SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS : CIVIL TERM : PART 43

- -X

CHERYL BLUE : INDEX NO.: 25605/09

PLAINTIFF :

- against - :

FORESURE TRANSPORT, INC.,d/b/a FORESURE TRANSPORT, PINE RIDGE FARMS, LLC, ERNESTO GARCIA :

DEFENDANTS : TRIAL

- -X

360 ADAMS STREET
BROOKLYN, NEW YORK 11201
APRIL 13, 2012

BEFORE: HONORABLE MARK I. PARTNOW,
JUSTICE, AND A JURY

APPEARANCES:

LAW OFFICES OF JAMES McCRORIE, P.C.
Attorney for Plaintiff
One Penn Plaza, Suite 5315
New York, New York 10119

FABIANI, COHEN & HALL, P.C.
Attorney for DefendantS
570 Lexington Avenue
New York, New York 10022
BY: THOMAS J. HALL, ESQ.

JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

COURT OFFICER: All rise, jury entering.

COURT CLERK: All jurors are present. You may be seated.

THE COURT: Good morning, ladies and gentlemen. I am sorry for the delay, but as I told you we can't get started until all nine of you are together.

I understand one of the jurors showed up a little late this morning. Try to show up on time next time, if you can.

If you recall yesterday we were in the middle of the plaintiff and about to start cross examination of the plaintiff, but for the convenience of the witnesses we are going to call a witness out of turn now.

The plaintiff is going to call a doctor to testify. Counsel, call your next witness.

MR. McCRORIE: Plaintiff calls, Dr. Paul Brisson, B R I S S O N

D R. P A U L B R I S S O N, having been called as a witness by and on behalf of the Plaintiff, having first been duly sworn, was examined and testified as follows:

COURT CLERK: In a loud, clear voice please give your name and office address.

THE WITNESS: Paul Brisson B R I S S O N 51 East 25th Street, sixth floor, New York, New York 10010.

COURT CLERK: Thank you. Please be seated.

THE COURT: Counsel, you can proceed.

MR. McCRORIE: For the record, there has been a stipulation into evidence and for the record we will state it. 2B and C are blow ups of certain portions of the Woodhull Hospital record. The MRI of Ms. Blue from -- the cervical, is number 4 in evidence from 11/8/08. Also from November of 2008 is the lumbar MRI and left shoulder MRI. That is all part of Plaintiff's 4.

Plaintiff's 4 was the actual film. Plaintiff's 5 is an actual film. Plaintiff's 6 is an actual film.

Going back to Plaintiff's 4A, B and C are blow ups of certain images of the cervical film. 5A is the blow up an image of the lumbar film. Number 7 is the Brooklyn Hospital records from October 10th, 2008. Number 8A and 8B are blow ups and Dr. Brisson actually brought the x-rays and the CD is here.

I failed to mark Dr. Brisson's file. I guess that would be 16 or any portions --

THE COURT: Counsel, I don't understand the last thing you are telling me.

MR. McCRORIE: Well, just do it this way. Going in the next order, Plaintiff's number 9 are the office notes of Dr. *Ilyce Maranga, chiropractor, RN.

Plaintiff's 10 is the notes of Angelic

Physical Therapy. Plaintiff's 11 is the notes of Dr. Hannanian. Number 12th are the notes of Dr. Jeffrey Kaplan. Number 13 are the procedure notes and office notes of Dr. Kushnerik. Plaintiff's 14 is the complete hospital record of Downtown Hospital regarding the cervical surgery. Plaintiff's 15 is the complete hospital record of Roosevelt Hospital regarding a shoulder surgery. Then number 16 would be a portion of Dr. Brisson's file that will be going into evidence.

THE COURT: That is all in evidence without objection; is that right, counsel?

MR. HALL: Yes, your Honor.

THE COURT: Thank you.

MR. McCRORIE: May I proceed, your Honor?

THE COURT: Yes.

DIRECT EXAMINATION

BY MR. McCRORIE:

Q. Good morning.

A. Good morning.

Q. Doctor, if you can please speak in a loud voice. The ceilings are high and direct your responses so the jury can hear you.

Can you tell the jury if you are licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. When did you become so licensed?

A. In 1993.

Q. Are you currently employed?

A. Employed, yes.

Q. Do you have your own practice?

A. Self-employed, that is really the word. Yes.

Q. How long have you had your own practice?

A. Since 1993 as well.

Q. Where is your current practice?

A. The address I stipulated to before is my office which is on 25th Street, Manhattan. And I do perform spinal surgery at New York Downtown Hospital.

Q. In September of 2009 and a period of time before that, was your office address at another location?

A. It was.

Q. Can you tell the jury the location and any other doctors that were within that office?

A. The location was on 56th Street 160 56th Street on the east side. Dr. Kaplan worked in that location, Dr. Crone worked in that location, Dr. Boppana worked in that location, Dr. Write worked in that location.

Q. Despite the fact that they worked at that location, were they part of your practice and were you part of theirs?

A. Independent practitioners.

Q. Does your practice accept work related accidents

and all the special rules and procedures that come along with it accepting those?

A. Yes, I did.

Q. How about the same with motor vehicle accidents, does your practice accept motor vehicle accidents and all the special rules and procedures that come along with billing and treating a patient with that type of care?

A. Yes as well.

Q. As distinctly as you can without leaving out any accolades or accomplishments, can you please tell the jury your educational and professional background starting with college going through internship, residency and taking us to where you are currently and because you are the first medical witness testifying, when you get to words like internship, fellowship, residency, if you don't mind defining them? I would be appreciate that.

A. Very well. I am from Canada, Montreal, so college in Canada is a little different than what you think it is here, but, the equivalent of college I did a small college in Montreal, a small private college.

I went to the University of Montreal for medical school, a french university. I graduated in 1979 and after that I did my internship year at the McGll Teaching Hospital. McGill in Montreal is an English university, so-called and I did various rotations in hospitals,

pediatric hospitals, Schreiner Hospital and so on and so forth.

Q. If you don't mind keeping your voice up because the feeling is I don't hear you fully.

Define internship and residency.

A. Internship is essentially a year that is done by obligation. In order to have the right to practice after your medical education you have to do an internship to obtain a license. So when it comes to internship from Canada, internship in the United States is the same.

Upon completion of my internship, I practiced as a family practitioner in a remote location in Canada called the Magna Islands.

I was a family practitioner a hundred miles away in the middle of the ocean, essentially. The Magna Islands are north of Prince Edward Island. I was one of five general practitioners taking care of a large remote community.

I came back to Montreal in 1983 to do a residency in orthopedic surgery. So residency is a medical indication meaning it is the definition of the years of training to be a specialist. In my case orthopedic surgery.

Somebody can do a residency to be a cardiologist, can do a residency to be an internist or whatever. My residency was orthopedic surgery and this was done at McGill Teaching Hospitals, four years 1983, 1987. 1988 I came here

in New York City and did a year a spinal surgery fellowship at the Hospital for Joint Disease.

So fellowship in a context of medical education, again, is the year that one does by virtue of choice, not by virtue of training requirements. And my choice then was to be a spinal surgeon or involving spinal care.

I did a year of spinal surgery training at the Hospital for Joint Disease and I had already planned a second year which I did in Buffalo with Dr. Simmons, very well known to this day at Buffalo General Hospital, another fellowship. I did two of those years and then came back as a house officer at the Hospital for Joint Disease from 1989 until 1997, actually.

Q. You stated that you did your fellowship in orthopedic spinal surgery, do surgeons that typically do shoulders, knees, ankles and other joints, can they do spinal surgery as well or is it a speciality within the field of orthopedics?

A. Certainly speaking from myself -- I cannot picture myself doing anything other than spinal surgeries. So if arthroscopic is doing shoulders or knees, I cannot see myself doing arthroscopic.

Q. How many spinal surgeries do you perform on a yearly basis currently?

A. About 100, 150 or close to 200.

Q. Do you do anything other than spinal surgery?

A. No.

Q. Are you board certified?

A. Yes, I am.

Q. Tell the jury what you are board certified in and explain the significance, if any, of the board certification?

A. So board certification is another voluntary program, if you want, although frankly it is required more and more by all sorts of agencies in the public. It is what is a certification to a level of training and competency in terms of practice and ability to sit and do exams and essentially pass them.

So I and like any other board certified physician, we have to first pass this exam which in my case, in the case of orthopedic surgery, is a practice base. You show what you did two years. At one point you do a written exam and you have an oral exam. And every ten years thereafter you have to recertify. And I did one recertification nine years -- eight years ago and I will have another one coming in a year or two.

Q. Do you hold any positions at any hospitals within New York City?

A. At New York Downtown I have the directorship in the spinal surgery division.

Q. Other than being director in spinal surgery at New York Downtown, in your current practice, can you tell the jury what types of patients you see?

Do you see trauma patients, patients that don't have trauma; what type of patients do you see?

A. I see, essentially, the whole gamut of what would be spinal care with certainly the exception of pediatric spinal problems, which often are deformity type problems. So I take care of people that have sequelas from trauma. I take care of people that have spinal problems, pinched nerve problems, weakness and so forth. And the gambet is quite wide.

It is all sorts of reasons for their problems, whatever brings them to the office I will be dealing with.

Q. And so just so we are clear, I asked you the question about accepting work related accidents and motor vehicle accidents, do you also see many other types of cases?

A. Oh definitely.

Q. Have you ever testified in court before?

A. Yes, I have.

Q. And on the times you testified in Court, how does that come to be?

A. Just about exclusively for the patients that I took care of.

Q. Okay, as opposed to being retained, some other way to review a file?

A. As example, that is correct.

Q. Have you ever testified in Court on behalf of a patient who you operated on that happened to be a client of mine?

A. Yes, I have.

Q. Can you tell the jury in the 15 years of my practicing how many times that has occurred?

A. Once.

Q. Can you tell the jury when this was?

A. In the autumn of last year.

Q. Before autumn of last year, despite the fact that you were seeing Ms. Blue since 2009, had you and I ever met each another prior to testifying in October of 2011 for some other patient?

A. No.

Q. Since August of 2011, from the time you knew that this case was going to come to trial, did you and I met again other than August 2011 regarding Ms. Blue's case?

A. Yes, we have.

Q. Approximately on how many occasions did we meet to prepare and go over this case?

A. We met on two occasions.

Q. On the first occasion what, if anything, did we

speak about or review or plan for trial?

A. We met a few weeks ago and we reviewed the medical material that I happen to know and you provided me with some additional pieces of information.

Q. And in addition to that, what you just testified to, did you look at Ms. Blue's MRI films and specifically pick out certain images from those films that would be instructive to the jury to explain whatever you wanted to tell the injury about her condition?

A. Yes, we have.

Q. Did you compare those enlargements to the originals?

A. Yes, we did.

Q. Are you being paid, as are all doctors that come before the jury will be, for your time away from your practice having been called on whenever the trial was going on?

A. Yes, I am.

Q. Okay and how much are you being paid and what does that entail? Why are you being paid?

A. The stipend is $10,000 and it means all the time and the effort required for the testimony and preparation and including changing office practices. Tomorrow for example I will be seeing patients all day, as an example.

Q. How many patients are you going to now see tomorrow

on Saturday?

A. I believe the day is over 46.

Q. Prior to coming before the jury, did you review all of the available medical records in this matter?

A. Yes, I have.

Q. Okay and I believe the office note portion and whatever portion, other portion Mr. Hall would like in, but the office note portion would be in evidence, so you can read from it, so if you need to read from it, look at your notes and tell the jury when did Ms. Blue first become a patient of yours and how did she become referred.

A. Mrs. Blue first came to the office September 21, 2009 at the request of Dr. Kaplan.

Q. Okay, can you just go to your office notes in front of you?

A. Yes, I did.

Q. Because you are the first doctor, when we say you took a history in the medical field or the context of medical treatment, what does history mean?

A. Well, I am sure you know anyway, but history in this case is the taking of a questionnaire where you try to obtain all the facts as they are, and try to understand from the information obtained the events that occurred to an onset of condition, traumatic or not.

What happens is whether in manifestations,

repercussions, response to treatment, failure to respond to treatment, it all comes. That is what a history contains.

Q. So, we are clear in September 21, 2009, you also told the jury your office was within the same facility or office of Dr. Kaplan, just in your separate practice?

A. Correct.

Q. At that time, did you have the availability of all Ms. Blue's medical records in addition to her history having been treated by Dr. Kaplan for the last year?

A. I had availability for some records, but not all of them.

Q. Can you tell us the history that was relayed to you?

A. They were described to me as while in a motor vehicle accident and apparently on a work assignment, that in particular, vehicle two was hit by a large motor vehicle. Apparently it was a large truck. And she points out to me immediately the experience of unpleasurable whiplash, some neck whiplash, resulting in her neck symptoms.

Q. Let me stop you there. That is a word that many people know, what does it mean medically, whiplash?

A. You know, when you are whipping a large a stick back and forth, that is sort of easy. In medical terminology or setting, whiplash refers just about exclusively to neck injury. It's when your head is whipping

and lashing from a sudden deceleration or sudden acceleration and that applies to a certain degree of force to have this quick motion that is not entirely under your control.

Q. We are not going to do this for each note, but just with this first note, would you continue on with the history that she told you in that 11 months after the accident?

A. She mentioned to me by way of occupation she was a legal editor. She had essentially cervical pain right from the get go, but within months she had increased symptoms and at that point was getting more and more intolerable. She had headaches and associated insomnia.

Q. Like inability to sleep?

A. Yes. It got to a point where even walking was problematic at some moment, at some exacerbation phase. She had developing forearm pain as well numbness to her fingers, gradually developing during this period of time from the date of accident to the moment that I saw her.

Even though she is right hand dominant she had difficulty dealing with her task or occupation. It requires a fairly detailed use of both upper extremities and that was becoming a problem and came to the left upper extremities.

She rated her pain anywhere from between five and ten. And in a physician's office, the doctors will ask you what is the pain, what is your pain level and it is hard to

refer to what is a personal experience or symptoms, but we try to put a subjective comment to an objective level. We say what is your pain, zero meaning no pain, ten the worst. Hers was five on that day.

Q. Did you say subjective, objective, in medical terms, what does that mean?

A. Simplest form, subjective means you the subject tell me the information based on the a question or a fact. Objective means that as the objective, the observer will note some details, some note, some findings that are either from what you are told or what I can examine and notice.

Q. Continue please, Doctor. You were continuing with the history?

A. Yes, she mentioned as well that she had lower back pain from this particular incident. And had occasionally weakness in her left lower extremity, but the main concern was the neck. And she pointed out to the fact that activities of daily living many of them were provoking more symptoms, make matters worse, in other words.

Q. Was it your understanding, despite it never being noted in your notes, that she was also being treated by Dr. Kaplan and other doctors for a left shoulder tear and was actually operated opted on?

A. I was aware of the fact that other physicians were involved in her care.

Q. Okay, when you dealt with her and you said here that her main concern was the neck which was your focus as a spinal surgeon in treating Ms. Blue?

A. Well, the focus was directed to the area, the symptoms, that lead to most significant limitations for her, in her case, which comes with spinal problems, the neck and arm condition that we just discussed.

Q. Okay, did you do any examination on that day?

A. Yes, I have.

Q. What did you find on the examination?

A. I found that she had, in essence, pain in the neck on palpation to touch. That she had at that point some degree of inflammation, but not excessive due to fact that her Sperling test -- that is a special neck test.

Q. Sperling?

A. Where I squeeze the cervical roots, the nerve if you want, that was not provoking sharp pain like it being with some patients. Otherwise, though, she did have weakness in the left arm. Her hand grip was definitely weaker than what it should be. She also had difficulty extending her wrist on the left side.

Q. Doctor, what does diffuse tenderness mean, both the word diffuse when it says that medically or any doctor and then tenderness as it relates to the neck?

A. Diffuse means that you have the white area with

palpation will cause symptoms that are instilled in pinpoint areas. Wide. Tenderness is exactly that, when you press the area the patient describes more symptoms.

Q. Did you have an opportunity on that visit to actually look at her MRI films and the reports with the films?

A. Yes, I have.

Q. Okay as well as x-rays performed by Dr. Kaplan?

A. Correct.

Q. To the neck. Again, you looked at x-rays of her neck and back and the MRI, that is it, correct?

A. Correct.

Q. Tell the jury when you looked at the x-rays you can also include the MRI and I want you tell them what you found then you can define words like spondylosis when you get to them?

A. So the films reported or discussed --

Q. Which films, if you can just tell us?

A. I have on my note November 8th, 2008 for plain x-rays they were executed by Dr. Kaplan in his facility.

Q. November 8th, 2008 you have MRI of the cervical spine; is that correct, as well as plain x-rays, but there is no date?

A. That is right. I stand to be corrected. MRI November 8th, x-ray I am not certain about the date. About

thereabouts.

Q. Regardless of what date, what did you see when you looked at them as well as what may have been noted, what did you see?

A. Plane radiographs radiographs in general are good to see the bone structures and there is still very useful even though we have modern imaging methodologies. When it came to the cervical x-rays, it showed that the cervical 5 and 6 -- we name a disc by virtue of the bone that it is sandwiched between. Cervical 5 and 6, what we call spondylosis. Spondylosis is the disc narrowing bone spurs at that particular level.

Q. Spondylosis is caused by trauma?

A. No.

Q. Is spondylosis a typical finding in a man or woman of 53, 54 years old?

A. It is common and actually expected almost.

Q. In addition to the spondylosis, what else was found?

A. The C6-7 level, therefore second disc had to some degree similar findings, just not as much as cervical 5 and 6. Then I had the opportunity to look at the MRI of the cervical spine, the MRI dated November 8th, 2008. What I talked to you about before. MRI's are good to show soft tissue and they show the relationship of the soft tissue

among themselves because each cervical tissue has a certain look compared to another one to the point also with bone. That showed that she had herniations, mass effects, as I like to call them.

Q. M-A-S-S

A. Yes, in other words, tissue occupying in an area that doesn't belong. A cervical 5 and 6 and cervical 5 and 6 and 7, the ones we just talked about.

Q. What is secondary straightening of the normal cervical lordosis mean?

A. That is that a description that the radiologist or in our case even ourselves can make. We have a normal alignment of the cervical spine, for example. So when somebody has an active spastic condition, presumably in this case, you end up with losing that posture.

Q. What do the words cervical disc herniation with myelopathy and lumbar disc herniation without myelopathy?

A. Disc herniations can have repercussions and in this case, in her case, it did for the arms so you end up with numbness and weakness that I talked about. That is the myelopathy I am referring to.

Q. Myelopathy meaning what?

A. Myelopathy refers to dysfunction of the neuro system and the one without myelopathy meaning refers to the lumbar because many lower lumbar areas refer to the fact

that the back pain or the disc abnormality as noted doesn't have the same repercussions on the neurological system as it did in the cervical area.

Q. Tell the jury these two words first, then we will get to what it was. What does diagnosis mean and what does prognosis mean?

A. Well, diagnosis is a term that describes the sort or medical conclusion you would come up with after obtaining information that is available, meaning history, physical examination, imaging information and others. You end up with a diagnosis. Progress is a term that describes what we believe is the potential outcome. In other words, the hope of recovery or not, improvement or not. The prognosis is a stipulation, a comment about the outcome.

Q. Did you ask Ms. Blue if she ever experienced or ever had any trauma to the neck or back before?

A. Yes, I have.

Q. Okay what, if any, past history did she relay to you?

A. None really.

Q. And what was your diagnosis and prognosis at least on the visit?

A. The diagnosis was cervical disc herniations with nerve pinching problems. She had associated weakness and the prognosis, in my view, was poor because of the duration

of symptoms. Meaning, from date of the accident which was in 2008, October to what was, approximately, one year after the accident in her first visit. Therefore, the prognosis just by virtue of clinical time was poor. And even discussed at the first consultation by the operation of surgery.

Q. Were you aware that in addition to medication in addition to physical therapy for the approximate year before that she had actually undergone cervical epidural injections into the neck with Dr. Kushnerik and had not had relief?

A. I was aware of the fact that she had from date of the accident active care.

Q. Were you aware that she had not be working other than one day since the accident?

A. I was made aware of that, yes.

Q. What was your opinion at that time whether or not that I was visible for her to go back to work at this point?

A. Based on the symptoms described and confirmed by the physical examination I didn't believe she could do it and that is the reason why she was the not. She didn't have the capacity to work.

Q. What would prevent her from doing it?

A. I am sorry, sir.

Q. What would prevent her -- assuming what I am holding is something called an Edgar document, it would be

required for her to sit for eight hours comparing this document to another one with her head down, what would prevent her with cervical herniations and the medications she is on and concentrating on such a document?

A. Well, that is what I understood. Also is the fact that she had very sort of time consuming, almost tedious type of work where she had to be very careful reading her material for these -- I believe these documents are financial documents and they have to be compliant and that requires attention and that is exactly the type of activity and posture this would produce more symptoms in a case of head flexion and arm numbness.

It would be hard for me, at least, to imagine that she could concentrate and do her work well.

Q. I want to go through the second note and would the Court's permission I will have you step down, but if you can go to the second note, the second time you saw her on October 14, 2009?

A. This is correct.

Q. Okay, did you take any further history, record on the symptoms, you don't have to go through the whole thing if anything was additional and also first tell us that?

A. Yes, I mean, I obtain additional details to the history. For example, this note reflects epidural injections that counsel was mentioning before, which is a

common used treatment modality for pain when it comes to spinal pain.

And there was also a better description possibly on her part also with regard to the finger numbness, arm infection as to the neck pain while she stood with her head forward.

Q. Did you take any imaging studies yourself on this date, if so, what did you find?

A. Yes, I have. And the x-rays were regular x-rays again were with a focus on dynamic instability. We ask her, we asked the patient to flex and have an x-ray in the flexed position and ask the patient to extend. We have an x-ray done in the extended position. And we had that x-ray done and the findings were that the cervical 4 and 5 had a rotation that exceeded the normal.

So she had, radiographically at least, evidence of cervical instability.

Q. Does assessment equal diagnosis in your notes?

A. Pretty close. The answer would be yes.

Q. What was your assessment on this second day?

A. Assessment was injuries resulting in instability at cervical 4-5 and the disc herniations C5-6, C6-7 with the weakness to the arm that we talked about.

Q. Did you make any recommendations regarding surgery at that point?

A. Yes, I have.

Q. What were the recommendations to the surgery?

A. The surgery was to address the disc herniations at C5-6, C6-7 and address the instability at C4-5.

Q. Are you permitted to just do surgery on her or do you have to seek authorizations and get someone else's approval and permission?

A. Yes, in the context of she presented -- she had a compensation case, you have to subject a package for review.

Q. You are also agreeing when you take a compensation matter to accept the compensation rate?

A. Yes.

Q. Is that rate significantly lower for both treatment and surgery than it would be if someone had a private benefit or say Donald Trump walked in and wanted to have his neck operation, is it different?

A. Yes, there is indeed prescribed fees that would not be considered customary in other settings, correct.

MR. McCRORIE: Okay, with the Court's permission, I would like the doctor to come down?

THE COURT: Doctor, you can step down. That is fine.

THE WITNESS: Thank you, your Honor.

Q. Doctor, I am going to put a model up if the court officer wouldn't mind getting the easel, please.

THE COURT: I don't think the model is going to go on the easel.

MR. McCRORIE: I have other illustrations we are going to use. Illustrations that are not in evidence, they are demonstrative only and I will refer to them.

Could you please using the model and this illustration of the cervical spine.

THE COURT: Is that in evidence or is that just for demonstrative purposes?

MR. McCRORIE: Demonstrative.

THE COURT: That is fine.

Q. Can you use the model and the board up here called anatomy of the vertebral column to explain to the jury anatomy first of the spine, the lordosis, what an axial view and sagittal view is. As much as you can tell them about the spine.

A. Okay, well, what you have in front of you is a classic depiction that we often, even use ourselves, to explain to patients or to instruct students to what would be considered normal anatomy, at lease in a schematic way.

So, what you have on this particular easel demonstrating is a lateral view and the back view of the whole spinal structure. C1 through S1. Cervical 1 to sacral 1.

Based on what we just discussed before, what I would point out to you is the fact we have natural curves in our spine, so we tend to have a cervical lordosis, meaning a curve toward the back. A thoracic psychosis, you tend to have a little rounding formed in the thoracic spine, which is the mid part of our spine. We tend to have a lumbar lordosis, lower down, the sway that you are aware of.

Q. Is that on the model, is that depicted basically what the spinal looks like?

A. Yes, this is depicted. This is a classic way to present and appear and what this depicts to some degree to what we are talking about, lordosis circle, lordosis lumbar, thoracic psychosis.

What counsel has asked me before and also when we comment on films and when see images, we like to point out the type of views. So if we were to see an x-ray from the side, we call that the sagittal view. If we've looked down, and the view through the arm is called the axial view. It is important when it comes to MRI's, we tend to look at axial view quite a bit. Sometimes we have a coronal view or frontal view.

One of the other things that is important to bring to your attention is these little red plastic --

Q. Yellow?

A. Yes. Yellow here depicts nerves. So, what is good

to retain is that there is a tight intimate anatomy between the bone and the nerves. It doesn't take too much to get nerve compression and here you have the exit point where you can picture inside, especially if we have the axial views, that things can get pretty tight fast if we have what is called the mass effect.

Q. Okay, now if we can go to Plaintiff's 8 in evidence, I just want to have you explain to the jury what they are looking at. Obviously this is Ms. Blue.

A. Yes, it is.

Q. The date is on there is whatever the date is, but it is a view of her before the surgery, correct?

A. Yes.

THE COURT: For the record, what exhibit is that?

MR. McCRORIE: 8.

Q. Can you tell the jury when you said that you did these stability views on October 29, 2009 or whenever the second visit was, October 14, what they are seeing here, what it shows you?

A. So what you are looking at is a sagittal, side view, cervical points, cervical spine x-rays, the bone x-ray. You look from the side and in this case we are doing the dynamic study referred to before as flexion extension.

And what that x-ray added in terms of information

compared to what I believe was known before, is that yes, you have cervical 5-6, cervical 6-7 to lesser extent showing narrowing. Cervical 5-6 bone spurs and so forth, but if you were to do a little geometry exercise and do the angulation between cervical 4 and 5, you would realize that the arc of rotation is excessive.

Normally we have a certain arc of rotation and in her case it was double the normal.

Q. Again, even the disc space narrowing, would that be caused by a car accident or is that something that you already talked about, spondylosis?

A. These changes were present before.

Q. Okay, I am going to hold up Plaintiff's 4B, again the actual films are in evidence and so before we tell the jury about the films, an MRI comes maybe 16 to a view, we are looking at one view, correct?

A. What counsel is telling all of us is the fact when you look at the film and it is possible for you to see that there is multiple small images and they correspond to the part of the spine, in this case, that was sliced. It is a technology that slicing the body form.

So what counsel is trying to tell all of us is that two of these slices were identified for demonstration purposes.

Q. If you can tell the jury, if you can put these back

and tell the jury what they are seeing, what view this is and point out everything from the round part, the line coming down and what we are looking at?

A. So you are looking at the sagittal, side view, MRI. So we talked about that before, the MRI shows more, shows more of what? Shows more of soft tissues and different soft tissues have different densities.

So that is how we worked this through. So for example, you have this particular dark degree of density that's the muscle nuba. What he was pointing out is the cerebellum, the back part of your brain.

Q. I want to go back to the illustration for a moment and in the illustration coming from the skull what is the yellow line and what would be the black around the yellow line be?

A. Looking at that it refers to the spinal cord and space around the spinal cord. So what you have depicted here in this long gray tube lighter than the muscle is the a spinal cord itself.

Q. Is the spinal cord connected to the brain?

A. Yes, otherwise we wouldn't be able to do much.

Q. And the little yellow the nerve endings that are coming out, this is the spinal cord, are those nerve endings what goes out on branches to our arms our legs, back up to our brain?

A. Yes, it is the main table that brings all the feelers that we need to act, move and so forth.

Q. One more point for the jury, the spinal cord appears to be thick at the top and trail off at the bottom and we can show them here a cervical as opposed to a lumbar, what is the cordus equinus as opposed to the full spinal cord?

A. What really happens somewhere in the high low mark area of the spinal cord, the main cable stops and really leads to this series of little nerves we call nerve roots and that is what you see here. And somewhere somehow someone said they like the term, it has to stick and that is why we call it cordus equinus, horse tail. It looks like a horse's tail. You have a dense bunching of lumbar and sacral roots that innervate the leg and the bottom part of our body.

Q. What would happen if the thick full spinal cord up in the cervical region were severed to any degree?

A. Severed to any degree? Severed is a bad word. One would have definitely some form of paralysis or serious impairment, but it can be compromised and have dysfunction, arm weakness, for example, numbness, like Mrs. Blue has.

Q. Okay, so one last thing going to -- the pink in between the brown, can you tell the jury which is the bone which is disc and talk about the end plate of each in the

illustration first?

A. So from the illustration point of view the pink here refers to the disc. So the disc is the area of the spine that allows us to have some motion, otherwise we would be living as bamboo sticks and the disc is a flexible structure, but its content has to remain where it supposed to be, if it comes out, you have a herniation and may or may not have resulting neurological compromise from that, if not pain alone.

Q. When you say, "comes out", is that into the spinal canal passing the end plate of the bone?

A. It could factly come out in any direction, but the dorsal extrusion or protrusion which is the commonest is the one that leads to neurological problems.

Q. Is there a ligament holding the disc in place in between the spinal canal and the where the disc is being held in?

A. Yes, there is actually two main ones. The first one is called annulus and the annulus is the tough mesh that holds the jelly part of the disc together.

Q. Pointing the axial views of the disc?

A. Annulus around here and you have another one that is the, I believe, the sort of whitish portrayed here -- correction, the gray portrayed hear. That is the so-called posterior longitudinal ligament. That is another touch

structure. Things are usually contained by those structures.

Q. Things are contained where they are supposed to be by annulus and posterior ligament?

A. Correct.

Q. The middle part or nucleus pulposus of the disc, what is that?

A. That is your jelly part. That is what we call jelly for all intents and purposes nucleus pulposus, it's a discus structure that allows a little motion within itself some we can move our body and have head turning and flexion and so on and so forth.

Q. Which we call that jelly, is it a tough jelly, a hard jelly?

A. Unfortunately it hardens up over time, we talked about that, but generally it is relatively soft.

Q. What we are going to do is go back to Plaintiff's 4B and if you could explain the jury -- what I will have you do, you if you don't mind, is to do just the C levels, writing in here C1 through 7 on the bone.

Let's see where the vertebrae are?

A. One is little hard to see but it is just -- you have to the dorsal ring and the front ring here. But here is C2, C3, C4, C-5, C 6 and c7.

Q. Just so it is clear, you said that the C4-5 disc

would be the disc between the forth and fifth vertebra, correct?

A. Yes, a disc is named by the sandwiching bone.

Q. And can you tell the jury what we are looking at C 5-6 and the difference in the disc space as it looks above and below?

A. Well, counsel has it the wrong way, 5-6 is right here.

Q. I am not a doctor.

A. It is narrower, the disc on this particular image shows a lot of darker signals, it is almost black compared to the one --

Q. By signal you mean --

A. MRI signal. In other words, okay, this white signal versus a gray signal versus a black signal, I'm referring to the depiction the images on the films that I get to see in the office. So that particular disc is not having its normal signal compared to the ones say above C4 for example. It is darker and it is narrower. C6-7 to lesser extent has the same findings. C4-5 from a hydration, from a water content, doesn't look so bad.

Q. And although C4-5 has a hydration content, if the disc, in fact, coming out past the end plate, if one were to cover that white what we call contiguous material --

A. Yes, it looks from this view it is bunching out, it

is not where it should be, contained as well as it should be.

Q. We are going to put up 4A, although it is the same date, November 8th, it appears to look different, can you tell the jury what T1 image is compared to a T2 image in MRI's?

A. MRI technology is one of the these marvel of modern of science and engineering. The scientist behind it won the a Nobel Prize. I don't pretend to understand the spinical hydrogen atoms, like technology implies.

What you have is modulation that captured the spinic energy in a way. The T2 weighted image points out a water signal, so whatever structure that has water will show up bright on the MRI and that's what you have.

The T1 is more for soft tissues like bone edges and things like that. This one is the one that we use often and I think it is a little more illustrative and it is also a good one to show disc herniations.

Q. Almost if someone were to hide behind the telephone pole and keep moving a little to the left or right, you would see a bigger view of them, could you explain to the jury while the person is in the MRI machine, how it takes a picture, moves takes a picture, because I would like you to explain how you see things different in one view that you don't see on another view?

A. Well, what counsel is putting up here that you have a different weighted image and that can be completed with technology.

Again, it is focused on a different type of the structure, we can see ligaments better on this particular imaging than we would have here.

Q. Now we are looking at 4A for the record?

A. The technology is slicing the body -- virtually slicing the body. I am not sure if you want to get into that, but the point here is that as we have a slice at a particular point of the newer canal we see some exchange he is in the disc. These are not so bad here, but then we were to look at this particular one as we see that the C5-6 and C6-7 have disc herniation, loss of disc containment, for example.

Q. And if you can can you circle those two disc herniations is that you speaking of?

A. So that is C-5 six and that is C6-7 (Witness complies.)

Q. So we are clear, on this view if you were on cover the end plate of disc those anything that extend out into the spinal canal would be called herniation?

A. Yes yes. I think even from your viewpoint you can see well that there is loss of containment there compared to what normal should be.

Q. Okay less go to 4C and now look at the axial view dated the same date and tell the jury what they are looking at describing the full circle around the spinal cord in any time it appears that the disc is touching the spinal cord?

A. Well here you have the axial look, the look down view. And this one here points out to the relationship that you have, the spinal cord, nerve canal and disc or bone area.

The best way here to approach is probably to look at normal or near normal. In here you have the white signal that the space, that the loose space, the neural canal has. You need to have a loose space.

Q. Write normal on this view?

A. You have a nicely shaped spinal cord.

Q. Indicated with an N, the normal.

MR. McCRORIE: I am telling the Court reporter.

A. It is a nicely shaped spinal cord. We think about it as round, but it is a little more oval, it looks like it is in tact.

Q. One other thing which might be confusing, how does the MRI get different views in terms of looking down?

How does it get the down look? How does it bypass one view? I know you already you don't know the exact technology.

A. I know the slicing concept. In other words, these

white lines you have on this particular vignette reflect corresponding slicing levels. So, the computer related to -- the computer attached to MRI machine will slice our body a different levels a different points and that is what the resulting vignettes or images are.

Q. Why don't we do this to speed it up. If you feel you have to tell the jury tell them, show them a disc that is being that is abnormal on the axial view?

A. You know if you were looking, for example, at this particular set of images here you see that this particular disc has lead to some change in the spinal cord that's vignette 11.

Q. Write changes if you want to?

A. Or 12 even changes. So that is the cervical disc 4-5. There is some changes that are not as impressive at the other levels, but there is some changes.

Q. You said at 4-5?

A. Cervical 4-5.

Q. So the jury is clear, this one you circled the mass effect on 4B on 4-5?

A. That is cervical 4-5 compromise.

Q. We are going to move off cervical just so we can move along. I want to put up a lumbar view and those films are here, 5A for identification. Tell the jury -- now they know they are looking a sagittal view, can you show them any

abnormality, if any, that you found and see on the lumbar film?

A. Yes, I think the first one I would strike me as worth mentioning is lumbar L5 S1 where you see again is some degree of loss of containment of the disc.

Q. If you draw a line from end plate to end plate?

A. I was going to do that. This line here, so you can see, there is some form of bulging.

Q. Just so the jury is clear, you talked about the cordus equinus or horse's tail, at one point it goes from solid to trailing off, is that actually a good view to see that?

A. Yes, the lumbar roots, the little spaghetti strands you see that.

Q. How would somebody receive a lumbar epidural during pregnancy without any fluoroscopy?

A. It is like trying to spear a spaghetti string while it is being cooked, so it is a hard thing and the same thing here.

Q. Just use this illustration to discuss how a cervical epidural injection is done and if you need to go back to the film?

A. Well, I think it is this is good view because it points out the cervical segment and an epidural on the cervical segment are a little trickier and you need to be a

little more careful on this. You are putting a needle in a very small space. It is a virtual space. It is a called epidural and you don't want to pierce the dura. The dura is the sack that contains the neural tissue. It has a fluid that, we call the cervical spinal fluid, the watery fluid, but you don't have much more to go to spear the spinal cord itself, that would be a bad thing and worse would be throwing medication into it. That is catastrophic.

Q. Dr. Kushnerik's epidural procedure records are here as 13, but as we hold up one view of it it looks like there is a hypodermic needle in there.

Is that the epidural needle being shown through something called fluoroscopy so the doctor can see where he is going?

A. Yes, so people who do these things safely, as hers was done, use complete technology. A little bit like a camera view of what we are doing when they put a needle in the space, when you put the medication in.

Q. Doctor, did their come a time that you got an authorization for the surgery to do what you requested on the second visit for Ms. Blue?

A. Yes.

Q. When did you do that surgery?

A. The surgery was executed 04/28/2010.

Q. Pull the surgical report out of your file please if

you don't have it handy, Doctor, I will get it for you.

A. Do you mind maybe?

Q. So why don't we do this.

Can you explain the jury the type of surgery using this illustration and what type of implants were put into it and I will get the record.

A. So as you heard, Mrs. blue was defined as having three cervical problems. Two of them were disc herniations, one of them with instability.

The purpose of the surgery is to get safely to the bone, to the bones, cervical 4-5 and 6 and 7. Have the exposure required to proceed to discectomy and implantation of six implants.

Q. Tell the jury when you use a term like discectomy, if you don't mind before you sit down, what procedure was done and you now have the record, there is an operative report?

A. So Phase I is access surgical incision and access the epidural space. I mean, we have the God given anatomy that makes it possible to reach the cervical bones safely. That doesn't take away the fact that you are next to the windpipe and next to the esophagus the feeding tube or next to the carotid artery, which is the one that goes to the brain.

I mean, there are some pretty important structures

there, having access to the bone. The next step is to do the discectomy. The discectomy entails removing the damaged disc material and do it in such a way that you are safe. That is where you are getting close to the spinal cord and the neurological structures.

So that is the so-called neurological phase that people are so concerned about. Those surgies have a certain element of risk.

Q. So once the disc is removed, in this view it is hollowed out, what do you then do and how long does this procedure take?

A. Okay the discs are removed and in her case she had three discs removed and that is subsequently followed by implantation. In other words, you remove from top down the tissue that is either weak or damaged by the cervical 4-5, or relating mass effect C5-6 C6-7, but you have to fill the space that you would -- that existed before because the disc was there, you fill it with an implant and it is now a fairly common technology used that they called a Peek implant. It is a polymer or orthopedic plastic, if you want to call it that.

That implant is filled in its hollow portion with a bone phase, because ultimately you want the bone to take over in healing. And all of this is held in position by applying an interior cervical plate. You don't want

implants to move, you want bone fusion and keep the anatomy that is reconstituted with a normal alignment as much as possible.

Q. Are you doing this with your eyes; how do you see what you are seeing?

A. Okay, the first phase the access, pretty much. All this work when it comes to the discectomy is done from a microscope and the actual implantation of the cervical plate is done with my own eyes.

The whole process in a case like hers -- I cannot recall how long it took for her, but traditionally it takes over three hours.

Q. And she was under anesthesia, correct?

A. Yes.

Q. I am going to hold up and put up 8B in evidence, tell the jury what they are looking at?

A. You are looking at a side x-ray, the resulting effect, if you want, from the spinal surgery. What you have here is a side view that shows the cervical plate, the attachment of the cervical plate to the vertebral body to the bones.

These little dots are markers in the implant. The implants are radiolucent, if we didn't have little markers in there we would not know where they are. So these are implanted at the manufacturing stage and when we do the

x-rays we can see where they are. And this particular view, for example, here and here, this one maybe here. You are starting to see the bone starting to ossify. So you have the resulting effect with implant cervical fusion C4-5, C5-6, C6-7.

Q. For how long will that three level plate system been in Ms. Blue?

A. The rest of her life.

Q. I am going to show you Plaintiff's 8A and that would be compared to the views, the other side views we took, in Plaintiff's 8A, what view is this and is this one before and after?

A. Well, yes, this is the front view before the surgery. This is the front view after the surgery. For the assessment of the fusion, that is the only one we had before, it is easier to work with. That is, I suppose, an illustration by counsel of the fact that she had an implant in her body and it is there to stay.

Q. Prior to having you sit down Doctor, did you have an opportunity prior to rendering the opinions regarding or final prognosis regarding Ms. Blue, did you have an opportunity to review all the available records including her initial hospital record and emergency room record?

A. Yes.

Q. Okay, that is in evidence as Plaintiff's 2. Were

you aware her chief complaint to the EMS, having been taken right from the car put on to a long board, was my neck and head hurts?

A. I am aware of this, yes.

Q. When she got to the emergency room, and we can go through it looking at Plaintiff's 2B, first what does triage mean?

A. Well, emergency rooms are very busy places and you have to prioritize care. Some people have real emergencies, some people have lesser problems, that is what triage does.

You have to use your best judgment based on criteria to put somebody ahead because of the severity of the medical condition versus another type of injury where you would have somebody wait longer.

Q. This one is called an emergency physician record, they have a form for MVA, and MVA meaning what?

A. Motor vehicle accident.

Q. Okay if you take this highlighter, Doctor, where is her injury and when did it occur according to the physician that is seeing her after the accident?

A. So that is sort of a templated form. I see this like you are now injury to neck, is what is reported and that is, I suppose, her talking to the triage nurse or the physician and that is at the facility and occurred just prior to arrival.

Q. Indicating with a highlighter, the location of her most significant complaints?

A. Head and neck.

Q. At the time noted you don't have do it, it is right there as 5:20 and if you could circle down here indicates memory loss or highlight headache and back pain for ROS, what does ROS mean?

A. Review of system.

Q. So they indicated at least at that time she had memory loss, headache, neck pain; can you see that, can you highlight that?

A. Whatever is circled is indeed what has been identified.

Q. What are her associated symptoms right up here?

A. Dazed is what is circled.

Q. What does it say she remembers prior to coming to the hospital?

A. She remembers the impact and she remembers coming to the hospital.

Q. This is just an illustration, it talks about flexion, hypertension and it has a brain moving within a space, can you explain that to the jury, what happens during a whiplash like injury, the head is whipped back and forth?

A. To some degree her brain was suspended in the cranium in the skull. So when you have a severe

deceleration accident there is little bit of suspension in the brain going one way or the other.

Q. Just show the jury, please.

A. (Witness complies).

Q. When we talk about whiplash, it doesn't have to involve that but does it often involve that?

A. The whiplash event led to the neck injury that we talked about and some degree of brain dysfunction depicted on the ER assessment.

Q. There is an "X" over here on the bottom of the head, can you just please highlight the "X"?

A. Yes and the "X" points out to the left proximal area of the area that hurt the most this day.

Q. The written notes indicate headache initially was diffuse, six out of ten, then gradually became more localized to the left mastoid process; is that the left mastoid process?

A. Yes.

Q. Can you please above this when you look at this physical exam when someone tells the emergency room do doctors typically do a head, neck and systems exam regardless of what you are coming in for?

A. Yes, especially in this case, you make sure of the level of consciousness and so on and so forth.

Q. If you like, you can highlight and go over what is

checked off, I want you to tell the jury what the words vertebral point tenderness, muscle spasm and pain on movement, tell them what each word means?

A. Vertebral point tenderness points out to the fact that palpation at certain points of the spinous process, for example, the bony spikes we feel when put our hand in the back of our neck is tender. Muscle spasms are felt. You feel the muscles being tight, tender. And the fact that she when moves her neck has more motion than normal.

Q. Is muscle spasm, a word you used before, objective or subjective, meaning can a person fake a muscle spasm or exaggerate it?

A. No, it is subjective.

Q. Ok, so the doctor feels that when they note it?

A. Correct.

Q. Let's go to the back, the next page, when they examined Ms. Blue's back, can you indicate what they indicated here with the line?

A. Okay, it is somewhat analogous. Vertebral point tenderness, low back area spinous process, the bone you can feel that is tender to touch, she had tenderness reported.

Q. What does CVA mean?

A. I am not sure what it means in this case.

Q. Okay.

A. Muscles spasms were reported as being indeed

present.

Q. And this circle, can you highlight the circle, those are marks made by the physician?

A. Yes. What we are looking at in these markings here on this body diagram is pointing out what is lumbar, for me at least.

Q. At least in the clinical impression, what does clinical mean in those terms?

A. It is the resulting judgment to what they say in the emergency room. It is what the diagnosis is or assessment, like I call it.

Q. What is the clinical assessment, MVA sprain of what, when it says neck and lumbar, what does lumbar mean?

A. Lumbar is low back, neck and cervical.

Q. Just highlight those, please.

A. We are talking about lumbar, we are talking about neck, cervical in this case, we talk about and explain and mention the fact that she had MVA.

Q. Going to down to the x-rays, could you tell us what part of her body was x-rayed and what does head CT mean?

A. They did x-rays in case of trauma. You want to make sure you don't have fracture or things of that sort in her neck, so she had cervical x-rays, she had lumbar sacral x-rays, low back x-rays. The findings were that she had a straight cervical x-ray in terms of the alignment.

We talked about that, she lost the sway that normally exists in the neck.

Q. So the actual highlighted and circled by the doctor says straightening of the cervical lordosis, correct?

A. Yes, correct and referring to the cervical segment, correct.

Q. Is that consistent with trauma?

A. It is consistent with some event. It is consistent muscle spasms and in this case trauma was involved.

Q. Okay and the head CT, what is a CT?

A. Well, because I suppose the physicians took note of some mental change in function, so they wanted to make sure she had no brain injury and they asked for plain CT of the brain.

Q. Let's go to the x-ray reports from the hospital there's both a cervical AP view and they did lateral views, lumbar sacral view, it is here on a disc, but by report, what does the impression of both the cervical lumbar and what if any medical significance does that have.

MR. McCRORIE: I am sorry, 2C is a larger version of what is in evidence.

A. So, one they rule out actual fractures, but they rule in what we have been talking about, the fact that she had muscle spasm and that is inferred because the cervical spine lost its lordosis. We have a straightened cervical

spine.

They talked about the findings that we discussed, the spondylosis. In this case they used the word spondylo lordosis, which literally means the same, at least to me it does, narrowing of the disc space of the spurring.

Q. What do they call minimal disc spacing?

A. Again, it is a term describing a varying from normal where the disc space is narrowed a little bit. We know C6-7 is not as changed as C5-6.

Q. What about the lumbar spine, only because there is a word there uterine fibroids and some other terms, tell the jury what was found?

A. They pointed out the fact that for the most part the bony relationship in the lumbar segment was within normal limits.

Q. Okay, what does that mean, degenerative uterine fibroids in the pelvis, lumbosacral graphs are otherwise within normal range?

A. The uterine fibroids refer to a gynecological issue.

Q. Just before we have you sit down too, in evidence Plaintiff's 7, are you aware that Ms. Blue three days before this accident was in an incident where she was assaulted, punched in the arm and had a sprain to the right wrist and punched in the right shoulder?

A. I was made aware of that eventually.

Q. You have seen the actual report?

A. Yes.

Q. It is in evidence, but it indicates a punch to right arm today complaining of pain to same. Color pink in skin, warm to the touch.

I wanted to go to the record portion where they did a physical exam. If you can with this highlighter indicate where the neck exam was and what it is indicates?

A. This is a typical medical -- again, it is a templated form. There is a word, in the neck --

Q. What does supple mean in the neck?

A. Yes, I was going to get to that. What we see here and I agree with gentleman, I would interpret that as being supple impling that the neck has no range of motion, no particular tenderness and you don't have suppleness if you are having spasms and then after that there is a zero to bar which means negative something, but after that I cannot tell you what it is.

Q. Just so we see that it is negative something. Right above it does that state 53 year old here with pain in right shoulder and right wrist status post assault, negative head pain; is that what that states?

A. Correct.

Q. So a line with a question means she was

experiencing no head pain three days before the time she was in the emergency room getting a CT scan for head pain?

A. Correct.

Q. At least suppleness of the neck is inconsistent with three days later there being spasm, pain on movement and vertebral point tenderness?

A. Very much so.

Q. You can have a seat, Doctor.

Is taking a history and writing the word whiplash is that what is known as the mechanism of injury?

A. In this case, yes.

Q. I meant just when you take a history and you write how it happened, if someone fell, what is mechanism of injury?

A. Well, it is just that whiplash, we use as a diagnosis as well as in the cervical spine, but literally she experienced whiplash to cause her trauma. Whiplash is neck pain, occipital pain, mastoid pain.

The disc herniations happened because of a whiplash, but it is not a whiplash disc herniation --

Q. I want to get some definitions, then we do some opinions and you are done, but what does degeneration mean, medically, as it relates to the spine?

A. Degeneration in the spinal context, spinal care context, is a term describing changes from normal anatomy.

And that changes occur normally as we get older. I have disc generation for certain because I reached this famous threshold point.

Q. Meaning age?

A. Thank you. Meaning disc narrowing. Meaning dryness of the disc. Meaning that when you look at a disc in an MRI it is dark instead of being white, watery. Meaning bone spurs that occur as we get older. Yes, that is disc degeneration, the condition we hear about a lot.

Q. Does disc degeneration equal herniation?

A. No.

Q. Can you have a herniation and have it be asymptomatic?

A. Yes.

Q. Tell the jury what asymptomatic means?

A. Means that you don't have symptoms. You have almost like a radiographic diagnosis, but no clinical diagnosis. No symptoms.

Q. Can trauma cause the previously asymptomatic disc herniations to become symptomatic?

A. Yes.

Q. Can trauma cause a previously asymptomatic degenerative disc disease, like spondylosis, that doesn't have herniations can that cause a herniation superimposed on the previous weakened spondylosis?

A. Yes.

Q. The more degenerated a spine is, could you agree, the less trauma is needed to cause a herniation?

A. Generally speaking, yes.

Q. When you were with the microscope looking in Ms. Blue's -- in her spine, did you actually note and visualize herniations and tears to the annulus?

A. Yes, I did.

Q. If someone had such herniations prior to an accident and they were symptomatic, would you expect being the level they were that you showed the jury and saw with your own eyes, would you expect that person to have some complaints in the 50 some odd years prior to the accident some to some physician?

A. Yes.

Q. How about if she was actually before a physician within 72 hours of the accident, would you expect that someone, that she would complain of neck pain to a physician?

A. I would think so. I would say yes to that.

Q. Would you expect her neck to be supple within 72 hours if she had a herniation that was pressing out into the canal, multiple herniations, but actually indenting as it is on the axial view?

A. I would expect her to have symptoms and complain

about it.

Q. Okay, I am going to ask you your opinions with regard to the cause of Ms. Blue's herniations and conditions.

I would like you to first assume that there was testimony, but there will be testimony by Mr. Garcia, that he was driving a 53,000 pound truck and that Ms. Blue was sitting within a stopped vehicle in front of this struck and whatever the degree of impact was, it caused the vehicle in front of it to be thrown four feet forward, it caused the transmission gear to break on the vehicle because the driver was on the break at the time.

MR. HALL: Note my objection for the foundation.

THE COURT: I will allow it subject to connection.

MR. HALL: Thank you.

Q. I would like you to further assume that the rear bumper, rear bumper shock was replaced on the vehicle and that the metal was dented underneath the bumper, that may have even looked not so damaged at the scene, it was replaced within a week of the accident.

I would like you to assume that the trunk latch of that trunk of that vehicle was broken. I would like you to further assume that Ms. Blue was in the emergency room and

picked up by ambulance immediately after the accident, never got out of the vehicle and when she was taken out of the vehicle was strapped down in a long board and it is even indicated she was unable to sign because she was strapped down when they came in they got there.

I would like you to further assume she convalesced at home and tried to go to work a week later, went to Dr. Maranga and on November 7, 2008, had a complete physical exam that indicated reduced range of motion to the neck, reduced range of motion to the back, reduced range of motion to the left shoulder, associated pain -- I am only going to be asking you about the neck and back. And that was as a result -- and that after the date of the accident until today she has had all the medical care that you have testified about and all the medical care with you including the epidurals to the neck and back, any other injections, medication, physical therapy and that she's is in condition she's in that you operated on.

Do you have an opinion within a reasonable degree of medical certainty as to the need, first, for that surgery that you did to her neck?

A. Yes, I do.

Q. What is your opinion as to the need and cause of the surgery?

A. That it is based on a trauma.

Q. What did you base that opinion on?

A. On the fact that she had no prior history of medical care for such problems.

Q. Do you have an opinion knowing what you know and having the hospital record and having not seen any other record in a 53 years of any other treatment and seeing what you see on the films, seeing what you saw on the operation, do you have an opinion as to the cause not of the spondylosis, of herniations that are within her neck that were operated on?

A. Yes, I do.

Q. What is your opinion as to the cause of the herniations?

A. Again, the cause is due to the trauma that we know about.

Q. I would like you to assume in a hypothetical world that herniations were there, but were asymptomatic; is that possible?

A. Yes, it is.

Q. So I would like you to assume that herniations were there in the hypothetical world, out there, this is not your opinion, but they were there and that as a result of the truck hitting the back of the car and her head doing the whiplash like motion, that from that point on she had symptoms that hadn't stopped until today, in that

hypothetical do you have an opinion within reasonable degree of medical certainty as to whether or not the accident where the 53,000 pound truck hit the car and caused her neck to do that, whether or not that was the cause of aggravating of a preexisting previously latent and asymptomatic herniation?

A. I agree that is the cause. The trauma is the cause.

Q. What is latent mean?

A. Latent means a condition that is not manifested and that eventually comes about due to all sorts of circumstances.

Q. Absent the motor vehicle accident, do you have an opinion whether Ms. Blue would require any of the treatment that she has undergone from the emergency room until today?

A. Nothing indicating to me based on history she would have needed any care for her neck.

Q. If I took out any of the questions in that hypothetical or the actual question about let's say for instance the man's transmission didn't break or didn't get that bumper replaced, but there was an impact how ever light or heavy with the truck and the car that was stopped causing Ms. Blue's neck to whip back and forth, would that change your opinions on any level?

A. No.

Q. Do you have an opinion within a reasonable degree

of medical certainty as to whether or not Ms. Blue will require future medical care beyond the date of this trial?

A. Yes, she would need future care.

Q. And for what period of time would you expect and you can tell us the categories, that Ms. Blue would require future medical care?

A. I think it is logical to assume because we have a history to also base judgment on, that she will need care for pain relief. She will need care for flexibility in her neck and need improvement of range of motion and she will need medical opinions of various stages to assess the cervical fusion and to assess the other areas of the cervical spine lumbar spine, based on history.

Q. I am sorry to do this to you, and the jury I want to back up. I only did the neck.

Do you have opinion within a reasonable degree of medical certainty as to the cause of Ms. Blue's lumbar herniation?

A. Yes.

Q. What is your opinion with regard to her lumbar herniation?

A. The opinion is also the symptoms are triggered by the trauma that we know about.

Q. You mentioned pain management, are you treating Ms. Blue for pain management in her shoulder and even ongoing

back conditions or are you a surgeon waiting to see if the surgery is going to be done?

A. Literally --

Q. Or some combination?

A. To a point literally I don't consider myself a surgeon who is interested only in surgery, but my role, my involvement for Ms. Blue has been in the cervical area. That was the most important area. Other people have been involved in lumbar, shoulder and pain management.

Q. Without going through every single question, would your opinions be the same as the cervical; in other words, could the lumbar herniation have been there before in the hypothetical world and be asymptomatic, she just didn't complain about it?

A. Yes.

Q. And given her history, is it your opinion that it is caused by the accident based on her prior history?

A. Same answer, yes.

Q. Okay are you aware of Ms. Blue's current treatment by the doctors where they are requesting, prior to considering back surgery, spinal cord stimulator and rhizotomy?

A. I am aware of that.

Q. We will have other doctors discuss that. Let's get back to the future medical opinion, please.

You said she might need medicals, you said therapy or maintenance, let's go to your specialty first.

Do you have an opinion within a reasonable degree of medical certainty as to whether or not she should continue, given the symptoms she is still having, to see a orthopedic surgeon, spinal surgeon, specificly spinal surgeon, into the future, such as yourself?

A. Yes.

Q. What is your opinion -- I know it is tedious, but we have to do it this way.

What is your opinion?

A. Generally speaking, patients of spinal surgery need follow-up at reasonable intervals. I could see a patient like Mrs. Blue requiring -- she would require visitation at least once a year with an x-ray probably at the same frequency or at least every two years and depending on the symptoms, MRI's would be in need on average every two, three years.

Q. Okay, so what is a cost, if it wasn't a compensation case? I would like you to assume there would be an instruction that after this trial that Compensation gets all their money back, I would like you to assume that and in the future, what would it cost someone to come to a follow-up visit whether it be yourself or the general area, a spinal surgeon, for a follow-up visit with the x-rays at

least once a year? Separating out the cost.

A. For a visit ot the office is usually $150 to $200. X-rays up to $300, I suppose. MRI's, I will speak for what I believe is the general cost in New York City at $1,200 is what I know about.

Q. When you say depending on symptoms, you are aware that Ms. Blue still had had symptoms both in the shoulder and the back, correct?

A. I am aware of that correct.

Q. Was surgery a success in the neck?

A. I believe so.

Q. Medical success?

A. I believe it was.

Q. Does Ms. Blue still exhibit symptoms in the cervical region post surgery?

A. She has one persistent very difficult problem and a few others that are not so severe. The severe one is the spasm. The left trapezius muscle group with limitation in the range of motion, especially when it comes to turning her head.

Q. What is the trapezius muscle, where is that?

A. It is a shoulder muscle that gives us the swing shaping of our shoulder, if you want.

Q. Ms. Blue is currently 56 years old, again, I note tedious for what period of time would you recommend with a

reasonable degree of medical certainty, she continues to at least check out her neck once a year with a spinal surgeon and back?

A. My opinion she would need frequent visits, at least once/twice a year.

Q. When you said $300, would that be $300 for the neck, $300 for the back in terms of series of x-rays?

A. Most likely, yes.

Q. Does Ms. Blue still have what is -- what are radicular symptoms, radiating symptoms, where do they come from, the disc herniation, cervical disc herniation?

A. When we talked about the yellow string on the plastic model, they are the nerves that reach the part of your limbs. She has a little bit of numbness left in her left hand, compared to what she had before surgery. It's better, but she has some left.

Q. Did the surgery take away the -- it is noted in your notes, the electric-like symptoms?

A. It certainly took away a lot of the sharp, very severe symptomology. She is now left with some residual numbness, which by the way is fairly common after such condition.

Q. Does that have to do with -- I am holding up Plaintiff's 4A, the fact that you actually took out the disc materials and actually -- I am holding up 4C, took the disc,

the disc was no longer there pressing where it was pressing and now the peak implant?

A. The persistent numbness has more to do with the duration of the compression on this neural tissue that existed until the point of surgery.

Q. The three screws, bars, in her neck, do they limit her motion?

A. To some extent, yes.

Q. And the spasm that you said in the trapezius muscle, are you aware that she goes for weekly injections to attempt to break that spasm as well as therapy to try and loosen up the motion?

A. I am aware of that.

Q. Would you have any opinion as to whether or not that should continue until the spasm which hasn't broken since April of 2010, breaks, if it does?

A. It has been a very difficult problem for her and I anticipate will need care for this until it gets better, if it does.

Q. Can trauma cause previously asymptomatic spondylosis or degeneration to now advance?

A. Yes.

Q. In fact, do you have an opinion as to whether or not the truck hitting Ms. Blue had an affect on her previously asymptomatic spondylosis, whether or not it will

continue to progress despite the fact that you have done the fusion?

A. Well, she is at risk of having problems in the future, so the answer is yes

Q. When you state in your notes that she is not ready for vocal rehabilitation, what do those words mean?

A. They apply to the fact that based on my understanding of her level of competency and work history, but mainly based on the symptoms she has now, she will not be able to attend any vocational program.

It would be the sentiency in her occupation, and would be the type of neck spasms that would make it impossible for her to do that at this time.

Q. Given her previously being asymptomatic as a result of the accident and given any knew traumatically caused herniations and issues you have told the jury about, would you expect someone with Ms. Blue's condition to have pain upon sitting for a period of time?

A. She has already and the answer is yes.

Q. How about standing for a period of time?

A. Same applies.

Q. Bending her neck or back to any degree?

A. She as limitation, range of motion definitely provoking pain.

Q. Are her conditions permanent given the time they

have been going on, in your opinion, are they permanent conditions?

A. My opinion is that they are permanent.

Q. Within a reasonable degree of medical certainty, is Ms. Blue facing the prospect of any further surgeries of the spine, neck or back?

A. To some degree yes.

Q. What is your opinion as to whether or not she requires same?

A. Surgery?

Q. Yes.

A. Moderately likely.

Q. And what is it -- when you fuse discs whether it is one level, two levels, three levels, what happens to the levels above and below, what can happen?

A. When can happen due to the change in mechanics you can have an accelerated wear of those discs, therefore, resulting in symptoms, neurological problems. It is always a problem.

Q. Are you aware to date of the amount of -- under the compensation rates, you have been compensated by another entity for Ms. Blue's care?

A. I believe it is --

THE COURT: I don't understand the question. Where are you going with that?

Q. I have the bills?

THE COURT: Well, why don't you move the bills into evidence.

MR. McCRORIE: Okay, the bills have come to approximately $24,000 in treatment.

A. Yes counsel asked me before to do summations, $23,330.72

Q. If is this was a private matter, such as in the future, how much would that number be?

A. Higher.

Q. A lot higher?

A. It would be higher.

Q. Okay, can you put on the record -- I don't know if I did this -- please bear with me then I will be done, your objective basis, rather than -- not Ms. Blue's history, can you tell the jury any of the objective basis you have for telling them her herniations were caused by the accident? So anything objective, seeing the discs findings, just for the record?

A. Well, we had objective weakness in the arm. Objective numbness in the arm. Objective loss of range of motion of the neck. We had spasms to the neck. We had two disc herniations proven. One level with cervical instability and a patient who did not have any clinical improvement in one year from the date of trauma.