SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK : CIVIL TERM : PART 18

----------X Index No. 161091/2019

FINTAN McKENNA,

Plaintiff,

-against-

JURY TRIAL

TEACHERS INSURANCE AND ANNUITY ASSOCIATION OF AMERICA FOR THE BENEFIT OF ITS REAL ESTATE ACCOUNT, WEWORK REAL ESTATE LLC, WEWORK CONSTRUCTION LLC, WEWORK COMPANIES INC., and OC DEVELOPMENT MANAGEMENT,

EXCERPT OF PROCEEDINGS

Defendants.

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Supreme Court
71 Thomas Street
New York, New York 10013

November 18, 2025

B E F O R E:

HONORABLE ALEXANDER M. TISCH
Supreme Court Justice

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

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(Appearances continued on the following page.)

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A P P E A R A N C E S: (Continued.)

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MARY BENCI, RPR
Official Court Reporter

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(Whereupon, Plaintiff's Exhibit 6, Dr. Roberts' chart, was received and marked in evidence.

(Plaintiff's Exhibit 7, Joint Effort and Chiropractic records, was received and marked in evidence.

(Plaintiff's Exhibit 8, New York Spine Institute records, was received and marked in evidence.

(Plaintiff's Exhibit 9, New York Orthopedic & Comprehensive records, was received and marked in evidence.

(Plaintiff's Exhibit 10, MRI image dated 2/6/19, was received and marked for identification.

(Plaintiff's Exhibit 11, surgical demonstrative, was received and marked for identification.

(Plaintiff's Exhibit 12, MRI films, was received and marked in evidence.)

COURT OFFICER: All rise.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated, everyone.

Mr. Moore, do you have another witness to call for the plaintiff?

MR. MOORE: I do, your Honor. At this time we would call Dr. Timothy Roberts.

THE COURT: Dr. Roberts, can you take the stand, please.

(Whereupon, the witness took the witness stand.)

COURT OFFICER: Remain standing, raise your right

hand.

T I M O T H Y R O B E R T 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: You may be seated. In a clear and loud voice, please give your name and business address to the Court, spelling your first and last name.

THE WITNESS: Sure. It's Timothy Roberts, T-I-M-O-T-H-Y, R-O-B-E-R-T-S. New York Spine Institute, 761 Merrick Avenue, Westbury, New York 11590.

THE COURT: Your witness.

MR. MOORE: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. MOORE:

Q Good morning, Dr. Roberts.

A Good morning.

Q Are you a doctor duly licensed to practice medicine in the State of New York?

A I am.

Q And when were you so licensed?

A 2013.

Q Could you please tell the jury a little bit about your education and your professional background.

A Sure. I went to Tufts University School of Medicine.

I graduated in 2010.

I did a five-year orthopedic surgery residency in Albany Medical Center. I graduated in 2015.

Then I did a combined orthopedic and neurosurgical spine Fellowship at the Cleveland Clinic; graduated in 2016.

I've been in practice since then.

Q Okay. And when you say you did a residency, what is a residency?

A A residency is a -- well, for orthopedic surgery it's a five-year program. It consists of an internship where you would do various types of surgery, followed by four years of orthopedics. I focused on spine surgery because it was what I was interested in.

Q And what is a Fellowship?

A A Fellowship is some additional training you can do after your residency if you want to specialize in certain things, with spine surgery being the one I chose.

Q Okay. And Doctor, have you been published in your field?

A Yes, I have.

Q What does it mean to be published in your field?

A It depends on the publication, but my publications have involved various articles, research papers, review articles, as well as several textbook chapters, and I also edited and wrote a textbook.

Q Currently, are you engaged in ongoing medical research?
A Yes, I am.
Q What type?
A Mainly to do with spinal outcome cervical and low back procedures.
Q You mentioned orthopedics. Can you tell us, what is the field of orthopedics?
A Yeah. So orthopedics is a surgical specialty which involves treatment of bones, ligaments, muscles, typically skeletal injuries.
Q Okay. And do you have a specialty within the field of orthopedics?
A Yes. So that would be spine surgery, yes.
Q Are you actively doing surgeries?
A I am.
Q When did you do your last surgery?
A I finished about 1 a.m. last night.
Q Thank you for being here.
A Sure.
Q As an orthopedic spinal surgeon, what type of surgeries do you do?
A Predominantly, I do disc surgeries for discectomies, and herniated discs, spinal fusion decompressions, as well as trauma.
Q And do you have hospital privileges?

A I do.

Q Where?

A I'm an Assistant Professor of Medicine at NYU. Also operate out of the Catholic Health system of Long Island.

Q And Doctor, are you Board certified?

A Yes, sir.

Q What does it mean to be Board certified?

A To be Board certified in orthopedic surgery, you would complete a residency, followed by additional training, which I did. You then sit for a long written exam which tests you on the field of orthopedics.

And then in my particular specialty you would basically go to practice for a couple of years, document all cases and surgeries you do, and then you submit those to the American Board of Orthopaedic Surgery. They review those cases.

They summoned me to Chicago to defend, I think it was, 12 cases. You know, why I did that, what was I thinking, that kind of thing. And if they find it satisfactory and they think you're doing the right thing, they give you the full Board certification.

Q And when was this?

A This was in 2021 for me. 2020, '21.

Q And the patient you are here today on behalf of, Mr. McKenna, was that patient a part of your Board process?

A He was one of my Board patients, yes. I thought I was

done with that, but here we are.

Q Now, are you presently part of a medical practice?

A Yes, sir.

Q What is the name of that practice?

A It's the New York Spine Institute.

Q Okay. How long have you been with that practice?

A Since 2019.

Q The term doctor-patient privilege or relationship, what does that mean?

A Well, it means I have -- you know, once I see and establish a relationship with a patient, I have an obligation to help that patient. It means that, you know, the patient can certainly confide in me for certain things, and that should be kept confidential and used to help the patient.

Q And how important is that relationship?

A I think it's very important.

Q Okay. Now, Doctor, did there come a time that a patient by the name of Fintan McKenna presented to you as a patient in your practice?

A Yes.

Q When was that?

A I believe I first saw the patient in 2019, I think April. I'd have to refresh my memory.

Q Okay. Are you still treating Mr. McKenna?

A Yes.

Q Do you know when you last seen him?
A I saw him I think a couple of months ago.
Q Do you know if you have any future or if he has any future appointments with you?
A Yeah, I think I'm seeing him again in January.
MR. MOORE: Okay. So, your Honor, in addition to being Mr. McKenna's treating doctor, I would proffer Dr. Roberts as an expert in the area of orthopedic spine surgery.
MR. FALEY: No objection, Judge.
THE COURT: Okay.
Q Doctor, before this morning, have you and I ever met?
A No. I met you this morning.
Q And we have spoken over the phone to coordinate your appearance here today?
A That's correct.
Q If you weren't here, where would you be?
A I would be in the OR today.
Q Okay. And as a result of this appearance, did you have to cancel patients?
A I did. That was part of why I operated late last night was to move a case from today to yesterday, and then -- yeah.
Q In order to be here today, are you being compensated for your appearance?
A I believe so.

Q Do you know how much?
A I actually don't.
Q Do you testify in court often?
A This is my -- it's my third time in court.
Q Okay. When you do -- strike that.
When you have had to testify, is that for your patients or for some other people?
A Yes, it's been on behalf of my patients.
Q Okay. Doctor, before we discuss Mr. McKenna specifically, have you brought some models with you today?
A I did, yeah, yeah. Do you want me to go through them?
Q Can you tell us what you brought?
A Absolutely, sure. I have a spine model. So, basically, I can show the spinal herniation that Mr. McKenna has. I have another model of a fusion surgery. And then I have some spinal needles just to demonstrate an epidural injection.
Q Those models, will they assist you in explaining the anatomy of the injury to the jury?
A I think so.
Q Okay. And just briefly, can you explain the anatomy of the human spine to the jury.
A Sure. So --
THE COURT: Do we need to mark these at least for ID?
MR. FALEY: I think they can be deemed mark, Judge,

right?

THE COURT: Deemed marked as what though?

MR. MOORE: We could mark it as Exhibit 13.

MR. FALEY: Deemed into evidence. He can take them home with them. He doesn't have to leave them here, Judge.

THE COURT: Plaintiff's Exhibit 13?

MR. MOORE: 13, yes.

(Whereupon, Plaintiff's Exhibit 13, models, was received and deemed marked for identification.)

Q Doctor, if you don't mind, can you --

A Yeah, absolutely. So we'll talk about the lumbar spine. So in the low back, basically, the sequence throughout the whole spine will go bone, disc, bone, disc, and so on. There are five bones and five functional discs in the low back.

Basically, behind the bones runs a canal where the spinal cord and nerves go, and at each level -- this is falling apart, sorry -- at each level between the bones is a hole called the foramen where the nerves will come out on the left and right side (indicating).

And then this is a model basically demonstrating a herniation. So, the cliché, the thing we tell patients is that the discs themselves kind of are like a jelly doughnut, a shell around it, and basically has got a gel in the middle, and that allows the bones to move a little bit, gives you some motion, gives you cushioning if you go jogging or something like that.

But what can happen is that shell around it can tear and then, basically, you could get a herniation where that gel will squirt out. If it comes out the front or the side, it's not a big deal; you probably wouldn't even know it. But if it goes out the back, it ends up pinching these nerves, either all the nerves that run down the legs to the pelvis, or it can pinch these individual nerves which in the low back will go to the legs and basically do different things.

Q Okay. Thank you.

Doctor, I'm just going to mention a few terms to you. If you could just tell us what they mean.

A Yes.

Q Radiculopathy?

A Yes. So radiculopathy is basically when you have compression or irritation of a nerve, a root. So at each level, basically, as I said, is a left and right nerve root that comes off, and radiculopathy means irritation or dysfunction of that particular nerve root.

Q Okay. What is a diagnosis?

A A diagnosis is basically stating what the provider thinks the patient has. You know, sometimes it can be very vague. If we don't have any imaging and don't have a good idea, we say something simple, like back pain. If we have a good idea and a clear idea of what's going on, we say it's a lumbar disc herniation with an L5 radiculopathy. So it can be broad or very

specific.

Q And what is a differential diagnosis?

A A differential diagnosis is basically as you're working down, as you're getting more narrow and more specific in figuring out exactly what's wrong, you often provide a short list -- hopefully short -- of the potential things, the contenders for what you think is going on. Typically, a handful of diagnoses that might apply to the situation.

Q And finally what is a prognosis?

A A prognosis is stating basically what you think is going to happen. You know, obviously, if somebody has, like, a spinal cord injury, paralyzed, prognosis is poor. They will have a very dramatically affected quality of life.

If somebody has, you know, a small infection, goes away with antibiotics, they are going to be fine. Good prognosis.

Q Now, Doctor, back to Mr. McKenna.

When does he appear in your office for the first time?

A Yeah. I don't recall the exact date, but it was in early 2019.

Q Okay. And today did you bring a chart with you?

A I did. I brought my cheat sheet here.

Q And is that the chart that you maintain in your office for Mr. McKenna?

A It is.

Q Okay. I just want to let you know that that chart is

now evidence, and with your Honor's permission, if you need to look at it to refresh your recollection, you can do so.

A Great. Thank you.

Q Now, before the initial exam of Mr. McKenna, had you had the opportunity to review any of the records with any of his prior treating doctors?

A I don't recall exactly what I reviewed. I think I had seen maybe his ER records, but -- and then a record from one of my partners Dr. de Moura, who I think had seen him first.

Q Did you see a record from a Dr. Donath?

A I believe so.

Q I'm just going to show you what we have marked; it's in evidence as Exhibit 7. So it's Dr. Donath's record, and I'm just going to put it up on the screen for you.

MR. MOORE: Your Honor, if you would just bear with me one moment just when I try to log in. It has logged me out.

THE COURT: Technical difficulty.

MR. MOORE: I was hoping not, but yeah. I just need to turn on the screen, your Honor. I'm sorry.

Your Honor, with your permission, I'm just going to give the record, because I have to log in and it will take a few more minutes, and I don't want to belabor the issue.

THE COURT: Okay.

MR. MOORE: So we have Exhibit 7 from Joint Effort

& Chiropractic.

COURT OFFICER: (Handing.)

Q Do you have the record in front of you, Doctor?

A I do. Am I allowed to open it?

Q Yeah.

A All right.

Q It should be open.

A It is.

Q What facility, Doctor, is that record from?

A This looks like it's from the Joint Effort Chiropractic of Westchester.

Q And is this one of the records you have reviewed in relation to Mr. McKenna?

A I believe it is.

Q Okay. Looking at the first visit, what date is it?

A Just making sure these are in order here.

It looks like January 31st of 2019.

Q Okay. So that's three days after the incident that brings us here today, correct?

A Yes, sir.

Q Now, could you read for the jury the portion that describes how the incident occurred.

A Fintan McKenna is a 31-year-old male who came into my office for initial evaluation today. The patient complains of sharp and shooting pain and discomfort in the low back. He

rates the pain intensity as ten on a numerical rating scale from zero to ten. He notices the problem constantly, 75 to 100 percent of his awake time.

On January 20 -- sorry -- on January 28th, Fintan was on a ladder fixing a top track, which is the number -- sorry -- which is the runner for stud walls and soffits -- I don't know -- while he was firing a gas-powered shot gun which pins the track to the concrete slab. The gun misfired. Fintan then tried this again, and this time the gun fired and sent a shock wave through him and that is when he felt like a pop in his back.

Q Okay. And does that note go on to describe the complaints he's having at that point?

A It does.

Q Can you please read that.

A Sure, yeah. So Fin thought this was no more than just a pulled muscle and he continued to work. Fintan says that it wasn't until he stopped moving and cooled down for a bit that it became apparent to him that something was wrong. Fintan said this is when he began to feel a sharp pain in his lower back. Getting out of his car once he got home caused him a lot of pain, and getting up from the couch after resting caused such severe low back pain that he fell to his knees. The pain is radiating down to his right buttock. Fintan relays that lying down makes the symptoms better, whereas movement made the

symptoms worse.

Q In terms of that history as to how the incident occurred, is that consistent with what Mr. McKenna told you at his first visit with you?

A Yes.

Q Okay. And from a clinical standpoint, as a spine surgeon, those complaints that he's making, what is the clinical significance of that?

A You know, I mean, it sounds very much like an acute disc herniation with an associated radiculopathy. It's that nerve pain we talked about earlier.

Q And did Dr. Donath send Mr. McKenna for an MRI?

A Yeah, I believe he did. He saw him a couple of times.

Q Well, when Mr. McKenna appeared in your office for the first time, did he bring with him an MRI?

A Yes, he did.

Q Okay. Can you tell us, what is an MRI?

A An MRI is a magnetic resonance imaging. It basically uses magnetic fields to excite molecules in the body, which then put off little radio waves which are picked up by detectors. Basically, it's a way of performing, you know, very high-resolution noninvasive imaging, getting a good idea of what's inside people in a 3D way.

So, you know, an X-ray may give you basically an idea of the bones and dense tissues, but it's only kind of a one --

you only get a 2D image.

An MRI will provide a whole 3D scan. You can go through each layer of the tissues.

Q Okay. Thank you.

We'll come back to that MRI in a moment.

Just moving forward to your first visit with Mr. McKenna's first visit with you. What did you do for him?

A Initially, I think we provided him with some physical therapy and did some anti-inflammatories. And I recommended -- either with the first visit or the second visit, I recommended an epidural injection for him because he was in severe pain, and that wasn't something he really wanted to do at the time.

Q Just as a reminder, if you need to refresh or refer to any of your records, feel free.

A Thank you.

Q Did you take a history from Mr. McKenna at the first visit?

A I did.

Q What is a history?

A A history is basically just getting the story from the patient, typically in their words, finding out, you know, what happened, how long have they had the pain, where is the pain, how bad is the pain. Yeah, and then basically going over their other medical issues, allergies, things like that, which may or may not be relevant.

Q Do you want to know if they have any pre-existing conditions?

A Yes, quite important, yes.

Q Why is that important?

A Well, you know, if they've had multiple back injuries in the past or had a prior back surgery, you know, you typically want to order different tests than somebody that has a fresh injury. Yeah, I mean a variety of different medical issues can affect things in different ways. You want to make sure you're treating the patient appropriately.

Q Did Mr. McKenna have any pre-existing conditions prior to the date of this incident?

A He did not. I don't think he had any significant issue of back pain or any issues.

Q And is that significant?

A Yeah, I think so. I mean, certainly we treat a fresh acute injury different than somebody who has chronic pain and long-term issues, sure.

Q Did you perform an exam of Mr. McKenna the first visit?

A I did.

Q And can you describe the type of exam that was performed?

A Yeah. So I performed basically an evaluation of the patient; inspect them, watching them walk, performing range-of-motion testing.

And then specifically for the low back, we'll look at strength testing in the lower extremities. So, is there a weakness? Does he have pinching of a nerve and that nerve is not functioning properly? Typically, you'll have weakness in certain muscle groups, and then areas of numbness, tingling, different sensation changes which often correlate depending on which nerves in the spine are getting pinched.

Q Can you tell us a little bit more about that. The phrase dermatomal pattern, what is that?

A Yes. So the dermatomal pattern is basically, as I said, each nerve in the spine, each nerve root, typically -- some variety -- but typically goes to a pretty consistent part of the legs and the low back, for instance. So numbness in the big toe, top of the foot, maybe the front side of the shin, is very classically an L5 dermatomal distribution. Derm means the skin. That's where the nerve goes to the skin. You know, you can get a pretty good idea where an issue may be based on that examination.

Q And the exam on April 26, 2019 with Mr. McKenna, what was the results of your exam?

A Yeah, so he had -- he had -- let me see exactly. Predominantly left bilateral EHL weakness, extensor hallucis longus. That's the muscle that pulls up the big toe.

Let me read it verbatim here. Okay. So just to clarify my earlier point, this was April 26 of 2019.

So on my examination, he had what we call a Lasegue positive sign. That's basically pushing down on the shoulders or putting some compression over the spine and basically seeing if you could kind of bulge that disc out a little bit; and if that reproduces the pain, it's very suggestive, if not diagnostic, of a nerve compression typically from a herniated disc. And so that was markedly positive on the left side.

And weakness in his anterior tibialis muscle; that's the muscle that pulls up the feet.

Weakness in the extensor hallucis longus. As I said, that's the muscle that pulls up the big toe.

He had paresthesias, meaning numbness on the lateral thigh, shin, the top of the foot.

And then normal reflexes.

Q And based on the initial complaints he makes to you and the results of those -- of that exam, what is the clinical significance for you as a spine surgeon?

A Well, he's got, you know, weakness and dysfunction of the nerves leaving his low back and going down his legs. Depends on the severity, how long they've had it, how bad it is. I mean, if it's something he can tolerate, we'll typically watch it, see if it does get better. If it is absolutely searing, nightmare pain, often we'll proceed with surgery or an injection or something like that to get the patient comfortable.

Q And at that visit did he describe to you the pain he

was feeling in relation to his lower back?

A Yeah. I mean, I remember he was pretty, pretty miserable. Yeah, actually, I don't think I graded it, but yeah, no, I remember him being in a lot of pain.

Q And as a result of all of that, did you recommend a course of treatment for Mr. McKenna?

A Yeah. So on that first -- sorry.

I offered him an epidural injection. He wasn't particularly interested in that, I mean, somewhat understandably. And basically, as chiropractic and physical therapy weren't working, I basically talked to him about potential surgery, and I recommended we get an updated MRI to see, you know, if it had changed in any way.

Q Okay. Now, just briefly, what is an epidural injection?

A Yeah. So, well, I have a model here -- or I have an actual spinal needle here (indicating). An epidural injection -- dura means the tissues around the spinal cord and nerves. So you've probably heard the term in the context of like a pregnancy or something. So, you know, if a patient is delivering a baby they will often -- let me show this without poking myself.

So this is a basic spinal needle, and it will be inserted into the back into this epidural space (indicating). And, basically, if you put it in the center here, you can numb

up all the nerves. Depending on the medication and the dosing, you can totally knock them all out, so say if you want to deliver a baby. Or in this case, you can put them right by a nerve root, and if a nerve root is getting pinched by a bulging disc the epidural won't help that, it won't fix the bulging disc rather, but it can calm down the nerve.

Basically, you can inject a pretty high dose of steroids right to where it needs to go to calm down the nerves. The amount of medications you need to take by mouth, you can imagine if some fraction or some percent goes where it needs to go, and the rest just goes around the body. If you do an epidural, you can deliver it exactly where it needs to go and not anywhere else.

So it is a good option for something like this. It's also terrifying. And it's not something people typically go to sleep for. And, I mean, I'm sure we'll get to it, but in his case he had such a large herniation as well that I didn't really think it was going to offer much really, at least not in the long term.

Q Getting to that, Doctor, at that first visit you mentioned you reviewed an MRI he had underwent, correct?

A Yes.

Q As part of your practice do you regularly review MRI films?

A Yeah, virtually always, yes.

Q How often would you review them?

A I mean, I personally review the reports and the actual images of every MRI that I -- at least that I order.

Q Would you have provided a patient of yours with a clinical diagnosis without personally reviewing the MRI films if they're available?

A Yeah. I mean, so again, it depends on the diagnosis. Certainly, if somebody comes in with some back pain and we don't have an MRI, then I'll diagnose with back pain. But in order to give any kind of diagnosis, like a herniated disc or radiculopathy or something like that, we virtually always have an MRI to review.

Q Do you treat patients solely on what an MRI shows?

A No, no. I mean, I guess it sounds kind of tacky, but we treat the patients, not the images. So, you know, I mean, I'm not -- in his case, I mean, it was such a large herniation that, you know, it was pretty clear what's going on.

But there are situations where people have, you know, some things and maybe they're symptomatic and maybe they're not. So some patients got a little, you know, small bulge in a disc but they don't have pain. I mean, that would be crazy then to operate on them.

Q And have you selected an image from that February 6, 2019 MRI to show to the jury?

A Yeah, I did. I think there's a screenshot somewhere.

Q Would that image assist you in explaining the MRI image of Mr. McKenna on that date?

A I think so.

MR. MOORE: Your Honor, at this point I would just like to show Dr. Roberts what has been marked for identification as Exhibit 10.

THE COURT: Okay.

MR. FALEY: Which date is it?

MR. MOORE: February 6, 2019.

Is this okay here, your Honor?

THE COURT: Yes.

MR. MOORE: Can everybody see it?

MR. FALEY: Judge, is it okay if I move a little bit over there?

THE COURT: Yeah, sure.

THE WITNESS: Do you want me to come down there?

THE COURT: Can you see it, Doctor?

MR. MOORE: With your Honor's permission, can the witness step down to describe to the jury what we're looking at.

A So this is the MRI image from February 6 of 2019.

MR. FALEY: Excuse me, Judge. Can I go up there?

THE COURT: Yeah, yeah, sure.

MR. FALEY: Thank you. Thanks. Okay.

A So this image here is what we call a sagittal image,

meaning it's basically a cut down the center of the patient (indicating). His head is up here. He's facing toward me. Buttocks are here, legs are below.

The squares here are the bones in the back and in between are the discs of the spine (indicating). This is the L5-S1 disc, and you can fairly clearly see, I think, that it's quite different to the others. So it's basically narrowed down a little bit compared to all of these.

And this kind of white area back here is the spinal cord and the nerves running down behind the spine. And it all looks pretty good and open till you get to here (indicating), and you can see this big herniation here, meaning a chunk of the disc has gone loose and squirted out into the spinal canal and it's pinching the nerves as they go by. This is actually that L5 root there that's getting pinched on by this herniated disc.

This picture is what we call an axial cut, meaning it's kind of like I cut the patient up like a salami, and we're looking at different slices (indicating). So this picture here is a slice right through this L5 disc. And there's a lot going, on but, basically, this kidney-shaped thing here is the disc at this level. And this kind of white triangle back here is the spinal canal where the nerve sac is and all of the spinal roots. And then on this side and on this side are where those nerve roots are exiting the spine and going down the legs (indicating).

And I should have provided a normal example. But, basically, this space here should be open, and this scale should be basically the size of my index finger, and it's not. There's this big bulging disc here, herniated disc here (indicating). And especially here as you get to the right side, there's this big chunk of disc that's sitting right in the canal, and the nerves on both the left and the right are getting pinched, but especially on this right side here.

Q Thank you, Doctor.

Now, Doctor, looking at the -- you said it was the axial image.

A Yes, sir.

Q We see different colors within the disc. Can you explain what we are looking at?

A Yeah, absolutely. So the normal disc should be -- at this level should be kind of this kind of darker gray. But on this particular MRI sequence, anything that's got a lot of what we call edema or inflammation, basically anything has a lot of water content is going to glow a bright white. And so all of the spinal fluid here is obviously bright white. Some of the fluid in the pelvis is white.

But what I think is helpful here is that basically this disc herniation here has quite a bit of edema around it. It's inflamed. And typically we see that in what we call a subacute injury, so typically within about three months or so of getting

the images. And so, you know, this suggests -- I mean, it doesn't suggest. It shows a fairly acute herniation here, something that's relatively fresh.

Q Now, Doctor, just in terms of MRIs, can you timestamp an injury from looking at an MRI?

A You can't -- no. I mean, you can't get an idea of, hey, that's exactly three and a half weeks old. As I said, I mean, edema here and things like that will be very suggestive of a fresh injury or at least a very recent exacerbation of an injury. You know, and there are changes you can see, you know, that a process has been going on for ten years kind of thing. But, generally speaking, no, you can't tell exactly when something occurred.

Q Looking at that MRI, do you see processes that's going on for ten years in Mr. McKenna's lower back?

A No, sir. I mean, this looks pretty fresh to me. As I said, a lot of edema here. This is a fresh injury. This thing popped out recently.

You know, I mean, for example, like all of these discs look great. These are healthy, normal discs. One at the bottom is just really badly injured.

So, you know, if we're distinguishing between something that's, let's say, degenerative, and the patient is 70 years old, wearing down their spine their whole lives, all the levels are going to show various degrees of wear and tear, maybe in

different stages.

But if you see a young -- I think he was like 33 at the time -- patient with healthy, perfectly normal discs, and one disc that recently looks terrible, that's an injury.

Q Okay. And in terms of what we're seeing on this MRI, does that correlate with the complaints that Mr. McKenna is making initially following the incident and to you in April of 2019?

A Yeah. I mean, he has a pretty textbook presentation. He felt a pop, sudden back pain, and then searing leg pain. I mean, that's a classic example of an acute herniation.

Q Okay. Doctor, I want you to assume that we expect that the defendants are going to bring in a radiologist, and the radiologist's opinion is that there's no edema and no swelling, no injury to the soft tissues in this initial MRI of February the 6th of 2019.

Do you have an opinion as to that?

A Yeah. I mean, I respectfully but thoroughly disagree with that.

Q Why?

A I mean, you can see the edema here (indicating). I looked at all these images. I read all the reports. And the benefit of looking at the images and a lot of people going in and seeing what it actually looks like with my own eyes, and this again looks pretty textbook for an acute injury.

Q Just one thing you mentioned there. Who has a better vantage point when it comes to viewing an injury, a radiologist or a doctor reviewing an MRI film, or a surgeon who actually goes in and operates on the body part?

A Well, I would -- certainly, radiologists have their value and, you know, they're some very, very smart people. I think, you know, in terms of picking up tumors and things like that, a radiologist -- you know, I would never assume to do any of that better than they do.

I would say that, you know, somebody who predominantly treats disc injuries, you know, it's something that I look at all the time, and then have the added benefits -- well, two benefits I would say over radiologists.

One, getting to talk to the patient and correlating what I'm seeing with what they're telling me.

And then, two, actually, on some of them going in an seeing what it actually looks like.

Q Okay. Thank you, Doctor.

A Sure.

MR. MOORE: I think that's it with regard to the MRI image for now.

THE COURT: So can we take the stand?

MR. MOORE: Yeah. Thank you, Doctor.

I'm just going to move this.

COURT OFFICER: Just take it off.

MR. MOORE: Thank you, Officer.

Q Okay. Doctor, you see Mr. McKenna in April 2019. When do you see him next?

A I believe I saw him in May, I believe a couple of months later or a month later. April 19th, and I saw him May 31st.

Q Okay. And that exam, can you tell us what happened.

A He returned with severe ongoing symptoms, especially worsening on the right side. It's now about three, four months of it. The pain was basically shifting from the left, which was initially worse, to also involve the right side. At that point he had tried chiropractic manipulation, yoga, home exercise therapist, physical therapy, anti-inflammatories, none of which really offered much relief.

And, well, actually, that was the visit where I said we still need that new MRI. So I think he came back after that with a new MRI, and that was basically when we made the decision to just perform a discectomy and get that thing out of there.

Q Did he get the repeat MRI?

A He did.

Q Did you review the MRI images yourself?

A I did.

Q Did they confirm the complaints that Mr. McKenna was having and the diagnosis that you had earlier provided?

A Yes, yeah. I mean, he still had that large herniation

there. It wasn't as inflamed as it was when I first saw him, but it was still there, still pinching the nerves, and basically said, okay, let's just go do the discectomy procedure.

Q Got it.

Doctor, just to assist making it more efficient, there's a lot of visits, so I'm going to jump and maybe skip a few.

A Sure.

Q But just with regard to you see him September 19, 2019, correct, just before your surgery, before the surgery?

A Yeah, September 19, 2019, yes.

Q At that point do you discuss the surgical options available?

A I did, yes.

Q And did you discuss with him the option of undergoing a fusion as opposed to the discectomy?

A I did. So I mean, ultimately, you know, I'm trying to do the minimum amount of surgery, especially on a young active person. I want to do the minimum amount of surgery necessary to get his symptoms better.

Obviously, I showed you the disc was pretty badly injured. And so any time we start seeing the disc collapse and large parts of the disc come out, I'm always thinking in the back of my head, hey, is this going to need a fusion? Because once that disc is popped, for lack of a better term, once that

shell around it tears out, and the disc material keeps working its way out, the disc is typically eventually going to collapse, and indeed that's what's happening for him.

So, you know, in an effort to do the minimum amount of surgery necessary to get him good relief, basically said, all right, let's do a laminectomy -- and I'll go over that, I guess, in a little bit -- and then do a discectomy, take out the portion of the disc that's bulging, and leave the rest of it, and that's what we ultimately ended up doing.

Q When was the surgery?

A The surgery was November 13th of 2019.

Q And just we'll get to the surgery in a moment.

You see Mr. McKenna for a preop appointment on November 5th of 2019?

A That's correct.

Q Okay. And at that point there is talk about your opinion as to his ability to do heavy labor; do you see that?

A Oh, yeah, okay. Yes. I said based on this patient's history and clinical evaluation, the current problem is causally related to the accident. The patient is a hundred percent temporarily disabled. Typo here. But I said, basically, he's been with this pain and injury since January of 2019. I anticipate at least three months out of work for recovery from this procedure. The patient should plan accordingly. In the future I have advised him strongly against heavy labor.

Q Why is that?

A Well, you know, as I said, that disc was badly injured. I mean, it was continuing to collapse. And yeah, and I -- you know, heavy labor, a lot of bending, squatting, lifting, twisting, all day on your feet, is really not great. It's not good for anybody's back.

But if you've got a bad injury like that, it's really not good. And especially if you're not doing a fusion and you are leaving that disc intact, or you want to preserve whatever is left of that disc, you really want the patient to avoid anything that's going to potentially further injury.

Q Okay. And the surgery you said was November 13th, 2019?

A Yes, sir.

Q Okay. Doctor, we have a MediVisual in relation to that surgery. It's going to be Exhibit 11.

MR. FALEY: That's fine.

Q Doctor, this MediVisual, the portions that's shown, does it fairly and accurately depict the kinds of surgery you performed on Mr. McKenna in November 2019?

A Yeah. Yeah, it looks pretty accurate. It's pretty good. Pretty good image.

Q Would this demonstrative aid assist you in describing the procedure to the jury?

A Yeah, I think so.

MR. MOORE: With your Honor's permission, could the witness please step down and just explain to the jury?

THE COURT: You may, Doctor.

A Yeah, okay. So, basically, the patient comes in the operating room, gets a breathing tube, is basically paralyzed with some anesthetic agents so they don't move. They're flipped forward onto their front in what we call a Superman position with their arms up.

We then typically use X-ray to identify exactly the best place to put a small incision, typically one, one and a half inches over the area, and an incision is made.

And using cautery and different blades, we'll dissect down through the skin layer, the fat layer, a number of blood vessels, cut into the fascia, which is kind of like this thick coating around the muscles. And then we cut through the muscles and release them and then put some, basically, retractors in which kind of crank open, and then you can get down to the bones of the spine.

So am I allowed to grab a model?

MR. MOORE: With your Honor's permission.

THE COURT: Yes.

A So, basically, once we expose these, take an X-ray, make sure again we're in the right spot, and then basically remove a portion of the lamina. The lamina is basically what we call the roof of the spine. It's this bit of the back that

protects the spinal cord and the nerves, and it provides some places for muscles to attach, but it's not a major structural part of the spine, so you can remove it, you know, without too much future issues.

So, basically removed the lamina at the bottom of the L5 level and the top of the S1 level to get into the disc space. And when you do that, you remove some extra ligaments and some blood vessels around there, and then you expose the nerve sac here, and that's basically where the spinal cord ends here, and then the nerves are coming down (indicating). And then at each side there's these roots that come off. And then right behind here is the disc.

So after we expose this, we'll gently, very gently, pull this nerve sac just to the side without, you know, tugging or damaging the nerves, and when we do that it allows us to expose, basically to get in here and expose that bulging disc, if I can show that.

So once that happens, typically we'll use different graspers and tools to kind of loosen this lump of herniated disc, loosen it up and get it out of there so it's no longer pushing on the nerves.

And then this is basically a picture where you're looking at the spine like this, and you can see this is the disc here (indicating). There's a shell around it, and then this is kind of the jelly part of the jelly doughnut. This part is kind

of squirting out.

And with the nerves pulled to the side you can basically pull that material out and free up the nerves. And then when we pulled out enough, you can see here, basically, that the nerves are relatively free.

Here's where the lamina has been removed, and then you can, you know, clean everything out, put some antibiotic stuff in, make sure nothing is bleeding, and then you close the spine in layers, bringing the fascia, the muscle back together, the subdermis under the skin, the fat layer and the skin layer (indicating).

That was what we did for Mr. McKenna.

Q Thank you, Doctor.

A Sure.

THE COURT: Thank you. You may retake the stand.

Q Just in relation to the surgery you just described, where was this performed, Doctor?

A I think this was at NYU.

Q Okay. And was Mr. McKenna admitted?

A Yes, I believe so.

Q Okay. And in relation to this type of surgery, what are your expectations regarding recovery?

A It highly varies for sure. Typically, the patients will have some relief in nerve pain pretty quickly. Back pain, much less predictable. You know, certainly, there's the pain at

the cut and, you know, removing the bone, and that's going to ache for six weeks, three months, that kind of thing.

If everything goes ideally, you know, the nerve pain should go away, and maybe the patient has some back pain from time to time, but it's not terrible.

In a certain number of cases, especially when the disc is badly injured, as his is, you know, you will get new herniations. And, unfortunately, you know, once that -- again, that shell around the disc is injured, you know, it's very common for new pieces of disc to eventually work their way out, and, you know, in this case that's what, you know, I'm sure we'll get to. But that's what's going on. That's what I've talked to him for the past few years about.

Q In terms of the instructions you gave Mr. McKenna upon discharge, what did you tell him?

A Yeah. So certainly, I wanted him to take his pain medications, get plenty of rest, plenty of fluids. I want him to avoid deep bending, twisting. You know, the worst thing you can do is lean all the way forward and pick up a heavy weight, right, because that's exactly how you can basically squeeze out a new chunk of disc.

And, certainly, in the first six weeks or so, three months after surgery, this area is still raw. It's not sealed over, and so you've got a hole here that's just ready for a new piece to come out. So that patients that are much less well

behaved than he is, who went to the gym right after and called me three days later and they're like in a ton of pain because they just squirted out a new piece. He was pretty good but you know, as I said, eventually a new disc did work its way out.

Q In terms of the treatment plan you started for him from first seeing him, up to the present day, has he followed your instructions with what you have prescribed for him?

A Yeah, he has. He's pretty compliant.

Q What we'll do, Doctor is jump forward. We'll go to June of 2020.

A Okay.

Q And just to be clear, you have seen him in between the surgery and this visit, correct?

A Yes, sir. Yeah, that looks to be maybe five visits in between.

Q June of 2020, how is Mr. McKenna doing?

A Patient seven months status post microdiscectomy, doing well overall, has ongoing back pain but improving. He states that he feels sore after exercising, walking, and he has postsurgical myalgias, which is a fancy way of saying muscle aches after surgery.

He had actually had several flare-ups, basically where those nerves got irritated, and some of that radicular leg pain had come back, but I did note, at least as of that visit right there and then, it had gone away.

And then he had one flare-up I noted over that previous weekend where he had intolerable pain in his thoracic spine, his low back as well. But I think when I saw him by that -- whatever weekday that was that it had gotten better.

Q Did you do range-of-motion testing of Mr. McKenna at that visit?

A I did, yes.

Q And what is range-of-motion testing?

A Range-of-motion testing is basically either actively, meaning you'll kind of move the patient, or passively, meaning you'll let them do it -- sorry -- actively, letting them do it, and passively, telling them to kind of go limp and then you kind of move them. But, basically, you want to see how the spine moves. Are there any blocks to motion? Is there too much motion or is it really stiff? That kind of stuff.

Q And what were the results of Mr. McKenna's range-of-motion testing at this visit?

A Pretty significantly decreased. You know, for example, Flexion I measured at 30 degrees; normal is about 60. Extension I measured 20; normal is about 45. Right and left rotation were 20 and 15 degrees respectively; normal being about 80. And left lateral flexion, leaning to the side, right lateral flexion is 15 and 20 respectively; normal is about 45. So pretty significantly limited.

Q And what's the clinical significance of that seven

months post surgery?

A Well, I mean, ideally, you know, I would like that to be better than it was. But, you know, it indicates ongoing stiffness, certainly what we call guarding; meaning, he knows probably subconsciously at this point if he moves in a certain way he's going to pinch those nerves, so he's probably not even going to let himself do it. That leads to a lot of spasms, muscle tightness, where the muscles are involuntarily tight because you're trying to limit anything that's going to cause that lightning bolt of pain.

Q And do you recommend a prescription for any pain medication at that visit?

A I gave him a steroid pack at that point, so a five-day course of a pretty high dose of oral steroids, yeah. Try not to do it for too long because it comes with lots of side effects. But if somebody is miserable I will give it to them.

Q And he returns to you about a month later, six weeks later?

A Yeah, July 22nd.

Q Okay. And does he complain to you about his pain levels at that visit?

A Yeah. So he felt like he was doing worse. He described a trip where he went to Pennsylvania and had a severe increase in his back pain and he had to get out of his car and lie down. And that was resulting in back pain and pain

basically shooting into the buttock area on both sides, which at that point I think was pretty persistent.

Q At that point do you recommend that he undergoes another MRI?

A Yeah, I think I did at that point. Let me see. Sorry. Yeah, I said at this time the patient has severe new onset pain which is not responding to six-week course of anti-inflammatories. Hadn't responded to the steroids. And I said, therefore, I wish to get a new MRI. We'll see him back when the results are available.

Q And does he return, after he has that MRI, for review with you?

A He did. Let me see. Yeah, I V saw him on August 20th, yeah, and still is having severe pain. So I said his pain is still involving his bilateral buttocks and then radiating out of his posterior thighs, so the backs of his thighs.

Q And at that visit you reviewed the MRI from August 5th?

A Yes, sir. So I had the August 5th MRI, and it demonstrates substantial what we call black disc disease. Meaning on the MRI, you know, that previous white region within the disc is now basically a dark color, and that indicates it's completely lost its water content it's dried out. It's hardened, scarred, basically, no longer acting like a nice cushion between the bones, and it's basically sagging or collapsing down.

And then I noted that there is, you know, a new broad-based right-sided paracentral herniation, so more on the right than the left, just off the center, which is extending from the lateral recess on the left. So basically right where the nerves start to come out on the left, all the way over to where the nerves exit on the right, and I said there's multiple nerves being compressed.

Q And to you as a spinal surgeon, what's the clinical significance of observing all of that?

A Yeah, I mean, look, it sounds like a fairly significant chunk of disc had works its way back out. You know, there was very little disc left in the disc space at that point because most of it had already herniated or cut loose, and it was large enough that it was pinching at this point multiple nerve roots in the area.

Q Okay. At this visit you recommend an epidural injection?

A Yeah. Hold on. I lost my page here. Yes, yes, I did. An epidural injection bilateral. So one on each side at that L5-S1 level, same level.

Q Why are you recommending an epidural at this stage?

A Well, I mean, at this point he's pretty miserable. He had pain that seemed pretty consistently every time I saw him was getting worse and worse. A relatively large disc herniation; there were multiple nerves being compressed.

I even said, hey, you know, at this point he's a candidate for another surgery, and not just another discectomy, but an actual fusion removing the whole disc so it doesn't happen again. I know for a fact he's not keen on that, which is very understandable, and so I said, okay, next best thing is the injection.

Q Just briefly, Doctor, can you explain for the jury in terms of this fusion surgery what is involved?

A Yeah. So there's two different ways to approach or two main ways to treat a disc herniation like that. And, obviously, it depends on a number of different factors. But you can do what we call a decompression surgery. So that's some variation of what we did on him, where you're going in and making room for the nerves so they don't get pinched.

You can either just do a laminectomy, where you basically remove the bone here, so the nerves can float free. You can remove some of the disc. There's a number of different ways to do it. But you're basically not removing anything structural from the spine. That way the patient, at least in theory, should retain some motion and, you know, most of the time heals okay and people live a pretty normal life.

When the disc is really badly injured or so much disc that's comes out that it's no longer acting like a nice normal cushion and it's not really moving properly, then we will do something called a fusion which, you know, frankly, it's a great

surgery for the right person, but it's a lot to go through.

So, in addition to doing basically what we did for Mr. McKenna, you're also putting implants in the spine. So you're basically immobilizing the bone above and below the disc, and then in some way stimulating these bones to heal together.

This is an example of what we call TLIF, T-L-I-F; it stands for transforaminal lumbar interbody fusion. And, basically, it means pulling the nerves aside, entering this disc space like we did, but instead of removing the bit that's loose, removing all the disc material and then putting some sort of spacer in.

In this model, the one that I've been using, it looks like a mini car jack. It's made of titanium. It goes in small between the bones, and you crank it open and it gets the disc space open. We then put bone graft either from the patient's own bone, cadaver bone or some sort of synthetic material in between the bones, which is going to stimulate bone growth.

It's basically like if you broke your leg, it goes into a cast, you hold it still for six weeks, the bones heal together and you can take it off.

You know, back before we had good screws we would literally do this and put a patient in a body cast for three months, which is torture. And then somebody figured out how to put, you know, safe screws in the spine. So now, basically, instead of doing that part, we'll put the screws into the bones,

and then they attach with the rods and that locks everything together, so the patient can get up, get moving right away while this level is held still, and it will heal together over the next three to six months and basically becomes one solid bone.

After that if the screws want to come out or you don't need them anymore, but most of the time you leave them because no one wants to get cut again.

But that is basically in a nutshell the fusion procedure, and the benefits of it mean that no more disc can come loose.

Now, downsides are not insignificant. You would lose complete motion of this level. And it can lead to the other levels above and below having to overcompensate and then wearing out with time. Not to mention it hurts a lot more.

Q What you just mentioned there moments ago, Doctor, in terms of levels above and below, is there a specific term for that?

A Yes. So that's referred to as adjacent segment disease; meaning, the segment or level of the spine next-door to where you worked is breaking down rapidly.

Q And Doctor, as you sit here today, do you have an opinion to a reasonable degree of medical certainty as to whether Mr. McKenna will require a fusion surgery in the future?

A Yeah. I mean, I've been talking about two or three years now, close to a hundred percent certainty that he will

need it. Not an emergency, but I would say within the next year or so.

Q Now, Doctor, do you know if Mr. McKenna underwent that epidural injection that you recommended?

A I believe he did, yes.

Q And do you know with whom he underwent that injection?

A Yeah. He ended up getting a number of them, I believe, but the first epidural I think was with John Akhnoukh. That's A-K-H-N-O-U-K-H.

Q And who is Dr. John Akhnoukh?

A He's a pain management physician. He was affiliated with our group. He went on to do his own thing. He's excellent. He's a good doctor.

Q If you know, did the epidural injection provide relief to Mr. McKenna?

A Yeah. I mean, I think it gave him some relief temporarily. I mean, obviously, I saw him another ten times or so, so it wasn't perfect, but -- and I think he had another one. But no, it didn't offer sustained relief.

Q Okay. Doctor, if you don't mind, we're going to move forward to January of 2021. You see Mr. McKenna on January the 21st.

A I have one from January 27th, 2021.

Q If it is January 27th I'll go with that.

A Okay.

Q We're now nearly two years post incident. How is Mr. McKenna doing?

A So he's over a year status post his surgery. He's continuing with physical therapy, but he's running out of sessions; I guess being approved by the insurance. Still having increases in back pain. He's had increased pain in his back in his buttocks and was radiating to his thighs. He was taking muscle relaxers. He was taking anti-inflammatories. Yeah, pain was persistent. It wasn't getting better.

Q At this visit does Mr. McKenna discuss with you his desire to return to work?

A He did, yes. And I basically said he remained a hundred percent temporarily totally disabled for the job he had. He's been out of work with his injuries since January 2019, but he may return to work, and he's aware of his weight restrictions of no more than 20 pounds.

Q Okay. And Doctor, when you made that recommendation that he's a hundred percent disabled from the job he had, that opinion, does that -- is that still true today or has it changed?

A No, I believe that's the same. Yeah, I mean, I really don't want him, you know, in his current state lifting heavy weights, bending, squatting, putting nail guns in the air. I think that would be bad for him.

Q Now, at that point Mr. McKenna returns to work. When

does he next see you, Doctor?

A I saw him in June, June 16th. So about six months later.

Q And Doctor, at that visit do you recommend he get a sacroiliac joint injection?

A Yeah, I think that was recommended by Dr. Akhnoukh, and I, you know, I defer to Dr. Akhnoukh and agreed. I thought that might be helpful, hoped it would be helpful.

Q What is a sacroiliac joint injection?

A Yeah. So, basically, it's similar to the epidural injection, but instead of going into the space around the nerves it's placed in what we call a sacroiliac or SI joint, and that's -- I don't know if we have -- we don't have a picture of it.

But, basically, that's the joint of where the sacrum, or the lowest part of the spine, attaches to the pelvis, and it can be inflamed. Especially when patients have a lot of stiffness and they're guarding from a spinal injury, they'll end up exacerbating or, you know, basically overloading those sacroiliac joints as well. So it's pretty common to see that in conjunction to the disc herniations.

Q Okay. And the purpose of that, is that therapeutic, is it diagnostic or is it both?

A In this case I certainly think it is both.

So, basically, when you do these injections, you'll do a strong steroid, but you'll also mix it with a local

anesthetic, kind of like the Novocain you get from a dentist; that's real effective at blocking pain, but only lasts eight, ten hours, something like that. So we always tell the patient when we are doing this, you know, it's going to take a few days for the steroid to kick in and really give you some relief, but the local anesthetic should kick in right away.

So if the patient gets good relief even for, like, the first few hours, again, you get a good idea that, hey, we found the spot. Now maybe the steroid is not strong enough. Maybe the issue is too bad and not going to get better with the injection. But if you do have a good response even for a brief period, it helps you figure out where the issue is coming from.

Q And you continue seeing Mr. McKenna. I'm just going to ask you, Doctor, to fast forward to September of 2022.

A Okay.

Q What are Mr. McKenna's complaints at this visit?

A He's approximately two and a half years status post discectomy procedure in 2019. Despite extensive conservative therapy, including physical therapy, pain management, multiple injections, his symptoms continue to worsen. He was no longer seeing Dr. Akhnoukh, I think because that doctor had left our group at that point. Pain is ten out of ten. States it's progressive. It's an ache that's constant. Dull ache in his back. He's having still frequent flare-ups of the pain periodically. He was taking muscle relaxers and

anti-inflammatories at that time without much success.

Q Okay. And if we can jump forward now, if we could go to June 26th of 2023. Let me assist you, Doctor. He goes for a pain management visit with Dr. Ventrudo and goes for an EMG.

What is an EMG?

A An EMG is an electromyography study, and basically you're putting little needles into different muscles of the arms or legs. And then depending on exactly what type it is, you could stimulate the nerves and basically fire a signal down the nerve and time it for the muscle to twitch; and if gets there late or it gets there weak, then you know there's some sort of blockage or issue along that nerve root. So it can be a way of diagnosing, hey, you know, that L5 root is not acting like it should be. You know, clearly there's something wrong, something blocking it, whether it's a disc or something like that affecting it along the way.

You can also use it to pick up other things like diabetic neuropathy and things like that that don't apply here.

Q Do you know what the result of Mr. McKenna's EMG test showed?

A You're going to have to give me a second. I'm sorry.

He had a right L4 radiculopathy.

Q What does that indicate?

A That indicates that actually above where the previous issue was, now it's not acting normal. So there's some sort of

blockage or something irritating the nerves, so the signals aren't getting through in a normal manner.

Q And to you as a spinal surgeon, what clinical significance is that?

A Well, I think, you know, with a condition of that L5-S1 disc, that I think it's extended so far lateral that, basically, even though the nerve exits at the level above -- so let's say this is the bottom level (indicating). This is his disc that's in here. This is the L4 nerve that's exiting over but it drapes down the side of the disc, and I think this disc herniation is now so big that it's also involving that L4 root.

Q Okay. Now, Doctor, you have sent Mr. McKenna for a number of MRIs to his lower back, correct?

A Yes.

Q Okay. And I'm not going to get you to go through them all. But most recently you sent him in July of this year for an MRI?

A Yeah.

MR. MOORE: And I am going to, with the Court's permission, just put that on the screen, your Honor?

THE COURT: Sure.

MR. MOORE: Your Honor, with the Court's permission, could I just get Sinead to assist me? She knows this better than I do.

THE COURT: Yes.

Q Okay. Now, Doctor, the image that I'm showing you right now, is this an image that you have selected from the MRI film that you reviewed of Mr. McKenna of July the 28th of 2025?

A That's correct, yeah.

MR. MOORE: Your Honor, with the Court's permission, could I just ask for the witness to step down just to explain what we're looking at?

THE COURT: You may.

A Okay. So, yeah, this is the July 28th, 2025 MRI. So basically the same thing. This is a slice down the middle of Mr. McKenna, and then this is a slice through this L5-S1 disc space (indicating).

But what I wanted to draw your attention to is that, you know, I measured the heights of each of these discs, which are all, up until here (indicating), within relatively normal range.

But you can see here this disc at the bottom is really getting very narrow, and that's basically because more and more of that disc material has worked its way out over the past few years. Now I'm measuring about 6.3 millimeters, whereas before, you know, this is fresh after his injury, we're measuring at 9.5. So it really is, you know, significantly collapsing, and he's getting close to having bone on bone grinding when there's no more disc or cartilage left between the bones, which, you know, is basically miserable.

And then this is just a demonstration showing the disc is still largely broadly herniated. Still quite a bit of narrowing. You can see where I basically removed that lamina, and, you know, the nerve sac is relatively free, but the disc is still bulging where the nerves come out.

Q What's the clinical significance of that decrease in the disc height at the L5-S1 level?

A Yeah. So you can see here this is again the demonstration of this ongoing black disc disease where basically the normal discs are kind of a light gray, almost look like a macaroon cookie. But down here, you know, very, very narrow, dark throughout, indicating it's lost all of that water content. It's no longer acting like a nice firm cushion between the bones.

And if I can just grab some models. Sorry. You can imagine that, again, as this disc deteriorates and shrinks down, the space available for the nerve here gets smaller and smaller and smaller even without the herniation. And so, you know, it's another example of -- or a good indication for why I think he does need that fusion surgery, because we need to get something in between the bones, like I demonstrated, to get that space open again, or it's just going to continue until it's bone grinding on bone, and as I said, that's really a major pain generator.

Q Thank you, Doctor.

A Sure.

Q Now, Doctor, just going back to March of 2025, did you see Mr. McKenna for the purposes of an exam?

A Yes, I did. I think I saw him March 21st, 2025. Let me see.

Q Okay.

A Yes.

Q And at that visit did you do an exam of Mr. McKenna?

A Sorry. These are getting longer and longer the more I see him.

Yes, I did.

Q Okay. And I just have some questions for you, Doctor.

You explained to us earlier what a prognosis is. What is your prognosis for Mr. McKenna?

A Well, I can see exactly what I wrote. I think I wrote it was guarded, meaning somewhat uncertain. I mean, not great in the sense that, again, I do think he needs that surgery, which, you know, is pretty invasive; and I won't lie, it's a lot to go through.

But I do think if he does eventually get it he will have significant improvements with it. He also has, you know, the risk of the other levels breaking down. I mean, frankly, he does have that risk whether we do the surgery or not, because that disc at the bottom is not moving anyway. So these levels are going to have to compensate anyway. So in that sense not

ideal. So I said guarded.

Q And Doctor, the next few questions I'm going to ask you are to a reasonable degree of medical certainty. Do you understand that?

A I do.

Q Okay. With regard to Mr. McKenna's condition, is that going to get better, get worse, or something else?

A Well, the natural history of his condition, meaning what happens statistically if we just leave it and let it go, is it will almost a hundred percent guaranteed get worse. Not overnight, but over the next few years.

Q And at the visit in March were you asked to provide an opinion as to the future medical care needs that Mr. McKenna will have?

A Yes, I was.

Q Okay. And to a reasonable degree of medical certainty, what was your opinion to his future medical care?

A Well, as I said, you know, I put that he -- I pretty bluntly put that he needs the surgery. He will need physical therapy with that. He would need MRIs. And then, you know, relatively routine checkups to make sure it heals properly. So yeah, I had detailed that in my note.

Q Okay. And if we can just go through those individually in relation to what the costs of those items are.

A Sure.

Q What is the cost of the surgery?

A $50,000 with the surgeon and assistant's fee. Not including the hospital or anesthesia fees.

Q And to a reasonable degree of medical certainty, do you know what the fees for the hospital and anesthesia are?

A Probably around probably 75 to 100,000, I would imagine. It depends.

Q And is Mr. McKenna going to need one more surgery or more than one?

A Well, he certainly needs at least one more. With adjacent segment disease which occurs, you know, up to 4 percent, 5 percent per year, compounded, you know, there's probably upwards of 50 percent chance or more of needing another surgery, you know, a decade later, let's say.

So, you know, in these situations, especially in a young, active 30-something-year-old gentleman, I would say it's pretty likely that he would need multiple spine surgeries over the next 50 years.

Q The cost of PT, did you give an opinion as to that?

A Yes. I put it as 375 a session.

Q Okay. And did you give an opinion as to how much PT he would need after the surgeries?

A Yeah. So I had one year following surgical intervention, and then up to three months a year for maintenance therapy.

Q How about orthopedic care?

A Three times -- so visits for about three times a year on average at 377 a session. Plus $200 for an X-ray to follow-up.

Q How many X-rays per year?

A That would be three X-rays a year.

Q For the rest of his life or for a certain time period?

A I mean, depends on how it's healing. I would say for the first five years. It's spread out. So in the beginning after surgery we're getting more, every two weeks, four weeks, kind of make sure everything is healing okay; and maybe every six months after a few years.

Q And MRI studies.

A Yeah, I think I put, you know, on average once a year, with contrast, without contrast.

Q The cost of those?

A 2,000 and 3,500, respectively.

Q And what is the basis for your opinion in relation to his future medical care needs?

A I'm sorry. I don't understand the question. I apologize.

Q When you provide those future medical care needs, what are you basing that on?

A Oh, I mean, you know, standard rates and basically, you know, what we would expect on an average patient, you know. I

mean, I've been following patients like this for a long time and know, you know, basic idea of how often we need to see them and what we're ordering on average, and I think these are consistent with that.

Q Got it. Now, Doctor, I want you to assume the following facts: A 31-year-old gentleman is injured on the job site January the 28th, 2019. He's using a gas-actuated nail guns that kicks back, sends a shock wave through his spine. He thinks initially it's a pulled muscle. When he wakens the next day, he realizes it's something more than that. He gets some physio, sees a chiropractor. Within three days he goes for an MRI.

The MRI shows injury to the discs in his lower back, primarily at the L4-L5, L5-S1 level, and he ultimately receives conservative care, treatment, chiropractic. When that doesn't resolve, he undergoes a decompressive laminectomy, microdiscectomy, and decompressive bilateral L5 foraminotomies. He undergoes epidural injections, trigger-point injections and sacroiliac injections.

Subsequent MRIs show black disc disease, and an EMG reveals bright L4 radiculopathy. He's also recommended for a fusion, a lower back fusion.

And further assume, Doctor, that prior to the date of this incident this gentleman never injured his back before and missed a day of work because of any injury.

Assuming shows facts, Doctor, do you have an opinion as to a reasonable degree of medical certainty whether Fintan McKenna sustained a traumatic injury to his lower back as a result of the January 28th, 2019 incident?

A Yes. I believe he had that injury, and I believe that injury in 2019 caused his back issue and the subsequent treatments and issues.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether that incident resulted in the need for him to undergo surgery in November of 2019?

A Yes.

Q Okay. And what is that opinion?

A Well, I believe that that injury injured the disc badly and necessitated eventually the surgery.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether all of the treatment he has received since the date of this incident is causally related to the January 28th, 2019 incident?

A Yes, I believe all of this is causally related to that accident.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether Mr. McKenna sustained a permanent injury on January 28, 2019?

A Yes. Unfortunately, I think these are permanent injuries at this point.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether Mr. McKenna is disabled as a result of the January 28th, 2019 incident?

A Yes, I think he is disabled and I think it is because of that accident, yes.

Q And when you say disabled, what degree of disability?

A Well, certainly a hundred percent disabled from his previous line of work, as I said. And, you know, I think he works as a project supervisor which, as long as he can tolerate that, that he should have some partial disability, but obviously some accommodations made.

Q Finally, Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether the injuries to Mr. McKenna's spine are caused by the construction incident on January the 28th of 2019 or they're just degenerative in nature?

A No, it's very clear to me that they are caused by that accident in January 2019.

MR. MOORE: I have no further questions at this moment for the witness. Thank you, Doctor.

THE WITNESS: Thank you.

MR. FALEY: Judge, I just want to ask a couple of questions and then we can take a break?

THE COURT: Oh, you want to ask him some questions and then take a break?

MR. FALEY: No, I'll ask a couple of questions now

before we break, is that all right, because I know we need a break, but I just wanted to ask four or five questions and then we can break. Can we do that?

THE COURT: Yeah, we can do that, sure.

CROSS-EXAMINATION

BY MR. FALEY:

Q Doctor, now you said everything and all the treatment that New York Spine has given the plaintiff is causally related to the accident, correct?

A Yes, sir.

Q Okay. So then why was he sent in 2024 for an EMG of his cervical spine when he had never said that was injured in his accident?

MR. MOORE: Just note my objection, your Honor.

THE COURT: Overruled.

Q Why?

A Yeah, I'm not -- I mean, he is complaining of some neck pain. I mean, you know, obviously it's something that I treat.

Q Right. Not related to the accident, correct?

A No, I don't --

Q Okay.

A Yeah. Sorry.

Q So not everything in there is related to the accident, correct?

A Well, certainly everything we talked about this morning

was.

Q Is everything in there in your record that you brought with you related to his accident, or are you treating him for other things as well? Correct?

A I mean, there was an offhanded comment about a neck issue, but we didn't discuss it today. I've never at one point said the neck is related to this case.

Q I understand that. But what you did say is everything that you treated him for was related to the accident. It's not, correct?

If you treated him for a back -- for the cervical, the neck, and he got an EMG, and you sent him for MRIs which showed herniated discs in his cervical neck, none of that is related to the accident, correct? Yes or no.

A Correct. The cervical spine is not related to the accident. I never claimed that, sir.

Q So any treatment, any MRIs would show five herniated discs in his cervical spine, and EMGs which show he has a radiculopathy because of these discs, that's not related to the accident? Yes or no.

MR. MOORE: Note my objection, your Honor.

Q Yes or no.

MR. MOORE: The neck is not even alleged.

Q Just yes or no. The question is --

MR. MOORE: Note my objection, your Honor.

THE COURT: It's overruled.

Q The question is: You had treated him for that and it's in your record, but it's not related to the accident? Yes or no.

A I'm not disagreeing with you, sir.

Q Okay.

A If a patient comes in and says I have chest pain, I can't be, like, oh, no, no, you didn't hurt your chest, we're not going to even talk about that. That's crazy.

Q No, no, no. I didn't say that.

You're saying that everything in there was related to the accident, but it's not. That's my point. Yes or no.

MR. MOORE: Just note my objection, your Honor.

Q Yes or no.

MR. MOORE: Everything that I asked him about --

THE COURT: Hold on, hold on, hold on. The reference to the cervical spine is in the records that are in evidence, correct?

MR. FALEY: Yes, your Honor.

MR. MOORE: Yes, but the question is related to what he has testified to. I never talked about the --

THE COURT: Go ahead.

Q So I know you're saying yes, but I just -- you're trying to say yes, but I need you to say yes if it's correct.

There are things in there, the treatment of the

cervical spine, the herniated -- the MRIs of the cervical spine, the EMGs of the cervical spine that are not related to the accident but are in your records. Just yes or no.

A Sir, I noted that the patient had an appendectomy, it had nothing to do with this, but I'm going to take care of the patient. But it's in my note and I think it's part of the patient history.

Q You don't have any records from the appendectomy, other than the plaintiff saying he had an appendectomy.

A Correct.

Q I'm talking about records.

A Yeah.

Q So let's do it again.

A In my note it says appendectomy, just like it says cervical spine, but it's not what I'm saying is associated with this.

Q Do you have an operative report from the appendectomy in there? Of course not, right?

A No.

Q But you have the MRI report of the cervical spine, you have an EMG report of the cervical spine, and you have notes about the cervical spine, and all that is not related to the accident but it's in your records. Just yes or no, Doctor.

A I really don't understand what you're getting at.

Q Okay. I will get there.

But I just want to know, are those records -- those records are -- those records are in your chart but have nothing to do with the plaintiff's injury on the day of the accident? Yes?

A I agree.

MR. FALEY: Okay. That's it, Judge, and I'll take a break.

THE COURT: Okay. Let's take a short break.

MR. MOORE: Thank you, your Honor.

COURT OFFICER: All rise.

(Whereupon, the jury exited the courtroom.)

THE COURT: Okay. We'll take like a five-minute break or so.

MR. MOORE: Thank you, your Honor.

MR. FALEY: Thank you, your Honor.

THE COURT: Doctor, you can step down.

THE WITNESS: Thank you.

(Whereupon, a recess was taken.)

THE COURT: Doctor, retake the stand.

(Whereupon, the witness resumed the witness stand.)

COURT OFFICER: All rise.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated.

Mr. Faley, you may continue with your cross-examination.

MR. FALEY: Thank you.

Q Dr. Roberts, in your direct testimony you had said that it was kind of surprising that someone of Mr. McKenna's age had a herniated disc, correct?

A Yeah, to the extent that it's injured, yeah. It looks --

Q Let me ask you again. Didn't you say that it was surprising that Mr. McKenna had a herniated disc for someone his age? Just yes or no.

A Yeah, I can't remember exactly what I said, but yes.

Q Okay. All right. So would it surprise you to know that he also had five herniated discs in his cervical spine, totally unrelated to the accident?

A Yeah, I mean, I didn't review that. I'd have to look at it again, but yeah.

Q Well, sometimes it may be surprising if someone has a herniated disc. It's also the case that depending on the person's activities, depending on the person's spinal canal, that that person can have herniated discs at a relatively young age. You've seen that, correct?

A I don't think that, you know, the canal morphology has anything to do with the discs, but --

Q I'm sorry?

A I don't think the canal morphology or the shape of the canal has any correlation on the discs.

Q Okay. Yes. But a person -- a person's condition, congenital condition, can just be that a person could be more susceptible to have herniated discs, correct?

A Yes.

Q Yeah, yeah. And if you couple that with, you know, maybe a lifestyle of construction, well, that also can result in someone having herniated discs at an earlier age, correct?

A Yes, especially if there's an injury.

Q Well, and even -- no, no. That's fine. And even if there's no injury, correct?

A I mean, you can have some disc pathology, sure, you know, wear and tear, yeah, but not to this extent is what I was trying to say.

Q Okay. I'll get there.

And that wear and tear, that results in a disc becoming desiccated, correct, one of the things, correct?

A Yes.

Q And a disc is 90 percent water, approximately?

A Yeah. It depends on the part, but yes, sure.

Q Okay. When I say -- what do you mean, "It depends on the part"?

A Well, the inner nucleus pulposus which probably has water content upwards of 90 percent.

Q That's what I'm talking about. The nucleus pulposus, that is the jelly within the doughnut?

A Yeah.

Q Yes, okay. Yes.

So that has 90 percent water?

A Yes.

Q Okay. And then with wear and tear it gets desiccated, which mean it gets dried out, correct?

A Yes.

Q Okay. And desiccated also means dehydrated? The water, again, evaporates, right, for lack of a better term?

A Yeah, sure. For the purpose of this discussion, sure.

Q Yes. Okay. All right. And what other -- what other wear and tear, degenerative findings do you see? And again, not in this case yet, but do you see when it comes to degeneration of discs. What do you see? What are, you know, the main things that determine that a disc, in your view, is degenerative?

A Yeah. So you'll get -- a common finding is osteophyte development or bone spurring. You know, typically, you'll see multiple discs with kind of various levels of wear, but it's generally kind of distributed throughout the spine. You can see associated facet arthropathy. You can see a variety of different changes.

Q You said arthropathy?

A Yes, sir.

Q Okay. Arthrop -- well, how do you spell it?

A A-R-T-H-R-O-P-A-T-H-Y.

Q Arthropathy. And what is arthropathy?

A Well, arthropathy just means pathology of a joint. It's a very grab-all term, a nonspecific term.

Q But it means some sort of wear and tear or degeneration?

A Well, it doesn't necessarily mean degeneration, but it can be seen in degeneration, yes.

Q Okay. All right. What's the facet?

A The facet is -- can I?

Q Sure, absolutely.

A Yeah, it's these little joints at the back of the spine, here and here, that kind of guide the motion of the back (indicating).

Q Okay. And what is facet arthropathy?

A Well, broadly speaking, it's any kind of injury or disease to these joints. You know, they can break down. There could be a cartilage tear. There can be narrowing. There can be instability. A number of different things.

Q And that's part of the wear and tear process, the degenerative process?

A It can be. It can also be from an injury.

Q And what other -- you said bone spurring and osteophytes. Now, that's bone formation within or around the disc?

A Yeah. So when there's prolonged inflammation it causes

the bone to react. And basically, you know, when the cartilage and the joint itself or the disc breaks down, the bone will grow. Basically it's trying to grow into the bone below it, which is what's happening in the lower back. And so you get bone spurs growing over, trying to basically grab the other side and hold together, what we call autofusion.

Q Right. So prolonged irritation can result in this bone growth that we are talking about?

A Prolonged?

Q Prolonged irritation or degeneration of a disc could result in this bone growth, correct?

A Yes. As well as trauma, yes.

Q What's that?

A As well as trauma.

Q I understand. I understand.

But if trauma happens, let's say day one, you're not going to have the bone growth day two?

A No, it can happen quickly, but yeah.

Q The bone growth and this degeneration takes some time to occur. The formation of bone and osteophytes doesn't happen overnight, correct?

A Correct.

Q Right. It doesn't happen in nine days either, correct?

A Generally not, no.

Q Okay. And this first MRI was taken nine days after the

incident, correct?

A I believe so.

Q Okay. And at that point was there some facet arthropathy found at L5-S1?

A Looks like there's some mild facet arthropathy there, yeah. It's minimal but it's there.

Q And that's something that can occur over time, correct?

A Sure.

Q Just yes or no. And that is some -- is it arthritis or is it arthropathy or is it enlarging of the joints? What exactly is arthropathy?

A Well, again, arthropathy is a pretty broad term that just means pathology of the joints. Arthritis just means inflammation of the joint. But I think what you're getting at is degenerative arthritis, meaning wear and tear over a while, causing inflammation of the joint.

Q Uh-hm.

A Can you see that in this situation or can you see that in facet, sure. Again, you can also see it with trauma.

Q No, I understand.

You're going to see that seven days after trauma, arthropathy?

A Sure, in the facet.

Q You're sure?

A Yeah.

Q Okay, okay. And, well, you know, I'm going to come back to that. Let me just -- let me start.

You first saw the patient, the plaintiff, April 26th of '19, correct?

A Yes, I believe so. Am I allowed to check?

Q Absolutely, please do. Please do.

A I think that's right.

Q And, actually, the first doctor to see Mr. McKenna was Dr. de Moura, correct?

A Yes, that's correct, at least in my practice.

Q I'm sorry. At least in what?

A At least in this practice.

Q Yes, right, right.

Well, what do you mean, "At least in this practice"?

A Well, I think you saw on my notes a chiropractic doctor.

Q Oh, no, no. Right, okay, yes.

So the first -- right, the first time at New York Spine Institute he saw Dr. de Moura, correct?

A That is correct.

Q Okay. And so when you first see a patient you obviously take a history, correct?

A Yes.

Q And I think we went over it a little bit. The history is very important, correct?

A Yes, sir.

Q And you're asking a patient, and in this case Mr. McKenna, to give you truthful answers to your questions, correct; that's what you want?

A I would hope so, yes.

Q Right, right. And you do that because it's important to know what he's been through before, correct?

A Yes.

Q It's important to know if there has been any prior incidents regarding his back, correct?

A Correct.

Q And you ask him how the accident happened, correct?

A Yes.

Q And you also ask other questions concerning social history and other things, correct?

A Yes.

Q Okay. So he denied any past medical history, correct?

A Yeah.

Q He did.

A Sure.

Q All right.

A I'm not disagreeing.

Q That's okay. But now when he gives you the description of the accident, he says he was working as a carpenter when he felt a sharp pull in his back.

A Yes.

Q Right. Okay. All right. At this stage, that's all the information you have about the accident, correct?

A No. I mean, that's what I documented, and admittedly poorly. I mean, totally about the nail gun thing, I should have written it down.

Q Well, let's forget about that documentation. Let's go to your conversation with the plaintiff. That's what I'm talking about, okay? Yes?

A Yes.

Q What did he tell you?

A Well --

Q According to your notes. What are in your notes? What did he tell you?

A I thought this was based on what he told me? Sorry.

Q Well, didn't he tell you, because you put it in your note, plaintiff was working as a carpenter when he felt a sharp pull in his back?

A Yes.

Q Okay. So that's what he told you?

A Yeah. I mean, again, he told me the nail gun thing too.

Q When did he tell you the nail gun thing?

A I don't know. Probably when I first met him.

Q Do you know?

A Yeah, I'm pretty sure I remember it.

Q Do you know if he told you that or are you just telling us that now because you have heard of a nail gun in this case?

A I don't know. I got it in my head somehow.

Q Right.

A I honestly don't recall. I mean, I did a crappy job documenting it, that's for sure.

Q Okay. That's not a good thing for a doctor.

A You heard it here first.

Q What's that?

A You heard it here first.

Q So you're a poor historian. Well, no, no. That's not right. You're a poor note-taker as a doctor?

A I would say in this particular instance I'm not proud of my note-taking.

Q Okay. But you still don't know if he mentioned a nail gun. You know that you've heard about a nail gun. But you don't know if he said that the first time, correct?

A I'm fairly certain he did.

Q Okay. Where in that record? Because it's six and a half years ago. Where in that record is there anything to do with a nail gun?

A Well, I already told you it's not there.

Q Okay. And you're certain he told you about it, but it's not there?

A Yes, sir.

Q Is that your testimony?

A Yeah.

Q Okay, okay. So when he tells you he didn't have any past medical history, is that accurate, because you're a poor note-taker, or not?

A I believe that is accurate, yes.

Q Okay. All right. Is there anything -- take a look at that first page of that. Tell me what else is inaccurate.

A When you say, "What else is inaccurate" --

Q Or I should say, what's inaccurate there. Not what else is. Let me do it that way.

Is there anything inaccurate?

A No. I mean, look, again, I could have done a better job flushing out the exact story.

Q Okay.

A I think when I saw this guy I was, you know, relatively fresh out of training. I was more focused on the injury. I did not think I would be here seven years later. If I did, I would have done a much better job documenting exactly the mechanism of the injury. But it seemed entirely plausible to me that that's what caused it; and indeed as we got MRIs and did a further workup, that was the case.

Q I'm not saying what you're saying -- I'm not saying you're not saying that today.

My whole point is the only thing you wrote down based on your conversation with the plaintiff the first time that you saw him, as a young doctor, and you only put he said he felt a sharp pull in his back. Yes or no.

A Yes. Did I write that? Yes.

Q Okay. Did he tell you that?

A Yes.

Q Okay. All right. So again, it's obviously important that the patient, the plaintiff, whoever it is, gives you accurate information, correct?

A Yes, sir.

Q Okay. All right. So one thing you note is the social history, and you ask him his occupation, and he says carpenter. You're asking social alcohol, which we all do, so I'm not -- it's fine. If it's -- you know, not in this case, but of course you ask that because if someone -- and not in this case, but if someone is drinking a lot of alcohol you want to know that because that's not good for the person's health, correct?

A Correct.

Q Okay. And then you ask about smoking too, and he denied smoking, correct?

A Well, I said he denies tobacco.

Q Well, what does that mean to you?

A Well, I mean it's the consumption of tobacco.

Q Okay. Does that include smoking?

A Well, it would include smoking tobacco, sir.
Q I'm sorry?
A It would include smoking tobacco.
Q Okay. It just says denies tobacco. So denies smoking, correct?
A Yes.
Q Okay. Now, and that's important that someone's not a smoker who is going to have surgery or physical therapy, correct?
A Yes.
Q And that's because smoking, according to you, has a major detrimental effect on the spine, correct?
A Yeah. I mean --
Q Yes or no.
A Well, it's not a yes-or-no question.
Q Well, didn't you give an interview where you gave five tips that patients can do in order to help them with back pain, correct?
A I believe so, at some point I did, yes.
Q And you were asked -- and you volunteered that smoking has a major detrimental effect on the spine, correct?
A Yeah, that's correct.
Q And it reduces the ability of the disc in the spine to absorb nutrients and stay healthy, correct?
A Correct.

Q Okay. And it will lead to more rapid degeneration and arthritis of the spine, as well as in other joints, correct?

A Yes, sir.

Q And it also slows down, if not completely stops, your ability to heal from a medical procedure or injury, correct?

A Yeah, I mean, I would flush that out better, but yes.

Q Okay. And smoking not only raises your risks of getting injuries, but it also lowers or slows your chances of getting better, correct?

A That's correct, yes, sir.

Q Okay. So you're very attuned to the effects of smoking, and that's one of the reasons you will ask a patient whether or not that patient smokes, correct?

A Yeah.

Q Now, do you know that the patient smokes?

A No. I thought he does not smoke, or at least I thought he does not use tobacco.

Q Now, wait a minute now. Don't back off. You said tobacco included smoking when I asked you, correct?

MR. MOORE: Note my objection, your Honor.

Q Right?

A I feel like you're playing word games here, sir.

Q It's your note. When I asked you to explain it, you said tobacco, denies tobacco also means he denied smoking, correct?

A No, I said he denied smoking tobacco.

Q Well, okay. Smoking tobacco is smoking cigarettes, correct? Yes or no.

A Nicotine containing tobacco cigarettes, yes.

Q Yes, okay.

A Sir, I don't mean to get so persnickety here, but it seems that you like to grab on to things that I don't intend to say or mean, so I have to be unusually careful here.

Q So that's why I quoted you in the article.

A There you go.

Q So when you said -- and let's go over it again.

When you said that he denies tobacco, you said that he denies smoking tobacco; that's what you understood it to be, correct. Just yes or no.

A Yes.

Q Okay. So look on the left side of your chart.

A On that date?

Q Well, not on that date, but look on the left side of the chart.

A Okay.

Q May I just approach and look?

A Sure.

Q Okay. Just flip a couple of pages and I think you'll get to the page that I'm talking about.

A On this --

Q On the left side.
A Understood.
Q And you can stop when you get to that page, and let me know.
A Is it the informed consent for smokers?
Q Right. That's signed by Mr. McKenna?
A It's initialed by Mr. McKenna.
Q Okay. Well, that is the chart for the preop for Mr. McKenna before he had the surgery November 19th, 2020 -- I'm sorry -- 2019 for the laminectomy, correct?
A That's correct, yes.
Q So when he was doing his preop and they asked him questions then, he said he was a smoker, correct?
A Yeah. It looks like he did, actually. He said, yes, he started 16 years of age and he smokes one pack a week.
Q Okay. All right. And he never told you that, correct?
A I don't believe he did.
Q Right.
A At least not at that first visit when I wrote no tobacco.
Q All right. I think, if you want to, we could go through every one, but it says denies tobacco on every entry that you have.
A Okay.
Q Fair enough?

A I'll take your word for it, yes.

Q Okay. So in part of your intake you were again asking questions that you hoped that Mr. McKenna would answer truthfully, but apparently he did not, correct?

A Yeah. I mean, in that instance.

Q Right?

A Yes.

Q Right, in that instance, of course.

A Yeah.

Q And we already know, because we went through this, what the detrimental effects of smoking are, correct?

A Correct.

Q And that could result in complications or issues post-surgery, correct? Just yes or no.

A Yeah. I mean, again, the whole -- I should say that the whole informed consent here is pertinent to fusion, which is what this thing is about, which we did not do for him. But, yeah, generally speaking, you are correct.

Q I understand.

But it's also important because it reduces the ability of the disc in the spine to absorb nutrients and stay healthy, correct?

A Correct.

Q And it will lead to more rapid degeneration and arthritis of the spine, correct?

A That's correct.

Q And it can stop your ability to heal from a medical procedure or injury, correct?

A Yeah. As I said, I should have flushed it out to specifically pertaining to fusion surgeries, but yes.

Q Right. It's fusion, but he didn't go under -- he didn't have a fusion. This was actually the preop for a back surgery where this came to light, correct?

A Well, it came to light to me now.

Q Well, right, but it came to light to -- well, to whoever did the preop?

A Yes.

MR. FALEY: Is this a good time to break, Judge?

THE COURT: Yeah. It's one o'clock, we can take a break. Okay.

So we're going to break for lunch and then return for the remainder of the cross-examination, and I believe we have other witnesses after the doctor.

MR. FALEY: Yes.

THE COURT: So I remind you, don't discuss the case, and I'll see you at 2:15.

COURT OFFICER: All rise.

(Whereupon, the jury exited the courtroom.)

THE COURT: Okay. Have a good break, everyone.

MR. MOORE: Thank you, your Honor.

(Whereupon, a luncheon recess was taken.)

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

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THE COURT: Doctor, you can retake the stand.

(Whereupon, the witness resumed the witness stand.)

THE COURT: All right. Are we all set to go?

MR. MOORE: I'm sorry, your Honor?

THE COURT: Are we ready to go?

MR. MOORE: Yes.

MR. FALEY: One second.

THE COURT: It's okay. You could get the jury.

MR. FALEY: I'm ready, Judge. Thank you.

COURT OFFICER: All rise.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated.

All right. I hope everybody had a good break, a nice lunch break. It's a little warmer today than yesterday.

Mr. Faley, would you like to continue your cross-examination of the doctor?

MR. FALEY: Okay.

THE COURT: Okay.

Q Good afternoon, Doctor.

I think we were talking about bone formation, I think,

in the discs and the spine, correct?

A Yeah.

Q Okay. And we talked about osteophytes, correct?

A Yes.

Q Okay. And that they take some amount of time to form, correct?

A They can, yes.

Q All right. And the bone, bone forms kind of also to give stability to the area of the spine, correct?

A Yes, that's the end process. I mean, it takes a while, but yes.

Q It's kind of protecting itself in a way?

A In a way, yes.

Q Yeah, yeah. And we would like the bone to grow faster, but we have to wait for the bone process to take care of itself before it actually forms there, correct?

A Yes.

Q Okay. All right. Now, we have here the -- it's Plaintiff's 10 and this is the two cuts of MRI films for -- is it nine days -- eight days, nine days after the accident, February 6, 2019, correct?

A That's correct.

Q And so is this -- the one on the right, this one, is that a T2 (indicating)?

A No, that's a STIR sequence, S-T-I-R.

Q And what is a STIR sequence?

A I think it stands for spin town version resonance, but basically it looks for acute inflammation.

Q Okay. Now, I understand you obviously look at MRI films, you've been doing that for a while?

A Yes, sir.

Q You're Board certified in orthopedic spine surgery?

A In orthopedic surgery, subspecialty of spine surgery. Same thing, yes.

Q Any Board certification when it comes to radiology?

A No, no.

Q Okay. All right. And many times Board-certified radiologists will look at these films, MRI films, produce reports, correct?

A Yes. Almost always, yes.

Q And you usually review those reports, correct?

A Almost always, yes.

Q And that and also your review helps you come to an opinion about the -- about the person's -- the condition of the person's spine, correct?

A Yes, sir.

Q Okay. All right. So now, on this STIR, here it's sag, S-A-G, STIR.

A Yes.

Q On this STIR cut, is it a side, like this view

(indicating)?

A It is, yes.

Q Okay. And now, this -- which disc is this one at the top?

A That would be -- five, four, three, two, one. That's T12-L1.

Q Okay. All right. So that's the end of the thoracic spine?

A Correct.

Q And then we have the lumbar spine down further?

A Yes.

Q And when you have these MRI films, the discs -- well, let me take that back.

When you have these MRI films, when the discs are white that means they're full of water? Among other things.

A Yeah. I mean, it can mean a variety of things. If they're fairly consistent, well-shaped, then yes, it means -- I mean, they're not full of water, but they have a high water content, yes.

Q Okay. And they show up white on some MRI films, correct?

A They can appear as what we call hyperintense where they look whiter. But, I mean, it's -- yeah, it's all shades of gray, if you will.

Q Right. Okay, right. There's shades of gray, but then

there's bright -- brightness?

A Correct.

Q And those show healthy disc, correct, usually?

A Yes, sir, yes.

Q So we have L1, L2, L3, L4, and those show white hydrated discs, correct?

A Yes, sir.

Q Okay. And now we have L5-S1, correct?

A Yes.

Q And the nerve root that we're talking about is the S1 nerve root, right?

A We have a combination of L5 and S1 nerve compression.

Q Okay. So there's a couple of nerves there?

A Yes.

Q Okay. All right. Now, when a disc -- when there's dehydration, when the water dehydrates, desiccates, that will show up black on the MRI film, correct?

A On certain sequences. So it applies to STIR and T2 predominantly.

Q So T2, and it's called weighted T2; is that what it's called?

A Correct, yes.

Q So there's T2 and that will show up -- that desiccation will show up dark, correct?

A Yes.

Q Okay. And then this sag STIR will also -- desiccated discs will also show up dark, correct?

A Yes.

Q So now we're looking at the L5-S1 area here, and you can see that this disc is narrower than the others, correct?

A Yes.

Q Okay. And you can see that it's lost height, correct?

A Correct.

Q And you can see that it's lost water, correct?

A Yes, in parts.

Q Okay. All right. And you can see that there's some bone formation there too, correct?

A It's minimal bone formation, yes.

Q Do you know what the endplate -- I know you do. You know what the endplate is, right?

A I do.

Q What is the endplate?

A Well, there's a cartilaginous endplate and a bony endplate. But, basically, it's the bottom part of the bone that cups the disc.

Q Okay. And it's where the disc comes into or approaches the spinal canal, the endplate is usually there?

A Not really. I mean --

Q It can be?

A Yeah, it depends which part. Yes, a part of the

endplate does abut the canal, that's correct.

Q Okay. And is that -- is that showing the endplate here? Is that showing bone formation of the endplate?

A We're looking at a cross-section through the middle of the endplate, so L5 and S1 at that level.

Sorry. Maybe I don't understand your question.

Q Okay. Is that endplate formation -- does that show endplate formation?

A I'm not familiar with that term.

Q Well, let me see if I have it right. Okay.

So instead of endplate formation, just endplate, would that be a better word?

A Yeah, but the endplate is just an anatomical structure. I mean, yes.

Q And if there is degeneration to the endplate that would show long-term degeneration in that area, correct?

A I mean, it can. It can --

Q Okay, okay. Is there degenerative endplate -- is there a degenerative endplate here?

A There's some mild changes there, yes, but there's acute changes too.

Q Is there a Schmorl's node there?

A No.

Q Okay. And is there an endplate signal change at that level?

A There's some slight edema that maybe constitutes some mild changes, but I wouldn't say it's significant.

Q And endplate signal changes are evidence and can be evidence of degeneration, correct?

A I mean, it could be evidence of any kind of pathology, acute trauma as well.

Q Can it be evidence of degeneration?

A Yes.

Q Okay. All right. Now, you were talking about -- there's edema that you're saying is on the axial view, which is this one over here (indicating)?

A Yes.

Q What type of edema?

A I'm not even sure what you're getting at. What are the options?

Q I was hoping you would know.

A I mean, edema is edema.

Q Is there marrow edema?

A Oh, you mean where is the edema?

Q Yes, yes.

A So there's edema in the annulus and there's edema in the nucleus pulposus.

Q I'm sorry. What?

A Edema in the annulus and there's edema in the nucleus pulposus. I'm sorry. I'll get closer here.

Q All right. And so let's do this. Where are you saying the marrow edema is?

A Oh, I didn't say it. You said marrow edema.

Q Okay. Is there marrow edema?

A I don't think so.

Q Okay. No, I agree with you. There's no marrow edema.

Is there -- so what edema are you seeing?

A I mean, I pointed it out earlier, but there is edema in the annulus where the disc has been herniating, and there's inflammation around that nucleus pulposus. Again, it's what we see with a fresh injury to the disc.

Q But what -- where is that edema coming from?

A I mean, the edema is inflammation of the tissues. So when the tissues get inflamed, they get -- water and fluid gather there, and that's what shows up as bright on this particular MRI sequence.

Q Okay. Now, is there such a thing as chronic edema?

A There can be, yeah.

Q Okay. Is there such a thing as endplate edema?

A Yes.

Q Okay. How do you differentiate between the two?

A Well, endplate edema would be on the endplate. And chronic edema would technically be -- I mean, it's not nearly as intense as an acute edema.

Q Okay. All right. Do you see any disc fluid?

A I mean, by -- there's no, like, actual collection like you would see with an infection or something. But, I mean, there is evidence of hydration within the disc. Maybe -- sorry. I don't understand that question.

Q Okay. All right. Do you know what peridiscal fluid is?

A Yes.

Q Okay. Is there any peridiscal fluid here?

A No.

Q All right. And you would see peridiscal fluid if there was an acute injury, correct? You could?

A Yeah. I mean, again, it's more an infection until proven otherwise.

Q Okay. All right. Now, so we have here -- now we're going back to the STIR -- sag STIR view. The black part on the other -- outside of the disc, what would you say that is?

A So that's the cortex. So that's the hard, thick part of the bone, part of the endplate that, I guess, is kind of almost like a rafter, almost like, you know, basically supports the disc.

Q Okay. All right. Now, you understand that Dr. Sherman a Board-certified radiologist, is going to come in and testify that these are chronic degenerative findings, correct?

A Well, I don't know what he's going to say, but I understand he's coming.

Q Okay. That's -- I'm telling you he's going to say that, okay. Just accept that, okay.

Now, if this condition L5-S1 that we see here, if it's a chronic degenerative condition, it would exist like this before the accident, correct, if it was a chronic degenerative condition, correct?

A You're saying if it were a chronic degenerative condition would it look just like that?

Q Yes, at the time before the accident.

A No, strongly disagree.

Q Okay. All right. Did the plaintiff have degeneration at L5-S1 at that disc before the accident?

A Hard to say for sure. There does look like some mild degenerative changes there in addition to very obvious acute changes.

Q Okay. And you're saying there's edema and those are the acute changes, correct?

A Yes.

Q Anything else?

A Well, the herniation. But, yeah, I mean, edema is the giveaway. That's the thing that would -- that's the number one clue for the chronicity of it.

Q That's fine.

Now, herniations, we know that they can occur for whatever reason; degeneration or trauma, correct?

A Yeah.

Q Among other things.

A Yeah. I mean, yeah, you'd certainly pay attention to the context, but yeah.

Q Sure, sure. And we don't have and people don't go in for MRIs as a matter of course. So we don't have an MRI of the plaintiff's back before the accident; we just don't, right?

A Yeah.

Q It's not the way we do business, correct?

A Correct.

Q Okay. And if this plaintiff had some pre-existing condition, you don't -- withdrawn.

If this plaintiff had this condition before, would an MRI pick this up?

A Pick what up?

Q What we have here.

A Well, that is an MRI.

Q Okay. So, okay. All right. All right.

Now, Doctor, going back to -- well, let me say -- let me ask you this: The plaintiff, according to the notes in there, had five herniated discs in his cervical spine, okay. Let's accept that.

A Okay.

Q All right. That doesn't have to be the result of trauma those five discs. Let's just talk about those five discs

for now. Correct, it doesn't have to be?

A No, sir.

Q It could be degenerative, correct?

A Yeah. I mean, again, he's pretty young, but --

Q Right. But, so those are all traumatic though, those five discs in his neck, herniated discs?

A They could be. I honestly didn't review those prior to coming here. They're not fresh to me. I don't remember.

Q That's okay. What I'm saying is, if he has five herniated discs in his back, it could be traumatic or it simply could be degenerative, correct?

A That's true, yes, yes.

Q And that would show that at least with the cervical spine he's had, if it's degenerative, that's a lot of degenerative changes for a 30 -- let's say -- five-year-old, correct?

A If it is degenerative, yeah, yeah. That's above average.

Q If it's degenerative, right.

A Yes.

Q And if he has that condition also in his thoracic spine, degenerative disc herniations, and no -- yes, degenerative disc herniations in the thoracic spine, that could also be degenerative, correct?

A I believe that's a tautology, right? If he's got

degenerative changes, it's degenerative.

Q Right, right, yes.

A I mean, that makes sense.

Q Yes. And in this case we don't know what the condition of the L5-S1 disc was for months or years before the accident, correct? We wouldn't know?

A Yeah, he never got an MRI because he never complained of pain prior to the accident.

Q Not everyone who complains of pain gets an MRI, correct?

A Correct.

Q So he could be in pain before the accident and not get an MRI, and we would not know what the L5-S1 area looked like, correct?

A Yes, correct. Yeah, sure.

Q Right. And an L5-S1, even if it's a degenerative condition, an L5-S1 disc that is degenerated, that can still cause pain, correct?

A Say that one more time for me. I'm sorry.

Q A degenerative disc, as opposed to a herniated disc, they both can cause pain, correct?

A Yes, yes.

Q And a degenerated disc that is pressing, let's say, on the S1 nerve root before the accident, could cause some pain and radiation, correct?

A Sure.

Q Okay. All right. And I know you're saying that disc didn't -- you're saying that this couldn't be the day before the accident, this MRI film. It wouldn't be like this the day before the accident, correct; that's what you're saying?

A Yeah, I don't think you would see that kind of edema and -- yeah.

Q All right. But if a Board-certified radiologist testified that, yes, this is what it looked like a day before the accident, then there would be some impingement on that nerve, and that person would have some pain from a degenerative disc before the accident, correct?

A So -- I'm sorry. So the radiologist, the Board-certified radiologist says?

Q If. I'm just saying if a Board-certified radiologist said this is how his -- this is how a person's lumbar spine L5-S1 would look at -- look like before the accident, then that person, even though he had a degenerative condition, could have some pain, correct?

A Yes.

Q Okay. All right. Now, just going back to your first note, which was April 26th, 2019, and could you actually go to the day before or the entry before. It was Dr. -- when Dr. de Moura looked at the plaintiff.

A Okay, yup.

Q And you see the history there?
A Yes.
Q So this is April 11th. It's about two weeks before you spoke to the plaintiff?
A Yes.
Q And in the history that the plaintiff gave two weeks before he saw you, he gave the same history to Dr. de Moura, that he felt a sharp pull in his back, correct?
A Yeah. I mean, exactly the same, like word for word.
Q What's that?
A It's exactly the same. It's word for word.
Q Yes. Yes, I understand.
A Because it's been copied over.
Q Sharp pull. Well, no. And I knew you were going to say that.

You spoke to the plaintiff --

A Correct.
Q -- on the day that you saw him on April 26th, and you told us you asked him how the accident happened, and he told you he had a sharp pull in his back, correct?
A Yes.
Q Okay. So it's exactly the same what was said to Dr. de Moura two weeks before, and then what was said to you?
A Yes.
Q Okay. That's all. I just want to make sure.

Now, pain, as you know, comes in various ways, correct?

A Yes.

Q Okay. And pain is also something that's tough to measure, correct?

A Yeah. I mean there's subjective and objective components to it. But yeah, it's tough to gauge somebody's pain, sure.

Q Right. And sometimes some of the subjective components of pain is when a patient complains of pain and says I have pain in my arm, and you write that down and say, okay, you have pain in your arm, right?

A Yes.

Q And that's a subjective complaint, correct?

A Yes.

Q And then there are -- you have these range-of-motion testing, correct?

A Yes.

Q Okay. And the range of motion that can be subjective as well at times, correct?

A Yeah. I mean, look, I measure with a goniometer. It's a combination of active and passing testing, best of three. It's an attempt to be as objective as possible.

Q I understand.

But it still requires the cooperation of the patient. When you say twist as far as you can, you note as far as he

twists. You don't push him any further. You just note what he says he can do, correct?

A Well, I mean, that's the active component. The passive component is taking and seeing if he can do more.

Q And did you do that?

A Yes.

Q Now, also, a person who has decreased range of motion it could be because of a condition that existed before the accident, correct?

A Sure, yeah. It could be a number of different things, yeah.

Q Again, if this condition at L5-S1 existed before the accident, he would have similar complaints that he made to you, correct?

A Sure, yes.

Q Yeah. He would have complaints of some radiating pain. He would have complaints of range of motion, loss of range of motion, correct? It would be similar to what he would have if he had an acute traumatic injury, correct?

A Yeah. Yes, broadly speaking, yes.

Q Yes, yes, of course. Okay.

Now, did you -- did you check for atrophy?

A Yeah, I don't think he has any atrophy. At least not at the first presentation.

Q Okay. How about did you ever check for atrophy?

A Yeah. I mean, every time I examine a patient I'm inspecting for atrophy, sure.

Q Okay. And what is atrophy?

A Atrophy is basically wasting of the muscle because it's -- well, it can be from a number of different things. But when it's localized atrophy, it's basically the muscle is not getting nerve signals, so it's not firing. It gets, you know, weaker and it gets smaller, and you can obviously see a difference compared to the other side or compared to the muscles.

Q It's kind of because it's not working as fully as -- let's say with the two legs. One leg isn't working as fully as the other, and you'll get a smaller calf muscle or smaller thigh muscle, correct?

A Exactly, yes.

Q And three years after the accident a person measures for atrophy in the legs, in the thighs and the calves, and there's no atrophy three years after the accident and two years after -- almost three years after the surgery. What does that tell you?

A Well, nothing at all.

Q It doesn't?

A No, I don't think so.

Q Doesn't it tell you that the muscles in the legs, which an L5-S1 disc would affect in a certain way, doesn't it tell you that the legs are working well?

A No, not at all. I mean --

Q Okay. I'll ask another question.

A Sure.

Q Okay. All right. So what does -- if there's atrophy, what does it tell you?

A I mean, to have real true atrophy, you really need to have almost total denervation of the muscles. So that's, you know, paraplegics, patients who break their necks, like they will have real atrophy.

Q That's the only time you get atrophy?

A No. I mean, if -- if a muscle is completely denervated or significantly denervated, then you will see it. But I would never say the absence of atrophy means the nerves are fine. That's simply not true.

Q I'm not saying that. But it does show that, for instance, in the legs, that the legs are working properly?

A No, not necessarily, no.

Q That's fine. That's fine.

Now, you also looked at -- let's see -- the MRI of 2025, I believe?

A Yes.

Q And do you have that report there?

A Yeah, I think I do. Hold on for one second. Yes.

Q Okay. All right. You have the report of the MRI in front of you?

A Yes, sir.

MR. FALEY: Okay. Judge, if I could just approach for a second or just look at that before I --

THE COURT: Yes.

MR. FALEY: Because I forgot what it was. Okay. Thank you.

Q Do you see that, sir?

A Yes.

Q Now, you said that this MRI or another one shows a recurrent disc herniation?

A Yes.

Q Okay. What does the report say, L5-S1?

A Disc bulge and bilateral facet arthrosis with evidence of previous microdiscectomy. No recurrent disc herniations visualized. Mild right lateral recess stenosis.

Q So that says no recurrent herniation, correct?

A Yeah. But in the next sentence they say recess stenosis.

Q I understand. I understand.

A It's a contradictory --

Q All right. Stenosis is a narrowing of the spine in certain areas; is that correct?

A Yes, sir.

Q That could be a degenerative change, correct?

A Yeah, it can be, sure.

Q It could be congenital also? You could be born with stenosis or a narrowed spine?

A Well, not in the recesses, but yeah.

Q So now, what you do with your -- with the microdiscectomy, is you attempt to get the herniation out, correct?

A Yes.

Q Okay. All right. And that radiologist who reviewed the report -- reviewed the MRI is saying that there is no disc reherniation, correct?

A Yeah, but he contradicts himself in the next sentence.

Q What's the next sentence?

A It's mild right lateral recess stenosis.

Q Okay. And you're saying that's a disc -- that's a recurrent disc herniation?

A I'm saying that -- well, something is causing the stenosis and it's the disc.

Q Are you saying that's the recurrent disc herniation, what he is calling stenosis?

A Yes.

Q Okay.

A I believe so, yes.

Q Okay. All right. Now, Doctor, your report of -- I forget when the report was. Was it March 27th of this year, your narrative report?

A Let me double-check that. I think so. March 21st, 2025.

Q March 21st, yes.

A Yes.

Q Okay. You indicate, if you're looking at that third paragraph, that his low back -- his mid and low back pain, his preoperative low back pain improved, and the lower extremity radicular pain resolved. Do you see that? It's in the last paragraph there.

A On page 1? I'm sorry. I'm trying to find it.

Q That's okay. It's the third -- I guess the third line. During the time he was also undergoing physical therapy and pain management treatment following surgery. Although the patient did continue to experience some mid and low back pain, his preoperative low back pain improved, and his lower extremity radicular pain resolved. Do you see that?

A Yes, I do.

Q And then you say eight months later -- eight months after the surgery, you now said there was an exacerbation. Do you see that?

A I do.

Q Okay. What was -- did he explain -- well, withdrawn.

Did he say how he exacerbated it?

A Well, I mean, that's my word, not his.

Q Okay. All right.

A Yeah. I mean, I think, as I said, he re-herniated. You know, he did fine initially. He did great initially. And then a new piece of disc came out and he was miserable again.

Q Well, was there another accident that caused that? What caused that?

I mean, I know you're saying, well, this is what happened. But do you know why it happened? Do you know if he did anything during that time period to cause that?

A No. I mean, you know --

Q Just yes or no. Do you know?

A No, I don't know exactly. But I would say that nothing needs to happen for it to happen. When there's an annular injury of that size, the big hole, stuff's going to come out.

Q I understand that.

A Sure.

Q But it didn't come out for eight months, and now after the pain is -- the radicular pain is gone, did something happen or could something happen, another injury, something to cause that exacerbation? Just yes or no.

A Yes, yes.

Q Now, Doctor, you mentioned -- well, withdrawn.

Do you have the bills for all of the treatment that New York Spine received payment for for the treatment they received it for? Do you have the bills?

A I didn't see those in here. They may be in here.

Yeah, they may be in here. I don't know where they are though.

Q Okay. But you -- how much did you charge for the laminectomy?

A Oh, I have no idea.

Q 10,000, 15, 5, 30?

A I have no idea.

Q What would it be today, give a ballpark?

A I mean, I would say Workers' Compensation probably pays 4,000, 5,000 for a single-level laminectomy.

Q All right. And what are you getting paid to testify? What are you being paid to come to court today?

A I have no idea. I have a check in my pocket. I have not looked at it.

Q Should we look at it?

A Yeah.

Q Well, what did you ask for?

A I didn't ask for -- it's my group's policy. I don't know. It's not my money. It's going to my company.

Q Well, Dr. Post is one of your -- is in your group?

A He was. He left, unfortunately.

Q When did he leave?

A Maybe six months ago or so.

Q Do you know he charged $40,000 to come in to testify? Do you know if that was his going rate?

A Okay.

Q Did you?

A No, I have no idea.

Q So, I mean, do you think it was $10,000 that's in your pocket? I mean, I just want to know.

A I really don't know. I'm guessing somewhere around that. I don't think it's 40.

Q Okay. So who sets the rate, Dr. de Moura?

A Yeah, I'm assuming. I don't know. I mean, somebody. Either the office manager or de Moura, yeah, it's possible.

MR. FALEY: All right. Judge, can we take a look at it?

THE COURT: Take a look at what?

MR. FALEY: The check.

THE COURT: Is it in evidence?

MR. FALEY: I just want to know what he's getting paid. That's all.

THE WITNESS: I mean, again, it's not what I'm getting paid. It's not my money.

MR. FALEY: I understand.

THE COURT: Is there any objection?

MR. MOORE: No objection, your Honor. And if we could just confirm who the payee is to make sure and confirm it's not to Mr. -- Dr. Roberts.

MR. FALEY: Okay. If he says it's for the practice, I'm not going to disagree with that. I just want

to know how much it is. This will be a surprise to both of us, okay, a surprise to both of us.

THE WITNESS: I had this debate with them before that I would like the money, and got nowhere. It's made out to New York Spine Institute for $20,000.

Q Okay. Now, you said you testified three times?

A This is the third time.

Q Did you get -- did you look at those checks?

A I think I saw one of them.

Q Was it $20,000?

A I think it was 15. I'm not sure, to be honest with you.

Q All right. Now, how much -- how much money has New York Spine charged, or received, I should say, from treating Mr. McKenna through the Workers' Compensation? How much?

A I have no idea.

Q He's been treating for a while, correct?

A Yes.

Q Okay. Do you think it's $50,000, $75,000?

A Yeah, I think it's probably reasonable. Yeah, I don't know. I mean, it's probably less than that. He just had a laminectomy. A lot of office visits.

Q So let's say $50,000, all right; is that okay? And now you receive $20,000?

A Again, I didn't receive it.

Q New York Spine Institute has received $20,000 on top of the $50,000, correct?

A Yes.

Q Okay. And New York Spine Institute, you know, they sent him for that EMG for his cervical spine. Are they running that through Workers' Compensation?

A I don't know. I doubt it because it's not an established body part.

Q Right, right. Okay. Do you know for a fact or not?

A No, I don't know.

Q Okay, okay. And then you mentioned some future costs and one was a fusion, correct?

A Yes.

Q Okay. Now, we know he hasn't had a fusion, correct?

A That's correct.

Q We know you said you mentioned a fusion to him four about years ago, correct?

A Yeah, I mentioned it many times to him, yes.

Q And he has said no?

A Correct.

Q You don't know when or if he's going to have a fusion? As you sit here today, you don't know, correct?

A Correct.

Q So you don't know if he's ever going to have the fusion, correct?

A Correct.

Q Okay. And you don't know if you're -- not you, but if New York Spine Institute and you do the surgery, New York Spine Institute would get that $50,000 as well, correct?

A Yeah. I mean, it depends on a number of things, but yeah, they'd get a large part. I mean, you have to pay the assistant fee and depending on who that is. But, yes, generally speaking, yes.

Q And then all the other things about the life care plan, that would be things that would be paid to New York Spine Institute, correct?

A Well, it depends where he gets the MRIs and the X-rays, but I would imagine that New York Spine would get a portion of that. Yes, that's fair.

Q Most of it?

A Potentially.

Q Now, you're not a life care planner, are you?

A I'm not.

Q You haven't taken any courses in life care planning?

A No.

Q No, okay.

So first you say -- just to go over those numbers. First you say he might need a fusion, but we don't know if he's going to have a fusion, okay. Agreed, right?

A Yeah.

Q Then you have, well, if he had the fusion, he would need physical therapy for a year. But if he doesn't have the three times a week, I think you said. But if he doesn't have a fusion, he wouldn't need that physical therapy that you say is needed because of the surgery, right? He wouldn't need that?

A Well, yeah. I mean, he probably would receive physical therapy for his ongoing issues.

Q But the amount you said was needed to do after the surgery, he wouldn't have to do that, correct?

A Sure.

Q Okay. And this segmentation, with the segmentation, if I understand this correctly, if there is a fusion, that there could be issues with the above disc and the below disc, correct?

A Adjacent segment disease.

Q Yes.

A Yes, that's correct, yes.

Q And it's usually -- it happens more when there's more than one-level fusion, correct?

A Yes.

Q Okay. So this would not be a two-level fusion. It's a one-level fusion?

A Correct, but I would --

Q Just let me finish. Just let me finish.

So the incidence of that is less when you have a one-level fusion than a two-level fusion, correct?

A Generally speaking, yes.

Q Yes. And, generally speaking -- and, first of all, if he doesn't have the fusion, this doesn't even come into play, correct? Right?

A No, disagree.

Q Okay. All right. Anyway, so if he has a one-level fusion -- well, withdrawn.

The incidence of these adjacent-level fusions, they only occur in 2 to 10 percent of the people who have fusions, correct?

A Per year.

Q Okay. Per year, okay.

But you can't -- well, first of all, he's not having a fusion.

Can you say to a reasonable degree of medical certainty that he's going to have this in the future, to a reasonable degree, which means more than just 2 or 5 percent?

A A year.

Q I understand, a year, yes.

A Right. So he's got 50 years at least.

Q Okay. All right.

A So I think it's pretty likely that he will get the fusion surgery. I think it's very likely he will get the adjacent segment disease.

Q When is he getting the fusion surgery, what day?

A I don't know.

Q Okay. When is he getting the segmental adjacent surgery, what date?

A Don't know.

Q Okay. Mr. -- Dr. Roberts, have you ever used a nail gun?

A I have once, long time ago.

Q What's that?

A One time, like a camp, a long time ago.

Q A camp. How old were you?

A I don't know. 19, 18.

Q Was it a Hilti GX-3?

A I don't believe so. I don't recall.

Q Okay. Now, you were asked questions about how this accident happened and how it could possibly cause this injury.

What type of recoil does a Hilti gun have? How much? How much force?

A Don't know.

Q Okay. If it's being used and it has the normal amount of recoil, and it -- someone gets injured, well, it doesn't mean the gun did anything wrong; do you know what I mean?

MR. MOORE: Note my objection.

Q That the gun acted properly, correct?

THE COURT: Sustained.

Q Okay. If the gun was acting properly and someone got

an injury -- well, withdrawn. Let me withdraw that.

Let's go back to the Hilti gun. Again, you don't know how much force is generated in the recoil, correct?

A No.

Q Okay. You don't know how much force is generated if a nail doesn't fire, correct?

A No, I don't know.

Q Okay. So you're not saying that the Hilti gun malfunctioned, are you? You're not here to say that?

A No.

MR. MOORE: Just note my objection.

Q Right. You're not here to say there was something wrong with the Hilti gun, correct?

A No.

Q Right. Okay. You don't know if it was being operated correctly or not, at the time, correct?

A No, I don't know.

Q Okay. And you don't know if it was simply the normal course of the operation of the gun that may have caused this injury; you don't know that?

A I don't know that.

Q Okay.

MR. FALEY: Just one second, your Honor. I have no further questions, Judge.

THE COURT: Redirect?

MR. MOORE: Yes, please, your Honor.

REDIRECT EXAMINATION

BY MR. MOORE:

Q Good afternoon, Dr. Roberts.

A Good afternoon.

Q I'm just going to follow up with some questions, and I could jump around a lot, so I'm just giving you a heads up on that. Okay?

Doctor, we've heard a lot of terms mentioned. Desiccation, we've had arthrosis, atrophy, bone spurs, osteophytes.

Looking at Plaintiff's Exhibit 10 for identification purposes, after hearing and discussing all of those terms, does that change your opinion as to the cause of the herniation shown in this MRI taken on February the 6th of 2019?

A No, sir, not at all.

Q With regard to smoking, would smoking cause a herniation like that?

A No, no, not at all.

Q In your dealings or your treatment of Mr. McKenna, have you ever felt that he was ever less than truthful with you about anything?

A No, he was a pretty standup guy. You know, I think he was pretty authentic. I mean, he wants to get back to work. I mean, I'm sure I don't need to tell you how many Workers' Comp.

patients do not want to work. No, I think he's been very honest and very motivated, truly.

Q In all of the treatments and the visits that Fintan has had with you, has he ever told you that he injured his neck on January 28th, 2019?

A No.

Q Okay.

A No.

Q Now, you heard a lot about if we're not in the business of getting MRIs, and if we got an MRI before, what it may show.

Do you have an opinion, Doctor, as to whether -- strike that.

I want you to assume the following: A union carpenter works a full-time job and has not missed a day's work in the last five, seven, ten years.

Do you have an opinion as to whether that union carpenter doing a labor-intensive job every day would be walking around with a herniation like this in their lower back?

MR. FALEY: I have an objection, Judge.

THE COURT: Sustained.

Q Doctor, do you have an opinion as to whether this herniation and edema that's shown in Plaintiff's Exhibit 10 would have existed before January the 28th of 2019?

A No, I don't think -- I truly don't think it would. I mean, that again has all the hallmarks of a fresh acute or

subacute injury. Again, typically within three months or so of obtaining said images. Yeah, I mean it looks -- it looks very fresh to me. I'm surprised that they're even being contested, but here we are.

Q And just to be clear, Doctor, when you say subacute, can you just elaborate on what you mean by subacute.

A Yeah, sorry. So acute typically means -- I mean, there's different terms, but typically acute is within 48 hours or up to a week. And subacute is that, you know, 2- to 12-week or so period.

Q Okay. And you mentioned -- also, we talked about endplate changes, acute changes. Do you see acute changes in this MRI?

A Yeah. I mean, as I said, either acute or subacute, but fresh either way, yes.

Q And we're going to hear from a Board-certified radiologist tomorrow. You made a reference to shades of gray. The colors that are shown on an MRI film, is that dictated by the type of MRI machine that is used?

A Yeah. I mean, certainly, there's variation between different types. You know, there's different sequences. I mean, there's dozens of different ways to obtain these images.

So, yeah, you can see -- right. You can see variations in brightness depending on the machine, even depending on the -- you know, the same patient could come back an hour later and it

might be a little different. The trick is to compare it to the other levels that you know are normal or assume are normal and then you can compare it.

Q Okay. And you compared the L5-S1 level to the L4-L5, L3-L4 and L2-L3?

A That's exactly right, yes.

Q And you said you've seen edema in the annulus and the nucleus pulposus?

A Yes.

Q Can you elaborate on that?

A Yes. So do you want me to come down there?

MR. MOORE: Your Honor, with your permission, could the witness step down?

THE COURT: Sure, Doctor.

THE WITNESS: Thank you.

A So, again, this herniation here, this protruding disc that obviously shouldn't be there, it's much brighter than the other parts of the disc, indicating it has edema there, fresh inflammation. And then there's some edema within the nucleus here and working its way out here, which again indicates that it's all pretty inflamed (indicating).

Q So in both the nucleus pulposus and the annulus?

A Yes, yes. So the annulus rim is right here and that's lit up, especially right there. And then this bit of kind of white or lighter -- lighter gray is the fresh herniation that's

coming out (indicating).

Q And forgive me if I got this wrong.

Just in relation to this different color here, did you say that that was fresh (indicating)?

A Well, I think that this is probably a void that's filled with some -- basically some fluid as this kind of worked its way out, it left a vacuum there, and that collected some fluid. I think that's what you're seeing there.

Q Okay. Thank you, Doctor.

And we heard what we expected to hear from Dr. Sherman in terms of his opinion as to his interpretation of this MRI. Do you agree with Dr. Sherman?

A Yeah. I mean, again, I'm not exactly sure what -- you know, what he says. But, I mean, there are some mild -- you know, arguably some mild degenerative changes there. But the vast majority of what I see there and I think a hundred percent of what's causing his symptoms, are acute fresh injuries.

Q Okay. And that word that we -- that has been thrown around here, degenerative, what is degenerative?

A Yeah. So degenerative just means, you know, wear and tear of the spine. You certainly, you know, tend to see it as people get older. And then you certainly see it in a lot of patients who do construction, heavy lifting, lots of bending, twisting. In certain athletes you'll see earlier degeneration than others. And then, you know, that's going to be marked by a

lot of disc desiccation.

So, you know, on his more recent images, as that disc has injured, you see the disc darkening. You know, you see it losing fluid content, things like that. So, you know, those can be degenerative, and they can also be what we call sequela of trauma, meaning the trauma and that set off rapid degeneration of that disc.

Q And the condition of Mr. McKenna's disc at L5-S1 in the most recent MRI that we looked at, is that a condition that is degenerative or is it a sequela of a traumatic incident?

A I think it's -- yeah, it's a sequela. It's the result of that disc being severely injured and then, you know, as more and more disc worked its way out, the disc loses its blood supply, it gets pressure pushed on it. Then you have the trauma of the surgery and everything else, and basically the disc just dies and collapses.

Q Now, Doctor, if we got this MRI film and had ten Board-certified radiologists look at it, would they all say the same thing?

MR. FALEY: Objection, Judge.

THE COURT: Sustained.

Q Okay. You were asked about atrophy, Doctor, and the fact that if there's no atrophy that means the legs are working fine.

A Yes.

Q You wanted to provide a fuller answer. Can you provide that now.

A Yeah, I wanted to clarify. I can count on one hand the number of times I've seen true atrophy. You know, I've seen thousands of patients. I mean, it takes a lot of denervation to have true atrophy of the muscles. And the absence of atrophy by no means means that, you know, there's not, you know, ongoing nerve issues.

Q Okay. And we heard reference to the neck and there was a question about an established body part, correct?

A Yes.

Q Okay. And as you sit here, what are the established body parts for Mr. McKenna related to the January 28th, 2019 incident?

A I believe it's the lumbar spine and probably the thoracic spine, but not the cervical spine.

Q Okay. Why do you say the thoracic?

A I remember talking to him about his thoracic spine and I saw that in some of my notes. I guess I just assumed it was included. Because the injuries weren't surgically significant, I wasn't concerned about them. But, yeah, but again, the cervical spine was not part of his initial injury.

Q And when a body part is established --

A Yes.

Q -- the patient involved in a work-related incident gets

treatment for that body part, correct?

A Yes.

Q You need it established to get the treatment?

A That's correct.

Q Okay. Now, you confirmed you're not a life care planner?

A That's true.

Q Okay. How many patients do you treat on a daily basis?

A Probably see seven to eight patients a day on a normal clinic day.

Q And do you see them once or do you see them over a period of time?

A I generally see them over an extended period of time, yeah.

Q And do you listen -- do you take their history?

A I do.

Q Do you do examinations?

A I do.

Q Do you send them for MRIs?

A I do.

Q Do you prescribe a course of treatment?

A Yes.

Q Do you see them for as long as they need to see you?

A Correct.

Q As a result do you feel that you're in a position to be

able to give an opinion as to their future medical care needs?

A Yeah, I do. I mean, with regard to the spine, yes, yes.

Q Do you think that they need to go get a life care planner to find out what future medical care needs they need?

MR. FALEY: Objection, Judge.

THE COURT: Sustained.

Q Okay. We mentioned or we heard reference to adjacent segment disease. You had mentioned it earlier.

A Yes.

Q And there was talk about it's less if it's only a one-level fusion as opposed to a two-level fusion?

A Yeah, generally speaking, true, yes.

Q And then there was reference that if he doesn't have a fusion it doesn't come into play. You rejected that.

Can you elaborate?

A Yeah. I mean, for the same reasons we were talking about. You know, there's such a thing called autofusion. So, you know, as we saw in his most recent images, as that disc collapses you do get more bone spurs, and the bones are basically above and below trying to grab at each other to stabilize. That's, you know, where those osteophytes or bone spurs come from.

And, eventually, as the thing hardens and stops moving, then naturally the levels above are going to compensate for that

motion, and that will lead to adjacent segment disease, the other discs wearing out.

So, yeah, I think I mentioned earlier, but basically whether he get the surgery, the fusion, or not, he will have adjacent segment issues.

Q And especially at the L5-S1 level, so the sacrum is below. What significance does that have as it relates to adjacent segment disease?

A Yeah. So, normally, like if you were to, say, severely injure the disc in the middle of the spine, and then you've got a fusion, the disc above and below would share the compensation.

But when it's at L5-S1, a junctional level, that's where the whole spine attaches to the pelvis, which is rigid and one piece, so that doesn't move. So then that disc, that L5-S1 disc is going to work doubly hard. And then if you fuse that, the L4-5 disc above is going to work doubly hard.

So the rates of adjacent segment degeneration are much higher when the fusion concerns L5-S1, the bottom level.

Q And has your opinion changed in any way as to the question earlier about whether, to a reasonable degree of medical certainty, you believe that Mr. McKenna will need a future fusion and adjacent segment fusion at a later date?

A I think it's extremely likely he will need both, unfortunately.

Q One final thing on the adjacent segment. We heard

percentages. Earlier, you said it was a percentage, but you said it was compounding.

A Yes.

Q And is that compounding year by year?

A Yeah. So, you know, I guess the statement was made, well, it's only 2 to 10 percent, but that's per year. So over 10 years, that's 20 to 80 percent. So it's not a small number is my point.

Q And that's what you mean by compounding, the increase?

A Yes.

Q Okay. Now, you were asked, Doctor, if you used a nail gun before, correct?

A Yes.

Q When did you use a nail gun?

A Twenty-five years ago.

Q Okay. Do you recall what size of a nail gun you used?

A No. I mean, it was sizeable. I remember it being heavy. But no, I don't know.

Q Have you any idea what size the nail gun Mr. McKenna was using on the date of the incident is?

A I don't know.

Q Is this what you imagined it to be (indicating)?

A No, that is larger.

Q Okay. Now, Doctor, I want you to assume that on the day of this incident Mr. McKenna is not standing on solid ground

like I am. He's standing on the third or fourth rung of an A-frame ladder --

A Yes.

Q -- at a height, his left hand in the air and his right and on the nail gun. And it's his testimony that the gun kicks back and sends a shock wave through his body.

Based on those complaints, do you have an opinion as to whether that body movement would cause an injury to the lower back?

MR. FALEY: Objection, Judge.

THE COURT: Overruled.

A Yeah. I mean, I don't know how much it weighs. It's large. He's reaching. It's above his head. He's bracing himself. And then, yeah, it's very feasible that that force will recoil down. It's going to go through the spine. And, I mean, it makes sense that it's an L5-S1 level because that's right where, you know, the shock wave going down the spine hits the solid pelvis. He is probably bracing his legs to stand on the ladder or whatever he's standing on. And the weakest point is going to be that last disc right before his locked leg and pelvis hits the force coming down from above. Again, I think it's entirely feasible. Yeah.

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

THE COURT: Cross exam.

RECROSS-EXAMINATION

BY MR. FALEY:

Q Doctor, what force was generated by that nail gun?

MR. MOORE: Just note my objection.

Q What force --

THE COURT: Overruled.

Q What force was generated by that nail gun?

A I don't know, sir.

Q Do you even know it happened this way? Do you know?

A That's my understanding of what happened, sir.

Q Okay. Do you know for a fact that it happened that way?

A I was not there.

Q That's exactly my point. You don't know. You're only given hypotheticals. You don't know if it happened that way at all, correct?

A Correct.

Q Right. And you don't know if the nail gun was acting properly on that day or not, correct? You don't know?

A I'm going by what I'm told, sir.

Q So you don't know?

A Correct.

Q Right, okay. And you mentioned the thoracic spine MRIs. The plaintiff didn't testify in court about anything about his thoracic spine, okay.

A Are you asking me or telling me? I'm sorry.
Q Do you know that?
A I'm not sure what you're asking me. Sorry.
Q Okay. Well, you mentioned something about an established -- what was it? An established body part, was it? What did you say for Workers' Compensation? It was -- something was an established injury, was it? What were those words?
A I mean, I said that I know the lumbar spine was an established body part with regard to this injury.
Q Yes. That was what I was asking.
Established body part, right?
A Yes.
Q That's it, yeah. Okay.
So he did not complain when he was in court about his thoracic spine at all, okay, just letting you know.
A Okay.
Q You accept that? Okay.
A Sure.
Q Okay. And he had herniated discs in his thoracic spine, correct?
A Yeah, I mean mild, but --
Q Just yes or no. Yes?
A Well, I mean, that's not answering the question, sir, you know.
Q Well, yes, did he have herniated discs in his thoracic

spine? Yes or no.

A There was a report that indicated there were some herniated discs. In my opinion, I didn't think they were very bad. I wouldn't have called them herniations. I would have called them bulges.

Q Okay. That's fine. That's fine.

Same with the cervical spine. We've been through that. Herniations there as well, correct? Just yes or no.

A I mean, again, I didn't review that.

Q Okay. All right. And as far as smoking, I'm not saying smoking causes a herniated disc, but there's issues when someone has back problems and injury to the discs and surgery that smoking exacerbates, correct?

A Yes. That's correct. Absolutely.

Q That's what I'm saying.

And you also mentioned that you didn't think -- you thought he was -- the plaintiff was honest with you, but he did tell you -- we've been through this. He did tell you that he denied smoking? Yes or no.

A Yes.

MR. FALEY: Okay. Thank you.

THE COURT: Thank you, Dr. Roberts, for your testimony. You are excused.

THE WITNESS: Thanks.

(Whereupon the witness was excused.)