CIVIL COURT OF THE CITY OF NEW YORK
COUNTY OF KINGS: TRIAL TERM PART: 67

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GERALD DORMEVIL and RACHELLE DORMEVIL,

Plaintiffs,

- against - Index No.
TS 300197/18
A.E. ABDELRAHIM and MRS. CAB CORP., EXCERPT

Defendants.

- - - - - - - - - - - - - - - - - - - -X

141 Livingston Street
Brooklyn, New York 11201

December 14, 2018

B E F O R E : HONORABLE SHARON A.B. CLARKE J.C.C.

and a jury

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

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WENDY LIFTON
OFFICIAL COURT REPORTER

COURT OFFICER: All rise for the jury, please.

(Whereupon, the jury entered the courtroom.)

THE COURT: Good morning to everyone. You may be seated. We are missing one juror.

We are going to break for a few minutes and give the jury clerk an opportunity to reach out to the missing juror.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury left the courtroom.)

COURT OFFICER: All rise for the jury, please.

(Whereupon, the jury entered the courtroom.)

THE COURT: Good morning to everyone. You may be seated. Counsels, are you ready to proceed?

MR. ROTH: Yes, your Honor. At this time Plaintiff calls Dr. Carfi.

J O S E P H C A R F I, having been first duly sworn, was examined and testified as follows:

COURT OFFICER: State your name and address in a loud clear voice.

THE WITNESS: Joseph Carfi, C-A-R-F-I, M.D., 2001 Marcus Avenue, Lake Success, New York 11042.

THE COURT: Before you get started, just for the jurors edification, when we last left, I believe Mr. Dormevil was testifying. His testimony has not

concluded.

As I indicated to you, sometimes we would be taking witnesses out of turn, so this doctor will be testifying and then you will hear again from Mr. Dormevil to complete his testimony. We do this because of scheduling issues sometimes. Thank you.

Counsel, you may proceed.

MR. ROTH: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. ROTH:

Q. Dr. Carfi, did you bring your file with you today?

A. I did.

MR. ROTH: Can we please have it marked for identification, your Honor?

(Whereupon, the above-mentioned document was marked as Plaintiff's Exhibit 19 for identification.)

MR. ROTH: Your Honor, we would like to offer it in evidence, Exhibit 19 by stipulation.

MR. SCAHILL: Agreed, your Honor.

THE COURT: So moved.

(Whereupon, the above-mentioned document was marked as Plaintiff's Exhibit 19 in evidence.)

Q. Doctor, at any time we are talking about your report, please feel free to consult it.

Can you please tell us a bit about your education

and training?

A. Surely.

So, I have a bachelor of science in biology, that's from SUNY Albany, a masters of chemistry from Rensselaer Poly Technic Institute, and I earned my medical degree, M.D., from the Mount Sinai School of Medicine in Manhattan.

I then went on to my residency training program in physical medicine and rehabilitation. That was at the Rusk Institute for rehabilitation medicine, New York University.

That's my training.

Q. Are you currently licensed to practice medicine?

A. I am.

Q. Are you board certified?

A. Yes.

Q. What board certifications do you have?

A. Physical medicine and rehabilitation.

Q. Can you tell the ladies and gentlemen of the jury what that is, board certification?

A. The physical medicine -- first of all, board certification is a process by where, first of all, you have to have the basic educational credentials.

Then, in my field, we take a written exam at the end of residency. Assuming you pass that, then a year later you sit for an oral exam where other doctors examine you, present cases and you have to pass that.

My particular field, physical medicine and rehabilitation, the physical medicine side of what I do is basically taking care of people who have pain, hurt the neck, shoulder, sprain your ankle, whatever it is you came in evaluate. You diagnose, treat, and hopefully you get better.

The rehabilitation side is people have more permanent issues, could be spinal cord injury, could be amputation, stroke, multiple sclerosis, disabling types of conditions, and what we are trained to do is take care of the person that has that disabling condition, and I say it that way because as the doctor, we have to be familiar with the potential medical or surgical complications or issues specific to that disabling condition, whatever it might be, but those people many times have an emotional reaction, psychological reaction to their disablements, maybe vocational issues, need special equipment, special treatments, more of an holistic approach to somebody that has had some sort of injury that way.

Q. And after residency, what did you do next professionally?

A. Well, then I entered a private practice situation with an older doctor in Westchester County. I was a junior associate, he was the senior doctor, it was his practice, more of a community medicine hospital, consultation, nursing home, work office, that sort of thing.

I did that for a couple of years, and then I had the opportunity to return to academic medicine. So, I then became full time academic physician at Mount Sinai. That's where I went to medical school, and I joined the new chairman there in the department rehabilitation medicine.

So, I was an associate professor of rehabilitation medicine. I became the associate clinical director of the department. I ran the inpatient unit. My particular area is traumatic brain injury.

I did a bunch of rolls in that department, excuse me. I did that for a few years and then went into, you might call it corporate medicine situation, in the sense that I worked for a company that had a brain injury facility that I became medical director of that facility in Great Neck out on Long Island.

We had day and a half programs, people with brain injuries would come in for treatment. Simultaneous with that position, I started a little private practice, evenings, weekends, that sort of thing, and then after a couple of years, I felt comfortable in stepping out into my own practice.

So, since 1992, I have basically been in my own business.

Q. And did you say academic medicine, does that mean you're teaching doctors?

A. Yes, I was doing it, then, more full time, obviously. I still do that actually. I still volunteer my time at Mount Sinai. I run the brain injury clinic there once or twice a month, depends on their needs, and that's a teaching situation for medical students and residents who are in training.

Q. How long are you in private practice for, Doctor?

A. Well, I started part-time 1990. '92, that's all I've done.

Q. And from '92 to present, has your practice evolved at all?

A. It has changed significantly.

So, I became interested actually in medical legal work while I was still in academics, and so I had started a very small, when I was in private practice, and certainly I was taking a lot of patients, doing a little bit of medical legal work.

As time went on, things started to evolve and flip where eventually it became 50/50 of time. Then it started to morph into more time related to forensic. I say it that way because it wasn't all medical legal. I also did independent medical examination, disability evaluations.

I also currently serve as an expert for the Department of Health, Office of Professional Conduct, and then, eventually, in 2016, October, I stopped seeing private

patients in the office.

So, I don't see, perform patient care for any kind of compensation currently. So, the last couple of years it's all really been forensic work in my office.

Q. So, are you being compensated for your time away from your forensic work today?

A. Yes.

Q. How much is your compensation?

A. I'm being paid for my time today, expertise, etcetera, is $4650.

Q. I want to talk to you a little bit about anatomy.

Generally, Doctor, can you explain the anatomy of the shoulder to the jury?

A. Sure.

Q. Before you get into it, would this help?

A. That is a shoulder model, sure.

MR. ROTH: May I approach, your Honor?

THE COURT: You may.

THE WITNESS: Could I get some water, your Honor, would that be all right?

THE COURT: The officer will get that for you.

A. Okay, so the shoulder, you're looking at a right shoulder. This is the front of the right shoulder, and anatomically the shoulder is an unstable joint, as compared to the hip, which is a very stable enjoyment. Hip is a very

deep ball and socket joint. In the shoulder, the socket is very shallow, and it is essentially an unstable joint.

So, you're looking at the collar bone. We call that the clavicle. This is the shoulder blade on your back. This is your arm bone, and so over the top of the arm bone you have what's called the rotator cuff. It's really a continuous sheet of tendon, not separated like you see there, and then between the rotator cuff and this bone, which is called the acromion, that's part of the shoulder blade, there is usually a bursa, which is a fluid filled sac. It's a cushion. We have them all over the body's normal structure. When that becomes inflamed, we call that bursitis.

This is the acromioclavicular joint. The clavicle is a structure which basically keeps your shoulder out. Otherwise, your shoulder would be hanging down by your chest. That really keeps the shoulder away, and that's pretty much the shoulder.

Q. What is the labrum?

A. Labrum. So, the labrum, you really can't see it, but where the arm bone connects to the shoulder blade, the very shallow socket like I told you, and so the labrum is Latin for lip, and what that is, it's a little lip of cartilage that sort of the arm bone kind of rests on it, on that little lip, and it helps to keep it in that very shallow socket.

The main structure that keeps your shoulder in the socket, are the muscles, muscles and tendons that really keeps it locked in.

Q. So, what are the symptoms of a torn labrum?

A. Symptoms of a torn labrum typically are pain. The individual will have pain with motion, with use. They may have clicking, they may not, but when the labrum is torn, sometimes they will have a click when they move. So, those would be typical symptoms.

Q. What about a subacromial impingement?

A. Well, impingement means pinching essentially, so remember, I said this bone is the acromion, so subacromial means under the acromion, and there is something pinching between the acromion bone and the arm bone.

So, the structures in here, the tendons, the bursa, they get squeezed, they get inflamed, ergo, your get bursitis, tendonitis, which is inflammation of the tendon.

So, the symptoms would be pain, again, with use, or laying on the shoulder could be painful because you're compressing those areas.

Q. And what is a frozen shoulder?

A. Frozen shoulder refers to basically lack of mobility of that shoulder, typically due to scar tissue or fibrosis that occurs in the capsule. Overlying this joint is a capsule that holds everything together, keeps the joint

fluid in there, and sometimes that capsule gets thickened, gets scarred, gets foreshortened, and that limits your range of motion.

Q. Okay, what are the treatments -- is that adhesive capsulates?

A. Adhesive capsulates is more of an acute frozen shoulder in the sense there is inflammation there, and that inflammation that gets swelling that can then cause the scarring, and then the shoulder becomes frozen.

It hurts, you don't move it, and because you don't move it, things start to bind down a bit, then it hurts more if you try to move it, more then if you don't move it so much. It's sort of a vicious cycle, and eventually the shoulder becomes frozen.

Q. What is the range of treatments for that?

A. Range of treatment options are certainly going to include things like medications, anti-inflammatories by mouth, cortisone injections, which is injection of a steroid into the shoulder area.

So, there is anti-inflammatory inside the joint, physical therapy to provide pain alleviating modalities, stretching to get that range back. Ultimately, if it involves to the point where the shoulder is frozen, not responding to treatment, you then may need surgery, which could be manipulation under anesthesia, where a doctor puts

you to sleep and then really works at the shoulder, or they go in and they have to snip the scar tissue, certain ligaments and things to free things up.

Q. Thank you, doctor. You could put the shoulder down, I'll take it back. Can we talk about the spine a little bit?

A. We could, sure.

Q. Okay. So, is the spine divided into sections?

A. Yes.

Q. Approximately, how many sections are there in the spine?

A. Four sections.

Q. What are those four sections?

A. Cervical, which is the neck. Thoracic is the mid back or the chest where the limbs are attached to. Lumbar is lower back, that's next, and below that, is the sacrum, which is basically a triangular shaped bone in the back of the pelvis, several vertebrae fused together into a triangular shape bone.

Below that is the coccyx, which is the tailbone. There might be a few little extra pieces down there.

Q. You mentioned vertebrae fused together. What are vertebrae?

A. So, the way the spine works is that there are bones which are called vertebrae. Between the bones you have

discs. What the discs provide, A, is spacers between the bones and provides the flexibility. In other words, that's why you can bend and move is because you have those flexible spacers between the bones, and that allows you to move around.

Q. What function do the discs serve?

A. The discs are shock absorbers and spacers, essentially.

Q. Are the discs -- are there parts of the discs?

A. Yes.

Q. What are the parts of the disc?

A. So, the discs have an inner called the nuclear pulposus, which is more of a gelatin toothpaste. Around that, you have the annulus fibrosis, which is a much more tougher grisly like material that holds that disc in place.

So, those are the two components, and then to keep the disc where they belong within -- between the bones, there are ligaments and various tissues that kind of surround the bones and keep everything in place.

Q. What is a herniated disc?

A. A disc herniation is when there is a little bit of a tear in that tough fibrous ring and some of that toothpaste at this material leaks out, pushes out. That's a disc herniation.

Q. And what are the signs and symptoms of a patient

who presents with a disc herniation?

A. Well, possible signs and symptoms would include pain. If it's neck or back, depends where the disc herniation is, you can have local pain.

You can also frequently have pinched nerve pain. Sometimes you call that radiculopathy or radiculitis or sciatica, you are familiar with that.

It would be symptom of a disc herniation pressing on the nerve and causes pain down the leg.

Q. You said radiculopathy. You said there is localized pain and radicular pain?

A. Yes.

Q. Can you explain those two concepts?

A. Sure.

So, localized pain in medical parlance, we call that axial pain, that's to the actual axis of the spine. That's local pain, neck pain or back pain, that's the localized pain.

Then, the radicular pain or radiculopathy pain that would be in the extremities, somewhere down the extremity and that's variable.

Some people say my butt hurts, some will say the side of my leg or someone will say it goes all the way down to my foot.

Similar with the pain, pain just in the shoulder,

upper arm, sometimes it can go all the way down into the hand. Everybody presents a little bit differently.

Q. Let's talk specifically about C5-C6. So, can you point on your neck where C5-C6 would be?

A. C5-C6, this big bump you feel in the back of your own neck is C7. So, you go up a couple of levels and C5-C6, around there, the upper back.

Q. You mentioned the nerves that surround the spinal cord. Where do those nerves go at C5-C6?

A. Okay. Well, C5-C6 -- well, C5 is one nerve root and C6 is another one, and they both go to slightly different areas.

So, the C5 nerve root would go to muscles around the shoulder, shoulder blade muscle, muscles over the top of the shoulder, little bit into the biceps, and the sensation distribution of C5 is also around the shoulder or the biceps.

C6 goes a little bit further down. C7-C8 down further still. So, C6 also gives some contribution to the shoulder area, more into the biceps area and then a little bit forearm, but the sensation goes all the way down to the thumb.

So, C6 is going to give your thumb and pointer finger sensation.

Q. In your practice, did you have the opportunity to ever treat a patient with a herniated disc at C4-C5 and

C5-C6?

A. Sure, many times.

Q. If there are radicular symptoms for such a patient, what would the common presentation be?

A. Common presentation is somebody will come in, say Doc, my neck has been bothering me and I have a lot of pain in my shoulder and my arm, and, you know, it's a little bit weak, and so that might be typical complaints, and then when I examine them, I might find that the reflex is a little bit different on that side versus the other.

Testing sensation, that there would be a sensory difference in a particular distribution, C5-C6 distribution. As I am examining, there may be some weakness.

Now, not everybody presents with all those things. Some have none of those findings, just the story they tell me is consistent with what the problem is.

So, you have to listen to the story, it's called a history, very carefully. So, the things I am telling you isn't universal for a C5 radicular presentation of C4-C6 (sic), but these are the types of things that they may complain about.

Q. Understood.

What is a life care plan, Doctor?

A. A life care plan is a document which details the medically -- necessary medical care, services, treatments,

equipment, things of that nature for somebody who has been seriously or catastrophically injured.

Q. What is the purpose of a life care plan?

A. Well, the purpose is to provide a program of optimal care for somebody who has a permanent condition or expected to have a permanent condition, and actually the plan also has cost. So, it will list what those items are and what those costs would be.

Typically, the purpose is used in litigation. It's also used by trusts. In other words, the people who are dispensing the funds for the care of this person may want to have a life care plan in place so they understand what they are spending money on.

Q. Do you prepare life care plans professionally?

A. Yes.

Q. Do you do that for both people bringing lawsuits and for Defendants who are defending such lawsuits?

A. Yes.

Q. Okay.

Did you prepare a life care plan for Mr. Dormevil?

A. I did.

Q. And what information did you review, if any, before preparing a life care plan for Mr. Dormevil?

A. I had various records that I reviewed. I had records from St. Vincent's Hospital, New York Methodist

Hospital, a whole punch of doctors, Dr. Kleyman, Dr. Kim, Dr. Manual, Dr. Willer, Dr. Gablonsky, (phonetic), Dr. Lewin, (phonetic), Dr. Horowitz, and then various other providers like the Rehabilitation Associates of Brooklyn, Brooklyn Endoscopy and Ambulatory Surgery Center, Jewett Orthopedic Clinic, Jewett Physical Therapy, a variety of imaging centers. So, those were the records that I was able to review.

Then I interviewed Mr. Dormevil by phone. He lived in Florida, so I didn't have the opportunity to examine him at that time. So, I interviewed him on July 27, 2016. That's the information I had to develop the plan.

Q. At some point did you examine Mr. Dormevil?

A. I did.

Q. And when did you examine Mr. Dormevil?

A. I examined him this year, August 28, 2018, where I, again, took a history. I had a couple of more records to review as well.

I reviewed records from Celebration Orthopedic and Sports Medicine. They were treating him in Florida. So, I redid the history and then I had the opportunity to examine him.

Q. What did that examination consist of?

A. Well, the three areas of complaints were his lower back, his neck, and his shoulder, so those were the body

areas that I examined.

Q. Okay, and what did the examination of the neck, back and shoulder consist of?

A. Okay.

So, I checked his range of motion. We will start with the back. So, I examined his range of motion. There is an instrument called goniometer which measures angles. If you can imagine two of those big lollypops with the sticks, you put the two heads together, now you have two sticks that can move around, and there are angles on the circle things.

Using that, I can measure range of motion, and so I checked his lumbar range of motion, lower back range of motion. Forward flexion bending forward was 40 degrees.

Q. What's normal, Doctor?

A. I'm sorry?

Q. What's normal?

A. 80. We usually expect about 80. Bending backwards, we call that extension, he was able to get to 20, and 30 is what we normally expect.

Left and right lateral bending, side to side, 15 degrees with him, and 35 is normal. All of these movements increased his pain that he had, his underlying constant pain.

I checked his reflexes, which were diffusely absent, but that's okay. Not everybody has reflexes. As

long as it's symmetrical, same on both sides, it's okay.

Strength was okay from ankles to hips. When I put pressure on the right hip, when he flexed the hip and I pushed down, that caused some back pain.

Checking his sensation on the right, below the knee on the outside of his leg, there was a little bit of a decreased pin pick appreciation into the side of the foot and over the top of the foot compared to other body areas.

I then checked with a measuring tape. I measured his calves, his thighs, length of his legs. Everything was the same on both sides.

I did a straight leg test. The doctor lays you on the back, picks you up usually by the heel, support under the calf and raise your legs straight up in the air, straight leg raising. So, with him, on the right side, at about 45 degrees. Now, if your leg is pointing at the ceiling, that's 90, on the bench is zero, so, 45 is half up. He complained of lower back pain at that point.

I then checked hip range of motion. Hip range of motion was fine, but he had back pain as I am manipulating that leg. Left side, I can get him up to 60, couldn't get him up any higher. That's due to flexibility. He didn't complain of any pain though, but when I started manipulating his hip, which had full range, he complained of pain, less then the other side.

So, then I check tenderness in the back and he had tenderness in the lower back muscles, left and right from the lumbar area down to the lumbosacral. On the right side, that continued into the butt as well as the back of the upper part of the back, the thigh.

What I was doing, I was sticking my thumb into what's called the sciatic notch. Sciatic notch is where the sciatic nerve comes out of the pelvis into your butt muscle and goes down your leg, sends branches to different muscles, sensory areas. I was putting my thumb on that nerve and it was tender for him. I could trace that down the black of his leg. That is suggestive that he has some inflammation, sciatic nerve was inflamed, and that's why it was painful when I was pressing on it.

Then I moved on to the neck, cervical spine, and I also have another goniometer, smaller for the neck. Right lateral rotation, turning your head to the right was 45 degrees. We expect 80 as normal. Left was 60. Again -- I'm sorry, 55. Again, normal is 80.

Then, extension, looking up 20 degrees, 60 is normal. Looking down he had 40, 80 is normal, and then right lateral bending, tilting ear to shoulder on the right was 15 degrees, left lateral bending 35 degrees, and 45 is what we expect.

He had pain with all those movements. The worst

was turning his head to the right and tilting to the right.

So, again, reflexes were absent symmetrical, that's fine. Strength was fine in the arms, fingers, the shoulder, and we will get to the shoulder exam in a sec.

Sensory examination, he had decreased pin prick appreciation in the forth and fifth finger. Fifth is pinky, forth is your ring finger, and that extended up the pinky side of the forearm. Then I started touching, looking for tenderness. He had tenderness, tightness actually in the left trapezius muscle. That's the muscle which some buff guys stand up between the neck and the shoulder. We all have them, they don't show up.

He had tenderness in that muscle that went up the side of the neck as well. Right side was not tender.

Then I turned my attention to the left shoulder. Now, he had surgery so I could see the surgical ports throughout the shoulder. Then I did passive range of motion. The first movement is turning his arm outward, turning the palm so it's facing out. That's called external rotation. On the right, I could get him about 30 degrees, okay, so straight ahead is -- 90 is all the way to the side, so 30 about a third of the way. That was his good shoulder, 30 degrees.

The left shoulder, I couldn't actually move it past neutral. If I tried to pass it, essentially past zero, that

caused him pain. I couldn't get it any further than that.

Internal rotation is when you rotate palm towards your belly. That was 90 degrees, that was fine. Shoulder abduction, that's when you raise the shoulder sideways, 180 degrees is kind of the holdup position, that was his right shoulder. Left, I could get him up to about 150 or so, so it looks about 30, and he had pain when I got up to that point.

I then did various orthopedic maneuvers on him looking for impingements, and, you know, signs of impingement and tendonitis, and, he, in fact, had those signs with the different things I was doing to his shoulder, and then when I felt, palpated, touched, he had tenderness in the area of the, just below the acromion, that's the bump on the end of the shoulder I showed you on the model there.

So, in the subacromial space, there was tenderness. That's where your rotator cuff is located, bursa is located there. Tenderness on the front of the shoulder, the top bone, the AC joint acromioclavicular joint was not tender, and so that was the examination of those three areas.

Q. Now, you mentioned you performed the life care plan in -- you actually prepared the life care plan in 2016?

A. Yes.

Q. And you actually prepared a report which you submitted and has been exchanged; is that correct?

A. I don't know if it's been exchanged, but I submitted it.

Q. Fair enough. I will represent to you we exchanged it.

A. Okay.

Q. Do you have a copy of that with you?

A. Yes.

MR. ROTH: Your Honor, with your permission, I would like to put the blowups up for ease of reference.

THE COURT: That's fine.

MR. ROTH: Thank you.

Q. I am going to let you pick out the ones you want to use.

THE WITNESS: May I step down?

THE COURT: You may.

Q. The first question I have for you is, after examining -- when you examined Mr. Dormevil, did he give you an updated history?

A. Yes.

Q. And did any of your initial projections change after taking the history?

A. Well, sure. I mean after I saw him, remember, I prepared the plan based upon records and the history which gave me the foundation, but that was always going to be subject to my examination, and after I saw him, actually,

some things did change, which I will actually do real time here showing you what changed from that plan.

Q. Okay, sure.

If you could, could you explain, just take your slide and explain what it is we are looking at?

A. I am just going to give you the general orientation of how I do the plans. This is, in essence, an excel spread sheet, if anybody is familiar with that, that's how I am able to do the rows and columns.

Every page is organized in a very similar way. This page is medical care. So, first column you are going to have whatever the item, service, the care. Next typically would be the purpose of that. Next is going to be the frequency. So, here is the frequency of visits, equipment, frequency of replacement, that sort of thing, the cost of whatever that is. The resource at the end that -- page seven of this plan is a list of resources.

I am generally familiar with what things cost, but I always do research to make sure that things are accurate, and so at the end, there will be a list of resources based upon these numbers, so you can see where the specific numbers came from, and then the last thing is a calculation of the annualized cost, where I take the cost of the item, the frequency, and then just do the calculation, whether it's division or subtraction.

So, let me get out my trustee magic marker because there will be come changes. Remember, this is 2016, I wasn't able to do an updated plan, but I have to make some changes right here because of my resent history and physical.

Q. What changes would you like to make?

A. I will do that. I am going to start from the top and go down and I will make those changes.

So, the first thing we have is the rehabilitation specialist, someone like myself, dealing with people who have painful conditions. Functional status, some equipment, we will talk about his therapy. Twice a year $164.75 per visit, times two, is $329.50. That's not changing. He still needs the orthopedist to monitor his injuries.

Once a year to check things out, $164.75. Now, he no longer needs the pain management doctor, so crossing that right out. The reason being that his medications changed from the time I talked to him until the time I saw him. He was taking some opioid meds, which a pain management doctor has to watch. He's not taking anything significant anymore.

Psychotherapy, that comes out. When I first spoke to him, he was depressed, his life had changed, there was some other issues that occurred, very devastating to him, based upon the injuries that he suffered.

MR. SCAHILL: Objection, your Honor.

THE COURT: Objection sustained.

Q. That's fine, go ahead.

A. Anyway, so when I spoke to him, things seemed to have stabilized for him, so he didn't need that anymore, that's gone.

Cervical surgery, this is something that was recommended.

MR. SCAHILL: Objection, your Honor.

Q. This is based -- I will ask this. Did you review certain records in preparing this report?

A. I did.

Q. And in reviewing those records, did they help formulate an opinion for you?

A. Yes.

Q. Was that those opinions that you formulated to a reasonable degree of medical certainty?

A. Yes.

Q. And is there a report that you're now referencing -- is the report you're now referencing based on your opinions?

A. Yes.

MR. ROTH: May I proceed, your Honor?

THE COURT: Overruled.

MR. ROTH: Thank you.

A. So, the cost of that surgery is about $95,000. That includes the surgeon's fee, operating room, anesthesia,

all that stuff.

Now, in addition to this, based upon the new records I saw from the Florida orthopedist, the spine doctor down there was talking about possible lumbar surgery.

MR. SCAHILL: Objection, your Honor.

MR. ROTH: He will withdraw that.

A. Okay. So, in any event, cervical surgery. So, next --

Q. Can I take this down for you, Doctor?

A. Thank you. I should have done that first.

Q. No problem.

A. Okay.

So, next we have the medications. Organized the same way. Does not take the Oxycodone anymore.

Now, when I do these things, I have to base it on what the person tells me they are taking at the time that I do the evaluation. Certainly that can change, and, in this case, it did.

Ibuprofen, not taking prescription dose anymore. Let me look at my notes. Tramadol is decreased. He's taking this three times per week now, and so the annualized cost changes. It goes down to $175 three times a week, the same number of pills here. I didn't change that. So, $175.89. So, that's three times a week to treat his pain, that's the annual cost, $175.89 based upon the $202.95 for 180 tablets.

MR. SCAHILL: Can we mark these boards in evidence once he's finished?

MR. ROTH: We will make it 19A.

A. What I have here is his injuries need to be monitored. He's got the three areas, the lumbar, cervical, left shoulder. The lumbar MRI to monitor is going to be done approximately once every five years. It could be two years, seven years, but generally the doctor is going to want to see what's going on based upon his symptoms and other issues. That cost, $1762.65. Now, we divide by five year cycle, gives you annualized cost of $352.53.

Cervical MRI, that cost $1751.95. Again, divide by the five year cycle is $350.39, and then the left shoulder to be monitored, $1537.45, divided by five, is $307.49. So, those are the diagnostic studies in this case.

Now we are going to have a couple of pages of simple equipment. Thermidor heating pad is a good quality heating pad which he uses heat to help with his pain. It throws moisture in from the surrounding air, so it gives you a moist heat affect, $56.72, lasts about five years, $11.34. A cold pack, he also uses cold. I have two. I have two because one is in the freezer while using the other one, and those cost $12.88 each, $25.76 for the two of them, replace every two years, so that's a $12.88 item.

The other thing that he reported to me that he was

using was a back brace, lumbar orthosis that helps with support, reduce his pain, and I should have two here because this number is for two. The reason I would have two is one is in the wash, one is on him, if he's needing to wear it, so that's $36.58 for each, $73.16 for the two of them, divided by two, is $36.58. He also was using a TENS unit.

Q. Doctor, what is a TENS unit?

A. It's a little electrical stim box, maybe about the size of your cell phone or so. There are electrodes that go in there, you put them on your painful body parts, you turn on the juice, and that helps to block pain signals.

Q. Also the --

A. The TENS unit cost $91.70, replace every three years or so, $30.60. The wires and the pads have to be replaced much more often, and that's a set of four at a time, once a month or so, $529 for four, that's $63.48.

Now, when I had interviewed him, both the first time and second time, his walking, ambulation was very limited. After 15 minutes he has to sit, doesn't get you very far.

So, I have this electric scooter here that would allow him to go distances, if he goes to the small local street fair, if he wants to go to one of the amusement parks, whatever he wants to do with his family or accompany his friends. I am not suggesting he's going to be going on the

rides, necessarily, but in any event, the cost $1649, replace these items every five years, so that's $329.80.

If you're going to transport it somewhere, you have to have a lift, so that goes on the trunk, lift for the scooter. That's a $1669 item. I replace it every 11 years. Why do I have such a weird number? That's because statistics tells us that the average age of an automobile is 11 years old on the streets of the United States of America. So, divide that by 11, that's $151.73.

The purpose of the reacher is exactly what it sounds like. One of those things with pistol grips, little rubber fingers on the end so he can get things off the floor more easily, he can get things off the shelf, doesn't have to climb, etcetera, with his painful back, $24.25, divided by two, is $12.13, and then the dressing stick and the long shoe horn, same idea.

So, when he's dressing, he doesn't have to bend over so far, and that is $26.50. That will last a good ten years, that's a $2.65 item. That didn't change with the second history. He had the same functional issues as when I initially evaluated him talked to him.

THE COURT: Everyone okay?

THE JURY: Yes.

A. Sort of awake, okay.

So, this is the last bit of equipment. I call this

home equipment adaptations. Given his back, and he just had one good arm, he really should be sitting while he showers. I think that's the safest option for him. My concern is always safety with people who have orthopedic injuries as well as function. So, $93.20 divided by three year life expectancy of the chair, $31.07.

Since he is going to be sitting, the handheld shower, the shower head needs to be mobile, so that's a $30.72 item. Lasts about three years, so that's $10:24.

Long handle bath brush. The idea is that he can get all his body parts without having to bend and twist too much. That's $23.25, replace that every year.

Grab bars in the tub area, stable purchase when he's getting in and out while he's in there. It's a wet soapy environment. You fall in the bathroom, there is no soft place to fall really, you get hurt. Bar cost $29.89, two is $59.78, figure about ten-year life span, so that's a $5.98 item.

The other problem he would be having by history is difficulty with transitions, get up from a seated position is painful. Low seats are particularly troubling, and the lowest seat in your house is the toilet. He specifically was having trouble, he would have to use his arms to get himself up and down. Toilet frame is basically handle bars around the toilet that gives you someplace to push. That's $42.16,

lasts about 3 years, $14.05.

We are in the home stretch. This is therapy. Because he has chronic conditions, I have ongoing therapy here. Now, the important thing to understand, it says here maintenance, maintenance for general strengthening, pain prevention, reduction, etcetera. It says maintenance. It doesn't say restorative. I am not suggesting that physical therapy will restore him to where he was. This is to maintain what he has. So, I didn't want you to misunderstood that.

Twice a week, he has several body areas that need to be treated, and it's $111.10 per treatment. So, you do the math, twice a week, 52 weeks in a year, that's $11,554.40.

This is the resource page as I was explaining to you before, the websites, publications. For example, this website here RXpricequotes.com, medication cost based on zip code, put in the zip code, put in the meds, then you get a survey of 20 pharmacies in that zip code. I will average as many as come up. So, that's kind of how the work is done.

These are commonly relied upon by people who do life care planning. Obviously we all have our favorites and such but that's how it's done.

Q. Did you create a summary of the total cost?

A. Yes.

Q. So, you want to present that --

A. That's next.

Q. -- to the jury please?

A. I have to get my -- okay, so what I did in this page is basically compressed all the numbers in each category into one number, but I have to change numbers for you because now the medical care is $494.25 instead of the prior $6700. Medications now $175.89. Diagnostic studies all added together is $1010.41. All the equipment, all the annualized cost for that equipment comes down to $735.78, and the therapy is still the $11,554.40, and so what I did also is add those up. So, the sum total on an annualized basis is $13,970.73, and over here you have that cervical surgery that I talked about before.

Q. That's a one time cost?

A. That's one time, you have that and hopefully that's it. That's the plan.

Q. Okay, so if you could take back to the witness stand. A couple of more questions to ask you then we are going to be done with our direct.

Okay. Do you have an opinion to a reasonable degree of medical certainty whether Mr. Dormevil suffered injuries as a result of a car accident from November 3, 2008 --

MR. SCAHILL: Objection, your Honor. He saw

him once ten years after the accident. I don't think he can give an opinion as to whether he suffered injuries in the accident.

MR. ROTH: Judge, I think the objection instruction that you asked for might have been different. I would like to approach.

MR. SCAHILL: I have a pending objection, your Honor.

THE COURT: The objection is sustained.

MR. ROTH: Can we sidebar? CPLR 3301 D, what it says, what his review is, and the basis of his opinion.

THE COURT: The objection is sustained.

MR. ROTH: Judge, I would like the sidebar.

THE COURT: Okay.

(Whereupon, a sidebar discussion was held at the Bench, out of the hearing of the jury.)

MR. ROTH: May I inquire, your Honor?

THE COURT: You may.

MR. ROTH: Thank you.

Q. Okay.

So, now, Doctor, you formed this life care plan based on records you reviewed?

A. In part, yes.

Q. And in addition to your examination?

A. Yes.
Q. Are those opinions formed to a reasonable degree of medical certainty?
A. Yes.
Q. And did you form an opinion as to the proximate cause of the need for future medical care that you expressed to the jury?
A. Yes.
Q. And was your opinion as to the proximate cause for the need for future medical care?
MR. SCAHILL: Objection.
THE COURT: What's the objection?
MR. SCAHILL: Repeat, your Honor, that he saw him once ten years after the accident.
THE COURT: So noted. The objection is overruled.
MR. ROTH: Thank you, your Honor.
A. Okay.
Yes, it was due to the motor vehicle accident that he suffered November 3, 2008.
Q. And what's the basis for your opinion, Doctor?
A. Well, the basis is that the medical records are very clear from the temporal sequence, the emergency room, his complaints of back, neck pain, radiating pain, pain management within a week of that, orthopedist, neurologist,

he had ongoing care from then forward for all of these complaints.

Q. And do you have an opinion to a reasonable degree of medical certainty whether he's capable of performing electrical work?

A. I do have an opinion.

Q. What is your opinion?

A. He cannot perform that sort of physical work.

Q. Do you have an opinion to a reasonable degree of medical certainty whether he's capable of performing plumbing work?

A. I do have an opinion.

Q. What is your opinion?

A. He cannot do that type of physical work either.

Q. And do you have an opinion to a reasonable degree of medical certainty as to the proximate cause of Mr. Dormevil's failure to perform electrical and plumbing work?

MR. SCAHILL: Objection.

THE COURT: Overruled.

A. Yes.

Q. What is your opinion?

A. Well, due to the injuries that flowed from the car accident we discussed earlier.

MR. ROTH: I have nothing further. Thank you

very much, your Honor.

MR. SCAHILL: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. SCAHILL:

Q. Good morning Dr. Carfi.

A. Good morning, sir.

Q. Doctor, is this the first time you have testified in court?

A. The first time, no.

Q. How many times have you testified in court?

A. I believe today is 315 times. We keep track because I get asked frequently.

Q. So, you're familiar with the back and forth of cross-examination; is that fair to say?

A. Yes, sir.

Q. So, if I ask you a question that calls for a yes or no answer, will you be able to give me a yes or no answer?

A. Depends on the question, and I will do my best, Counsel.

Q. And I would ask you, if I ask you a question and you can't answer it yes or no, tell me that and I will rephrase the question, okay?

A. Yes, sir.

Q. Now, the testimony you gave this morning with respect to a life care plan, you talked about the life care

plan that you prepared here.

Am I correct that that plan was exclusively for this litigation?

A. That's correct, yes.

Q. And am I also correct that the -- both the phone interview you had with the Plaintiff in 2016 and the in person exam that did you in 2018, August of 2018, were all because of this lawsuit?

A. Yes.

Q. So, am I also correct that you're involvement with Mr. Dormevil has nothing to do with his treatment, but everything to do with this lawsuit; is that fair to say?

A. In essence, that would be correct, yes, sir.

Q. Now, you said since 2016 this is what you do exclusively, you prepare life care plans for lawsuits, correct?

A. No, I didn't say that.

Q. Since 2016 you haven't seen a patient?

A. I haven't seen a patient for compensation, that's correct. I volunteer my time.

Q. So, we are talking about what you get paid to do. What you get paid to do is being a consultant for litigation; is that fair to say?

A. In part, that is correct, yes.

Q. In fact, you've been doing the consulting work for

lawsuits for a number of years, correct?

A. Yes, sir.

Q. And am I also correct that 95 percent of that work is for Plaintiffs?

A. I can't answer that the way you posed the question.

Q. Could you quantify the percentage of work you do for Plaintiffs?

A. Yes I can give you two quantifications. Trial testimony 98, 99 percent Plaintiff. In terms of office work, consultations, things of that nature, is more 80 percent Plaintiff, 20 percent defense. So, those are the numbers.

Q. Okay.

So, 98 percent of the time that you come into court over the 315 times that you said you testified, those are all for Plaintiffs in personal injury cases, people in Mr. Dormevil's position, correct?

A. It could be medical malpractice, but generally, correct.

Q. But Plaintiffs, people suing for money damages for personal injury suits, correct?

A. Yes.

Q. Now, in fact, you give talks to lawyers about the essentials for prevailing at a damages trial in litigation, correct?

A. That was the title of a seminar as I recall, yes.

Q. So, you spoke to a group of lawyers about what's essential for winning at a trial as a Plaintiff; is that correct?

A. That was not my role among the many speakers in that panel, no.

Q. I'm looking at your resume and you put down, as of March 6, 2008, you spoke at the New York City Bar Association on the issue of essentials for prevailing at the damages trial in tort litigation; is that correct?

A. As I said, I was a speaker among a panel for that. The rest were attorneys and judges, yes.

Q. How many of these life care plans do you do per year for Plaintiffs?

A. I am doing approximately 150 plans in a year, between 150 and 200, depends on the year.

Q. What do you charge the Plaintiff's lawyers for those plans?

A. The plans, I currently charge a flat rate of $3000.

Q. So, you do 150 a year at $3000, correct?

A. Yes.

Q. And you also said you testify 315 times, that wasn't this year, that's over a number of years, correct?

A. That was over probably 25 to 27 years.

Q. So, in addition to the 150 life care plans for Plaintiffs at $3000 per plan, how many times do you testify

in court for Plaintiffs in a year?

A. I understand. In a year, I will testify anywhere from 12 to 18 times, depends upon the year.

Q. So, let's take the lower number, 12, and per testimony is approximately $5000; is that right?

A. A little bit less, but that's makes the math easier, that's fine.

Q. So, just quick math, you're earning 150 times a year, $3000 for the life care plans for Plaintiffs, plus another $70,000 for trial testimony; is that fair to say?

A. Well, that is revenue to the office, that's not what I am being paid, but that's revenue to the office before all of my expenses, but that is accurate, yes.

Q. Would it be fair to say that you make a substantial income from testifying for Plaintiffs and preparing life care plans for Plaintiffs?

A. I think substantial is a fair characterization, yes.

Q. In fact, the life care plan that you prepared for Mr. Dormevil here, you sent that to his lawyer at Hach & Rose in August of 2016; is that right?

A. Yes, sir.

Q. And you never discussed that life care plan, all the things that you talked about, you never discussed it with Mr. Dormevil, correct?

A. That is correct.

Q. So, you prepared this extensive plan for his life, for all of this equipment, and all of this therapy, and his medications, and you even had cervical surgery there, and as a doctor, an expert in your field, you didn't even bother to talk to the person that's affected by all of this; is that fair to say?

A. Well, I'm not his treating physician, so that is fair to say, yes.

Q. So, you talked about earlier that you never saw him until August of this year; is that right?

A. Yes, that's correct.

Q. And when you first prepared this plan, all of these numbers, everything that you wrote down here and showed the jury, you did that based on a phone interview, correct?

A. As well as the medical records.

Q. But your contact with the Plaintiff was over the phone, you had a conversation with him on the phone?

A. Yes, I did take a history by phone, correct.

Q. How long did that take, that phone conversation?

A. I don't have a specific recollection, but generally histories take anywhere from 20, 30 minutes, it just depends on the complexity.

Q. So, you spoke to him over the phone for a half hour and you prepared this report and you decided back in 2016

that everything that you are putting down in this report was caused by an accident that happened eight years previously in 2008; is that accurate?

A. Based upon the foundation of the records, yes.

Q. And then, when you did see him -- well, withdrawn for the moment.

And did you form an opinion in 2016 that the treatment you prescribed is necessary was all due to the accident that happened in 2008?

A. I did not, because I hadn't seen him, so I didn't have an understanding of the physical nature. So, I reserved that until I actually saw him.

Q. Okay.

So, when you prepared this plan with all of this treatment and all of these costs, you had no idea whether or not the injuries that he was complaining about had anything to do with the accident of November of 2008; is that fair to say?

A. No, it is not. I had an idea, I just wasn't willing to opine that without actually examining the man.

Q. Okay.

Did you put down in 2016 that he needed cervical surgery?

A. I did.

Q. Is that good and accepted medical practice for a

doctor, a medical doctor, a scientist, a board certified physiatrist, to make a recommendation for cervical spinal surgery after interviewing someone on the phone for a half hour, that's a yes or no question?

A. Then I can't answer the question, I need to explain.

Q. Now, these recommendations that you made in 2016, scooter, shower chair, the reacher, all of those things, this entire plan was put together in 2016. You modified it today, but it was all put together two years ago, correct?

A. That's accurate, yes.

Q. Did you ask Mr. Dormevil what he was doing for treatment in 2016?

A. No, not specifically. I asked him what his personal pain management was, what he did for himself.

Q. So, you made up this plan, which you already admitted was purely for litigation, and you never asked Mr. Dormevil what he's doing himself for any of this, you didn't ask him about what he's doing for pain management, for orthopedics, for diagnostic studies, you didn't ask him about the reacher, the cold pack, the lumbar orthotic device, the handheld shower, you didn't ask him about any of those things you just put it in this life care plan you prepared for litigation; is that fair to say?

A. You're partly correct and also incorrect. I did

ask about the cold back, the hot pack, TENS unit, those are all questions I did ask him.

Q. You asked about the hot pack; is that right?

A. That was one of the things, yes, sir.

Q. That was important. All the other things that costs thousands and thousands of dollars, you picked the one item that cost $24, that's the only thing you asked about?

A. No, the TENS unit, the back brace, hot pack, cold pack, how he manages his own pain, whether it was medications. He did tell me physical therapy is helpful for him. The other things were based upon my own experience in taking care of people who have these.

Q. We are talking about Mr. Dormevil who is the Plaintiff in this case.

When you talked about physical therapy, all these recommendations, you had no idea what he was doing in 2016 when you made up this life care plan, correct?

A. No, that is not a correct statement, Counsel.

Q. Now, what you just said earlier this morning on direct examination, that all of these problems that you're talking about were all due to the motor vehicle accident of November of 2008. That opinion is based on the one visit that you had in August of 2018?

A. No, it's based upon the plethora of medical records and continued treatment from the date of accident forward.

Q. Did you ever talk to any of his doctors?
A. No.
Q. Would you have a more informed opinion if you had a conversation with Dr. Kleyman, the doctor that first saw him?
A. I don't believe so, no. I have his records.
Q. What about if you had a conversation with his orthopedist Dr. Yun Kim (phonetic), do you think you would have a more informed opinion whether or not the injuries he's describing were caused by this accident, would your opinion have been more informed if you spoke to Dr. Kim, the orthopedic surgeon?
A. No, sir.
Q. What about if you spoke to Dr. Willer, the doctor that treated him through 2009, would your opinion have been more informed if you spoke to Dr. Willer?
A. No, sir.
Q. What about any of the diagnostic testing that he had, EMGs, NCVs, MRIs, all the doctors that did the testing on him, would your opinion have been better if you spoke to any of those doctors?
A. No, I had the results of the tests, I didn't need to speak to them.
Q. What about the doctor that had treated him since he moved to Florida in 2013. Did you talk to any of those doctors?

A. I did not, no.

Q. Is that typical for you when you do these life care plans, you don't tell the person that you're doing it for and you don't talk to any of his doctors, is that your typical modus of operandi?

A. I typically do not give the plan to the individual, correct. I very rarely talk to the doctors. I don't generally need to, and if I do need to, I will.

Q. So, your opinion is based on that one visit that you had with him, and your review of his records, correct?

A. Well, the original history as well, but yes, that's correct.

Q. Now, when you spoke to Mr. Dormevil, first in 2016, you said you took a history from him, correct?

A. Yes.

Q. And that history is important as far as the accuracy of your opinion; is that fair to say?

A. History is always important, you're right, Counsel.

Q. And when you spoke to him in 2016, you interviewed him and took a history because, you know from medical school, that the history you take from a patient has a direct correlation to a proper diagnosis, correct?

A. Yes.

Q. The more accurate the history, the more accurate your diagnosis is?

A. That is generally correct, yes, sir.

Q. Now, when you took a history of him before you gave this opinion that everything that he's complaining about was caused by the accident, did you discuss with him the severity of the impact?

A. No.

Q. Did you ever see any photographs of the damage to the vehicle that he was driving?

A. I did not, no.

Q. Did you know that he drove from the scene?

A. I was not aware of that, no.

Q. Were you also aware that he was pain free and ambulatory at the scene of the accident?

A. I'm not aware of that information.

Q. Do you know that his first treatment after the accident was at St. Vincent's?

A. Yes.

Q. Did you look at those records?

A. The emergency room records, yes.

Q. I'm going to review those records with you now, if I can take a moment to go over them with you.

MR. SCAHILL: And this is from Plaintiff's 1 in evidence, your Honor.

Q. Do you know how long he was in the emergency room on the day of the accident?

A. I do not know, I don't recall.

MR. SCAHILL: It would help if I put the screen up. Can I have my assistant check this out so it works properly?

THE COURT: You may.

Q. Can you see that, Doctor?

A. I cannot read that from here.

MR. ROTH: I think it's going to be the size.

MR. SCAHILL: I will take care of this. May be we can try the lights first, Judge.

A. It's getting better. A little out of focus on the right.

MR. ROTH: I just ask for judicial notice that the highlights are from Counsel, those aren't part of the medical records that is in evidence as Exhibit 1.

THE COURT: Okay.

Court officer, can you turn the light back on please? Is that better?

Q. Can you see that, Doctor?

A. I see it better now, yes.

Q. There is an arrival time noted on the hospital record at 11.45 a.m.; is that correct?

A. I see 11:45. I don't see the a.m. part, but --

Q. Do you see the depart time there, 12:54?

A. Yes, I see that.

Q. Would it be fair to say that he's in the emergency room for approximately an hour?

A. Yes, very efficient emergency room.

Q. Have you worked in emergency rooms?

A. In a prior life, residency, yes, we were responsible to cover the emergency room, but that's really it.

Q. There was a history taken of Mr. Dormevil on the date of the accident listed in the medical chart from St. Vincent's, Gerald Dormevil is a 36 year old male who reports being a driver involved in a motor vehicle collision when a car struck the passenger side of his vehicle. Patient states he was jerked violently, but was pain free and ambulatory at the scene. Is that accurate?

A. That's what it says, yes, sir.

Q. And now complains of lower back and neck pain. Are you aware that at St. Vincent's there was no diagnostic testing performed?

A. I didn't document any, so if there had been, I would have documented it, so I am aware in that sense.

Q. Do you know the level of his pain when he was at St. Vincent's?

A. I do not know the number that he gave them, no.

Q. You're familiar with the pain scale one to ten, correct?

A. I am, yes, sir.
Q. I would ask you to take a look at the pain scale that's listed for Mr. Dormevil at St. Vincent's Hospital on the day of the accident?
A. I see it.
Q. What is that, Doctor?
A. Two out of ten is what it says.
Q. That would be consistent with a description of mild?
A. I would say that would be in the mild category, yes, at that time, yes.
Q. Do you know what the diagnosis was?
A. Yes, I have a diagnosis of lumbar strain/sprain.
Q. That's a back sprain and strain, correct?
A. That was the diagnosis, yes, in the E.R.
Q. Something you take Advil, Ibuprofen, you rest a little bit, and maybe take some physical therapy and that's relieved within a short period of time; is that fair to say?
A. We would hope so, yes.
Q. And are you familiar with emergency room practice as to whether or not radiology testing is done?
A. Well, I know it is done, yes, of course.
Q. Do you know if any was done in this case?
A. As I said, I didn't document any having been done, so if there had been, it would be in my report. So, I am

inferring that it was not done.

Q. Not only was it not done, the E.R. record indicates not clinically indicated, non-clinically indicated.

When you're talking about clinically indicated, is it fair to say that the emergency room physician at St. Vincent's came to the conclusion that no diagnostics were clinically indicated because physical exam failed to reveal a serious injury?

MR. ROTH: Objection. It was a PA not an M.D. as it says on the bottom there. I ask for him to accurately read what the note says.

Q. Is that fair to say, Doctor?

A. That appears to be his evaluation, that it wasn't indicated. I don't know what his thought process was though.

Q. Are you also aware that there was no complaints at all with respect to Mr. Dormevil's shoulder in the emergency room on the day of the accident?

A. Yes, I don't see it documented, so there were no complaints at that time.

Q. Do you know when he started complaining about his shoulder?

A. Well, the first reference that I saw in the records was in March in the neurologists record, March 2009, a few months later. That was the first time I remember seeing it.

Q. So, his first complaint to anyone, any medical

professional about his shoulder was about five months after the accident?

A. Well, as I said, that's the first time I saw it. I don't know if I missed it somewhere else or there is something else, but it was about four months is the first time I saw it, shoulder pain documented, yes.

Q. But yet your opinion to this jury today is that that shoulder injury was caused by the motor vehicle accident, that's a yes or no question?

A. That's a yes answer.

Q. Okay.

Now, you're aware that following the emergency room, the first treatment that Mr. Dormevil had was with a Dr. Kleyman; is that correct?

A. Yes.

Q. And you're also aware that Dr. Kleyman referred the Plaintiff for an MRI of his lower back, you're aware of that?

A. Yes.

Q. You're also aware that the MRI evaluation is the gold standard for diagnostic radiology, as far as the soft tissues and disc structure of the spine; is that fair to say?

A. Currently that is correct, yes.

Q. And it was also true in 2008 when Mr. Dormevil went to Dr. Kleyman, correct?

A. I'm sorry?

Q. It was the gold standard in 2008?
A. Thank you for clarifying, yes.
Q. And the reason that a physician would send someone for an MRI is because they wanted to have an accurate picture of what's going on inside that person's body at the level that the doctor has concern about, correct?
A. That is generally accurate, yes, sir.
Q. And the MRI that Mr. Dormevil went to was at Delta Diagnostic Radiology, correct?
A. Yes.
MR. SCAHILL: And, your Honor, I'm referring to Plaintiff's 2 in evidence.
Q. That MRI evaluation was done within 25 days of the motor vehicle accident, correct?
A. Yes, sir.
Q. And that MRI evaluation, I am putting it up here for you to see it, can you give the impression to the jury, what the impression was on that MRI?
A. It does say that it's a normal MRI of the lumbar spine.
Q. So, within 25 days of the accident, Mr. Dormevil undergoes the gold standard for diagnostic radiology, an MRI of the lumbar spine that visualizes the soft tissue structures of the spine, correct?
A. Yes, sir.

Q. Everything that you spoke about before, that MRI was able to reveal the intervertebral discs, correct?

A. Yes.

Q. It was also able to see the facet joints, correct?

A. That would be correct.

Q. It showed the openings where the nerves go through the spinal column, correct?

A. That is accurate, yes.

Q. Did you read the body of this report?

A. Um, I generally do not. Unless I have some concerns or questions, I just go right to the impression because my report is a summary of, its not a recitation of everything that is stated.

Q. I want to go through some of these findings with you?

A. Sure.

Q. There is no spinal stenosis, there is no narrowing of any of the lumbar vertebrae or the openings in the vertebrae; is that fair to say?

A. Hold on. It says no spinal stenosis, I see that.

Q. Is that a fair statement?

A. Yes.

Q. It also says that there -- the facet joints are normal, the joints at the back of the vertebrae, they are all normal, correct?

A. That does say that, yes.

Q. The neural foramina, the openings that the nerve roots go through, they are all normal?

A. It say patent, doesn't say normal. That means open.

Q. It means open, so when a physician sees that the lateral neuro foramina are patent, that means they are normal, that's what they are supposed to be, correct?

A. It doesn't say normal. Patent means that it's open and the nerves are not being impinged, that's how I would interpret it.

Q. When we talk about that, you talked about the nerves not being impinged. The reason someone has that sciatica pain that you described earlier is because there is impingement at the nerve root at a particular level of the spine, correct?

A. Yes.

Q. So, when the report of the MRI says the neural foramina are patent, they are open, there is no impingement of any nerves, correct?

A. That's what it says, but --

Q. I am just going over the report with you, Doctor. It also says the paraspinal soft tissues are unremarkable. That means that all the ligaments, fat tissue, all of the surrounding tendons of the spine in the lumbar spine were all

normal; is that correct?

A. That's generally what that means, yes.

Q. Unremarkable. When a doctor puts in a report unremarkable, meaning there is no pathology, everything looks normal, correct?

A. That would be accurate, yes, sir.

Q. So, within 25 days of the accident, an extensive exam was done under MRI. Everything came back as normal, and you read this report, but yet you gave an opinion to this jury that every complaint with respect to his lower back was all due to the motor vehicle accident, despite this diagnostic test that you already told me was the gold standard; is that fair to say?

A. That is generally accurate, yes, sir.

Q. Now, you understand that he also underwent various MRI evaluations in 2009 and in 2013 -- I'm sorry, 2011 for his lower back, correct?

A. He did additional, I don't remember the dates, but he did have additional studies, yes.

Q. I'm going to ask you to take a look at the MRI from Highway Imaging Associates that was done at the request of Dr. Horowitz in February of 2011. The date of this exam is 2/23/11.

MR. SCAHILL: And this is, your Honor, from Plaintiff's 6 in evidence.

Q. There is another impression on the 2/23 MRI. It notes there is no evidence of focal disc herniation, significant intervertebral disc bulge or spinal stenosis at any level. Is that accurate?

A. Yes, you read it correctly.

Q. Does that impression in 2013 lead you to the conclusion that Mr. Dormevil suffered a traumatic injury to his lower back?

A. Well, based upon strictly that report, no.

Q. When it talks about minor degenerative changes, that's age related changes that happen to everybody as they age, correct?

A. That would be accurate, yes.

Q. And the reason that a repeat MRI was done, was the doctor who saw him in 2011 wanted to know what's happening to the spine at that time, correct?

A. I would presume so, yes, of course.

Q. There was also an MRI that was done back in 2009 at New York Methodist Hospital. Did you also review that?

A. Yes, I see it in my report here.

Q. And without going through every one of these MRIs, that was also devoid, meaning that there was nothing on that report that would show that he had a traumatic injury to his lower back, correct?

A. Based upon my summary here, there is nothing

traumatic, as you point out, correct.

Q. So, despite the fact that there is three MRI studies, one in 2008, within 25 days of the accident, one at New York Methodist Hospital in 2009, in February of 2009, and then again in February of 2011, three MRI studies that are completely negative, devoid of any reference to trauma, yet it's your opinion that Mr. Dormevil suffered a life changing injury in the motor vehicle accident of February -- of November of 2008; is that accurate?

A. That's accurate based upon the totality of the medical records, yes.

Q. Did you look at his Methodist Hospital, Methodist Hospital records?

A. Yes, he was admitted for a few days. So, yes I did look at those.

Q. Would they be important to you in formulating your opinion?

A. It was part of the entire package of records, so it was no more or less important then anything else necessarily.

Q. I will refer you to the diagnosis at New York Methodist Hospital, was he diagnosed with hypolipidemia?

A. I don't have that specifically in my summary, so I don't know.

Q. Do you know that Mr. Dormevil had diabetes?

A. I know that, yes.

Q. You didn't mention that on your direct examination. Do you know that Dr. Willer, Dr. Kleyman and various physicians that he's seen over the years said whatever his complaints could be -- whatever his complaints are could be caused by diabetic neuropathy; are you aware of that?

MR. ROTH: Note my objection, incorrectly stating Dr. Willer's opinion. You will hear from him, I will withdraw it.

Q. Are you aware of that, Doctor?

A. I am not aware that they made those statements.

Q. Do you know what the instructions were to Mr. Dormevil when he left New York Methodist Hospital after four days of admission in February of 2009?

A. No, I did not document his discharge instructions.

Q. I'm going to show that to you now. When he left New York Methodist Hospital --

MR. SCAHILL: And this is Plaintiff's 4 in evidence, your Honor.

Q. -- he was told to FU, meaning follow up with your endocrinologist for DM, meaning diabetes mellitus education and better glycemic control; is that fair to say?

A. That's what it says, yes, sir.

Q. Now, those were his instructions when he left the hospital?

MR. ROTH: Same objection, your Honor, it's

three of four.

Q. Those were his instructions when he left the hospital?

THE COURT: I believe those documents are all in evidence?

MR. ROTH: Yes.

MR. SCAHILL: It's four.

MR. ROTH: The jury can look at them.

THE COURT: So, the documents will speak for themselves.

MR. ROTH: Thank you, your Honor.

Q. Do you see anything on his discharge instructions about following up with an orthopedist?

A. No, not in that sheet of paper, I do not.

Q. Do you see anything on his discharge instructions about following up with a neurologist?

A. No, sir.

Q. Is there anything on his discharge instructions about following up with a physiatrist, someone like yourself?

A. Again, not on that form, I don't see that, correct.

Q. How about with a pain management doctor?

A. I don't see that.

Q. Does that change your opinion as to whether or not Mr. Dormevil's complaints are associated with the motor vehicle accident?

A. It does not, no.
Q. Could you look at your report from 2016, Doctor?
A. Yes, sir.
Q. On page two of seven of your report, you discuss the findings of Dr. Kim, the orthopedic surgeon who evaluated Mr. Dormevil within a month of the accident. I would ask you to look at that last sentence. Could you read for the jury what the last sentence is in that middle paragraph. Do you see what I'm talking about?
A. Yes, I do.
Q. It begins the patient was referred. Could you read for the jury that sentence?
A. Surely. The patient was referred back to the neurologist as the doctor did not believe this was spine related.
Q. Now, is it fair to say that based on that statement, Dr. Kim did not feel that Mr. Dormevil had anything wrong with his spine?
A. That appears to be the orthopedic surgeon's opinion on that, yes.
Q. But yet it's your opinion from your one visit with him ten years after the accident that everything that's wrong with his back was due to the motor vehicle accident; is that correct?
A. Based upon the totality of his treatment, not a

single visit, sir.

Q. What about the sentence above the one you just read, can you read that for the jury as well, it begins an MRI?

A. Yes. It says an MRI had been performed on 02/17/09, which again was normal without evidence of disc herniation.

Q. Does that change your opinion as to whether or not Mr. Dormevil's complaints were caused by this accident?

A. It does not.

Q. The next paragraph discusses Dr. Justin Willer, a neurologist who saw him, correct?

A. Yes, sir.

Q. And it discusses a history and impression that Dr. Willer took. You wrote that after the history and physical examination, the doctor's impression was low back pain, possibly related to lumbosacral radiculopathy, possibly involving S1 as suggested by diminished angle reflexes. What's the next sentence?

A. This could also be related to diabetic neuropathy. That is the diminished angle reflexes, Counsel.

Q. As a physician, you're trained to perform a differential diagnosis, correct?

A. Yes.

Q. Can you tell the jury what a differential diagnosis

is?

A. Sure. So, when a patient gives you a history, um, you're already starting to formulate a possible list of diagnoses. That's called a differential diagnosis. Then you do your physical examination, and perhaps you can narrow that list, and then you may or may not need to get tests to sort of zero in on what that diagnosis is. Differential is a list of possibly diagnoses, basically.

Q. Based upon your phone interview and your review of records in 2016, did you formulate a differential diagnosis as to Mr. Dormevil's complaints?

A. I did not.

Q. I would ask you to look at page three of seven in your report. Doctor, there is a sentence in the middle of the page where you're discussing an MRI of the lumbar spine that was performed at New York Methodist Hospital. Could you tell the jury what that sentence says?

A. The impression line?

Q. Yes.

A. Okay. The impression was intractable pain with spinal stenosis versus nerve impingement versus disc, and then, in parenthesis, illegible, because I couldn't read whatever the disc thing was.

Q. What does it say about the MRI?

A. The next sentence. On an MRI of the lumbar spine

found, mild degenerative facet changes bilaterally at L5-S1, right greater then left. There was a congenital root sleeve anomaly on the right of S1.

Q. You yourself, did you review Mr. Dormevil's MRI studies?

A. I did not review the film, no.

Q. Are you trained to review the MRI films?

A. Not specifically, no. We do do it, but we are not trained like a radiologist is trained.

Q. So, you would defer to a board certified radiologist for an accurate read of the MRI, correct?

A. That's correct.

Q. So, that MRI that was taken at New York Methodist Hospital was also normal with no evidence of trauma, correct?

A. Right. I see nothing traumatic based upon that report.

Q. On the next page at the top, you note that x-rays of the hips and the sacral ileac joints were taken in March of 2010, correct?

A. Yes, sir.

Q. What was the results of those x-rays?

A. Normal study.

Q. Going down on the bottom of the page, you indicate Highway Imaging Associates, an MRI of the lumbar was performed in March of 2011. What was the results of that

study?

A. This found no evidence of focal disc herniation or significant intervertebral disc bulge or spinal stenosis at any level. There were minor degenerative changes.

Q. So, in layman's terms, that MRI was basically normal, just age related changes, correct?

A. You stated it correctly, yes.

Q. There was also an MRI of the left shoulder done in June of 2013, correct?

A. Yes, sir.

Q. Can you discuss -- well, can you read for the jury what the findings on that MRI that was done in June of 2013?

A. Surely. It found minimal bone spur acromial process with minimal impingement. There were mild changes of tendinosis throughout the supraspinatus tendon. A rotator cuff tear was not seen.

Q. So, that MRI that was done in 2013 was the first MRI of the left shoulder five years after the accident, correct?

A. First one that I saw in the records, yes, sir.

Q. And that MRI report found no evidence of trauma; is that correct?

A. You can develop spurs because of a trauma, but there is no tear, which would be more obviously traumatic.

Q. Well, what you're describing, would you

characterize that as a traumatic process?

A. If somebody had a trauma to the left shoulder, you can develop bone spurs, so I don't know.

Q. Let's talk about Mr. Dormevil's MRI that was done in June of 2013, found minimal bone spur acromial process with minimal impingement. That's essentially normal of someone of his age and body habitus, correct?

A. It can be normal.

Q. The rotator cuff -- a rotator cuff tear was not seen, meaning the rotator cuff is intact, correct?

A. That's what it says, yes, sir.

Q. So, these findings, looking at that MRI evaluation, I will ask you again, is there anything on that MRI report that would lead you to believe that Mr. Dormevil suffered a traumatic injury to his left shoulder?

A. Well, I will say what I said before, not acutely, but you can get bone spurs from a remote trauma.

Q. Is that your explanation of how the shoulder is related to the accident, these minimal bone spurs that are seen five years later, that's your explanation as to why it's traumatic?

A. No, I didn't say that was my explanation.

Q. There was another MRI done of the left shoulder?

THE COURT: We are going to take a short recess, five minutes.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury left the courtroom.)

(Whereupon, a brief recess was taken.)

COURT OFFICER: All rise for the jury please. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: You may be seated.

CROSS-EXAMINATION CONTINUED

BY MR. SCAHILL:

Q. Doctor, when we left off, we were talking about the MRI of the shoulder that was done in June of 2013, and my question to you was, was that MRI of the left shoulder five years after the accident essentially normal, and you were talking about the minimal bone spur and you thought that perhaps that might be traumatic; is that correct?

A. Based upon prior remote trauma, yes.

Q. Now, you're aware that there was also an MRI of the shoulder that was performed in Florida in October of 2014 before the surgery was performed, correct?

A. Yes, sir.

Q. Do you know when his left shoulder surgery was?

A. It's actually the day after I interviewed him, so that would have been July 28th, I believe, 2016.

Q. And the MRI of the shoulder that was performed in 2014 also found no rotator cuff tendon tear, correct?

A. That's accurate, yes.
Q. And there was an impression of mild supraspinatus and infraspinatus tendinosis; is that right?
A. Yes.
Q. And that is all compatible with someone of the same age without a trauma; is that fair to say?
A. That would be accurate, yes, sir.
Q. Now, you talked about all the range of motion restrictions before.
Those range of motion restrictions, those depend on the report of the patient, correct?
A. In terms of the neck and the lower back, it is what we call active range, depends on the patient who is doing the movement clearly, yes.
Q. So, the patient, meaning Mr. Dormevil, said I can only bend this far, and you took him at his word, correct?
A. In essence, yes.
Q. So, when Mr. Dormevil was telling you that, that's something that's purely subjective on his part, correct?
A. Yeah, he stops when the pain gets to the point he doesn't want to go any further, or he can't, but it is based upon him, yes.
Q. I just want to review with you for a moment and discuss with the jury the difference between a subjective complaint and objective finding.

For analogy, we can say if someone tells you as a doctor they feel nauseous, that's a subjective complaint, correct?

A. Yes, it is.

Q. But if you see them vomiting, that's an objective finding that you could say that's an objective finding, correct?

A. For anybody to see, that is correct, yes.

Q. So, in terms of complaints with respect to the shoulder and the back, the restrictions that Mr. Dormevil said that he had when you saw him four months ago, those restrictions are all subjective, depending on what he tells you, correct?

A. Well, not the shoulder. The shoulder was passive range, meaning I controlled the movement. I moved it as far as it could be moved. The neck and the back, you're correct, he moved his neck and his back.

Q. Now, there is a concept in medicine known as secondary gain; is that correct?

A. Yes.

Q. You're taught that in medical school, the concept of secondary gain?

A. I don't remember where I learned it, but I did learn it somewhere along the way.

Q. It's not part of legal jargon, it's a medical term,

correct?

A. It is.

Q. And the reason that you're taught in medical school the issue of secondary gain, is because people that come to you for consultation may have other motives other than their own well being, correct?

A. That can be true the way you stated it, yes.

Q. To put it bluntly, secondary gain could be someone involved in a motor vehicle accident that has a personal injury lawsuit and reporting to you things that are inaccurate because they have a secondary motive, they want to get money from the lawsuit. Is that fair to say?

A. That is a potential scenario, sure.

Q. The same way that if someone is out on Worker's Comp, they tell you they can't work, but they are telling you that not because they can't go out to work, but they want to stay out on Worker's Comp, is that also a secondary gain?

A. That's also a potential, yes.

Q. So, you, as a physician, have to keep that in mind because you want to give an accurate portrayal of what actually is going on with that person that you see?

A. That is something we keep in mind, sure.

Q. Did you keep in mind with Mr. Dormevil the issue of secondary gain?

A. I got a general sense in speaking to him and

examining him of that, so I was keeping my eyes open for any unusual behaviors, inconsistent reports, things that didn't make sense, versus the medical records and the treatment, so sure, I had that in mind.

Q. And did you rule out secondary gain as it pertains to Mr. Dormevil?

A. I did not feel that he was exaggerating in any way or going outside what I would have expected based upon the records and his injuries.

Q. Did he tell you that he was involved in another accident in Florida in 2015, motor vehicle accident?

A. No.

Q. Did he tell you that he had another lawsuit pending in Florida?

MR. ROTH: Objection, there is no evidence and, in fact -- well, objection.

Q. I will rephrase it. Did he tell you that he has another claim pending in Florida --

MR. ROTH: Same objection.

Q. -- for personal injuries?

THE COURT: Objection is overruled.

Q. Did he tell you he has another claim pending in Florida and that he hired a lawyer to pursue a claim for a back injury from a car accident?

A. I was not aware of that.

Q. Did he tell you he had another accident in 2017 in Florida, another motor vehicle accident?

A. No.

Q. You were not aware that he had a motor vehicle accident in 2015, before he had his shoulder surgery in 2016, correct?

A. Correct, that would be the timeline. No, I was not aware.

Q. Would it change your opinion if you had any of those records?

A. It would depend whether or not he had documented injury to that left shoulder in that record, so I cannot answer that without the record.

Q. Would it change your opinion about the issue of secondary gain if you had known about the second claim for the same injury?

A. No, injuries can be aggravated from one accident to another, so not necessarily.

MR. SCAHILL: No further questions. Thank you, your Honor.

THE COURT: Redirect?

MR. ROTH: Thank you, your Honor.

REDIRECT EXAMINATION

BY MR. ROTH:

Q. My adversary mentioned the term gold standard; do

you recall that?

A. Yes.

Q. What's the gold standard for analysis of the shoulder injury under arthroscopy?

A. Well, actually the MRI is the gold standard imaging, but really the doctor's eyeball looking at the injuries from the inside is the gold standard in determining what is anatomically actually going on.

Q. So, you reviewed the operative report for the left shoulder, Doctor, correct?

A. I did look at that, yes.

Q. When that operation is going on, they made the incisions in Mr. Dormevil's shoulder, there is an arthroscope inside the shoulder, correct?

A. They put an endoscope in there. One incision is the camera to look around, you can see it on the T.V. They make several incisions because they have to get instruments into various places as well.

Q. Was there a SLAP tear found on arthroscopy?

A. There was, yes.

Q. My adversary keeps bringing up the lumbar. Did you review a cervical MRI report?

A. Yes.

Q. What did the cervical MRI report from March 20, 2009, show?

A. That MRI report indicated both cervical disc bulges as well as herniations.

Q. So, in terms of the cervical herniations, I know this is going to be a little bit rudimentary medicine, am I pointing to the cervical or the lumbar right now?

A. That's the cervical.

Q. Am I pointing to the cervical or lumbar with my left hand?

A. The left hand is pointing to the lumbar area.

Q. So, if you're doing a lumbar MRI, are you going to be able to visualize a cervical herniation?

A. No.

Q. So, in terms of the first gold standard diagnostic radiologic test to the neck, what did it show?

A. It showed, as I say, disc bulges that was at two levels, C2-C3 and C3-C4, and then posterior disc herniations at C4-C5 and C6-C7.

Q. And what was the treatment that, from your review of the records, was indicated in the neck?

A. So, well, he had several treatments, documented medications, he had therapy, he had injections, things of that nature, and certainly the only way to fix, so to speak the disc herniations, would be surgical.

MR. ROTH: I have nothing further. Thank you.

RECROSS EXAMINATION

BY MR. SCAHILL:

Q. Doctor, what you just described as findings in the cervical spine, an individual about Mr. Dormevil's age, body habitus, work life, they can have those same findings with or without trauma?

A. One can have bulges and herniations without trauma, but he, in fact, did have a trauma.

Q. You don't know anything about the trauma, you don't know the severity of the impact, you don't know what happened to him immediately after the accident, you didn't know he was ambulatory at the scene, you didn't know his time in the E.R. was approximately an hour, and you didn't know that they didn't even do any diagnostic testing; is that fair to say?

A. Well, I did know that. I did review those records. I was aware of that actually.

MR. SCAHILL: Nothing further.

MR. ROTH: One question, your Honor.

THE COURT: One question.

MR. ROTH: I promise, one question.

I want you to assume for the sake of this question that Mr. Dormevil testified that the cab hit the side of the van, the van lifted on two wheels and slam back down, and the bumper fell off the cab. Does that change your opinion?

THE WITNESS: It sounds like a significant impact, certainly.

MR. ROTH: Thank you very much, I have nothing further.

MR. SCAHILL: Nothing else.

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

(Whereupon, at this time, the witness was excused.)

THE COURT: We are going to break now and return at 2:30 promptly, please, thank you.

COURT OFFICER: All rise for the jury, please.

(Whereupon, the jury left the courtroom.)

(Whereupon, a luncheon recess was taken.)