SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM: PART 80

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TAMARA ADAMS,

Plaintiff,

- against -

BHARATKUMAR PAREKH & ALOK PAREKH,

Defendants.

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Index No. 5273/2015

360 Adams Street
Brooklyn, New York 11201
October 18, 2021

B E F O R E:

HONORABLE GENINE D. EDWARDS,
Justice of the Supreme Court, and a Jury.

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

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AMBER SCHIANO
SENIOR COURT REPORTER

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: You may be seated.

So good morning, ladies and gentlemen of the jury. I hope you enjoyed your weekend. We're going to resume with the plaintiff's counsel.

Counsel.

MR. RUBIN: Yes. Thank you, Your Honor.

The plaintiff calls Dr. Alexandre De Moura.

THE CLERK: Please stand and raise your right hand.

D O C T O R A L E X A N D R E D E M O U R A, called as a witness, having been first duly sworn/affirmed by the clerk of the court, took the stand and testified as follows:

THE CLERK: You may have a seat.

Please state your name and business address.

THE WITNESS: Alexandre De Moura, 761 Merrick Avenue, Westbury, New York 11590.

THE CLERK: Thank you.

THE COURT: Good morning, Doctor.

THE WITNESS: Good morning, Your Honor.

THE COURT: Just keep your voice up so all the jurors can hear you.

Counsel, you may proceed.

MR. RUBIN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. RUBIN:

Q Good morning, Dr. De Moura.

A Good morning, sir.

Q As the judge said, just keep your voice up. With the mask we're finding obviously it's difficult to project your voice, but try the best you can.

So we had an opportunity to discuss this matter briefly?

A Yes.

Q Okay. And when was the last time that we spoke about it?

A You spoke to me a couple of days ago.

Q Okay. Are you a physician licensed to practice medicine in the State of New York?

A Yes, I am.

Q When were you licensed to practice medicine in New York?

A 1996.

Q And has your license been current since then?

A Yes, it has.

Q Have you ever been licensed to practice medicine in any other state?

A Yes.

Q What other state?

A Pennsylvania, New Jersey, Florida.

Q Okay. Are those licenses current?

A New Jersey and Florida is.

Q Okay. Can you tell the jury about your educational background and medical training.

A Okay. So I went to the George Washington University in Washington, D.C., obtained my bachelors after four years there. I subsequently went on to become a doctor. I went to med school, Chicago Medical School. That was another four years. After that I decided to go into orthopedic surgery. Orthopedic surgery is surgery of the bones and muscles and it's one year of general surgery following by another four years of residency. And then I decided to specialize in spine surgery and I did one added year of spine orthopedic neurosurgery fellowship at NYU.

Q Okay. Can you just tell us the years that you graduated medical school and completed this residency in fellowship.

A 1990, Chicago Medical School. Another six years training. Around '96 I finished. I then went into practice and I started at New York Spine Institute. I'm the director of New York Spine Institute. I'm an assistant clinical professor of orthopedic surgery at NYU. So I actively treat patients. I train residents, fellows, and my institute is involved with

research.

Q And what is your specialty of medicine? I think you touched on that.

A My specialty is spine surgery. That includes the neck, middle part of your spine and lower part of your spine.

Q And you've been doing that since the completion of your fellowship?

A Correct.

Q Okay. That was 1997 approximately?

A Yes.

Q Are you board certified in any area of medicine?

A I'm board certified in orthopedic surgery.

Q When were you board certified in orthopedic surgery?

A Around '98, around there.

Q Can you just tell the jury what it means to be board certified in specifically orthopedic surgery.

A After you have gone through all that training you then have to take boards and that just adds an extra level of qualifications to show that you really know what you're doing. So when you finish your training you do a written examination. That's about five hundred questions. And if you pass that that's part one of the board.

Now is the practical part to the board where you actually go into practice. You're treating your own patients now and you collect about twenty of those cases that you have

done and about two years after you've actually been practicing as a doctor you go to Chicago. You present those twenty cases. There's a board of about five orthopedic surgeons that are spine specialists and they will ask you any question they want as to why you did the case, what was the case about, what was the outcome. If you answered the questions properly and they feel that you're competent, you're now board certified and you pass part two. And then every ten years you have to be certified. I was certified three times after that.

Q I see that you're holding something in your hand, correct?

A Yes, this is the chart, my records of my encounters with this patient.

Q Okay. And this is kept in the ordinary course of your business as a physician?

A Yes.

Q Are you being paid by my firm for your time here today?

A Yes.

Q And in what amount?

A It's usually $10,000 I believe.

Q Okay. If you weren't here testifying in court, where would you be?

A I would be seeing patients that I have to see this morning or be in surgery.

Q Okay. Did you reschedule patients to be here today?
A Yes.
Q Okay. So I just want to ask you some questions about your prior times that you may have testified in court. Have you ever testified in court prior to today as an expert in orthopedics or spinal surgery?
A Yes, I have.
Q Can you approximate how many times you have appeared in court to testify such as today?
A I really don't keep track. If my patients need me I'm willing to testify for them. It's usually less than a handful per year.
MR. CRAVEN: I'm sorry. I didn't hear the answer, the last part.
THE COURT: It's usually less than a handful every year.
Correct, Doctor?
THE WITNESS: Yes, Your Honor.
Q Is it fair to say when you testified in court that they've always been on behalf of your patients?
A That's correct.
Q Okay. And they were -- and these patients were, when you testified, have been plaintiffs in lawsuits?
A Yes.
Q Have you ever testified in court as an expert for the

defense or defendant in a case?

A I don't think so.

Q Have you ever testified on behalf of any clients of my firm in the past?

A I believe so.

Q Do you know how many?

A No.

Q Is that something you keep track of?

A No.

Q Have you ever testified in any case that I handled before today?

A I don't think so.

Q I think you're right. We haven't.

But so I'm going to be asking you some questions today regarding your care and treatment of Ms. Adams and you can -- I'm going to have portions of your chart that we're going to project on to the wall. But you can feel free to review the record that you have in your hand in answering any of those questions.

So when was the very first time that you saw Ms. Adams as a patient?

A So the first time I saw Ms. Adams she came to my office on April 7, 2016.

Q Okay. And at that time where was your office?

A I have offices in all the boroughs. I'm not sure

where I saw her at this point, probably either my New York office or Long Island.

Q Okay. I'm going to put your -- so what's up there on the screen, is this is your note dated 4/11/2016?

A That's correct.

Q And that matches up with what's in your hand?

A Yes.

Q Okay. And so just going a little further in the note. It says chief complaint. What is a chief complaint?

A That's when a patient comes to you and they tell you why they're there, what symptoms they're having, what's bothering them.

Q Okay. And it was reported to you that the patient presents with a chief complaint of neck pain which radiates into the right shoulder and upper extremity?

A That's correct.

Q Okay. What does that mean, neck pain which radiates into the right shoulder and upper extremity?

A So she primarily was having pain in her neck and the symptoms were actually traveling into her upper extremity, which is your right arm.

Q Okay. Is that something that can happen for patients that have a neck injury?

A Absolutely.

Q Okay. And we'll get into a little bit about the

anatomy of that. But that's something that's from a nerve running into the arm; is that correct?

A Yes.

Q So just to go a little bit further in your note. History of present illness. This is a thirty three year-old female that was involved in a motor vehicle accident on November 25th 2014. So this history of present illness, this is information that you're eliciting from Ms. Adams?

A Yes. She's now telling me she has this problem. This is how I got the problem.

Q Okay. And then the note goes further. The patient was a restrained passenger sitting in the right front seat of an automobile. Restrained, that refers to a seatbelt?

A That's correct.

Q Okay. Vehicle was struck by a van. She denies any prior motor vehicle accident history. She denies any prior history of her present symptomology. To date the patient has exhausted conservative treatment. She present at this time is unable to work. Overall her symptoms remain unchanged. Is that what it says?

A Yes.

Q Okay. So what is the significance of a patient that's coming to you complaining of neck -- radiating neck pain that's never been in an accident prior to the one that she's presenting for and never had a history of her present

symptomology?

A So what's important here is that, number one, the patient has a problem. There's a history of how she got that problem. She was in an accident. The accident occurred almost a year and a half before she came to me. So it's not like it happened and all of a sudden she wants to do this surgery. She comes to me after almost a year and a half. She's been treated. She's done conservative treatment which includes physical therapy, injections, things of that nature. None of that has helped. What's important in the history also is she's never been in an accident before and she never had this problem before that accident.

Q Going a little further down in the note it says past medical history, no medical history.

A That means she doesn't have any diabetes, doesn't have any heart disease. There's no past medical history.

Q Underneath that it says hospitalizations and surgeries. It says cholecystectomy, right shoulder surgery.

A That's correct. She had her gallbladder taken out and she had a procedure on her shoulder.

Q Okay. And this moving down to the next portion where it says radiology. An MRI of the cervical spine dated January 29th 2015 is available for review. Now, is that referring to a report, or the images, or both?

A Usually both.

Q Okay. How would you have access to those images at that time?

A Either I can access the pictures online or the patient would bring a CD from where she had the images taken.

Q I'm going to represent to you this MRI was done at Damadian Open MRI. Is that something you would have access to at that time?

A Yes.

Q Reading a little further in this with the radiology. There's evidence of a disc herniation at C5-6 and C6-7. There are some ligamentous bulges at C3-4 and C4-5. Okay.

So Doctor, I think before we get into what these MRI results mean, it's probably a good idea to talk about the anatomy of the spine. Okay. Would it be of assistance in discussing the anatomy of the spine if I showed you some and showed the jury some medical illustrations?

A Yes.

Q Give me one second. I'm going to show you what's been marked for identification as Plaintiff's Exhibit 19. Can you explain what's shown in this diagram?

THE COURT: You can get up if you need to, Doctor. Can you see it?

MR. RUBIN: I think that it's going to block the projector if I move it any further.

A So this is an artist picture of what the spine looks

like. First of all, the spine are little bones we have in our neck, our mid-back and our lower back and in the tailbone. That's why we're called vertebrae. Each one of those little square cubes is a bone. It's called a vertebrae in the neck. We have seven of them. In the thoracic spine we have twelve of them. The lower back we have five. And then we have the tailbone. So when you hear these numbers like C1, C6, that just refers to C, meaning the cervical. If you hear T, that's thoracic which means like the mid-part of your spine where the ribs attach. Lumbar is the lower part of your back. So if I say C5, C6, that means I'm talking about the fifth vertebrae and the sixth vertebrae.

Between each of these bones we have discs. If you didn't have those discs you would have a solid spine and you would be very stiff. The spine wouldn't move at all. Just imagine the purpose of the spine. Everything in the body attaches to the spine. If it didn't, you would be an invertebrate or jellyfish. That's no spine, very soft and squishy, wouldn't be able to walk.

So the spine connects, first of all, the brain to the rest of your body. The spine allows the nerves in the spinal cord to go through it and as the spinal cord comes down the spine, nerves come off of it like branches off of a tree. Those nerves go to different parts of your body and those nerves allow your brain to sense whether you have sensation,

pain, touch, feeling, or whether you have an injury and get severe pain.

It also allows the nerves to communicate with the brain to tell your muscle to move. So when you move your biceps muscle, this muscle here, your brain sends a signal and your muscle contracts and your arm goes up. So the spine is important to provide support for the body because all your other bones, your pelvic bones, your shoulder bones, attach to the spine for that support. And then it also allows protection for the nervous system of the spine. So it's important.

As I said, we have these little structures between the vertebrae. They're discs and the disc is like a little soft structure. The best way I can explain is like a shock absorber. If we didn't have those, the spine would be extremely stiff and wouldn't move. Because we have those little discs, it allows each vertebrae to act as a different motion segment. What's important about the disc, it's also a very fragile, delicate structure.

If you think about a jelly doughnut, you go out and buy Dunkin Donuts one morning and get a jelly doughnut. It's nice and soft. If you squash it, the jelly pops out. That jelly that pops out, that's what we call a herniation. And that's what happened in this case here. When that jelly pops out -- it's not jelly in real life. It's more like crabby. It has a consistency to it. So if that material pops out and goes

into the canal, it's like having a pebble in your shoe. There's something in an area where it's not supposed to be. When that jelly pops out, if it goes into the spinal canal and it's near a nerve of the spinal cord, it's going to effect that nerve and then that nerve is going to tell the patient I got severe pain.

I'm sure everybody heard of sciatica. Sciatica is the pain that travels down your leg. Almost everybody in the world gets back pain at some time in their life, eighty percent of the population. But people who don't get better and they tried everything because this disc is pinching on a nerve, that's when they come to me and that's what happened.

Q When you say pinching on a nerve, are those nerves depicted in this diagram, this illustration?

A Here where it says nerves, pointing to this structure right here. As I said, this is the neck vertebrae. So up top here would be your cranium, your brain, and the brain comes down. It connects to the spinal cord. The spinal cord goes down the vertebrae and each branch is just like a branch on a tree or the roots coming out of the bottom of the tree. We have these nerves and those nerves serve a function, sensation, providing information back to the brain or sending signals to the body to move muscles and things like that, control your bowels, things like that. So these nerves, as they come out of the spine if this disc pops out, you can imagine how it pinches

that nerve and then the patient has pain.

Q Now, you talked about the cervical disc being somewhat like a jelly doughnut. Is there a name for the jelly of the disc?

A Yes. So the inside of that disc is called a nucleus. That's the center of a disc and the interior is called pulposus. It's a term of what it looks like. As I told you earlier, it's more crabby in consistency.

Q Is there a name for the outer part of the jelly doughnut?

A The outer part of the disc, like the dough of a doughnut is called the annulus and it has fibers in it that can contain the disc material inside. Just like on a tire, the tire is round like a doughnut and you have steel belts on the outside of a tire. Those steel belts provide integrity and strength to the tire. In the human body we have collagen fibers. That collagen is what holds the disc together.

Q Okay. I'm going to show you another exhibit. This is what we marked as Exhibit 20 for identification.

And you were explaining before a herniated disc. So here we have an image on the left and an image on the right, correct?

A Correct.

Q What is this an image of on the left?

A So here, first of all, we're looking at a vertebrae.

So the vertebrae is cut in half.

Q This is a cross section?

A Cross section. If anybody has ever had a T-bone steak, there's a small portion on the steak and then a big portion. When you have a T-bone you cut the bone down the middle. This would be the filet mignon over here, the muscle over here. And there's a big piece of muscle back here. That's the sirloin. So now you know when you eat a T-bone, you're actually eating a bone that comes off of a vertebrae.

Since this is a vertebrae we took a cross section of it. So here in the front you're going to see where the disc is and this is a portion inside the disc as you see here. That's a normal disc. Everything is contained nicely. That jelly portion is in the middle. It hasn't came out. You can see where the spine is here. That's the spinal cord and then the nerve comes out and this itself is the spinal canal here. So the vertebrae is an actual ring and the ring is drawing around. And inside the ring is where the tube travels, which is the spinal cord.

This is an abnormal disc. You can see here the disc has been damaged, and when it gets damaged this material pops out and that material is like the jelly that popped out of the doughnut. That happened because some kind of pressure was given, was transmitted to the human body, puts pressure on that disc and then the jelly pops out. When that pops out, it pops

out here. It's not a problem. There's really nothing over here, just muscle. If it pops out into the spinal canal it can pinch the nerve. Which you can see here the nerve getting pinched is red, gets irritated. It actually looks like that in real life. You see the redness. If it came in here that would go to the spinal cord and that would cause problems, things like paralysis, things like that.

Q So I just want to get back to the MRI findings.

THE COURT: Can he sit down?

Q Yes, you can sit down. I may have you get back up in a few minutes.

Okay. So in your note for this first visit on April 11th 2016 you wrote there's evidence of a disc herniation at C5-6 and C6-7, correct?

A Correct.

Q Okay. And so C5-6 refers to the disc that's between the C5 and C6 vertebrae?

A Right. Correct.

Q And the C6-7 disc refers to the disc between the sixth and seventh vertebrae?

A Correct.

Q Okay. Now, did you have an opportunity to review the report associated with this MRI study?

A Yes.

Q Okay. Who issues a report for an MRI study?

A So there's a radiologist that's a doctor that's trained to become an X-ray MRI doctor. So he reads the pictures. He documents what he sees and that's the radiology report.

Q Okay. Now, in terms of your treatment of a patient, what weight, if any, do you give the radiology report as opposed to your view of the images?

A So the buck stops with me. I'm the one that's going to be going into the person's body. I need to know what's there and what I'm going to encounter. So I read my own MRIs. I also take into consideration, of course, what the radiologist does, but I believe I'm an expert also at looking at MRIs and picking up -- I picked up things on MRIs that the radiologist has missed. So it's important to be able to read the pictures, look at the report, put them together and figure out that with the patient, what's causing the patient to have pain.

Q Now, just generally, did you agree with the findings in the report?

A Yes.

Q Okay. I'm going to pull up that report and we'll just go through that if we can. Bear with me one moment. Okay.

I'm going to highlight the first paragraph. Where it says interpretation, diffused cervical lordotic curvature. What does that mean, the very top?

A Basically the neck has to have a nice curve so it goes

this way. When you look in the X-ray you can see how the bones are lined up. So a nice relaxed X-ray will show nice curve of the vertebrae. If the neck becomes very stiff. Because the muscles are tense, you lose that curvature and you can also put the neck into what we call kyphosis, which means just a forward bend. And that's what this talks about. It says there was a forward bending of the vertebrae, which is not normal. So it's very stiff. The muscles are causing that to happen.

And then further down, once again as we discussed earlier, C refers to the cervical vertebrae and the patient has disc damages here and both levels are involved, C5-6 and C6-7.

Q What does that mean, that C5-6 posterior central disc herniation extends to approximate the ventral cord?

A Remember the picture we saw earlier, where that little pink thing popped out. That shows that the disc between 5-6 has come out and it's up against and near the spinal cord.

Q Okay. We're going to show -- I'm going to pull up those images in a bit. I want to go through the report. The next line says there's central canal stenosis present. What does that mean?

A There's narrowing of the canal.

Q And is that due to -- what is that due to?

A That's just the way the picture is.

Q Okay. It says, next line, disc adjacent osseous vertebral reactive edema was seen at this level. What does

that mean?

A Where is that?

Q Disc adjacent.

A It just show that there's irritation of the bones between number 6 and 7.

Q What is the significance of that?

A Significance of that, there's irritation going on in that area.

Q And then here it says C6-7 posterior broad based central disc bulge is seen. What is a broad based central disc bulge?

A It's that the disc is protruding out, but it hasn't ruptured out. If you think of that jelly doughnut, you start squeezing it, put pressure on the doughnut. The jelly wants to come out. As it comes out, the side of the doughnut gets a bubble in there. That's what we call a bulge. But once you have the jelly come out all the way, that's an extruded herniation. There's also different degrees of herniation, but just making it easy for you. A herniation we talk about is when a disc is ruptured. And when the disc is still pretty much where it starts out, that we call a bulge.

Q Going to the next line below that where it says -- it's partially highlighted. C2-3 through C6-7, disc hydration loss is noted with C5-6, diminished disc space height and anterior disc extension and anterior spurring. So what does

disc hydration loss mean?

A When you buy that jelly doughnut, the first day it's nice and soft. It has plenty of water in there when you mix that dough. When you keep the doughnut on the table for five days and come back to eat it, it's going to be stale. It's going to have lost some water to the environment, evaporation, in the jelly scenario.

The same thing can happen in the human body over time after an injury. This MRI was done almost two months after the injury. So the disc is no longer normal. That's what this is showing here, that that disc has lost some of its freshness, so to say.

Q Can disc hydration loss occur without an injury?

A Yes.

Q Okay. What is the significance of a patient having disc hydration loss if it's possibly before they have a trauma or injury to their spine?

A Well, if they had no symptoms, there's no significance.

Q Okay. And what does that mean, C5-6 diminished disc space height?

A So if you get a small leak on the air of your tire, the tire starts to go down. So diminishes the space between the rim and the asphalt. Same thing with the disc in your neck. The disc can lose some of that height and that's what

the radiologist is reporting there.

Q And what does that mean, anterior disc extension and anterior spurring right underneath that?

A That's what it means. It's means there's some spurring and the disc has popped out through the front.

Q Now, is there a term known as degenerative disc disease?

A Yes.

Q What does that mean?

A Over time the disc can degenerate on its own.

Q In your opinion, Doctor, based upon your review of the films, which we will get to in a moment, and based upon this report, is there any evidence of degenerative disc disease in Ms. Adams in this MRI study?

A It shows here that between C2-3 through 7, disc hydration loss is noted. That's when we talked about losing some of the fluid and diminished space at 5-6 and the spurring. That's like a little bit of arthritis that has been setting in even before the accident.

Q Now, what is the significance of that degenerative disc disease in a patient such as this who doesn't have any pain associated with it?

A That's very significant. I'm sure we all drive cars here and if you have a car with a tire, has anybody ever seen a bubble on the side of that tire? Right. We call it a bleb on

the side wall of a tire. You can get a bleb on the side wall of your tire, but you keep driving the car. It's not a problem, right. You drive it.

Living here in New York we get potholes in the winter. One day in December you're driving that car and you hit a pothole and now you get a blow out on that tire. The tire was doing fine before, had no problems, just a bleb, was doing fine. But when it hit that pothole it blew out the tire and you're stuck with a flat tire on the side of the road.

So even as a person who has had a degenerative condition in the past is doing fine, they never had complaints, never was treated, but now they're in an accident. Trauma has occurred and now that disc has popped out. So just keep that scenario about the tire. You're doing fine with it. You hit a pothole and now you get a blow out. A person can have degeneration evident on an MRI, was probably before the accident but never treated before the accident, and now at the time of the accident develops pain and the MRI now shows a herniation where that disc popped out.

Q Just using your analogy of a bleb on a tire. Does a patient with underlying disc degeneration, are they more susceptible to a disc herniation from trauma than a patient without such degeneration?

A I would say yes, probably.

Q Okay. So I'm going to pull up the MRI images. Bear

with me a moment. I'm not so sure how visible it is in this light.

MR. CRAVEN: Can you identify what we're looking at?

MR. RUBIN: Yes, I will.

THE COURT: Can we turn the light out.

Q Doctor, I'm showing you one image that was from Ms. Adams' cervical MRI from Damadian MRI on January 29th 2015. This is Exhibits -- or at least one image from Exhibit -- give me one second -- Exhibit 9.

MR. CRAVEN: Your Honor, may I ask that he identify which image from that exhibit, which one we're looking at specifically?

THE COURT: Do you have it?

MR. RUBIN: Yes. I think it should be on here.

MR. CRAVEN: Thank you.

Q Down on the bottom, Doctor, does it says images eight of thirteen?

A Yes, it does.

Q So, Doctor, what are we looking at here?

A So first we're looking at here is an MRI. Let me try to give you an idea what an MRI is. MRI stands for magnetic resonance imaging. X-ray is just a beam of radiation that gets thrown through the body and then a picture is taken. What's important about the difference between the two, X-rays show

bones and that's all they show. So if you shoot an X-ray and then you take that picture, you're going to see where the bones are and it will look like a skeleton for Halloween. That's all you see, the bones. You don't get to see any of the soft tissue that make up the human body with an X-ray. You just see the bones, but you won't see anything here.

It looks like a ^ vacuum, just an empty space, but there's something there. That something that's there picks up on an MRI. An MRI shows soft tissue. It's going to show muscle. It's going to show nerves. It's going to show your organs. That's what's nice about an MRI. It gives you much more detail about what's in a human body.

What we're looking at here is an MRI of the patient, a side view. So up here, here are her lips. Here is the chin, coming on down to the front of the chest. Up there would be her eyes. And the brain is up here, the skull. The back of the neck coming down. You can see the base of the brain and you can see her spinal cord coming down here. So that's the cord that connects the brain to the rest of the body. These are the vertebrae number two, three, four, five, six and seven. Between each disc -- between each vertebrae is a disc. That's what we see by the white structure here. See how they're all contained. They're all within the boundaries of that vertebrae. Nothing is coming out the back. Let's look at between five and six. This is two, three, four, five and six.

Five and six, there's something coming out here.

Q Doctor, would you like me to enlarge that?

A Okay. That's a little too much.

Imagine my finger. If I put my finger here, it's right at the back of that disc. There's a space here. There's nothing touching that spinal cord. If I put my finger here on that I am now in the spinal canal. So there's something popped out here and it's up against the spinal cord. Imagine that jelly. That jelly has been squashed. The jelly popped out and now it's in an area where it's not supposed to be. Like if you get a pebble in your shoe, I don't care how small that pebble is, you know there's something in your shoe. It can be the smallest little pebble. You know there's something in your shoe. It's not where it's supposed to be and the bottom of your foot is not nearly as sensitive as your spinal canal. When something pops out of your spinal canal, you know it. You feel it and it's not a pleasant experience.

Q Is there -- I know I understand there's a different type of weighting of MRIs. Can you explain that?

A That's too complicated.

Q That's fine.

MR. CRAVEN: I'm sorry. I didn't hear the response.

THE COURT: It's too complicated.

THE WITNESS: He wants to know about the

weighting for images. There's no need for that.

Q Let me show you another MRI image if I can. This is image eight of thirteen as well, but it's a different weighting. That's why I was getting into this. Is this another image of the same study, Doctor?

MR. CRAVEN: I'm sorry. Can you identify which image?

MR. RUBIN: Eight of thirteen.

MR. CRAVEN: The same one?

MR. RUBIN: Well, it's a different image, but it's labeled eight of thirteen.

MR. CRAVEN: The other one was series 104. Is there a series in this?

MR. RUBIN: Series 103.

MR. CRAVEN: Thank you.

MR. RUBIN: No problem.

For the record this is also Exhibit 9.

A So once again this is a different MRI taken with a different sequence. You can see once again this is the second vertebrae, two, three, four, five, six and seven. Coming on down here the vertebrae are all in line. So the disc out here you see something pops out. It pops out here because there's pressure of this material, the jelly that got pushed out.

Q So that area there that's pushing out is the correlation to the same area on the prior image?

A Yes, same area.

Q Now I just want to show you one other image from the MRI.

A So here we're looking at the MRI.

MR. RUBIN: Actually, one second. This is series 104, image thirteen of nineteen.

A Here we're looking at the patient lying down on the table. Just imagine taking an Italian loaf of bread and slice it up. The first slice might be smaller. Get to the middle the slice is bigger. Same thing here. We're looking at slices through the spine going this way. This would be the muscles on the back of her neck. This is the windpipe over here, the trachea where you breath. Coming here we see now the vertebrae. Remember the bone I told you about cutting. So here is the vertebrae and here is the spinal canal. White is water. The gray is the spinal cord and the disc is in this area here. But if you come around the ends of the disc, there's something right here. Can you see that material? So that's where the jelly has actually ruptured the dough of the doughnut. The jelly here, the disc has ruptured the annulus of the disc.

Q Okay. Doctor, switching gears back to your medical record for that day. Bear with me one moment.

Doctor, the next part of your note says ROS. What does that refer to?

A Review of systems.

Q Briefly what does that mean?

A Whether the patient -- do they feel sick. Are you having fevers. Is your stomach bothering you. Does your, you know, nervous system bother you, your heart. Review of all the systems in your body.

Q Is it fair to say the review of systems was essentially negative?

A Correct.

Q Just moving on to the second page of your report. There's a portion that says ortho and next to that neurological exam UE. What does that refer to?

A So now I'm examining the patient. I'm documenting what I found. Since I'm a spine surgeon I'm focusing on the nerves. How the nerves are functioning. I'm focusing in on the muscles, the bones, things of that nature. Here we can see the exam states neurological exam. UE means upper extremity. Those are the arms and hands. And it says that there was four over five muscle weakness in the right wrist dorsiflexor. So what that means is five over five means normal muscle strength.

So you have the patient contract their muscle. Then the patient makes a muscle. I go on the other side and I pull and to my resistance I can feel whether they have full muscle strength, which is five over five. If there's a little bit of give, I can assess that it's four over five. We can assess it

all the way down to where the patient can't even lift the arm against gravity, for example. You put the hand on the table and they can go against gravity. That denotes a certain number. And zero is when they're completely paralyzed. So it's a grading scale to see if the person has any weakness in their extremity and that specifically was examined, the right wrist dorsiflexor. That's the muscle that allows you to raise the wrist up.

That's important because that muscle comes from the sixth nerve and the sixth nerve is the nerve that shoots off between number five and six. So where the herniation is, it's irritating the sixth nerve. That sixth nerve goes down the arm. The patient having some weakness in that area, they also lose a reflex. The reflex is where you hit a hammer on the muscle. When you hit the muscle, that signal goes to the spinal cord. It comes back down and causes the muscle to jerk away. If you tap your knee, your knee will jerk out. That's a reflex. If something is effecting that part of the nerve from the muscle or from the tendon to the muscle and spinal cord and brain, then there's something blocking the normal function of that. And that can be picked up if you don't have normal reflexes.

So she didn't have a reflex in this part of the wrist and she also had diminished sensation. That means I usually take a paperclip and the paperclip is round on one side. If

you open the paperclip, it's pointy on the other side. So you have normal sensation. You can tell the difference between the point and the blunt side. So I ask the patient is that sharp or dull. Sharp or dull. And we can do it down the arm. And when you got to the distribution of where that sixth nerve goes into the area, she couldn't tell the difference between sharp or dull.

Everything correlates together. She had diminished sensation, absent reflex, and also some weakness of that muscle. And that all correlates to the sixth nerve that happens to be at the same level where the herniation was between C5 and C6.

Q Okay. So did your physical findings correlate with the MRI findings?

A Absolutely.

Q Okay. Now, did your exam -- at least in this note your exam only makes mention of, you know, abnormal findings. Were there any normal findings on your exam as well? I mean, that aren't documented.

A When you do an exam, if it's a normal exam you write normal examination. This is not a normal examination. These are what I found in that examination. This is not a normal examination.

Q Really what I'm asking, were there findings that you made on your exam for other like nerve areas that were normal

that were just not documented is really what I'm asking? I'm not sure if I'm making myself clear.

A You're trying to say did I check all seven nerves, all eight nerves in the neck and document each one? The ones that are normal I don't state they're normal. I state the ones that are abnormal and that implies in my report that the other ones are normal.

Q That was my question. Thank you, Doctor. Bear with me one second.

Just moving along to some more of your findings on exam. Can you describe what else your exam consisted of other than testing the nerve?

A Like I said, I'm interested in not just the nerves, also the muscles, the nerves and bones in the body, see whether they have normal range of motion. Here we have an examination of the cervical spine. So touching that area when I examine here, it was tender to palpation. That means when pressed on, the muscles in the neck are very tense. Tenseness is very important. You have no control over tenseness.

Muscle. If you have children, when you go into labor, that muscle, the uterus, and when it contracts it's very painful. So when a muscle goes into spasm, we say that that's an important finding. Her muscles were in spasm around the neck. They were tender to be pushing on them. I also documented what the normal range of motion is and how limited

her range of motion was, because when she would move too far it would cause pain.

Q I want to go through those range of motions with you. So on the top it indicates what you found as Ms. Adams' range of motion and then on the bottom, below that, is the normal range of motion.

A Yes.

Q And it's measured in degrees?

A Yes.

Q Okay. Can you just explain how you make those findings, how you make those degree findings?

A Well, degrees are like one through three sixty. One through ninety. One through one hundred eighty. And pretty much most motion you can measure it zero to ninety degrees. Everybody sitting here, if you turn your head, you turn your head, you will know what a normal range of motion is. So you can't turn your head all the way around. You probably can go pretty far, eighty degrees to the left, not completely ninety. That's what these numbers are here. For example, left rotation, right rotation, about eighty degrees. If you look at what she did, she was only able to do about twenty degrees at a time. So less than fifty percent reduction on that day.

We see that also an extension was limited. When you put your neck back. When you put your neck forward. Side bending. So it just shows that in the examination in the

office she was complaining of neck pain. That was found to be real from the muscle spasms in the neck, her limited range of motion and things of that nature, the neurological findings. Everything really ties together to give the complete picture of the puzzle as to why she's having this problem.

Q Doctor, in your opinion, given the range of motions that you found compared to normal, did you consider this to be a significant limitation of her range of motion?

A Absolutely.

Q Moving along to the next portion of your note. Assessment: The patient is status post motor vehicle accident with a resulted cervical disc herniation. We discussed that. Herniation of cervical disc. Radiculopathy cervical region.

A That's just a fancy term for sciatica. When you have nerve pain and when it goes down your leg we call that sciatica. When you have nerve pain down your arm they're both called radiculopathy.

Q What is cervicalgia?

A That the neck hurts.

Q And then below that is your treatment and plan and you write at this point the patient requires an ACDF at C5-6.

A The patient came to me because the patient is having pain. She had been to physical therapy. She's been through injections, all conservative treatment. She had this problem for over a year since she was in the accident, almost a year

and a half when she saw me. At this point when a patient comes to me I say to them, one, if you can live with the pain you don't have to have surgery. If you come to the point and say, doc, I just can't put up with this anymore, then I think I can help you with my surgical technique.

Same thing in that pebble with your shoe. It's a little pebble. You know it's in there, but at the end of the day at one point you're like I have to get this pebble out of my shoe. Think same thing here. There's something in her neck that wasn't there before the accident. She's now had to deal with it for quite some time and having spinal surgery is a scary thing. We're talking about your spine. When people come to me I'm the last resort.

In her condition she was having ongoing symptoms, pain ongoing and I offered her the treatment of an ACDF. ACDF means anterior, which means through the front. Cervical is the neck spine. Discectomy means taking out the disc. And fusion means making those bones grow together. And she needed that between five and six where I showed you on the disc where the disc was herniated.

Q Doctor, I want you to assume that the last time that Ms. Adams had treatment, such as physical therapy or chiropractic or acupuncture treatment prior to her visit with you was in approximately the middle of March of 2015. So a little more than the year before. Does that change your

recommendation for a patient such as this?

A No, because the pebble is still in your shoe. It's just how long do you put up with it.

Q I also want you to assume that prior to seeing you in approximately March of 2016, Ms. Adams consulted with a pain management physician that had recommended epidural steroid injections, but Ms. Adams opted not to have those injections. Does that change your recommendation with regards to performing ACDF?

A No. When you have something in your shoe I can give you medicine. I can inject your leg. I will make you forget that pebble in your shoe. But when that medicine wears off, if that pebble is still irritating you, you know, it's still there.

Q With regard to an ACDF, are there risks associated with that procedure?

A So the major risk to this type of surgery are infection and bleeding, which are usually less than three to five percent. You can get some paresis of the vocal cord nerve. So you have a raspy voice. Anesthesia runs a risk of death. If I don't know what I'm doing and I press too hard in the area, I can bump the spinal cord. The patient can be paralyzed after the surgery. So those are some potential risks from this procedure.

Q Are these risks risks that you discussed with Ms.

Adams before doing surgery on her?

A Yes.

Q She was aware of those risks?

A Yes.

Q Did she agree to undergo the surgery?

A Yes.

Q Did you discuss the benefits of the surgery with her?

A So the benefits, I always tell a patient I'm not a God. I'm not going to say I would make you one hundred percent better. But I'm a pretty good surgeon. A lot of my patients get a hundred percent improvement. There's probably eighty, ninety percent to get some improvement. Maybe five percent chance to stay the same and probably, for some reason we don't understand, less than five percent, some people actually get worse.

Q How, if at all, does a patient's range of motion of their neck, how is that effected by performing an ACDF surgery?

A So, as I said, between the vertebrae we have little discs. The discs act as shock absorbers but they allow the vertebrae to move. When I take that disc out completely and make the bones fused or grow together, I completely limit the motion at that level. So the patient, if you want to know the technical amount, they actually lose one seventh of fifty percent of the flexion extension motion. So they do lose motion at that level.

Q Okay. For patients that undergo ACDF, in the future is there other treatments that is associated with undergoing that surgery?

A So when we fuse that level, that level no longer moves. So technically the level before it, number four five, and the level below it, number six seven, those two levels probably take on the motion of that level that was lost. So they have to move a little bit more. Moving a little bit more there's a chance, twenty to thirty percent chance that they could develop degeneration over time and that those levels may require surgery in the future. Usually twenty to thirty percent of the time those levels will need to be operated on in the future.

Q Okay. Doctor, I just want to ask you a few questions, opinion questions. And so, first of all, I'm going to ask you, do you have an opinion with a reasonable degree -- withdrawn.

I want to, you know, I want you to make certain assumptions when answering this question. I want you to assume that Ms. Adams was involved in a motor vehicle accident on November 25th 2014 as reflected in your chart. That she was a front passenger in that vehicle. She was wearing a seatbelt and the vehicle that she was in was struck on the right passenger side at or near the front of the vehicle. That Ms. Adams described that impact as being heavy. That she had no advanced warning of the impact. At the time of the impact she

was looking toward the driver of the vehicle and was talking to the back seat passenger.

And that she testified that as a result of the impact, her body moved. First her right shoulder struck the interior passenger door of the car. Her left shoulder then struck the driver's seat and the back of her head struck the seat back or headrest.

I want you to assume that she was taken to the hospital via ambulance and that at the hospital she complained of pain in her right shoulder. And then the day following the accident she was seen by an acupuncturist at a Ralph Medical Clinic and she complained of six to seven out of ten pain in her neck and seven of ten pain in her right shoulder.

I want you to assume, as reflected in your notes, prior to this accident Ms. Adams never had any prior injury to her neck. She never had any pain and discomfort in her neck, nor did she have any prior care or treatment to her neck. And I also want you to assume the results of the MRI that we just discussed and the results of the examination and your findings.

Do you have an opinion with a reasonable degree of medical certainty whether the motor vehicle accident on November 25th 2014 was a substantial factor in causing herniation of Ms. Adams' C5-6 disc?

A So I believe that within a reasonable degree of medical certainty that this patient sustained this injury from

the accident in November of 2014, and that means more probably than not. She had no problems before. She's in the accident and now she developed those injuries that ultimately required her to have surgery.

Q Given that same set of facts that I just gave you, do you have an opinion with a reasonable degree of medical certainty whether the accident from November of 2014 was a substantial factor in causing her to suffer from neck pain which radiated into her right upper extremity and shoulder?

A Yes.

Q What's the reasoning for that, same as before?

A Exactly.

Q And same set of facts I want you to assume. In your opinion, with a reasonable degree of medical certainty, was this accident a substantial factor in Ms. Adams requiring anterior cervical discectomy and fusion procedure at her C5-6 disc level?

A Yes.

Q And the reasons for that?

A As I stated prior, because of the accident.

Q What is the significance, if any, that Ms. Adams didn't have any impact -- any warning of this impact?

A Well, one, I think that's important. Because let's look at it this way. You see a football player playing football every Sunday. They do big tackles. They see the

tackle coming. They're pretty much always prepared for it. They're not all taken off the field paralyzed. When you prepare for something your muscles tense up and you're ready for an impact. When you're not ready for something, if you're walking in your bedroom at night and you stub your little toe, you know how important that little toe is when it get injured. In an accident when the energy from one vehicle is transferred to another vehicle, it can jar the human body. When it jars it and you're not prepared for it, it puts pressure on the area.

As I said before, these discs are delicate and they're sensitive. So your head is heavier than a bowling ball. We all picked up a bowling ball. It's pretty heavy. And that balances on seven little bones in your neck. When you move your neck a certain way you can get whiplash. You can put pressure on the disc because the neck is going one way. The weight of the skull is heavy and that's how you can injure yourself when you're not prepared and one vehicle can strike another vehicle transmitting that kinetic energy from that van into the vehicle that she was in.

Q Okay. Thank you.

So Doctor, I just want to go through -- well, did you indeed perform an anterior cervical discectomy and fusion on Ms. Adams?

A Yes.

Q And when was that?

A May 4, 2016.

Q So a little less than a month after your first visit with her?

A Correct.

Q And where was that procedure done?

A Do you know?

Q It was Hospital For Joint Diseases.

A I agree with you.

Q I'm just going to put up the operative report. This is the second page of the report. So I don't need you to read it in. If you can, just looking, if you can go paragraph by paragraph and explain to the jury what this surgery involved.

A So what the surgery involves is, first of all, the patient is put to sleep under general anesthesia. They're lying on their back face up. I prep the area where the surgery is going to take place. We sterilize it and put the sheets on so we're working under sterile conditions.

We then have to get to the spine. So the reason why we go through the front is because if we went through the back you're going to see the spinal cord in front of you. And if you try to move the spinal cord out of your way to get to the disc, the patient wakes up paralyzed. So we do these surgeries through the front. Remember that picture of the bone in the front is the disc and behind the disc is her spinal canal. If I'm working through the front I have to get there. So we have

to go through the skin. I have to get the food pipe, the windpipe out of the way. You have major blood vessels. You have the carotid artery, jugular vein. You need to get in there and spread those structures without causing any damage. If you puncture the carotid artery, it's like a water hose. The patient bleeds and could die on the table. Once we go through that you don't want to puncture the food pipe. The esophagus, that can pause major problems also. It's very delicate. You have to be very precise too to get into that area, move those structures safely out of the way.

And now you see the spine in front of you. Once I see the spine in front of me I put in retractors to keep that area open for me to do what I have to do. I then take out the disc. I use a sharp knife to excise the disc. I have little pincers that go in and take the disc material out. I'm using high power magnification and bright lights so I can see clearly what I'm doing. I'm very close. I can see the structures.

So the goal of the surgery is to take that doughnut out. You want to take out the dough of the doughnut and you want to take out the jelly of the doughnut that has squirted out the back. That's what we call anterior, coming in through the front. Discectomy means I take the disc out. As I'm coming through the front I go to the back of the disc. That's where I can see clearly where that disc material had squirted out. I then get a very fine little pincer to go in there and

grab the disc material. That's the herniation. That's the thing that was causing the problem all the time. We take that out.

So now I remove the disc and I remove the jelly. If I just left it like that those two bones would not have the shock absorber anymore between them. They would then start to grind about against one another and the patient would have continued friction. Also the space for the nerve that come out would still be squeezed because the disc had to be removed so the two bones come together.

So in order to prevent that I open the space up. I put in the little spacer. The spacer looks like a sugar cube in your coffee or tea. It's very square. I use one that's made out of titanium. It's a measure of titanium but it looks like a little cube. So it's very strong. That goes in. That keeps the space open. That also will allow the bones, number five and six, to grow through that to then come together in the future. That's what we call a fusion. I put a little plate with tiny screws in there and the plate with tiny screws adds more stability to where I did the surgery to keep it still so the bones will grow together better.

If you break your forearm I can either put you in a cast so the bone doesn't move, which gives it a chance to heal, or I can put plates and screws on that bone to keep it still. If you keep on moving, it doesn't have a good chance to grow

together. If you hold the bones still, then it grows together. Just like when you build a model airplane. You take the pieces of wood and keep moving it, it doesn't glue together. If you put a vise clamp on there the model airport will glue together. So the plate we put in there is like an added device to hold the two vertebrae still which give them a better chance to grow together and get a very high success rate. So the F is for fusion. So anterior cervical discectomy and fusion.

Q Now, your operative report makes mention of a fibular allograft. What is that?

A That's the sugar cube that I use. It's actually bone from a cadaver. It's fashioned to look like a little spacer that I can easily insert it into that space.

Q Did you -- in performing this procedure did you actually see the disc herniation that was being depicted on the MRI study?

A Yes, that's what I just told the jury.

Q Did you encounter any complications during this procedure?

A Not that I recall.

Q Did you follow-up with Ms. Adams after this procedure?

A Yes. Routinely we will see the patient and follow-up after the surgery. Usually come back to the office around ten days, two weeks later to look at the wound. We usually start physical therapy around four to six weeks after surgery and

usually by three to four months the bones should have started to grow together really nicely. I get an X-ray the first time they come back to show the patient what surgery they had and then we get follow-up X-rays usually up to one year just to make sure everything is healing nicely.

Q Okay. From what I can see from your chart, the next time you saw her was on May 12th 2016.

A Okay.

Q And at the top of this note it says provider. It says Leeann Tricarico-Floman. Do you see that PA?

A Yes.

Q Who saw the patient, Ms. Adams, on this date?

A Well, I always see my patients but I also have physician assistants that help me in the office and they usually will get things ready for me, start the note. For example, when a patient comes in after surgery they will take off the bandages, make sure everything is clean so I can come there and inspect the patient. So we have PAs that also assist.

Q Okay. Just to refer you to a portion of the note. It says patient complains of some occasional tingling at left wrist area, but otherwise denies any numbness, tingling or pain in the upper extremity. She admits to some upper back and shoulder tightness pain, but overall feels much improved as compared to preoperative status. So those complaints of

tingling at the left wrist and upper back and shoulder tightness, what is significant of those findings, those complaints?

A Not too much significance, but the patient has some numbness and tingling of the nerve. Remember that nerve was irritated before the surgery by the disc interior. So it has some memory to it. If I put a fire cracker next to your ear right now and drive you a mile away, your ear still rings. So the nerves, when they're traumatized and shocked they have a little bit of memory to them. They see that sometimes.

Q Okay. Bear with me one second.

Would it have been your practice to take an X-ray on this follow-up visit?

A Yes.

Q Okay. Just give me one second. I want to pull that up. Sorry. Just bear with me.

Okay. I'm going to show you what is one of the images marked as Exhibit 12. This is dated May 12th 2016. What are we looking at here?

A We're looking at an X-ray which shows the bones of the neck and the skull and it shows the plate that we put in.

Q Is the plate right here where I have the pointer over?

A Yes.

Q And this is another image from the same date. What are we looking at here?

A Here we can see the vertebrae number two, three, four, five and six. Five and six is where the patient had surgery. This is the plate with the little screws that hold the two bones together, this little cube in here, the little sugar cube that I discussed earlier that acts like a little spacer.

Q Based upon this X-ray how are things progressing at this time?

A Fine. Everything looks good. The plate's position and graft is in proper position.

Q Bear with me.

Okay. Doctor, I just want to show you a note for a visit that Ms. Adams had with you on September 13th 2018, two and a half years after your surgery. Did you continue to see her after the surgery between 2016 and 2018?

A Yes.

Q Okay. In terms of her fusion, how did that ultimately turn out, meaning did the vertebrae actually fuse?

A That's my understanding. It did fuse. It did heal.

MR. CRAVEN: I'm sorry. He said something after that was my understanding. I didn't catch that.

THE WITNESS: Healed.

MR. CRAVEN: Thank you.

Q So Doctor, if you can turn to your notes from 9/13/2018.

A Okay.

Q Okay. So the note says patient returns status post spinal fusion. She is in stable condition. She still has neck pain. Overall her condition has improved, however, she still does have pain.

Just moving a little bit further down your notes. For your neurological exam it says there was evidence of four over five muscle weakness in the right biceps, decreased sensation to pinprick and light touch in the right C5 distribution, absent right biceps reflex. Do you see that?

A Yes.

Q What is the significance of those findings?

A She had permanent nerve damage and she will continue to have that.

Q But you're talking now, at least in this note, in the C5 distribution, whereas the surgery, before the surgery she was having issues with the C6 nerve.

A Yes. That's the nerve above it so that nerve appears to be irritated.

Q In your opinion was the findings that you stated here caused by the accident from November of 2014?

A Well, the accident occurred at C5-6. We discussed earlier the patient over time can develop problems at the levels above or below. So I think this might indicate that she's now starting to develop some mild irritation of the nerve above where she had the prior surgery.

Q Okay. So just, you know, looking at -- you measured her range of motion on this date?

A Yes.

Q It says that you used a goniometer to do that. What is a goniometer?

A It's a device that we use to measure the range.

Q And with regard to her range of motion of her neck, in your opinion did she have objective limitations of range of motion in her neck?

A Yes.

Q Do you consider those limitations to be significant at this point?

A Yes.

Q In your opinion, Doctor, with a reasonable degree of medical certainty, were the limitations of her range of motion in her neck at this time in 2018 causally related to the accident of November 2014?

A Yes.

Q Bear with me one second.

There's a note I'm pulling up from March 21st 2019. Patient returns today status post cervical fusion surgery. She is in stable condition. She continues to have good and bad days. Your exam is similar to the prior visit. There was evidence of four over five muscle weakness in the right biceps, decreased sensation to pinprick and light touch in the right C5

distribution. Absent right biceps reflex. Is this similar to findings you made on your prior visit?

A Yes.

Q In your opinion were these findings causally related to the accident in November 2014?

A Yes.

Q Just going down to your treatment and plan. At this point I would like the patient to obtain a new X-ray of the cervical spine. Future spine surgery is anticipated. Then it goes over the cost of it. When you say future spine surgery anticipated, what type of surgery are you referring to?

A The same surgery she had before but at a different level.

Q I'm sorry?

A The same surgery she had before but at a different level, if that levels been symptomatic.

Q And that's what you were talking about before because of the stresses placed on the levels above and below?

A Correct.

Q What is the cost generally for an anterior cervical discectomy and fusion?

A Well, these are the ranges of the fair health database for private insurance. So it's in the range for hospital, anesthesia, equipment, surgeon's fees, in the $150,000 range.

Q With what frequency would a patient need to undergo

these additional surgeries?

A Well, I stated earlier, a twenty, thirty percent chance you can develop problems at the levels above and below where you have prior surgery and that can occur anywhere from five to fifteen years after the initial procedure.

Q Okay. Bear with me one second.

According to your records you most recently saw her on August 12th. I'm sorry. There's a note from -- let me go to the August. I'm sorry. Give me one second. You most recently saw her on August 19th 2021?

A Correct.

Q Okay. Your note states patient returns status post ACDF C5-6 on 5/4/2016. The patient reports worsening neck pain over the last few months, increased numbness and tingling to the upper extremities. What is the significance of those complaints?

A She still continues to have that numbness and tingling at the level above, and as a result of that I want her to get new pictures to see exactly what's going on.

Q When you say new pictures, meaning MRI?

A Yes.

Q So just going to the neurological exam for this most recent visit. Are your finding, more or less, the same as they were the prior visit?

A Correct.

Q Prior visits that we just discussed?
A Yes.
Q Okay. You write here the patient was viewed to be in excessive discomfort.
A Yes.
Q Where was that discomfort?
A Her neck.
Q And it says there was evidence of bilateral paraspinal musculator spasms.
A Yes.
Q Is that an objective finding?
A Yes.
Q And you said range of motion was painful.
A Yes.
Q Did you measure her range of motion on this visit?
A Yes, still a significant loss.
Q On the top you have what her range of motion was and on the bottom you have what the normal range of motion is.
A Yes.
Q Do you consider that to be a significant loss of range of motion of the neck?
A Yes.
Q At this point, given the fact that we're almost seven years after the accident, do you have an opinion, with a reasonable degree of medical certainty, as to whether her --

the condition of her neck is permanent in nature?

A It's absolutely permanent.

Q And can you explain that?

A We discussed this already. She already had surgery. She lost motion. That's permanent. You can no longer put the real disc back where that disc was.

Q I just have a couple more questions and I will be done.

So Doctor, do you have -- and this may be similar to what I just asked you. Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether the motor vehicle accident of November 25th 2014 caused Ms. Adams to sustain a permanent consequential limitation of use of a body organ or member?

A Yes.

MR. CRAVEN: Objection, your Honor.

THE COURT: Sustained.

Rephrase it.

Q Do you have an opinion, with a reasonable degree of medical certainty, as to whether the motor vehicle accident of November 25th 2014 caused her to sustain a permanent limitation of use of a body part?

A Yes.

MR. CRAVEN: Objection, your Honor.

THE COURT: What's the objection, counsel?

MR. CRAVEN: Can we approach?

(Whereupon, a bench conference was held off the record outside the hearing of the jury.)

MR. RUBIN: Your Honor, do you want me to restate the question?

THE COURT: It's up to you. You want to withdraw your objection?

MR. CRAVEN: I withdraw the objection if he's going to rephrase it.

THE COURT: Counsel, you can proceed.

Q Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether the motor vehicle accident that Ms. Adams was involved in on November 25th 2014 caused her to sustain a permanent limitation of use of a body organ or member?

A Yes.

Q And what is your opinion?

A My opinion is that she has lost permanent motion as a result of the date of injury in that accident.

Q In your opinion did Ms. Adams sustain a significant limitation of use of a body function or system as a result of the accident of November 25th 2014?

MR. CRAVEN: Objection, Your Honor.

THE COURT: What's the objection?

MR. CRAVEN: The same objection that I had

before.

THE COURT: Overruled.

You can answer.

A Yes.

MR. RUBIN: Thank you very much, Doctor.

THE COURT: Jurors, do you need a break or we can keep going? Keep going? Okay.

MR. RUBIN: Troopers.

THE COURT: Cross.

MR. CRAVEN: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. CRAVEN:

Q Good morning, Doctor. How are you today?

A Good, sir.

Q As you previously testified to this jury, you have testified many times before. I ask that you answer all of my questions in a yes or no fashion. If you cannot do so, let me know. Is that fair?

A I will.

Q Thank you.

And I believe you testified that you previously have testified less than a handful of times each year; is that correct?

A I believe so.

Q Okay. And is it accurate that it's closer to --

excuse me -- closer to five to six times per year that you testify?

A I don't keep track.

THE COURT: No. Wait. I didn't get that.

THE WITNESS: I can't answer yes or no.

Q Okay. And you have done so for over twenty years, correct?

A Yes.

Q And so you testified approximately 100 or more times, correct?

A That's possible.

Q Okay. And in each of those times it was for plaintiffs in lawsuits wherein somebody is seeking money, correct?

A Me representing my patients, yes.

Q Again, Doctor, I ask that you answer yes or no and, if you can't, you let me know that, okay?

A I will. Thank you.

Q So those more than 100 times it's more plaintiffs seeking money in lawsuits, yes or no?

A Yes.

Q Okay. And what percentage of your patients do you actually operate on?

A I can't answer that yes or no. I can answer it, but not yes or no.

Q I'm sorry?
A It's not a yes or no. I can answer it, but it's not a yes or no question.
Q Fair enough. This is not a yes or no question. What's the percentage of patients that you actually operate on?
A I probably see -- I probably do anywhere from two to three hundred surgeries a year and I probably see with my PA assistants over two thousand patients a year. So that's probably ten percent.
Q And what's the percentage of individuals -- strike that.
And Doctor, you would agree with me that there's no difference between an orthopedist and orthopedic surgeon, correct?
A Correct.
Q And patients are referred to you from time to time; am I correct?
A Yes.
Q And some come from doctors, correct?
A Yes.
Q And some come from attorneys, right?
A Yes.
Q And, in fact, Ms. Adams was referred to you by her attorneys, correct?
A I believe so.

Q You believe so or you know?
A I don't. I don't recall.
Q Can you check your file to confirm?
A Referral was Wingate Russotti Law Firm.
Q And you knew when you first saw Ms. Adam the year and a half after the accident that she had a lawsuit, correct?
A I don't recall at this time, but I know that she was involved in an accident, yes. I didn't know if it was a pending lawsuit. I don't always review the chart to see who had referred me the patient but, as we know now, yes, she was referred by her firm.
Q When you saw her that first time you had no idea about the severity of the impact, if it was light, heavy, or something else, right?
A I was aware of the mechanism of action of the van striking the right side of the vehicle, yes.
Q You were aware that a van struck the vehicle, but you didn't know what side of the vehicle it was to; am I correct?
A My understanding it was the right side of the vehicle.
Q Can you take a look at your April 11th note and indicate to me if you actually put in your note that it was on the right side.
A My note of August 19th '21 states that the patient was struck.
Q Doctor, I didn't ask you that. I asked you about your

April 11th 2016 note. The very first time that you saw her you did not know the severity of the impact; am I correct, yes or no?

MR. RUBIN: Objection. That wasn't the question that was just asked.

THE COURT: That was the question, Counsel.

The objection is overruled.

A My notes indicate that she was a restrained passenger on the right front seat of her automobile struck by a van.

Q And again, you had no idea of the severity of that impact on April 11th 2016, correct?

A I don't recall the severity of the accident sitting here today.

Q You didn't put any note in your report as to the severity of the accident; am I correct?

A That's correct.

Q And you didn't put in your note whether or not you knew what portion of the vehicle was involved in the accident; am I correct?

A Not in that note.

Q And are you aware that at the scene of the accident the only complaint that she made was concerning her right shoulder, yes or no?

A No.

Q No, you're not aware?

A I'm not aware that was just the right shoulder, no.
Q I'm sorry. I didn't hear.
THE COURT: I'm not aware it was just the right shoulder.
MR. CRAVEN: Thank you.
Q Are you aware that she made no complaints about her neck at the scene of the accident?
A That's possible.
Q Are you also aware that she made no complaints of her neck at the hospital?
A That's possible.
Q Did you ever have any conversations with any of the doctors at Ralph Innovative Medicine?
A Repeat that, please.
Q Did you ever have any conversation with any doctors who she saw at Ralph Innovative Medicine?
A No.
Q Did you ever have a conversation with a Dr. Reyfman concerning Ms. Adams?
A No.
Q Did you ever review the emergency room records at LIJ?
A I have had access to the records.
Q Do you make any note in any of your reports that you actually reviewed the emergency room records from Long Island Jewish?

A No.
Q Okay. But you're going to tell this jury now that you actually have reviewed those records?
A I said I had access. Counsel, I specifically said I had access to the records.
Q Fair enough. Given that you had access, did you actually access them to look at them?
A Yes.
Q Did you make any note concerning anything that you saw in those records that you're telling us that you saw?
A Not in these records.
Q In any records?
A The records in my mind, yes.
Q In your mind. As you sit here today, do you have recollection --
THE COURT: Wait. No. She's not getting it.
What's your question? What's your question?
MR. CRAVEN: I'm sorry. Can you have it read back?
THE COURT: Can you read back the last question, please.
(Whereupon, the requested portion was read back by the court reporter.)
A In my mind, yes. I have the records given to me last night and I have reviewed them.

Q So last night was the first time that you saw the emergency room records; is that correct?

A I just stated that, counsel.

MR. CRAVEN: I didn't --

THE COURT: I just stated that, counsel.

MR. CRAVEN: Thank you.

Q And am I correct other than the MRIs and other than perhaps something you saw last night, you never saw any of her records that predate her first visit with you?

A No, I believe that to be inaccurate.

Q What other records did you see other than the MRI that predate her visit with you?

A Specifically sitting here today I don't have a clear recollection of the records I reviewed five years ago. It's my usual and customary fashion to review records and I believe I have done so in this case.

Q You believe or you know?

A I believe.

Q And isn't it good medical practice to list in your report what other medical records you have seen?

A No.

Q Well, you found it important to put in your report that you reviewed the MRI study, correct?

A Because the MRI is my road map when I'm going to do surgery. I need to know what I am going to encounter.

Q And yet you didn't put in your report any other records that you may have possibly looked at?

A No, because they are in and of them self a record. That doesn't determine what I'm going to be doing when I have to go in and do my surgery.

Q But doesn't that have anything to do with your opinion as to causation?

A As I stated, counsel, after reviewing records last night, sitting here as an expert I believe, within a reasonable degree of medical certainty, that this accident was the competent causing factor that caused my patient to sustain that injury that ultimately required surgery.

Q Well, you actually made that conclusion that it was causally related back in 2018, right?

A Yes, because the patient had a point in time where she had an accident. She never had problems before. She was never treated before and subsequent to that she developed her problems.

Q But you didn't look at the hospital record back in 2018, did you?

A That's inconsequential. I believed that my patient was in the accident. We're here because you know that she was in the accident and we know that she developed problems after the accident.

Q We know that she complained about problems, but we

don't know that she developed them. That's what we're waiting for the jury to determine at the end of the trial. Is that fair enough, Doctor?

A That's fine.

Q And you first saw her a year and a half after the accident, correct, on that April 11th date?

A That's what the record shows.

Q Does your mind tell you something different?

THE COURT: You can answer.

A That's what the record shows.

Q And I'm asking you, does your mind tell you something different?

A Are you inferring that my mind would match a different date than is put in the record?

Q Well, you previously told me that you have remembrances in your mind that aren't in the records, so I just want to clarify.

A I don't understand your question.

Q Fair enough. Do you have a memory of seeing her at any time before April 11th 2016?

A I have never seen this patient before the first visit I saw her.

Q And at that time on April 11th 2016 did you know that she only had approximately three and a half months of what we'll call conservative treatment?

A Yes.
Q You knew that?
A I believe so, yes.
Q How did you know that?
A Because she informed us she had undergone conservative treatment.
Q Did she tell you the extent of the treatment she had?
A I don't recall sitting here today.
Q Did she tell you what treatment she had?
A My notes from 2016 indicate she denies prior history of her present symptomology. To date the patient has exhausted conservative treatment.
Q What does exhausted conservative treatment mean to you, Doctor?
A That they tried physical therapy. They have tried pain management and that they continue to still have pain.
Q Okay. Are you aware that she didn't try any pain management?
A Because she didn't want to undergo the injection.
Q Okay. Are you aware that she had less than thirty visits of physical therapy in those three months?
A Am I aware of the exact number, no.
Q Did you recommend to her to try physical therapy before you actually were going to do the surgery?
A She already had it.

Q Well, she had physical therapy for less than three and a half months immediately after the accident, but now you're seeing her a year and a half after the accident. Did you recommend that she try physical therapy?

A No, because she already had physical therapy.

Q Are you aware that she had no medical attention whatsoever in the year before seeing you?

A As to those specifics, I'm not aware.

Q Because you didn't look at the records, right?

A Which records?

Q Any of her records.

A On the contrary I already stated to you it's my usual and customary practice to review records.

Q It's your custom and practice, but that doesn't mean you did it in this case, correct?

A It doesn't mean I didn't.

Q But there's no record of you actually reviewing anything, right?

A You have my records, counsel.

Q I'm sorry?

A You have my records.

Q I do have the records and there's no record indicating that you looked at any of her records, correct?

A The answer is there.

Q It's yes or no.

A I can't answer yes or no.

Q Can you show me any of the records where you reviewed any records besides the MRI?

A I stated, counsel, with your chuckle, that it's my usual and customary practice to review recordings.

Q Just because something is usual and customary doesn't mean you did it. We're here so the jury gets a full picture. So I'm asking you --

A It's my usual and customary --

MR. RUBIN: Objection.

THE COURT: The objection is sustained.

Next question.

MR. CRAVEN: Fair enough.

Q The MRI that was done on January 29th 2015, there was no indication that there was trauma, correct?

A Yes.

Q And you indicated before that there was spurring, correct?

A Yes.

Q And spurring is a degenerative condition, you would agree with me?

A Yes.

Q And that has to do with the bone, correct?

A Yes.

Q And that happened over time, right?

A Yes.
Q And it happened way more than two months, correct?
A No. You can get spurring in a matter of a couple of months.
Q And generally speaking, the term degenerative means something that's long standing in nature as opposed to acute; am I correct?
A Exactly. Yes.
Q And you would agree with me, Doctor, that the MRI is the gold standard in diagnosing traumatic injuries to the spine?
A No.
Q You would not agree with me?
A Depends on the trauma you're talking about, counsel.
Q Doctor, do you recall giving trial testimony on September 13th 2021?
A No.
Q Do you recall a case Brian Durlack (ph) against Thomas Shade (ph)?
A September 13, 2021?
Q September 13th 2021, about a month ago. Do you remember that?
A Maybe a video deposition, not in court, right?
Q I ask, do you recall giving trial testimony on September 13th 2021?

A I gave testimony, but I don't remember. It wasn't in court.

THE COURT: It wasn't. Okay. It's not in court but it's still testimony.

Go ahead, counsel.

Q And that testimony was videotaped to be presented to a jury at some other time, correct?

A Correct.

MR. CRAVEN: And page 133, Your Honor.

THE COURT: What line?

MR. CRAVEN: Line 11, Your Honor.

THE COURT: Go ahead.

Q Do you recall being asked this question and giving this answer about a month ago on September 13th:

"Question: So you already told us that the MRI is the gold standard in diagnosing traumatic injuries to the spine because the MRI can visualize not only the bony structures that an X-ray can show, but also the soft tissues of the spine including the musculator, the ligament and the discs. Is that fair to say?

Answer: Yes."

A Yes.

Q All right. So you would agree that the MRI is the gold standard, correct?

A The MRI is good for looking at soft --

Q Yes or no, Doctor?
A If you really want the answer I will give you the answer.
Q I want you to answer yes or no. You would agree that the MRI is the gold standard in identifying a traumatic injury to the spine, yes or no?
A No.
Q And you testified about that a month ago; am I correct?
A Do you want the answer?
Q Did you testify to that about a month ago, yes or no?
A Can you let the jury hear the answer?
Q Did you testify to that a month ago, yes or no?
A I answered a month ago, yes.
Q Okay. And you would agree with me that disc hydration is a degenerative condition -- strike that.
You would agree with me that disc hydration loss is a degenerative condition, correct?
A Yes.
Q And that diminished disc space is also a degenerative condition?
A It can be an acute situation also depending on the size of the disc.
Q And, Doctor, we talked a lot about range of motion testing. That a subjective test, isn't it?

A Yes.
Q The patient has -- I'm going to put in quotes -- "control over the extent to which they move", correct?
A Subjective.
Q Okay. And the goal of the surgery was to remove what has been called by you at times the pain generator, correct?
A Yes.
Q And you actually did remove the pain generator, the thing that was causing pain, correct?
A Yes.
Q And you did a good job, right?
A Yes.
Q Surgery was successful?
A Yes.
Q And these types of single level surgeries, the patients usually go home the same day of the surgery, right?
A When I do it.
Q I'm sorry?
A When I do it.
Q When you do it. Because you're good, right?
A Yes.
Q Okay. And, in fact, the plaintiff did go home the same day of that surgery, right?
A Yes.
Q And you would agree with me, Doctor, yes or no, that

the recovery time for the wounds to heal is about ten days?

A For the skin, yes.

Q And you would typically recommend that your patients start light activities ten days after the surgery, right?

A Yes.

Q And then you would recommend that heavy lifting can be done six to eight weeks after surgery, right?

A Yes.

Q And you would also recommend that the patients start physical therapy three to four months after the surgery, correct?

A If not sooner.

Q And why would you want the patient to undergo physical therapy three or four months after the surgery?

A Hopefully try to increase their strength, range of motion, things of that nature.

Q And are you aware that this plaintiff did not undergo any sort of physical therapy after the surgery, yes or no?

A No.

Q No you're not aware?

A No.

Q In any of her follow-up visits did she indicate to you that she started physical therapy?

A Counsel, I just answered no.

Q So you are -- okay. Perhaps it was a poorly worded

question. I apologize. Yes or no, are you aware that she did not have any physical therapy after the surgery?

A No, I'm not aware.

Q Are not aware. Doctor, I want to refer you to the July 25, 2016 note that was about two months after the surgery, right?

A Notes indicate for her to start PT.

THE COURT: I didn't get that, Doctor. The notes indicate --

THE WITNESS: Note on July 25th 2016, Your Honor, indicates for her to start PT.

THE COURT: To start --

THE WITNESS: PT.

THE COURT: PT. Physical therapy.

Q And then I want to refer you to your October 27th note. That was about five months after the surgery and she had not started physical therapy, correct?

A Yes.

Q And you were aware of that, right?

A My note indicates that.

Q So having looked at these notes, does that refresh your recollection as to whether or not you are aware that she did not do any physical therapy after the surgery?

A Well, as indicated, my physician's assistant saw the patient on that date and the note indicates that she's

recommended to start physical therapy. Do I recall whether I spoke to the patient regarding her not having started physical therapy on that date, I have no clear recollection of that conversation five years ago.

Q But your own report notes, quote, "She has not started PT", am I correct?

A Correct.

Q And when you saw her two years later in 2019, did you ask her if she had done any physical therapy?

A That's not documented in this note.

Q And when you saw her another year later in March of 2020, did you ask her if she did any physical therapy?

A No.

Q And when you saw her this year in August, did you ask her if she did any physical therapy?

A Not that I recall.

Q And about three months after the surgery is when you would anticipate the bones to have fused, correct?

A Yes.

Q And they did, in fact, in this case, correct?

A Yes.

Q And in light of that you would expect that there would be no limitation in that area; am I correct?

A In the C5-6 area?

Q Yes.

A How could you not have a limitation when that area is fused?

MR. CRAVEN: Page 68.

THE COURT: Line?

MR. CRAVEN: I'm going to start at line seven, Your Honor.

THE COURT: Go ahead.

Q Doctor, again I'm reading from a transcript of last month on September 13th 2021. Just yes or no. Do you recall being asked this question and giving this answer:

"Question: What's the recovery time for the cervical procedure you discussed, Doctor?

Answer: Ten days for the wound to heal. Light activities within ten days. Heavy lifting six to eight weeks. Physical therapy around six to eight weeks. Takes about a full three or four months for the bones to fuse and then there shouldn't be any limitation for that area."

Do you recall being asked that question and giving that answer?

A Yes.

Q Doctor, you would agree with me that because the surgery was a success, that when she reported to you that she was greatly improved, that would be expected, right?

A Yes.

Q And she actually did report to you or somebody in your

office that she was greatly improved a month after the surgery, correct?

A Yes.

Q And she reported that again in July of 2016, am I correct, that she was, quote, "greatly improved"?

A Yes.

Q Are you aware that she has not had any medical attention other than your follow-up visits since the date of the surgery?

A You asked me that question prior.

Q Well, I was asking you about medical attention before. But I will ask you now. So from May 4th 2016 up until today, in those five and a half years are you aware that she has not had any medical attention?

A I'm aware that she's followed up with me.

THE COURT: You're aware that --

THE WITNESS: I'm aware that she has followed up with me.

Q When you made your first -- strike that.

The first time that you made any causal connection between the accident and her condition was in September of 2018; am I correct?

A What date did you just state?

Q I said September 13th 2018. That was the first time you ever made any causal connection between the accident and

her condition, correct?

MR. RUBIN: Objection.

THE COURT: What's your objection to that question?

MR. RUBIN: Objection.

THE COURT: What is the objection to that question?

MR. RUBIN: The objection is, is he asking if that's documented or in his mind?

THE COURT: No. Overruled.

You can answer the question.

A That question is actually false.

Q Did you document anywhere before September 13th 2018 your opinion as to the causation of her injury?

A Absolutely.

Q When did you first document that?

A First visit, counsel.

Q In that first visit, other than using the word resulting, do you make a causal connection between the accident and her complaints?

A My notes clearly state: Based on this clinical evaluation, comma, the current problem is causally related to this accident.

Q And that was on April 11th 2016?

A April 11th 2016.

Q That was the first time you saw her, correct?
A Yes.
Q And that was without the benefit of looking at the ER record, correct, yes or no?
A I can't answer --
Q You didn't have the ER record back then?
A I can't answer it yes or no.
Q That was without the benefit of not knowing what portion of the vehicle was involved in the accident; is that correct?
MR. RUBIN: Objection, asked and answered.
THE COURT: Overruled.
A Repeat the question.
Q You made that assumption or opinion on April 11th 2016 without the benefit of knowing what portion of the vehicle was involved in the accident, correct?
A I can't answer that yes or no.
Q And you made that assumption without knowing the severity of the impact; am I correct?
A I don't believe you're correct.
THE COURT: You don't believe what?
THE WITNESS: Read back the question.
THE COURT: No. What did you just say?
THE WITNESS: I responded to his question.
THE COURT: That's what I want to know. What did

you say?

THE WITNESS: He said correct. I said I don't believe that's correct.

THE COURT: Okay. Next question.

Q But I am correct that you did not document anywhere that you knew the severity of the impact?

A That's correct.

Q And am I correct that you did not document anywhere that you knew the portion of the vehicle that was involved in the accident?

A My records do indicate that.

Q Okay. On April 11th is that noted?

A That's correct.

Q And as of April 11th you did not document if you saw any medical records that predated her visit with you other than the MRI, correct?

A Correct.

Q And when you saw her in March 12th of 2020, last year, the sole purpose for that visit was not for care or treatment, it was for you to prepare a narrative report; am I correct?

A That's possible.

Q But am I correct? I know it's possible. I'm asking you, am I correct?

A I answered the question, counsel.

Q The only reason why she came to see you last year in

March of 2020 was for you to prepare a narrative report, right?

A As I just stated, that's possible, yes.

Q And the only reason why she saw you in March of 2020 was because this case was scheduled for trial back then, correct?

A That's possible.

Q Do you, in your mind, have a recollection of actually seeing her that day?

A No.

Q The record indicates that your PA saw her, correct?

A As usual my PA could have seen and started on that date, yes.

Q And back on March 12th 2020 there was no immediate plan for any further treatment for her, correct?

A Correct.

Q And when you did see her back in March of 2020, she again reported that she had improvement of her symptoms, correct?

A Yes.

Q And when you saw her in March of 2020, she only had intermittent neck pain, correct?

A Correct.

Q You talk about the adjacent segment, also called the adjacent segment syndrome, correct?

A Okay.

Q I believe you testified in only twenty or thirty percent of people who undergo her surgery will actually have that issue, correct?

A Yes.

Q And it's only within that twenty or thirty percent of people that do have that issue would surgery then possibly be recommended?

A Repeat that.

Q Sure. Would you mind repeating it?

THE COURT: Please.

(Whereupon, the requested portion was read back by the court reporter.)

A Correct.

Q Doctor, you're aware of the term secondary gain; am I correct?

A Yes.

Q Would you agree with me that --

A We're not taught that in medical school.

Q So you do remember testifying. Fair enough.

Secondary gain is when somebody wants something secondarily to whatever their complaints are. So, for example, if somebody goes to a doctor, the primary gain would be to take care of those symptoms. A secondary gain would be something else, correct?

A Yes.

Q And would you agree with me that a complaint of pain to a doctor, a secondary gain, could be financial reward?

A Potentially if they know about that. But usually when patients present to me for quite some time having had an injury that MRI studies show it, clinically they show it, they clinically have a real problem.

MR. CRAVEN: Thank you, Doctor.

THE COURT: Redirect?

MR. RUBIN: Yes. Thank you.

REDIRECT EXAMINATION

BY MR. RUBIN:

Q Doctor De Moura, what is the significance of a patient such as Ms. Adams who, at the very time of the accident, the date of the accident, doesn't have neck pain but develops neck pain the next day; is that something that you see?

A I see that very frequently. A patient is injured. Something else can overlap or mask what they have and subsequently they start developing symptoms at a later time.

Q The fact that Ms. Adams at least in terms of documented pain in the neck only happened the day after the accident, does that effect your opinion that you gave earlier regarding causation?

A No.

Q You were asking questions about the MRI being gold standard and diagnosing injuries to the spinal and you wanted

to explain that. Well, I'm going to give you that opportunity. Can you explain that?

A MRIs, as I showed earlier, MRIs are excellent for looking at the soft tissue of the spine. They also can show damage to the bone. But more frequently an X-ray or a CAT scan will show a fracture of the bone better than the MRI can. So that's my explanation.

Q You were read some testimony from the prior, I think, video deposition that where you said something to the effect that after you have a fusion, there's no limitation in that area. Can you -- do you agree with that?

A So it's common sense if you fuse the level at that specific level you can't have normal motion. It is effected by that surgery. But in my question -- answer to that question, after the patient had been to physical therapy, globally they should have global functioning or not be aware of that specific loss from that specific level that was fused during the surgery.

Q Doctor, to provide an opinion regarding causation between an accident and injury, is it necessary for you to know the severity or precise point of impact of vehicles?

A Sometimes I can add to the puzzle to figure out how the person got struck. But here I have a person who never had any problems before.

MR. CRAVEN: Objection, your Honor.

THE COURT: Sustained.

Next question.

Q As far as the history that you took, did Ms. Adams have any issues, treatment or injury to her neck prior to the date of the accident?

A None that I'm aware of.

Q She never had any imaging done to her neck prior to that date?

MR. CRAVEN: Objection, Your Honor, beyond the scope.

THE COURT: Sustained.

MR. RUBIN: Thank you very much.

THE COURT: Thank you.

MR. CRAVEN: Nothing further, Judge.

THE COURT: Thank you, Doctor.

You may step down.

(Whereupon, the witness was excused from the witness stand.)

THE COURT: So at this time we're going to adjourn for the day.

Don't discuss the case. Don't come to any conclusions. We have issues with witnesses and their times they're able to come in so we'll be here tomorrow at 9:30. Enjoy your evening.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom.)

MR. RUBIN: So Mr. Craven had objected to my questions regarding serious injury. Specifically I asked the questions pretty much part of what the statute -- what the insurance law provides, the serious injury provisions of the insurance law provide. So I asked it in that nature. There was an objection and I believe that objection at first was sustained and then --

THE COURT: It was sustained because you used the characterization permanent consequential. And when I charge the jury regarding consequential, I explain or define consequential. But then you went back and rephrased it as permanent limitation and I said that was admissible.

Go ahead.

MR. RUBIN: I don't believe there's any prohibition about using language that mirrors the statute. I don't think there's anything improper. In fact, I think it was entirely proper to use the term consequential.

I want to make a record of that objection and the judge's ruling on it.

THE COURT: Right. But what was objectionable is that consequential is not defined. When I give the charge I define consequential. The jury doesn't know what that is and that's why it's objectionable.

MR. RUBIN: I used the term significant afterwards.

THE COURT: That was a different question.

Have a good evening. I will see you tomorrow at 9:30.

(Whereupon, the matter was adjourned to October 19, 2021.)

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

I hereby certify that the foregoing is a true and accurate copy of the stenographic proceedings of the hearing held in the above matter.

Amber Schiano
Senior Court Reporter