In The Matter Of:

Pedro Ramirez v.

255 West 108th Street Corp. et al.

Dr. Thomas Kolb & Dr. Jeffrey Kaplan

February 27, 2024

Monica Hahn

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK : CIVIL TERM : PART 22

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PEDRO RAMIREZ,

Plaintiff,

-against-

Index No.
154692/2013

255 WEST 108TH STREET CORP.
and ALL-CON CONTRACTING CORP,

Defendants.

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Supreme Courthouse
80 Centre Street
New York, New York
February 27, 2024

B E F O R E:

HONORABLE JAMES G. CLYNES,
Justice, Supreme Court

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

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NICOLE C. ROBINSON, CSR
Senior Court Reporter

MR. GASTMAN: Your Honor, the prep team is seeking permission to get a TV set up and discs handed over so they could get ready to show them.

THE COURT: Sure.

MR. GASTMAN: Thank you.

THE COURT: You said the TV?

MR. GASTMAN: Yes, your Honor.

(Brief pause.)

MR. GASTMAN: Your Honor, good morning. Since we have the radiologist here this morning, we'd like to mark in one more record that came in through subpoenaed records room, and that would be the radiology disc from Saint Luke's Hospital. This is the hospital from the day of the accident. I am going to grab that out of the bin.

Your Honor, it was here in my hand. It was received in the subpoena records room. It is a disc with the typical business certification and subpoena.

We ask that this be marked as Plaintiff's 12 for identification and at this time we move this into evidence.

THE COURT: Ms. Camacho?

MS. CAMACHO: I have no objection.

THE COURT: Comes in. All right.

(Whereupon, Plaintiff's Exhibit 12 is marked and received into evidence at this time.)

MR. GASTMAN: For efficiency and the jury's better

understanding, we have some of the films in evidence blown up so the jury could see them easily and see them well. And I suppose if we will show them to the jury, they need to be marked.

THE COURT: Yes.

MR. GASTMAN: May I do that now?

THE COURT: Yes.

MR. GASTMAN: In no particular order, your Honor, the order they were presented to me, this first one here is an MRI of the back. This is Lennox Hill Radiology, the date of this picture is March 14th, 2015. And, your Honor, since Lennox Hill Radiology is Plaintiff's 4, I don't know if you want to do 4A, 4B, 4C, something like that.

MS. CAMACHO: It's only marked for I.D., so that is fine.

MR. GASTMAN: I will put them into evidence.

MS. CAMACHO: Blowups can't be put into evidence. If you want the little one, you can't put a blowup into evidence because it can't be made part of the record.

MR. GASTMAN: I disagree. I have been doing this for twenty-five years.

MS. CAMACHO: I know, and you never seen Cross longer than twenty-five minutes.

MR. GASTMAN: Never more than an hour is what I said.

MS. CAMACHO: I object to blowups going in. The actual film itself is in evidence.

MR. GASTMAN: The problem --

MS. CAMACHO: If you want to use them for illustrative purposes, that is fine. If he has small ones that he wants to offer, it's cumulative. They are being offered for illustrative purposes.

MR. GASTMAN: The reason why we have for decades, as counsel well knows, the reason why we blow them up and put them into evidence is that the jury has no way of looking at film images on a CD. They come from the hospital in CD format. And we've marked them into evidence. These are simply the corresponding images, your Honor. We put these into evidence on I would say every case.

MS. CAMACHO: Never had a blownup put into evidence.

MR. GASTMAN: They are on the disc. These are something the jury could touch and see and the doctor could demonstrate with.

THE COURT: Yes. Just mark them and I will reserve decision.

MR. GASTMAN: Okay, your Honor.

Should I go with the A, B, C thinking or some sorry way? So, for example, the ones that come from Plaintiff's 4 are marked A, B, C.

MS. CAMACHO: That is fine.

MR. GASTMAN: Thank you.

THE COURT: Okay.

MR. GASTMAN: Your Honor, this first one here is 4A.

THE COURT: Well, let's get back to what you were supposed to do initially.

Did you explain to your client the high/low?

MR. GASTMAN: Yes, your Honor. I did my best to explain how that works.

THE COURT: And the result is?

MR. GASTMAN: The offer is rejected, your Honor.

THE COURT: Okay. Go ahead.

MR. GASTMAN: Thank you. This first one is Lennox Hill Radiology. It's the back MRI of March 14, 2015. 4A on this one, Judge. That is the first one.

MS. CAMACHO: Is there any way to identify which slice or -- I mean --

MR. GASTMAN: Well, sure.

MS. CAMACHO: You are saying it's in evidence. You need to put in which -- what are we looking at?

MR. GASTMAN: As I just said, this is from the MRI taken on March 14th, 2015, at Lennox Hill Radiology. And, your Honor, just so that your Honor knows, these very same films were read by defendant's radiologist. They issued a

report on them and they will come and testify.

MS. CAMACHO: But my --

MR. GASTMAN: I suspect defendant would like to use these as well.

MS. CAMACHO: My issue, Judge, as counsel and the Court well know, there is -- there are numerous slides on that exhibit and he's going to mark this as 4A and that is great. I know the date and time. They all have the same date and time.

But there's different views and different levels. And for the record I would like to know what we're marking, other than a slide from a group of slides.

THE COURT: Okay.

MR. GASTMAN: Your Honor, defense counsel is being a little disingenuous.

MS. CAMACHO: I am not at all.

MR. GASTMAN: I will explain. As defense counsel knows, the markings are right on the pictures, Judge. So, for example, this is Series 4, image 18 out of 25.

MS. CAMACHO: So that is what I was asking you to put on the record. I don't have a copy of it. It's the first time I am seeing it. We are marking it in as a letter. I am just saying --

MR. GASTMAN: Okay. I will read them in.

MS. CAMACHO: Thank you. That is all I wanted.

MR. GASTMAN: Thank you. That wasn't understood. Now it is.

Your Honor, as I said, this is Series 4, image 18 out of 25. You could see it right on the image.

MS. CAMACHO: Series 4? What did you say?

MR. GASTMAN: 18 out of 25.

THE COURT: I see. Okay.

MS. CAMACHO: Okay.

MR. GASTMAN: And Series 2, 7 of 13. Same film, same day.

MS. CAMACHO: 7 of 13?

MR. GASTMAN: That is what it says.

MS. CAMACHO: Thank you.

MR. GASTMAN: You're welcome. These have been in the courtroom for days and I encourage you to look at them.

MS. CAMACHO: I thought you said they hadn't arrived yet last time we spoke.

MR. GASTMAN: Those were blowups of photos.

MS. CAMACHO: Well, I will not go through your stuff. And, by the way, we're leaving at 5 o'clock.

MR. GASTMAN: 4:30.

MS. CAMACHO: I know that, but when --

MR. GASTMAN: Can I finish this, counselor? You seem to be running out the clock. That is what you seem to be doing.

Your Honor, the second one is also from Lennox Hill Radiology, it's also the back. It's also from March 14, 2015. And this is Series 2, image 8 of 13.

4B for that one, your Honor?

THE COURT: All right.

MR. GASTMAN: Thank you.

(Brief pause.)

MR. GASTMAN: This next image, your Honor, is also from Lennox Hill Radiology, also from March 14th, 2015. This is also the back. This particular image is Series 4, image 23 of 25.

MS. CAMACHO: Okay.

MR. GASTMAN: And that could be 4C, your Honor. Thank you.

Your Honor, the next film is an X ray of the cervical spine; in other words, the neck. This image is from November 25th, 2015. And this is Series 1002, image 1002/1.

Your Honor, this is from Dr. Brisson's office. That is in evidence as Plaintiff's 2. So I would suggest this one is 2A, your Honor.

MS. CAMACHO: 2 is the chart. Brisson's chart.

MR. GASTMAN: Yes, I agree.

MS. CAMACHO: Are the films in with the chart?

MR. GASTMAN: Let's go see. May we see Plaintiff's

2?

MS. CAMACHO: Maybe you put them in there, but I know they came in separate.

MR. GASTMAN: If it's separate and needs to be marked, we shall do so.

(Brief pause.)

(Exhibit submitted.)

MR. GASTMAN: Thank you. Plaintiff's 2 seems to be all paper.

You think there is a separate envelope, Ms. Camacho?

MS. CAMACHO: I do.

MR. GASTMAN: All right. We will see. I don't see a separate envelope.

(Brief pause.)

MR. GASTMAN: Do you have an issue with this one?

MS. CAMACHO: Yes, they are not coming through the record room.

MR. GASTMAN: Do you have an issue with this one? I will put it to the side.

MS. CAMACHO: Let's put it to the side. What films did you give -- I thought they came through.

MR. GASTMAN: I don't know. Did your office subpoena them?

MS. CAMACHO: All right. Whatever. That is fine.

MR. GASTMAN: Okay. Thank you.

(Brief pause.)

MR. GASTMAN: Your Honor, this is an X ray of the neck, the date of this is December 16, 2013. This comes from -- it says 51 East 25th Street, I believe that is Dr. Brisson's office.

MS. CAMACHO: So that is not in evidence yet either.

MR. GASTMAN: You object to this, counselor? Correct?

MS. CAMACHO: For now, until we find where the films are.

MR. GASTMAN: Okay. Off to the side it goes.

Your Honor, this next one is from New York Ortho Sports. It's an X ray of the neck. It's dated April 10th, 2017.

And since it comes from New York Ortho Sports Radiology, that is Plaintiff's 7 in evidence. So I will call this one 7A. This is Series 1, image 1 of 1.

Thank you.

Your Honor, this next one is also an X ray of the neck. But it is from Dr. Brisson's office. It's dated 12/16/2013. This is image 1005/1. And it's of the neck.

MS. CAMACHO: That one is not in evidence yet either.

MR. GASTMAN: This is from Dr. Brisson's office. There is an objection?

MS. CAMACHO: Yes.

MR. GASTMAN: I will put this to the side.

(Brief pause.)

MR. GASTMAN: Your Honor, the three that we put to the side were taken by Dr. Brisson's office. Dr. Brisson testified. His chart is in evidence. Defense counselor objects to these, so I put them off to the side for now.

(Brief pause.)

MR. GASTMAN: I will separate the ones that were marked and the ones not marked to avoid any confusion later. The ones that were not marked are behind the well. The ones that were marked are here where they could be seen next to me.

Any other images?

No. We're good. Your Honor, the -- we're going to ask for the disc be put in evidence so they could be used for demonstration today. We're looking for St. Luke's Radiology disc, Plaintiff's 12 in evidence. And, your Honor, the radiology disc from Lennox Hill Radiology is Plaintiff's 4 in evidence.

(Exhibit submitted.)

MR. GASTMAN: Thank you. Your Honor , do I have ten seconds?

THE COURT: You have all the time in the world.

MR. GASTMAN: Thank you, your Honor.

THE COURT: Don't make me say it again.

MR. GASTMAN: Okay.

(Recess taken.)

THE COURT: All right. Are both sides ready for the jury?

MS. CAMACHO: Your Honor, could we just have the witness step out for a second? I have an application with regards to his testimony.

THE COURT: Yes.

(Witness excused.)

THE COURT: All right.

MS. CAMACHO: I just want to -- obviously I don't know how far plaintiff's counsel will go with him, I don't know what he plans to question him about, but I have his 3101(d), I believe plaintiff's counsel provided a copy to the Court.

It indicates here Dr. Kolb comprises his practice to the field of radiology. And then he will testify regarding his interpretation of the radiology films, which I have no problem with. However, the end of his 3101(d), it suggests that he is going to testify about diagnoses being permanent. He doesn't diagnose patients, he reads films. So I object to any diagnoses.

And I also object to any testimony or opinions regarding competent producing cause of diagnoses and the prognosis for plaintiff. That is not his job. He's an expert radiologist, not a treating physician who could opine as to prognosis and causation.

So I just want to make sure we're just going to be listening to him interpret what the films are.

THE COURT: Yes?

MR. GASTMAN: Your Honor, it's true that Dr. Kolb is a board-certified radiology, that is true. But he is also a licensed physician, licensed to practice medicine in the State of New York and he's going to testify about his knowledge of these films, of this patient. And I accept what defense counsel has said about permanency. I suspect that means her radiologist will not be able to discuss those sort of things either. But I think he should be able to discuss what a normal medical doctor could discuss, what could be seen in a film.

MS. CAMACHO: Your Honor, the 3101 --

THE COURT: Well, he never examined the plaintiff, correct?

MR. GASTMAN: Yes. Only talking about the films. You are correct, Judge.

MS. CAMACHO: The 3101(d) says he is a duly licensed radiologist and he confines his practice to the

field of radiology. He is a board-certified or Board eligible for his field of specialty, which is radiology. It says nothing about diagnosing patients. He doesn't see patients, he reviews films.

MR. GASTMAN: Your Honor, well, as this jury has heard and will continue to hear, medical practices rely on radiologists all the time every day to take images, and interpret those images, provide that information to the treating practices to aid and diagnose, prognosis --

THE COURT: In the X ray report, does he use the word diagnosis or prognosis?

MS. CAMACHO: No. He just interprets the films.

(Brief pause.)

MR. GASTMAN: Each of these reports has an impression after the read.

MS. CAMACHO: Right.

MR. GASTMAN: No more, no less.

MS. CAMACHO: There are times based on my review of his other testimony that somebody will ask him to opine as to certain things and, you know, he could do that or not do that. Here he did not do that.

THE COURT: Okay.

MR. GASTMAN: I will note for the Court, I did not ask a single question for the doctor yet.

MS. CAMACHO: I did not want to do this in front of

the jury.

MR. GASTMAN: Thank you.

(Brief pause.)

THE COURT: All right. Let's see where it goes. I will -- decision reserved. I will keep it in mind.

MS. CAMACHO: Okay.

THE COURT: Can I see just one of the reports? Any one. It doesn't matter.

(Brief pause.)

(Exhibit submitted.)

MS. CAMACHO: The other thing I would ask, your Honor, if we could limit the speaking objections and --

THE COURT: That is on my list to talk about to both of you.

This is Dr. Kolb, K-O-L-B?

MS. CAMACHO: Yes.

THE COURT: All right.

(Brief pause.)

THE COURT: Okay. This is on the record and it applies to both attorneys. I think it's one of the first things I said to both of you. Neither of you are in a rush. You could take as much time as you want. I do not want to hear words telegraphed to the jury while you're questioning a witness, the words rush or that you are out of time, or that you wish you had more time, or, quote, sometimes in

life there's not time for everything. You have all the time in the world to question a witness. You have all the time in the world to cross-examine a witness. Your option is to bring the witness back the following day if you cannot finish the witness by 4:30. Nobody is rushing you.

You have all the time in the world with a witness. You are not to discuss scheduling in front of the jury. That's done privately with me. No more speaking objections, no more telegraphing to the jury. It should just be the word object, grounds for your objection, and I will make a ruling and that is it.

You have a solution. We don't finish the witness, you bring the witness back the following day or whenever. Yesterday what we should have done, in hindsight, we should have had the doctor in the morning and should have had your client in the afternoon. That's what should have taken place. And then the doctor, if the doctor wasn't finished in the morning, the doctor's Cross could have continued into the afternoon.

Any reason why we didn't do it that way?

MR. GASTMAN: Your Honor, as you know, as we all know, there are difficulties despite what I wished to do, and despite what your Honor wishes to do, it's hard to get these practicing doctors into court. And so when I was -- when we first were assigned to your Honor, as you know, when

we read the Part Rules --

THE COURT: Don't say those rules again. I took the paragraph off.

MR. GASTMAN: I understand that. I had to operate under those rules when we were assigned to you.

THE COURT: No, you didn't. The first time you told this doctor to come in yesterday was on Friday. And I told you that there was a change in the rules on Thursday, the first day I met you.

MR. GASTMAN: Your Honor, if I could continue that thought, I lose my thought easily. All the time --

THE COURT: This doctor found out for the very first time that he was supposed to come in yesterday on Friday. You already knew that there was a change in the rules and that that rule no longer existed on Thursday. Not only that, but I told you I removed a paragraph from the rules.

MR. GASTMAN: Your Honor --

THE COURT: So now what is the reason why you had him in the afternoon?

MR. GASTMAN: I am trying to tell you.

THE COURT: Instead of the morning.

MR. GASTMAN: I am trying to tell you. We had to operate under the rules as they existed at that moment in time.

I scheduled the doctors, I got promises from them. They were probably paid by my office and once the schedule was locked in, there seemed no reason to change it as we have been completing witnesses.

THE COURT: But this witness, the doctor yesterday wasn't told to come in until -- he was told on Friday to come in yesterday afternoon.

MR. GASTMAN: Respectfully, your Honor --

THE COURT: That is what he testified to.

MR. GASTMAN: Respectfully, your Honor, this schedule was set last week. As proof of that, defense counsel has on her phone, because I sent it to her, the exact typed list, the order of the doctors and dates.

As soon as we were assigned to you, your Honor, I immediately scheduled the doctors and I immediately shared that with defense counsel, that schedule, immediately.

THE COURT: That is what he testified yesterday, the first time he knew to come in yesterday was on Friday.

MR. GASTMAN: I am sure that it was one hundred percent truthful, your Honor. We called the office to arrange for testimony, as the doctor mentioned to you, I believe he mentioned to you, he happened to be on vacation when this case was sent out and called for trial. And his office probably, since he is an employee, arranged for his schedule to comport with your Honor's schedule.

THE COURT: Okay. No more stacking doctors. There is to be only one doctor a day and the doctor is to be in the morning. And this way, if the doctor is not finished in the morning, we have the afternoon as a buffer for a continued Direct or for Cross-examination. One doctor a day, and the doctor is to come in in the morning. You are to cancel this afternoon's doctor.

Okay. Both sides ready for the jury?

MR. GASTMAN: No, your Honor. If you are telling me now to cancel the afternoon witness no matter what, I think I better do that right away.

This is a treating doctor --

THE COURT: I told you that in there an hour ago.

MR. GASTMAN: And I said, respectfully, let's see if we could get the first witness done.

THE COURT: It's now a quarter to 11.

MR. GASTMAN: He is only a radiologist. Not a treating doctor.

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THE COURT: The afternoon doctor, will he be able to come in tomorrow morning if he isn't finished in the -- today?

MR. GASTMAN: I could have my office make those inquiries. It may take just a little while more than a few seconds.

THE COURT: Yes. Have your office do that.

MR. GASTMAN: Sure. You want me to do that now or at the break.

THE COURT: Yes.

MR. GASTMAN: Okay. Should the doctor need to continue is for tomorrow morning? Is that your preference, Your Honor?

THE COURT: Whenever you want to continue with the doctor.

MR. GASTMAN: Okay.

THE COURT: Doctor, do you understand if you are not finished by one o'clock, you are going to come back at 2:15 for continuation of your direct or your cross? Do you understand?

THE WITNESS: Okay.

THE COURT: Okay. All right. Bring in the jury.

THE CLERK: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Okay. Good morning everybody. Welcome

back. Have seats. We will now continue with the plaintiff's case.

MR. GASTMAN: May I inquire, Your Honor?

THE COURT: Yes.

MR. GASTMAN: Thank you. We call Dr. Thomas M. Kolb, M.D. to the witness stand.

THE COURT: Okay.

T H O M A S M. K O L B, a witness called by the Plaintiff, after having been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

THE CLERK: Please state and spell your full name for the record and afterwards, please, put your address on the record.

THE WITNESS: Dr. Thomas K-O-L-B, M.D. Address is 257 West 34th Street, New York 10001.

THE CLERK: West?

THE WITNESS: 34th Street.

THE CLERK: Zip code?

THE WITNESS: 10001.

THE CLERK: Was there a suite or apartment number?

THE WITNESS: No.

THE CLERK: Your last name one more time.

THE WITNESS: K-O-L-B like boy.

THE CLERK: Thank you.

Your Honor, the witness is sworn in.

MR. GASTMAN: May I proceed, Your Honor?

THE COURT: Yes.

MR. GASTMAN: Thank you.

DIRECT EXAMINATION

BY MR. GASTMAN:

Q Dr. Kolb, good morning.

A Good morning, sir.

Q Are you a physician licensed to practice here in the State of New York?

A I am.

Q Doctor, could you tell this jury a little bit, please, about your academic and your educational background?

A Sure. I went to college here, Queens College City of New York, graduated in 1979. Then went to medical school here in Brooklyn at Downstate Medical Center for four years and became a physician in 1983.

I then became a pediatrician. I spent an internship and two years residency, three years total, at the Albert Einstein -- Jacobi Hospital Medical Center, Albert Einstein and Montefiore Medical Center in the Bronx and became board certified in pediatrics.

I then went back and did another four years of training from 1986 through 1990 at Columbia University, Columbia Presbyterian Medical Center in Washington Heights in Manhattan here and became board certified in radiology as well.

Q Thank you, Doctor.

Do you presently have a medical practice in New York?

A I do.

Q What type of practice is it, Doctor?

A So my practice is split into two parts. Part of my practice is doing breast cancer detection. I specialize in young high-risk women. I've been doing that for more than two decades, more than 25 years, and it entails physically examining every patient, reviewing their mammograms that are done at the time that I'm with the patient; if necessary, an ultrasound. I do them myself and if necessary, a biopsy. Less frequently, but, of course, biopsies are done and I do them myself. Also in this day and age, breast MRIs.

So I spend a good portion of my practice, let's say half of my practice, in doing breast cancer detection and breast cancer diagnosis working with the breast surgeons predominantly at Memorial Sloan-Kettering. The younger surgeons who are fellows come through my office to be trained in breast cancer detection.

I've written papers in the science of breast cancer detection and that's part of what I do every day. Other part of what I do every day is reading X rays, MRIs, and CAT scans in patients who complain of problems, most often pain, but all different types of problems. And that, I do also every single day.

Q Thank you, Doctor.

Doctor, could you help the jury to understand the differences or similarities between X ray, CAT scan and MRI?

A Sure. So X rays were discovered more than a hundred years of ago. They are a form of energy and what we do as radiologists, we shoot them in the body. Let's say we will shoot X rays and, of course, we will -- most of us have had X rays, and they are painless. We shoot the X rays through a body part and they are very, very good for telling the difference between hard versus soft.

So, for example, if you were to do an X ray of the neck or of the hand or any body part, you would see the bones very clearly. So if you were looking for a fracture, it is a very good test to look for a fracture because it sees things that are hard like bones.

But things that are soft, like nerves, arteries, veins, tendons, ligaments, cartilage in the joints disks that are in the neck and back, X rays cannot see that. They're just spaces, gray areas on X rays.

CAT scans use X rays, but they take the X rays and we make pictures in very, very thin slices, right. Patient, of course, doesn't feel anything, but we're able to look at these pictures, very thin slices, and that gives us a better view of all the things that are soft, whether they're disks or whether they're ligaments or tendons or muscles. So that gives us a

better view.

MRIs are a totally different technology. The M for MRI stands for magnetic. We use magnetic waves. We pulse magnetic waves into the body. The body reacts to these magnetic waves and we have a very strong computer that takes the information given by the body's reaction and generates pictures and you will see all that, and these pictures are very sensitive for looking at all the soft tissues.

Not only can we see the bone, but we can see the bone marrow, what's inside the bone. We can see the disks. We can see muscles tendons and ligaments. So MRIs are now very commonly used to look throughout the body to see if there is something abnormal or if everything is okay. That's a quick understanding of different technologies.

Q Thank you.

Doctor, did there come a time when my office asked you to review certain X rays, CAT scans and MRIs taken of this patient, Pedro Ramirez?

A Yes.

Q Would it be helpful for the jury to understand you for you to display some of the images while you were discussing them?

A Yes.

MR. GASTMAN: Your Honor, with your permission, we have some of these imaging studies. They're all in

evidence. We can put some up on the screen. Others are printed out.

THE COURT: All right.

MR. GASTMAN: Thank you, your Honor.

Q Dr. Kolb --

MR. GASTMAN: Your Honor, permission for the witness to step down from time to time if it helps demonstrate that which we are trying to show.

A Yes.

MR. GASTMAN: Thank you.

MR. GASTMAN: If I need an easel, it is back there somewhere?

THE COURT: It is.

MR. GASTMAN: Thank you.

Q Doctor, you are free to step down should you wish to and if you would, please, guide us, Doctor, what images you are going to look at?

MS. CAMACHO: Your Honor, may I?

THE COURT: Sure. There is a seat over.

MS. CAMACHO: Thank you.

A We can start with the neck, cervical spine. We can start with a CAT scan.

Q Doctor, because we are creating a written record while we are all working, I may pause for a moment to moment just to read into the record the evidence number or the date or some

information such as that.

A Just a minute of anatomy, so we are all on the same page and we are all going to learn about the spine. So in the spine, in the cervical spine, there are seven bones and we are going to talk about the lumbar spine anatomy is going to be pretty much the same so -- and also, you don't really have to remember any of the medical terminology. It is all going to be very obvious and easy for you to understand, I believe so.

So there are seven bones. Each one of these white structures here is a bone in our spine and you can feel them. You can feel the outside of these bones if you put your hand on the back of your neck here (indicating). So we start counting this as the second bone, the first bone is in the front here, second, the third, the fourth, the fifth, the sixth, and the seventh. We call these C for cervical, 1 through 7. So if I tell you C6, that means I'm looking at the sixth bone in the cervical spine.

But in order for us to move our neck and move around, these bones are really little joints. And in order for that to happen, there are these structures that you only see gray areas here between the bones that are called disks and disks in the back, in the neck, in the back are like shock absorbers because we don't want the bones to touch each other. So the bones are separated, whether it is the neck or the back or your elbow or your knee, or your shoulder, the bones in a joint should never

touch each other because that would be very, very painful. So we have separation by cartilage.

In this case, disks, when we talk about the spine, and these disks are held in place, so that when you move around or jump up and down, the bones don't touch each other. They are little shock absorbers that keep the bones apart.

Q Excuse me, Doctor, and I do apologize. Can we, please, be told the date and the facility where this image comes from, please.

A This is a CAT scan using X rays, a CAT scan on this patient, Pedro Ramirez Allende. The date of the scan is April 29, 2013 from St. Luke's Hospital.

Q All right. This is the day of the accident, Doctor?

A I believe so, the day of the accident.

Q Please continue.

MR. GASTMAN: Oh, and Your Honor, St. Luke's Radiology, it is in evidence as Plaintiff's 12.

A So we have these disks between the bones, so why when we move around don't the disks just spurt out? There are little shock absorbers, what keeps them in place. There are very strong coverings, ligaments that hold these disks in place and there is a ligament that runs behind the spine called the posterior longitudinal ligament. You don't have to remember the names for anything here, just the concept.

There is a ligament that runs down the back of these

bones. There is a ligament that runs in front of these bones, and then there is a ligament that runs around the bone like a circle, right. We're looking at this as a three-dimensional neck with a two-dimensional picture and I will show you the other pictures as well. This ligament that runs around the bone is called the annulus. That holds the disks in place. What goes wrong with these coverings and the disk are as follows:

You can have a partial tear of the ligament in the annulus and so the disk that was supposed to go to the margin of the bone, which it does here, and you'll see another -- in other pictures stops because it is supposed to stop. It is not supposed to go beyond that margin of the bone, but if you see a disk that also beyond the side of the bone, that means the covering, the ligament and the annulus has been torn.

So if it is partially torn and just peaking out a little bit, that's a disk bulge, so a partial tear, a partial tear of the annulus and ligament with disk material coming out is a disk bulge. If you have a complete tear of the ligament and annulus, the disk will poke through completely and that's called a disk herniation, a herniated disk.

So why do we care about herniated disks? What difference does it make? This is the patient's brain up here. This is the neck if you're standing like this, the patient's nose is here, and the brain is here, and this is the spine here. From the brain, this gray brain, this gray stripe coming down is

the spinal cord and the distance between the normal disk being held in normal position in the spinal cord is a few millimeters. So any time disk material pushes into a space that it is not supposed to go, it causes a pressure on nerves or the spinal cord even if it doesn't touch the cord. Some of these disk herniations are so big that you actually push directly on the spinal cord and if something pushes on the spinal cord, a patient may have pain.

So it is important for radiologists to diagnose or to be able to diagnose and evaluate disk herniations. So with that, we can start looking at these pictures. One other concept, we have the spinal cord coming down. All of the nerves of our body, right, our nerves eventually have to get down out of the spinal cord coming from the brain and have to get down your arm and in your back. They have to go down your leg to your toes, right, and your nerves have to go everywhere. All of these nerves that go out to different parts of your body originate in the spinal cord and at each level, this is the middle picture, like you took a picture in the center, but if you take a picture of the sides, you'll see holes on the side of the spinal canal, both, of course, in the neck and in the back.

And out of these holes on the side, and I'm going to show them to you, a nerve will come off the spinal cord and go out and that nerve at each level between C2 and C3, for example, C3 and C4, a nerve will come out and go where it is supposed to

go. That's how we feel things. That's how we feel pain. That's how our muscles are able to move by our brain telling our muscles to move. These nerves come out to different parts of our body.

Herniations can obstruct or impinge on these holes. Their medical term is neural foramen. The hole that contains the nerve root, the neural foramen, the hole that contains the nerve, that's another probability of a problem that a disk herniation can cause. That's pretty much everything you need to know in anatomy.

Now, we can look at these pictures. So on CAT scans, what we are going to do is take a picture, a side view like this, and then we can take multiple pictures this way through the disk level here. The easiest way to understand this is if you have a long loaf of bread, either Italian bread, French bread, there are two ways to cut it. You could cut it completely lengthwise, open it up, and what do you have? A hero sandwich. You have one sandwich that only has two slices. Part of the bread, top part and bottom part.

If you hold it up, you will see a long piece of bread from the top to the bottom and you'll only have two pieces of bread and you'll see from the top to the bottom, but you can also cut bread and make slices, right. And if you make slices, you'll be able to take each slice out and hold it up and each slice will either be round or square and you can make many

sandwiches.

So we do both as radiologists. We take pictures from the side, which are called sagittal views, from the side, and we take axial views which are those little pieces of bread that you hold up, and I'm going to show you both. The reason we take it from different parts, different ways is because as I said, everything in our body is three-dimensional, but these pictures are two-dimensional, so we are going to look at things in different ways. It'll all make sense in one second.

So this is the way the spine looks from a side, sagittal view. So let's go to the axial views. We need an axial --

Q Excuse me, Doctor. Just before we move on, so that we don't go back and forth too much, this imaging here, this is the side image, the sagittal image; is that correct?

A Right.

Q And the white squares up and down, those are the bones?

A Correct.

Q Doctor, does this CAT scan taken at the hospital on the day of the accident, does it give us any information as to the quality or condition of the vertebrae bones in in patient?

A Yes, it does.

Q Please tell us.

A So when you look at the bones, when you look at CAT scans, there are three stages of arthritis that can happen in

our backs, whether it is cervical, or mid back, or lower back. The three stages of arthritis are as follows:

The first stage is, and you won't see this on CAT scan well, but you will see it on MRI, is the disk dry-out. If you remember, I told you the disk is like a little shock absorber. There's jelly, literally a gelatinous type of material inside the disk and that will dry out as we age.

The second thing that will happen is because it dries out, the bones won't separate as normally as they would and bones don't like doing that. Bones want to be separate. So if you look at the heights of the disk, if you look at -- between this disk and that one and that one, you can actually measure and see whether there's been a change in height, that can be important.

The third thing is as the bone starts getting closer together, they form what's called osteophytes, little bone spurs and they do that -- the body does that in order to rebalance out the spine that's getting unbalanced because these disks are drying out. So you can see abnormal disk spaces here and you can see osteophytes in the cervical spine on CAT scans and X rays, too.

Q Doctor, are there any -- I believe the word you used was "osteophyte."

Are there any osteophytes in this patient's neck on the day of the accident?

A So in the front of the neck here, these little protrusions, these little -- instead of being completely square, you can see there is a little irregularity there. There are small osteophytes anteriorly.

Q When you say anterior, that means front?

A Yes.

Q What effect, if any, would osteophytes of this size and those locations, facing frontward, have on the spinal cord or the exiting nerve root?

A The ones that face to the front won't.

Q Please continue.

A Small ones, much lower down that the thoracic -- in the cervical spine, much lower down here, going a little bit towards the back as well. That's at the very lower cervical levels.

Let's go to -- can you do one-on-one? Can you do two pictures on the same screen? Yeah, beautiful. On that side, this is amazing. Scroll down. Do you have a line? Look at that. Stop at 2, 3, here, quick --

MS. CAMACHO: What slice? What slide are you looking at?

A So on the right side of the screen, my right side of the screen is the same picture of Pedro Ramirez, St. Luke's Hospital, 4/29/2013 and it is series 11, image 24. On the left side of the screen right now, if you go up on the axial, go up

one slice on the axial, perfect, stop, same patient, same hospital, same date. It's series number six, image number 46.

Let's look at this picture right here on your right. Everything here is round now. This is the analogy of taking slices from a long loaf of bread. This round area here is going to be the level of the disk and the bone between the second and the third bones. And if you'll see, this is -- assume that this is normal because you are not seeing any disk material. This is what you are supposed to look like. And this gray area here, which is a little difficult to see because it is a CAT scan, is the spinal cord. Remember the spinal cord is coming down this way, but when you take a picture like that, like a sandwich and pull it out, the spinal cord instead of being long is round here (indicating).

These spaces here is where the spinal cord gives off a nerve that goes out to the body on the left side of the patient and this space here is where the nerve comes out on the right side of the patient (indicating).

Q Excuse me. Doctor. I apologize. The left image, I see horizontal line at a certain place in the neck. Does that correspond in any way to the image on the right?

A So that's showing you that this round picture is being taken through this level, this yellow line.

Q Thank you, Doctor.

A So let's go down to 3-4. Yup. Yup. Keep going.

Stop. Back up. Okay. This is image -- series six, image 56. You'll see now that there's a gray area here behind the bone and that is disk material that's pushing out on to the thecal sac which is in front of the spinal cord. If you go up and down a little bit, you'll see -- go up one. Yeah. Down. Okay. Yeah. Go up a little bit. One more. It is hard to do it on this.

In any case, the disk material pushes out here towards the left side of the patient. Let's go down. We will see a little better as well. Stop. Go back up. Go to 4-5. Here. I know you can't see me. Go to 4-5. You know where that is. Yeah. Down. Stop.

So this here, all of this -- you're going to see this much better on MRI, okay, but on a CAT scan, this material -- this series six, image number 64, this gray area coming down here is a disk herniation that's pushing on the thecal sac and touching the spinal cord right here. You're going to see this much better, but that's the way it looks like on a CAT scan. Then go down to 5-6. Go up. Go up. Okay. Back down one. Good.

All of this material is pushed out, is a disk herniation, also that's pushing on the sac as well. So these are examples of disk herniations as seen on this patient. It turns out on this examination, this patient had four disk herniations between C3- 4, C4-5, C5-6, and C6-7. So there's a

quick tour through the CAT scan of the neck.

Q Doctor, since we're looking at CAT scans at this time, I'm wondering, is this a sort of test that doctors would consider to be objective or subjective and why?

A The pictures show what they show.

Q As long as a patient remains relatively still during the image taking, can the patient alter the outcome of what we see on these films?

A No.

Q Thank you, Doctor.

A So we can move ahead to an MRI done less than two months later and here, you'll really see more.

MR. GASTMAN: Your Honor, I believe we are about to demonstrate images that come from Lenox Hill Radiology. These images are in evidence as Plaintiff's 4.

Q Doctor, I apologize, but for the record, if you could identify the date and the facility, please.

A So this is Pedro Ramirez. The date is 6/26/2013 which is almost two months after the CAT scan that we just looked at. It was done at Lenox Hill Radiology. Now, it kind of looks like the CAT scan except you're going to see a lot more. Here, you can really see the brain, the bottom of the brain. Here, you can easily see the spinal cord that was so hard to see on a CAT scan, but now it is obvious this X ray stripe coming down, all the nerves from the body will come from that spinal cord.

You can also see the bones which are these gray squares and you can also now really see the disks. They're not just spaces between the bones, but they're actually disk material that you can actually see on here. And you can see very easily that this disk here goes to the margin of the bone and stops which means that the ligament and the annulus holding the disk in place is not torn. That's between 2 and 3.

You can see here if you go back and forth one, a little bit. Come back the other way. Go the other way. Go back. Stop. One at a time. Here, you see how obvious it is that this disk material is pushing out. That's a disk herniation and it is touching and abutting the spinal cord coming down. See how abnormal it is from the one above.

Now, go back and forth to 4-5. Back the other way. One more. That's it. Stop. Again, very obvious that the white line which is the fluid in front of the spinal canal is being pushed away and this disk here between C4 and C5 is touching the spinal cord. If you go back and forth, you'll also -- one click at a time. The other way. You're looking back. A small herniation at 5-6 and here, you can obviously see a small one at 6-7. So all the herniations that were there on the CAT scan two months earlier are shown better here on the MRI. It is much easier to see the anatomy.

Now split two screens and bring the axials up. We are going to do the exact same thing we did on the CAT scans but

you'll see it much easier. So on my right side is the sagittal view of the patient Pedro Ramirez, Lenox Hill Radiology on 6/26/2013. On my left side is the round view, the axial view. And look how beautifully between 2 and 3 with a normal level. You see the spinal cord. It is round just like the analogy that we made. You're taking a picture like that taking it out and looking at it like that. So everything is round.

You will see here are the nerve roots coming out to the patient's right side and the patient's left side. Go down between 3 and 4. There. Stop. Go back up. Yeah. See here now how these herniation is pushing here on the thecal sac and even a piece of the herniation is going out to the left side of the patient here, and it pushes on the left front part of the spinal cord right there.

So I showed you touching the spinal cord here, but here, you can see on the axial very well. Series four, image number six, go down to 3-4. Down. Good. Look. Look how different it looks than the normal one there. We saw the herniations on the side view. Now, you see it on the axial view pushing right on the spinal cord right there and down 5-6. Much of the same thing. So you get the idea. Here, it is flattened out. It is not touching the spinal cord. It is just flattened out and then the one lower, there's also a small herniation there. So the major problem here is the patient has four herniations. Two of them touch the spinal cord and the larger

one is at C4-5 between the fourth bone and the fifth bone. So you see it very nicely here on the MRI.

(Continued on the next page.)

Q Doctor, just to make sure we're all following, when you find that the herniation is pushing on the thecal sac, or pressing on the spinal cord, this is good or not good?

A It could cause pain. It's -- the answer to the question is it's not good.

Q Thank you, Doctor.

A So those are the findings. On the CAT scan and MRI.

Q Doctor, are there other images or studies?

A Just sticking with the neck, just the x-rays. Two x-rays we could show.

Q Okay.

A There are no other CAT scans or MRIs of the neck.

Q Okay. Are there other body part images you wish to review?

A I would do the X-rays first. Or do the back.

Q Doctor, do you know which office did the x-rays come from?

A Um, I could look at it. New York Orthopedic Sports Medicine and Trauma.

Q By all means, Doctor. Have a look at these images and see if any of these are what you are looking for.

MS. CAMACHO: I think this one is in evidence.

MR. GASTMAN: This one?

THE WITNESS: 4/10/17.

Q Okay. Good. Doctor, when you put something up that

has a sticker on it, just read that sticker. Let me find an easel for you.

(Exhibit displayed.)

Q Is this okay?

A Yes.

Q Doctor, one more time in case it's not yet in the record, the date and the facility name please.

A Yes. So the date of this is April 10th, 2017. It's an X ray of the cervical spine. It was done at New York Orthopedic Sports Medicine and Trauma.

Q And, Doctor, there is a sticker on that in the upper left corner. Read that into the record please.

A 7A.

Q Thank you, Doctor. Please proceed.

A So this X ray that I am showing you was done after the patient had surgery. We looked at the herniations and it's still up here behind. And right here at this level at C4/5 was the largest herniation that was pushing on the spinal cord right there. The surgeon went in and fused the two bones, C4 and C5. And put a disc stabilizer between the two bones.

Surgeons will do this in order to reduce the mobility so that when patients move their spine, C4/5 doesn't move anymore. Because with motion the patient -- if the patient is complaining of pain and could not tolerate anymore, the surgical fix to that is an anterior disectomy, taking the disc out that

was herniated and putting in a stabilizer, there is a metal stabilizer right there, and then putting screws in the bones at C4 and C5 and connecting the screws with a metal plate. Doing all that so it's fused.

Now when the patient moves their neck, C4/5 won't move, but there's now more -- there is more pressure at the disc above, C3/4 and the disc below. This is the surgical way of fixing the disc herniation that is causing a patient to have problems. So that is the finding. Patient -- all of the -- all of what you are seeing here in white is put in by the surgeon.

Q Thank you. Doctor, in your radiological practice, are MRI or other images taken of a patient after spine surgery, after hardware was put in?

MS. CAMACHO: Objection, Judge.

Q Withdrawn. Continue, Doctor.

A I think that is it for this picture.

Q Very well. Thank you. Are there other images or body parts you wish to demonstrate?

A The back.

Q We could proceed as you wish, Doctor. And if you are done with this, leave it right there. That is fine.

And Doctor --

A Lumbar --

Q These are all marked. I will place them where you could reach them. Use them as you wish. I don't know if you

are working off the blowups or the video. As you wish, Doctor.

(Brief pause.)

A So all of the anatomy we talked about is pretty much the same. There are bones, but in the lumbar spine there are five bones. And we call them L for lumbar, L1, L2, L5. And the final bone in the bottom is the sacrum. So it's called S. So we have the bones and you can put up a sagittal. The one on the bottom. 52.

MS. CAMACHO: What are we looking at?

A Yes, so we are now looking at a CT scan of the lumbar spine. Go further in a little bit.

(Brief pause.)

A Great. CT of the lumbar spine on Pedro Ramirez done on 4/29/13. Same day as the CAT scan of the cervical spine from Saint Luke's Hospital. And since we know this, let's go -- all right. We know all the anatomy. Each one of these is a bone.

This is L1, L2, L3, L4, L5 and this is S1. In between the bones is the disc. Discs are held in place by ligaments. Everything is normal otherwise, and it stops. Something is abnormal or torn, this will go beyond.

Go with the sagittal a little more. Put the sagittal. Go the other way.

(Brief pause.)

A Okay. Stop. One more. Back. No, the other way. One more. One more. Go back. Perfect. Okay.

So let's go down to 5/1 on the -- all right. I will identify everything. Great.

(Brief pause.)

A All the way down to 5/1. More.

(Brief pause.)

A Stop. Okay. Perfect. So same anatomy but five bones instead of seven bones. The discs are in between the bones here.

Okay. This is the sagittal view on the right side, for example Series 15, image 25. And now we're looking at axial view just like we did in the neck where everything is more round here, and that is let's say Series 8, image 69. You could see very clearly here disc material which should stop at the edge of the bone here is pushing out a great distance here. And it's pushing onto the thecal sac. One thing you should know, again you don't have to remember, but you should know the spinal cord that came out of the brain and goes down, it stops at around here and just gives nerves coming down through here. And the nerves come out through holes on each side of the patient to the left -- the right of the patient and left of the patient. Same concepts in the lower back.

Again, there is a disc herniation here that is pushing on the thecal sac. And this particular patient in this particular image -- you could go up one, it doesn't matter. You could see here that this nerve root here is being pinched off by

part of the herniation on the left side of the patient. So there is a herniation at L5/S1, that is both central and lateral to the side. Go up to L4/5.

(Brief pause.)

A One more down. Yes, one more. Okay. Go up one. You will see here that there is a disc herniation pushing out on Series 8, image 61. Same thing. Pushing into a space that it shouldn't be. Go up to L3/4. Go up. Down. Through the disc space. Beautiful. A little down. Yes.

So here you see is where the disc should end and here it's a little -- there is a gray area here peeking out. Again, you will see it much better on the MRI just like the cervical spine. Bottom line, on the CAT scan there were three herniations at L3/4, L4/5, L5/S1. Those were the major findings on the CAT scan.

Q Excuse me, Doctor. This is a CAT scan of the back and this is taken at the hospital.

Day of the accident, yes?

A Yes.

Q Doctor, do these images help us understand whether there is a lot of degeneration, a little degeneration or something else in this patient on the date of the accident?

A So there are -- there is some bone spurring. For example, here, here is a piece of bone coming up here anteriorly, and another piece of bone in the back at 4/5. So

those are osteophytes, or, bone spurs in the back. You could look at the disc spaces.

Again, if you go to the sagittal, go through the middle cut, just the sagittal -- no, the other one. Yes.

(Brief pause.)

A Go to the middle. Yes. So you could see the disc space here between the bones are relatively well-preserved here. In other words, they haven't significantly decreased in size. So that is what we look for also for degenerative changes. And they are relatively well-maintained.

Q Thank you. Doctor, are there other portions of this image or other images you wish to demonstrate?

A That is it. Let's just go to the MRI and we'll get a better look at all this.

Q Very well.

A MRI was done on June 26th, 2013. Again, less than two months later.

(Brief pause.)

A Great. Let's do one-on-one. So this is a MRI of the lumbar spine done on 6/26/13, patient Pedro Ramirez from Lennox Hill Radiology.

MR. GASTMAN: Your Honor, these radiology studies are in evidence as Plaintiff's 4.

A So on the sagittal, click one. Click the other way. Okay. Stop.

So here is normal. Look at the disc above here, like L1/2. Here where the disc comes to the margin of the bone and stops. But look what happens mostly on the bottom of the spine where the disc material is now pushing out beyond the bone because there is a tear of the annulus in here and here. To a lesser degree there. But at 3/4, 4/5 and 5/1 there are obviously disc herniations pushing out.

Take it down to 5/1. All the way down.

(Brief pause.)

A Stop. Now you could see better than the CAT scan. This is relatively normal. This mild narrowing right here at the right foramen with the nerve root coming out. This actual line right here, the nerve root that came from the middle here is travelling out to the patient's buttock and thigh. Here you see that it's all closed down. The space here is closed down because this part of the disc is herniated, like you see here. It's pushing out on the -- on the other view you could see where it's pushing out.

Go up to 4/5. Stop. There. Here you see a large herniation. Again, all of this is herniated disc. All of that at L4/5. For example, the axial only, go higher. Up. Yes, go up. Up. Stop. Perfect. Yes. Okay. Good.

So this is normal. This round circle that contains the nerve roots, this is all disc material here. Nothing pushing anywhere. That is what normal looks like.

Go down to, you know, L4/5 again. Here. Stop. Go down. And you see how abnormal it looks here. So there you see what a herniation looks like on both views. So the findings are three herniations on the MRI, which push on the sac and push on the -- at this level, 5/1, it pushes on the left side, nerve root coming out. At L4 -- so those are the major findings on the MRI. You could see how nicely the disc height is maintained. Look at the normal disc here. Each of these are relatively the same height. So they hadn't diminished in height very much at all. I think that is really --

Q Thank you, Doctor. There are a few more images. Perhaps you covered what you wanted to cover.

A I think that -- yes.

Q Good?

A Yes.

Q Doctor, if you are done demonstrating, you could please feel free to have a seat.

(Witness complies.)

Q Will the imaging studies be used by you or take them down?

A Not by me.

Q Okay. We'll take them down. Thank you.

(Brief pause.)

Q Doctor, you went to medical school like any other medical doctor?

A Yes, sir.
Q And then you became board-certified in radiology?
A Yes.
Q Well, in medical school do doctors learn how to read the type of films we've been looking at?
A Yes, they do.
Q Why do medical practices frequently rely on radiologists' reports on films if any doctor could read them?
MS. CAMACHO: Objection.
THE COURT: Overruled. You could answer.
A Well, every part of the medicine is specialized. You learn about kidneys also in medical school, but that is not enough to be a doctor to take care of kidney disease. You have to focus on kidney disease and become a nephrologist. It's the same answer of any doctor.
Q And, Doctor, what type of medical practices refer images to you to be read or to be taken?
A Orthopedists. Surgeons. Pain doctors. Any doctor who has a patient that is complaining of symptoms and can -- can ask for an X ray, MRI or CAT scan if it helps the patient.
Q Doctor, do you have -- I want to ask you a question or two. I want you to assume that on the date of the accident Mr. Ramirez had never ever had medical care for the neck and back.
I want you to further assume there were no large times

lost from work due to any neck and back problems before this accident. Given the films that you have read and reported on, Doctor, do you have an opinion that you could express to a degree of medical certainty as to whether all these herniations are degenerative; in other words, not from the accident, from something before?

MS. CAMACHO: Objection.

THE COURT: Overruled. You could answer.

A I need to know a little more. Are you saying that the patient wasn't seeing doctors --

MS. CAMACHO: Objection, Judge. He couldn't answer the question.

THE COURT: Wait for the next question. Yes.

THE WITNESS: Sure. Sure.

Q Do you have an answer to that last question, Doctor?

A I need more information.

Q Sure. I want you to assume that Mr. Ramirez has never had medical care for his neck and back prior to this accident. I want you to assume that there are, therefore, no imaging studies of the neck and back ever taken before the date of this accident. I want you to further assume that the plaintiff never lost significant amounts of work due to neck and back problems prior to the accident. And then he fell on the date of the accident approximately fifteen to twenty feet, knocked unconscious, taken to the hospital. And you looked at those

imaging studies with the jury today from the date of the accident.

Doctor, do you have an opinion that you could express with a degree of medical certainty as to whether the herniations predate the accident?

MS. CAMACHO: Objection.

THE COURT: Overruled. You could answer.

A Yes.

Q Please tell us.

A If the patient wasn't being treated, wasn't complaining about anything, had a trauma and then started to complain, and then started being treated to the point of getting films, MRIs, X-rays, CAT scans, to the point of needing surgery, then the herniations that are the cause of this patient's pain because they push on nerve roots, would be caused by the trauma that the patient suffered since the patient wasn't complaining about any of these symptoms prior to the trauma -- to answer your question, whether it's due to arthritis or not, degenerative or not, there is no reason to believe that it would be because arthritis takes many months to years to form.

At this -- if this patient -- and definitely was there before the date of the accident, whatever arthritis was there was there before the date of the accident. If the patient was not complaining, seeing doctors, getting images or surgery, therefore the answer to your question is that these herniations

are caused by the trauma.

Q Doctor, are herniations always painful?

A No.

Q Surgery was performed at some levels, not all the levels of the herniations you found?

A That's correct.

(Brief pause.)

Q Doctor, if I told you that a chart here in evidence, St. Luke's Roosevelt, the day of the accident, if I told you the only mention of degeneration in that chart with regard to films was mild degeneration, would you agree, would you disagree or something else, Doctor?

A I would agree.

Q Doctor, and your opinion as a radiologist, if you want to see injuries such as herniations, which of the type of film studies we looked at would be the best?

A Oh, the best would be MRIs.

Q Okay.

A Honestly.

Q Doctor, I thank you. Please stand by for the Court's instructions and additional questions. Thank you.

A Sure.

THE COURT: All right. Any Cross?

MS. CAMACHO: Yes, your Honor.

CROSS-EXAMINATION

BY MS. CAMACHO:

Q Still good morning.

A Good morning.

Q I will just ask you a couple follow-up questions. Now, you have a specialty in breast research and breast scanning, correct?

A Specialty in radiology which includes doing breast imaging, yes, correct.

Q You spend a majority --

A No, I didn't say that. I said about half my time. It's hard to quantify time, so I will say about half my time doing breast cancer diagnosis and half doing scans on patients who have pain.

Q What percentage of those scans are sent to you by attorneys to review?

A Oh, when I say that I do scans, I actually do the scans. So when I read MRIs, the vast number, I can't give an exact number, but the vast majority are scans that I actually do as a radiologist.

To answer your question, what percentage are sent to me by attorneys, that's a tiny, tiny fraction of what I do.

Q Well, doctors refer patients to you for scans; is that correct?

A Yes.

Q And that could be anything from looking at a spleen or

looking at internal organs to looking at bones, necks, anything like that, correct?

A Yes.

Q And that is sent from another doctor?

A Yes.

Q And you get referrals from New York Orthopedic, Dr. Kaplan and Dr. Grimm, correct?

A They do send patients to be scanned, yes.

Q And with regard to Mr. Ramirez they didn't send you -- they didn't send him to you for scans in this case; is that correct?

A Of the neck and back, that's correct.

Q And the reason you reviewed those films was because his other -- Mr. Ramirez's attorneys sent the scans to you to look at, correct?

A Yes.

Q And you have been working for them -- with them for years, correct?

A They have sent me films over the years.

Q I think I went back and found some over twenty years ago?

A Yes, for sure.

Q You testified for them as well?

A For many years, yes.

Q And you were also sent -- you were sent films by other

doctors to review? Or primary --

A Yes.

Q Primarily when you are sent a film to do a review, it's by a law firm?

A If I am sent films which make-up a tiny fraction of what I see, yes, doctors also send me films, yes.

Q And you have had different types of practices over the years, fair to say?

A Um, I have had two practices over the last thirty years.

Q And one of those practices was Precision Imaging?

A Yes.

Q And that company was formed pretty much for -- to provide services for individuals who are involved in some type of litigation, correct?

A No.

Q You were a shareholder with a Dr. Jacob Lichy?

A Yes.

Q And that was primarily -- it was dissolved after some issues, but it was formed I believe for purposes of dealing with individuals who had been in accidents?

A Not that I am aware of. And Dr. Lichy died. That is why it was dissolved.

Q You didn't have a dispute with him?

A Dr. Lichy, as much as I could say here, Dr. Lichy had a

fatal illness, unfortunately. I have been his partner for over twenty years and we have been completely harmonious together. We have written papers together. We saw each other every single day. He wanted me to continue the practice without him for his family but I had to start a different practice. That was the dispute from Dr. Lichy who soon after passed away.

Q There were several litigations with regard to contract disputes, no?

MR. GASTMAN: Your Honor, objection. Relevancy. Side-bar.

MS. CAMACHO: I will move on.

(Brief pause.)

Q Now, when you see water lost in the discs, that suggests to you degeneration, correct?

A Yes, another way of saying it is aging, degeneration, yes.

Q And arthritis forms over a long period of time, correct?

A Yes.

Q So first we have loss of fluid, correct?

A Yes.

Q And then we have narrowing, correct?

A Correct.

Q And then we have osteophytes?

A Correct.

Q So by the time you get to the third level, that process is something going on for a long time, correct?

A To the osteophytes, at least months or years, correct.

Q Okay. Now, let me ask you a question.

A Sure.

Q If somebody has degeneration with herniations, and advises their treating doctor that they have been able to control the pain, is that -- does that suggest to you that there's been some sort of impingement during that period of time?

A I couldn't answer that yes or no. It's the same question I was asked before. The answer is yes, you could have a herniation without pain. You may have pain or debilitating pain. I can't look at the picture and tell you if the patient has debilitating pain.

Q That is -- I didn't ask you about debilitating pain. I asked you about being able to control pain.

A Can patients control pain?

Q If Mr. Ramirez advises his doctor that he was able to control pain over a period of three years, does that suggest to you that there was something going on during that period of time?

A That is outside the realm of me being a radiologist. I don't treat patients to control their pain.

Q Fair enough. And you can't look at a film on a

specific day and indicate whether or not a particular patient has pain or not, can you?

A No, I can not.

Q So there are people who have herniations who have pain?

A Correct.

Q And people who don't have pain with herniations?

A Correct.

Q And you -- the CAT scans taken of Mr. Ramirez's neck and back on the date of the accident --

A Correct.

Q Okay, let's take two steps back. You have seen -- what is the difference between traumatic and degeneration?

A In terms of herniations you mean?

Q Yes.

A Trauma could cause a herniation by tearing those ligaments or just regular aging, getting older or your spine degenerating, you could also have those ligaments tear.

Q Okay. Now, once somebody has arthritis in their spine, the areas become more brittle, correct?

A In general, they become more unstable, yes.

Q And brittle. You used that word, correct?

A That is fine with me, yes.

Q Okay. Brittle. Now, I want you to assume that after this accident Mr. Ramirez was sent to a trauma 1 hospital. You know what that is?

A Go ahead.
Q I am asking you --
A No, I don't know the definition.
Q You practice in New York --
A I don't know the definition of what trauma 1 stands for.
Q Are you familiar with that term?
A I assume it's a high level trauma center.
Q Are you familiar with Saint Luke's Hospital?
A Yes.
Q And the ER there?
A No, I am not familiar with the ER.

- Proceedings Continue Next Page -

Q And the ER there?
A I'm not familiar with the ER.
Q Do you know what code red means?
A It means that a patient is in extremis and a medical team has to immediately get to the patient.
Q A team -- a team of doctors?
A In general, a code red, I would imagine so.
Q Did you review Mr. Ramirez's records?
A I did not.
Q Were they provided to you by counsel when they asked you to review the films?
A I don't remember whether they provided it. I don't have a recollection of reviewing it.
Q Fair to say that one of the things the radiologists were looking for was if somebody fell from a height, fractures in the vertebra?
A For sure.
Q Because there are burst fractures, correct?
A Oh, there are many types of fractures. That's correct.
Q What type of fractures have you seen in the spine as a result of a fall?
A Fractures of the vertebrae? I'm not sure I understand the question.
Q Well, you said there were several different types of fractures, correct?

A Yes.
Q That's what you just said, so now I'm asking if you could explain yourself.
A There are fractures that could be displaced. There are fractures that are not non-displaced.
Q With regard to the spine?
A With regard to the spine.
Q Burst fractures?
A Burst fractures.
Q Those vertebrae, they can fracture, correct?
A They can.
Q And they do fracture very often as a result from a fall from a height, correct?
A I don't know what "very often" means in terms of herniations. They very rarely fracture, but patients who fracture their bones from a height end up in an ICU, yeah --
Q So --
A -- which is uncommon.
Q There were no fractures seen on Mr. Ramirez's lumbar or cervical spine, correct?
A Correct.
Q And there was degeneration seen, correct?
A Yes.
Q Were you able to see any tearing of the ligament?
A No. You see the disk material pushing out where it

shouldn't be and and you know that the ligament is torn.

Q Okay. What happens with the ligaments in the spine? Are they the same as the ligaments we have in the rest of our body?

A By and large. I'm not sure what the question is, but are they the same? Yes.

Q Are they made up of the same --

A Material?

Q -- material?

A Material, yeah.

Q And they have blood vessels supplying them like the rest of our tendons do?

A There has to be some degree of blood vessel supplying the cells.

Q And what happens when they tear?

A They come apart.

Q Okay. And when we tear tendons in other parts of our body, generally, you can see evidence of the tearing. You can see bruising, right, where the blood -- where the tendons basically bleed inside your body, right?

A No. Other parts of the body if a tendon tears, it's possible to see blood. Again, most often, you don't.

Q Okay. Any evidence of the tearing of the tendons that you saw on those CAT scans?

A Well, there are no tendons that I talked about.

Q Did you see any evidence of torn --

A There are to tendons.

Q Withdrawn. That was my misstatement.

Did you see any evidence of torn ligaments?

A Yes. By definition, the ligaments are torn because the herniations has poked through, yes.

Q And the evidence that they were torn that day, any bleeding, any -- any evidence that those herniations were created that day?

A No, because that would be extremely unusual and the answer to the question is no, I don't see any evidence of bleeding. Again, that type of patient would end up in the ICU and that's unusual.

Q Because you worked in an emergency room and you know how many people end up in the ICU or --

A Because I read CAT scans and MRIs in patients that have herniations that weren't in the ICU.

Q Okay. But you don't read the MRIs or the CAT scans of the hospital patients that are seen, correct?

A I don't work in a hospital, that's correct. At this point in my career, I don't work in a hospital. That's correct.

Q And I believe you told this jury that you can't -- the only way, right, that you can give them an opinion within a reasonable degree of certainty is based on all those hypotheticals counsel asked you about, right?

A That's correct.

Q That's assuming there was no issues before. That was assuming there were no complaints before. That's assuming all of that information, correct?

A That's correct. No one can look at that film and say it occurred that minute or that ten minutes before. In other words, you need -- to answer your question or to answer his question, I needed that additional information. That is correct.

Q But it's fair to say that all the arthritis, all the degenerative changes, you can tell the jury within a reasonable degree of medical certainty that has been there for a good period of time?

A Sure.

Q Months, if not years?

A Sure, absolutely.

Q Now, when you looked at the C.T. -- the X ray of the cervical spine that was taken on April 10, 2017 you wrote the vertebrae or in normal alignment correct?

A Yes.

Q So everything that the surgeon wanted to do, he did do? It was aligned properly?

A No. I don't understand the question.

Q Well, what did you mean that they visualized vertebra in normal alignment? Those were your words.

A Sorry. Which date are you reading from.
Q April 10, 2017, the one you showed the jury.
A Oh, sorry. Oh, the X ray of the cervical spine?
Q Yes.
A Yeah. So one thing you want to make sure of is that each one of the vertebrae, the bones are lined up correctly because you can get slippage either forward or backward from the surgery or after the surgery, and so you want to tell the surgeon that things are normally aligned and the surgery looks okay.
Q If they slip or out of line, you would have then -- you might have impact on the cord or the thecal sac or some nerves, correct?
A I mean, it is a possibility.
Q Yeah. But here, in 2017, four years after, based on your review of the film, there was normal alignment, correct?
A Yeah, that's overwhelming. This is the majority of the cases there are and this one is.
Q Then you wrote "no evidence of listhesis."
A That's the same thing. The medical term for slippage is listhesis.
Q And so you wrote again two times visualized normal alignment and no evidence of listhesis, correct?
A I agree with you, yes.
Q You didn't review the reports from the hospital,

correct?

A I don't remember doing that, no.

Q But you remember reviewing the films or --

A Well, the films I wrote reports on, so I did review the films.

Q Let me ask you a question. I know you said you've been working with Gorayeb's office for years. Can you estimate for us how often you -- will you review films? I'm not asking how often you come to court. Right now, how often do you review films for them.

A I have no idea.

Q Is there anybody in your office who keeps track of that?

A No, not that I'm aware of. I'm not aware of it.

Q Do you review films on a daily, or weekly basis, or biweekly basis that are sent to you to review for law firms?

A By any law firm?

Q Any law firm.

A No, definitely not.

Q I mean law firms as a whole, not one --

A Yeah, any law firm. Absolutely not.

Q So when you were sent these films to review, that was a separate charge from coming to court to testify, correct?

A Yes.

Q And what was the charge?

A $850, if I remember correctly, for MRIs, CAT scans and a smaller charge for X rays.

Q Each one?

A Each one, yeah. There were two C.T. scans and two or three MRIs and then some X rays. Each one is separate.

Q Do you know what you were paid for all of them here?

A 850 for a CAT scan and MRI and some smaller number, 350 or 300, for an X ray. I don't know exactly, but it is around that area.

Q How many films did you review?

A I don't know. So I think two C.T., three MRIs, and what I have here. I have one, two, three, four, five, six X rays, seven X rays of the cervical spine. One, two, three, four, five, six X rays of the lumbar spine, yeah.

Q And then is there a charge for prep when you went through what you were going to look at with the jury?

A No.

Q And what's your fee for coming in today?

A $9,500 for my office.

Q Well, it is your office, though, right? You're the --

A It goes to my office.

Q You're the president, CEO and owner of your office?

A That's what I mean. It goes into my office, not to me.

Q Do you have any other shareholders or officers of your company?

A I don't.

MS. CAMACHO: I have nothing further.

THE COURT: Okay. Any redirect?

MR. GASTMAN: Yes, Your Honor, brief. Thank you.

REDIRECT EXAMINATION

BY MR. GASTMAN:

Q Doctor, you were asked by defense counsel a few questions about arthritis and degenerative findings.

Doctor, let me ask you, if a radiologist on behalf of the defendant has an opinion that the MRIs of the neck we looked at from 2013 show osseous remodeling reflecting chronicity, do you agree or disagree with that?

A Well, I'm not sure I understand the wording of what is being remodeled. I said -- when I said there are small osteophytes or bone spurs, which are mild, I don't know if there is any more -- maybe there's more specificity in what the word "remodeling" means and what bone or part they're talking about. I can't interpret that phrase.

Q Doctor, you did point out some small osteophytes in some of the films, true?

A Yes, true.

Q Could they have affected the spinal cord for the exiting nerve roots?

A No.

Q Why?

A They're in the front of the spine.

Q And if I told you, Doctor, that a radiologist on behalf of the defense also declared that they see in the MRI of the neck of June 2013 adjacent end plate remodeling and scarring, do you agree or disagree?

A Osteophytes come from the endplates, so maybe that's what they mean. I don't know, but that's where osteophytes are, from the endplates.

Q Okay. Doctor, is soft tissue something that is reported on from time to time in films, soft tissue seen in films?

A I don't understand the question. You mean abnormalities in soft tissue?

Q Yes?

A Any abnormality can be reported on a report including soft tissue, yes.

Q All right. Doctor, you were asked questions about fees earned by you and your office.

Doctor, if you were not reading these films for this patient and if you were not here in this courtroom, what would you be doing?

A I would be in my office.

MR. GASTMAN: Thank you, Doctor.

MS. CAMACHO: One question, maybe two.

THE COURT: Yes.

RECROSS-EXAMINATION

BY MS. CAMACHO:

Q Didn't you tell the jury when you were looking at the C.T. scans and the MRIs of the cervical spine that not only were there osteophytes anterior, but you also went kind of oh, yeah, there's some back here too, right?

A Yeah, right, but I wasn't asked that. I was asked whether it pushed in any nerves or anything. In other words, it wasn't near any herniation or any nerves. The same answer as anteriorly, correct.

Q Okay, but you did see some in the back, correct, and some in the back at certain levels could cause pain and impingement, correct?

A It didn't. I mean, like I said -- let me be very clear. There's nothing going on in terms of degenerative, long-standing chronic things that are anywhere near nerves, spinal cord or the holes that the nerves are traversing through. Whether the patient has pain or not is what the patient is feeling, but there's nothing from a degenerative point of view that says that the degeneration is causing any pain.

Q The degeneration including the herniations could cause pain. We just don't know whether they are or not. That's what you are saying?

A I'm being told that this patient was not having pain until he fell down, but I also know and we've said in court here

that these spurs, or bone, or remodeling, or sclerosis, or scarring takes months and months and years to form. But this patient wasn't having pain, so I was asked a question whether the herniations are from the trauma and I'm answering your question as well can there be little things in the back that are also causing the patient's pain, but if they were causing the patient pain, they could have caused pain before the trauma.

Q So you are assuming there was no pain before?

A I don't know the answer to that.

Q I'm saying take away that assumption, take away the assumption that there was no pain before.

A Sure.

Q That there wasn't three years of controlled pain, or let's take that away.

A Yeah.

Q Then I'm asking you if the degeneration and the bone spurs and osteophytes and herniations, if those objective findings could cause pain.

MR. GASTMAN: Objection to form, Your Honor.

THE COURT: Overruled.

You can answer, if you can.

A Yeah. The same answer no, because again, there's nothing pushing on nerves or any -- or near any nerves to be causing pain. So to the best, the best of my ability in looking at the films, for me to predict whether the patient was having

pain from any arthritic changes, I don't see that.

Q I included herniations in that.

A Yeah. So I don't know the answer to that. All I know is the patient has herniations and is complaining of pain herniation and so those herniations and they're pushing on nerve roots and it is pushing on the spinal cord --

Q Right.

A -- which the osteophytes are nowhere near.

Q But I said to you --

A I'm sorry. Go ahead.

Q -- you don't know when those herniations were formed.

A I can't look at the picture and tell you date and time that those herniations formed, that's correct. Nobody can.

Q They could have been there three months before?

A Well, they could have been there at any point you can make up. In other words, no one -- anything could be anything, but there's no reason to believe it. But the answer to your question is yeah, anything can be anything, but there's no medical reason to believe that based on the films and what I'm being told about the patient's symptoms.

Q And what you're being told?

A Yes. I'm going to repeat that again. I have to be told that the patient is actually having pain, right?

Q Because you don't know -- you can't --

A Right. I didn't speak to the patient myself.

Q You can't give this jury an opinion under oath within a reasonable degree of medical certainty without completely relying on what Mr. Ramirez tells you, correct?

A I did not examine or speak to the patient, so I'm relying on what the patient is saying, that's correct.

MS. CAMACHO: I have nothing further.

MR. GASTMAN: Just a brief re-direct.

REDIRECT EXAMINATION

BY MR. GASTMAN:

Q Doctor, how long have you been reading films as a board-certified radiologist?

A 30 years or more.

Q Yes or no, do you typically meet about the patients for pain cases, or you just see the films, or something else?

A I just see the films. For MRIs, CAT scans, X rays, I just see the films.

Q And when you read those films, you report on them?

A I give the information back to the doctor.

Q If you find herniations, you say so?

A Correct.

Q If you find that the herniations are pressing on a fecal sac or exiting nerve root, you say so?

A Correct.

Q You report on the abnormalities?

A Correct.

Q Anything in the films that you looked at that suggest to you degeneration to the point where these herniations were painful and pre-existing this accident?

A There's nothing that tells me that in terms of degeneration as I've said.

Q Have you given your medical opinion to this jury with a degree of reasonable medical certainty?

A Yes.

MR. GASTMAN: Thank you, Doctor.

MS. CAMACHO: Nothing further.

THE COURT: Okay. You're excused.

THE WITNESS: Thank you.

THE COURT: Yes.

(Witness excused.)

THE COURT: We will take a five-minute break.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exited the courtroom.)

THE COURT: From now until 1:00, I want to have a jury charge, verdict sheet conference and then you can call the doctor if the doctor confirms with me that he is going to come back tomorrow, if he's not finished by 4:30 today.

MR. GASTMAN: Your Honor, thank you for all that information and those instructions. I need a couple of minutes to confer with my office, the doctors that you wish to alter schedules. I'm going to need a little while.

THE COURT: It is not altering the schedule. It's if he is not finished by 4:30, he has to come back on Wednesday or some other time.

MR. GASTMAN: That's what I'm trying to find out, Judge, which day -- I'm trying to find out what day or days these doctors are and are not available.

THE COURT: No, only today's, this afternoon's doctor.

MR. GASTMAN: I'm only talking about that doctor. Yes, it may take a little while. Your Honor, I'll do my best to suffer through a charge conference, but once the evidence is in, defendant hasn't even started yet. I don't know if I have all those materials with me this morning. I will make my phone calls, come back, and I will search to see if I have that. Thank you.

THE COURT: Let's concentrate on the doctor first.

MR. GASTMAN: Thank you. I'll do that.

(Whereupon, a lunch recess was taken.)

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

* * * * *

MS. CAMACHO: The next witness is Dr. Jeffrey Kaplan who is another physician from the same practice as the doctor we had yesterday.

THE COURT: Yes.

MS. CAMACHO: In terms of numbers, this doctor saw

him maybe ten percent of the time and primarily with regard to his knee and the last time I think he saw him was in 2019.

We have had a notice of medical exchange back in '15 and that was a report that he completed at the request of the attorney's office, but primarily, it reviews Dr. Grimm's treatment. And the 3101(d) we received primarily reviews the treatment of, again, Dr. Grimm and Dr. Brisson.

Because Dr. Grimm and Dr. Brisson have testified here, I want to avoid cumulative opinion and cumulative testimony. I understand Dr. Kaplan can come in and attest to the handful of times that he saw him, but I want to avoid having duplicative testimony, duplicative opinions especially since he was basically a minor player in the practice.

THE COURT: Any response?

MR. GASTMAN: Yes, Your Honor, you bet. Dr. Jeffrey Kaplan is not just an expert in this case. Dr. Kaplan is not limited to what may be found in a 3101 and what may be found in notice of medical exchanges. Dr. Kaplan is a treating physician who has had hands on this patient since early on. The accident was more than ten years ago.

I will avoid duplication. I don't want to bore the jury and there's no reason to do things twice. However, the

treating doctor may certainly discuss medical treatment and his medical opinions. He's been treating this patient for more than ten years.

MS. CAMACHO: Maybe counsel didn't hear me. I had no objection to him providing the jury with the information of his treatment and information that he -- or opinions he wants to give regarding his treatment.

What I said with regard to the 3101(d) and the expert disclosure is that that primarily is duplicative of the testimony we've had here. So I don't know if I wasn't clear the first time. If so, I apologize. What I'm trying to avoid is him reviewing and restating Dr. Brisson and Dr. Grimm.

THE COURT: Okay.

MR. GASTMAN: Well, that will depend in part what you ask him.

MS. CAMACHO: I'm not --

THE COURT: Are both sides ready for the jury?

MR. GASTMAN: Absolutely .

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Okay. Have seats. Thank you very much. It has also been brought to my attention that there have been some concerns about scheduling. Don't worry, be patient and both attorneys are working expeditiously and

efficiently in order to have this case finished when it is appropriate, okay.

So call your next witness.

MR. GASTMAN: Yes, Your Honor. At this time, we call Jeffrey Kaplan, M.D.

THE COURT: Okay.

J E F F R E Y K A P L A N , a witness called by the Plaintiff, after having been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

THE CLERK: Please state and spell your full name for the record and also place your full address on the record.

THE WITNESS: Sure. My name is Jeffrey Kaplan. J-E-F-F-R-E-Y, K-A-P-L-A-N, and my office is at 160 East 56th Street, 10022.

THE CLERK: 1-0.

THE WITNESS: 0-2-2.

THE CLERK: No floor, apartment or suite, no?

THE WITNESS: No.

THE CLERK: Thank you.

Your Honor, the witness is sworn.

And you may be seated.

THE WITNESS: Thank you.

MR. GASTMAN: May I inquire, Your Honor?

THE COURT: Yes.

MR. GASTMAN: Thank you.

DIRECT EXAMINATION

BY MR. GASTMAN:

Q Dr. Kaplan, good afternoon.

A Hi.

Q Are you a person licensed to practice medicine here in the State of New York?

A Yes.

Q And Doctor, could you tell this jury a little bit, please, about your medical education and background?

A Education, I went to college at Yale University. When I graduated from college, I went to medical school here in the city at Columbia. I then did a residency training program in orthopedic surgery. I did that at a place called Campbell Clinic in Memphis, Tennessee. After I finished that program, I moved back to New York where I have been in private practice ever since.

Q Thank you.

Are you board certified in any field of medicine?

A I'm board certified in orthopedic surgery and combat medicine.

Q Doctor, could you tell the jury a little bit, please, what does it mean to be board certified as a physician here in New York?

A Well, it's actually a national thing, not a state

thing, and it is simply taking a number of examinations over a number of years, after you finished college, medical school and residency training program.

You take a series of examinations that are both written and oral examinations given by a panel of expert physicians, in my case, called the American Board of Orthopedic Surgeons and the American College of Sports Medicine, and they have to do -- they ask you questions about your practice specifically and your basic knowledge of orthopedics and if they feel you've reached a certain level of expertise and knowledge, they deem you board certified.

Q Thank you.

Doctor, do you currently have a medical practice -- Doctor -- withdrawn.

Could you tell us, please, a little bit about your current medical practice? What sort of patients do you see, please?

A My practice?

Q Yes, Doctor.

A I see orthopedic injuries and abnormalities and orthopedics is the study of bones and joints and injuries and abnormalities, so the supporting structures of the bones and joints, so like muscles, tendons, ligaments, cartilage, things like that. And it has to do with treatment either conservatively with medications, injections, physical therapy,

or if those things don't work or are inappropriate, then surgical treatment of those problems.

Q Doctor, do you perform orthopedic surgery from time to time on your patients?

A Yes.

Q Could you tell us, Doctor, when is the last time you performed surgery?

A Last Friday was my last surgical day and tomorrow is another surgical day.

Q You correctly anticipated my next question.

Doctor, did there come a time where the plaintiff in this case, Pedro Ramirez, came under the care of your office?

A Yes.

MR. GASTMAN: May the doctor kindly be provided with the medical chart in evidence, New York Ortho Sports. It's Plaintiff's 10 in evidence. Thank you.

Q Doctor, I may refer to the chart as you wish.

A Okay.

Q Let's start at the beginning, please. Can you tell us when did Mr. Ramirez -- withdrawn.

Doctor, what is the -- does your medical office have a name?

A Yes.

Q And what is that?

A It's called NY Ortho Sports Medicine and Trauma, PC.

Q Thank you.

Doctor, can you tell us, please, when did Mr. Ramirez first come under the care of New York ortho?

A You have to give me a minute here, get this in the proper order. This appears to be shuffled a little bit. I'm sorry. Give me sometime here.

Q Doctor, since the chart is in evidence, would it be helpful if I offer a date?

A Yeah, but I can find --

Q May of 2013, May 8th.

A Okay. Got it. Okay.

Q Doctor, could you tell us, please, what was the name of the physician who first met with Mr. Ramirez at New York Ortho?

A He was first seen by one of my associates Eric Crone.

Q Is Dr. Crone presently with the practice?

A No, Dr. Crone retired from medicine.

Q And could you tell us just approximately, Doctor, just approximately, when did he leave the practice, approximately?

A Approximately 2014, so it's been quite a while.

Q Any surprise that we don't see that doctor's name again in this chart?

A No.

MS. CAMACHO: Objection.

THE COURT: Overruled.

You can answer.

A Yeah. No, he retired shortly after this.

Q In addition to yourself, Doctor, and Dr. Crone when he was with the practice, could you tell us, please, what other physicians do you recall by name that were with the practice at around this time, 2015?

A We had a Dr. B-O-P-P-A-N-N-A. We had Dr. Grimm, who's still with us, and myself.

Q You should know, Doctor, that Dr. Grimm appeared before this jury in the recent number of days.

A Correct.

Q Doctor, when Mr. Ramirez came to the offices, did he indicate why he was there?

A He was there for injuries that were sustained to his neck, back and shoulder, so it occurred in a work-related accident on April 29, 2013.

Q Did you come to have an understanding, Doctor, generally speaking what happened to the man that day?

MS. CAMACHO: Objection, Judge.

THE COURT: Overruled.

You can answer.

A Yeah. He had a 13-foot fall recorded by Dr. Crone while working. He was initially evaluated at St. Luke's Hospital.

Q Thank you.

Doctor, did we hear the date already? I apologize if

we did. What was the date of the event, the accident?

A April 29, 2013.

Q Okay. So he got to your offices about a week later, nine days later, approximately?

A Yes, correct.

Q Doctor, could you tell the jury, please, what sort of treatment was offered to Mr. Ramirez and in the first six months or a year of his treatment at New York Ortho?

MS. CAMACHO: Objection, Judge. Cumulative and it is -- we went through all of this already.

THE COURT: Could you read back the question again, please.

(Whereupon, the requested portion of the record was read back.)

THE COURT: Are you the treating physician?

THE WITNESS: Yeah, I treated him.

THE COURT: I will allow it.

You can answer the question.

A So he had treatment with both orthopedics and pain management. Pain management was seeing him for neck and low back pain. I was managing his neck and low back pain conservatively with physical therapy, prescriptions, things like that, and that was the primary focus of the treatment at that time.

Q Doctor, is pain management appropriate care for

orthopedic injuries?

A Pain management is definitely appropriate care for orthopedic injuries. We try conservative means first. Obviously, there is surgery can be done and as long as it is not an emergency, conservative treatment should be exhausted.

Q Doctor, in addition to pain management, what other conservative treatment did Mr. Ramirez receive through New York Ortho?

A He had oral medications prescribed. He had injections of different types of medications for trigger point injections, which is for muscular spasm. He had some steroid injections and he was eventually referred because of continued pain to a spinal surgeon.

Q Well, Doctor, if you, yourself, are an orthopedic surgeon, why was this patient referred to another orthopedic surgeon?

A Spinal surgery is a subspecialty to orthopedic surgery, so there are physicians who only do spinal surgery and rarely, certainly in the last ten years, do we find someone who is a general orthopedist who does spine surgery.

Q Doctor, you mentioned physical therapy.

Would that be an appropriate type of conservative care for an orthopedic patient with these sort of complaints?

A Absolutely.

Q Doctor, within New York Ortho Sports, is there a

physical therapy center?

A There is.

Q Is there a registered physical therapist there?

A There is.

Q What is his or her name please?

A Adrian P-U-A-I.

Q Doctor, if Mr. Ramirez had physical therapy through your offices, and he testified he did, would those physical therapy records be found in your chart?

A Yes.

(Continued on the next page.)

Q Doctor, I see the chart is right near you.
A It is.
Q Is it easy or hard to flip through to see if you could locate the physical therapy section?
A I saw them here.
Q I am just wondering if it's a minority or majority or maybe you could describe what portion of the chart that might contain?
A It's a huge portion of the chart.
Q Would it be fair to say over one hundred pages, Doctor?
A Yes.
Q Okay. Thank you.
(Brief pause.)
A It's roughly this section of the chart (indicating).
Q Thank you. Dr. Kaplan, how did Mr. Ramirez do with conservative care? Did he do well, did he do poorly, something else?
MS. CAMACHO: Objection, Judge. We went through all of this with Dr. Grimm.
Are we just going to do the same questions?
THE COURT: Overruled. I will allow it.
Q Go ahead, Doctor.
A He had some relief with different therapies but nothing long-standing. And so he eventually underwent surgery because conservative measures eventually failed for the neck and back.

He did develop compensatory pains and abnormalities for long-standing abnormal walking and abnormal gait. Those things we treated conservatively and continue to do so.

Q Doctor, for people that may not be familiar, what is meant by a -- when the injuries are described as a compensatory injury?

A Compensatory means that it's an injury that results usually over time from abnormal use of the body part. So as in this case, Mr. Ramirez had symptoms in his legs from his initial injury, his low back injury which caused him to eventually have pains in his knees from abnormal walking, long-standing, in my opinion. We see that quite often. And so I have done some treatment to his knees and I believe that is related to this injury as well.

Q All right. So if I am understanding, Doctor, the knees were not injured on the day of the accident itself, am I getting that part right?

A They were certainly not significantly injured on the day of the accident. But over time because of compensating for the back pain and the leg pain, I believe he developed symptoms that required treatment.

Q Doctor, the medical chart has many references to antalgic gait?

A Yes.

Q Would that have something to do with compensatory

injuries to the knee over time?

A It does have something to do with it. Antalgic gait simply means a limp, a gait, walking pattern. With antalgia, which refers to pain, so it's a painful gait, painful walking pattern. And that is related to the back pain, the pain that radiates in the lower extremities, the legs.

Q Doctor, do you know one way or the other if this patient was caused to use a walker and a cane for a period of time?

A I don't recall. I would not -- it would not surprise me that postoperatively he required the use of a walker and cane. I just don't recall.

Q Okay. Doctor, do your orthopedic patients that are on a cane after an accident, or after an injury, does that sometimes lead to compensatory injuries?

MS. CAMACHO: Objection.

THE COURT: Overruled. You could answer.

A Patients who use a cane generally use it because of an antalgic gait. So I think the answer to your question is, I don't think it's the cane that causes the compensatory injury, I think it's the reason they are using the cane which is the antalgic component.

Q Thank you. Doctor, from time to time did you personally see Mr. Ramirez in the offices of New York Ortho?

A I did.

Q Doctor, when you would see the patient personally, were you -- would you -- what is the procedure? Are there questions? Is there an examination? How does that work?

A Yes, yes, there is a general format we follow. Basically you ask the patient how they are doing that day, if there's anything new, any new complaints, anything I should know about such as recent surgeries or injections or change in the history, medical history. I will then do a physical examination of the portion of the body they are complaining about, and I will decide a treatment plan.

Q Thank you. Doctor, would -- may I refer to certain dates in the chart because there isn't time -- we're not going to cover every date.

A Sure.

Q It's ten years worth of material.

A Yes.

Q 2014, Doctor. July 31st, 2014?

A Yes.

Q Would that be an example of a date that you saw Mr. Ramirez?

A I did see him on that date, yes.

Q Did you perform an examination?

A I did.

Q Is that right in your chart?

A It is.

Q Please tell the jury, what were your findings on your examination at that time?

A So at that time I asked him, you know, if there is anything new bothering him, he advised me that he had recent neck surgery. And that had been performed about a month and a half earlier on 6/13/14. He noted at that time that he felt some improvement in the neck pain as well as the pain which was radiating into his arms and shoulders. He still had neck and shoulder pain according to his complaints. And stiffness, as well as some numbness and tingling in the arms and hand. He mentioned to me that he was being treated for his low back as well and that they were contemplating surgery at that time. Then I performed an exam.

I noted that he had markedly decreased cervical motion, meaning motion of the neck with a healing scar on the front of the neck. I noted he had crepitus with motion. Crepitus is popping and clicking that you hear when abnormal joints move. He had some decreased reflexes at the biceps on the left.

I also noted that he had a decreased patella reflex in the lower extremities, consistent with a lower back injury. He had limited lumbar, or, low back motion. And he had straight leg raising test which is a test of the low back and the pain that radiates into the legs to see if the source is the low back. And he had a test that was productive of back and leg pain; so a positive straight leg raising test indicating back

pathology causing leg pain.

I took some X-rays, there is a -- as a portion of the exam. And he did have evidence of having had surgery on the neck at the C4/5 level. With an anterior plate and some grafting in between the two bones at -- the C4 bone and C5 bone. So I advised that he continue with pain management at that time. And that was the plan.

Q Okay. Doctor, did your examination findings match, not match, something else with regard to the plaintiff's complaints?

A They do match with the plaintiff's complaints, yes.

Q And, Doctor, can the physicians directly measure pain?

A Pain is not measurable in a -- what is called an objective fashion. There are two types of complaints. One is called objective, one is subjective. Subjective means that what the subject of the inquiry tells you, you take as the complaint. Objective means that I could make a measurement, or assign a number that is reproducible with other physicians.

So a pain complaint, anybody could tell you they have pain. It has to go along with what your findings are. So if I walk out on the street and get hit by a car and my leg gets smashed, I could complain about pain but no one could feel my pain. But if there is evidence, like bleeding and all that, that makes sense together.

Your question earlier, do his complaints match up with his findings, and that is a way to see if subject complaints

make sense. In this case they do.

Q Doctor, what is meant by the phraseology a clinical correlation?

A Exactly what I just explained. Clinical correlation means that -- when I am in my clinic talking to a patient I correlate, I make a match between what he says and what I find. And that helps me understand if the complaints make sense, if they are reasonable, if they are treatable.

Q Thank you. Doctor, X-rays are taken from time to time in your offices?

A Yes.

Q Are X-rays objective, subjective or something else?

A X-rays are an objective examination; meaning, I look at an X ray and see a fusion at C4/5. Any one of you with the proper knowledge could look at the same X ray and see the same thing.

Q Doctor, MRI exams, we've heard that they were done over time.

Are they objective, subjective or something else?

A The findings and images are objective findings.

Q Doctor, do orthopedic surgeons such as yourself rely on objective testing, radiology testing in order to help complete the picture of what was wrong with this patient?

A Yes.

Q Do you rely from time to time on radiology reports

prepared by radiologists?

A I do.

Q Okay. Doctor, let's choose just one more date that your -- November -- I am sorry. The year is 2014. November 25th.

A Yes.

Q 2014.

A Yes.

Q Did you see the patient again at that time?

A I did.

Q Did the plaintiff have complaints?

A He did.

Q What were they please?

A He had continued complaints of low back pain, pain radiating to his right buttock and posterior leg to the knee. He indicated that Dr. Brisson who had operated on his neck was also planning a surgery for his low back. He complained of neck pain and stiffness. And he complained of pain at the right knee. He was complaining that the right knee pain had been worse for the last couple weeks and that it had been associated with a buckling episode. Buckling is the knee giving way when you walk. And usually indicates a mechanical problem.

Q Is there any mention at that time with regard to the use of a cane?

A Let's see.

(Brief pause.)

A Yes, he noted that occasionally he required a cane for stability.

Q Doctor, from an orthopedic point of view, what is the significance, if any, if a patient is reporting low back pain that radiates into the buttock towards the knee?

A The radiation of pain along a nerve root is called a radiculopathy. That is an indication that there is a problem in the back, the low back in this case, where one of the nerve roots comes off the spinal cord and down the leg. Usually the pain could be in the back and leg but the source of the pain is at the low back usually associated with a disc problem or joint problem.

I try to make it understandable for patients by indicating that even though you have pain in your leg, it's coming from somewhere else just in the way we could turn this row of lights on by flipping off a switch over on the wall over here. And the source is there, but the evidence is here. And that is -- in the case of a back, you sort of flip -- in the case of radiculopathy, you flip the switch in the back but a light goes on in the leg.

Q Thank you. Doctor, let's move forward through time. Let's move into 2015.

Did you see the patient early 2015 in February?

A Yes, I did.

Q Okay. Could you tell us when that was, Doctor?
A I saw the patient February 9th of 2015.
Q Did the patient have any complaints at that time, Doctor?
A He did. He was having severe low back pain. He was complaining of pain radiating into the right leg. He was having worsening pain and buckling episodes of the right knee. He did tell me his neck pain had improved following surgery although he still had residual stiffness, limited motion and pain radiating into the upper extremity on the left.
Q Thank you, Doctor.
A Sure.
Q Moving forward in time a bit. Doctor, let's move into the following year. 2016.
Did you see the patient in January of 2016?
A Yes.
Q When was that, Doctor?
A I saw him 1/29/16.
Q So at this point he is post neck surgery and post back surgery, is that correct, Doctor?
A That is correct.
Q Did the patient have any complaints at that time, Doctor?
A He did. He still had neck and low back pain and he still had findings consistent with a lumbar radiculopathy

irritated nerve root in the back, causes pain down the leg, as well as cervical radiculopathy.

Q Is there any mention in your records at that point whether he was or was not using a cane?

A Let's see. At that point I note he has an antalgic gait. I do not note a cane.

Q I am looking at a section of the page marked objective, second sentence.

A Yes, oh, I am sorry. I missed that. Use of a cane. Yes. Antalgic gait.

Q Thank you.

(Brief pause.)

Q Doctor, let's move a little bit further into the chart.

Doctor, did you see the patient again in April of that year?

A I did.

Q When was the date?

A April 29th, 2016.

Q What were the parent's complaints at that time?

A Very similar. Neck and low back pain. He was complaining of difficulty sleeping because of pain in the neck. Couldn't find a comfortable position. And, again, still had limited lumbar motion, limited cervical motion and antalgic gait. Still positive straight leg raising at that time.

Q What was your assessment at that time, Doctor?

A I noted he was status post lumbar surgery with persistent pain and radiculopathy symptoms. And he still had a cervical radiculopathy.

Q Doctor, what is the medical significance, if any, of persistent radiculopathy -- persistent radicular pain a year and two after the surgeries were done?

A Yes, so the surgery that's done is a fusion surgery in order to stabilize the spine, the goal of that surgery is to reduce the irritation of the nerve roots. It is not unusual for people to still have some nerve root pain from the change in the anatomy. And I think that is what he is showing here. And this is not uncommon. It's not a failure of the surgery, per se, but it's a limitation.

Q Doctor, let's move forward towards the end of that year.

Did you see the patient around Thanksgiving of that year?

A Thanksgiving would be November 30th, 2016.

Q What were the patient's findings at that time, Doctor?

Sorry. What were the patient's complaints at that time?

A At that time he was complaining of pain in the left knee. He told me at that time he had had pain present in the left knee but it had gotten worse and, in fact, the week before this visit he indicated that it was severe.

Q Okay.

A That he was having difficulty walking. He was complaining of persistent low back pain radiating into the legs.

Q Okay.

A And on the exam he had limited motion of the lumbar spine, the low back, he had a positive straight leg raising test indicating ongoing nerve root irritation. And at that time he had some swelling and tenderness about the knee, both at the lateral and medial joint lines.

He had crepitus, cracking and popping in the knee and limited flexion in the knee. He had pain with full extension of the knee. Again, he had an antalgic gait. At that time he was again using a cane. And he even had difficulty, I noted, getting up onto the examination table because of knee pain. And so I took some X-rays which showed some lateral compartment osteophytes. That means bone spurs, squaring of the joint, but no obvious fracture through the structural part of the bone.

So I gave him an injection at that time at the knee, a steroid medication, because I thought he had some compensatory inflammation and pain.

Q Thank you, Doctor. Moving into the next year, 2017.

A Okay.

Q Did you see him early on, shortly after the new year?

A I saw him several times early on. January and February of that year.

Q Okay.
A As well as March.
Q Let's look at January, please.
A Okay.
Q What was the exact date, Doctor?
A January 5th, 2017.
Q Thank you.
A Sure.
Q What were the patient's complaints at that time?
A At that time he indicated that he had gotten some relief from the knee injection. He did have continued buckling or mechanical symptoms of the knee. He did indicate that pain was less. I had sent him -- and he was noted to have what is called a nondisplaced trabeculare fracture on one of the bones. That is like a bone bruise that comes from abnormal use, pain -- abnormal use of a joint, rather, in this case. And some, what I call attritional problems, meaning things that occur over time, partial tearing of the ligament, the ACL ligament. And a tear in the cartilage called the meniscus. And the medial. He continued to complain of low back pain and pain radiating into the legs.
Q Doctor, do those radiological findings comport with pain?
A They do, yes.
Q Let's move forward in time, Doctor. Summer.

Did you see the patient in July, 2017?

A I did.

Q What date please?

A I saw him on July 10th of 2017.

Q How was plaintiff reporting he was doing at that time?

A At that time he still had knee pain. He had no buckling at that time. He did note his pain was worse climbing and descending the stairs. And he continued to complain of back pain.

Q Doctor, were there any further findings of crepitus in the knees?

A He continued to have crepitus of the knee, and he had atrophy or loss of muscle bulk around the knee. On the left and the quadriceps muscle.

Q Doctor, we have been talking a little bit about objective versus subjective.

How about the crepitus, the clicking and popping you have been describing.

Would that be objective or subjective?

A That is objective; meaning, I hear it, you hear it, the patient hears it. It cannot be made up or complained about and not made sense by the patient. It's an objective finding.

Q Doctor -- thank you. Doctor, at that time, 2017, July, what was your assessment of this patient?

A At that time I felt he had lumbar radiculopathy status

post surgery. I felt he had an internal derangement of the left knee with a trabeculare fracture. I thought he had post-traumatic arthritis of the knee, the left. And he had cervical radiculopathy.

Q Doctor, arthritis. The jury heard a little bit about that at other points.

A Yes.

Q From an orthopedic standpoint, what is arthritis? Is that good, bad? What is it?

A Arthritis is an abnormality in the joint. Anything with the letters "itis" at the end means inflammation. Arthro means joint. So arthritis is inflammation of the joint. It occurs because of an abnormality in the joint, usually an -- it could certainly have to do with damage to the cartilage and things like that, the meniscus.

Q Okay.

A Arthritis is not -- technically not an X ray finding, but it's a syndrome, a collection of symptoms that usually include pain, limited motion, inflammation, change -- increased pain with activities or weather changes, things like that.

Q Doctor, is arthritis a form of degenerative condition?

A Can be, sure.

Q And is arthritis the type of degenerative condition that forms overnight or over time, or, you tell us?

A So there are different types of arthritis. You could

have post-traumatic arthritis that occurs because of a fracture into the joint. That occurs immediately. You could have degenerative arthritis, which means because of abnormal use, the joint changes over time. You could have osteoarthritis because of age, we all get some arthritis over time. Everyone in this room will get it. It occurs. And you could have blood born arthritis, rheumatoid arthritis, things like that that come from proteins in your blood that destroy the joint surface.

So there are -- most of the arthritis occur over time, and occur in this case because, in my opinion, abnormal use of the joint.

Q Doctor, if we rule out fractures of the neck and back for this patient, if there were no fractures --

A Sure.

Q -- arthritis, if it was present in the neck or back, that would be overnight, that would take time? You tell us.

A It takes time.

(Brief pause.)

Q If there were -- if there was arthritis in this patient before the accident and CAT scans were taken on the day of the accident, is that something that a radiologist would report on, arthritis?

MS. CAMACHO: Objection, Judge. We have had the radiologist --

MR. GASTMAN: I will withdraw and move on. Thank

you, counselor.

(Brief pause.)

Q Doctor, did you continue to see the patient over time?

A Yes.

Q Did his condition change dramatically from what we were talking about so far or is this approximately what the patient is?

MS. CAMACHO: Objection. Form.

THE COURT: Sustained. Can you rephrase it?

Q Sure. Patient's present condition, similar to what you have been describing or different now?

MS. CAMACHO: Objection. Lack of foundation. We don't know when the last time he saw him was.

THE COURT: True. Sustained.

Q Doctor, was the patient seen by your offices in 2017?

A Yes.

Q And 2018?

A Yes.

Q And 2019?

A Yes.

Q Did the condition continue to change? Did it remain approximately the same? Something else?

A The condition remained approximately the same. Yes.

Q Okay.

(Brief pause.)

Q Doctor, your chart is in evidence so the jury could review that --

A Sure.

Q -- at their convenience. At their pleasure. I have a few questions for you.

I want you to assume a couple things, Doctor. I want you to assume that Mr. Pedro Ramirez was around forty-five years old on the date of the accident, April 29th.

A Sure.

Q 2013. He has never had prior back treatment. He's never had prior neck treatment. There is no prior medical care to these parts of the body.

A Okay.

Q I want you to further assume, however, that he did have a slip and fall at work about three years before this accident.

A Right.

Q It's written up in your chart.

A It is.

Q He lost about three days of work at that point but there was no medical care. And then he had this accident in 2013. He fell from a twenty foot ladder. He fell thirteen feet, fifteen feet, something to that effect. He landed hard on a metal floor, knocked unconscious, taken to the hospital. And the rest of the medical treatment you know of.

Doctor --

A Yes.

Q -- do you have an opinion that you could express with a reasonable degree of medical certainty as to whether the injuries we've been talking about are from the accident?

MS. CAMACHO: Objection to form.

A I do.

THE COURT: Overruled. You could answer.

A I do have an opinion.

Q What is your opinion, Doctor?

A My opinion is that given the history provided by the patient, the records that I reviewed, that the injuries are related to the accident, caused by the accident.

Q Doctor, are the herniations to the neck and back that underwent surgery and continue to be treated with pain management, are these injuries painful?

MS. CAMACHO: Objection.

A Yes.

THE COURT: Sustained. Can you rephrase it before you answer it that way?

THE WITNESS: Sorry.

Q Does the patient have any painful injuries from this accident?

MS. CAMACHO: Objection.

THE COURT: Sustained.

Q Doctor, do you have an opinion that you could express

with a degree of medical certainty as to whether the patient has been exhibiting pain since the accident?

MS. CAMACHO: Objection, Judge. There is no way to measure pain. It's subjective. That is what we've heard from everybody so far.

MR. GASTMAN: The question was exhibiting pain.

THE COURT: I will allow it. I will allow you to answer that. Exhibiting pain.

THE WITNESS: Sure.

A In my opinion the complaints of pain do go on with the findings -- along with the findings. And so having an antalgic gait, limited motion is exhibiting pain to some degree, especially in the neck and low back. And the symptoms of radiculopathy along the nerve root is exhibiting pain. So, yes, I think so.

Q Doctor, do you have an opinion that you could express to a degree of medical certainty as to whether the compensatory injuries to the knees you described are related to the accident?

A I believe they are, yes.

Q Doctor, do you have an opinion you could express to a reasonable degree of medical certainty as to whether these injuries are now deemed permanent?

A Well, certainly. I think at this point, you know, almost ten years later, they are definitely permanent.

Q Thank you. Doctor, have you ever testified on behalf

of your patients before?

A Yes.

Q Would that include patients represented by the law firm of Gorayeb & Associates?

A Yes.

Q And Doctor, if you were not here today where would you be?

A Still be at my office seeing patients.

Q Is your office expected to be compensated for your time away from the practice today, Doctor?

A I am sure they have already been compensated.

Q Could you tell us approximately how much?

A $6,500.

Q And Doctor, before today, did you charge the law firm any fees for any reports that you may have written on behalf of this patient?

A I have been asked to write several reports. I think three, in total. And we do charge for those. They take time to compile and review records and put in an opinion. That is a fee of $450 for the report.

Q Thank you, Doctor. Please standby for the Court's instructions.

A Sure.

THE COURT: All right. Any Cross?

MS. CAMACHO: Yes.

(Brief pause.)

CROSS-EXAMINATION

BY MS. CAMACHO:

Q Good afternoon, Doctor.

A Hi.

Q New York Ortho Sports Medicine and Trauma P.C. is your practice, correct?

A It is, yes.

Q And you are the sole owner?

A That's correct.

Q So when you say my practice is going to be compensated, it's your company, correct?

A It is my company. And that compensation pays our rent, pays our employees, pays me. Everything.

Q Okay.

A Yes.

Q But it's yours?

A I own it, yes.

Q And when Dr. Grimm was here yesterday, he indicated that you would have a better understanding of, for example, the recordkeeping.

A Yes.

Q And if you go to some of the records, for example, July 10th, 2013, go ahead. You --

A Why don't you show it to me. It's somewhere in this

pile.

Q Can you pull out July 10th, 2013?

A I could certainly try.

(Witness complies.)

A Okay. I have July 10th, 2013.

Q Okay. And can you tell us what happened on that date?

A Can I tell you what happened on that day? I imagine that Dr. Grim opened the chart for some reason and it generated a notation of that date. That is not an office visit. This was -- 2013 we implemented a new computer system. There were some glitches. I think there were two in a row of those. There is a similar thing, right, from 10/12.

Q Yes. 11/13/14?

A Yes.

Q 12/4/14.

A Yes.

Q There is a few throughout the chart. So are you --

A There are two in the chart that I see here. Those are glitches.

Q So there was no treatment that day?

A I don't think so. There is none recorded.

Q Okay.

A There is no --

Q Well, there is a superbill at the end of that chart, isn't there?

A I have a bill, yes.
Q So go to the date there and tell me if there is a charge for office visit that day?
A What is the date?
Q Let's start with July 10th, 2013.
A Okay.
Q Yes.
A It looks like a charge was generated, nothing was paid and it was written off.
Q Well, Dr. Grimm told us there was a visit that day. Can you explain that?
A I can't. I don't think there was. It looks to me like a computer glitch.
Q Okay. Now, he also told us that you would be able to explain where all of the initial paperwork was. So, Mr. Ramirez testified when he went to the office the first time, when Mr. Gorayeb's office sent the card to come to your office he filled out paperwork?
A Okay.
Q And that paperwork isn't in the certified records?
A Right, it's not part of the medical record which is what --
Q So when somebody comes in and gives their background and history in their own handwriting that is not part of the medical record?

A That is just demographics.

Q Their medical history?

A They don't fill out a detailed history.

Q You don't have, like, when you go to the doctors and they ask what your allergies are, and next of kin, and what your familial -- what their parents --

A No.

Q You don't have them fill that out?

A You do that for a medical visit, a primary care physician. Orthopedics is a much more directed thing. In the first note Dr. Crone does discuss the past medical history with the patient. Drug allergies, no medical problems. No surgical history. So that is covered in our notes.

Q Okay.

- Proceedings continue next page -

Q Where do you keep that if it's not with the chart? Where do you keep all the handwritten notes that they fill out?

A It's somewhere in our computer system, I'm sure.

Q So it is scanned and saved somewhere?

A Yeah.

Q You also indicated that it wasn't uncommon for plaintiff's counsel's office to refer individuals to you directly.

A I don't think I said it was uncommon. I certainly have gotten referrals from Mr. Gorayeb's office.

Q I was actually referring to Dr. Grimm's testimony.

A Oh, I don't know what he said. I wasn't here for that, as you know.

Q So he testified it wasn't uncommon for that to happen.

A I can't speak to that.

Q And there was documentation that he knew when this patient came to see him, that he had been referred by plaintiff counsel's office.

A Okay.

Q Where is that documentation?

A That's the intake sheet.

Q That's another intake sheet that's not part of it or that's included with it? It's the same intake sheet?

MR. GASTMAN: Excuse me, Your Honor. I offered to stipulate yesterday. I offer to stipulate again. The law

firm of Gorayeb & Associates referred this injured man to this doctor's office. I stipulate to that.

MS. CAMACHO: Thank you.

Q Now, how often does that happen?

A I don't keep a record of how often, but we definitely get referrals from Mr. Gorayeb's office. As an orthopedic practice, we get injured patients.

Q And other plaintiff's counsel's offices as well?

A Absolutely.

Q And you keep track at least on the referral sheets, correct?

A We ask the patients to write it down because, as you know, you, Mr. Gastman will ask us for records. We have to know who we can send records to, so we have to have a list of that.

Q Well, you had a HIPAA authorization for any time someone is going to receive records. It doesn't matter if you have it written down or not.

A That's correct, but this has been a practice that's been present before HIPAA was even in force.

Q And you also have a relationship with Dr. Brisson, correct?

A You would have to define "relationship." I certainly know Dr. Brisson.

Q You refer patients to him?

A I don't anymore, but I have offered patients to him in

years past.

Q How about 2013? You were referring patients to him?

A Yes.

MR. GASTMAN: Your Honor, would it be okay if the witness finishes each one of his answers before the next question begins?

THE COURT: Yes.

MR. GASTMAN: Thank you.

Q Back at the time that Mr. Ramirez came to your office, you were referring patients to him, correct?

A Some, yes.

Q And that's because you respected him as an orthopedic surgeon who specialized in necks and backs, correct?

A I still respect him as an orthopedic surgeon who specializes in necks and backs. We don't work at the same hospital. There was a period actually -- we do now. There was a period we didn't work at the same hospital, so I changed my referral pattern. That's the way it worked.

Q We have a limited amount of time. If you could answer my questions yes or now, we could get out of here.

A I'm trying to answer your questions the best I can.

Q Okay. At the time you referred Mr. Ramirez to Dr. Brisson, you respected him as an orthopedic surgeon, correct?

A I still do, yes.

Q And at that point in time, you were not operating on

spines, correct?

A I still am not, correct.

Q And -- but you treat both cervical and lumbar?

A I treat them conservatively. I recommend physical therapy. I recommend pain management. I make recommendations.

Q Let me ask you this question.

Dr. Brisson testified to this jury that the fusions today involve far less trauma to patients than they compared to the fusions in the past. You agree with that?

A I would have to defer that to Dr. Brisson because I don't do that surgery.

Q Okay. He testified that people often find that they have better function after the fusion surgery because they no longer have pain with every moment. Do you agree with that?

A That's the goal of the surgery, so I would agree with that, yes.

Q Do you agree that more often than not, that goal is reached.

A I would not say it is more often than not. I would say it is about 50/50.

Q Dr. Brisson told this jury under oath that once a fusion heals, the level or levels that have been fused should not cause further pain or require further treatment down the road. Do you agree with that?

A Is the question should it or does it?

Q Should not.

A It should not, but that often doesn't happen. The goal of the surgery and about 50 percent get better for sure.

Q He testified that spinal fusion is the most common surgery for chronic, non-specific back pain with degenerative changes. Do you agree with that or disagree?

A I would defer to him. Not my area of specialty.

Q Many spinal fusion surgeries are minimally invasive. Do you agree with that?

A Again, I don't do spinal surgery, so --

MR. GASTMAN: Your Honor, I'm just wondering if we have any questions for the orthopedic doctor because the surgeon has come and gone already. I'm just --

THE COURT: No speaking objections. Just the word "object" and what your grounds are.

MR. GASTMAN: Your Honor, objection; relevancy.

THE COURT: Sustained.

Q Do most of the patients that you treat conservatively and refer to spinal surgeons return to participating in activities that they enjoyed including recreational activities after a fusion surgery?

A Not fully, no.

Q Let's go back. Counsel asked you on direct examination if you could generally describe the treatment that Mr. Ramirez received in the first six months up to a year. Do you recall

that?

A Yes, I think so.

Q And I objected and said, "You weren't treating him at that time." Do you remember that?

A Sure.

Q And the judge asked you and you said, "I was." Do you remember that?

A I do. And if I made a mistake, I'll tell you. Let's see.

Q Let me ask you this question. Based on your review of the records, when was the accident?

A I'm going to agree with you. I saw --

Q My question first is when was the accident?

THE WITNESS: It is all right. Let her berate.

MR. GASTMAN: Please answer each question before the next question is heard.

THE COURT: Sustained.

A That's fine. His accident was on April 29, 2013. I first saw him on 7/31, so it was not in the first year.

Q So when you told the judge that you were treating him in the first six months to 12 months at that practice, that was not true, was it?

A I obviously made a mistake, but you just corrected me.

Q Okay.

A Thank you for pointing that out.

Q Now, you told the jury that the knee pain that you -- that plaintiff was complaining about was compensatory, correct?

A That's my opinion, that's correct.

Q And let me ask you this question.

You treat something like 50 patients a day; is that correct?

A No, I see about 35 to 40 patients in a day.

Q And you've testified before at trials, correct?

A Yes.

Q You testified before, yes, for Mr. Gorayeb's office?

A I have.

Q Other firms?

A That's correct.

Q Other plaintiff's firms?

A Yes.

Q And you've been asked that question?

A Okay.

Q And you testified between 35 and 50, haven't you?

A 35 and 40.

Q Post-pandemic, it is less?

A It is less, yeah.

Q Okay. But back in 2013/2014, it was upward of 50 a day, wasn't it?

A Could be, 35, 30.

Q Do you have an independent recollection of treating Mr. Ramirez?

A I know his face. I don't have an independent recollection of each visit.

Q Do you think you have a better recollection of his complaints or he has a better recollection of his complaints?

A Again, I don't have an independent recollection. I have what I have on the notes, and those are, you know, a record that was made at the time, so I can go through them and talk about his complaints.

Q So you think your notes are better than his recollection? Is that what you're saying?

A I think for a given day, what he told me is accurate.

Q Well, Mr. Ramirez told this jury under oath this morning on direct and cross that his knees didn't start bothering him until after the lumbar surgery, after he used the cane. You disagree with that?

A My notes, if they disagree with that, I would believe my notes because I would have no reason to put that down.

Q Okay. You wrote down that he had antalgic gait from the time you first treated him in 2000 -- actually '14, right, July 31, 2014 up until the last time when you saw him? When was the last time you saw him?

A Last time I saw him was, I believe, 5/22/19.

Q Over four years ago?

A That's right.

Q So from July 31, 2014 through May 22, 2019, did he have in your records an antalgic gait that entire time?

A When it's noted, he had antalgic gait. I don't recall.

Q Well, take a look. Your section of the notes is pretty small in comparison to the whole chart, right?

A It is. It just means reading the entire note for you each time. I'm happy to do it for you because you've asked. Let's see. It looks like the second time I saw him, if I recall, particularly initially and through the mid portion I noted and when he was having knee pain, I noted the antalgic gait.

Q That was --

A But it's not every visit.

Q I'm sorry. You were saying something else?

A I said it is not every visit.

Q And when you wrote that he had antalgic gait, that was something you observed?

A That's correct.

Q And would that be something that we would be able to observe?

A I can't speak for you. I can't speak for you. I don't know. You should be able to, but you're not trained in it the way that I am.

Q Okay. You say it was an objective finding, correct?

A That's correct.
Q And so when people normally walk, they walk one foot in front of the other?
A That's correct.
Q Smooth, even gait, correct?
A That's the way most people walk, yes.
Q So if somebody has an antalgic gait, there's something out of sync, right?
A Correct. That's right.
Q Favoring one side or the other?
A Usually.
Q Which side did he favor?
A Probably both because his pain is from his back primarily.
Q But you don't write down?
A If it is specific, I do. Here, it is not written specifically.
Q But there were times you actually wrote down marked. What does that mean?
A That means he was having more trouble than I would expect that he has.
Q Does that mean a marked antalgic gait would be even more obvious to the untrained eye?
A Should be.
Q Now, let me go back to the cane. He was using a cane

when you saw him in 2014, November of 2014?

A Before the surgery. Let's see. Yes, occasionally.

Q And then January of 2016, still using the cane?

A Yes.

Q And November of '16, still using the cane?

A I don't know that he wrote is using a cane in November of 2016.

Q You don't say marked --

A I do. I do. Still using a cane at that point.

Q It was your understanding he was using it pretty regularly at that time because of the pain he was having?

A He was using it when I saw him, yeah.

Q Was it your understanding he was using it pretty regularly at that time or did you write down "just to come to my office"?

A Again, I don't have an independent recollection of every date because this was a long time ago. When I saw him, he was certainly using a cane.

Q Let's go to your July visit.

A July of what year?

Q I'm sorry. July 10, 2017.

A Okay.

Q In that note, you indicate that he -- plaintiff is suffering from quadriceps atrophy, correct?

A I don't say suffering. I just note that he has quad

atrophy.

Q Can you tell the jury what that is?

A That's decreased tone. In this case, in the quadriceps, the thigh muscle.

Q And had you you ever measured the quadriceps at any point in time before that to show the atrophy?

A Not at the regular office visits, no.

Q At any visit, anywhere in the chart?

A No, not in the office visits.

Q Well, did you do it somewhere else? Where else would it be? Where could we find it?

A You can find it in my note as quadriceps atrophy.

Q There is no way for us to know what it was before?

A I hadn't noticed it before, that's right.

Q So let me ask you this question.

Were you testing like muscle strength, his bilateral lower extremity muscle strength up to that point in time?

A I wasn't doing a neurologic exam on him, no.

Q Well, did he have normal muscle strength in his quadriceps?

A I didn't test his strength. It is not part of my exam.

Q I thought you told the jury that you were monitoring and following conservatively the treatment of his lumbar spine.

A That's correct.

Q And that would include his lower extremities

neurologically, wouldn't it?

A No, it has to do with his level of pain, his findings, his testing, and what should be done as far as having Dr. Grimm treating, send him to a spine surgeon, and what he needed in terms of physical therapy.

Q So you didn't check to see if there was nerve involvement in his legs?

A It is not my area, that's why, as far as muscle strength. He's got pain which is the focus of the treatment.

Q Can you have atrophy without loss of muscle strength?

A You can, yeah. Muscle --

Q You don't know what it is because you didn't include the measurements in your chart?

A You're correct.

Q Well, let's take a look at Dr. Grimm's closest in time report from July 19, 2017.

MR. GASTMAN: Objection. Side-bar, Your Honor.

THE COURT: No. Overruled.

You can answer, if you can.

MR. GASTMAN: This is on a different doctor, okay.

THE WITNESS: She's asking me to look at something.

THE COURT: Wait for the next question.

Q July 19, 2017.

A Okay.

Q That was nine days later, correct?

A Sure.

Q And based upon Dr. Grimm's exam, Dr. Grimm is not a neurologist, is he?

A He's not.

Q He is a pain management doctor?

A That's right.

Q But he checked his bilateral lower extremity muscle strength, correct?

A Okay. Let's see. Yes. He notes five over five strength.

Q Bilateral, that means he's got normal strength in his legs, right?

A That's a gross examination meaning that he can push against resistance. Yeah, that doesn't mean normal strength. It means that he can push against resistance. That's what five over five strength is.

Q If he told us five out of five is normal, he was wrong?

A It is not a measure of the strength in pounds per square inch, newtons, that's the unit. It is simply a measure. Zero means you can't lift against gravity. One means you can lift against gravity so on. Five means you can push against resistance, so it means that the muscles are working normally, it is firing, not the strength.

Q He said if you didn't have full strength, it would go down to four out of five?

A If you couldn't push against resistance, it would go down to a four out of five, that's correct.

Q Let's go to your next visit on October 11, 2017.

A October 11, 2017. Yes.

Q There, you document quadriceps weakness?

A That's right.

Q So what did you do there that you didn't do in July?

A I had him get on the table and he had trouble doing that. That's the only way I would have noticed.

Q Where does it say there in the note that he had trouble getting on the table?

A It doesn't, but that's the only way I would have noticed it.

Q So you're testing for quadriceps weakness as if he has difficulty getting on the table?

A It is not a test of quadriceps weakness. It is an observation.

Q What kind of trouble did he have?

A As in other notes, I say he has difficulty mounting and dismounting the table.

Q Right, but in those other notes when you say he's got difficulty getting on and off the table, you don't say that he has quadriceps weakness, do you?

A In my mind, yes. In your mind, clearly, not. I mean, you're holding me to a standard of not being able to read my own

notes and trying to anticipate what you're asking, and I'm sorry. I just can't do that. So I write notes the way I write notes and it's the way I've been doing it for the last 40 years and that's all I can tell you.

Q I didn't -- I specifically asked you, and if you could just tell the jury, when you wrote and you've seen it because you've mentioned that he had trouble getting on and off the table. You never wrote in those notes where you saw him having difficulty getting on and off the table that he had quadriceps weakness, did you? It is a yes or no.

A It is not easily answered yes or no because it is a mischaracterization.

Q Did you write it down or not?

MR. GASTMAN: Excuse me, Your Honor. I wish the patient -- I wish the witness would be permitted to complete their answer before we hear the next question, please.

MS. CAMACHO: It was a yes or no, Judge.

THE COURT: Well, you can answer the question.

THE WITNESS: Yeah, I can't answer it yes or no because she's indicating that that's the only way -- in my mind, she's indicating that's the only way to note that I have to use her exact words and the answer is I didn't put it down the way you would like me to, but they're both indications of weakness.

Q Couldn't he have trouble getting on and off the table for a reason other than quadriceps weakness?

A Anything is possible, I guess, but that's the reason in my mind, in my opinion.

Q So in your mind, every other time that he had trouble getting on and off the table that's marked in your notes, we should now know that that means quadriceps weakness?

A As of now since we're talking, yes.

Q Okay.

A Yeah.

Q And if Dr. Grimm on all those occasions before and after had full strength on his bilateral extremities, that was wrong?

A He has five over five strength, so I wish that I could give you a lesson in medicine in five minutes, but I can't do that. So you're just going to have to take my word for it as a trained orthopedic surgeon who's been working for 40 years. You can pick at it all you want. I'm going to give you the same answer.

Q You make office notes at the time you see your patients?

A That's right.

Q And you do that, so that there is information about your exam that can be looked at later on, correct?

A That's right.

Q And you have many patients involved in litigation. This is not the first time you've come to testify, correct?

A I certainly have patients who have been hurt and involved in litigation, yeah.

Q And pretty regularly sending your records to court?

A I don't make my records for the court, though. I make my records for myself and other physicians.

Q Now, when was the last time -- Adrian, I think you said this person Adrian was the physical therapist back from 2013 to 2019?

A Yes.

Q And Adrian is a man?

A Yes.

Q When was the last time --

MR. GASTMAN: Objection; relevancy.

THE COURT: Sustained.

You don't have to answer that.

Q When was the last time Mr. Ramirez had physical therapy at your facility?

A It looks like, and I can't be sure without going through everything, but it looks like 8/29/19.

Q And only because Dr. Grimm had difficulties finding in the chart, when was the last time he had trigger point injections?

A I don't know the answer to that.

Q You can't figure that out from the chart?
A No.
Q What about from that super bill in the back?
A I don't know that I could figure it out from that.
Q Can you take a look at it and see?
MR. GASTMAN: Just note my objection, Your Honor; relevancy to this witness.
MS. CAMACHO: The other witness couldn't answer.
MR. GASTMAN: The chart is in evidence.
A I can't tell from this. I can't tell from that.
Q Did he have trigger point injections since 2019?
A Not from me certainly.
MR. GASTMAN: Just objection to the relevancy.
THE COURT: Sustained.
Q Have you ever --
THE COURT: He said he couldn't tell.
Correct.
THE WITNESS: Correct, yeah.
Q So there's no way for the jury to know from that chart that's in the record when the last time was that he had trigger point injections?
A They could find it in the medical note, sure.
Q But you can't find it?
A I'm not going to go through Dr. Grimm's notes because I don't follow his notes.

MR. GASTMAN: And your objection, relevancy to this witness.

MS. CAMACHO: Again, the doctor that was here yesterday was unable to look at the chart, either the one he brought with him or the one that was in evidence, and give us the answer to this and he said Dr. Kaplan would be able to do that for us. We have Dr. Kaplan here. I'm just asking.

THE COURT: Sustained. I'll allow him to answer.

A I don't think there were any trigger point injections given after 2019. I do not know the last date that it was given.

Q What about epidural injections?

A That would be Dr. Grimm's area.

Q And can you -- did you say that you gave trigger point injections or no?

A No, I gave a knee injection, I believe. Let me just make sure of that. Hold, please. Oh, yes, I give him a trigger point injection in 2015.

Q Where?

A Lumbar.

Q Plaintiff is no longer treating with you at the facility, correct?

A I haven't seen him since 2019.

Q So is that a fair answer?

A I think that's fair.

Q And can you tell the jury, do you have the prescription section?

A What prescriptions actually?

Q Can you -- is there a prescription section in the record that the jurors could look to to see what prescription medication was prescribed to Mr. Ramirez?

A I think they can see where it is initially prescribed. I don't think it records every time that prescriptions are given.

Q So the certified records don't --

A I don't think they show refills.

Q Isn't it New York State law mandate you to keep track of prescriptions, medications prescribed especially if it is a controlled substance to a patient?

A They are on our computer system.

Q They are not part of the chart?

A I don't know that it generates a refill. I just don't know the answer to that. I've never been asked that before. I don't even know that there is a prescription section. Looks like we did record some off the computer system, yeah.

Q I'm sorry?

A I said it looks like there are some recorded prescriptions that came through.

Q Are those all of them or you don't know?

A I don't know. You would have to ask my computer tech.
Q The certification that came with that to court indicates those are the complete certified medical records for Mr. Ramirez.
A That's what we can print, yeah.
Q So you can't print the other ones? Is that what you are saying?
A You would have to ask my computer person honestly.
Q You've testified numerous times about torn ligaments in the knee, correct?
A Yes.
(Continued on the next page.)

Q And, generally speaking, more often than that, and maybe all of those times, it's because torn meniscus, torn tendons are caused by trauma, correct?

A The ones I testified for, yes.

Q Yes. Plaintiff has testified he didn't hurt his knee in that accident?

A That's correct.

Q Correct. Now, when people fall --

A Yes.

Q -- impact their body on a hard surface, there is generally injuries to their body, correct?

A Sometimes.

Q So it was your opinion to this jury that Mr. Ramirez suffered a trauma as a result of that fall; is that correct?

A That is what the records indicate, yes.

Q Well, you gave them your opinion within a reasonable degree of medical certainty --

A That's right, that is where my opinion is from.

Q -- that the herniations were caused by the fall, correct?

A That is not what I said. If you go back -- what I said was the symptoms that were being treated which are caused by the herniations are from the fall. There is no way to know with one hundred percent certainty when the herniations occurred. The likelihood is, my opinion is that they are from the accident

because he didn't have significant back pain prior to this. So in my opinion within a reasonable degree of medical certainty the herniations are from that.

But you asked me if I am sure; you can't be sure of that. That is not what I am asked. I am asked with a reasonable degree of medical certainty.

Q And that is based upon what Mr. Ramirez's history --

A That, and -- yes, the emergency room record. The CT. They x-rayed him up. They took a history of the fall. Yes, I think that is what occurred.

Q A herniation is caused when the ligaments surrounding the vertebrae in your back tear, correct?

A That can happen, yes. That is one way.

Q What are ligaments made of?

A Collagen fiber. And these are not strictly ligaments. It's called the annulus fibrosa. It's a fibrous ring or tissue.

Q And they have a blood supply that goes to them, correct?

A Yes.

Q And what happens when you tear a tendon, some of --

A If you tear through the blood supply they do. But you don't always tear through the blood supply.

Q Here the herniations are through the tendon, correct, full herniations?

A That is what a herniation is, yes, that means the jelly

part on the inside of the disc moves to the outside through the annulus. You --

Q Through the tendon?

A It's not a tendon. It's the annulus fibrosae.

Q And so if the radiologist who just testified told the jury that it was a tendon, that was wrong?

MR. GASTMAN: Your Honor, objection.

Q A ligament.

A You keep saying tendon.

Q My bad.

A Your bad.

Q Sorry. My bad. Excuse me. Ligament?

A It's a ligamentous tissue.

Q Ligament blood supply, yes?

A They have a blood supply, yes.

Q And if you tear through a ligament, it bleeds?

A Sometimes, if you tear through the blood supply.

Q Soft tissue.

A Yes.

Q If you treat a patient who has injured their soft tissue, what do you see?

A You could see a number of things. Number one, you could see nothing. Number two, you could see a laceration. Number three, you could see a bruise or swelling. All of those things are possible, or not.

Q Depends on the impact?
A It actually depends on what is damaged, yes.
Q What was damaged here?
A I believe his disc was damaged. And I believe that he has formed herniations which have caused radiculopathy. Those are all sort of a sequelae of things that occurred.
Q Herniations are the only injury that occurred during this fall?
A I have no way of knowing that.
Q Did you look at the hospital records?
A I did look at the hospital records. With a reasonable degree of medical certainty, without objective evidence you don't know that.
Q Did you see any evidence of bruising or swelling, redness, anything?
A I don't recall. I will be happy to look at it. By the way you are asking me it, I guess they didn't notice -- note those things, not noticed -- note them. They may have not been there. A disc is very deep in the body. You don't get -- you often don't get bruising at all from a herniated disc. I would say great majority of herniated discs are not associated with bruising because of that.
Q The radiologist told the jury within a reasonable degree of medical certainty that you cannot look at the CT scan or the MRI and tell us when that herniation was formed.

A Which is exactly what I just said, yes.

Q But you said based on the history it's your opinion within a reasonable degree of medical certainty, if I understood you, it's your opinion that that herniation was caused on that day, is that fair?

A That is not what I said at all. What I said was that the annulus fibrosis was damaged and over time, the herniation, which is the jelly substance in the middle comes out. It can happen immediately. Doesn't necessarily happen immediately. In this case, you know, again, there is no time stamp on the MRI, so I can't tell you with one hundred percent certainty. So I am asked to tell you within a reasonable degree of medical certainty. And that means greater than fifty percent in my mind that these injuries were caused by the accident.

Q Did I understand your testimony correctly, and I am sure you will correct me if I am wrong, that it's your opinion that the ligament was damaged that day and the herniation came thereafter?

A I don't think you understand the concept. So I will explain it to you guys again. The ligament holds in the disc.

Q Right.

A What happens is, the part that is contained is injured in some way and then the disc comes out. It herniates. It goes through the ligament. That is what you see. It's an X ray representation of the injury. You see a herniation --

Q My question was, was the herniation there on the day when he was at the hospital?

A There is no way to know that with one hundred percent certainty. If you could give me a way to know it, I will opine on it.

Q How about the CAT scan?

A Doesn't necessarily show it. That is not the gold standard.

Q So if the radiologist hired by plaintiff's counsel put the CAT scan up in front of the jury and said there is a herniation, C3/4, C4/5, C5/6, you disagree with that?

A I didn't say I disagree with that at all.

Q But you said you --

A I said you can't necessarily see it. So a trained radiologist may be able to see it, and someone may be looking at a CAT scan which is a gold standard for bone injuries and they'll be looking at bone injuries and not note it.

MS. CAMACHO: I have nothing further.

THE COURT: Any Redirect?

MR. GASTMAN: Thank you, your Honor. Brief.

REDIRECT EXAMINATION

BY MR. GASTMAN:

Q Doctor, thank you for your time. A few more questions please.

A Sure.

Q A defense --

THE COURT: You don't have to be brief.

MR. GASTMAN: Yes. I agree, your Honor. However, I will be brief because there is very little to cover.

Thank you.

Q Defense counsel had a number of questions about prescriptions, your chart, whether things were missing. You remember that line of questioning?

A I do.

Q Doctor, the prescriptions are in the chart, yes?

A The prescriptions are logged, yes.

Q Would you believe me, Doctor, if I told you Dr. Grimm opened them up and read them to this jury, would you believe me?

A I note, as do I -- he sometimes dictates them. Sometimes doesn't. Depends how busy we are in a day, and sometimes we forget. If they are made, they are logged in the computer. Whether they generate to a printed page, I don't know.

Q Let me take you back in time a little bit, Doctor. Before the age of digital medical everything.

A Yes.

Q How were medical prescriptions, in other words, medication, how was that prescription written by a doctor?

A Until a couple years ago when the e-Prescribe system came in, we would write it on a small piece of paper and handed

it to the patient. We usually took a Xerox copy of that, just to have a record, and the patient would take it to the drugstore themselves. These days prescriptions are done via computer, it gets sent to the pharmacy and picked up. The --

Q Dr. Grimm told this jury with that very chart in front of him that the paper prescriptions are in the chart. He opened them up, read them to the jury and he said that the renewal prescriptions might be digital in nature and they are no longer reduced to paper.

A That's correct.

Q Is that correct, not correct?

A That is correct.

Q Doctor, do you happen to know, if you do, what pharmacy was handling the prescription medication for Mr. Ramirez, if you happen to know?

A I have no idea.

MR. GASTMAN: Your Honor, at the appropriate time, now or whenever, the pharmacy records of Titan Pharmacy, they are here. I will mark them for identification and move them into evidence so everybody could see everything.

MS. CAMACHO: That will clear a lot of things up, great, Judge.

THE COURT: Okay.

MR. GASTMAN: We will do that outside the jury's presence or right away.

THE COURT: You could do it now.

MR. GASTMAN: Sure. Is it over here, officer?

COURT OFFICER: Underneath.

MR. GASTMAN: Your Honor, I have in my hand the subpoenaed records from Titan Pharmacy. They were stamped in by this court on February 16, 2024. I offer them for I.D. as Plaintiff's --

MS. CAMACHO: 15.

MR. GASTMAN: I am told it's Plaintiff's 15. Thank you. And I offer this as evidence.

THE COURT: Yes?

MS. CAMACHO: Subject to redaction, Judge, no objection.

THE COURT: Granted.

(Whereupon, Plaintiff's Exhibit 15 was marked and received into evidence at this time.)

Q Doctor, defense counsel asked you a few questions in the area of nerves and muscles.

Do you remember that?

A Yes.

Q Doctor, what is an EMG?

A An EMG is a study of the nerve firing as it relates to the spinal column and the muscles that are effected.

Q Dr. Grimm does those tests in the office, doesn't he?

A Yes, he does.

Q These charts contain EMGs of this patient, doesn't it?
A I believe it does.
Q And, finally, Doctor, you were asked about antalgic gait. And I think the question generally was when did this all begin.
A Yes.
Q Doctor, let me ask you, if you take a look at your chart, and the first -- in the first two weeks of treatment, take a look at May 15th, 2013. May 15, 2013. This is just a few weeks after the accident.
A Okay.
Q Doctor, is there any record in this chart at that time by a physician with regard to antalgic gait of this patient?
A There is.
Q Thank you, Doctor.
MS. CAMACHO: Very briefly.

RECROSS-EXAMINATION

BY MS. CAMACHO:

Q When you write your notes?
A Yes.
Q You rely on what Mr. Ramirez tells you, correct?
A To some degree, yes.
Q And how he presents to your office, correct?
A Yes.
MS. CAMACHO: I have nothing further.

THE COURT: Okay. Thank you. You are excused.

(Witness excused.)

THE COURT: All right. Ladies and gentlemen, we will continue tomorrow morning, 10 a.m.

Thank you.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom at this time.)

(Whereupon, the case was adjourned to February 28, 2024, at 10:00 a.m.)

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