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(Jury enters courtroom.)

THE COURT: Be seated, everybody.

Mr. Bottari, proceed.

MR. BOTTARI: Your Honor, the Plaintiffs call Dr. Michael Gerling.

M I C H A E L G E R L I N G, called as a witness on behalf of the Plaintiff, having been duly sworn, testified as follows:

THE COURT: State your name and business address.

THE WITNESS: Michael Gerling, G-E-R-L-I-N-G, 506 Fifth Avenue, Brooklyn, New York 11215.

THE COURT: You may inquire.

DIRECT EXAMINATION BY

MR. BOTTARI:

Q Good afternoon, Dr. Gerling.

A Good afternoon.

Q Prior to today, have you ever met me?

A No.

Q Did we speak last night with regard to this case?

A Yes.

Q Have you ever testified in court before?

A Yes.

Q Do you know the difference between a Plaintiff

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and a Defendant?

A Yes.

Q You usually testify for Plaintiffs or patients?

A The only time I testify in personal injury type lawsuits is for a patient that I operated on.

Q Have you ever testified for the William Schwitzer office prior to today?

A Yes.

Q About how many times?

A I would guess four times over the years, five times, I don't know.

Q Do you anticipate being compensated for your time away from your practice today?

A I would assume so. I don't make those arrangements.

Q Do you know how much you are being compensated?

A Normally, $8,000 for the half day.

Q Can you briefly, and I mean briefly, give us your educational and professional background?

A Yes. So I went to medical school in California at UC San Diego. I was there for four years. I graduated in 2000 and then I did an orthopedics residency for five years.

focuses on musculoskeletal care, so any of those surgeries you have heard of where people replace joints or nerves -- bones, broken bones, fixing the spine, we do a lot of different types of surgeries on adults and children, so that's a large field and within it, it has eight subspecialties, one of which is spine surgery.

After you finish your residency, you can go and do a fellowship to subspecialize in one of those, so afterward, in 2005, I went to Cleveland and did a fellowship for one year with Henry Bohlman, so at Case Western, I was there for a year.

It's a specialty center which specializes in trauma and degenerative disease, so it's a site for helicopters that bring in traumatized patients from four different states.

It's very -- it was one of the original spinal cord injury centers in North America, so it's very focused in trauma, but also degenerative changes of the spine, so when people have arthritis that causes spurs in bone particles to pinch nerves, people have deformity, things like that, from arthritis, that's degenerative medicine of the spine.

So after finishing in 2006, my first job was in Brooklyn at SUNY Downstate campus, an academic center

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where I was there for four years.

By the time I finished there, I was the chief of research and the chief of spine surgery and I was transferred to -- I was offered a job at a level one trauma center in Brooklyn called Lutheran Medical Center where I was there for four years.

As an employee, I was the chief of spine surgery there, taking call on level one trauma patients and treating patients with traumatic and degenerative problems of the spine.

After four years there or during that period, actually, I became a faculty member at NYU and I continued to do research that I had been doing all along through the NYU campus at that point and doing larger scale surgeries on that campus, in parallel with being at the Lutheran campus.

Subsequently, now, that campus became NYU Brooklyn and so I continue to be at NYU since 2014. I'm still the chief of spine surgery at that center.

I do the same type of practice that I had been doing throughout, degenerative and traumatic injuries of the spine.

My group continues to take call in the hospital

or even light trauma, so whatever comes through the ER is fair game.

We also see a lot of patients in the office that are referred to us, not from the ER, but also just from the community, so we have a very large practice and I have a junior partner that works with me as well in that practice.

I'm very academically involved still through NYU. I train residents, medical students, nursing students, technician students, all different types of students will work in the operating room with me and in the office. I teach them basically how to practice clinical spine surgery, really.

I also am very involved in academic societies where I train other surgeons from other parts of the country and the world, really.

I'm on the Board of Directors of the Cervical Spine Research Society. I'm the president of the Federation of Spine Associations in 2020, I think, so the Federation of Spine Associations is -- it's an association of all the major academic societies.

There are about four of them that are sort of ordaining over the different sectors of spine surgery, like one of them is deformity, one of them is spinal cord

injury, one of them is the Cervical Spine Research Society, the other is the North American Spine Society.

So we run the academic education day at the American Academy of Orthopedics and through the -- I am also involved in the American Academy of Orthopedics as one of the members of the spine content educational committee which the Academy of Orthopedics is set up.

So we are the ones who are sort of streamlining and creating a sort of a central body of education and standards of education for spinal surgeons in North America, so I have been very involved in that.

Within their umbrella, we have created a lot of instructional course lectures. I am involved in a lot of different educational materials that are produced including chapters for textbooks.

A lot of peer reviewed journal articles, I publish on a yearly basis. I go to meetings and present primary research, probably four times a year.

I think that my group at NYU, we are responsible for probably about fifteen basic science studies per year and of those, some of them, I am particularly a direct author on the publication, so these peer reviewed journals are -- they are considered the highest level of medicine and in particular, spinal surgery.

We use the data from these studies in order to gear the standard of care and create the standard of care.

Peer reviewed means that other academic spine surgeons have reviewed that research and deemed it appropriate to be published and reasonable, so I'm very involved in that.

I still teach primarily in these instructional course lectures that are associated with major societies such as the Lumbar Spine Research Society, giving lectures. I gave four at that meeting.

I am at the Cervical Spine Research Society, the academy giving instructional course lectures to other surgeons and other type of mid level providers like physician assistants or nurse practitioners.

Q Doctor, have you ever received a grant for any of your work?

A I've had an NIH grant in the past.

Q And NIH is National Institute of Health?

A Yes, and we have had the Cervical Spine Research Society grant. I haven't had anything else recently.

Q Well, you mentioned peer reviewed journals, approximately, ballpark, approximately, how many peer

reviewed articles have you been an author or co-author of?

A You know, I haven't really counted in a long time. I'm going to guess 20 to 30, 30.

Q Do you know what an abstract is?

A Yes.

Q Can you tell us what is an abstract is and have you ever been involved in publishing an abstract?

A Yes. Abstracts are the first summary section of an article and in theory, when you give a podium research presentation at a meeting, you submit the abstract and that's what's accepted at the meeting, so I mean, I presented three different abstracts at just the Lumbar Spine Research Society in April, so the beginning of the month.

Q April of this year?

A Yes, yes, so I am regularly involved in submission and acceptance of those papers.

Q Can you tell us what grand rounds are and are you involved in that?

A Well, when you are invited as a lecturer to different institutions and what not to teach if you're deemed to be an expert in a certain subject, you will

through grand rounds, directly with residents and fellows.

More often, on a regular basis, I am -- like on Monday, I was in the operating room with a resident, so teaching him what we do.

Q Have you or your group ever gotten any awards in the orthopedic field?

A Yes, we have, yes.

Q You are Board certified, of course, correct, doctor?

A Yes.

Q Can you tell us briefly what Board certification is and what is your particular specialty and area of expertise in that field?

A So when you graduate from your training, you take a written test by the board, the American Board of Orthopedic Surgery, and that's something that is also universally taken by graduates of training programs.

Then after two years in practice, you have an expert panel review literally the work that you do, so the MRIs and postoperative x-rays and what not on the patients you treat on their charts and see how they did, so it's sort of like a trial to see how you did in your first two years of practice and whether you are

appropriate for certification.

So after I passed my two years and passed the test and became Board certified, every ten years, you get recertified, so I recently in 2017 was recertified, so that now, I am Board certified until, I think, 2028, so, yes.

Q Did there come a time when Mr. Edward Carter became a patient of yours?

A Yes.

Q Do you know how he was referred to you?

A Yes.

Q You can look at your notes, we have actually marked some of your notes in evidence and we have already marked in evidence the hospitals where you did the surgeries on Mr. Carter.

A I believe he was referred to me by his primary care doctor, Dr. Williams.

Q When was the first time that you saw him?

A On October 29, 2014.

Q At that time, can you tell us, did you take a history, did you ask him what his complaints are? Just go through what you normally do and what you did at that time and as I said, you can look at your notes to refresh

A So, actually, I know Edward quite well because I saw him a lot and he was a very difficult case because of his comorbidities and because of the extent of the challenges we had with diagnosing his problems.

So at the time when I first saw him, he was 52 and he had been injured in a car accident. He was -- the accident occurred on July 3, 2012.

He had neck and back injuries in addition to some other extremity pains. He had pain radiating into his shoulders, into his right arm and hand. He had numbness in his right upper extremity. Actually, he had, I guess, numbness extending into both extremities.

He had pain in his back that went down into both legs. He had difficulty carrying out regular daily activities since the injury. He had not been working.

He reported clumsiness in the hands, weakness in the right upper extremity, balance problems that caused him to trip.

He had occipital cervical headaches, that means that he had pain radiating from the neck back into the back of his head which is a characteristic finding of neck problems and he said that that was occurring almost all of the time.

He had difficulty walking, due to the leg pain,

even one block at a time. He said that the pain was worsened when he stood up or walked, that he had undergone three months of physical therapy for the neck and the back.

He had tried Tylenol and Tylenol Number 3 which is a narcotic that has Codeine in it, basically, so it's a medicine that he had been taking that's a little bit stronger. He had tried injections twice in the back without substantial relief.

That day, we reviewed his comorbidities, the other medical problems he had which included heart failure, high blood pressure, diabetes. He had obesity.

We reviewed the fact that he had undergone knee surgery on the right -- bilaterally, one on the right in 2005, the other 2007. We did a physical exam on him that day.

Q What type of physical exam do you do and what's the clinical significance of that, doctor?

A Well, physical exam is where -- so the first -- everything I just told you was really what we discussed. It's verbal.

In the physical exam is when you actually record and measure different aspects of a person's being, so you

help diagnose and refine your diagnosis through that.

So in general, I reviewed that his low back had significant restricted range of motion, so he had difficulty moving his back, his neck as well. In both his neck and his back, he had spasm and tenderness.

Q Doctor, let me ask you this. A, what is spasm and B, can you fake it?

A Well, spasm is involuntary, so by definition, you don't.

Spasm is when you don't -- you don't want to, but your muscle is contracting, so you're not actually purposely intentionally tensing up the muscle.

It's a protective reflex the body has in order to protect your spine if the body thinks that there is something wrong with it, so, for example, if five hundred years ago, you were alive and you broke your back, well, what would keep you alive longer.

Well, if you had the muscles tense up and tighten up, it would sort of be like a splint to hold you stable or at least help you be stable and also, probably restrict your activities a little bit until the body had a chance to try and heal it, so it's a protective reflex that the body has. It's palpable.

I mean, anybody who has had a calf cramp or what

not, that's a spasm of the muscle and you certainly don't like it. It doesn't feel good. Nobody would involuntary do that. It does restrict the motion too, so your body is intentionally trying to stop you from moving your back or your neck.

The point of recording that is really that people have spasm and tenderness when they have an injury at that site, so you don't normally just spontaneously walk around with tenderness in a spot, a focal tenderness.

That's how we diagnose things. We look at the sites, we touch them, we try to identify where it is most tender and if there is spasm or instability, those are the types of things we record.

Anyway, those were the findings. They were significant in his neck and back.

I looked at his extremities. I did not find any significant evidence of pinched nerves in his upper extremities so we test to see if people have carpal tunnel or cubital tunnel syndrome by tapping on the places where the nerves are and we try to investigate whether there is evidence that the nerves are being irritated in the arm or leg and I did not find any evidence of that.

he had weakness in the lower extremities, in both legs, both in the -- in his quadriceps muscles, his hip flexors and also in his extensor hallucis longus muscles which is -- that's when you left your toe up and if you have weakness in that, it suggests that the nerve that controls that muscle is either damaged or not working properly.

Q Let me stop you right there.

What nerve are we talking about, from what --

A That's the L-5 nerve root and that nerve root was found to have two grades of weakness on the left side, so that's the L --

Q Can you describe for us the zero to five scale of --

A So if somebody has five out of five strength, that means that they have normal full strength.

If they have a grade of weakness, that means that they have four out of five. If they have two grades, that means three out of five.

Zero means you can't even tense your muscle or get the muscle to fire at all, somebody who is completely paralyzed, but then people can have three out of five strength which means that you can move the joint, but you don't have enough strength to really break gravity.

Four to five would mean that you can break gravity, but you really don't have a lot of strength to resist any type of force, so that's -- I mean, that's a direct test that I performed with my hands and it's something that is -- when you performed thousands and thousands and thousands and thousands of those tests, you have a pretty good sense of whether it is real or not real.

It's something that in theory, the patient has some control over, but you can, as a clinician, you can detect whether or not there is -- whether there is effort. And usually, if there is not effort, you make note of that.

He also had weakness of the upper extremities including his triceps muscle on the left side, his grip, so weakness in the hands bilaterally.

He had blunted reflexes in the upper extremity and the lower -- in the lower extremity, so what does that mean.

Well, if a nerve is being pinched that goes to a certain area of the body, that nerve doesn't function or react the same way it normally would because it is either delayed or the signals aren't going through the nerve

So if a reflex is decreed, then that means that the nerve is not functioning as well, so we have reflexes that we test in order to test each nerve root and in this case, I found that he had blunted biceps reflex, so that means that the nerve that controls that biceps reflex was being pinched and that's typically the C-6 nerve root or C-5.

Q C-6, we are talking in the neck, the cervical --

A Right, the cervical --

Q 6 out of the 7?

A Right, so that's a reflex that comes from the neck down into the arm and that nerve root is associated with disc herniations at the C-5-6 level.

He also had reflexes in the lower extremity, they were blunted as well.

The patella reflex which I have in my note is the reflex that when people tap on your knee and your foot jumps, that reflex is the L-4 reflex and so that reflex was flattened as well.

Bilaterally on both sides, he had -- he had abnormal heel cord reflexes which is the Achilles tendon, when you hit the heel, which is the S-1 nerve root.

During my examination, he had numbness in his fingers and in his toes and I also reviewed a CT scan

that day of his neck and his back and his right shoulder.

The CT scan was from 2012 and CT scans are performed --

MR. McGUINNESS: Can we get a question and answer?

Q Doctor, can you tell us the difference between a CT scan and an MRI and why you deem -- what you deem significant about each with regard to soft tissue injuries as opposed to fractures in bones?

A Sure, right. So a CT scan is similar to an x-ray. If you have ever seen an x-ray, it just looks like you see the outline of a bone.

The reason for that is that CT scans shoot a beam of radiation through you and what stops the beam is calcium, basically, the calcium that's in your bones so that mineral that's in the bones, that density is what you see on the x-rays, and we're going to review an x-ray later today and you will be able to see that.

CT scans are really the same type of technology, but instead of just being a blanket picture of you, it's actually a slice through you, so you can see everything in detail in slices, so it's very popularly used to image the bones.

for a broken bone or for spurs or other type of abnormalities in the bone itself.

It's not great for looking at soft tissue that doesn't have mineralization, so discs, especially a fresh disc herniation that wouldn't have any calcium at all in it, or nerve, for example, they don't really have minerals in the nerves, typically, that's why it's not so great for looking at those.

Sometimes, you can see shadows and you can see the outlines and, particularly, the more aged a structure is that's been damaged, the more likely it will show different aspects on a CT scan.

An MRI is very different. An MRI is literally a magnet that slices through your body, the same way a CT scan does, but the MRI is a magnet.

So magnets are able to distinguish the difference between soft tissues like, for example, water, liquids that are in the body, like blood or like the fluid around the spine, the nerves, the discs and what not.

So MRIs are more commonly used to evaluate those things, but because of the presence of the strong magnetic field, we can't always use it.

Sometimes, people have metal shrapnel in them or a debridement, as in this case, that prevents you from

being able to use a big magnet.

The magnet would pull those tissues around where the metal is or they would damage the implant, so like in this case, a debridement would get damaged by the magnet.

Q So you said you reviewed a CT scan, CT scan from 2012, correct?

A Yes.

Q And what, if anything, was significant when you reviewed those CT scans?

A The main thing that was significant really was that it didn't show any fractures, any broken bones.

It was a very early study that was done very soon after the accident had occurred, so really, what you would expect to see is if there was a broken bone or if the bones had shifted because the bone was dislocated or literally shifted in its position because of the extent of the injury.

Typically, we would see that in people who have extremely high energy injuries, like if you fell off a building, literally got run over by a truck or something like that, you would expect to see fractures, you would expect to see completely dislocated bones, that type of thing.

like skull fractures, things like that. But when we use that, we don't -- we're not -- we are really using it as a screening tool to look for something that's catastrophic that really needs to be treated immediately at that moment.

Q In a perfect world, if Mr. Carter did not have the defibrillator, the better technique would have been an MRI, correct?

A Yes.

Q Now, as a result of your initial screening of him, your physical exam, the tests you did and everything else, did you, in fact, order any tests at that point in time?

A Well, at that point, we recommended, because he couldn't have an MRI, that he continue with physical therapy, that he continue with taking the medications he had been taking and come back in six weeks.

Q Did he, in fact, do that?

A Yes. So he came back on December 10, 2014 --

Q Doctor, let me stop you, I apologize.

Clinically, what did his symptoms suggest to you as an orthopedic surgeon, especially in the fields that you are talking about, the spine and head and neck and the spinal cord, clinically, what did he show symptoms

of?

A So, clinically, he had radiculopathy. I basically diagnosed him with cervical and lumbar injuries.

He had evidence of radiculopathy on examination which means that the nerve roots from the spine, there was suggestion that there was something wrong with them.

We talked about the fact that his reflexes had changed, that he had some weakness and that there were some numbness on examination and by history, so those all were very strongly suggestive of the fact that he had a pinched nerve or some type of insult to the nerves and we call that a radiculopathy.

Q So did you tell him to come back in six weeks?

A Yes, so he came back on December 10, 2014.

Q What type of exam did you do, what were his complaints and what did you deem significant at that point in time?

A Well, he had -- he really didn't have significant change in his symptoms, despite the fact that we had been following him for his conservative management, so we examined him and we really didn't find much change in his examination during that visit.

Q What was the date of that --

A -- during that visit --

Q What was the date of the CT scan that you reviewed?

A 11/13/14.

Q Was it of the cervical spine or the lumbar spine or both?

A It's the cervical spine.

Q And you reviewed that CT scan yourself?

A Yes.

Q What did that show, doctor?

A It showed multi-level disc herniations in his neck. It showed central disc herniations at C-3-4, 4-5 and C-5-6, broad based disc herniation.

Q Now, what does that mean in English, what does that affect in terms of parts of your body, where would that impact, for example, the C-5-6 level, who would that manifest itself in terms of pain or discomfort to a person?

A Do you have a spine model that I could show that would help me explain that?

Q I have one here.

MR. BOTTARI: We will mark this for demonstrative purposes.

THE COURT: For identification.

A It's quite small, I would like to show you, if I can approach.

So it's confusing because normally, the spine has muscles and tissue around it, but also normally, you have a rib cage, so when you see skeletons, normally, you would see a rib cage coming around in the thoracic zone of the spine and you would have, of course, legs and what not.

This is the pelvis down at the bottom of your spine, so the cervical spine is in the neck and its anatomy is different than the other parts of the spine, so the thoracic spine is different from the cervical spine which is in the neck.

This is the base of the skull and then the lumbar spine is everything below the ribs above the tailbone.

What you will notice is that there is some mobility of the spine, everybody knows that you can bend your back and twist and bend your neck. Well, the reason you can do that is because of the joints that are between each of these bones.

These bones are kind of like rings and the reason that they were made that way by God is because there is a

spinal cord goes through so it comes from your skull where your brain ends, it goes into the canal here and extends down through this canal into the body.

It ends around the middle of the lumbar spine and these nerve roots are exiting the spinal cord throughout the whole way.

You could see sort of a view of the spinal cord right here, but the spinal cord just is sort of -- it's almost like a part of the brain and once the nerve roots exit the spine, they are called nerve roots, and that's actually considered a part of the peripheral nervous system.

These nerves are what control your whole body. They control your muscles. They control your reflexes, the way you reflex. If you stepped on a nail and your foot jumps up, that's what a reflex is.

It also controls sensation. It also controls your belly, some of the different things that are controlled in your -- for example, like your heart, what not.

So if you're scared, your brain is telling the heart, you better get ready to run, it makes the heart beat faster, right, so that's the nerve roots.

These discs that are in the front are joints that

are slightly different than the joints you might be used to like your knee where it really has a lot of mobility and they slide.

Instead, these are discs that are almost like the heel of a shoe where it's a gel insole type heel. The Jello that's in the middle of those discs is called the nucleus and it has like a ring around it, so it's almost made like a shock absorber.

That ring is really good for shock absorption, but it's not great in other ways, like, so, for example, if you twisted really hard or you jerk it in a certain way, sideways, it's not so great for that.

Just like you would imagine for a shoe, the heel isn't made for resisting side to side motion, right, the sole of the shoe does, but the cushioning side doesn't really do that, right.

There are joints in the back of the spine that do that that help kind of keep the spine from shifting around, so there are some joints in the back.

Then the joint in the front is relatively vulnerable when it gets twisted or jolted in some way, like sideways and what can happen is, if it gets damaged like that, just like a balloon, if you blow up a balloon

MR. McGUINNESS: Can we try to get this into a question and answer --

THE COURT: Overruled.

Q You may continue.

A The outer rim of this disc, that outer rim can get damaged just like a balloon does and when it pushes out, it's called a herniation.

A herniation is something where basically that disc isn't supposed to be in that area and just like any joint, if you damage a joint and you have that herniation, it's going to hurt in that area, right, you would imagine, it's like anything, any other type of injury to the body is going to hurt at that site.

But beyond that, if that herniation now is pressing on a nerve root, you can imagine it can stop the function of that nerve root, but it can also hurt, right, so if the nerve root gets irritated and inflamed, it will hurt.

What we found is that even small disc herniations can cause that pain and the reason is --

MR. McGUINNESS: Your Honor, I have got to --

THE COURT: Ask some more questions.

Q Doctor, can a nerve root, if it gets irritated,

cause pain?

MR. McGUINNESS: Can we have him take the stand?

THE COURT: If he's through with the --

THE WITNESS: I'm not through with the --

THE COURT: Okay.

MR. BOTTARI: He's not through with the model.

Q Just use the model, let us know when you are finished with the model.

MR. McGUINNESS: Your Honor, side bar. That's not the issue.

THE COURT: Come on up.

(Discussion held at side bar.)

BY MR. BOTTARI:

Q Doctor, specifically, let me ask you this question before you continue.

Specifically, a nerve root irritation at L-4-5 or L-5-1 level, where would that manifest itself in terms of pain and what would a patient typically feel, can you answer that question? You can use the model.

A So it really depends on where the disc herniation is and the type of disc herniation.

nerve directly and sometimes, when it's smaller, it's just leaking the internal enzymes that are in it.

That's why we think that smaller disc herniations can cause just as much pain as the big ones.

If those enzymes leak out where the nerve is, they can start almost eating up or damaging the nerve and the nerve is on fire, almost. It will shoot pain in the distribution of where that nerve is.

That's why people have very characteristic zones of where they would have numbness, very characteristic zones of where they have pain and very characteristic muscle weakness or reflex changes.

THE COURT: Tell us about L-4, L-5.

Q At L-4-5, where do you normally see pain, does it radiate down the leg, tell us?

A So it would radiate down the leg the way it did with Mr. Carter.

MR. McGUINNESS: Objection.

A The side of the leg --

THE COURT: Overruled.

A -- where it would go down the side of the leg to the front of the shin, to the dorsal foot. That's L-5 --

Q What is that?

A The top of the foot.

Q How about L5-S1, what is the traditional radiation pattern of injury with regard to that irritated nerve at that level?

A That would be the lower nerve and that would go down the buttocks area down the back of the leg, more in the calf area and to the side of the calf and to more of the sole of the foot.

Q If you have a broad based herniation, could that go into one or both legs?

A Yes, so it can go into both, exactly. It depends on how broad based it is because sometimes, the herniation such as in this case actually extends from the midline, so the middle of the back, the canal there, out to where the hole is.

Sometimes, it can capture more than one nerve root or irritate more than one nerve root, more than one nerve root on the same side or it can also extend to the other side as well.

Q Have you finished using the model for now?

A Yes.

Q Thank you.

So you have now seen updated CT scans for Mr. Carter, correct?

Q Did you come to any sort of a determination as a result of the clinical picture and the updated CT scans that you ordered?

A Yes, that he had a cervical disc herniation with radiculopathy.

Q At what level?

A At the C-3-4, 4-5 and 5-6 levels, so at three of those levels.

Q So did you make any determination at that time with Mr. Carter as to whether he should continue what's called conservative treatment or undergo surgery, what did you discuss?

A So at that point, we discussed removing the pressure off of the nerve with a cervical surgery, basically, where we would remove the disc and put in an implant, a fill-in.

Q At what level?

A Well, we discussed doing it at three levels that were injured, but that's with the understanding that when I'm actually in there and I'm looking at them, that I would make a determination of which one I thought was the most significant or the most important to remove.

Q Is that, in fact, what happened?

A Yes.

Q So you actually planned to do surgery, correct?

A Yes.

Q And on at least two or three levels and what did you actually do when you got into Mr. Carter's neck?

A So on February 23, 2015, he was brought to the operating room.

Q Where?

A At Lutheran Medical Center.

Q Just so you know, we put the Lutheran records in evidence, from the surgeries, the two bottom parts, the pile there.

Can you tell us what the name of the surgery is and what your pre-op diagnosis was, what your post-op diagnosis was, what you did and then I'm going to ask you to step down because we have some blow-ups that I would like you to comment on.

A Sure, so anterior cervical discectomy and fusion, so ACDF, sounds like a lot, but if you know what each part means, it's kind of obvious.

Anterior means that we're going through the front of the neck. Cervical means it's the neck part. Discectomy means we are removing the disc, the bad disc and fusion means that we are actually making the bone

puts in a cavity and puts in a filling, same idea.

Q What level or levels did you determine needed this type of procedure once you got in and saw his neck?

A I determined that the C-5-6, that's the one disc at the bottom, that that was the most severe and that we would treat that at that time.

Q And that's what you did?

A Yes.

MR. BOTTARI: With the Court's permission, I would like to have the doctor step down and review some blow-ups and explain to the jury in more detail what he did using several of them as demonstrative at this time.

I do need an easel, if we have one. I think it's over there in the corner.

Let the record reflect that the doctor is using Plaintiff's Exhibit 9 for identification.

Q Go ahead, doctor.

A So this is, believe it or not, this is actually a fairly common procedure.

The neck, if you looked at a person just standing in front of you, these structures are relatively deep within the neck in the center of the neck, underneath what you call the apple core or the front of your throat.

So once the patient is positioned and in this case, Mr. Carter, once he was positioned, he would have been cleaned up and prepped for the surgery.

We would make a cut on the front of the neck right here and through that cut, we would actually make an approach to the spine in order to safely be able to operate on the spine, so we remove some of the structure to the side.

We would pass the throat where you swallow and where you breathe through, so we call that the trachea and the esophagus and we would sweep that to one side.

On the other side, we would have some muscles and the carotid sheet that has the carotid and the jugular vein in it.

Once those structures are safely swept to the side and we are actually on the spine itself, that's when we can directly with our eye see the spine.

We use magnified loop glasses, we call them, just like you may have seen in the dentist office, I don't know, but we use those in order to actually be able to see the structures that are present.

Once I did that, I determined that the C-5-6 level and the way we -- why we call it C-5-6, each bone

on the number, so the C-5-6 disc is the disc that's between the C-5 and C-6 bones.

When I decided to remove that disc, we would then literally cut it out with a knife and with different tools to try and remove it and we would use literally a drill to square off the end plates.

At that point, we can actually remove the posterior disc herniation and take the pressure off the nerve.

When I did the procedure I actually did find a disc herniation in there with my eyes. I actually removed this disc herniation.

Then once I am satisfied that I have removed all the pressure and all of the issues that are in the spine, that's when we would actually go through the process of stabilizing and making the disc now sits in a good position, because you don't want to just remove it and then let it flop around, because it's not stable.

So at that point, once we square things off, I would place a spacer which is like a cage, it's made of a -- in this case, I believe it was made with PEEK, let me just see, excuse me one second.

So there is a choice of what type of cage you use and in this case, it's a type of plastic that's very

similar to bone in terms of its flexibility and it's inert, so the body doesn't see it, it doesn't know it's there, the immune system doesn't attack it, so it can just sit there forever.

What it does, it sort of holds the bone in the right position, so they can't collapse and then so the bone could heal in that position. That's called a cage.

So after placing that nicely and having it in a nice clean fashion, sitting in a really stable position, then I would put on a metal plate on the front that holds the bone perfectly still, almost like a cast or an internal splint, so that when he wakes up and starts moving his head, the bone isn't rotating and moving.

The more stable it is, the more likely it's going to heal in that position and heal well, just like a cast on the arm. If you didn't put on a cast, well, it might heal, but it might not heal in the right way or it might not heal at all, so the point of doing the plate is to really stabilize it and to help it heal.

The next -- so then, once the procedure is over and we sort of get control -- we have control of the fluids, the bleeding or other issues that might be present, we inspect the area and make sure everything is

This is sort of what it looks like if you're looking from the front, but in the bottom left image, you could see what it would look like if you sort of transected it, looked at it from the side.

There is a cage in between where the disc used to be. The posterior part is decompressed. The anterior plate with the screws, they are stabilizing the plates in the bone.

These are the actual x-rays from May 8, 2015, of Mr. Carter, that showed the actual implant in between them. That's the little markers that are there in the disc space and then the actual plate that's sitting on the front.

You could see from the side, because it's metal, it has that mineralization, that's why you can see it on the x-ray. You could also see that discs that don't have implants in them, you can't see them. They are clear.

Q Now, doctor, does this implanting of the PEEK spacer and the plate and screws, does that affect the range of motion of Mr. Carter's neck?

A Yes, well, there will not be motion at that level again unless it doesn't heal. In this case, it did heal.

If it didn't heal, then there would be ongoing -- there would be motion at that level, but because it

healed, we accomplished our objectives here, it healed. There will never be motion again at that joint.

Q That's permanent?

A It is permanent, yes.

Q That's a restriction of motion he has to live with forever?

A Yes.

Q Let's briefly talk about the complication that happened with regard to the seroma.

Can you tell us what that is?

A So I was saying before that before you close the wound, you have to sort of inspect the area and try to make sure that there is no bleeding.

The body has natural secretions, just like when you skin your knee, when you are a kid and you could see that there was sort of like a sweating of the tissue on the exposed portion, that's tissue, that's serous liquid that's actually in all of your tissues right now.

The reason it doesn't leak out all over the place is because you have an outer skin that sort of seals it.

Sometimes, when we do a surgery, for whatever reason, the body, it secretes that seroma, that serous fluid into the area and it creates an accumulation of

That plus maybe some bleeding or what not can accumulate in the wound and it can be detrimental. It can start pressing on the airway. It can start pressing on the esophagus so you can't swallow very well and it can start leaking out of the wound.

The concern is that it could be pus, like, in fact, infection or it could get infected because you have this fluid and like bacteria would love to live in it.

So when he came back to my office at his two-week visit, it was obvious that he had quite a bit of fluid in because of the fullness of his neck and because some leakage of fluid was noted, so that's why we had to send him to the hospital and have him evaluated.

Imaging was done, including a CT scan, that showed that there was a large accumulation of fluid in his neck and also, unfortunately, that we needed to take it out.

The labs that were performed showed that it wasn't infected, luckily, but if we didn't do anything about it, it likely would have become infected. It certainly would have been very difficult with him to live with that much fluid pressing on his esophagus.

That's not a common complication. I would say that it happens in one in three hundred or four hundred

people, maybe one in five hundred people and it can be just -- because you start over again, it's almost like you had your surgery, recovered for two weeks and had the surgery again.

I mean, I would say that he was definitely predisposed to that because of his illnesses, all the different issues he had including the diabetes.

Q We have now discussed his first two neck surgeries, correct?

A Yes.

Q Just resume your chair for a few minutes, we will talk about post-op, et cetera, and what you found with regard to his back and then I will ask you again to use the blow-ups to talk about the back surgeries that you did, okay?

A Yes.

Q We are now past the seroma, that's sometime in March of 2015, I believe, doctor?

A Yes.

Q Did Mr. Carter then come back to you after the -- we will call it the second neck procedure, and what were his complaints, do you recall?

A Well, throughout the perioperative, the

pretty common in people who have a surgery like this, so swallowing issues, soreness on the back of the neck, pain.

He also complained about his speech and he had been seen by speech and swallow which is a therapy that you can get which helps you sort of regain your swallowing, it's like rehabilitation for the throat.

He also complained of the pain radiating into his trapezial area, so in March, those are the issues that we focused on until his follow-up visit on March 25, 2015.

Q What happened at that time?

A So up until that point, we continued to focus on the neck and rule out the fact that he had had an infection, so we reviewing his labs, making sure that the tissues that had been taken out during that wash-out procedure were fine. He returned again in May of 2015.

Q What were his complaints and what areas did you focus on at that point in time?

A So he continued to have the neck discomfort and numbness, but we also discussed his back pain at that point, so we sort of started to take a look at his bigger picture again.

He continued to have back pain that was radiating into both legs in the L-5 and S-1 dermatomes with

paresthesia which is sort of tingling, numbness type sensations.

He was only able to walk one to two blocks because of the pain. He had difficulties with his daily activities because of it.

He was taking Percocet, still, which is a pretty strong narcotic pain pill and he was doing a home exercise program, so, really, that, in addition to bracing, he was really doing all the things that we can do to try and abate the symptoms or try and improve his situation.

His examination did show now, a straight leg raise which is something that is -- which is a test that we do where we lift somebody's leg and if you have a pinched nerve in your back, it will actually cause the pain to radiate into the leg.

Q Just so we are clear, straight leg raising test is usually performed one of two ways, correct, you are lying down on the table and you lift someone's leg up?

A Yes.

Q And 90 degrees would be normal, correct, 80 to 90 degrees?

A Yes, normally, you can raise your leg 80 to 90 have a tethered nerve root, if your nerves are being pinched in your back, when you raise the leg beyond 60 or 70 degrees, the tethered nerve root starts -- the symptoms start getting worse.

Q And you found -- you said he had a positive straight leg raising test?

A Yes.

Q That would indicate what in terms of where the problem is in general?

A It indicated that the nerve was being pinched in his back. Before the days of MRI, that was one of the principal findings that we used to determine whether to operate on somebody.

Q What level would that be at, the pinched nerve root, essentially?

A Well, in this case, it would have been at the L-4-5 and/or the L5-S1 discs, so both places can cause that type of symptom.

So at that point, we ordered a new CT scan of his low back. We saw him again in May -- May 14, 2015, really, with no substantial change in his symptoms, and at that point, we discussed the possibility of doing surgery on his lower back.

Q Just so we can put this into perspective, he had

clinical symptoms of problems in his low back, correct?

A Yes.

Q He had a positive straight leg raising test?

A Yes.

Q And the CT scan showed what, you reviewed the CT scan?

A Well, in addition to that, he also had neurologic problems that we had already reviewed earlier that really hadn't changed.

He still had had the weakness in the L-5 muscles and he still had the lost reflex down below in his lower leg, all of which pointed to the L5-S1 nerve roots.

So we reviewed the CT scan and it showed an L-4-5 disc herniation and that's when we brought him to the operating room on June 8, 2015.

Q What type of procedure did you perform on Mr. Carter at that point in time?

A So we went into the spine and removed the disc that was damaged. We identified it.

Do you have anything that could help me demonstrate that?

Q Absolutely. In fact, we have a plate that shows that.

So when somebody has a disc that's damaged in the lower back, similar to what we saw on the model which I'm going to bring over as well, so when the disc is herniated, but it's inside the canal, the goal is to go into the canal, into the area where the disc is and actually remove the disc and take it off the nerves.

Sometimes, as in this case, the nerve is being pinched in a broad based disc herniation so that the disc herniation is not just a little bump like this, but actually, it extends around the disc and out the hole where the nerve is.

So the goal is to go in and try and resect and remove bone and disc to make space for the nerve and that was the goal of the procedure, was to go in and make that space.

So after cleaning up his back, this is looking at him from behind, this is just a cartoon, of course, but the exposure is cut whereby we would go down and pull the muscles to the side and expose the spine.

These are the joints in the back of the spine that I was telling you about earlier, that's called the facet joint and then the disc would have been deep inside the canal.

In order to take out enough of the disc to make

space for the nerves, enough of this facet joint had to be removed whereby I felt that his back pain would get worse and it would be unstable if I didn't actually stabilize it, so that's the reason why after we took out the bad disc with this picture right here, we elected to actually put in screws and stabilize the bone.

Q At what level did you do that?

A At the L-4-5 level.

Q Using yourself as a model, could you just point to approximately where that is?

A That would be in the lower back, just above the buttocks, so right -- if this is his pelvis, right in the lower back, in this area.

So after -- we could see here, it's pretty obvious, once you have taken out enough of the bone, that that bone would be sort of flapping around if you didn't do something about it.

What we did was we actually removed the balance of the disc and put in this cage just like the cage we put in the neck and actually stabilized the front of the spine with that cage and we put in bone graft.

Then afterwards, we put in screws that are about the size of your small finger and these screws go from

looks like this, and actually, lock the bones together.

So we put a rod between them, this is made out of titanium which is an inert metal as well so you don't have an immune reaction to it.

After we removed the bone and put in these rods and screws, we would put in bone grafting material in the back as well and this is ultimately what it would look like at the end of the procedure. Let's see what else we have here.

Q The two plates that you just showed us are Plaintiff's Exhibits 12 and 13 for identification.

A Yes. Then in this last model, you could see the sort of finished product.

That is similar to what his x-ray looked like where the screws are actually extending into the bone and then you could see the inner body spacer right here.

This is what it would like from the side where you removed the disc, placed in sort of like a stabilizing cage and bone graft.

Then here, you have the screws with the rod connecting them from the side, so those screws extend from the back of the spine to the front of the spine. They are very strong so that he could get up and move around without the bone shifting.

Now, this x-ray was actually taken not immediately postoperative, but actually later and at this point, this x-ray was taken because he was having a lot of postoperative pain.

Q Can you give us a date, doctor?

A That was on October 19, 2017, and if you look carefully at it, the cage is supposed to be in between the bones.

If you look at this cage here, these are the markers of the cage. The cage has gone from where it's supposed to be and it's pushed back out into the back of the spine and, in fact, the space that we had made that should be about this big has collapsed.

So that's what I was saying before, if you don't put something in there, the bones will collapse and in this case, for whatever reason and probably because of the combination of his medical issues, the bone didn't heal together when we did this procedure.

If you don't heal over the course of time, there is going to be more and more motion and if there's enough motion, eventually, things fail and you can imagine how painful that is, but these screws inside his spine are wobbling around and compressing the bone around them.

trying to stabilize things, and because it collapses, you have implications because the nerve roots that are exiting would get pinched and indeed, the nerve root passes right by here where this cage is.

So one would expect, if you put a cage into this area here, that's like putting a huge disc herniation or a thumb almost into the area where the nerve root is exiting, so that, you could see, right here, the cage is pushed out to the side and pushed backwards.

Q So those x-rays are taken over two years after the spinal surgery?

A After the initial surgery.

Q Yes, okay. You did a second surgery on his back; am I correct?

A Right, that's correct.

Q If you can find those in a second.

A So initially, this x-ray that we were just looking at was a little bit delayed because in the interim, between the first surgery and that x-ray we are just looking at, we had done a CT scan that showed that the bone wasn't healing.

So the goal had been to have these screws in the bone stable and that the bone would heal together, but because it wasn't healing, I took him back to the

operating room and we diagnosed him with what's called a pseudoarthrosis which means that the bone hadn't healed.

So after it's about a year, if the bone hasn't healed and you start having that pain and the back is not feeling better, that's when we order a CT scan and we determine whether or not we have to go back in and try to help it heal.

So he had a second surgery and that second surgery, I believe it was September 26 --

Q Yes, 2016, it's on the top of the board?

A I just wanted to confirm that's correct, but so this second surgery, the point of it was to try and help the bone heal.

We went in and we removed the screws. We went in and exposed it. We did a much more aggressive exposure with much more bone graft, new screws to try and stabilize it and try and basically force the bone to heal.

We actually diagnosed the fact that -- we actually diagnosed the fact that the bone had not healed during that procedure, so the post-op diagnosis was that he had a pseudoarthrosis.

So where was I? So after we did a more

at that point, again, the hope is that it's going to heal.

This was in September of 2016, when he continued to have pain and we ordered a post-op x-ray, that was the x-ray that we were looking at before, so this x-ray was done a little over a year after this revision x-ray, this revision surgery.

This x-ray shows the way the spine would be now with the screws in the bone still, but the bone -- the interbody spacer has pushed backward and it's pressing on the nerve root.

So this is an x-ray that was done a little over a year later and at that point, we would expect that it would have healed. This is unusual for somebody to have the bone not heal after two procedures on it.

Q Doctor, given the two procedures that you did on his back and the fact that the spacer has become dislodged and the screws aren't where they were when you put them, they are not in the same place as when you did the surgery, does that cause him pain at this point in time?

A Yes.

Q Is it your opinion that he needs an additional surgery on his back to correct --

MR. McGUINNESS: Objection, leading.

Q What clinically does that mean in the future for Mr. Carter with regard to his back?

A Well, it's an absolute indication for revision surgery, so he's going to require somebody to take that spacer out and somehow force the bone to heal and we discussed that during his visit on February 1, 2017.

Q Let me ask you this, approximately, what is the cost of the two surgeries you have done, well, actually -- the neck surgery and the seroma surgery, do you know what the cost was, approximately, of those two?

MR. McGUINNESS: I'm going to object as to whether or not it's compliant with the regulations that apply to the surgeries. Object to the form of the question as posed.

THE COURT: Rephrase it.

Q What is the usual and customary charge for a surgeon such as yourself --

MR. McGUINNESS: There is a regulatory price that they are allowed to charge under the regulations. Ask if he establishes that he knows that and that's what he is entitled to.

THE COURT: I will sustain that.

you are allowed to charge for neck and back surgeries?
A Yes, well, there is a usual and customary rates fees schedule.
MR. McGUINNESS: Your Honor, the regulatory charge is what --
THE COURT: Excuse me, if you want a side bar, ask for one.
MR. McGUINNESS: Yes.
(Discussion held at side bar.)
BY MR. BOTTARI:
Q Dr. Gerling, you performed a neck surgery in early 2015 and a revision with regard to the seroma for the neck in March of 2015, correct?
A Yes.
Q You also performed a surgery on the L-4-5 or L5-S1 level in 2015 and then an additional back surgery in September of 2016, correct?
A Correct.
Q Do you know how much Mr. Carter has paid you for all of those operations, approximately?
A No, I don't.
Q Can you estimate?
MR. McGUINNESS: Objection.
THE COURT: If he doesn't know, he doesn't

know. You can always recall the Plaintiff.
Q Is there a way you can check with your billing department at any point in time in the next few minutes, if we took a short break? Let me just --
A That would be really easy for me to do.
Q Okay.
Now, when you --
A If you give me a second, I could just send a text to somebody.
Q Can we do that, just send a text or can we do it on a break?
THE COURT: We will take a five-minute break. Don't discuss the case. Short break.
(Jury exits courtroom.)
(Recess taken.)
THE COURT: We are sustaining it to the extent it should be usual and customary, it has to be either the no-fault rate or the actual rate.
MR. McGUINNESS: Yes, your Honor. We are just objecting to him, just as to personal knowledge, him going back to parts of the chart that he didn't bring with him electronically. Thank you.
THE COURT: Before we bring the jury back in,

you are able to establish through this witness that the person he is talking to is one of his employees who he deals with in the regular course of business and they keep those records and, effectively, you can establish that it is coming directly from a business record, you can do that.
MR. BOTTARI: Yes.
THE COURT: If you can't --
MR. BOTTARI: Then I will move on.
THE COURT: You will move on. You can always recall the Plaintiff as to what he actually spent.
MR. BOTTARI: Understood, your Honor.
THE COURT: I am given to understand that he didn't receive no-fault.
If he did, obviously, you can either have an agreement or a hearing in the nature of a collateral source after the verdict, so at this point, no one is unduly prejudiced.
MR. McGUINNESS: I'm okay with having that kind of hearing. I'm just not sure that that is something in the first instance and hearsay, actually hearsay on hearsay.
THE COURT: We will see how little hearsay there is. If it's too much, we will keep it out.

MR. McGUINNESS: I understand.
MR. BOTTARI: My understanding is that Mr. Carter has told me that he had to pay Dr. Gerling out of his pocket.
THE COURT: I'm going to allow you to recall him, if you wish.
MR. BOTTARI: Okay, we don't need to do that right now.
THE COURT: In terms of where to go with this witness.
MR. BOTTARI: Understood.
THE COURT: I don't want to confuse the jury.
MR. BOTTARI: Understood.
THE COURT: Let's bring them in.
MR. BOTTARI: He is awaiting a text back. We will do other questions.
THE COURT: It's probably best to move on.
MR. BOTTARI: He can cross him and I can reserve the right to ask him that question.
(Jury enters courtroom.)
THE COURT: Be seated, everybody.
Mr. Bottari, you may continue.
BY MR. BOTTARI:

you to do what's called a narrative report with regard to this case?

A I believe so.

Q Just quickly, I'm going to ask you to refer to certain sections of that narrative report so that we can -- do you have a copy of it in front of you?

A No. Actually, I have it on my phone. I will refer to it. Okay.

Q On page 2, when you originally tested out Mr. Carter with regard to his range of motion of the cervical spine, did you use what's called a goniometer?

Doctor, I can give you a copy of it?

A On page 2?

Q Page 2.

A Yes, I did.

Q First, tell us what a goniometer is and then tell us what the range of motion was you found and how that differed from normal?

A Well, actually, that day, I did not quantify them in my note, so I didn't actually write how much --

Q Well, let me just -- if I can, just to save time, I will let you look at my --

A Yes, so it just -- I didn't actually quantify the amounts. These are just the normal amounts, that the

-- so that's just the normal levels. I didn't actually quantify the range of motion and then there as well.

Q So you said it was restricted, but you didn't quantify it?

A Right.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether or not the two neck surgeries you did, the two back surgeries that you did and the back surgery that you are projecting that Mr. Carter needs because of the loose screws in his back are causily related to the accident of July 3, 2012?

MR. McGUINNESS: Objection.

THE COURT: Overruled.

Q You can answer.

A Yes, I believe they were.

Q What is the basis of your opinion, doctor?

A Well, he was asymptomatic prior to the accident. He had clear injuries to the neck and back that correlated with the injury itself.

He had consistent symptoms that ultimately were diagnosed with herniations that ultimately required the surgical treatment because they didn't get better with conservative management.

Mr. Carter, did you, in fact, see and remove herniated disc material?

A In the back and the neck.

Q Now, do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Carter would need what's called adjacent level surgery at any point in time in the future?

MR. McGUINNESS: Objection.

Q Can you tell us what that is?

THE COURT: Overruled.

A Yes, I do. So when you stiffen up a part of the spine and parts of the adjacent levels now have to bear the brunt of what that part normally would have beared, so if you have a --

MR. McGUINNESS: Your Honor, could we specify the level where he's going to need adjacent level surgery?

THE COURT: If you can specify it, it applies to the --

A Sure, I am happy to. So when you stiffen up a level or if a level is stiffened up on its own through an accident, then what can happen is the other levels have more stress than they normally do.

Also, the fact that you had a surgery in that

area doesn't help either because blood flow and what not might not be the same as it usually was before the surgery.

But despite that, it's a common phenomenon for people to develop problems at the level above and below because not only were those discs subject to injury during the initial insult, but now, they have more intermittent and regular stresses on them than normal and we call that adjacent segment disease because it's right adjacent to where the surgery was.

In this case, he had a C-5-6 cervical fusion and the C-4-5 and the C-6-7 are herniated and on the most recent CT scan, it showed that he actually healed well at the place where I operated in his neck, but the disc above and the disc below are herniated and pressing on the nerves, so it's very reasonable to expect that he will require surgery to remove those specific discs and he is manifesting the symptoms associated with them, so it's expected that he will.

Q That's for the neck?

A Yes.

Q What about for the back, adjacent --

A We know for the lower back, he has an unstable

MR. McGUINNESS: Objection.
THE COURT: Overruled.
A -- an interbody spacer that's actually ejected into this space where the nerve exits into the foramen so that is an automatic -- if he went to an emergency room today, they would immediately offer him that surgery. There wouldn't be a question.
Q This adjacent level surgery you talked about for the neck, about how much would that cost?
MR. McGUINNESS: Objection, your Honor. Particular to the regulations.
THE COURT: I'm going to allow this.
A So the typical range is between $80,000 and $100,000.
Q Does that include hospital costs?
A Yes, typically.
Q In fact, it's not just you in the operating room, there is a whole team of people in there, correct?
A I have an assistant surgeon. There is an anesthesiologist. There is somebody monitoring his spinal cord. There are two technicians. There are circulating nurses. There is a hospital facility. There are implants. It's very expensive.
Q Will he need any further physical therapy or

medications in your opinion as a result of the injuries that he sustained in the past going forward into the future?
A Well, yes. He currently does. I mean, he is taking a lot of medications. He is involved in pain management, injections and therapy.
Q Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Carter has sustained a significant limitation of a use of a body function or system as a result of the injury that he sustained in July of 2012?
MR. McGUINNESS: Objection.
THE COURT: Overruled.
A Yes, of course. He has lost significant range of motion in the cervical spine in addition to the additional loss of motion from the adjacent levels that are causing pain.
Then he also has lost significant use of his low back where he now every time he moves, the screws are shifting and the spacer is compressing the nerve root.
Q Is that within a reasonable degree of medical certainty?
A Yes.
A By the fact that he has been demonstrated to have adjacent segment disease, he has a fusion in his cervical spine and in his lower back, he has loose implants that are noted on CT scan that are seen on x-ray with the interbody cage ejected posteriorly compressing the nerve roots.
Q Do you have an opinion within a reasonable degree of medical certainty whether Mr. Carter has sustained a permanent consequential limitation of use of a body organ or member as a result of the accident of July 3, 2012?
MR. McGUINNESS: Objection.
A Yes.
THE COURT: Overruled.
Q You can tell us.
A Well, he not only has lost the function -- functional range of motion of the neck and back, but he also has substantial neurologic deficits in his lower extremities and ongoing numbness in his arm.
Q Now, doctor, that's all within a reasonable degree of medical certainty?
A Yes.
Q And one last time, the basis, just so we are clear?
A The same as before, I mean, he has undergone

surgery. He has over a course of several years has been demonstrated to have damage to the nerve roots and neurologic deficits, not only in my own examinations, but by the other doctors treating him.
Q Now, you mentioned some comorbidities that Mr. Carter had, correct?
A Yes.
Q Diabetes, obesity, things of that nature, correct?
A Yes, sir.
Q I want you to assume that Mr. Carter was on Lyrica for several years prior to July 3, 2012, and that he had indicated that he had pins and needles going down his legs into his feet from time to time and that's why he was treating with Lyrica, okay.
A Yes.
Q I want you to assume that he has testified that his pain levels from the diabetic neuropathy, if you will, was in the two to three range.
I want you to further assume that after the accident in July of 2012, his pain levels were in the seven, eight, nine, range, give or take the day, et cetera.

of medical certainty as to whether some of the pain that Mr. Carter has, that he is experiencing today and in the future is as a result of the car accident as opposed diabetic neuropathy?

MR. McGUINNESS: Objection.

THE COURT: Overruled.

Q You can answer.

A So there is some discomfort associated with diabetic neuropathy. Some people have more than others. Some people only have numbness, but in a radicular type pattern, it's very different.

It's not diffuse like a stalking or a glove distribution, it's much more focused and it's much more severe and he has demonstrated through multiple years of observation to have substantially higher levels than would be expected with a neuropathy and also with more characteristic levels or distributions of a radiculopathy.

So if one has -- if one has an accident and they have back pain and neck pain with a demonstrated disc herniation and it fits with the distribution of the pain in the extremity, I think that it is reasonable to assume that those symptoms are coming from the injury that was demonstrated in the neck and the back.

MR. McGUINNESS: Objection to what he assumes.

Q Is that within a reasonable degree of medical certainty?

A Yes.

Q And the basis, this is the last question, the basis of your opinion?

A Just what I said.

MR. BOTTARI: Thank you, doctor. I have nothing further.

MR. McGUINNESS: Your Honor, could I have a few minutes with the doctor's chart?

THE COURT: Sure, you can have a few minutes. We will take a five-minute break. Don't discuss the case.

(Jury exits courtroom.)

(Recess taken.)

MR. McGUINNESS: As part of the discovery, the first records that we were ever provided of Dr. Goswami's contact was a document entitled -- it was entitled, follow-up visit, which I think is a typo, but it's date of visit, 10/29/14.

There are findings in it, in this record, findings. There are comments about his medical history.

The record he shows up with at trial is now a document called initial patient report.

It is omitting information in what was previously disclosed.

THE COURT: Well, so you have plenty to cross examine.

MR. McGUINNESS: No, your Honor, he is altering his reports.

THE COURT: You can examine him on it.

MR. McGUINNESS: Your Honor, I'm going to move to strike the entirety of his testimony.

THE COURT: Okay, that's denied. You could cross examine on it.

MR. McGUINNESS: All right, thank you.

THE COURT: You can decide after your cross examination whether or not you want to renew the motion or not.

Let's bring the doctor back in.

(Jury enters courtroom.)

THE COURT: Be seated, everybody. You may begin.

MR. McGUINNESS: Thank you.

CROSS EXAMINATION

BY MR. MCGUINNESS:

Q Doctor, if you kindly have a seat.

I would like to kind of define some terms and concepts for the jury, if we could, sir?

A I'm sorry, I couldn't hear what you were saying.

Q Are you familiar with what's called an objective finding, are you?

A Yes, I am.

Q And by an objective finding, that's something that you can see, feel, touch, you can verify its existence with the use of your own senses, completely independent of what the patient tells you, fair enough?

A Correct.

Q And you contrast that with something called a subjective complaint or subjective finding and that's something where you are entirely relying on what the patient tells you as to whether or not it exists, fair enough?

A Correct.

Q So, for example, you can see a deformity, you can see redness, you can see bruising, you can take a temperature, those are all objective findings, correct?

Q And tests like an x-ray, CT scan, an MRI, those are generally regarded as objective tests, correct?
A Correct.
Q That's something like when a patient tells you that they feel numbness or they feel tingling, that's subjective?
A Correct.
Q And if a patient says they feel pain, that, again is purely subjective, you have no way of verifying what the patient tells you, correct?
A Well, there are objective physical findings --
Q If they state that I feel pain or how much pain I have, without performing some kind of objective test on them, that statement in and of itself is objective?
A Right, if you don't have a physical exam.
Q In putting together a diagnosis, ultimately, what you're trying to do is find an objective reason for the subjective complaint so you have some -- you have -- you make a diagnosis, form a plan -- find an anatomic basis for it and put together a plan to treat and take care of the patient's problem, fair enough?
A Yes.
Q Now, you would agree that with range of motion, in terms of if you compare range of motion to, let's say,

a number representative of the population at large, that doesn't necessarily show what a specific patient has actually lost; is that correct, I mean, you want to know what the patient's baseline was, what their level of function was before, correct?
A Well, there are expected ranges of motion.
Q Right, I understand that, but in a particular patient's case, as to whether or not they have actually lost something, you want to -- you would like to know what their original baseline was, fair enough?
A Right, and nobody will.
Q Well, one of the things as an orthopedist, what you would do is perhaps check the contralateral arm range of motion, let's say you are dealing with one side --
A Assuming that there was no injury to the other side, yes.
Q All right. I just want to go through kind of the anatomy, a couple of things.
You have touched on the bulk of it, but in the cervical spine, are there -- when you talk about the vertebral bodies, that's the blocky part in the front, correct?
A Yes.

transverse processes?
A Yes.
Q These are what are called the spinous processes, the bumps you see on a skinny person's back at the beach?
A Yes.
Q These structures here, these are the laminae?
A Yes.
Q And you got one on both sides, right?
A Correct.
Q Now, you use the word foramen or foraminal, below the bottom of one vertebrae and above the top of another vertebrae, they form a window and that's the foramen?
A Correct.
Q And you have got a foramen on both sides, correct?
A Correct.
Q And you screw that foramen that the nerve roots exit?
A Yes.
Q So as I like to put it, two halves of a clam shell and the nerve root passes through? I'm trying to keep it in lay terms, keep it simple.
A Yes.
Q Now, you mentioned in the lumbar spine about

facet joints, there are other joints also up in the -- there are joints up here in the cervical spine, correct?
A Correct.
Q And those are these little joints between the vertebrae sequences in this area, correct?
A Yes.
Q And they are actually joints, they have got cartilage in them in their pristine state?
A Yes.
Q Those are what they call uncovertebral joints?
A No, they are facet joints.
Q You use the term facet all the way through?
A Yes, sir.
Q When someone is talking about a cervical spine and they are referring to the uncinate joints, what are they referring to, the same thing?
A No. They are actually at the edges of the disc space where the disc space ends. The bone curves up and it sort of forms an articulation with the level above.
Q Now, that would be on this side, the --
A Well, it's not really -- it's more just deep.
Q Okay.
A It's very difficult, 3-D anatomy that would

Q To actually see it, okay.

So the jury understands, in life, there are ligaments, touch ligaments that surround all of these vertebral bodies, that connect them from one to the other?

A Yes.

Q There are large muscles, small muscles that are connected by large and small tendons and they lay into all these recesses, so this whole entire thing forms a structure?

A Well, I'm not sure that I know what you mean by that, but they are considered functional units with basically the unit between two bones where -- yes, there are muscles, there are ligaments.

Q It gives it strength, you have the joints, you have the ligaments, you have got the muscles and they all form, in effect, a structure, a supporting structure?

A Well, it's the --

Q A framework for the body?

A I guess so, it's the spine.

Q I'm trying to keep it in lay terms.

A Everything is a structure. Each thing you look at and point at in the spine is a structure.

Q All right. Now, you mentioned that you treat

both patients with degenerative conditions and traumatic conditions --

A Yes.

Q -- on your direct. And you are familiar with a condition called degenerative disc disease?

A Yes, sir.

Q And is there a progression that degenerative disc disease goes through in terms of --

A Typically, yes.

Q Just for the benefit of the jury, typically, you would find the discs, the intervertebral discs over time, they desiccate, they can lose fluid content?

A Yes.

Q That's something that you can see on an MRI, if you look at an MRI, on the T tube, you have a water view, the central portion instead of being bright and light, it becomes dark?

A Yes, and you could see it on a CT scan.

Q And when you -- once these discs begin to desiccate and, again, I'm going to try to keep it in lay terms, these discs, you got the nucleus, nucleus pulposus, the inside, I've heard it described the consistency of caramel or gel, how would you describe the

A Just to be brief, because we have so little time, I'm going to say it's like a Jello.

Q And that's surrounded by the annulus of the disc, the annulus fibrosis, tough fibers outer coating, correct?

A Correct.

Q And that's -- those sit between each of the bottom vertebral body of the disc -- of the vertebrae above and below the top of the vertebral body from below?

A Right. I did my best to explain it with the model earlier.

Q I understand, but I want to kind of give a little flavor of the consistency of what we are dealing with.

If you removed some of the fluid, the liquid from the discs, they tend to flatten, I'm trying to think like a jelly donut to some extent, if you took the jelly out, they become narrower, the disc height becomes less?

A Well, it's a generic statement. That isn't present at the levels we did surgery in this case, but yes.

Q I'm asking generic statements at this point, all right.

And typically, that would be called a bulge?

A No.

Q You don't call that a bulge?

A Not what you're describing, no.

Q As part of the degenerative disc disease process, disc do bulge?

A They can, yes.

Q The ligaments that hold the disc in place, they can become thickened?

A They can.

Q That's called ligamentous hypertrophy, hypertrophy meaning growth, overgrowth?

A Yes.

Q The disc can continue to degenerate further and you can have discs that herniate over time, correct?

A Not without trauma, no.

Q Never without trauma is what you're saying?

A Right, not without trauma.

Q That's your opinion?

A That's the way it is. That's how you define a disc herniation.

Q That's your opinion?

A No, that's the way it is defined.

MR. BOTTARI: Objection.

Q Now, you can have -- as these discs, either the

that form along the edge of the vertebral bodies?
A They can. It wasn't present in this case, but yes.
Q We're not talking this specific case, I'm talking about its process.
Those are bone spurs, they are sometimes called osteophytes, the bone spurs are sometimes called osteophytes, correct?
A In a scenario where somebody has degenerative disc disease as their primary issue, then you would find those, but not in this case.
Q I'm not asking you about this case, I know that's your opinion, I want to get there, but I'm trying to get you through the degenerative disc disease process.
And these discs, the disc in the osteophytes, basically, what these osteophytes do are try to buffer up the sides of the disc, the degenerated disc, correct?
A Well, I'm not a hundred percent sure that's been proven, but --
Q That's the general case?
A That's the belief.
Q When you change the architecture of a -- a difference in height, between one vertebral and one -- between two vertebrae, you refer that to the disc height,

that's something you can see on a x-ray?
A Or CT scan.
Q And one of the things you look for on an x-ray or CT scan, whether or not those disc heights are maintained, correct?
A Yes.
Q And that's an indication that the disc has not collapsed or lost content, correct?
A Or herniated, yes.
Q Now, when the disc space narrows, that changes the relationship between these joints, does it not?
A Yes, it can.
Q And these joints, when you change that relationship, they become arthritic, right, they are wearing?
A In some people, they do. In some people, they don't, yes.
Q And when they become arthritic, they form bone spurs or arthrosis, correct?
A They can, in some people.
Q And those bone spurs, they can encroach down on the neural foramen and a nerve root passing over one of those bone spurs can become irritated, correct?

Q And similarly, if there are bone spurs on the other side on the uncinate area, if they encroach into the foraminal space or into the spinal cord area, they can inflame the radicular nerves or the spinal cord, the thecal sac, correct?
A They can, yes.
Q So you can have degenerative bony conditions that can cause radicular symptoms, correct?
A Yes, but that's not related to this case.
Q I understand that's your contention.
Now, doctor, you have your chart with you.
MR. McGUINNESS: May I approach the witness, your Honor.
THE COURT: You may.
Q We were provided with what's been marked as Defendant's Exhibit I and I ask you, have you seen that document before?
A Yes.
Q Do you have that document, your copy of that document with you here today?
A Yes, I believe so.
Q Double check it word for word, if you would, doctor. What you have here today is different than the other visit note that's shown in Defendant's Exhibit I,

correct?
A Yes. It appears that the subject heading is different and that there are -- I'm not sure, one was done before the other. One is the unedited version. It looks like the one that you have is --
Q It's the original. When was that edited, doctor, if that was edited?
A I'm not sure which one came first, but it looks like --
Q This is the one we got.
THE COURT: Don't interrupt.
MR. BOTTARI: Objection.
A I'm not sure which one you -- I don't know when you got this. When did you receive this?
Q When your client's lawyer gave it to us.
A Maybe this was generated like initially when the patient was initially seen before I actually had a chance to go through it and put the headings in.
The substance of it is the same, it's just that there is not a heading here and this was -- this was an issue --
Q We will get to whether or not the substance is the same. You first saw Mr. Carter -- let me back up a

We talked about the degenerative disc disease. Talking about your practice in general, when you see a patient for the first time, you take a history from him, correct?

A Correct.

Q It's important, history is important?

A Yes.

Q I mean, it's important enough because you can actually sometimes make a diagnosis based on the history alone, correct?

A Well, you would never rely on it on purely history alone, but certainly, you can get most of the way there.

Q And when you do a physical examination of the -- do a physician examination of the patient, there is a process that you go through, a methodology, basically, because you do the same exam with every patient, generally, you get a gestalt of how the patient is generally, an overview, of how is he walking, how is he moving, things of that nature?

A You are simplifying thirteen years of practice and seven years of training into two sentences, so I wouldn't say that I only diagnose somebody based on your gestalt, what you just described.

Q No, no, I'm saying there are two parts to your initial encounter with the patient, you take a history, you do a physical exam, okay.

As part of your physical exam, all I'm saying is, you have a process that you go through, that because of those seven years of training and thirteen years of experience, you look at a patient and you have a certain thing -- you have a certain methodology that you go through to evaluate as part of the examination, fair to say?

A I would agree with that, yes.

Q I mean, you get an overview of them, you start up with the cranial nerves, however you do it, but you have a process, you follow every time and you go through --

A That's what I disagree with. Every time implies I do the exact same thing every time, that's not true.

Q You focus on things where things need to be focused on, but in the back of your head, you have a mental outline, if you will, of what you want to look at, through your years of training?

A I don't know what you're talking about, the mental outline.

Q That's fine, doctor.

things like the onset of complaints, correct?

A Yes.

Q You want to find out if the person has had prior problems, prior treatment, correct?

A Yes.

Q You want to find out all the comorbidities, correct?

A We try to focus on what we think is important, yes.

Q You want to look at the mechanism of injury because you want to understand how the physical forces are acting on the body?

A Well, we can't look at the force of injury when we are speaking to them in the office, no.

Q But you would like to know how it happened?

A Yes, we ask them about that, definitely.

Q I mean, you know that -- you would expect that a certain kind of accident would have certain kind of forces, be capable of causing a certain kind of injury, you see different patterns of injury?

A Of course, if somebody has a certain type of injuries that are different.

Q I guess what I'm saying, understanding the mechanism, how the forces work on the body, gives you

some insight as to the kind of injuries you might expect?

A Yes. It gives you some insight.

Q Diabetes, it's a fairly insidious disease in terms of its reach, is it not?

A Yes.

Q I mean, it can cause destruction of the peripheral nerves, both the hands and the feet and legs or hands, arms, feet and legs, correct?

A It can, yes.

Q It causes injury to the peripheral vascular system where the blood vessels start to shut down over time, the blood supply to the tissues, its loss, the tissues can die over time?

A There are a lot of things that can happen, yes.

Q But peripheral vascular disease and, actually, there is a relationship between diabetes and coronary artery disease, the same inflammatory process, the inflammatory process that are behind both are related, correct?

A You know, honestly, I am an expert --

Q It's not your area?

A I am an expert in the spine and I don't have a lot of time. I can't come back on Monday, so I can't

Q So you don't have an opinion, you have no knowledge whatsoever?
A I'm just not an expert in that. I can't give you great answers on the mechanism of coronary artery disease in patients with diabetes. I really would love to help you with the spine, though.
Q Well, doctor, my question is, the extent of his heart condition, any coronary artery disease, they would impact on whether or not a person is a surgical candidate, would they not?
A Of course, that's why we do preoperative testing and clearances.
Q But still, ultimately, you are the surgeon, the captain of the ship, you have to make the final call whether or not you have clearance or not, correct?
A Yes, of course. Well, actually, that's not true. The anesthesiologists are the ones that really ordain over the cardiovascular exam and whether or not they are cleared.
Q That's your practice choice, that's how you choose to --
A No, that's just a fact. I mean, if I'm in the hospital and we are doing the surgery and it's not appropriate because of the cardiovascular status, then

the anesthesiologist can at any time trump me and say no, we're not doing it because it's inappropriate.
That really has no bearing on whether or not a patient -- their cardiovascular status does not affect whether or not they have fusion in their spine and whether or not they have a successful outcome from surgery.
Q But it might have some effect as to whether or not they wake up from the anesthesia and that's not your problem?
A That's correct and Mr. Carter did.
Q Now, you saw Mr. Carter for the first time on October 29, 2014, correct?
A I believe so.
Q At that point, you said he had severe neck pain radiating to the right upper extremity down to the hand, bilateral shoulders down the back with severe associated headaches, correct?
A Yes.
Q He talked about low back pain radiating down his buttocks and down both legs, numbness extending down both arms and into the bilateral thighs and legs, correct?
A Correct.

you say all of these symptoms emanated from a car accident where he was a passenger on 7/3/12, right, what do you know about that car accident?
A My understanding is that he was rear ended.
Q Other than rear ended, do you have any idea of the force of the impact?
A I don't think anybody does.
Q Do you have any idea of the speeds involved in the vehicle?
MR. BOTTARI: Objection.
A Yes, I do.
Q It's not in your chart, when did you -- it's not in your chart, is it?
A Nor would I include that type of thing in my chart.
Q Well, you didn't?
A I'm sorry?
Q You didn't ask Mr. Carter what the speeds were involved, correct?
A How do you know that?
Q Well, I'm asking you, you didn't note it in your chart?
A You said it, you didn't ask it.
Q Did you ask Mr. Carter on the day of the -- on

the day of your first encounter what the speed of the vehicles were?
A I don't recall whether I did.
Q And certainly it's not -- the speed of the vehicles is not mentioned in the chart, correct?
A No.
Q And the chart doesn't even mention it was a rear end accident, correct?
A Correct.
Q Now, he talks about having complaints and difficulty of walking a block at a time because of severe back pain and leg pain.
Do you know what his baseline was before the accident about his walking?
A It's my understanding that he was walking normally.
Q Normally?
A Yes.
Q Did he tell you that or did you just assume it?
A Well, I asked him about whether or not he had problems beforehand, but I don't have -- I didn't actually document whether he told me that, no.
Q Now, on that first visit, did you make any

failure -- well, you make mention that he had heart failure with an internal defibrillator, right?

A Yes.

Q You made mention that he had diabetes and high blood pressure. Did you make mention as to whether or not his diabetes was under control?

A No.

Q Now, after taking that history, you began -- you started your physical examination and in terms of his thoracolumbar or the mid spine, you found that his range of motion was restricted but restricted by pain, that was your finding there?

A Yes.

Q That's subjective?

A No, this was in the objective section.

Q I haven't got there yet.

A No, you just asked me a question, I answered it.

Q I understand.

But when you said his range of motion is restricted by pain, that's subjective, correct?

A No. This is in the objective section in the physical exam section.

Q Now, doctor, when you asked him to move, you asked your patient to move, how do you do the range of

motion in the thoraco -- in the thoracic area, do you ask the patient to bend, move, twist, what do you ask him to do or how do you do it?

A We have them flex. We get to the point where they say that they are in pain and then we palpate their spine for spasm and tenderness. We look for visual cues of pain that patients have.

That's what we do as a diagnostician and we actually feel for a physical end point, typically, as well.

Q But you ask him to actively move?

A And passively.

Q And passively, all right.

Now, did you specifically note where the spasm was in the mid spine?

A In the lumbar spine.

Q Well, I'm talking about the thoracolumbar spine, you said tenderness and spasm, did you describe what muscle groups or where it was?

A No, that's not a part of my customary practice.

Q But you could do it?

A It's not necessary.

Q In your opinion?

MR. BOTTARI: Objection.

A -- well known clinician, yes.

Q How about in the cervical spine, you note that his cervical range of motion is due to pain and again, you state that he has got spasm and tenderness.

Did you make notation of where, what muscle groups were involved, yes or no?

A No. Again, not specifically --

Q All right, doctor, that's all I'm asking you.

A I can finish the answer. Not specifically --

Q Well, doctor, it was a yes or no question.

A I could finish the answer. I will finish the answer if you'd like me too.

THE COURT: Doctor, if you just answer yes or no, it's sufficient, it will go faster.

THE WITNESS: Okay.

Q You did the range of motion testing of the back and the neck in the mid spine, correct?

A Yes.

Q Now, you evaluated his gait, you made note that he has poor balance and an antalgic gait. Under your musculoskeletal evaluation, you make a statement, there is painful range of motion of the right shoulder which was nonconcordant with radicular symptoms extending down

to the hand.

Did you make that statement, doctor?

A Can you show me what you're referring to?

Q Yes, that statement is not in the copy of the report that you have, correct?

A I don't think so.

Q Confirm, doctor, is it in there or not?

A I have to look at what you're referring to. Can you repeat what you said then?

MR. BOTTARI: Objection. Can you show the doctor --

Q There is painful range of motion right shoulder which was nonconcordant with radicular symptoms extending down to the hand. Is that statement in the report that you brought to court today?

A No.

Q When you say the symptoms are nonconcordant with radicular symptoms, what you're saying is that those symptoms are not matching up with your understanding of the nerve distributions; is that correct?

MR. BOTTARI: Objection.

A Yes.

THE COURT: Overruled.

nonconcordant with radicular symptoms, that are not explained by the wiring diagram, if you will, that we have as far as the nervous system in the body, correct?

A Yes, sir.

Q You mentioned earlier, three functions, they have a reflex function, they have a motor function, they have a sensory function, fair enough?

A Yes.

Q The motor function, you know that certain nerve roots form certain branches and they go to specific muscles and I'm saying, there is some variations from person to person, but generally, you understand what nerve goes to what muscle, fair enough?

A Yes.

Q And there are certain nerves, sensory nerves that go to certain areas of the skin and the -- certain areas of the body, that provide certain sensory functions in that area?

A Yes.

Q In those regions, those are called dermatomes?

A Yes.

Q And just to kind of -- have you seen Dr. Netter's drawings?

A Yes.

Q I can show you what's been marked as Defendant's Exhibit H and ask you, before we show it to the jury, would that help explain what the sensory dermatomes are for the body?

A Yes.

Q In effect, they lay out a wiring diagram of where the sensory nerves go --

A Yes.

Q -- from the nerve endings. Okay.

A No, that is with the caveat that people are not all wired exactly the same. There is anatomic variations.

Q You can usually see a one -- you can have a one level --

A Sometimes, the distribution is slightly different, that's the typical pattern that's believed. I mean that was published in the fifties or something like that, but it is still reasonably accurate.

Q For example, Mr. Carter was complaining of problems in his pinky fingers and index finger or did you not make note of it?

A I don't think that I made note of that.

Q You mentioned that he was having some clumsiness

A Yes.

Q And he was complaining of some numbness and tingling and kind of a glove or a stocking pattern, correct?

A No. I didn't say that.

Q You didn't find that, he didn't make those complaints?

A Well, I didn't document that, no.

Q I mean, so the jury understands, if you hold your finger like that, generally, that finger, that thumb, the side of your index finger, that's affected by the C-6 nerve root, correct, and the C-7 would cover the sensory function in the middle and ring finger, part of the ring finger?

A About 75 percent of the time, yes.

Q And then C-8 -- so basically, it would be -- in order for the entire hand to be numb, you would need -- you would typically expect to find the C-6, 7 and 8 nerve roots, there would be some problem with those nerve roots to cause complete numbness in the hand, if it were a radicular problem, fair enough?

A Well, when you are talking about the subjective which you're right now, first of all, I didn't delineate whether he was referring to one digit or the other, but I

mean, in fairness, that's true, but most patients, though, have difficulty discerning exactly what finger is going numb or that's bothering them. I mean, you would be surprised at what people say.

Q I understand, but with diabetic polyneuropathy, you have problems with all the fingers and all the surfaces of the hand, that's not uncommon, is it?

A No.

Q That's what you expect with peripheral neuropathy, right, and similarly, if you got stocking pattern numbness, in the calf, the entire foot, that's what you expect with diabetic polyneuropathy, you expect that stocking pattern, because the nerve roots that go into the leg, again, you've got specific nerves that go to specific muscles and specific areas of the body, for example, the areas shown here provide sensation, the L-4 root covers the first four toes, S-1 covers the outer rear aspect of the leg, L-5 covers basically the ass aspect of the calf and to have numbness up in this area, you would have to have the L-2, L-3, L-4 nerve root involvement if the problem was radicular, correct?

A Really, not necessarily. I mean, honestly, if I felt that he had a stocking/glove distribution of his

complaining of that type of sensory, I would make note of it. But you're right, it was significant. I knew that he had diabetes.

Q Now, he brought with him his CT scan of his neck and his back that he got back on, I believe it was, July 12 of 2012, do you have that in the chart there?

A Yes.

Q And you reviewed that, correct?

A I don't have the report from it.

Q I believe it is clipped in one -- in the smaller package of documents that you have. If I could approach, I will find it for you. Here it is, you got it.

A That's from 2015.

Q Okay, I'm sorry, it is back there further. Do you have another group of papers? I thought I saw it.

A No.

Q Just to save time, I'm going to borrow Plaintiff's Exhibit 4 from Dr. Hostin's records.

Doctor, you don't have the prior 7/12 CT scans in your chart?

A I don't have the report, no. I have what I said about it, what I referred to it as.

MR. McGUINNESS: Just to kind of keep things going, may I approach the witness, your Honor?

THE COURT: You may.

Q There you go.

A Thank you.

Q I just want to go through some points with you. On this one, normal alignment was seen at the time, correct?

A Yes.

Q No perispinal abnormalities, that means soft tissue around the spines were normal, correct?

A No, it doesn't mean that they were normal, just that they can't see any in the CT scan because the CT scan doesn't really look at that.

Q But you were able to tell from the study that they were able to state from the study that there was no soft tissue swelling seen?

A Correct.

Q C-2-3, that's the first level where there is a disc, right?

A Yes.

Q That's normal, correct?

A Yes.

Q C-3-4, there is no evidence of disc herniation or central canal stenosis. There is bilateral uncinate

seen, correct?

A Right.

Q Foraminal, the uncinate spurring, those are the bone spurs?

A Yes.

Q They wouldn't occur within nine days of the accident, correct, that is something that takes years, correct?

A Right, these are mild changes as it says.

Q Well, actually, it doesn't say that?

A Yes, it actually says mild.

Q Mild disc bulge?

A They don't actually quantify how bad those are.

Q It doesn't say mild, it says mild disc bulge, but it doesn't quantify it mild or severe?

A Uncinate is a part of the disc area, so it is saying that -- if you want me to interpret this, because that's what you want me to do, this is saying --

Q No, doctor, I want to -- what it says is bilateral uncinate spurring with foraminal narrowing, those are bone spurs?

A It's not quantifying that, the only place that quantifies this is mild.

Q That's all it says, doctor.

C-4-5, there is no evidence of disc herniation, foraminal narrowing or central canal stenosis at the 4-5 level, posterior bony spurring with underlying disc bulging is noted at the C-4-5, level, correct?

A Yes.

Q That's bone spurs again, that's something that would have taken place over time, correct?

A Correct.

Q It would not have happened in the nine days between the accident and when the CT scan was taken, correct?

A Correct.

Q C-5-6, there is no evidence of herniation or central canal stenosis, there is bilateral uncinate spurring with foraminal narrowing, correct?

A Correct.

Q And that foraminal narrowing, that's also called foraminal stenosis, stenosis meaning a choking down or narrowing?

A Well, it doesn't say that there is stenosis. It says there is no central stenosis, but it doesn't say that there is foraminal stenosis.

Q It doesn't say that there is central canal

spurring with foraminal narrowing?
A But it doesn't say that there is clinically significant stenosis.
Q Radiologists aren't clinicians, correct?
A They are not.
Q No, they don't actually lay their hands on the patient?
MR. BOTTARI: Objection.
Q Right, they don't have any history?
THE COURT: Let's just move it along.
Q It says foraminal narrowing?
A Narrowing, yes.
Q It says straightening of the spine which can be seen with muscle spasm, but it can also be position, correct?
MR. BOTTARI: Objection. Overruled.
Q It talks about spondylosis as noted above, that spondylosis is the degenerative disc disease process, correct, yes or no?
A The natural aging process.
Q The natural aging process?
A Yes.
Q Now, he also had a lumbar CT scan that was done nine days after the accident, at L-4, L-1-2 -- I'm

sorry, lumbar -- I'm sorry, space L-1-2, L-1, L-2, no evidence of disc herniation, foraminal narrowing or central canal stenosis, same findings at all levels from L-1 through L-5, this is essentially a normal exam, the lumbar spine?
A There is no fractures or dislocations.
Q There is no evidence of disc herniation, foraminal narrowing or central canal stenosis on the CT scan from nine days after the accident, correct?
A Correct.
Q It is essentially a normal exam on the lumbar spine, correct?
A Within the limits of that exam, yes.
Q Now, you saw him for a couple of visits before you took him to the operating room and what I want to do is just turn to your operative report for your first neck surgery, if you don't mind, doctor.
A Yes.
Q 2/23/15?
A Yes.
Q You have it there with you?
A Yes, sir.
Q Now, your actual plan before that from the

and fusion at C-3-4 -- I'm sorry, at three levels of the spine, correct?
A Well, we had discussed the possibility, yes.
Q All right, and after conferring with the anesthesiologist and the cardiologist, you felt that was too high a risk to do more than a single level and that you were just going to proceed with the 5-6 level; is that correct?
A I recommended that I do as little as possible given his risk factors, yes.
Q But your original plan was that he needed surgery at all three levels where he had the uncinate spurring, correct?
A We described and discussed --
Q Yes or no, doctor.
A It's not a yes or no question.
Q The original plan was to do those three levels, that was your recommendation, correct?
A It's not a yes or no answer. Can I answer?
Q All right, doctor.
A Okay, so I discussed the possibility with him that all three would be taken and given all of the different circumstances associated with, first of all, his risk factors and then also, when I found that it did

not look as bad as the C-5-6 level, I felt that it was appropriate to just do that level.
Q But when you went in and -- in any event, he had uncinate spurring, those bone spurs, at all three of those levels where you originally intended -- you originally had contemplated doing the surgery, right?
A That's not a yes or no answer.
Q That's what the CT scan of the 12th indicated, correct?
A Can I answer without a yes or no?
Q Yes or no, doctor?
A It's not a yes or no question.
MR. BOTTARI: Objection.
THE COURT: You can answer it yes or no.
A I can't answer it yes or no.
Q Just look at the report, doctor, did he have uncinate spurring at those three levels, C-3-4?
A I can't answer your question with yes or no.
Q 5-6?
A I don't know why you wouldn't want me to answer the question.
Q Doctor, I just want you to answer the precise question I'm asking.

Q You have testified --
THE COURT: Let's stop the back and forth. Doctor, if you can answer yes or no, you will do that. If you can't, you will say I can't do that.
A I can't do that.
Q Did the report indicate that there was uncinate spurring at 3-4, 4-5 and 5-6 in the cervical spine, yes or no?
A Yes, it does.
Q When you had the visit with Mr. Carter before his surgery, that was the surgery that you initially had discussed with him, correct?
A I don't know what you mean by that.
Q Doing a surgery at all three levels was the initial thought, correct?
A We discussed the possibility that I may have to remove all three, yes.
Q But in any event, when you took him to the operating room, you only did the 5-6 level, correct?
A Correct.
Q Now, you did an anterior approach and when you are coming basically through this side of the neck, correct?
A The left side.

Q On left side, the left side but you are coming from front to back, you're going in anterior, coming in from the anterior side of the body?
A Yes.
Q Now, once you made the opening, you got access where you can see the 5-6 level, you were able to determine that the posterior longitudinal ligament was intact and you were able to leave it intact, you have your operative report?
A During the surgery.
Q During --
A Yes, yes.
Q And you noted that there is a posterior disc herniation that you visualized, how wide was this herniation?
A I don't directly recall exactly how wide it was.
Q You certainly didn't make any mention as to whether it was broad or narrow or focused or anything like that in your report, correct?
A That's not clinically relevant.
Q You didn't do it?
A It's not clinically relevant.
Q Doctor, you didn't do it?
A Correct.
Q You didn't do it?
A Correct.
THE COURT: He said right. Move on.
Q But you went beyond the disc in the neck and you did -- decompression was carried out laterally at the uncovertebral joints, correct?
A Correct, that's my standard protocol.
Q I didn't ask you that.
I asked you simply, did you do that, you went beyond removing the disc out to the uncovertebral joints and these are these joints back here?
A Yes.
Q And you removed those -- as part of that surgery, you removed those bony joints, the bony portions of those joints, correct?
A No, not all of it, just a portion.
Q The portion where they came into contact?
A No, just enough to fashion space for the spacer, the interbody, the grafted cage.
Q Now the spacer is between the vertebral body, correct?
A That's where the uncovertebral joint is.
Q What joints are these back here, these facet

joints, uncovertebral joints?
A No.
Q The uncovertebral joints are where?
A In the side of the disc.
Q And you actually removed -- but you actually removed the uncovertebral joints, correct?
A Not entirely, no.
Q Entirely?
A No, it's just to square off the space to fit the cage in.
Q And then you put the -- you placed the cage in, you put on the plate and the screws?
A Yes.
Q Did the closure on it, correct?
A Yes.
Q Now, when your patient leaves you, you give them certain instructions?
A Yes.
Q You want them limited in their activities, limited to some bed rest for a period of time, what instructions did you give a patient who just had a cervical fusion?
A Not to lift anything heavy for six weeks, to be

Q Why?
A To not submerge their wound.
Q Why to be careful about what they eat?
A Because they will have a very sore throat and it can cause swelling.
Q And a swelling can cause collection of fluid and can cause a seroma?
A I'm not actually familiar with that.
Q But it's an accumulation of fluid in the area and we were talking that also, ultimately, it's fluid that tears through tissues that have already been irritated by virtue of the surgery, right?
A I'm not sure what you're referring to. You mean the swelling from the surgery or you mean from eating food?
Q You just told the jury that eating inappropriate foods can cause swelling?
A There is swelling and it can exacerbate and irritate the tissues.
Q And irritate the tissue can cause accumulation of fluid?
A No, that doesn't cause seroma. You said that, I didn't.
Q I'm asking, you're saying it doesn't, you're

saying it does not cause accumulation?
A Every single patient I do surgery on has inflammation in the throat and it doesn't cause seroma very often, maybe one in five hundred, really.
Q And but anyway, you instruct your patients to eat soft foods, correct?
A We encourage them to eat pureed soft foods.
Q For how long after the surgery?
A It's not clearly defined.
Q About how long would you like to see them do it?
A It's not clearly defined. It's just a matter of how much swelling they have.
If they feel they can tolerate, then they are fine eating more coarse food. We warn them if they are having swelling, difficult to swallow, use a pureed diet.
Q When Mr. Carter came back on his first visit, I believe he came back and saw you on March 4 after the surgery, he was having -- he was having swelling?
A I'm sorry?
Q He still had swelling?
A Well, he had a fluid in his neck. He had a seroma.
Q But he still had some swelling as well, correct?

That wasn't the issue.
Q You made a point in your chart to remind him about eating soft foods, yogurt and pureed vegetables and stuff, correct?
A Well, that would help him in the context of his symptoms.
Q But you are reinforcing something that you have already told him and you are noting it specifically in your chart, correct?
A Sure, yes.
Q Now, you took care of the seroma, it was a complication and to kind of just keep moving, try to focus on now the lumbar spine, when you did the first lumbar spine surgery on what, 6/8/15?
A Yes.
Q So that would be a month shy of three years after the accident, correct?
A Yes.
Q And you had just prior to having lumbar surgery, you went back and you had another CT scan done by Dr. Cole?
A I don't know who did it. I will look.
Q Dr. Cole's office?
A From May 8, 2015, it was done at Lenox Hill

Radiology.
Q And that's Dr. Cole's facility?
A Not that I know of. I don't think it is.
Q But anyway, it was about a month prior, are you familiar with something called interval change, correct?
A Yes.
Q Did you review the films from 6/8/15 with the films of --
A From --
Q -- of 7/12/12?
A Yes. I have reviewed both, it is from 5/8/15, yes.
Q You actually looked at the films?
A I have actually looked at the films from both, 12 and 15.
Q You went ahead and did you make any note of any interval change?
A I believe there was.
Q Okay. You believe that there were herniations that appeared in 2015 that weren't present on 7/12/12, is that what you're saying?
A Well --
Q Yes or no, doctor?

tissue.
Q Yes or no, is that what you're saying?
MR. BOTTARI: Objection.
THE COURT: Repeat the question.
Q The interval change that you are stating is that you believe that there are herniations in May of 2015 that you didn't see on the July 12, 2012, CT scan, correct?
A No, I see the disc protruding posteriorly in 2012 as well.
Q Protruding, but you didn't see a herniation, what's the specific --- withdrawn.
In any event, you took him to surgery, you went in there, you did basically -- you approached from the rear, you removed the disc, but in addition to removing the disc, once you placed -- if you could refer to your report, you were able to visualize the L-4-5 facet joints and the lamina, correct, where the foraminal stenosis and slight instability was noted on the right side, correct?
A Yes.
Q And that foraminal stenosis, that was caused by the arthritic facet joints at that level?
A I didn't note any substantial arthritic changes, no.

Q But in any event, the right L-4-5 facet joint, you removed that?
A Yes.
Q You performed a hemilaminectomy, what that means is that you removed a portion, let's see --
A The low back.
Q You removed a portion of the lamina?
A Yes.
Q And you removed a portion of the facet joint on the right side?
A Correct.
Q After doing that, you then went in there and you did -- the right L-4-5 facet joint was fully excised using a burr and pituitary -- so scrape it out, so you removed the entire 4-5 facet joint?
A After we determined -- after I determined that I was going to fuse it, yes.
Q In addition to doing the laminectomy, you also did a foraminotomy, correct?
A Yes.
Q And what you mean by that is, not only did you remove the bone from the facet joint, you removed bone from the foramen, the bony window?
of the bone in the foraminal window trying to make space.
Q And what you do is trying to open up the air, remove any existing bone spurs, make the window larger so there is nothing there to irritate the nerve root, fair enough?
A Not just bone spurs, but disc.
Q Okay, but foraminotomy, you are removing bone, correct?
A Correct.
Q A laminectomy, a hemilaminectomy, you are removing bone, correct?
A Correct.
Q The facet joint is bone, correct?
A Yes.
Q Thank you.
And it was the facet joints that were encroaching into the foramen, the spurring, correct?
A No.
Q You disagree with that?
A Yes.
Q Thank you.
Then you went to the other side, after you put -- going through, I'm just going to focus on some of the dissection that you did.

When you put the spacer in, you put half the plate in or you put the plate in, secured half of it, then went to the other side of the back, made another incision, went in again, correct? I'm trying to keep it simple.
A Not a plate, a cage.
Q A cage, but I mean, once the cage is in, you put a -- there is a support on both sides?
A No, once you put the cage in, you just put screws in.
Q All right, fair enough.
A And the rod.
Q Now, when you went to the left side, you did an osteotomy of the L-4-5 facet joint on the left, correct, the posterior infusion on the contralateral side was carried out, osteotomy of the L-4-5 facet joint, so you are working on the left side?
A Correct, to help the bone fuse.
Q But you are also removing the facet joint on that side, correct?
A Yes, after you determine that you want to fuse it.
Q All right, and then you note that you

correct?
A Yes.
Q So at that point, the facet joint on both sides has been removed completely?
A No.
Q How much is left on either side?
A Well, we wouldn't do that unless we were fusing.
Q I understand.
A After we decide to do the fusion, then we resect the entire facet on the side that we are working on, where we put the caging, we need space and on the other side, we just remove really the cartilaginous part and a portion of it in order to have a surface to put bone grafting on to diffuse it.
Q But you removed the cartilage from both the top and -- from both halves?
A To try and fuse that, yes.
Q Now, that part of the surgery is fine.
At some point, when he came back to you, and noted -- and you noted that the screws were -- or that the instrumentation you put in was not where it was supposed to be the first time, did Mr. Carter tell you that shortly after your surgery, he had fallen down in the bathroom?

A I don't recall.
Q Is that something that you would have liked to have known?
A Well, I mean, it would explain -- people do beat themselves up. I mean, nobody wants to fall and, yes, I mean, it doesn't change the fact that the screws were loose.
Q I mean, nobody went in there and twisted the screws, but the fact that he fell could very well cause the screws to be loose, correct?
MR. BOTTARI: Objection.
A It could be one reason why.
Q But in any event, he never told you about the fall, correct?
A I don't recall.
Q Falling after a fusion surgery could be a reason why you have a non-union?
MR. BOTTARI: Objection.
Q Yes or no.
THE COURT: He can answer that.
A I mean, not -- that's not really described in the literature very much. Most of the time people fall after surgery because they are on medication, because of

Q All right, or they are having problems staying within their physical limitations and their comorbidities is another explanation, correct?
MR. BOTTARI: Objection.
THE COURT: Overruled.
A Most of the time, people fall after surgery because they are on pain medication and they are in a lot of pain.
Q Right, but part of your postoperative instructions, I mean, you have to -- part of one of the things you do, you do a fall assessment, right?
A We don't normally say things like, don't fall or don't hit yourself in the head.
Q I understand.
A No.
Q But you might tell them, live within your limitations?
MR. BOTTARI: Objection.
Q Correct?
A I would love to hire you and have you help me with my counseling of patients post-op.
Q Well, what do you tell them, doctor?
A The same types of things I just told you already before, don't lift anything heavy. I will from now on

tell them not to fall.
Q I'm not asking you to do that, doctor.
I'm asking you, what your expectations are of the patient, simply be aware of their limitations and their problems and try to live within them, correct?
A I feel terrible for him that he fell.
Q I understand, but him falling for whatever reason certainly explains the first disruption of the screws and the -- as an explanation for the disruption of the screws --
MR. BOTTARI: Objection.
THE COURT: Sustained. Move on.
Q In any event, he didn't tell you?
MR. BOTTARI: Objection.
THE COURT: Mr. McGuinness, would you stop repeating and move along.
MR. McGUINNESS: Your Honor, can I have a side bar.
(Discussion held at side bar.)
BY MR. McGUINNESS:
Q In any event, three months after he comes back after you did the first surgery, he comes back and the screws are disrupted and the spacer is out of place,

activities during that time; is that correct?
A I'm not sure where you get the information that you are just saying.
Q Well, you saw him after the lumbar surgery, the first lumbar surgery, correct?
A I don't think that I proved that his screws and spacers were out at that point. It was more than a year afterward.
Q In any event, the first time you saw him -- did you not make a follow-up visit three months after the lumbar spurs in September of 2015?
A He was seen in August 13, 2015, and then October 2015.
Q And at that point, at that point, there was a disruption or a failure of the hardware?
A Not that I know of.
Q When did you first notice that?
A When we attained the x-ray.
Q When was that?
A I believe it was the x-ray that we were reviewing earlier that was in 2017, a little past one year.
Q And if the Plaintiff had other fall down incidents in that time interval, he never related those to you, correct?

A I don't know what you're referring to. I mean, are we talking about hypothetical patients or our patient?
THE COURT: I think the question is, did he ever tell you that he had any fall incidents?
THE WITNESS: Not that I know of. I guess he is implying that he did.
THE COURT: That's the question that he is asking.
Q All we are trying to establish is whether or not he related information to you?
A Not that I know of.
Q You went back and when you actually -- when you went back and did the second surgery on his low back, and that was -- I'm sorry, that was September 26, 2016, at that point, you actually -- you removed the old hardware, correct?
A Yes.
Q After removing the hardware, you also removed -- you also did additional facetectomy, correct?
A In order to try and help the bone fuse, yes.
Q So you removed additional facet joint?
A Additional bone.

already been removed prior?
A Well, some of it still remained.
Q You had to do a neurolysis, you went in there and probed around the nerve root where it exited, correct, on the right side?
A Yes.
Q And that was the foramen that you already opened up before, correct?
A Right, we were trying to make sure that there was nothing additionally causing the symptoms.
Q At that point, you went in, you put a larger spacer in, correct?
A Yes.
Q It was larger -- how many -- I'm not sure how they are sized, how much larger was it, the one you placed in before?
A I don't think I quantified that.
Q But you put another one in and then you went in with larger screws on the -- larger screw -- on either side of the spine, is there a bar, is there a spacer, what is that that the screws go through?
A They pass through the bone and through the pedicle into the front of the vertebral body.
Q Do they pass through a plate or anything of that

nature?
A No.
Q The screws just go into the vertebral bodies?
A That's the standard of care, yes, they go into the body -- into the bone and then we connect the screws with a rod.
Q And you just happen to use larger screws that time?
A Well, when the screws are loosened, you can't put in the same size, they would just be loose, so you upsize them, you go higher.
MR. McGUINNESS: Doctor, I believe that's all I have. Thank you.
THE WITNESS: Thank you.
MR. NASTRO: Nothing further, your Honor.
MR. BOTTARI: Two minutes, your Honor.
REDIRECT EXAMINATION BY
MR. BOTTARI:
Q Mr. McGuinness asked you about umpteen problems in the spine --
MR. McGUINNESS: I'm going to object to prefacing the comment with a personal attack.
THE COURT: Disregard that.

problems in Mr. Carter's neck or back prior to July of 2012?

MR. McGUINNESS: Your Honor, unless he can establish that he supplied him all the records --

THE COURT: He can ask that.

MR. McGUINNESS: All right, but it is misleading unless he has given him all the records.

THE COURT: We would rather not have any speeches.

Q Anything that you have seen?

MR. McGUINNESS: Am I overruled, your Honor?

THE COURT: Yes.

Q You can answer.

A I'm sorry, what's the question?

Q Have you seen anything about problems to Mr. Carter's neck or back where he was symptomatic with pain prior to July of 2012?

A I'm not aware of him ever having neck or back problems before the accident.

Q Now, you talked about the fact or you were just asked if someone fell, could that have anything to do with screws being loosened, correct?

A Yes.

Q You said it might, you don't know?

A I mean, if somebody -- theoretically, you could damage what we did, but I haven't seen evidence of that ever.

Q If someone fell because of a comorbidity such as diabetes or lightheadedness from medication, is that also a possibility?

A It is more likely postoperatively that somebody who doesn't have a pattern of falling --

MR. McGUINNESS: Your Honor, I'm going to object to him giving an opinion that's not based on this specific patient, the patient never related --

THE COURT: I understand.

Q We are talking Mr. Carter here, Mr. Carter has a history of diabetes, he has a history of peripheral neuropathy, correct?

A Yes.

Q He is also on lots of medication?

A Yes.

Q Could any of his comorbidity factors influence his ability to walk and/or fall, just yes or no?

A Yes.

Q Someone with Mr. Carter's overall medical picture, diabetes, hypertension, on lots of medication

risk factor for fusion surgery?

A Yes.

Q Why is that?

A They have a higher complication rate.

Q And that's -- what is your knowledge, what's the basis of that, is that in the literature?

A In the literature, we have shown, in fact, I have been -- some of my studies have shown, patients who have diabetes have a higher risk of wound complication, such as the one he had in his neck and he has higher risk of not healing from the surgery.

Their healing potential is worse than others. That doesn't mean we don't treat them and don't still do the surgeries that we think are appropriate to try and relieve them of nerve pain, to try and remove disc herniations.

MR. BOTTARI: I have nothing further.

THE COURT: Briefly.

RECROSS EXAMINATION BY MR. MCGUINNESS:

Q Other than the CT scans of July 12, 2012, do you have any other records that belong to Mr. Carter?

A I'm sorry?

Q Were you provided any other records for

Mr. Carter other than the CT scans of July 12, 2012?

MR. BOTTARI: Objection.

A I have reviewed pain management records. I have reviewed physical therapy assessments and notes as well.

Q And these are from the pain management, this is from Dr. Reyfman and Dr. Goswami, Dr. Thomas, that group?

A From their office.

Q Now, there is nothing in your chart there without those records, correct?

A Right.

Q And there is nothing in your chart there about who referred Mr. Carter to you, is there?

A No, it does. I carbon copy the primary care doctor, Dr. Williams.

Q Well, you happen to know, you are inferring that, correct?

A No, I did put that in there because that's what I do when I carbon copy people. I send them a cover letter.

Q That's the person who you -- where you would customarily ask the patient, who is your primary care provider and copy them a letter, but that doesn't mean necessarily that they are the referring person, correct,

A As I said, that's my standard operating procedure, so if he was referred by Dr. Reyfman, I would have carbon copied him and sent him a cover letter.

Q And if Dr. Reyfman had sent them to you or sent Mr. Carter to you and you asked him who his primary care provider was because you needed medical clearance, you would contact the primary care provider, would you not?

MR. BOTTARI: Objection.

A Maybe, but that has nothing to do with what I just said about who referred the patient to me.

Q But in any event, other than -- did you ever see his family doctor's records?

A No, I have not.

Q Did you ever see a videotape or photographs of the property damage to the vehicle?

MR. BOTTARI: Objection. Beyond the scope.

THE COURT: It is beyond the scope. Let him answer that last question.

A No.

Q Doctor, do you have a mental picture of what kind of accident was involved here?

MR. BOTTARI: Objection.

THE COURT: That is beyond the scope. We have been through that.

PROCEEDINGS

MR. McGUINNESS: That's fine, your Honor.

MR. BOTTARI: Nothing further, Judge.

THE COURT: Thank you, doctor. You can step down.

MR. BOTTARI: You can take your records, but you can't take anything that's been marked.

THE COURT: We are done for the day. We will start again with a medical witness tomorrow in the morning.

MR. McGUINNESS: There is one in the morning and I have got one in the afternoon.

THE COURT: We will have a busy day tomorrow. Be here at 9:30 and enjoy your evening and don't discuss the case.

(Jury exits courtroom.)

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