Objection.

MR. TENENBAUM: You can answer.

A. I do believe that the April 15, 2015 accident was a competent causative factor that caused the patient to develop the disk herniation that ultimately led him to have incapacitating pain and radiculopathy symptoms.

Q. Why is that?

A. The patient has no prior history of being treated for these problems. He was involved in the accident. He's hit from the rear. And that in and of itself is enough to cause the patient to become symptomatic. Your foot, when you bump your little toe in your bed 2:00 in the morning, you're traveling 50 miles an hour. So once you bang that little toe you know how important the little toe is. So

A. De MOURA, M.D.

it's not until you are injured, it's not until you develop that splinter while walking on a wooden floor how just a little splinter can bother you. The same thing can happen when you damage your disk, neurological structures in the body, when that comes to your awareness that it's been damaged it's painful and it's something you have to deal with.

Q. Doctor, with those same assumptions do you have an opinion within a reasonable degree of medical certainty and orthopedic certainty about whether the April 15, 2015 motor vehicle accident was a substantial factor in causing pain and suffering to Brian?

MR. SCAHILL: Objection.

A. Yes, I do. I feel within a reasonable degree of medical certainty, which means more probably than not, the accident of April 15, 2015 is what caused the patient to develop the damage to his spine.

Q. Doctor, do you have an opinion

A. De MOURA, M.D.

within a reasonable degree of medical certainty about whether the April 15, 2015 motor vehicle accident was a substantial factor causing loss of enjoyment to Brian?

MR. SCAHILL: Objection.

A. Absolutely.

Q. Why is that, Doctor?

A. Because the patient has sustained major damage to his spine, failed conservative treatment, he ultimately will require surgery to fix this and that comprised with everything together in its totality is a debilitating scenario.

Q. Doctor, again, with respect to the above assumptions, can you state within a reasonable degree of medical certainty whether Brian Durlach sustained injury to his cervical spine because of the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. Yes, I believe so.

Q. Again, can you state, Doctor, again with the above assumptions that we discussed within a reasonable degree of

A. De MOURA, M.D.

medical certainty whether Brian Durlach sustained injury to his lumbar spine because of the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. Yes, I believe that also.

Q. Doctor, based on the above assumptions can tell the jury within a reasonable degree of medical certainty whether Brian Durlach sustained a permanent consequential limitation of use to his cervical spine because of the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. Absolutely. The patient has sustained irreparable damage to the cervical and lumbar spine.

Q. Doctor, again, the same assumptions that we set forth above, can you tell the jury within a reasonable degree of medical certainty whether Brian Durlach sustained significant limitation of use to his cervical spine because of the April 15, 2015 motor vehicle accident?

A. De MOURA, M.D.

MR. SCAHILL: Objection.

A. Yes, I believe he has.

Q. Doctor, based upon the assumptions can you tell the jury within a reasonable degree of medical certainty whether Brian Durlach because of the April 15, 2015 motor vehicle accident sustained a non-permanent jury, that being one to his cervical spine that prevented Brian Durlach from performing substantially all the material acts which constitute his usual and customary daily activities for not less than 90 days no more than 180 days following the occurrence of the injury?

MR. SCAHILL: Objection.

A. Yes, I believe so.

Q. With respect to the lumbar spine, Doctor, can you tell this jury with a reasonable degree of medical certainty whether Brian Durlach sustained an injury to his lumbar spine because of the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. Yes, I believe that.

A. De MOURA, M.D.

Q. Why is that, Doctor?

A. Because the patient sustained significant disk herniation of L-4, 5 and that damage incapacitated his low back region giving him sciatic type symptoms which require surgical intervention.

Q. Doctor, based upon the above assumptions can you tell the jury within a reasonable degree of medical certainty whether Brian Durlach sustained impermanent consequential limitation of use to his lumbar spine because of the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. Yes, he has.

Q. Again, Doctor, based upon the above assumptions can you tell the jury within a reasonable degree of medical certainty whether Brian Durlach sustained a significant limitation of use to his lumbar spine because of the April 15, 2015 accident?

A. I believe he has.

Q. Doctor, again, based upon the

A. De MOURA, M.D.

above assumptions can you tell the jury within a reasonable degree of medical certainty whether Brian Durlach because of the April 15, 2015 accident sustained a non-permanent jury, that being one to his lumbar spine that prevents Brian Durlach from performing substantially all the material acts which constitute such persons' usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury?

MR. SCAHILL: Objection.

A. I agree with that also.

Q. Doctor, based upon your examination of Brian and your review of the records can you tell us how long in the future Brian will have the pain of which he presented to you for?

MR. SCAHILL: Objection.

A. If the patient does not have surgery he will continue to endure this pain for the rest of his life.

Q. Doctor, based upon your

A. De MOURA, M.D.

examination of Brian and your review of the records, can you tell us within a reasonable degree of medical certainty whether the surgery you proposed will increase Brian's functionality?

A. I believe it will.

Q. Doctor, based upon your examination of Brian and your review of the records, can you tell us within a reasonable degree of medical certainty Brian's prognosis should he not receive the surgeries we discussed?

MR. SCAHILL: Objection.

A. It will continue to be poor.

Q. Two more questions. Doctor, in terms of Brian's -- Doctor, what's a disability rating?

A. It determines the percentage the person can function normally.

Q. What's Brian's disability rating in your opinion, Doctor?

MR. SCAHILL: Objection.

A. I believe he is permanently totally disabled.

A. De MOURA, M.D.

Q. The spine itself, can you tell us about its sensitivity?

A. Extremely sensitive.

Q. Doctor, because of its sensitivity, can you tell this jury the type of impact or trauma that is necessary to sustain the type of trauma that Brian suffered?

MR. SCAHILL: Objection.

A. You can go through a normal activities of daily living, twisting, lifting and injure your spine, you can do it from a heavy work activity or you can be involved in an accident of this magnitude where unexpectedly kinetic energy is transferred from one vehicle through the other damaging your body.

Q. So based on the facts that he presented with, Doctor, within a reasonable degree of medical certainty you can assert that the injuries that Brian sustained came from the April 15, 2015 motor vehicle accident?

MR. SCAHILL: Objection.

A. De MOURA, M.D.

A. Absolutely.

MR. TENENBAUM: Thank you, I have nothing further at this time.

CROSS EXAMINATION BY
MR. SCAHILL:

Q. Doctor, good afternoon. My name is Frank Scahill and I'm representing the person being sued, Mr. Schade, in this lawsuit. Thank you for spending time with us this afternoon. I will ask you questions, Doctor, with respect to the testimony you have just given and the encounters that your office has had with the Plaintiff in this case, Brian Durlach.

A. Yes, sir.

Q. And I would ask you to answer my questions with a yes or no if possible and if that is not possible to let me know and I will either rephrase the question or move on to another subject matter. Is that okay?

A. Yes, sir.

Q. You indicated on direct

A. De MOURA, M.D.

examination that you testified on average five to six times per year. Is that correct, Doctor?

A. I would surmise so.

Q. And you have done that for the last twenty years?

A. I would think so, yes.

Q. So you testified well over a hundred times, is that correct?

A. That sounds correct.

Q. And you've testified well over a hundred times for personal injury Plaintiffs, people bringing lawsuits for personal injuries as a result of accidents, is that fair to say?

A. It's fair to say that I've testified on behalf of my patients.

Q. But those patients are also personal injury Plaintiffs that brought lawsuits to collect money for the injuries they claim happened in accidents, is that fair?

A. Well, I testified in their court hearing for their injuries.

A. De MOURA, M.D.

Q. And you testified in court five to six times a year on a regular basis, meaning each year for the last twenty years you have gone to court five or six times, is that fair to say?

MR. TENENBAUM: Objection.

A. I believe I answered your question, Counsel. I don't keep track, as I stated, and it could be up to five, it could be less.

Q. Did anyone ask you to come to court and testify in this case before a jury about the Plaintiff in this case, Brian Durlach?

A. Not that I'm aware of.

Q. Are you being compensated today for your time testifying on behalf of the Plaintiff, Brian Durlach?

A. Yes, I am. My fee is $10,000 because I'm not operating or seeing patients this afternoon.

Q. So this afternoon for your testimony to compensate you you're being paid $10,000, is that correct.

A. De MOURA, M.D.

MR. TENENBAUM: Objection.

A. That my office is being paid that, that's correct.

Q. The Plaintiff in this case, Brian Durlach, he was referred to you by someone for your examination and treatment, is that correct?

A. That's possible, sir. I don't have the referral source on this matter.

Q. So if you look in your chart, Doctor, on the left, on that first page, there's an indication of referring physician, that's part of your form that your office puts together for people that come to your office, correct?

A. Yes, it does say here under referring physician.

Q. I'm asking you about the form, Doctor. Let's take that one part at a time.

MR. TENENBAUM: Objection.

Q. Let's take that part. Your office has a form for patients that come to your office and on that office form there

A. De MOURA, M.D.

is a box that says "referring physician", is that fair to say?

A. That's correct.

Q. The referring physician in this case was in fact not a Doctor, the person that referred Mr. Durlach to your office was an attorney, correct?

A. Correct.

MR. TENENBAUM: Objection.

Q. And the attorney that referred Mr. Durlach to your office was the attorney that is representing the Plaintiff in his personal injury case, Mr. Goodman, is that fair to say?

MR. TENENBAUM: Objection.

A. That's fair.

Q. Do you take referrals from attorneys for personal injury Plaintiffs?

A. Sure.

MR. TENENBAUM: Objection.

Q. As part of your practice referrals from attorneys for patients that come to you through lawyers?

MR. TENENBAUM: Objection.

A. De MOURA, M.D.

A. I answered that earlier, Counsel. I told you I have approximately thirty percent patients that are involved in major motor vehicle accident injuries, patients that are injured while working and self-referring patients.

Q. Doctor, you remember we talked about answering questions yes or no if you could?

MR. TENENBAUM: Objection.

A. I remember what you said.

Q. In terms of the referral in this case, just to be clear, the referral was from Mr. Goodman, the Plaintiff's lawyer. Is that fair to say?

MR. TENENBAUM: Objection.

A. Yes.

Q. Did you know when Mr. Durlach came to you that he had a personal injury lawsuit pending?

MR. TENENBAUM: Objection to the form of the question.

A. I don't recall that.

Q. When Mr. Durlach came to you

A. De MOURA, M.D.

your first encounter with him was June 12, 2017, is that correct?

A. Yes, it is.

Q. And that was approximately two years and two months after the accident that he was complaining of, the April 15, 2015 motor vehicle accident, is that fair to say?

A. That's correct.

Q. During those two years and two months Mr. Durlach saw other doctors, is that fair?

A. That's possible.

Q. And he also underwent other treatments, correct?

A. That's possible.

Q. And when you questioned him he denied to you that he had a prior history of neck and back pain, is that fair to say?

A. Yes, it is.

Q. In fact you interviewed him and you took down information that you put in your chart under a heading known as History, is that fair?

A. De MOURA, M.D.

A. Yes, it is.

Q. And the history that you take from a patient is one of the critical components in coming to your diagnosis, is that a fair statement?

A. Yes, it is.

Q. And the reason that you take a thorough history is because as a medical professional, as a doctor, as a scientist, you want to base your opinion on as much information as you possibly can?

A. That's correct.

Q. And in this situation Mr. Durlach came to you and told you that he was involved in a motor vehicle accident on April 15, 2015 and he was complaining of pain to his neck and back, is that true?

A. Yes.

Q. And he also told you that he had no prior history of neck and back pain, is that also true?

A. Yes.

Q. So if the history that was given to you by Mr. Durlach was incorrect

A. De MOURA, M.D.

that could affect your opinion as to a reasonable degree of medical certainty as to whether or not you believe the injury which was the competent and producing cause of his complaints actually occurred in that motor vehicle accident, is that fair to say?

A. Yes.

Q. If Mr. Durlach was either not telling you the truth, was evasive or failed to tell you the complete truth, that could affect the accuracy of your diagnosis, is that fair?

A. Regarding a prior history, yes.

Q. So in terms of giving an opinion, the first day that you saw him on June 12, 2017 you gave an assessment that Mr. Durlach sustained injuries to his neck and back in that motor vehicle accident and you put down as your assessment the patient is status post blunt trauma from a motor vehicle accident resulting in severe neck and back pain, is that correct?

A. Yes, it is.

A. De MOURA, M.D.

Q. So the first day that you saw him, June 12, 2017, you are giving opinion that he was injured in an auto accident that occurred two years and two months prior?

A. That's correct.

Q. And that opinion was without the benefit of knowing the severity of the impact, is that fair to say?

A. I can't answer that yes or no.

Q. Well, you didn't put down in any of your chart or your note any indication of the severity of the impact. Is it fair to say that you when you saw him on June 12, 2017 did not know the severity of the impact other than what he told you he was wearing a seat belt and he was struck in the rear by another vehicle, is that fair to say?

MR. TENENBAUM: Objection.

A. It's fair to say my note indicates that the patient was a restrained driver, that was rear-ended by another automobile.

A. De MOURA, M.D.

Q. But you had no idea when you saw him in June 2017 the severity of the impact, correct?

A. Sitting here today I don't recall the severity of the impact that the patient may have explained to me occurred during the accident at that time in June 2017.

Q. If the rear end accident was between four and seven miles per hour or between thirty and fifty miles per hour that would affect your opinion as to whether or not the accident itself was the competent producing cause of what the complaints were, correct?

A. Is that a yes or no question?

Q. That's yes or no?

A. I can't answer yes or no.

Q. So you didn't know in June of 2017 when you gave that opinion that he was status post blunt trauma whether or not the accident was at four or seven miles an hour or at fifty miles an hour, is that a fair statement?

A. De MOURA, M.D.

A. No, Counsel, sitting here today I know the mechanism of the injury at the time, I have not documented the velocity of the offending vehicle, but I can't state almost four years later the exact vehicle mileage per hour that the car was hitting him. He may told me that but I don't recall.

Q. You talked about working with biomechanical experts before. You have worked with biomechanical experts to determine whether or not a specific event caused an injury, correct?

A. I may have, yes.

Q. And that's because a biomechanical expert can give an opinion on the force or the trauma that's imparted to an individual in an accident --

MR. TENENBAUM: Objection.

Q. -- is that also fair to say?

A. I don't agree with that.

Q. Let's go back to the history that was given to you by Mr. Durlach. Did you ever see pictures of the damage to the

A. De MOURA, M.D.

vehicles involved?

A. I believe so.

Q. When did you see pictures of the damage to the vehicles involved in the accident?

A. I don't recall. I said I may have. I don't recall.

Q. Were you aware that Mr. Durlach made no complaints of injury at the scene of the incident?

A. I don't recall that.

Q. Were you also aware that he drove his vehicle from the scene and went to work?

A. I don't recall that.

Q. Were you also aware that he did not seek medical treatment for approximately two weeks after the accident?

A. I'm aware of that.

Q. Did you ever have a conversation with the physicians that were treating him for the two years up to the point that you saw him?

A. Conversation, no.

A. De MOURA, M.D.

Q. Have you ever spoken to those doctors up until today?

A. No.

Q. So you never had a conversation with Dr. Perry, the first Doctor that he went to after the incident?

A. That's correct.

Q. Were you aware that Dr. Perry diagnosed Plaintiff with a sprain or a simple strain, were you aware of that for both the neck and back?

MR. TENENBAUM: Objection.

A. I'm not aware of that.

Q. Would you agree with that diagnosis that he had a simple sprain or strain to the neck or back?

MR. TENENBAUM: Objection.

A. Do I agree with that, no.

Q. Did you ever have a conversation with Dr. Obedian (phonetic), the doctor that saw him after Dr. Perry following this auto accident?

A. No.

Q. Did you ever have a

A. De MOURA, M.D.

conversation with Dr. Feldman, the pain management Doctor that he treated with after the incident?

A. No.

Q. You did you ever talk to his primary care physician, Dr. Rizzo?

A. No.

Q. Were you aware that Dr. Rizzo was treating him prior to the accident?

A. Was I aware that all of those doctors that were treating him for the injury?

Q. I'm talking about Dr. Rizzo, were you aware that he was treating with Dr. Rizzo prior to the accident?

A. I'm aware that he was treating with multiple physicians in the past, I don't have a clear recollection of a Dr. Rizzo.

Q. Would it be important for you as a clinician to have available to you before you give an opinion the records of the doctors that treated him up until the point that you saw him, and that's yes or

A. De MOURA, M.D.

no, Doctor?

A. I can't answer yes or no.

Q. Were you aware that prior to this accident in November of 2014 Mr. Durlach was complaining to Dr. Rizzo that he had extremity weakness, he had resting pain and he had pain while walking, were you aware of that?

A. No, I'm not.

Q. Would that affect your diagnosis as to whether or not the accident that we're discussing was the competent producing cause of the pain that he is complaining about?

A. Are you saying he was being treated for those symptoms before this accident?

Q. I will refer you to Plaintiff's Exhibit 6, the November 10, 2014 notation from the patient, Mr. Durlach, when he is listing his symptoms they include extremity weakness, resting pain and pain while walking, were you aware of that?

A. Those specific, no.

A. De MOURA, M.D.

Q. Would that affect your diagnosis as to whether or not the accident in question was the competent producing cause of the pain that he's talking about, that six months prior to the accident he was complaining of weakness in his extremities, pain while walking and pain while resting?

A. No, I believe the accident of April 15, 2015 is the competent causing factor that caused the patient to seek multiple physicians for help which he has not done prior to that.

Q. So let's talk about your encounters with Mr. Durlach. You saw him June 12, 2017, correct?

A. Yes.

Q. He came back to your office in August two months later but you didn't see him at that time, a physician's assistant Karen Groyer (phonetic) saw him at that point, correct?

A. He presented back on that day with increasing pain and lumbar --

A. De MOURA, M.D.

Q. I didn't ask you that, Doctor. I just asked you when he came back two months later you didn't see him, your PA saw him, Karen Groyer, is that accurate?

A. My PAs always see patients with me.

Q. Well, where it says the provider it lists not you but it lists Karen Groyer, your PA.

A. Correct, but they are in the facility with me when I see the patient, so I may have popped in and seen the patient wanting to see the MRI which was not fruitful at that time and subsequently saw him back with the film for review.

Q. So you him on June 12, he came back in September and you went over the MRIs with him?

A. Yes.

Q. And then he came back to you approximately nine months later in June of 2018?

A. Correct.

Q. And that's the last time you

A. De MOURA, M.D.

saw him?

A. Yes.

Q. So other than today you haven't seen Mr. Durlach for over three years?

A. That's correct.

Q. Is that fair to say?

A. That's correct.

Q. June of 2018 is the last time you saw him?

A. It's possible I saw him in June of this year. Once again my physician's assistant was seeing patients with me. I could have popped in and seen him, I don't have a clear recollection but it's possible.

Q. Well, Mr. Durlach came to your facility a total of seven times.

A. That's correct.

Q. The provider that is listed for the visits that he had in August of 2017 was your PA. The provider that is listed for his visits in June and August 2018 was Dr. Passias and then he didn't come back to your facility for the last three years. Is

A. De MOURA, M.D.

that fair to say?

A. Yes.

Q. There is a three-year gap --

A. That's correct.

Q. -- between when he last came to you in November 2018 --

A. Yes.

Q. -- and this recent visit in June of 2021?

A. Yes.

Q. Did he tell you in June of 2021 the reason he hasn't been here in three years and the reason he was coming to see you in June was because his case was coming up for

?

MR. TENENBAUM: Objection.

A. It's my understanding he knew he was a surgical candidate in 2013. There are certain medical conditions that confound him undergoing that type of major surgery and I would believe that following up in this year he was here based on the fact that, yes, he was going to have proceedings of his legal case.

A. De MOURA, M.D.

Q. So the reason he came to see you in June was because his case was coming up for trial, is that a fair statement?

MR. TENENBAUM: Objection.

A. I would think so.

Q. It had nothing to do with your treatment, it had to do with the fact that his case was coming up for trial, is that fair to say?

MR. TENENBAUM: Objection.

A. I would say that's fair.

Q. So your treatment of him ended three years ago and your treatment spanned the course of a year that started in June of 2017 and ended in November of 2018, is that fair to say?

A. Yes.

Q. And during that period of time your office saw him a total of six times and you saw him personally three times and other people in your office saw him during those other three visits, is that fair to say?

MR. TENENBAUM: Objection.

A. De MOURA, M.D.

Asked and answered.

A. Yes.

Q. So you recommended to him a procedure or two procedures three years ago and he hasn't done anything in terms of moving forward with those procedures, is that also a fair statement?

A. Yes.

Q. In terms of your recommendations, he has not followed your recommendations to proceed with these surgeries, he has not done anything in terms of going forward with the surgeries that you recommended, is that also fair to say?

A. Correct.

Q. When he came to you in June of 2017 did he tell you that he had prior accidents?

A. My notes indicate the contrary.

Q. Did he tell you in June of 2017 that he had prior surgery to his right shoulder?

A. Yes.

A. De MOURA, M.D.

Q. I'm looking at your notes and it says, "left shoulder surgery 2016 and 2017". There's no indication in your June 12, 2017 record that he had a prior right shoulder surgery in 2014, the year before the accident that we're here to talk about?

A. That's correct.

Q. So he didn't tell you about the prior right shoulder injury, is that fair to say?

A. Well, it's not documented.

Q. Well, it would be significant, something that you would put in your notes, a prior surgery, correct?

A. Yes.

Q. That's good and accepted medical practice to list a prior surgery, that's the reason that you asked him about prior hospitalizations and surgeries, correct?

A. That's correct.

Q. And he failed to tell you that he had a prior surgery to his right

A. De MOURA, M.D.

shoulder in 2014, correct?

A. It wasn't documented as I stated.

Q. He indicated to you his only past medical history was hypertension, high blood pressure, correct?

A. Correct.

Q. And you went through with Plaintiff's counsel his height and weight at that point, he's five-foot, eleven, 240 pounds, he would be considered morbidly obese, correct?

A. Not morbidly but he is obese.

Q. And he was a regular smoker, he smoked a pack a day by his own admission?

A. Correct.

Q. And you indicated that would have no affect on the health of the person's spine, is that accurate?

A. That's not what I said.

Q. It would have an affect, a delatorius affect on the health of the person's spine, correct?

A. That's not what I said.

A. De MOURA, M.D.

Q. I'm asking you. Would it have a delatorius affect on the health of a person's spine if they were a one-pack-a-day smoker?

A. My answer to that question prior was that smoking a pack of cigarettes a day did not cause a disk herniation.

Q. That wasn't my question, Doctor. My question was would it have a delatorius affect on the health of that person's spine if they're a one-pack-a-day smoker?

A. I think it depends on the person. Some people have problems, some people don't.

Q. How about being morbidly obese, does that have a delatorius affect on the health of a person's spine?

A. Well, according to your criteria I'm morbidly obese and I have no problems with my spine.

Q. I'm not asking you about you, I'm talking about the patients you see, is someone that is morbidly obese that's five-

A. De MOURA, M.D.

eleven, 240 pounds, would that have a delatorius affect on the health of that person's spine?

A. As I stated, Counsel, I'm five-ten, 240 pounds, I have no problems with my spine.

Q. Well, you didn't answer my question, Doctor, but we will move on.

MR. TENENBAUM: Objection.

Q. When you spoke to him in June of 2017 you indicated in your records that he had no known drug allergies, correct?

A. Yes.

Q. Were you aware in June of 2017 that he was opioid dependent?

A. I don't think my notes indicate that.

Q. Would that be significant?

A. Significant for traumatic injury, no.

Q. I'm asking if it would be significant if you had a patient that was opioid dependent?

A. In which context, Counsel?

A. De MOURA, M.D.

Q. Is that something that you would put into your notes because it's significant and it's something that impacts your diagnosis and treatment, the fact that someone is opioid dependent?

A. Yes, if that information was elicited, yes, we would put it in our notes.

Q. Did you ask him when he came to see you what medications he was on?

A. That's our usual custom and practice.

Q. Is there any indication in your June 12, 2017 note following your first encounter that you list the medications that Mr. Durlach was taking?

A. As I stated, Counsel, there's nothing documenting that in this note.

Q. If it's not in your notes is it fair to say that you didn't ask him what medications he was on?

A. No, there's an intake form that they fill out, our patients, that it could be documented in that.

A. De MOURA, M.D.

Q. And you have your chart in front of you, is his intake form documenting the drugs he was taking?

A. I don't have his intake form in this record in front of me here today.

Q. Have you ever seen a list of the medications that Mr. Durlach has been taking for the at ten years prior to the April 2015 accident?

A. Not that I recall.

Q. I will show you what's marked as Plaintiff's Exhibit 9 in evidence and I will review that with you. Those are the Plaintiff's records from Spage's Pharmacy going back through 2005. The first medication that is listed is Hydrocodone. That's an opioid medication, is that correct?

A. Yes.

Q. And Mr. Durlach going back to December of 2005 was being prescribed Hydrocodone an opioid medication from an osteopath named Dr. Michael Kennedy as shown by these records, is that fair to

A. De MOURA, M.D.

say?

A. Yes.

Q. And at the same time he was also getting a prescription, an opioid medication, based on a prescription that's written by a dentist, Dr. Steven Bogart, is that fair to say?

A. Yes.

Q. He's also getting Hydrocodone from multiple other doctors in addition to the osteopath and the dentist, he's getting Hydrocodone from a Dr. David Cooling, from Dr. Melina Kawadra (phonetic), and from a Dr. Yan Sun. Is that fair to say based on your review of these records?

A. Yes.

MR. TENENBAUM: Objection.

Q. In fact, if you go on to the following page, for at least ten years up to the accident of April of 2015 Mr. Durlach was getting prescriptions for Hydrocodone from multiple providers including the doctors that I just mentioned, another dentist, Dr. Norman

A. De MOURA, M.D.

Rubin, another Doctor by the name of Dr. Joseph Lodisi (phonetic) and every month Mr. Durlach would get prescriptions filled for opioid medication.

MR. TENENBAUM: Objection.

Q. Is that fair to say based on the records that are before you, Doctor?

A. Yes.

Q. Would you consider that an individual who is opioid dependent, a ten year history of taking opioid medications before the accident that he's complaining about?

A. Yes.

MR. TENENBAUM: Objection.

Q. Is it good and accepted medical practice to continue to prescribe opioid medication to an individual from multiple medical providers?

MR. TENENBAUM: Objection.

A. There are multiple parts to that the question.

Q. Let's break it down.

If you had a patient that came

A. De MOURA, M.D.

to you and told you that they're getting opioid medication from multiple doctors at the same time would you consider that to be good and accepted medical practice?

MR. TENENBAUM: Objection.

A. According to these records it's not at the same time. It appears that he's been prescribed medication on a monthly basis throughout this period. I don't see an overlap in my brief perusal of this document that you handed to me thirty seconds ago. It appears that overall he's been prescribed medications on a monthly basis from different physicians.

Q. Let's break it down.

On the first page in December of 2005, December 28, 2005, he gets a prescription for Hydrocodone from a Dr. Michael Kennedy, three weeks later he goes to a dentist Dr. Steven Bogart for another prescription for Hydrocodone on January 23. On January 27 he goes back to that same dentist, Dr. Steve Bogart, and gets another prescription four days later

A. De MOURA, M.D.

and then three days after that on February 1, 2006 he goes to a Dr. David Cooling and gets another prescription for opioid medication. Would you consider that to be overuse of opioid medications?

MR. TENENBAUM: Objection.

A. It seems he has been given quantities of medications, for example 20 pills at a time, and he's been taking these and following up briefly looks like a week or so later, sometimes a month later. So that in and of itself for a patient that has chronic pain or whatever reason that he might have been given the medications the physicians did give him medications for pain.

Q. Would it be fair to say based on your review of those records that Mr. Durlach had a ten-year history of opioids use prior to this April 2015 accident?

A. I answered that already.

Q. And your answer is?

A. My answer was yes.

A. De MOURA, M.D.

Q. So the accident that we are here to talk about was April 15, 2015, if you turn to March of 2015, March 23, 2015, is it in fact true that Mr. Durlach got a prescription for opioid pain medication three weeks prior to the accident that we're discussing on March 23, 2015 from a Dr. Jennifer Robinson?

A. Yes.

Q. And that same doctor gave prescriptions to Mr. Durlach for opioid medication, Oxycodone, February 2015?

A. Yes.

Q. December of 2014.

A. Yes.

Q. December of 2014.

A. That's possible, yes.

Q. November of 2014?

A. Yes.

Q. If you look at those records, Doctor, in November of 2014 Mr. Durlach is receiving multiple medications, including the Oxycodone, he's also getting multiple prescriptions for Viagra. You had

A. De MOURA, M.D.

mentioned the fact that the impotence that Mr. Durlach was complaining about was causely related to the accident. Were you aware that going back to 2013 he was obtaining 100 milligram prescriptions on a regular basis for Viagra?

A. It appears he was taking Viagra, yes. I thought we were talking about 2015 just before the accident.

Q. We're talking about this is 2013.

A. What about 2015? Are we going to discuss the medication after 2015 and the accident?

Q. I'm talking about all the medications that he was on prior to the accident.

A. Right. We know he's been on medication since 2010.

Q. I asked you to assume he denied that, that he gave sworn testimony under oath that he was under no opioid medication prior to the April 15, 2015 accident. Would you consider that to be truthful?

A. De MOURA, M.D.

MR. TENENBAUM: Objection.

A. I would consider that the patient has been on medication as documented for quite a period of time but that has no relevance to traumatic injury damaging his spine.

Q. Let's talk about that traumatic injury. When you first saw him in June 2017 you also reviewed not the actual MRIs but you reviewed the reports that were ordered by Dr. Obedian at Zwanger Pesiri radiology and those reports were taken in 2015, is that accurate?

A. Yes.

Q. So you didn't look at the actual MRI films themselves, you just looked at the reports from Zwanger Pesiri Radiology. Is that fair to say?

A. At one point in time I had reviewed the actual film but he was presented for the first time with a report.

Q. The day that you gave your diagnosis, your assessment that he was traumatically injured in the accident, you

A. De MOURA, M.D.

did not look at the actual films, you just looked at the reports that were prepared in 2015 from Zwanger Pesiri Radiology, is that fair to say?

A. Yes.

Q. So can we review those reports together?

A. Okay.

Q. The first report is the MRI of the lumbar spine that was taken on June 26, 2015, and that report is addressed to Dr. Richard Obedian who was his treating physician who ordered that MRI?

A. Okay.

Q. There's an impression on that report, is that correct?

A. Yes.

Q. Could you read the impression for the jury?

A. The impression is "mild multilevel degenerative disk disease as above".

Q. So let's talk about that sentence, "mild multilevel degenerative

disk disease". Degenerative disk disease is an arthritic process, correct?

A. Yes.

Q. As a person ages, depending on their level of activity, their body habitus, their occupation, their genetics, they can suffer degenerative disk disease or arthritis to the spine?

A. That's correct.

Q. The same way that you get arthritis in a knee joint or a wrist joint or an elbow joint you can also get arthritis in the spine, is that correct?

A. That's correct.

Q. When we talk about degenerative disk disease or arthritis that's a longstanding process, that's not something that is a traumatic process, that's something that is longstanding that occurs over multiple years, is that fair to say?

A. Yes.

Q. So the impression on the MRI that was taken in June of 2015 within three months of the accident was in fact mild

multilevel degenerative disk disease, is that fair to say?

A. That's not all the report says.

Q. I didn't ask you that, Doctor. I'm asking you, am I accurately reading the impression mild multilevel degenerative disk disease, is that fair to say?

A. That's what the impression states.

Q. So you already told us that the MRI is the gold standard in diagnosing traumatic injuries to the spine because the MRI can visualize not only the bony structures that an X-ray can show but also the soft tissues of the spine including the musculature, the ligaments and the disks, is that fair to say?

A. Yes.

Q. When we talk about the spine being sensitive, someone that's a seat belted occupant of a bucket seat in a motor vehicle accident, when we talk about the spine being sensitive, that spine is surrounded by musculature and ligaments

A. De MOURA, M.D.

that protect the spine, correct?

A. Yes.

Q. In fact one of the largest ligaments in the body runs down the entire length of the spine and protects the spine and provides stability for the spine, correct?

A. Yes.

Q. When we talk about the disk material, the disk material, you poke somebody in the back, you're not touching their disks, that disk is surrounded by muscles, ligaments and bone that protect it, correct?

A. What do you mean poke? What do you mean by poke?

Q. When you poke somebody in the back, you're not touching their disks.

A. Who got poked in this incident?

Q. This is a hypothetical. We are talking about the spine being sensitive. When you slap somebody in the back you're not touching their disks. There's muscles there that protect the spine, there's

A. De MOURA, M.D.

ligaments there that protect the spine, there's bone there that protects the spine, is that fair to say?

A. Regarding a poke?

Q. I just used the term "slap". But I'm talking about trauma to the back.

A. Now we're talking about slapping or trauma? What are we talking about? We're all over the place.

Q. The anatomy. Surrounding the spinal canal or the spinal column are muscles, ligaments and bone that protect the spinal column, correct?

A. Yes.

Q. So going back to this MRI that was taken within three months of the accident is there any mention in the entire MRI report of the word "trauma"?

A. That's not something a radiologist reviews.

Q. Is there any mention in the MRI report of the word "traumatic disk herniation"?

A. Once again the word "traumatic"

A. De MOURA, M.D.

is never used by a radiologist.

Q. So let's look at the words that were in fact used. In this report there is a mention at L-3, L-4 there's "diffuse", meaning throughout, correct?

A. Yes.

Q. "Degenerative bulging disk with mild stenosis"? When we talk about diffuse degenerative bulging, that's something that's not a traumatically induced condition, that's something that happened over time over years to develop, is that fair to say?

A. Yes.

Q. There's also an indication at L-4, L-5 there's a right paracentral disk protrusion abutting without compressing the exiting right L-5 nerve route. When we talk about radiculopathy or radicular pain there's radicular pain because the disk that is exiting the vertebral space is in fact compressing on a nerve, correct, that's what causing the radicular pain?

A. You're ill-informed, that's not

A. De MOURA, M.D.

correct.

MR. TENENBAUM: Objection.

Q. I will break it down.

When someone has sciatica, sciatica pain, that's because there's compression on the nerve and that sciatica pain is not found in the back but it runs down their leg because the nerve route is being compressed at a particular level of the spine.

A. You're ill-informed, that's not correct.

MR. TENENBAUM: Objection.

Q. This disk profusion that's described in the MRI has no compression on the exiting right L-5 nerve route as per this MRI evaluation, is that fair to say?

A. That's correct.

Q. So there's no where in this MRI report that was taken within three months of the accident that would support a diagnosis of radiculopathy because there's no nerve route compression as shown on the MRI?

A. De MOURA, M.D.

A. You're misinformed.

Q. Can we also go on to the cervical spine MRI, did you review this report when he first came in in June of 2017?

A. I believe so. I don't have it with me. Do you have it?

Q. I do.

A. Thank you.

Q. Can you take a look at the impression and read the impression, Doctor (handing)?

A. "Limited examination with mild multilevel degenerative spondylitic changes as best can be ascertained. More detailed examination may be obtained with non-contrast CAT scan as the image acquisition time is significantly faster".

Q. Let's talk about this MRI. This MRI was done at Zwanger Pesiri Radiology at the request of Dr. Obedian and it was completed on June 26, 2015 within three months of the accident, is that correct?

A. De MOURA, M.D.

A. Yes.

Q. This MRI evaluation showed also mild multilevel degenerative spondylitic changes as interpreted by the radiologist who read this study, is that fair to say?

A. The main thing is this says "limited examination". This wasn't a full examination, Counsel.

Q. But you were basing your opinion that Mr. Durlach sustained an injury from the accident of April 15, 2015 based on your review of this MRI report. This MRI report notes "mild multilevel degenerative spondylitic changes", is that fair to say?

MR. TENENBAUM: Objection.

Q. Is that exactly what it says in the report, Doctor?

A. My note specifically states --

Q. I didn't ask you about your note, Doctor, I'm asking what is shown in the MRI. I just handed it to you. Am I accurately reading the impression that says "mild multilevel degenerative spondylitic

A. De MOURA, M.D.

changes"?

A. The MRI report states that C-3, 4 there is a central --

Q. Doctor --

A. I'm reading the report, Counsel.

Q. Is there an impression noted in that report?

MR. TENENBAUM: Objection.

A. Counsel, I'm reading the report.

Q. I asked you, am I accurately reading the impression where it says, "mild multilevel degenerative spondylitic changes"?

A. Yes, but you're omitting important information that's in the body of the note.

Q. Mr. Durlach's lawyer can ask you any questions that he wants, but I am asking you the questions now, Doctor, and I'm asking you to answer my question. Am I accurately reading that the MRI impression notes "mild multilevel degenerative

A. De MOURA, M.D.

spondylitic changes"?

MR. TENENBAUM: Objection.

A. The impression does read that following "limited examination".

Q. So in fact mild multilevel degenerative spondylitic changes is another word for arthritis of the cervical spine?

A. Yes.

Q. That's what is shown in the impression for Mr. Durlach's MRI that was taken within three months of the accident. Is that fair to say?

A. Yes.

Q. Not only was there a finding of degenerative spondylitic changes there was also a finding of osteophytes, is that correct?

A. Yes.

Q. Osteophytes is an outgrowth of bone at the edge of the vertebral bodies, is that fair to say?

A. Yes.

Q. And osteophytes take years to develop, is that also fair to say?

A. De MOURA, M.D.

A. That's correct.

Q. And the reason that osteophytes develop is because there's stenosis or narrowing of the space between the vertebrae and the osteophytes are bone growth that the body itself builds to increase stability for the spine. Is that a fair statement from a layperson?

A. Yes.

Q. So in fact this MRI that was taken three months prior to the accident, it noted osteophytic ridging at C-3, C-4 as well as similar findings at C-4, C-5 and C-6, C-7, is that fair to say?

A. Yes.

Q. So throughout his cervical spine there was a finding of arthritis that was shown in June of 2015, is that fair to say?

A. Yes.

Q. There's no indication in this MRI report that he had a traumatic disk herniation to his cervical spine that required surgery, is that fair to say?

A. De MOURA, M.D.

MR. TENENBAUM: Objection.

A. I don't agree.

Q. There's no words in this report that indicate any type of a traumatic disk herniation, is that fair to say, Doctor?

MR. TENENBAUM: Objection. Asked and answered.

A. I answered numerous times that the radiologists do not use the terminology of traumatic. Unless of course you see a broken spinal column or broken bone. Then that could be read as traumatic in the body of the radiologist report.

Q. Your office also ordered MRI evaluations, is that correct, Doctor?

A. Yes.

Q. And those MRIs were taken at a different facility than Zwanger Pesiri Radiology where he had the 2015 studies performed, correct?

A. Yes.

Q. The MRIs that your office ordered were at Stand Up MRI of Islandia, correct?

A. De MOURA, M.D.

A. He went there.

Q. That's where the MRI was performed?

A. That's correct.

Q. And he underwent an MRI of the lumbar spine in September of 2018 three years and four months or five months after the April 15, 2018 accident?

A. Yes.

Q. Is that fair to say?

A. Yes.

Q. He also underwent an MRI of the cervical spine on August 26, 2017 at two years and four months after the accident of April 15, 2015?

A. Correct.

Q. Now, the MRI evaluations that were done within three months of the accident, there were significant changes for the MRIs that were done several years later, is that fair to say?

A. Repeat that.

Q. There was significant changes in the MRI studies that were done in 2017

A. De MOURA, M.D.

and 2018 by your office than the MRI studies that were done within three months of the accident as ordered by Dr. Obedian, is that fair to say?

MR. TENENBAUM: Objection.

A. There was no MRI done by my office. We requested further information and sent the patient for new MRIs as time transpired.

Q. I'm bringing out the fact that the MRIs that were done within three months of the accident showed arthritic changes and the MRIs that were done by your office or ordered by your office in 2017 and 2018 showed significantly different pathology than the ones that were done contemporaneous to the accident.

MR. TENENBAUM: Objection.

Q. Is that a fair statement?

A. Regarding the cervical spine MRI, the MRI performed in September of 2017, which is for the full examination, did indeed prove positive for disk herniation which is consistent with the

A. De MOURA, M.D.

accident of April 15, 2015.

Q. Well, it wasn't consistent with the MRI that was done within three months of that accident as ordered by Dr. Obedian. In fact, it's completely different than the report that was done --

A. That's right, Counsel, but it was a limited examination.

MR. TENENBAUM: Objection.

Q. So, Doctor, did you review the MRI studies, the actual studies that were done within three months of the accident?

A. Sitting here today I don't recall. I believe the patient returned to the office on 9/17 with the actual MRIs for review and based upon my notes we honed in on the lumbar spine at that time as the major problem the patient was dealing with, which was the disk herniation at L-4, L-5.

Q. But in fact Doctor the MRI that was done within three months of the accident did not show disk herniation but in fact showed diffuse degenerative disk disease, meaning he had arthritis

A. De MOURA, M.D.

throughout his spine?

MR. TENENBAUM: Objection.

Asked and answered.

A. No, to the contrary, the MRI of the lumbar spine immediately after his accident showed a disk herniation at L-4, 5.

Q. Well, here is an individual that is taking opioid medication for ten years, here is an individual that told his primary care physician six months prior to the accident that he had weakness in the extremities, he had pain while walking and at rest. Is it in fact more likely than not that he had disk herniation long before this accident and the accident itself had no impact on the health of his spine either his neck or his back, and that's a yes or no, Doctor?

MR. TENENBAUM: Objection.

A. You know I can't answer that yes or no.

Q. As a scientist, as a spinal surgeon, wouldn't it have been good and

A. De MOURA, M.D.

accepted medical practice to review and compare the MRIs studies that were done in 2015 within three months of the accident with those that were done three years later when he came to see you, yes or no?

MR. TENENBAUM: Objection.

A. I can't answer yes or no.

Q. Doctor, are you familiar with a concept known as secondary gain?

A. Yes.

Q. Is secondary gain taught in medical schools?

A. No.

Q. You never heard the concept of secondary gain while you were in medical school?

A. No.

Q. Is secondary gain a medical phenomenon?

A. Not that I'm aware of.

Q. Is it something that you --

A. Maybe it's a legal phenomenon not a medical phenomenon.

Q. Is it something that you take

A. De MOURA, M.D.

into account when you see your patients?

A. I take my patients at face value when they present to me of having no history of treating for a condition, having for example in this case a traumatic injury as small as you try to make it out to be --

Q. Doctor, do you remember we talked about --

A. -- where they were involved in a car accident, developed an injury and was treated afterwards, that may not be your question but that's my answer.

Q. You may want to give a narrative but I was trying to focus your response into a discussion of secondary gain.

MR. TENENBAUM: Objection.

Q. Is in fact secondary gain a motivation by patients other than their health and well-being that they have motivation to obtain money or some other type of secondary gain from the treatment that you're providing, is that something you take into account?

A. De MOURA, M.D.

A. Well --

Q. That's a yes or no, Doctor.

A. It's multiple questions.

Q. Do you take into account, yes or no, do you take into account the concept of secondary gain when you treat your patients.

A. Again, it depends on the patient-doctor relationship that I can assess after having seen thousands of patients over the years. If I feel that the patient is faking something then I usually can elicit that and I probably would not recommend surgery. That's why I said, I only operate on five percent of the patients that I see. Only a few substantive patients require and are willing to undergo spinal surgery.

Q. Mr. Durlach was recommended by you to undergo these procedures years ago, he never came back other than his visit to you within the last three months because his lawsuit was coming up, is that a fair statement?

A. De MOURA, M.D.

MR. TENENBAUM: Objection.

Asked and answered.

A. Yes.

Q. In terms of your treatment of Mr. Durlach, based on the fact that he was referred to you by a personal injury lawyer, that you knew he had a lawsuit pending, that he didn't follow any of your treatment recommendations, did you take into account the concept of secondary gain when you were treating this patient?

MR. TENENBAUM: Objection.

A. No, I thought this patient had a legitimate history of an accident, was never treated for this in the past, subsequently had studies that correlate with his symptomology, correlate with his physical findings and correlate with his ongoing pain for almost two years after the injury.

Q. And you're basing this opinion on your three visits with him over three years ago, is that fair to say?

MR. TENENBAUM: Objection.

A. De MOURA, M.D.

A. Yes.

MR. SCAHILL: Nothing further. Thank you, Doctor.

THE VIDEOGRAPHER: This is the end of Media Unit 2. We are now off the record at 4:36 p.m.

(Whereupon, a short recess was taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit 3, we are now on the record at 4:40 p.m.

RE-DIRECT EXAMINATION BY
MR. TENENBAUM:

Q. Good afternoon, Doctor. I want to start off just covering a couple things that were discussed on cross here. Let me ask you, there was a term that was used, a sprain and a strain that Mr. Scahill inquired about. Can you define that for the jury.

A. A sprain is when you have a stretching of a ligament, a strain is when you can pull a muscle. So those are

A. De MOURA, M.D.

pulling injuries that cause micro damage to the structures affected.

Q. So sprains and strains can actually be significant, correct, Doctor?

A. Sometimes a strain can be worse than breaking a bone.

Q. So when a term was used of a minor strain or sprain, that's not necessarily a true statement, correct, Doctor?

MR. SCAHILL: Objection.

A. Well, it was the person's feeling at the moment that the person may have a strain or sprain.

Q. And as we discussed a sprain or strain can be significant, correct?

A. Yes.

Q. Doctor, Mr. Scahill read to you parts of a November 16, 2014 encounter with Brian's primary physician Dr. Rizzo. I want you to assume that in that note there Brian did not make complaints of neck pain, I want you to assume that in that November 2014 note Brian did not make complaints of

back pain and I want you to assume that Brian in that November 2014 report did not make complaints of left shoulder pain, okay, Doctor?

A. Okay.

Q. Based on those assumptions would any of the findings that you discussed with reference to Mr. Scahill's question having any relevance?

MR. SCAHILL: Objection.

A. I don't believe so.

Q. I want to discuss with you, there was a -- I want you to look at your June 12, 2017 report. The first page where it says "allergies".

A. Yes.

Q. It says Brian presented to you with no known drug allergies, correct?

A. Correct.

Q. What's an allergy, Doctor?

A. Inflammatory reaction to a substance.

Q. So based on as you sit here today you don't believe that to be a false

statement, correct?

A. Correct.

Q. That's not a deceitful statement, correct?

A. Correct.

Q. There was a discussion and Mr. Scahill spent a lot of time discussing that Zwanger Pesiri MRI. Can you look at that, please, Doctor.

A. Yes.

Q. An MRI report has two portions, correct, the findings and the impression?

A. Correct.

Q. Can you tell us what the difference is?

A. The findings is what is in the body of the note that indicates what the radiologist interpreted while reviewing the films.

Q. What's the impression?

A. The impression is usually a summary of what he or she has seen within the body of the note.

Q. So in your practice as an

A. De MOURA, M.D.

orthopedic surgeon which portion of the report tends to be more accurate?

MR. SCAHILL: Objection.

Q. You can answer.

A. Well, the body of the report is usually more detailed in nature because it describes everything that the radiology has seen upon his examination of the study.

Q. I want you to tell the jury what's in the body of the report, and we can start with the lumbar spine. Do you have that there?

A. The body of the note shows that there is a disk herniation at L-4, 5 and that's what is important about that MRI report.

Q. Why is that important, Doctor?

A. Because the disk herniation at L-4, 5 is what is causing the patient's -- is causing this patient to experience pain in the back and his legs.

Q. And that herniation, Doctor, as you previously testified, was that traumatic in origin?

A. De MOURA, M.D.

MR. SCAHILL: Objection.

A. I believe so.

Q. How about the cervical spine, Doctor, can you look at that Zwanger Pesiri MRI report?

A. You have that report, I don't have that one.

Q. I don't have that one.

A. 6/2016, I have that.

Q. Can you discuss the body of the report for the jury, Doctor?

A. The body of the report shows that there are seven bones in the neck between number 3 and 4, there is a disk ridge complex and similar findings are seen at 4-5, 5-6 and 6-7.

Q. What's the significance of the findings in the body of the report, Doctor?

A. Once again this was a limited MRI. Why it was limited it doesn't state, it could have been motion artifact or time to do it, the patient tolerating it, but it does show that there's osteophytes which preexisted the accident but it also talks

A. De MOURA, M.D.

about disks and we subsequently see in an MRI later that indeed there were disk herniations there at that time that they discussed in this report and could also have given the patient what I surmise were his radicular symptoms and neck symptoms.

Q. And those findings, Doctor, those are present on the initial Zwanger report?

A. The initial Zwanger report shows there's osteophytic disks and ridges abutting the spine.

Q. And then you stated that herniations were formed, Doctor?

A. And then the later MRI indeed did confirm that there were indeed disk herniations in the cervical spine.

Q. How do you correspond those two reports, Doctor?

A. One is a complete report and one is a report that's incomplete. It's limited.

Q. Fair enough, Doctor.

There was also a notation where

A. De MOURA, M.D.

again I just want to look at your June 12, 2017 report where it says, "hospitalizations and surgeries".

A. Okay.

Q. I want you to assume that Brian had a right shoulder surgery somewhere between 2013 and 2015. The date currently escapes me at the moment, but it would be before the motor vehicle accident, and I want to ask you, Doctor, had you known that right shoulder surgery had occurred would have that have changed in I in the opinion us gave here today?

A. No.

Q. Mr. Scahill discussed a slap in the back, Doctor. Let me ask you this, if it's a hard slap in the back could that cause injury to a disk?

A. Well, if we're talking about a martial art expert one finger can kill you. It depends how fast, what the force is and the acceleration.

Q. Again, just going back, I want you to assume that Mr. Durlach was sitting

A. De MOURA, M.D.

in a motor vehicle on April 15, 2015, I want you to assume that Mr. Durlach had his seat belt on and I want you to assume that Mr. Durlach's vehicle was rear-ended and I want you to assume that his body moved forward and back, as he testified to, would that impact cause injury to the disks in Brian's neck and his?

MR. SCAHILL: Objection.

A. Yes, I believe that type of kinetic energy transferred from one vehicle to the other, when you're not expecting it, and jarring the subject within the other vehicle at times can cause people to develop symptoms and pathology of damage to the disks as we see in this picture.

MR. TENENBAUM: That's all I have Doctor, thank you.

RE-CROSS EXAMINATION BY
MR. SCAHILL:

Q. Just to clarify, Doctor, that MRI study that you had just described, that was done within three months of the

A. De MOURA, M.D.

accident, June 26, 2015, for the cervical spine, there's no mention of disk herniations in that report, in that report they're only talking about osteophytic disk ridge complexes at three levels which you already told me is a longstanding degenerative condition, is that fair to say, yes or no?

A. I can't answer yes or no.

MR. SCAHILL: Nothing further. Thank you.

MR. TENENBAUM: Thank you.

(Continued on next page to include Jurat.)

A. De MOURA, M.D.

THE VIDEOGRAPHER: We are off the record at 4:50 p.m. and this concludes today's testimony given by Dr. Alexandre de Moura. The total number of media units used was three and will be retained by Veritext New York.

(Whereupon, at 4:50 p.m. the Examination of this Witness was concluded.)

_____

ALEXANDRE de MOURA, M.D.

Subscribed and sworn to before me this _____ day of _____ 20___.

_____

NOTARY PUBLIC

A. De MOURA, M.D.

E X H I B I T S

PLAINTIFF EXHIBITS

EXHIBIT NUMBER	EXHIBIT DESCRIPTION	PAGE
(None)		

I N D E X

INFORMATION AND/OR DOCUMENTS REQUESTED

INFORMATION AND/OR DOCUMENTS	PAGE
(None)	

QUESTIONS MARKED FOR RULINGS

PAGE	LINE	QUESTION
(None)		

A. De MOURA, M.D.

C E R T I F I C A T E

STATE OF NEW YORK)
: SS.:
COUNTY OF NASSAU)

I, FRANCINE DELFINO, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose examination is hereinbefore set forth was duly sworn and that such examination is a true record of the testimony given by that witness.

I further certify that I am not related to any of the parties to this action by blood or by marriage and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 16th day of September 2021.

FRANCINE DELFINO

ERRATA SHEET

VERITEXT/NEW YORK REPORTING, LLC

CASE NAME: Durlach, Brian L. v. Schade, Thomas F.
DATE OF DEPOSITION: 9/13/2021
WITNESSES' NAME: ALEXANDRE de MOURA, M.D.

PAGE	LINE (S)	CHANGE	REASON

_____
ALEXANDRE de MOURA, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME
THIS ____ DAY OF _____, 20__.

_____ _____
(NOTARY PUBLIC) **MY COMMISSION EXPIRES:**

b

n

New York Code

Civil Practice Law and Rules

Article 31 Disclosure, Section 3116

(a) Signing. The deposition shall be submitted to the witness for examination and shall be read to or by him or her, and any changes in form or substance which the witness desires to make shall be entered at the end of the deposition with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness before any officer authorized to administer an oath. If the witness fails to sign and return the deposition within sixty days, it may be used as fully as though signed. No changes to the transcript may be made by the witness more than sixty days after submission to the witness for examination.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.