

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.

1 A. De MOURA, M.D.

2 THE VIDEOGRAPHER: Good

3 afternoon, we are going on the record
4 at 2:07 p.m. on September 13, 2021.

5 Please note that the microphones are
6 sensitive and may pick up whispering,
7 private conversation and cellular

8 interference. Please turn off all

9 cell phones or place them away from

10 the microphones as they do interfere

11 with the deposition audio. Audio and

12 video recording will continue to take

13 place unless all parties agree to go

14 off the record. This is Media Unit

15 1, the video recorded deposition of

16 Dr. Alexandre de Moura, taken by

17 counsel for the Plaintiff in the

18 matter of Durlach, Brian L. versus

19 Schade, Thomas F, filed in the

20 New York State Supreme Court, Suffolk

21 County, index number 0602430/2016.

22 This deposition is being held at the

23 New York Spine Institute,

24 Dr. Alexandre de Moura's office, 761

25 Merrick Avenue, Westbury, New York

1 A. De MOURA, M.D.

2 11590. My name is Marco Sozio from
3 the firm Veritext and I am the
4 videographer. The court reporter is
5 Francine Delfino from the firm
6 Veritext New York. I am not
7 authorized to administer an oath, I
8 am not related to any party in this
9 action, nor am I financially
10 interested in the outcome. Counsel
11 will now state their appearances and
12 affiliations for the record. If
13 there are any objections to the
14 proceeding please state them at the
15 time of your appearance beginning
16 with the noticing attorney.

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

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

1 A. De MOURA, M.D.

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

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

8 A L E X A N D R E d e M O U R A, M.D.,
9 called as a witness, having been first duly
10 sworn by a Notary Public of the State of
11 New York, was examined and testified as
12 follows:

13 DIRECT EXAMINATION BY

14 MR. TENENBAUM:

15 Q. Please state your name for the
16 record.

17 A. Alexandre de Moura.

18 Q. What is your address?

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

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

25 Q. Good afternoon, Doctor. My

1 A. De MOURA, M.D.
2 name is Jason Tenenbaum, I represent
3 Brian Durlach with respect to a personal
4 injury matter that has been brought against
5 Thomas Schade. I'm sure you have sat
6 through depositions before, just a couple
7 rules I have to put on the record. First
8 please wait until I finish my question
9 before you answer, okay?

10 A. Okay.

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

15 A. Okay.

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

22 A. Okay.

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

1 A. De MOURA, M.D.

2 A. Okay.

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

6 A. Yes, I am, since 1996.

7 Q. What's your specialty, Doctor?

8 A. Spine surgery.

9 Q. Where are you currently
10 employed?

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

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

15 A. Greater than ten years.

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

19 A. I was in private practice.

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

22 A. I believe in 1996.

23 Q. Doctor, where did you go to
24 undergrad?

25 A. I went to George Washington

1 A. De MOURA, M.D.

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

9 Q. Doctor, when did you graduate
10 undergrad?

11 A. 1984.

12 Q. When did you finish medical
13 school?

14 A. 1990.

15 Q. You indicated you are Board
16 Certified, correct?

17 A. That's correct.

18 Q. What are you Board Certified
19 in?

20 A. Orthopedic surgery.

21 Q. When did receive your Board
22 Certification, Doctor?

23 A. I believe on or about 1997.

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

1 A. De MOURA, M.D.

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

1 A. De MOURA, M.D.

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

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

18 A. That's correct.

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

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

1 A. De MOURA, M.D.

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

6 Q. Doctor, are you involved with
7 any research?

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

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

17 A. I think since 2000.

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

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

1 A. De MOURA, M.D.

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

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

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

9 A. Yes.

10 Q. Can you tell us what your
11 experience is?

12 A. With disk issues?

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

15 A. That's kind of broad-ended.

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

18 A. Yes.

19 Q. Can you tell us what your
20 experience is?

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

1 A. De MOURA, M.D.

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

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

14 A. I would say about five percent.

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

18 A. That's correct.

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

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

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

1 A. De MOURA, M.D.

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

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

9 A. No.

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

12 A. Can you be more specific?

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

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

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

23 A. I believe so.

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

1 A. De MOURA, M.D.

2 expert?

3 A. I believe so.

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

7 A. Yes.

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

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

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

17 A. That's one facet of my
18 practice.

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

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

1 A. De MOURA, M.D.

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

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

8 A. Yes.

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

12 A. Yes.

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

15 A. Yes.

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

18 A. Correct.

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

21 A. For 2020?

22 Q. Yes, year 2020.

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

25 Q. How about in the last five

1 A. De MOURA, M.D.

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

4 A. It would be that times five.

5 Q. About fifteen hundred?

6 A. Yes.

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

10 A. They're one in the same.

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

13 A. That's possible.

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

19 A. Yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 A. Yes.

3 Q. When did you first become
4 acquainted with Brian?

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

7 Q. Approximately how many times
8 have you seen Brian?

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

12 Q. What is a doctor-patient
13 relationship?

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

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

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

1 A. De MOURA, M.D.

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

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

6 A. Yes, I do.

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

10 MR. SCAHILL: Objection.

11 MR. TENENBAUM: You can answer.

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

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

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

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

1 A. De MOURA, M.D.

2 correct?

3 A. I believe so.

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

6 A. Yes, I read the films.

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

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

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

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

1 A. De MOURA, M.D.

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

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

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

1 A. De MOURA, M.D.

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

12 Q. Doctor, what is a disk bulge?

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

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

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

1 A. De MOURA, M.D.

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

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

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

16 Q. Doctor, can a trauma cause a
17 bulge?

18 A. A trauma could cause a bulge,
19 yes.

20 Q. Could a trauma cause a
21 herniation, Doctor?

22 A. Yes.

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

25 A. They could.

1 A. De MOURA, M.D.

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

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

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

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

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

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

1 A. De MOURA, M.D.

2 seeing the doctor.

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

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

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

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

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

1 A. De MOURA, M.D.

2 can you tell us how the examination would
3 take place?

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

21 Q. Are you also looking for
22 radiculopathy, Doctor?

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

1 A. De MOURA, M.D.

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

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

12 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

10 A. Yes.

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

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

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

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

1 A. De MOURA, M.D.

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

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

12 A. Yes.

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

16 A. Can I test for it?

17 Q. Yes, can you test for it.

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

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

1 A. De MOURA, M.D.

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

4 A. Correct.

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

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

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

19 MR. SCAHILL: Objection.

20 MR. TENENBAUM: Can you answer.

21 A. Yes.

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

25 A. Well, as I stated earlier, I

1 A. De MOURA, M.D.

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

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

15 A. Yes.

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

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

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

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

1 A. De MOURA, M.D.

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

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

10 A. Yes, sir.

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

14 A. That's correct.

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

19 A. That's the history that patient
20 has told me regarding his development of
21 his symptoms from the accident of April
22 2015.

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

1 A. De MOURA, M.D.

2 Doctor?

3 A. What is significant is that he
4 was involved in the accident on April 15,
5 2015. He was a driver in an automobile
6 that was struck by another automobile. He
7 also denied any prior motor vehicle
8 accident history. Also of importance is he
9 never had neck or back problems before this
10 accident. So I believe those are all
11 significant things to note in the history.

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

15 A. Yes.

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

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

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

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

1 A. De MOURA, M.D.

2 along with injections that unfortunately
3 did not help him.

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

8 A. Yes.

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

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

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

21 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

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

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

13 A. Yes.

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

17 A. Yes.

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

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

1 A. De MOURA, M.D.

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

6 A. Yes.

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

10 A. Yes.

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

15 A. Yes.

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

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

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

1 A. De MOURA, M.D.

2 Doctor?

3 A. That's correct.

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

8 A. Yes.

9 Q. What is a spasm?

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

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

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

17 Q. You determine a spasm how?

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

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

24 A. Yes.

25 Q. Can you tell us what a painful

1 A. De MOURA, M.D.

2 range of motion is?

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

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

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

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

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

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

23 A. Flexion is when you bend your
24 neck downwards.

25 Q. What is the American Medical

1 A. De MOURA, M.D.

2 Association note as normal for flexion?

3 A. Normal is close to about 50
4 degrees.

5 Q. And you found what?

6 A. About 20 degrees.

7 Q. Can you tell the jury what
8 extension is?

9 A. When you put the neck
10 backwards.

11 Q. What would the normal value for
12 that be?

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

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

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

24 Q. So 80 is normal and you found
25 10 degrees, Doctor?

1 A. De MOURA, M.D.

2 A. Yes.

3 Q. What about right bending?

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

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

9 A. Yes.

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

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

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

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

1 A. De MOURA, M.D.

2 Extension, going backwards, is about 60
3 degrees normal, patient could only do about
4 10 degrees, rotation and bending also
5 significantly reduced.

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

9 A. Yes.

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

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

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

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

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

1 A. De MOURA, M.D.

2 MRIs, correct?

3 A. Correct.

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

6 A. That's right.

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

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

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

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

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

22 A. Yes.

23 Q. What is ACDF surgery?

24 A. Anterior cervical disectomy
25 and fusion.

1 A. De MOURA, M.D.

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

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

7 A. Yes.

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

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

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

19 A. Okay.

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

22 A. They could.

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

1 A. De MOURA, M.D.

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

4 A. Yes.

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

7 A. Yes.

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

11 A. Correct.

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

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

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

19 A. I think the MRI was...

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

22 A. I don't have the actual report.

23 Q. October 27, 2017.

24 A. I take you by your word.

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

1 A. De MOURA, M.D.

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

5 Let's go back. Doctor, looking
6 where it says "radiology" when you reviewed
7 that MRI film that was taken in August
8 2017, can you tell us what that showed?

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

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

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

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

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

1 A. De MOURA, M.D.

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

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

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

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

15 A. Yes.

16 Q. That's actually with you?

17 A. Correct.

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

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

1 A. De MOURA, M.D.

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

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

8 A. That's correct.

9 Q. I want to look at the treatment
10 plan here if I may, Doctor, on the June 7,
11 2018 exam.

12 A. Okay.

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

18 A. Yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 Doctor?

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

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

9 A. That was by Dr. Passias.

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

12 A. Yes.

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

16 A. For the November note?

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

19 A. Yes.

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

22 A. Yes.

23 Q. That hasn't changed has it?

24 A. No.

25 Q. And it says he continues to

1 A. De MOURA, M.D.

2 report lower back pain central that
3 radiates outward, correct?

4 A. Correct.

5 Q. That's that radiation we were
6 discussing?

7 A. Yes.

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

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

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

20 A. That's correct.

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

25 A. Yes.

1 A. De MOURA, M.D.

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

4 A. That the sciatica is getting
5 worse.

6 Q. Meaning the radiculopathy?

7 A. Correct.

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

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

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

16 A. Yes.

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

20 A. Yes.

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

24 A. Yes.

25 Q. And then it says, "he feels

1 A. De MOURA, M.D.

2 back and leg pain worsens with laying
3 supine."

4 A. That's correct.

5 Q. Why would that happen?

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

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

12 A. That's correct.

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

15 A. Yes.

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

19 A. Yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 consistent, Doctor?

3 A. Yes, it is.

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

7 A. It can be.

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

13 A. Yes.

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

17 A. Correct.

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

23 A. That's correct.

24 Q. Why would that be, Doctor?

25 A. The canal is very tight, it

1 A. De MOURA, M.D.

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

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

8 A. That's correct.

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

12 A. Yes.

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

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

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 2015, let's assume that Brian sustained
3 herniations in his neck and back due to the
4 motor vehicle accident on April 15, 2015,
5 let's now assume that more than three years
6 have lapsed since that motor vehicle
7 accident. Doctor, could you tell us
8 whether or not the herniations and symptoms
9 can form stenosis?

10 A. They could, yes.

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

13 A. That's correct.

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

17 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

7 A. Yes.

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

11 A. Correct.

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

17 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

8 A. Yes.

9 Q. Could those be death?

10 A. Yes.

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

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

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

21 A. Yes.

22 Q. What is informed consent,
23 Doctor?

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

1 A. De MOURA, M.D.

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

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

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

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

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

1 A. De MOURA, M.D.

2 are done in the hospital.

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

5 A. Inpatient.

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

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

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

19 A. Yes.

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

1 A. De MOURA, M.D.

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

5 A. Can we zoom in on this?

6 Q. That one, Doctor?

7 A. Yes.

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

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

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

14 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

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

16 Q. What's a spacer made of?

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

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

25 A. Yes.

1 A. De MOURA, M.D.

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

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

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

25 A. That's correct.

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

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

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

24 A. Exactly.

25 Q. In terms of the cervical

1 A. De MOURA, M.D.

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

5 A. Anterior cervical diskectomy
6 and fusion.

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

11 A. Yes.

12 Q. What happens after a patient
13 enters the hospital?

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

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

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

11 A. Face up.

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

15 A. That I would do, not my
16 assistant.

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

19 A. About an inch.

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

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

1 A. De MOURA, M.D.

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

6 Q. How long would this procedure
7 take?

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

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

12 A. The patient intubated and
13 asleep.

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

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

20 Q. And depending on the patient it
21 can keloid?

22 A. Yes.

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

25 A. Then the patient goes to the

1 A. De MOURA, M.D.

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

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

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

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

20 A. Completely, yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 or she is healing from the procedure that
3 you performed?

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

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

11 A. Yes.

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

15 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

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

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

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

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

20 A. That's correct.

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

24 A. Yes.

25 Q. Let's talk about the lumbar

1 A. De MOURA, M.D.

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

5 A. Yes.

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

9 A. Yes.

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

13 A. Yes.

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

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

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

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

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

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

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

18 A. Yes.

19 Q. How large is that incision,
20 Doctor?

21 A. Three to four inches.

22 Q. That's a vertical or horizontal
23 incision?

24 A. Vertical.

25 Q. At that point is when you

1 A. De MOURA, M.D.

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

5 A. Yes.

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

8 A. Yes.

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

12 A. Yes.

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

17 A. Exactly. That's the same
18 principle.

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

21 A. Yes.

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

24 A. Couple hours.

25 Q. Couple meaning more than two?

1 A. De MOURA, M.D.

2 A. Two to three hours.

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

5 A. Yes.

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

9 A. Correct.

10 Q. The patient is intubated,
11 correct?

12 A. Correct.

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

16 A. Yes.

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

19 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

13 A. No.

14 Q. Same risks?

15 A. Yes.

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

19 A. Yes.

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

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

1 A. De MOURA, M.D.

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

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

6 A. Yes.

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

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

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

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2 A. It's possible.

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

8 A. Yes.

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

11 A. My prognosis is hopefully he
12 would be better.

13 Q. Be better?

14 A. Yes.

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

18 A. Correct.

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

21 A. Based on what?

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

25 MR. SCAHILL: Objection.

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2 MR. TENENBAUM: You can answer.

3 A. Based on the Fair Health
4 Database as mandated by former Governor
5 Cuomo, the out-of-network rate for surgery
6 of this magnitude for a lower back can be
7 \$300,000 to half million dollars, for the
8 cervical it can be \$100,000 to \$200,000.

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

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

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

24 MR. SCAHILL: Objection.

25 A. That's correct.

1 A. De MOURA, M.D.

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

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

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

20 A. I believe so.

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

25 A. The patient was taking a

1 A. De MOURA, M.D.

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

7 Q. Percocet is an opioid, correct,
8 Doctor?

9 A. Correct.

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

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

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

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2 A. Okay.

3 Q. And I also want you to assume
4 that there's been testimony that the amount
5 of opioids Brian has taken from at least
6 2005 up until even today was within the
7 limits that were set by various
8 governmental standards, okay?

9 A. Okay.

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

13 A. No.

14 Q. Can you tell us why?

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

1 A. De MOURA, M.D.

2 he could have been taking prior.

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

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

8 (Whereupon, a short recess was
9 taken.)

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

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

17 A. Yes.

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

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

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

1 A. De MOURA, M.D.

2 that?

3 A. Yes.

4 Q. And that would be overweight,
5 correct?

6 A. Yes.

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

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

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

18 A. Yes.

19 Q. So Doctor, I want you to assume
20 that Brian was a driver of a vehicle
21 stopped at a traffic light on April 15,
22 2015. I want you to assume that Brian's
23 vehicle was completely stopped with his
24 right foot on the break. I want you to
25 assume that Brian was struck from behind

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

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

19 A. I do.

20 MR. SCAHILL: Note my
21 objection.

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

1 A. De MOURA, M.D.

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

7 MR. SCAHILL: Objection.

8 MR. TENENBAUM: You can answer.

9 A. I do believe that the April 15,
10 2015 accident was a competent causative
11 factor that caused the patient to develop
12 the disk herniation that ultimately led
13 him to have incapacitating pain and
14 radiculopathy symptoms.

15 Q. Why is that?

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

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

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

18 MR. SCAHILL: Objection.

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

25 Q. Doctor, do you have an opinion

1 A. De MOURA, M.D.

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

6 MR. SCAHILL: Objection.

7 A. Absolutely.

8 Q. Why is that, Doctor?

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

15 Q. Doctor, again, with respect to
16 the above assumptions, can you state within
17 a reasonable degree of medical certainty
18 whether Brian Durlach sustained injury to
19 his cervical spine because of the April 15,
20 2015 motor vehicle accident?

21 MR. SCAHILL: Objection.

22 A. Yes, I believe so.

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

1 A. De MOURA, M.D.

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

6 MR. SCAHILL: Objection.

7 A. Yes, I believe that also.

8 Q. Doctor, based on the above
9 assumptions can tell the jury within a
10 reasonable degree of medical certainty
11 whether Brian Durlach sustained a permanent
12 consequential limitation of use to his
13 cervical spine because of the April 15,
14 2015 motor vehicle accident?

15 MR. SCAHILL: Objection.

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

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

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2 MR. SCAHILL: Objection.

3 A. Yes, I believe he has.

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

16 MR. SCAHILL: Objection.

17 A. Yes, I believe so.

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

24 MR. SCAHILL: Objection.

25 A. Yes, I believe that.

1 A. De MOURA, M.D.

2 Q. Why is that, Doctor?

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

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

15 MR. SCAHILL: Objection.

16 A. Yes, he has.

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

24 A. I believe he has.

25 Q. Doctor, again, based upon the

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

14 MR. SCAHILL: Objection.

15 A. I agree with that also.

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

21 MR. SCAHILL: Objection.

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

25 Q. Doctor, based upon your

1 A. De MOURA, M.D.

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

7 A. I believe it will.

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

14 MR. SCAHILL: Objection.

15 A. It will continue to be poor.

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

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

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

23 MR. SCAHILL: Objection.

24 A. I believe he is permanently
25 totally disabled.

1 A. De MOURA, M.D.

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

4 A. Extremely sensitive.

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

10 MR. SCAHILL: Objection.

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

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

25 MR. SCAHILL: Objection.

1 A. De MOURA, M.D.

2 A. Absolutely.

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

5

6 CROSS EXAMINATION BY

7 MR. SCAHILL:

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

17 A. Yes, sir.

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

24 A. Yes, sir.

25 Q. You indicated on direct

1 A. De MOURA, M.D.

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

5 A. I would surmise so.

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

8 A. I would think so, yes.

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

11 A. That sounds correct.

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

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

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

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

1 A. De MOURA, M.D.

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

7 MR. TENENBAUM: Objection.

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

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

16 A. Not that I'm aware of.

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

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

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

1 A. De MOURA, M.D.

2 MR. TENENBAUM: Objection.

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

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

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

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

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

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

22 MR. TENENBAUM: Objection.

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

1 A. De MOURA, M.D.

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

4 A. That's correct.

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

9 A. Correct.

10 MR. TENENBAUM: Objection.

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

16 MR. TENENBAUM: Objection.

17 A. That's fair.

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

20 A. Sure.

21 MR. TENENBAUM: Objection.

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

25 MR. TENENBAUM: Objection.

1 A. De MOURA, M.D.

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

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

11 MR. TENENBAUM: Objection.

12 A. I remember what you said.

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

17 MR. TENENBAUM: Objection.

18 A. Yes.

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

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

24 A. I don't recall that.

25 Q. When Mr. Durlach came to you

1 A. De MOURA, M.D.

2 your first encounter with him was June 12,
3 2017, is that correct?

4 A. Yes, it is.

5 Q. And that was approximately two
6 years and two months after the accident
7 that he was complaining of, the April 15,
8 2015 motor vehicle accident, is that fair
9 to say?

10 A. That's correct.

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

14 A. That's possible.

15 Q. And he also underwent other
16 treatments, correct?

17 A. That's possible.

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

21 A. Yes, it is.

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

1 A. De MOURA, M.D.

2 A. Yes, it is.

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

7 A. Yes, it is.

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

13 A. That's correct.

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

19 A. Yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

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

9 A. Yes.

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

15 A. Regarding a prior history, yes.

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

25 A. Yes, it is.

1 A. De MOURA, M.D.

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

7 A. That's correct.

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

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

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

21 MR. TENENBAUM: Objection.

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

1 A. De MOURA, M.D.

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

5 A. Sitting here today I don't
6 recall the severity of the impact that the
7 patient may have explained to me occurred
8 during the accident at that time in June
9 2017.

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

17 A. Is that a yes or no question?

18 Q. That's yes or no?

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

20 Q. So you didn't know in June of
21 2017 when you gave that opinion that he was
22 status post blunt trauma whether or not the
23 accident was at four or seven miles an hour
24 or at fifty miles an hour, is that a fair
25 statement?

1 A. De MOURA, M.D.

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

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

15 A. I may have, yes.

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

20 MR. TENENBAUM: Objection.

21 Q. -- is that also fair to say?

22 A. I don't agree with that.

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

1 A. De MOURA, M.D.

2 vehicles involved?

3 A. I believe so.

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

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

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

12 A. I don't recall that.

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

16 A. I don't recall that.

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

20 A. I'm aware of that.

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

25 A. Conversation, no.

1 A. De MOURA, M.D.

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

4 A. No.

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

8 A. That's correct.

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

13 MR. TENENBAUM: Objection.

14 A. I'm not aware of that.

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

18 MR. TENENBAUM: Objection.

19 A. Do I agree with that, no.

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

24 A. No.

25 Q. Did you ever have a

1 A. De MOURA, M.D.

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

5 A. No.

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

8 A. No.

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

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

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

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

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

1 A. De MOURA, M.D.

2 no, Doctor?

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

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

10 A. No, I'm not.

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

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

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

25 A. Those specific, no.

1 A. De MOURA, M.D.

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

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

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

18 A. Yes.

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

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

1 A. De MOURA, M.D.

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

6 A. My PAs always see patients with
7 me.

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

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

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

20 A. Yes.

21 Q. And then he came back to you
22 approximately nine months later in June of
23 2018?

24 A. Correct.

25 Q. And that's the last time you

1 A. De MOURA, M.D.

2 saw him?

3 A. Yes.

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

6 A. That's correct.

7 Q. Is that fair to say?

8 A. That's correct.

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

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

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

19 A. That's correct.

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

1 1 A. De MOURA, M.D.

2 2 that fair to say?

3 3 A. Yes.

4 4 Q. There is a three-year gap --

5 5 A. That's correct.

6 6 Q. -- between when he last came to
7 7 you in November 2018 --

8 8 A. Yes.

9 9 Q. -- and this recent visit in
10 10 June of 2021?

11 11 A. Yes.

12 12 Q. Did he tell you in June of 2021
13 13 the reason he hasn't been here in three
14 14 years and the reason he was coming to see
15 15 you in June was because his case was coming
16 16 up for
17 17 ?

17 17 MR. TENENBAUM: Objection.

18 18 A. It's my understanding he knew
19 19 he was a surgical candidate in 2013. There
20 20 are certain medical conditions that
21 21 confound him undergoing that type of major
22 22 surgery and I would believe that following
23 23 up in this year he was here based on the
24 24 fact that, yes, he was going to have
25 25 proceedings of his legal case.

1 A. De MOURA, M.D.

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

5 MR. TENENBAUM: Objection.

6 A. I would think so.

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

11 MR. TENENBAUM: Objection.

12 A. I would say that's fair.

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

18 A. Yes.

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

25 MR. TENENBAUM: Objection.

1 A. De MOURA, M.D.

2 Asked and answered.

3 A. Yes.

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

9 A. Yes.

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

17 A. Correct.

18 Q. When he came to you in June of
19 2017 did he tell you that he had prior
20 accidents?

21 A. My notes indicate the contrary.

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

25 A. Yes.

1 A. De MOURA, M.D.

2 Q. I'm looking at your notes and
3 it says, "left shoulder surgery 2016 and
4 2017". There's no indication in your
5 June 12, 2017 record that he had a prior
6 right shoulder surgery in 2014, the year
7 before the accident that we're here to talk
8 about?

9 A. That's correct.

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

13 A. Well, it's not documented.

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

17 A. Yes.

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

23 A. That's correct.

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

1 A. De MOURA, M.D.

2 shoulder in 2014, correct?

3 A. It wasn't documented as I
4 stated.

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

8 A. Correct.

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

14 A. Not morbidly but he is obese.

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

17 A. Correct.

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

21 A. That's not what I said.

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

25 A. That's not what I said.

1 A. De MOURA, M.D.

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

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

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

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

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

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

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

1 A. De MOURA, M.D.

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

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

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

10 MR. TENENBAUM: Objection.

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

14 A. Yes.

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

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

19 Q. Would that be significant?

20 A. Significant for traumatic
21 injury, no.

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

25 A. In which context, Counsel?

1 A. De MOURA, M.D.

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

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

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

12 A. That's our usual custom and
13 practice.

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

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

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

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

1 A. De MOURA, M.D.

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

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

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

11 A. Not that I recall.

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

20 A. Yes.

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

1 A. De MOURA, M.D.

2 say?

3 A. Yes.

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

9 A. Yes.

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

17 A. Yes.

18 MR. TENENBAUM: Objection.

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

1 A. De MOURA, M.D.

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

6 MR. TENENBAUM: Objection.

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

9 A. Yes.

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

15 A. Yes.

16 MR. TENENBAUM: Objection.

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

21 MR. TENENBAUM: Objection.

22 A. There are multiple parts to
23 that the question.

24 Q. Let's break it down.

25 If you had a patient that came

1 A. De MOURA, M.D.

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

6 MR. TENENBAUM: Objection.

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

16 Q. Let's break it down.

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

1 A. De MOURA, M.D.

2 and then three days after that on February
3 1, 2006 he goes to a Dr. David Cooling and
4 gets another prescription for opioid
5 medication. Would you consider that to be
6 overuse of opioid medications?

7 MR. TENENBAUM: Objection.

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

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

23 A. I answered that already.

24 Q. And your answer is?

25 A. My answer was yes.

1 A. De MOURA, M.D.

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

10 A. Yes.

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

14 A. Yes.

15 Q. December of 2014.

16 A. Yes.

17 Q. December of 2014.

18 A. That's possible, yes.

19 Q. November of 2014?

20 A. Yes.

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

1 A. De MOURA, M.D.

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

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

11 Q. We're talking about this is
12 2013.

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

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

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

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

1 A. De MOURA, M.D.

2 MR. TENENBAUM: Objection.

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

8 Q. Let's talk about that traumatic
9 injury. When you first saw him in June
10 2017 you also reviewed not the actual MRIs
11 but you reviewed the reports that were
12 ordered by Dr. Obedian at Zwanger Pesiri
13 radiology and those reports were taken in
14 2015, is that accurate?

15 A. Yes.

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

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

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

1 A. De MOURA, M.D.

2 did not look at the actual films, you just
3 looked at the reports that were prepared in
4 2015 from Zwanger Pesiri Radiology, is that
5 fair to say?

6 A. Yes.

7 Q. So can we review those reports
8 together?

9 A. Okay.

10 Q. The first report is the MRI of
11 the lumbar spine that was taken on June 26,
12 2015, and that report is addressed to
13 Dr. Richard Obedian who was his treating
14 physician who ordered that MRI?

15 A. Okay.

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

18 A. Yes.

19 Q. Could you read the impression
20 for the jury?

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

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

1 A. De MOURA, M.D.

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

4 A. Yes.

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

10 A. That's correct.

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

15 A. That's correct.

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

22 A. Yes.

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

1 A. De MOURA, M.D.

2 multilevel degenerative disk disease, is
3 that fair to say?

4 A. That's not all the report says.

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

9 A. That's what the impression
10 states.

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

19 A. Yes.

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

1 A. De MOURA, M.D.

2 that protect the spine, correct?

3 A. Yes.

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

9 A. Yes.

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

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

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

20 A. Who got poked in this incident?

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

1 A. De MOURA, M.D.

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

5 A. Regarding a poke?

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

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

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

15 A. Yes.

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

20 A. That's not something a
21 radiologist reviews.

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

25 A. Once again the word "traumatic"

1 A. De MOURA, M.D.

2 is never used by a radiologist.

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

7 A. Yes.

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

15 A. Yes.

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

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

1 A. De MOURA, M.D.

2 correct.

3 MR. TENENBAUM: Objection.

4 Q. I will break it down.

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

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

14 MR. TENENBAUM: Objection.

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

19 A. That's correct.

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

1 A. De MOURA, M.D.

2 A. You're misinformed.

3 Q. Can we also go on to the
4 cervical spine MRI, did you review this
5 report when he first came in in June of
6 2017?

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

9 Q. I do.

10 A. Thank you.

11 Q. Can you take a look at the
12 impression and read the impression, Doctor
13 (handling)?

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

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

1 A. De MOURA, M.D.

2 A. Yes.

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

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

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

17 MR. TENENBAUM: Objection.

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

20 A. My note specifically states --

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

1 A. De MOURA, M.D.

2 changes"?

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

5 Q. Doctor --

6 A. I'm reading the report,
7 Counsel.

8 Q. Is there an impression noted in
9 that report?

10 MR. TENENBAUM: Objection.

11 A. Counsel, I'm reading the
12 report.

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

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

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

1 A. De MOURA, M.D.

2 spondylitic changes"?

3 MR. TENENBAUM: Objection.

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

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

9 A. Yes.

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

14 A. Yes.

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

19 A. Yes.

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

23 A. Yes.

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

1 A. De MOURA, M.D.

2 A. That's correct.

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

10 A. Yes.

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

16 A. Yes.

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

21 A. Yes.

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

1 A. De MOURA, M.D.

2 MR. TENENBAUM: Objection.

3 A. I don't agree.

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

7 MR. TENENBAUM: Objection.

8 Asked and answered.

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

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

17 A. Yes.

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

22 A. Yes.

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

1 A. De MOURA, M.D.

2 A. He went there.

3 Q. That's where the MRI was
4 performed?

5 A. That's correct.

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

10 A. Yes.

11 Q. Is that fair to say?

12 A. Yes.

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

17 A. Correct.

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

23 A. Repeat that.

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

1 A. De MOURA, M.D.

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

6 MR. TENENBAUM: Objection.

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

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

19 MR. TENENBAUM: Objection.

20 Q. Is that a fair statement?

21 A. Regarding the cervical spine
22 MRI, the MRI performed in September of
23 2017, which is for the full examination,
24 did indeed prove positive for disk
25 herniation which is consistent with the

1 A. De MOURA, M.D.

2 accident of April 15, 2015.

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

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

10 MR. TENENBAUM: Objection.

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

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

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

1 A. De MOURA, M.D.

2 throughout his spine?

3 MR. TENENBAUM: Objection.

4 Asked and answered.

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

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

21 MR. TENENBAUM: Objection.

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

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

1 A. De MOURA, M.D.

2 accepted medical practice to review and
3 compare the MRIs studies that were done in
4 2015 within three months of the accident
5 with those that were done three years later
6 when he came to see you, yes or no?

7 MR. TENENBAUM: Objection.

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

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

11 A. Yes.

12 Q. Is secondary gain taught in
13 medical schools?

14 A. No.

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

18 A. No.

19 Q. Is secondary gain a medical
20 phenomenon?

21 A. Not that I'm aware of.

22 Q. Is it something that you --

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

25 Q. Is it something that you take

1 A. De MOURA, M.D.

2 into account when you see your patients?

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

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

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

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

18 MR. TENENBAUM: Objection.

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

1 A. De MOURA, M.D.

2 A. Well --

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

4 A. It's multiple questions.

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

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

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

1 A. De MOURA, M.D.

2 MR. TENENBAUM: Objection.

3 Asked and answered.

4 A. Yes.

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

13 MR. TENENBAUM: Objection.

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

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

25 MR. TENENBAUM: Objection.

1 A. De MOURA, M.D.

2 A. Yes.

3 MR. SCAHILL: Nothing further.

4 Thank you, Doctor.

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

8 (Whereupon, a short recess was
9 taken.)

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

13

14 RE-DIRECT EXAMINATION BY

15 MR. TENENBAUM:

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

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

1 A. De MOURA, M.D.

2 pulling injuries that cause micro damage to
3 the structures affected.

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

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

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

12 MR. SCAHILL: Objection.

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

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

18 A. Yes.

19 Q. Doctor, Mr. Scahill read to you
20 parts of a November 16, 2014 encounter with
21 Brian's primary physician Dr. Rizzo. I
22 want you to assume that in that note there
23 Brian did not make complaints of neck pain,
24 I want you to assume that in that November
25 2014 note Brian did not make complaints of

1 A. De MOURA, M.D.

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

6 A. Okay.

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

11 MR. SCAHILL: Objection.

12 A. I don't believe so.

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

17 A. Yes.

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

20 A. Correct.

21 Q. What's an allergy, Doctor?

22 A. Inflammatory reaction to a
23 substance.

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

1 A. De MOURA, M.D.

2 statement, correct?

3 A. Correct.

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

6 A. Correct.

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

11 A. Yes.

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

14 A. Correct.

15 Q. Can you tell us what the
16 difference is?

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

21 Q. What's the impression?

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

25 Q. So in your practice as an

1 A. De MOURA, M.D.

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

4 MR. SCAHILL: Objection.

5 Q. You can answer.

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

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

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

18 Q. Why is that important, Doctor?

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

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

1 A. De MOURA, M.D.

2 MR. SCAHILL: Objection.

3 A. I believe so.

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

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

9 Q. I don't have that one.

10 A. 6/2016, I have that.

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

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

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

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

1 A. De MOURA, M.D.

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

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

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

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

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

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

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

24 Q. Fair enough, Doctor.

25 There was also a notation where

1 A. De MOURA, M.D.

2 again I just want to look at your June 12,
3 2017 report where it says,
4 "hospitalizations and surgeries".

5 A. Okay.

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

15 A. No.

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

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

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

1 A. De MOURA, M.D.
2 in a motor vehicle on April 15, 2015, I
3 want you to assume that Mr. Durlach had his
4 seat belt on and I want you to assume that
5 Mr. Durlach's vehicle was rear-ended and I
6 want you to assume that his body moved
7 forward and back, as he testified to, would
8 that impact cause injury to the disks in
9 Brian's neck and his?

10 MR. SCAHILL: Objection.

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

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

20

21 RE-CROSS EXAMINATION BY

22 MR. SCAHILL:

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

1 A. De MOURA, M.D.
2 accident, June 26, 2015, for the cervical
3 spine, there's no mention of disk
4 herniations in that report, in that report
5 they're only talking about osteophytic disk
6 ridge complexes at three levels which you
7 already told me is a longstanding
8 degenerative condition, is that fair to
9 say, yes or no?

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

11 MR. SCAHILL: Nothing further.

12 Thank you.

13 MR. TENENBAUM: Thank you.

14
15 (Continued on next page to
16 include Jurat.)
17
18
19
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24
25

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

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(None)		

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INFORMATION AND/OR DOCUMENTS	PAGE
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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

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

[illegible]

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

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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.

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