SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM : PART 91

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OSCAR TORRES,

Plaintiff,

INDEX NO.
505461/2016E

- against -

ZHILA RASTEGARMEHR and KEIVAN SHIFTEH,

Defendants.

TRIAL EXCERPT

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360 Adams Street
Brooklyn, New York
November 5, 2018

B E F O R E : HONORABLE DEVIN COHEN,
Justice (and a jury)

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

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BY: ROBERT B. BROWN, ESQ.

Dell Ashby
Official Court Reporter

DA

THE COURT OFFICER: Ready for the jury?

THE COURT: Yes.

THE COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom and the following occurred:)

THE COURT: All right, thanks. You can all be seated. Welcome back.

Just as a program note, it's a little reminder, we are going to hear from a medical witness today. You will be off tomorrow. Because of Election Day, the courts are closed except for criminal arraignments and one emergency part somewhere, the election part.

So, we'll be off tomorrow and then we'll pick back up on Wednesday when we expect to hear from two doctors.

Yes?

MR. BROWN: Yes, sir.

THE COURT: And then we'll see about what Thursday is going to look like; okay?

All right. Ready to call your next witness, sir?

MR. PFLUGER: Yes, sir.

THE COURT: Please.

MR. PFLUGER: Good morning.

THE COURT: Good morning.

MR. PFLUGER: Dr. Lerman.

THE COURT CLERK: Raise your right hand, please.

Do you swear or affirm the testimony you are about to give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: I do.

THE COURT CLERK: In a loud, clear voice, please state your name and address for the record.

THE WITNESS: Vadim Lerman. V-A-D-I-M, Lerman, L-E-R-M-A-N. And address is 7089 Sheepshead Bay Road, Brooklyn, New York, 11235.

I'm sorry, I'm a little bit under the weather.

THE COURT: Everybody here is. And are you a D.O. or M.D.?

THE WITNESS: D.O.

THE COURT: Thank you.

D R. V A G I M L E R M A N, called as a witness by the Plaintiff, having been first duly sworn by the Court Clerk, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PFLUGER:

Q Good morning.

A Good morning.

Q What is your educational background, please, sir.

A I'm graduated from Binghamton University in 2001 with a biochemistry degree, B.S. in biochemistry. From where I went on to New York College of Osteopathic Medicine

receiving my Doctor of Osteopathy degree.

Then, I went into Peninsula Hospital internship where I was a chief intern, I was nominated to be a chief intern.

From where, another four years of orthopedic residency as part of Peninsula Hospital which is part of the North Shore University system which is now the Northwell system, it's a big conglomerate.

And after completing orthopedic surgery residency, I went on to Beth Israel Spine Institute completing one year of fellowship in spine surgery.

Q What is it when you say "fellowship"? What does that mean?

A Orthopedics is a broad knowledge of all the bones, ligaments in our body, whether it's pediatric or adult. Spinal surgery is concentrated only on the regions of the neck, middle back and lower back.

That's all you do for a year. You are seeing patients with the problems with the neck and the back, the lower back, whether it's a trauma, degenerative disease or deformity like something that kids are born with.

Since the fellowship, that's the only thing I have been doing is just spine surgery.

THE COURT: Sorry. Where did you say you did your spine --

THE WITNESS: Beth Israel Spine Institute.

THE COURT: Beth Israel South, 14th Street?

THE WITNESS: Yes. Not anymore, unfortunately.

Q So, you did your fellowship in spine surgery?

A Yes.

Q Did you have to take an exam -- series of examinations to become -- to do the fellowship training in spine surgery?

A It's a board certification in orthopedics for which you have to take after completing five years of residency, you complete a written exam. Once you pass the written exam, you go on to taking the oral exam where you apply to the state where it's taken. It's usually either in Chicago or New Orleans.

You have twenty patients, two physicians per station, that gives you a problem and you have to on the spot solve the problem, give the answer and treatment plan.

Once completing that, you go on to two years of completing cases which you then submit to the board of orthopedic surgeons.

They review two hundred cases out of which they pick twenty, for which they come into your office, they review every single chart on your education, why you did the surgery, your outcome. And then they want you to do two cases in the operating room, so two examiners come to your

office.

Q Are you licensed in New York?

A I am licensed in New York?

Q Any other states?

A New Jersey.

Q Okay. Where is your practice, sir?

A Our practice is located in multiple boroughs. It's in Brooklyn, Bronx, Long Island and Manhattan.

Q Okay. Do you have admitting privileges to any hospitals?

A Yes. I am an assistant clinical professor at Mount Sinai School of Medicine. I am the associate director of spine surgery at Nassau County Hospital or Nassau University Medical Center, NUMC.

And we're actually lucky enough to start a residency program in the hospital about three years ago where we teach residents.

Q Okay. What kind of practice do you have?

A I would say about fifty percent of it is private practice and fifty percent is because we have a contract with the hospital, Nassau University Medical Center, so it's educational.

Q So, what kind of patients do you see there?

A We see -- fifty percent of our practice is trauma patients because Nassau University Medical Center is probably

one of the biggest Level 1 trauma centers in Nassau county.

What it means by Level 1 trauma is the most serious trauma in Nassau county could be flown into the area by helicopter. And it's located between four highways, major highways, so you get to see everything from minor, you know, fender-bender accidents to plane crashes, actually.

Q Okay. And the types of patients when you speak about trauma, can you give an example of what the trauma patients sustain, what kind of injuries?

A In my case, we only deal with spine trauma. We even had a plane crash, three people survived with burst fractures of the spine so you have to go in and fix it.

Q Okay. So, at some point you met Oscar Torres; right?

A Yes.

Q And he came to you as a patient; is that fair to say?

A Correct.

Q Before I forget, how many times have you testified in a court like this?

A In my career, about seven times.

Q Have you and I ever met before?

A No. Only, you know, not until we went over the case.

Q Involving Oscar Torres?

A Yes.

Q And do you have to take time from your practice; correct?

A Yes. I am not seeing patients today which is my office hours.

Q What is your compensation?

A About five hundred dollars an hour.

Q Okay. When you talk about you're a spine surgeon --

A Yes.

Q -- so the type of surgery that you perform on patients include what?

A I mean, just spinal injury, whether it's something that, again I mentioned, disc problems, or bony fractures, or degenerative scoliosis, or something like acquired scoliosis, like kids are born with scoliosis.

Q Congenital?

A Congenital, correct.

Q What kind of surgery, if any, did you perform on Oscar Torres?

A It was performed anterior cervical discectomy and fusion at C5, C6.

Q How many of those fusion surgeries have you done in your career?

A Over a thousand.

Q Okay. And with reference to trauma, what types of events could result in a herniated disc at C5, C6?

A Actually, some people come in with weakness in their arm because they sneeze really hard leading to a herniated disk. I actually had one of my employees in the office had that.

Some people can strain really hard on the bathroom toilet seat that can cause a herniated disk.

It can be a whiplash injury; it can be a trip and fall injury; it can be a car accident. It can be a wide variety of things that can cause a herniated disk.

Q I want you to assume that Oscar Torres told us that on the day of the accident, February 25, 2015, he was driving his car and felt a heavy impact. His body twisted to the right and then went forward and back.

Now, what significance, if anything, does that have in assisting you in formulating an opinion as to what caused a herniation C5, C6?

A An unexpected movement that jerks the patient around, that's usually the thing that causes the problem. Because patient is not focused, patient's muscles are relaxed, and any kind of movement as a sneeze comes also can give you that almost like a whiplash type of mechanism.

Q Tell us what comprises a disk at C5, C6.

A I mean, any disk in our body comprises of annulus

which is like a wraparound, like almost like Saran Wrap. And then you have nucleus inside that looks more like crabmeat.

So, once there is an injury to that Saran wraparound, that crabmeat -- that crabmeat starts to leak out.

Q Did you say "crabmeat"?

A Yes. It looks like crabmeat, correct. That's the best way explanation.

Q When is the first time you saw him?

A Do you mind if I refer to my notes?

MR. PFLUGER: Before we do that, your Honor, can we mark this for identification?

THE COURT: Sure. You do not have a copy marked for I.D.; right?

MR. BROWN: No.

THE COURT: You can mark it for I.D. but you have to show it to counsel first.

THE COURT OFFICER: Plaintiff's 15 for identification.

MR. PFLUGER: Thank you, sir.

(Whereupon, Dr. Lerman's chart of Oscar Torres was marked for identification as Plaintiff's Exhibit 15, as of this date.)

THE COURT: Let the record reflect that the witness is being shown, which is his own exhibit, but it's

Plaintiff's 15 for I.D.

Q Do you also have a film?

A Yes.

Q And that's part of your chart?

A Yes.

Q And what's the date of your film?

A 8/28/2013.

Q Sir, are these records kept in the ordinary course of your business?

A Yes.

Q And is it the business of your office to create the notes contained in the chart in or around the time you see the patient, in this case, Oscar Torres?

A Yes.

Q And is it also the practice that you keep and maintain those records?

A Yes. It's all electronic.

MR. PFLUGER: We offer that in evidence.

MR. BROWN: No objection, your Honor.

THE COURT: Without objection it's accepted in evidence.

(Whereupon, Dr. Lerman's chart of Oscar Torres was received into evidence as Plaintiff's Exhibit 15, as of this date.)

Q Sir, when a traumatic event happens and there is a

herniation, tell the jury what the process is when a disc is herniated.

A I mean, there is different processes that is going on. So, as I described to you, we have the Saran Wrap and crabmeat around there. So, once the Saran wrap tears, it -- depending on the impact, the disc can immediately or the crabmeat can immediately descend back and push either on the spinal cord or the nerve ending and you can see immediate traumatic event. Some people can even be paralyzed if the trauma of the disc is significant on the spinal cord.

It takes usually about two centimeters of height and two grams of weight for you to paralyzed, that's how much an impact it takes. If anything hits your spinal cord from two centimeters up and two grams of weight, you will be paralyzed. So, if that disk with the impact extrudes or it comes out immediately and hits the spinal cord, you can be pretty much paralyzed immediately.

If it's just a tear and some disc comes out, people can immediately have this pain down the arms.

And if there is a tear and then the crabmeat starts to come out, as you move around with time, that can set off your symptoms by a week or two, a month or two.

So, we don't know exactly when it can set off that kind of symptoms. So, again, it's all patient based so you can't just say this herniated, this causes the problem right

now. It can herniate but cause a problem in two days, yes, three days, yes, a month, yes.

Q I want you to assume that Mr. Torres told us that on the day of the accident he did not experience any symptoms that you were just talking about and that over the course of days he did develop radiating and numbness.

What significance, if any, does that testimony assist you in formulating an opinion about the cause of his injuries?

A Sure. All these symptoms if he never had any prior -- if he never had any prior symptoms like this before, then it came after the accident. If that tear occurred and that disc started slowly moving out as the patient is moving the neck -- because our disks, the way you describe it is an air mass bubble that gives it the cushion. So, once you have the tear in that air mass bubble, the more you're going to wear off the cushion, the more you are going to have less of that air bubble and it's actually going to collapse. The same thing with the discs, it's the air mass bubble.

And you can see that we have different regions in our spine. We have a cervical region in our neck which consists of the seven vertebrae or eight disks, actually.

Then, we have a thoracic which is the middle spine which consists of the twelve vertebrae.

Then, we have the lower back or lumbar spine, it's

five vertebrae. And we have discs -- the way you name the discs is the disc that is located between -- if the disc is called L1-L2, that's the disc located between L1 and L2. It makes it nice and simple for us orthopedists.

Then, we have our sacrum and then we have our coccyx which is the tailbone. So, if you have any tears in your discs and the disc starts to push back, you have your nerves that exit on each side from a little window that's called the foramen. And then the disc can actually herniate all the way back and that's where you have the actual spinal cord.

There are different types of herniation. You have a central herniation where the disc just pushes on the spinal cord or you have actually the most settled herniation, it's the most commonly missed on M.R.I. is the disc herniation that exits into those little foramen and they actually start irritating that nerve that gives you innervation to your upper extremities.

The way we describe our nerves, we have our electrical wiring in your -- here (Indicating), and every little nerve is that electrical wiring that connects to our muscles or skin, that either takes the pain and sends it back to your brain or vice versa, it takes it from here and sends it back to your arm. It's called the radiating pain.

And that's why when people talk to me about neck

pain, I'm not very concerned about the neck pain. I'm more concerned about the symptoms that they describe as neurological, like pain shooting down my arm. I have numbness, tingling.

Because, unfortunately, you never do surgery for the neck pain because you're gonna be a very unsuccessful surgeon. If you do procedure for something -- because the most important thing in my eyes is prevent any neurological deficit like permanent.

Because the nerve cells in our body are the only cells that do not regenerate. So, if you miss that threshold and patient comes in already with weakness, you might help them not get weaker but you might never be able to restore that strength back. Because if the nerve cells die out, that's it, you're done.

Q In Mr. Torres' case, how many patients have you treated where they had a similar -- they didn't have signs and symptoms immediately, but over the course of days and weeks they did?

A I can't count on my fingers. You see a lot because people come into the emergency room, they are evaluated there and then the emergency room sends them to follow up with us at spine surgery. So, initially they had no complaints at the time of the injury and then once they get to the office, you already see the problems.

Q It's a progression of pain, and numbness, and tingling?

A Yes, absolutely. As I described.

Q You have the 2013 M.R.I. --

A Yes.

Q -- as part of your records?

A Yes.

Q And we have it in evidence. You also have the 2015?

A Yes. It's on-line, actually.

MR. PFLUGER: May I have both, please, sir.

MR. BROWN: Did he say on-line?

THE COURT: He said we have it on-line.

Q Sir, we've marked an exhibit in evidence as Plaintiff's 14.

What are we looking at right there?

A This is the 2015 M.R.I.

Q Yes. And that's Plaintiff's 14.

A Can I stand up?

THE COURT: Yes, sir, you can step down.

THE WITNESS: May I see the model for a second so I can explain it a little bit more?

(Model handed)

A (Continuing) So, we have two sets of M.R.I.'s. M.R.I. is magnetic imaging. When you come in we have

portions that spin around and they take the image of the soft tissue, so it's not really so much for the bony images. Bony images is x-rays and CAT scans; M.R.I. is meant for the soft tissue. And a lot of people have misconception you can get radiation from M.R.I. There is absolutely none from M.R.I.

There are two views. This is the axial view and then we have a sagittal view.

This is the view looking from the side like this (Indicating) and the light comes from left to right.

And then we have our view that we're looking into the canal. So, this is the view that we're looking at like this and we're looking at it inside the canal. (Indicating)

Q Top to bottom?

A Yes. And basically, if you take a salami and you take slices of it, this is exactly what we're looking at.

So, looking on the side, this is your brain. (Indicating) From the brain stem you have a spinal cord that runs down.

Looking at this imaging, you can see the spinal cord is not touched by anything in the front or in the back, you have a nice straight line. This is the exact space you need for your spinal cord.

But, as I mentioned to you before, there are different types of disc herniation. There is disc herniations that are central that you can see pushing back

out into the canal and pushing on the spinal cord. Or, we have the view that we're looking inside and we actually can see these little nerve endings exiting on each side. (Indicating)

So, this is the window that the nerve exits. But, you can see that there is no -- this is the spinal cord. I call it the sunny-side-up egg. You have a yolk in the middle and the egg white around it. And then we have the disc which should be nice and round.

And in this case, we can see these sharp edges on both sides where the nerve root exits. This is your left side, this is your right side. (Indicating)

In your case, you can see the left side is a little more open, I can put the pen through here. (Indicating)

On the right side, you can see there is a sharp edge right here and there is a sharp edge right here. (Indicating) If I put my pen here (Indicating), it would not be able go through.

And this is the exact disc herniation we are talking about, a foraminal disc herniation more to the right side that's pushing on the nerve or electrical wiring that shoots down into your muscles, your biceps, which comes out and innervates your biceps and the brachial radialis. So, it gives us the extension of our wrist and the flexion of our arm and forearm.

So, it's directly involved with the symptoms the patient was describing. So, it's not only just seeing the M.R.I. itself, it's also doing the physical exam as well and talking to the patient as to where the symptoms are coming from.

Q So, what level is that?

A We're looking at C5-C6 level.

So, if you take a look, there is C2, C3, C4 and C5. And I mentioned to you guys that the discs are named at which level they are located between. So, in this case it's C5, C6 level and the disc is called C5-C6.

Q Now, what is clinical correlation?

A In our case, clinical correlation is the physical exam and the X-rays or the pictures.

Q And the first time you saw him was what?

A It was April 4, 2016.

Q And what complaints, if any, did he make to you?

A He complains of neck pain with bilateral upper extremity pain, and back pain, bilateral lower extremity pain, and numbness and tingling sensation.

Q Once again, what significance, if any --

A (Continuing) Sorry. And sharp pain, sharp pain in my description.

Q What significance, if any, does numbness and tingling have?

A The disc damaged that the electrical wiring. There is interference with the signal that is sent from your brain to your muscle.

Q And you had your -- the first office visit, April 4th?

A Yes.

Q Tell us what the chief complaint was.

A Patient presents today with neck and back pain.

Q And what's S1, the paragraph that says Oscar Torres.

A It's history of present illness. Patient describes what happened to him.

Q And what about prior treatment? Before he got to you on April 4, 2016, what, if any, treatment did he get?

A Yes. Actually, patient had extensive physical therapy for about one year and four months and he already had a cervical epidural injection which did not help him.

Q And you did write denies history of trauma?

A Correct.

Q I want you to assume that Mr. Torres told us that he did have a prior accident in 2013.

A Correct. We are aware of that.

Q And I want you to assume that he went to Third Avenue Medical on November 5, 2013. He was discharged from that facility when he came in with no complaints of pain, no

numbness or tingling, full range of motion.

A Right.

Q What significance does that have for you, if any, in determining whether the 2015 accident caused those injuries that you just performed an operation on?

A It's not contributory at all.

Q Tell us what -- if you noted the patient's neck pain. What was the level?

A Neck pain was nine on a scale from one to ten; one being no pain, ten be the worse pain of your life. And eight is severe so nine is beyond severe.

Q And what about back pain?

A The back pain was eight so it was severe.

Q And what did he state -- you wrote "patient states pain is the same since the accident."

A Correct.

Q "Symptoms are aggravated by prolonged sitting, standing, walking and laying."

A So, basically he is describing the pain is constant.

Q And you noted one cervical epidural injection with no relief. What does that entail? What is a cervical injection?

A Basically, the pain management doctor who does the injections, we have to allocate the level which is usually

between C7 and C1, which is the most prominent spinus process and the most easiest to locate, and has the most amount of space for the needle to get in.

And usually, the injection is given with the steroid around this level right here, C7 and C1. (Indicating) And the steroid enters into the spine to our nerve. So, it basically doesn't take care of the actual disc herniation, just the inflammation around the neck.

Q Okay. So, you looked at the 2018 M.R.I. -- 2013.

A Yes.

Q Can you just step down and show us the cervical regions in the M.R.I. from 2013 that's in evidence.

A Yes. It's right there on the shadow box.

So, the same exact picture -- can everyone see?

(Jurors nod heads)

A (Continuing) We're looking at exactly the same picture that we see here. This is done in 2013. And we can see how nice and clean that white line in the front and white line in the back, it demonstrates there is nothing pushing on the spinal cord.

So, again, but we looking for that foraminal disc. And now looking at the other view, the foraminal view, so we get to the level which is right about here. (Indicating) And you can see a big difference how nice and round this area is and then you can see how the nerve on each side exits.

(Indicating)

But, the most important is that round disc, we don't see these sharp edges on both ends.

Q Which film is that?

A This is, uhmm -- it's the second one. One, two. It's the second one from the third row.

Q Now, do you have sagittal view?

A Yes. I showed the sagittal view before. This is the axial. This is the main view that we need to look at.

Q And how would you describe Oscar Torres' spine? And what's the date of that?

A This is 8/28/2013.

Q When you look at his spine, sagittal and axial, tell us what you found globally?

A Globally, I didn't see any disc herniations. I didn't see any degenerative changes, meaning, arthritis. He is a young man, at that time, thirty year old. You wouldn't have arthritis.

And on top of that, you don't see any disc herniations which is the most important thing.

Q Okay. I want you to assume that the defendant called a radiologist Arthur Trout. Agree or disagree that there is -- with Dr. Trout that there was no herniation at C5-C6 in the 2013 film?

A Correct.

Q Now, in the 2013 M.R.I., do you see any degenerative changes going on in the spine?

A Absolutely not, no.

Q Thank you, sir.

So, you have a past medical history on that April 4, 2016 office visit.

A Mm-hmm.

Q And you wrote "Has never been diagnosed with significant problems."

What does that mean?

A There is no preceding problems to what we're dealing with right at that particular moment or any issues that he takes medications for or had surgery for.

Q And sir, I want you to assume that Mr. Torres told us that after the 2013 accident he was out -- he stayed of work about four days and went back full duty after that, up until February 25, 2015, the day of the accident that we're involved with today.

A Okay.

Q So, when a patient comes to your office, you took the history and what is the next thing you did?

A Physical exam.

Q And why do you do that?

A Because again, I'm correlating the findings on the film with what I can find in the human being, physical exam.

If there is any emergency weaknesses, or severe numbness, or decreased reflexes, it can turn from just a regular visit to an emergency visit.

Q And what was your finding with reference to correlating the films to your examination?

A Patient had decreased range of motion in his neck. Patient had tenderness in his neck. Luckily, he still normal strength and normal sensation.

And let me just remind myself.

(Witness perusing documents)

A (Continuing) And that's pretty much it.

Q Tell us, you did a range of motion; right?

A Yes.

Q So, tell us what the range of motion was, what your findings were in your range of motion exam?

A On flexion he had more or less decent range of motion. It's usually sixty and he had fifty degrees, so just about ten degrees loss of flexion, forward flexion.

Extension, he lost about fifty percent of his range of motion which is normally sixty degrees and he had only thirty.

Right lateral flexion or side bending, usually about fifty degrees and he had about twenty-five degrees, so he lost about fifty percent of that range of motion.

And also lateral flexion, he lost about forty

percent range of motion because normal is fifty and he had about thirty-five.

Q Did you do a lumbar examination?

A Yes. I performed lumbar examination, as well.

Q Did you look at the M.R.I. films for 2015 with reference to L5-S1?

A Correct.

Q And what was your findings?

A Our findings was (A), we found the patient has multiple disc herniations now in his neck. I review every single M.R.I. film by myself; I don't rely on the report.

In my eyes, C5-C6 was much more significant disc herniation. And as I demonstrated here on the right side, I mean, it's pretty severe for spinal stenosis which is agreeable with the radiologist who read the report.

Then, we reviewed the M.R.I. of the lumbar spine which is the lower back as I pointed out to you earlier. And the patient had L5-S1 disc herniation there, as well.

MR. PFLUGER: Do we have in evidence Dr. Winter, a radiologist? It's an affirmation.

THE COURT OFFICER: Is it in evidence, Counsel?

MR. PFLUGER: Yes.

(Exhibit handed)

Q Now, Dr. Winter was the radiologist that did the M.R.I., March 26, 2015, of the cervical spine.

Agree or disagree with what he found at C5-C6: "There is right larger than left lateral sub-ligamentous disc herniation encroaching" into the narrowing -- "and narrowing the right more than left neural foramen"?

A Correct.

Q Agree or disagree?

A Agree, of course.

Q So, you used the word interpretation, a radiologist's interpretation.

What does that mean?

A A radiologist reads the report, looks at the imaging, and then describes what he sees in the imaging without seeing the patient.

Q But, you kind of mentioned that I don't rely on the reports, I look at it myself.

Why is that?

A Because you're going to put ten radiologists in your room and everyone is going to give you a different report.

Q If I ask you what's the best way to diagnose a herniation at C5-C6?

A The best way is to speak to the patient, see the imaging and do a physical exam. That's the only way.

Q So, did you operate on Mr. Torres?

A I did.

Q And when was that?

A The surgery was performed -- the exact date was May 17, 2016.

Q And tell us the process of what you did.

A So, once we discuss with patient all risks and benefits of the procedure in the office, the date was scheduled.

And then patient comes into the hospital. Once again we go over the procedure. We go over risks and benefits. We examine the patient on the day of the procedure, as well as two surgeons must review the imaging before the patient -- that's part of actual timeout; you cannot proceed with surgery unless two --

THE COURT: That's part of what?

THE WITNESS: Timeout.

THE COURT: Timeout.

THE WITNESS: Yes, timeout.

THE COURT: Got it.

A (Continuing) So, basically timeout is when you do a surgery you have to say patient's name, the problem, what you're doing. And part of it became two surgeons had to review the imaging and agree on the procedure. In this case, it was me and Dr. Avanesov, one of my partners who was my co-surgeon on the case.

Once patient has signed consent and goes into the

operating room, patient is being intubated because it's all under general anesthesia. We prep and drape the patient, extend his neck, take appropriate action to locate the area. We do minimally-invasive procedure so it's a small scar that we do on the right side because we're right-handed surgeons.

Once you go through the skin, we go in between the muscles to the area or to the --

Q Finish your sentence. I would just like to mark this for identification.

A (Continuing) We go into the vertebra. And once you are at the vertebrae, you once again identify the correct level, because the most common problem with these type of surgeries is operating on the wrong level.

MR. PFLUGER: Give me one second.

(Document handed)

THE COURT: All right. It's in evidence or for I.D. now?

MR. BROWN: Just for I.D.

THE COURT: So, what is being shown, Plaintiff's 16, is a three-page document for I.D.

THE WITNESS: Can I stand up?

THE COURT: You can't show it to the jury yet; it's not in evidence.

MR. PFLUGER: Well, I would like to use it as a demonstrative.

THE COURT: I know. You can't show it to the jury yet; it's not in evidence. You have to authenticate it in some way first.

MR. PFLUGER: Okay.

BY MR. PFLUGER:

Q So, can you take a look at what is depicted in those three pages.

A The procedure that we performed.

THE COURT: It's not just demonstrative. It includes copies of the images, of the actual images.

MR. PFLUGER: Yes.

THE COURT: So, it can't be just demonstrative.

Q So, included in those three pages are X-rays?

A Of the patient, yes.

Q Are they intraoperative or postoperative?

A It's postoperative.

Q And that was done where, sir?

A One of the X-rays was done in my office and the second one is also done in my office.

Q And that would be part of your chart?

A Yes, of course. It's part of my record.

Q And the illustrations, are they accurate?

A Yes. They're pretty accurate, yes.

Q So, the anatomy and the fusion that you performed on Oscar Torres?

A Correct.
Q Did you approve those?
A Yes.
THE COURT: Approve them?
MR. PFLUGER: Yes.
Q Is it something that you use, sir?
A Huh?
Q These illustrations, do you --
A Yes.
MR. PFLUGER: I would just like to use it as an illustrative --
THE COURT: You can't use them as just -- you have to be able to get them admitted on their own because they include actual massages or alleged to include actual images of the plaintiff, so they're evidence.
You can use them for demonstrative purposes once you get the rest of the document in evidence. But, the images themselves have to be admissible first.
I don't mean cartoons, they're -- I don't want to call them cartoons, the illustrations. But, because you included actual X-ray images on the documents, you have to be able to get those X-ray images in evidence in order to get the rest of the document in evidence.
Q Sir, are those X-rays made in the ordinary course of business?

A Yes.

Q Were the X-rays done of Mr. Oscar Torres contained in that exhibit?

A Yes.

Q Is it your business to keep and maintain those forms?

A Correct.

MR. PFLUGER: I just offer it in evidence.

MR. BROWN: Your Honor, the objection is that's not in the chart. The X-rays are not part of the chart that was in evidence.

THE COURT: They're not?

MR. BROWN: Not that I saw.

THE WITNESS: It's part of the electronic record that we have.

THE COURT: They're part of the M.R.I.?

THE WITNESS: Yes.

THE COURT: Was an authorization exchanged to the defendant for that EMR?

Did you get an authorization for this doctor's chart.

MR. PFLUGER: We gave it all to him.

THE COURT: No, I'm asking him.

Did you get an authorization for this doctor's chart?

MR. BROWN: We did get an authorization for his medical records. Whether they included a M.R.I. --

THE COURT: He just testified that it does, that that was included within the EMR.

Again speaking of what you personally received, but if you were given an authorization that that's he had you to get the entire EMR and he just testified under oath this was not the illustration, but that the X-rays were part of the EMR, then I'm not sure -- I mean, I understand why you're objecting. I don't understand why I wouldn't allow it.

MR. BROWN: I can speak to that.

THE COURT: Well, speak to that. If you were given an authorization and you didn't see them because you didn't order them, that's one thing. If you're saying the authorization wasn't exchanged, that's a different problem.

MR. BROWN: I was given it.

THE COURT: You were given what?

MR. BROWN: A copy of them.

THE COURT: How long ago?

MR. BROWN: I'm not sure when.

THE COURT: But, not today or yesterday?

MR. BROWN: Correct.

THE COURT: Some time ago?

MR. BROWN: Some time ago.

THE COURT: Overruled.

Anything else?

MR. PFLUGER: No, Judge. I would like --

THE COURT: It's admitted in evidence. The images themselves, meaning, the electronic reproductions of the X-rays the doctor described are admitted as evidence/evidence. And as to the medical illustrations, those are admitted for demonstrative purposes only.

MR. BROWN: Just note my objection.

THE COURT: Your exception is noted.

(Whereupon, the X-rays were received into evidence as Plaintiff's Exhibit 17 for identification, with the above-mentioned caveat, as of this date.)

THE COURT: Sir, could you just step down.

(Witness complies)

THE WITNESS: So, this is a quick illustration of the surgery that we performed. This is the illustration of the positioning of the patient. The patient is laying flat on their back. They're intubated. Their neck is extended.

We put in cranial tongs to detract the area where there is a problem, particularly the C5-C6, and we make a small incision, vertical incision. We try to do it in the crease, in the fold of the skin, so it would be more

cosmetically appealing. And three months down the line people don't even see that scar.

But, even though it looks very small, there is a lot of work that needs to be done. So, you get to the level. You have to identify the correct level. Once again, the most common problem is the wrong level, as I mentioned earlier.

Once the level is identified, you start doing a decompression. You start taking that disc out literally a step at a time, until -- this is the spinal cord, actually. (Indicating) And the disc that is coming out, luckily it's not pushing on the spinal cord but it's pushing more on that nerve.

So, once we get down, we can notify that Saran wrap rupture and the actual -- that little piece of crabmeat -- you see it does look like a piece of crabmeat -- that was sitting more in the right foramen.

You scoop all of this stuff out. Then, you use a burr to roughen up that bone to create a little bit of a bleeding bone, because once you put that implant with cadaver bone, that blood with some bone that exits, it gives you the pressure to ossify itself that causes the bone growth.

Because our purpose here is to create a solid fusion. Even though we put this implant here -- and

this is the new generation. Back in the day, it was a big plate with four screws. Now it's an implant that comes with a preset little holes and a small plate. And it enters and looks like this; this is a better picture of how this implant looks. (Indicating)

The inside part is actually consists of this special material that conducts the bone. So, our goal is to create a bony fusion. Now we have no pressure on the nerve and so the goal is to create a bony fusion to eliminate the pain as well as eliminate the neurological symptoms the patient described.

Because if you just leave the screws in without the bone formation, the screws, anything that is hammered will eventually break. And I never want to go back and redo the surgery. My goal is to do it once and for all. So, that's why the actual fusion needs to occur.

And these are the actual X-rays from 2017, the most recent visit the patient had. And you can see the location of the screws is perfect.

And this is the view from the front to back. (Indicating)

This is the view from the side. You can see here. (Indicating)

(Whereupon, the witness resumes the stand.

MR. PFLUGER: Judge, I'm referring to Plaintiff's

Exhibit 13.

Q Referring to Plaintiff's Exhibit 13, Dr. Steven Winter, the radiologist that interpreted the M.R.I. of March 29, 2015 -- actually, March 26, 2015, agree or disagree?

"At L5-S1, there is a broad posterior disc herniation and radial annular tear that is impressing on the ventral thecal sac and has a right predominant bubonic component pressing on the right more than the left S1 nerve root exiting from the thecal sac, displacing the right S1 nerve root posterior and laterally as it exits the thecal sac."

A Correct. The lumbar spine for the lower back, yes.

Q Sir, after the exam, what, if anything, was discussed with Mr. Torres of what kind of treatment he was going to get?

A You are talking about the first visit or the first post-op visit?

Q No, no. April 4, 2016.

A So, yes. At that particular moment, we discussed all the possible options with the patient regarding his condition, of one year of physical therapy and four months of not helping him. Epidural injection not helping him. And now we're at that point where we either wait until he's going to have a settling of his weakness and progression of his

numbness in his upper extremities, or you have to go in and do the procedure where you take the pressure off the nerve and prevent a young man from becoming someone who is going to become a permanent injury.

Q When you say progression of numbness, what significance is that?

A That's proprioception, when you put your hand in your pocket, you don't know what kind of change you have. It's important.

Sensation, you can burn yourself. A lot of times people come in and all their hands are burned. And you ask them what is going on and they say, oh, you know, when I -- especially, older individuals -- when I'm boiling my tea, I don't even feel the temperature. So, every time I get burned by the tea. When they boil their eggs.

So, it's important. Sensation is an important part of our lives.

Q Progression, I mean --

A The fact that the patient still had strength, good strength, is very important in my eyes because I don't want him to start having weakness. As I mentioned earlier, there is no return once the nerve cells die out.

And if patient has already weakness, that's something that you have to tell the patient, that most likely you can take care of the problem getting worse but you might

never be able to recover the strength that he had before, especially a year and a half later.

Q So, what you're saying is it's not really -- it's not reversible once he gets the damage?

A It's getting worse, correct.

Q Sir, under "impression," can you just tell us what that means and what you did.

A Under "impression," we spoke, as I mentioned earlier, surgery to the ACDF or anterior cervical discectomy. You go from the front, take the disc out, and fusion, put the implant there and create a bony -- a bridge over time. That's ACDF.

At C5-C6 level has been recommended as the patient failed with conserve efforts. The surgical and nonsurgical options were discussed.

So, I spoke to the patient saying, listen, we can sit and wait until that weakness will start or we can act on it right now and prevent it from getting worse.

Is it preventative surgery? Yes. Is it prophylactic surgery? No.

Q So, what risks?

A I mean, you explain to patient that anything can happen, from death, to paralysis, to infection, to cardiac failure. There is also kind of an unusual nerve that runs in the back that no one knows exactly where it's going to exit.

So, you have to be very careful as you are making that approach because if you damage that, you're gonna have hoarseness for life or you lose your voice.

Blood clots. I mean, death from anesthesia. I mean, it's -- as little of an incision that it looks like or as minimally invasive as we do it, it has so much risk to it.

Q Okay, you said blood clots. DVT is what?

A DVT, unfortunately, is a blood clot.

Q Okay. And the surgery of May 17, 2016 that you performed, what complications, if any, occurred as a result of that fusion surgery?

A Unfortunately, patient developed a DVT. He came to my office complaining of the calf tenderness.

So, I never wait and assume he pulled his muscle. Even though his young age and it's a small procedure, we sent patient to the Doppler. And, fair enough, patient had DVT which now puts him to the risk now he did the surgery and you have to start blood thinners.

And you have fresh wound so (A), you have to be watched constantly not to have the swelling in your neck and die from the swelling in your neck. But, if you don't do anything about the clot in your leg, you can die from the clot dislodging and causing either a pulmonary embolism or a stroke.

Q And that's what happened to Mr. Torres?

A Luckily, just a blood clot.

Q But, he had a DVT?

A Yes, he had a DVT.

Q Now, when was the next time you saw him post-op? You have in your record, I believe, it's May 23, 2016.

A Yes, exactly. We saw him about six days post-op and that was when patient was complaining of right superficial calf tenderness.

Q Adjacent segment degeneration, what does that mean?

A It's part of the complications of the surgery. It's once you have -- as I mentioned to you guys earlier, you have seven vertebrae or eight discs in our cervical spine. Once you -- and those are the vertebrae that give us that motion forward, sideways, side to side. (Indicating)

The tiny little joints are called facets. So, in our case, once you lock out that one level, C5-C6, the other levels -- the way I usually describe it to my patients, if we're five people carrying that heavy box, now one of them got sick and now four of us carrying the same distance, we're gonna get tired much quicker.

So, the same thing with joints. Once you lock out that one particular joint, C5-C6, the level above and the level below start overworking time because now they have to produce the same kind of motion but now there is less guys doing it.

So, adjacent level disease, it's part of the discussion prior to surgery that you have to discuss, and there is a potential of future surgeries once you perform that level.

Q What, if anything, does a fusion at C5-C6 have with reference to flexibility?

A It locks out -- it takes away about thirty to forty percent of your range of motion.

Q And when you fuse the spine at C5-C6, is that a permanent limitation?

A It's a permit limitation. You can't do anything with that.

Q And if someone was -- he was born August 1983 and you saw him -- you did the surgery in 2016.

What about the prognosis for future surgery in somebody so young?

A Unfortunately, we even discussed with the patient that it's not a matter if patient is going to have the surgery, it's matter of when he is going to have the surgery.

Q Why?

A Because of that adjacent level degeneration disease. And now we set forth to actually have the degenerative process at the level above and below.

Q Have you formulated an opinion whether that is a traumatic accelerated degeneration?

A It's part of the procedure, yes. It's part of the trauma, yes. Correct.

Q So, what complaints, if any, did he make? You told us about the calf pain.

A He actually denied any problems swallowing or any problems bleeding and that's pretty much it. At that point, his main concern was the calf.

But, he was doing good after the surgery. He didn't have any more pain shooting down the arm, so I think it was a great success in that sense.

Q At some point, did that change?

A Yes.

Q Can you give is the date that it did change?

A Uhmm --

Q Do you have your December 14, 2016 note?

A Yes.

Q You have "chief complaint"?

A Patient says pain has now gone up to seven and patient is currently working. Patient does not attend physical therapy anymore because of the financial situation. And no new injuries.

So, he just -- the level of pain in his neck went up.

Q You did a range of motion -- I'm just going to go back for a second to May 23, 2016.

You did a range of motion for his neck and back?

A The May 23rd one? Okay, 2016.

Q Correct. Can you tell us with the range of motion examination what your findings were for the neck first and then the back?

A His flexion was restricted by about fifty percent. His extension was restricted by about fifty percent. And his right flexion and left flexion was reduced by about fifty percent, as well.

Q How about his back?

A His back was unchanged.

Q Meaning, what was --

A It was still decreased by about forty-five percent range of motion, as well.

Q And you next saw him on June 6, 2016; correct?

A June 6, 2016, correct.

Q And what was the range of motion?

A It was unchanged. It was the same.

Q And what complaints, if any, did he make?

A Pain is about three on a scale from one to ten. So, it was minor to medium pain.

Q And the cervical range of motion examination?

A Unchanged. It was the same.

Q Can you just tell us the percent?

A About fifty percent probably, the same. Nothing

changed.

THE COURT: Five-zero?

THE WITNESS: Yes.

Q And what was the impression?

A Patient was in global postoperative period for cervical ACDF. Treatment is instituted as listed above. Patient to continue activity modification. Follow up with PCP for Xarelto, which is that blood thinner medication for his blood clots.

We want to make sure, as I mentioned to you earlier, to have a closer look to make sure there is no DVT and his level of blood medication is normal.

Q You wrote a couple of times global post-op period.

What does that mean?

A Meaning that there is no complications in his neck from the surgery.

Q And what, if any, medications were you prescribing after the surgery?

A We usually give -- for the first month, we give a painkiller, which is Oxycodone. And Baclofen, which is a muscle relaxer.

Q July 25, 2016, how was he doing overall?

A Patient was doing great. He endorses pain as weakly as one on a scale from one to ten. He has relief with medication. Patient does not attend physical therapy.

Patient says he finished medication prescribed by the hospital for the ultrasound of the right calf.

Q Were any medications prescribed?

A I don't remember then. I know that we gave him another script for physical therapy. At that point, we really don't give medication because it's now a month and a half, about, past the surgery.

Q It says "work status."

A Uhmm --

Q And you have "see restrictions." And you have "upper extremity restrictions."

A Where are you looking? I'm sorry.

Q It's the last pages.

A We told him to return to modified duty.

Q Okay. "Upper extremity restrictions"?

A Limit lift, push, pull to five pounds.

Q Why is that?

A Because we don't want him to strain anything and cause worsening of the discs above or below.

Q So, how many months post-op was this?

A This is about two months post-op.

Q I don't see a notation for range of motion.

A Because it was unchanged so we were not documenting it. If there had been any changes, we would document it. But, it was unchanged.

Q And December 14, 2016, chief complaint says "The patient follows up today status post C5-C6, 5/17/16. Patient rates pain as a seven on pain scale to ten."

A Correct.

Q Does that have any significance, he went from an one in July to a seven in December?

A The neck -- the neck pain again, it can come and go. And the reason why we do surgery is not for the neck pain so much but with the weather changes, especially, in December, I don't particularly know whether there was, you know, a severe drop.

Once patient have instrumentation in their neck for the first year they are very sensitive to the weather. So, that could have been one of the triggers to actually worsen his symptoms or neck pain itself.

Q And the musculoskeletal, second page, you have "straightening of the normal lordosis."

What does that mean and what significance, if any, does that have?

A Lordosis is the normal curve of the spine. So, this is lordosis, this is kyphosis, and back lordosis. (Indicating)

So, the straightening of the normal lordosis, if you have muscle spasms, usually what happens is they tighten up your neck and this is what happens, you go into spasm and

you have a straight neck instead of having a nice curvature because you have muscles coming down on both sides.

If they tense up, they straighten up your neck so they lose --

Q Why does the body do that?

A It's our protection mechanism. The body protects itself by tensing up the muscles, protecting the spine around it.

Q And you have "lumbar spine." You did a range of motion.

What was that, sir?

A It was unchanged.

Q How much loss of range of motion?

A About forty-five percent of range of motion was lost.

Q Did you formulate an opinion within a reasonable degree of medical certainty whether that injury to the spine was a permanent loss of range of motion?

A Correct. Yes, it is.

Q You also saw him on March 13, 2017. You have that the patient rates pain as six on a pain scale of ten.

A Okay.

Q Then you wrote "Patient participates with physical therapy. No new injuries."

Why did you write "No new injuries"?

A To make sure the patient did not sustain any new injuries that could have caused worsening of his symptoms or worsening of his pain.

Q And what was your plan, sir?

A The plan was activity modification. Avoid prolonged bending, stooping or lifting. Avoid cigarette smoking. Continue conditioning program. Change conditioning program if needed. Avoid activities that can aggravate the neck pain.

We spoke to him about working with a disability. We talked to him about not lifting anything heavy. Monitor, again, his neck to make sure there is no changes in his scar tissue or swelling.

Again, we kept him limited to lift, push, pull no more than five pounds. And we still said he can work modified duty.

Q So, for the year 2017, what was his condition?

A I would say it was, like, guarded.

Q And you did see him on July 11, 2018; correct?

A July 11th? Patient was seen by RPA and the surgeon who covered that day.

Q What does that mean, "RPA"?

A We have a PA in-house that is covered by whoever the surgeon they need. Like, low post-op visits are seen by PA. And the surgeon follows up and sees -- makes sure that

he sees the patient, as well.

In that case that day, Dr. Levin was in-house, another spine surgeon. So, he co-signed and checked the note of our physician assistant.

So, basically, patient never have such day where they cannot follow up with someone to continue their care.

Q You talked about future surgery.

A Possibility of future surgery, correct.

Q I want you to assume that Mr. Torres told us that there was a discussion about he would need a future -- another surgery.

Do you have a memory of discussing that?

A Of course, yes. Even before the surgery, we discuss the possibility of future surgery.

Q Right. I don't know if you can do it, but someone at thirty-one, do you have an estimate of when he would probably need a subsequent surgery?

A Give or take, about five to ten years from now.

Q So, that would mean if he had it in '16, you're saying --

A Probably, 2020 -- between '20 to '25.

Q And what kind of revision surgery or subsequent surgery would he need?

A He would have to -- depending on that particular time which level is affecting him the most, we would have to

go from the other side to avoid scar tissue and do the same exact thing that we did on C5-C6, on either C4-C5 or C6-C7.

Q What were your findings with reference to radiating pain in 2017, if any?

A I know patient started -- I was referred back to pain management because he started to have something, like, in his arm.

Q And what significance does that have?

A If it's going to continue, then it warrants getting a new M.R.I. and see what is going on at the levels above and blow.

Q So, you did prepare a narrative report; correct?

A Correct.

Q Do you have it?

A Yes.

Q And this report was prepared August 21, 2018; correct?

A Correct.

Q And Mr. Torres' law firm requested that of you?

A Yes, correct.

Q What records did you review?

THE COURT: For his report? At all or for that report?

MR. PFLUGER: For the narrative.

A We had an opportunity to review records from his

previous M.R.I.'s. We reviewed records from current M.R.I.'s. My office visits. We reviewed records from Dr. Westerband (Phonetic) which is Energy Acupuncture. Beth Israel Medical records which is my operative report. New York Surgery Center. We reviewed Dr. Thomas's records, Jamaica Wellness, Omega Diagnostic Imaging, as well.

Q Did you mention Third Avenue Medical?

A Third Avenue Medical, correct.

Q Now, what future medical treatment, if any, is in his future?

THE COURT: Regarding the spine?

MR. PFLUGER: Yes, sir.

A At this point, we're looking again at revision -- well, not even revision surgery but more of an adjacent level surgery at either C4-C5 or C5-C6.

And again, patient still has issues with his lower back which was not looking good to begin with. And he still has complaints of that lower back so there is always the potential for that, as well.

Q And what is the cost of a fusion in the neck?

A About between hospital fees and, you know, monitoring, anesthesia, implants, about a hundred thousand dollars.

Q And how about for the back?

A About the same, yeah.

Q What about any diagnostic tests, M.R.I.'s, X-rays?

A I mean, he would need follow-up with M.R.I.'s. And if another surgery is done, once you do more than one level, you have to have a constant follow-up with C.A.T. scan to make sure that the bony bridge fusion occurs.

Q Sir, do you have an opinion within a reasonable degree of medical certainty whether Mr. Torres sustained a permanent, consequential limitation of use of a body organ or member as a result of the accident on February 25, 2015?

A Yes. We discussed earlier his neck is permanently limited on range of motion.

Q Do you have an opinion within a reasonable degree of medical certainty whether Mr. Torres sustained a significant limitation of use of a body function or system as a result of the accident of February 25, 2015?

A Yes. His neck.

Q Well, how about his back, L5-S1?

A His back, again, will need potential surgery but we don't know exactly where, and how, and what.

Q Well, have you formulated an opinion that the accident of February 25. 2015 resulted in a herniation at L5-S1?

A Yes.

Q What is your opinion?

A That it was a result of the accident. He did not

have any injury there before.

Q You did look at the 2013 M.R.I. of his back; correct?

A Yes, correct.

Q Did you see a herniation at that level?

A No, I did not see a herniation.

Q Doctor, I forgot to ask you: What is the best way to diagnose a herniation at C5-C6?

MR. BROWN: Objection. Asked and answered.

THE COURT: You're saying you didn't ask that question already?

Q So, when you went in --

MR. PFLUGER: I'll do it this way, Judge.

Q How do you go into someone's neck? You told us; right?

A Yes.

Q Did you actually see the C5-C6 herniation?

A Yes. As described earlier, you see the actual piece that we took it out from the foramen.

Q Okay. Because you told us you put ten radiologists in the room and you get ten different opinions.

A Unfortunately, that's correct.

Q So, the best way to diagnose the herniation is to actually look at it and see it?

A Absolutely.

Q And did you?

A I did.

THE COURT: It's one clock. We will see you at 2:15.

Doctor, you remain under oath.

As always, please don't discuss the case amongst yourselves or with anyone else. Don't do any research. See you back at 2:15.

(Whereupon, the jury exits the courtroom and the following occurs:)

THE COURT: (To the witness) You're under oath and that means you can't discuss your testimony.

MR. PFLUGER: I'm on direct.

THE COURT: I know that. But, you still can't discuss his testimony while he's under oath.

(Whereupon, a luncheon recess was taken.)

(After the luncheon recess, the following occurred:)

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A F T E R N O O N S E S S I O N

THE COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Ladies and gentlemen, okay, you can all be seated. Thank you.

Your witness.

MR. PFLUGER: Thank you, Judge.

CONTINUED DIRECT EXAMINATION

BY MR. PFLUGER:

Q Good afternoon, sir. Just a couple of questions.

In your narrative, summary of future plan or prognosis, you commented on traumatic cervical disc herniations as a result of the February 25, 2015 accident.

A Mm-hmm.

Q What herniations were they?

A The dangerous disc herniation was C5-C6. There was also herniation of C3-C4, C4-C5, C6-C7 and C1 -- that's it.

Q And you formulated an opinion with a reasonable degree of medical certainty that the accident of February 25, 2015 caused those herniations at those levels?

A Yes, I did.

Q And have you formulated an opinion whether those herniations are permanent?

A Yes.

Q What is your opinion?

A They are permanent.

MR. PFLUGER: That's it.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. BROWN:

Q Good afternoon, Dr. Lerman.

A Good afternoon.

Q I have some questions for you. And we understand you've testified in court before; correct?

A Correct.

Q And I just want to let you know about the rules of cross-examination. I'm going to ask you questions that require a yes or no only, and if you can answer yes or no. And if you can't, will you let me know that?

A Okay.

Q Thank you, Doctor.

Now, you indicated earlier that you practiced medicine as part of a facility called Advanced Orthopedics and Spine Care, PLLC?

A PLLC.

Q But, on your reports that are in the chart, at the top it says Advanced Orthopedics and Spine Care; correct?

A It's PLLC. There is a little note there, it's d/b/a.

Q So, they're one and the same; correct?

A Yes.

Q And that organization has locations in Brooklyn, manhattan and the Bronx and an office in Long Island?

A It used to be Manhattan, not anymore.

Q But, you now have them in Long Island; correct?

A That's correct.

Q Now, and the Total Orthopedics, does that have a website?

A Yes.

Q And you indicated that about fifty percent of your practice is private practice; correct?

A Correct.

Q And you said about fifty percent is patients that you see through Nassau University Medical Center; correct?

A Correct.

Q Now, what's the percentage of the patients at your facility that have personal injury cases pending in court?

A Roughly, about fifty percent.

Q And you indicated that previously you've testified about seven times?

A Throughout my career, yes.

Q And each time that you testified, it was a lawyer who paid you to testify; correct?

MR. PFLUGER: Objection.

THE COURT: Whether a lawyer paid him to testify when he testified?

MR. PFLUGER: He was compensated for his time in court.

THE COURT: But, it was a lawyer who retained you to testify; yes.

THE WITNESS: On my patients only, yes.

THE COURT: I understand.

BY MR. BROWN:

Q Now, do you consider yourself to be independent in this case?

A Correct.

Q And you indicated that you've testified in court seven times over your career.

About how many years does that span?

A Seven years.

Q And when you do testify, you indicated that you testify for your own patients?

A Only, yes.

Q And with those people because they're your own -- withdrawn.

Are those patients when you testified plaintiffs in personal injury accidents?

A Correct.

Q And in the last seven years, you've testified only for plaintiffs?

A Only for plaintiffs.

Q Now, in this case, it's the plaintiff's attorney, William Schwitzer & Associates, who is paying you for your time here today; correct?

A Correct.

Q And does William Schwitzer & Associates refer

patients to you?

A They have not referred patients to me.

Q Does Dakoff, Ishai & Associates refer patients to you?

A No. We only get referrals from other doctors.

Q And isn't it true that you have worked with plaintiff's attorney, William Schwitzer & Associates, before on a personal injury case?

A I don't personally work with attorneys, I work with my patients. So, there was one case before that that was represented by that firm.

Q Was that in November of 2016, a case in Supreme Court, Bronx county called Raymond (Phonetic), Silvas & Morales against the City of New York?

A I don't remember that.

Q Now, Doctor, in this case you indicated that you first saw the plaintiff on April 4th of 2016; correct?

A Correct.

Q And this was over one year and almost two months after the accident on February 25, 2016?

A Yes. One year, four months.

Q Now, you earlier testified that about fifty percent of your practice involves patients through the Nassau University Medical Center; correct?

A I mean fifty percent of the practice, not from the

Nassau University but it's the injury, the traumas, ER's. People we have operate out of many hospitals.

Q And Nassau University Medical Center you said is a Level 1 trauma center; correct?

A Correct.

Q And I want you to assume that Mr. Torres testified earlier that he did not go to a trauma center after the accident.

Is that significant to you?

A No.

Q I want you to also assume Mr. Torres testified earlier that he didn't go to the emergency room of any kind right after the accident.

Is that significant to you?

A No, it's not.

Q Now, during the visit on April 4th of 2016 --

A Mm-hmm.

Q -- you indicated that you took a history; correct?

A Correct.

Q And do you agree, Doctor, that if you did not take a proper history, your opinion would be less than valid?

A Yes, I agree.

Q And you do take that history so that you can be accurate in your diagnosis; correct?

A Yes.

Q And did all the information that you got from that history come from the plaintiff himself?

A Correct.

Q And did you call or speak to any of his doctors?

A No, I did not.

Q And you consider, like you said on direct, Mr. Torres to be your patient; correct?

A Correct.

Q Did you conduct an extensive interview with him when you met with him for the first time?

A Yes.

Q And did you ask him about his medical history?

A Yes.

Q Do you think you obtained an accurate medical history from the plaintiff?

A Everything that this patient provided, we have it here, yes.

Q And you also gave an opinion that the plaintiff's neck and back injuries, and the surgery, are related to the plaintiff's accident on February 25, 2015; correct?

A Correct.

Q Now, in order to give that opinion, do you agree that you would need an accurate history from the plaintiff? Correct?

A Correct.

Q And if you didn't have an accurate history, could you be mistaken in your opinion on causation of those injuries?

A I cannot answer yes or no on this one.

Q And Doctor, is a motor vehicle accident considered a trauma?

A Not necessarily. I mean, it's an accident.

Q And after you saw the plaintiff, did you ever review any photographs of the vehicles involved in the accident on February 25, 2015?

A I'm not a body mechanic. No.

Q Now, Doctor, in rendering your opinion, do you consider what is subjective and then use an objective test to measure, confirm, the subjective?

A Sure.

Q And I used this example previously and I hope you can agree: Is it fair to say that a doctor -- to say, Doctor, that a subjective complaint is nausea and an objective confirmation of that complaint is vomiting?

THE COURT: It's the other way around. You mean that nausea is a subjective complaint, not that a subjective complaint is nausea.

MR. BROWN: Yes. That a subjective complaint is nausea.

A Yes.

Q And the objective complaint of have would be vomiting; correct?

A You could have nausea without vomiting.

Q But, that could be one subjective -- sorry, objective confirmation; right?

A But, if someone doesn't vomit that doesn't mean that they are not nauseous; right?

Q But, an objective confirmation of the subjective complaint of nausea could be vomiting; correct?

A Sure. Could be vomiting.

Q Now, Doctor, did you take into account that a person's subjective complaints may be tied to a personal injury lawsuit?

A At the time of the injury, a patient that comes to see me, I'm not sure whether it's a personal injury lawsuit until someone reaches out or --

Q Yes or no, Doctor? If you can't --

A I cannot answer yes or no.

Q And during your visits with Mr. Torres, you indicated that you performed range of motion testing; correct?

A Correct.

Q And isn't some part of range of motion testing subjective?

A Correct.

Q Now, in your reports that counsel went over with you, you indicated the range of motion findings; correct?

And in those reports do you also list what would be considered normal?

A The program doesn't have it here, no.

Q Doctor, are you aware of the term secondary gain?

A Sure.

Q And is that a medically-accepted concept that recognizes that a patient has a motivation beyond their own symptoms and complaints that affects the way that they relay problems to you?

A Sure.

Q And is it that a patient may be motivated by a desire for personal gain in how they make their complaints to you?

A Some of these things are, of course.

Q Now, Doctor, do you consider secondary gain when forming an opinion or a diagnosis?

A It tends to be something really suicidal to put themselves through a spine surgery for secondary gain.

Q Doctor, do you consider it?

A Absolutely not.

Q Okay. So, if you don't consider it, you just take them at their word?

A You have to trust the patient. Yes.

Q Now, after the first visit on April 4th of 2016, you go to complete your report; correct?

A Correct.

Q And that's part of your chart; correct?

A Correct.

Q And in that report dated April 4, 2016, did you ask the plaintiff about his medical history?

A Yes.

Q And did the plaintiff deny any history of trauma?

A Patient said he did not have any trauma, correct.

Q And did the plaintiff also tell you that he had never been diagnosed with a significant problem?

A Correct. But, actually, the patient bought the previous M.R.I. and --

Q Doctor, you answered the question. Thank you.

Now, at your office visit on April 4th of 2016, was the plaintiff's height measured?

A Yes.

Q Was he listed at five feet, six inches tall?

A Correct.

Q Was he weighed that day?

A Yes, he was.

Q And was his weight listed at two hundred fifteen pounds?

A Yes.

Q Was his body mass index 34.7?
A Correct.
Q And is that considered obese?
A It's -- I think it's borderline obese.
Q So, isn't obesity defined as a body mass index equal to or greater than 30?
A 33.
Q So, 34.7 is above the 33; correct?
A Yes.
Q Now, Doctor, after that first examination on April 4th of 2016, did you diagnose the plaintiff with spinal stenosis, cervical region?
A Yes.
Q And did you also diagnose the plaintiff, Mr. Torres, with spinal stenosis, lumbosacral region?
A Right.
Q And lumbosacral is the lower back; correct?
A Correct.
Q And cervical is the neck area; correct?
A Correct.
Q And is spinal stenosis a common source of chronic pain that is caused by gradual narrowing of nerve pathways in the cervical spine?
A Not necessarily.
Q Can spinal stenosis be caused by a trauma?

A Absolutely.

Q And can spinal stenosis be caused by degenerative disc disease?

A Yes. If someone is old enough.

Q And can spinal stenosis be caused by age-related conditions?

A Yes.

Q Can spinal stenosis be caused by wear and tear?

A Yes.

Q And can spinal stenosis occur over time with or without a trauma?

A Yes. With age.

Q And is spinal stenosis a -- considered a degenerative condition?

A Not necessarily.

Q Now, are you familiar with the term degenerative disc disease?

A Yes.

Q And does degenerative disc disease occur when a person's intervertebral discs begin a natural degeneration?

A Yes. At forty-five, forty-six years old.

Q Does that mean there is a lot of fluid in the discs?

A You can have a lot of fluid loss with degeneration or you can because of a trauma. If something, as I told you,

the Saran wrap ruptures, the fluid can leak out as well, so --

Q But, it can be both; correct?

A Yes.

Q And does this process of degenerative disc disease flatten the disc and bring the vertebrae closer?

A It has to be a lot of time for it to happen.

Q But, that's what happens; correct?

A Sometimes, yes.

Q And you just indicated to me that this occurs when a person is around forty-five years old?

A Or older.

MR. BROWN: Officer, can I have this marked for I.D. only, please.

THE COURT OFFICER: Defendant's M for I.D.

THE COURT: Defendants' M as in Mary?

THE COURT OFFICER: Yes.

(Whereupon, a copy of a page from the witness's website dealing with degenerative disc disease was marked as Defendant's M for identification, as of this date.)

Q Doctor, having seen that --

A Yes.

Q -- is that a page of a section from your website?

A Correct.

Q Is that specifically a page from your website that deals with degenerative disc disease?

A Yeah.

Q And in the first paragraph under that heading --

MR. PFLUGER: Objection.

THE COURT: Objection what?

MR. PFLUGER: Objection reading from something not in evidence.

THE COURT: He didn't read from it yet. If he does, then it's objectionable.

Q Does that website discuss a different age that degenerative disc disease can come into play?

A Yes. Because of previous trauma, it can happen at different ages.

Q Does it say it can happen in your thirties and forties?

A Yes, it does.

Q Now, does degenerative disc disease make it harder for a disc to absorb shock?

A Correct. As I discussed with different levels of degeneration, that can happen at twenty years old, as well.

Q Do many acquire disc disease in their thirties and forties?

A You can acquire it at fifteen, sixteen. It's a gray line; there is no definitive age.

Q If a person has degenerative disc disease, does that person -- withdrawn.

If a person has degenerative disc disease, can that person also have spinal stenosis?

A They're not the same.

Q They could, though; correct?

A They could. Again, can we go back and explain what spinal stenosis is?

Q No, Doctor. I'm going to move on.

Now, in your April fourth, 2016 report, Doctor, you mentioned the M.R.I. findings of the plaintiff's cervical spine taken on March 26, 2015?

A Correct.

Q And you stated on direct that you found herniated disc at several levels; correct?

A Correct.

Q Now, Doctor, can a herniation of a disc be caused by an injury?

A Yes.

Q And can a herniation -- withdrawn.

Can a herniated disc come from active use?

A Uhmm, yes.

Q And can a herniated disc be caused by obesity?

A In the lower region, yes, not in the neck.

Q Can a herniated disc be caused by heavy smoking?

A You can have degeneration but not really disc herniation.

Q Can a herniated disc happen over time as we all age?

A Sure.

Q Can a patient who is diagnosed with a herniated disc suffer a reoccurrence of a herniation in the same disc within three months of recovery?

MR. PFLUGER: Objection.

THE COURT: Three months of recovery.

A I'm not sure what you mean.

Q Can a patient suffer a reoccurrence of that herniated disc in the same level?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q Can a person recover from a herniated disc?

A Never.

Q Can the symptoms of a herniated disc go away?

A Yes.

Q Can a person then have a recurrence of those symptoms?

A Yes.

Q And does your website say that approximately ten to fifteen percent of people have a reoccurrence of a herniated disc at the same level?

MR. PFLUGER: Objection.

THE COURT: Overruled.

A Again, if it's post the surgery, then, yes, it's about ten to fifteen percent of reoccurrence, meaning, if you have done a discectomy there is a chance of ten to fifteen percent of reoccurrence.

MR. BROWN: Officer, please mark this for I.D. only.

(Whereupon, a photocopy of a section from the witness's website dealing with cervical disc herniation was marked as Defendant's Exhibit N for identification, as of this date.)

Q Dr. Lerman, is that a copy of a section of your website?

A Yes, correct.

Q Is that a section that covers cervical disc herniation?

A Yes.

Q And after having read that, does your website say that --

THE COURT: Sustained. You can't say does yours website say. You can ask to have it in evidence and it can be published, but you can't say does your website say X, Y, Z because it's not in evidence. You know that.

Q After reading that section in your website, is it true that ten to fifteen percent of patients diagnosed with herniated discs have a reoccurrence of a herniated disc at the same level?

THE COURT: Sustained.

Q Now --

THE COURT: One, because it's hearsay. And one, because it's asked and answered.

Q Doctor, can spinal stenosis be treated surgically?

A Yes.

Q And can spinal stenosis also be treated non-surgically?

A Yes.

Q Now, after your very first visit with Mr. Torres on April 4, 2016, did you recommend surgery?

A Yes.

Q And before making that recommendation, did you review any of the plaintiff's medical records?

A I had an opportunity to review the previous M.R.I.'s 2013.

Q Other than that?

A Just the M.R.I.'s.

Q So, just the M.R.I.'s; correct?

A Yes. That's all I needed.

Q And there were -- and all the M.R.I.'s and records

that you reviewed were listed in your report; correct?

THE COURT: That he reviewed from that time until today?

MR. BROWN: No, I'm talking about the first visit. And he said --

THE COURT: You can't mumble. You can object or you can say you do not object. You can't --

MR. BROWN: I object. It's not accurate.

THE COURT: Sustained.

Q After the first visit, you reviewed his M.R.I.'s only; correct?

A No. I had to chance to -- after the first visit, I had a chance to review other records, as well, during the whole time the patient was under my care.

Q Understood. But, at the time you wrote the report on April 4, 2016, you had the M.R.I.'s; correct?

A From the first visit I just had the previous M.R.I., the new M.R.I. and the physical exam.

Q Now, on May 17th of 2016, you performed the surgery that you went over with us; correct?

A Correct.

Q And was your preoperative and postoperative diagnosis neck pain?

A Hmm? It was cervical radiculitis, as well.

Q And did it also include a diagnosis C5-6 disc

herniation with central foraminal stenosis?

A Yes.

Q Now, Doctor, is it possible for a person the plaintiff's age, work history and body habitus to have this condition without an accident?

MR. PFLUGER: Objection to form. Anything is possible.

THE COURT: Sustained.

Q Can a person of the plaintiff's age, work history and body habitus have spinal stenosis without an accident?

A He should have symptoms prior to that but not immediately after the accident.

Q Can they have it, though?

A Anything is possible.

Q Now, in the -- you indicated earlier you did review the Beth Israel Hospital records from the surgery; correct?

A Yes. It's in my operative report.

Q Is that all you reviewed with just the operative report or did you review the records from the hospital?

A There is nothing else I needed. No.

Q And you also indicated that Dr. Avanesov was the co-surgeon; correct?

A Correct.

Q And in your operative report that is part of your chart, you can refer to it in your operative report, Doctor,

does it list the surgeon as Karen Avanesov?

A Because you have to dictate, two people have to dictate. When you do co-surgeons you have to dictate the same report. So, you might have a copy that says Avanesov surgeon and a report that says Lerman, and I have a copy listing Lerman surgeon and Avanesov co-surgeon. So, you have to have double of the dictation for record purposes.

Q Understood. At the end of the report, it would be page three --

A Mm-hmm.

Q -- it says for the closure, please see Dr. Lerman dictation for detailed closure.

A Correct.

Q Does that refer to the closure of the plaintiff's skin after surgery?

A Skin, yes.

Q And is that the part that you did?

A No. I did the whole part. It's just my dictation is more detailed.

Q And you did that exclusively, the closing part?

THE COURT: Meaning, no one else did that?

Q (Continuing) Meaning, no one else, you did that closure?

A Of course, yes.

Q And you again saw the plaintiff on May 23rd of

2016; correct?

A Let me see.

(Witness scanning documents)

A Yes, correct.

Q And again in that report, you again state that the plaintiff denies any history of trauma?

A Correct.

Q And in that report, you again state that the plaintiff has never been diagnosed with a significant problem?

A Correct.

Q And after that visit, did you again state that the plaintiff has spinal stenosis in the cervical region?

A Correct.

Q And did you again state that the plaintiff has spinal stenosis in the lumbosacral region?

A Correct.

Q Now, by the time of that visit, did the pain that you indicated on the plaintiff's calf resolve?

A The DVT?

Q Yes.

A Which note are we talking about?

Q May 23rd of 2016.

A He might still have the tenderness -- no, May 23rd, 2016, that's when he first complained of that right calf.

Q But, at some point that resolved; correct?
A Yes.
Q Now, Doctor, you again saw the plaintiff on June 6th of 2016; correct?
A One second.
(Witness scanning documents)
A (Continuing) June 6th? June 6th, yes. Correct.
Q Do you have that?
A Yes.
Q And Doctor, after that visit did you generate a report that you have in front of you?
A Yes.
Q And in that report, did you again state the plaintiff denies history of trauma?
A Correct.
Q And in that report, do you again state the plaintiff has never been diagnosed with a significant problem?
A Correct.
Q And in that report, did you also state that the plaintiff has spinal stenosis in the cervical and lumbar region?
A Yes.
Q And then you again saw the plaintiff on July 25th of 2016; correct?

A Yes.

Q And in that report, you again state that the plaintiff denies history of trauma and ever being diagnosed with a significant problem?

A It will be repeated because it's generated as part of the first entire visit so that's why it keep repeating. So, from the time he came on, this is the history and it will generate exactly the same note --

Q So, in each report does it say that?

A Yes.

Q After the July 25th of 2016 visit, did you again state that the plaintiff had spinal stenosis in the cervical and lumbar spine?

A Correct.

Q And you again saw the plaintiff on -- in December of 2016; correct?

A Correct.

Q Did you again say that the plaintiff has spinal stenosis in the cervical and lumbar spine?

A Yes.

THE COURT: You mean was it auto-populated into the record again?

THE WITNESS: It's part of the chart, yes.

Q And would that be the same for your visits of March 13, 2017 and June 26th of 2017?

A Correct.

Q So, it would be fair to say that the history is the same and the diagnosis was the same?

A Yes. The diagnosis didn't change because he still has other history and issues that --

Q Fair enough. I don't want to go through each one if I don't have to. Thank you, Doctor.

Now, the last time that the plaintiff was seen at your office was July 11th of 2018; correct?

A One second.

(Witness scanning documents)

MR. PFLUGER: Can I have the question read back?

A July 11th.

THE COURT: The last time that he saw him.

Q And Doctor, it was after that that you generated the narrative report that's dated August 21st of 2018; correct?

A Correct.

Q And you indicated that -- on direct that you didn't see Mr. Torres that day, that a physician's assistant saw him; correct?

A Correct.

Q So, the physician's assistant was not Dr. Avanesov; correct?

A No.

Q And in that report dated August 21, 2018, you address it to Williams Schwitzer & Associates; correct?

A Correct.

Q And did William Schwitzer & Associates pay you for that report?

A Yes.

Q How much?

A I think it was seven hundred dollars.

Q And at that time when you wrote the report on August 21st, 2018, at the end did you sign it?

A Yes.

Q And at that time on August 21st, 2018, did you know that this case was coming up for trial?

A I figured that it's part of the -- I didn't know if it was going for trial or not, but I know that it became a part of the legal part of that.

Q Now, in that report did you state that the plaintiff had a prior motor vehicle accident in 2013?

A Correct.

Q And you also state that he returned to work and was asymptomatic at the time of accident of February 25, 2015?

A Correct.

Q Again, did you get that information from the plaintiff?

A We also saw the Third Avenue Medical records, yes.

Q So, this is the first time that you listed it in your report dated August 21st.

Was the plaintiff untruthful to you on the prior occasion?

A No. We never had an issue. We talked about it. Why would he be untruthful?

Q But, you put it in this report without putting it in the other reports; correct?

A Because this is a more of a detailed narrative of --

Q Yes or no, you put it in this report; correct?

A Yes, of course.

Q You didn't put it in any other report; correct?

A No. I didn't feel that it was necessary for my notes.

Q And you didn't put it in the other reports because you didn't know about it; correct?

A I knew about it. I have a previous M.R.I. I gave you.

Q But, you had the previous M.R.I. when you looked at things in 2018; correct?

A No. I had the previous M.R.I. from day one.

Q Wait. You're saying that you reviewed the prior M.R.I. in April of 2016?

A Yes. And it was not significant.

THE COURT: He testified to that now two or three times on direct and cross.

Q But, you didn't list that you reviewed that M.R.I. in your report of April --

A No. It was not significant to me.

Q Now, did the plaintiff's attorney give you the information about the -- withdrawn.

Did the plaintiff's attorney give you the records regarding the 2013 accident?

A I don't remember who gave me the report.

Q And earlier we talked about secondary gain; correct?

A Correct.

Q And because the plaintiff did not tell you about any prior history of trauma, do you think secondary gain is in play in this case?

MR. PFLUGER: Objection.

THE COURT: Sustained. First of all, it calls for speculation. Second of all, the jury's recollection of the testimony controls.

But, the witness has now testified at least three times, maybe four times, that he was aware of the prior accident because he had the prior M.R.I. on the first visit. I just finished ruling on Mr. Pfluger's previous objection to that.

Q And in the July 11, 2018 visit, did you state that the plaintiff returned to work?

A Hold on one second. Returned to -- hold on one second. Just one second, I have to find that one.

(Witness scanning documents)

A (Continuing) Patient currently working and does not participate in physical therapy, correct.

THE COURT: That record is in evidence; correct?

THE WITNESS: Yes.

THE COURT: Sorry, I'm just getting a little punchy.

Q Now, and in your narrative report, Doctor, you state the records that you reviewed in a section that's called review of M.R.I. and medical records?

A Yes, correct. We went over it.

Q And you listed the M.R.I. from the back of the neck in 2015; correct?

A Correct.

Q And you listed the M.R.I. of the cervical and lumbar spine of August 28, 2013; correct?

A Yes.

Q And you indicated that you reviewed the records from Dr. Westerband and Energy Acupuncture?

A Right.

Q And you also reviewed the records from Third Avenue

Medical and Beth Israel Medical Center?

A Correct.

Q And you also indicate you reviewed records from Dr. Thomas and Jamaica Wellness?

A Yes.

Q And you also reviewed the records from Omega Diagnostic Imaging; correct?

A Correct.

Q And now did you review any of the records from Dr. Nathaniel Mazza (Phonetic)?

A No.

Q Did you review any records from a Dr. Fritz Gonje (Phonetic)?

A I don't recall.

Q Did you review any records from a Jean Baptiste Simeon (Phonetic)?

A Again, I don't recall the names.

Q Did you review any records from North Valley Medical and Dr. Capers (Phonetic)?

A I don't remember.

Q Did you review any records from Landsman Acupuncture?

A Whatever you see here is the records that I reviewed.

Q Did you review a legal file from Andrew Hirschhorn,

Esq.?

A No.

THE COURT: A legal file? Okay.

Q And Doctor, would you agree that without reviewing these records, that your diagnosis would be less than valid?

A Absolutely not.

Q Would you agree that without a review of those records, that your diagnosis would be incomplete?

A No.

Q Without a review of those records, is your opinion on the cause of the plaintiff's injuries less than valid?

A Nope.

Q Now, being a physician who wants to be accurate in his diagnosis, would you want to see those records to give an accurate opinion to the jury?

A Not necessarily.

Q Now, again, you gave an opinion that the plaintiff's neck and back problems are related to the 2015 accident; correct?

A Correct.

Q And when the -- withdrawn.

You list in your narrative report that the first time you saw the records from Third Avenue Medical was in July of 2018; correct?

A Correct.

Q Now, when you first reviewed the records from Third Avenue Medical in July of 2018 right before trial, did that cause to you question the accuracy of the information you received from the plaintiff previously?

A No.

Q When the plaintiff told you the first time you list in your report in the narrative that he had an accident in 2013, did that cause you to question the plaintiff's truthfulness?

A No. I knew he had a car accident from day one; we spoke about it.

Q Now, are you aware that the plaintiff underwent therapy after 2013 accident?

A Yes.

Q And you're aware that he had M.R.I.'s after the 2013 accident, obviously; correct?

A Yes. I said that.

Q And if the plaintiff had a M.R.I -- withdrawn.

After the 2013 accident, he had M.R.I.'s of neck and his back; correct?

A Correct.

Q And if the plaintiff had a M.R.I. of his neck and back as a result of the 2013 accident, does that mean that some physician determined that he had significant pain to warrant that expensive test?

MR. PFLUGER: Objection.

THE COURT: Can I hear that question back.

(Whereupon, the question as requested was read by the reporter.)

THE COURT: Well, the doctor already testified that he read the M.R.I. on the first visit, so sustained. If you want to ask him a question about whether it's meaningful that someone ordered that test, you can ask that question without objection.

MR. BROWN: Okay.

Q Is that significant to you that some doctor ordered the M.R.I. of his neck and back after the 2013 accident?

A No.

Q And are you aware that Mr. Torres hired a lawyer for the 2013 accident?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q Do you think that you are well informed of the plaintiff's history?

A Yes.

Q Now, in your operative report you indicate that the plaintiff had a herniated disk at the C5-6 level; correct?

A Correct.

Q Is that herniation a significant problem in your view?

A Yes.

Q Now, in your chart you indicated that you reviewed the August 28, 2013 M.R.I. of the plaintiff's neck; correct?

A Correct.

Q And that report is part of your chart and it's in evidence; correct?

A Correct.

Q And are you aware that Dr. Robert Traflick diagnosed the plaintiff with --

MR. PFLUGER: Objection.

Q -- herniation at C5 and C6?

THE COURT: Hold on, there is an objection. Stop talking. Let's step outside.

(Whereupon, an off-the-record discussion was held outside the courtroom.)

THE COURT: All right, the objection is overruled. If you can just do me a favor and restate the question.

MR. BROWN: I will.

Q Now, Doctor, are you aware that Dr. traffic lick after reviewing the M.R.I. of the plaintiff's cervical spine --

THE COURT: The 2013 M.R.I.

MR. BROWN: Yes.

Q -- on August 28, 2013, diagnosed -- gave an impression of anterior disc herniation at C3-4, C4-5 and

C5-6?

A Yes.

Q Are you also aware that Dr. Traflick gave an impression of posterolateral annular bulging at C2-3, C4-5, C5-6 and C6-7?

A Sure.

Q And are you also aware that Dr. Traflick gave an impression of posterolateral disc herniation at C3-4?

A Correct.

Q And are you also finally aware that he gave an impression of straightening of the cervical lordosis?

A Correct.

Q Now, having -- and did Dr. Traflick after reviewing the plaintiff's lumbar spine M.R.I. also give an impression that the plaintiff had a disc herniation at L5-S1?

A Correct.

Q And did Dr. Traflick also state that the plaintiff had a bulging disc at the levels of L3-4 and L4-5?

A Correct.

Q And isn't it true that you operated on a herniated disc at C5-6?

A Correct.

Q And is it true that a person can be a surgical candidate after being diagnosed with a herniated disc?

A Correct.

Q Now, Doctor, I want you to assume that the plaintiff testified under oath at his deposition at page 73, line 24, to page 74, line 4, that he had never injured his neck before the 2015 accident and he never had any treatment for his neck before the motor vehicle accident in 2015?

Can you assume that?

A Sure.

Q And I also want you to assume that the plaintiff testified during this trial that he never injured his neck before the 2015 motor vehicle accident and that he did not recall any prior treatment for his neck before the 2015 accident; okay?

MR. PFLUGER: Objection.

THE COURT: Do you have the testimony -- as to the E.B.T.'s, you can check. As to the trial, does anybody have the dailies?

MR. BROWN: No.

THE COURT: Then, the objection is sustained. The jury's recollection controls.

Q Doctor, does this make you question the plaintiff's truthfulness here?

A Maybe he didn't feel like he hurt his neck so --

Q Well, Doctor, reviewing those records, he obviously had treatment for his neck; correct?

A Yes, he did have some treatment for his neck.

MR. BROWN: Objection.

THE COURT: Overruled.

Q So, what the plaintiff told you was untrue about his prior treatment; correct?

A He never told me that he didn't have any treatment.

MR. BROWN: Objection.

THE COURT: Sustained. You're a little late with that.

MR. PFLUGER: Sorry.

Q Doctor, if the plaintiff had a herniated disc at C5-6 as Dr. Traflick opined in 2013, isn't it possible that he could have be a surgical candidate for the 2013 accident?

MR. PFLUGER: Objection.

THE COURT: If he had a herniation after 2013?

MR. BROWN: Right.

MR. PFLUGER: Is it possible?

THE COURT: Sustained as to form.

Q If the plaintiff had a herniated disc at C5-6 as Dr. Traflick opined in 2013, could he have been a surgical candidate for the 2013 accident?

A He didn't have a disc herniation.

Q And it's not possible at all?

MR. PFLUGER: Objection.

THE COURT: Sustained. You don't get to ask those questions.

Q Now, knowing that Dr. Traflick diagnosed the plaintiff with the herniated disc at C3-4, 4-5 and 5-6 after the 2013 accident, could that have been a direct cause of the plaintiff's injury and discectomy?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q Now, doctor, does seeing Dr. Traflick's report change your opinion as to the cause of the plaintiff's neck injuries?

A Absolutely not.

Q Now, you also in your narrative report talk about a future plan for the plaintiff; correct?

A Correct.

Q And you state that the plaintiff will need M.R.I.'s and C.A.T. scans of the cervical spine; correct?

A Correct.

Q And you also state that the plaintiff will need therapy, injections and medication?

A Correct.

Q Now, with regard to the injections, are you aware that the plaintiff has only seen the pain management doctor, Dr. Thomas, on two occasions?

A I know he has been seeing him; I'm not sure how many occasions.

Q Do you know if the plaintiff is currently taking

any medication?

A I'm not aware, no.

Q Now, in your report you also state on July 25th of 2016 that the plaintiff was not participating in physical therapy; correct?

A Correct.

Q And then you state that he was not participating in physical therapy on December 12, 2016, March 13, 2017, and June 26th of 2017; correct?

A Because he had financial difficulties.

Q But, he wasn't participating; correct?

A And due to the clot he cannot participate. He was participating on and off.

THE COURT: I'm sorry, I didn't understand.

THE WITNESS: Because of the DVT, you cannot do physical therapy at the time because his range of motion can set the clot off.

Q You're talking about the DVT in May of 2016; correct?

A Yes.

Q Do you still feel that the plaintiff needs physical therapy even though he is working full-time since soon after the surgery in May of 2016?

A Only if there is an exacerbation of symptoms.

Q And earlier you testified on direct that you feel

that the plaintiff will probably need another surgery on his neck in 2020 or 2021.

Do you remember giving that testimony?

A '20, 2025, correct.

Q Did you speak to the plaintiff about this future plan?

A I spoke to the plaintiff even before doing the first surgery. It's not an if, it's a matter of when he is going to have another surgery.

Q Now, in your report under future plan, do you also write with regard to the surgery "if the symptoms worsen"?

A Correct.

Q So, you're not certain if he needs future surgery, it's something that he may need; correct?

A As was mentioned earlier, it's not a matter of if, it's a matter of when.

Q So, then you do state if the symptoms worsen he needs surgery; correct?

A Correct.

Q Now, you also state that the surgery would cost an estimated seventy thousand dollars; correct?

A Correct.

Q Is that in today's dollars?

A I'm not sure I understand.

THE COURT: Meaning if the surgery was done today,

would it cost seventy thousand dollars?

THE WITNESS: No. We're talking about future. So, if the surgery is done today it will probably be twenty percent less depending on inflation.

Q Did you put that in your report about what you just said inflation and today's dollars?

A No, I didn't put it in the plan.

Q You also state it would cost an additional one hundred thousand dollars for hospital fees, anesthesia, implants, and room and board; correct?

A Correct.

THE COURT: Stop. We're going to take five.

MR. BROWN: Okay.

THE COURT OFFICER: Ladies and gentlemen.

(Whereupon, the jury exits the courtroom.)

THE COURT: Sir, you remain under oath.

(Whereupon, a recess was taken.)

THE COURT OFFICER: Ready for the jury?

THE COURT: Yes.

THE COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Okay, you can all be seated. Thanks.

BY MR. BROWN:

Q Now, Doctor, earlier I asked you about the cost that you associated with the surgery that you think the

plaintiff needs; correct?

A Correct.

Q In your report, did you list any source for those costs, how you arrive at that figure?

A What it is about right now, the cost of the surgery?

Q In your report did you put where you found it or --

A No, I did not. I'm not a financial planner.

Q Do you have any proof with you today of what the charge was for the plaintiff's surgery in 2016?

A No, I don't.

THE COURT: Is he carrying the proof with him?

Q Do you know what you charged him in 2016?

A I'm not the billing department; I don't know the answer to that.

Q Now, earlier again you indicated that the plaintiff would need pain management; correct?

A Correct.

Q And I believe on direct you indicated that you're aware the plaintiff had only one epidural steroid injection to his neck since this accident; correct?

A Prior to surgery, correct.

Q Right. Yes.

Now, because he only had the one injection in 2015 before the surgery, isn't your estimate for future epidural

injections speculative?

A No.

Q Now, I believe in answering my question you said you are not a financial planner; correct?

A Correct.

Q You're a doctor licensed to practice in New York; correct?

A Correct.

Q You are not an economist; correct?

A No.

Q Did you discuss these costs with the plaintiff?

A No.

Q And do you feel that your plan is accurate even though you haven't seen the plaintiff since June of 2017?

A Yes.

Q Now, Dr. Lerman, on direct you said if you put ten different radiologists in a room and those ten radiologists looked at a M.R.I., you can get ten different opinions; correct?

A Correct.

Q So, is it fair to say that one or some of those radiologists could be right?

A There is no such thing.

Q Okay. Could some be wrong?

A I mean, there is definitely no such thing. They

are gonna have a different opinion of what they see. But, it would be within the same reason but it could be a bulge versus herniation, or this versus that.

Q And Dr. Traflick reviewed the surgical M.R.I. in 2013 and you did, as well; correct?

A Yes.

Q And is it fair to say that Dr. Traflick can be right?

A We're not saying he's right or wrong here.

Q Is it fair to say that reading that M.R.I. from 2013 that you could be wrong?

A I rely only on my own reading.

Q Now, on direct you also said that the only real way to see a condition of a person's spine is to see it with your own eyes; correct?

A Correct.

Q And is it accurate that the only thing that you can be certain about is what you observed about the plaintiff's neck on the date of May 17, 2016 when you did the surgery?

A I'm not understanding your question.

Q On May 17, 2016, that was the only time that you actually saw the plaintiff's spine, correct, with your own eyes?

A You mean when we did the surgery? You mean the patient's discs, and the patient's nerves, and the patient

spinal cord?

Q Yes.

A Yes, that's the only time besides the M.R.I.

Q Wait. That's not what I asked you. The only time you saw --

THE COURT: That actually is what you asked.

Q (Continuing) The only time you saw it with your own eyes was during the surgery; correct?

A No.

Q He only had one surgery; correct?

A Correct. But, I saw it first on the M.R.I. and then confirmed it with seeing it directly --

Q I'm not talking about through a film, Doctor.

I want to know the only time you saw it with your own eyes without the benefit of films was on the date of the surgery?

A Yes.

Q So, is it fair to say you can't be sure of the condition of the plaintiff's spine anytime before that?

A Yes, of course. I saw the M.R.I. before.

Q But, you can't be sure because you didn't see it with your own eyes. Can you be sure?

A No one can be a hundred percent sure.

MR. BROWN: Thank you, Doctor. I have no further questions.

THE COURT: Redirect.

MR. PFLUGER: Yes, sir. Thank you.

REDIRECT EXAMINATION

BY MR. PFLUGER:

Q Sir, we were just talking about you looking at his spine.

A Correct.

Q So the jury understands, you saw the herniated disc at C5-C6; correct?

A Confirmed it, yes. With visualizing it during the surgery, yes.

Q So, we can agree that a surgeon's two eyes are the --

A Four eyes.

Q Tell us why you say four eyes.

A Because you have to always have the presence of a second spine surgeon as I mentioned earlier. Even the M.R.I. has to be done prior to surgery by two surgeons.

Q When you looked at his spine, what visual aids did you use?

A We also have a special light that you mount on your head and 2.5 times millimeter magnification loops. These are the glasses with the microscope in them.

Q So, when you saw the herniation, tell us what it looked like.

A There was a tear and as I showed in the pictures the little crabmeat that was inside of the foramen or the little window where the nerve root is impinging the nerve of the spinal cord.

Q Are you able to tell us, was it a herniation that resulted from the 2015 accident?

A You can always tell a fresh herniation versus an old herniation.

Q Tell the jury why.

A It's a soft material versus hard. If it's been there for a while, the disc becomes calcified so it becomes hard and almost impossible to remove it.

If it's a soft matter like in this case, it's not -- it's full of water and you just pull out the soft matter so you know it's acute or a/k/a new.

Q Just so we're clear, this was a herniation that happened as a result of the February 25, 2015 accident; correct?

A Correct.

Q And, sir, I want you to assume because defense counsel has informed us that he is calling Dr. Frau (Phonetic), a radiologist, and a Dr. Nicholas Post, and they both looked at the M.R.I. films for 2013. And I want you to assume they're going to tell us that neither of those defendant's doctors saw a herniation in the 2013 M.R.I.

MR. BROWN: Objection. It's beyond the scope.

THE COURT: No, it's not beyond the scope.

MR. PFLUGER: You brought it up.

A I agree with them.

Q Now, I think you wanted to tell us about spinal stenosis. What is it?

A So, spinal stenosis, steno in Latin means narrowing. So, anything can narrow the canal is called stenosis.

Stenosis in the arteries is when your arteries are narrow. Stenosis in the spinal canal is when something is narrowing, whether it's a large disc herniation, whether it's degenerative disease, or any trauma that can be compressing.

So, it not necessarily refers to spine, not necessarily refers to someone smoking, not necessarily -- stenosis in reality is just a narrowing of the canal, simple.

Q And did you formulate an opinion within a reasonable degree of medical certainty what the cause of that narrowing was?

A In this situation, yes. It's the disc herniation.

Q Okay. Caused by what?

A By the trauma.

Q Of the accident of February 25, 2015?

A Yes.

Q When you visualized the operative field and you saw

the spine located at C5-C6, did you see any degenerative disk disease with your own two eyes?

A No. He's too young for degenerative disk disease.

Q Why?

A I didn't see any degenerative disc disease.

Q And I think the Court mentioned auto-populated notes.

THE COURT: Auto what?

MR. PFLUGER: Did you say auto-populated notes?

THE COURT: No, he said it. And he said it would auto populate. So, the fourth time when the question got asked, I said the same auto-populated notes that he mentioned. It's not my term.

MR. PFLUGER: Your Honor, I'm sorry.

THE COURT: No, it's okay. I just want the record to be clear and I want the jury to be clear, I'm just trying very hard. And I don't want to make up terms, I just want to repeat things that are said in response to objections.

MR. PFLUGER: You're a big man, but you're a soft-spoken person.

THE WITNESS: It's just my voice right now.

BY MR. PFLUGER:

Q So, what does that mean? Because counsel kept reading the note --

A Instead of going back to every time to the first note, you have from the beginning it generates the same note. So, you can add to it in your first half all the new stuff that's going on, but at the same time you can refer to all the stuff that's been there from day one.

MR. PFLUGER: Thank you, sir.

THE COURT: Any recross?

MR. BROWN: I have none. Thank you, sir. Thanks for being here.

THE COURT: Plaintiff have anything further?

MR. PFLUGER: No, sir.

THE COURT: Do you have any other witnesses?

MR. PFLUGER: No, sir. Plaintiff rests.

THE COURT: Thanks. I assume -- I know that you plan to call witnesses. You're going to start doing that on Wednesday; correct?

MR. BROWN: That's correct, your Honor.

THE COURT: So, ladies and gentlemen, you have now heard all of the plaintiff's case in chief which I described to you would happen during the opening charges I gave you.

When -- we're going to go off tomorrow, as I mentioned, all day. And when we come back, it will be defendant's chance to put on their case in chief in opposition.

And then I don't anticipate this happening, but as I mentioned to you during opening charges, at that point the plaintiff would have a right, although no obligation, if he wants to present rebuttal witnesses. But, in general, we expect it's going to be plaintiff's case, defendant's case, end of story.

And then that's Wednesday, and you'll be here Wednesday for sure, Thursday, we believe. And then the only question is whether we will be back on Friday or finished by Friday. But, my suspicion is we will be back on Friday for deliberations; okay?

And that's it. And it is my very strong goal that were gonna be finished by this Friday and that we won't carry into next week.

9:30, Wednesday. And we've got two doctors to get through on Wednesday so let's try to get a fresh start on Wednesday and that way we'll hopefully finish them both in a timely way.

Thanks very much for your work. Please don't talk to who you are not allowed to talk to. Don't do any research of what you are not allowed to research.

I look forward to seeing you then.

THE COURT OFFICER: Ladies and gentlemen.

(Whereupon, the jury exits the courtroom and the trial was adjourned to November 7, 2018, at 9:30 a.m.)