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

- -x
VERONICA MARTINEZ,
Plaintiff,

- against -

Index No.
002827/2015
TRIAL/EXCERPT

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

360 Adams Street
Brooklyn, New York 11201

March 15, 2018

B E F O R E:

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

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

WINGATE RUSSOTTI SHAPIRO & HALPERIN
Attorney for the Plaintiff
420 Lexington Avenue, Suite 2750
New York, New York 10170
BY: ANDREA V. BORDEN, ESQ.

PICCIANO & SCAHILL, P.C.
Attorney for the Defendant
1065 Stewart Avenue, Suite 210
Bethpage, New York 11714
BY: JESSE M. SQUIER, ESQ.

MIRIAM KAPLAN
Senior Court Reporter

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

DIRECT EXAMINATION

BY MS. BORDEN:

Q Good morning, Dr. De Moura.

A Good morning.

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

A Yes, I am.

Q When did you become so licensed?

A I believe 1996.

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

A Okay. It goes way back. First, my father was an orthopedic surgeon, so I followed in his footsteps, went to the Chicago Medical School in 1990, graduated.

I then decided to become an orthopedic surgeon, so I did my residency. So you go to college for four years, medical school for four years, then residency is another five years to learn about orthopedic surgery, which is basically surgery on bones and muscles throughout the entire body.

And then I decided to specialize one more year just on the spine. So I do spine surgery at NYU.

Q Okay. Doctor, what is the difference between a general orthopedic surgeon and a spinal surgeon?

A So my practice now is limited just to the spine. So I operate on people's necks, mid back and low back areas. If I wanted to, I could do hip replacement, knee replacement, things like that, which is sports medicine, which is what a general orthopedic surgeon does. But I specifically just focus my practice on the spine.

Q All right. Are you board certified?

A Yes.

Q In what?

A Orthopedic surgery.

Q Can you tell us a little bit about your current practice as it is today?

A So I'm the Director of the New York Spine Institute. We are comprised of three spinal surgeons. We have a large facility on Long Island with offices in all the boroughs. Our practice is dedicated just to all problems related to the spine. So when patients have spinal complaints, back problems, neck problems, we could treat them with physical therapy, pain management. We have MRI, X-rays onsite.

So we try to give a comprehensive center where patients can be treated with any problem related to the spine. And if all else fails, surgery's an option.

Q And you have hospital affiliation?
A Yes.
Q What is that?
A I'm affiliated with NYU in the city, St. Francis hospital, Mercy Interfaith Medical Center, Winthrop Hospital in Long Island, and some hospitals in New Jersey also.
Q Doctor, as part of your practice are you sometimes asked to come and give testimony in court regarding care and treatment that you provided to some of your patients?
A Yes.
Q Doctor, have you and I ever met before preparing for this trial last week?
A No.
Q Have you ever testified in a case in which I was the trial attorney?
A No.
Q Are you being compensated for your time here today?
A Yes.
Q How much?
A $10,000.
Q Okay. What did you have to cancel to be here with us this morning?
A 60 patients.
Q I won't have you start from scratch and explain the anatomy of the spine to us because we heard about that two

days ago, Doctor, but can you tell us a little bit about a herniated disc. What is a herniated disc?

A So basically the spine is made up of little bones. If that was not the case you'd have one solid bone and it would be very stiff. So the bone basically supports the entire human skeleton, and it also allows the brain to communicate with the body via the spinal cord and nerves that come out of the vertebras.

So in order to make the spine flexible there's something called a disc. The disc acts like little shock absorbers. There's soft structures between each of the vertebra.

Just imagine a jelly donut. If you squeeze it hard enough the jelly comes out. That's something that can cause pain. If that jelly material pinches a nerve, I'm sure you've all heard of sciatica, when you have pain shooting down your leg.

So there's certain processes that can cause a person to develop a herniation and damage to the disc, and when that happens it's very painful.

Q Can a herniated disc be caused by trauma?

A Yes.

Q Can it also be caused by the general aging process or wear and tear?

A It could.

Q All right. Doctor, generally speaking, how do spinal surgeons go about treating patients with herniated discs?

A Primarily, I can easily break it down into two main options for the patient. If the patient gets a herniated, it's not like jelly, it's more like crab meat. It has a consistency to it. If you have a herniated disc in your lower back and you just have leg pain, then you can pretty much undergo a small surgery where you go in and take out that material that pinched the nerve. It's like going in and taking the jelly that's coming out of the doughnut. And then the patient goes home the same day.

If the patient has mechanical back pain because the disc itself is causing a lot of pain, then you have to take out the jelly and the doughnut. If you do that, just imagine that would be in the between the vertebras, they would grind against. To prevent that grinding, help the person with the back pain, we can do something called a fusion where we actually make the two bones grow together. Once they grow together they don't have that friction anymore.

Q All right. Doctor, at some point did Veronica Martinez become your patient?

A Yes.

Q When did you first see her?

A I don't have the --

MS. BORDEN: I spoke to counsel. We have no objection to moving your chart in as Plaintiff's Exhibit 5.

MR. SQUIER: No objection, Judge.

THE COURT: All right. The records of this doctor, is that what that is?

MS. BORDEN: Yes.

MR. SQUIER: Yes, Judge.

THE COURT: It will be in evidence without objection as Plaintiff's Exhibit Number 5.

(Whereupon, the item referred to as Plaintiff's Exhibit Number 5 was received in evidence.)

A I saw the patient back in 2015.

Q Okay. And was that in December of 2015?

A Yes.

Q All right. By the way, how do you generally speak to your Spanish-speaking patients? Do you use an interpreter?

A No, I speak in Spanish.

Q All right, okay. So when you first saw Miss Martinez did you review her MRI films from 2014?

A Yes.

Q All right.

MS. BORDEN: I'd like to have the 2014 MRI

marked as Plaintiff's Exhibit 6.

MR. SQUIER: No objection, Judge.

THE COURT: I'm sorry?

MR. SQUIER: No objection.

THE COURT: You're moving it into evidence?

MS. BORDEN: Yes.

THE COURT: All right. The MRI disc will be in evidence without objection as Plaintiff's Exhibit Number 6.

(Whereupon, the item referred to as Plaintiff's Exhibit Number 6 was received in evidence.)

Q Doctor, as an orthopedic spinal surgeon do you have expertise in reviewing and reading MRI films?

A Yes, I do.

THE COURT: Diane, we just admitted an exhibit into evidence, Plaintiff's Exhibit Number 6.

THE COURT OFFICER: Okay, thank you.

Q I'm just gonna show some images up to show you what we're talking about.

MR. SQUIER: Judge, could I just have permission...

THE COURT: Yes, wherever you're comfortable.

Q Let's start with this view.

MS. BORDEN: Your Honor, could I ask that we dim the lights?

THE COURT: Is that necessary? I think you could see it.

Can you see it, Doctor?

THE WITNESS: Yes, sir, yes, sir.

THE COURT: Then we don't need to dim the lights.

Q Okay. Doctor, what are we looking at here in this view?

MS. BORDEN: May the doctor come down?

THE COURT: You could step down, Doctor.

A So this is what an MRI looks like. MRI's are for looking inside the body, for looking at soft tissue, so muscles, nerves, discs, things of that nature. X-rays show bone, and CAT scans and X-rays we would take if we want to see hard structures. So in this case the patient has a soft tissue injury and we get an MRI.

Looking here, these are the vertebras. This is as though we sliced you in half and we're looking at you from the side. Each one of these are vertebras. There are five of them in the lower back. And this is the sacrum, which is the tailbone. So this is five, four, three, two, one.

These discs, if you could see, are white. And just imagine buying a plump, fresh doughnut today at Dunkin Donuts. It's gonna be nice and soft. If you keep it on

your table, probably in a couple of days it's gonna be very hard. It loses its water content by getting hard. It then becomes hard and almost like brittle.

So in the human body the same thing can occur. When the disc loses water it starts to turn black. And we can see that this disc here is not normal compared to these other discs. This is the back of the spine and is actually the skin lying down on the table. So this tissue here, you could see, it's very smooth here, but here it looks very irregular. There's a lot of scar tissue there. And that's because something was done there in the past which is the patient had surgery in the past.

Q Okay. And Doctor, when we're looking at the disc, specifically at L4/5 in this view here, other than it being dried out, do you see any abnormalities with the disc itself?

A Not so much on this view. This view pretty much shows that the internal structure of that disc is not normal compared to the disc next to it.

Q Oh, okay. Let me show you a different view from that same MRI.

Doctor, how about this view? Tell us what we are looking at in this view?

A Here we're looking at almost a bird's eye view. Imagine you're lying down getting this test done. And this

picture is looking from your foot up to your head. This would be your back on the table. These are the muscles around your spine. This is the bone which is the vertebra, and the white portion is the canal that carries all the nerves from the brain down through the vertebras to the body. So this is like a sack of water. And because it's white, white is water. Water is white on MRI. And inside that just imagine spaghetti strands inside a water balloon. That's what it looks like in the lower part of the spine where the nerves travel through that area.

So here on this side -- so since we're looking from the foot to the head, the patient's lying down, this is right and is left.

You could see here there's bone here but there's not here. This looks different than over here. This is actually a little joint in the spine where the vertebras meet. This vertebra's intact. It's no longer here because that's where the patient had surgery before.

Also you could see something protruding down here. Imagine where my finger is. If I move my finger, there's something here. And that disc can pop out. Imagine the jelly that came out of the doughnut, and that's what occurred after this accident.

Q So what we're looking at here after this accident is a herniation at that L4/5 disc?

A Yes.
Q Now let me ask you. You said there's a joint down there?
A Yes.
Q Is that called the facet joint?
A Yes.
Q One type of aging is called facet joint hypertrophy?
A Yes.
Q Do you see any of that here?
A No.
Q Let me go back and ask you about that. This view, you said that the disc at L4/5 is a little dried out. Do you see any other age-related changes such as spondylosis or bone spurs?
A I really don't see much there.
Q Do you see any other type of degenerative changes such as spondylolisthesis?
A No.
Q How about the height in between the disc, how does that relate to age-related changes?
A The patient still has good height there.
Q So what does that mean in totality with respect to how her spine has deteriorated by this point?
A So the patient had prior surgery. That level is

not normal compared to the other levels next to it. So that one level between number 4 and 5 has deteriorated over time. So we know that she had some degeneration but nothing major that's really showing up on the X-ray right now or MRI.

Q Okay. Thank you, Doctor.

I want to ask you something right now, Doctor, about your first visit when you saw Miss Martinez.

Did you perform an examination of Miss Martinez at that time?

A Yes, I did.

Q What did your examination, specifically with respect to the low back, reveal?

A My examination showed that the patient had tenderness.

THE COURT: Counsel, why don't you put the screen down if you don't need it anymore.

MS. BORDEN: Okay, thank you. We'll come back to it though, I'm sorry.

Q I'm sorry. Go ahead, Doctor.

A So there was tenderness when I touched the patient in that area. There was also muscle spasm, which means the muscles are very tense. You can't control muscle spasm so someone can't fake that. There was also decreased range of motion which was showing she had pain when she would move in that area. Also, neurologically testing the nerve function

as to how the muscles work, she also had specific weakness of pulling the foot up. And that's very important because that indicates the nerve part of the sciatic nerve that comes out of the spine that goes down the leg is not working properly so that the foot doesn't have full strength.

Q What treatment had she already undergone since the accident in August of 2014 until that first visit when she saw you?

A So usually most patients come to me as a last resort because I just do surgery. And this patient had undergone conservative treatment before this and she had failed conservative treatment, meaning that everything she had done up until the point she had seen me really didn't help her. So she had physical therapy, she had injections, she had this percutaneous discectomy procedures. She also had another procedure where they tried to heal the perimeter of the disc itself. So all these treatments did not help the patient.

Q What is the significance of the fact she had exhausted those conservative treatments when you first saw her?

A So the significance is now the patient is a surgical candidate, or if they don't want to have surgery they have to live with pain the rest of their life.

Q And what did you recommend following that first

visit?

A Well, I recommended we get some new films.

Q All right.

A But I had in mind that the patient was gonna require surgery at that level between fourth and fifth level in the low back area.

Q Did you take new films at that time?

A I believe we saw her back.

Q And did those confirm your diagnosis?

A Yes.

Q All right. What did you know about her surgical history at that point with respect to her low back?

A So I knew that she had a prior surgical history where we just looked on that MRI showed you she had jelly that was taken out of the doughnut for her condition in the past. That was over four years before this accident, and she was doing fine for four years with no problems.

Now we have the accident in question, and since that time the patient started developing severe back pain and sciatic pain, underwent conservative treatment which did not help her.

Q Doctor, somebody who has already had a prior injury at that level, a prior microdiscectomy and laminectomy, is that person more susceptible to a new injury at that level if they're in an accident?

A Yes.

Q You saw Miss Martinez several additional times before she underwent the surgery. Did her range of motion or her surgical exam change during that time?

A No.

Q Prior to performing the surgery did you have a diagnosis as to what was wrong with this patient?

A I felt the patient had a re-disc herniation, mechanical back pain and sciatic pain.

Q Do you have an opinion to a reasonable degree of medical certainty as to what the cause of that reherniation with mechanical pain and sciatic pain was?

A Yes, I believe the accident on August 30, 2014 is the accident that caused her to have these symptoms develop after that accident.

Q Doctor, I want you to assume that we heard testimony from Dr. Reyfman two days ago that prior to Miss Martinez being under your care he performed a discogram where he actually injected that disc at L4/5 with contrast material, saw it leak out, and visualized for himself the annular tear of the disc at L4/5.

Doctor, assuming that that's what Dr. Reyfman said, does that have an effect in your opinion in this case?

A Yes.

Q What is that?

A It further strengthens my opinion that the damage that he saw when he did his test came from this accident.

Q And why is that? What is the significance of the annular tear?

A So imagine a steel belted tire. A tire nowadays have steel belts on them. Eventually the steel belt can fray. When these steel belts fray they create weakness in the side of the tire, and sometimes you get a blowout of a tire, and that blowout occurs because the steel fibers break.

In the human body we have collagen fibers. And these collagen fibers are like steel belts on a tire. If they get a rip or a tear, that weakens the side of the disc itself and then that could be an area where more disc material can come through it.

But also, when those little fibers rip it's very painful because there are nerve endings that go in there. I don't care if I put a little splinter in the bottom of your feet or in the tip of your finger, that little splinter is very painful. Because of all the nerve endings in the tip of your finger, you can feel that little piece of wood even though it's a little tear in your finger.

The same thing could be felt inside the human body. When that disc is damaged or ripped, you can feel severe pain, and that's what this patient experienced.

Q Doctor, before we talk about the surgery that you performed itself, can you tell us what the purpose of it is?

A So the purpose of my surgery, because as we all know, the patient did not get better from other treatments, the goal of my surgery was to make the fourth and fifth vertebrae grow together so they would become one bone and then the patient would not have friction in that area that causes the pain.

Q Okay. Is that a guarantee of pain free after surgery?

A No. I tell all my patients, I'm not God, but usually with my experience and in my hands we probably usually get about a 90 percent success rate. And then the fusion rate is usually in the 90 to 95 percent success rate that the bones will grow together.

Q Okay. Doctor, were there any other good treatment options available to the patient prior to the fusion after she had exhausted all that conservative treatment?

A No.

Q I want to walk through the surgery that you did itself. And I have a diagram here, Doctor, that I've already shown defense counsel and he does not have objection.

Doctor, does that diagram fairly and accurately depict the surgery that you performed?

A Yes.

Q All right. Would you mind coming down, with the Judge's permission, show the jury what it is that you did?

A So here we see the first picture which shows the spine when I have the patient facing down on the table. And we need to get into the spine. So I need to make an incision, go down to where I feel the bone, which is in the back of the spine. Then we take the muscles off that area so I can actually work on the bone. The goal of the surgery, I want the bones to grow together. We know the fourth and fifth area is the ones that have been damaged and that disc in between it is the culprit. So my goal was that if I make those two bones grow together, they become one block of bone and then they won't have that friction that causes pain for the patient.

So, as I said, we come down to the spine here at the fourth and fifth vertebra. The muscles have been spread to the side.

I then prepare the bone. The way bone will grow together is if you take off the surface of the bone, then the bone cells underneath are exposed and available that they will actually then start to migrate, eventually they will grow together.

If you're building a model airplane, anybody ever done that, with little boxes of wood, if you put the

little pieces of wood together they probably will stick together after a couple of hours. If you put a clamp on that piece of wood, the piece of wood will then further stick together. That's the reason why we need screws and rods inside the human body, to give it a better chance to heal.

In the old days, if you broke your arm they probably would put new a cast. That cast holds the two bones still that are broken, that then allows them to grow together. Nowadays we put plates and screws on broken bone. It's the same idea. When you have two fresh ends of bone that need to grow together, if you hold them still with a plate or screw, those bones will grow together.

And the same thing here. We then put screws into the human body and rods that connect it. We can see here on the X-ray, this is what the screws look like on the rod. It's holding those two bones still which will then allow them to grow together.

We have bone graft, which is bone material we can procure from a bone bank. We sprinkle that bone around the area because we want the bones to eventually grow together, and that acts as like a scaffold for the little bone cells to grow together. So once we do this it's usually about a 95 percent chance that those bones will eventually heal.

Q All right. And doctor, just to be clear, you put in a screw in the L4 vertebrae, a screw in the L5, you connect them with a rod. And then what is this bone material?

A This is calcium. This is bone that comes from a human that has died and donated their body. That bone goes to the bone bank. The bone is processed, becomes pure calcium so there's no diseases that can be transmitted to the patient.

So by taking that little piece of bone from the bone bank, as I said, it acts like a scaffold. A scaffold is something that will allow other bone cells to grow through it and give them -- it's like a bridge to go from one bone to the other. Since we want number four to go to five, we need a bridge to allow those two bone to then come together.

Q Doctor, let me ask you this. Was any purpose or was any part of the surgery that you performed on Miss Martinez in July of 2016 to address scar tissue from her surgery six years earlier?

A No.

Q I want you to assume that the defendants intend to call a doctor whose intended testimony is that the purpose of your surgery was to deal with pathologies unrelated to the August 2014 accident.

Do you an opinion as to the accuracy of that anticipated testimony?

MR. SQUIER: Objection.

THE COURT: Subject to connection.

A Well, I feel that's inaccurate. We know the patient had prior surgery but she did well for four years. She wasn't treated, she didn't have any problems.

Now there's a point in time she's involved in the accident. That disc gets damaged again. The patient does not get better.

And it's not a matter of scar tissue, because scar tissue has been there for years. The problem now, as you know is the disc has been reherniated.

If I gave you a jelly doughnut, like I said before, and you squash it, a little bit of jelly comes out. If a couple of days later, even though it's still dried out, if you squash it hard enough again you'll get more jelly out.

That's the problem here. The patient had trauma again to the spine. That disc reherniated. It gets reinjured, develops tears in it. And all these factors put together causes that disc to be the culprit to cause pain for the patient.

Q All right. Thank you, Doctor.

Doctor, you took post-operative X-rays. I

just want to show the jury your post-operative X-rays. They're part of your chart.

All right. Doctor, we're looking at a post-operative X-ray that you took?

A Last week.

Q Sorry?

A Last week.

Q Okay, yes. This one isn't last week's though, this was immediately after.

THE COURT: All right. Are you testifying or is the doctor testifying?

MS. BORDEN: I'm sorry.

Q Doctor, can you tell us what it is that you're looking at here?

A Here we're looking at X-rays, which, as I said earlier, is to look at bones. And the X-ray shows two objects there that are not normally in the human body. This is an X-ray taken after surgery. We can see that there are two screws, one screw into L4, another screw into L5, and there's a little rod, a little bar between the screws that hold that segment together. So this shows what we put into the human body, the hardware after the surgery.

Q Doctor, are those screws and that rod going to stay in Miss Martinez's spine, that cadaver, bone graft going to stay in her spine forever?

A Yes.

Q All right. Doctor, how many times did you see her on follow up?

A Multiple times.

Q All right. Doctor, did she ever regain that loss of range of motion she had in her lower back?

A No. She lost that range of motion in that segment. We fused that segment, so that's lost forever.

Q Doctor, the last documented range of motion that you have, could you tell that to us, what's normal versus what you found?

MR. SQUIER: Can we have a sidebar?

THE COURT: Come up.

(Whereupon, an off-the-record discussion was held at the bench.)

THE COURT: Continue, counsel.

Q Doctor, I'm just looking for you to explain to the jury the last range of motion that you found versus what is normal range of motion for the lumbar spine?

A So even if you do it yourself, if you bend forward at the waist, you probably can bend about 60 to 90 degrees forward. Bending sideways, you could probably move about 45 degrees to the side. So I quantify that the patient had over 50 percent loss from being able to bend normally forward versus what she has to deal with. So there is a

significant loss of motion that the patient is experiencing.

Q And Doctor, would you qualify that loss of range of motion as mild or minor or slight?

A No; significant.

Q Okay. Doctor, following your fusion surgery did the patient report to you radiating pain down her left leg?

A Yes.

Q And what is the reason for that from a medical perspective?

A Well, what's important to note, we put screws on the left side to hold that area still. She had right leg pain before. Now, as I said, the goal of the screws is to hold the bone still until the bone heals together. So it's a race of time. Any metal will break. For example, you take a metal hanger and keep bending it, it will break, but if you hold the metal still it doesn't break.

So there is motion when we leave the operating room in that area. If the bones grow together solid, which I said is about a 95 percent chance, the patient will then develop a solid union and the screws won't toggle or they won't break.

In this instance I believe the patient does not have a solid union and those screws are toggling in there, and I think that's why she's developed these new symptoms of opposite side new leg pain and continued back

pain.

Q What does that mean for her going forward, for Miss Martinez moving forward that she has this toggle in this looseness of screws?

A One, she's gonna require more surgery at that level to try to get those bones to fuse. I might have to go to the front of the spine now to get the bones to fuse. That's a problem for her.

Q Doctor, let me ask you this question. Do you have an opinion to a reasonable degree of medical certainty as to whether Miss Martinez sustained a significant limitation to her lower back as a result of the accident on August 28, 2014?

A I believe she did.

Q All right. What is that opinion based on?

A It's based on the fact she was doing well before, it's based on the fact that the studies that we saw after the accident that showed new injuries, based on the fact that she had an area that ultimately required spinal surgery, and also based on the fact that she still is going to require more surgery.

Q And Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether or not Miss Martinez sustained a permanent, consequential loss of use to her lumbar spine as a result of that accident?

A Absolutely.

Q And why is that?

A Because, as stated, the patient lost motion forever at that area. She had to undergo a major spinal procedure and she still is being treated.

Q And to a reasonable degree of medical certainty what was the need for that spinal fusion that you performed?

A Based on the facts that the patient had incapacitating mechanical back pain at that level, and the goal of the surgery was to stop that motion to allow those bones to grow together and become one bone where they would not have further striking against one another.

Q So the fusion surgery itself does what to that segment?

A It takes away motion.

Q Permanently?

A Permanently.

Q Doctor, I want you to assume that we heard from Miss Martinez that after your surgery her back felt a little better but that she still has continuing back pain, continuing loss of motion in her back and continuing pain down her left leg. Is that clinically consistent with her picture, in your medical opinion?

A I believe so.

Q And Doctor, to a reasonable degree of medical

certainty are those conditions now permanent?

A Absolutely.

Q What is her prognosis at this time?

A Poor.

Q What is she going to require in the future, to a reasonable degree of medical certainty?

A Well, first of all, she needs to get a CAT scan now. As I said, CAT scan and X-ray show bone. I need to get thin slices through the area where the bone graft is to see if the bone graft has taken.

If the bone graft is solid then she doesn't need another spine surgery at that level now. But I think since the screws are toggling in that area she will require further surgery to try to get those bones to heal. And also once we take away motion at one level it takes care of the patient, but it's not a type of procedure that will provide benefit for the entire life of the patient. Usually around 15, 10 to 15 years after that initial surgery the levels above and below, which are now doing the work for the 4/5 level, could degenerate, thus requiring more surgery at those levels too.

Q Okay. So Doctor, it's your opinion, just to sum up, to a reasonable degree of medical certainty, she may need a revision at this level and then another fusion either at a level above or the level below; is that correct?

A That's correct.
Q And Doctor, how much do each of these surgeries cost?
A About a hundred thousand dollars.
Q Each?
A Yes.
Q If she needs a revision in a level below and above that's $200,000?
A Correct.
Q Thank you very much, Doctor. I have no further questions.
THE COURT: Counsel.
MR. SQUIER: Thank you, Judge.
CROSS-EXAMINATION
BY MR. SQUIER:
Q Good morning, Doctor.
A Good morning, sir.
Q How much did the surgery that you performed cost?
A I'm not sure. Probably hospital cost, anesthesia, probably close to that, less 50,000, 75.
Q Why did you just tell us a hundred thousand per surgery?
A That's the usual and customary rate.
Q Why did you cut her a break?
A I didn't.

Q Why did you tell us 5-75,000?

A This was an accident. She will have to have private insurance to cover that in the future. That's what private insurance costs.

Q Okay. Well, how did you get paid for this surgery?

A I don't remember. I believe it was a car accident, so it's usually no fault.

Q But take a look at your records.

A Okay.

Q Take a look at that April 4th record.

A April 4th?

Q Yes, sir, and the May 12th addendum to it, page four out of five.

A Yes. Addendum patient surgery denied by her insurance company with question of disc pathology at L5/S1.

Q Right. And it goes on to say you reviewed MRI requested for surgery -- is not radiographically or clinically relevant, does not require surgical intervention. Correct?

A At L5/S1. She required surgery at L4/5.

Q Why did you request surgery at L5/S1?

A She didn't.

Q Why did you request it?

A We requested surgery at that level, but the problem is the doctor who did the first surgery called the surgery

level that he operated on at L5/S1.

Q Okay.

A So that's why the insurance company didn't know. It was confusing to the insurance company.

Q Regardless, we can agree the insurance company didn't pay you, correct?

A I don't remember, sir, whether I got paid or not.

Q What's your title at the spine institute?

A I'm the director.

Q You're the director. Your main office is in Westbury?

A Correct.

Q And then you have ten other locations, right?

A Yes.

Q Okay, but you're in charge of the whole thing, right?

A Yes.

Q Okay. And you would know if you didn't receive fifty to seventy five to a hundred thousand dollars in your practice, right?

A I do about three, four hundred surgeries a year. I have my own billing staff that takes care of that thing. I pretty much take care of patients, not the billing aspect of the practice.

Q Doctor, come on. I'm at a law firm with forty

attorneys. We have a managing partner. He also has someone in charge of billing. You better believe she notifies him if we don't get paid.

MS. BORDEN: Objection; relevance.

THE COURT: Sustained as to form.

Q Doctor, are you telling me that if you don't get paid for an operation, one of these three to four hundred surgeries that you will perform, your billing manager doesn't say to you, hey, by the way --

A Not that I'm aware of, no.

Q What's the name of your billing person?

A Sandra.

Q How long has Sandra been working with you?

A At least eight years.

Q In those eight years she never once come and said, we've got a problem, we need payment on that?

A I have a COO managing the practice, I have an office manager, manager of billing. They take care of all that.

Q Okay, okay. So it's your testimony you don't know how you got paid for this surgery, but we can agree the insurance company didn't pay for it; is that right?

A Evidently, my notes say that the insurance company denied -- no fault insurance company denied that insurance for this surgery, yes.

Q Okay. So is it possible you haven't been paid for the surgery yet?

A It's possible too, sir.

Q Okay. So is it possible you're waiting for an award potentially in this case to get paid for the surgery?

MS. BORDEN: Objection to form.

THE COURT: You could answer the question, Doctor.

A Like I said, sir, I'm not aware whether I got paid or didn't get paid for it, this surgery. My standard in my practice is to treat patients as a doctor, not as a business man.

Q Come on, Doctor. If you weren't a businessman why would you have eleven locations spread out all over Long Island and New York?

MS. BORDEN: Objection.

THE COURT: I'll allow it.

A We are the premier spine institute in New York, the New York Spine Institute. I have two other spinal surgeons, along with pain doctors. I don't go to all ten locations. I go to probably Long Island, Queens and Manhattan locations.

Q Okay, so there's at least two other spinal surgeons, correct?

A Yes.

Q How many pain doctors?
A One.
Q One, okay. Any other doctors on staff?
A Doctor of physical therapy, we have a doctor of psychiatry.
Q What about radiology?
A And a radiologist.
Q One or more than one?
A One.
Q How many MRI facilities do you have?
A I only have one MRI.
Q Is that in Westbury?
A Yes.
Q How many support staff do you employ?
A 30 people.
Q Okay. Over the eleven offices?
A Yes.
Q Okay. Everybody has to get paid, right?
A Yes.
Q So you would agree with me this is a business and you're in your business to make money, correct?
A I'm in the business to help people, like my father did.
Q Okay.
A But I have to make a living, yes.

Q If you weren't making money would all of your employees volunteer to work for you for free?

A No.

MS. BORDEN: Objection.

THE COURT: I'll sustain it.

Q Are you familiar with the term secondary gain?

A Yes.

Q Tell us what that is?

A Theoretically, secondary gain is what the patient might have in the interest of getting a beneficial outcome from a case if they're injured.

Q Sure. Like monetary benefit, correct?

A Yes.

Q Like a lawsuit?

A Yes.

Q Asking this jury to award millions of dollars for an injury?

A I'm not asking for millions of dollars. I'm testifying on behalf of my patient.

Q Very good, Doctor, very good. All right.

You've had your New York license since 1996?

A '95.

Q When did you first open the New York Spine Institute?

A About five years after that.

Q So 2000, 2001?
A I think so, sir, yes.
Q How long have you been testifying in court?
A Probably as long as I've had patients.
Q Since '95 or '96?
A Yeah, short time after that, yes.
Q Okay. Let me ask you this. On average, how many times a year do you testify in court?
A I don't keep track.
Q Never once looked at it?
A I don't keep track. I don't make it a profession of appearing in court. I have a very busy schedule taking care of patients in my own offices and performing surgeries throughout the year.
Q Well, you said three to four hundred surgeries per year?
A Last year I did around three hundred and fifty surgeries.
Q This surgery that you did, the fusion, how long does that take?
A The surgery?
Q Yes, sir.
A It can take up to anywhere from three to six hours.
Q Okay. And all the surgeries you perform are on the neck, middle back, lower back?

A Yes.
Q So there's 357 surgeries you did last year?
A Yes.
Q Do you work on weekends, doing surgeries on weekends?
A No.
Q So that's gotta be Monday through Friday?
A I operate three days a week, see patients two days a week.
Q What days do you operate?
A Usually Monday, Wednesday, Fridays.
Q Monday, Wednesday, Friday?
A Or Tuesday, Wednesday, Friday.
Q Okay. Three days a week though, right?
A Yes.
Q Okay. So how many weeks are in a year? 52. I'll help you.
What's 52 times three?
A Times three days?
Q Yes, sir.
A 156.
Q Very good. So you've got 156 days to perform 357 surgeries?
A Yes.
Q Do you take any vacations?

A Yes.
Q How long do you take each year for vacation, two weeks, three weeks?
A I could take one vacation a year, ten days.
Q Ten days?
A Uh-huh.
Q So two weeks?
A Yeah.
Q So we've got to knock six days off of that. Now we're down to 150 days.
A Okay.
Q For 357 surgeries.
A Yes.
Q At fifty to seventy five to a hundred thousand a pop; is that right?
A I don't get all that money. The hospital, anesthesia, equipment charges.
Q All right, okay. How much do you get?
A Per surgery?
Q Yes, sir.
A Are you talking about usual and customary from a normal insurance company or no fault, worker's comp?
Q How much do you get in your pocket on the typical lumbar fusion surgery?
A How much do I get in my pocket?

Q Yes, sir.
A After my overhead, paying all the thirty employees, running all the offices, I have no idea, sir.
Q No idea?
A No.
Q Well, do you get paid when your other two doctors perform surgeries?
A Do I get paid when they get --
Q Right.
A I don't make money off of them.
Q Okay. What's the setup of your spinal institute?
MS. BORDEN: Objection.
A What are you specifically asking, sir?
Q Are you a shareholder, are you the sole proprietor?
A I'm the sole proprietor.
Q You're getting $10,000 for being here today?
A Correct.
Q Is that on top of whatever money you received to see Miss Martinez in your office?
A Correct.
Q That's on top of whatever money you received to perform the surgery?
A Correct.
Q When was the first time you saw Miss Martinez in your office, what day? I know you told us December, but

December what?

A I think it's December 7th.

Q 7 or 17?

A I have a note here, December 7th.

MR. SQUIER: Your Honor, may I approach? The first record I have is December 17th.

THE COURT: Why don't you approach the doctor's records, make sure he has what you have.

MR. SQUIER: Absolutely, Judge. Thank you.

Q Did you actually meet with her on the 7th?

A Doesn't look like it.

Q Your first meeting with her was on the 17th?

A I believe so, yes.

Q When she came to you, was she only complaining about her lower back?

A She had a chief complaint of neck and low back.

Q Okay. And you had -- well, somebody at your facility did MRI of both her cervical and lumbar spine, correct?

A Okay.

Q I'm sorry, I didn't hear you, Doctor. Is that yes? I apologize. I was rustling paper.

A I don't see the cervical. If you're telling me that, I believe you.

Q Take your time, take your time. I don't want to

rush you. Take a look at your report, your notes from December 17th, if you would.

Page three out of four under treatment plan.

A On December 17, 2015. I only have page three of three on this record here.

Q Okay. On page three of three did it say treatment plan?

A Yes.

Q Okay. What does it say there regarding cervical MRI?

A I'm awaiting the actual MRI report of the cervical spine.

Q That would seem to indicate cervical MRI was taken, right?

A Yes, I believe so, yes.

Q But what about the first page of that report under radiology. Does it say what you reviewed?

A I reviewed recent cervical and lumbar MRI dated December 15, 2015.

Q All right. There's something about evidence of disc herniation and prior surgery at L4/5, right?

A Yes.

Q How about right up above that where it says past medical history? What does it say there?

A No medical history.

Q Underneath where it says hospitalization and surgeries, what does it say there?

A No surgical history.

Q How would you get that information, from your client or actually reviewing records?

A Asking the client.

Q You told us about what she told you regarding her symptoms, how she was absolutely pain free, had no worries in the world, free and easy. All of a sudden after this accident, excruciating pain?

A Yes.

Q You're relying on her veracity, you're relying on her to tell the truth?

A Yes.

Q As you do with everyone that comes to see you?

A Right.

Q You're not a mind reader, you can't tell if somebody is exaggerating or fibbing?

A Right.

Q Where in your report of December 17th does it say anything about reviewing that October 2014 MRI of the lumbar spine?

A It doesn't. It says I reviewed the 2015.

Q Correct. Did you review any records at all other than the MRI your facility took when you first met with her

on December 17th?

A I don't recall.

Q You probably would have made a note of it?

A I could.

Q You might not have?

A It's possible. I don't recall.

Q Is it missing from your report?

A I don't recall so, sir.

Q Is it standard practice to put down what you actually review as you did with this 2015 MRI?

A Yes.

Q We could agree there's nothing in here about her prior records other than her statement she never had surgery before and your review of the 2015 MRI, right?

A Correct.

Q Okay. Did you ever talk to Dr. Barshay?

A Dr. who?

Q Dr. Barshay?

A No.

Q Do you know who Dr. Barshay is?

A I know the name but I don't know him personally.

Q How about Dr. Trimba?

A I know who he is also.

Q Did you talk to him?

A No.

Q Did you talk to Dr. Sclaris?
A No.
Q Did you talk to Dr. Reyfman?
A No.
Q Did you review any of their records?
A I reviewed Dr. Reyfman's.
Q When did you review Dr. Reyfman's records?
A I reviewed them for this case, and I believe I had the discogram result before this surgery.
Q Okay. But at what point in time did you review them? It was clearly after December 17th of 2015, correct?
A I don't recall reviewing them back at that time, sir.
Q Would you have made a note of it? Probably, maybe?
A I would think so, yes.
Q Me too. You seem like a thorough guy. I would assume they would be in here.

At any point does it show that you reviewed the actual records for her actual treatment from the other doctors that actually treated her?

Take your time.

A I don't think so, sir.
Q Okay. Thank you, Doctor.

Let me back up for a minute. I know you told us you don't recall or didn't keep track of how many times

over the last 20 years, 25 years you testified total.

When was the last time you actually testified?

A I think a couple of months ago.

Q Okay. When is the next time you're gonna testify?

A Nothing on my schedule.

Q Okay. You have somebody to keep your schedule?

A Of course.

Q So they tell you when you're gonna go testify?

A Yeah.

Q Okay, all right.

Let's go back to that December 17th of 2015 report, please. You have Miss Martinez's height and weight listed, correct?

A Yes.

Q 5 foot 1, 220 pounds?

A Yes.

Q Can we agree that a person's weight can factor into degeneration and back problems?

A It could.

Q Let's go back to the treatment plan on page three. That's where you're talking about awaiting the MRI of the cervical spine and you also say that you're already anticipating surgery of her spine, correct?

A The low back, yes.

Q The very first time you met her?

A Yes.
Q Without reviewing any records?
A No.
Q Without knowing if she actually did conservative treatment or management?
A No, the patient told me she did.
Q But you didn't see any corroboration or verification or evidence of that?
A I did not see any corroboration. The patient told me she had failed conservative treatment. She hadn't gotten better. I know she had prior surgery. I saw the MRI. I examined her. She came to me for a surgical opinion.
Q Okay. You actually put in there that you saw evidence of the prior surgery on MRI, right?
A Yes.
Q In that prior surgery what did they do to her spine? Did they remove part of the bone?
A Yes.
Q That can lead to destabilization?
A It could.
Q The procedure that you performed, what's the purpose of that again? Is it stabilization?
A No, the purpose is to hold those bones still for them to fuse together.
Q That's not stabilization?

A It adds stabilization but she didn't have an unstable spine.
Q At all?
A No.
Q What evidence do you have that those screws are toggling, besides what she told you?
A The X-ray I took last week in my office.
Q That shows -- wait. Last week in your office?
A Last week.
Q What date?
A I think I saw her Monday last week.
Q Monday of last week, okay. The same day we started picking a jury?
A I don't know, sir, when you picked a jury.
MS. BORDEN: Objection.
Q When was the last time you saw her before that?
A It looks like February of last year.
Q When did you see her before that?
A December of 2016.
Q And how about before that?
A October.
Q And before that, was it the follow-up two weeks after the surgery?
A I'm sure if you're asking me it is, right?
Q I'm not a witness. I can't testify.

A So it looks like July I saw her, it was two weeks after surgery.

Q July 25th?

A Uh-huh.

Q Okay. Would you agree with me that an MRI is a better way to view a disc and possible herniation of the spine than an X-ray?

A Yes.

Q Why is that?

A Because, as I said to the jury earlier, MRI shows disc, shows soft tissue. X-rays shows bone.

Q Do you perform annuloplasties?

A No.

Q Percutaneous discectomies?

A No.

Q Do you know what gauge needle is used for perc-disc?

A No.

Q Does the pain management doctor in your office perform those procedures?

A No.

Q How many patients do you have right now, personally?

A I don't understand your question.

Q Sure. The number of patients, how many do you

have? I know you cancelled 60 patients.

A 60.

Q Above and beyond that 60, how many more do you have?

A I have a lot of patients, sir.

Q More than a thousand?

A That I've seen over the years, absolutely.

Q No. Right now, current patients that you're providing treatment or office visits to?

A Like I know for today I had 60 patients I didn't see all that day. That's from 8:00 to 5:00 in the afternoon. I would say probably two thirds of those are follow-up patients and probably one-third of those would probably be new patients.

Q Okay. What percentage of patients do you actually perform surgery on?

A Well, if I see 60 patients a day, twice a week, as I said, roughly, I see a hundred patients a week, that's almost four thousand patients a year, and I operate on ten percent of those.

Q What percentage of -- so now we've got to a number, at least a thousand people. Was it four thousand or a thousand? I didn't hear you.

A All right. If I see about hundred patients a week with the assistance of my PA's also, so there's a hundred

patients seen a week, that's four hundred a month, that's about four thousand patients a year.

Q A year, got it.

What percentage of your patients are referrals from plaintiff personal injury attorneys?

A I really don't keep track, but based on insurance, everything is probably broken down, third, third and a third.

Q When you come into court to testify, is that generally on behalf of plaintiff's personal injury attorneys, at their request?

A Yes.

Q Like this case, right?

A Yes.

Q Have you ever testified for her firm before?

A I believe so.

Q There's nothing wrong with that. You're treating the patients who come in to testify.

A Right.

Q So remind me again, how old is Miss Martinez?

A She must be -- last year she was 33. She's probably 34, 35.

Q That first procedure she had back in 2010, she was 27 years old at that time?

A Correct.

Q Is it common or usual to see degeneration or back issues similar to what she had, in people at 27 years old with no precipitating events, no motor vehicle accident, no slip and fall, no injury?

A Is it common to see degenerative changes in a 27-year old?

Q Yes, sir.

A No.

Q Little unusual?

A Yes.

Q And the procedure where they actually took part of her bone out in 2010, like you said, that can lead to destabilization, it can also cause arthritic changes?

A You said that.

Q You agreed with me?

A I didn't agree. You asked me if there was instability there. I said no.

Q Can it cause instability, that procedure?

A Just unilateral, one side. They didn't take out enough bone to destabilize the spine.

Q Is it possible for that procedure to cause instability of the spine?

A Microdiscectomy?

Q From 2010.

A She had a hemilaminectomy.

Q What is that?

A Half of the bone was taken out and they took the disc out. That doesn't destabilize the spine.

Q They took the disc out?

A Yeah.

Q At what level?

A At 4/5.

Q Okay. So when you looked at the MRI and you were describing the dark space to us, is that because there was no disc at all there from her prior surgery?

A No. As a matter of fact, if you look at that MRI, counsel, you'll see she still has high space. I showed the jury it was high space there, it was dark. So it's like getting the jelly. In the Dunkin Donuts scenario, if you take the doughnut today and you keep it on the table for three days, if you took a little bit of the jelly out the first day but didn't eat the doughnut, it's still there three days from now.

Q You just told you they took the disc out?

A They didn't take the whole disc out. They took the jelly of the disc out.

Q Okay. So you've got an empty doughnut is what you're telling us?

A Partial empty. They didn't take the entire jelly out of the doughnut. They took the jelly that came out of

the doughnut, which I think that was causing pain. So they took that portion out in the initial surgery.

Q Okay. Did you see any jelly coming out of the doughnut when you opened her up?

A No.

Q Okay.

The range of motion measurements that you did, you testified to muscle weakness in her ankle?

A Right.

Q What about her hand or wrist? Did you find muscle weakness there?

A I don't believe that was documented.

Q Are you sure?

A No, I'm not sure.

Q Okay, let's look.

A It looks like she also had some weakness in her wrist.

Q And you actually thought she had radiculopathy in her cervical spine as well, right?

A I was focusing on the lower back, sir.

Q Right. But you agree with me that you said the patient is status post motor vehicle accident with result in cervical and lumbar radiculopathy, right?

Page three, where it says assessment.

A Yes.

Q Okay. Did you do anything for her neck?
A No.
Q When is her next back surgery scheduled?
A It's not scheduled.
Q When is her CAT scan scheduled?
A CAT scan, I gave her prescription for the CAT scan.
Q Do you do those in your office?
A No.
Q What's the difference between a subjective test and an objective test?
A One is when the patient controls something versus one they can't control.
Q Subjective would be in their control, objective is out of their control, right?
A Correct.
Q Subjective can include a lot of these range of motion tests that you're doing?
A Right.
Q Okay. If somebody's injured as a result of a motor vehicle accident for instance, there are indicators that you could see on MRI and X-rays, acute injuries or trauma, correct?
A Repeat that, please.
Q Sure. For instance, if someone like Miss Martinez were actually injured in a motor vehicle accident and MRI or

X-rays were taken shortly thereafter, you would expect to see indications of an acute or traumatic injury, right?

A You would expect to see, if there is evidence of damage, damage on the MRI. The MRI would show damage.

Q Sure. You'd expect swelling, that's something you'd like to see? Fluid, right?

A Yes.

Q Okay. You didn't see any of that in the MRI from October 6th, weeks after the accident, right?

A I saw a herniated disc there.

Q Right. Did you see any swelling or fluid buildup?

A As I said, there was a dried out disc. There wasn't that much fluid to start out with.

Q What about the level above?

A That was the level I looked at.

Q Desiccation, that's a process, as you explained to us. You used the jelly doughnut there. Really the water starts to leave the disc, they start to get dehydrated?

A Yes.

Q Dried out?

A Yes.

Q There's no way to reinflate them? You can't put the water or jelly back in?

A Yes.

Q That happens to all of us as we age, right?

A Yes.
Q You have a website, right?
A Yes.
Q And you've got a whole bunch of references in there to how it naturally happens, neck and back pain, and address those in yours too, right?
A Yes.
Q But again, 27 years old, you wouldn't expect to see significant desiccation or degeneration?
A After her surgery?
Q No, no; at all, in general?
A Well, she had surgery.
Q I'm not referring to her. In general?
A No.
MS. BORDEN: Objection; relevance.
THE COURT: I'll allow it.
A An average 27-year-old, you would not expect to see degeneration of a disc.
Q Okay. Let me ask you this. Do you have an independent recollection of actually meeting with her on December 17th of 2015?
A No.
Q Do you how many people you did meet with that day?
A No.
Q Do you type your report or dictate?

A Dictate.

Q Who types it?

A It's dragged onto a computer. It's automatic.

Q Perfect. I've got to get one of those.

When do you dictate a report, as you're doing your examination or afterwards?

A As I'm doing it.

Q The MRI that your facility did, do you take them with contrast or without?

A I don't recall. Usually after surgery is done with contrast.

Q What about before surgery?

A No.

Q You don't do it with contrast?

A Contrast is only indicated after surgery.

Q What is contrast? Tell us about that.

A So counsel is talking about contrast. Contrast is something we inject into the patient veins to give us a contrast. And what we want to contrast is if a person's had surgery and you want to see whether they have scar tissue or whether they have, let's say, just a new herniation, you give them contrast. Contrast goes into your veins. It's gonna go all over your body that has veins and arteries. And if there's scar tissue, they would theoretically -- the dye will give -- you would be able to see a difference where

the scar tissue is versus where the dye goes.

So if you inject the dye, you're gonna be able to determine whether that's scar tissue or whether that's not scar tissue. I don't know if I'm explaining that.

You understand?

So we do dye after surgery because we want to determine whether the person -- any time you cut yourself you develop scar tissue. If you have surgery, the body heals with a scar. So if you've had surgery and you get MRI after surgery, you have to get a normal MRI and an MRI with contrast. The contrast is given to the patient in order for the radiologist to look at film and try to determine whether they're looking at scar tissue or normal tissue.

Q All right. Can we agree she had scar tissue from the 2010 surgery?

A Absolutely.

Q Okay. What did you do to address that in your surgery in 2016?

A I didn't address the scar tissue. I addressed the fact she had a damaged disc and that we wanted to fuse that level to make those bones grow together so she wouldn't have that motion in that level that causes the pain.

Q Did you do anything regarding decompression?

A No.

Q Just stabilization?

A Let me review my note.
Q Please do.
A If you're asking me a question you know the answer.
Q Certainly not the smartest person in the room, Doctor, but...
A Yes. So my operation note from July 12, 2016 says that I did just the fusion.
Q Right. Okay, okay.
And how long after that did she start reporting left leg pain?
A So about three months later she started getting some pain on and off.
Q She told you she didn't have any pain in her left leg prior to that; is that right?
A Right.
Q The surgery you performed, that was done in a hospital, correct?
A Yes.
Q Would you agree with me it's a better practice to perform surgery at a hospital than, let's say, a doctor's office or clinic?
A Well, major surgery we do in hospitals. Small procedure you could do in doctor's offices.
Q Okay. Would you ever do a surgical procedure in your office versus taking your patients to NYU?

A I do all my big surgeries at a hospital.
Q Okay. So Westbury, that's on Long Island?
A Yes.
Q About what exit do you take on the Long Island Expressway?
A I don't know.
Q You don't know, okay.
A I just know how to get there.
Q Ever drive on the Long Island Expressway?
A Yes, all the time.
Q Ever go to exit 70?
A All the way out?
Q Yeah. Brookhaven?
A I guess so.
Q Okay. If you were driving back from Brookhaven, say the BQE on that Long Island Expressway, how many different hospitals would you drive past on your way down?
MS. BORDEN: Objection.
THE COURT: I don't understand the relevancy.
MR. SQUIER: I'll move on, Judge.
Q Did you ever review films, any sort of images, diagnostic images from the 2010 procedure or treatment?
A I don't think so.
Q So, there's -- when you're asked what a prognosis is, what does that mean?

A How well I think the person's gonna do.

Q And your testimony today is that your prognosis for Miss Martinez is poor; is that right?

A Yeah.

Q And your prognosis in all your reports from the whole time that you did treatment with her from 2015, '16 and February of '17 is guarded. What is guarded?

A Concerned.

Q Concerned, but not poor, right?

A Well, now that I know she might have more surgery I think it's going from the guarded to poor. I'm concerned.

Q Now that you came into testify to this regarding her attempt to get money from my clients, now you changed your prognosis to poor?

MS. BORDEN: Objection.

THE COURT: Sustained.

MR. SQUIER: I have no more questions.

REDIRECT EXAMINATION

BY MS. BORDEN:

Q Doctor, do you have the 2010 op report as part of your records?

A Yes.

Q I want to refer you to the second page of that op report. And it's in evidence.

MR. SQUIER: It is, sir.

Q They use the word on the second page of the op report. They use a word "microdissector." Did they do -- they did a microdiscectomy during that laminectomy?

A You're talking about my op report?

Q No, I'm talking about the 2010 op report. I'm sorry.

A That wouldn't be here in my --

Q Let me just give you a copy. You've seen it, correct, Doctor?

A I believe so, yes.

Q And let me just provide you with this copy for reference. They did what was called a microdiscectomy during that 2010 procedure, correct?

A Yes.

Q Meaning, they took a very, very small portion of the jelly within the disc; is that right?

A Correct.

Q All right. And let's call it by its medical name. It's not jelly. The outside is called the annulus and the inside is called the --

A Nucleus pulposis.

Q And when you went in and did your surgery -- and by the way, Doctor, let me just ask you. We used this the other day. Is this a healthy-looking disc?

A Yes.

Q And this gray part is the annulus and this part is the nucleus?

A Yes.

Q All right. And when you went in -- and this is the procedure, by the way, that was done by Dr. Reyfman before you saw Miss Martinez and before you performed your surgery.

When you went -- you were asked on cross-examination, did you see the jelly leaking out during your surgery, and you said you didn't. Why is that?

A Because I didn't want to go through all that scar tissue and further damage the -- potentially damage the patient even further. My goal was to stay away from that. My goal was to merely make those bones grow together. They would become one bone and then you don't have the friction any more.

Q And Doctor, didn't Dr. Reyfman actually cauterize or close that tear in the annulus that the jelly couldn't get out further before you ever even saw Miss Martinez?

A Yes.

Q Thank you.

MS. BORDEN: No further questions.

THE COURT: Anything, counsel?

MR. SQUIER: One question.

RECROSS-EXAMINATION

BY MR. SQUIER:

Q Just to be clear, when you cut her open and you were drilling in the spine, you didn't actually see anything leaking out of the disc, no jelly?

A Correct.

MR. SQUIER: Nothing further.

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

(Witness steps off witness stand.)

* * * *

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

MIRIAM KAPLAN
Senior Court Reporter