

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

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

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3 PEDRO RAMIREZ,

4 Plaintiff,

5 -against- Index No.
154692/2013

6 255 WEST 108TH STREET CORP.
7 and ALL-CON CONTRACTING CORP,

8 Defendants.

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9 Supreme Courthouse
10 80 Centre Street
New York, New York
February 27, 2024

11 B E F O R E:

12 HONORABLE JAMES G. CLYNES,
13 Justice, Supreme Court

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

15 GORAYEB & ASSOCIATES, PC
16 Attorneys for Plaintiff
17 100 William Street - 19th Floor
New York, New York 10038
18 BY: GREGORY GASTMAN, ESQ.

19 CAMACHO MAURO, LLP
20 Attorneys for Defendant
21 40 Wall Street - 41st Floor
New York, New York 10005
BY: ANDREA SACCO CAMACHO, ESQ.

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23

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25 NICOLE C. ROBINSON, CSR

Senior Court Reporter

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

4 THE COURT: Sure.

5 MR. GASTMAN: Thank you.

6 THE COURT: You said the TV?

7 MR. GASTMAN: Yes, your Honor.

8 (Brief pause.)

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

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

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

20 THE COURT: Ms. Camacho?

21 MS. CAMACHO: I have no objection.

22 THE COURT: Comes in. All right.

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

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

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

5 THE COURT: Yes.

6 MR. GASTMAN: May I do that now?

7 THE COURT: Yes.

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

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

16 MR. GASTMAN: I will put them into evidence.

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

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

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

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

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

3 MR. GASTMAN: The problem --

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

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

15 MS. CAMACHO: Never had a blowup put into
16 evidence.

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

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

22 MR. GASTMAN: Okay, your Honor.

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

1 MS. CAMACHO: That is fine.

2 MR. GASTMAN: Thank you.

3 THE COURT: Okay.

4 MR. GASTMAN: Your Honor, this first one here is
5 4A.

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

8 Did you explain to your client the high/low?

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

11 THE COURT: And the result is?

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

13 THE COURT: Okay. Go ahead.

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

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

19 MR. GASTMAN: Well, sure.

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

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

1 report on them and they will come and testify.

2 MS. CAMACHO: But my --

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

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

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

13 THE COURT: Okay.

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

16 MS. CAMACHO: I am not at all.

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

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

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

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

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

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

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

6 MR. GASTMAN: 18 out of 25.

7 THE COURT: I see. Okay.

8 MS. CAMACHO: Okay.

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

11 MS. CAMACHO: 7 of 13?

12 MR. GASTMAN: That is what it says.

13 MS. CAMACHO: Thank you.

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

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

18 MR. GASTMAN: Those were blowups of photos.

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

21 MR. GASTMAN: 4:30.

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

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

1 Your Honor, the second one is also from Lennox Hill
2 Radiology, it's also the back. It's also from March 14,
3 2015. And this is Series 2, image 8 of 13.

4 4B for that one, your Honor?

5 THE COURT: All right.

6 MR. GASTMAN: Thank you.

7 (Brief pause.)

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

12 MS. CAMACHO: Okay.

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

15 Your Honor, the next film is an X ray of the
16 cervical spine; in other words, the neck. This image is
17 from November 25th, 2015. And this is Series 1002, image
18 1002/1.

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

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

23 MR. GASTMAN: Yes, I agree.

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

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

1 2?

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

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

6 (Brief pause.)

7 (Exhibit submitted.)

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

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

12 MS. CAMACHO: I do.

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

15 (Brief pause.)

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

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

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

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

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

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

1 MR. GASTMAN: Okay. Thank you.

2 (Brief pause.)

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

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

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

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

13 MR. GASTMAN: Okay. Off to the side it goes.
14 Your Honor, this next one is from New York Ortho
15 Sports. It's an X ray of the neck. It's dated April 10th,
16 2017.

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

20 Thank you.

21 Your Honor, this next one is also an X ray of the
22 neck. But it is from Dr. Brisson's office. It's dated
23 12/16/2013. This is image 1005/1. And it's of the neck.

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

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

3 MS. CAMACHO: Yes.

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

5 (Brief pause.)

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

10 (Brief pause.)

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

16 Any other images?

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

23 (Exhibit submitted.)

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

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

2 MR. GASTMAN: Thank you, your Honor.

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

4 MR. GASTMAN: Okay.

5 (Recess taken.)

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

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

11 THE COURT: Yes.

12 (Witness excused.)

13 THE COURT: All right.

14 MS. CAMACHO: I just want to -- obviously I don't
15 know how far plaintiff's counsel will go with him, I don't
16 know what he plans to question him about, but I have his
17 3101(d), I believe plaintiff's counsel provided a copy to
18 the Court.

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

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

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

8 THE COURT: Yes?

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

19 MS. CAMACHO: Your Honor, the 3101 --

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

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

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

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

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

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

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

13 (Brief pause.)

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

16 MS. CAMACHO: Right.

17 MR. GASTMAN: No more, no less.

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

22 THE COURT: Okay.

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

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

1 the jury.

2 MR. GASTMAN: Thank you.

3 (Brief pause.)

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

6 MS. CAMACHO: Okay.

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

9 (Brief pause.)

10 (Exhibit submitted.)

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

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

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

16 MS. CAMACHO: Yes.

17 THE COURT: All right.

18 (Brief pause.)

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

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

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

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

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

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

1 we read the Part Rules --

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

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

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

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

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

18 MR. GASTMAN: Your Honor --

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

21 MR. GASTMAN: I am trying to tell you.

22 THE COURT: Instead of the morning.

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

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

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

8 MR. GASTMAN: Respectfully, your Honor --

9 THE COURT: That is what he testified to.

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

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

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

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

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

8 Okay. Both sides ready for the jury?

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

12 This is a treating doctor --

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

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

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

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

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

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

7 THE COURT: Yes. Have your office do that.

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

10 THE COURT: Yes.

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

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

16 MR. GASTMAN: Okay.

17 THE COURT: Doctor, do you understand if you are
18 not finished by one o'clock, you are going to come back at
19 2:15 for continuation of your direct or your cross? Do you
20 understand?

21 THE WITNESS: Okay.

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

23 THE CLERK: All rise. Jury entering.

24 (Whereupon, the jury entered the courtroom.)

25 THE COURT: Okay. Good morning everybody. Welcome

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

3 MR. GASTMAN: May I inquire, Your Honor?

4 THE COURT: Yes.

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

7 THE COURT: Okay.

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

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

14 THE WITNESS: Dr. Thomas K-O-L-B, M.D. Address is
15 257 West 34th Street, New York 10001.

16 THE CLERK: West?

17 THE WITNESS: 34th Street.

18 THE CLERK: Zip code?

19 THE WITNESS: 10001.

20 THE CLERK: Was there a suite or apartment number?

21 THE WITNESS: No.

22 THE CLERK: Your last name one more time.

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

24 THE CLERK: Thank you.

25 Your Honor, the witness is sworn in.

1 MR. GASTMAN: May I proceed, Your Honor?

2 THE COURT: Yes.

3 MR. GASTMAN: Thank you.

4 DIRECT EXAMINATION

5 BY MR. GASTMAN:

6 Q Dr. Kolb, good morning.

7 A Good morning, sir.

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

10 A I am.

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

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

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

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

1 Q Thank you, Doctor.

2 Do you presently have a medical practice in New York?

3 A I do.

4 Q What type of practice is it, Doctor?

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

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

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

1 Q Thank you, Doctor.

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

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

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

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

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

1 better view.

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

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

15 Q Thank you.

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

19 A Yes.

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

23 A Yes.

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

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

3 THE COURT: All right.

4 MR. GASTMAN: Thank you, your Honor.

5 Q Dr. Kolb --

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

9 A Yes.

10 MR. GASTMAN: Thank you.

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

13 THE COURT: It is.

14 MR. GASTMAN: Thank you.

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

18 MS. CAMACHO: Your Honor, may I?

19 THE COURT: Sure. There is a seat over.

20 MS. CAMACHO: Thank you.

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

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

1 information such as that.

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

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

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

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

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

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

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

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

14 A I believe so, the day of the accident.

15 Q Please continue.

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

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

25 There is a ligament that runs down the back of these

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

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

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

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

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

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

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

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

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

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

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

1 sandwiches.

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

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

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

16 A Right.

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

18 A Correct.

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

22 A Yes, it does.

23 Q Please tell us.

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

1 our backs, whether it is cervical, or mid back, or lower back.

2 The three stages of arthritis are as follows:

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

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

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

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

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

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

5 Q When you say anterior, that means front?

6 A Yes.

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

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

11 Q Please continue.

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

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

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

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

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

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

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

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

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

24 Q Thank you, Doctor.

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

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

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

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

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

1 quick tour through the CAT scan of the neck.

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

5 A The pictures show what they show.

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

9 A No.

10 Q Thank you, Doctor.

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

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

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

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

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

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

14 Now, go back and forth to 4-5. Back the other way.
15 One more. That's it. Stop. Again, very obvious that the white
16 line which is the fluid in front of the spinal canal is being
17 pushed away and this disk here between C4 and C5 is touching the
18 spinal cord. If you go back and forth, you'll also -- one
19 click at a time. The other way. You're looking back. A small
20 herniation at 5-6 and here, you can obviously see a small one at
21 6-7. So all the herniations that were there on the CAT scan two
22 months earlier are shown better here on the MRI. It is much
23 easier to see the anatomy.

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

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

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

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

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

3 (Continued on the next page.)

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

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

6 Q Thank you, Doctor.

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

8 Q Doctor, are there other images or studies?

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

11 Q Okay.

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

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

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

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

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

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

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

23 MR. GASTMAN: This one?

24 THE WITNESS: 4/10/17.

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

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

3 (Exhibit displayed.)

4 Q Is this okay?

5 A Yes.

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

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

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

13 A 7A.

14 Q Thank you, Doctor. Please proceed.

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

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

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

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

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

14 MS. CAMACHO: Objection, Judge.

15 Q Withdrawn. Continue, Doctor.

16 A I think that is it for this picture.

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

19 A The back.

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

22 And Doctor --

23 A Lumbar --

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

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

2 (Brief pause.)

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

9 MS. CAMACHO: What are we looking at?

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

12 (Brief pause.)

13 A Great. CT of the lumbar spine on Pedro Ramirez done on
14 4/29/13. Same day as the CAT scan of the cervical spine from
15 Saint Luke's Hospital. And since we know this, let's go -- all
16 right. We know all the anatomy. Each one of these is a bone.

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

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

23 (Brief pause.)

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

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

3 (Brief pause.)

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

5 (Brief pause.)

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

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

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

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

4 (Brief pause.)

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

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

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

18 Day of the accident, yes?

19 A Yes.

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

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

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

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

5 (Brief pause.)

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

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

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

15 Q Very well.

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

18 (Brief pause.)

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

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

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

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

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

9 (Brief pause.)

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

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

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

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

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

13 A I think that -- yes.

14 Q Good?

15 A Yes.

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

18 (Witness complies.)

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

21 A Not by me.

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

23 (Brief pause.)

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

1 A Yes, sir.

2 Q And then you became board-certified in radiology?

3 A Yes.

4 Q Well, in medical school do doctors learn how to read
5 the type of films we've been looking at?

6 A Yes, they do.

7 Q Why do medical practices frequently rely on
8 radiologists' reports on films if any doctor could read them?

9 MS. CAMACHO: Objection.

10 THE COURT: Overruled. You could answer.

11 A Well, every part of the medicine is specialized. You
12 learn about kidneys also in medical school, but that is not
13 enough to be a doctor to take care of kidney disease. You have
14 to focus on kidney disease and become a nephrologist. It's the
15 same answer of any doctor.

16 Q And, Doctor, what type of medical practices refer
17 images to you to be read or to be taken?

18 A Orthopedists. Surgeons. Pain doctors. Any doctor who
19 has a patient that is complaining of symptoms and can -- can ask
20 for an X ray, MRI or CAT scan if it helps the patient.

21 Q Doctor, do you have -- I want to ask you a question or
22 two. I want you to assume that on the date of the accident
23 Mr. Ramirez had never ever had medical care for the neck and
24 back.

25 I want you to further assume there were no large times

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

7 MS. CAMACHO: Objection.

8 THE COURT: Overruled. You could answer.

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

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

13 THE COURT: Wait for the next question. Yes.

14 THE WITNESS: Sure. Sure.

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

16 A I need more information.

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

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

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

6 MS. CAMACHO: Objection.

7 THE COURT: Overruled. You could answer.

8 A Yes.

9 Q Please tell us.

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

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

1 are caused by the trauma.

2 Q Doctor, are herniations always painful?

3 A No.

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

6 A That's correct.

7 (Brief pause.)

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

13 A I would agree.

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

17 A Oh, the best would be MRIs.

18 Q Okay.

19 A Honestly.

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

22 A Sure.

23 THE COURT: All right. Any Cross?

24 MS. CAMACHO: Yes, your Honor.

25 CROSS-EXAMINATION

1 BY MS. CAMACHO:

2 Q Still good morning.

3 A Good morning.

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

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

9 Q You spend a majority --

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

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

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

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

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

24 A Yes.

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

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

3 A Yes.

4 Q And that is sent from another doctor?

5 A Yes.

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

8 A They do send patients to be scanned, yes.

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

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

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

16 A Yes.

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

19 A They have sent me films over the years.

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

22 A Yes, for sure.

23 Q You testified for them as well?

24 A For many years, yes.

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

1 doctors to review? Or primary --

2 A Yes.

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

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

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

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

11 Q And one of those practices was Precision Imaging?

12 A Yes.

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

16 A No.

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

18 A Yes.

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

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

24 Q You didn't have a dispute with him?

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

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

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

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

11 MS. CAMACHO: I will move on.

12 (Brief pause.)

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

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

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

19 A Yes.

20 Q So first we have loss of fluid, correct?

21 A Yes.

22 Q And then we have narrowing, correct?

23 A Correct.

24 Q And then we have osteophytes?

25 A Correct.

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

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

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

5 A Sure.

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

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

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

18 A Can patients control pain?

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

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

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

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

3 A No, I can not.

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

5 A Correct.

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

7 A Correct.

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

10 A Correct.

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

13 A In terms of herniations you mean?

14 Q Yes.

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

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

20 A In general, they become more unstable, yes.

21 Q And brittle. You used that word, correct?

22 A That is fine with me, yes.

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

1 A Go ahead.

2 Q I am asking you --

3 A No, I don't know the definition.

4 Q You practice in New York --

5 A I don't know the definition of what trauma 1 stands
6 for.

7 Q Are you familiar with that term?

8 A I assume it's a high level trauma center.

9 Q Are you familiar with Saint Luke's Hospital?

10 A Yes.

11 Q And the ER there?

12 A No, I am not familiar with the ER.

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14 - Proceedings Continue Next Page -

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1 Q And the ER there?

2 A I'm not familiar with the ER.

3 Q Do you know what code red means?

4 A It means that a patient is in extremis and a medical
5 team has to immediately get to the patient.

6 Q A team -- a team of doctors?

7 A In general, a code red, I would imagine so.

8 Q Did you review Mr. Ramirez's records?

9 A I did not.

10 Q Were they provided to you by counsel when they asked
11 you to review the films?

12 A I don't remember whether they provided it. I don't
13 have a recollection of reviewing it.

14 Q Fair to say that one of the things the radiologists
15 were looking for was if somebody fell from a height, fractures
16 in the vertebra?

17 A For sure.

18 Q Because there are burst fractures, correct?

19 A Oh, there are many types of fractures. That's correct.

20 Q What type of fractures have you seen in the spine as a
21 result of a fall?

22 A Fractures of the vertebrae? I'm not sure I understand
23 the question.

24 Q Well, you said there were several different types of
25 fractures, correct?

1 A Yes.

2 Q That's what you just said, so now I'm asking if you
3 could explain yourself.

4 A There are fractures that could be displaced. There are
5 fractures that are not non-displaced.

6 Q With regard to the spine?

7 A With regard to the spine.

8 Q Burst fractures?

9 A Burst fractures.

10 Q Those vertebrae, they can fracture, correct?

11 A They can.

12 Q And they do fracture very often as a result from a fall
13 from a height, correct?

14 A I don't know what "very often" means in terms of
15 herniations. They very rarely fracture, but patients who
16 fracture their bones from a height end up in an ICU, yeah --

17 Q So --

18 A -- which is uncommon.

19 Q There were no fractures seen on Mr. Ramirez's lumbar or
20 cervical spine, correct?

21 A Correct.

22 Q And there was degeneration seen, correct?

23 A Yes.

24 Q Were you able to see any tearing of the ligament?

25 A No. You see the disk material pushing out where it

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

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

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

7 Q Are they made up of the same --

8 A Material?

9 Q -- material?

10 A Material, yeah.

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

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

15 Q And what happens when they tear?

16 A They come apart.

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

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

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

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

1 Q Did you see any evidence of torn --

2 A There are to tendons.

3 Q Withdrawn. That was my misstatement.

4 Did you see any evidence of torn ligaments?

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

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

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

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

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

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

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

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

1 A That's correct.

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

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

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

14 A Sure.

15 Q Months, if not years?

16 A Sure, absolutely.

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

20 A Yes.

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

23 A No. I don't understand the question.

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

1 A Sorry. Which date are you reading from.

2 Q April 10, 2017, the one you showed the jury.

3 A Oh, sorry. Oh, the X ray of the cervical spine?

4 Q Yes.

5 A Yeah. So one thing you want to make sure of is that
6 each one of the vertebrae, the bones are lined up correctly
7 because you can get slippage either forward or backward from the
8 surgery or after the surgery, and so you want to tell the
9 surgeon that things are normally aligned and the surgery looks
10 okay.

11 Q If they slip or out of line, you would have
12 then -- you might have impact on the cord or the thecal sac or
13 some nerves, correct?

14 A I mean, it is a possibility.

15 Q Yeah. But here, in 2017, four years after, based on
16 your review of the film, there was normal alignment, correct?

17 A Yeah, that's overwhelming. This is the majority of the
18 cases there are and this one is.

19 Q Then you wrote "no evidence of listhesis."

20 A That's the same thing. The medical term for slippage
21 is listhesis.

22 Q And so you wrote again two times visualized normal
23 alignment and no evidence of listhesis, correct?

24 A I agree with you, yes.

25 Q You didn't review the reports from the hospital,

1 correct?

2 A I don't remember doing that, no.

3 Q But you remember reviewing the films or --

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

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

11 A I have no idea.

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

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

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

17 A By any law firm?

18 Q Any law firm.

19 A No, definitely not.

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

21 A Yeah, any law firm. Absolutely not.

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

24 A Yes.

25 Q And what was the charge?

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

3 Q Each one?

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

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

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

10 Q How many films did you review?

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

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

17 A No.

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

19 A \$9,500 for my office.

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

21 A It goes to my office.

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

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

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

1 A I don't.

2 MS. CAMACHO: I have nothing further.

3 THE COURT: Okay. Any redirect?

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

5 REDIRECT EXAMINATION

6 BY MR. GASTMAN:

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

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

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

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

21 A Yes, true.

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

24 A No.

25 Q Why?

1 A They're in the front of the spine.

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

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

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

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

14 Q Yes?

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

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

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

22 A I would be in my office.

23 MR. GASTMAN: Thank you, Doctor.

24 MS. CAMACHO: One question, maybe two.

25 THE COURT: Yes.

1 RECROSS-EXAMINATION

2 BY MS. CAMACHO:

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

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

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

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

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

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

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

8 Q So you are assuming there was no pain before?

9 A I don't know the answer to that.

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

12 A Sure.

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

15 A Yeah.

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

19 MR. GASTMAN: Objection to form, Your Honor.

20 THE COURT: Overruled.

21 You can answer, if you can.

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

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

2 Q I included herniations in that.

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

7 Q Right.

8 A -- which the osteophytes are nowhere near.

9 Q But I said to you --

10 A I'm sorry. Go ahead.

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

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

14 Q They could have been there three months before?

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

21 Q And what you're being told?

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

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

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

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

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

6 MS. CAMACHO: I have nothing further.

7 MR. GASTMAN: Just a brief re-direct.

8 REDIRECT EXAMINATION

9 BY MR. GASTMAN:

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

12 A 30 years or more.

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

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

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

18 A I give the information back to the doctor.

19 Q If you find herniations, you say so?

20 A Correct.

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

23 A Correct.

24 Q You report on the abnormalities?

25 A Correct.

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

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

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

8 A Yes.

9 MR. GASTMAN: Thank you, Doctor.

10 MS. CAMACHO: Nothing further.

11 THE COURT: Okay. You're excused.

12 THE WITNESS: Thank you.

13 THE COURT: Yes.

14 (Witness excused.)

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

16 THE COURT OFFICER: All rise. Jury exiting.

17 (Whereupon, the jury exited the courtroom.)

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

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

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

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

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

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

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

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

18 (Whereupon, a lunch recess was taken.)

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

20 * * * * *

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

24 THE COURT: Yes.

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

1 him maybe ten percent of the time and primarily with regard
2 to his knee and the last time I think he saw him was in
3 2019.

4 We have had a notice of medical exchange back in
5 '15 and that was a report that he completed at the request
6 of the attorney's office, but primarily, it reviews Dr.
7 Grimm's treatment. And the 3101(d) we received primarily
8 reviews the treatment of, again, Dr. Grimm and Dr. Brisson.

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

16 THE COURT: Any response?

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

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

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

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

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

14 THE COURT: Okay.

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

17 MS. CAMACHO: I'm not --

18 THE COURT: Are both sides ready for the jury?

19 MR. GASTMAN: Absolutely .

20 THE COURT OFFICER: All rise. Jury entering.

21 (Whereupon, the jury entered the courtroom.)

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

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

3 So call your next witness.

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

6 THE COURT: Okay.

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

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

13 THE WITNESS: Sure. My name is Jeffrey Kaplan.
14 J-E-F-F-R-E-Y, K-A-P-L-A-N, and my office is at 160 East
15 56th Street, 10022.

16 THE CLERK: 1-0.

17 THE WITNESS: 0-2-2.

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

19 THE WITNESS: No.

20 THE CLERK: Thank you.

21 Your Honor, the witness is sworn.

22 And you may be seated.

23 THE WITNESS: Thank you.

24 MR. GASTMAN: May I inquire, Your Honor?

25 THE COURT: Yes.

1 MR. GASTMAN: Thank you.

2 DIRECT EXAMINATION

3 BY MR. GASTMAN:

4 Q Dr. Kaplan, good afternoon.

5 A Hi.

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

8 A Yes.

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

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

18 Q Thank you.

19 Are you board certified in any field of medicine?

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

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

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

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

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

12 Q Thank you.

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

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

18 A My practice?

19 Q Yes, Doctor.

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

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

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

5 A Yes.

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

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

10 Q You correctly anticipated my next question.

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

13 A Yes.

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

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

18 A Okay.

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

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

23 A Yes.

24 Q And what is that?

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

1 Q Thank you.

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

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

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

9 A Yeah, but I can find --

10 Q May of 2013, May 8th.

11 A Okay. Got it. Okay.

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

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

15 Q Is Dr. Crone presently with the practice?

16 A No, Dr. Crone retired from medicine.

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

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

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

22 A No.

23 MS. CAMACHO: Objection.

24 THE COURT: Overruled.

25 You can answer.

1 A Yeah. No, he retired shortly after this.

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

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

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

10 A Correct.

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

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

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

18 MS. CAMACHO: Objection, Judge.

19 THE COURT: Overruled.

20 You can answer.

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

24 Q Thank you.

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

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

2 A April 29, 2013.

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

5 A Yes, correct.

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

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

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

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

15 THE COURT: Are you the treating physician?

16 THE WITNESS: Yeah, I treated him.

17 THE COURT: I will allow it.

18 You can answer the question.

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

25 Q Doctor, is pain management appropriate care for

1 orthopedic injuries?

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

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

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

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

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

21 Q Doctor, you mentioned physical therapy.

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

24 A Absolutely.

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

1 physical therapy center?

2 A There is.

3 Q Is there a registered physical therapist there?

4 A There is.

5 Q What is his or her name please?

6 A Adrian P-U-A-I.

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

10 A Yes.

11 (Continued on the next page.)

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1 Q Doctor, I see the chart is right near you.

2 A It is.

3 Q Is it easy or hard to flip through to see if you could
4 locate the physical therapy section?

5 A I saw them here.

6 Q I am just wondering if it's a minority or majority or
7 maybe you could describe what portion of the chart that might
8 contain?

9 A It's a huge portion of the chart.

10 Q Would it be fair to say over one hundred pages, Doctor?

11 A Yes.

12 Q Okay. Thank you.

13 (Brief pause.)

14 A It's roughly this section of the chart (indicating).

15 Q Thank you. Dr. Kaplan, how did Mr. Ramirez do with
16 conservative care? Did he do well, did he do poorly, something
17 else?

18 MS. CAMACHO: Objection, Judge. We went through
19 all of this with Dr. Grimm.

20 Are we just going to do the same questions?

21 THE COURT: Overruled. I will allow it.

22 Q Go ahead, Doctor.

23 A He had some relief with different therapies but nothing
24 long-standing. And so he eventually underwent surgery because
25 conservative measures eventually failed for the neck and back.

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

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

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

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

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

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

24 A Yes.

25 Q Would that have something to do with compensatory

1 injuries to the knee over time?

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

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

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

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

16 MS. CAMACHO: Objection.

17 THE COURT: Overruled. You could answer.

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

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

25 A I did.

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

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

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

14 A Sure.

15 Q It's ten years worth of material.

16 A Yes.

17 Q 2014, Doctor. July 31st, 2014?

18 A Yes.

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

21 A I did see him on that date, yes.

22 Q Did you perform an examination?

23 A I did.

24 Q Is that right in your chart?

25 A It is.

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

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

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

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

1 pathology causing leg pain.

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

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

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

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

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

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

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

1 make sense. In this case they do.

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

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

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

11 A Yes.

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

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

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

19 Are they objective, subjective or something else?

20 A The findings and images are objective findings.

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

24 A Yes.

25 Q Do you rely from time to time on radiology reports

1 prepared by radiologists?

2 A I do.

3 Q Okay. Doctor, let's choose just one more date that
4 your -- November -- I am sorry. The year is 2014. November
5 25th.

6 A Yes.

7 Q 2014.

8 A Yes.

9 Q Did you see the patient again at that time?

10 A I did.

11 Q Did the plaintiff have complaints?

12 A He did.

13 Q What were they please?

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

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

25 A Let's see.

1 (Brief pause.)

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

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

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

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

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

24 Did you see the patient early 2015 in February?

25 A Yes, I did.

1 Q Okay. Could you tell us when that was, Doctor?

2 A I saw the patient February 9th of 2015.

3 Q Did the patient have any complaints at that time,
4 Doctor?

5 A He did. He was having severe low back pain. He was
6 complaining of pain radiating into the right leg. He was having
7 worsening pain and buckling episodes of the right knee. He did
8 tell me his neck pain had improved following surgery although he
9 still had residual stiffness, limited motion and pain radiating
10 into the upper extremity on the left.

11 Q Thank you, Doctor.

12 A Sure.

13 Q Moving forward in time a bit. Doctor, let's move into
14 the following year. 2016.

15 Did you see the patient in January of 2016?

16 A Yes.

17 Q When was that, Doctor?

18 A I saw him 1/29/16.

19 Q So at this point he is post neck surgery and post back
20 surgery, is that correct, Doctor?

21 A That is correct.

22 Q Did the patient have any complaints at that time,
23 Doctor?

24 A He did. He still had neck and low back pain and he
25 still had findings consistent with a lumbar radiculopathy

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

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

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

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

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

11 Q Thank you.

12 (Brief pause.)

13 Q Doctor, let's move a little bit further into the chart.
14 Doctor, did you see the patient again in April of that
15 year?

16 A I did.

17 Q When was the date?

18 A April 29th, 2016.

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

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

25 Q What was your assessment at that time, Doctor?

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

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

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

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

16 Did you see the patient around Thanksgiving of that
17 year?

18 A Thanksgiving would be November 30th, 2016.

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

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

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

1 Q Okay.

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

4 Q Okay.

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

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

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

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

22 A Okay.

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

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

1 Q Okay.

2 A As well as March.

3 Q Let's look at January, please.

4 A Okay.

5 Q What was the exact date, Doctor?

6 A January 5th, 2017.

7 Q Thank you.

8 A Sure.

9 Q What were the patient's complaints at that time?

10 A At that time he indicated that he had gotten some
11 relief from the knee injection. He did have continued buckling
12 or mechanical symptoms of the knee. He did indicate that pain
13 was less. I had sent him -- and he was noted to have what is
14 called a nondisplaced trabeculare fracture on one of the bones.
15 That is like a bone bruise that comes from abnormal use, pain --
16 abnormal use of a joint, rather, in this case. And some, what I
17 call attritional problems, meaning things that occur over time,
18 partial tearing of the ligament, the ACL ligament. And a tear
19 in the cartilage called the meniscus. And the medial. He
20 continued to complain of low back pain and pain radiating into
21 the legs.

22 Q Doctor, do those radiological findings comport with
23 pain?

24 A They do, yes.

25 Q Let's move forward in time, Doctor. Summer.

1 Did you see the patient in July, 2017?

2 A I did.

3 Q What date please?

4 A I saw him on July 10th of 2017.

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

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

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

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

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

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

19 Would that be objective or subjective?

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

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

25 A At that time I felt he had lumbar radiculopathy status

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

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

7 A Yes.

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

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

16 Q Okay.

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

21 Q Doctor, is arthritis a form of degenerative condition?

22 A Can be, sure.

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

25 A So there are different types of arthritis. You could

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

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

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

14 A Sure.

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

17 A It takes time.

18 (Brief pause.)

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

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

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

1 you, counselor.

2 (Brief pause.)

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

4 A Yes.

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

8 MS. CAMACHO: Objection. Form.

9 THE COURT: Sustained. Can you rephrase it?

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

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

14 THE COURT: True. Sustained.

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

16 A Yes.

17 Q And 2018?

18 A Yes.

19 Q And 2019?

20 A Yes.

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

23 A The condition remained approximately the same. Yes.

24 Q Okay.

25 (Brief pause.)

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

3 A Sure.

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

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

9 A Sure.

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

13 A Okay.

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

16 A Right.

17 Q It's written up in your chart.

18 A It is.

19 Q He lost about three days of work at that point but
20 there was no medical care. And then he had this accident in
21 2013. He fell from a twenty foot ladder. He fell thirteen
22 feet, fifteen feet, something to that effect. He landed hard on
23 a metal floor, knocked unconscious, taken to the hospital. And
24 the rest of the medical treatment you know of.

25 Doctor --

1 A Yes.

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

5 MS. CAMACHO: Objection to form.

6 A I do.

7 THE COURT: Overruled. You could answer.

8 A I do have an opinion.

9 Q What is your opinion, Doctor?

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

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

16 MS. CAMACHO: Objection.

17 A Yes.

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

20 THE WITNESS: Sorry.

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

23 MS. CAMACHO: Objection.

24 THE COURT: Sustained.

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

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

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

6 MR. GASTMAN: The question was exhibiting pain.

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

9 THE WITNESS: Sure.

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

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

19 A I believe they are, yes.

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

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

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

1 of your patients before?

2 A Yes.

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

5 A Yes.

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

8 A Still be at my office seeing patients.

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

11 A I am sure they have already been compensated.

12 Q Could you tell us approximately how much?

13 A \$6,500.

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

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

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

23 A Sure.

24 THE COURT: All right. Any Cross?

25 MS. CAMACHO: Yes.

1 (Brief pause.)

2 CROSS-EXAMINATION

3 BY MS. CAMACHO:

4 Q Good afternoon, Doctor.

5 A Hi.

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

8 A It is, yes.

9 Q And you are the sole owner?

10 A That's correct.

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

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

15 Q Okay.

16 A Yes.

17 Q But it's yours?

18 A I own it, yes.

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

22 A Yes.

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

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

1 pile.

2 Q Can you pull out July 10th, 2013?

3 A I could certainly try.

4 (Witness complies.)

5 A Okay. I have July 10th, 2013.

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

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

13 Q Yes. 11/13/14?

14 A Yes.

15 Q 12/4/14.

16 A Yes.

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

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

20 Q So there was no treatment that day?

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

22 Q Okay.

23 A There is no --

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

1 A I have a bill, yes.

2 Q So go to the date there and tell me if there is a
3 charge for office visit that day?

4 A What is the date?

5 Q Let's start with July 10th, 2013.

6 A Okay.

7 Q Yes.

8 A It looks like a charge was generated, nothing was paid
9 and it was written off.

10 Q Well, Dr. Grimm told us there was a visit that day.
11 Can you explain that?

12 A I can't. I don't think there was. It looks to me like
13 a computer glitch.

14 Q Okay. Now, he also told us that you would be able to
15 explain where all of the initial paperwork was. So, Mr. Ramirez
16 testified when he went to the office the first time, when
17 Mr. Gorayeb's office sent the card to come to your office he
18 filled out paperwork?

19 A Okay.

20 Q And that paperwork isn't in the certified records?

21 A Right, it's not part of the medical record which is
22 what --

23 Q So when somebody comes in and gives their background
24 and history in their own handwriting that is not part of the
25 medical record?

1 A That is just demographics.

2 Q Their medical history?

3 A They don't fill out a detailed history.

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

7 A No.

8 Q You don't have them fill that out?

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

14 Q Okay.

15

16 - Proceedings continue next page -

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

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

4 Q So it is scanned and saved somewhere?

5 A Yeah.

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

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

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

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

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

15 A I can't speak to that.

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

19 A Okay.

20 Q Where is that documentation?

21 A That's the intake sheet.

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

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

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

3 MS. CAMACHO: Thank you.

4 Q Now, how often does that happen?

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

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

9 A Absolutely.

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

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

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

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

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

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

24 Q You refer patients to him?

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

1 years past.

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

3 A Yes.

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

7 THE COURT: Yes.

8 MR. GASTMAN: Thank you.

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

11 A Some, yes.

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

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

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

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

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

24 A I still do, yes.

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

1 spines, correct?

2 A I still am not, correct.

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

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

6 Q Let me ask you this question.

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

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

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

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

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

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

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

25 A Is the question should it or does it?

1 Q Should not.

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

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

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

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

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

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

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

16 MR. GASTMAN: Your Honor, objection; relevancy.

17 THE COURT: Sustained.

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

22 A Not fully, no.

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

1 that?

2 A Yes, I think so.

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

5 A Sure.

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

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

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

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

13 Q My question first is when was the accident?

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

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

17 THE COURT: Sustained.

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

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

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

24 Q Okay.

25 A Thank you for pointing that out.

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

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

5 Q And let me ask you this question.

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

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

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

10 A Yes.

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

12 A I have.

13 Q Other firms?

14 A That's correct.

15 Q Other plaintiff's firms?

16 A Yes.

17 Q And you've been asked that question?

18 A Okay.

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

20 A 35 and 40.

21 Q Post-pandemic, it is less?

22 A It is less, yeah.

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

25 A Could be, 35, 30.

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

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

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

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

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

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

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

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

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

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

25 Q Over four years ago?

1 A That's right.

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

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

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

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

13 Q That was --

14 A But it's not every visit.

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

16 A I said it is not every visit.

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

19 A That's correct.

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

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

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

1 A That's correct.

2 Q And so when people normally walk, they walk one foot in
3 front of the other?

4 A That's correct.

5 Q Smooth, even gait, correct?

6 A That's the way most people walk, yes.

7 Q So if somebody has an antalgic gait, there's something
8 out of sync, right?

9 A Correct. That's right.

10 Q Favoring one side or the other?

11 A Usually.

12 Q Which side did he favor?

13 A Probably both because his pain is from his back
14 primarily.

15 Q But you don't write down?

16 A If it is specific, I do. Here, it is not written
17 specifically.

18 Q But there were times you actually wrote down marked.
19 What does that mean?

20 A That means he was having more trouble than I would
21 expect that he has.

22 Q Does that mean a marked antalgic gait would be even
23 more obvious to the untrained eye?

24 A Should be.

25 Q Now, let me go back to the cane. He was using a cane

1 when you saw him in 2014, November of 2014?

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

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

4 A Yes.

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

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

8 Q You don't say marked --

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

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

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

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

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

19 Q Let's go to your July visit.

20 A July of what year?

21 Q I'm sorry. July 10, 2017.

22 A Okay.

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

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

1 atrophy.

2 Q Can you tell the jury what that is?

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

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

7 A Not at the regular office visits, no.

8 Q At any visit, anywhere in the chart?

9 A No, not in the office visits.

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

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

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

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

15 Q So let me ask you this question.

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

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

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

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

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

24 A That's correct.

25 Q And that would include his lower extremities

1 neurologically, wouldn't it?

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

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

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

10 Q Can you have atrophy without loss of muscle strength?

11 A You can, yeah. Muscle --

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

14 A You're correct.

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

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

18 THE COURT: No. Overruled.

19 You can answer, if you can.

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

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

22 THE COURT: Wait for the next question.

23 Q July 19, 2017.

24 A Okay.

25 Q That was nine days later, correct?

1 A Sure.

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

4 A He's not.

5 Q He is a pain management doctor?

6 A That's right.

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

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

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

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

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

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

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

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

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

4 A October 11, 2017. Yes.

5 Q There, you document quadriceps weakness?

6 A That's right.

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

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

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

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

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

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

18 Q What kind of trouble did he have?

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

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

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

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

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

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

13 Q Did you write it down or not?

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

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

19 THE COURT: Well, you can answer the question.

20 THE WITNESS: Yeah, I can't answer it yes or no
21 because she's indicating that that's the only way -- in my
22 mind, she's indicating that's the only way to note that I
23 have to use her exact words and the answer is I didn't put
24 it down the way you would like me to, but they're both
25 indications of weakness.

1 Q Couldn't he have trouble getting on and off the table
2 for a reason other than quadriceps weakness?

3 A Anything is possible, I guess, but that's the reason in
4 my mind, in my opinion.

5 Q So in your mind, every other time that he had trouble
6 getting on and off the table that's marked in your notes, we
7 should now know that that means quadriceps weakness?

8 A As of now since we're talking, yes.

9 Q Okay.

10 A Yeah.

11 Q And if Dr. Grimm on all those occasions before and
12 after had full strength on his bilateral extremities, that was
13 wrong?

14 A He has five over five strength, so I wish that I could
15 give you a lesson in medicine in five minutes, but I can't do
16 that. So you're just going to have to take my word for it as a
17 trained orthopedic surgeon who's been working for 40 years. You
18 can pick at it all you want. I'm going to give you the same
19 answer.

20 Q You make office notes at the time you see your
21 patients?

22 A That's right.

23 Q And you do that, so that there is information about
24 your exam that can be looked at later on, correct?

25 A That's right.

1 Q And you have many patients involved in litigation.
2 This is not the first time you've come to testify, correct?

3 A I certainly have patients who have been hurt and
4 involved in litigation, yeah.

5 Q And pretty regularly sending your records to court?

6 A I don't make my records for the court, though. I make
7 my records for myself and other physicians.

8 Q Now, when was the last time -- Adrian, I think you
9 said this person Adrian was the physical therapist back from
10 2013 to 2019?

11 A Yes.

12 Q And Adrian is a man?

13 A Yes.

14 Q When was the last time --

15 MR. GASTMAN: Objection; relevancy.

16 THE COURT: Sustained.

17 You don't have to answer that.

18 Q When was the last time Mr. Ramirez had physical therapy
19 at your facility?

20 A It looks like, and I can't be sure without going
21 through everything, but it looks like 8/29/19.

22 Q And only because Dr. Grimm had difficulties finding in
23 the chart, when was the last time he had trigger point
24 injections?

25 A I don't know the answer to that.

1 Q You can't figure that out from the chart?

2 A No.

3 Q What about from that super bill in the back?

4 A I don't know that I could figure it out from that.

5 Q Can you take a look at it and see?

6 MR. GASTMAN: Just note my objection, Your Honor;
7 relevancy to this witness.

8 MS. CAMACHO: The other witness couldn't answer.

9 MR. GASTMAN: The chart is in evidence.

10 A I can't tell from this. I can't tell from that.

11 Q Did he have trigger point injections since 2019?

12 A Not from me certainly.

13 MR. GASTMAN: Just objection to the relevancy.

14 THE COURT: Sustained.

15 Q Have you ever --

16 THE COURT: He said he couldn't tell.

17 Correct.

18 THE WITNESS: Correct, yeah.

19 Q So there's no way for the jury to know from that chart
20 that's in the record when the last time was that he had trigger
21 point injections?

22 A They could find it in the medical note, sure.

23 Q But you can't find it?

24 A I'm not going to go through Dr. Grimm's notes because I
25 don't follow his notes.

1 MR. GASTMAN: And your objection, relevancy to this
2 witness.

3 MS. CAMACHO: Again, the doctor that was here
4 yesterday was unable to look at the chart, either the one he
5 brought with him or the one that was in evidence, and give
6 us the answer to this and he said Dr. Kaplan would be able
7 to do that for us. We have Dr. Kaplan here. I'm just
8 asking.

9 THE COURT: Sustained. I'll allow him to answer.

10 A I don't think there were any trigger point injections
11 given after 2019. I do not know the last date that it was
12 given.

13 Q What about epidural injections?

14 A That would be Dr. Grimm's area.

15 Q And can you -- did you say that you gave trigger point
16 injections or no?

17 A No, I gave a knee injection, I believe. Let me just
18 make sure of that. Hold, please. Oh, yes, I give him a trigger
19 point injection in 2015.

20 Q Where?

21 A Lumbar.

22 Q Plaintiff is no longer treating with you at the
23 facility, correct?

24 A I haven't seen him since 2019.

25 Q So is that a fair answer?

1 A I think that's fair.

2 Q And can you tell the jury, do you have the prescription
3 section?

4 A What prescriptions actually?

5 Q Can you -- is there a prescription section in the
6 record that the jurors could look to to see what prescription
7 medication was prescribed to Mr. Ramirez?

8 A I think they can see where it is initially prescribed.
9 I don't think it records every time that prescriptions are
10 given.

11 Q So the certified records don't --

12 A I don't think they show refills.

13 Q Isn't it New York State law mandate you to keep track
14 of prescriptions, medications prescribed especially if it is a
15 controlled substance to a patient?

16 A They are on our computer system.

17 Q They are not part of the chart?

18 A I don't know that it generates a refill. I just don't
19 know the answer to that. I've never been asked that before. I
20 don't even know that there is a prescription section. Looks
21 like we did record some off the computer system, yeah.

22 Q I'm sorry?

23 A I said it looks like there are some recorded
24 prescriptions that came through.

25 Q Are those all of them or you don't know?

1 A I don't know. You would have to ask my computer tech.

2 Q The certification that came with that to court
3 indicates those are the complete certified medical records for
4 Mr. Ramirez.

5 A That's what we can print, yeah.

6 Q So you can't print the other ones? Is that what you
7 are saying?

8 A You would have to ask my computer person honestly.

9 Q You've testified numerous times about torn ligaments in
10 the knee, correct?

11 A Yes.

12 (Continued on the next page.)

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1 Q And, generally speaking, more often than that, and
2 maybe all of those times, it's because torn meniscus, torn
3 tendons are caused by trauma, correct?

4 A The ones I testified for, yes.

5 Q Yes. Plaintiff has testified he didn't hurt his knee
6 in that accident?

7 A That's correct.

8 Q Correct. Now, when people fall --

9 A Yes.

10 Q -- impact their body on a hard surface, there is
11 generally injuries to their body, correct?

12 A Sometimes.

13 Q So it was your opinion to this jury that Mr. Ramirez
14 suffered a trauma as a result of that fall; is that correct?

15 A That is what the records indicate, yes.

16 Q Well, you gave them your opinion within a reasonable
17 degree of medical certainty --

18 A That's right, that is where my opinion is from.

19 Q -- that the herniations were caused by the fall,
20 correct?

21 A That is not what I said. If you go back -- what I said
22 was the symptoms that were being treated which are caused by the
23 herniations are from the fall. There is no way to know with one
24 hundred percent certainty when the herniations occurred. The
25 likelihood is, my opinion is that they are from the accident

1 because he didn't have significant back pain prior to this. So
2 in my opinion within a reasonable degree of medical certainty
3 the herniations are from that.

4 But you asked me if I am sure; you can't be sure of
5 that. That is not what I am asked. I am asked with a
6 reasonable degree of medical certainty.

7 Q And that is based upon what Mr. Ramirez's history --

8 A That, and -- yes, the emergency room record. The CT.
9 They x-rayed him up. They took a history of the fall. Yes, I
10 think that is what occurred.

11 Q A herniation is caused when the ligaments surrounding
12 the vertebrae in your back tear, correct?

13 A That can happen, yes. That is one way.

14 Q What are ligaments made of?

15 A Collagen fiber. And these are not strictly ligaments.
16 It's called the annulus fibrosa. It's a fibrous ring or tissue.

17 Q And they have a blood supply that goes to them,
18 correct?

19 A Yes.

20 Q And what happens when you tear a tendon, some of --

21 A If you tear through the blood supply they do. But you
22 don't always tear through the blood supply.

23 Q Here the herniations are through the tendon, correct,
24 full herniations?

25 A That is what a herniation is, yes, that means the jelly

1 part on the inside of the disc moves to the outside through the
2 annulus. You --

3 Q Through the tendon?

4 A It's not a tendon. It's the annulus fibrosae.

5 Q And so if the radiologist who just testified told the
6 jury that it was a tendon, that was wrong?

7 MR. GASTMAN: Your Honor, objection.

8 Q A ligament.

9 A You keep saying tendon.

10 Q My bad.

11 A Your bad.

12 Q Sorry. My bad. Excuse me. Ligament?

13 A It's a ligamentous tissue.

14 Q Ligament blood supply, yes?

15 A They have a blood supply, yes.

16 Q And if you tear through a ligament, it bleeds?

17 A Sometimes, if you tear through the blood supply.

18 Q Soft tissue.

19 A Yes.

20 Q If you treat a patient who has injured their soft
21 tissue, what do you see?

22 A You could see a number of things. Number one, you
23 could see nothing. Number two, you could see a laceration.
24 Number three, you could see a bruise or swelling. All of those
25 things are possible, or not.

1 Q Depends on the impact?

2 A It actually depends on what is damaged, yes.

3 Q What was damaged here?

4 A I believe his disc was damaged. And I believe that he
5 has formed herniations which have caused radiculopathy. Those
6 are all sort of a sequelae of things that occurred.

7 Q Herniations are the only injury that occurred during
8 this fall?

9 A I have no way of knowing that.

10 Q Did you look at the hospital records?

11 A I did look at the hospital records. With a reasonable
12 degree of medical certainty, without objective evidence you
13 don't know that.

14 Q Did you see any evidence of bruising or swelling,
15 redness, anything?

16 A I don't recall. I will be happy to look at it. By the
17 way you are asking me it, I guess they didn't notice -- note
18 those things, not noticed -- note them. They may have not been
19 there. A disc is very deep in the body. You don't get -- you
20 often don't get bruising at all from a herniated disc. I would
21 say great majority of herniated discs are not associated with
22 bruising because of that.

23 Q The radiologist told the jury within a reasonable
24 degree of medical certainty that you cannot look at the CT scan
25 or the MRI and tell us when that herniation was formed.

1 A Which is exactly what I just said, yes.

2 Q But you said based on the history it's your opinion
3 within a reasonable degree of medical certainty, if I understood
4 you, it's your opinion that that herniation was caused on that
5 day, is that fair?

6 A That is not what I said at all. What I said was that
7 the annulus fibrosis was damaged and over time, the herniation,
8 which is the jelly substance in the middle comes out. It can
9 happen immediately. Doesn't necessarily happen immediately. In
10 this case, you know, again, there is no time stamp on the MRI,
11 so I can't tell you with one hundred percent certainty. So I am
12 asked to tell you within a reasonable degree of medical
13 certainty. And that means greater than fifty percent in my mind
14 that these injuries were caused by the accident.

15 Q Did I understand your testimony correctly, and I am
16 sure you will correct me if I am wrong, that it's your opinion
17 that the ligament was damaged that day and the herniation came
18 thereafter?

19 A I don't think you understand the concept. So I will
20 explain it to you guys again. The ligament holds in the disc.

21 Q Right.

22 A What happens is, the part that is contained is injured
23 in some way and then the disc comes out. It herniates. It goes
24 through the ligament. That is what you see. It's an X ray
25 representation of the injury. You see a herniation --

1 Q My question was, was the herniation there on the day
2 when he was at the hospital?

3 A There is no way to know that with one hundred percent
4 certainty. If you could give me a way to know it, I will opine
5 on it.

6 Q How about the CAT scan?

7 A Doesn't necessarily show it. That is not the gold
8 standard.

9 Q So if the radiologist hired by plaintiff's counsel put
10 the CAT scan up in front of the jury and said there is a
11 herniation, C3/4, C4/5, C5/6, you disagree with that?

12 A I didn't say I disagree with that at all.

13 Q But you said you --

14 A I said you can't necessarily see it. So a trained
15 radiologist may be able to see it, and someone may be looking at
16 a CAT scan which is a gold standard for bone injuries and
17 they'll be looking at bone injuries and not note it.

18 MS. CAMACHO: I have nothing further.

19 THE COURT: Any Redirect?

20 MR. GASTMAN: Thank you, your Honor. Brief.

21 REDIRECT EXAMINATION

22 BY MR. GASTMAN:

23 Q Doctor, thank you for your time. A few more questions
24 please.

25 A Sure.

1 Q A defense --

2 THE COURT: You don't have to be brief.

3 MR. GASTMAN: Yes. I agree, your Honor. However,
4 I will be brief because there is very little to cover.

5 Thank you.

6 Q Defense counsel had a number of questions about
7 prescriptions, your chart, whether things were missing. You
8 remember that line of questioning?

9 A I do.

10 Q Doctor, the prescriptions are in the chart, yes?

11 A The prescriptions are logged, yes.

12 Q Would you believe me, Doctor, if I told you Dr. Grimm
13 opened them up and read them to this jury, would you believe me?

14 A I note, as do I -- he sometimes dictates them.
15 Sometimes doesn't. Depends how busy we are in a day, and
16 sometimes we forget. If they are made, they are logged in the
17 computer. Whether they generate to a printed page, I don't
18 know.

19 Q Let me take you back in time a little bit, Doctor.
20 Before the age of digital medical everything.

21 A Yes.

22 Q How were medical prescriptions, in other words,
23 medication, how was that prescription written by a doctor?

24 A Until a couple years ago when the e-Prescribe system
25 came in, we would write it on a small piece of paper and handed

1 it to the patient. We usually took a Xerox copy of that, just
2 to have a record, and the patient would take it to the drugstore
3 themselves. These days prescriptions are done via computer, it
4 gets sent to the pharmacy and picked up. The --

5 Q Dr. Grimm told this jury with that very chart in front
6 of him that the paper prescriptions are in the chart. He opened
7 them up, read them to the jury and he said that the renewal
8 prescriptions might be digital in nature and they are no longer
9 reduced to paper.

10 A That's correct.

11 Q Is that correct, not correct?

12 A That is correct.

13 Q Doctor, do you happen to know, if you do, what pharmacy
14 was handling the prescription medication for Mr. Ramirez, if you
15 happen to know?

16 A I have no idea.

17 MR. GASTMAN: Your Honor, at the appropriate time,
18 now or whenever, the pharmacy records of Titan Pharmacy,
19 they are here. I will mark them for identification and move
20 them into evidence so everybody could see everything.

21 MS. CAMACHO: That will clear a lot of things up,
22 great, Judge.

23 THE COURT: Okay.

24 MR. GASTMAN: We will do that outside the jury's
25 presence or right away.

1 THE COURT: You could do it now.

2 MR. GASTMAN: Sure. Is it over here, officer?

3 COURT OFFICER: Underneath.

4 MR. GASTMAN: Your Honor, I have in my hand the
5 subpoenaed records from Titan Pharmacy. They were stamped
6 in by this court on February 16, 2024. I offer them for
7 I.D. as Plaintiff's --

8 MS. CAMACHO: 15.

9 MR. GASTMAN: I am told it's Plaintiff's 15. Thank
10 you. And I offer this as evidence.

11 THE COURT: Yes?

12 MS. CAMACHO: Subject to redaction, Judge, no
13 objection.

14 THE COURT: Granted.

15 (Whereupon, Plaintiff's Exhibit 15 was marked and
16 received into evidence at this time.)

17 Q Doctor, defense counsel asked you a few questions in
18 the area of nerves and muscles.

19 Do you remember that?

20 A Yes.

21 Q Doctor, what is an EMG?

22 A An EMG is a study of the nerve firing as it relates to
23 the spinal column and the muscles that are effected.

24 Q Dr. Grimm does those tests in the office, doesn't he?

25 A Yes, he does.

1 Q These charts contain EMGs of this patient, doesn't it?

2 A I believe it does.

3 Q And, finally, Doctor, you were asked about antalgic
4 gait. And I think the question generally was when did this all
5 begin.

6 A Yes.

7 Q Doctor, let me ask you, if you take a look at your
8 chart, and the first -- in the first two weeks of treatment,
9 take a look at May 15th, 2013. May 15, 2013. This is just a
10 few weeks after the accident.

11 A Okay.

12 Q Doctor, is there any record in this chart at that time
13 by a physician with regard to antalgic gait of this patient?

14 A There is.

15 Q Thank you, Doctor.

16 MS. CAMACHO: Very briefly.

17 RECROSS-EXAMINATION

18 BY MS. CAMACHO:

19 Q When you write your notes?

20 A Yes.

21 Q You rely on what Mr. Ramirez tells you, correct?

22 A To some degree, yes.

23 Q And how he presents to your office, correct?

24 A Yes.

25 MS. CAMACHO: I have nothing further.

1 THE COURT: Okay. Thank you. You are excused.

2 (Witness excused.)

3 THE COURT: All right. Ladies and gentlemen, we
4 will continue tomorrow morning, 10 a.m.

5 Thank you.

6 COURT OFFICER: All rise. Jury exiting.

7 (Whereupon, the jury exits the courtroom at this
8 time.)

9 (Whereupon, the case was adjourned to February 28,
10 2024, at 10:00 a.m.)

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