UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
CASE NO. 2:21-cv-19162-KM-CLW

JUAN ALFREDO GANDO AMAT, AND LILIA HAYDEE GARCIA,

Plaintiffs,

vs.

HAND TO HAND EXPRESS AND ANGELITO AQUINO-SANTANA,

Defendants/Third Party Plaintiffs,

vs.

ALVARO GUERRA JIMENEZ,

Third Party Defendant.

- - - - - - - - - - - - - - -

VIDEO CONFERENCE

DEPOSITION OF:

DR. MICHAEL GERLING

B E F O R E: FRANK BIELY, a Certified Court Reporter of the State of New Jersey, remote deposition conducted through Zoom connection on Monday, March 24, 2025, commencing at 3:31 P.M., pursuant to Notice.

REPORTING SERVICES ARRANGED THROUGH
SENTRY COURT REPORTING
&
LITIGATION SERVICES, LLC
100 Hanover Avenue, Suite 202
Cedar Knolls, New Jersey 07927
Phone: 1-973-359-8444 Fax: 1-973-359-1049

A P P E A R A N C E S

HELEN F. DALTON & ASSOCIATES, P.C.
80-02 Kew Gardens Road, Suite 601
Kew Gardens, New York 11415
avshalumovr@yahoo.com
BY: ROMAN AVSHALUMOV, ESQ.
Attorney for Plaintiffs

HARDIN, KUNDLA, MC KEON & POLETTO, ESQS.
673 Morris Avenue
Springfield, New Jersey 07081
pdaly@hkmpp.com
BY: PAUL DALY, ESQ.
Attorneys for Defendants/Third Party Plaintiffs

CIPRIANI & WERNER, P.C.
11 Stewart Avenue
Huntington, New York 11743
BY: MICHAEL NOBLETT, ESQ.
Attorneys for Defendants/Third Party Plaintiffs

LAW OFFICES OF NANCY L. CALLEGHER
P.O. Box 258829
Oklahoma City, Oklahoma 73125
Jessica.adams@farmersinsurance.com
BY: JESSICA ADAMS, ESQ.
Attorneys for Third Party Defendant

I N D E X

E X H I B I T S

(Exhibits were marked after the deposition and are attached to the transcript.)

DR. MICHAEL GERLING

740 Park Avenue, New York, New York 10021, Sworn

DIRECT EXAMINATION BY MR. DALY:

Q. Good afternoon, Doctor. My name is Paul Daly. I'm an attorney with the law firm of Hardin, Kundla, McKeon & Poletto. We represent some of the defendants in a lawsuit brought by a Mr. Amat regarding injuries that he sustained in a car crash that happened in November 2020, and we're here today for the purpose of taking your deposition because you've been identified as an expert witness who may testify at the time of trial in this matter.

Have you ever had your deposition taken before, Doctor?

A. Yes.

Q. Okay. Approximately how many times?

A. I don't know. I mean I take Workman's Compensation insurance. I do depositions a couple times a month for them.

Q. Okay.

A. I've been doing it -- I've been in practice for almost 20 years, so I've done a lot.

Q. Sure. That's all I need to know. That's fine.

Do you maintain a list of cases where you have

testified as an expert witness?

A. I have somebody in my practice who does that, yes.

Q. Okay. And have you testified in court, in Federal Court as an expert witness ever?

A. Yes.

MR. DALY: Okay. So, Roman, I don't think I have his testimony list. I'll follow up with you for that, if you could provide that.

MR. AVSHALUMOV: Sure. I'll supplement it if you don't have it.

MR. DALY: I appreciate it. Okay.

Q. Doctor, when you've testified in court, has it always been for treatments that you've -- sorry -- for patients that you've treated?

A. Yes. Yes.

Q. Okay. So in other words, there haven't been any occasions where you've been asked to do what might be called an independent medical examination of someone that you have not been involved in the treatment?

A. Correct.

Q. Okay. Now, your attorneys in this case have made a representation with respect to your association with NYU Langone, and I'd just like to

ask you to validate that representation for me. The representation is that you resigned your privileges at NYU Langone while there was an investigation that was in process.

Is that an accurate representation?

MR. AVSHALUMOV: I just want a notation of my objection for the record, but he can answer over my objection.

A. Yes. That's true.

MR. DALY: Okay. And, Roman, just so you know, I'm well aware of the court's order on the motion to quash. I fully intend to. But I understood that part of the ruling was based upon that stipulation from counsel, so...

MR. AVSHALUMOV: Yes. Yes.

Q. Okay. Doctor, have you ever resigned your privileges at any other hospital?

A. Yes.

Q. Which others or other?

A. At Lenox Hill.

Q. Okay. And what were the circumstances there?

A. I was -- I was -- I was at the point where I was renewing my privileges, and due to the fact that there was a -- like I wasn't practicing

there, I had to renew them, and because of the fact that there was a -- an ongoing civil lawsuit which was causing significant disruptions in investigations, I chose not to renew and then resigned.

Q. Okay. Any others other than just NYU and Lenox Hill?

A. No.

Q. Okay. Have you ever had your privileges revoked or suspended?

MR. AVSHALUMOV: Just note my objection to the question. I'll allow him to answer.

A. The only time was when I was in the middle of the administrative investigation due to the civil lawsuit.

Q. Was that at Lenox Hill or NYU?

A. At both.

Q. Okay.

A. But I mean at Lenox Hill it was irrelevant, because I wasn't practicing there.

Q. Okay.

A. It was more symbolic, really.

Q. How many surgical procedures do you perform on an average week or month or whatever time frame you want to use?

A. It depends on the week. Sometimes two. Sometimes six.

Q. Okay. And what percentage of the surgeries that you perform are spinal surgeries?

A. 100 percent.

Q. Okay. Can you break that down further into fusion surgeries?

A. Probably between 50 percent and 75 percent.

Q. Okay. Doctor, when you testify in a case involving a patient, do you consider yourself to be acting at all as an advocate for your patient?

A. When I do a surgery on them?

Q. No. When you testify.

A. Yes. Of course. I mean I'm being asked -- I'm being asked to testify as their treating doctor, and I have intrinsically their interests at, you know, you know, I'm their -- I'm their -- I'm their treating doctor. I mean I'm there as a fact witness to some extent I guess, and of course I have opinions. But most of my opinions relate to the care that I performed, and the care I performed is in keeping with the standard of care and -- and in, you know, and those are the things I agree to testify to when I go to court.

Q. Okay. Now, you treated Mr. Amat for injuries to his neck and back, correct?

A. Yes.

Q. Okay. And one of the opinions that you have offered is that the injuries you've treated Mr. Amat for were caused by the car crash of November 23, 2020.

Is that correct?

A. I believe so. I'm just going to open up my initial note. Let's see. The initial note I believe was May 12, 2022, correct?

Q. I believe that's when you first saw him, correct, yeah.

A. Right. Right.

Q. Yeah.

A. And that was -- that was based -- when he presented, he did complain of injuries related to an accident on 11 -- on November 23, '20, 2020.

Q. Got it. You might be answering a slightly different question than the one I asked, so I'll ask it again to clarify, if that's all right.

A. Sure.

Q. One of the opinions that you offered is that the injuries you treated Mr. Amat for were caused by the car crash of November 23, 2020.

Is that correct?

A. Yes.

Q. Okay. And in forming an opinion as to causation, one thing that you would consider as a physician is the onset of symptoms.

Is that correct?

A. Yes.

Q. Okay. In other words, if a patient complained of pain in his neck and back immediately after a crash, that would tend to support the conclusion that the crash caused or contributed to the injury, correct?

A. That it contributed to, yes, to neck and back issues, yes.

Q. And likewise, if there was a significant lapse of time in the onset of symptoms, that would tend to support the conclusion that the injury did not support -- did not cause or contribute to the injury.

Is that correct?

A. It's all relative. I mean it depends on the circumstance. If they have significant distracting injuries, like other broken bones and whatnot, it's well-known that they won't complain or focus upon disc herniations and things like that in

the short term. That's why we do skeletal surveys and do examinations of other body parts, because of that issue. So when patients have high energy trauma, in those scenarios they're more likely to have a delay in their complaints of axial pain than in patients that have isolated, more minor injuries.

Q. Sure. And I understand that Mr. Amat did have other injuries in this crash. That's not I don't think at all disputed. But and while there may be other explanations for a delay in onset of symptoms, generally speaking a delay in onset is something which would support the conclusion of a lack of causation as to -- as opposed to causation.

Is that correct?

A. It depends on what the delay is. That's a very open statement. It's very broad. Certainly there are circumstances where a substantial delay would -- would imply that the -- that the symptoms were not related.

Q. Okay. And I know it's an open ended question, but at what point, what would you consider a substantial delay that would begin to imply that the symptoms are not related?

A. Like two to three months.

Q. Okay. Now, Doctor, we've been provided

with some records from you, and I'll show them. I'll show you -- hold on. I've got to share my screen, don't I?

Are you able to see my screen, Doctor?

A. Yes, sir.

Q. And you see --

A. Yes.

Q. -- plaintiff's expert witness disclosure?

Okay. I'm going to go to your report, which is part of -- part of this, and specifically page seven of your report. I'll shrink it a little bit so the whole thing fits on the screen. Hopefully it's still legible.

According to your -- page seven of your report, you reviewed a number of records from various medical providers for treatment that Mr. Amat received during the days right after the crash, correct?

A. Yes.

Q. Okay. For example, you reviewed records from Raritan Bay Medical Center and Jersey Shore Hospital, correct?

A. I believe so. I'm just looking for it on the list. It's very small.

Q. Hold on. I can increase that size.
A. Oh. I see it. I see it. Yes.
Q. Okay.
MR. AVSHALUMOV: Yeah. Paul, I think you can maximize it, but it's completely small. It's better now.
A. That is so much better.
Q. Yes. I just wanted to try to get the whole page on, but that doesn't work. All right.
And you reviewed records from when he was in rehab in December 2020, correct?
A. Yes.
Q. Okay. To the best of your knowledge, do any of those records contain any reference to Mr. Amat complaining of pain in his neck and back?
A. Oh, I don't recall off the top of my head.
Q. Do you have an understanding of when Mr. Amat first began to complain of symptoms to his neck and back?
A. I -- I don't recall right now. I haven't -- I did not review those records in preparation for this deposition.
Q. Okay. Did you review anything in preparation for today's deposition?

A. I briefly reviewed my narrative report.
Q. Okay. How did Mr. Amat become a patient of yours?
A. He made an appointment in my -- it looks like my Coney Island office, and I did not make note -- I don't think that there is a referring provider. I think he just made the appointment.
Q. Okay. So do you know if he had a referral from somebody?
A. No.
Q. Okay. Do you typically note in your chart or other records if a patient was referred to you?
A. Yeah. We try to. Yeah. When we -- like regardless of whatever way they found us, we try to keep track of it. So he may have told the front desk that he was in treatment, that he had multiple people telling him to go see a specialist, and he didn't recall specifically who told him that he should come see me. So if it says in the referral, referring provider section direct professional, so it could have been like some -- it could have been a physical therapist, a doctor, it could have been a -- it could have been anybody. It was like a professional helping him with his care.

Q. Where --
A. Or it could be that he doesn't even recall at all. But if they find me specifically on the Internet, we do specifically try to put in that, you know, we try to keep track of it.
Q. In your last answer, were you referring to a document?
A. No.
Q. No. Okay. Is there -- where would you -- if you did record that somebody was referred, where would that be recorded?
A. In here, in the front of the progress note, at the top of it, it says, "Referring provider."
Q. That's what I was asking about. Which progress note are you referring to?
A. May 12, '22.
Q. Okay. Thank you.
Have you treated any patients represented by the law office of Helen Dalton before?
A. I'm -- I'm not sure. I mean I've heard of them before possibly.
Q. Okay. Have you worked on any cases where the patient was represented by Mr. Avshalumov?
MR. DALY: Did I say your name close to

correctly, Roman?

MR. AVSHALUMOV: That's pretty good, yeah.

A. I don't think so.

Q. Have you worked with Roman before today, before this case?

A. If you can consider working with him being on this deposition with him as the plaintiff's attorney, I guess so. This is the only time, yeah.

Q. Do you ever receive referrals of patients from attorneys?

A. I'm sure that I do. I mean I specialize in -- in orthopedic spine surgery patients, I see patients that have a real wide variety of degenerative and traumatic injuries, and some of them I'm sure, you know, are given lists of good providing doctors. I'm sure that I'm getting referrals from them, sure.

Q. Okay. And if you are referred by an attorney, would that be in the referring professional section of the initial intake?

A. Right. We try to keep track of it. Yeah. It would be in there.

Q. Okay. Were you able to communicate with Mr. Amat in English?

A. I don't recall another language specifically. Let me see. I mean I think so.
Q. Okay. You performed two surgeries on Mr. Amat, correct?
A. I believe so.
Q. Okay. Do you classify either or both of them as elective surgeries?
A. Yes.
Q. Okay. And how do you define elective?
A. Well, the patient had a scheduled surgery, they had a choice of whether to have the surgery or not. The surgeries were not life threatening. There are patients that refuse cancer care. There are patients that refer -- refuse surgical care, despite the fact that they're in pain or have some disability caused by the -- the symptoms and the ailment. So I mean I think that that makes it elective, yes.
Q. Okay. What is The Gerling Institute?
A. It's an academic private practice. Basically it's an institute where we do research and conduct practice of orthopedics.
Q. And who is or who are the owners of The Gerling Institute?
A. I am. I started it.

Q. Okay. So I'm going to show you an -- well I've got to share the screen again. I'm going to show you what I've premarked as Exhibit G-2 -- Gerling-2. Sorry.

So do you see this document, Gerling-2?

A. Yes.

Q. Okay. And this is a statement from The Gerling Institute. And on the second page of this, it shows -- I'm sorry -- the bottom of the first page, not the bottom of the second page, has a balance due of $456,325.73, if I read that correctly.

Do you see that?

A. Yes.

Q. Okay. And it indicates in the header, the first part that Mr. Amat is insured by -- under a policy of insurance issued by an insurance company, it's identified as Bristol West Claims.

Do you see that?

A. Yes.

Q. Did Bristol West pay for any of the services that you rendered to Mr. Amat?

A. It looks like they -- I don't know. It looks like there was a payment of $535.30.

Q. Okay.

A. Could you just scroll up -- scroll up and let me see the top of the page, the very top?
Q. Sure. I'm sorry. The top, the very top.
A. Okay. Thank you.
Q. Do you know why the insurance company didn't pay for more of the services?
A. No.
Q. Okay. And the statement also has a reference to Mr. Amat's attorney. Do you know why there is -- the billing statement includes a section for Mr. Amat's attorney?
A. This -- this is an outside insurance company -- I mean an outside billing company, so they manage my billing, and they probably put that in there because the patient has a type of insurance, a class of insurance that requires statements and support from an attorney where they would give, you know, supporting documents that would help the billing process.
Q. Okay. Who is the billing company that you were using for this -- this particular invoice?
A. MBA.
Q. Is that like Mary Brown Arthur, like that?

A. Yes.
Q. Okay. Is the law firm in any way responsible for satisfying the outstanding balance shown on Gerling-2?
A. Yeah. Usually they are. I mean they're not personally responsible, but I mean we normally, if we take on performing a procedure, we -- we will -- will indicate the patient clinically, we'll make recommendations for care. If they -- if they would like to proceed with that, if they agree to it, then we would investigate the status of what types of insurance they have, figure out what the appropriate billing would be. If in fact it's a type of billing where we're uncertain of payment, such as like a car accident insurance, then we usually will ask the attorneys to sign a letter of -- letter of protection, which basically means that the patient agrees that they will -- that any money that's not paid by the insurance company would be covered by their lawsuit.
Q. Okay. And do you know if you have a letter of protection in this case?
A. I don't recall right now.
MR. DALY: Okay. And, Roman, I'd ask that to follow up on that, and if there is an LOP,

to be provided a copy of that.

Q. And the way that works with a letter of protection is that assuming there is a recovery in the case, your firm will be paid out of the recovery, correct?

A. Yes.

Q. Your I said firm. I meant practice. You knew what I meant, right?

A. Yes.

Q. Okay. Are you familiar at all with the term litigation funding agreement?

A. Not specifically that term, but I understand the concept of it.

Q. Okay. Are you familiar with the idea that there are companies that will advance funds to litigants against the proceeds of a lawsuit?

A. Yes.

Q. Okay. Do you personally have any ownership interest in any company that deals in litigation funding agreements in any way?

A. No.

Q. Okay. And just slightly different question. Does any company that you have an ownership interest in have an ownership interest in any company that does litigation funding agreements?

A. No.

Q. Okay. And a just slightly different question. Do any of your immediate family members have an ownership interest in any litigation funding companies?

A. No.

Q. Okay. You've performed -- and I can pull up the operative report if that helps you. I'll just do that. Whether it helps you or not, I'll do it. I've marked this as Gerling-7, or I will mark this as Gerling-7, and then this is your operative report for -- I'm sorry. I pulled the wrong one. One moment. Your operative report for July 27, 2022. You operated on C5-6.

Is that correct?

A. Yes.

Q. And you performed a fusion surgery generically speaking?

A. Yes. Yes.

Q. Okay. And can you explain why you operated on that level as opposed to any other level in his cervical spine?

A. Because I believed that was the symptomatic level.

Q. Okay. And how is it that you came to

that determination?

A. Based off of my findings in the history, physical examination, and review of imaging.

Q. Okay. When you take a history from a patient, is it correct that you are relying on the patient being accurate and candid in providing that history?

A. Yes.

Q. Okay. And you're familiar with the term secondary benefit.

Is that correct?

A. Yes.

Q. Okay. And basically it means when a patient is pursuing medical treatment for some reason other than or in addition to improving their health.

Is that a fair statement?

A. I guess so, yeah.

Q. Okay. Have you ever had a patient where you thought to yourself, "This patient is here pursuing a secondary benefit"?

A. Yeah. I've been in practice for 20 years. Of course.

Q. Yeah. Okay. And what have you done in

those situations or what types of things do you do in those situations?

A. I mean I try to help them, and, you know, I really try to be objective about -- about what symptoms they're having and whether or not -- whether they can be helped in a reasonable fashion. I mean I do what I think is appropriate to help them feel better. I mean I refer them for extensive conservative management, and I try to avoid doing surgeries or anything aggressive or invasive with them, but you know, if somebody says that they're in pain, just because you suspect that they have some secondary gain by -- by complaining of it doesn't mean that you have the, you know, the ability to ignore it. As a doctor we're obligated to try and help them, if they complain of pain, we're obligated to try and help them with their pain, so I will, you know, I will offer them -- I will offer them options. I certainly would be very cautious about doing any type of aggressive intervention though, of course, unless I believe that it's something that's reasonably going to help them.

Q. What are the sort of things that you look for that might indicate to you that a patient is pursuing a secondary gain?

A. There are -- there are things called Waddell signs, W-A-D-D-E-L-L, that are -- that they're kind of -- kind of classically used for that. So, you know, patients that -- patients that where their history doesn't match up with their, you know, their mobility and their function in the office, so in other words, the physical exam doesn't match the history, where their history doesn't somehow make sense. Most of the Waddell signs are related to physical examination findings. You know, at the end of the day, it's very challenging. I think that's one of the major issues that doctors face with patients of all -- all types, even patients that are, you know, even pediatric patients, sometimes they're accompanied by their parents, and their parents are -- are -- are, you know, are telling a history that doesn't make sense, and there have been disorders whereby they -- they have, you know, they have noted psychological disorders the parents have, secondary gain issues the parents have, so there are a lot in every field, we have to be conscious of it. Sometimes patients have psychological factors that are impacting the symptoms that they have. So we have to be very careful and conscious, and we do our best to

mitigate those issues.

Q. Going back to Mr. Amat and going back -- I'm sorry to jump around a bit here with regard to the billing. Did you at all request that any payment be made up front for the services that you rendered?

A. I don't recall at all right now. I mean it looks like we used insurance.

Q. Okay. And do -- did you receive any payment up front for the services you rendered?

A. I don't know.

Q. Okay. Now, different payers of medical services, they pay different rates for the same service.

Is that correct?

A. Yes.

Q. Okay. In other words, like Medicare may pay one rate, an auto insurance company may pay another rate, and a health insurance company may pay an even different rate, all for the same procedure, correct?

A. That's true.

Q. Okay. Going back to Gerling-2, which is your -- your invoice here. The rates that are reflected here, what rates are these? In other

words, these aren't Medicare rates I assume, right?

A. These are the same rates that we would send to Medicare. They're -- they're called usual and customary rate fee schedule or Fair Health based rates. In other words, we -- we don't bill insurance companies or patients differently based off of insurance company. In other words, we don't use a fee schedule that's special for Medicare versus, you know, a car accident insurance or a commercial insurance company. We send the same bill to everybody, unless we participate as an inpatient -- as an in network provider and there's a specific fee schedule that we're required to follow.

Q. Okay.

A. But otherwise everybody else we send the same bill for, and those rates for each individual procedure or service are based off of usually Fair Health. Fair Health is a database that compiles the reimbursements for services by specialty and by sort of region or sub area, and so within like zip codes, for example, they'll collect all of the bills from all the providers, and they'll -- they'll give you a range of what the values are for what providers performing the service that you performed are getting paid. So it's based off of

actual payments to doctors by -- by insurance companies.

Q. Okay. I just want to clarify. So you will, regardless of who the payer is, you're going to bill the UCR rate, correct?

A. We usually do, yes.

Q. And usually. Okay. But the payer will pay a different rate irrespective of what you billed.

Is that correct?

A. Well...

Q. Let me clarify that. That was poorly phrased.

A. Yeah. You know, there are people that work in insurance companies that look at the bill, and they have ways of analyzing it and interpreting it, and it seems like it's kind of it does vary quite a bit from insurance company to insurance company, and that's true not just with my billing and with even with surgeon or medical doctor services, but that's true with all services. That's true with radiology services. That's true with hospital services. Regardless of the medical organization that's sending the bill, insurance companies seem to treat the bills uniquely, and even

the same insurance company can get the exact same bill and still pay differently from patient to patient, just for whatever reason. And, you know, and so it's not the most simple thing in the world, but that's the reason why we base our rates off of what's called the usual customary rate fee schedule, which is very similar to like Fair Health, basically it's Fair Health, which is the Fair Health database, it has sort of the averages and the range of which doctors are being paid for their services.

Q. Okay. So and are those done by codes? Are there codes for each service?

A. Yes.

Q. And so, for example, on your invoice, the first one here is for May 12, 2022. There's a five digit code of 99245, office consultation, and that's charged at $760.

Do you see that?

A. Yes.

Q. Okay. So if I'm understanding you correctly, there's some database that -- and I'm sure it varies by geography and specialty and some other information, but there's some database where you would type in the numbers 99245, and the result would be $760.

Is that more or less correct?

A. Yeah. Well, yup. It would give you a range. It doesn't give you an exact number. It would say, because there is a range, as I said, like insurance, even the same insurance company will pay different depending on what the weather is outside that day, I don't know what they decide, but there will be a range of what's being paid. In this case for that 99245, the range might be between $500 and $850 let's say, you know, and that's -- that's the range by which they're reimbursing.

Q. Okay. And is it your billing company that actually does those codes and inputs the billing amounts?

A. Yes. So the -- the -- they would create this document. They -- they confirm that all of those codes are relevant to the surgery that I performed, and then they would send, or the office visit, whatever the services are that are performed, and then they would send that bill to an insurance company.

Q. And getting into some nitty gritty details I suppose, do you actually just send them the medical records and then they look at the medical records and determine the appropriate codes

to put in or do you give them more information than that?

A. It's based off of what's documented.

Q. In terms of treatment records?

A. Yes.

Q. Okay. And your rates, are they generally higher than what an insurance -- auto insurance company would pay?

A. No. Not necessarily.

Q. Okay. Are they generally higher than what Medicare would pay?

A. Yes.

Q. Okay. And I'm going to ask you to estimate here obviously, although you might have an exact number, I don't know.

What percentage of your patients are seeing you because of a traumatic condition, they were in some kind of a crash or a collision or something like that, a fall down?

A. Like 30 percent historically probably around there.

Q. And this may be -- this may overlap with the last question, but what percentage are seeing you because of an injury which is acute, but not necessarily traumatic, if that's a fair

distinction to make?

A. That's not really -- that's confusing, because --

Q. Yeah.

A. -- traumatic injuries are acute.

Q. Okay.

A. Yeah.

Q. So it may be something that happened traumatically, in other words, they were just walking down the stairs, and all of a sudden, they had tremendous back pain, but they didn't fall. You're classifying that as that's within traumatic as well?

A. No. It would be -- that would be, if they didn't fall and get injured, if they just had back pain that occurred, but it happened recently, then it would be acute. It would not be considered traumatic. Traumatic is when somebody has an injury.

Q. Okay. And what percentage, again, if you know, what percentage of your patients are involved in litigation of any type?

A. I have no idea.

Q. Okay.

A. I'm going to guess that it's less than

20 percent.

Q. Okay. Going to the bills in this case, Mr. Amat, he was a manual laborer. How would you expect him to pay $450,000 in medical expenses if he doesn't have insurance or if he doesn't have a recovery in this lawsuit? Would you?

A. Oh, if he doesn't have a recovery in the lawsuit?

Q. Yeah.

A. Oh. I don't know. We'd have to -- I don't judge people based off their profession, you know, we -- just like a hospital, a hospital would send you a bill if you go to the emergency room, and then if you have, you know, a certain income level, they -- they work with you and try to help you with the -- with it. It's no different with my practice than if you went into the hospital and went to the emergency room and had care. He probably has bills from the hospital from his treatment, and I'm sure that's the same thing.

Q. Yeah. Have you referred his account to a debt collection agency?

A. I don't think so. I don't think so.

Q. Okay. Is that because of the letter of protection?

A. Probably.
Q. My office retained Dr. Edward Decter to examine plaintiff.
Have you reviewed his reports at all?
A. I don't think so. I mean I -- I don't think so, no.
Q. Okay. I did not see them referenced in your report, so --
A. Right.
Q. -- that's why I ask.
Okay. Do you know Dr. Decter at all?
A. No.
Q. So you have no opinion as to either his skill as a physician or his integrity as a witness?
A. No.
Q. Okay. Have you ever in any way sought out or solicited referrals of patients from law firms?
A. No. I mean I wouldn't say so.
Q. Okay. Have you ever done any like speaking events for groups of lawyers or anything like that?
A. I don't think so.
Q. Okay. I marked as Gerling-4 progress notes and treatment records from your office. I put

them all together into one exhibit. Just I thought -- I thought it might make it easier. I might be wrong. But that's what I was trying to do. And we have -- what I have here is Exhibit 4 is treatment records from May 12, 2022, October 11, 2022, and January 13, 2022 -- I'm sorry -- 2023, and then March 14, 2023. Just I didn't press that. Hold on. I'll represent to you and I'll show you if you want each of these has your signature at the end of the record, or electronic signature probably, it looks like an electronic signature to me, but you can tell me.

Do you see that?

A. Yes.

Q. Okay. Does that mean that you personally examined Mr. Amat on each of these occasions?

A. If I -- if the patient had a visit with me, yes.

Q. Okay. So I can take that, the fact that each of these is signed to mean that you saw him on each of those dates.

Is that correct?

A. Yes.

Q. Now, there are sections of each of

these reports that are verbatim in many if not all of the records, for example, the first paragraph of each of the reports. And I'll show you. I'm happy to do that. The first paragraph is identical in each of these reports. I don't know if you need me to, but I'm happy to do it.

A. No. No. You do not need to.

Q. Okay. Thank you.

How does it happen that we wind up with the identical sections in each of these reports? Can you explain that to me?

A. Yeah. So that section right there is sort of what we consider like a summary section of the way that person had their -- like their problems start. So let's just say that it was an 80 year old that, you know, had a chronic non traumatic condition that started at home and it was mechanical pain. You know, we would make an effort to put that summary in -- in this section of the chart, and so that every time that you open the chart you kind of know the general injury of the patient, and we add to it, like if there was a subsequent injury or something like that, or if we find out about something else, we'll add to that section, we think that's like the most pertinent information related

to the overall condition that the patient is presenting with.

Q. Okay.

A. But it didn't change, if we didn't find out more information about the accident, for example, we would not change that section.

Q. Yeah. I meant it in a more mechanical sense, and so I'll clarify. Do you use a particular type of software for your medical records?

A. Yes.

Q. Okay. What -- what type is that or what type was that during this relevant time period?

A. Prognosis.

Q. Prognosis. Okay. And when a patient comes to see you on a particular date, how do you go about generating a record in Prognosis?

A. It's electronic medical record. We go in and we -- there are different sections of the patient's chart that we have to go in and we have to adjust or -- or verify with the patient, for example, there will be windows for like past medical history, and we'll -- we'll have to review them with the patient and make sure that they haven't changed their medications and review it, make sure they haven't changed, so you have to -- it's sort of like

-- it's like most electronic medical records, you point and click, and then in areas you fill in, you type in whatever you feel like is relevant to the issue.

Q. If a patient is seeing you for a second or a subsequent time, does the software auto populate certain fields?

A. If you tell it to.

Q. I mean from prior visits.

A. But you check boxes, you check boxes, and it will have, when you check the box, it will have what was there the last time, and then you go in and you verify, and you change whatever you think needs to be changed.

Q. Okay. So, yeah. So like when he came to see you, Mr. Amat came to see you on August 11, 2022, which I think was his second visit to you, when you opened this record, would there be this information?

A. Yes.

Q. Mechanism of injury, would that already be there?

A. Yes.

Q. And then you would need to verify that and check that, correct?

A. Well, it would be the first thing that we see, yes, we would look at it and we would just, in this case it's usually something that hasn't changed, but we would ask them, have you had any new injuries or issues. If they say no, then we just -- we would -- we would continue that. I mean usually I'll read it just for accuracy to make sure that there were no mistakes in it, but...

Q. Okay. So and maybe a dumb question, but you don't actually retype this each time?

A. No.

Q. Okay. Now, and again, help me out with understanding Prognosis and how that works. There are some sections, and I'm on page 11 of the PDF for this exhibit that are in red. What does the red indicate, if anything?

A. If it's -- if it's something with specifically changed that day, like if the patient changed, if their weight was changed.

Q. Okay.

A. If their, you know, we looked below where it's red, after cervical spine exam. Those are things that we specifically change that day or added to, yeah, manipulated.

Q. So red indicates that this was not in

the prior record essentially?

A. Or was modified.

Q. Or was modified. Fair.

A. That's not always true. Like up above there are sections that have new things in them that were not necessarily there during the prior visit. They just won't be red.

Q. Okay. Is there any way to know aside from doing a line by line comparison about those other ones?

A. No.

Q. Okay. And do you know why some changes are highlighted in red and others -- others aren't?

A. No.

Q. Okay. Prior to operating on Mr. Amat, did you personally review his imaging studies?

A. Yes.

Q. And did you review all of the available imaging studies?

A. Yes.

Q. Okay. Do you have x-ray equipment at your offices where you practice?

A. Yes.

Q. Did someone at your office take any x-rays of Mr. Amat in your office?

A. If we did, it's in the note.
Q. Okay. And if you didn't, it's not?
A. Most likely, unless there's a mistake.
Q. Okay. I'm going to show you again what I marked as Gerling-5, which is your operative report from July 27, 2022. And I have also, if you -- if you want to review it, it's fine, I have the -- an MRI report from May 14, 2022, which is the cervical spine. The reason I mention that is my question is during the course of this procedure on July 27th, were there any findings which you made which were in any way different or inconsistent with the MRI films that you reviewed?
A. I don't believe so. I don't recall right now.
Q. Okay. Did you take any photographs or I suppose more accurately digital images during the July 27th procedure?
A. No.
Q. Okay. The procedure took place at Hudson Regional Hospital?
A. Yes.
Q. Why did you choose this location?
A. I -- I didn't choose it. My coordinator and the patient did.

Q. Okay. You perform surgeries at more than one facility?
A. Yes.
Q. And essentially, your coordinator and the patient, they -- they pick the dates and the facilities, and you go where they tell you?
A. Yes.
Q. Essentially. Okay. I don't mean to be flippant there, but that's the basic process?
A. Yes.
Q. Okay. Do you have any ownership interest in Hudson Regional Hospital?
A. No.
Q. How about Care Point Health?
A. No.
Q. Okay. Do you know Yan Moshe at all?
A. Oh, yeah.
Q. You've met him?
A. Yes.
Q. How do you know him?
A. He was the former owner of Hudson Regional Hospital.
Q. Okay. And when did he cease to be the owner, do you know?
A. No.

Q. I actually wasn't aware of that. Okay. Have you ever had any business dealings with him of any kind?

A. Not -- not directly. I mean he -- he is very involved. I don't know what his title is or his direct involvement is with -- with Hudson Regional Hospital, but he's been involved in the acquisition and management of a hospital called Bayonne Medical Center, which is a part of the Care Point system which you brought up earlier, so I assume you're familiar with it.

Q. Somewhat.

A. And they asked me, the institution at Bayonne asked me to be their director of musculoskeletal care, and which I am now, and so he as a part of the organization of course would have been involved as a part of the organization, not personally, just direct -- just through the organization.

Q. Now, after the surgical procedure that you performed for -- sorry -- the cervical procedure that you performed for Mr. Amat, he remained symptomatic, correct?

A. Yes.

Q. Okay. Did he have any improvement with

respect to the symptoms of his neck after the surgery?

A. We'd have to review the chart.

Q. Okay. Progress note for March 14, 2023. Is there a particular section of the chart that you would look at to determine that? I'm showing you now your progress note from March 14, 2023, which I believe is your last progress note.

And my question is: Is there a particular section of this report that you would look at to determine what kind of improvement Mr. Amat had after the surgery?

A. Yeah. I mean it's not -- it's not one particular thing, it's everything. I mean in -- in everything below history of present illness, follow-up consultation, which is at the bottom of the page, everything is what we found that day, and so I mean it very specifically says the symptoms remain unchanged since the last examination. He is unable to work due to the symptoms. It specifies how much neck and shoulder and arm pain he had, which I believe is actually less than how he presented initially. He had pain going to his shoulder as opposed to during his initial visit, in his initial visit he had pain that was radiating

down his right arm and left arm, so on both sides, so not just the shoulder, but the arms bilaterally, and he had numbness and paresthesias extending into both hands with occipital cervical headaches versus, you know, during the -- during the visit that we were just referring to, his -- his neck pain was associated with pain radiating to the left shoulder only without numbness and paresthesias ranging down to the hand. His pain levels, the visual analog scale pain numbers were at four for neck and five for arm. So they were -- I think he did have substantial improvement at that point.

Q. Okay. You've answered the next question I was going to ask. How would you qualify or describe the improvement he had? You would say substantial?

A. Yes.

Q. Okay. Do you consider cervical fusion to be a high risk procedure?

A. In some doctor's hands, yes.

Q. You don't consider it to be in your hands? Is that what you're saying?

A. Well, I mean it's -- I would -- it depends on the patient, too. I operate on patients that are high risk all the time. You know, if it

were a healthy younger person, doing this procedure, it's less dangerous and less risky than in a patient of this age. I mean this gentleman, look, at the time of the accident, was 79 years old. Is that right?

Q. No. I don't think so. Wait. Hold on.

A. He was from '54 to 70 -- to 2022.

Q. I believe he was mid 60's, I believe it was.

A. He was born January 26, '54?

Q. Oh. Yeah. You're right. There it is. Sorry. Around 60.

A. 60 would be if he was born in '64. He was born in '54, right?

Q. You're right. You're right.

MR. AVSHALUMOV: He turned 71 just recently.

MR. DALY: Okay.

A. No. Right. Right. That makes sense.

Q. Last January. Yes.

A. Right.

Q. You're right.

MR. AVSHALUMOV: So he was 69 at the time, 68, 69.

Q. No. You're correct. Okay. So you

were saying? Sorry. I interrupted.

A. Yes. He was about 70 years old, so I mean he's not -- he's not a young person, and so, you know, obviously older people have more risk.

Q. So for Mr. Amat would you classify as high risk, given his condition and his situation?

A. I'd say moderate risk.

Q. Okay. And what risks did you tell Mr. Amat about prior to the surgery?

A. I mean older patients have the same risks that younger patients have, they just have higher percentages of occurrence.

Q. Yeah. No. I just meant what are the risks associated with this procedure that you informed him of?

A. There are a lot. There are anesthesia related risks and then there are surgical risks. Anesthesia can be anything from blindness, deaf, heart attack, stroke, ventilation issues with the lungs, organ failure, and then with the wound, you can have complications related to the surgery itself, cutting the skin, and no matter what the procedure is, there's always some intrinsic risk of infection, of bleeding, vascular injuries. I mean there are some pretty sensitive structures where

we're operating in the neck, and all of those structures could be damaged, problems with the esophagus, the trachea, the innervation to those areas, so patients can have hoarseness of their voice, they can have problems swallowing afterwards, they can have problems with -- with aspiration and other issues related to their -- the functioning of their throat. They can have wound complications like infection as I said and bleeding. They can have neurologic injuries related to the spinal cord and the nervous system that's actually coming out of the spinal cord, we call those nerve roots. They can have a recurrence of their injuries or of their symptoms. They can have what we call adjacent segment disease, where like other levels have accelerated arthritis. They can have major vascular injuries, which if you do enough of these, you will see those, you know. You could have hardware problems, hardware failure, which is something that we see occasionally. Yeah. So -- so I mean quite a few risks.

Q. Yeah. Okay. And what did you tell Mr. Amat about the potential benefits of the surgery?

A. That we hoped we would improve his -- his arm pain, his -- his numbness. Let me just go

back to his original symptoms here. He had headaches which did improve post op. He had difficulty with sleep, that his, you know, his neck pain was eight, his arm pain was eight. As I said, even in March, which was quite soon after the surgery, he was down to five and four, so, you know, the hope is that he has some improvement of the neck pain and that he had some improvement of the arm pain, you know, and that the neurologic symptoms, including like he said that he had instances of tripping and stumbling, so his balance was not ideal, that those things would ultimately be effected by things and the neck will improve.

Q. And did you discuss with him at all -- and this is a similar question, but just slightly different.

Did you discuss with him the likelihood that he would receive those benefits of the procedure?

A. Probably. You know, I don't recall specifically, but usually we talk about it.

Q. With respect to the lumbar spine, I can put that up if it helps you. I'll put it up whether it helps you or not. This was a procedure you did on June 2, 2023. And my first question is why did you perform a discectomy instead of a fusion like

you did on the cervical spine?

A. I'm looking at the notes.

Q. Sure.

A. Well, I do a discectomy when I believe that the patient has neurologic symptoms being caused by a nerve that's being pinched, but I don't think that there's like a structural problem that needs to be corrected.

Q. Okay. Did your decision to go with the discectomy at all have anything to do with the level of degeneration that he had in his spine at any point?

A. No.

Q. Okay. And I'll ask a similar question to what I asked with regard to the cervical spine.

During the course of your procedure, did you find anything which differed in any clinically significant way from the MRI studies that you viewed beforehand?

A. I don't believe so.

Q. All right. Similar questions to what I asked with the cervical spine. After he remained -- he had some symptoms after the lumbar surgery, correct?

A. Yes.

Q. Did he have some level of improvement after the lumbar surgery?

A. Well, preoperatively he had eight out of ten back pain, eight out of ten leg pain, primarily going down the left leg, it looks like numbness in the leg, balance -- or no, difficulty walking one to two blocks because of the symptoms, couldn't stand more than five minutes without symptoms, and then if we look at his post op, see, when was that surgery done?

Q. I just had it. Give me a second. June 2, 2023.

A. If we look at his post op visit on August 1, 2023, so the two month point, he had four out of ten back pain, he could walk 20 blocks, stand for 30 minutes, didn't have any leg numbness, so I would say that he had substantial improvements, even though -- even though there was, you know, there was still some residual symptoms.

Q. Okay.

(There is a discussion off the record.)

(There is a recess.)

Q. So, Doctor, I only have a few more questions for you. I won't be much longer.

So referring to the MRI's of the cervical

spine, do you acknowledge that there is some level of degeneration in Mr. Amat's spine?

A. Yes.

Q. Okay. I mean he's 60, whatever we figured out he is, 70 years old, you would be surprised if there wasn't degeneration in his spine, correct?

A. Not surprised. I mean just it's more common. He has degenerative changes that we see.

Q. So pretty typical and common.

Is that correct?

A. Yes.

Q. Okay. Now, counsel advised in his disclosure statement that you charge $11,000 per day for testifying.

Is that correct?

A. Yes.

Q. Okay.

A. I mean I haven't sent the invoices in a long time. I have somebody who does that.

Q. Okay. And is that whether you testify for an hour or full day, it's the same, same rate?

A. Yeah. I mean if they book, if they tell me they need me for the full day, yeah.

Q. Okay. Okay. If they don't tell you

they need you for the full day, you'll adjust for the charge accordingly?

A. Yeah. Oftentimes. I mean it depends. Yeah. If they tell me they only need me for two hours, it's different, of course.

Q. Okay. Okay. And how did you -- and maybe it wasn't you, but I'll ask it this way. How did you determine your rate to charge for testimonial work that you do?

A. You know, it's not like -- it's not -- not based off of some index or something like that. I mean I think that's the reasonable going rate in my area that I work in. I know surgeons that charge a lot more. I know defense doctors who charge a lot more. I know -- I know surgeons that charge less. You know, like I -- I have to cancel surgeries, I have to cancel sometimes 30 or 40 patients in the office in order to reserve the day for testimony, and it's very damaging to my practice, and oftentimes it gets moved around last minute, so it's very, very hard on my practice, very damaging, so I think that what I'm paid is -- is what I would consider acceptable for making those cancellations.

Q. But it sounds like, and I don't want to put words in your mouth, but it sounds like you've

asked other practitioners what kind of rates they charge and used that as something of a guide?

A. Yeah. I mean early on. I mean I don't think I've raised my rates for years, like for a long time, you know. I -- yeah. I mean I did back in the day, I guess.

MR. DALY: Sir, I don't have any other questions for you. I don't know if any other attorney does. I'd be surprised, but they have the right.

MS. ADAMS: I don't have any other questions. Thank you.

MR. AVSHALUMOV: Thank you, Doctor. Much appreciated, you being here today. We're done.

MR. DALY: Okay. All right.

(Plaintiff's expert witness disclosure is marked Gerling-1.)

(Itemized statement is marked Gerling-2.)

(Report of Edward M. Decter, M.D., FACS (2/27/2023) is marked Gerling-3.)

(Packet of progress reports is marked Gerling-4.)

(Operative report (7/27/2022) is marked Gerling-5.)

(Packet of radiology results (3/14/2022) is

marked Gerling-6.)

(Operative report (6/2/2023) is marked Gerling-7.)

(Packet of radiology results (3/14/2022) is marked Gerling-8.)

(Proceeding adjourned at 4:49 P.M.)

C E R T I F I C A T E

I, FRANK BIELY, a Certified Court Reporter of the State of New Jersey, certify that the foregoing is a verbatim transcript of the testimony of the aforementioned first duly sworn by me. I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which the deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in the action.

_____

FRANK J. BIELY

CERTIFIED COURT REPORTER

LICENSE NO. XI01521 (EXP. 6/30/26)