SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS : CIVIL TERM : PART 7

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MOAZZAM R. GILL,

Plaintiff,

Index No. 706989/20

-against-

JURY TRIAL

SIGFREDO VALLADARES-LOPEZ & FLEETWASH, INC.,

Defendants.

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Supreme Courthouse
88-11 Sutphin Boulevard
Jamaica, New York 11435
May 23, 2025

B E F O R E:

THE HONORABLE NICOLE McGREGOR MUNDY
Supreme Court Justice

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

For the Plaintiff:
LAW OFFICE OF MICHAEL S. LAMONSOFF
32 Old Slip, 8th Floor
New York, New York 10005
BY: JASON LESNEVEC, ESQ.

For the Defendant:
MULHOLLAND MINION DAVEY McNIFF & BEYRER
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BY: KEVIN McNIFF, ESQ.

VICTORIA A. BIFULCO
FRANCINE SPAULDING
Senior Court Reporters

THE CLERK: Come to order.

Queens Supreme Court Part 7, the Honorable Nicole McGregor Mundy presiding.

Calling continued case on trial, index number 706989 of 2020, Moazzam R. Gill, plaintiff, against Sigfredo Valladares-Lopez and Fleetwash, Inc., defendants.

Counsel, please state your appearances for the record.

MR. LESNEVEC: Good morning, your Honor.

The Law Office of Michael S. Lamonsoff, 32 Old Slip, Eighth Floor, New York, New York, 10005, by Jason Lesnevec for the plaintiff.

MR. McNIFF: For the defendants, Mulholland Minion Davey McNiff and Beyrer, 200 Park Avenue, Suite 1700, New York, New York 10166, by Kevin McNiff.

Good morning, your Honor.

THE COURT: Good morning.

Let's go off the record.

(Whereupon, at this time, a discussion was held off the record.)

THE COURT: On the record.

Okay. Before we get started today with the witnesses, I just want to resolve plaintiff's motion.

So plaintiff made a motion in limine to preclude

defendant from cross examination of plaintiff's treating orthopedic surgeon, Steven Touliopoulos, M.D., and treating neuropsychologist, mere dad Golzad, M.D., as well as anyone affiliated with that.

Before we get started, I understand that plaintiff is not calling Dr. Golzad to testify; is that correct?

MR. LESNEVEC: That's correct, Judge.

It would be duplicative of the testimony we heard yesterday.

THE COURT: Okay. So then motion is moot as to Dr. Golzad since he is not going to be called.

So plaintiff submitted a motion in limine along with supporting exhibits, and defendant submitted opposition to plaintiff's motion in limine along with supporting exhibits.

Off the record.

(Whereupon, at this time, a discussion was held off the record.)

THE COURT: On the record.

The motion record before the Court indicates that there are two lawsuits that were mentioned which named Dr. Touliopoulos, one of which has been -- just for the record I want to indicate -- one of which was voluntarily discontinued with prejudice. Okay.

Upon reading plaintiff's motion and supporting documents and defendant's opposition and supporting documents, the Court finds as follows:

Initially the Court notes that counsel for both parties were informed on May 8, 2025, which was the scheduled first day of trial that all motions in limine were to be submitted on that first scheduled trial date pursuant to the Court's part rules, and my directions were given to both counsel in court.

Plaintiff did not submit this subject motion in limine until May 15, 2025, however, although plaintiff's motion in limine isn't timely, the defendant was permitted by the Court time to submit opposition to do so.

The Court can not discern any prejudice to either party and entertain the motion at this juncture particularly since based on the subject matter of the motion entertain the motion will in the Court's opinion facilitate the continued efficient and orderly conduction of this trial.

Now, after reading plaintiff's motion and defendant's opposition thereto, the Court and the Court finding that defendant's opposition sets forth a good faith basis for cross examining Dr. Touliopoulos regarding the lawsuit in which the doctor's name is a

party and the specific allegations that defendant deems relevant to the doctor's credibility, the Court in its discretion will permit defendant to ask Dr. Touliopoulos limited, general, non self-incriminating questions regarding only the pending lawsuit against Dr. Touliopoulos.

The Court will Court will entertain and rule on any objections made by plaintiffs' counsel to any of the said questions.

In further discretion of this Court, defendant is not permitted to offer any collateral evidence with regard to this line of cross examination of Dr. Touliopoulos, nor questions that will confuse or mislead the jury or create a substantial risk of prejudice to the witness or to the party.

So off the record.

(Whereupon, at this time, a discussion was held off the record.)

THE COURT: On the record.

MR. LESNEVEC: Your Honor, I would just note our exception to your Honor's ruling on this matter.

MR. McNIFF: We also note an exception.

Thank you, your Honor.

THE COURT: Both exceptions are noted.

Is everyone ready to proceed?

MR. LESNEVEC: Yes.

MR. McNIFF: Yes, your Honor.

THE COURT: All right. Let us bring in the jury.

THE COURT OFFICER: Yes, your Honor.

THE COURT: Bring them in.

THE COURT OFFICER: All rise. The jury is entering.

(Whereupon, at this time, the jury enters the courtroom.)

THE CLERK: Do all parties stipulate to the presence and proper seating of the jury?

MR. LESNEVEC: I do.

MR. McNIFF: I do.

THE COURT: You may all be seated.

Good morning, members of the jury, welcome back.

We'll proceed with the trial of this action.

Counsel, you may call your next witness.

MR. LESNEVEC: Thank you, your Honor.

At this time plaintiff calls Dr. Steven Touliopoulos.

(Whereupon, at this time, the witness takes the stand.)

THE COURT OFFICER: Remain standing.

THE CLERK: Raise your right hand.

Do you swear or affirm to tell the truth, the whole truth, and nothing but the truth, under penalty of perjury?

THE WITNESS: I do.

S T E V E N T O U L I O P O U L O S, M. D., a witness called on behalf of the Plaintiff, after having been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

THE CLERK: In a loud, clear voice, please state and spell your name and give your address for the record.

THE WITNESS: My name is Steven John Touliopoulos. My address is 23-25 31st Street, Suite 800, Astoria, New York 11105.

THE CLERK: Please spell your name.

THE WITNESS: Last name, T-O-U-L-I-O-P-O-U-L-O-S.

THE CLERK: Thank you.

Witness has been sworn, your Honor.

THE COURT: Thank you.

Good morning, Doctor.

THE WITNESS: Good morning, your Honor.

THE COURT: You may proceed.

MR. LESNEVEC: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. LESNEVEC:

Q Good morning, Doctor.

A Good morning.

Q Have testified in court before where I was the attorney asking questions?

A Yes.

Q And that was approximately two times?

A That's correct.

Q Did we discuss this case before today?

A We discussed the medical facts over the phone a couple of days ago, yes.

Q Can you give us a brief history about your educational background?

A Yes. I attended college at Columbia University. I majored in chemical engineering. I stayed on at Columbia and obtained a master's in bioengineering before entering medical school at SUNY Downstate in Brooklyn.

After I finished medical school, I applied for and was accepted into a residency program also downstate.

After completing that in 1996, I did a fellowship in sports medicine at Lenox Hill Hospital which I finished in 1997.

After that I started in my private practice. I have been in private practice ever since.

I am board certified in both orthopedic surgery as well as orthopedic sports medicine.

Q Can you just tell us about the field of sports medicine?

A Yes. It's a branch of orthopedic surgery that studies and treats disorders of the musculoskeletal system related to sports injuries, specifically of the shoulder, hip, knee, elbow, wrist and ankle.

Q And what is the orthopedic surgery, specifically?

A It's a branch of medicine that studies disorders of the bones and joints. Muscles, ligaments and tendons. It includes the spine as well as the extremities, the upper extremities as well as the lower extremities.

Q Are you affiliated with any hospitals?

A Yes, I am.

Q Which hospitals?

A I am affiliated with Lenox Hill Hospital, Mount Sinai Hospital Queens, and New York Presbyterian Hospital lower Manhattan.

Q And how long have you been in private practice for now?

A Since 1997.

Q What parts of patients' bodies have you operated on throughout your career?

A So basically I limit my practice to the extremities. I do not treat or operate on the spine. So anything from the shoulder to the fingers and from the hip to the toes are areas

I have operated on.

Q Can you give us some examples of types of surgery you performed?

A Yes. It could be a hip replacement. Could be a shoulder replacement. It could be an arthroscopy where we operate with cameras of the elbow, wrist, hip, knee and shoulder. I also operate on fractures such as thigh fractures, ankle fractures.

Q And how do you obtain your patients?

A Through a myriad of referrals. Sometimes it's word of mouth from former patients and family members. It could be from the hospital from other physicians. Sometimes it is from law firms.

Q And are you being compensated for your time here today?

A Yes, I am.

Q How much are you being compensated?

A I believe it's $10,000.

Q How many offices do you have?

A I have two offices.

Q Where are they located?

A In Astoria, Queens, as well as in Manhattan.

Q What types of patients do you treat at your offices, Doctor?

A All types of patients, again. I have patients of all

ages from elderly to children. Of patients that have traumatic injuries, such as fractures or muscle tears. As well as degenerative conditions such as osteoarthritis.

Q I am going to be focusing specifically on the shoulder during your testimony today.

MR. LESNEVEC: I would like to have this marked, your Honor, for demonstrative purpose.

I will show it to defense.

THE COURT: Show it to counsel.

MR. LESNEVEC: Yes.

THE COURT: Would you mark that as Exhibit 20 for identification?

(Whereupon, at this time, Plaintiff's Exhibit 20 was marked for identification.)

THE COURT OFFICER: Plaintiff's 20 has been marked for identification.

MR. LESNEVEC: Thank you.

Q Doctor, what are we looking at with Exhibit 20? What is that?

A This is a model of a shoulder.

Q Can you just tell us the different parts of the shoulder by using the model?

A Yes. So the shoulder is made up -- it's a ball and joint socket. The ball is the upper part of the arm. It's right here (indicating). That's called the humerus, the

humeral head, and then the cup.

THE COURT: One second, Doctor.

Excuse me.

Come up, both of you.

(Whereupon, at this time, a discussion was held off the record.)

THE COURT: On the record.

I'm sorry, Doctor.

You may continue.

THE WITNESS: Yes, your Honor.

A The cup is called the glenoid. It's on the other side of the ball.

And the shoulder, unlike the hip, has a big ball and a small socket, so it's inherently unstable, and to keep the ball in the socket, we rely on ligaments that wrap around the shoulder depicted by this orange or yellow structure here (indicating).

And on top of the ligaments is an envelope of tendons and muscles which we call the rotator cuff. Those allow you to move the arm.

This is the clavicle or the collarbone (pointing), and the cup is part of the scapular which is just this bigger bone here.

Q And what happens if there is damage, let's say, to the rotator cuff?

How does that effect the functionality of the shoulder?

A If there is damage to any structure of the shoulder, it can result in symptoms such as pain or limitation of motion.

If you hurt the roots of the cuff which is a muscle and tendon, you obviously would have potentially weakness in the shoulder and difficulty lifting and carrying objects.

Q When a physician like yourself wants to look at the inner workings of the shoulder, how would you do that? What would you use?

A Well, we rely on various diagnostic studies. One could be x-rays of primarily the shoulder bones of the shoulder.

And another is an MRI scan which not only helps see bones but also helps see the soft tissue of the shoulder such as the muscles, ligaments and tendons, and the gold standard to know what is going on actually is to go into the shoulder with a camera.

Even with an MRI scan, you may have false positives and false negatives. In other words, the MRI may say something is there and it's not there, and vice versa.

Q What is the name of your practice by the way?

A University Orthopedics of New York.

Q Did there come a point in time where Moazzam Gill

came under the care of your practice?

A Yes.

Q As part of the your practice, do you keep medical records for patients that you treat?

A Yes, I do.

MR. LESNEVEC: Your Honor, if I could have this marked.

THE COURT: Yes.

Show it to counsel.

MR. LESNEVEC: Yes, Judge.

THE COURT: We are going to mark this as Plaintiff's Exhibit 21 for identification purposes.

(Whereupon, at this time, Plaintiff's Exhibit 21 was marked for identification.)

THE COURT OFFICER: Plaintiff's Exhibit 21 has been marked for identification.

MR. LESNEVEC: Thank you.

Q Doctor, take a look at Exhibit 21 and let me know if you recognize it.

A Yes. These are medical records from my office including office notes as well as interoperative photos. The office notes are from both myself as well as Dr. DeMarco.

Q Are those records for Moazzam Gill, a patient that you treated?

A Yes.

Q Are those accurate copies of those records?
A Yes, I believe so.
MR. LESNEVEC: I would ask that they be admitted into evidence.
THE COURT: Any objection?
MR. McNIFF: No objection, your Honor.
THE COURT: What was previously marked as Plaintiff's Exhibit 21 for identification will be entered as Plaintiff's Exhibit 21 in evidence.
(Whereupon, at this time, Plaintiff's Exhibit 21 was marked into evidence.)
THE COURT OFFICER: Plaintiff's 21 has been marked into evidence.
MR. LESNEVEC: Thank you.
Q And, Doctor, when did Mr. Gill come under your practice's care?
A First visit was on January 21 of 2020.
Q And do you know how he was referred to your practice?
A I'm not sure how he was referred to me.
Q What did he come under your care for?
A For injuries of his left shoulder.
Q Did you take a history from him?
A Yes, I did.
Q And what was the history that Mr. Gill gave to you, Doctor?

A At the time of his visit he was 45 years of age and right hand dominant. He was involved in a motor vehicle accident while driving. He states that he was rear ended in the accident, and during the accident his left shoulder struck the window on the driver's side.

He denied any prior history of left shoulder trauma or symptoms prior to this accident. He also reported injury is his neck and back in this accident, and he did have ongoing symptoms in his spine for which a consultation with a spine specialist was recommended.

With respect to his left shoulder, he reported his level of pain could be as high as nine out of ten. He also had feelings of looseness, that his shoulder was coming out of place and that his symptoms persisted despite the treatment he received which included medicine such as ibuprofen and physical therapy which he was attending five times a week.

This resulted only in partial and temporary improvement in his shoulder symptoms, and he had difficulty using his left arm and shoulder for daily activities.

He also reported developing tremors of his left upper extremity from the accident as well as episodes of the dizziness.

Q That was January 21, 2020?

A That's correct.

Q That was approximately seven weeks after the

collision?

A That's correct.

Q And tremors, can you describe what is a tremor?

A Basically, shaking.

Q Did you find any medical significance to the symptoms that Mr. Gill reported to you that day?

A Well, with respect to the shoulder, yes, I suspected derangement injuries of the shoulder, and I did recommend that he continue with conservative treatment including physical therapy.

I prescribed him an anti-inflammatory medication named Voltaren, and recommend he follow up with us.

Q Did you perform a range of motion testing on him on that day?

A Yes, I did.

Q And can you tell us what testing you performed and what the results were?

A Yes. On range of motion testing I found that his active flexion was one hundred degrees. In other words, flexion is your ability to raise your arm forward and over your head. Normally it's 180 degrees. In this case it was barely above his shoulder. It was about a hundred degrees. That was active. Basically active means you ask the patient to move his arm.

And then passively when I move his arm, it was up to,

like, 120 degrees. His abduction which is sideways motion again normally is 180 degrees. In this case it was 80 degrees. So it wasn't even to shoulder level. That was his active motion.

His passive motion based on when I moved it, it was about 95 degrees, still very limited.

His external rotation which is your ability to rotate your arm outward was 35 to 40 degrees. Normally it's approximately 90 degrees.

And his internal rotation which is your ability to turn your arm inward which he also measured by how far up our back you can reach, he could only reach into his rear pocket so that was also really limited.

He had positive apprehension and relocation tests, which are basically tests to assess your shoulder stability. He had complaints of his shoulder being loose, so that's something that we wanted to look into. That's basically done by bringing the arm backward and seeing if that reproduces his pain, and that usually signifies that the ball is kind of slipping out of the socket and you kind of reproduce the symptoms that he was having.

Relocation test is when I kind of pushed back the ball into the socket, and if that alleviates or reduced his pain, that is also considered positive.

Also on examination I did note that the shoulder was

looser when I applied forces to the left shoulder. It moved more than the right shoulder.

And also his rotator cuff was -- his rotator cuff strength was very weak when this was tested.

Q How do you test for rotator cuff strength specifically?

A Basically you ask the patient to hold their arms up, and you push down to see if there is weakness. Also you test strength in different plains of motion.

I asked him to push inward and outward, and those strength levels are assessed.

Q And did Mr. Gill undergo an MRI to the left shoulder?

A Yes, he did.

Q Did you review that MRI?

A Yes, I did.

MR. LESNEVEC: Your Honor, I have an exhibit I would like to offer and put on the screen.

THE COURT: Okay.

You have hard copies of it?

MR. LESNEVEC: Yes, I do. That copy is actually marked into evidence. This is a separate film.

THE COURT: Which is it?

MR. LESNEVEC: We would need a new exhibit number because this is for the shoulder, but the actual disk that it is on has been marked as an exhibit and is

in evidence.

THE COURT: As what?

MR. LESNEVEC: Exhibit 2, 3, 4 -- yes, 2, 3 and 4. So we would add this as a separate -- it would be a new exhibit with a new number.

THE COURT: Okay. Tell us the number so we can mark it for identification.

MR. LESNEVEC: It would be a new marking, Exhibit 22.

THE COURT: Okay.

MR. LESNEVEC: So we would mark this as Exhibit 22, and this would be sequence 104/5, and image 8/17.

THE COURT: You got it?

We are marking this as Plaintiff's Exhibit 22 for identification purposes.

MR. LESNEVEC: Yes, thank you, your Honor.

(Whereupon, at this time, Plaintiff's Exhibit 22 was marked for identification.)

MR. LESNEVEC: At the top right corner it indicates Moazzam Gill and the date, December 18, 2019, just for the record.

THE COURT: Yes.

Q Are you able to see this, Doctor, or do you want to step down to go over this with the Court's permission?

A With the judge's permission it may be easier for me

to look.

THE COURT: Just make sure you don't step in front of the jury.

Q Doctor, keep your voice up.

A Yes.

Q Do you recognize this, Doctor?

A Yes.

Q What are we looking adhere?

A We are looking at an MRI image of the left shoulder on patient Moazzam Gill. This is basically the way the MRI works. It kind of takes slices through your shoulder. This is a slice through the shoulder showing the humeral held, the ball and the glenoid which is the cup here (indicating).

This structure here on the outside is the deltoid muscle. That's something you can feel on yourself. It's the muscle on the outside of the shoulder.

The muscles here are the rotator cuff muscles (indicating). Those are something that you usually can't feel. They are areas that you may be able to feel if you touch on your scapular back here, but this is the supraspinatus muscle, and that becomes a tendon, and the tendon attaches to the humeral head which is bone, so when the muscle contracts, it pulls on the tendon, and the tendon pulls on the bone, and you are able to raise your arm up.

The tendon should be -- on the MRI scan should be a

very dark black structure. Here you see where it's attaching this white area, we call that petrogeneity. In other words, there is variations in the signal of the tendon. This is the area where we also noted during the surgery the partial tear in the rotator cuff.

Q So where you indicate that is the rotator cuff and that's the tear where you noted towards the right where it's a different color?

A Yes. On the MRI report it's noted to be like tendonitis or inflammation, although it is hard to tell from this MRI whether or not there was actually tearing, but the tear is what we did note at the time of the surgery.

Q Is that a fair and accurate copy of the MRI film of Mr. Gill's left shoulder that you reviewed?

A Yes.

MR. LESNEVEC: I would ask that it be entered into evidence.

MR. McNIFF: No objection.

THE COURT: What was previously marked as Plaintiff's Exhibit 22 for identification will be entered as Plaintiff's Exhibit 22 in evidence.

Q You can take a seat, Doctor.

A Thank you.

Q Can you just tell us about how MRIs work in terms of there being different slices or different sequences?

A Yes. So an MRI unlike an x-ray which uses radiation, MRI uses magnets, and it generates signals that are picked up, and you can see soft tissue structures like muscles and tendons that you can't see with the x-ray.

There are different sequences such as tier one and tier two, where tier one picks up more of a fat signal and the other picks up more of the water signal.

And then there are different plains, such as plains in this direction, coronal, and then the sagittal direction and then the axial direction, so there are three different kinds of cuts that you do through the shoulder.

Q And, Doctor, you saw Mr. Gill first on January, 2020, correct?

A Yes.

Q When was the next time you saw him?

A The in next time was on September 22 of 2020.

Q So in between that time period, covid 19 had started, correct?

A Yes.

Q And how was Mr. Gill progressing when you saw him in September of 2020?

A Well, he wasn't doing well. He still had pain, limitation of motion. He was not getting better with physical therapy and medications. He reported no significant improvement.

We discussed a possible shoulder injection, but since injections to his neck and back did not help him, he deferred the shoulder injection, and his examination on this date was not significantly different, and because of his ongoing symptoms of pain, the findings on examination as well as the imaging findings, I did recommend left shoulder surgery.

Q And what kind of surgery was that?

A Arthroscopic surgery.

Q And when was the surgery performed?

A That surgery was performed, I believe, on October 16 of 2020.

Q That's what I have.

A Yes.

Q And so can you just tell us about the operation.

A Yes. So basically the patient, once they are in the operating room, they receive anesthesia, and in this case he received both regional anesthesia where they inject the neck area to make the whole arm numb. And the benefit of that is when you wake up from the surgery, you may not feel pain for maybe even 12 hours because the arm is numb.

And they did general anesthesia that is used for the surgery, and that is with a tube that's placed into the trachea so the patient can breath during the surgery.

One of the first things that we do during the surgery is we do an examination of the shoulder because we have the

benefit of the patient not having any pain, so we are able to really move the arm around and perhaps get a better exam than we can in the office.

Q When you do that, Doctor -- sorry to interrupt -- is the patient conscious or unconscious?

A The patient is unconscious at this point in this case.

Q All right.

A Now, the significant findings of that examination under anesthesia was that the shoulder was loose. Again, we could feel like the ball slipping out of the socket when we examined the shoulder.

That's frequently -- that's a clinical diagnosis. That's the result of the ligaments around the shoulder being loose and stretched. It's a hard finding for an MRI to pick up on, so we rely on examination findings as well as interoperative findings for that diagnosis.

Then we proceeded with the surgery. We cleaned the arm up with Betadine, and we made four portals around the shoulder, one in the back, one on the side, and two in the front, through which we enter with a camera through one and with our arthroscopic instruments through the other portals to do the surgery.

MR. LESNEVEC: And so actually with the Court's permission, I would like to show some exhibits which are

blown up which are already in evidence as part of his records.

May I use the easel for that, your Honor?

THE COURT: Yes. The officer will set it up.

Counsel, move it back.

MR. LESNEVEC: Yes, your Honor.

THE COURT: You can move.

MR. McNIFF: Thank you, your Honor.

MR. LESNEVEC: With the Court's permission, I would ask that the doctor be able to step down.

THE COURT: You can step down towards the easel, Doctor.

THE WITNESS: Yes.

Q Just for the record, I am showing you Exhibit 21, Doctor.

Tell us what are we looking at here?

A Yes. So these are intra-operative photos, so on the camera that we use during the surgery, we are able to actually take pictures, and these are some of the photos that we capture during the surgery.

Q Before you go any further, just for the record, we are at the bottom left hand corner. It states Moazzam Gill; is that correct?

A That's correct.

Q And there is eight photographs on this page; is that

correct?

A That's correct.

Q And they are labeled one through eight; is that right?

A That's correct.

Q And your name, Dr. Touliopoulos, is in the center bottom?

A Yes.

Q And the right-hand corner is October 16, 2020, and there is a number one at the bottom?

A That's correct.

THE COURT: Doctor, I am just going to ask you to just stand a little bit farther back so the jury can see.

Q If you could go through those numbers, Doctor, and tell us what they show.

A Yes. So I would bring your attention to images two, three and four, and that is showing the partial tear of the rotator cuff tendon.

There are four tendons in the rotator cuff. The one that's torn is called the supraspinatus tendon. And originally if you look at number three, the tendon should be this white surface (indicating).

Here you could see the area where it's torn. Actually, this is where it's torn in here. And these are the

torn pieces of the rotator cuff tendon.

What we did is we debrided it with a shaver. This is on image number seven. In the corner you can see the image of the silver structure. It's a shaver that we use to remove the torn pieces of the rotator cuff tendon. We kind of gauge the depth of the tear to be about 75 percent of the thickness of the tendon, so it was enough for us to decide to repair it.

And, again, this is image seven and eight showing the tendon tear after we debrided it. But you can see how deep the tear goes into the substance of the rotator cuff tendon.

This image number six is showing the biceps tendon which was normal during the arthroscopy.

Q I'll go to the next page.

A Yeah.

Q On the bottom right-hand corner of this it's listed as page number two and it shows photos nine through sixteen; is that correct?

A Yes.

Q Can you tell us what we are looking at in this portion of the operation?

A Yeah. So this portion of the surgery is primarily showing the loose ligaments in the shoulder.

So, again, even from his initial visit he was complaining that his shoulder was loose. I noted it was loose during the office exam and also during the exam before the

surgery.

This structure here on image 13 shows the loose ligaments that we were able to actually grab and pull upon.

To address this we performed something called a capsulorraphy which was a tightening of the loose ligaments in the shoulder. We basically pass a suture through those ligaments with a suture passer, again, depicted in image 13.

This is the suture in image 14 after it is passed around the ligament, and then in image 15 it shows it after it's tied.

So basically we are implicating the ligament, we are tightening up the ligament so the shoulder is more stable, and he doesn't have a feeling like it's going to come out again.

Q I'll move on to the next page.

On the bottom of this page, it's indicated as number three.

A Yes.

Q It also indicates photos 17 through 24; is that correct?

A Yes.

Q Can you tell us what we are looking at here, Doctor?

A Yes. So on the top image on the left of image 17 it shows the two sutures that are in place after we did the capsulorraphy.

We then went on to entering the subacromial space of

the shoulder, so it's a space that -- if you pass me the model. I'm sorry.

Q Sure.

A It may be easier.

Q Okay.

A So there is a shoulder joint which is ball and socket, but there is a space above the ball and above the rotator cuff and above this bone here which is the achromia, which is a potential space.

So it's not part of the joint, but it's a space that is part of the shoulder structure, and we entered that space and we noted inflammation. You can see the redness here (pointing), which we call bursitis.

We address that with a bursectomy. We use a shaver to remove the inflamed bursa.

We also noted a bony prominence which is like basically a curvature of the bone. Obviously this is something that has been here his whole life, and that was never symptomatic, but following the accident it became symptomatic because of the instability of the shoulder.

And this can result in a second impingement syndrome. Impingement syndrome is when the arm is raised and this bone rubs against that bone and the tendon between the bones gets pinched.

Because he developed that impingement syndrome, we

did a decompression which involved the bursectomy that I described earlier, as well as shaving down this bone prominence and make it smooth.

Q I'll go to the next page.

This is page number four. It lists photos 25 through 30; is that correct?

A Yes.

Q Can you just tell us what we are looking at here, Doctor?

A So this goes through the steps involved with the rotator cuff repair.

So the rotator cuff tear is repaired using this anchor. The anchor is plastic, but it does have a metal core so it's a combination of metal which is titanium with the plastic.

After the sutures are passed through the tendon, they are attached to the anchor which is hammered into the bone. This is actually the tip of this anchor, once it's inside the bone. Then the sutures are tightened to bring the tendon down to the bone.

Again, in images 28 through 30 are just pictures of the repaired rotator cuff tendon.

Q And that hardware above that you had to insert, is that in there permanently?

A Excuse me?

Q Is the hardware permanent?

A Yes. The hardware is permanent. Usually it is not removed unless there a reason to, infection or it becomes loose.

Q Was there any issue with it becoming loose or any infection as you are aware?

A No. It was not as of the last visit I had with the patient.

Q Okay, Doctor.

You could take your seat.

A Thank you.

Q What is the recovery process like for this type of surgery, Doctor?

A Well, it's part of the lengthy recovery. Basically the first four to six weeks is spent in a sling. The patient is allowed to do some exercises at home. We don't usually start formal physical therapy for four to six weeks, sometimes even longer.

At this point they continue with therapy for a period of months.

Q Doctor, did you continue to see him at all after the surgery?

A Yes.

Q When did you see him after surgery?

A I saw him again on November 9 of 2020.

Q And how was Mr. Gill progressing at that point, Doctor?

A He was progressing. He had some improvement, and in his level of pain relief as well as his motion at this visit.

Q Did Mr. Gill continue to follow up with anyone else at your practice?

A Yes.

Q Who was that?

A Dr. DeMarco.

Q Who was that?

A He is also a board certified orthopedic surgeon that is a physician in the practice.

Q Did you form any opinions with regards to Mr. Gill's ability to work at all?

A Yes. At this point in time when I saw him on November 9, I had him as being totally disabled from his employment.

Q Why is that?

A By this point in time he had just undergone a shoulder surgery, and was recovering from he procedure.

Q Are you aware of any prior injuries that Mr. Gill had to his left shoulder?

A I asked him that question, and he denied any prior history of injuries to the shoulder or even ever having any symptoms in the shoulder such as stiffness and pain.

Q Are you aware of any prior accidents or car accidents or anything of that nature with Mr. Gill prior to this one?

A Only with reference to the shoulder there is no history of trauma.

Q Do you have an opinion within a reasonable degree of medical certainty as to what the cause of Mr. Gill's left shoulder torn rotator cuff as well as the impingement syndrome was?

A Yes.

Q What is your opinion?

A That it is as a result of the accident.

Q Why is that your opinion?

A This is a patient that never had a shoulder problem, never injured his shoulder.

He had pain immediately after the accident.

In fact, it was seen in the emergency room, and they even did x-ray of the shoulder because of his pain level.

This all developed the day of the accident. On findings and during the time of surgery, he had tearing of the rotator cuff tendon and stretching of the ligaments which I believe were traumatic in origin.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Gill's left shoulder injuries are permanent?

A Yes, I do.

Q What is your opinion?
A That they are.
Q And why is that your opinion?
A Because of the tearing in the shoulder and the need for other surgery and the anchors in the shoulder. Again, those are permanently in his shoulder.
MR. LESNEVEC: I have no further questions.
Thank you.
THE COURT: Thank you.
You have cross?
MR. McNIFF: Yes, thank you, your Honor.

CROSS EXAMINATION

BY MR. McNIFF:

Q Good afternoon, Doctor.
A Good afternoon.
Q How many times have you testified in a courtroom during your career?
A I don't know the exact number. I would say on average it may be four or five times a year on behalf of patients I have treated.
Q That's going back how many years?
A I started practice in 1997.
Q Has that been true pretty much throughout, four our five times a year?
A There is some years it is a lot less and many years

it is more, but I would say on average that that's about right.

Q In addition, do you prepare what's called a narrative report for some of your patients?

A When asked, I do for some of my patients.

Q And when asked that would be when asked by attorneys, for example, to prepare those reports?

A Usually it would be an attorney that would asking for narrative report, yes.

Q When you prepare narrative reports for attorneys, do you charge for that?

A It's up to my office manager, and I believe sometimes we do and sometimes we don't.

Q You are not involved completely with the billing in your office?

A I am not.

Q Okay. The procedure that you performed on Mr. Gill was described in your operative report, right?

A Yes.

Q Did you describe it as a left shoulder diagnostic arthroscopy?

A That's part of the procedure, yes.

Q Okay. And that's going in and taking a look as to what's going on; is that what that means in general?

A Yes.

Q And in total how many visits did Mr. Gill have to your practice?

A There were through myself -- I am just going to count and see how many times he saw Dr. DeMarco. Four times with Dr. DeMarco.

Q What was the date of the last visit?

A August 19, 2021.

Q So he hasn't seen you or anyone in your practice for three and a half years, something like that?

A Yes. Since August 21 he has not been seen.

Q The procedure that you performed, would you say that took about 45 minutes on average?

A You know, the time of the surgery would be noted in the anesthesia report.

I would say that for what I did, it would likely be under an hour, but it could be longer.

Q And this is done on an out patient basis; is that right?

A In this case it is, yes.

Q And that means the patient comes to the hospital in the morning, and they are released sometime later that day, right?

A That's correct.

Q The procedure as you described to the jury is done with portals; is that right?

A Yes.
Q It's not an open procedure where you use a scalpel and open up the shoulder?
A It's -- so -- I would --
Q Doctor, if you can't answer my question yes or no, just let me know.
A A scalpel is used.
Q To puncture?
A To make the portals.
Q But in terms of an open procedure with a scalpel where you slice and open somebody up, you didn't do that, did you?
A This is arthro, which is different from opening up. That's correct.
Q You would describe it as minimally invasive?
A I would call it arthroscopic which is different than open.
Q And it leaves I think you said a couple of portal marks on the shoulder, one in the back in the front and on the side?
A Yes. Four total.
Q When you were seeing Mr. Gill, what office was he coming to?
A I have two office locations. It doesn't specify in the note.

I would need to look at my computer database to tell you that.

(Whereupon, at this time, Senior Court Reporter Victoria Bifulco was relieved by Senior Court Reporter Francine Spaulding.)

Q So, what you have there is that a complete copy of your chart in front of you or is that part of it?

A This is a printout of my office chart that I brought with me that I am using today.

Q In addition, we've submitted into evidence the records from your office?

A Yes.

Q Do you have those in front of you?

A Yes.

Q The records that are in evidence, that you have in front of you, is that a complete copy of the chart?

A This is a complete copy of the office visit, but not of the entire chart.

MR. MCNIFF: With the Court's permission, can I look at the records in evidence?

THE COURT: Yes, please hand the attorney the records.

Q Doctor, let's go through what happens when a patient comes to your office. They come in for the first time, they see you, you took a history in this case; is that right?

A That is correct.

Q You asked them essentially how are you, what brings you here, something like that?

A Yes.

Q At that point, they put forth complaints to you, right?

A Yes. For the areas that I am going to be treating, yes.

Q I mean, you ask, I guess first in general and then you take note of areas that are within your field of expertise?

A In this case, he did have other complaints that I documented but I only examined his shoulder.

Q When they make complaints to you, a patient, those complaints are subjective in nature?

A That is correct.

Q Then you do a work up, among other things, to try to figure out if the complaints correlate with whatever your findings are, right?

A That is part of the visit, yes.

Q When you do range of motion testing in this case, you are relying on the patient to be accurate, right?

A I am relying on the patient to participate with the -- especially with the active motion which is something I ask the patient to do. So, they are actively involved during that part of the exam.

Q You are relying on the patient to be accurate and honest about when they actually feel pain?

A Yes.

Q You are not trying to push the patient to the point they can't take the pain any more, right?

A When I am asking them to do the motion, I say as much

as you can tolerate so pain can be a limitation. Also with past emotion, pain can also be a limitation. So, we take it to the point where it is uncomfortable but obviously we don't want to recreate a lot of pain.

Q So, when they do active range of motion, you ask them on their own to show you how far they can lift their arm?

A That is correct.

Q You are relying on the patient to tell you honestly when they feel pain?

A Yes.

Q When you do a passive range of motion test, you are actually pushing on the arm, true?

A It is raising the arm, yes.

Q But you are using force, some force, right?

A Yes.

Q When you use that force, you are also relying on the patient to be honest and accurate about when they feel pain; just yes or no?

A I can't -- I can answer, but I can't answer that yes or no.

Q Okay. You document your findings with regard to range of motion in your chart, right?

A Yes.

Q Do you mention in your chart the type of device you use to measure the range of motion?

A It is not mentioned but I use a goniometer when there is a numerical value.

Q In any of the visits that you have in the notes in front of you, did you actually mention you used a goniometer?

A No, it is just the custom in my practice to use it.

MR. MCNIFF: Thank you, Doctor, I have no further questions.

A Thank you.

THE COURT: Any redirect?

MR. LESNEVEC: Yes, your Honor.

REDIRECT EXAMINATION

BY MR. LESNEVEC:

Q Doctor, how many range of motion tests have you performed throughout your career of the left shoulder of patients?

A On patients? A number of hundreds or thousands, probably.

Q During any of the visits that you had with Mr. Gill, did you feel he was exaggerating in any way?

A No, I believe that his complaints were consistent with my physical findings which were also consistent with the MRI findings and also with the MRI arthroscopy findings.

Q Did you find in any way during any of the range of motion testing that Mr. Gill was giving less than full effort?

A No, I believed he was giving his best effort.

MR. LESNEVEC: I have nothing else.

THE COURT: Thank you, Doctor, you may stand down.

THE WITNESS: Thank you, your Honor.

(Whereupon, the witness exited the courtroom.)

THE COURT: Counsel, you may call your next witness.

MR. LESNEVEC: Yes, your Honor, at this time the plaintiff calls Dr. Debra Dwyer.

THE COURT: Please Bring in the witness.

THE COURT OFFICER: Witness is entering.

(Whereupon, the witness is entering the courtroom.)

THE CLERK: Do you swear to tell the truth, whole truth and nothing but the truth?

THE WITNESS: I do.

THE CLERK: In a loud clear voice, state and spell your full name and state your address for the record.

THE WITNESS: Debra, D-E-B-R-A, Dwyer D-W-Y-E-R address is 17 Springbriar, one word, and it is B-R-I-A-R, Centereach, C-E-N-T-E-R-E-A-C-H, New York, 11720.

THE CLERK: Thank you, please be seated.

THE COURT: Thank you. You may proceed, counsel.

MR. LESNEVEC: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. LESNEVEC:

Q Good afternoon. Is it Dr. Dwyer?

A Yes.

Q Have we ever met before today?

A I don't think so.

Q Have you ever testified before in court where I was an attorney asking questions?

A Yes, I believe we have actually. I don't recall, sorry. I was just actually trying to look that up because I don't remember. I don't think we testified before, I think I have worked with you before.

Q Did we speak at all before today about this case?

A No.

Q Can you tell us about your educational background?

A Sure. I got my bachelors degree from Queens College in Flushing, New York. That was in English literature and economics. I went on to get my masters and my Ph.D from Cornell University in economics with field specialities in health economics, labor economics, and public economics. Then I went on to do a one year post-doctoral fellowship at the Center of Policy Research in Syracuse University.

Q Are you here today as an economist?

A Yes, I am.

Q What is an economist?

A In general an economist studies how societies decide what to do with their resources. It is that broad. We answer

three basic questions, what to produce, how to produce it, and who gets what. Again that is very, very broad, so we have specialities within that.

So my specialities is to monitor trends and policy and what is going on in the health markets and the labor markets. And, those are two very large markets. So, I will keep up with what is happening with prices and costs and health care and equity issues and health care policy issues, that sort of thing. And, then in the labor market what is happening with wages, unemployment, industry analysis, that sort of thing.

Q Can you tell us about the honors, awards or publications that you have written?

A Sure, I have been doing this since 1996, so I have a couple of dozen peer review journal articles, a couple of book chapters, I have done a lot of reviews and I have received many honors and awards over the years including grants from the National Institute of Health, and others. I serve on the Board of Directors for an economics organization and I am a member of many economics organizations.

Q Are you also a professor?

A Yes.

Q Tell us where you teach and what you teach?

A I spent the last couple of decades in the State University of New York system, predominantly at Stony Brook, where I spent about 21 years. I was a faculty member, a

chairperson and ultimately the assistant dean for strategic planning. I stepped away from that role full-time. I am just teaching and doing research now. I teach health economics and public policy.

This semester I am teaching at Farmingdale State College, also a SUNY. I developed a relationship with a researcher there and we have grants to provide financial literacy training to vulnerable populations in New York. So, I am I working on that and teaching health economics.

Q Have you testified in court before?

A I have.

Q Approximately, how many times?

A Hundreds, I have been doing this since 2012.

Q Which jurisdictions have you testified in?

A All over the New York City area. That would be Nassau, Suffolk, Queens, Bronx, Brooklyn, Staten Island, Westchester and I testified a couple of times outside. Once in Connecticut, once in Maryland.

Q As part of your field of economics, do you get involved in the economic loss analysis of people who have litigation or cases that are going on?

A Yes, I do.

Q Can you tell us about the type work you do in that respect?

A Sure, one of the things I did when I stepped back from

my full-time administrative role was to start my own business, Deb Dwyer Analytics. And, within that, I do a lot of this kind of this work where I consult with attorneys on cases to determine economic damages for people who are involved in lawsuits like this.

So, if somebody is injured and unable to work or experiences a reduction in their earnings capacity, it is my job to determine what would they have earned for the rest of their work life had the incident never occurred. That includes losses in income, losses in fringe benefits. That sort of thing.

I also, because I am an health economist, have the expertise predict what is going to happen to prices and costs in health care. I am not a medical doctor, so, I would take the treatment recommendations of a medical expert, a life care planner and they provide me with the categorizes of services that would be required for the plaintiff, in this case Mr. Gill. The services required related to the injury in the case.

The doctor will provide the frequency, the duration, and the current costs. So, how much does it cost in today's dollars. I need to make sure Mr. Gill has enough money to cover those expenses into the future because we are predicting over the next 30 years or so. We know prices will go up. My main role is to talk about inflation. What is going to happen to those prices.

The US Bureau or Labor Statics collects data on prices,

they are the agency that puts out the consumer price index or the inflation rate in general, that you guys read about. That rate captures the change in prices and trends for the typical goods and services that a typical household would consume.

In doing that, the agency is very large and they collect data on all sub categories of goods and services including medical care. And, they break it down, the general inflation rate for medical care for example over the last 25 years has been about 3.3 percent, on average, which is pretty much in line with the general inflation rate. Which is good, because historically it has been very high. It has been very high again in the last few years as we all know.

I take the closest match of category of health care services from that Department Labor Data to the recommendations of the life care planner and I come up with what I believe is a good growth rate, an accurate growth rate to predict what the prices will be into the future. There is uncertainty, we don't want to take just one year's worth because it does change it -- while prices go up every year for the most part, they go up some years higher than others. Right now we are in a period of very high inflation.

So, if I were just to take the current rates to project forward the costs for Mr. Gill's case, it would be too much, probably too much money that he would need because right now the rates are really high and we know that they are not going to

stay that high for the next 30 years. If we happen to be in a recession where the rates were below one percent, then the prediction would not be enough money for Mr. Gill to cover those health care services.

So, my job is to say what is reasonable when we can't read the future in terms of reasonable amount to cover the expenses of health care for the plaintiff, in this case Mr. Gill.

I also do advising for advocacy groups and policy makers, that sort of thing. But, this is the biggest part of my business.

Q In terms of your business with economic loss analysis for injured plaintiffs, how many times do you think you have performed that type of analysis throughout your career?

A Again hundreds.

Q Are you being compensated for your time here today?

A Yes.

Q How much are you being compensate?

A $5,000.

Q If you were not here today, what would you be doing?

A I would be working on research analysis on other cases. I have a lot of grading to do. It is the end of the semester, that sort of thing.

Q In terms of the facts of this case, Mr. Gill, was he working as of December 4, 2019 the date of the accident?

A Yes.
Q Do you know what kind of work he did?
A He was involved in the car service, taxi industry.
Q He was an Uber driver; is that right?
A Okay.
Q As part of your work in this case, did you examine Mr. Gills' tax records?
A I did.
Q What did you examine?
A I examined the 1040 -- the one I relied upon the most was 2019, but I had 2018 and 2017. As well, in this case, the most recent one was the most relevant.

MR. LESNEVEC: Your Honor, I would like this marked.

THE COURT: We are going to mark this as Plaintiff's 23, for identification purposes.

THE COURT: Please approach, counsel.

(Whereupon, an off-the-record discussion was held at the bench.)

THE COURT: Members of the jury, we are going to take a brief five minute comfort break. During the break, do not discuss the case with anyone, including your fellow jurors, do not speak to with the parties, the attorneys or the witnesses. If anyone attempts to discuss the matter with you, please notify my court officer who will notify

me.

We are taking a very brief comfort break. Okay.

THE COURT OFFICER: All rise, jury exiting.

THE COURT: Off the record.

(Whereupon, a short recess was taken.)

THE COURT: On the record. Pleas bring in the jury.

THE COURT OFFICER: All rise, jury is entering.

(Whereupon, the jury entered the courtroom.)

THE CLERK: All parties stipulate to the presence and proper seating of the jury?

MR. LESNEVEC: I do.

MR. MCNIFF: I do.

THE COURT: You may all be seated.

We are going to mark this document as Plaintiff's 23, for identification purposes.

(Whereupon, Plaintiff's Exhibit 23, was marked for identification by the Reporter.)

THE COURT OFFICER: Plaintiff's 23, marked for identification.

Q Doctor, can you tell us what we are looking at, Exhibit 23, please?

A These are Moazzam Gill's tax returns, 2019. Let's see, maybe just 2019.

Q Yes, 2019, is that correct?

A Yes.

Q Is that a fair and accurate of the 2019 tax returns that you reviewed for Mr. Gill?

A Yes.

THE PLAINTIFF: I would ask they be admitted in evidence.

THE COURT: Any objection?

MR. MCNIFF: No objection.

THE COURT: What was marked as Plaintiff's 23 for ID, will be entered into evidence.

(Whereupon, Plaintiff's Exhibit 23, was marked in evidence by the Reporter.)

THE COURT OFFICER: Plaintiff's 23, in evidence.

Q Doctor, why did you primarily rely on the 2019 tax returns?

A The accident occurred in December, so it was pretty much a full year and it was consistent with what he had done the prior two years.

Q How much did he earn in the year 2019?

A He earned $22,939.

Q Did you calculate Mr. Gill's projected loss earnings meaning from the date of the December 4, 2019 accident until the present?

A Yes, I did

Q What were your calculations, what did that add up to?

A The total over his life work expectancy is $699,516 and that is over the next 22 or so years.

Q So, that would be -- is that from today's date moving forward or from the date of the accident moving forward; how do you calculate that?

A That was from the date of the accident moving forward.

Q Is that calculation based on a reasonable degree of economic certainty?

A Yes, it is.

Q How did you compute that or calculate that?

A So, just like I had to take averages in the change of prices for health care, I had to take into account average wage growth. So, I applied an average wage growth rate of 3 percent. That is based on the national average which is now up to 3.4 percent over the last 20 years. That is based on Department of Labor data also.

I could have started that 3 percent in 2025 because the years before that between 2020 and 2024 we know what the growth rates were and they averaged about 5 percent, so significantly higher. I was being conservative and I just used the flat 3 percent from 2020 until he would retire at age 67 and that is another one of my assumptions, the retirement age. I have him working until his full age of retirement under the social security system.

Q What age is that?

A Sixty-seven.
Q Did you chart that into a yearly break down?
A I did.
Q Yes.
MR. LESNEVEC: Can I have this marked?
THE COURT: Do one at time. Does it matter which one?
MR. LESNEVEC: Yes, the one that indicates, Income Loss at the top, in the center.
THE COURT: Okay. We will mark this document as Plaintiff's 24, for identification purposes.
(Whereupon, Plaintiff's Exhibit 24, was marked for identification by the Reporter.)
THE COURT OFFICER: Plaintiff's 24, marked for ID.
THE COURT: We are going to mark this document as Plaintiff's 25, for identification purposes.
(Whereupon, Plaintiff's Exhibit 25, was marked for identification by the Reporter.)
THE COURT OFFICER: Plaintiff's 25, marked for ID.
Q Take a look, Doctor, at Exhibit 24, first.
MR. LESNEVEC: With regards to income, this is for demonstrative purposes, your Honor, I blew this up. May I show the jury?
THE COURT: Sure.
MR. LESNEVEC: Thank you,

Q So, if you want to follow along with your chart or this one, whatever you prefer?

A Do you want me step down?

Q Whatever you prefer, whatever is easy for you.

THE COURT: You can come around.

Q Can you tell us how you charted his loss of income?

A Sure. You see the loss started 2020 because the accident was December 4, 2019, the end of the year. So, I took his annual salary and used that as his earnings capacity. What he was capable of earning on the lay market and what he was likely to earn. So, I said in 2019 he earnED $22,939. So, I will write that over here as the starting point. And, again, that is based on his tax return.

So, you see I have a loss at $23,627 in 2020, that is giving him a three percent raise from what he had earned in 2019, and again, the national average over the last 20 years has been 3.4 percent. I will write, I used a 3 percent growth rate. And, keep in mind, had I used the actual growth rate, these would be higher numbers. So, I am pretty conservative.

So, I give him a 3 percent raise every year from that starting salary of roughly $23,000 until he reaches the age of 67 which happens here in 2041. That is when he reaches 67, and it is a partial year because he would retire on his birthday and the life time cost then is $699,516, that's the value what he would have earned under the assumption he would have worked at

driving at $22,939 per year with a 3 percent raise each year and work until his full age of retirement under social security.

Q Did you also factor in the loss of social security retirement income?

A I did. So, your social security pension is based on your years of work and your highest earnings and given he lost over 20 years of work, he is going to collect less at age 62. What I calculated was the difference in the future between what he would have earned and what he will earn. So, roughly, $9,000 a little bit more annually in future dollars. So, current dollars that would be more like 7,000.

The growth rate here, I wrote this report in 2022. And, the 20-year average cost of living adjustment applied by the social security administration at that time was two percent. Under Joe Biden, it went up to 8.4 percent one year and that 20-year average jumped up 2.7 percent. So, now I am using the 2.5 percent. Nobody anticipated that big jump. But, it would have been significantly higher than what I did here. I did the math and it would be about a 100,00, maybe a little more difference than what I have here.

Q What do you have there by the way?

A I have a $105,532. The way I came to that was using that 2022, 20-year average of 2 percent average. I think I said 2022, 20-year average at 2 percent. Sorry, that was a lot of two's. Starting at the time he retires and you see it ends here

in 2051 using the data from the National Center for Health Statics I came up with this life expectancy. They put out what is called life tables every year, those are tables of survival probabilities. They tell you the average amount of time left to live, giving the year you were born and your gender.

So, in this case it is 78.4. That's the life expectancy age for Mr. Gill. So, he could collect his pension until the end, until he passes and that total comes out to $105,532. So, what this chart is telling you, is the life-time loss from losing all of those years of work comes out to the sum of these two numbers and I can give you that sum if you want.

Q Yes.

A So, the total sum wages and social security benefits is $805,048.

Q These calculations with the social security retirement economics as well as loss of income are made within a reasonable degree of economics certainty?

A They are.

Q Are you familiar with narrative reports, Doctor, by the way?

A Yes.

Q Life care plans, are you familiar with those?

A Yes.

Q Did you review a life care plan for Mr. Gill?

A I did.

Q Was that from Dr. Root?

A Yes.

Q What, if any, work did you do with regards to charting future medical care and costs?

A I took each recommendation of Dr. Root, each category of care, for example physical therapy, seeing the doctor, I analyze the costs and then projected how those costs would increase each year to determine how much money Mr. Gill would need to cover the recommended services.

Q Did you chart that separately?

A I did.

Q I will show you Exhibit 25, tell me if you recognize this?

A Yes.

THE COURT: Counselors.

(Whereupon, an off-the-record discussion was held at the bench.)

THE COURT: You may proceed.

Q Can you tell us what we are looking at in Exhibit 25?

A What you see here is the summary of the annual costs for each category of service recommended by Dr. Root. You see that the starting year here is 2023, my original report was in 2022, when Dr. Root also wrote his report. My job is only to tell you what the losses would be into the future. Anything that occurred in the past, we have receipts for. We know what

the past loss is. We start at 2023 because that is when I wrote the report but I will draw a line here, I don't add those years into the bottom. So, we will start with July 1, 2025 since we are already at the of May. So, I am counting the future from July 1, 2025 through his life expectancy age of 78 in the year 2051. So, that is true for all of these columns.

Now, the first category is medical care, Dr. Root recommends medical care, office visits, that sort of thing, the annualize cost of those services according to Dr. Root is $5,525. So, accounting for inflation, today the same visits would cost $5,839. And the growth rate I applied there is 2.8 percent. That is based on the US Bureau Labor Statistics Data, the 25-year average for general medical care services.

Diagnostic testing, I will go through each column and tell you what the growth rate is, the annualize amount and the total, and I failed to tell you this total. The total cost of visiting doctors and general medical care $238,005 over the course of Mr. Gill's life and we are projecting over 30 years.

Diagnostic testing, prescribed by a doctor, read by a doctor, so I use that general of 2.8 percent. Starting value is $2,475 worth of X-rays and MRIs, that sort of thing. In today's dollars it bumps up $2,616 with that 2.8 growth rate, Mr. Gill will require $106,617 of diagnostic testing according to Dr. Root.

Medications, pharmaceuticals had a higher rate of

growth than in other areas in medicine, 3.5 percent of growth rate, that we apply there based on a 25 year average. That doesn't include Tylenol because these are prescription drugs. So, the prescription drugs have a higher growth rate than non-prescription drugs. Annually, those prescription drugs would cost $192, in today's dollars $206, lifetime cost of prescription medications is $9,215.

Cervical fusions, two surgeries, one to the cervical spine, one to the lumbar spine. The surgery with the associated costs based on Dr. Root is $100,000 and it should occur within 8 and 13 years. So, I take the mid point which would take us to 11 years out. The cost then $157,385 and for surgery and the hospitalization costs, the growth rate on average is 4.2 percent.

So anything to do with surgical procedures, outpatient, inpatient those rates are higher than the average and that is why it is 4.2 percent. The lumbar fusion is 5 to 10 years. So, we have at it at 7 years and that costs, the $125,000 becomes $173,261 in the future. And, these are both just one time.

THE COURT: One moment, Doctor, I'd ask you to just step back to your chair.

Members of the jury, at this time we are going to break for lunch. Remember my admonitions. During the break, please do not do any research on any topic pertaining to the case. Do not discuss the case with

anyone including your fellow jurors and do not speak to the parties, attorneys or witnesses.

If anyone attempts to discuss this matter with you, notify my court officer who will notify me. Everyone have a good lunch. I will see everyone back here at two o'clock sharp.

THE COURT OFFICER: All rise, jury is exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Off the record.

(Whereupon, a lunch recess was taken.)

THE CLERK: All rise, come to order.

THE COURT: You may be seated.

MR. LESNEVEC: Yes, your Honor.

THE COURT: If Dr. Dwyer can take the stand, please.

Please bring in the jury.

THE COURT OFFICER: All rise, jurors are entering.

(Whereupon, the jury entered the courtroom.)

THE CLERK: Do all parties stipulate to the presence and proper seating of the jury?

MR. LESNEVEC: I do.

MR. MCNIFF: I do.

THE CLERK: To the witness, you are reminded you are under oath.

THE COURT: You may be seated.

Counsel, you may continue.

MR. LESNEVEC: If I could have the Doctor step back down.

THE COURT: Doctor, you may step down.

Counsel you may come around.

Q Doctor, if could you just pick up where you left off. I think we were talking about therapeutic intervention, if I am not mistaken?

A I think we were at steroid injections. So, the steroid injections and the nerve blocks are for pain management.

Dr. Root only prescribed them for three years. So, you would only get them for three years and then it stops. The cost annually for these injections, for the steroid injections, is 6,600 and for the nerve blocks 900. I used the 2.8 percent growth rate there, and this again is for the office visits.

Now, those pain management interventions can take place either at a doctor's office or at an outpatient facility. If it is in an office, it is a lower growth rate. That is the one I used here. If it took place at an outpatient facility, it would be a significantly higher growth rate, closer to that of a hospital. The life time cost of steroid injections then would be $20,360; and, for the nerve blocks it would $2,776.

Then we get to the physical therapy, the therapeutic treatment. $4,500 worth of physical therapy per year. Physical therapy has a lower growth rate over the last 25 years, it falls into the category of other medical professional services and 25-year average is 2.2 percent. So, using a 2.2 percent growth rate starting with $4,500 over the next 30 years, the lifetime cost is $177,031.

The last category, DME stands for durable medical equipment, that is just medical supplies like bandages, that sort of thing and Tylenol, a much lower growth rate is applied here 1.2 percent. And, the life time cost would be $13,649. This total that you see here was from the original report starting in 2023. So, I will give you the new total for future

health care costs for all categories based on Dr. Root is $845,717.

Q How did you come up with the $845,717 number?

A That is the sum of all these totals down here.

Q Those are the totals contained in the chart that you wrote, correct?

A Let me be clear, after subtracting off the first two rows. This $898,299 is the sum of this row but that is starting into 2023. So, I calculated the new total removing the past.

Q So, it is actually lower than what previously you calculated when you wrote the report?

A Yes, passage of time.

Q Got it. These calculations, future cost of medical care, are they made within a reasonable degree of economic certainty?

A Yes.

Q In terms of the totals of all the combined costs, health care, loss wages, loss of social security retirement income, would you calculate that total to us?

A Sure. The total with economic loss -- so the income loss, benefits loss, and future health care loss, is $1,650,765. And again, that is starting with today for health care into the year 2051.

Q Again, is that within a reasonable degree of economic certainty that calculation?

A Yes.
Q I would ask you to retake your seat?
A Sure.
Q Just to finish up here, you are not a medical doctor, correct?
A That is correct.
Q And, you relied upon Dr. Root who is a medical doctor in terms of his recommendations for future health care?
A Yes.
Q Is it fair to say that if his numbers are off, your numbers are off; is that correct?
A Yes.
Q In other words, if the categories he gave us and the values are lower, your numbers are different than what you presented today, correct?
A Correct.
Q If they were higher, if he needs more care, you would have to -- your numbers would be higher; is that correct?
A That is correct.
MR. LESNEVEC: I have no further questions, thank you.
THE COURT: Any cross?
MR. MCNIFF: Yes, thank you, your Honor.
CROSS EXAMINATION
BY MR. MCNIFF:

Q Good afternoon, Doctor.

A Good afternoon.

Q So to pick up where we just left off, your numbers are based on a report prepared by Dr. Barry Root, is that correct? Is that the foundation for your report?

A Yes.

Q And that report was provided to you by plaintiff's counsel?

A Yes.

Q Did you speak to Dr. Root?

A No, I did not.

Q Did you speak to any of the treating doctors that treated the plaintiff in this case?

A No.

Q So, if the cost for the surgery were whatever they were on your report, and the plaintiff doesn't need surgery in the future, we could remove that cost then from your analysis; is that correct?

A Sure. If he doesn't need it, that would be an amendment to the report.

Q That would be true for any item on the report, right?

A Yes.

Q So, you are not offering any opinions that he needs surgery for example, right?

A Right, I am not a medical doctor.

Q You are not offering an opinion for any one of those categories at all?

A No, I just take Dr. Root's recommendations.

Q You mentioned something before about when it comes to the earnings component, that sometimes you will prepare an analysis based on -- did you say diminutions in earnings?

A Yes.

Q Is that when you deal with the vocational rehabilitation counselor where somebody comes in and says, Yes you can go back to work, but you are not making as much money as you did?

A Sometimes. Sometimes it's if somebody actually returns to work and I have before and after numbers.

Q Is this a part of your professional life about preparing the reports in connection with litigation about 65 to 70 percent today, of your professional life?

A Okay. I wasn't sure -- yes, that's probably a little bit more. Like 75 percent.

Q And is it roughly about 93 percent plaintiff, 7 percent defendant. Not testifying, but in general?

A Yes, in general.

Q When you testify it is almost exclusively for plaintiffs, right?

A It is only more recently. I testified twice for defense.

Q In your career?
A Correct.
Q Did you say you testified hundreds of times?
A Yes.
Q Did you request any records or any other information from the plaintiff?
A No.
Q If you wanted to look at what the treating doctor said, you could have requested that information, right?
A I could, I wouldn't, because I could not distinguish between Dr. Root's recommendation and anybody else's.
Q So, you took what the plaintiff said he would need in the future from one source, Dr. Root?
A That is correct.
Q You did not look at what his treating doctor said about future care, correct?
A Correct.

MR. MCNIFF: Thank you. No further question.

THE COURT: Any redirect?

MR. LESNEVEC: No thank you.

THE COURT: Doctor, you can stand down. Thank you.

(Whereupon, the witness exits the courtroom.)

THE COURT: Counsel, you may call your next witness.

MR. LESNEVEC: At this time, your Honor, the plaintiff will rest on this case.

THE COURT: Okay. Please approach.

(Whereupon, an off-the-record discussion was held at the bench.)

Members of the jury, we are going to have an early out today. Another early out. So, I want to give you these admonitions for the last time today. That during this break, please do not discuss this case with anyone including your fellow jurors. Do not speak to the parties, attorneys or witnesses.

If anyone attempts to discuss the case with you during the break, notify my officer, who in turn will notify me. Everyone have a wonderful and relaxing weekend and holiday. I will see everyone back here Tuesday morning at 10:00 a.m. Have a good evening. Get home safely.

THE COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Okay. Any motions?

MR. MCNIFF: Can we approach for a second?

THE COURT: Sure.

(Whereupon, an off-the-record discussion was held at the bench.)

THE CLERK: All rise, come to order.

THE COURT: You may be seated. Any motions?

MR. MCNIFF: No, your Honor.

THE COURT: Okay.

Any motions, counsel?

MR. LESNEVEC: Nothing, your Honor.

THE COURT: So then we will resume on Tuesday morning at 9:30 because I can decide to -- read the decision on plaintiff's motions in limine with regard to one of the reports of the doctor, Dr. Chernoff, I believe that you are calling on Tuesday. The jury will come back at 10:00 a.m., counsel you come back at 9:30. Okay.

MR. LESNEVEC: Yes, your Honor.

THE COURT: Off the record.

(Whereupon, the trial was adjourned until May 27, 2025.)

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