1 SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS : CIVIL TERM : PART CSCP
2 --X
HALINA IMRAN,
3 Index No.
Plaintiff, 21083/12
4
-against-
5 PM Trial

6 R. BARANY MONUMENTS INC.,
RANDY R. BARANY,
7
Defendant.
8 --X
Supreme Courthouse
9 88-11 Sutphin Boulevard
Jamaica, New York 11435
10 June 9, 2015
B E F O R E:
11 HONORABLE MARTIN E. RITHOLTZ,

12 Justice, Supreme Court

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

14 For the Plaintiff:
IRWIN & POZMANSKI
15 233 Broadway
New York, New York 10279
16 BY: JOSHUA BRIAN IRWIN, ESQ.

17
For the Defendant:
18 PICCIANO & SCAHILL
900 Merchants Concourse
19 Westbury, New York
BY: PAUL DUER, ESQ.
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24 LYNDA A. ROSS, RPR
Senior Court Reporter
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1 (Whereupon, the document was marked for identification as
2 Plaintiff's Exhibit 11.)
3 (Whereupon, the panel of sworn jurors enter the
4 courtroom.)
5 THE COURT: Good afternoon, jurors. You may be
6 seated, every one may be seated. You may call your next
7 witness.
8 MR. IRWIN: I call Dr. Leon Reyfman, your Honor.
9 (Whereupon the witness took the witness stand.)
10 I believe Dr. Reyfman's chart has been marked in evidence.
11 THE COURT: Plaintiff's 11.
12 (Whereupon the witness took the witness stand.)
13 THE COURT: Swear him in.
14 (Whereupon the witness was duly sworn by the Clerk
15 of the Court.)
16 THE WITNESS: Leon Reyfman 2279 Coney Island
17 Avenue Brooklyn, New York 11223.
18 THE COURT: You may inquire.
19 MR. IRWIN: May I hand this to the witness, your
20 Honor?
21 (Handing.)
22 DIRECT EXAMINATION
23 BY MR. IRWIN:
24 Q Are you a physician duly licensed to practice medicine
25 in the State of New York?

1 A Yes, I am.
2 Q How long have you been so licensed?
3 A I have been licensed since 2007.
4 Q And, Doctor, can you provide the jury with educational
5 background?
6 A I finished pharmacist school in '97 moved onto medical
7 school.
8 Q Stop, speak up. If I cannot hear you the last juror
9 can't hear you.
10 A I received a bachelor degree in pharmacy, 1997,
11 completed medical school in 2002, internship at Maimonides
12 Medical Center 2003, completed anesthesia residency at SUNY
13 Downstate in 2006 and completed pain management fellowship at
14 Roosevelt Hospital, New York City in 2007.
15 Q Doctor, you said you went to pharmacy school?
16 A Yes, I did.
17 Q And can you tell us, the jury, why you did that and
18 what your studies were there?
19 A I received a bachelor degree in pharmacy science from
20 Long Island University in Brooklyn, New York. The studies were
21 for pharmacal science as well as pre medical courses.
22 Q And you have a bachelor of science in biochemistry?
23 A Yes.
24 Q Explain what that is.
25 A To receive a bachelor of science it requires a number

1 of courses in biochemistry and chemistry biology.
2 Q You said that you at some point you started the British
3 Institute of Homeopathy in England?
4 A Yes.
5 Q And explain what you studied then?
6 A When I completed, when I completed the pharmacy school
7 in transition of 1997, I spent six months in England studying
8 alternative medicine.
9 Q What was the purpose of that?
10 A Part of continuing education.
11 Q And after that, what did you go on to do?
12 A I moved on to receive a degree in medical school.
13 Q And what year was that?
14 A I completed medical school in 2002.
15 Q And after you completed medical school, you did an
16 internship?
17 A Yes.
18 Q Medical intern?
19 A Yes.
20 Q Tell the jury what that is and what field you studied
21 and where you did?
22 A I completed internship at Maimonides Medical Center in
23 Brooklyn, New York, internship was internal medicine, that
24 encompasses multi organ system and it's a generalized internship
25 which is less than a year.

1 Q Now, after your internship, what did you do?
2 A I started an anesthesia residency program at SUNY
3 Downstate from 2003 to 2006.
4 Q Explain what that is to the jury.
5 A Anesthesia program was three years long, only pertained
6 to anesthesia practice, it's education, how to become an
7 anesthesiologist.
8 Q And what did that entail, were you practicing in the
9 field of anesthesiology or something else?
10 A I was practicing in the field of anesthesiology.
11 Q And what do you do as part of that training?
12 A The training consists of rotations through different
13 parts of anesthesiology program, pediatrics, cardiothoracic,
14 spine surgery, neurology, neurosurgery, that last for three
15 years.
16 Q And did you continue on with your education after that?
17 A Yes, I was accepted St. Luke's Roosevelt Hospital. I
18 completed pain management fellowship from 2006 to 2007.
19 Q What does that entail? What type of things did you do
20 as a fellow in pain management and can you explain what is a
21 fellow?
22 A Fellow means after completing a residency, you are
23 allowed by standards of department of education to apply for a
24 higher degree or higher learning experience and specialize in
25 the certain field and that field that I chose was pain

1 management.

2 During the fellowship, I performed well over a thousand
3 injections pertaining to not just spine but also pertaining to
4 patient's who have cancer, arthritis of the shoulders, knees,
5 it's also entailed to do a minimally invasive spine surgery
6 procedures such as discectomy procedures and morphine pump
7 implant as well as a spinal cord stimulates implant and trials.

8 Q Now, you completed that in 2007?

9 A Yes.

10 Q And sometime in 2006, did you also become an attending
11 at SUNY Downstate?

12 A Yes, I did.

13 Q And how long were you an attending anesthesiologist at
14 SUNY Downstate?

15 A This was a part time position while still in fellowship
16 I worked weekend, nights, that lasted a year after that I
17 accepted a full time position after completion of my fellowship
18 in 2007.

19 Q And how long were you an attending anesthesiologist in
20 SUNY Downstate?

21 A Two years.

22 Q Do you still have privileges there?

23 A Yes, I do.

24 Q Do you currently practice?

25 A Yes, I do.

1 Q And do you also teach?
2 A Yes, I do.
3 Q Where and what do you teach?
4 A SUNY Downstate as well as Mount Sinai Medical Center
5 and I teach pain management.
6 Q How long have you been teaching, Doctor?
7 A Since 2008.
8 Q And do you maintain a practice for medicine?
9 A Yes, I do.
10 Q And what does your practice consist of?
11 A I have devoted a hundred percent of my time to
12 treatments of pain management, pain related to spine or knees or
13 neurological conditions such as headaches or neurology. The
14 best majority of my patients I see on a daily basis has pain
15 associated with lumbar or cervical or thoracic spine.
16 Q And do you own the practice or work for a practice?
17 A I own the practice.
18 Q And do you have employees?
19 A Yes, I do.
20 Q And do you have a facility?
21 A Yes, I do.
22 Q And?
23 MR. IRWIN: Your Honor, first I would like to
24 offer -- withdrawn.
25 Q Are you board certified?

1 A Yes, I am.
2 Q Do you have one or more than one?
3 A I'm certificate in anesthesia as well as pain
4 management.
5 Q And explain to the jury what being board certified in
6 anesthesia entails and what it means?
7 A Being board certified by definition, a physician has to
8 complete a residency and fellowship, pass the exams by each
9 specialty then which you are upheld to a higher standard of
10 education and training then you become board certified pending
11 the fact you passed the exams.
12 Q Now, you said you were board certified in
13 anesthesiology and pain management?
14 A Yes.
15 Q Is there a reason you did both?
16 A It's required in order to be board certified in
17 anesthesia.
18 MR. IRWIN: Your Honor, at this time I offer
19 Dr. Reyfman as an expert in the field of anesthesia and pain
20 management.
21 THE COURT: Any objection?
22 MR. DUER: No.
23 THE COURT: So deemed.
24 MR. IRWIN: Thank you, your Honor.
25 Q Are you being compensated for your time here today?

1 A Yes.
2 Q How much are you being compensated for your time?
3 A $6,000.
4 Q And how much time did you spend in court on your way to
5 court preparing for your testimony today?
6 A While being here about 5 or 6 hours.
7 Q And what time did you arrive, what time did you leave
8 home to meet with me?
9 A We met yesterday for about an hour.
10 Q And did you leave your office or home to come here?
11 A I left my office at 12:00.
12 Q Do you have duties or responsibilities to patients or
13 something else you are supposed to be tending to instead of
14 being here?
15 A Yes, I have office hours until 5:00.
16 Q Were there procedures or patients or something else
17 that had to be moved or rescheduled so you can be in attendance
18 here today?
19 A Thirty patients which 10 to 12 of them required
20 procedures.
21 Q Have you testified before?
22 A Yes.
23 Q How many times have you testified?
24 A About 12 or 13.
25 Q Over the course of how many years?

1 A Since 2008.
2 Q And who have you testified for?
3 A I testified for plaintiffs.
4 Q And are any of them, are they your patients, not your
5 patients?
6 A I only testify for my patients that I treated for.
7 Q So if someone represents a plaintiff or defendant in a
8 lawsuit, comes to you and asks you to testify in court for
9 someone who is not one of your patients, is that something you
10 would do?
11 A No.
12 Q Have you ever done?
13 A No.
14 Q Now, did you come to see a patient named Halina Imran?
15 A Yes.
16 Q And do you know how she came to your office?
17 A I believe she was referred by Dr. Gerling's secretary.
18 I believe she had an appointment to see him and his wait time
19 was 6 to 7 weeks for any patients.
20 Q Why do you say that that's how you believe how she got
21 to you?
22 A That's my recollection.
23 Q And do you know Dr. Gerling somehow?
24 A Yes, I do.
25 Q And when did you first meet Dr. Gerling and under what

1 circumstances?
2 A I met Dr. Gerling at SUNY Downstate, 2007. After I
3 finished my fellowship, he became a director of orthopedic spine
4 surgery and I took a position of director of pain program at
5 SUNY Downstate. We have a professional relationship since then,
6 shared a number of patients and I treated, and up until this day
7 we work together as a team to provide care for our patients.
8 Q When was the first time you saw Halina?
9 A I saw Halina on June 11, 2012.
10 Q And for what reason did you see her?
11 A She came to my office complaining of neck and lower
12 back pain.
13 Q And did you conduct a physical examination on her?
14 A Yes, I did.
15 Q And did you read her MRIs or did she have MRI's at that
16 point?
17 A Yes.
18 Q Did you read the MRI?
19 A I had a lumbar spine MRI available to me for review,
20 report and films.
21 Q And did you render -- can you tell us, the jury, what
22 your examination revealed?
23 A First she complained of lower back pain that she
24 described was radiating to her right leg. She stated her pain
25 was six out of ten, that means the worse. She stated the pain

1 was constant, dull, achy and sharp and mentioned that the pain
2 she was experiencing in her lower back was mostly mechanical
3 every time she twisted or walked. She started having more pain
4 upon standing and walking. She had neck pain that was radiating
5 to her right shoulder and she stated the pain was six out of ten
6 which was constant. Physical examine when I saw her for the
7 first time, she had lower back pain, limited range of motion.
8 She had a diffused, moderate muscle spasm. The most striking of
9 findings on the neurological exam, she had a loss of sensation
10 along the L4/L5 right vertebrae and this sensation was lost to
11 pinprick and light touch. What that means is when I examined
12 her and touched her leg on the right side, there is a special
13 map we follow, dermatome map and a map of different nerve
14 distribution of the lower back. And by examining someone we can
15 have an idea of which of these nerves are impaired or damaged or
16 compressed.
17 She also had a weakness four out of five of her hip
18 extensors, ankle extensors and knee flexors. Those are the
19 muscles innovated by L4 and L5 nerve root coming from the lower
20 back lumbar spine. She had diminished reflexes in the right
21 side, one plus we describe reflexes to be normal, one plus is
22 diminished and 0, no reflexes.
23 In her case, she had one plus on patella and achilles.
24 The patel is the knee, achilles which is the ankle and by
25 testing the reflexes we can see if there is nerve damage or

1 impingement.

2 On the orthopedic exam, she had a straight leg test

3 positive. The way the test is performed is patient is lying in

4 bed or could be done in the same position and leg is elevated by

5 a physician and the patient describes pain, special electrical

6 shock or shooting down the leg. It's consistent with nerve

7 damage or a radiculopathy, clinically it's significant because

8 we know there is a nerve impingement.

9 She had difficulty while walking on her toes and heels

10 and by this is one of the test to determine whether this is

11 nerve damage or nerve.

12 Q And what was the purpose of performing all of those

13 examinations, Doctor?

14 A The purpose of the exam as well as taking a history

15 from the patient is to determine the diagnosis and treatment.

16 Q And were you attempting to make any decisions related

17 to treatment on that day?

18 A Yes.

19 Q And did you make, first of all, did you make a

20 determination as to whether or not, in your opinion, Ms. Imran

21 had an injury to the lumbar spine?

22 A Yes.

23 Q And what was that opinion?

24 A Ms. Imran did not report any previous history of back

25 pain or complaints until she was involved in a motor vehicle

1 accident dated 4/17/ 2012. While examining her and reviewing
2 her medical records, I came to the opinion she had a traumatic
3 injury to her lower back as well as her neck and the diagnosis
4 was lumbar radiculopathy and lumbar herniated disc.
5 Q Is that to a reasonable degree of medical certainty?
6 A It is.
7 Q And it states in your report, Doctor, on page one
8 towards the middle, MRI of the L spine, paren -- L4/5 and L5/S1
9 disc bulges which impinge upon the thecal sac, is that upon your
10 reading of the film or report with it?
11 A This is information I gathered from the radiologist
12 report, but I reviewed the films on the same date.
13 Q Does it reflect somewhere in your report that you read
14 the films?
15 A No.
16 Q How long was this visit at your office?
17 A Probably 45 to an hour.
18 Q And what is the reason for that?
19 A This was initial consultation. The reason for that was
20 to spend time to examine the patient, gain the proper history as
21 well as she had a lumbar epidural injection on the same date.
22 Q At what point in time during your examination of her
23 did you read the MRI films?
24 A Before I came to that conclusion of diagnosis.
25 Q After you did your, took your history and did your

1 physical examination, what did you do?
2 A I spoke to her about treatment options. She did inform
3 me she had physical therapy. She did inform me that physical
4 therapy did not provide her with adequate pain relief. She was
5 experiencing pain. I advised her to consider lumbar, epidural
6 steroids injections to help her symptomatic with pain. She
7 consented to the procedure and the procedure was performed on
8 the same date.
9 Q Doctor, can you -- if there is a spine that I brought
10 to the courtroom, would this spine that's hanging assist you in
11 explaining what you did to the jury and explaining
12 Ms. Imran's injuries to the jury.
13 MR. IRWIN: May he step, counsel?
14 (Whereupon, the witness steps down.)
15 Q Can you explain what you did and how you did it and
16 where?
17 A The spine consists of vertebras which are bones and
18 separated by a disc. Each level of spine, there is exiting
19 nerve root. In her case the L5 nerve was impinged because there
20 was a disc herniation, L4/5 the second lowest level she has had
21 a diffused disc bulge. When I examined her, the diagnoses were
22 clear. She had lumbar, herniated disc and radiculopathy. She
23 had physical therapy. She had still significant amount of pain.
24 I advised her to do an injection. The injection was lumbar
25 epidural steroid injection done on the -- if I can demonstrate

1 how it's done, this is the epidural tray.
2 Q You brought something?
3 A Yes.
4 Q What is it?
5 A Sterile epidural tray used to perform lumbar and
6 cervical epidural.
7 Q Would that assist you in explaining the procedure you
8 performed to the jury?
9 A Yes.
10 Q May the doctor use it?
11 THE COURT: You may.
12 A The way it's performed, the first patient lays down
13 flat on their stomach, the x-rays are taken, the skin is washed
14 with iodine to minimized that she gets an infection so in her
15 case, the session meant involved is disc L5/S1 nerve, the skin
16 is being anaesthetized with local aesthetic Lidocaine by using
17 three and a half inch needle under the entry guide, the needle
18 is placed where the nerve impingement is. The procedure is done
19 under the extra guidance to minimize chances of nerve damage or
20 epidural leak and while the needle is in the place, the steroid
21 medication is injected and the purpose of that is to relieve
22 irritation and minimized the amount of pain that she experienced
23 in this case.
24 Q Is it done for diagnostic purposes?
25 A Yes.

1 Q And explain?
2 A By doing an injection in the spine, by having some kind
3 of response, whether there is no response, some response, you
4 can pinpoint what is the source of the pain.
5 So in her case, she had 3 or 4 hours worth of relief
6 after the injection and reported a very small pain scale after
7 the completion, then goes along with a diagnosis of herniated
8 disc. If she had no relief after the injection or for the
9 remainder of the day, most likely the pain is not the herniated
10 disc, it would be a muscle spasm or inflamed joint and spine,
11 her diagnosis and history when she came to the office was lower
12 back pain shooting down to her right leg, special neurological
13 finding as well as straight leg test positive and MRI findings
14 were consistent and the injection proved that the pain she was
15 experiencing is because of the herniated disc.
16 Q Now, are injections usually one performed, a series or
17 something else?
18 A There is no guidelines of how many injections someone
19 should have. The way it's done is to do one injection, if a
20 patient experiences 80 percent relief for 2 to 3 minutes, we
21 recommend to do second or third injection.
22 Q What is the case here?
23 A She only had relief after the first injection after she
24 saw and this discussion was to have a lumbar surgery which was
25 performed by Dr. Gerling.

1 Q And is there a reason that the second injection would
2 not be indicated for Ms. Imran at that point?
3 A The reason would be failure to relieve or alleviate
4 pain after the first injection and she didn't have only transit
5 mild pain relief.
6 Q Are there risk in preforming this procedure?
7 A Risk are infection, nerve damage, headaches, bleeding,
8 so those are the three common risk factors associated with this.
9 Q Was there a medical reason to not perform a second
10 injection on Ms. Imran?
11 A The medical reason was simply because she did not have
12 relief after the first injection, you normally would expect to
13 have a second injection performed.
14 Q Do you have an opinion to a reasonable degree of
15 medical certainty as to whether or not it would have been
16 medically appropriate to do another injection at that point or
17 shortly after that?
18 A I believe it would not be appropriate to do second
19 injections because of lack of efficacy of the first injection.
20 Q Did you see her again at some point in the future,
21 Doctor?
22 A Yes.
23 MR. IRWIN: Your Honor, may I take the spine down?
24 Q When was the next time you saw Ms. Imran.
25 A I saw her for the second time on January 7, 2013.

1 Q And can you tell the jury what your findings were?
2 A Ms. Imran came back, she reported she still had lower
3 back pain and described in five to six out of ten which was
4 constant. She didn't have as much right leg pain as she had
5 before. She informed me she had a lumbar surgery done by
6 Dr. Gerling. I didn't request a report from Dr. Gerling's
7 office which I had available during my second visit.
8 Dr. Gerling performed a lumbar fusion surgery on July 16th of
9 2012. I examined Ms. Imran again, she had very similar, almost
10 identical findings that she had on the first visit when I saw
11 her back in June. The only difference she didn't have as much
12 diffused back pain that she had. The muscle spasms were less
13 than what they were. But her neurological signs, the motor
14 deficits and reflexes were diminished when I saw her in 2013.
15 Q As a result of that, did you recommend a course of
16 treatment?
17 A I advised her to consider taking pain medication which
18 I gave her a prescription for pain medication called tramadol
19 and I told her if the pain gets worse she should consider an
20 epidural because on occasion after surgery people form scar
21 tissue around the nerve or surgery side and the purpose of the
22 injection would be to increase some inflammation for her to have
23 less scar tissue to heal.
24 Q I want you to assume that Ms. Imran testified the other
25 day that she was afraid to take pain medication because she

1 doesn't want to get addicted to it. Considering that, is there
2 any course of treatment, any other course of treatment she can
3 undergo?
4 A She can consider starting physical therapy. She can
5 consider doing conservative management with acupuncture or
6 chiropractor care. The fact that she is afraid of taking
7 narcotics for reason of being addictive, then the alternative
8 would be to consider more injections.
9 Q And I want you to assume that Ms. Imran testified that
10 the physical therapy in the past did not help her pre or post
11 surgery, would there be any reason to continue physical therapy?
12 MR. DUER: Objection. I don't believe that was
13 the testimony.
14 MR. IRWIN: Withdrawn. I will start the question
15 over.
16 Q Assume that Ms. Imran testified that physical therapy
17 only provided temporary relief for her, matter of hours, would
18 you consider physical therapy to be something that you would
19 recommend for her considering that?
20 A I would not. I mean if she had no relief before, after
21 surgery I would not recommend physical therapy. I would
22 encourage her to try to take pain medication to help with pain
23 and if still reluctant, I would advise her to consider more
24 treatment options, epidural injections or other injections.
25 Q Did Ms. Imran come to see you again at some point?

1 A I saw her again on February 13, 2015.
2 Q And can you tell the jury what your findings were then?
3 A She complained of lower back pain. She described four
4 out of ten, 0 being no pain ten being a lot of pain. She stated
5 the pain is constant, dull aching, throbbing, worse with
6 standing, sitting, bending forward, lifting, twisting and also
7 when she walked she had leg pain. Physical exam, her
8 neurological signs were diminished. There was no evidence of
9 normal reflexes or neurological signs she had prior in 2012 and
10 2013. She didn't have lumbar facet loading, facets are the
11 joint that starts at the base of the skull and inside of the
12 spinal column. The function of the joint is to give more
13 flexibility. When you turn and twist these joints are involved.
14 In her case, when I examine her she had very
15 sensitive lower pain due to the joint. It is common to see
16 patients with a trauma or more predominately after spine surgery
17 to develop this syndrome because the screws actually being put
18 in the lumbar spine through pedicle which is part of the joint I
19 can demonstrate if it makes it easier.
20 MR. IRWIN: Will the X-ray of the lumbar spine
21 from April of 2015 assist you in demonstrating this.
22 THE WITNESS: I would like to use the model, if I
23 may. I can use both.
24 (Whereupon, the witness steps down.)
25 MR. DUER: Objection, this doctor is not qualified

1 as a radiologist.
2 THE COURT: Objection overruled. In the future no
3 colloquy.
4 Q As part of your job, do you read x-rays and CAT scans
5 and MRI?
6 A Yes.
7 Q So is it an integral part of your job to read X-rays
8 CAT scans and MRI?
9 A Yes.
10 Q And is it more integral for you when you read a film,
11 more important for you to read a film correctly than a
12 radiologist sitting behind a desk?
13 A A radiologist does not see the patient. They see the
14 films. When you see the patient, you have a history of illness,
15 they tell you where the pain. Physical examination, when you
16 look at the MRI things have to make sense and be when they don't
17 make sense, if her nerve impingement on the opposite side, she
18 is complaining of right sided and there is nerve impingement on
19 the left side. That is a question. In her case everything was
20 consistent and that's part of the integral practice to do an
21 injection or offer treatment after reviewing all of the medical
22 records and looking at the films.
23 Q Do you base your medical determinations regarding what
24 procedures you are going to actually perform on your reading of
25 the films themselves or reports?

1 A I like to look at both. I like to see what
2 radiologist's have to do and describe a report. I look at the
3 films.
4 Q Why do you look at the films?
5 A It gives you a better understanding of the pathology or
6 source of pain.
7 Q When you read the films, is that a compilation of
8 medical procedure?
9 A Yes.
10 Q And could you have complications or be damaged if not
11 read properly?
12 A Yes.
13 Q Does a radiologist have the same consequences if they
14 make a mistake reading films in relation to reading lumbar and
15 cervical MRI?
16 A They have consequences in again, if misread, the film,
17 if they are not doing a procedure in this case, an epidural,
18 they have less consequences.
19 MR. IRWIN: Can I hand the doctor the X-ray of
20 April 16, 2015?
21 THE COURT: Yes.
22 A Going back to the facet loading I explained when I saw
23 her in 2013. Facets are joints, start at the base of the skull.
24 These are the joints, this is the joint L4/L5 and what happens
25 is, if I move the model, the joint opens up. This is the

1 ability to twist and turn and bend, that's the function of the
2 joint. Someone has lumbar fusion, they are prone to develop
3 early arthritis especially on the joint. The way the screws are
4 placed, this is the AP view. Straight.
5 Q AP front to back, from the patient's front to back?
6 A Yes, AP to front to back.
7 Q Anterior?
8 A Anterior, posterior. These white markings actually are
9 screws at L5/S1, right and left side. These little white
10 markings are the staples, but the facet joint, the screw is
11 placed right under the pedicle, which is right under the joint
12 line and it's commonly seen after six months or a year by former
13 fusion. What we see, we see a problem that these joints are
14 more arthritic and cause back pain, they can cause leg pain as
15 well.
16 Q Now, are you familiar with the term called nonunion?
17 A Yes.
18 Q And was there imaging done in May, on May 6th of this
19 year?
20 A My six.
21 Q May 6th CT scan I believe it was?
22 A I reviewed CT scan recently a month ago.
23 Q As far as what you see on the X-ray, can you describe
24 what you believe is going on to a reasonable degree of medical
25 certainty with the metal in her back from lumbar fusion?

1 A I think there is a nonunion on the right side, I
2 believe one of the screws have not fused correctly, but I will
3 refer to Dr. Gerling to give a formal opinion on that. He is
4 the spine surgeon. I see that there is a facet joint
5 inflammation. They are enlarged.
6 Q Do you have an opinion to a reasonable degree of
7 medical certainty as to whether or not the competent producing
8 cause of that is the automobile accident of April 17, 2012?
9 A Yes, I believe it is.
10 Q And what is the basis for that?
11 A Basis are she had never had former back pain. She had
12 traumatic injury, developed pain at the onset of the motor
13 vehicle accident, she seeked medical care soon after the injury,
14 and all her complaints are consistent in nature.
15 If someone reports to me that they had back pain prior
16 and we review medical records to see if there is a relationship
17 from the previous or just in general, then obviously it will not
18 be well determined. In this case she had clearly no other
19 previous complaints of back pain.
20 Q Is this something you see on the April 16, 2015 X-ray
21 that is consistent with your examination in February of 2015?
22 A Yes.
23 Q And something you would expect to become better, worse,
24 the same or something else as time goes by?
25 A Usually worse.

1 Q And did you see her again after February of 2015?
2 A Yes, I just saw her again May 15, 2015.
3 Q And were your findings the same, different or something
4 else on May 15th?
5 A She actually complained of more back pain, back pain
6 shooting to her buttocks. She had the same exam as the exam in
7 February of this year, diagnosis remained the same.
8 Q We see a significant difference between February 25,
9 2015 and May of 2015, only a three month period?
10 A Yes.
11 Q Can you explain to the jury why we see a difference
12 with a four out of ten and fewer symptoms in February and now in
13 May of 2015, we see significant differences in her complaint and
14 the examination?
15 A Well, when I saw her in May I had a chance to review
16 CAT scan of the lumbar spine order by Dr. Gerling, the CAT scan.
17 MR. DUER: Objection to his review.
18 THE COURT: Sidebar.
19 (Whereupon, an off the record discussion takes
20 place at sidebar among the Court and Counsel.)
21 Q We will skip your reading May 6th, 2015, CAT scan and
22 discuss the report you reviewed, did you review a report
23 May 6th, 2015, CAT scan of the lumbar spine?
24 A Yes, I did.
25 Q And based upon your review of that report, did you

1 reach a diagnosis for Ms. Imran?
2 A Yes.
3 Q And what is that diagnosis?
4 A The new report of the CAT scan done on May showed there
5 is an L4/5 herniated disc with foraminal stenosis, nerve
6 impingement of the level above the surgery, the L4/5
7 demonstrates there is a herniated disc, fusion in place, and
8 there is also an inflammation in the facet joint as I described
9 previously.
10 Q Is that a change at L4 and L5 from before that CAT
11 scan, is there a change at that level?
12 A Yes, there is.
13 Q And can you explain, is that to a reasonable degree of
14 medical certainty?
15 A Yes.
16 Q And can you explain to the -- do you have an opinion to
17 a reasonable degree of medical certainty as to the cause of the
18 change in the disc at L4 and L5?
19 A I believe it's causally related it's a normal
20 progression of the bulge or herniation she had initially and it
21 is not uncommon to see a lumbar fusion, a disc above the fusion
22 to become more damaged or degenerative or herniated.
23 Q Explain to the jury why?
24 A It's part of the degeneration process, unfortunately,
25 there is no specific explanation or literature why after fusion

1 people develop a degenerated disc above defusion. There is
2 theories involved, but ultimately it's common to see that.
3 Certain patient's review of the report, there is three new
4 problems, one is larger disc herniation L4/5 that she had not
5 had before, arthritic or inflamed joint and a nonunion of one of
6 the screws which again I would like Dr. Gerling to defer. He is
7 the spinal surgeon. He will need to express his opinion on
8 that.
9 Q Do you have an opinion to a reasonable degree of
10 medical certainty as to the competent producing cause of what
11 you just described to the jury?
12 A Yes, I believe it's the accident.
13 Q And what is the basis for that?
14 A The basis are again, that she had traumatic injury to
15 her lower back. She never had any symptoms. She had
16 conservative treatment, injection. She failed. She had
17 surgery, and after surgery, she still has quite a bit of lower
18 back pain.
19 Q Now, do you have an opinion as to whether or not --
20 withdrawn.
21 Do you have an opinion as to whether or not Ms. Imran
22 would require medical treatment in the future?
23 A Yes, I do.
24 Q And what is that opinion? Is that to a reasonable
25 degree of medical certainty?

1 A Yes, it is.
2 Q And what is that opinion?
3 A My opinion is based on the fact that she still has
4 lower back pain, her diagnosis would be at this point failed
5 surgery syndrome. She will need further care with conservative
6 treatment, physical therapy several times a year, pain
7 medications. She will need intervention treatment with
8 injections, the injections would be an epidural destroyed,
9 lumbar facet injection, she may need a radio frequency ablation.
10 This procedure is done to destroy the nerves that give sensation
11 to these joints. She may need a procedure that's called spinal
12 cord stimulater, a surgical procedure done for patient that had
13 surgery.
14 MR. DUER: Objection.
15 THE COURT: Sidebar.
16 (Whereupon, an off the record discussion takes
17 place at sidebar among the Court and Counsel.)
18 Q Doctor, I want you to assume that Dr. Gerling testified
19 yesterday afternoon, I further want you to assume that
20 Dr. Gerling testified that to a reason reasonable degree of
21 medical certainty he believed that Ms. Imran within less than
22 one year because of what he found on physical examination on the
23 X-ray from April 16, 2015, and based upon the CT scan from May
24 of 2015, he believed that Ms. Imran would need a revision
25 surgery of the L5 to S1 fusion and a fusion at L4 to L5, can you

1 assume that for me, Doctor?
2 A Yes.
3 Q Assuming that, are you able to state to a reasonable
4 degree of medical certainty what Ms. Imran will actually require
5 in the future as far as pain management and/or physical therapy
6 treatment?
7 A Yes, I can.
8 Q And also as far as diagnostic imaging?
9 A Yes.
10 Q And can you please do that?
11 A In terms of the diagnostic imaging, she will require
12 X-rays, MRI or CT scan. She may require a diagnostic nerve
13 conduction study or EMG. Usually these tests are performed once
14 a year or every other year depending on the circumstances.
15 Q And do you believe that she will require any pain
16 management treatment or physical therapy in the future in the
17 event if she does require this procedure?
18 A Yes.
19 Q And can you tell the jury what you believe she will
20 need?
21 A Pain management consists of three things, one is
22 conservative management physical therapy chiropractic care or
23 acupuncture, physical therapy done in the average of 8 to
24 12 weeks where someone does it 2 to 3 sessions a week. The
25 chiropractor and acupuncture usually go in conjunction with

1 physical therapy. Mitigations, even though she expressed before
2 she does not want to take pain medication, I feel at some point
3 she will not have a choice and she will need medication and
4 medications are anything from a mild narcotic such as tramadol
5 or Tylenol with codeine or Percocet or oxycodone or morphine.
6 There is other medication used for nerve pain which she
7 may need one day with regard to the injections, I believe that
8 based on what I see even before the surgery, if she ever had
9 surgery after the surgery she will need lumbar epidural
10 injections done usually 3 to 4 times a year. She will need
11 lumbar facet injections done two to three times a year. The
12 radio frequency procedure I described previously done twice a
13 year after destroying the nerve, nerve degeneration rate and it
14 takes six months for the nerve to regrow the nerve. I mentioned
15 spinal cord stimulater --
16 MR. DUER: Objection.
17 THE COURT: Sustained.
18 MR. IRWIN: We are.
19 THE COURT: I sustained the objection. Let's wrap
20 it up.
21 Q Doctor, you said that she will need X-rays in the
22 future?
23 A Yes.
24 Q And would that be, how frequently will she need them?
25 A Probably say once a year.

1 Q And starting at what point in the future?
2 A Probably fairly soon after the surgery.
3 Q Can you give a range for that?
4 A Two years from now.
5 Q And are you familiar with the cost in the greater New
6 York Metropolitan area for X-rays for the lumbar spine?
7 A Certainly.
8 Q And what is the cost?
9 A The cost per X-ray is 85 to $90.
10 Q You said CAT scans or MRI?
11 A Yes.
12 Q And would that begin in 1 to 2 years?
13 A Yes.
14 Q And which of those would she need in your opinion?
15 A CAT scan shows a better boney anatomy or infusion, MRI
16 shows soft tissue or nerves or spinal cord. She potentially may
17 need both. The cost of each one is $1,000.
18 Q Would that be $2,000 a year?
19 A Yes.
20 Q And is that the cost of X-rays, CAT scan and MRI in the
21 greater New York Metropolitan area?
22 A Yes.
23 Q And that would start in two years?
24 A Yes.
25 Q You said next EMG?

1 A Yes.
2 Q And can you tell the jury what that is and whether or
3 not it's different than NCB?
4 A NCB there is two parts to the electro diagnostic
5 studies, NCB is used to test a sensory nerve meaning several
6 types of nerves in our body, nerves that give sensation when you
7 touch your finger and larger nerves that give strength to the
8 muscles.
9 The first component of NCB test for sensory, the second
10 component done by knee placement in the muscle group, in her
11 case, it would be her legs, and that is fairly painful if it is
12 used to diagnose a nerve impingement or a radiculopathy.
13 Q How much will she need and how often?
14 A Usually once a year.
15 Q Starting when?
16 A Two years from now.
17 Q And are you familiar with the cost for that test in the
18 greater New York metropolitan area?
19 A The EMG is reimbursed at 1400 a test.
20 Q Now, you said physical therapy chiropractic treatment?
21 A Yes.
22 Q Both or one or something else?
23 A Possibly. The main goal would be physical therapy, if
24 she goes. The treatment would be up to her, but I would
25 recommend do both.

1 Q And how frequent and when would it start?
2 A It would start 2 or 3 months after the surgery or two
3 years from now. For example, it's usually done for three
4 months. It's performed three times a week so the average of 50
5 to 20 sessions a year.
6 Q So that would be 20 sessions per year for therapy and
7 20 a year for chiropractic?
8 A Yes.
9 Q And are you familiar with the cost for each session in
10 the greater New York metropolitan area?
11 A The physical therapy?
12 Q Yes or no.
13 A Yes.
14 Q What is it?
15 A It's ranges from 80 to a hundred, depends on the
16 modality being performed, chiropractic cost is 1 to 150 per
17 visit.
18 Q Now, you also stated, Doctor, that she will need
19 lumbar, epidural, steroid injection and lumbar facet injection
20 or one or the other?
21 A Both.
22 Q Can you explain to the jury using the spine what the
23 difference is and why?
24 A I demonstrated before the way the epidural is done.
25 Epidurals are done to alleviate pain that's due to herniated

1 disc or nerve impingement. Usually it's done 4 or 5 times a
2 year. The average cost of the epidural is $1,500. The facet
3 injections are usually done 3 to 4 times a year. It's done on
4 both sides. It's treating the joints that are inflamed or
5 damaged as a result of the trauma and the surgery. The cost of
6 that procedure is 14 to $1,500 each.
7 THE COURT: Wrap it up.
8 Q And the cost that you stated, the cost in the greater
9 New York metropolitan area that you are familiar with?
10 A Yes.
11 Q And all of the these expenses in the state as far as
12 far as the physical therapy, X-rays, MRI and the injections, are
13 to a reason reasonable degree of medical certainty?
14 A Yes, radio frequency procedure I mentioned.
15 Q Can you tell the jury what that is?
16 A Radio frequency is done to avoid -- procedures done at
17 the surgical center or hospital where a needle is placed along
18 the joint and under extra guidance with help of certain
19 equipment, we are able to identify the nerves and destroy them.
20 Q Is that a procedure you perform yourself?
21 A Yes.
22 Q And are you familiar with the cost of that in the
23 greater New York metropolitan area?
24 A 1900.
25 Q And is that something don't once or more than once?

1 A Twice a year usually.
2 Q And that will start when, Doctor?
3 A Two years from now.
4 Q Do you have an opinion to a reasonable degree of
5 medical certainty as to whether or not this will be necessary
6 for Ms. Imran in the future?
7 A I believe.
8 Q And can you explain why to the jury?
9 A She still has, she has gone for every possible
10 treatment medication, surgery. She is still having pain. She
11 had a new diagnostic test that would perform and show additional
12 problems and the chances of her having repeat surgery or pain
13 down the line are significantly higher than normal.
14 THE COURT: Okay.
15 MR. IRWIN: Thank you, your Honor. That's all I
16 have.
17 THE COURT: Cross examination?
18 CROSS EXAMINATION
19 BY MR. DUER:
20 Q Can I have the chart? Doctor, how are you?
21 A Hi.
22 Q You agree many of the patients have pending lawsuits?
23 A Some.
24 Q And you said you had to reschedule patients today?
25 A Yes.

1 Q You will see those patients eventually?
2 A I hope so.
3 Q You will be paid?
4 A I hope so.
5 Q Now, you say that Dr. Gerling's secretary referred her
6 to you?
7 A Dr. Gerling, we have been doing this for a number of
8 years. I mean, my wait time is shorter compared to him and this
9 is my assumption.
10 Q This is not your independent recollection, this is what
11 you believe?
12 A This is how our practices usually set up. If he has a
13 patient who is in need of pain management or urgent care, he
14 usually ask the secretary to call my office if I'm around to see
15 that patient.
16 Q You testified just now that you remembered
17 Dr. Gerling's secretary calling your office?
18 A I did not testify. I remembered, I assume or recall,
19 but I did not testify. I remembered that the secretary picked
20 up the phone and called my office.
21 Q You have no idea if that happened?
22 A Let's leave it at that.
23 Q You have no idea how she got to you?
24 A Fine.
25 Q Where in your initial report does it say that you

1 reviewed the lumbar spine MRI?

2 A I had direct access to stand up radiology, which the

3 MRI was done and able to log in from my office remotely to

4 radiology and review the films.

5 Q And you found bulging at L4/5 and L5/S1?

6 A This is the report from the radiologist that I have.

7 MR. DUER: May I?

8 Q I will refer you to the first page of your first report

9 from your first visit, you said MRI of the L spine, a few lines

10 down.

11 A Yes.

12 Q And it says 61, 2012, L4/5, L5/S1 disc bulges which

13 impingement on the cecal sack?

14 A Yes.

15 Q You read the films yourself, but you are putting down

16 the findings of a radiologist?

17 A I put down the findings that I had MRI reports and I

18 summarize the report, not my findings, but summarize the

19 radiologist report, which I had, I had available as well at the

20 time of the office visit.

21 Q Where on your report does it say you read the films?

22 A It doesn't say on my report.

23 Q It doesn't say disc herniation?

24 A In my diagnosis it has lumbar disc displacement and

25 lumbar radiculopathy.

1 Q The word herniation never appears?
2 A If you look at page three of my medical records under
3 the, actually page two on the bottom it says diagnosis code.
4 Q Where?
5 A Two, diagnosis on the bottom.
6 Q Page two?
7 A The session it says diagnosis listed as being lumbar
8 radiculopathy, lumbar disc displacement, if you look at my
9 indication for epidural injection, under the procedure down
10 plate, it states that the indication for the procedures are
11 discogenic back pain.
12 Q Where is this?
13 A Come here, I will show you.
14 MR. IRWIN: May he approach the witness?
15 A Discogenic back pain, herniated disc and diagnosis code
16 above it.
17 Q Nowhere does it say you read the film?
18 A Correct.
19 Q Nowhere does it say you had the film?
20 A Correct.
21 MR. IRWIN: Objection.
22 THE COURT: Overruled.
23 Q Now, you performed a physical exam?
24 A Yes, I did.
25 Q On that first visit and you said you did a neurological

1 exam and you had positive findings?
2 A Yes.
3 Q And you found loss of sensation?
4 A Yes.
5 Q What else did you find?
6 A I found loss of sensation, motor weakness and muscle
7 weakness and I found there is a sensory deficit.
8 Q And deep dent in reflexes?
9 A Yes.
10 Q Do you know if Dr. Gerling did his own neurological
11 examination a week later?
12 A I assume so.
13 Q And it would surprise you if Dr. Gerling found there
14 was no loss of sensation?
15 MR. IRWIN: Objection.
16 THE COURT: I will allow it.
17 Q Did you review Dr. Gerling's records?
18 A I only had an operator report at the second visit.
19 Q Doctor, on June 20th, nine days after your exam
20 Dr. Gerling did a neurological examination and you found all
21 extremities were examined, gross neurologic examination
22 demonstrated normal sensation motor function and deep tender
23 reflexes, straight leg raise negative, coordination was normal,
24 that differs greatly from what you found, correct?
25 A Yes.

1 Q Dr. Gerling is wrong?
2 A I would have to review the records. I'm not sure.
3 MR. IRWIN: Your Honor, they are in evidence,
4 objection.
5 THE COURT: Forget so quickly, no colloquy.
6 Q You did some tests, some test with regards to the
7 lumbar spine?
8 A Yes.
9 Q LASIK test?
10 A Yes.
11 Q Bragard test?
12 A Yes.
13 Q Kemp's?
14 A Yes.
15 Q Squatting?
16 A Yes.
17 Q Toe heel?
18 A Yes.
19 Q And that would confirm your belief that there was a
20 nerve compression here?
21 A Those tests were done too in addition to diagnosis of
22 nerve impingement.
23 Q And you would agree those are subject to?
24 A Not necessarily.
25 Q Well, you do the test and if the patient says they are

1 in pain, then it's positive?
2 A Right, but he is neurological science, these are deep
3 down in the reflexes where it's hard to fake. I would
4 understand someone can fake a muscle strength test, to fake a
5 sensory exam, you have to go to medical school.
6 Q You did a test on the cervical spine?
7 A Yes.
8 Q Valsalva you found positive?
9 A Yes.
10 Q And Jackson compression?
11 A Yes.
12 Q And max cervical route compression?
13 A Yes.
14 Q And Spurling?
15 A They are consistent with radiculitis.
16 Q Consistent with nerve compressions?
17 A Radiculitis is irritation of the nerve. There is no
18 physical evidence or MRI evidence.
19 Q Those tests are different?
20 A The concept is the same, but ultimately in this case,
21 her MRI of her neck was fairly normal, but, there is a term
22 called discogenic neck or back pain. So what that means is you
23 can have a normal MRI and normal EMG and you can have a patient
24 with a full-blown radiculopathy or pain from the neck down to
25 the fingertips or lower back down to the lower extremities and

1 the reason because of that, the inside part of the disc is
2 called nucleus have chemical mediators, when you hurt or you
3 have redness, same thing in the spine, when there is a trauma,
4 you have small tear which -- I'm not done. You can have.
5 THE COURT: Are you saying it's --
6 MR. DUER: The scope of the question.
7 THE COURT: We work here, question and answer,
8 okay.
9 Q Did you review the cervical MRI report?
10 THE COURT: Yes or no?
11 THE WITNESS: Yes.
12 Q Where does it say that in your records?
13 A I have a copy of it here.
14 Q Where does it say that in your records?
15 A The MRI was normal. I didn't feel I needed to include
16 a normal test. I have it here as part of my chart.
17 Q Now, you did a, numbness and tingling, are those signs
18 of radiculopathy?
19 A Yes.
20 Q Do you find any of that here?
21 A No.
22 Q You did lumbar epidural?
23 A Yes.
24 Q And you said it provided 3 or 4 hours of relief?
25 A According to the patient, yes.

1 Q When did you see the patient next?
2 A Roughly six months after.
3 Q Is that what she told you, 3 to 4?
4 A That's what she expressed.
5 Q Does it say that?
6 A It might, in my note January 7, 2013, stated, first
7 page, patient states that she had a mild pain relief after the
8 lumbar epidural steroid injection.
9 Q Where does it say?
10 A I don't have it here, but this is what she verbalized.
11 Q Now?
12 A Not now, sir.
13 Q That's what you remember from January 7, 2013, is that
14 she told you 3 to 4 hours based on the note that patient stated
15 she had mild pain relief in the lumbar?
16 A I'm not sure the terms of the hours, but it is, I mean
17 I have it written here. She had a mild relief after the
18 injection and that was the reason for not repeating the
19 injection.
20 Q Three to 4 records, that's not something you have in
21 your records?
22 A No.
23 Q You learned that recently?
24 A No, I'm not sure.
25 Q Now, after your first injection, you said RTC, 2 to

1 3 weeks?

2 A Return to clinic, 2 to 3 weeks.

3 Q When she returned to you on January 7, 2013, you

4 examined her again, correct?

5 A Yes.

6 Q And there is an area there on your report about

7 surgical history?

8 A Yes.

9 Q And it says no significant surgical history?

10 A It's a typo. I examined her. I saw surgical scars.

11 As soon as I examined her, I called Dr. Gerling's office to

12 request a report.

13 Q In January 7, 2013?

14 A Correct.

15 Q Where does it say in your report that she had surgery?

16 A I have the copy of the operative report.

17 Q Where does it say in your report she had surgery?

18 A Bottom of the exam, clearly visible, she has a two-inch

19 scar on her back. And it's very common in my practice to call a

20 surgeon to request the operating report, especially someone that

21 has pain after the surgery.

22 Q Where in your report does it say she had surgery?

23 A Again, I have a copy of the operative report.

24 Q Where?

25 A Not in my report. I have a copy of the surgical

1 report.

2 Q So you didn't have the surgical report when you made

3 that when you drafted that report?

4 A Perhaps, I'm not sure.

5 Q But you had, according to you anyway, you had it in

6 February 2015, right?

7 A That's correct.

8 Q And where does it say it in that report?

9 A Again, you go back and fourth with the medical records.

10 I have a copy of the operative report requested from me by

11 Dr. Gerling. I called his cell number to request the report.

12 This is what it is. You can go back and fourth. I know there

13 is a line there that says no significant surgical history, you

14 can talk about it for another hour. This is what it is.

15 Q For all I know, Doctor, you were handed that report

16 outside, where is it in your report that there was surgery?

17 THE COURT: Ask it, is it in his report, yes or

18 no?

19 Q Is it anywhere in your report?

20 THE COURT: Yes or no.

21 THE WITNESS: It's not in my report, sir.

22 Q No?

23 A No.

24 THE COURT: Move on.

25 Q Now, you testified that you would advise her not to

1 have a second injection because of the mild pain relief that she
2 got from the first one?
3 A Correct.
4 Q Can we look at your report from November, January 7,
5 2013?
6 A Yes.
7 Q It says patient was given the option to proceed with a
8 lumbar epidural steroid injection to elicit the pain generated
9 and provide therapeutic benefit in terms of --
10 A Correct.
11 Q Why would you give her that option if you were advising
12 against it?
13 A As I explained earlier, the reason for the option, and
14 I did talk about this, is because if someone had back surgery,
15 this formation of scar tissue, which can enwrap the nerve and
16 cause more pain and problems down the road, this was the only
17 reason I advised her to consider an epidural to decrease some of
18 the inflammation that took place after the surgery. I understand
19 that she had an injection that didn't help her before. After
20 the surgery, it's a total new pathology. It's not the same as
21 it was before. And the course of treatment to determine, again,
22 just because she didn't have previously, doesn't mean that she
23 shouldn't have the relief.
24 Q Where does it say that in your report? Everything you
25 said, that now there is a whole new situation with the surgery

1 and scar tissue.
2 A The recommendations are there to do another injection.
3 Q There is no recommendation not to do an injection?
4 A There is a recommendation to do an injection.
5 Q There is nothing saying I advise against the second
6 injection?
7 A This is not the same concept she had before. She had
8 the surgery now, different problem, that's the reason she was
9 advised to have another injection, not for the same problem she
10 came to me initially for.
11 Q It doesn't say that anywhere in the report?
12 MR. IRWIN: Objection.
13 THE COURT: Overruled.
14 MR. IRWIN: Move to strike.
15 THE COURT: Denied.
16 Q You prescribed medication again?
17 A Yes.
18 Q Do you know if she ever filled that prescription?
19 A I'm not sure.
20 Q Do you know if she filled the prescription the first
21 time?
22 A Not sure.
23 Q Did she tell you she was afraid of pain medication?
24 A I don't recall.
25 Q Would you prescribe medication if she told you she was

1 not?
2 A I saw her in the gaps of 5 to 6 months between office
3 visits and I reiterated the fact that she should consider taking
4 pain medication. I cannot force her to take pills. It's up to
5 her.
6 Q She never had a second injection?
7 A She did not.
8 Q On direct examination, on cross examination, she
9 testified that she only seen you one time, would that be
10 incorrect?
11 A I have records that I saw her four times in four
12 different occasions including 3 or 4 weeks ago. She might have
13 seen my PA which over time I come in to conclude the visit, but
14 I recall seeing her last time.
15 Q Are you saying?
16 A I signed all of my records. I saw her, four times.
17 Q She testified on Monday that she only saw you one time?
18 A I'm not sure what she have testified, but I have
19 records of four times.
20 Q But she may have seen your PA?
21 A I doubt it. If my PA sees a patient he usually signs
22 the charts.
23 Q You never reviewed any of the physical therapy records?
24 A Correct.
25 Q You don't know if she was approved for physical

1 therapy?
2 A I don't.
3 Q When you did the first injection on your first exam,
4 you had none of her records other than the lumbar MRI?
5 A Correct.
6 Q You don't think it's important to see records before
7 you inject somebody?
8 A She came in two months or two and a half months after
9 the injury. She started physical therapy, which I have written
10 in my notes that she had treatment consistent with medication
11 and physical therapy. She described quite a bit of pain when
12 she came in for the first time. And even though I don't have
13 written statements, as counsel wants me to write that she had no
14 relief with physical therapy, if someone says that it's enough
15 to make a conclusion that physical therapy was not effective and
16 I don't need medical records such as physical therapy to form --
17 I need to examine the patient, look to MRI and determine the
18 best treatment plan.
19 Q The MRI?
20 A And films.
21 Q After January of 2013, you didn't see her again for two
22 years?
23 A Correct.
24 Q That's fairly reasonable?
25 A Yes.

1 Q And there were pain complaints?
2 A Sorry.
3 Q She complained of pain?
4 A Yes.
5 Q And what did she rate her pain in the lumbar spine when
6 she saw you in February?
7 A Four out of ten.
8 Q Can I have, I don't have those reports.
9 MR. IRWIN: Sidebar?
10 (Whereupon, an off-the-record conference was held
11 between all counsel and the Court at the sidebar out of the
12 hearing of the jury.)
13 (Whereupon, the following occurred in open court:)
14 Q Going back to your first visit where it says imaging
15 studies, see chart for full report. Where is that chart?
16 A It's electronic chart and there is a copy of the report
17 attached to the chart. I print my medical records, electronic
18 everything is scanned and in order to prepare for the trial, I
19 print out the entire chart.
20 Q So the report you are talking about is the lumbar MRI
21 report?
22 A Yes.
23 Q Now, and the thecal sac has no nerves in it?
24 A What is in there?
25 Q Fluid.

1 A Fluid, the nerves underwrap, there are exit nerves,
2 nerves to the side by definition, thecal sac impingement means
3 the bulge is big enough to cause impression and some radiologist
4 use terms, herniation and bulge synonymously to a certain
5 extent. In her case, when I saw the MRI, I saw an extruded
6 disc.
7 Q You saw a bulge or extruded herniated disc?
8 A A broad base bulge at L4/5 and a small extruded
9 component.
10 Q It does not say that in your report?
11 THE COURT: Okay. I think everybody gets that
12 idea.
13 Q Now, when you saw her on February 13, 2015, but you did
14 some range of motion test?
15 A Yes.
16 Q And this is the first time you documented the range of
17 motion findings?
18 A Yes.
19 Q And what do you say normal forward flexion would be?
20 A Let me look in my notes. Normal flexion is 90 degrees.
21 Q Ninety.
22 A According to my notes, yes.
23 Q And what do you base that on?
24 A Based on, there is a reference based on American
25 Medical Association guidelines and New York State Division of

1 Disability guidelines. There are several guidelines, one are or
2 pediatric instead of 90 degrees, they use 110 as being normal
3 regardless of what the numbers are, the range of motion was 40
4 to 50 percent less than normal, whatever the number is.
5 Q If another doctor found range of motion of 70 degrees,
6 that would not be 40 to 50 degrees less than what you believe to
7 be normal?
8 A Out of 110 or 90?
9 Q Ninety?
10 A I believe, this is not what I believe. These are
11 published guidelines.
12 Q How do you come up with that those numbers?
13 A It's 90 being normal, but according to my abnormal
14 values, as you can see she is 50 or of 60 degrees.
15 Q Sixty?
16 A So about 30 percent less, right?
17 Q Based on what you saw?
18 A And I'm a treating physician and I saw her and examined
19 her.
20 Q And another treating physician.
21 THE COURT: Okay. Here we go again. Question and
22 answer.
23 Q And on February 13, 2015, you again give her the option
24 to proceed with lumbar injections?
25 A Correct.

1 Q Even though again you testified you wouldn't recommend
2 lumbar injections?
3 A If you heard me testify twice already, I mentioned
4 clearly that the first injection that she had where
5 therapeutically failed, was done to help pain due to herniated
6 disc. Now, this woman has major spine surgery and the purpose
7 of the injection is to alleviate pain because of the spinal
8 surgery and additional herniated disc as at L4/5 she never had
9 before.
10 Q Did you ever tell her not to have an initial injection
11 after the first procedure?
12 A I didn't. I didn't see her in the interim.
13 Q Now, you said you looked at that X-ray and you said
14 there was nonunion, but you would refer that to Gerling?
15 A Yes.
16 Q That's not something you actually saw?
17 A I see if you look at the right L5 screw, I believe it's
18 nonunion, but...
19 Q You cannot tell?
20 A You can, but I would defer to the spine surgeon to make
21 a formal opinion.
22 Q You are not a spine surgeon or radiologist?
23 A No, I review films all day long for the last eight
24 years.
25 Q When you say there is not a union, you are not sure?

1 A I'm 99 percent positive.
2 Q Do you know the last time Ms. Imran had physical
3 therapy was?
4 A Not sure.
5 Q Did you recommend physical therapy to her on any of
6 your recent visits?
7 A No.
8 Q Not in any of your reports here?
9 A No.
10 THE COURT: Almost done?
11 Q Do you suggest lumbar, let's talk about radio frequency
12 ablation in here in any of your recent visits?
13 A No.
14 Q Would you agree the part of your report from assessment
15 plan through the end of the report are essentially the same
16 thing on all four of your reports?
17 A She does have the same problem.
18 Q So it's a different problem?
19 A In conjunction to previous problems she has lumbar
20 facet loading which is positive on the previous two office
21 visits in 2015. I still feel that she should consider an
22 epidural as the modality of treatment at this point and that
23 would not be effective. I would consider a lumbar facet
24 injection.
25 Q Now, you said that one of the things she should have an

1 NCV?
2 A Yes.
3 Q Do you know if she had any NCV before the surgery?
4 A Nothing in my records.
5 Q You don't know if she had it?
6 A Nothing in my record.
7 Q Do you think it's a good test?
8 A To see if there is no nerve damage.
9 Q What about before?
10 A Possibly.
11 Q Could that have shown if there was nerve damage?
12 MR. IRWIN: Objection.
13 THE COURT: I will allow.
14 A It depends when the test is performed. Typically we
15 see nerve damage about 60 to 90 days after nerve impingement.
16 The test is performed 30 or 60 days after the onset of symptoms
17 most likely we will not see anything.
18 Q Why would the doctor not suggest one before?
19 A Not sure.
20 Q Now, on May 15th, 2015, you saw her?
21 A Yes.
22 Q Again, and at that time, the pain that had been a four
23 in February was now an eight?
24 A Yes.
25 Q And you attribute that to a change in her MRI or CAT

1 scan?
2 A Not necessarily attributing to CAT scan, I feel or we
3 know for a fact patients who had trauma, abnormal findings,
4 whether it's a bulge or herniated disc or inflamed joint and
5 especially having a back surgery are more prone to relapses.
6 When I saw her in May, she had worsening in her pain, whether it
7 was due to new pathology which was diagnosed in May, CAT scan or
8 because she has exacerbation of her previous --
9 Q Are you familiar with the term secondary gain?
10 A Yes.
11 Q What does that mean?
12 A Trying to do something for financial gain.
13 Q Like a lawsuit?
14 A Lawsuit.
15 Q And you would agree the pain rating is subjective?
16 A Yes.
17 Q Are you aware that 5/15/2015, that was right before we
18 were going to begin a trial?
19 A I only learned about the trial a week ago.
20 Q You only learned about it?
21 A I learned, yes.
22 THE COURT: Is that it?
23 Q Wouldn't you agree that an upcoming trial could be
24 incentive to increase the pain rating?
25 A When I saw her in May 15th, I had no idea there was a

1 trial coming up. I was notified by counsel there was a trial a
2 week ago.
3 THE COURT: Redirect.
4 REDIRECT EXAMINATION
5 BY MR. IRWIN:
6 Q Is the cat scan objective?
7 A It is not.
8 Q Is the May 15th, 2015, CAT scan something that shows
9 further damage to Ms. Imran's upper spine?
10 A Yes.
11 Q Is it progressing and worsening?
12 A Yes.
13 Q And can that worsen between February 2015 and May 2015?
14 A Yes.
15 Q And is it your opinion to a reasonable degree of
16 medical certainty that the change in the pain rating from four
17 in February to eight in May is because now we are watching
18 Ms. Imran's condition worsen and watch her develop failed spinal
19 surgery syndrome?
20 A Yes.
21 Q Is that to a reasonable degree of medical certainty?
22 A Yes.
23 Q And is there anything subjective about the CT scan and
24 the X-ray that show this occurring?
25 A Nothing subjective.

1 THE COURT: Is that it?
2 Q And is that consistent with your physical examination
3 that you did in February and then one you did later on in May?
4 A Yes.
5 Q And is this going to get better or worse?
6 A Worse.
7 Q Is this pain going to get better or worse in the future
8 over the course of the next year?
9 A Worse.
10 Q Do you agree or disagree with Dr. Gerling, is what we
11 are watching is the failed spinal fusion surgery in action right
12 now as this trial goes on moving toward her having to have a
13 fusion surgery at two levels instead of one in her lumbar spine?
14 A I agree with that.
15 THE COURT: Thank you.
16 Q Doctor, I need to go back a little bit and cover a
17 couple of things, did you bring your records to be knit picked
18 by a lawyer --
19 THE COURT: Sustained.
20 Q What was the purpose of you writing your records?
21 A To have recollection of treatment or condition that she
22 presented initially.
23 Q How do you know that you read the MRI if you didn't
24 write it down?
25 A I know because specifically with that etiology, I have

1 with that radiology, I have direct access to review films and I
2 know every time I see a patient from that radiology I'm able to
3 review it and it's a big aid to me as a physician to be able to
4 review the films.
5 Q What do you have to do to look at films from stand up
6 MRI?
7 A User name and MRI.
8 Q Did you use from your desk top?
9 A Yes.
10 Q How long have you been performing injections on
11 patients to the spine?
12 A 2007.
13 Q Is that a damaged procedure?
14 A Yes.
15 Q Have you ever done a single injection from the lumbar
16 or cervical spine when you did not look at the MRI?
17 A Yes, there are cases where MRI's are not -- the report
18 is available but the films may not be, but I try to make every
19 attempt to request records.
20 Q Who took this MRI of Ms. Imran's lumbar?
21 A Stand up radiology.
22 Q Did she have to have it with you for you to look at the
23 date injection?
24 A No.
25 Q What did you do once you decided to get her to do the

1 injection?

2 A I logged into the photo and viewed the films.

3 Q How far did you have to walk?

4 A Available in every exam room.

5 THE COURT: Is that it?

6 Q You were questioned about how Dr. Gerling, June 20th,

7 2012, reported different findings from you a few days earlier,

8 right?

9 A Yes.

10 Q Do you expect every single person with a lumbar injury

11 with Ms. Imran's history to have the exact same findings every

12 single day, all day?

13 A No.

14 Q Can you explain why you are not going to have perfectly

15 exact findings every day, all day with every?

16 A Pain changes. If someone takes pain medication, they

17 can come and say they have no pain. If the pain medication

18 wears off, perhaps she went to Dr. Gerling when she took pain

19 medication when she saw him, I'm not sure.

20 Q Two to 3 weeks on the 6/20/12 visit where was she on

21 June 20th?

22 A I believe Dr. Gerling.

23 Q Was there a reason to come back to you if she was going

24 to go to Dr. Gerling?

25 On my direct, I asked you to assume that Ms. Imran

1 testified that she only had 3 to 4 hours of relief from your
2 injection, is that where you know that fact from?
3 A Yes.
4 THE COURT: Thirty-five.
5 Q You were cross examined about the physical therapy not
6 working, not providing relief.
7 A Yes.
8 Q On my direct examination, isn't it true that I asked
9 you to assume physical therapy didn't help and Ms. Imran
10 testified about that?
11 A Yes.
12 MR. DUER: Objection.
13 THE COURT: I will allow it.
14 Q Are you trying to treat patients or investigate when
15 you see patients in your office?
16 A Treat patients.
17 Q And can you explain to the jury why you don't go and
18 get all of the medical records and scrutinize them with a
19 magnifying glass?
20 A I'm not sure I understand.
21 Q Is there a reason you don't collect every piece of
22 medical record you can for your patients before you do any
23 procedures or anything else at all?
24 A In medicine, you have to get the most pertinent
25 information pertaining to their condition. In our case, the

1 fact she came to my office and gave me a history of the injury,
2 I examined her, I had access to domestic studies and that was
3 adequate for me to render a diagnosis and treatment.
4 Q Were you able to do that.
5 A Yes. Yes.
6 Q You testified about physical therapy and radio
7 frequency ablation, correct?
8 A Yes.
9 Q Would that be before or after a revision fusion surgery
10 that has been recommended by Dr. Gerling in the future?
11 A It could be either or, before or after.
12 Q Do you have an opinion to a reasonable degree of
13 medical certainty as to whether or not Ms. Imran will be able to
14 avoid having further treatment or refuse further treatment as
15 time goes on?
16 MR. DUER: Objection.
17 THE COURT: Sustained.
18 Q Do you have an opinion regarding the likelihood that
19 Ms. Imran will change her mind about injections or radio
20 frequency or physical therapy after she has a revision fusion
21 surgery?
22 MR. DUER: Objection.
23 THE COURT: Sustained.
24 Counsel, you made a representation on the side war
25 that you had a certain number of questions, you are way

1 beyond that right now.
2 MR. IRWIN: I believe I'm done, your Honor.
3 That's it.
4 THE COURT: Recross?
5 MR. DUER: Briefly.
6 RECROSS EXAMINATION
7 BY MR. DUER:
8 Q Dr. Reyfman, is it your testimony that you just learned
9 that Ms. Imran claimed to only have 3 to 4 hours of relief from
10 the injection and that physical therapy did help her for the
11 first time now?
12 A Counsel asked me to assume the fact that this is what
13 she expressed and that's what my assumption is.
14 Q That's what you were basing it on?
15 A That's good enough for me.
16 Q You didn't know it during the times of your treatment?
17 A Sorry.
18 Q You were not aware during --
19 A There is a failure.
20 THE COURT: Yes or no?
21 THE WITNESS: No.
22 THE COURT: Thank you.
23 You may step down.
24 (Whereupon, the witness steps down.)
25 Mr. Irwin, do you rest?

1 MR. IRWIN: Literally when I get home figuratively
2 right now I rest, plaintiff rest.
3 THE COURT: Thank you, very much. Have a good
4 evening. We will see you tomorrow morning at 9:15, don't
5 discuss this case with anyone.
6 (Whereupon the panel of sworn jurors exit the
7 courtroom.)
8 (Whereupon, the trial was adjourned to June 10,
9 2015 at 9:15.)
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2 SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF QUEENS : CIVIL TERM : PART CSCP
3 --X
HALINA IMRAN,
4 Index No.
Plaintiff, 21083/12
5
-against-
6 Trial

7 R. BARANY MONUMENTS INC.,
RANDY R. BARANY,
8
Defendant.
9 --X
Supreme Courthouse
10 88-11 Sutphin Boulevard
Jamaica, New York 11435
11 June 10, 2015
B E F O R E:
12 HONORABLE MARTIN E. RITHOLTZ,

13 Justice, Supreme Court

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

15 For the Plaintiff:
IRWIN & POZMANSKI
16 233 Broadway
New York, New York 10279
17 BY: JOSHUA BRIAN IRWIN, ESQ.

18
For the Defendant:
19 PICCIANO & SCAHILL
900 Merchants Concourse
20 Westbury, New York
BY: PAUL DUER, ESQ.
21

22

23

24

25 LYNDA A. ROSS, RPR
Senior Court Reporter

1
2 (Whereupon, the panel of sworn jurors enter the
3 courtroom.)
4 THE COURT: Good morning, jurors. You may be
5 seated. Everyone may be seated. At this time I call upon
6 Mr. Duer to put on his witness.
7 MR. DUER: I call Dr. Sapan.
8 (Whereupon the witness took the witness stand.)
9 (Whereupon the witness was duly sworn by the Clerk
10 of the Court)
11 THE CLERK: Name and address.
12 THE WITNESS: Melissa Sapan, North Shore
13 University Hospital, 300 Community Drive Manhasset, New York
14 11030.
15 THE COURT: You may inquire.
16 MR. DUER: Thank you, your Honor.
17 DIRECT EXAMINATION
18 BY MR. DUER:
19 Q What is your profession?
20 A Diagnostic radiologist with subspecialty in radiology.
21 Q Are you licensed to practice medicine in the State of
22 New York?
23 A Yes, I am.
24 Q And when did you receive that license?
25 A In 1991.

1 Q And can you tell us a little bit about your education?
2 A Sure. I went to the University of Rochester
3 undergraduate where I received a bachelor of arts in psychology
4 and a bachelor of science in neuroscience. After that I went to
5 Chicago where I attended the Chicago Medical School. I received
6 a masters in physiology and medical MD degree in 1989. After
7 that I returned to New York and I duly did my training at North
8 Shore University Hospital in Manhasset. At that time we were
9 Cornell affiliated. I did one year of internal medicine. I did
10 four years of diagnostic radiology residency and then I did an
11 additional two-year fellowship specifically in neuroradiology.
12 Q What is a fellowship?
13 A A fellowship is after you completed your main training,
14 kind of similar when you do internal medicine and then you sub
15 specialize as a GI doctor. So in radiology, we can sub
16 specialize, we know all of radiology but we want to become
17 better in one specific facet of radiology. So I chose
18 neuroradiology and that's specifically all imaging that has to
19 do with brain, head, neck and spine.
20 Q And do you have any certifications?
21 A I do. I am boarded by the American Board of Radiology
22 in diagnostic radiology, that's all radiology and I have an
23 additional certificate called the certificate of added
24 qualifications in neuroradiology.
25 Q And do you have any professional memberships?

1 A I do. I may not be able to remember them all. The
2 American Society of Neuroradiology, Long Island Radiological
3 Society, Nassau County Medical Society, New York State Medical
4 Society.
5 Q How do you become a board certified radiologist?
6 A When I was doing it, it changes, but when I did it, I
7 had to take, first I had to take a written test, which was
8 predominantly regarding physics, and had to take images and then
9 we had to take a second part of the test which required us to
10 fly to Louieville, Kentucky where we had to take a ten part oral
11 examination in each section of radiology and pass all sections
12 to become board certified.
13 Q And you are qualified as a board certified
14 neuroradiologist?
15 A That's a separate certification. I had to fly back to
16 Louisville, Kentucky, take an oral examination in brain, head
17 and neck and spine. The certificate of added qualifications, I
18 have to re board every ten years. Every ten years I have to
19 take a test again, the follow-up tests are given in Chicago on a
20 computer.
21 Q And is it your job, tell us what does a radiologist do?
22 A Basically you probably all interface with radiology
23 radiology, basically a doctor who is seeing a patient whether it
24 be internal medicine, orthopedist, GI, they have a question that
25 they would like further information on so they wanted imaging

1 studies. Radiology includes X-rays for broken bones, chest
2 X-rays for pneumonia, CAT scans, ultrasound when are pregnant,
3 MRI of knees, backs, head, angiograms studies to inject dye to
4 look at vessels, diagnostic radiology encompasses all of those
5 aspects of imaging.
6 Q And you reviewed lumbar spine MRI?
7 A Yes.
8 Q And knee MRI?
9 A Yes.
10 Q And shoulder?
11 A Yes.
12 Q And how many films would you say you reviewed in your
13 career?
14 A In my work?
15 Q Yes.
16 A I have no idea, thousands, to give an example. I can
17 do about 50 MRI or CT a day and I have been working for almost
18 20 years.
19 MR. DUER: Your Honor, I would like to offer Dr.
20 Sapan as an expert in the field of radiology and
21 neuroradiology.
22 THE COURT: So deemed.
23 MR. IRWIN: No objection.
24 Q Doctor, are you being compensated for your time here
25 today?

1 A I am.
2 Q How much?
3 A $5,000.
4 Q And if you were not here today, do you have an office?
5 A I work at the hospital.
6 Q Which hospital?
7 A I work at North Shore University Hospital in Manhasset.
8 Q In 2014, did my office ask you to review the MRI lumbar
9 spine of Halina Imran on July 1, 2012?
10 A Yes.
11 Q And can you explain to the jury about the lumbar spine?
12 There is a model there?
13 A Yes, can I get up. So basically, all right, spine runs
14 from your skull base to your lower, all the way to your lower
15 back. On this model, this is the skull base, so this is all
16 your spine. We divide the spine to four segments, your neck, up
17 here which is cervical, your mid back here which is called
18 thoracic, the lower curve here which is lumbar and that has five
19 vertebral bodies and sacral and tailbone are here. Those are
20 the segments of the spine. The lumbar spine, since we will be
21 talking about that is composed of vertebral bodies which is the
22 bones of your back. These are in the most common configuration
23 that we see that most of us have is five lumbar vertebral bodies
24 there are the bones and vertebral bodies, in between each
25 vertebral body is this yellow disk, the bones obviously are

1 brittle like bones everywhere else in your body, the disks are
2 not. They are a jelly like substance. We have disks so we can
3 bend. If we were a solid bone, we would not have flexion
4 ability at all. That's the purpose of the disk. They allow
5 mobility as well as shock absorption. The vertebral bodies are
6 not these pieces that we see here, but they have what we call
7 posterior elements. That means there are projections of the
8 bone that go back from the vertebral body you don't need to know
9 the names, it makes another canal, a circle that is open on the
10 inside and I don't know if you can appreciate but this yellow
11 coming out are the nerve roots and inside is the spinal cord
12 which runs in the canal behind the vertebral bodies.
13 The disk and vertebral bodies sit directly in front of
14 the spinal cord and important thing about anatomy in the lumbar
15 region, your spinal cord does not go down to the body, your
16 spinal cord ends about L1 which is right here. So in your lower
17 back, you do not have a spinal cord. The cord ends up about
18 here and the nerve, you have nerve roots that come down from the
19 spinal cord and go out through the openings that called foramen
20 and then these nerve roots come out and send nerves to your
21 legs.
22 Q Doctor, have you had an opportunity to review the MRI
23 films taken of Ms. Imran on June 1, 2012?
24 A Yes, I did.
25 Q And?

1 THE COURT: So MRI films in evidence as what day,
2 April 6th are these the CDs, Plaintiff's 3 in evidence?
3 Q I want to take you through your report. You prepared a
4 report in connection with your examination?
5 A Yes, I did.
6 Q And you have that report with you?
7 A Yes, I do.
8 Q You find loss of normal lumbar lower --
9 THE COURT: Tell us the date you are referring to.
10 MR. DUER: June, the images are dated June 1,
11 2012.
12 THE COURT: They should be on there.
13 Q Is that the correct date?
14 A Yes, right here.
15 Q You found loss of normal lumbar lordosis.
16 A Yes.
17 Q What is that?
18 A Basically if you look when we looked at our model the
19 spine does not go straight up and down it has curves, the neck
20 curves forward and so does the lower spine. Usually the normal
21 curvature of lumbar spine comes out a little bit more like this.
22 This is a little straight. I'm not sure if this was done on an
23 open MRI or not. Open MRI can change the alignment, and usually
24 they look straight because they are sitting down in the open
25 MRI.

1 Q This was done standing up?
2 A This was done standing.
3 Q This was done at Stand Up MRI?
4 A Yeah, yes. It was done at stand up. All the patients
5 done at the Stand Up MRI have loss of the normal lumbar
6 lordosis. They do it differently than most people which is
7 lying down in supine position. They have them standing or
8 sitting and that makes the spine straighter, so that's
9 positional. We see that in all of the stand up MRI patients.
10 Q And was that the loss of the lumbar lordosis, would you
11 say that was mild?
12 A Yes.
13 Q You say that in your report?
14 A Yes.
15 Q Now, you then refer to disk L1-2, L2-3, L3-4 and those
16 disk spaces are normal?
17 A Yes.
18 Q What do you base that on?
19 A So when we evaluate the disk for a little anatomy,
20 these are the bones and in between are the disk spaces we use
21 this multiple images, MRI would consist of more than what we
22 call a sequence. This is a T2 weighted sequence and refers to
23 physics of taking the image the thing to know about T2 is
24 anything that's water will be white. So here are the vertebral
25 bodies, the squares in between are the disk spaces. This is a

1 spinal cord ending here. You see nerve roots coming down, all
2 of this white is fluid is cerebral spinal fluid. The fluid that
3 surrounds the spinal cord and nerve roots and normal disk, here
4 is the end of the spinal cord and these are nerve roots coming
5 down. So that's about L1, so when I look at the disk, the first
6 thing we do is look at this, a sagittal image, slicing through
7 the body like this and looking sideways. This is the front and
8 back and this is a midline image, the first thing I do is look
9 to see are they hydrated or not, what I mean, the normal disk
10 is, has water in it.
11 So the normal disk has water in it because it's a jelly
12 like substance. It has fluid in it. A normal disk on T2
13 weighted, it will not be as bright as water. It's not a hundred
14 percent water. It will be bright, these disks, L1/2, L2-3 and
15 L3-4 are bright on the T1 weighted images as compared to here is
16 L5 S, that disk is black. L4/5 it's not as black as S5/S1.
17 Q What does that indicate?
18 A That there is disk desiccation at L4/5 and L5/S1.
19 Q And desiccation, a drying out of the disk?
20 A Desiccation means drying out.
21 Q Is that something that occurs quickly or something that
22 occurs over time?
23 A That is something a long standing process. It's seen
24 with aging, some people develop it earlier than others, depends
25 on genetics and what your predisposition is toward disk disease.

1 It will take months to years for this to develop.
2 Q Do you see any ossification around L4/5, L5/S1?
3 A If you look at the regular, the normal vertebral body,
4 it's square. If you come down to L5/S1 there is a beak coming
5 out, there is bone spur and there is a beak at L4/5, again,
6 lesser than L5/S1 but still present. There are small
7 osteophytes or bone spurs at the L4/5 and L5/S1 levels.
8 Q What are osteophytes?
9 A Osteophytes represent bone formation so they are the
10 pieces of bone that extend off of the vertebral bodies since
11 that's bone formation that cannot develop overnight. It's
12 chronic and long standing and associated with degeneration disk
13 disease.
14 Q What did you determine there was at L4/5 and L5/S1?
15 A We said there is osteophytes and disk desiccation and
16 there's a little bit of disc bulging. If you look at the back
17 of the normal disk, they are pretty much flat with the back of
18 the vertebral bodies, there is a little convexity and a little
19 here and I look on a different set of images, the axial images
20 to look at the circumference to determine that's a disk bulge.
21 Q How is a disk bulge different than a herniated disk?
22 A Disk bulge, is that's disk bulge circumferential? It
23 involves the entire circumference of the disk. I think of a
24 disk bulge, if you think of a bagel and cream cheese and you
25 take the bagel and smush down on the bagel, the cream cheese

1 will come out circumferentially on all sides, a disk herniation
2 is different. The disk has a fibrous outer portion and gel like
3 inner portion in disk herniations, the gel comes out through the
4 fibres. When I think about a disk herniation, if you think
5 about a jelly donut and it has a hole, if you push the jelly
6 comes out in one location only. That's a disk herniation.
7 Q What about a herniated disk with extruding nucleus?
8 A Extruded means it comes out of the disk. So some disk
9 herniations, the inside portion of the disk can deform the outer
10 fibres and push it out without breaking all the way through and
11 extruded disk herniations, the disk, those outer fibres break
12 open and the gel like material on the inside of the disk comes
13 out through that opening.
14 Q So that would look different on this image if there was
15 a herniated disk or herniated disk with extruded nucleus?
16 MR. IRWIN: Objection.
17 Q Would it look different?
18 THE COURT: Objection, sustained. Leading.
19 Q Can you describe what a herniated disk with extruded
20 nucleus would look like?
21 A Extruded disk herniation, you would see disk material
22 coming down and out, it can go up and out, but usually goes down
23 because of gravity, so you would see a piece of disk coming out
24 and going down behind the vertebral body below it.
25 Q Is that seen here?

1 A No.
2 Q Is there any other images you can show to illustrate?
3 A Yes, the axial images.
4 Q What are the axial images?
5 A The axial images are the images that obtain in a
6 different plane, you see this looks totally different, this is
7 slicing the body from head to toe and think of it as looking
8 down on the disk. So this is the front of the bodies. Here is
9 the aorta, the main vessel in the bodies, the vertebral body or
10 disk depending on what level we are slicing through, these are
11 the nerve roots where at L4/5. Now the spinal cord has ended up
12 here, but we have the nerve roots coming out, dots here, the
13 neuroforamen are these openings here, that the nerve roots are
14 coming out corresponding to the yellow that I showed you on the
15 model. So it's imperative to look at the axial images. As I
16 said, here is the disk, you can see we are going through the
17 disk, it's imperative to look at the disk but we want to make
18 sure that disk looks symmetrical consistent with a disk bulge.
19 This disk looks symmetrical. If it was a disk herniation, you
20 would see a focal finding coming out.
21 Q Is that L5/S1?
22 A This is 4/5. I can go to 4/5, S/1. So now we are at
23 L5/S1 and here is the disk, again, you see that it's totally
24 symmetrical, looks like a disk bulge, no evidence of disk
25 herniation, bring you to this slice here, front of the body,

1 back of the body, here is the neurological foramen, nerve roots.
2 Q Is there anything compressing on the nerve roots?
3 A No.
4 Q You can see the nerve roots?
5 A No.
6 Q And the disk is not compressing on the nerve root?
7 A No.
8 Q And you can say that with a reasonable degree of
9 medical certainty?
10 A Yes, here is the L5 and S1 and there is nothing
11 compressing on either the L5 or S1 nerve roots.
12 Q And what would that look like if there was a herniated
13 disk or herniated disk with extruded nucleus?
14 A A piece of disk coming out into, hitting a nerve root
15 or hitting the central canal, it would be a focal finding. They
16 have different configurations but you would not have this nice,
17 oval border here, you would see something coming out focally,
18 hitting the nerve root.
19 Q On your review, did you see any loss of disk type?
20 A Not really.
21 Q Did you see any foramental stenosis?
22 A No.
23 Q What is foramental stenosis?
24 A Foramental stenosis, if this opening is narrowed and
25 that can be caused by multiple reasons, disk herniation in the

1 foramen, bone spurs, bone spurs and disk bulge, these are the
2 facets that represent the back of the foramen. The facets are
3 two bones from different vertebrae coming together and you can
4 get arthritis there and those can enlarge and cause foraminal
5 narrowing.
6 Q You don't see?
7 A No.
8 Q How do people get disk bulges?
9 A It occurs over time, it's degenerative and it takes
10 place over years. It's from gravity and the aging process.
11 Q Is it possible to have disk bulges or herniations and
12 not know it?
13 A Yes.
14 Q Doctor, can you say based on your review of these films
15 with a reasonable degree of medical certainty that the disc
16 bulges found on the MRI June 1, 2012, were not caused by a
17 traumatic accident?
18 A Yes.
19 Q And how can you say that?
20 A Because disk bulging is degeneration, you don't get
21 traumatic disc bulges.
22 Q And can you say with a reasonable degree of medical
23 certainty that there are no findings on this, on the films that
24 you reviewed of June 1, 2012, from Ms. Imran that were caused by
25 traumatic incidents, specifically the one on April 17, 2012?

1 A Yes.
2 Q And how can you say that?
3 A All of her findings are degeneration. There is nothing
4 here that's a single traumatic event.
5 Q Based on anything you reviewed in these films, was
6 there, do you see any indication for surgery?
7 A No.
8 Q And can you say that with a reasonable degree of
9 medical certainty?
10 A Yes.
11 MR. IRWIN: Objection, your Honor.
12 THE COURT: Objection overruled.
13 Q Did you see anything on your review of these films that
14 would indicate any nerve involvement or nerve root compression?
15 A No.
16 Q Again, you can see the nerve roots?
17 A Yes.
18 Q What is the thecal sac?
19 A The thecal sac is, you cannot see the thecal sac, but
20 it's the membrane that holds the fluid in around the spinal
21 cord. So the thecal sac borders the back of the vertebral
22 bodies and disk spaces and comes up again over here. It's like
23 a plastic bag that holds in the cerebral spinal fluid.
24 Q Just because a disk might impinge on a thecal sac,
25 would that be painful?

1 A No.
2 Q Why is that?
3 A The thecal sac, remember the disk is always touching
4 the thecal sac, the disk and thecal sac is behind it. If you
5 get a disc bulge it will be touching the thecal sac, whether or
6 not you get pain would depend if it's hitting a nerve root or
7 compressing a nerve root.
8 Q And that's not the case here?
9 A No.
10 Q Hypothetically, if another radiologist, board certified
11 radiologist in radiology and neuroradiology found there to be
12 diffuse disc bulges at L4/5 and L5/S1, would you agree with
13 that?
14 A Yes.
15 Q What does diffuse?
16 A Circumferential.
17 Q And that's what you described?
18 A Yes.
19 Q If anesthesiologist said that there was a herniated
20 disk, would you agree with that, hypothetically, if an
21 anesthesiologist came in here and said he reviewed the films and
22 said he found a herniated disk, would you agree with that?
23 A No.
24 Q If an orthopedic surgeon hypothetically came in here
25 and testified that he saw a herniated disk with extruded

1 nucleus, would you agree with that?
2 A No.
3 Q And can you say that with a reasonable degree of
4 medical certainty?
5 A Yes.
6 Q Now, did you review a recent CT scan performed in May,
7 2015?
8 A Yes.
9 Q Of Ms. Imran?
10 A Yes.
11 Q And what was the date?
12 A The date of the study was May 5, 2015.
13 Q And is the CT, is that the study of choice to evaluate
14 disk disease?
15 A No.
16 Q And why is that?
17 A CT is similar to X-ray, meaning that it uses ionizing
18 radiation, X-rays are exquisite for looking at bone as is CT, CT
19 sees shades of gray for soft tissue and evaluating the disk is
20 very difficult with CAT scan because there is bone all around
21 that we cannot see very well into the canal where the disk is.
22 We use CT to assess the bones. We use it post surgery to look
23 at the surgical hardware, is there hardware intact, evidence of
24 screw loosening, we do not assess the disk. Patients who have
25 had surgery can't have MRI, even if they have hardware in them.

1 We use contrast and MRI to evaluate the disk disease in a post
2 surgery patient.
3 Q On your review of those films, what did you see at
4 L4/5?
5 A L4/5, again, I saw small anterior osteophytes, a mild
6 disk bulging and mild bilateral facet, degeneration change.
7 Q L4/5 was a disk bulge?
8 A Correct.
9 Q And can you say that with a reasonable degree of
10 medical certainty?
11 A Yes.
12 Q And what did you see at L5/S1?
13 A The patient had surgery with vertebral body posterior
14 fusion and laminectomy.
15 Q Did you review any other MRI's for any other body
16 parts?
17 A Knee and shoulder.
18 MR. DUER: Can we change the disk?
19 THE COURT: Do we know what evidence it is?
20 What is it in evidence?
21 MR. DUER: Part of three.
22 THE COURT: Plaintiff's three.
23 A Basically this is the right knee, date of study is over
24 here, 5/10/2012. This is a sagittal image, slicing the knee
25 this way and looking at it from the side. This is the femur or

1 thigh bone. This is the tibia or your bones in your calf. This
2 is the kneecap also known as the patella. This black triangle
3 is the meniscus, that's the medial meniscus, patella tendon,
4 quadriceps tendon and then we have to slice through the knee to
5 see all of the structures. Here is that intra cruciate
6 ligament, that attaches the thigh bone to the tibia. If I move
7 over a little bit, you can see the posterior cruciate ligament,
8 and then there is not much to show on this knee because I didn't
9 find any findings.
10 Q What were your findings with regard to this?
11 A She had a little bit of fluid in her joint space, very
12 minimal, this here, this is, there was a little bit of fluid in
13 the joint space. In my opinion, it was an unremarkable knee
14 MRI.
15 Q Was there anything near that you can say attributed to
16 the accident?
17 A No.
18 Q Can you say that with a reasonable degree of medical
19 certainty?
20 A Yes.
21 Q Shoulder.
22 A So, here is the shoulder, this is a coronal image,
23 meaning that this time we are slicing the patient forward to
24 backward. This is like you are looking right at the shoulder,
25 slicing it through, this is acromioclavicular joint where your

1 collarbone hits the bone of your shoulder to make a joint, this
2 is the humeral head, this is the humorous and it's got a ball on
3 top, this is a ball and socket joint, here is the socket, here
4 is the ball, and the tendon that hooks onto the humorous, there
5 was not findings on this, this the acromion process and this is
6 tilting back laterally, the acromial process could have
7 configurations the fact it tilts down laterally is this
8 patient's normal anatomy. The rotator cuff is intact. There
9 may be minimal signal abnormality here, very minimal that is
10 consistent with tendinosis.
11 Q What is tendinosis?
12 A Tendinosis is degeneration of the tendon. We call
13 tendinosis versus partial intrastitial tearing.
14 Q What does that mean?
15 A We cannot tell the difference on MRI with the mild
16 tears, versus tendinosis. Intrastitial means in the tendon not
17 a through and through tear, within the substance of the tendon
18 there is signal abnormality, could be degeneration of the tendon
19 or small microscopic tearing in the tendon itself which does not
20 cause the tendon to break apart. The tendon is intact but there
21 is signal abnormality in it.
22 Q Is there anything that you saw on this film that would
23 be related to a traumatic event?
24 A Basically I was going to say that in settings of acute
25 traumatic injuries to the shoulder, we see other findings. Most

1 commonly would be a joint effusion, to indicate that something
2 acute or something recently has happened. This finding of this
3 tendinosis versus partial intrastitial tearing, probably about
4 50 percent of us have it and don't know it, most of us have some
5 degeneration of our rotator cuff, especially as we age.
6 Q Can you say that with a reasonable degree of medical
7 certainty that there were no findings on these films that can be
8 attributed to the April 17, 2012, accident?
9 A Yes.
10 THE COURT: Is that it?
11 MR. DUER: Nothing further.
12 THE COURT: Cross.
13 CROSS EXAMINATION
14 BY MR. IRWIN:
15 Q You work in North Shore Hospital?
16 A Yes, I do.
17 Q And where else are you employed currently?
18 A Nowhere.
19 Q Do you receive income from there?
20 A Yes.
21 Q And that income, is that a salary?
22 A Yes.
23 Q So it's based on the days you show up to work you get
24 paid, not how many films you read or anything like that?
25 A Correct.

1 Q And you are receiving how much compensation today?
2 A 5,000.
3 Q And that's for half a day you will be out of here by
4 11:30, 12:00 and work by one?
5 THE COURT: Could I hold you to that?
6 MR. IRWIN: I hope so. I have a lot of questions.
7 Q Doctor, you will be back to the office by 12, 1:00,
8 maybe 2:00?
9 A Yes.
10 Q Are you using a sick day today or vacation day?
11 A I use my vacation time.
12 Q Are you getting paid by the hospital too?
13 A I get paid a salary. I get a certain amount of days I
14 have to work and time I have to take off.
15 Q Whether you are here or not, North Shore Hospital is
16 giving you a check for the time you are here today, right?
17 A Yes.
18 Q So you are not being compensated for any time you are
19 missing anymore?
20 A I lose vacation time.
21 Q And are you taking a full day or half day vacation?
22 A Half day.
23 Q So half a day vacation time is worth $5,000 or less
24 than $5,000? Do you get $10,000 a day from the hospital?
25 A No.

1 Q So you are not being compensated for your time here,
2 right?
3 MR. DUER: Objection.
4 Q You are not losing money?
5 THE COURT: Objection sustained.
6 Q You are not losing money to be here?
7 A No.
8 Q You are making a pretty hefty profit today?
9 THE COURT: Sustained.
10 Q What is the difference between your half day of pay at
11 North Shore Hospital and $5,000 you are being compensated for
12 the half day?
13 THE COURT: Sustained. Argumentative and going
14 through another topic.
15 Q Do you know how many times you testified in court in
16 the last 12 years since 2003?
17 A I don't know the exact answer. I can guess, I don't
18 know.
19 Q And how much were you compensated back in 2003 for half
20 a day of testimony?
21 A The same.
22 Q Would it be more than 20 times?
23 MR. DUER: Objection.
24 Q Since 2003?
25 THE COURT: Sustained.

1 Q Would you be surprised, Doctor, if I have 40 times?
2 MR. DUER: Objection.
3 THE COURT: I will allow it.
4 Q Would you say 40?
5 A No.
6 Q Forty?
7 A No.
8 Q Could it be more than 40 times since 2003?
9 A I have no idea.
10 Q Could it be 60 times?
11 A Again, no idea.
12 Q And that's $5,000 for each time?
13 A Correct.
14 Q How many of those times were you a plaintiff in a
15 lawsuit?
16 A Probably most of them.
17 Q For a plaintiff?
18 A For plaintiff, probably none of them.
19 Q I found one. Do you remember one time you testified
20 for a plaintiff?
21 A I believe I did testify for a plaintiff, yes.
22 Q The way this works is there is a service or a law firm
23 that will send you MRI films or X-rays and CAT scans, correct?
24 A Yes.
25 Q And the service, the one I saw consistently for you

1 was?
2 MR. DUER: Objection.
3 Q The one I saw multiple times in the times in all of the
4 reports that I collected of yours --
5 THE COURT: Sustained. Sustained. Sidebar. I.
6 Q Are you familiar with a company called Certified --
7 sorry, Certified Medical Consultants?
8 A Yes.
9 Q And they are where?
10 A I believe Florida.
11 Q And what they do is they locate doctors and send
12 radiologists in particular and other types of experts to testify
13 at trial for people who are defending lawsuits, right?
14 A I don't work for that company so I would be remiss to
15 say what they do. They do send me cases.
16 Q They have a website, right?
17 A I have no idea.
18 Q You don't know if they have a website?
19 A I have no idea.
20 Q And you have been doing work with them for how many
21 years?
22 A Maybe a year.
23 Q I will talk to you for a minute about Picciano and
24 Scahill, how many times have you been asked to review films by
25 Picciano and Scahill?

1 A I don't know.
2 Q It's definitely in the dozens?
3 A Probably, yes.
4 Q More than 50?
5 A Again, I don't know.
6 Q More than a hundred?
7 A Again, I don't know.
8 Q When you receive films, they come from, they come
9 addressed from somebody, correct?
10 A Yes.
11 Q They come addressed from either certified medical
12 consultants or was there a service you worked for before then?
13 MR. DUER: Objection, a service, may we approach?
14 (Whereupon, an off the record discussion takes
15 place at sidebar among the Court and Counsel.)
16 THE COURT: Sustained as to form.
17 MR. IRWIN: Withdrawn.
18 Q I meant work with. Was there a service you worked with
19 before Certified Medical Consultants?
20 A There are multiple different services that do a
21 similar, that do a similar kind of activity.
22 Q How many different services do you currently work with
23 that do this type of activity?
24 A Two others.
25 Q So three total?

1 A Yes.
2 Q And they all work for people that are defending
3 lawsuits, don't they?
4 MR. DUER: Objection.
5 THE COURT: If you know, if you know.
6 A They don't work for anybody. They are responsible for
7 putting together the package to objectively review whether a
8 person has been injured and sometimes people have been injured
9 and that goes into the report.
10 Q Well, Doctor, let me ask you this: You only testified
11 once for plaintiff that I can recall and you can't recall,
12 right?
13 A Yes.
14 Q Now, you have three different services you work with,
15 right?
16 A Yes.
17 Q And there is law firms that send films directly?
18 A Very uncommonly.
19 Q You don't think it's a, you think it's a coincidence
20 that every time you remember you received films, it's been for
21 defendants except one time maybe? You don't think there is a
22 coincidence there, that's because the services work for people
23 that are defending lawsuits, you?
24 A Obviously they work with those people so those are the
25 kinds of cases they send to me, other people have approached me

1 for plaintiff work. If I don't agree there is an injury, I will
2 not take their case, and there are plenty of cases that get sent
3 to me by defense that I say oh, yeah, this person has a meniscal
4 tear or disk herniation and there is an injury on this case, not
5 every case that I look at do I say there is no injury.
6 Q Doctor, you said when you testified for a plaintiff,
7 it's because you found that there is a traumatic injury?
8 A I didn't say that. I said when plaintiff's have
9 approached me to look at cases, and if I have not taken them,
10 because I did not feel that I could go to court and say this
11 person had an injury.
12 Q So take that and turn it the other way, and you only
13 accepted cases to go to court for a plaintiff when you find the
14 traumatic injury, correct?
15 MR. DUER: Objection.
16 THE COURT: I will allow it.
17 A I will not review the case if I don't support what they
18 -- I can give you the report and say I disagree with you. They
19 will throw it in the garbage. I was approached recently and I
20 did not want to be involved with that case.
21 Q We are in agreement?
22 A I'm not sure what the question is.
23 Q You said that if you get films, right, and you don't
24 find that there is a traumatic injury, then you wouldn't take
25 the case for a plaintiff, correct?

1 A In the majority of cases, yes, I'm sure you will show
2 me something contrary to that.
3 Q You are changing your answer?
4 A I don't know.
5 Q You see a piece of paper in my hand, you anticipate --
6 THE COURT: Sustained. Sustained. Sustained.
7 Q Doctor, isn't it true in a case of Navalla versus
8 Dietrich (phonetic) in 2003, you took a case where you stated
9 that you were not able --
10 THE COURT: Sidebar.
11 (Whereupon, an off the record discussion takes
12 place at sidebar among the Court and Counsel.)
13 MR. IRWIN: Withdrawn.
14 Q You have been working with Picciano and Scahill in this
15 case since 2005, correct?
16 MR. DUER: In this case?
17 MR. IRWIN: The defense firm.
18 Q You have been working with that firm since 2005,
19 correct?
20 A I don't know since have I been working and --
21 MR. DUER: Objection to working.
22 THE COURT: Wait.
23 MR. IRWIN: I will withdraw.
24 Q Doctor, I will adopt your question. You have been
25 reviewing cases for Picciano and Scahill since 2005, correct?

1 A I don't know.
2 MR. IRWIN: Can I have it marked for
3 identification?
4 THE COURT: Show them, give it to the court
5 officer and if it refreshes her recollection, only if it
6 refreshes her recollection.
7 (Handing.)
8 A Yes, this says Picciano and Scahill, 2005, the answer
9 is yes.
10 Q Does that refresh your recollection?
11 A Yes.
12 THE COURT: She said yes.
13 Q Do you know how many times you testified for a lawyer
14 from Picciano and Scahill?
15 A No.
16 Q Picciano and Scahill, they send you films directly,
17 don't they? They don't use a service. They send them straight
18 to you?
19 A Not to my knowledge, no.
20 Q You address your reports back to them, right?
21 A That's because I'm told who the attorneys are, not that
22 they send them directly.
23 Q Your reports in this case are directed to Certified
24 Medical Consultants?
25 A Correct.

1 Q And what you looked at, it's directly to Picciano and
2 Scahill?
3 A It's different. It's not the same formats every time.
4 Sometimes it's addressed to the company, sometimes the company
5 knows who the attorneys are and then it's addressed to the
6 attorneys.
7 Q Doctor, you know -- withdrawn.
8 You know that when I get X-ray, MRI or CT films, you
9 know it's coming from someone, a service or law firm that
10 represents or is retained by defendants in lawsuits, correct?
11 A Yes.
12 Q So there is nothing independent about this, right?
13 MR. DUER: Objection.
14 THE COURT: I will allow an answer.
15 A It is independent, like I said, if someone comes in and
16 has a fracture, I don't say there is no fracture, go to court
17 and try to defend this case. I say hey, this person has
18 multiple fractures, they were injured, and then it's up to the
19 attorneys to do what they want. I'm saying yeah, there is an
20 injury here, like every case, there are plenty of cases that I
21 say, hey, there is an injury here and the attorneys can do what
22 they want with that. I don't determine anything after I give my
23 opinion as to what is on the films.
24 Q That's only to fractures?
25 MR. DUER: Objection.

1 THE COURT: Sustained.
2 Q Doctor, you used fractures as your example. When was
3 the last time you found a traumatically induced herniated disk
4 in a case sent to you by a service or a defense firm?
5 A Probably recently, because there are disk herniations.
6 I cannot tell how old and I don't try to pretend that I can.
7 Q So are you saying that you cannot tell when you look at
8 an MRI if a disk herniation is old or recent?
9 MR. DUER: Objection.
10 (Whereupon, an off the record discussion takes
11 place at sidebar among the Court and Counsel.)
12 THE COURT: Five-minute break.
13 (Whereupon the panel of sworn jurors exit the
14 courtroom.)
15 (Whereupon, a recess was taken.)
16 (Whereupon, the panel of sworn jurors enter the
17 courtroom.)
18 THE COURT: You may be seated.
19 You may continue.
20 Q Doctor, I try to understand what you said on an MRI,
21 you cannot tell how old the herniated disk is?
22 A I did not say that. I said in certain circumstances, I
23 cannot tell, in many, I can.
24 Q Now, you said before to be clear that circumferential
25 bulges which circumferential means from circumference, all the

1 way around?
2 A Yes.
3 Q That would a symmetrical bulge?
4 A Yes.
5 Q So you would expect to see the front appeared, the back
6 and both sides and all the way around took the bulging out the
7 same amount, right?
8 A Pretty much, yes.
9 Q And particularly, stand up MRI, you expect that you are
10 squishing a bagel?
11 A Yes.
12 Q And your testimony is that it's on axial views?
13 A And sagittal.
14 Q Axial access, both ways, every level you have symmetry,
15 front and back, left and right?
16 A Yes.
17 Q And if there are images without symmetry front, back,
18 left and right, are those consistent with something other than a
19 bulge? If you lack symmetry on an image?
20 A No, you can have mildly a symmetric disk bulge.
21 Q Mildly is a matter of?
22 A Mildly is a matter of circumference.
23 Q The distance you would see you would get down and
24 measure that?
25 A No.

1 Q It's eyeballing thing?
2 A Correct.
3 Q You cannot, you can see with the naked eye there is a
4 slight difference but not substantial?
5 A Correct.
6 Q Is there a percentage guideline, 50 percent,
7 10 percent?
8 A There is, disk bulge has to be over 180 percent
9 circumference of the disk that's what is in the literature.
10 Q Okay. Now, you consider Picciano and Scahill to be a
11 client of yours?
12 A No.
13 MR. DUER: Objection.
14 Q What do you consider your relationship to be? You have
15 been working since 2005?
16 MR. DUER: Objection, working.
17 THE COURT: You may answer.
18 A I don't have a relationship there with anybody. I
19 review films for their company. There is not one person I have
20 a relationship with.
21 Q Well, how do you come to reviewing films for Picciano
22 and Scahill?
23 A I don't know, ask Picciano and Scahill.
24 Q Do you know that they almost exclusively defend people
25 in lawsuits, right?

1 A I don't know that for a fact, no.
2 Q Have they ever hired you to do anything other than have
3 you review films in a case you were defending?
4 A I don't know for a fact that's the capacity I work with
5 them in.
6 Q To your knowledge, they defend people in lawsuits
7 that's what their firm does?
8 A To my knowledge.
9 Q And they do it in the Bronx, Brooklyn, Manhattan,
10 Nassau, Suffolk County, Westchester, Staten Island?
11 MR. DUER: Objection.
12 THE COURT: I don't understand why you are
13 objecting. They gave you good publicity.
14 THE WITNESS: I guess so. I don't know what their
15 parameter is.
16 Q You testified in all of those cases and reviewed cases?
17 A I don't think I have ever been to Staten Island, no.
18 Q Everything but at that time Staten Island?
19 A You have to repeat the list.
20 Q Brooklyn, Bronx, Queens, Manhattan?
21 A I have been to all of those places whether it was with
22 Picciano and Scahill.
23 Q Definitely defending lawsuits?
24 A You have all of my stuff, so you know better than I do.
25 I'm not sure where the one plaintiff was, so.

1 Q You are familiar with Jury Verdict Reporter?
2 A I have never looked into it.
3 Q You are familiar with who they are?
4 A Not really.
5 Q And so do you consider yourself to have a business
6 relationship with Picciano and Scahill?
7 MR. DUER: Objection.
8 THE COURT: Sustained.
9 Q When you get films from one of these services or
10 defense firms, you know exactly who is paying you, don't you,
11 Doctor?
12 MR. DUER: Objection.
13 THE COURT: Sustained.
14 Q The person that you are being paid by is the person who
15 sends you the films, correct?
16 MR. DUER: Objection.
17 A I don't know. I don't think so.
18 Q You receive money when you review your films?
19 A I do.
20 Q And it's $250 for the first film and a hundred for each
21 additional film?
22 A Correct.
23 Q And you receive income from that?
24 A I do.
25 Q And some years the income for that is more of your

1 income from the hospital?

2 A That's incorrect.

3 Q How many films do you review a week?

4 A It varies because I don't control what I do. It's

5 whatever they send me I look at, and I would say it averages 4

6 to 6 per week, but, I don't work every week because I take

7 vacation and sometimes I cannot do it and have other

8 obligations, it's variable and changes from year to year.

9 Q Are you able to estimate your income of 2014 that you

10 generated from testifying in court and reviewing films?

11 A No.

12 Q You just did your taxes a couple of months ago?

13 A I don't do my taxes. My husband does my taxes.

14 Q Do you receive a 1099 from the companies and law firms?

15 A I do.

16 Q That compensate you for reviewing the films?

17 A I do and I hand them over to my husband who does the

18 taxes.

19 Q And that's what you did back in, how long have you been

20 doing it this way, Doctor, without looking at the 1099?

21 A For a long time.

22 Q You were asked these questions a couple years ago about

23 your income, when you testified in Manhattan, New York County,

24 are you often asked this question?

25 MR. DUER: Objection.

1 THE COURT: Sustained.
2 Q Doctor, are you often asked this question when you are
3 being cross examined about how much income you received in the
4 past year from working for people defending lawsuits?
5 MR. DUER: Objection.
6 THE COURT: Have a sidebar.
7 (Whereupon, an off the record discussion takes
8 place at sidebar among the Court and Counsel.)
9 Q Doctor, you have been asked this question before at
10 trial, haven't you, about your annual income from doing this
11 type of work?
12 A Yes.
13 Q And every time you had the same answer, I don't look at
14 my income returns, right?
15 MR. DUER: Objection.
16 THE COURT: Sustained.
17 Q Have you answered any differently than you did today in
18 the past?
19 MR. DUER: Objection.
20 THE COURT: Sustained.
21 Q When is the last time you were able to testify in court
22 as to whether or not your annual income was from doing this type
23 of work?
24 MR. DUER: Objection.
25 THE COURT: Sustained.

1 Q Have you ever been able to testify about that dollar
2 amount?
3 MR. DUER: Objection.
4 THE COURT: Sustained.
5 Q Do you look at your tax returns before you sign them,
6 Doctor?
7 MR. DUER: Objection.
8 THE COURT: Sustained.
9 Q Isn't it true, Doctor, that you don't know how much
10 income you made last year from doing this type of work because
11 you don't want to know?
12 MR. DUER: Objection.
13 THE COURT: Sustained.
14 Q Doctor, you maintain an office at home to review films?
15 A Yes.
16 Q And you are able to read them at home also?
17 A Yes.
18 Q This is a second job for you?
19 MR. DUER: Objection.
20 THE COURT: Sustained.
21 Q Do you recall the last time you came to court for a
22 plaintiff?
23 MR. DUER: Objection.
24 THE COURT: I will allow it.
25 A I don't recall, probably the one you are holding for a

1 plaintiff.
2 Q When you get films you know that there has been an
3 accident, right?
4 THE WITNESS: Yes.
5 Q And you know there is a lawsuit going on every time you
6 get films?
7 A I presume there is a potential lawsuit going on.
8 Q And isn't it true that if you find trauma, a
9 traumatically induced herniation on a film, that the chances of
10 you going to court and testifying go down, you are aware of that
11 when you read the films?
12 MR. DUER: Objection, withdrawn.
13 THE COURT: You can answer it.
14 A Yeah, I'm aware of it. Why should they go to court?
15 I'm telling them there is an injury. There is no reason to go
16 to court. I don't think there is a conflict. I'm not an
17 attorney. I don't know how they think when they get this
18 information, but hopefully it doesn't go to court.
19 Q When you don't go to court, you don't get to make
20 $5,000 for a half day, correct?
21 A I'm not getting paid to alter my opinion to make money.
22 I get paid to make an honest and personal -- I prefer not to go
23 to court. People who are truly injured deserve to be
24 compensated. It's not about me. It's about them. I know it's
25 not going to go to court. I understand that.

1 Q And when the case doesn't go to court, you don't have
2 the opportunity to make $5,000 for a half a day?
3 THE COURT: Sustained. I think the jury gets your
4 idea.
5 Q Doctor, you testified back in November 20, '14 for
6 Picciano and Scahill and a case in the Bronx?
7 A If you say so.
8 Q Jose S. Rodriguez against Moon W. Lee, November 19,
9 2014, Timothy Jones from Picciano and Scahill is the defense
10 attorney, the Judge was Judge Mary Bragante Hughes, do you
11 recall that, 851 Grand Concourse Bronx Supreme Court?
12 THE COURT: Objection sustained. Sidebar.
13 (Whereupon, an off the record discussion takes
14 place at sidebar among the Court and Counsel.)
15 Q Do you recall that case, Doctor?
16 A No.
17 Q Do you recall the defense team on that case was you,
18 Dr. Klein who will testify this afternoon and Picciano and
19 Scahill?
20 MR. DUER: Objection.
21 THE COURT: Sustained.
22 Q Do you know who the orthopedic surgeon was that was
23 testifying with you on that day as the other defense expert?
24 MR. DUER: Objection.
25 THE COURT: Sustained.

1 Q Do you recall, in fact, Doctor, that you and Dr. Klein
2 disagree?
3 THE COURT: Is this from the same case you are
4 referring to?
5 MR. IRWIN: Yes.
6 THE COURT: Sustained. I don't want a reference
7 to something not a certified transcript and you are not to
8 ask questions she answered. She does not remember the case.
9 That's it. That's my ruling, continue.
10 Q Doctor, you said there was desiccation at only two
11 levels that you saw in the lumbar spine?
12 A Yes.
13 Q And you didn't see it at L1 to 2/L2 to 3/L3 to 4?
14 A Yes.
15 Q Did you also see small anterior osteophytes at L1/2, 2
16 to 3 and 3 to 4, the beaking you said?
17 A No.
18 Q Now, did you review, withdrawn.
19 Do you agree the more information you have, the better
20 it is for you to be able to render an opinion when looking at a
21 film?
22 A I cannot answer that yes or no.
23 Q Doctor, did you review the X-ray of the plaintiff for
24 April 30th, 2012?
25 A I don't think so.

1 Q Did you review the X-ray of the plaintiff from
2 April 16, 2015?
3 A As far as I'm aware, I have not reviewed any X-rays.
4 Q We were looking at the sagittal views before, correct?
5 A Yes.
6 Q And the sagittal views are slices taken on an angle for
7 the purpose of going through the disk?
8 A Sagittal is going this way.
9 Q Axial views are to go across the disk, that's when we
10 had the four boxes?
11 A Correct.
12 Q And on the views, you should be able to see the
13 neuroforamen, the passage where the nerve root goes through?
14 A Yes.
15 Q And you should be able to see them on all three of
16 those views?
17 A Not necessarily.
18 Q What circumstances would you not be able to see it?
19 A The neuroforamen does not go all the way through the
20 spine. It's a limited area, depending on the slice. It will
21 not show up on every single slice.
22 Q Three slices in the four boxes, 3 slices with a side
23 view, were they to the top left, the top left shows us --
24 A The crossing.
25 Q And was it top, middle, bottom?

1 A Yeah, it goes in sequential order.
2 Q The top red line is the one on the top right box. The
3 middle red line is the bottom right and the bottom one is on the
4 left?
5 A Yes.
6 Q You are not a surgeon?
7 A No.
8 Q Do you render opinions about surgery to patients ever?
9 A To the patient themselves?
10 Q Yes.
11 A No.
12 Q And you don't do physical exams either?
13 A No.
14 Q Also, you didn't see any involvement in the thecal sac
15 at L5/S1 here?
16 A As I said, the thecal sac is always touching the disk,
17 whether the disk is flat, it will touch it. If the disk bulges,
18 it will touch it. What do you mean by "involvement," that's the
19 normal anatomy.
20 Q The L5 to S1, the thecal sac doesn't always touch the
21 disk. There is a pad of fat in between the two?
22 A Usually below the level of the disk it can be at the
23 disk also and I did not see thecal sac involvement.
24 Q Did you see fat?
25 A Yeah, there is some fat there.

1 Q So, you, it's your opinion that there is no thecal sac
2 involvement whatsoever?
3 A At what level?
4 Q L5/S1.
5 MR. DUER: Objection.
6 A To my recollection, I believe that there was fat. I
7 believe the disk was touching the thecal sac and -- not always,
8 many times it is touching the thecal sac at L5/S1 and talking
9 specifically about that level.
10 Q You said there was fat?
11 A There is fat, but often times it's below the level of
12 the disk.
13 Q Which do we have here, the thecal sac?
14 A If I remember correctly.
15 Q Let me finish my question: Do we have thecal sac above
16 or fat in between?
17 A I believe hers was touching the thecal sac at L5/S1.
18 Q And there is a difference between touching and
19 impinging, right, those are two different things?
20 A I don't use the word "impinging," I don't understand
21 what people mean when they say impinging. I use the word mass
22 effect. Impinging I assume they mean pushing, touching. I
23 don't know what they mean. I assume there is a difference, but
24 I don't use the word impinging in my reports.
25 Q Impinging is a medical term?

1 A I don't think it is a medical term.
2 Q There are other terms?
3 A Impingement syndrome in the shoulder.
4 Q An impingement syndrome is when you have what?
5 A Acromioclavicular joint is compressing the outlet of
6 the rotator cuff.
7 Q That would be a bone pushing on what, the rotator cuff?
8 A Yes.
9 Q Is impingement when it's pushing?
10 A Yes.
11 Q And is a radiology term?
12 A It's not a classic radiology term. It's an adjective
13 that people use. I don't know if it's a radiology term.
14 Q And radiology is not an exact science, it's subject to
15 interpretation, correct?
16 A Yes.
17 Q When you read a film, are you always correct in your
18 interpretation of the film?
19 MR. DUER: Objection.
20 THE COURT: Sustained.
21 Q Your opinion, can you be wrong on occasion?
22 THE COURT: Sustained. The jury knows if you ask
23 one way or the other way will not make a better question,
24 ask your next question.
25 Q If the radiologist, if the radiologist that read, the

1 treating radiologist that blindly read --
2 MR. DUER: Objection.
3 THE COURT: Let him finish.
4 Q The radiologist who read, Imran 6/4/12 MRI of the
5 lumbar?
6 MR. DUER: 6/1.
7 Q Report date was 6/4, the examine date is 6/1/12, if the
8 radiologist that read the 6/1/12 MRI of Halina Imran's spine,
9 Steven Hirschowitz, who is a board certified radiologist and
10 neuroradiologist like you are saying that he sees impingement
11 upon the thecal sac, would that be a different finding from what
12 you saw?
13 A No.
14 Q So you agree with him there is impingement on the
15 thecal sac?
16 A It's touching the thecal sac. If it bulges a little,
17 it will touch the thecal sac. If he calls that impingement, I
18 will agree with him.
19 Q In the shoulder it means pushing down?
20 A If it's touching and pushing, I agree that's the oral
21 anatomy. If there is a disk bulge and thecal sac, it's going to
22 push it.
23 Q So, isn't there a differs between touching and pushing
24 and what you will see on the film that's important because a
25 radiologist is a practice of millimeters, isn't it?

1 A Not that I'm aware of.
2 Q There are inches in the lumbar spine or millimeters?
3 A I don't know what you are talking about.
4 Q The human lumbar spine, are these structures inches
5 away from each other or millimeters away from each other?
6 MR. DUER: Objection.
7 THE COURT: I will allow it.
8 A It depends on the structure.
9 Q L4 to 5 and L5/S1?
10 A The disk space itself.
11 Q Yes, the disk space in relation to the neurology for
12 this is a game of millimeters, correct?
13 THE COURT: I will let you testify, answer.
14 A Correct.
15 Q So, the difference between touching and impinging, that
16 is a matter of millimeters?
17 A Impinging is still touching, touching doesn't change,
18 it's just where is it touching it is resulting in a mass effect.
19 I don't use the word impinging, it's confusing to people.
20 Q In the thecal sac at L5 to S1 level you have nerves
21 down there, there is no more spinal cord left, it branches out
22 to nerves?
23 A Yes.
24 Q And that thecal sac is full of different nerves?
25 A Yes.

1 Q And if it was not, you would not have pain to L5/S1
2 herniation because the nerves, you get pain?
3 A Yes.
4 Q If there is pushing on the thecal sac that can be a
5 competent producing cause of pain, can you agree?
6 A Not necessarily.
7 Q I said "can", I didn't say has to be or always is. Do
8 you agree impingement or touching the thecal -- withdrawn.
9 Do you agree a disk that touches the thecal sac can be
10 a competent producing cause of pain?
11 A No, because the disk is always touching the thecal sac.
12 THE COURT: Sidebar.
13 (Whereupon, an off the record discussion takes
14 place at sidebar among the Court and Counsel.)
15 Q Doctor, you have two more witnesses today so I would
16 like to discuss this but I have to move on.
17 MR. DUER: Objection.
18 THE COURT: Overruled. At a certain price you can
19 go out after the trial and discuss it. Continue.
20 Q So, Doctor, if the treating radiologist, the treating
21 orthopedic spinal surgeon and treating pain management doctor
22 all found that there is a herniation at L5 to S1 and L4 to L5
23 impingement on the thecal sac, you would disagree with all
24 three?
25 MR. DUER: Objection. May we approach?

1 THE COURT: No, answer.
2 A I have to segment it, take out the impingement, it's
3 always touching and I'm not answering to the impingement. I
4 disagree in factually there is a disk herniation at L4/5 and
5 L5/S1.
6 Q And you also disagree with the radiologist
7 Dr. Charles De Marco who read the May 10, 2012, right shoulder
8 MRI?
9 A I don't know what he said. I don't know if I disagree
10 or not.
11 Q He didn't compare his report to you say when you read
12 the films?
13 A No.
14 Q And you didn't compare the doctor that read the lumbar
15 spine's report Dr. Hirschowitz to the films when you read those
16 films?
17 A No.
18 Q And you don't know whether you agree or not with
19 Dr. De Marco reading of the right knee MRI of May 12, 2012?
20 A Nope.
21 Q And you don't know if you agree with Dr. De Marco's
22 reading of the May 22nd cervical spine?
23 A I didn't review cervical spine MRI.
24 Q Straightening of the cervical lordosis consisting of
25 muscle spasm that can be an indication of trama, can't it?

1 A Qualifying, strange does not necessarily indicate there
2 is muscular spasm, it can be you put them, muscle spasm is a
3 clinical diagnosis, not radiological diagnosis.
4 Q It's within one of the possible causes, correct?
5 A Yes.
6 Q So it cannot be ruled out, right?
7 A No, but it cannot be ruled in either.
8 Q And you would have to correlate that in a physical
9 exam?
10 A Correct.
11 Q You didn't review the evaluation from May 2, 2012 of
12 Dr. Gutierrez, did you?
13 A No.
14 Q When did you do your review of --
15 A I did my review, I review films at the hospital, it's
16 not within my job to review every piece of medical information
17 available on every patient.
18 Q Do you agree the more information a doctor has the --
19 THE COURT: Asked and answered.
20 MR. DUER: Objection.
21 Q You read these films for Imran, 2014, right?
22 A Yes.
23 Q And did you call Picciano and Scahill and say can you
24 give me more stuff, can I look at the initial physical therapy
25 evaluation, operative report, did you ask them for that?

1 A No.
2 Q Would that have been of assistance to you?
3 A No, a film is black and white, what is on the film is
4 on the film. It does not change the end result.
5 Q I want you to assume, Doctor, that May 12, 2012, Imran
6 was examined by Dr. Gutierrez and this is before the MRI of the
7 lumbar spine?
8 A What day?
9 Q May 2, 2012?
10 A Yes, it was before.
11 Q And Dr. Gutierrez found positive straight leg raised
12 test and I want you to assume that Dr. Gutierrez help find spasm
13 and elicited a pain response, found spasm in her lumbar spine
14 and elicited pain response at L5 to S1 and L4 and L5, but not L1
15 to 2, 2 to 3 or 3 to 4, can you assume that for me?
16 A Sure.
17 Q Now, do you consider it a coincidence that on June 1st
18 there is pathology?
19 THE COURT: What year?
20 Q 2012, less than one month later, almost exactly one
21 month after this physical, the MRI start pathology exactly at
22 the level he found pain response in Ms. Imran and he circled
23 those levels in his report a month before the MRI?
24 A What kind of doctor is Dr. Gutierrez.
25 Q A physical therapist?

1 A Is he a doctor or a physical therapist?
2 Q He is a medical doctor.
3 A I really can't comment on his findings, his findings,
4 that's his opinion. I don't know that they are right. How can
5 I say, maybe she had back pain, I don't know, do I think it's a
6 coincidence?
7 THE COURT: Start wrapping it up.
8 Q And no, no history of prior treatment or complaints
9 ever in her life?
10 A You can have back pain that has nothing to do with the
11 disk maybe she had muscle spasm and back pain in that location.
12 Q People that have back pain go for a massage or
13 chiropractor something, right?
14 MR. DUER: Objection.
15 THE COURT: Sustained.
16 Q The knee MRI from May 10th, 2012, that's a poor quality
17 film?
18 A It was not the best.
19 Q So poor quality means they did not do a very good job
20 of what?
21 A It means you can get a better image.
22 Q Poor quality means it's not clear, fuzzy.
23 A It's not as clear as other machines can offer.
24 Q It's not as sharp as you would like to see?
25 A It's doable, but it can be sharper.

1 Q And you didn't talk about that on direct examination?
2 A I was not asked that question.
3 Q Fair enough, and what you are looking at is you are
4 looking at fluid in the knee, you are looking at MRI of the
5 knee, looking for fluid?
6 A Looking for a lot of different things, way more than
7 fluid.
8 Q One of the things is fluid, correct?
9 A One of the ancillary signs of recent trauma is a
10 significant joint effusion.
11 Q And that means fluid?
12 A Fluid specifically within the suprapatellar bursa.
13 Q Behind the kneecap?
14 A Yes.
15 Q And you saw a little something there?
16 A Yes, there is a little fluid there, it's a potential
17 space.
18 Q On a poor quality film?
19 A Yes.
20 Q Is it possible if he had a high quality scanner you may
21 visualize more fluid than a little bit?
22 A No.
23 MR. DUER: Objection.
24 THE COURT: Answer is no. Wrap it up.
25 Q The shoulder, Doctor, you said that you couldn't tell

1 the difference between on that film, between tendinosis, and
2 partial intrastitial tearing?
3 A Yes.
4 Q That type of tearing, Doctor, is microtearing that goes
5 on?
6 A Yes.
7 Q And that can be degeneration or through trauma,
8 correct?
9 A It's usually a spectrum along degeneration in trauma,
10 you get more full thickness tearing.
11 Q Is it within the realm of possibility that you can have
12 trauma or are you saying it's impossible to have this partial
13 intrastitial tearing from tearing?
14 A I never say anything is impossible.
15 Q Is it within the realm of possibility it can be
16 degeneration or trauma?
17 A It is a possibility.
18 Q And you cannot tell if this is tendinosis or some type
19 of tearing?
20 A Intrastitial tearing, correct.
21 Q It's within the realm of possibility, you cannot
22 completely rule out that finding is traumatic?
23 A I cannot completely but there is no other findings that
24 confirm any trauma to the shoulder.
25 Q One finding it does which is an automobile --

1 THE COURT: Sustained. Sidebar.
2 (Whereupon, an off the record discussion takes
3 place at sidebar among the Court and Counsel.)
4 MR. IRWIN: One question.
5 I have two.
6 Q You reviewed the X-ray -- sorry, withdrawn.
7 You reviewed the CT lumbar spine of Ms. Imran from
8 May, 2015?
9 A I did.
10 Q And you testified about your findings, right?
11 A I did.
12 Q You didn't mention, you left out when you testified
13 that there is mild to moderate bilateral neuroforaminal stenosis
14 on that CT, didn't you, Doctor?
15 A It is in my report.
16 Q That's not what I asked, you did not testify that that
17 was one of your findings when you testified for Mr. Duer?
18 A I don't recall.
19 Q Is that significant, Doctor?
20 THE COURT: That's your last question, you can
21 answer.
22 A Significant in terms of what?
23 THE COURT: That's your last question.
24 MR. IRWIN: One.
25 THE COURT: You have a different interpretation

1 what is considered 1 or 2, 1 or 2 means seven, right?
2 Sustained as to significant. Ask your last
3 question.
4 Q Do you agree, Doctor, that the gold standard of
5 determining whether or not someone has a traumatic herniation is
6 to open them up and do surgery and look at it with your eyes,
7 that's the real gold standard?
8 A No.
9 THE COURT: No.
10 MR. Duer, redirect?
11 REDIRECT EXAMINATION
12 BY MR. DUER:
13 Q Do X-rays show disks?
14 A No.
15 Q You cannot see them on X-ray?
16 A You can see the disk space but you cannot see the
17 actual disk.
18 Q And is an MRI an objective or subjective test?
19 A Objective.
20 Q And what does that mean?
21 A It means that if you take a hundred people and a
22 hundred people look at the MRI, pretty much a hundred people can
23 agree on what the findings are.
24 Q And is the straight leg raise test?
25 A I think there is some, I don't do them.

1 Q Is S5/S1 a common area to find disk bulge?
2 A Yes, S5/ S1 is a common area to find disk desiccation
3 and disk bulging.
4 Q And that is a result of degeneration?
5 A Because of the curve of the spine like in the neck C5-6
6 and C6/7 are most common, those parts of the spine have curves
7 so it has to do with the weight distribution.
8 MR. DUER: No further questions.
9 THE COURT: Five minute recess.
10 (Whereupon the panel of sworn jurors exit the
11 courtroom.)
12 (Whereupon, a recess was taken.)
13 THE COURT: Before we have the next witness,
14 Mr. Irwin, I understand you have an application, and it can
15 be oral. Whatever you want to say.
16 MR. IRWIN: Your Honor, I cannot, it's a 14 page
17 brief. I need it marked as a court exhibit and regarding
18 the cross previously, I attempted to use a transcript that
19 was not certified. I believe that I should have been able
20 to use it. I think I have two transcripts that have
21 signature amounts of things.
22 THE COURT: I do not allow any cross examination
23 from a transcript not certified. That's true. That's my
24 ruling.
25 MR. IRWIN: As far as my brief, there is no way

1 that I can argue the whole thing in five minutes. I need it
2 to be marked as a court exhibit.
3 THE COURT: Mr. Duer, do you have a response?
4 MR. DUER: I never seen this.
5 THE COURT: I will not accept a motion in limine
6 if you did not serve it to him. You will not be able to put
7 it on the record. You cannot hand him over something now
8 and expect him to respond. My ruling is either you get an
9 in limine motion by doing it orally in five minutes or you
10 get nothing at all. You cannot hand over a 12 page written
11 document.
12 MR. IRWIN: Your Honor, in this instant it's
13 critical to note Dr. Gerling, Dr. McGowan relies on methods
14 that are not generally accepted by the scientific community
15 as he only appears to only rely on property damage photos
16 and repair estimates to calculate the forces sustained by
17 the plaintiff's vehicle thereby not meeting the Frye
18 admissability standard. The case of Clemente versus
19 Bloomenberg, 705 New York sub second, 792.
20 THE COURT: And you have a copy for me?
21 MR. IRWIN: Yes. Judge Maltese in Staten Island
22 held that.
23 THE COURT: So this is not a Second Department
24 case?
25 MR. IRWIN: No, it has multiple siting cases, and

1 it is a judge who is a Supreme Court justice.
2 THE COURT: And we are talking about this specific
3 expert Mr. McGowan?
4 MR. IRWIN: No, this technique with L4 to 5 and L5
5 to S1 injuries and that the method used by the doctor, by
6 the biomechanical engineer there is, I believe, the same as
7 here using a repair bill and photographs without any
8 inspections of the vehicle itself.
9 THE COURT: Can I see the case?
10 It is a 1999 case?
11 MR. IRWIN: Yes.
12 THE COURT: Let me put it this way, quick look at
13 the decision, they talk about he may render an opinion as to
14 the general formula forces upon objects and relation to the
15 facts in evidence, but he may not render a specific opinion
16 based upon, in other words, things that are not in evidence.
17 So I agree with you. I will only allow this expert to
18 testify on things that are in evidence.
19 MR. IRWIN: There is crash test.
20 THE COURT: That is its own expertise. He is
21 allowed to do it. Whatever is in evidence now. This is a
22 damages only trial. We have no evidence as to the happening
23 of the evidence.
24 MR. DUER: We have photos and property damage
25 estimates and testimony from Ms. Imran on how the accident

1 happened.
2 MR. IRWIN: On that issue, he ignores the
3 testimony.
4 THE COURT: You can cross examine him on the other
5 parts of the testimony, but I will allow him to testify. My
6 ruling is that I will allow him to testify on evidence that
7 is in evidence. That's it. Nothing else. And your
8 exception is noted for the record.
9 MR. IRWIN: Can I have a definition of evidence so
10 I don't object.
11 THE COURT: You do that anyway. This record
12 indicates every other question you object.
13 MR. IRWIN: Your Honor, he relies on the
14 institute, the insurance institute crash test to correlate
15 property damage.
16 THE COURT: As an expert, unless you have a Second
17 Department case that said such reliance is impermissible and
18 with all due respect in Judge Maltese in 1999 case, I think
19 you could come up the last minute in limine, my advice to
20 you is when you are in TAP and you are about to be sent out,
21 this case was early May, you would indicate you want a Frye
22 Hearing, something of that nature. To indicate at this
23 time, and even though you mentioned you had problems with
24 the biomechanical, to hand up a full motion at this time
25 that is not acceptable.

1 I did make my ruling, exception noted for the
2 record. We are not marking it because I'm not accepting it.
3 You cannot hand up a document like that the last minute
4 without Mr. Duer even having notice of it beforehand. You
5 cannot do that. You cannot do that. Bring the jury in.
6 COURT OFFICER: All rise, jury entering.
7 (Whereupon, the panel of sworn jurors enter the
8 courtroom.)
9 THE COURT: Good afternoon, jurors, you may be
10 seated. You may call your next witness, Mr. Duer.
11 (Whereupon the witness took the witness stand.)
12 (Whereupon the witness was duly sworn by the Clerk
13 of the Court.)
14 THE CLERK: Name and business address for the
15 record.
16 THE WITNESS: Dr. Joseph Charles M-C-G-O-W-A-N
17 address, 17 Kynwyd K-Y-N-W-Y-D Road in B-A-L-A C-Y-N-W-Y-D,
18 Pennsylvania.
19 THE COURT: You may inquire.
20 MR. DUER: Thank you, your Honor.
21 DIRECT-EXAMINATION
22 BY MR. DUER:
23 Q Good afternoon, Dr. McGowan.
24 A Good afternoon, sir.
25 Q What is your occupation?

1 A I'm a professional engineer and bioengineer and
2 president of McGowan Associates, Inc.
3 Q Tell us a little about your educational background,
4 school degrees?
5 A I have a bachelor's degree in mathematics and that's
6 from the United States Naval Academy, after that Master's Degree
7 in bioengineering from the University of Pennsylvania. After
8 that I got a Ph.D. in bioengineering from the University of
9 Pennsylvania. I have additional training in the field of
10 nuclear engineering obtained in the United States Navy.
11 Q Have you completed or been involved in any other
12 engineering training?
13 A Yes, as a professional engineer, licensed to practice
14 engineering I have requirements to complete ongoing engineering
15 training every year. I'm licensed. I'm doing training this
16 year. I have done weekend seminar-type courses and participated
17 in conferences which are included in the answer to that.
18 Q And you testified you have a Doctrine in
19 bioengineering, explain what bioengineering is?
20 A Bioengineering may be defined as the application of
21 engineering principles to biological systems. In my case the
22 biological systems we are talking about is the human body and
23 sometimes animals that's an overarching view of bioengineering
24 it extends through primarily the study of human tolerance to
25 neurology.

1 Q And can you give examples what you studied on your way
2 to obtaining a doctrine in bioengineering?
3 A I studied biological systems, things like anatomy and
4 physiology and I studied advanced engineering topics in my
5 graduate degree and specifically they were engineering topics
6 quite often applied to a biological system. For example fluid
7 flow course, but the fluid flow course was directed toward heart
8 applications. That was the core of my bioengineering training.
9 Those are examples.
10 Q And what is biomechanics?
11 A Biomechanics is specifically the mechanical engineering
12 applications. It's a sub field of bioengineering where we are
13 talking typically about forces and motions, and as I mentioned
14 before, their application to human tolerance to injury, human
15 tolerance to the creation to pathology, that field.
16 Q Can you describe your work history?
17 A I graduated from the Naval Academy, my first work
18 history was Navy, I was submarine officer on US nuclear
19 submarine. I supervised maintenance and operation of the power
20 plant and I worked with a team of in one case mechanical
21 engineering professional Navy en lessoned men who did the work
22 on part of the submarine, that was my first job. After that I
23 taught at the Navy Nuclear Power School and topics including
24 mechanical engineering. After that I went to work for the
25 General Electric company in the nuclear engineering division and

1 I anticipated using my mechanical engineering expertise, I
2 participated in building and testing nuclear power plant.
3 After that I left the service of General Electric and
4 went to the University of Pennsylvania as I testified to change
5 fields, if you will, to bioengineering. I was able to take the
6 mechanical engineering expertise and bring it to Bio. At Penn I
7 spent four years getting that degree. At the same time I was a
8 Navy reserve officer and I was working within the organization,
9 the Office of Naval Research and I was serving as an officer and
10 executive officer and getting promoted.
11 Q Do you have any other, do you have any awards or
12 declarations in the Navy?
13 A I did, I received five declarations, three awards in
14 meritorious service metal, and two awards of the Navy
15 commendation metal.
16 Q And who awarded you the meritorious metal?
17 A The president.
18 Q What academic title or position do you hold or have you
19 held?
20 A I was an assistant professor of radiologic science in
21 the School of Medicine at the University of Pennsylvania, after
22 that I was an associate professor of electrical engineering at
23 the United States Naval Academy. Those were full time
24 positions. After that I transferred to engineering consulting
25 work and received an adjunct position at Temple University. I

1 was a full professional adjunct of mechanical engineering at
2 Temple University. I was and I currently am a full professor
3 rank adjunct in bioengineering at Drexel University. I was
4 adjunct professor at Penn for a time I was at the naval academy
5 and I have been called onto lecture at Princeton University.
6 Q And have you received any honors or awards over the
7 course of your career?
8 A Apart from the Navy honors I have been inducted into
9 the Engineering Honor Society and the National Physics Honor
10 Society. I received a research paper award from the Journal of
11 Computer Associated tonography for a brain injury paper. I
12 cannot think of others at this point.
13 Q Do you belong to any professional associations?
14 A I'm a member of the Society Automotive Engineers,
15 member of the National Society of Professional Engineers, I'm a
16 member of the Standards Organization, ASTM.
17 Q Have you published any scientific articles or books?
18 A I published scientific articles and books, I have more
19 than 100 publications including journal articles, edited, book
20 chapters, abstract and other types of articles.
21 Q Have you written articles for medical?
22 A I have.
23 Q And did you write articles both with and without
24 medical doctors as co-authors?
25 A I did.

1 Q And did you write articles about tolerance to injury,
2 for example, how much force the body can withstand without
3 injury?
4 A I did write articles in that field.
5 Q Have you performed peer reviews for medical journals?
6 A Yes.
7 Q What are examples of that?
8 A I reviewed for the journal, brain, Journal of
9 Perinatology, Journal of Neurology, and the American Journal of
10 Neuroradiology.
11 Q What is peer review?
12 A The way that scientific research gets published in this
13 country and in the world, when a scientist does a research study
14 and writes it up for public, typically that scientist will send
15 it to a journal. The journal will have editorial board and
16 editors, and they will decide to, if they think the article is
17 good enough, they will send the article out to perhaps 2 or 3
18 designated reviewers who review for that journal and have
19 cognizance of that field, are knowledgeable in that field
20 sometimes in different areas of the field and they will get
21 opinions from that panel on whether or not the article shall be
22 published.
23 It typically, the review will include suggestions to
24 improve the article on a recommendation to publish it or not and
25 quite often, it will be an iterative process so it may go back

1 and fourth a few times before the journal accepts or rejects the
2 article.
3 Q Did you serve on the editorial board on medical
4 journals?
5 A I'm on the editor board of American journal of
6 neuroradiology.
7 Q And what is that?
8 A So I have a role in peer review, I do peer review for
9 that journal and write editorials in that journal.
10 Q So you would be in any particular issue of that
11 journal. There is a good chance to find your name?
12 A If you open up any issue of the journal, the first
13 couple of pages you will find a list of the editorial board and
14 you will find my name there.
15 Q And what is the profession of most of the other board
16 members?
17 A Medical doctors for that journal mostly.
18 Q And when you review for the American Journal of
19 Neuroradiology, are you limiting to commenting on technical
20 issue as opposed to medical issues?
21 A There are no limitations on what I comment on what I
22 review for that journal.
23 Q What is your current title?
24 A I'm a president and principal engineer of McGowan
25 Associate, Inc.

1 Q What is McGowan Associates?
2 A Engineering consulting firm that provides in large part
3 two services, one part of the work of the company is to do
4 analysis of injuries, often in conjunction with a lawsuit such
5 as why I am here today, and the other part of the company is
6 outside of litigation and it deals with the medical device
7 industry, we consult to the large multi national of implanters
8 of medical devices with regard to the compatibility of the
9 device to magnetic imaging, those are what the company does it's
10 60/40 split or 50/50.
11 Q And when you analyze auto accidents do you,do you only
12 use bioengineering...
13 A I'm a licensed engineer and I'm competent in mechanical
14 engineering and some other kinds of engineering. There are some
15 analysis that I do that are not bioengineering, they are
16 mechanical engineering.
17 Q And are you educated and experienced in mechanical
18 engineering principles?
19 A I'm educated and experienced in mechanical engineering.
20 Q And how long have you been performing analysis
21 specifically of car accidents?
22 A Around 15 years.
23 Q And can you estimate how many accidents you analyzed in
24 this way?
25 A Hundreds, but never counted.

1 Q Does the field of biomechanics, does that include the
2 study and knowledge of human anatomy?
3 A It does.
4 Q From your time as a medical school faculty member, are
5 you familiar with who teaches anatomy?
6 A Certainly. Often it's people that have a Ph.D. and it
7 might be in anatomy or other related field, other times it's
8 medical doctors, most med school faculty anatomy departments
9 have some of each.
10 Q How did you learn?
11 A I had course work during my graduate school program and
12 I did research during my graduate school program and that
13 included surgery on animals, I would perform the surgery and it
14 included in my research I had to be familiar with whatever part
15 of the body I was working on. If I was publishing something
16 about the brain, I had to be cognizant of the brain anatomy and
17 that's continued after my training time as a graduate student
18 that continued with my faculty position at the University of
19 Pennsylvania which was seven years and continued since then
20 since I continue to do research and publish since then.
21 Q Have you preformed and published research involving the
22 human body?
23 A Many times.
24 Q And was your work in the area was it peer review?
25 A Large part, most of my creation were in peer review

1 journal.
2 Q And can you give an example from your publications
3 regarding the spine?
4 A Certainly.
5 THE COURT: Sidebar.
6 (Whereupon, an off the record discussion takes
7 place at sidebar among the Court and Counsel.)
8 THE COURT: Do you have an answer to the question?
9 A One example is an article entitled characterization of
10 experimental spinal cord injury with magnetization of
11 histograms.
12 Q Dr. McGowan, to publish in those areas that you just
13 described as an author of peer review studies, do you have to
14 know the anatomy you were discussing on an expert level?
15 A Yes.
16 Q And through your background and experience, have you
17 gained special knowledge in human anatomy you used to practice
18 in the field of bioengineering?
19 A Yes.
20 Q And does that --
21 THE COURT: Slow down.
22 Q Does that specialize knowledge include the ability to
23 understand and explain anatomical drawings?
24 A Certain anatomical drawings, certainly I don't claim to
25 have the corpus of anatomy but the anatomy I deal with, those

1 drawings I can explain.
2 Q And will you offer testimony and opinions that reflect
3 and draw on your expert knowledge of human anatomy in this case?
4 A I will.
5 Q Will that include an explanation of the forces
6 associated with motions of the spine?
7 A It will.
8 Q And specifically will that include intervertebral
9 discs?
10 A It will.
11 Q Are you a medical doctor?
12 A I am not a medical doctor.
13 Q You are a bioengineer?
14 A I am a bioengineer.
15 Q And that's a type of engineer?
16 A Yes, I would say I am an engineer as the general rule
17 and a specific area in which I practice is bioengineer. I could
18 describe myself as bioengineer, mechanical engineer, electrical
19 engineer and I could describe myself as biomechanical engineer.
20 They are all within the practice of engineering, I'm trained to
21 do.
22 Q And you are licensed to practice engineering in the
23 State of New York?
24 A I am.
25 Q And does this type of work that you have done in this

1 case, is that in your field of engineering and within the scope
2 of what New York State licensed you to do?
3 A It is within the scope of what New York licensed me to
4 do.
5 Q And you will testify in this case as to matters within
6 the practice of engineering?
7 A I will.
8 Q And from your time on the faculty and medical school,
9 do you understand the -- from your time on the faculty of Ivy
10 league medical school, do you understand the difference between
11 how medical doctors address questions about human injury and how
12 engineers and bioengineers do?
13 A As a typical rule yes, every individual is different.
14 But in general, I do understand the differences of a medical
15 approach and an engineering approach to those questions.
16 Q You talk about the spine in the same way as a medical
17 doctor?
18 A No.
19 Q And you use the same diagram or model as a medical
20 doctor?
21 A I would use the same anatomy. It's the same spine. I
22 talk about it differently.
23 Q Do you rely on scientific medical literature to
24 practice bioengineer?
25 A I do.

1 Q Are you trained to read scientific articles related to
2 human injury as found in the literature? Do you specialize in
3 knowledge that allows you to read and understand scientific
4 literature that addresses how human injury is caused?
5 A I have that knowledge.
6 Q In your specialized knowledge, does that enable you to
7 read and understand literature, for example, how spine injury is
8 caused?
9 A Yes, that's within my field.
10 Q Do you review medical and hospital records in practice
11 of bioengineer?
12 A It is routine, I do.
13 Q Why is that?
14 A Biomechanics typically is going to be focussed toward a
15 structural injury in the engineering sense any structure can be
16 characterized by what it's made of and what it's property are
17 how it might bend and stretch. That is all of engineering.
18 With bioengineering, we are talking about bio structures and how
19 they might move or be stretched or be bent or things like that.
20 So it's a straightforward application of engineering to this
21 specific part of biology which is the human anatomy.
22 Q With biomechanics, can you determine whether or not a
23 particular force in a direction would be affected to cause an
24 injury in a human?
25 A Certainly, as long as there is literature to support

1 the studies that a routine part of biomechanics practice in
2 litigation, but also outside of litigation, all of the other
3 ways that biomechanics is used in the world.
4 Q And you can determine that by the practice of
5 bioengineering?
6 A Yes.
7 Q And you have been admitted as an expert to testify in
8 United States Federal Court?
9 A Yes.
10 Q And you have been admitted to testify in engineering
11 and Grand Jury?
12 A Yes.
13 Q And you have been admitted to testify in Brooklyn and
14 Nassau and Suffolk County in bioengineering?
15 A Yes, I have.
16 Q And you have been admitted to testify here in Queens?
17 A I am.
18 Q And what parts of the body were you admitted to
19 testify?
20 A Shoulder, knee, neck, and back, ankle, I'm not,
21 shoulder, knee, neck and back, head injury, yes, I'm not sure if
22 there was more.
23 Q Can you summarize background specifically prepared you
24 to practice in the area of bioengineering?
25 A I had a lot of background in bioengineering before I

1 was well founded and licensed as an engineer before that. And
2 therefore, when I went to graduate school to study, it was
3 mostly to study the Bio part of it and just incorporating the
4 skills that I had into studying the human body in various ways.
5 Subsequent to my training, I worked in the field and continued
6 to publish in the field of bioengineering and biomechanics, the
7 act of publishing and doing research is actual post Ph.D. it's
8 how we scientists learn and are capable to grow.
9 Q Can you specifically summarize the aspect of your
10 background and expertise that you utilize in an investigation of
11 a low speed auto accident?
12 A Straight physics Newton's laws and engineering. In
13 order to characterize the severity of the crash before there is
14 anyone involved, I need to know the severity of the crash from
15 the standpoint of vehicles impacting each other and then after
16 that, I use the bioengineering and Newton's laws to determine
17 how the body moves in a bulk way, how the whole body moves.
18 After that, I look at individual component loading for whatever
19 body parts are identified in the medical records as having a
20 structural finding I need to address. I look at the loading
21 associated with those structures. After that, I use literature
22 and do force comparisons for example, the force that it would
23 take to do a routine activity by comparison to the force that I
24 determine that is associated with the incident and my last part
25 of the practice is scientific method validation and sensitivity,

1 you look at the result of analysis, you go back and say, if one
2 of these input variables was wrong, ten percent off, does that
3 change the answer and you criticize your own analysis and you
4 figure out what could have gone wrong and with that, you assess
5 the strength of your final result and whether or not you are
6 confident in that result to what is called a reasonable degree
7 of professional certainty.

8 MR. DUER: I would like to offer Dr. McGowan as an
9 expert in engineering and bioengineering.

10 MR. IRWIN: I object for the reason --

11 THE COURT: Nothing stated previously. I will
12 give you an opportunity to voir dire if you like or you can
13 reserve in your cross examination.

14 MR. IRWIN: I will reserve.

15 THE COURT: So you may have heard me deem experts
16 throughout the trial. The case law says I don't have to but
17 you will get an expert witness charge and it's up to you to
18 assess whether you accepted the opinions or not. I will
19 give you the charge later. It's unnecessary for me to make
20 a ruling on that. You may continue.

21 Q Dr. McGowan, what were you asked to do in this case?

22 A I was asked to do two things in this case. I was asked
23 to assess the severity of the auto accident from the standpoint
24 of vehicle forces and motions to do straight engineering
25 analysis. The next thing I was asked to assess the

1 biomechanical analysis, I was asked to evaluate the forces and
2 motions associated with the plaintiff in this case, Ms. Imran,
3 and specifically to look and see if there was a mechanism for
4 causation of the types of injuries that were claimed in the
5 legal filings in this and in addition or in parallel, the
6 medical findings contained in the medical records that I was
7 provided to review.
8 Q And did you receive materials?
9 A I did.
10 Q And what did you review?
11 A I had a police accident report, two different versions
12 of the same information from New York State. I had information
13 from State Farm, damages estimate for several of the vehicles
14 involved in this incident. I had a verified Bill of
15 Particulars, a legal document which outlines claimed injuries.
16 I had depositions and statements. Actually, I had five
17 depositions, sworn testimony regarding this incident from Miss
18 Ircardaro (phonetic), Imran, McCulcoe, Bernie and Kegloona
19 (phonetic). I had medical records, chiropractor records, X-ray
20 reports. I had MRI reports. I had records of surgery and
21 various other records. I had 25 digital color photographs of
22 the 2000 Ford Focus and 16 digital photographs of 2010 Honda CRV
23 involved in this incident and I had a hard copy of black and
24 white photographs which was represented to show the interaction
25 between the Ford Focus and subject CRV at the subject incident.

1 Q Without getting specific, what is your general
2 understanding of the facts of the accident?
3 A This is a multiple vehicle, sometimes chain reaction
4 crash, four vehicles involved, we might number the vehicle 1
5 through 4 where one is in the front. In this incident, as it's
6 been represented and reported, vehicle four hits 3, 2 hits and
7 vehicle two hits vehicle one. And those vehicles were
8 specifically Ms. Imran was the front vehicle one and that was a
9 Honda CRV, that was impacted by a smaller car, a Ford Focus,
10 behind that was a work van type of vehicle and behind that the
11 initial impacting vehicle was a truck. It was listed as a Ford
12 flatbed, clear, daylight, clear weather, roadway straight and
13 level, traffic light that was listed as being present, in terms
14 of physical complaint --
15 MR. IRWIN: Objection, your Honor.
16 THE COURT: Unless it's in evidence.
17 MR. IRWIN: It's not in evidence, your Honor.
18 THE COURT: Talking about physical, your client's
19 complaint.
20 (Whereupon, an off the record discussion takes
21 place at sidebar among the Court and Counsel.)
22 THE COURT: Objection sustained, without getting
23 into any physical complaints.
24 A Point of impact for vehicle one was listed as the
25 rear center, for vehicle two, also the rear center was damaged

1 to the front and similar for vehicle 3 and 4, so that indication
2 in the record was that it was a relatively aligned crash
3 scenario.
4 Q And now, you testified that the first part of your
5 analysis was an engineering analysis, what is the objective of
6 that part of your analysis?
7 A Simple, to characterize the crash severity.
8 Q And why is that important?
9 A Crash severity in an engineering term, means I will put
10 a number on crash severity, crash severity is related through
11 engineering to the energy involved in the crash. Crash severity
12 is related to the potential for injury, all else equal, a crash
13 severity that's higher for any particular injury mechanism. It
14 has a higher propensity to cause that injury. There is a
15 connection between the kind of crash severity that I determine
16 and the likelihood of injury.
17 Q With regard to Ms. Imran, crash severity is important
18 for every vehicle?
19 A In this particular case, the scope of my investigation
20 was limited to the occupant;s motion in vehicle one and that
21 means the only crash severity I need to do to stay within the
22 scope of my analysis is the crash severity for vehicle one.
23 Q Is there a way that as an engineer you can talk about
24 the severity or energy involved in the crash?
25 A In that way, a metric and measure called Delta-v.

1 Q And what do they need to understand about Delta-v?
2 A Delta-v is change in velocity and this type of auto
3 crash happens in about the same amount of time. We are talking
4 a small fraction of a second for auto crash in this realm of
5 speeds that we are talking about today. And so the change in
6 velocity, the Delta-v, gives you essentially the autos
7 acceleration, and if you are standing still and something hits
8 you from behind and immediately you are going five miles per
9 hour, that's a Delta-v of five miles per hour. That's a simple
10 example. It's not always that simple, but that serves to get us
11 involved with if we can get the Delta-v we can have something to
12 compare other accidents and compare it with result of crash
13 testing.
14 Q Is Delta-v the same as speed of the striking vehicle?
15 A It is not. It is based on conservation of momentum and
16 that means the size of the vehicle as well as the speed is
17 important.
18 Q In a multi vehicle accident like this one here is it
19 necessary to calculate the forces involved in each of the
20 individual crashes?
21 A The only thing I need to know about is the occupant
22 motion of the first vehicle, the only vehicle I need to fully
23 align in terms of Delta-v is the first vehicle, although if I do
24 that, I will pretty much automatically get the analysis for the
25 second vehicle, but as far as vehicles 3 and 4, if I'm not

1 worried about occupants behind vehicle one, then I don't need
2 them to do that. There are certain different analysis you could
3 do if you had information on the vehicle. There are many ways
4 to analyze this crash, but to answer that question, what do I
5 need in order to get the motion of the occupant of vehicle one,
6 I need something that tells me the energy, acceleration, Delta-v
7 of just that vehicle.
8 Q Does it matter if the accident involves a large truck
9 or small vehicle?
10 A Hypothetically speaking, if you have a car and you will
11 impact it from behind and you know the Delta-v was ten, I know
12 as an engineer, I can get the Delta-v from a small car moving
13 fast or big car moving slow and the Delta-v would be the same.
14 The important thing to know from the standpoint of the occupant,
15 the occupant's motion is the same in both of those cases. The
16 thing that matters is the energy and acceleration of that
17 vehicle. How you get there, doesn't matter, for the occupant
18 they cannot see what hit them and there would be no way to tell
19 if it was a big car going slow or small car going fast. Delta-v
20 is the answer for crash severity.
21 Q What information do you use to do the analysis on the
22 vehicle Ms. Imran was riding in?
23 A I had photographs of that vehicle, the CRV and I had
24 photographs of the Ford Focus that impacted the CRV and I had
25 specific damage estimates for the CRV and another for the Ford

1 Focus as well and very importantly, I had a crash test that had
2 been run that had a high degree of similarity to this actual
3 event and I actually had pictures from that crash test to
4 illustrate that. I don't know when would be the appropriate
5 time to show them.
6 Q Would you like to show the crash test?
7 A I think that would be appropriate.
8 THE WITNESS: May I step down?
9 THE COURT: There is a standing objection to this.
10 MR. IRWIN: Objection.
11 THE COURT: Overruled.
12 MR. DUER: You have it up.
13 THE COURT: It's in evidence the photo.
14 THE WITNESS: This is not. This is the crash
15 test. It looks similar.
16 MR. IRWIN: Objection, your Honor.
17 THE COURT: Objection overruled.
18 THE WITNESS: There is a couple of things we need
19 to look at.
20 THE COURT: I'm going to give the basis of my
21 ruling. The basis of my ruling is, the jury has already
22 seen photos of the accident and your opinion was based on
23 the photos, it's up to the jury to decide whether these are
24 similar photos, up to you to decide.
25 THE WITNESS: This is a Honda CRV that is an

1 exemplar, the front, for engineering purposes means it is
2 identical to the subject vehicle Ms. Imran is riding it.
3 This is being impacted by a Honda Civic. The Honda Civic is
4 higher and weighs 200-pounds, but in engineering sense this
5 is like the impact that is the subject of this litigation.
6 Here is the same two vehicles, the same photo, if I can
7 point your attention to the bumpers, there is a bumper
8 mismatch here and this is very key for this crash severity
9 because when the bumpers don't lineup, instead of getting a
10 bumper to bumper hit you, you get the bumper going into
11 something relatively soft. A softer structure. If you look
12 at the bumper of the CRV, and look how much higher it is
13 than the bumper for the Civic and Ford Focus is lower than
14 that, you can see that bumper, when these cars come
15 together, the bumper of the CRV will be into the grill and
16 hood of the car that's hitting it and that is what happened
17 in this crash.
18 Here is what happened in this test and you can see
19 that the hood is bent up and if you have seen the picture of
20 the Ford Focus and the subject crash, you see a similar
21 thing. This is a similar crash involving the 2010 CRV
22 that's the subject of this litigation. This is the picture
23 of that CRV after the IRHS, Insurance Institute for Highway
24 Safety ran the crash test. So this is the picture of that
25 vehicle after the crash test when you have taken the bumper

1 cover off of the vehicle. Most vehicles these days you see,
2 there is a bumper bar. This is a bumper bar. It's called
3 reinforcement before and impact bar. There is a Styrofoam,
4 foam absorber. You never see this on most cars because
5 there is a plastic bumper cover over that. And the subject
6 CRV and here is our subject CRV. This is the vehicle
7 Ms. Imran was riding. This looks the same. You see the
8 bumper cover is off. It was photographed lying on the
9 street, held on by plastic clips. You see the impact bar
10 was not damaged, and the reason it was not is because first
11 of all, two reasons, it was a relatively low speed impact
12 and it was also an override under ride situation in that the
13 bumper of the CRV was higher than the bumper of in this case
14 the Ford Focus.
15 So the take home from that, is that there is a
16 damage estimate for our crash and there is another damage
17 estimates for the IRHS crash. And that damage will be
18 related to the Delta-v. I made a calculation of the Delta-v
19 for the crash test I showed you and the Delta-v in that
20 crash test I showed you from the standard of the CRV was
21 5.7 miles per hour. That means in that crash test, CRV
22 standing still moves forward and gets to 5.7 miles per hour
23 in a fraction of a section that's the Delta-v. That's a
24 number, I know that number is from the crash test. That's
25 the number for the crash test. Is the severity of the crash

1 test.
2 I have the damage estimate from the crash test and
3 the damage estimate from subject crash the damage estimate
4 were similar but the damage estimate from the crash test was
5 severe. I will tell you the important thing about the crash
6 test damage that was more severe when you have two cars
7 coming together you can damage. When you have two cars
8 together you can damage cosmetic structures like headlights,
9 it doesn't take much to damage a headlight, you can break a
10 headlight with a rock. That doesn't have much to do with
11 crash severity. If you bend sheet metal, that's more and if
12 you damage the frame that takes more force to do than that
13 impact bar or in the case of the CRV, the floor pan in the
14 back comprised as part of the frame of that vehicle. So, in
15 our subject crash with the Imran vehicle there was two hours
16 on the estimate, two hours of repair work to the floor pan.
17 In the crash test, there was six hours of repair
18 plus two hours of pulling on a frame machine, plus one hour
19 to set up the frame machine and the end result of knowing
20 those two things and knowing that's where the structure is
21 of that car. The end result of knowing that, is I can say
22 as engineer, that the crash test was worse than the crash
23 with the Imran vehicle.
24 THE COURT: It's 1:00. Can I have a sidebar?
25 (Whereupon, an off the record discussion takes

1 place at sidebar among the Court and Counsel.)
2 THE COURT: Come back at 2:00. I will try to get
3 things done by 4:30. Enjoy your lunch.
4 (Whereupon the panel of sworn jurors exit the
5 courtroom.)
6 (Whereupon, a luncheon recess was taken.)
7
8 A F T E R N O O N S E S S I O N
9
10 * * * * *
11 (Whereupon, the document was marked in evidence as
12 Defendant's Exhibit B1.)
13 THE COURT: Good afternoon. You may be seated.
14 We will take a witness out of order, but we will come back
15 to the last witness. Call your witness.
16 MR. DUER: I call doctor Jeffrey Klein.
17 (Whereupon the witness took the witness stand.)
18 (Whereupon the witness was duly sworn by the Clerk
19 of the Court.)
20 THE CLERK: Name and business address.
21 THE WITNESS: Jeffrey D. K-L-E-I-N, MD, address
22 NYU Hospital for Joint Diseases, 380 Sixth Avenue suite
23 11001 New York, New York, 10010.
24 THE COURT: You may inquire.
25 MR. DUER: Thank you, your Honor.

1 DIRECT EXAMINATION
2 BY MR. DUER:
3 Q Good afternoon, Dr. Klein?
4 A Good afternoon.
5 Q Do you specialize in a particular field of medicine?
6 A I do, yes, sir.
7 Q And are you licensed to practice medicine in the State
8 of New York?
9 A Yes, I am.
10 Q And what is your specialty?
11 A My specialty is orthopedic surgeon and within
12 orthopedic surgery, my practice is and always has been
13 100 percent devoted to spine surgery.
14 Q When did you become licensed to practice in the State
15 of New York?
16 A I returned to New York after all my training in 1994
17 and have been in New York and licensed to practice in New York.
18 Q Can you tell us about your education briefly?
19 MR. IRWIN: Objection, your Honor, reputation.
20 THE COURT: Education.
21 Overruled. Objection withdrawn?
22 MR. IRWIN: Yes, your Honor.
23 A Where should we start?
24 Q Start with college.
25 A I went to Harvard University College, then returned to

1 New York and returned to New York, I went to Columbia University
2 College of Physicians and Surgeons for medical school, following
3 medical school, I chose orthopedic surgery, returned to Harvard
4 and did all of my surgical and orthopedic surgery training at
5 Mass General and Brigham and Women's Hospital.
6 While in residency in orthopedic residency and that is
7 where you are really learning your specific field, we tend to
8 sub specialize further. I chose spine surgery. I spent an
9 additional six months at Children's Hospital in Boston doing
10 pediatric spine surgery. That's part of fellowship. And then
11 another year out of University of California San Diego doing
12 adult spine surgery in neuroscience program that brings us to
13 the summer of 1994 and that is when I returned to New York and
14 I have been in New York at Hospital for Joint Disease ever
15 since.
16 Q Have you received any awards or honors?
17 A Yes.
18 Q And what were they for?
19 A Well.
20 Q Have you been, received any awards for low back pain
21 research?
22 A Yes.
23 Q And what was that for?
24 A The senior most award given by the international
25 society for the study of the lumbar spine, Volvo award,

1 sponsored by Volvo company. I won that award for my research
2 essentially devoted to how to minimize complication in spinal
3 surgery and make low back surgery safer, lower infection and
4 complication rates.
5 Q You have teaching experience?
6 A
7 the entire time during training through Harvard system, but I
8 have been part of the teaching program, I'm part of the full
9 time faculty at NYU Hospital for Joint Disease. My I'm part of
10 the full time group there and therefore in part of their faculty
11 all the while since ' 94 and then there was a ten-year period
12 between 1996 and 2006 when I was also on the teaching faculty of
13 Maimonides Medical Center, but a bit too much of a schlep to get
14 back and forth, so hundred percent at Joint Disease from 2006.
15 Q You have published articles dealing with spine surgery?
16 A Yes.
17 Q Are you board certified in orthopedic surgery?
18 A Yes.
19 Q What does that mean?
20 A Every field in orthopedic surgery has an organization
21 of board and the idea is to make sure that people are up to
22 certain standards, high standards, every field does it
23 differently, it can be written or oral exams, orthopedic surgery
24 it's both. And so, you know, if we take our oral and written
25 exams two years after the completion of training, and then there

1 is voluntary recertification as well. I have done that as well.
2 Q How many spinal surgeries would you say you performed
3 this year?
4 A On average in a typical year I probably preform about
5 90 to 135, 145 cases. This year the first half of the year it's
6 been less than average only because I personally had surgery so
7 I was not operating for four to five weeks.
8 MR. DUER: I offer Dr. Klein as an expert in the
9 field of orthopedic surgery.
10 THE COURT: Any objection?
11 MR. IRWIN: No.
12 THE COURT: So deemed.
13 Q Doctor, you and I ever met before today?
14 A No, sir, never.
15 Q And you testified in court before?
16 A I have, yes.
17 Q How often do you testify?
18 A I typically say on average four to five times a year.
19 This year one or two less. I think this year up to the halfway
20 point maybe about that, maybe two or three in that range.
21 Q And are you being compensated for your time here today?
22 A I am, yes.
23 Q And when?
24 A For the entire day and preparation up to this, $7,500.
25 Q Do you treat patients regularly?

1 A That's what I do primarily.
2 Q Is that the majority of your practice?
3 A The vast majority of my practice.
4 Q If you were not here today would you treat patients?
5 A I would.
6 Q Would you reschedule patients to be here today?
7 A Absolutely.
8 Q In 2014, did my office ask you to perform an
9 independent medical examination?
10 MR. IRWIN: Objection.
11 THE COURT: Overruled.
12 A The answer is yes, and the only thing I add to that is
13 I don't know if it was your office, it was not your office. I
14 was contacted by an organization called Certified Medical. I
15 think they set it up, but I subsequently learned when I get the
16 paperwork and records I saw your office was involved.
17 Q Did you have an opportunity to examine Ms. Imran?
18 A I did, yes.
19 Q And when was that?
20 A I actually have the report from that visit here, so I'm
21 quite familiar with it. I may refer to it as well, that was on
22 April 21, 2014.
23 Q And when you did that, did you take a history?
24 A Well, I tried.
25 Q What happened?

1 A You know, every evaluation is different. I try to
2 explain to everybody, everybody is treated equally in my office
3 whether a patient is coming in for an independent evaluation or
4 my own patient. I understand the frustration that patients have
5 for IME. In this case, Ms. Imran was there with an individual
6 that I think was hired by her attorney's office and there was an
7 awful lot that she had refused to answer or was guided to not
8 answer. I didn't make notes about that in her report, but this
9 was difficult. We have a questionnaire they fill out at first
10 she refused. My nurse starts with the history and then I repeat
11 the history. I'm the only one that examines her but basically
12 they were refusing to answer questions about her medical
13 history, certainly details about her history, employment
14 history. So it ultimately, we had to say as they suggested to
15 find it from the records. I got whatever I could, but it was
16 curtailed and I have to respect that I cannot force people to
17 answer questions.
18 Q Is a history important?
19 A Of course.
20 Q If you asked her if she was employed before and after
21 the accident?
22 A I did. I learned more about her employment as I went
23 through the records, they were, they didn't want to answer any
24 questions about employment.
25 Q Did you ask her if she smoked?

1 A I asked her if she smoked, she said she didn't.
2 Although I saw in the records later she did smoke or had smoked.
3 Again, I refer to get it out of the horse's mouth if I can from
4 the patient but that's what the record showed subsequentially.
5 Q Did you review any records and reports in preparation
6 for your examination?
7 A I did, yes, detailed on my report, was there something
8 in particular?
9 Q What did you, what medical records?
10 A It's not that long of a list, ten items that I have
11 listed here. I reviewed records from her chiropractor care,
12 records from Dr. Gutierrez. I think more importantly I reviewed
13 MRI of lumbar spine from the June 20th, '12.
14 Q What did that show?
15 A Well, the report basically showed and then I reviewed
16 myself and this is, the report of a treating radiologist
17 described -- I have a copy of it here, rather than be
18 inaccurate, I can be completely accurate. I agree completely
19 with the reading of the treating radiologist which makes life
20 pretty simple. The radiologist that her doctor sent her to
21 reported the following: That the there was desiccation, which
22 means loss of water, which is disc degeneration at all the
23 lumbar levels, no evidence of disc herniation at any levels.
24 Sorry, disc bulging present at L4-54 and L5/S1, minimal
25 bilateral facet hypertrophy at L4-5 and L5/S1, neural foraminal

1 narrowing is not identified. There is no evidence of loss of
2 height involving the lumbar vertebral bodies, and that was
3 essentially the impression ultimately was L4-5 and L5/S1 disc
4 bulges, minimal degenerative disease that was the radiologist
5 report. So the radiologist that she was sent to, and I don't
6 always, but that was completely accurate.
7 Q Did you review the films yourself?
8 A I did at the time of her visit I didn't have the MRI.
9 I asked for them and they were provided to me promptly. And I
10 reviewed them at that point and again, I completely agree with
11 the reading of the treating radiologist.
12 Q Did you state you reviewed the MRI in your report?
13 A That's right. You will notice the date of the report
14 is May 14th, though I saw her on April 21st, that's because I
15 was waiting for the MRI.
16 Q When you review the films yourself, do you generally
17 put that in a report?
18 A Of course.
19 Q As opposed to reviewing the report?
20 A I review the report versus I reviewed the scan. At
21 this point, I will say both.
22 Q Now, what is a diffuse disc bulge?
23 A A disc bulge, it means it is a fatiguing of the disc,
24 the disc, and I think you heard about this already, the disc are
25 the structures between the bones and they allow for movement and

1 shock absorption. They conform to the shape of the bones which
2 is roughly not exactly circular, a little bit oval. If you look
3 at the disc, it has a little indentation which is designed
4 exactly as the vertebral body, so that's exactly where the
5 spinal canal fits in. If a disc is bulging, typically a bulge
6 is broad, often times circumferential type of fatiguing of the
7 disc and it is like sitting in a bean bag chair and everything
8 pushes out to the side. It's a very broad fatiguing of the
9 disc. As opposed to a herniation, big difference is herniations
10 are focal. When we describe a herniated disc, it's protrusion
11 of disc in a focal area.
12 You can have a -- to give you an idea, if a disc bulge
13 is on 1 to 10, 1 or 2, to make simple, if you have a small
14 herniated disc that's contained, means the annulars are intact
15 and the disc -- let me step back. You have a soft inner core of
16 disc and a firm outer shell, you can protrude but still be
17 contained.
18 So we will call that a contained herniated disc. So
19 maybe that's a 3 or 4 on this analog scale.
20 Q What about an extruding herniated disc?
21 A Well the next thing that can happen, if the disc tears
22 right through the annulus and it can tear through the ligament
23 next door, the disc can extrude right into the spinal canal and
24 it can be fitting as fragment material in the spinal canal.
25 That is a different picture. That's 8 or 9. And then the last

1 step is if it extrudes so far that the piece of disc that came
2 out has completely lost contact with the disc space not sitting
3 by itself that is called a sequestered disc, that's a ten plus.
4 In this case, the radiologist, the treating
5 radiologist had studied the films and I agree there were disc
6 bulges at both levels at L4-5 and L5/S1.
7 Q Assume another doctor here testified that he looked at
8 the films and saw a herniated disc with extruding nucleus, is
9 that something that is seen here?
10 A No.
11 Q Is that something that would look very different on
12 those films?
13 A It's not really a matter of opinion either. It is what
14 it is. And that would look dramatically different. And again,
15 I am, I am agreeing with the radiologist who was treating the
16 patient. This is where the patient was referred. I'm not
17 taking or disagreeing with anything that is not an extruding
18 disc. It's a disc bulge, an extruded herniated disc in the
19 spinal.
20 Q And just a herniated disc would look different?
21 A If you have a herniated disc that's contained, you
22 would see a protrusion of disc focally, not broadly and
23 circumferentially. An extruded disc would look different.
24 Q What is a facet?
25 A Again, as we age, we undergo degeneration and the spine

1 is the same. The lowest two levels, L4-5 L5/S1 and that's
2 confusing. We name motion levels and discs for the two bones on
3 either side of that disc. L4-5 disc or L5/S1 disc, each one is
4 one disc. The L5/S1 is one disc, the one that sits between
5 L5/S1, not two different discs. The L4-5 and L5/S1 are where
6 the majority of motion occurs in the lower back.
7 They are subject to the most wear and tear. They tend
8 to undergo degeneration. So in this case, as again I agree with
9 the radiologist, there was disc desiccation or degeneration
10 there which is commonly seen in symptom free people in their mid
11 40s regardless and another thing associated with that gradual
12 degeneration process is enlarging of the facet joint. The facet
13 joint at every level of the spine, and two little joints in
14 the back. And those little joints in the back of every level of
15 your spine are called facet joints. As we age and things
16 slowly, gradually degenerate the facet joint enlarge. Facet
17 hypertrophy and disc desiccation and disc bulge all go together
18 and it's a gradual process of aging, basically.
19 Q You reviewed the report of Dr. Sapan as well?
20 A Dr. Sapan.
21 Q In your records, Dr. Cohen?
22 A I did not. I reviewed a report by a Dr. Cohen, I don't
23 know either but my record says Dr. Cohen.
24 Q And you reviewed the report of Dr. Reytman?
25 A Yes.

1 Q And Dr. Gerling as well?
2 A Yes.
3 Q When you say, when a treating, in your experience, when
4 a treating radiologist reviews lumbar films, are they going to
5 be more prone to under crawl or over crawl?
6 THE COURT: Sustained.
7 Q Did you perform an examination of Ms. Imran's lumbar
8 spine?
9 A Focussed exams focusing of the motion of the spine and
10 neurological exam, the spine exam.
11 Q And range of motion testing, is that objective or
12 completely subjective? What does that mean?
13 A It's what I tell patients when they come in, the only
14 person that knows how much somebody can move when they leave my
15 office is the patient. I cannot know nor can anyone that they
16 bring with it. It's volitional on the part of the patient.
17 Whatever motion I see from a patient, all I know is it's the
18 minimum motion that they have. I don't know if they have more
19 motion, but that's the minimum motion. How can anyone know? I
20 cannot know if someone went as far as they can. I never
21 literally put my hand on a patient to try to get them to go
22 further. I am standing next to them with a measuring device and
23 ask them to do the best they can.
24 Q If you ask a patient to perform lumbar flexion and
25 wherever they stop, that's where you mark?

1 A Is all you are doing, yes.
2 Q And you use a goniometer to do this?
3 A A goniometer is a device that measures motion by the
4 degree. We use it, but we are measuring something purely
5 subjective. It's funny to measure something that can't be
6 measured. I measure motion as I said I view it as a minimum,
7 but that was the motion that I got on that date.
8 Q And can you tell us what were your findings on your
9 examination with regard to the lumbar spine?
10 A Sure, well, you alluded to the motion, the motion of
11 the lower back was approximately inflexion about 55 degrees,
12 normal range. I'm pretty aggressive I think normal range is 80
13 to 90 degrees, the AMA guidelines is 60 to 90. I believe most
14 people can do better than 60. I had 55 degrees of the flexion.
15 Extension 55 and normal lateral bending, bending to the side I
16 had 15 degrees normal is 25 to 30 degrees. And I remark that we
17 measure this with a goniometer and that means subjective
18 findings.
19 Q Did you perform a motor exam?
20 A Yes. Motor exam means testing the motor strengths of
21 all of the muscles and those were all normal.
22 Q You tested the reflexes?
23 A Reflexes were normal and symmetric, same on both sides.
24 There were no pathologic reflexes. I wrote straight leg raising
25 was above on the right at 45 degrees. This is a subjective

1 test, what straight leg raising means, with the patient sitting
2 or laying down, we can straighten out the leg and we are trying
3 to see if it reproduces pain that runs down the leg. Again, we
4 are relying on the patient for the information, but when I did
5 that, she responded it was positive at 45 degrees.
6 Q And their exam took place after there -- she had spinal
7 surgery?
8 A That's right, yes. The one thing on the exam that is
9 not subjective, reflexes are not subjective. The other thing
10 that's not subjective, meaning objective, it's involuntary, is
11 whether or not there is paraspinal muscle spasm and there was
12 not paraspinal muscle spasm. Generally checking the muscles of
13 the lower back and seeing if there is any muscle spasm, those
14 are muscles not like your bicep which you can actively flex.
15 Q Patient came to you with two months after an accident
16 with an MRI report of a bulging disc, would you suggest spinal
17 surgery to that patient?
18 MR. IRWIN: Objection.
19 A No, sir.
20 Q What would you suggest?
21 A Two months after an accident, no matter what
22 conservative care has been given, it's simply not enough,
23 especially in someone that is neurologically intact. There is
24 no neurologic catastrophe impending disaster, especially with
25 someone with minimal findings. We are talking about imaging

1 findings that preexisting the accident, common degeneration
2 features we see, certainly I would not -- the other problem
3 there is multiple levels involved, it's not possible to know
4 what the pain generator is. There is no evidence on the scan of
5 nerve compression.
6 Q You say there is no evidence of pain generator?
7 A No, I said I'm explaining why I would not rush into
8 surgery. We don't have a definitive pain generator. There is
9 multiple different levels, could be L4-5, L5/S1, could be a
10 disc, a facet, ligament.
11 Q Spasm?
12 A These are all contributing to back pain.
13 Q Could it be scoliosis?
14 MR. IRWIN: Objection.
15 THE COURT: Sustained.
16 Q If you don't know the cause, if you are not certain as
17 to the cause of the pain, is it a good idea to do surgery?
18 A No, that would be yellow light, red light.
19 Q What does that mean?
20 A Especially if you are not certain of what the cause of
21 the pain is. In this setting, with findings of this level and
22 again, the radiologist were clear and I agree no nerve
23 compression, we have no explanations for the leg pain, when
24 things don't fit together you stop, you pause. We can't operate
25 based on subjective complaints because we are not going to get

1 the results that we hope for.
2 Q Assume Dr. Gerling read this as extruded herniated disc
3 but did a neurological exam and found the neurological exam to
4 be normal. Would you perform surgery out a normal neurological
5 exam?
6 MR. IRWIN: Objection.
7 THE COURT: Overruled.
8 A Having a normal neurological examination does not
9 preclude having surgery. Many patients have surgery with a
10 normal neurological exam. Their issue is pain. There is a few
11 things that go into deciding when someone should have surgery.
12 The pain has to not respond to an extensive course of a
13 conservative treatment. If someone has a catastrophic,
14 neurological exam, a progressive, neurologic deficit, they are
15 dramatically weak and getting worse before our eyes, you rush
16 them to surgery.
17 If someone has -- there has to be imaging studies that
18 correlate to that. You say oh, yes, here is dramatic, terrible
19 nerve compression. You rush that patient off to surgery. If
20 you have imaging studies that explain that, you rush that person
21 to surgery. If someone has a normal neurologic exam and only
22 pain complaint, and we cannot be certain where the pain is
23 coming from, I read in one of the treating surgeon's notes that
24 he couldn't be sure where the pain was coming from. I applaud
25 that, that's true. That's what I mean by yellow light, red

1 light, stop. The indication for surgery has to all be there.
2 Q If a patient complains of pain but has the radiological
3 findings found here by the treating radiologist and Dr. Cohen
4 and yourself and a normal neurologic exam, would that be an
5 indication for surgery?
6 A I think we answered that, no.
7 THE COURT: That was a correct ruling, asked and
8 answered. Sidebar.
9 (Whereupon, an off-the-record conference was held
10 between all counsel and the Court at the sidebar out of the
11 hearing of the jury.)
12 (Whereupon, the following occurred in open court:)
13 THE COURT: Limited in time.
14 Q Doctor, can you say with a reasonable degree of medical
15 certainty that the bulging disc, the disc that you saw in this
16 accident in your review of the films were from this accident?
17 A No, that's not correct.
18 Q And?
19 A With a reasonable degree of medical certainty, the disc
20 bulges we see there, because of the whole picture, disc
21 degeneration, disc bulges, facet hypotrophy at multiple levels,
22 this is the stuff of chronic degenerative change and really on
23 the mild to moderate side of degenerative change, not the stuff
24 of focal, traumatic change.
25 Q And you can say with a reasonable degree of medical

1 certainty?
2 A With a reasonable degree of medical certainty, yes.
3 Q And quickly with regard to the neck, you reviewed the,
4 you examined the neck?
5 A I examined her neck in the sense that her neurological
6 exam which was normal there, her range of motion was normal and
7 her MRI was normal. It didn't seem like there was much to
8 discuss after that.
9 Q Can you say with a reasonable degree of medical
10 certainty that there is, there were no objective findings that
11 you saw in your review of the records and in the films to
12 warrant surgery?
13 A There is nothing that I saw here that would warrant
14 surgery to be recommended two and a half months after an
15 accident. These are mild, degenerative changes and, you know,
16 in that setting, you would expect an extraordinary period of
17 conservative treatment. If there was a neurologic catastrophic
18 situation, that would be different.
19 MR. DUER: Thank you.
20 THE COURT: Cross?
21 CROSS EXAMINATION
22 BY MR. IRWIN:
23 Q Doctor, how much are you paid to conduct an examination
24 for testimony in court?
25 A $350.

1 Q Your compensation for today?
2 A $7,500.
3 THE COURT: No question.
4 Q Doctor, does it say $1,450 for what they call an
5 independent medical examination including the exam and report?
6 A Right, you asked what the exam was that's $350 and
7 report is $100.
8 Q You wrote a second report here so?
9 A No second report.
10 Q There is one from, did you ever examine or X-ray from
11 April 30th, 2012?
12 A The X-ray was not able to be provided. I saw the
13 report of the X-ray, not the X-ray.
14 Q And you knew you were retained by the defendants in
15 this case, right?
16 A Yes.
17 Q And you knew who was paying you for the examination,
18 you knew it was coming from someone defending a lawsuit,
19 correct?
20 A I know that it was a defense IME. It was, as I said,
21 certified medical, ultimately someone defending a lawsuit is
22 paying them, of course.
23 Q And you insist on using the word independent when you
24 know who is paying, right?
25 A Yes.

1 Q Doesn't the fact that you know you are being paid by
2 someone who is defending a lawsuit have, make it non independent
3 because you know who it is that is paying you?
4 A It doesn't change anything. It's completely
5 independent and there is nothing that changes for me.
6 Q And how much are you getting to testify?
7 A $7,500.
8 Q And you know when this person comes into your office
9 and you are receiving $1,450 for the examine and report and half
10 a day of testimony you receive $7,500, correct?
11 A Well, testimony is extremely rare. So that's, as I
12 said that's happened 2 or 3 times this year. I'm not
13 anticipating that, no.
14 Q And how many of those examinations do you perform a
15 week?
16 A In a month, on average, I might do in a month, 4 to 6.
17 Q Now, you said that you, nobody knew what the cause of
18 the pain was from in Ms. Imran's lower back. You said that
19 before on direct examination?
20 MR. DUER: Objection.
21 THE COURT: I will allow it.
22 A I think what I said was there was multiple, possible
23 sources of pain, multiple levels and structures and that even
24 her treating doctor mentioned that he couldn't be sure of the
25 source of the pain. I'm having trouble, I am.

1 THE COURT: Mr. Irwin, stay in one place.
2 This business of walking around might be good for
3 your exercise but as a trial counsel, I want you to stand
4 there. Don't walk around.
5 Q You testified before that a bulge is fatiguing of the
6 disc?
7 A One way to describe it.
8 Q And I want you to assume that Dr. Sapan whose last name
9 is Sapan-Cohen earlier testified that when you have bulging and
10 particularly circumferential bulging, you see the injury to the
11 disc of the bulging in the MRI?
12 A It's not going to be perfect symmetrically.
13 Q Close?
14 A If you have a bulge it will be broad, often times
15 circumferential but not perfectly symmetrically.
16 Q Nothing is perfect?
17 A Right, some element of symmetry but it will have its
18 irregularities.
19 Q And these irregularities will be microscopic, we are
20 talking about millimeters?
21 A The whole thing is millimeters. I will not call it
22 microscopic.
23 Q Any asymmetry will be closer to microscopic?
24 A The whole disc bulge is minimal, yes, any asymmetry
25 will be minimal.

1 Q Would the asymmetry be visual to the eye necessarily?
2 A I'm not sure what you are referring to.
3 Q The asymmetry when you compare the symmetry to
4 different parts, it is a 360 thing here?
5 A You are dealing with something that's a millimeter or
6 two in size, like 16th of an inch. I'm not sure I understand
7 your question. The resolution of the scanner, you know, a
8 millimeter difference is on an MRI scan is not accurately
9 distinguished. It's not even a question.
10 Q Doctor, do you agree that, you said before the most
11 degeneration occurs in L4-5 and L5/S1, that's the part of the
12 lumbar spine that moves the most?
13 A L3-4 would be next.
14 Q Most is in L4-5, L5/S1?
15 A The three lowest levels 3/4, 4/5 and 5/1 are where most
16 of the motions are in the lumbar spine 4/5 is the most motion.
17 In a normal person that's not a perfect assessment, the three
18 lowest levels.
19 Q And those are also always the most susceptible to
20 trauma, both degeneration and trauma they are susceptible to?
21 A Correct.
22 Q And that's L4 to 5, L5 to S1 is the most likely place
23 where you have somebody in an automobile accident that they are
24 going to have an injury to a disc, correct?
25 A In the lumbar spine, yes, most likely.

1 Q And your examination was performed after the surgery,
2 right?
3 A Yes.
4 Q So can we agree, Doctor, that any findings you had on
5 your examination have no relation whatsoever to any of the
6 findings before the surgery, right, because that's an
7 intervening act?
8 A That's a broad statement you made. I'm sure I agree
9 with you in theory, but not sure what you are asking.
10 Q By doing an examination after a surgery, is it possible
11 to determine if the surgery should have done beforehand from
12 looking afterwards?
13 A My exam from that day at that time is not, really not
14 what I'm basing that opinion on. I'm basing it on the exams,
15 information that was present after the accident before her
16 surgery and imaging studies from before the surgery and treating
17 radiologist interpretation of those studies which I agree with.
18 That's the only thing you can do.
19 Q History is important also, a patient's history as far
20 as the mechanism of injury and the specific details of the
21 mechanism of injury are important?
22 A They are only important to a point, the least common
23 denominator ultimately is the three things we talked about, pain
24 which is purely subjective, hard to verify, then we go to the
25 imaging studies. Are there imaging studies that correlate to

1 support it, if not, you will not get a successful result,
2 actually that is pretty much what happened here. The patient
3 said the symptoms were quite similar and obviously, an extensive
4 course of physical therapy, conservative treatment in general,
5 these are the things that make us determine whether surgery
6 should be performed or not.
7 Q You said there was no spasm in the lumbar spine, can
8 you show me where it says that in that report?
9 A Physical examination, no paraspinal muscle spasm.
10 Q And incisions?
11 A There were well healed lateral, bilateral, that means
12 to the lower back off to the side, lateral, bilateral, means
13 both sides, incisions in the lower back and they were each
14 approximately 7 to 8 centimeters in length which is about two
15 and a half inches.
16 Q Doctor, you said reflexes were involuntary, correct?
17 A Yes.
18 Q And you only found one plus, you didn't find two, two
19 is normal, isn't it?
20 A One plus is normal, two plus is normal, for some people
21 0 is normal. What makes this normal is that one plus
22 everywhere, one plus or two plus could be normal. There is a
23 range of normal.
24 Q You said that there was no, no one knew the cause of
25 the pain when the surgery was performed or you don't know the

1 cause of the pain when the surgery was performed?
2 A I think we answered that. I will answer it again.
3 THE COURT: The truth of the matter is asked and
4 answered. I'm watching the clock and letting you use your
5 time.
6 Q You said that nobody knew the source of the pain at the
7 time?
8 A I think that's where you started earlier. What I said
9 was, there is multiple sources of pain and levels. So its,
10 therefore, it's not possible to know with certainty what the
11 sources of the pain are and even her surgeon in his notes
12 mentioned that he wasn't certain of the source of the pain.
13 Q Are you always certain about everything in your
14 practice or is there some degree of judgment used in the
15 practice of medicine. You keep using the word "certainty"?
16 A We want to be as certain as possible. The way to be as
17 certain as possible is to have physical findings that correlate
18 with the MRI study that show neurocompression, that show that
19 neurocompression to be on the correct side that correlates with
20 the patient's symptoms and et cetera. There is a whole
21 constellation of things that we use to generate, not perfect
22 certainty, but as close to a real high likelihood as we can.
23 When this comes together, that is what gives you the best ---
24 Q Doctor, do you agree that performing a lumbar epidural
25 steroid injection is diagnostic and therapeutic, it can be both?

1 A It can be therapeutic and it can help symptoms. In
2 terms of being diagnostic, it's rarely diagnostic in a situation
3 where there is no focal finding -- standard of care, particular
4 of what, of the fact, that it helps with what?
5 Q Doctor, you didn't mention the fact that there was an
6 injection performed to L5/S1 for Ms. Imran by Dr. Reytman before
7 the surgery, to actually relieve the pain and you didn't talk
8 about that on direct examination, did you?
9 A Nothing was asked of me, no.
10 Q And you know for a fact that was done, right, and you
11 note in your report, you say injections, there was only one?
12 A There was one injection done and I think I wrote and
13 you have my report, she told me her report to me, so this is the
14 history I took from her, she had no significant improvement with
15 the injection.
16 Q Assume that yesterday Dr. Reytman and Monday
17 Dr. Gerling testified in their opinion lumbar epidural steroid
18 injections can be diagnostic under circumstances where they only
19 provide very brief or no pain relief?
20 A That is not a reasonable conclusion in the setting of
21 an MRI that shows no neurocompression.
22 Q Is every MRI read perfectly all of the time?
23 A MRI's are read very close to that, yes. When you have
24 agreements between opposing sides on an MRI read, that's usually
25 pretty solid.

1 Q Sometimes yes, sometimes no. It's a subjective thing
2 to read an MRI. The interpretation, that's what you do, you
3 interpret the MRI?
4 A If the treating radiologist --
5 MR. IRWIN: Your Honor, could I have yes or no or
6 I cannot answer?
7 THE COURT: At this point, you are right, he
8 determines what it is, on future questions answer yes or no
9 or I can't answer.
10 THE WITNESS: I can't say yes or no.
11 THE COURT: You have to ask questions.
12 Q The decision to perform a surgery is a judgment call by
13 a doctor based on the history, the physical and the diagnostic
14 testing and things of that sort, correct?
15 A The imaging study is a critical component of those
16 three things. You have to have an imagining study that shows,
17 pathology that shows neurocompression if you are trying to
18 operate on someone to correct neurocompression.
19 Q The gold standard, the best way to know exactly what is
20 going on isn't an MRI or CAT scan or straight leg raise, it's to
21 do the surgery and visualize?
22 A Is not the gold standard. That's only the gold
23 standard to the one person that is looking at it. The MRI is
24 for all to see so there is no questions. You can have other
25 radiologist look at that if you don't take my word for it.

1 Q Looking and seeing a herniated disc during surgery is
2 not more reliable and more accurate than an MRI?
3 A There is no way to verify what somebody is saying when
4 you are looking at surgery.
5 Q Are you saying that Dr. Gerling is lying when he said
6 he saw a lumbar herniation at L5 S1 that needed repair?
7 A I can answer that --
8 THE COURT: Answer it.
9 A I did not say that at all. I simply said don't words
10 in my mouth.
11 THE COURT: One at a time.
12 A I did not say that. I'm not implying that. You asked
13 me what I think if I think the imagining study, what do I do
14 when a surgeon says they saw something by themselves but an
15 imagining study that is ut there for everyone to see does not
16 reveal that. It's hard to figure out. And the treating
17 surgeon's notes he was calling it an extruded herniated disc,
18 even in the beginning, not in the operating room, when the
19 treating radiologist was calling it a disc bulge. And looking
20 at that study, I agree and seems like others do too. I'm laying
21 the facts before you. This is what it is. Talk to your
22 treating radiologist --
23 Q Doctor, we have Dr. Gerling on the stand who visualized
24 the disc and did the surgery and stated he visualized a
25 herniated disc and you are saying there is symmetry on the MRI,

1 there is no neurological signs but isn't weakness a neurological
2 sign?
3 A What do you mean by "weakness"?
4 Q In the lower extremities?
5 A That's a subjective complaint.
6 Q Doctor?
7 A Is not a neurological complaint.
8 Q Isn't it true that you have to go to medical school or
9 have some kind of medical knowledge to fake a positive
10 neurological or orthopedic exam, examination of the lumbar spine
11 if you will fake an exam like that, right?
12 A No one is suggesting anyone is faking anything. You do
13 not have to go to medical school.
14 Q Do you agree, Doctor, that numbness and weakness
15 bilaterally is significant, is a significant finding?
16 A Again, I think all historical complaints are important,
17 but they are all purely subjective.
18 MR. IRWIN: Could I get a yes or no?
19 THE COURT: As long as you understand the time.
20 Q You said that you didn't have all of the information
21 that you wanted from Ms. Imran, correct?
22 A No, I said that she was instructed to not answer my
23 questions.
24 Q And that's because?
25 A By the way, she was instructed, it's not a statement

1 about her.
2 Q You were retained by the defense attorneys in this
3 lawsuit, correct, Ms. Imran was represented by counsel and there
4 was no court reporter to take down what was said, correct?
5 A Of course not, no.
6 Q And people make mistakes sometimes?
7 A I'm not sure what you are asking. You can be making
8 mistakes.
9 Q We are all human. You are aware that there is 146 page
10 deposition transcript taken on February 4, 2014, three months
11 before your examination, right?
12 A I know there was a deposition. I don't know the date
13 of it offhand.
14 Q You know there was a deposition before your exam, did
15 you ask for that and did you read it?
16 A I didn't know there was and I only, I ask for things
17 that I need. I needed to see her MRI scan. I don't ask people
18 to send me the records. They send me what they have and what I
19 can look at. I did not review her deposition in this case.
20 Q Doctor, is this significant to you that Ms. Imran
21 testified that her right knee struck the dashboard?
22 A Not as a spine surgeon, no.
23 Q As to causation, you are testifying about causation.
24 A Not about her knee.
25 Q And isn't it true even if she had a bulging disc at L4

1 L5, this accident could have caused it from going asymptomatic
2 to symptomatic?
3 THE COURT: Do you understand the question?
4 THE WITNESS: I think so.
5 MR. DUER: Objection.
6 THE COURT: I will allow it.
7 A There was a lot there. I think the last part was if
8 somebody has disc bulge in these degenerative features that are
9 laying there quietly and somebody has an accident, could they
10 become symptomatic?
11 THE COURT: Sustained as to form. If it has to be
12 related to this accident.
13 Q I want you to assume that Ms. Imran testified that in
14 this accident her pelvis was twisted sideways when the impact
15 occurred, her vehicle was struck from behind while looking
16 backwards she was thrown back into the seat and forward and
17 struck her knee on the dashboard. Can you assume that for me?
18 A Sure.
19 Q I want you to assume that Ms. Imran, according to your
20 opinion, further assume that before April 17, 2012, Ms. Imran
21 never saw a doctor, never saw a chiropractor, never got a
22 massage or never had any injuries or complaints or complaints
23 related to her lumbar spine, can you assume that?
24 A Yes.
25 Q And further assume subsequent to the accident, May 2,

1 2012, which is two weeks post accident, there was findings of
2 swelling, the anterior left and right knee, there were lumbar
3 complaints, there was numbness and weakness, bilateral radiating
4 pain to both legs, can you assume that for me?
5 A Absolutely.
6 Q Assuming those facts, do you have an opinion to a
7 reasonable degree of medical certainty as to whether or not the
8 two disc bulges in her lumbar spine that you say pre existed
9 were aggravated by the accident of April 17, 2012?
10 MR. DUER: Objection.
11 THE COURT: I will allow it, if you can answer it.
12 THE WITNESS: I think I can, your Honor.
13 A You listed an awful lot of things and the two disc
14 bulges which have no neurocompression at all cannot cause a lot
15 of the things you said. But can they be aggravated and cause
16 back pain, yes, but there is nothing, no imaging or objective
17 imagining and you have to have that to explain all of the
18 various things, you listed a lot of things, I agree that you can
19 aggravate a quiet situation and it certainly can awaken back
20 pain in somebody, I agree.
21 Q Doctor, I want you to assume on May 2, 2012,
22 Dr. Gutierrez performed an examination, you reviewed that,
23 right?
24 A Yes, checking on the dates.
25 Q If you can assume?

1 A Yes.

2 Q And I want you to assume after Dr. Gutierrez finished
3 his examination, he concluded that there was pathology at L5/S1
4 and L4/L5, can you assume that also?

5 A I'm only assuming it because you are asking me to, and
6 it's not an assumption one can make, this is well before imaging
7 studies.

8 Q I'm asking you to assume that was his conclusion?

9 A I will assume that's his conclusion, yes.

10 Q And how do you explain the fact and it was only L4/L5
11 S1 to the lumbar spine? How do you explain the fact a month
12 later on June 1st the MRI of the lumbar spine comes back and
13 here it is, we have pathology exactly at those two levels?

14 A Do you think Dr. Gutierrez doesn't know those are the
15 two levels where pathology is going to come back in the vast
16 majority of MRI's, both on people who are symptomatic and A
17 symptomatic?

18 Q And he doesn't include L3?

19 A I don't think he was trying to do anything mysterious
20 here. Those are the two common levels in lumbar spine. You are
21 going on a limb to make a statement. He has no hard, neurologic
22 findings. We are not putting anything on Dr. Gutierrez. He is
23 estimating what he thinks it might be. It is no surprise she
24 has an MRI mild, degenerative 4/5, S1. Frankly, 50 percent of
25 the world in their mid 40's have the same MRI. It's pretty

1 consistent.
2 THE COURT: Wrap it up.
3 Q You are colleagues with Dr. Gerling?
4 A No.
5 Q And you are both at Hospital for Joint Diseases?
6 A Dr. Gerling as has not been at Hospital for Joint
7 Disease for quite a while.
8 Q You know him?
9 A I know him.
10 Q You met him?
11 A Yes.
12 Q Did you contact him about this case?
13 A No, he did not contact me about this case.
14 Q Did you contact him?
15 MR. DUER: Objection.
16 THE COURT: Let him answer.
17 A Of course not, I have no contact with Dr. Gerling. At
18 one point he did sporadic cases at Joint Disease. I don't think
19 I seen him there for quite a while, many months, maybe longer.
20 Q When you read the MRI of the lumbar spine the film
21 itself, you had the report of the original MRI report and you
22 had Dr. Sapan-Cohen's report in your hands while you read it?
23 A I didn't have either of those things in my hand. I had
24 the MRI in my hand, the CD scan.
25 Q And you compared it to the two reports?

1 A I reviewed the study, and I got the study in a time, in
2 several weeks after I saw her and reviewed records. I looked at
3 the disc, went back to my report and said look at that, every
4 one agrees, it's easier when I read something and the treating
5 radiologist agrees with me I'm thinking, there you go.
6 Q You knew, did you read the treating radiologist's
7 report and then receive the film later?
8 A I read the treating radiologist report weeks before and
9 I probably seen hundreds of patients or MRI's in the --
10 Q You didn't do it the other way around?
11 MR. DUER: Objection.
12 A I had the records initially, but I asked for the MRI.
13 I was not satisfied with the record. I wanted to see the MRI
14 myself.
15 THE COURT: Third time the jury heard that.
16 Mr. Duer, very limited.
17 REDIRECT EXAMINATION
18 BY MR. DUER:
19 Q Can you say with any reasonable degree of medical
20 certainty that the disc bulges here at L4-5 and L5/S1 were made
21 worse by this accident?
22 A I can say with reasonable certainty that one can't say
23 that. There is no way to say that. That's a fact, yes.
24 Q You are not certain about where a complaint of pain is
25 coming, would you perform a spinal fusion three months after the

1 accident?

2 A I would not.

3 THE COURT: Step down.

4 (Whereupon, the witness steps down.)

5 THE COURT: Step out. You are going to the

6 hallway for a minute.

7 (Whereupon, a recess was taken.)

8 CONTINUED DIRECT EXAMINATION

9 BY MR. DUER:

10 Q Doctor, we left off with your summary of your

11 conclusion for engineering accident analysis?

12 A I said that the result of my calculation was that the

13 incident was no more than 5.7 miles per hour Delta-v. That

14 establishes a range. It can't be lower, can't be higher and

15 that's the conclusion of the accident analysis.

16 Q Moving now to your biomechanical analysis. I ask you

17 to describe the process you did and your findings.

18 A I will say it will go faster if I use the slides. The

19 process that I go through from the engineering analysis we just

20 covered now into biomechanics is four steps. First step is how

21 does the body move as a whole, the whole body. That's called

22 kinematics the second step is what loading is associated with

23 that motion to individual joint and body parts and the next step

24 is an engineering comparison between that particular loading and

25 any loading from the literature research in biomechanics that

1 establish what kind of loading is actually that. And that
2 enables me to have opinions that tie the crash loading or
3 incident loading to whether or not there is a mechanism to cause
4 damage, to cause pathology. And the last step is the scientific
5 method validation and sensitivity.
6 THE COURT: Next question.
7 Q What did you do here? What is this, what does that
8 photograph show?
9 A This is the last one I used. I think I heard your
10 question was what are my findings.
11 Q Moving onto biomechanical analysis.
12 A Yes.
13 Q For the second half of your investigation, you
14 testified that you determined forces and motion that people like
15 Ms. Imran would experience in the accident, how would you do
16 that?
17 A The picture I have here is a crash test. We used the
18 crash test already in order to establish severity. Now I'm
19 interested in characterizing what happens to an occupant, not in
20 that particular vehicle, but in that particular Delta-v, in the
21 particular severity of a crash, what happened to the occupant.
22 How do they move? How forcefully do they move? Which direction
23 do they move? And in order to do that, we have crash test.
24 Here is one. We had two similar vehicles and we crash one into
25 the back of the other. We know the speed because we measure it,

1 we get high speed video and we have a crash test dummy.
2 Q Isn't that called anthropomorphic test device?
3 A We can call it an ATT. This is crash test dummy you
4 see them on commercials. This is a complicated and expensive
5 piece of scientific equipment that can measure a variety of
6 things. And we will only be talking about a couple of them.
7 The particular crash test I used here, this crash test which
8 produced a Delta-v right here of 6.5 miles per hour Delta-v.
9 And so this is the crash test that I know is stronger than the
10 crash involving Ms. Imran. This is an upper. I know that
11 Ms. Imran forces and motions were less than what is described on
12 this crash test. And specifically, we have to remind ourself
13 of, before we evaluate the forces, we have to remind ourselves
14 of what the interior of the car looks like. So here is the
15 driver's compartment and we can see there is plenty of room
16 between the seat and dashboard. We can see the passenger
17 compartment, driver and passenger seat. There is an extendable
18 head restraint. We can see there is a cushion back rest and.
19 This is fairly standard for this type of vehicle. So we confirm
20 we understand that.
21 Now, when one is hit from the rear, we in vote Newton's
22 laws and we say which way do we move? What is happening at that
23 time is the car being hit from the rear, the car is moving
24 forward, but due to Newton's law of inertia an occupant of the
25 car is standing still. So, what it feels like to the occupant,

1 you go backwards and you go backwards into the backrest and is
2 what happened in this crash by the law of physics. This happens
3 within a couple of two tenths of a second. It's too fast to
4 react.
5 Now, in an occupant compartment like this, you go back,
6 the seat has a little bit of spring to it, that takes up some of
7 the energy, it gives you what is called a ride down, that means
8 some of the energy is dissipated. Afterwards you come back
9 forward, but it's with much less velocity. There is a published
10 paper I brought with me, the speed going forward is one third of
11 what you were going backward. Theory in this, you are not going
12 back very fast and going forward one third of that.
13 In a rear impact when you go backward and forwards, if
14 you were to go forward fast enough, this car has what is called
15 a locking re tracker type of seat belt. If you went forward, in
16 a regular car, often if you lien forward, you can make the
17 re tracker lock up.
18 MR. IRWIN: Objection.
19 THE COURT: Sustained.
20 A With the locking re tracker seat belt if you rebound
21 forward --
22 MR. IRWIN: Objection.
23 A Quickly it will lock up.
24 THE COURT: Sustained.
25 Q Dr. McGowan, I want you to assume that Ms. Imran

1 testified she was turned or twisted in her seat at the moment of
2 impact.
3 A I looked at that, I understand that testimony and I
4 looked at that testimony in the context of everything else she
5 said how she described her motion she said she went back and
6 forward and what she described she was doing with her hand after
7 the incident knowing that the crash or impact happens within a
8 couple of tenths of a second. It's faster than you can react.
9 I looked at that, one of the ways I looked at that was
10 I reviewed a research paper on work I did and I published where
11 I looked at crash test dummy.
12 MR. IRWIN: Objection.
13 THE COURT: Sidebar.
14 (Whereupon, an off the record discussion takes
15 place at sidebar among the Court and Counsel.)
16 Q Doctor, quickly, can he give your opinion with regards
17 to if someone testifies that their body was twisted?
18 THE COURT: Get to the result, not the analysis
19 what was in this case. What was the impact on the body and
20 basically that's what you are here to tell us the impact,
21 get to that point.
22 A As I was talking about the crash test, we can go to
23 lumbar spine compressive loading.
24 MR. IRWIN: Objection.
25 THE COURT: Overruled.

1 A This number 26 point 5 pounds and because of the
2 negative sign that is compression on the spine, you can see the
3 time that it occurred in the crash test. That is the maximum
4 amount of compressive loading associated with this crash test at
5 six and a half miles per hour Delta-v which is greater than 5.7
6 Delta-v. Let's say it's less than 50 pounds, which is a
7 reasonable engineering proximation of that less than 50 pounds
8 of compressive loading is my analysis of the maximum amount of
9 compressive loading on the spine of Ms. Imran with her size in
10 this incident. That's my first result and the reason that that
11 result is there is because for the pathology that we are talking
12 about today, which is lumbar spine disc bulge, compressive
13 loading is what is important. This is the result of the joint
14 loading portion of my analysis. Recognizing the several degrees
15 of conservatives I talked about.
16 Q Is there enough loading to cause bulging?
17 MR. IRWIN: Objection.
18 THE COURT: Overruled, yes or no.
19 A It would not be expected based on the signs.
20 Q And that's based on these studies?
21 A Based on studies I have not talked about, based on
22 extensive studies in the scientific literature, preformed by
23 bioengineers like myself and studies important in this analysis
24 on the loading on the spine with normal daily activity.
25 Q If we had more time would we be able to discuss the

1 studies?
2 MR. IRWIN: Objection.
3 THE COURT: Overruled. You are objecting to the
4 fact that he is going to curtail it so you can have cross
5 examination. Are you in favor of him going ahead? That's
6 what he said.
7 Q Can you say with a reasonable degree of medical
8 certainty that --
9 MR. IRWIN: Objection.
10 Q Reasonable degree of engineering and biomechanical
11 certainty that any disc pathology claimed as a result of the
12 accident was not caused by this accident?
13 A I want to review the opinions.
14 THE COURT: Yes or no?
15 Q Can you give your opinions?
16 MR. IRWIN: Objection.
17 THE COURT: Overruled.
18 A For lumbar spine pathology considering the subject
19 occupant kinematics as well as the crash test result and their
20 application to subject scenario and subject occupant, the force
21 direction, the magnitude, the loading were below levels
22 associated with injury in the biomechanical literature. But
23 given this geometry was inconsistent with an expectation of --.
24 I went on lower extremity, did not provide a biomechanical
25 mechanism for knee injury as alleged and consistent with the

1 science, that I don't have time to talk about. Similarly
2 shoulder kinematics did not provide a mechanism for shoulder
3 injury due to the direction of motion back and where the seat
4 belt hits the body of a person, the size and weights of
5 Ms. Imran, and finally, that the loading of normal activities
6 such as doing sit ups, grocery shopping, simply bending over and
7 not lifting any weight, all of those and the area of 2, 3, 4,
8 500 pounds on the spine much greater routinely than the less
9 than 50 associated with this incident.
10 Q Doing sit ups would be greater force on the lower
11 lumbar spine than this accident did?
12 MR. IRWIN: Objection.
13 THE COURT: You may answer.
14 A Each sit up has two compressive loading peaks and the
15 range of a compressive loading peak through the science for
16 someone like Ms. Imran would be 2 or 400 pounds of loading,
17 twice doing sit ups, she testified she did 70 sit ups at one
18 time, 200 to 400 again, again, again by comparison to less than
19 50 for the subject incident compressive loading.
20 THE COURT: Cross examination.
21 CROSS EXAMINATION
22 BY MR. IRWIN:
23 Q In your report and the materials being relied on, did
24 you use any studies with or set any studies related to go 5'6",
25 145 pound females in the age range from 40 to 45 years old?

1 A I use studies and population.
2 Q Tell me which ones include that population?
3 A In general.
4 Q Of living human beings?
5 MR. DUER: Objection, let him answer the question.
6 A I use studies with cadavers and models and living human
7 beings.
8 Q Living including females of Ms. Imran's heat and
9 weight?
10 THE COURT: Do you know offhand otherwise?
11 THE WITNESS: I don't know offhand.
12 Q Doctor, I will be all over the place. There is so much
13 to cover.
14 You state in your report that you, if I heard it right,
15 that you are not considering that there was an impact to the
16 knee in your conclusion; is that right?
17 A Not I'm not considering it.
18 MR. DUER: Objection. He is not letting him
19 answer the question.
20 THE COURT: Sustained. Answer the question.
21 A I came to the conclusion based on law of physics in
22 this incident with this geometry, there is no knee impact
23 associated with the rear impact that becomes over in a belted
24 occupant.
25 Q There is no what impact?

1 A Knee impact on the dashboard.
2 Q So, you are assuming there is no knee impacts?
3 A No, sir.
4 Q That's a rotational twisting force on the lumbar spine
5 not up and down, right?
6 A Not right.
7 Q If the right knee strikes the dashboard while her
8 pelvis is tilted, if she comes up into the seat with her pelvis
9 tilted and forward and strikes her right knee, that happens in
10 two tenths to four tenths of a second, the back movement and
11 forward?
12 A Your hypothetical makes no sense.
13 Q Where is your calculation for forces involved in the
14 knee striking the dashboard?
15 A If you are going to calculate the force on the knee
16 strike and there is no knee strike, the force is zero.
17 Q How are you concluding there is no knee strikes?
18 A The laws of physics, crash test results, high speed
19 video, what happens in crash tests, my experience in publishing
20 literature in the society of automotive engineers with out of
21 position occupants with lumbar spine, with higher velocities
22 than this particular and this is a start, I can go on with more
23 foundation.
24 Q You are ignoring Ms. Imran's testimony, correct?
25 A Absolutely not. I do not discount or ignore anything

1 in my analysis.
2 Q Where can are you --
3 MR. DUER: Objection, her deposition.
4 MR. IRWIN: Your Honor, the trial testimony is
5 that she struck her knee on the dashboard. I read it in.
6 MR. DUER: Objection.
7 THE COURT: Are both sides, have you both read the
8 appropriate portion?
9 If they want to find out, they will ask to have a
10 read back on the appropriate deposition.
11 Assume now for the purpose of this expert in the
12 cross examination, ask him to assume.
13 Q Assume Ms. Imran's knee struck the dash. Assume there
14 was testimony that Ms. Imran's knee struck the dashboard, would
15 that be significant to you?
16 A Completely out of context. It's a question that cannot
17 be answered.
18 THE COURT: He cannot answer yes or no.
19 Q And, Doctor, there has been no studies whatsoever
20 performed on anthropomorphic crash test dummies that were in a
21 turn with their pelvises tilted in an accident?
22 A I said I published a study with ATT.
23 Q With a twisted pelvis?
24 A I said that, yes.
25 Q Can you point to that study in your report?

1 A Under occupant response in rear impact crash
2 observation with respect to large occupant size and position.
3 Q That is about obese people.
4 MR. DUER: Objection.
5 Q That relates to obese people, 300 pounds or more?
6 A Some did and some didn't.
7 Q Does that relate to females who are 140 to 145 pounds
8 and 5'6"?
9 A The scientific method to humans it relates.
10 Q Doctor, while I look for it, did you have, I want to go
11 quick, how did you reach the conclusion that this damage that
12 you compare to a 2008 Honda Civic striking a 2010 CVR and said
13 it was the same as a 2004 Ford Focus striking a 2010 CRV?
14 A Not exactly what I testified.
15 Q You said there was less force involved between the two?
16 A I talked about damage. I talked about Delta-v,
17 acceleration.
18 Q And did you look at the property damage estimate?
19 A Certainly.
20 Q And those are estimates?
21 A Certainly.
22 Q And they are subjective, right?
23 A I disagree. I mean there is probably some element of
24 subjectivity in any product of human endeavor.
25 Q Are they done by an engineer?

1 A Specialist who does that for a living?
2 Q No, no.
3 (Whereupon, an off the record discussion takes
4 place at sidebar among the Court and Counsel.)
5 Q The person who does this and fills out the property
6 damage estimate, isn't that someone that works for someone who
7 defend lawsuits?
8 MR. DUER: Objection.
9 THE COURT: I will allow it.
10 A Not necessarily.
11 Q In this case it was, wasn't it?
12 MR. DUER: Objection.
13 Q You want to look at your property damage estimates?
14 THE COURT: Say assume.
15 MR. IRWIN: He has them in front of him. I want a
16 yes. I want him to agree with me, they are not going in
17 front of the jury that way.
18 THE COURT: I thought they were in evidence.
19 MR. IRWIN: Subject to redaction.
20 Q The person that did that estimate is someone who works
21 for people that defend lawsuits, right?
22 A I don't know that. I don't actually agree with it. I
23 don't know who signed the paycheck.
24 THE COURT: No sidebar.
25 Q They were hired by, they were retained by, they were

1 sent there by on behalf of, if you want someone that defends
2 lawsuits, right, and particular property damage lawsuits?
3 THE COURT: Yes or no?
4 THE WITNESS: I cannot answer. I don't know.
5 Q It's not an engineer, right, not a biomechanical
6 engineer?
7 A As far as I know, I don't see EP. I don't see the name
8 of whoever did it.
9 Q We have no idea of who did that, do we?
10 A I disagree.
11 Q Who did it?
12 A There is a name and a phone number on it.
13 Q You don't know who it is? You never met him and didn't
14 talk to him?
15 A Correct.
16 Q And you look at two estimates of damage, are estimates
17 always exactly perfect?
18 A I don't think any human endeavor is perfect.
19 Q And there are structures in automobiles you don't see
20 with the naked eye, like the frame of the automobile?
21 A It depends on what was disassembled what you can see.
22 Q As far as the frame goes, you do have to disassembly to
23 see if there is frame damage?
24 A Not necessarily.
25 Q There are circumstances where from a rear end, from a

1 rear end hit like this there can be frame damage you will not be
2 able to see without doing disassembly?
3 A It makes sense, but it's not my work. I don't do that.
4 I'm an engineer.
5 Q Did you ever go and get the paid bill after the work
6 had been done, after they took the cars apart, after they looked
7 under everything in person and inspected by the mechanics who
8 fixed it?
9 A It's part of my practice that I ask for that a hundred
10 percent of the time. I very rarely get it.
11 Q You didn't get it here?
12 A No.
13 Q That would be the best thing to use, wouldn't it?
14 A I disagree.
15 Q You will rely on an estimate, not what actually was
16 fixed?
17 A I can only rely on material I'm provided.
18 Q Do you know what percentage of the time the estimate
19 that's prepared by someone who is employed by someone that
20 defends lawsuits is exactly perfect?
21 A I never seen a scientific study of that.
22 Q There can be an incredible variation, isn't it the job
23 of someone defending a lawsuit to minimize the amount paid?
24 MR. DUER: Objection.
25 THE COURT: Sustained.

1 Q Do they have a motive to not -- does someone who is
2 defending a lawsuit and employed by someone defending a lawsuit
3 have a motive to minimize the damage in an accident?
4 A I have no idea.
5 MR. DUER: Objection.
6 THE COURT: Sustained.
7 Q Is it a fair assumption to make?
8 A I don't have an opinion. It's out of my field.
9 Q The laws of physics apply to shooting pool?
10 A Certainly.
11 Q And if you lineup four balls and you hit ball one into
12 2, 3 and 4, the ball that goes the furthest is the first one
13 usually?
14 A I disagree. It depends on how you set it up.
15 Q If there was a way to have a square ball and you set
16 them up perfectly in line so they hit even, you have an even
17 hit, it's bumper to bumper to bumper, correct?
18 A Unlikely to be that perfect but the best information we
19 have.
20 MR. DUER: Objection.
21 Q This accident was close to that?
22 A With the information that I have, I assess this
23 collision as being essentially aligned.
24 Q I want to read to you, do you know whether or not the
25 break on car one was depressed when it was struck by car two?

1 A My recollection of testimony is that the driver of the
2 car one, the Imran vehicle testified that she had her foot on
3 the brake at the moment of impact and as her body came back her
4 foot came off the brake.
5 Q That's how you remember the testimony?
6 A No, there is no testimony right after, in the tenth of
7 a second of the impact, the testimony was that her foot was on
8 the brake at the time of the impact, which is reasonable. And
9 no matter what people remember and no matter what people think,
10 when you get hit from behind and your body moves back, your foot
11 comes off the brake.
12 Q The testimony is that her vehicle got pushed 30 to
13 40 feet.
14 A Issue that testimony.
15 Q Did you calculate for that to confirm or deny it. If
16 it's confirmed, then you can use that to calculate how hard the
17 force had to be to initiate the moving forward?
18 A That's very wrong, you cannot do that.
19 Q In a crash test that you compare this to, you say that
20 in the crash test you compare this to, the struck vehicle, the
21 CRV that's hit from behind in the crash test, the brakes are not
22 on, it's a neutral and there is no foot on the brakes, right?
23 A I would have to refresh my memory of the set up. I
24 have the protocol to do that. Essentially it should be that way.
25 Q That's not the same as this accident, is it?

1 A Yes, in an engineering sense, in order to compare those
2 crash tests, it is the same because the foot comes off the
3 brake. But in the hypothetical that the foot did not come off
4 the brake, and hypothetically, you can have the brakes locked
5 up, remember, Delta-v is how fast the car jumps forward when hit
6 from behind. If the brakes are locked up, what does that do to
7 the Delta-v all else equal, it will reduce it, and make it a
8 less severe crash.
9 Q And there was under ride here and the bumpers did not
10 match each other?
11 A Yes, and that reduces the severity of the crash.
12 Q Did you calculate for a Delta-v somewhere?
13 A Delta-v?
14 Q Yes.
15 A As I testified earlier, and by Delta-v, I understand
16 the time that it took for the impact to happen. And so I
17 reviewed hundreds of crash tests. In this speed range, below 20
18 and 15 miles per hour, it's remarkably similar that the crash is
19 essentially over in a couple of tenths of a second, 1, 2, a
20 little over 200 milliseconds, that is it. It doesn't change
21 much. The Delta-v from that standpoint is about that, that's
22 why the Delta-v, which is a change in velocity gives you
23 acceleration. Which is what we really care about.
24 Q Delta-v is the amount of time it takes to be to
25 transfer from one vehicle to the other vehicle, correct?

1 A You can define your Delta-v however you want.
2 Q That's how long it takes the energy to move, what is
3 happening, the energy is moving from the striking vehicle into
4 the struck vehicle. There is energy being transferred?
5 A Yes.
6 Q And the reason we have energy absorbing bumpers is
7 because the energy absorbing part of the vehicle spreads the
8 time to transfer the energy out?
9 A You got that wrong. I mean there is some degree bumper
10 observing energy to do that but when you have an under ride
11 override --
12 Q I was speaking not here, Doctor, and when there is
13 bumper to bumper contact, and specifically energy absorbing
14 bumper to energy absorbing bumper, the time is slowed down
15 because of that energy absorption. So it's spreading out the
16 time which the pulse of energy moves into the struck vehicle?
17 A What you are saying would be true if you were comparing
18 an energy absorbing bumper to non-energy absorbing bumper. In
19 this scenario where we are missing the bumper, your argument
20 reduces the severity of this crash as I have been talking about.
21 Q Because it makes the energy transfer faster because
22 there is nothing absorbing the energy between the two striking
23 vehicles?
24 A Opposite. We are talking about transferring energy
25 into the lead vehicle. That energy takes two forms, one part of

1 that energy is going to crush the vehicle and the other part of
2 the energy will move the vehicle forward. If you buy an
3 expensive car, typically, and it's in a relatively low speed
4 crash, you might be amazed at how much damage there is. You
5 hear about crumple zones and what we are talking about here, we
6 have energy crushing and some energy accelerating. When we have
7 the bumpers missed like we did, we crush the hood, bend the hood
8 up and those are soft structures and they take a while to bend
9 and in the parlance of engineering, we slowed down the crash
10 pulse the way you are talking about energy absorbing bumper.
11 This crash had a slower crash pulse, this one is actually on the
12 slow end because of the way the vehicles came together. So from
13 the standpoint of the occupant by comparison from bumper to
14 bumper, from the standpoint of occupant this is much less
15 severe.
16 Q Doctor, did you measure any of the damage to this
17 vehicle, did you measure any of the crushed damage involved?
18 A Did I see the vehicles?
19 Q Yeah.
20 A No.
21 Q That would be important for you to see them and take
22 measurements to calculate how much crushed damage there was?
23 A In this particular analysis, although sometimes I use
24 the magnitude of crush in this analysis, I didn't. If the case
25 where there are no vehicles available which is the case with

1 this lawsuit, none of the vehicles were available for me to
2 personally inspect. I have to look at the data I do have and
3 one of the first things I do is say, do I have enough data to
4 come to an answer in this analysis to a reasonable degree of
5 professional certainty. If I don't have the data, I call the
6 person who wants me to do the analysis and I say I cannot help
7 you on this one. If I have the data, I perform the analysis.
8 In this case I had plenty of data to do that.
9 Q Doctor, how did you come to the conclusion in 2010
10 Honda Civic and a 2000 Ford Focus were substantially similar to
11 each other. Is there a weight difference?
12 A There is an engineering comparison. There is a weight
13 difference, 200 pounds.
14 Q What percentage is that? Which vehicle weighs more?
15 A The Honda.
16 THE COURT: Compound question.
17 Q The Honda weighs more?
18 THE WITNESS: I will get my data.
19 Q That's between 5 and 10 percent.
20 A Ford Focus, I recall it being a 200 pound difference,
21 is that right?
22 Q What is the weight of the Focus?
23 A 274 pounds.
24 Q 210 pounds, 2564 for the Ford, right?
25 A Some calculations include the weight of the passengers,

1 so if you are reading off my calculation.
2 Q So it's more than that because there is a passenger in
3 it?
4 A What I'm saying --
5 Q Is more?
6 MR. DUER: Objection.
7 A What I'm saying, whatever calculation I'm doing at the
8 time, if I'm the calculating Delta-v with no -- if I'm
9 calculating Delta-v with regard to occupant in vehicles, I do my
10 best to get the weights of the occupants and include them in.
11 Q With the damage to the 2000 Ford, you couldn't find a
12 2000 Ford that was crash tested, you relied on a 2008 crash test
13 for the Ford, to compare the damage?
14 A I did get a 2008 Ford Focus crash test because they
15 were available, as it happens every car is crash tested, if a
16 car is essentially the same from year to year.
17 MR. IRWIN: Objection, beyond the scope.
18 THE COURT: You want a yes or no?
19 MR. IRWIN: Please.
20 THE COURT: Yes or no.
21 MR. IRWIN: I have 28 minutes left.
22 THE COURT: Yes or no.
23 A Doctor, when you did this major decision to use the
24 crash test property damage estimate, which by the way the crash
25 test, that was conducted by a group of people who work for

1 people who defend lawsuits, they perform natural crash tests
2 that you rely on.
3 MR. DUER: Objection.
4 THE COURT: Can I have a sidebar?
5 (Whereupon, an off-the-record conference was held
6 between all counsel and the Court at the sidebar out of the
7 hearing of the jury.)
8 (Whereupon, the following occurred in open court:)
9 THE COURT: Sustained.
10 Q How did you go about deciding it was acceptable to
11 compare a 2008 Ford Focus crash test and the property damage
12 estimate here with each other?
13 A First of all, let's be careful because the 5.7
14 Delta-v --
15 MR. IRWIN: Withdrawn.
16 Q Doctor, isn't it true you used the vehicle year and
17 model interchange lists, sisters and clones, domestic and import
18 makes, 1974 to 2009 to decide that it was acceptable to use the
19 2008 crash test data for the Ford Focus and compare it to the
20 2000 Ford Focus crash that was involved in this accident?
21 A I find that list to be reliable.
22 Q Yes or no?
23 THE COURT: I think the answer is yes.
24 Q Yes or no?
25 MR. DUER: Objection.

1 Q Yes or no?
2 A I did use that list.
3 Q And you find that reliable?
4 A In general find that list reliable.
5 MR. IRWIN: Can we have strict instruction to yes
6 or no or I cannot answer?
7 THE COURT: The jury and I can leave you can yell.
8 When I run this court, especially now, when every minute
9 counts, he is allowed to give his answer.
10 Next question.
11 Q Doctor, this is compiled by a company called Scalia
12 Safety Engineering, yes or no?
13 A Yes.
14 Q And, Doctor, there is a preamble of sorts or a warning
15 of sorts, yes or no, before you receive the actual data, yes or
16 no?
17 A That is my recollection.
18 Q And can I read to you, often, the degree of change is
19 arguable, if you believe some of the manufacturers their cars
20 are all new every year whether to start a new base year is a
21 judgment call and you may disagree. When there are changes like
22 these, the remarks will generally restyle in some form or
23 another. Do you agree that's what it says, yes or no?
24 A I have no recollection that's what it says.
25 Q May I show this to the doctor to get a yes or no?

1 THE COURT: Okay. Look at it. The question is?
2 Q Is that what it says, yes or no?
3 A It says a lot more.
4 Q Yes or no and can I have it back, you can answer
5 whatever questions.
6 THE COURT: He will have two minutes for redirect.
7 MR. IRWIN: Can I have it back?
8 THE COURT: And by the way, it is not in evidence.
9 Q Doctor, is this something you relied on here and you
10 read the first part of this before you made your decision?
11 A Absolutely, it's industry standard I use it.
12 Q Please allow me.
13 MR. DUER: Objection.
14 Q The standard disclaimer, I do not in any way guarantee
15 the accuracy of these lists, some similarities represent my own
16 estimate and some of the older years are from memory. Most are
17 called from specification tables which may contain inaccuracy on
18 their own.
19 Do you recall reading that part of the warning
20 preamble to what you relied on when you decided to use the 2008
21 crash test data and call it the same as the 2000 that happened
22 to this vehicle?
23 MR. DUER: Objection.
24 THE COURT: I will allow it.
25 A I dispute the use because my number is it did not use

1 that crash test. I did refer to that crash test. It was part
2 of the validation and sensitivity part of my work, the 5.7
3 number did not come from that. That being said, I rely on that
4 list. I consider it reliable. It's industry standard and every
5 one I know in the field that does engineering accidents,
6 reconstruction for plaintiff and defendant and both as do I --
7 MR. IRWIN: Objection.
8 THE COURT: I will allow it.
9 Q So, Doctor, you read the part where I said that it may
10 say restyle, right?
11 A I read that.
12 Q And restyle, according to the author of the list that
13 you relied on could mean that there is significant changes and
14 insignificant changes, correct?
15 A Could mean, I don't know.
16 Q According to what I read to you by the author, the word
17 restyling could mean insignificant changes or significant
18 changes, right?
19 A What the author is saying is this is the best
20 information available and I believe that to be true.
21 Q When there are changes like these, the remarks column
22 will generally say restyle in some form or another, often the
23 degree of changes are viewable. If you believe some
24 manufacturers, their cars are all new every year, whether to
25 start a new base year is sometimes a judgment call and you may

1 disagree.
2 MR. DUER: Objection.
3 Q That's what we agreed. It says before, right?
4 THE COURT: Normally I would sustain the objection
5 for the sake of what we are trying to move the case on, I'm
6 allowing it. How do you like that? You can answer it.
7 A Actually, if the question is that's what it says, I
8 don't dispute.
9 Q Heads up or a warning if something is restyled there
10 may be significant changes, insignificant changes and it's a
11 matter of opinion as to whether or not that's what happened and
12 this doesn't reflect that, it tells you it was restyled?
13 A To answer your question, I do consider that to be a
14 heads up. It's the standard heads up in engineering. Any time
15 you have data, you evaluate the source of the data and if the
16 data has variability into it, you need to assess it. It is
17 simply reading the caveat of someone that doesn't want to get
18 sued. It's understanding if it is wrong, how could it be
19 wrong. Most importantly, for my purposes, how much could that
20 affect my final opinion. I was not able to go through the
21 sensitivity and validation in detail that I performed in this
22 case. I have done that. In this type situation it is
23 absolutely included in the scientific method of how I practice.
24 Q To a reasonable degree of engineering certainty, what
25 differences -- withdrawn.

1 It says restyle 2005 for the Ford Focus, correct, yes
2 or no?
3 A I have it in front of me.
4 MR. IRWIN: Can I hand it to the doctor and
5 refresh his recollection?
6 Q It says restyle, correct?
7 A Ford Focus.
8 Q Is that a yes?
9 Do you know in what way it was restyled, yes or no,
10 please.
11 A I know enough, yes, I know enough.
12 Q And so you went and compared the 2000 to 2008 and took
13 measurements and have the data, can you show us the data you
14 relied on?
15 A I have some data. When I referred earlier to the
16 height of the bumper with the Ford Focus --
17 Q It just has to do with the bumper, we talked about it?
18 A The engineering parameters I used in this analysis I
19 pretty much already talked about and the overall design of the
20 car, height of the car, weight of the car, those are the most
21 important things for me. In this particular case, whether or
22 not it had a sun roof would make no difference.
23 Q The property damage estimate for the Ford Focus here,
24 do you have that, can you pull it out for me?
25 A I had two of them and I want to make sure which one I'm

1 looking at.

2 Q The total amount of money that it cost in the estimate
3 for the Ford Focus's damage was how much?

4 A Well, there is two estimates, and one estimate reflects
5 that that car had a lot of prior damage to it, and so, and there
6 is another estimate that covers the rear crash damage in this
7 particular incident and the front crash both in the same
8 estimate and where the rear crash was more substantial and it's
9 like $5,000.

10 Q And that's to a vehicle that was 12 years old at the
11 time of the accident, right?

12 A If it's a 2000?

13 Q Yes.

14 A Doing the math, sounds right.

15 Q And the 2008 vehicle, how much was the cost to repair
16 the estimate?

17 A $588.

18 Q That's for the Ford Focus 2008?

19 A Right, and to do apples to apples comparison, that
20 number is only for the front and it's a dedicated bumper
21 contact.

22 Q The person that did the property damage estimate here,
23 their job was to take photographs of everything that was damaged
24 in the accident, correct?

25 MR. DUER: Objection.

1 THE COURT: I will allow it.
2 A I don't know their job.
3 Q You know who they work for?
4 MR. DUER: Objection.
5 THE COURT: Sustained.
6 Q Without saying who they work for, you know who they
7 work for, correct?
8 MR. DUER: Objection.
9 A I don't know who signs their paycheck.
10 Q Are you saying that you don't know if it was their job
11 to take photographs of every hard piece of evidence you saw,
12 they may not have taken photographs of all of the damage?
13 MR. DUER: Objection.
14 THE COURT: Sustained.
15 Q Do you know photographs that were taken of --
16 A I believe I reviewed every photograph taken and I know
17 what is in the photographs, I have copies, and I can look at
18 them if you need me to but that's all I know.
19 Q Doctor, isn't it true that there was damage to the hood
20 of this vehicle, the hood?
21 A Certainly, I discuss that in detail.
22 Q Was there damage to the hood on the Honda Civic?
23 A Of course.
24 Q Can you show me where the property damage estimate it
25 says in the Honda Civic they prepared the hood?

1 A Of course.
2 Q How about the roof of the car, was there damage to the
3 roof of the car?
4 A It might be quicker to show you the picture again.
5 Q Was there damage to the roof of the car in the 2010
6 Honda Civic crash test?
7 Let's talk about the roof, was there damage to the roof
8 in the 2010 crash test of the Honda Civic against the Honda CRV?
9 A Let me get the crash test.
10 Q Was there damage to the roof in the 2008 Ford Focus
11 crash test?
12 MR. DUER: Two questions.
13 A Ford Focus there is no roof damage documented.
14 Q There is a photograph of the room here that's in
15 evidence for the Ford Focus. It was not taken for no reason,
16 was it?
17 (Handing.)
18 THE COURT: Objection sustained.
19 Q That's a photograph of the roof, right?
20 COURT OFFICER: Witness being handed what has been
21 marked as A.
22 A That appears to be the back of the roof. The backside
23 of the roof. It appears to be, it's hard because it's zoomed in
24 extremely.
25 Q There is a photograph of the window that may look like

1 it was spattered a little bit, you read the deposition
2 transcripts of everybody in this case?
3 MR. DUER: Objection, is there a question,
4 correct.
5 A I listed them earlier, I believe the number was five
6 and whether or not that's every deposition that was taken, I
7 don't know.
8 Q And one of them was the defendant in this lawsuit?
9 A Yes.
10 Q And he said how much he believed his vehicle weighed,
11 right?
12 A I recall seeing that. I recall seeing that.
13 Q And you did an accident reconstruction data form you
14 fill out, correct?
15 A That's something that staff does in the beginning of a
16 case, yes, that's our practice.
17 Q And under you put unknown for the weight of his
18 vehicle?
19 A At the point of analysis that that was filled out it
20 probably was unknown.
21 Q You have the deposition transcript and he said it was
22 13,000 pounds fully loaded?
23 MR. DUER: Objection.
24 THE COURT: I will allow.
25 A In that form that may have been filled out before we

1 had the deposition and before anyone read it.
2 Q You had the weights of the other vehicles but not his
3 vehicle, correct?
4 A If you say so.
5 Q Can you put it in front of you? I'm not trying to make
6 you guess, it's your report.
7 A My report is my report.
8 Q Doctor, your job is to collect data and analyze data,
9 so take a look at the data?
10 A Okay. Looking at that form.
11 MR. IRWIN: May I have them marked?
12 THE COURT: Are they something you exchanged?
13 MR. DUER: They have never been exchanged, never
14 seen them.
15 THE COURT: Not being marked.
16 Continue cross. As a matter of fact, you have
17 three minutes. I'm giving Mr. Duer two minutes?
18 Q You put unknown for the weight of the vehicle, Ford?
19 A At the time it was filled out it was unknown.
20 Q And then you went on yes or no, it was not filled out,
21 you bent, you research vehicle 1, 2 and 3 and calculated the
22 weight of the occupants and how much the people weighed,
23 correct, but it's unknown for vehicle four the defendant's
24 vehicle, right?
25 A I'm not sure --

1 THE COURT: Yes or no?
2 A Part of his question I can say yes to. I don't know
3 how far I took vehicle three. I didn't need it when I found out
4 I got the analysis.
5 Q You have 4,470 pounds from Edmonds.com for vehicle
6 three, I'm not making the numbers up.
7 A No, you are not.
8 Q If you went to Edmonds.com to get the vehicle weight, a
9 website is reliable for you, for vehicle weight, yes or no?
10 A Yes or no?
11 Q You did it here, it say it's not reliability, your own
12 data is not reliable, you are agreeing with me, right, I'm
13 running out of time?
14 THE COURT: Problem with you right now is you are
15 giving your summation. If you ask questions, just simple
16 questions, you will get answers. If you go on run on
17 sentences, trying to make a point without having him answer,
18 that's your summation. You have two minutes.
19 Q Do you consider Forbes website to be reliable for
20 weights of their own vehicles?
21 THE COURT: Yes or no?
22 THE WITNESS: I don't know.
23 Q Ford motor companies website for 2002 super duty F 450,
24 do you consider that to be reliable?
25 MR. IRWIN: Can I show it to the doctor?

1 THE COURT: Yes, show it and answer yes or no or
2 can't answer.
3 A I don't know because I look at multiple sources of
4 data.
5 Q Would you be surprised if the weight of the 2002 super
6 duty F 450 was --
7 THE COURT: Where are you reading it from?
8 MR. IRWIN: Ford. Com.
9 THE COURT: Is it something in evidence?
10 MR. IRWIN: I'm asking him.
11 THE COURT: I want to know is that in evidence,
12 yes or no?
13 MR. IRWIN: This is not in evidence.
14 THE COURT: Sustained. You have another minute.
15 Q Doctor, how much did you investigate the weight of the
16 vehicle four?
17 A Not at all because I did not use that weight in my
18 analysis.
19 THE COURT: He gave you your answer.
20 Q Did you ever calculate the force exerted by vehicle
21 four itself?
22 A I have no need to do that.
23 Q It was well over 10,000 pounds, 13, 15 or more?
24 A That's a weight not a force.
25 Q It was going at least 15 to 20 miles per hour?

1 A I know what the testimony is.
2 Q You didn't bother to try to calculate that at all?
3 A I did an analysis.
4 THE COURT: Yes or no?
5 A I did not calculate anything based on the force of
6 vehicle four, I didn't need to.
7 THE COURT: Mr. Duer, your turn.
8 REDIRECT EXAMINATION
9 BY MR. DUER:
10 Q Dr. McGowan, many of the questions that were asked of
11 you, can you answer those questions with a simple yes or no
12 answer?
13 A No, I would have if I could.
14 Q Did you need to know, did you need to look at all four
15 vehicles to perform your analysis and form your opinion?
16 A As I said, I was able to get a number to a reasonable
17 degree of engineering certainty, 5.7 and I told the jury exactly
18 how I got that number and so I had everything I needed to get to
19 that number. I did not need to calculate the vehicle four and
20 vehicle three crash because as I said before, once you have a
21 certain amount of energy impacting the back of the CRV, that is
22 of issue here. It doesn't matter how you get there; big truck
23 going slow, smaller car going fast can result in the same amount
24 of energy from the standpoint of the occupant sitting in that
25 car. It doesn't matter, that's physics, that's engineering.

1 There are many variabilities and ways to do an analysis. All I
2 said is this is how I did this analysis and all of the stuff we
3 have been talking about is on things that didn't figure into the
4 analysis at all, the 2008 Ford Focus, the weight of the Ford.
5 As I described, in another case, I might have needed to use them
6 in a variety of ways.
7 THE COURT: That was a one minute answer.
8 Q Did you need to see the vehicles physically to form
9 your analysis?
10 A I did not in this case.
11 THE COURT: Is that it?
12 MR. DUER: Yeah.
13 THE COURT: Thank you, you may step down.
14 (Whereupon, the witness steps down.)
15 THE COURT: Mr. Duer, do you rest?
16 MR. DUER: Defense rest, your Honor.
17 THE COURT: We have 30 seconds. Tomorrow it's
18 important that you all please come on time, 9:15 because we
19 will have summation and charge and you will get to
20 deliberate, okay. So have a good evening, see you tomorrow
21 morning.
22 (Whereupon the trial was adjourned to June 11,
23 2015 at 9:15 a.m.)
24
25

1 SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF QUEENS : CIVIL TERM : PART CSCP
2 ---X
HALINA IMRAN,
3 Index No.
Plaintiff, 21083/12
4
-against-
5 Trial

6 R. BARANY MONUMENTS INC.,
RANDY R. BARANY,
7
Defendant.
8 ---X
Supreme Courthouse
9 88-11 Sutphin Boulevard
Jamaica, New York 11435
10 June 11, 2015
B E F O R E:
11 HONORABLE MARTIN E. RITHOLTZ,

12 Justice, Supreme Court

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

14 For the Plaintiff:
IRWIN & POZMANSKI
15 233 Broadway
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16 BY: JOSHUA BRIAN IRWIN, ESQ.

17
For the Defendant:
18 PICCIANO & SCAHILL
900 Merchants Concourse
19 Westbury, New York
BY: PAUL DUER, ESQ.
20

21

22

23

24 LYNDA A. ROSS, RPR
Senior Court Reporter
25

1 (Whereupon, the panel of sworn jurors enter the
2 courtroom.)
3 THE COURT: Good morning, jurors, be seated. Every
4 one may be seated. At this time I will have the summations.
5 At this time we will have the summations for the first
6 summation I call upon Mr. Duer.
7 MR. DUER: Good morning. On behalf of myself
8 and Randy Barany, I want to thank all of you for serving on
9 this jury. I'm sure it's not easy to sit and listen for
10 your full attention for 6 to 7 hours a day. I want to say
11 thank you.
12 Now, I told you during my opening argument that
13 the evidence will show that Ms. Imran did not sustain a
14 serious injury. And that's exactly what the credible
15 evidence showed you. Let's talk about that evidence.
16 Now, the first witness to testify was Halina
17 Imran, and right away, right away there were inconsistencies
18 between the trial testimony and her deposition testimony.
19 Ms. Imran testified at trial that she turned around after
20 hearing the first impact and she saw the impact between her
21 vehicle and the vehicle behind her, but she testified at her
22 deposition that she didn't remember that.
23 She then testified about her body movement and she
24 testified at trial that after the impact, her body went
25 back. She was turned to the side. She went back and went

1 forward and struck her knee on the dashboard. That's what
2 she testified here at trial. And this testimony about the
3 knee striking the dashboard was even used by plaintiff's
4 doctors to try to explain why the knee hitting the dashboard
5 would make it more likely that she would sustain a back
6 injury here and it was used. That testimony was used to try
7 to discredit Dr. McGowan for not considering it in his
8 analysis.
9 Her deposition testimony was read to you on this
10 issue, this was read to you about her body movement and
11 whatever contact the people made with the vehicle. Page 45,
12 line 12, taken from Ms. Imran's deposition testimony
13 February 4, 2014, when you went forward, did any part of
14 your body hit the dashboard?
15 "ANSWER: My hand just stopped.
16 "QUESTION: You braced yourself on the dashboard?
17 "ANSWER: Yes.
18 "QUESTION: With both hands?
19 "ANSWER: Yes.
20 "QUESTION: Other than that, did any part of your
21 body come in contact with any part of the inside of the car
22 when you moved forward, the second movement, the back and
23 forward?
24 "ANSWER: No, there was never any testimony about
25 her knee striking the dashboard before coming into trial and

1 developing this new theory.
2 Next the trial she identified the photo of the two
3 cars in contact with one another and she testified at trial
4 she got out of the car at the scene and saw the two vehicles
5 in contact with one another. That's not what she said at
6 her deposition. At the deposition she testified she didn't
7 remember if she got out of the vehicle before her sister
8 moved it to Jefferson, different answer than at trial, 16
9 months later. She is saying this. At trial she testified
10 that the police came before the ambulance at the deposition,
11 the ambulance came before the police. Regardless, she
12 claims she was experiencing pain and she decided to go home
13 after the accident rather than go to the hospital. Now she
14 claims she wanted to go to the hospital but she had to be
15 home because of the kids. I'm sure she was really in pain.
16 Her sister would have gone home and watched the kids while
17 she went to the hospital. That's not what she did, she went
18 home in the car that they were driving. They get home and
19 they decide they want to go to the hospital. So they go to
20 Wyckoff Hospital, allegedly. There is no evidence that they
21 ever went to Wyckoff Hospital that evening and Ms. Imran
22 testifies that they get there and they stay 15, 20 minutes
23 and it's too crowded so they are worried about the kids and
24 they want to get home. At her deposition she testified
25 about this and I read this and that was at page 65, line two

1 of her deposition:
2 "QUESTION: What happened at Wyckoff Hospital?
3 "ANSWER: Way too many people and there was no
4 parking so they went home, nothing about kids. Now we
5 learned that Ms. Imran did not seek medical treatment for
6 another ten days before she went to the physical therapy
7 facility that she apparently learned of from a police
8 officer that was giving them a parking ticket.
9 Now, according to her sister's deposition
10 testimony, they learned of the physical therapy place from a
11 friend of her sister's. Now, we learn from Miss Orszulak
12 that what she meant when she said a friend of hers, she was
13 actually talking about that same police officer that was
14 writing them the ticket and that they now become friends
15 since that day. Don't you think common sense that that
16 would have been something that went into the answer, the
17 both of their answers that Ms. Imran would have testified,
18 you know, that they learned about it from the police officer
19 and now they are friends with the police officer or from
20 Miss Orszulak that it was a friend of hers and the friend of
21 hers happens to be a guy writing a ticket and then they told
22 her about it and became friends after. There is two
23 different versions of this because it is not true.
24 Now, before we get to the ten days when she goes
25 for the treatment, let's talk about the ten days, she

1 testified that she felt pain during those ten days like she
2 was hit by a baseball bat. During the ten days she don't go
3 to the doctor, she continues on with her usual activities.
4 She vacuums the house, goes to the grocery store with her
5 sister. Remember she testified that her sister carried all
6 of the bags for her, but that's not what she said at her
7 deposition. If you recall I read from her sister's
8 deposition, and you know the sister she brought a lawsuit
9 from this accident as well which has since resolved, and her
10 sister testified at the deposition that she needed help
11 herself with the groceries. Her sister responded to that on
12 the stand. She said well, my sister needed to help more
13 than her. She helped her. It's easy for her to say that
14 now.
15 Miss Imran during the first ten days and then they
16 finally get to the ten days and she goes to the place
17 referred by the police officer and she gets examined. You
18 recall this is a facility on Flatbush that she couldn't tell
19 us what the name of that was and that was interesting
20 because Dr. Gutierrez, who worked there, couldn't tell us
21 the name of the facility either. And she goes there and
22 what will happen on the first visit, she was given business
23 cards for her return at the physical therapy place. Right
24 away the litigation of the physical therapy, she testified
25 that she now began a course of physical therapy 3 to 4 times

1 a week for the next six months. Even if we assume it was
2 three types a week for six months, that will work out to 78
3 business days and you can go through the physical therapy
4 records and you will see 35 visits in there, less than half
5 of what she testified to 13th May, 3rd of July, 3rd August,
6 6th September, 3rd October is not three times a week. Not
7 even close. It's not even two times a week. The you heard
8 that the physical therapy session sometimes last as little
9 as 15 minutes and they were helping her.
10 Next, Ms. Imran is examined by the Dr. Gutierrez.
11 And you heard from Dr. Gutierrez, he testified he was
12 practicing several different areas of medicine, from Brazil,
13 he went to medical school in South America, and he had
14 several specialties, plastic surgery that you recall, wrote
15 articles about breast implants, and he didn't know the name
16 of the facility on Flatbush that he was at. We learned that
17 he saw Ms. Imran that one time on May 2, 2012 and the one
18 time depending on whether or not you believe that he
19 performed the nerve conduction test that you heard about
20 that of course has his name on it. He said that he didn't
21 do it.
22 Anyway, in the exam on that day May 2, range of
23 motion restrictions, now, neck, back, shoulder, knee, hip,
24 the parts of the body she was knew specifically with regard
25 to lumbar spine, he said he found range of motion, muscle

1 spasm, we had to agree, tender point at L4/L5 S1 which
2 Dr. Klein pointed out any doctor knows those are the most
3 likely levels to show up on the MRI and then straight leg
4 raise test possible bilaterally, as we know, like the range
5 of motion is completely controlled by the patient.
6 This is the part we have the significant
7 differences. This is what they are claiming is injured, the
8 lumbar spine. And the way I read this report is if you have
9 choices and everything is on a report before she does the
10 exam, you have choices and some things you check it off and
11 circle it and if something is negative you leave it alone,
12 and you have straight leg raising test, all of these tests,
13 heel to toe, not checked off.
14 Now, he said he didn't do them. He doesn't
15 remember if he did them, three years ago, over three years
16 ago at one time he seen a lot of patients since then. I
17 don't expect you to remember if you did this or not. He had
18 no idea if he did or didn't do it. The point is it doesn't
19 make sense.
20 The argument was made, it may have caused pain if
21 they were positive. That's what the test is. You do the
22 test, if there is pain, that's a positive finding. To say
23 that the test was not done because it may cause pain doesn't
24 make much sense. There is nothing there to indicate nerve
25 root therapy. We go to the end of this report and you get

1 this paragraph about disability and prognosis that you heard
2 about. And it says it is my opinion, based on the history
3 of the patient's symptoms, diagnosis and examination finding
4 that the above noted injuries were sustained/aggravated --
5 no, not sustained or anything like that in the accident that
6 occurred on 4/17/12 and the disability wrote in 4/17/12, and
7 the disability resulting from it is slash maybe of a
8 temporary, permanent nature. You have a choice of those,
9 maybe, temporary, permanent. The prognosis for complete
10 recovery is presently and there is a choice, cautiously
11 optimistic or guarded. Those are your choices. None were
12 circled, wrote the date, signed his name wrote the date at
13 the bottom. I asked him why didn't he circle it? His
14 response, maybe I was tired that day.
15 Now, let's go back to Ms. Imran. She goes for an
16 MRI of the neck, knee, shoulder and leg. Before that, she
17 had a lumbar X-ray which we learned had degenerative changes
18 and dextroscoliosis, which is not related to the accident.
19 The Doctor tried to say scoliosis is spasm, but
20 you can see, it says degenerative changes and scoliosis.
21 She has the MRI and all of the reports from the treating
22 radiologist. I will not go into much detail about the
23 shoulder and knee, there was not a lot of testimony that she
24 has pain in those body parts or treated for the body parts.
25 Mr. Irwin tried to argue the treating radiologist

1 said there was a fusion in the knee, so she must have struck
2 the knee on the dashboard, but Dr. Sapan told us there was
3 traces amount of fusion which was normal and she did not
4 testify on the deposition that she struck her knee on
5 anything.
6 The MRI of the shoulder showed degenerative
7 changes, tendinosis. I will not really get into that. MRI
8 of the neck was essential, normal, no disk problems or disk
9 pathology and then that brings us to the MRI of the lumbar
10 spine.
11 Ms. Imran had an MRI of the lumbar spine on
12 June 1, 2012, and that film was read by a board certified
13 neuroradiologist, Dr. Steven Hirschowitz.
14 He found there to be desiccation, this is who her
15 doctor sent her to, desiccation of all of the lumbar
16 intervertebral disks. So there is desiccation, drying out
17 of the disk, something that occurs over time, degeneration,
18 that's a degenerative condition, there is no evidence of
19 disk herniation or bulging at L1/2, diffuse disk bulges are
20 present at L4/5 and L5/S1, levels which impinge upon the
21 minimal bilateral facet hypertrophy which is present at
22 L4/5, S1. That's a degeneration condition, facet
23 hypertrophy.
24 There is degeneration right at the level she is
25 claiming she was injured, gallstone present that had nothing

1 to do with the accident. You would think her doctor would
2 tell her she had a gallstone. She testified she was never
3 told by anyone she had a gallstone.
4 The spine canal in normal limit, no lesions are
5 noted, foraminal narrowing is not identified, normal lumbar
6 lordotic curve is present, no evidence of loss of height
7 regarding the lumbar vertebral bodies, something that
8 Dr. Gerling finds the complete opposite. That's
9 essentially, you can see the report, it's marked in
10 evidence.
11 The next she sees, she testified that she saw
12 Dr. Gerling and Dr. Gerling referred her to Dr. Reyfman and
13 in reality we learn she saw Dr. Gerling first on June 20th,
14 and Dr. Reyfman first on June 11, 2012. Dr. Reyfman
15 attempted to clarify this inconsistency by testifying on
16 direct examination. He testified that Dr. Gerling, she
17 called Dr. Gerling's office and due to the 6 to 7 week wait
18 of Dr. Gerling, Dr. Gerling's secretary referred her to him.
19 When I questioned him on that, I asked him, you
20 know, do you remember that, do you know that, is it written
21 anywhere in the records? He changed his answer to not that
22 that is what happened, but that's what he assumed happened
23 and ultimately, he agreed he had no idea.
24 That brings us to Dr. Reyfman. Ms. Imran
25 testified that she saw Dr. Reyfman one time on June 11,

1 2012. According to Dr. Reyfman, he saw Ms. Imran a total of
2 four times, June 11th, January 7, 2013, February 13, 2015,
3 and then again as recently as a few weeks ago in May, 2013.
4 Ms. Imran did not remember seeing Dr. Reyfman since
5 June 20th, '12 when she alledgedly saw him a few weeks ago,
6 but you heard her testimony she never mentioned the recent
7 exams. It's odd that she would go for treatment there when
8 outside of that one injection, it doesn't seem to do
9 anything for her other than recommend injections that she
10 doesn't have and prescribe medicine she doesn't take. He is
11 a pain doctor. He injects and prescribed medication either
12 neither of which she seems interested.
13 Back to June 11th, and right on the first page of
14 his reports, he talks about imaging studies, see chart for
15 full report, full report I'm guessing is Dr. Hirschowitz
16 which said report, chart, report other than what we know he
17 reviewed from Dr. Hirschowitz, the treating radiologist.
18 And underneath imaging studies, MRI of the L5, S1 2012,
19 L4 led by L5, S1 disk bulge, this which is impinging upon
20 the thecal sac. If you read his reports that's what it says
21 throughout them. It never changes.
22 Let's Go to May 15th, 2015, MRI of the lumbar
23 spine 6/1/2012, L4/5, L5/S1 disk bulge. It's the same thing
24 L4/5, L5/S1 disk bulge impinging upon the thecal sac. It's
25 the same thing. But his reports, when it says MRI of the L5

1 spine never deviated from bulges. If he really read the
2 films himself and saw herniation like he said he did,
3 wouldn't that be in the report. If not, the first report
4 than the second report, third report, fourth report, no,
5 it's not there. He didn't have the films. When she first
6 came in he claimed he can log onto Stand Up MRI and review
7 it himself. There is no evidence of that. There is no
8 evidence he saw the MRI reports. And whose opinion with
9 regard to the reading of those films is a better one, board
10 certified neuroradiologist or pain management.
11 When Ms. Imran goes to see Dr. Reyfman for the
12 first time she rates her pain and back, neck and back a six.
13 Remember the back, the neck everybody essentially agrees the
14 MRI was negative. He reviews her systems, no numbness or
15 tingling or anything like that. He does a physical
16 examination and he finds, he says there is range of motion.
17 He says there is range of motion and then he does a
18 neurological test and he says that they show evidence of
19 nerve root compression, nerve compression, LASIK test and
20 Braggard's test. He also does tests on the cervical spine
21 as well and comes up with similar findings to indicate a
22 cervical route compression positive on right, Jackson
23 compression test positive on right. These are similar tests
24 done on the lumbar spine that all have positive findings and
25 we know there is no injury to the cervical spine.

1 You have to question the validity of Dr. Reyfman's
2 testing right there especially combined with what we learned
3 from Dr. Gerling when he did his own neurological
4 examination. Dr. Reyfman that same day gives her an
5 injection and tells her to come back in 2 or 3 weeks and she
6 never did until January 7, 2013. And she goes back the next
7 time to Dr. Gutierrez, sorry, before that she doesn't go
8 back to Dr. Reyfman until January, 2012. So next, what does
9 she do next, June 12, 2012, she goes back to Dr. Gutierrez
10 or someone doing tests in Dr. Gutierrez's name, a nerve
11 production study, patient 41 old female presents with lower
12 back pain. Why are they doing this test if they are not
13 testing for evidence of nerve compression or any nerve
14 problem with regard to lumbar spine. That's all it seems
15 she is having this test for. Findings, all nerve conduction
16 studies are within normal limits all. This is a normal
17 study. This is an objective test.
18 Now, there was testimony it's not a good test,
19 doesn't apply. Of course they will say that, if it had
20 positive findings, they would be waving it around. Next
21 goes to see Dr. Gerling on June 20th. We learn that
22 Ms. Imran was referred to Dr. Gerling by her attorney,
23 Mr. Irwin. And this is in evidence, you can see this,
24 referring physician's name and right above physician it says
25 lawyer. So her attorney sent her to see Dr. Gerling, not

1 another doctor.
2 Now, this was interesting, too, Dr. Gerling takes
3 a history and he puts in a history she hadn't worked since
4 the accident, but we know she was not working at the time of
5 the accident, so what relevance is it she has not worked
6 since the accident. He finds forward flexion 70, what he
7 considers to be normal 110. Every other doctor we heard
8 from except for Reyfman said normal is anywhere from 70 to
9 90 degrees, but even Dr. Gutierrez had to admit that 110
10 might be normal if the patient was an olympic gymnast. So
11 when he says 110, that's not what the normal range of motion
12 is for lumbar flexion.
13 Dr. Gerling then examines the musculoskeletal
14 system. He examines the musculoskeletal system and he finds
15 everything to be essentially normal, checks the joint, knees
16 and shoulders, range of motion, normal. It's in his report.
17 He then does a neurological examination and this is
18 important, you remember I asked Dr. Gerling, isn't it true
19 that any abnormality in strength and sensation in particular
20 parts of the body found in the neurological examination
21 provides most objective evidence of nerve root compression.
22 He disagreed at first and after he was familiar with that
23 website and then he had to agree with me once, he had to
24 agree that every one will eventually have degenerative
25 changes in their back and it is impossible to be walking

1 around with bulging or herniated disk and not know it. We
2 get to the part about the MRI, and he found MRI of the
3 lumbar spine, June 1, 2012, shows L5/S1 disk herniation with
4 extruded nucleus. There is high gloss with a foraminal
5 stenosis. Where is this coming from? No one has seen this?
6 Dr. Hirschowitz didn't see it? Dr. Klein didn't see it?
7 Nobody? It's not close to this.
8 You heard Dr. Klein, the reading from Hirschowitz
9 which said on a scale of 1 to 10 is a 1 or 2 and this is a
10 nine, this is not a subjective interpretation. This is a
11 blatant misrepresentation. There is no herniated disk with
12 extruded nucleus, the doctor said, and there was nothing
13 even those close to resembling that. Then they talk about
14 the foraminal stenosis. It's opposite of what doctor
15 Hirschowitz found. And not only that, these findings are
16 completely at odds with his own neurological examination.
17 Dr. Gerling did his own neurological examination. He found
18 that the gross neurological examination demonstrated normal
19 sensation. There is no numbness or tingling, motor
20 functioning, straight leg raise test is negative he said he
21 found it to be positive, when he does the neurological exam
22 he finds it to be negative; no pathologic reflexes,
23 everything was normal. There was no indication to have this
24 surgery, but he recommends it anyway. And one month later,
25 he tells her one month later, after she goes to her family

1 for her second opinion, she has the surgery and Dr. Gerling
2 describes, he said he preforms what he calls a minimally
3 invasive TLIF procedure and then he goes into his report.
4 He goes on to state, which he said she understood that she
5 understands the diagnosis of back pain can be challenging
6 and despite the fact she had very localized pain and
7 tenderness at that site, and marked reduction of activity,
8 including range of motion, it would still be uncertain as to
9 whether or not the L5/S1 was the absolute cause of her pain.
10 So, after 6 to 8 weeks of physical therapy, one
11 epidural injection, normal neurological examination and
12 discrepancy in the MRI, he is doing a surgery on a disk that
13 he cannot say for certain is the source of the patient's
14 subjective complaint of pain.
15 Now, he preforms the surgery, goes in and says he
16 sees the herniation. He has to say that to justify that he
17 did a surgery on a degenerative disk bulge with no
18 indication for surgery. Next she sees Dr. Gerling again
19 August 1, 2012, and according to Ms. Imran, that's the last
20 time she saw him. I read to you from her deposition. She
21 said she last saw him in the summer, 2012. I asked her on
22 the stand, she said since that she learned she saw
23 Dr. Gerling February, May, 2015, again, I guess she doesn't
24 remember those visits. I asked her when was the last time
25 you saw her, she said back then she didn't remember.

1 Apparently she saw her a couple of weeks ago.
2 Now, after that August 1, 2012 visit, she has a
3 few more physical therapy visits until May, after May,
4 that's it until January 7, 2013. She goes back to
5 Dr. Reyfman. At that time, Dr. Reyfman on his report says
6 disk bulge, no herniation, no mention of herniation in that
7 area. She tells him the last epidural she had gave her mild
8 relief which is contrary to what she testified to.
9 Interesting, there is a surgical history section in his
10 report, surgical history nor significant surgical history.
11 Now, he claims he knows about the surgery. In here, there is
12 the report of Dr. Gerling. We don't know when he received
13 that. If you read Dr. Reyfman's reports, May 15th, 2015,
14 surgical history, no significant surgical history. How can
15 you put that in a report if he knew about the surgery?
16 Now, when she sees him he recommends another
17 injection, despite also testifying that it would not be a
18 good idea to have another injection because the first one
19 didn't work. He maybe said something about if it wasn't for
20 the specific condition he did the first time, if it didn't
21 have scar tissue from the surgery, even though there is no
22 mention he knew about the surgery. Wouldn't that be
23 something you put in the report that you are recommending
24 another injection for that purpose as opposed to the initial
25 purpose? It says the same thing.

1 She goes back and sees him again in February,
2 2015. Then she says she reached a pain of four in her back.
3 Then she sees him again May 15th and that jumps to eight.
4 Mr. Irwin will argue that and I have to try to anticipate
5 what he will argue, he goes afterwards. I have to try to
6 anticipate what he does. I anticipate that he will argue
7 that the reason it jumped from a 4 to 8, in two and a half
8 months from mid February to early May, that disk bulge at
9 L4/5 turned into a herniation and he will try to say that
10 she had a CAT scan done in May which the radiologist said it
11 was a herniation in L4/5 and that's why the pain jumped. Is
12 that the likely reason, or is it a more likely reason that
13 the number jumped from 4 to 8 because she knew we were set
14 to begin trial on June 1, 2015. Use your common sense here,
15 please.
16 If she was really in that much pain on May 15th,
17 2015 when she went to see Dr. Reyfman, would she have gone
18 to the Poconos a week later for Memorial Day Weekend, a week
19 later like we learned. You heard Dr. Sapan's interpretation
20 on those films, the May, 2015 films and her testimony was
21 that the bulge is there, still a bulge at L4/5.
22 Dr. Reyfman, he has to try to tell you that the
23 X-ray was up of the back with the screws, that he saw there,
24 that there was a screw loose and that he can see it and she
25 will need a revision. When I challenged him on it, he said

1 he couldn't really say that. In fact, the radiologist who
2 reviewed that X-ray talks about, and it says the pedicle and
3 interpedicular distances are intact. There are no erosive
4 or destructive changes. They are trying to tell you that
5 the screws are loose so that you will award her money to go
6 have a revision surgery.
7 Now, we learned from Dr. Gerling recently that
8 Ms. Imran is now working, this was from the February exam,
9 February 18, 2015. First of all, Ms. Imran testified she
10 has not worked since the accident. She testified that she
11 needed help cleaning as a result of the accident. That she
12 cannot clean for herself as a result of the accident. What
13 do we learn on February 18, 2015, when she goes to see
14 Dr. Gerling?
15 "QUESTION: Are you currently able to work with
16 this problem?
17 "ANSWER: Yes, with difficulty.
18 Occupation, cleaning lady, part time. Not only is
19 she working but she is working doing a job that she
20 testified that she cannot do in her own home. What else did
21 we learn from this recent exam. In February of 2015 exam
22 and this is the first time I had an opportunity, you saw I
23 did not have this, she talks before the injection, she talks
24 about physical therapy. She testifies she stopped going to
25 physical therapy because it was not helping. Here she said

1 she went for physical therapy six months after the accident.
2 She stopped going because she was not going and family
3 reasons, not because it was not helping. She talked about,
4 you heard the testimony about the injection, she never had
5 another injection because it didn't help her, gave her three
6 hours relief I believe she said, and it was not much relief.
7 How about three days relief at 50 percent relief. So much
8 for it not working, for only working for three hours. And
9 why did she not do it again, not because it didn't work, she
10 didn't like it. So when Dr. Reyfman talks about awarding
11 future damages to go future injections, she is not going to
12 do it. Why did she go? In February and May, did she go for
13 treatment or did her -- was it because her attorney wanted
14 her to go there. You can go through this. May 7th, 2015 --
15 THE COURT: Let's start wrapping it up.
16 MR. DUER: Let's go back to Ms. Imran and her
17 testimony about things she said she couldn't do. In
18 addition to the cleaning, she said she couldn't do push ups.
19 She did 70 push ups a day before the accident, that's what
20 she testified at trial. At her deposition, she said she
21 used to do 70 sit ups a day. I asked her if she knew the
22 difference between sit ups and push ups. She said she did.
23 She said it was push ups she cannot do. At her deposition,
24 she was asked about the sit ups, how she did them and she
25 said no, push ups, I cannot do sit ups. The truth is she

1 doesn't do sit ups, push ups, we will never know the answer
2 to that because she gave two completely different answers.
3 She talked about her divorce and then attempted to
4 testify about a bad marriage and testified how she cannot go
5 back to Poland to see her mom. The Judge will give you
6 instructions about sympathy and these are things solely done
7 to elicit sympathy, what was the reality, the bad marriage
8 has nothing to do with the accident. She is currently in a
9 long term relationship with someone that sounds like a good
10 guy, good to her kids, helped raise her kids. What about
11 Poland? She cried she cannot go back to Poland to see her
12 mother. We learned depending on what you believe or said at
13 the deposition, Ms. Imran is either not been to Poland once
14 since 1992, which is 20 years before the accident or once in
15 those 20 years. She said 2010. Now in her deposition '92,
16 been in the US since' 92 continually. One time in 20 years
17 before the accident and she is crying because now she said
18 she cannot go back. She testified she cannot enjoy time
19 with her family. She testified at her deposition she went
20 to the Catskills and Poconos this past Memorial Day weekend
21 and she testified it takes her all day to vacuum. We
22 learned in the deposition she does two rooms, sits for 15 to
23 30 minutes and does the other rooms. Not all day. She
24 washes windows, carries groceries, which she said at the
25 deposition that she does in a few moments.

1 Mr. Irwin will stand up and ask you for a number.
2 What did he ask you for, seven figures, aren't you entitled
3 to open and honest answers from the plaintiff if she is
4 going to come in here and ask for that kind of compensation?
5 Shouldn't you at didn't minimum expect that? You didn't get
6 that, you got a base of answers, exaggerations. In a case
7 there is so little objective evidence, everything is
8 subject, subject evidence, complaints of pain, you know,
9 isn't credibility so important here?
10 You heard from the doctors, Dr. Sapan-Cohen. She
11 testified about those films. She showed those films to you.
12 I will not do that. You saw the films on the screen and
13 L5/S1, it was darker than the rest. It was dried out,
14 desiccated. It was dried out. There was no disk material.
15 If there was the disk material it would have lit up pressing
16 on the thecal sac. He will try to argue I think that
17 Dr. Sapan, you heard Dr. Sapan-Cohen and Dr. Klein and
18 McGowan, all IVY league educators, experienced in training,
19 do you think they will put that on the line to make an extra
20 $5,000 for coming to trial to give a positive report?
21 You heard the testimony of Dr. Klein. Dr. Klein
22 examined the plaintiff. He reviewed the films and the
23 records. He said this is a degeneration finding.
24 Dr. Sapan-Cohen, this is a degeneration finding. They
25 agreed with the treating radiologist, there were disk bulges

1 degenerative in nature. There was nothing here that was
2 caused by this accident.
3 Again, compensation for the doctors, Dr. Reyfman
4 got $6,000, Dr. Gutierrez got three, Dr. Gerling got
5 $16,000, Cohen, five, Gerling $7,500, McGowan, I didn't ask
6 him about that. I expected Mr. Irwin would, he did not, but
7 he was compensated, but not --
8 MR. IRWIN: Objection.
9 MR. DUER: Withdrawn.
10 You heard Dr. McGowan. It was a little, I guess,
11 rushed from what he would like. You heard his credentials,
12 you heard the test that he did, he did crash tests that
13 resembled this accident. He relied on studies. He has
14 obviously studied this area extensively, forces of impact on
15 the body, mechanisms of injury and he talked about things
16 like Delta-v and things of that nature. And we saw the
17 studies, the crash test and all of that and his analysis, he
18 determined he came to the conclusion that this accident
19 could not have caused the injuries that that plaintiff are
20 claiming here.
21 Again, Mr. Irwin, he will argue it wasn't the
22 same. You cannot say that. He never exactly duplicated,
23 did studies of similar nature, property damage estimates on
24 the crash test were different than the property damage was
25 here. The property damage on the crash test, of course, is

1 only dealing with the front, not the rear or any other part
2 of the car.
3 Now, finally, you will go back and deliberate and
4 you will be asked questions, did the plaintiff sustain a
5 significant limitation -- as a result, of a body part as a
6 result of this accident. No. There is no limitation
7 significant limitation as a result of this accident. Let me
8 do something else. Remember this, Dr. Gerling on May 7th,
9 2015, at his recent exam, he examines Ms. Imran forward
10 flexion FF, what he said was limited the first time he saw
11 85 degrees, that's by all of the other doctors, 85 degrees
12 out of 90. That's not as a result, certainly not as a
13 result of this accident. As a result of this accident, did
14 the plaintiff sustained permanent consequential use of body
15 organ or member, same thing, no, not as a result of this
16 accident.
17 Even if you believe she has limitations, which I
18 think that clearly permanent consequential, that finding
19 surely would contradict any testimony or go against any
20 testimony of there being a significant limitation or
21 consequential limitation, certainly five degrees out of 90
22 on forward flexion on the lumbar spine would not be a
23 consequential limitation and certainly not as a result of
24 this accident because the injuries that they are claiming
25 here, injury to L5/S1, most importantly was not caused by

1 this accident. It was a degenerative disk bulge, which as
2 we know, many people, and this comes from Dr. Gerling, are
3 walking around with disk bulges and herniations and do not
4 know it.
5 Ms. Imran's complaints of pain everywhere in her
6 body, goes for multiple MRI's, she said she has a bulging
7 disk at L4/5, S1 and next thing she is having surgery, two
8 and a half months later or three months later, if you get
9 past those questions, and I don't think you should, but if
10 you do, pain and suffering from past, future pain and
11 suffering, she is working, she goes to Poconos, Catskills,
12 vacation, all of this talk about boyfriend who she does
13 things with, she is enjoying her life. But again, you
14 shouldn't even get to that last question is about future
15 medical expenses, and all of that talk you heard about the
16 need for future revision surgery which you know is not true,
17 the pedicle screws, everything is intact, injections she
18 will never have, physical therapy that she said she didn't
19 stop going to physical therapy back in May, 2012, do you
20 think she will go now? Why? What evidence do we have that
21 she would never go? She doesn't need these things. She
22 will not utilize these things, but they are asking for it.
23 Finally, and again, I want to thank you all, I
24 believe that plaintiff has not satisfied the burden of proof
25 here proving that Ms. Imran sustained a significant

1 limitation or permanent consequential limitation as a result
2 of this accident and I believe the verdict sheet should
3 reflect that. On behalf of myself and Mr. Barany, thank
4 you.
5 (Whereupon, an off the record discussion takes
6 place at sidebar among the Court and Counsel.)
7 MR. IRWIN: May it please the Court, Mr. Duer.
8 When did it start becoming okay or required to say I'm
9 sorry? When did the strategy and a lawsuit to come court
10 and attack everybody you can personally, scrutinize
11 everything beyond anyone could believe, the big assumption
12 every doctor you see is not there to help you. They are
13 there to go through every test, right and torture you until
14 it's proven beyond a reasonable doubt that you were hurt.
15 MR. DUER: Objection.
16 THE COURT: Beyond a reasonable doubt, do not
17 mention an improper burden of proof.
18 MR. IRWIN: I apologize, beyond any doubt.
19 THE COURT: No, in this case it's a preponderance.
20 Let me talk about the burden of proof.
21 MR. IRWIN: Having your entire life and all of the
22 doctors' records scrutinized to a degree that who could
23 imagine having it scrutinized that way. Dr. Gutierrez when
24 he saw Ms. Imran sees her. The reason he is here is because
25 he was the first doctor that saw her. I had to go find him

1 after years and ask him if he would come into court. How
2 much more did he need? Then the X-ray that showed
3 dextroscoliosis which Dr. Gerling explained to you when you
4 get spasm in the lumbar spine, you get twitching of the
5 muscles and it will twist it a little bit and that's what
6 that is.
7 Dr. Gutierrez examines her and finds that her
8 knee, both knees hurt, her shoulders hurt, her upper and
9 lower back, she got thrown around by a truck that smashed
10 into a van, a car and another SUV and pushed them 30 to
11 60 feet into the intersection. Mr. Barany shows up he
12 didn't testify, he didn't say no, I didn't hit hard or push
13 the vehicles. No, an ambulance did not come. No, Halina
14 Imran did not get into an ambulance. No, she was not crying
15 at the scene, silence, nothing. He shows up today, Mr.
16 Duer's firm who goes and gets two of their favorite experts,
17 Dr. Sapan-Cohen has been testifying for that firm for ten
18 years. She tries to claim she is being compensated for her
19 time. She takes a half day from work, which she is getting
20 paid and gets this and she is trying to tell you she is
21 getting compensated for her time from work. Look at the
22 objective evidence, remember one thing, Halina Imran told
23 you on the stand she came here at 19, didn't speak any
24 English, took English classes for two years, when she came
25 here, you heard her testify on the stand, she never sued

1 anyone, never been an accident, never had her life
2 scrutinized, she never imagined what the inside of the
3 courtroom would look like, let alone a trial. Do you think
4 she was comfortable on the stand? She was crying on the
5 third question. Do you have kids, you don't think she was
6 nervous and upset and in pain sitting on the hard benches?
7 She was in the front row when we started, now the second row
8 because she has to lean forward on something, you can see
9 it.
10 MR. DUER: Objection.
11 THE COURT: Overruled.
12 MR. IRWIN: Should Dr. Gutierrez have done the
13 Braggard's test. Mr. Duer tries to argue that this is
14 because she was going to bring a lawsuit, listen, how does
15 she end up with the telephone to the physical therapy
16 facility? Her sister is about to get a ticket. At the time
17 of her deposition in 2014, a year and a half after the
18 accident, that police officer was still in contact with her
19 sister. So at the time of the deposition, he is a friend to
20 her, a friend. She got a card for me and her physical
21 therapy office. Are you going to go to somebody is
22 recommended by someone or are you going to call 88888 from a
23 commercial on the radio or go to someone that's recommended
24 and someone that handles this type of stuff and handles
25 these cases.

1 This is a big conspiracy, but at the same time the
2 sloppiest records ever. Does that make any sense? This is
3 oh, no, she got referred to her lawyer by a physical therapy
4 offer. Well, guess what, when you get hit from behind by a
5 truck going 15 to 20 miles per hour, that pushes four cars
6 into an intersection and you are hurt and you show up at a
7 physical therapy facility, you will probably need a lawyer.
8 Halina is not from here. She didn't go to high school here.
9 She doesn't know what these cases are like. She had no idea
10 what she was expecting in the future. She had no idea she
11 would end up here.
12 Dr. Gutierrez, was he thinking about that the
13 first day? Were any of the doctors thinking about that?
14 Were they preparing your records for Mr. Duer to put under a
15 microscope? No. Let's look at the objective evidence in
16 the case. To attack the plaintiff is the only defense
17 really when you look at the real objective evidence. You
18 didn't see this in front of you by Mr. Duer and these images
19 were not shown to you. Do you remember the DVD I played of
20 the surgery? You could see as clear as day.
21 Dr. Sapan-Cohen and Dr. Klein couldn't get the fact that a
22 circumferential disk bulge is circumferential even in the
23 front and the back. Do these look even? Does this look
24 even, pushing in here on these images? See it's pushing in
25 flat in the back and pushing in, pushing in, these are not

1 pushing in, these two are. You see them? Did
2 Dr. Sapan-Cohen say these are even? Did Dr. Klein, no. You
3 know it's one thing, you have a radiologist who knows.
4 Maybe he didn't look at the axial images and only a
5 sagittal. They are done in slices, you get slices through,
6 these are millimeter size structures, maybe the radiologist
7 was distracted. Maybe he read it three days later. It's
8 done on the first of June and read on the fourth of June and
9 there was an objection because I said the June 4, 2012 MRI I
10 accidentally read the date it was read three days later. So
11 they agree when its convenient, because we have Delta
12 Diagnostics, and this is in evidence, we have a joint
13 effusion. Sorry, suprapatellar effusion, which is right
14 behind the right knee cap. But this is not convenient to
15 Dr. Sapan. So for this report, which is Dr. De Marco, she
16 says Dr. De Marco, she said trace amount of fluid. He said
17 there is an effusion, there is fluid. He said sprain or
18 partial tear of anterior cruciate ligament. Sprains are not
19 degenerative. There is trauma here he thinks he sees. You
20 look at the shoulder MRI. Dr. Sapan had to admit after I
21 fought with her for how long, she had to admit that there
22 could be a tear in the shoulder. She couldn't rule it out
23 by looking at the film, right? Intrastitial tearing,
24 partial intrastitial tearing, she had to admit that could be
25 from trauma. It cannot be ruled out. Look at the report

1 from the radiologist who read the original film, he says
2 there is increased signal, in that consistent with partial
3 tear or tendinosis, but it's not convenient.
4 Cervical spine, it was not completely negative, it
5 was not negative. There is straightening of the neck for
6 muscle strain. And she has complaints there and they do
7 physical therapy there. If it's a bulge, it's the same in
8 the front and the back. Take that in the back, take it with
9 you. I will put a sticky on it.
10 She fills out this part of the record. She fills
11 out at the physical therapy facility which Dr. Gutierrez
12 said it said medical office in the front, because there were
13 a bunch of different practices, different doctors, when you
14 look at the records, rehabilitation center because they are
15 different, multi disciplinary, there is physical therapy,
16 acupuncture, physical therapist don't do acupuncture,
17 acupuncturist don't do physical therapy, so guess what,
18 those are different people, and they have different
19 companies obviously and they all treat whatever needs to be
20 treated.
21 You go through the physical therapy records and
22 take a look at these here. This one physical therapist
23 actually charted for you in real time Ms. Imran's complaint
24 and what the therapy did for her. Look at that them, these
25 are her complaints, this is in evidence. It's seven or

1 eight and with she walks in. The circle is not perfect.
2 The circle is not perfect, maybe it's in between 70, who
3 cares, what does that matter? When she leaves after
4 treatment six, you see improvement. When she leaves on each
5 visit and she is coming back the next day or next session
6 and she is pretty much lingering around 5 to 7 and there is
7 no progression or improvement with the pain going down and
8 it's consistent, you look all the way through, after the
9 surgery October, 2012, the best it is 5 or 6 when she walks
10 in, 6, 6, 6 after treatment 5, 5 or 6, 5 or 6. That's after
11 therapy. That's after being treated.
12 Now, she ends up with Dr. Reyfman for injections.
13 You don't do more than one injection when it doesn't help.
14 This is before surgery and, you know, you are trying to be
15 confused here, before surgery injections are different than
16 after surgery injections. Dr. Reyfman explained it to you.
17 Before surgery, you are doing it first of all to see if will
18 an injection calm down the swelling, is it the swelling
19 causing the problem or a disk. Can we calm down the
20 swelling and get an improvement and second, is it something
21 diagnostic, if you do an injection and you see improvement,
22 even if it's a short-term improvement, when you see
23 improvement, what does that tell you? It's telling you this
24 is where the pain is coming from. You turn off the switch
25 and the light goes off. You got the right switch. Just

1 common sense.
2 So they injected, turned off the switch for a few
3 hours, but then it was right back to where it was. That
4 tells them she got temporary relief. This is probably where
5 it happened and this whole thing about Dr. Reyfman and
6 Dr. Gerling, 2007, SUNY Downstate Medical Center, level one
7 trauma center who is in charge of anesthesia at SUNY
8 Downstate. Dr. Reyfman is the head of anesthesiology for
9 all of SUNY Downstate Medical Center a level 1 trauma
10 center, intubating patients, putting them under for major
11 surgeries, being shot, being hit by cars, saving people's
12 lives and he is the one in charge of everybody for wanting
13 him to put them under, make sure they survive the procedure.
14 Who does he meet, Dr. Gerling. It's his first job
15 after finishing his training and he is the chief of
16 orthopedic spinal surgery for SUNY Downstate, a level one
17 trauma center. You fall three stories and break your back
18 and you are paralyzed, they rush you to his hospital, he is
19 in charge of every single spinal surgery at the hospital
20 that is what being chief of orthopedic spinal surgery in a
21 level one trama center is. He is in charge of all of the
22 doctors, nurses all the operating rooms, emergency room
23 services and that's his first job out of medical school when
24 he finishes medical training. And guess what, they happen
25 to meet there because they are both right out of school and

1 chiefs of their departments and they have to work together,
2 obviously. So yeah, of course they know each other, for
3 eight years now and of course they trust each other and all
4 of this about me sending her, me referring her. If in June
5 of 2012 Halina Imran came to me and said, my chiropractor
6 says I need a spinal surgeon, can you recommend one? As her
7 attorney and counselor at law and someone who has been
8 working my entire career representing people like Halina,
9 would I recommend Dr. Gerling, yes, in a minute. He trained
10 under who he told you was the founder, sorry, the father of
11 modern spinal surgery, Henry Bullman in Cleveland. You
12 don't move to Cleveland to train in medicine unless there is
13 a really good reason. And that's why he went there and
14 that's why when he finished, his first job wasn't attending
15 physician at NYU like Dr. Klein, who has been doing this for
16 how long and is still there, his first job was to take over
17 SUNY Downstate's final service and a level one trauma
18 center.
19 If Dr. Klein worked at SUNY Downstate, Dr. Gerling
20 would be his boss. Dr. Gerling is being criticized for
21 doing surgery on her lumbar spine. Guess what he does for a
22 living, he tries to help people with spine pain. She had
23 the injection, didn't respond. He decided he needed to do
24 surgery. Based on his physical examination, the amount of
25 pain she was in, she didn't respond to an injection, that's

1 objective, that's not subjective. You get relief or you
2 don't from it. Period.
3 You know, we have in the operative report for
4 Dr. Gerling, he tells you, he tells you about May 7th,
5 May 6th and the CAT scan of May 6th, 2015, he tells you
6 about what is going on right now, then they did the
7 injection, provided a pretty good relief and on page two of
8 his operative report, if you read it, he gives a heads up
9 for this. He doesn't fuse both levels together. That's a
10 major, much bigger surgery to do both levels at the same
11 time. He tries to go and get L5 to S1 and fuse it and hopes
12 that if I fuse this, I don't have to do the one above it.
13 I'm not going to put anymore metal in the back than I have
14 to, and he says in his report she understood that diagnosis
15 of back pain can be extremely challenging and despite the
16 fact she had very localized pain and tenderness at this
17 site, and marked reproduction and range of motion testing in
18 the office, it would be uncertain as to whether or not L5/S1
19 was the absolute cause of her back pain.
20 If you are a doctor, you don't give an absolute
21 nothing. You don't find a doctor that will give you an
22 absolute, this is a science. We think we understand, we do
23 our best to figure things out.
24 And I will go back to Dr. Gutierrez. First of
25 all, Halina Imran and her training in medical school, which

1 she didn't go to, told her to complain at L4/5 and L5 to S1
2 on May 2 because she didn't go to medical school and she
3 knew where the MRI a month later would show problems, right.
4 Dr. Gutierrez told you all the way down, he pushes
5 on the back, pushes on the back of the spine to find out the
6 source of pain, because when you push in the back, it moves
7 the disk forward. It only makes sense. You push in the
8 back, it pushes forward, forward is where the spinal canal
9 is. You push the disk more into the spinal canal and you go
10 ooh, she has no response until L4/5, L5/S1 and he circles
11 them, look at his report from May 2. And a month later
12 June 1st, guess what, there is something there.
13 Dr. Gerling goes on, that being said, this is the
14 most likely suspect given MRI findings and her clinical
15 examination, residual pain often does occur. We discuss
16 other complications including neurologic injury, or
17 irritation, all the nerve roots, you saw the procedure that
18 had to be done, all the nerves down there, there are no
19 guarantees that it will be perfect, doctors are not perfect,
20 humans are not perfect. So he goes in, he also discusses
21 nonunion, that's a possibility, which is what occurred here,
22 hardware problems, nobody can predict the future, right.
23 And he explains to her, the chart is in his report, he says
24 that also she understood and she may require revision
25 surgery for these reasons. She understands that there is

1 one entry randomly about smoking and first of all, I'm sure
2 you seen Halina around the courthouse at lunch time. I
3 mean, I don't know where on earth that came from. There is
4 one random entry with smoking instead of not smoking. It's
5 from a physical therapy doctor early on and what would that
6 matter anyway? She doesn't take pain medication. She
7 wouldn't. She don't want to get addicted. We know what
8 oxycodone does to people.
9 MR. DUER: Objection.
10 THE COURT: Overruled.
11 MR. IRWIN: Dr. Reyfman deduced and it was
12 obviously Ms. Imran going to Dr. Gerling she must have come
13 to me through his office somehow, secretary called or
14 something, it doesn't matter.
15 Dr. Gerling is chief of orthopedic spinal
16 surgeries. He is the head of all the spinal surgeons at a
17 level one trama center called Lutheran Medical Center which
18 serves terrible, catastrophically injured people. He is the
19 boss of all of the doctors in the spinal surgery. He is the
20 boss of all of the nurses. He has to coordinate with all of
21 the other departments and services. He cancelled the
22 surgery to be here. He was supposed to be here last Friday,
23 as he testified. He had to cancel patients last Friday,
24 because we didn't know if we were going to start quickly or
25 slowly. Then he cancelled patients for tomorrow because we

1 didn't know if the Judge would go fast or slow. And then he
2 had to move again to Monday in the afternoon and cancel
3 surgery in the afternoon, cancel surgery for someone in pain
4 and needs spinal surgery, he had to cancel.
5 MR. DUER: Objection.
6 THE COURT: Sustained.
7 MR. IRWIN: And needed to go back as he told you,
8 he got called back because the previous surgery that day,
9 there was a complication, so he was a half hour late getting
10 here. As opposed to Dr. Sapan-Cohen took half a vacation
11 day and Dr. Klein cancelled a few patients so they can make
12 extra money, not because they were taking away from their
13 practice.
14 Dr. Reyfman who has been helping people, he has a
15 pharmacy degree, you don't have to get a pharmacy degree.
16 He went to pharmacy school. He told you before he went to
17 medical school to help people with pain. And he's taking
18 away from his practice, away from his practice where he had
19 30 something patients and ten procedures on Tuesday
20 afternoon he was supposed to handle, he was taken away from
21 his practice to come here for that. He runs the entire
22 facility helping people. He has employees and things like
23 that.
24 We go to Dr. Gerling's post-op visit, he notes
25 that she is doing okay. She has small issues. She has

1 ankle pain in her right ankle when she bends her foot. The
2 back bone is connected to the hip bone connected to the
3 thigh bone connected to the knee bone, and we will talk
4 about the knee bone in a few minutes.
5 Dr. Reyfman, she goes back, it's pretty clear
6 here, I will tell you something, I think it's obvious Halina
7 Imran does not like to go to doctors. Does anybody? Did
8 Halina Imran want to be in that car in that spot on
9 April 17, 2012? Did she want her life to take the course it
10 has and end up sitting here? Do you think this is fun? Is
11 this where she wants to be now? Isn't it a hospital's
12 choice when you think about it? Do you want to take
13 narcotics for the rest of your life? Do you want to try to
14 deal with the pain? What is worse?
15 Do you notice I didn't ask Dr. Reyfman a single
16 question about how much pain medication costs, not a single
17 one. I don't know if she will take it or not. I don't know
18 if she will break down at some point and say you know what,
19 I cannot handle this. Does she look comfortable in the
20 courtroom all day?
21 In February she goes back to Dr. Gerling and she
22 has not seen Dr. Gerling in a while. She has not seen
23 Dr. Reyfman in a while, why, because the surgery was not so
24 long ago in July, 2012, and things don't break down
25 immediately. It takes time for things to break down. It

1 takes time for things to start to fall apart. It's humpty
2 dumpty. You break it, it will never be the same after it's
3 broken. And what we see here is in February, she goes back,
4 by the way, Dr. Gerling must be a horrible person. He still
5 has her weight at 140 pounds. You saw Halina's daughter on
6 the stand. She told you she is wearing Halina's old clothes
7 from before the accident. Remember what she looked like? I
8 know it was a little while ago and things went fast, Halina
9 fit in those clothes. Oh my God, Dr. Gerling has her at 140
10 pounds, is that an imposter? He is worried about getting
11 her better.
12 Mr. Duer is checking spelling, back in February
13 when she filled that out for Dr. Gerling. Was she doing a
14 little work and cleaning houses or something, trying to do
15 anything, sure, maybe. Did I have enough time to question
16 her as long as I wanted to or do everything I could, no.
17 Was she terrified of coming into a courtroom in the first
18 place? It was obvious when she started crying on question
19 three, put the spotlight on her, feel the heat of the
20 spotlight in a courtroom like this, with all of these
21 questions and scrutiny when this is not your first language.
22 She told you at her deposition there were 5 or 6 lawyers
23 questioning her, yelling, nobody could prepare a client for
24 that. I speak good English and I'm not sure I would be
25 comfortable if someone who obviously doesn't like doctors,

1 doesn't want to go to therapy, want to imagine there is
2 nothing wrong, because isn't that what we all want to do
3 when something is wrong that we cannot do anything about.
4 It goes back to Dr. Gerling in February and he says
5 something might be going on, go get a lumbar spine X-ray and
6 a CAT scan and he says come back in two months. So Halina
7 being someone that loves to go to doctors and wants hard to
8 make sure she is pumping up that lawsuit she has and going
9 to therapy when it doesn't work and pretending she needs it.
10 She takes almost three months to go and get it. She goes
11 and gets it in the beginning of May. And when she does,
12 this is probably my favorite part of the entire trial
13 Dr. Sapan-Cohen, good lord, her report, you know, mild to
14 moderate bilateral neuroforaminal stenosis is what it said,
15 but she doesn't say it on direct. She reads everything in
16 her report except that one sentence. I have to question her
17 about it. Her report is in front of her, she can see and
18 read. I know she can read. And she is holding the report
19 right here and that is the significant, because what does
20 that mean? That means there is stenosis which means there
21 is something pushing into the neuroforamen, which means
22 that's the hole where the nerves are bilateral, on both
23 sides, at L4 to L5.
24 Dr. Sapan is not imagining that. I can't find the
25 report now. If you need the testimony read back, ask about

1 my cross, the May 6th, 2015, report from Dr. Sapan. The one
2 sentence she didn't read, and of course as soon as that went
3 down, I underlined and put it up front. Can you read the
4 one thing you didn't read from your report? There is mild
5 to moderate bilateral neuroforaminal stenosis. So she goes
6 back to Dr. Gerling and by the way, the CAT scan of the
7 lumbar spine, the actual report, the report is in evidence,
8 it's in Dr. Gerling's chart, you can go get it and they said
9 in the conclusions, L5 to S1 posterior pedicle screws with
10 interlocking stabilization rods are seen at L5 to S1 with
11 intervertebral body spacers. That's what they put in
12 Dr. Gerling hammered in instead of the disk that was there.
13 There is a disk bulge and a right paracentral
14 herniation and impingement upon the S1 nerve root more
15 prominent on the right than on left side. There is lateral
16 recess stenosis. She still has issues in L5 to S1, L4 to 5
17 there is a broad base central disk herniation with thecal
18 sac impingement and severe lateral recess stenosis. There
19 is significant bilateral neuroforaminal impingement. So
20 things are moving around again back there.
21 The X-ray of the lumbar spine, Dr. Reyfman says he
22 thinks he may see a screw coming loose but he referred to
23 Dr. Gerling. Dr. Gerling said he read the CT and he knows
24 how he put crews screws in a back. He knows exactly how
25 they go in and how far. He has his report to compare it to.

1 .he tells you yes, the screws are not exactly where, the one
2 screw is not where it's supposed to be. Why, he is worried,
3 she has metal in her back. If it's moving, she needs to
4 know.
5 The operative report, it's detailed as to what he
6 does, and the procedure that you saw. That was not the
7 whole thing obviously. Do you think that takes ten minutes,
8 it's hours.
9 THE COURT: It's the evidence that counts.
10 MR. IRWIN: I have 24 minutes.
11 THE COURT: Twenty.
12 MR. IRWIN: If you need anything read back, please
13 get it read back. This may not be exact words, everybody
14 talked way too fast during this entire trial and I may be
15 talking too fast and I apologize.
16 The first thing you need to know is the severity
17 of the crash. That's what he told us. The second thing is
18 how the whole body moved and he said the whole body. The
19 third thing is you need to know individual component
20 loading. Then you look at literature, then you validate and
21 sensitivity test, I think it was and it says does ten
22 percent change an answer? Well, you know, sometimes in
23 science one percent can change an answer, ten percent can,
24 sometimes it doesn't. That's not the real issue. The real
25 issue is are we starting with the right premises? Are we

1 making the correct assumption? Do we have the right
2 hypothesis before we start to project forward with things.
3 And I think something that was important was when I asked
4 Dr. McGowan about the weights in his accident reconstruction
5 data. Remember I questioned him about the data he used to
6 start the calculation from, with the vehicle weight and how
7 he had a vehicle weight for vehicle one and a vehicle weight
8 for vehicle two and three, but none for vehicle four, which
9 is defendant's truck that started the whole thing. That's
10 not important. But it's in a nice deposition transcript.
11 Mr. Barany says it's 13,000 pounds and he is going 15 to
12 20 miles per hour. I need a calculator. Those two things,
13 I can figure out force from that, but he puts none, why?
14 Well, I ask him if he recognizes Ford. Com, Ford Motor
15 Company's website, a reliable source for vehicle weight
16 information and he said I don't know. You used Edmonds.com
17 for the Honda CRV, you used Edmonds.com and Edmond's is not
18 the manufacturer of the Honda, Edmond's. Com for the Ford
19 Focus weight, for car two, Edmonds.com for car three, the
20 van, but Ford. Com is not good enough.
21 Do you think that's because that 13 thousand
22 pounds in the deposition was an overstatement or under
23 statement. There is a reason that this is missing.
24 Clearly, I mean he is thorough and scientific and leaves out
25 the weight of the vehicle that started the chain reaction

1 and doesn't use the defendant's estimate of the weight of
2 his own vehicle as an assumption in there. Hog wash.
3 That's not science. That's a departure from the scientific
4 method.
5 Do you think Mr. Barany was going 15 to 20? Could
6 have been more. It's his truck. Did he bring us pictures?
7 Did he give them to Dr. McGowan? Did Dr. McGowan go and
8 inspect Mr. Barany's truck at any point in time? No, you
9 would have heard it if he did. So a blind eye one way and
10 instead, let's go and use the vehicle year end model
11 interchange list by Scalera (phonetic) engineering and
12 Dr. McGowan read to you right out of it, often the degree of
13 the changes arguable, they talk about restyling. This guide
14 does not in any way guarantee the accuracy of the list.
15 Some similarities may represent my own estimates and some of
16 the older years are from memory. This is one person making
17 a list. That's why it's written that way. It's written in
18 the first person from my memory, not the whole group of a
19 scientific list. The Focus was restyled in 2005, he doesn't
20 know how. Is his accident reconstructionist actually
21 reliable? Is there anything about that we can rely on?
22 They did an MRI of the right knee and attending
23 radiologist said there was an effusion behind the kneecap,
24 swelling that Dr. Sapan tries to minimize. Doctor, it's
25 poor quality, right, you wrote that, a poor quality MRI? If

1 it was better quality you would be able to see better, no.
2 It's fluid and the MRI stimulates the electrons and fluid so
3 you can see them and it becomes brighter or darker. It's
4 poor quality. So if we had a better scanner, that would not
5 make a differs. She knows it's poor quality. Does that
6 make sense? The property damage estimates are done by
7 people who work for people defending lawsuits and try to
8 minimize things.
9 MR. DUER: Objection.
10 MR. IRWIN: The best evidence, we can find out
11 where these vehicles got picked. We can subpoena the
12 business records. Mr. Duer could have done that, gone and
13 hunted them down and gave it to them so it's not an
14 estimate.
15 Dr. McGowan admitted, you don't know what is
16 underneath until you get in there with a mechanic and figure
17 out is the frame bent.
18 Mr. Duer wants a perfect world where the doctors
19 are preparing for litigation from the first day. You have
20 to randomly call a lawyer that advertises on television or
21 the radio. You cannot get a doctor from a traffic cop who
22 knows a good therapy place. A doctor can't say this is a
23 good lawyer I know. I don't know. I don't understand the
24 planet he lives on other than I will take the cynical
25 possible view of every fact and circumstance and coincidence

1 that I can and instead of paying attention to this, instead
2 of paying attention to the fact that what on earth happened
3 to saying I'm sorry. I'm going to defend my client who at
4 15 to 20 miles per hour smashed into three cars and pushed
5 them 30 to 40 feet and the 30 to 40 feet --
6 MR. DUER: Objection.
7 THE COURT: Sustained. Counsel makes reference to
8 figures. It's not necessarily what he says, it's what the
9 evidence shows. You may continue.
10 MR. IRWIN: When you get pushed 30 to 40 feet
11 Dr. McGowan says that doesn't matter, no, no, no, her foot
12 had to come off. What are you talking about? She testified
13 she is sitting in the car and I hear a crash that was
14 Mr. Barany's truck hitting the van and they heard it. And
15 what happens, Dorota braces herself with her foot and turns
16 around and looks in the mirror and sees in the mirror the
17 silver car getting pushed into their car. Are you taking
18 your foot off the brake or pressing it for dear life? You
19 are at a red light and there is a cross street. You are
20 pressing for dear life. Your foot is not coming off that
21 peddle and you are holding the steering wheel and bracing
22 for the fact that you are going to get hit. And Halina, she
23 hears it and turns to the left and looks over her shoulder
24 because if something is coming, I want to see it, what the
25 hell was that.

1 And as Dr. Gerling explained, seats in cars and
2 crash tests, okay, are done in this position, seating
3 against the back, sitting straight, seat belt on, because
4 they are designed to absorb as you come back across your
5 whole back and spread out the impact. They are bouncy.
6 Halina is twisted. She hits the hip, the left side. The
7 reason I read the transcript, that's what she said in her
8 transcript. It's all consistent about the left side. That
9 questioning by Mr. Duer's office or his law firm is very
10 thorough about her body being turned to the left and her
11 left side hitting.
12 And Dr. Gerling explained when you are flat, it
13 gets absorbed why, because there is more surface area. You
14 hit somebody with a hammer, right, and there is a direct
15 hit, you make a dent, you put a plate on somebody's back and
16 hit the plate, it gets spread out. When you are sitting
17 normally, they are designed to absorb when you come back.
18 She is turned and what did Dr. Gerling explain to you, he
19 ran during his training and fellowship level one trauma
20 center, had people flown in from all of the region, with
21 catastrophic spinal injuries, he knows what it looks like
22 when you get into an accident.
23 THE COURT: Sidebar, Mr. Irwin.
24 (Whereupon, an off the record discussion takes
25 place at sidebar among the Court and Counsel.)

1 MR. IRWIN: And what happens when you take the
2 flat back that's supposed to hit the seat, you will get
3 thrown forward a little more and you are twisted, you are
4 going to twist back naturally, the inertia from getting
5 pushed forward and coming back and it's the right knee and
6 guess what, and then there is a secondary throwing of her
7 body around because as being pushed with the brake on, do
8 you think the truck bounced off of those cars and went
9 backwards like a cartoon or something? No, it employed
10 right through and pushed everybody straight into the
11 intersection.
12 I read the transcript to you in preparation for
13 Dr. McGowan. I specifically read those parts to you. He
14 hit his break about three feet before the impact. If you
15 beleive he was going 15 to 20, three feet is this far before
16 the bumper of the van. Do you think that hitting your brake
17 with three feet is enough? Is three feet enough to take the
18 vehicle slow in any measurable fashion? That's if you
19 assume it's true. Because, you know, not recognizing Ford.
20 Com for a vehicle weight, that makes me real suspicious.
21 Putting the vehicle weight for every other vehicle except
22 the one that caused the accident saying unknown, he had and
23 read the deposition and the report, he talks about Mr.
24 Barany's deposition. In the deposition he said about 13
25 thousand pounds and then magically it's unknown to

1 Dr. McGowan.
2 What is Halina Imran facing? She goes with her
3 sister to go get her taxes done. Is her English perfect, is
4 there ways she can misunderstand things? She has 5 or 6
5 lawyers questioning her. You heard her English. Is she as
6 articulate as all of us? Is it her fault? Does it make a
7 difference, yeah, is it almost unfair. The impact, the
8 impact, the word impact, is her vocabulary that broad? Are
9 there things she wants to understand? Do you know when you
10 misunderstand a word? Everything has to be her being in
11 that car on April 17, 2012, is part of a massive plot.
12 The torture that Mr. Duer wanted Dr. Gutierrez to
13 do May 2, 2012 of all of those different tests and some of
14 them if she had an undiagnosed fracture could paralyze her
15 and they all cause more pain. That's her reality. That's
16 what she has to look at and deal with every day.
17 Does she do her best in trying to do things with
18 her kids who are 16, 13 and 10? You heard from her
19 daughter, this has completely changed her into a different
20 person. Am I trying to get sympathy from you, no. This is
21 her reality. She is in a bad relationship with her husband
22 for 15 years and then finally about a year before the
23 accident, he is gone, she leaves him and then this. And now
24 this is what her future holds. A revision surgery, more
25 doctors that nobody wants to go to including Halina.

1 Hearing Dr. Reyfman say that she doesn't take pain
2 medication but I think she will have to, she doesn't want to
3 do therapy, but I think she will have to. I will not stand
4 here and tell you she is going to therapy in the future.
5 I'm not.
6 Dr. Reyfman told you he thinks she has to. He
7 deals with these people all day every day since 2007. He
8 has a pharmacy degree he understands these things.
9 THE COURT: Sidebar.
10 (Whereupon, the witness stepped down from the
11 stand.)
12 MR. IRWIN: In an hour it's almost impossible to
13 talk about 44 years of Halina Imran's life, three years plus
14 since the accident, a trial with all of these witnesses
15 moving so fast in five days and then talking about the rest
16 of her life and what she is looking forward to from this. I
17 think you all can imagine from the testimony this is
18 painful. And pain is a funny thing. It follows you
19 everywhere you go. You cannot sleep all night. You cannot
20 keep your patience with your kids. We have a broken woman,
21 literally broken. You heard from her daughter, she yells at
22 us now, she gets impatient. They don't do the stuff they
23 used to. Mom was the first one on the rides now she sits
24 and watches. Oh my God, she went to the Poconos. I'm sure
25 there are people in wheelchairs capable of going to Disney.

1 .she went to the Poconos. She has children, what should she
2 do, tie them in the house and say we cannot go somewhere.
3 There are certain expectations it comes to the point of
4 being absurd.
5 THE COURT: Wrap it up.
6 MR. IRWIN: Ms. Imran trading places looking at
7 where she is and what she went through and what she will go
8 through. How do you compensate that? How do you compensate
9 a life with pain? Her relationship with her children, she
10 has a boyfriend, she is trying to get a little happiness of
11 some sort in her life. Should she commit suicide, no.
12 Should she try to find enjoyment somewhere? What do you
13 compensate someone for a life that has taken such a drastic,
14 terrible course?
15 You heard from Dr. Reyfman about the medical cost
16 and things like that, 80 to $100,000 for Dr. Gerling. I
17 don't think there is any doubt in Dr. Gerling's opinion she
18 needs to have that revised and fused and $80,000 or $100,000
19 for that procedure and it will happen within the next year.
20 Dr. Reyfman, he testified about what he thinks she
21 will need. She testified that she doesn't go to therapy
22 because it doesn't help and she doesn't want to do
23 injections and do you blame her? Who wants to go get their
24 flu shot? That's a shot in your shoulder. Who wants to get
25 a needle in their spine that Dr. Reyfman showed you.

1 As far as her future medical expenses, I don't
2 know and that will be the hardest question and I apologize
3 and that's something I will ask you all to try to figure
4 out. As far as the first question on the verdict sheet as a
5 result of the accident, has plaintiff sustained a
6 significant limitation of use of a body system or function?
7 Here is the spinal cord and here is the none circumferential
8 disk extruding in and pushing into the cord.
9 THE COURT: Sidebar.
10 (Whereupon, an off the record discussion takes
11 place at sidebar among the Court and Counsel.)
12 MR. IRWIN: Has Ms. Imran sustained a significant
13 limitation of a use of a body system or function? Yes. As a
14 result of the accident, yes, good lord.
15 Does she have a permanent consequential
16 limitation, is it permanent, yeah. Is it consequential,
17 yeah, is it from this accident, what else would it be from?
18 What on earth else would it be from? She has been through
19 hell, torture, poked, twisted, bended, see this doctor, that
20 doctor, of course it's from this accident. There is no
21 explanation for any of this. None. In her normal, usual
22 state of health until boom, April 17, 2012.
23 Pain and suffering, president pain and suffering
24 in the future for the rest of her life and you will hear her
25 life expectancy 36 more years, 36 more years of this. What

1 is the life worth? What is the life worth? To take a human
2 being's life and in a moment move it into the direction that
3 Halina Imran has been pushed or smashed into a million
4 dollars to now with all of the surgeries and poking and
5 prodding, 36 more years of this, hopefully the revision
6 surgery Dr. Gerling will now be able to put both of them
7 together because that's what he suspects in his report. And
8 maybe things will improve and not keep getting worse,
9 because we see them in the films, 2 million, is that the
10 cost of a broken life and broken woman, who loves and can't
11 stop herself sometimes from yelling at her own children,
12 obviously, it's up to you.
13 Clearly, we discussed this during jury selection
14 and the one thing I hate having to do in a trial, I don't
15 know, is there an out? I hope I didn't leave anything out.
16 I try to do everything I can for Halina and I hope that when
17 you go to deliberate, you really think about what really
18 happened here not what defense might attack the second
19 victim. Thank you.
20 THE COURT: Thank you Mr. Irwin.
21 Members of the jury, we come now to that portion
22 of the trial where you are instructed on the law applicable
23 to the case and after which you will retire for your final
24 deliberations. You have now heard all of the evidence I
25 have certain commitment and I will not be available, so what

1 I will do is finish this charge and send you home and
2 tomorrow morning you will deliberate. You will have the
3 entire day, not including the alternates. I will have you
4 come back. Unfortunately something came up and I cannot be
5 present.
6 You have now heard all of the evidence introduced
7 by the parties and through arguments of their attorneys you
8 learned the conclusions which each party believes should be
9 drawn from the evidence presented to you.
10 You will recall at the beginning of the trial I
11 stated for you certain principles so you can have them in
12 mind as the trial progressed. Briefly, they were you are
13 bound to accept the law as I give it to you. Whether or not
14 you agree with it. You are not to ask anyone else about the
15 law. You should not consider or accept any advice about the
16 law from anyone else but me.
17 Furthermore, you must not conclude from my rulings
18 or anything I said during the course of the trial that I
19 favor any party to this lawsuit. Furthermore, you may not
20 draw any inference from an unanswered question, nor consider
21 testimony which has been stricken from the record in
22 reaching your decision. In deciding how much weight you
23 choose to give to the testimony of any particular witness,
24 there is no magical formula which can be used. The test
25 used in your everyday affairs to decide the reliability or

1 unreliability of statements made to you by others are the
2 tests you apply in your deliberations. The items to be
3 taken into consideration in determining the weight you will
4 give to the testimony of a witness include the interest or
5 lack of interest of the witness in the outcome of the case;
6 the bias or prejudice of the witness, if there be any, the
7 age, the appearance, the manner of the witness as the
8 witness testified, the opportunity that the witness had to
9 observe the facts about which he or she testified, the
10 probability or improbability of the witness's testimony when
11 considered in the light of all of the other evidence in the
12 case.
13 If you find that any witness has willfully
14 testified falsely as to any material fact that is as to an
15 important matter, the law permits you to disregard
16 completely the entire testimony of that witness upon the
17 principle that one that testifies falsely about one material
18 fact is likely to testify falsely about everything. You are
19 not required however to consider such a witness as totally
20 unbelievable, you may accept so much of his or her testimony
21 as you deem true and disregard what you feel is false.
22 By the processes which I just described to you,
23 you, as the sole judges of the facts decide which of the
24 witnesses you will believe, what portion of their testimony
25 you accept and with weight you will give to it. The burden

1 of proof rests on the plaintiff. That means that it must be
2 established by a fair preponderance of the credible evidence
3 that the claim plaintiff makes is true. The credible
4 evidence means the testimony or exhibits that you find
5 worthy to be believed.
6 A preponderance of the evidence means the greater
7 part of such evidence. That does not mean the greater
8 number of witnesses or greater length of time taken by
9 either side. The phrase refers to the quality of the
10 evidence, that is its convincing quality, the weight and
11 affect that it has on your minds. The law requires that in
12 order for a plaintiff to prevail on a claim, the evidence
13 that supports her claim must appeal to you as more nearly;
14 representing what took place than the evidence opposed to
15 her claim. If it does not or if it weighs so evenly that
16 you are unable to say there is a preponderance on either
17 side, then you must decide the question in favor of the
18 defendant. Only if the evidence favoring the plaintiff's
19 claim outweighs the evidence opposed to it, that you can
20 find in favor of the plaintiff.
21 In deciding in this case, you may consider only
22 the exhibits which have been admitted in evidence and the
23 testimony of the witnesses as you have heard it in this
24 courtroom or as there has been read to you testimony given
25 on examination before trial. Under our rules of practice,

1 an examination before trial is taken under oath and is
2 entitled to equal consideration by you notwithstanding the
3 fact it was taken before the trial and outside of the
4 courtroom. However, arguments, remarks and summations are
5 not evidence nor is anything I now say or may have said with
6 regard to the facts evidence.
7 Throughout the course of this trial, several
8 exhibits were introduced in evidence. Your are entitled to
9 have any and all exhibits with you during your
10 deliberations. By stipulation here all exhibits will be
11 given to the jury, before they are given to you and while I
12 am out, there are certain items you marked on your own. You
13 will mark with the court reporter. There are items subject
14 to redaction and you will have plenty of time to work on it.
15 Do you understand each other?
16 The plaintiff's testified before you as a party to
17 the action she is an interested witness. An interested
18 witness is not less believable than a disinterested witness.
19 The fact she is interested in the outcome of the case does
20 in the mean she has not told the truth. It's for you to
21 decide from the demeanor of the witness on the stand and
22 such other tests as your experience dictates whether or not
23 the testimony has been influenced, intentionally or
24 unintentionally, by her interest. You may, if you consider
25 it proper under all of the circumstances not believe the

1 testimony of such a witness, even though it's not otherwise
2 challenged or contradicted. However, you are not required
3 to reject the testimony of such a witness, and may accept
4 all or such part of her testimony as you find reliable and
5 reject such part as you find unworthy of acceptance.
6 You will recall that the witnesses Dr. Michael
7 Gerling, Dr. Gutierrez, Dr. Reyfman, Dr. Sapan, Dr. McGowan
8 and Jeff Klein testified concerning their qualifications as
9 experts in the fields of orthopedic spinal surgery,
10 anesthesiology and pain management, diagnostic radiology,
11 accident reconstruction, biomechanical analysis and
12 orthopedic surgeon and gave their opinions concerning their
13 issues in this case. When a case involves a matter of
14 science or art or requires special knowledge or skill not
15 ordinarily possessed by the average person, an expert is
16 permitted to state his or her opinion for the information of
17 the court and jury. The opinions stated by each expert who
18 testified before you were based on facts as the expert
19 obtained knowledge of them and testified to them before you,
20 or as the attorneys who questioned the expert asked the
21 expert to assume. You may reject an expert's opinion if you
22 find the facts to be different from those which formed the
23 basis for the opinion. You may also reject the opinion if
24 after careful consideration of all of the evidence in the
25 case, expert and other, you disagree with the opinion.

1 In other words, you are not required to accept an
2 expert's opinion to the exclusion of the facts and
3 circumstances disclosed by other testimony. Such an opinion
4 is subject to the same rules concerning reliability as the
5 testimony of any other witness. It is given to assist you
6 in reaching a proper conclusion, and entitled to such weight
7 and as you find the expert's qualifications in the field
8 warrants and must be considered by you, but is not
9 controlling upon your judgment.
10 In this case you will decide only the question of
11 damages, that is, what amount of money will fairly and
12 justly compensate the plaintiff for all loss resulting from
13 the injuries she sustained as a result of the accident of
14 April 17, 2012. Since the question of liability has been
15 decided, any evidence concerning how the accident happened
16 will be received only on the question of damages.
17 During closing remarks, counsel for plaintiff
18 suggested a dollar amount he believes to be appropriate
19 compensation for specific elements of plaintiff's damages.
20 An attorney is permitted to make suggestions as to the
21 amount to be award, those suggestions are argument only and
22 not evidence and should not be considered by you as evidence
23 of plaintiff's damages. The determination of damages is
24 solely for you, the jury, to decide.
25 Certain threshold issues must be considered by you

1 before you may consider the measure of damages.
2 You must answer the following question: Did
3 plaintiff sustain a significant limitation of use of a body
4 function or system as a result of the accident. A
5 limitation of use of a body function or system means that
6 the function or system does not operate at all or operates
7 only in some limited way. It is not necessary for you to
8 find that there has been a total loss of the body function
9 or system or that the limitation of use is permanent.
10 However, the limitation of use must be significant, meaning
11 that the loss is important or meaningful. A minor, mild or
12 slight limitation of use is not significant.
13 If you find that plaintiff sustained a limitation
14 of use as a result of the accident and that limitation is
15 significant, you must answer the question yes. If you find
16 that plaintiff did not sustain a limitation of use as a
17 result of the accident, or that the limitation is not
18 significant you must answer the question no.
19 You must answer the following threshold question:
20 Did plaintiff sustain a permanent, consequential limitation
21 of use of a body function, body organ or member as a result
22 of the accident, a limitation of use of a body organ or
23 member means, the body organ or member does not operate at
24 all or operates only in some limited way. It is not
25 necessary for you to find there has been a total loss of use

1 of a body organ or member. The limitation of use must be
2 consequential, which means that it is significant, important
3 or of consequence. A minor, mild or slight limitation of
4 use is not significant, important or of consequence. If you
5 find that plaintiff sustained a permanent limitation of use
6 as a result of the accident and the limitation is
7 consequential as I have defined it, you must answer the
8 question yes. If you find that there is no permanent
9 limitation of use as a result of the accident or that the
10 limitation is not consequential, you must answer the
11 question no.
12 If your answer to any of the foregoing questions
13 is no with respect to the plaintiff proceed no further and
14 report to the Court. If your answer to any one or more of
15 those questions is yes, you must consider the measure of
16 damages.
17 What is the measure of damages. Plaintiff is
18 entitled to recover a sum of money which would justly and
19 fairly compensate her for any injury and pain and suffering
20 to date caused by defendant.
21 In determining the amount, if any, to be awarded
22 plaintiff for pain and suffering, you may take into
23 consideration the effect that plaintiff's injuries have on
24 plaintiff's ability to enjoy life. Loss of enjoyment of
25 life involves the loss of the ability to preform daily

1 tasks, to participate in the activities which were a part of
2 the person's life before the injury, and to experience the
3 pleasures of life. If you find plaintiff as a result of her
4 injuries suffered some loss or ability to enjoy life, you
5 may take that loss into consideration in determining the
6 amount to be to be awarded to plaintiff for pain and
7 suffering to date and in the future.
8 If your verdict is in favor of plaintiff,
9 plaintiff will not be required to pay income tax on the
10 award and you must not add or subtract from the award any
11 amount on account of income taxes.
12 With respect to any of the plaintiff's injuries or
13 disabilities, the plaintiff is entitled to recover for
14 future pain and suffering, disability and the loss of her
15 ability to enjoy life. In this regard you should take into
16 consideration the period of time that the injuries or
17 disabilities are expected to continue. If you find that
18 injuries or disabilities are permanent, you should take into
19 consideration the period of time that the plaintiff can be
20 expected to live.
21 In accordance with the statistical life expectancy
22 tables, plaintiff has a life expectancy of 81 years of age.
23 Such a table however provides nothing more than a
24 statistical average. It neither guarantees that plaintiff
25 will live an additional 36 years or means that she will not

1 live for a longer period. The life expectancy figure given
2 you is not binding upon you, but may be considered by you
3 together with your own experience and the evidence you heard
4 concerning her health, habits, employment and activities in
5 deciding what her present life expectancy is.
6 If you make an award for future pain and
7 suffering, then you must take the period of years of which
8 the amount awarded is intended to provide compensation and
9 the amount you fix must represent the full amount awarded to
10 plaintiff. Then you must state the period of years which
11 the amount awarded is intended to provide compensation and
12 the amount must represent the full amount awarded plaintiff
13 for that item of damage that future period without reduction
14 to present value.
15 Plaintiff is also entitled to recover the amount
16 for reasonable expenditures for medical services including
17 physician charges, hospital expenses, diagnostic and X-ray
18 charges. If you find that plaintiff will need such expenses
19 in the future, you will include in your verdict an amount
20 for those anticipated charges which are reasonably certain
21 to be incurred in the future and that were necessitated by
22 plaintiff's injuries.
23 If you make an award for future medical expenses,
24 you will state your verdict in the amount awarded and the
25 period of years which such award is intended to provide

1 compensation, do not state the amount per year but only a
2 total amount for the entire period.
3 If in the course of your deliberations, your
4 recollection of any part of the testimony should fail or you
5 have any question about my instruction to you on the law you
6 have the right to return to the courtroom for the purpose of
7 having such testimony read to you or have such question
8 answered.
9 While it is important that the views of all jurors
10 be considered, a verdict of five of the six members of the
11 jury will be sufficient under the law. Whenever five of
12 your members are in agreement on a verdict, you may report
13 your verdict to the Court.
14 This case will be decided on the basis of the
15 answers you will give to certain questions that will be
16 submitted to you. Each of the question asked calls for a
17 yes or no answer or some figure. While it is important that
18 views of all jurors be considered, five of the six of you
19 must agree on the answer to any question, but the same five
20 persons need not agree on all of the answers. When five of
21 you agree on any answer, the foreperson of the jury will
22 write the answer in the space provided and each juror will
23 sign in the appropriate place to indicate his or her
24 agreement or disagreement. When you have answered all of
25 the questions that require answers, report to the Court.

1 Do not assume from the questions or wording of the
2 question or my instruction on them what the answer should
3 be. To aid you during deliberations, a jury verdict sheet
4 will be given to you to be taken with you into the jury
5 room.
6 In Reaching your verdict, you are not to be
7 affected by sympathy for any of the parties, what the
8 reaction of the parties or of the public to your verdict may
9 be, whether it will please or displease anyone, be popular
10 or unpopular, or indeed, any consideration outside of the
11 case as it has been presented to you in this courtroom.
12 Consider only the evidence, both the testimony and
13 exhibits, find the facts from what you consider to be the
14 believable evidence and apply the law as I now give it to
15 you. Your verdict will be determined by the conclusion you
16 reach, no matter who the verdict helps or hurts.
17 I have now outlined for you the rules of law that
18 apply to this case and the processes and the processes by
19 which you weigh the evidence and decide the facts. On
20 Monday morning you will reconvene at 9:15 and in order that
21 your deliberations may proceed in an orderly fashion, you
22 must have a foreperson, but of course, his or her vote is
23 entitled to no greater weight than that of any other juror.
24 Your function to reach a fair decision from the
25 law and evidence is an important one. When in the jury room

1 listen to each other and discuss the evidence and issues in
2 the case among yourselves. It is the duty of each of you as
3 jurors to consult with one another, deliberate with a view
4 of reaching an agreement or verdict, if you can do so
5 without violating your individual judgment and your
6 conscience. While you should not surrender conscientious
7 convictions of what the truth is and of the weight and
8 effect of the evidence and while each of you must decide the
9 case for yourself and not merely consent to the decision of
10 your fellow jurors, you should examine the issues and the in
11 evidence before you with candor and frankness and with
12 proper respect and regard for the opinions for each other.
13 Remember in your deliberations, the dispute
14 between the parties is for them an important matter. They
15 and the Court rely upon you to give full and conscientious
16 deliberations and consideration to the issues and evidence
17 before you. By so doing, you carry out to the fullest your
18 oaths as jurors to truly try the issues in this case and
19 render a true verdict.
20 Ask the jurors to rise.
21 Tomorrow morning, reconvene tomorrow morning at
22 9:15 a.m. Please do not discuss the case among yourselves
23 and definitely do not go on the internet. Don't do
24 anything. I will see you tomorrow morning 9:15.
25

1

2 SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF QUEENS : CIVIL TERM : PART CSCP
3 --X
HALINA IMRAN,
4 Index No.
Plaintiff, 21083/12
5
-against-
6 Trial

7 R. BARANY MONUMENTS INC.,
RANDY R. BARANY,
8
Defendant.
9 --X
Supreme Courthouse
10 88-11 Sutphin Boulevard
Jamaica, New York 11435
11 June 12, 2015
B E F O R E:
12 HONORABLE MARTIN E. RITHOLTZ,

13 Justice, Supreme Court

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

15 For the Plaintiff:
IRWIN & POZMANSKI
16 233 Broadway
New York, New York 10279
17 BY: JOSHUA BRIAN IRWIN, ESQ.

18
For the Defendant:
19 PICCIANO & SCAHILL
900 Merchants Concourse
20 Westbury, New York
BY: PAUL DUER, ESQ.
21

22

23

24

25 LYNDA A. ROSS, RPR
Senior Court Reporter

1
2 THE CLERK: All rise.
3 THE COURT: Case that's deliberating, Imran versus
4 Barany.
5 Good morning, alternate jurors. Your role is
6 extremely important because in case any of the jurors will
7 be incapacitated, you would step in but since there will not
8 be a part two to this trial, once they start deliberating,
9 that's it.
10 So we want to thank you for your service and we
11 want to discharge you. If you are interested you can always
12 stick around and find out what the verdict is; but you
13 cannot walk in and ask them now because they are
14 deliberating. And I will ask on behalf of both attorneys,
15 thank you for your service. I hereby discharge you.
16 (Whereupon the alternate jurors exit the
17 courtroom.)
18 THE COURT: We received a note. Request all of
19 the evidence. That's Court Exhibit 2. And then the jury
20 has reached a verdict, Court Exhibit 3.
21 (Whereupon, the notes were marked as Court Exhibit
22 2 and 3.)
23 THE COURT: We reached a verdict be seated except
24 for the foreperson. Ask the clerk to take the verdict from
25 the foreperson.

1 THE CLERK: Sir, matter of Halina A. Imran and
2 Randy Barany Monuments, Inc., Randy Barany, index 21083/2012
3 question one: As a result of the accident has plaintiff
4 sustained a significant limitation of use of a body system
5 or function, yes or no?
6 JURY FOREPERSON: No.
7 THE COURT: Is that unanimous or five out of six?
8 JURY FOREPERSON: Five out of six.
9 THE CLERK: Question two: As a result of the
10 accident, has plaintiff sustained a permanent consequential
11 limitation of use of a body organ or member, yes or no?
12 JURY FOREPERSON: No.
13 THE CLERK: Unanimous or five out of six?
14 JURY FOREPERSON: Unanimous.
15 THE COURT: You may show the verdict to both
16 counsel, you may be seated.
17 Members of the jury, you have completed your
18 service in this case on behalf. On behalf of the judicial
19 system, before you leave the courtroom, however, I want to
20 inform you you do not have to answer questions about the
21 case asked by anyone other than me. The public interest
22 requires the jurors have the utmost freedom of debate in the
23 jury room, and each of you be free to express what others
24 may think. Although you are not required to maintain
25 secrecy about what occurred in the jury room, you should

1 keep in mind your own best interest as jurors before before
2 discussing the case with anyone or answering any questions
3 about it. In sum, you are free to discuss the case with
4 anyone and free to decline to discuss the case. At this
5 time I hereby discharge you.
6 MR. IRWIN: May I have the jury polled?
7 THE COURT: Okay. Be seated.
8 THE CLERK: Members of the jury, you say you find
9 question one as a result of the accident has plaintiff
10 sustained a significant limitation of use of a body system
11 or function, you answered no, juror one no, is that your
12 answer.
13 JUROR ONE: Yes.
14 THE CLERK: Juror two no, is that your answer?
15 JUROR TWO: Yes.
16 THE CLERK: Three, no is that your answer?
17 JUROR THREE: My answer is yes.
18 THE CLERK: Juror four, no, is that your answer?
19 JUROR FOUR: No is my answer.
20 THE CLERK: Juror five, no, is that your answer?
21 JUROR FIVE: No is my answer.
22 THE CLERK: Juror six, no, is that your answer?
23 JUROR SIX: No is my answer.
24 THE COURT: Jury have been polled. Poll the
25 second question.

1 THE CLERK: As to question two, as a result of the
2 accident, has plaintiff sustained a permanent consequential
3 limitation of use of body organ or member? Juror one, no,
4 is that your answer?
5 JUROR ONE: No was my answer.
6 THE CLERK: Juror two, no, is that your answer?
7 JUROR TWO: Yes.
8 THE CLERK: Three, no, is that your answer?
9 JUROR THREE: Yes.
10 THE CLERK: Juror four, no, is that your answer?
11 JUROR FOUR: Yes.
12 THE CLERK: Juror five is no your answer?
13 JUROR FIVE: Yes?
14 THE CLERK: Juror six, is no your answer?
15 JUROR SIX: Yes.
16 THE CLERK: Your Honor, the jurors have been
17 polled.
18 THE COURT: At this time I hereby discharge you
19 and look forward to seeing all of you in four years.
20 (Whereupon the panel of sworn jurors exit the
21 courtroom.)
22 (Whereupon, an off the record discussion takes
23 place at sidebar among the Court and Counsel.)
24 THE COURT: Mr. Irwin, I understand you have a
25 motion?

1 MR. IRWIN: I move to set aside the verdict as
2 against the weight of the evidence and also as to what I
3 believe were errors committed during the trial, they were
4 reversal and I ask a new trial to be granted.
5 THE COURT: Delineate.
6 MR. IRWIN: The first basis, your Honor, is the
7 PJI 2:282 and 2:283 I believe one or both should probably
8 been charged, it was discussed at the bench and requested by
9 me. I established through Dr. Klein I believe that as a
10 matter of law, once it's established by me, Mr. Duer on
11 redirect cannot unestablish once I cross that threshold and
12 establish it.
13 THE COURT: We are talking about susceptibility
14 and aggravation. Do you want to respond?
15 MR. DUER: I believe there was no basis for charge
16 of susceptibility and aggravation. I don't believe it was
17 specifically pled in the Bill of Particulars. There was no
18 claim that from any of plaintiff's experts to suggest that
19 this was preexisting condition that was exacerbated by the
20 accident and I don't believe that was the testimony of
21 Dr. Klein either.
22 THE COURT: The record speaks for itself. This is
23 a motion to set it aside and all of the documents will be
24 provided, if when based on the one side will take the
25 appeal. Let's continue.

1 MR. IRWIN: In furtherance to the first one, I
2 need the pleadings to be marked as a Court exhibit.
3 THE COURT: For the Appellate Division, I don't
4 think they come in automatically. There is no need to mark
5 it as a Court exhibit. If the Appellate Division request
6 it, I deem it marked.
7 MR. IRWIN: Thank you, your Honor.
8 Now, the second basis is that I believe that --
9 THE COURT: You want me to help you.
10 MR. IRWIN: I'm trying to word it properly. I
11 believe there were time constraints that made it difficult,
12 if not sometimes impossible for me to fully develop my
13 theory of the case. I apologize to the Court.
14 THE COURT: I understand.
15 Didn't you pay $16,000 for an expert?
16 MR. IRWIN: Yes.
17 THE COURT: And he was supposed to be here at
18 2:00?
19 MR. IRWIN: Yes.
20 THE COURT: And he arrived at 2:30?
21 MR. IRWIN: The reason for that is as he stated on
22 the stand, he was called back to the hospital and the reason
23 I paid him --
24 THE COURT: Gerling and do you know that you went
25 with him from 2:30 to 3:46 and Mr. Duer was restricted to

1 4:30. He had half of the time that you had. Do you recall
2 what I said at the end when you wanted to have redirect?
3 MR. IRWIN: Yes.
4 THE COURT: What did I say?
5 MR. IRWIN: I could have him back and I stated I
6 wanted to have him back and the doctor nodded his head.
7 THE COURT: The doctor made it clear to you that
8 he was not going to be available the next day and under
9 certain circumstances.
10 MR. IRWIN: Your Honor, when we appeared last
11 Friday, I had paid the doctor for today for a full day
12 because he actually does surgeries and I booked him for a
13 day where he had patients only and he cancelled all of his
14 patients for today.
15 THE COURT: The problem is --
16 MR. IRWIN: The issue is I didn't get to do any
17 redirect whatsoever.
18 THE COURT: -- I offered you the redirect and the
19 doctor refused. He is someone that you paid so much money
20 for, I'm not faulting you, counsel, but I have to deal with
21 the availability of the experts and I did on the record in
22 front of the jury all for you, whatever time constraints I
23 did the same to Mr. Duer. He had his experts where he was
24 ready to go and I literally cut him in half.
25 So, if this record should indicate that you feel

1 that I could only deal, and as it was, this trial took from
2 last Friday to Friday. This is a week long trial, you know,
3 and I have been patient, but anyway, let the record reflect
4 that I had specific time slots for witnesses and that I
5 accommodated the experts so that they would be able to come
6 in at a certain time and be finished at a certain time and
7 that is the schedule we adhered to. So that's in the
8 record.
9 MR. IRWIN: Additionally, your Honor, I had made a
10 motion relating to the biomechanical and I believe I had a
11 standing objection to every question and answer the entire
12 time including his lack of qualifications.
13 THE COURT: One point you couldn't hold yourself
14 back, all of a sudden you made an objection with me when you
15 have a standing objection, then all of a sudden you make an
16 objection. It's up to the Appellate Division to decide at
17 what point it's standing or not standing. We have on the
18 record your objection to this biomechanical and the grounds
19 and that's there and I denied it and in effect, you are
20 renewing it as part of your motion to vacate the verdict to
21 set it aside. That's three. Anything else?
22 MR. IRWIN: I believe that's it.
23 THE COURT: I think, you indicated that it is
24 contrary to the evidence and the law, is that what you are
25 saying?

1 MR. IRWIN: Yes.
2 THE COURT: And opposition?
3 MR. DUER: Yes, the verdict was consistent with
4 the evidence that was given. The charge was given as to
5 Falsus in Uno, where a jury has a right to disregard
6 anything if they believe someone is lying about someone and
7 there were repeated inconsistencies in the testimony and
8 what I would call outright lies.
9 THE COURT: You're lucky you didn't say that as
10 part of your summation. That might have been objectionable
11 there were inconsistencies is what you are saying?
12 MR. DUER: And as a result of that the jury is
13 permitted to disregard any testimony if they find
14 inconsistencies.
15 THE COURT: I want on the record to say that I
16 tried to post verdict resolve it. I suggested a number, a
17 certain number was offered, which I will not put on the
18 record. It needed some more, so I'm going to deny the
19 motion to set aside the verdict, but I'm making a specific
20 request there be an extensive camp conference should there
21 be an appeal, they make an attempt to revisit. The truth of
22 the matter is Mr. Irwin, who is an excellent attorney,
23 expended tremendous amounts in the preparation of this case
24 and simply saying a certain amount is not going to
25 compensate him and of course, he is serious about all of the

1 matters he has mentioned. So I am denying it. Your
2 exception is noted for the record.
3 MR. IRWIN: Thank you, your honor.
4 MR. DUER: Thank you, your Honor.
5 ************************
CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE
6 ORIGINAL MINUTES TAKEN OF THIS PROCEEDING.
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8 LYNDA A. ROSS, RPR
Senior Court Reporter
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