SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM: PART 43

- -x
VERONICA MARTINEZ,
Plaintiff,

- against -

Index No.
002827/2015
TRIAL/EXCERPT

GINA MARIE CHINESE and GANDOLFO CHINESE,
Defendants.
- -x

360 Adams Street
Brooklyn, New York 11201

March 13, 2018

B E F O R E:

HONORABLE MARK I. PARTNOW,
Justice of the Supreme Court, and a Jury.

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

WINGATE RUSSOTTI SHAPIRO & HALPERIN
Attorney for the Plaintiff
420 Lexington Avenue, Suite 2750
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BY: ANDREA V. BORDEN, ESQ.

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BY: JESSE M. SQUIER, ESQ.

MIRIAM KAPLAN
Senior Court Reporter

L E O N R E Y F M A N, M.D., after having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. BORDEN:

Q Good afternoon, Doctor.

A Hi.

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

A Yes, I am.

Q Okay. When did you become so licensed?

A I became licensed in 2004.

Q Can you tell us a little bit about your medical educational background?

A I started my undergraduate career at Stony Brook University. Thereafter I completed a Bachelor of Science. I transferred to Long Island University College of Pharmacy here in Brooklyn. I completed pharmacy school in 1997. I worked as a pharmacist for a year, accepted to medical school in 1998 which I completed in 2002. From 2002 through 2005 I completed anesthesia residency at Suny Downstate Interfaith Medical Center. And lastly, I completed a fellowship in pain management at St. Luke's Roosevelt Hospital, Columbia University, in 2007.

Q And Doctor, what is pain management? What is that

specialty that you did your fellowship in?

A Pain management is a field where a physician gets trained in performing, evaluating patients that have painful conditions, such as back pain, neck pain, arthritic pains of the knees and shoulders, traumatic injuries, headaches, anything where pain is a symptom. And pain management doctors are trained to come up with a treatment plan and help patients to combat this painful symptom.

Q And Doctor, are you board certified?

A Yes, I am. I'm board certified in anesthesia and pain management.

Q What does it mean to be board certified?

A Board certification means that the physician must complete a training, take a written and oral exam. After successful completion of both the doctor gets granted a board certification.

Q Okay. Doctor, can you tell us a little bit about your current practice?

A My practice -- I'm in private practice since 2008. I am still on faculty at Suny Downstate Interfaith Medical Center as well as Mount Sinai Hospital of Brooklyn. I serve as the director of pain management at Suny Downstate. I've been there for ten years or so. I see patients in the hospitals, both at Suny Downstate, Mount Sinai, and I also see patients in my office in Brooklyn.

Q You have teaching responsibilities?
A Yes, I am teaching at SUNY Downstate. I also travel. I teach at several seminars a year, teaching fellows how to perform certain procedures. Yes, I do teach.
Q Doctor, as part of your current practice are you sometimes asked to come to court and give testimony regarding care that you've provided to your patients?
A Yes.
Q Have you and I ever met before this case?
A No, we did not.
Q Have you ever testified in a case in which I was the trial attorney before this time?
A No, I did not.
Q Was Veronica Martinez a patient of yours?
A Yes, she was.
Q How did she come to be a patient of yours?
A She was referred by Dr. Barshay who is a chiropractor who started treating her for the injury she sustained.
Q Now, before we discuss care and treatment that you provided to Veronica, can you please give the jurors some background and a general understanding of the anatomy and the structures in the lower spine?
A Sure.
Q I have a model here. Doctor, is this anatomically

correct?

A It is.

Q Would this help you explain the anatomy to the Members of the Jury?

A Yes, it would.

THE COURT: Do you have any objection?

MR. SQUIER: No objection.

MS. BORDEN: Thank you.

THE COURT: You could approach.

A Okay. So the anatomy of the spine starts at looking at the varied structures. There's something called the cervical spine, which is part of the neck, the thoracic spine, which is the mid back, and the lumbar spine, which you could see here is the lower back, and the sacrum, which is the tailbone here. The spine is broken up into various parts, bones, ligaments, which you don't see here, nerves, and also what's called intervertebral discs, which are discs between each bone. So these white structures here, as you can see, they're called vertebras. This, between each vertebrae is a beige structure. Here you could see. It's called a disc.

And the way the anatomy is broken is it's between each bone there's disc, and on each side of the bone and the disc there's a nerve that exits on the left and the right, as you see here in yellow. And these nerves exit

from the base of the neck, travelling down to mid back as well as lower back. Right next to the nerve there are vascular structures such as arteries and veins which you can't see here. The discs -- so the bones -- the purpose of the bones is to stabilize the spine because it's a rigid structure, okay. In each bone is a disc.

And typically, it's a shock absorber. It obtains two elements, the outer part called the annulus and the inner part called the nucleus, which is more of a soft, gelatinous material. The annulus, which is the outer part, is more elastic, more rigid in comparison to what's inside. So in a case where there's herniation or bulge or nerve entrapment, that means that part of this disc here in beige gets protruded into the area where the nerves are, which is called epidural space.

Epidural space consist of various vascular structures, arteries we call veins, as well as nerve structures that traverse all the way down and exit on each side of the spine, on the left and right. And it starts at the base of the skull.

Q And now, Doctor, you talked about a herniated disc. Can a disk herniate due to trauma?

A Yes.

Q All right. Can it also herniate as a result of an actual process, just general aging and degeneration?

A Yes, it can.

Q All right. What physical symptoms does a herniated disc produce or what can it produce?

A It can be a combination of symptoms. One can complain of lower back pain. They can also complain of pain traveling down the buttock area, leg. This could also be symptoms of nerve impingement, such as pins and needles, numbness. And it could also be physical exam findings that are consistent with nerve entrapment, nerve impingement.

Q Okay. Generally speaking, from a pain management physician's perspective, how do you treat a herniated disc?

A As a rule, we always try to offer conservative treatment to our patients. That means pain medications, muscle relaxants, physical therapy, conservative modalities, chiropractic, even acupuncture. Sometimes we try to initiate this treatment.

In cases where the patient has severe pain, where they're taking tolerance for physical therapy, we like to do this for two to three months, sometimes four months. If patients continue to have pain beyond that point, the next thing is to consider interventions or surgeries in some cases.

Q And Doctor, when did you first see Veronica Martinez as your patient?

A I saw Veronica on December 3, 2014.

Q Okay. At this time I would like to move your records into evidence.

THE COURT: Any objection?

MR. SQUIER: Judge, I don't know if we have the actual records from the records room. If we do, there's no objection.

THE COURT: I'm sorry?

MR. SQUIER: If we have the actual records from subpoenaed records room.

THE COURT: Are they here now?

THE COURT OFFICER: No.

THE COURT: So I'll sustain the objection for the time being.

MR. SQUIER: If I can review Dr. Reyfman's records briefly, Judge.

THE COURT: All right, you could approach.

MR. SQUIER: Your Honor, I have no objection to Dr. Reyfman's records, supplemental records, records from other providers. MRI, I would object to.

THE COURT: Those records, you have no objection to counsel, subject to redaction?

MR. SQUIER: I have no objection to his actual records, Judge.

THE COURT: His records?

MR. SQUIER: He has records from other

facilities.

THE COURT: Then take out what you're objecting to.

MR. SQUIER: Certainly, Judge.

I have no objection to this package, Judge.

THE COURT: That will be in evidence without objection as Plaintiff's Exhibit Number 4.

(Whereupon, the item referred to as Plaintiff's Exhibit Number 4 was received in evidence.)

Q All right. Doctor, I think I had just asked you before, when is it that you first saw Veronica Martinez as your patient?

A I saw her on December 3 of 2014.

Q Okay. And at that point what medical records of hers did you have available to you?

A I had available an MRI of her lower back. That's all I had available.

Q What did you do when you saw her on that first visit in December of 2014?

A I spoke to her about the accident. She gave me history of how the accident performed. I performed a physical exam, I reviewed her records, MRI, and we discussed the treatment plan.

Q Okay. What did your examination reveal with respect to the lower back on that first visit?

A With regards to her lower back she had a diffused back pain in various segments of her lower back. She had moderate muscle spasm along the lumbar vertebra. Those are the muscles that surround the spinal column, as well as the multifidus, which is another deeper muscle in the lower back, and also gluteus, piriformis. Those are the muscles around the buttock area.

She had straight leg raise positive 30 degrees.

This test is performed -- a patient lays on their back and examining physician will elevate the leg. Any time patient describes painful symptoms, shooting pain down the leg, that's usually indicative of a nerve irritation nerve impingement.

She had difficultly with squatting.

Her neurological exam, which is broken down by three elements -- I'm sorry, it's a sensory exam -- which was normal. Motor exam is by testing strength in the lower extremities. And she had a weakness at the knee flexors rated as 4/5; 5 being normal, 4 is impaired.

And her also, what's called deep tendon reflexes, were diminished, 1 plus to be normal, and that's also consistent with evidence of nerve impingement.

So three things. She had a straight leg test positive, she had weakness in her leg and she also had

diminished reflexes on the left side. So all those three things are consistent with nerve impingement.

Q Okay. Did you actually review the MRI film at that time?

A Yes, I did.

Q What did you recommend for her at that point based on your physical examination and your review of the MRI film?

A We discussed several things. One is an option of doing lumbar epidural steroid injection. In addition to that, giving her stronger pain medication. And also she was advised as to properly exercise and take care of her back. I asked her not to lift anything that's very heavy, or pushing. Those are the recommendations. That's the discussion we had.

Q Okay. Now Doctor, during that first visit in December of 2014, what information if any did you have with respect to her prior surgical history?

A She reported to me that she had a lower back surgery in 2010 at Coney Island Hospital, and which was evidenced also on the MRI. There was a degree of scar tissue, as well as in the physical exam there was scar tissue in her lower back. She stated that she had had severe back pain and saw a surgeon at Coney Island Hospital and she had a successful surgery, after which she had no

pain up until leading to this accident.

Q Okay. Doctor, is that prior surgical history actually noted on the office visit record from that date?

A On that date it's not, but it is noted along the other office visits that are clearly here in the chart.

Q Okay, thank you.

Now Doctor, is a patient who has had a prior back issue, a prior herniation with the back surgery, are they more susceptible to a new injury at that level?

A That's correct. The way her prior surgery was performed, a surgeon removed part of the disc and also a bone in the back of the disc which is called the lamina. And yes, that patient is more susceptible to be reherniated and to actual pain after a traumatic event.

Q Okay. Now, Doctor, did the patient undergo -- what care did you next provide for Miss Martinez?

A I gave information to Miss Martinez about lumbar epidural steroid injection, which she had done on the follow-up visit.

Q And what is a lumbar epidural steroid injection?

A Lumbar epidural steroid injection -- epidural is a space where nerves are. And the idea with this injection is to administer a very strong steroid into the area where the herniation or below, and to have what's inflammatory -- a steroid is a very strong antiinflammatory medication. We've

been using it for years and years, and they help with inflammation that occurs in the presence where there's herniation in the lower back or the neck for that reason.

Q Now, can this epidural steroid injection cure a herniated disc?

A Epidural steroid injection do not cure herniated disc but it can help.

Q When did she under undergo the first epidural steroid injection?

A She had the first injection on December 29, 2014.

Q Did the patient report relief from that?

A She stated that she had about five days of pain relief after the injection.

Q What is the significance of that, medically speaking?

A Medically, it's a good sign that someone that had an injection had five days of relief, that they were able to function. It means that the steroid had worked, but not to the point where pain was fully resolved for longer than five days.

Q Okay. Now, how many injections into that epidural space did you ultimately give Miss Martinez?

A She had a total of three injections in the course of a six-month period.

Q Okay. How many do you typical recommend a patient

undergo?

A Two to three.

Q And after her third what did she report?

A She had some relief but the pain returned.

Q What did you next recommend after she had undergone those three injections?

A After failure of response to an epidural steroid injection and based on the MRI results of her physical exam, I wanted to figure out the source of her pain, whether it's the L5/S1 disc, which is the lowest disc, or the L4/L5 disc, which is the prior surgery we spoke about.

There's a procedure called discogram, which is a prophetic procedure where a doctor inserts a needle into the disc and inserts a dye, and this dye can be visualized on live X-ray which is called fluoroscopy, which we have available in the office. And once we see a problem in the disc we can also treat it by either coiling certain tears as they occur or doing what's called discectomy procedure, where we actually shrink the disc a little bit to a different approach.

Q Why was she indicated for that surgery at that point?

A At that point she had extensive course of therapy, she had tried multiple medication and muscle relaxants. Still had pain. She also had series of three epidurals

which she had some relief in between injections.

Q Okay. And so when was that surgery done?

A Surgery was performed on July 16, 2015.

Q Okay. Doctor, I want you to walk us through what was done during the surgery, and I would like to have this marked for identification purposes.

MR. SQUIER: No objection, Judge.

MS. BORDEN: And I've shown it to defense counsel already.

THE COURT: Are you going to be moving it into evidence?

MS. BORDEN: No.

THE COURT: Then he can use it for demonstrative purposes.

Q Doctor, have I shown you a diagram that depicts the surgery that you performed?

A Yes.

Q And is it anatomically correct, and would it assist you explaining to the members of the jury what it was that was done during this procedure?

A Yes, it would.

Q All right. Thank you.

THE COURT OFFICER: Can he step down?

THE COURT: Okay. Doctor, you could step down.

THE WITNESS: Thank you.

Q Doctor, if you could just explain to us what it is that you do as the pain management physician during this surgery?

A Sure. This is the picture of a patient lying on their back and exposed lower back, but this is also a picture of a normal disc. The inside of the disc that's shown here in green is the nucleus, which is the soft part of the disc. The outside, which is shown in gray, it's called the annulus, which is a more elastic membrane. So whenever there's herniation the disc structure protrudes out, as you can see here, okay. So the idea is that when patient lies flat, you take a needle and put it inside the disc, which is called the nucleus. We inject contrast, as here you can see it demonstrated in green. What we do is we're looking at the pattern of the contrast spread inside the disc. By injecting contrast, once we see contrast leaking out of this grey membrane, if we see here there's no leakage here, there's no green leaking out of this space.

You can see this in real life. Patient is semi awake. And we ask patients whether this is reproducing their pain while this procedure is performed. That's why it's called prophetic diagnostic procedure. We want to ensure that the actual disc that we're treating is causing patient symptoms.

In her case she had pain both at L4/5 and L5/S1. L5/S1 being the lowest disc in the body and L4/5 is above. She had annulus tear in both. We also tested L3/4 disc as control to make sure L3/4 is not symptomatic, which was negative. She did not have any pain at L3/4.

Patient has no control or knowledge of what disc is being injected. Patient lies on the belly and semi asleep, arousable enough for us to communicate with the patient to once we identified the problem, which in her case she had a tear.

Q Now Doctor, can I just stop you there. How is it that you know she has a tear in the annulus?

A The leak. So the green stuff, which is the contrast, will leak through this membrane. So normally if you want to inject contrast it should stay in this area, it shouldn't leak through this membrane.

Q How are you able to tell by sticking a needle in whether or not it's leaking?

A We have -- we can see it on the real life machine. As this procedure is performed we take live X-rays.

Q So you found an annular tear at which two levels?

A L4/L5, L5/S1.

Q Okay. And let me just go through your op report right now. I'll ask you to have a seat, Doctor.

So this is a copy of your op report which is

in evidence as Plaintiff's Exhibit 4?

A Yes.

Q What was your preoperative diagnosis?

A Preop diagnosis L4/5 disc herniation impingement as well as L5/S1 disc herniation with impingement.

Q I'm just gonna go to the next page. And I want to just focus right now on the section that says discograph. Just explain to us again what it is you did in each of the three discs that you tested in the procedure?

A If I may use this to demonstrate. This is L3 disc, L4 and L5. So what we did is we put a needle in L3, needle in L4, needle in L5. We took a syringe with contrast and we injected each of these discs with a needle, and we took X-rays as we injected the dye into this disc.

L3 disc was normal. Patient did not have any pain. The contrast stayed within that membrane. It didn't leak anywhere. L4/5, there was pain, and also contrast have spread out through the membrane, as I described the annulus. And same thing happened at L5/S1. Patient had more back pain, some leg pain and buttock pain than she previously had had, as well as leakage of the contrast.

Q Okay. And so when you note in your operative report, post annular tear noted for both L4/5 and L5/S1, what is the significance of those tears that you found during this operation?

A Significance is that there has been a compromise of the membrane. From my experience, from the literature, annular tear either happened from a traumatic event or if a patient get a lot older. When these discs are dryer, degenerative disc, they can just fracture, break by themselves.

So this case, this is a young patient that had no evidence of degenerative condition in her spine and had a tear in both L4/L5, L5/S1. And usually these are tears only found as a result of trauma.

We also know that on the MRI's we rarely see tears. They do happen, but this procedure is more safe and more sensitive in diagnosed tears than the typical CAT scan or MRI.

Q So Doctor, why is it that this procedure is more diagnostic of that annular tear than the MRI?

A You can actually inject contrast and see live leaking. When we do the MRI we don't inject contrast inside the disc. We can actually see the integrity of the disc on the MRI.

Q Okay. So let me ask you this, Doctor. Do you have an opinion to a reasonable degree of medical certainty as to what the cause of the herniated disc with the annular tear at L4/5 was that you found that day?

A The cause is the accident of 2014.

Q How do you know that?

A Patient had no symptom. She had surgery in 2010, no documented history of any back pain or leg pain up until the accident. She was involved in a car accident and given discograph analysis of annular tear. And her symptoms, I think this tear is related to the accident.

Q All right. And Doctor, the same question I'm gonna pose for the lower disc at L5/S1.

Do you have an opinion with a reasonable degree of medical certainty as to what the cause of the herniated disc and annular tear at that L5/S1 level was?

A I'd say it's related to the accident in 2014.

Q Okay. Now Doctor, walk us through what you did for the rest of the procedure?

You did what's called a discectomy at L5/S1. What does that involve?

A The discectomy is removing the inner part of the disc. So what we did is we extracted a little bit of disc material from inside. And what it does, it decreases the pressure inside the disc so the herniation will slowly resolve in the course of 6 to 8 weeks.

Q By the way, Doctor, that material that you removed during that discectomy at L5/S1, is that a permanent removal of that material?

A Yes, it is.

Q Can it grow back or regenerate on its own?

A It does not.

Q Okay. Now Doctor, you did not perform a discectomy of the material at the higher up disc, that L4/5 disc. Why is that?

A Because it was scar tissue, and this procedure is contraindicative to someone that had prior surgery or scar tissue along that area.

Q So what is it that you did? And let me just go back to the last page of your op report.

You then did an annuloplasty at L4/5 disc and L5/S1 disc. What does that part of the surgery entail?

A We have special needles where the tip of the needle can be heated up to certain temperature by introducing special probe inside the needle.

Annuloplasty means coiling. The annulus is the actual annular membrane, the outer part of the disc. What we do is increase the temperature to about 80 degrees centigrade for two to four minutes. Because it's collagen, it's elastic. By applying heat, it melts it. It basically coils. It's like putting glue in it.

Q All right. And what is the purpose of that annuloplasty that you performed on those two discs?

A The purpose is to seal the leak.

Q All right. Doctor, I want you to assume that

yesterday we heard testimony from Miss Martinez that she did not go to the hospital on the day of the accident, that she didn't seek medical treatment until the next day.

Does that information at all change your opinion as to the cause of these two herniated discs with the annular tears in them?

A It does not.

Q I want to discuss briefly the operative report from her prior surgery in 2010 at Coney Island Hospital.

MR. SQUIER: Judge, I have an objection to this.

THE COURT: What was your question counsel? Repeat that, please.

MS. BORDEN: I don't have a question yet. I was setting it up. And sort of the objection --

MR. SQUIER: I object to the line of questioning. The doctor hasn't been qualified as an expert in any field at this point.

THE COURT: Okay. Let me hear the question.

Q Doctor, have you seen the operative report for the 2005 -- I'm sorry, 2010 microdiscectomy and laminectomy at L4/5?

A Yes, I have.

Q Okay. And my question to you is, based on -- where does that operative report say the operation took place on?

MR. SQUIER: Objection, Your Honor.

THE COURT: Is the operative report in evidence?

MS. BORDEN: Yes, it is.

MR. SQUIER: From --

THE COURT: It's in evidence?

MR. SQUIER: It is, Judge, but at the same time this gentleman is an anesthesiologist and pain management doctor. He's not an orthopedist. He doesn't perform that type of surgery.

THE COURT: I'll allow that question. Let's see where it goes.

A The operative report states that the surgery was performed at L5/S1.

Q Does the operative report say something about sacralization of the L5/S1 vertebra?

A Yes, it does.

Q What is sacralization of the L5/S1?

A There's no disc at L5/S1. It means that the vertebrae, which is L5, is fused, stuck together with the sacrum, which is the pelvic bone.

Q Okay. Doctor, did you find there to be sacralization of the L5 vertebrae to the sacrum during your procedures, in your surgeries?

A I did not.

Q Okay. And how do you know it wasn't sacralized?

A Because if it would be sacralized I wouldn't be able to perform a procedure at L5/S1. In order for me to perform such procedure there has to be a disc in place, in which this case there was.

Q And your review of the MRI revealed that the surgery from 2010 had taken place at what level?

A L4/L5.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty as to what the cause of the two herniations at L4/L5, L5/S1, the two annular tears that you performed, the need for the three epidural injections that you performed and the need for the percutaneous discectomy with anuloplasty was?

A The cause is the accident dated 8/28/2014.

Q Okay. Now Doctor, let me ask you this. How do you know to a reasonable degree of medical certainty that those herniations, that those annular tears weren't from her prior issue back in 2010?

A If those herniations were still there there's a very good chance she would have pain after the surgery and she would seek more medical attention to control the symptoms. She stated she had no pain after or soon after the surgery. There are no records showing that she went to see any other doctors to get help. She stated that her

symptoms returned after the car accident. So my basis for my opinion is purely because of --

THE COURT: Doctor, just keep your voice up. I'm having trouble.

A The basis of my expenditure is the fact she had no pain after the surgery or prior to this accident.

Q Do those annular tears that you found during your surgery affect that opinion as well?

A These tears are traumatic in nature.

Q Okay, thank you very much. I have no further questions.

THE COURT: Counsel, you could proceed.

MR. SQUIER: Thank you.

THE COURT: Counsel, do we need the screen up?

MS. BORDEN: No, I'm gonna close it up.

CROSS-EXAMINATION

BY MR. SQUIER:

Q Good afternoon, Doctor.

A Hi.

Q When were you licensed in New York?

A 2004.

Q 2004, okay. It wasn't 2007?

A I was licensed in New Jersey in 2007.

Q Okay. Let me ask you this. You have given testimony in court before?

A I have.
Q How many times approximately?
A I testify approximately five to six times a year, maybe seven times. I've been doing this for about five years or so.
Q Okay. You've had your own practice since 2008, correct?
A That's correct.
Q You have been testifying since 2008?
A I started testifying in 2013, somewhere along those lines, 2012.
Q Okay. Do you recall giving testimony in the matter in the Supreme Court of the State of New York in the County of Queens, civil term, captioned Halina Irman or Imran, rather, against R. Barany Monuments, Incorporation, Randy R. Barany on June 9th of 2015?
A I don't, I'm sorry.
Q Okay. Is it possible that you did?
A It's possible.
Q Okay. Is it possible that you testified then that you finished pharmacy school in 1997, went to homeopathy school in England for about six months then came back and did residency here?
A Homeopathy was a remote program in England. I went there for several days or so but I didn't have to stay

there.

Q Oh, okay. You stayed there but did that program for six months through that facility or location in England?

A Yes.

Q Okay. You completed medical school in 2002, correct?

A Yes.

Q You started your anesthesia residency program at Suny Downstate from 2003 to 2006, correct?

A That's correct.

Q And you practiced in anesthesia while you did the one year pain management program, correct?

A That's correct.

Q Is it fair to say the majority of your patients are with your private practice, not the two hospitals where you have privileges?

A That's correct.

Q The fellowship in pain management, you completed that in 2007?

A Yes, I did.

MR. SQUIER: May I just have a moment, Judge? I apologize.

THE COURT: Sure.

Q So when you were asked -- do you know plaintiff's counsel Joshua Irwin?

A Yes, I did.

Q When Mr. Irwin asked you if you were a physician duly licensed to practice medicine in the State of New York, do you recall what your response was?

A I am.

Q Sure. Then he asked how long have you been so licensed. Do you recall what that response was?

A I don't, I'm sorry.

Q If I told you the answer is "I have been licensed since 2007," would that surprise you?

A It's probably a mistake. I received my license in 2004.

Q Okay.

A Yeah.

Q But all the other things I just asked but that are in this transcript, those are all correct?

A That's correct.

Q The home, the fellowship, the anesthesiologist?

A Yes.

Q You're not an orthopedist, correct?

A I'm not.

Q Do you perform any actual surgeries aside from the injection and percutaneous discectomy procedure you described?

A Not orthopedic surgeries. I also perform spinal

cord stimulus and morphine pump, but I don't perform orthopedic surgeries.

Q Okay, okay. The operative report from Coney Island from 2010, is that an orthopedic surgery report?

A It's neurosurgery.

Q Neurosurgery. What's the difference?

A Essentially, not many differences. Neurosurgeon and orthopedic surgeons are both specialists that can perform spine surgeries.

Q Okay. Let me ask you this. How many patients do you have in your private practice?

A A lot.

Q More than a thousand?

A Yes.

Q Okay. How do you get the majority of your patients?

A Hospital referrals, physician referrals, online resources.

Q Plaintiff's personal injury referrals?

A I do not advertise to plaintiffs. I get referrals from doctors, primarily online resource, word of mouth.

Q Okay. Well, do you also get referrals from plaintiff personal injury attorneys?

A Like I said, I don't directly get referrals from attorneys.

Q Not at all?
A Attorneys may recommend me as a physician but I don't get attorneys, referrals.
Q But you have your chart there in front of you?
A Yes, I do.
Q Do you have a notation in there from referring source from Miss Martinez?
A I do not.
Q How do you know it's Dr. Barshay?
A Because he refers patients.
Q How do you know he did it in this case?
A He's the one who initiated treatment, ordered the MRI, and he's the one who referred me.
Q Okay. Let me ask you this. That first visit was December 3rd of 2014?
A Yes.
Q Do you have an actual independent recollection of actually meeting with Miss Martinez?
A I don't.
Q So you're going based on what's in your report?
A That's correct.
Q Nowhere in your report does it say Dr. Barshay referred Miss Martinez?
A That's correct.
Q Just like you told us nowhere in your report do you

have anything noted about her prior back problems in 2010 nor her back surgery, correct?

A I'm sorry, repeat the question.

Q The report you were asked about from December 3, 2014, you don't have any notations in there about her prior back surgery or back issues of 2010?

A That's correct.

Q Okay. But your statement was -- your testimony was it is present in your future reports?

A That's correct.

Q Okay. So where is it present in your future reports? For instance, the next time she came to see you, when was that?

A She -- the report dated 3/3/15 indicates she had lumbar discectomy in 2011 at Coney Island Hospital.

Q I'm sorry, what was the date on that?

A Says 2011.

Q Not the --

A I'm -- the office visit dated 3/3/15.

Q When was the next time she came to see you after December 3rd?

A It was on December 29th.

Q Okay. That report doesn't have any mention --

A That's correct.

Q Prior, what about January 28th?

A Same thing.
Q Okay. Who did she see on January 28th?
A She -- on January 28th she saw Dr. Mendosa who is a doctor that practices in my practice.
Q Who actually gave her her first set of injections, you or Dr. Mendosa?
A I -- let me double check.
Q Please do.
A The first injection performed by me.
Q Okay. What about the second set?
A Dr. Mendosa.
Q What about the third set?
A It was by me, but let me double check. I performed the third injection.
Q You did, okay.
So when she first came to meet with you, where did she see you; in your office in the ambulatory surgery center or somewhere else?
A She saw me in the office.
Q This ambulatory surgery center, is that connected to your facility?
A We're a floor apart.
Q Floor apart, okay. Do you own that as well?
A It's part of the hospital system, Mount Sinai. And I have ownership, yes.

Q Okay. So same building?
A Same building.
Q Got you, all right.
When you talked to her about the accident in 2014, do you have a specific recollection of what she told you?
A Direct recollection, no. I have to base it on my chart.
Q Based on whatever is in your chart, when she came to talk to you she didn't just explain about her lower back, right?
A According to the chart she explained of other symptoms.
Q Such as shoulder and neck?
A That's correct.
Q Okay. And throughout your report you did make a recommendation for injections for her lower back, correct?
A Yes.
Q What about for her cervical spine, her neck?
A Recommendations were made also to consider an injection in her neck.
Q Did you ever perform injection in her neck?
A I did not.
Q Why not?
A Because her symptoms were more pronounced on her

lower back, and she had more limitation from her lower back pain and she wanted to proceed with the treatment for her lower back primarily.

Q Okay. But you never performed injections on her neck, correct?

A I did not, yes.

Q You didn't review Dr. Barshay's records that first time you met with her, right?

A I did not.

Q Did you ever review Dr. Barshay's records?

A No.

Q When was the first time you saw the operative report from Coney Island Hospital?

A I don't know.

Q Was it this year, 2015?

A It was somewhere in 2015.

Q Before or after you did the perc-disc?

A Before.

Q Okay. So the injection, that's just a really long needle, correct?

A Yes.

Q Is she awake when you do those?

A She was awake, yes.

Q And this percutaneous discectomy procedure you described, that's also a really long needle with a tiny

little scoop on the end?

A Yes.

Q You take that tiny little scoop, you remove a very small amount of material from her disc?

A That's correct.

Q How much did you remove?

A About one milliliter, approximately.

Q How is one milliliter compared to, say, an M&M?

A About an M&M size.

Q It's about an M&M size. You scoop that out, pulled it out?

A Yes.

Q You didn't take a scalpel, cut her open?

A No.

Q You didn't actually view the disc or the vertebrae with your eyes, you just looked at this X-ray of the fluoroscopy?

A Exactly, yes.

Q At the end of your operative report you talk about how she did during the operation, correct?

A Yes.

Q How did she do?

A She did fine.

Q Okay. Do you remember what you wrote specifically?

A Sorry, counsel?

Q Do you remember what you wrote specifically regarding --

A I mean, I can reference to my report.

Q Please do.

A (Reading:) Patient tolerate procedure well, entered recovery neurologically intact, there were no complications.

Q Right. (Reading:) During this entire procedure, including the needle intersection, decompression, the patient experienced no discomfort, no evidence of paresthesia.

What's that?

A Numbness or tingling.

Q Or nerve root irritation?

A No.

Q No CSF or blood was noted at any time during the procedure. What is CSF?

A Cerebrospinal fluid.

Q So you put the needle out, took out little bit of scoop, cauterized whatever tears might have been in there and that's it?

A That's it.

Q She went home the same day?

A She went home the same day.

Q Did you see her again after that?

A I saw her again on 11/18/2015.
Q Okay. And what did you do for her on 11/18/2015?
A I gave her pain medication, advised her to restart physical therapy.
Q Okay. At that point had you reviewed any records from physical therapy?
A I did not.
Q Had you spoken to Dr. Barshay?
A I don't recall.
Q Okay. Would you have made a note of it in your chart?
A I would.
Q Okay. You indicated you reviewed the MRI for her lower back on that very first visit, correct?
A Yes, I did.
Q I believe you told us that's the only thing you reviewed?
A Yes, it is.
Q You did not review an MRI of her cervical?
A I did not.
Q You didn't review MRI of her shoulders?
A I did not.
Q Why not?
A They were not available.
Q How did you get her MRI for her lower back?

A I called Stand Up Radiology and asked for copy.
Q You didn't ask for her neck and shoulders?
A The focus of treatment was to her lower back.
Q Where in your report does it say that you looked at her MRI?
A I had direct access to Stand Up Radiology. I can pull up film, review them online.
Q Okay. Well, what it actually says is imaging study, see chart for full report.
A Right. I review all the MRI if they're available, and in this case Stand Up MRI is readily available.
Q And how did you know that you reviewed the lumbar MRI in this case?
A I review all MRI prior to discectomy, especially for injections, if they're available.
Q Sure. Especially on December 3rd of 2014, how do you know you reviewed the lumbar MRI?
A Again, I have access to Stand Up Radiology, and it's easy access to gain to review the film.
Q Let me put it to you this way. Where in your report does it indicate that you actually reviewed the actual MRI?
A It does not. It's a part of my practice to review MRI.
Q It does not, correct?

A Correct.
Q You already told us you don't have a specific recollection of Miss Martinez or this particular consult, correct?
A That's correct.
Q How do you know you were reading the MRI?
A That's my routine practice is to actually review MRI.
Q Sure. Were you in a hurry this day?
A No.
Q How many other people did you see this day?
A I'm not sure but I'm sure I spent enough time with Miss Martinez to, you know, examine her, come up with a treatment plan.
Q Was there anybody else present when you talked to Miss Martinez?
A Probably not.
Q Did you communicate with her in English?
A I'm sorry, I had a translator. She speaks Spanish.
Q At the very top of your chart there there's a section that says preferred language, right?
A Yes.
Q What does that say?
A English.
Q English. How come it doesn't say Spanish?

A It's a mistake.
Q Sure, I understand.
A I don't speak Spanish but there's a translator available.
Q That's what I am getting out. You don't speak Spanish?
A I don't.
Q I don't either.
A There's a translator available.
Q Who is the translator -- what's her name?
A I don't remember who it was at that time in the office.
Q Just like you don't remember the actual consult, you don't remember if you actually reviewed the MRI?
A I do remember that I reviewed the MRI. I don't have the direct recollection of Miss Martinez because I haven't seen her in three years.
Q You just told us you didn't have a specific recollection of reviewing the MRI, now you have a recollection of reviewing the MRI?
A Counsellor, my routine practice is to review MRI if they're available. I have direct access to Stand Up Radiology. I can view the MRI. That's my answer.
Q I understand that part. You told us several times. What you just told us is that you actually remember

reviewing the MRI, but you do not, correct?

A Correct.

Q The history that you get from people, in this case, especially since you didn't have any medical records, you have to take her word for it when she tells you what happens, what symptoms she's experiencing; is that correct?

A That's correct.

Q So she came in, met with you, and the very next time she came to your building she had injections, right?

A The next visit, yes.

Q How about the visit after that?

A She had injection, yes.

Q When was that?

A January 28, 2015.

Q That was with Dr. Mendosa?

A That's correct.

Q Okay. The next time she came in, when was that?

A That was March 3, 2015.

Q What did you do for her then?

A She reported relief after the injection. We spoke about possibly trying a third injection. She wanted to wait and she was given appointment to come back.

Q You wanted to give her more injection in March but she wanted to wait?

A We offered to do a series of three, but it was up

-- she wanted to wait. She felt somewhat better after the second injection and there was no rush to do a third injection.

Q Okay. How long -- is that the one where she told you she felt better for five days?

A That's the one she told us she felt better about a month.

Q About a month, okay, okay. Then she came back when?

A She came back in May, May 6th.

Q Okay. What did you do for her then?

A She reported worsening of pain. And one second, I'm sorry, let me just review this one minute. She stated that she felt better. Her pain returned two weeks prior to her appointment, which was 5/6/15. She described pain as seven out of ten. Again we suggested -- I suggested to have another injection, and she had her third injection.

Q Okay. Where did you do the first set of injections?

A Where?

Q Where? Not on her body. In your office?

A No.

Q Not in the ambulatory surgery center?

A We have OBS, office-based surgery center, yes. It's procedure room. It's office-based surgery center.

Q Okay. Were you actually in your office when you did the injection, were you actually in an operating room?

A An operating room.

Q Would that be in the records from ambulatory surgery center?

A It should be.

Q Okay. Would it surprise you to learn that neither of the first two set of injections are in there, only the third set?

A Because the two set of injections were done at my facility, 813 Quentin Road, which I moved to 2279 Coney Island Avenue.

Q When did you move to 2279?

A September 15th -- I'm sorry, September 15, 2014. The surgery center opened in April of 2015, I think.

Q Okay. Doctor, are you familiar with the term "secondary gain"?

A Yes, I am.

Q What is that?

A It's basically overexaggerating complaints for financial gain.

Q Right. It has to do with financial gain, correct?

A Correct.

Q An example of that would be a lawsuit, right, financial gain?

A Yes.
Q What percentage of your patients bring lawsuits for their injuries?
MS. BORDEN: Objection.
THE COURT: Percentage of your patients?
MR. SQUIER: Involved in lawsuits.
THE COURT: I'll allow it.
A I treat -- probably 20, 25 percent of my practice are patients who have sustained some form of injuries.
Q Sustained what type?
A Sustained injuries.
Q I thought there was another word I couldn't hear.
A Hear? No, sustained injury.
Q I apologize. I'm a little deaf. Okay.
Did you ever give her any treatment for any other body part other than her lower back?
A I did not.
Q Did you refer her to any other doctors when she came back and told you about her lower back pain in November?
A I did not.
Q Do you know if she saw any other pain management doctors aside from yourself?
A I'm not aware of it.
Q Did you ever get to review those cervical spine and

shoulder MRIs?

A I did not.

Q How do you know that?

A They're not part of my chart.

Q Okay. Let me ask you this. Do you have an opinion as to whether scar tissue from a surgery, for instance, could impact somebody's disc or the way they feel in their lower back?

A Scar tissue, yes, it can.

Q In what way could it affect or impact it?

A It can cause muscle spasm, it can cause pain.

Q Okay. Are you aware she had scar tissue when you first saw her?

A She has a scar, yes.

Q Were you aware that she had scar tissue when you first saw her?

A When I did the injection it's obvious there's scar tissue.

Q How big is the scar?

A It's about an inch, inch and a half.

Q Where is it located?

A Midline, L4/5.

Q So what specifically -- if somebody has back surgery, it's my understanding that scar tissue can wrap up around a nerve and cause pain and problems in somebody's

back; is that fair to say?

A That's fair to say.

Q Have you ever experienced that?

A Yes.

Q Okay. Did you do anything to rule that out in this case?

A One of the reasons we gave epidural is to help break the scar tissue, if there's any. That's typical course of treatment. So that was the intervention that was taken, to do injection.

Q This fluoroscopy procedure you did, are you able to see scar tissue through that process?

A Not always.

Q Okay. Is it easier to see it with an MRI?

A Only if it's done with contrast, with and without contrast.

Q The MRI that you observed from Stand Up MRI, was that done with or without contrast?

A Without contrast.

Q You wouldn't be able to see if there was scar tissue there?

A Not clearly.

Q Any idea if you broke up any scar tissue with your ESI, epidural steroid injection?

A I'm not sure.

Q Okay.

MR. SQUIER: If I could just have a moment, Judge.

Q Did you ever speak with anyone from her attorney's office, not necessarily this attorney, but anybody from the attorney's office about this case before today?

A I did not.

Q Not at all before today?

A I met counsellor last week to prepare for the trial.

Q That was the first time you ever had any contact with the plaintiff's office?

A That's correct.

MR. SQUIER: Nothing further at this point, Judge.

THE COURT: Anything?

MS. BORDEN: Just one question.

REDIRECT EXAMINATION

Q Doctor, do you have an opinion within a reasonable degree of medical certainty as to whether Miss Martinez's back problem that you were treating her for were caused by scar tissue or by a new herniation with an annular tear?

A I feel that her symptoms are because of the new herniation and annular tear and not the scar tissue.

Q Okay, thank you.

THE COURT: Anything?

MR. SQUIER: No, Judge. Thank you.

THE COURT: Okay. Thank you, Doctor. You can step down.

Leave the exhibit.

(Whereupon, the witness steps off the witness stand.)

* * * *

It is hereby certified that the foregoing is a true and accurate excerpted transcript of the proceedings.

MIRIAM KAPLAN
Senior Court Reporter