SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX: CIVIL TERM PART IA-26

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JOSEPH MCMANUS,

Plaintiff,

-against-

THE CITY OF NEW YORK,

Defendants.

Index No.
307029/12

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851 Grand Concourse
Bronx, New York 10451
June 1, 2017

B E F O R E:

HON. RUBEN FRANCO, JSC, and a jury of six plus two alternates.

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

FOR THE PLAINTIFFS:
LAW OFFICES OF JAMES J. McCRORIE, P.C.
150 Broadway, 4th Floor
New York, New York 10038
BY: JAMES J. McCRORIE, ESQ.

FOR THE DEFENDANTS:
FABIANI, COHEN & HALL, LLP
570 Lexington Avenue
New York, New York 10022
BY: JOHN V. FABIANI, ESQ.

DINA LUDWICKI, RPR
Senior Court Reporter

(Whereupon, items was received and marked as Plaintiff's Exhibit 37, 38, 39 for identification.)

(Whereupon, items were received marked as Plaintiff's Exhibit 35, 36, 40 in evidence.)

THE COURT: You may be seated.

(Jurors entered the courtroom.)

THE COURT: Good morning, members of the jury.

THE JURY: Good morning.

THE COURT: We are all ready to go?

THE JURY: Yes, we are.

One day off and we are good.

THE COURT: Mr. McCrorie.

MR. MCCRORIE: Yes.

Thank you, Your Honor.

Plaintiff calls Matthew Grimm of NY Ortho to the stand.

M A T T H E W G R I M M , has been called as a witness and is sworn and testifies as follows:

COURT OFFICER: In a loud, clear voice state your name and business address for the record.

THE WITNESS: Matthew Grimm, 160 East 56th Street, New York, New York 10022.

COURT OFFICER: You may be seated.

MR. MCCRORIE: May I proceed, your Honor?

THE COURT: You may inquire.

MR. MCCRORIE: Thank you.

DIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Good morning, Dr. Grimm.

A. Good morning.

Q. Dr. Grimm, I'm sure you know me.

Dr. Kaplan has already testified, so you don't need to define any medical terms unless I ask you to.

A. Yes, okay.

Q. If you happen to do it, it's fine.

Things like residency, internship, Fellowship, symptomatic, asymptomatic, I will ask you if it needs to be defined.

A. Okey-dokey.

Q. Can you please tell the jury how long you have been licensed to practice medicine in the State of New York?

A. I became licensed in 2011.

Q. Why don't you do this: Tell the jury your educational background up until current employment, then I will have you stop.

A. Undergraduate Pennsylvania State University. Graduating with a degree in electrical engineering.

I then went to medical school at Jefferson Medical College in Philadelphia.

Then I went on to do an internship in internal medicine

for a year at Graduate Hospital.

Then I specialized in physical medicine and rehabilitation and I did a residency at the University of California, Irvine, for a year.

Then I got married and my wife had me move to Michigan. So I finished up my residency at William Beaumont, B-E-A-U-M-O-N-T, Hospital in Royal Oak, Michigan just outside of Detroit for three more years where I was the Chief Resident my last year.

And then I went on to do a Fellowship and interventional pain management at Marietta Georgia Nonsurgical Orthopedics.

That was one year.

Then when I finished that I -- my first position was working in New York for New York Ortho Sports Medicine.

Q. When did you start working at New York Ortho Sports Medicine?

A. 2011.

Q. What is your -- withdrawn.

Are you Board Certified?

The jury knows what the term means.

Are you Board Certified in any field?

A. Yes.

I'm Board Certified in physical medicine and rehabilitation.

Q. I want to ask you to define these things:

Is physical medicine and rehabilitation shortened in the medical field as PM&R?

A. Yes, PM&R.

Q. Can you tell the jury what a physiatrist is?

Sounds like psychiatrist, but a it's physiatrist.

A. It's kind of like nonsurgical orthopedics. It's patients who have joint complaints, back complaints. Anything sort of relating to the musculoskeletal, the muscles of the bone, the bones of the body, who aren't necessarily at a surgical point yet, but have pain that needs to be treated or a condition that needs treatment.

So we will do a consistent of injections, medication, physical therapy, exercises, and sort of guide the patient in those nonsurgical roads.

Q. You told the jury, I think it was your Fellowship. You used these terms together "interventional pain management." What does that mean?

A. There are some doctors that just do pain management. That means they are sort of treating with medications, physical therapy, but I trained in doing injections into the spine or sort of nonsurgical procedures into the spine; be it epidural, facet blocks.

I do procedures called spinal cord stimulators where we will actually put devices into the spine to try and block pain,

injections into various other joints, the hips, the shoulders.

It's sort of more invasive pain management if conservative efforts don't really cut it.

Q. You told us about your Fellowship and your education. Now we know you are employed at New York Sports Medicine & Trauma.

Are you an employee/owner or something else?

A. I'm an employee of the practice.

I sort of do -- I'm the only pain management physician there and only interventional pain physician there.

Q. Have you ever testified in court since you became a physician?

A. Since 2011 I have testified for four -- this is my 4th time. So for three other patients.

Q. Have any of those patients that you have testified ever been a client of mine, whether it was a construction worker or not?

A. No.

Q. Did you and I meet before, though, in anticipation of your testifying here today?

A. Yes. A few weeks ago we met in my office.

Q. Did we also meet this morning?

A. We had some coffee at a Dominican restaurant down the street.

THE COURT: Was the coffee good?

THE WITNESS: Yes.

Q. Okay, so, when we met, what did we go over?

A. We went over just sort of broad strokes of the case and had some coffee.

Q. And you had some coffee?

A. I had some coffee.

I had some eggs.

Q. Dr. Kaplan already testified, but the practice you are employed by accepts work accident matters and the rules that are associated with that; is that correct?

A. Yes.

Q. And in your time, since 2011, have you treated not just Mr. McManus, have you treated other construction workers from the various trades in New York that have had injuries?

A. Yes.

My practice is the scope of broad treatments and I have treated other patients like that.

Q. Also non-work related injuries?

A. All across the board.

Q. Have you treated other steamfitters -- I'm looking for --

Do you know what a New York City steamfitter, a member of the Steamfitter's Union, what he or she does at their work?

A. Yes. It's very labor intensive.

Q. Is your office being compensated, meaning the practice

known as New York Sports, for your time here away from the patients?

A. Yes.

My office is being compensated because I had to cancel or inconvenience about 35 patients that needed to be either rescheduled or some of them, I believe, may have canceled and said they would call back to reschedule their appointment as well.

Q. What, on a daily basis, typically, how many patients would you see?

A. Between 35 to 45 patients.

Q. So, the file, I know you maintain your own file. You have the file of all of the records New York Sports Medicine & Trauma in evidence as Plaintiff's 21, so that you can refer to it, if you need to, and what I would like to ask you is:

For the record, can you tell us, is Mr. McManus a patient of you?

A. He is a longstanding patient of mine.

Q. Dr. Kaplan's already testified when he first became a patient of the practice in April of 2012.

When did you first see Mr. McManus?

A. My first time I saw him was on June 11th, 2012.

Q. Okay, the history of the accident -- withdrawn.

When you see patients within the practice known as New York Sports, who are they typically referred by?

A. I mean, I see patients referred by various number. I mean, some patients find me on the Internet, some patients are referred by Dr. Kaplan.

Q. In this case, how did you come to be the physician for Joseph McManus?

A. Dr. Kaplan referred him to me.

Q. What was the specific referral form as noted in your note?

A. Patients who come into our practice will have back complaints, neck complaints. Oftentimes I see myself, because I specialize in -- a lot of my patients are involved with injuries to the neck or to the back, so they come see me for that.

Q. Okay, what I meant is, specifically, you go to the note, the history of the accident or injury, what was he referred to you for?

A. He was referred to me for low back pain treatment.

Q. Did you have an understanding of how the accident occurred?

A. Yes.

Q. Not the specifics, but what caused the injury?

A. Yes.

A large fall and then injury to his hip and fracture of his femur bone and then an injury to his back.

Q. Can you define this word -- I told you I would only have you define words.

What does lumbar radiculopathy mean?

A. Well, lumbar is pertaining to the back.

Radiculopathy is just a term for, if you have heard of sciatica, pain radiating down the leg or pain shooting down the leg in more of an electricity fashion. Not like an aching pain like arthritis, like an electricity pain shooting down the back of the leg or side of the legs depending on what nerves are in the back.

Q. What was causing Mr. McManus, if any, his pain to become worse at that time in June of 2012?

A. He was describing pain worse with transitional activities and pain that would get worse if he would stand for long periods of time or sit for long periods of time.

Q. Again, ambulation means what?

A. Walking.

Q. Transitional activities means what?

A. Just a lot of times going from sitting to standing, standing to sitting, walking. Anything that is sort of movement of position.

Q. Did you note there whether or not he was in physical therapy?

A. He reported.

Q. I know you noted that he was in the hospital for physical therapy.

Was he in outpatient physical therapy?

MR. FABIANI: It's apparent that the witness is reading from something.

Can I have an idea of what he is reading from?

THE COURT: Sure.

MR. MCCRORIE: It's in evidence.

THE COURT: Let him look at it.

MR. FABIANI: I want to know what he is reading from.

May I take a look at this, please?

MR. MCCRORIE: Yes.

MR. FABIANI: Looks like there is two things up here.

May I just take a look?

THE WITNESS: Yes.

MR. MCCRORIE: Judge, at this time can we do it on a break and mark it for identification and can I continue?

THE COURT: What are we talking about? We are reviewing Plaintiff's 21?

MR. MCCRORIE: Dr. Kaplan put in 21 as all of the notes of the practice.

They maintain separate files. The notes are also brought here. They can go in, but just instead of doing it now, there will be a time.

If we can just continue?

MR. FABIANI: I prefer that he not refer to a

document not in evidence. This is the one that is in evidence. There are some differences.

THE COURT: Is it correct that the witness has in his possession 21, which is his notes as well as Dr. Kaplan's notes?

MR. FABIANI: That's my understanding.

MR. MCCRORIE: Yes, the notes of the practice.

He can still have this file to refer to and not read from.

I'm going to ask that it be marked and handed back to the witness.

THE COURT: You mean marked?

MR. MCCRORIE: Marked for identification 21G.

THE COURT: No, no. Let's not have this in front of jury. Step up.

(Discussion at bench.)

THE COURT: Just administrative matters, members of the jury, you can understand, but very important administrative matters because they have to do with the exhibits that are in evidence or may not be in evidence.

We have to distinguish, because you have been informed that you will consider only exhibits that are in evidence.

Mr. McCrorie, you may proceed.

MR. MCCRORIE: Thank you.

Q. I'm going to hand you 21 in evidence. That's the notes of Dr. Kaplan which contain all of your notes and procedure notes, at least that's what his testimony was.

21G is the file you brought from the office today; correct?

A. Correct.

Q. You two maintain separate files that have the notes of each other in it, correct?

A. Correct.

THE COURT: The witness should be clear, though, that he should not testify from 21G for identification.

Q. You can only read from a document in evidence.

I'm going to put 21G over here.

If it you need to refresh your recollection, if you have any notes in there, you can -- but you can't read from it. You can read from anything in 21, okay?

A. Okay.

Q. Go to your first note, June 11th, 2012.

A. My notes were all tabulated.

THE WITNESS: It will take me a second.

MR. FABIANI: We are looking at 6/11/12.

MR. MCCRORIE: Yes.

MR. FABIANI: Hold on a second, please.

Okay.

Q. If you can tell us, doctor, when you are there.
A. Okay.
MR. MCCRORIE: Can we do this, Judge?
Q. Is that file that you brought, 21G, your file that you maintained for Joseph McManus?
A. Yes.
Q. Did you bring it from your office at East 56th Street?
A. Yes.
MR. MCCRORIE: I would enter it into evidence subject to any redaction.
THE COURT: We are talking about 21 now?
MR. MCCRORIE: 21G, Judge, the file that he has tabulated.
MR. FABIANI: I haven't had a chance to look at it.
THE WITNESS: I found the note, okay.
MR. MCCRORIE: Judge, we can either take a break now and he can look at the file, or, like Dr. Kaplan testified without looking at the file.
I want to go through the notes.
THE COURT: You want to go through the notes in 21G?
THE WITNESS: I figured it out. It was set up a little differently. Mine was tabulated and his has my notes

and his notes in the same one.

THE COURT: So we are only going to make reference of 21, not 21G.

MR. MCCRORIE: Yes.

MR. FABIANI: We are -- looking at 21 not 21G.

THE WITNESS: Right.

MR. FABIANI: Okay.

MR. MCCRORIE: I still move 21G into evidence subject to redaction, so we don't have to have the issue.

THE COURT: We are not going to take that in evidence yet.

We have to have Mr. Fabiani look at it.

MR. MCCRORIE: Understood.

Q. June 11th, 2012, okay.

A. Okay.

Q. We already went through part of the history.

I asked you about physical therapy.

Was he in physical therapy after getting out of the Lubin -- let's do this.

Plaintiff's 40 in evidence. That's the record of Westchester Square Physical Therapy.

Did you come to learn that Mr. McManus was in physical therapy?

A. He stated he was about to start physical therapy.

Q. For what part of the body?

A. For his lower back as well as his hip.
Q. Was he on medication when he first saw you?
A. Yes.
He had been stating pain and taking four Percocet daily.
Q. Now, did you read -- when Dr. Kaplan referred the patient to you, do you have access, either on the computer or in the hard file, to Dr. Kaplan's notes?
A. Yes.
Q. Did you read the history, as given to Dr. Kaplan and the few notes, before he saw you when you first treated Mr. McManus?
A. Yes, I did.
Q. Did you know about something that happened in high school where he saw a chiropractor four or six times?
A. Yeah, he had a slight injury to his back and he treated with a chiropractor and then he didn't have issue with since that time.
Q. Understanding the words you wrote about -- withdrawn.
When had Mr. -- withdrawn.
Lumbar radiculopathy, you told the jury what the words mean, right?
A. Yes.
Q. Was Mr. -- did Mr. McManus make any complaints of radiating pain?

A. Yes.
Q. And just tell us what you noted?
A. On the note he had noted radiating pain into his lower extremities posterior, below the thighs, with associated numbness and tingling.
Q. I hate to be so technical, where was it radiating from as noted?
A. It was radiating from his lower back down into the posterior thigh, down past the knee into the calf region.
Q. It says since when?
A. Since the accident.
Q. Just so we are clear, understanding his accident occurred approximately five months, five-and-a-half months before he saw you, when it says "past medical history," what did you note?
A. Well, on here it says "lumbar radiculopathy."
Q. What were you referring to?
A. Well, I was still getting a hold of the electronic medical records, and when I couldn't ever figure out how to put lumbar radiculopathy into our assessment and plan at that time, and I'm the only one at our office who was really was -- no one could tell me how to do it. I discovered that by putting something in the past medical history would allow me to put it under the "assessment and plan," so that's why lumbar radiculopathy is actually in the past medical history, but he

didn't report to me that he had ever had a past medical history of lumbar radiculopathy.

Q. In any event, you wrote above it "since the injury"?

A. Since the injury that's when he had it.

Q. In the physical exam, the jury knows what antalgic means.

What did you note about his gait?

A. He had an antalgic gait.

Q. Is that something you observed, what he tells you, or something else?

A. That's something I observed.

Q. The jury knows subjective and objective. You can use those words if you want to without defining what they mean.

What is lumbar facet loading?

What does that mean?

A. That means in the spine you have facet joints, which are sort of the joints in between each vertebrae, and facet loading is sort of bending back, bending to the side, putting mechanical pressure on those joints to try and reproduce pain, and he was able to show that when we tested it.

Q. I want to read something from your notes in the physical exam that says: "Lumbar facet loading was positive bilaterally."

So I read that from the first note.

Can you tell the jury that, they don't know this yet,

medically when a doctor says something is "positive" and something is "negative" as a symptom or an assessment, can you please tell the jury what "positive" refers to?

A. Means that it's present. It's there.

Q. And "negative" in the medical notes refers to what?

A. Not present.

Q. What do those words mean in the physical exam, "lumbar facet loading was positive bilaterally?"

A. It meant that on testing when I would have him extend his back or extend to the left, to the right, that's sort of what we do to put pressure onto your facet joints in the spine.

That it was reproducing some of his axial low back pain. So the low back pain that is sort of present in the back, but not radiating or going into the legs.

Q. Just tell the jury from the time you first saw Mr. McManus in June of 2012 until today, with what frequency, approximately, has Mr. McManus been your patient, and you have seen him?

A. I see him approximately on a monthly basis.

Q. During that entire time, other than treating his back, were you aware from the first visit on that he had other complaints?

A. Yes.

Q. Did you know the body parts that Dr. Kaplan was treating for as well as other doctors?

A. Yes.
Q. What was your understanding from visit one of the other body parts that he was complaining of pain from?
A. My understanding is he was complaining of pain in his hip.
Q. Okay, so, a couple of more definitions.
It says: "Positive muscle spasm in the lower lumbar musculature."
We now know what "positive" means.
What is "spasm"?
A. Spasm is when your muscle, for one reason or another, be it pain, be it a signal not reaching it, will start to contract and you could feel some taught bands as well, and you could sometimes visualize it contracting, and you could reproduce pain or you could feel the spasm if you palpate it or touch it, touch the back.
Q. When you write "muscle spasm is positive and present, in a note is that objective, subjective? In other words, do you see it, do you feel it, does he tell you about it or something else?
A. It's an objective finding on an exam.
Q. When you say "palpate", did you feel the muscle spasm?
A. Yes.
Q. If you wrote it, did you feel it on this occasion?
A. Yes.

Q. It says in the lower lumbar musculature, where is that?
A. That's sort of back right here on the sort of the para-spinal muscles that's where you will generally feel it and have it, but you could have it in any muscle. (Indicating.)
MR. MCCRORIE: Standing up indicating his lower back.
Q. Were you aware of diagnostic testing that Dr. Kaplan has sent out for and the results were in the office?
A. Yes.
Q. Okay, the jury knows what an MRI is and a CAT scan and an x-ray, so you don't need to define those.
Do you -- withdrawn.
Did you in Mr. McManus' case, review the MRI was that was performed yourself, review an interpret, the MRI that was performed in May of 2012?
A. Yes.
Q. If we speak about subsequent MRIs, say January of 2017, did you review that film as well and interpret it yourself?
A. Yes.
Q. So, I'm going to have you define something that might be repeated throughout notes, but it's in the first note.
What is UDS?
What is that an acronym for?
A. Urine drug screen. Any patient I have on opiate medication has to undergo testing, regular testing, to check for

compliance, to make sure they are not on any medication that could be interfering with the medication. It's every patient that takes anything has to undergo it. It's the CDC that recommends it and any doctor who doesn't do urine drug scene testing on opiates I wouldn't trust.

Q. Define CDC?

A. Center for Disease Control.

Q. Doctor, can you just tell the jury, we are not going to do it every note, what was your assessment which Dr. Kaplan has defined and your plan on the first visit?

A. I diagnosed him with a lumbar radiculopathy, and our plan as recommending neuro-diagnostic testing with an EMG nerve conduction study to determine neuromuscular damage and to assist with possible injections that would be done in the future. I agreed with the plan for Percocet for pain control, Flexeril for spasm, physical therapy. He was also given in office sacroiliac joint injections for his back pain on that day.

Q. So, I just want to go through on the assessment when you speak about lumbar radiculopathy combined with sacroiliac bilateral. It says: "Sacroili --

A. Sacroiliac joint injection.

Q. That's the injection. Look at the top. What is the lumbar radiculopathy is combined with sacroiliitis?

MR. FABIANI: Sacroiliitis.

THE WITNESS: Bilateral sacroiliitis.

Q. Define the word.

A. So in your spine where your coccyx attaches to your pelvis. There is a small joint, a ligament, that holds them together.

Oftentimes with trauma that joint can become inflamed and irritated and cause significant pain in the lower back.

I think it's worse with prolonged sitting. It's worse with standing, but it won't radiate down the legs. It will cause back pain, significant back pain, and so that's what we gave an injection for symptomatic relief.

Q. You did the actual UDS on that time period?

A. Yes.

I think the next visit we did the UDS.

Q. How often had you performed UDS on Mr. McManus?

A. We generally do them -- I mean it's a random study, so there is not any set time frame, but generally it's recommended between two and four a year.

Q. It's noted in your notes whenever you have done it?

A. Generally in the notes or it's in the chart.

Q. Okay.

You used a term, if you can define it, EMG/NCB. I think you said nerve conduction. Tell them what "EMG" with a slash "NCB" means?

MR. FABIANI: He has in his records NCS.

A. NCS is short for nerve conduction studies. EMG is

short for electromyography. What that is, it's a test of the muscles and nerves of the body.

The one part, the nerve conduction studies, were testing the conduction of the nerves. Used almost like a zapper to say, and you stimulate a nerve to send a signal down it and you have electrodes at another point over muscles that then record the velocity, the amplitude, and you are looking to see if there is any degeneration of the signal or if there is any blockages of the nerve as it goes down the pathway.

The pin-portion of the exam, you are taking a small pin and putting it in different muscles that correspond to different nerves in the back because the nerve conducted to the muscles an supply movement to that muscle; and if there is, say, if you think of it as a water hose if it gets cut off, the nerve gets cut off, you will start to see some degeneration downstream at the muscles farther down the leg.

So, if you see some irritability in that muscle, then you can contribute it, meaning that the nerve in the back is being impinged or inflamed in some manner, and it sort of helps direct treatment and determine how severe the injury is.

Q. In any of the times in your notes you say you are seeking authorization for it. If you get authorization and do the procedure or the test, do you note that in your record?

A. Generally.

Q. What is neuro-diagnostic and neuromuscular mean?

You referenced both of those.

The EMG is what type of test?

A. EMG is, I mean, we are testing the nerves and then, I mean, neuromuscular is just the nerves are going to the muscles. So we are testing the muscles as well with the needle portion. So it's both the stimulation and the pin portion of the exam.

Q. The jury has heard Percocet is what's known as a narcotic pain killer.

What is Flexeril as noted for muscle spasm?

What is that drug and what type of drug is it?

A. Flexeril is an anti-spasm agent. It helps control if patients are experiencing spasms or back contractions that could contribute to pain. Flexeril will help relax the muscle.

Q. A lot of things drugs can be called one thing a generic version, what is Flexeril called now?

A. It's only as a generic called cyclobenzaprine.

Q. The injections that you said you put into in the biliteral sacroiliac joint, what did you inject into Mr. McManus on that date?

A. It's a combination of anesthetics or something that can help immediately with pain and also lessen the pain of the injection, which is Lidocaine and then also a steroid Celestone. That is actually used to treat the inflammation and bring the inflammatory down.

C-E-L-E-S-T-O-N-E.

Q. Can you tell the jury if Mr. McManus was giving any advisements or counseling regarding drug usage on that day?

A. Yes.

I mean, I'm pretty stingy with opiates in my office. I get phone calls daily from patients trying to prescribe opiates, so I don't like to prescribe them, but I only prescribe them when necessary; and if I do, I go over with the patients.

I mean, I'm kind of a hard ass about it. I'd say --

MR. MCCRORIE: Hard nose in court.

THE WITNESS: Sorry.

THE COURT: We are big boys and girls here.

MR. MCCRORIE: All right, "hard ass."

MR. FABIANI: Not the first time we have heard off-color words.

A. So I let them know that they can't get medication from any other doctor. They are going to be given random drug screens. They have to take them as described. We are using them as a necessity, it's not a guarantee. We are going to try to come off them if we can. If they deviate from that, then I'm not going to be able to prescribe them any longer, and that they are very dangerous drug. You can't drive on it or drink on it. It's actually not good to be on these medication because of the problems they make in your life.

Q. Only because it's in Mr. McManus notes and other notes. Is that something you say an note on every patient or something

particular to Mr. McManus?

A. It's something particular to patients on opiate medication. I mean, I talk about the side effects with every drug I give a patient, but opiates that's the one that are sort of controlled and that we sort of strongly regulate.

Q. Can you tell the jury, I'm going to only have you, unless we are speak being a specific hip injection, I'm going to have you only talk about the anatomy of the spine and Mr. McManus' spine injuries and complaints; unless, for whatever reason, it also involves the hip and you want to discuss that.

Can you tell the jury regarding the word "degeneration" and the lumbar or cervical spine, the spine itself, what does "degeneration" mean?

A. Degeneration is just kind of normal wear and tear of the spine as we get older or of any joint in the body.

Q. It's not referenced anywhere, but if any doctor ever calls something "degenerative joint disease" as it relates to the back, is that a disease like the common thought of what a disease is?

A. No. It's just sort of, like I said, I always describe it as wear and tear. It's not a virus. It's just sort of as we go in life you are putting more strain on the back. I mean as we evolved we went on being on all fours to going up. As we did that it started putting pressure on the lower lumbar spine especially where it curves at the bottom at the L-4/5 L-5/1 is

where you see the most degeneration, and then C-5/C-6 is in the third place you see a lot of it.

Q. When you say you see the most degeneration, in this case or every case?

A. In every case.

MR. FABIANI: Can I have that answer read back, please.

(whereupon, the record was read.)

THE WITNESS: We as being human beings.

Q. What does desiccation mean?

A. Desiccation, that means the discs, they are moist. They sort of shock absorbers of the spine, so that gives it movement. As degeneration occurs, some of that moisture starts, if it is becoming degenerative, that moisture will sort of go away and the disc will sort of become less moist and more dry.

Q. All right, going to 7/31/2012, next note.

Did you perform an EMG nerve conduction study on Mr. McManus?

A. Yes.

Q. What was the result?

A. It revealed an L-5/S-1 radiculopathy.

Q. In a little while I will have you explain where the L-5/S-1 is when you do the anatomy.

Is that an objective or subjective finding?

A. That is an objective diagnostic test like an MRI.

Q. If you state that "PT is helping transiently," what does the "PT" stand for?
A. Physical therapy.
Q. What does "transient" mean?
A. That means it is helping for the moment, note some improvement, but the pain returns.
Q. Skipping to the end in the assessment: Did you discuss an interventional pain management that could be considered in the future with Mr. McManus on that visit?
A. Yes.
We discussed doing an epidural steroid injection, which is an injection into the spine to assist with pain control and inflammation of the nerves.
Q. What is intralaminar L-5/S-1 versus right-sided transforaminal L-5/S-1 mean?
A. Two different techniques for the epidural. One is you are going in through the posterior space, into the epidural space, kind of like when woman will get an epidural in the hospital, it's going into that space. Just different medications they are putting in, they are putting a catheter in as well to block the pain.
Q. During birth?
A. Yes.
Where I would be going into that same space but injecting anti-inflammatory medication.

Transforaminal is going in from the side and putting medicine essentially close to the same, in the same area, just a different approach. Different patients respond to either approach.

Q. What is the Gramercy Surgery Center?

A. Procedures are done at a surgical center, which is an out-patient facility where they have the devices that are needed to do the procedures.

Q. That's where you do your procedures?

A. That's where I do some of my procedures, yes.

Q. How about Mr. McManus' epidurals?

A. I have done them both there and at Manhattan Surgical Center.

Q. Two different places?

A. Yes.

Q. Let's first just go with:

Have you ever performed epidural injections upon Mr. McManus lower back?

A. Yes.

Q. If you can give us the number of injections.

A. I think I have done close to 11 injections roughly.

Q. On that date did you do some other form of injection after discussing the interventional injections known as epidural? Did you do anything else on that date?

A. We did lumbar trigger point injections into the lumbar

spine.

Q. What does that mean "trigger point", and what is in the injection that you did to it?

A. Trigger points are oftentimes if you have nerve damage or pain syndrome, similar to spasm, but more directed and a more painful muscular band can form, which can be tender to palpation. You can get them in any muscle of the body. A lot of people get them in the shoulders. A lot of people get them in the lower back in the para-spinal muscles, which are the muscles going down the side of the spinal cord. You could get them in the butt or the calves. Anywhere you could develop.

He was developing them in his lower back, and so what we do is we sort of palpate, I feel for it, and you could actually feel a taught trigger point and I mark it and you mark out the back, and then you take a needle and you inject it into the muscle, and what it is that muscle is very tight and when you put the needle in it, it releases and can provide almost immediate relief.

I inject a little bit of Lidocaine into it, that sort of helps with comfort an relaxes the muscles a bit.

After that I usually instruct him on stretching.

They usually get some immediate relief of that muscular pain.

Q. On any of the epidural procedure notes it states your address and New York Sports Ortho.

Were all of those done, though, at those various surgical centers?

A. Which one?

Q. When did you do the first epidural?

A. The first epidural, according to this, looks like August 23rd, 2012.

Q. So, for instance, that states New York Sports Ortho Trauma. It has your address, but it was performed somewhere else?

A. Right. That's just our letterhead.

Q. You rent the surgical center?

A. Pardon.

Q. You pay a fee to be at the surgical center?

A. No.

Q. Understood.

MR. FABIANI: I didn't hear the answer.

MR. MCCRORIE: They bill it separately.

THE WITNESS: I do my procedure there. I bill for the facility and my office bills for the procedure and doctors fee.

Q. And the medication?

A. They bill for it.

Q. Understood.

The MRIs that you ordered these days Dr. Kaplan has talked about, they are on CDs in evidence as Plaintiff's 35A and

35, which are the lumbar MRI studies and we have done some blow-ups.

We are going to have you step down, with the Court's permission, if you can step down now just to do the anatomy.

THE COURT: Step down.

Mr. Fabiani do you have a question?

MR. FABIANI: I had an objection to the question. Apparently it was only a statement and not a question.

MR. MCCRORIE: Yes.

Q. If you can step down. I'm going to put up 37 for identification. An illustration of the anatomy of the spine.

I'm also going to put up 36 for identification, the model of a spine for identification.

Dr. Kaplan brought 31 for ID.

What I would like you to do is please teach the jury the anatomy of the spine concentrating on the lumbar spine.

You can still tell them about the rest of it as it relates to discs, spinal cord?

THE COURT: Can we have that pushed back a bit?

MR. MCCRORIE: Yes.

THE COURT: That's fine with me.

We have to be sure that the jury sees it too.

THE JURY: Yes.

MR. MCCRORIE: I'm going to leave the model higher up and we will move the books.

THE COURT: Is that okay now?
THE JURY: Yes.
MR. FABIANI: Can't imagine Mr. Santiago can see from there.
THE COURT: Mr. Santiago are you good?
THE JURY: Yes, I'm good.
THE WITNESS: I will try not to be too boring.
THE COURT: Please.

A. In the spine you have seven cervical vertebrae. You have 12 thoracic vertebrae, and the cervical is the neck. The thoracic is the mid part of the back.

Q. Vertebra means bone?

A. Vertebra means bone.

Then you will have five lumbar vertebra.

In between those vertebra you have the discs.

The disks I always like to describe it as a jelly doughnut. There is a soft interior and a hard exterior. It's an old jelly doughnut.

Q. Can you tell the jury the name of the hard exterior and the name of the soft interior medically?

A. The hard exterior is annulus fibrosus. It's made up of very strong fibers that hold the nucleus pulposus in there. The nucleus pulposus is the jelly. That's the vertebra that enables gives the spine motion and cushioning so that it's not bone-on-bone sort of interacting causing a lot of pain. It also

allows space, indicating here, for the nerves to get out around the foramen. The foramen are these holes on the side where the nerves come out.

Also, on the spine like we are talking about earlier the facet joints, which are these joints in between each of the vertebra, and that sort of is where each one interacts with each other.

So you could see mechanically bending back put more pressure on it. Bending the sides puts more pressure on it.

Q. Can you explain what it's called the natural curvature of the spine and explain where someone's stomach would be using the model.

First tell them where the curvature is and why it occurred?

A. So the curvature is, the term is lordosis.

You get, I mean, it's just physics, at the bottom of the spine, it curves at the bottom because you are supporting the entire upper portion of the spine.

In the thoracic region it's very straight, so there is not a lot of curvature there, and at the neck again you are supporting your head, so it curves again at the neck.

Generally two areas where it curves is the two areas where you see most of the injuries to the spine.

It's uneven pressure. It already has a curve in it, so any trauma to that region will cause injury, and it could cause

the nucleus pulposus to then push against the annulus fibrosis, that harder outside so the jelly will push on it and if there is enough force or pressure, the nucleus pulposus can actually break the annular fibers, and then you will have what's known as a herniation, which is that area of pushing and out and actually causing degeneration and breakage through those annulus fibers.

It generally pushes backwards towards the spine, and it could cause compression of where the nerve roots -- this is the spinal cord. The nerve roots will come out through the foramen. So that's looking -- this picture is looking down on it. (Indicating.)

So if you think of these nerves are these yellow parts coming out right here. (Indicating.)

Then this red area is signifying a herniation, meaning the jelly, the nucleus pulposus, pushes out and it can cause compression on both either the thecal sac, which is just the sac covering the spinal cord, which is then this black area here could be cerebral spinal fluid, sort of cushioning.

If that gets pushed on it, it could cause compression on the cord or compression on the nerve roots, all of which can cause pain and pain shooting into the legs.

Q. I just have to stop before we go any further.

When you say "this area coming out", you pointed to the nucleus pulposus.

If it came out, it would be a herniation?

A. Yes.

If it breaks through the annulus fibrosis, if you have sort of breakage of that hard exterior, then the jelly can push out and cause compression --

You could also have something called "bulging", which it's pushing, but the annulus fibrosis, that hard outer area is still intact.

So it's not broke but a bulge as well can cause compression of the nerves, but it's not quite as severe because the outside is still intact.

Q. I would like you to define these terms using the illustration up there because they relate to MRIs when we speak about, views, doctor, sagittal views and axial views for MRIs or imaging, what do they mean and can you show us that on that illustration?

A. A sagittal view would be this view here looking in from the side. So an MRI will take many cuts, and then you will see a picture looking similar to this. An axial view is cutting this way, so you will see this picture here. Both views give you sort of a look at what's going on in the nerves and the bones and the discs in the spine.

Q. Focusing on both the axial view of the cervical vertebral and this yellow item in the middle, and the lumbar vertebral and the series of yellow called the cauda equina, could you please tell the jury first, is the spinal cord a full

complete spinal cord from the base of the brain all the way to the lower lumbar back or something else?

A. No. Your spinal cord starts up here and generally ends at L-2. Then at L-2 you start having nerve roots or the cauda equina, which is a collection of these nerve roots, they then come down and come out of the spine at different foramen, which are the holes in the spine. It ends at about L-2.

Q. Cauda equina Latin for the horse's tail?

A. Yes.

Q. Look that way on the MRI?

A. You will see a very dense region, which is the cord and then roughly on average at about L-2 every patient is a little different. It could be a little lower or higher. That's when you will see the cauda equina or the nerve roots coming down, so you will see a lot more nerve roots on this view.

Q. Is the cauda equina an extension of the spinal cord?

A. Yes.

Q. Okay.

So, just in terms of describing radiculopathy -- if you have to go back to any of the illustrations, please do so.

I'm going to put up 38 for identification and define the word sciatica and use it in connection with radiculopathy?

A. Sciatica is a sort of a generalized term of the sciatic nerve, which is a collection of multiple nerve roots in the lower back, but then will produce pain down the back portion of the leg

should they become inflamed at some region either in the spine or along the course of the sciatic nerve.

When they do become inflamed, that's when you will get the pain. You hear people saying: "Their sciatica is acting up", that means the nerve is inflamed. You will generally get pain down the back of the calf to the lateral portion of the calf or the medial portion of the calf depending on what levels are involved.

Q. If either a disc is bulging or herniation, can that be, if it touches an exiting nerve root, will the cauda equina, can it be a competent producing cause of pain?

A. Yes.

Q. Can a herniation be preexisting? Can it be present without any symptoms?

In other words, it's not touching a cord or an exiting nerve root?

A. Yes.

The pain is not caused by the disc itself.

A disc can be herniated out or bulging out as long as it's not coming into contact with the spinal cord or as long as it's not broken and some of this material is leaking out. It could just be there and not having any problem, not causing anything. A lot of people have disc bulges and disc herniations that don't effect anything.

Q. Can I please have the model behind you for one second.

In other words, if the herniation is away from the exiting nerve root and not touching it, it's possible to be there but not cause pain, correct?

A. Correct.

Q. So, I'm going to hand you up two enlargements from the CD, 35. It's going to be 35B and C. Enlargements from the May 2nd, 2012 MRI.

As I do that, can you tell the jury, an MRI imaging, are there two different types of images, T-1 and T-2?

A. There is T-1 and T-2 imaging.

Just basically T-2 imaging is used to visualize fluid in the spine much greater. It will come up very bright white when you see the more fluid or if there is fluid in the spine.

Q. Can you see discs, actual intervertebral discs, can you see them on an x-ray?

A. You cannot see the disc, you can see the space. The x-ray goes right through the disc. The x-ray stops at very dense material like bone, metal, but you won't see soft tissue. It will just sort of go through it and you will see a space there.

Q. Can you see intervertebral discs; and, in fact, nerves and nerve roots, cauda equina, on an MRI?

A. Yes.

Q. If you can take up 35-B.

I'm going to place a blue Sharpie pen up on the table. If at any time you need to write on anything, you need to tell us

which exhibit it is.

Is that 35-B just for the record?

A. This is 35-B.

Q. So, if you can take the blue pen and label the vertebral bodies, the bones, L-1 through L-5, please.

A. Okay. So, like I said, it goes L-1 through L-5. Generally start at lower region, L-5, which is the one right before you start to see the sacral levels right here. (Indicating.)

Q. We will actually have you put the number of the bone. Starting up at L-1 and L-5 indicating the last one.

Where does the sacrum begin?

A. The sacrum begins right here. (Indicating.)

This is the tail bone right here.

So this right here is L-5, and this is where the sacrum begins right here. (Indicating.) These are all fused together.

Q. So I was going to ask you: Are there discs in between the sacral bones?

A. There is small areas that's mostly just ligaments, but these are all fused together with bone. So it's one continuous area with holes in it where the nerves can come out of the foramen.

Q. Just because they say things S-1, can you just label the S-1?

A. Yes. S-1, S-2, S-3. (Indicating.)

Q. When we say there is a disc L-4, L-5 or L-5/S-1, what does that mean?
A. Like we said before, in between the bones you have discs.
So, the discs in between L-4,5 will be right here. (Indicating.)
Q. Indicating with an outline of the blue pen?
A. And then again the disc between L-5/S-1 is here. (Indicating.)
Q. Indicating with an outline as well.
So the discs are labeled as the discs between two bones?
A. Correct.
Q. So, can you tell the jury your interpretation when you saw this film back in June of 2012 and today, what, if any, abnormalities there are?
THE COURT: June or May.
MR. MCCRORIE: That's when he saw him in June of 2012.
THE COURT: When he saw him for the first time, I'm sorry.
MR. FABIANI: I'm not sure we ever established when he first reviewed the film.
Q. Did you review the film when you saw Mr. McManus?
A. Yes.

Q. Does your practice maintain a copy of the film?
A. Yes.
Q. When did you review it, if you saw him in June?
A. The first visit. The visit in June. I don't remember exactly, but when it was made available to me, I viewed it.
Q. Did you compare it eventually to another MRI that was taken in January of 2017?
A. Yes.
Q. Did you review them both before coming here today?
A. Yes.
Q. Did you select these images for me to enlarge from the MRIs?
A. Yes.
Q. Please tell us any findings on the MRIs?
A. So, I mean, right away you could see up here the disc spaces. The discs are fairly straight with the cord.

So they are not pushing out or protruding.

Then when you get down to L-4,5 L-5/S-1 you can see when you extend it down, you could see it is this black space coming out here, and this black space coming out here, and it is coming in contact. It is going through this white area, the cerebral spinal fluid, and then this is the sack, the ventral/thecal sac where all the cauda equina and the nerves are that are in here. (Indicating.)

It's coming into contact with that and up here you

could see, it's a little hard to see, but the cord ends about right there. (Indicating.)

Q. I'm going to point to something, the solid piece behind L-1 and L-2, what is that?

A. That is the spinal cord.

Q. What is the area that you just did at L-3?

A. You see that sort of come down to a point, that's the end of the spinal cord. That's where the cauda equina start and this is where the cauda equina and the nerve roots are coming down.

Q. You drew a line there.

Are these called vertebral bodies, the body of the disc?

A. Yes.

Q. If disc material extends, if you were to cover up the vertebral body L-3 and L-4, just go from vertebral body to vertebral body.

If disc material extends beyond the vertebral bodies, what that is called?

A. It's called a protrusion or disc bulge or herniation.

Q. Is at L-4, L-5, does the disc material extend beyond both of the vertebral bodies of both the bones above and below it?

A. Yes.

Q. Does that also occur at L-5/S-1?

A. Yes.

L-5/S-1 extends out and you see a little bit of extension down into the S-1 region.

Q. Do you see degeneration on this?

A. Yes.

Q. Do you see desiccation?

A. Yes.

Q. Does everyone in this courtroom have degeneration?

A. Yes.

I would say there are no five years olds or ten year olds -- yes, everybody has degeneration in the courtroom.

Q. Do the discs desiccate as the natural part of aging?

A. Like I said, the most area of curvature where the most pressure would be is on that L-4/5, L-5/S-1. So like a sponge, as we age, that moisture is getting squeezed out, which will then cause some degeneration and desiccation primarily starting at the L-4,5/L-5/S-1 Level.

Q. Only because it's taken the very same day, 35-C you told them what T-1 and T-2 is why do the images appear brighter, different or something else?

A. T-2 imaging is meant to show fluid in the spine better. So these white areas, that is the vertebral spinal fluid, and then the white areas in the discs are just showing greater moisture in the discs so that they haven't lost, like I said, a sponge, it's not being pushed out as much in these levels.

Q. Is the spinal cord still present, although you don't see it like you see it in the image before?

Is it still present in 35C?

A. This white area is the vertebral spinal fluid, which sort of gets cushioning into the cord.

That's why it's lit up.

Q. Is the cauda equina still present on this?

A. Yes.

That's down in this region.

Q. Can you please tell us what, if any, abnormalities are on this view?

A. Again, the abnormalities you will see is this area right here, which is the L-4,5 disc herniation, and then right here you will see the L-5/S-1, and like we discussed before, you do see some disc desiccation, loss of the moisture of the disc, the sponge pushes the fluid out.

Then just incidental findings to these areas right here Schmorl nodes. They are just an incidental finding. A lot of people will have them. It's, again, related to age and degeneration. Some people have them, some people don't. They don't cause any real problems.

Q. So we can handle the images and then have you sit down in a little bit:

Did you ever order further MRI testing?

A. I know Dr. Merola had ordered further MRI testing. I

can't recall if I sent him for one or not.

Q. Understood. We will talk about Dr. Merola once we have you sit down.

Did you review MRIs from January 4th, 2017 Plaintiff's 35A in evidence and compare it to the MRIs that were performed approximately four-and-a-half years before?

A. Yes.

Q. I'm going to put up 35D, and I'm going to leave up 35B.

If you can just, on 35D, if you could, once again, just label L-1 through S-1, please?

A. Okay. (Indicating.)

Q. So, could you please indicate on -- withdrawn.

Once a herniation is present, can it be what's known as progressive?

A. Yes.

Q. What does that mean?

A. I mean, progression just means, like I said, it's the disc is a moveable object. As that annulus fibrosis or that hard exterior area is broken, if more pressure is put on the jelly doughnut it could cause more jelly to come out, which is what has occurred in this case.

You could see at L-5/S-1 if you compare the two, it does look to be a little bit of progression and farther retrograde extension down into S-1.

Q. What does retrograde extension mean?

A. Movement down into this region.

So farther out almost getting close to a disc extrusion, which would be a piece of the disc actually coming off and sort of floating in free space.

Q. What about anything else?

A. Again, you could see that at L-4,5. If you compared the two, you could see some progression here as well pushing greater into the epidural space and into the region where the thecal sac and nerve roots are.

Q. When a disc herniates, does it always present symptoms immediately?

A. No.

The disc herniation itself isn't what causes the pain, it's if that disc comes into contact with the nerves.

So, oftentimes people will experience it with straining, bowel movements, walking for long periods of time. They call that neurogenic claudication. As you are walking, more pressure is being placed on the disc, which can cause more protrusion out and it can come in contact in with the nerve.

If the nerve is already inflamed, that's when you get that reproduction of the pain.

Bending can reproduce it. It's like a jelly doughnut. Anything that is putting pressure on the disc, can cause it to push out further and come into contact with the nerve.

If it comes out of contact with the nerve, then you

could have reduction on the pain.

Q. In addition to the sacroiliac injections and the trigger point injections and approximately 11 epidural injections, did you also do what's called a facet injection?

A. Yes.

Q. I'm going to have you put up for illustration so we can have you sit down thereafter.

You can compare it to any of the things that are in evidence.

MR. MCCRORIE: This is 39 for identification.

Q. Can you tell the jury, using the exhibits, go in more detail as to what an epidural injection entails?

A. So this is -- what we were talking about before the two different approaches for the injection.

One being the interlaminar approach, which is coming in from the back.

The other being the transforaminal approach, which is coming in from the side, which is what this diagram is showing.

So, as you are coming in right here, you are coming around these foramen or the holes where the nerves come out, and you are taking pictures live with a fluoroscope, which is just an x-ray machine, and I will have a petal and first take a view of the side.

MR. MCCRORIE: For the record, we will mark it for identification, but you take pictures when you are in there?

THE WITNESS: Yes.

Q. Gramercy Surgical Record?

A. This is a picture similar to this. This is actually a set.

THE COURT: Mr. McCrorie, what document is that?

MR. MCCRORIE: We didn't mark it yet. I will mark it when he sits down.

THE COURT: No. You just should the witness documents and said we will mark them later.

We have a procedure.

MR. FABIANI: Are the Gramercy records in evidence yet?

MR. MCCRORIE: We will mark them and I will offer them in when he sits down.

We will do that.

Just continue.

THE WITNESS: It's different approaches. These are, I'm taking a picture from the side driving the needle down to the area where the nerve is coming out of the spine and then I'm taking a picture.

So the patient is laying on the table like this with their back up. (Indicating.)

I'm standing over them right here. I will take a picture from the side. Again, drive the needle down. So I'm getting it down to the area about right here where the

nerve is. (Indicating.)

Then I took a picture from the top because as with any procedure there is risk involved with an epidural.

If you were to came into contact or hit the dura matter or have some cerebral spinal fluid leak, it could cause severe headaches, bleeding, infection.

It's pretty important that I'm in the right location, or if you are not in the right location or just in soft tissue, then the injection isn't really going to do anything.

That's why it's also important to have a doctor know what they are doing. Oftentimes patients will come in and say: "I had an epidural." I will take a look at the images you will see the shot was in soft tissue, so it's not going to work.

Here you could see the injection was right around the nerve root. Then you inject a dye. The dye is, for multiple reasons, one is for safety to make sure we are not in a blood vessel. You inject into a blood vessel you could cause death, paralysis. Medicine can go to the brain and cause a hemorrhage or thrombus or you could be in soft tissue. Like I said before, not in the epidural space so it's not going to work.

Once you inject the dye in, see that you are around the nerve root in the epidural space, then you inject

the medicine.

The patients oftentimes will describe reproduction of the pain because you are around an inflamed nerve. Unfortunately that means we're in the right spot. I take it out and the medication generally takes between 24 to 72 hours to start to kick in.

You could see some improvement over about a week.

MR. MCCRORIE: I think that's it for being up here. I will take the model back and have you take your seat.

THE COURT: Why don't we take, members of the jury, why don't we take a ten-minute break. Ten-minute break. We will come back at ten to. Ten to the hour.

(Jurors exited the courtroom.)

(Whereupon, a recess was taken.)

(Whereupon, an item was received and marked as Plaintiff's Exhibit 41 in evidence.)

THE COURT: Are we ready?

MR. MCCRORIE: Yes, Judge.

(Whereupon, an item was received and marked as Plaintiff's Exhibit 42 in evidence.)

(Whereupon, court resumes.)

(whereupon, the jury is seated and present.)

THE COURT: Members of the jury, we took a little longer than we expected.

Again, we have been hard at work with matters relative to this case. I'm sure you understand that.

THE JURY: Yes.

THE COURT: Let's proceed, Mr. McCrorie.

MR. MCCRORIE: Okay.

Q. During the break, not relevant to you, but 42 in evidence is the Lenox Hill Hospital record of the hip surgery in December of 2012 and the certified records of the epidural injections you performed at Gramercy Surgical Center.

That's 41 in evidence, okay.

A. Okay.

Q. Can you tell the jury in terms of epidural injections, why they are of tendon in a series of three?

A. Well, an injection will be done initially, again, to fight the inflammation, and you do the injection and then you have the patient return after approximately two weeks, three weeks after the injection because you are generally going to see your maximum improvement by that time, and you reassess the patient.

If they show, if they say: Hey, the pain is gone or at a tolerable level, then you monitor them.

If they say the pain is improved, but there is some residual symptoms or pain and there is room for more improvement then you can do a second injection too.

Again, I always describe it as the inflammation is sort

of the fire and the epidural steroid as the water trying to put the fire out.

If it's still sort of simmering, then you can go in with another injection to try and knock out the fire, the inflammation.

Then, again, you re-assess after two, three weeks after that injections, and again ask the same questions: Is the pain at a tolerable level, or is it at a level where we could see further improvement, and then you can repeat the process again. You can do up to three injections safely on the body in a six-month period.

Like taking any medication, if you take too much Tylenol in a day it could start to effect the liver. If you take too much Ibuprofen in a day it could start to effect the kidney. If you were to inject too much steroid in the body, it could start to effect your bodies natural steroid production of cortisol, it could start to effect your bones, and any number of medical issues.

If you keep it under that amount, multiple journal articles found that it's generally safe to do upwards of three in a six-month time frame in a given area.

So you re-assess up to three injections.

Some patients have one.

Some patients have three.

It's not just: Boom, boom, boom you do three. Some of

the less respectable physicians might just say: You have to have three, but they are doing that because they want to bill three times, but not actually do it in the patient's best interest.

A doctor doing it appropriately will assess after each injection to assess for another one.

Q. We are going to have you skip all the way, you said it was once a month, go all the way, March, 2013, March 27th. Just highlight it.

A. Okay.

THE COURT: We are inquiring to another visit?

MR. MCCRORIE: Yes, the monthly visits approximately, and I'm having him go to March 27, 2013. Tell us when you are there.

THE WITNESS: I'm there.

Q. The records will bear out, you said there are 11 injections when they were done, but on this occasion would Mr. McManus inform you of the percentage of improvement with each epidural; would you ask him?

A. Yes.

He returned following an epidural injection and he noted improvement by roughly 50 to 60 percent.

Q. What was the recommendation with that?

A. Recommended proceeding onto additional injection in the hopes of further improvement.

Q. Does the percentage -- you always note the percentage,

it could change the improvement, correct?

A. Yes.

Q. Can you tell the jury, are epidurals intended to be permanent fixes, temporary, something else?

A. Acutely if patients are injured initially the injections can sort of improve the pain, and then if the body natural healing process takes over and it could be long lasting, they may not need them ever again.

In Mr. McManus' case, the pain returned. So now they are more of a symptomatic treatment, improving quality of life for a period of time, then the symptoms return, and we generally have been doing them again.

So different patient's, again, have different responses. So right now it's sort of a transient improvement for comfort, quality of life, and function and also to help reduce his reliance on opiate medications because CDC recommendations, they have come out saying they would like a multi-disciplinary approach consisting of physical therapy, acupuncture, injection therapy, all of that to bring down reliance on medication for treatments.

Q. Looking at the end of that note there is something called an addendum note.

Can you tell us what the addendum was?

A. Yes, there is an error, a typo, in the plan.

The patient had right labrale tear surgery and

initially it was an error and it was put in left labrale tear surgery.

Q. An error in the record, did that get repeated on more than one occasion?

A. Yes.

Q. In any event, you had access to the Lenox Hill Hospital record, Dr. Bharam records.

You knew it was his right labrale tear that was repaired, correct?

A. Yes.

Q. Did he ever complain of left hip injuries to you ever?

A. No.

Q. Or left hip pain ever?

A. No.

Q. From the point when you made the addendum on, is "left" ever mentioned with regard to the hip?

In fact, in the same note as the addendum on top it says: "Left labrale tear surgery, December 17th."

Do you see that?

A. Yes.

Q. It says: "Patient is post right labrale tear on December 17th, right?

A. Right.

Q. If you go to the next note, May, 2013. I want you to just define something.

A. Okay.

Q. "Reports worsening axial lower back pain."

What does that mean axial lower back pain?

A. Pain in the back can be both just pain in the back itself without radiation or pain coming from the back shooting down the legs, which is radicular pain.

As we had done epidurals previously to that, that sort of, again, put out the fire around the nerves.

Like we were talking earlier, there is multiple pain generators in the pain.

Unfortunately, Mr. McManus had what we call "mechanical", which is the joints or sacroiliac issue causing pain and both discogenic, which is the discs causing compression on the nerve, pain which will cause radiating pain.

When it's facet pain or mechanical pain, you will have what's called axial pain, just pain in the back. When you are bending right or left you will feel pain in the back, but not the burning nerve pain that goes down into the legs.

Q. In the treatment plan you write the words: "He was given trigger point injections;" correct?

A. Yes.

Q. What does myo-fascial, M-Y-O-F-A-S-C-I-A-L, release being observed indicate?

A. Often it's kind of rewarding when you are doing trigger points in patients.

When you palpate the trigger point and you put the needle in, you can often visualize that muscle sort of releasing, and so you will see the myo-fascial, the muscular release, and the patient oftentimes feels an immediate relief of pain. Patients usually say "Wow." Oftentimes they say: "Can this work immediately?" And I will say: "Yes, it can."

That's what it's talking about.

You see the visual description of it releasing.

Q. That was in the lumbar para-spinal musculature.

What does that mean "para-spinal musculature?"

A. The para-spinal musculature are just the muscles sort of running up and down sort of beside the spine so to give your back support.

Q. In that note you noted the trigger point injection is a 1.5-inch needle.

Can you give the jury an idea of how about how big the epidural needle?

A. The epidural needle that I use is a three-and-a-half inch, 20 gauge. 20 gauge is a fairly think needle. 30 gauge, which is used for the trigger points is oftentimes a 25 or 27 gauge. The higher the number the smaller the needle.

Oftentimes to numb the skin if you had any type of procedure or if you are at the dentist and they say: "you are getting Novocaine, that is 25, 27 or 30 gauge needle.

That's what's sort of used in for trigger points. So

when an epidural is done in the 20 gauge, that's a pretty think needle, and it's three-and-a-half inches, roughly "yay" long. You numb up the skin with a 25 or 27 gauge needle with Lidocaine and then the 20 gauge, which is a thicker needle, once the skin is numb will be placed in; and, again, depending on the patient, some patients you go all the way in three-and-a-half inches, some patients go in five, depending on how deep the epidural space is you go down. It's usually on average you go down two-and-a-half to three inches.

Q. June 26th, 2013, please.

If you can go to that note.

A. Yes.

Q. It indicates Mr. McManus post medial branch blocks.

A. Yes.

Q. That it was helping him 60 to 80 percent decreasing the pain by?

A. Yes.

Q. What is that?

Not the 60 to 80 percent that's self-explanatory, the medial branch block?

A. The medial branch block is the injection for the facet joints. In the spine there are medial branch nerves which are the pain generating nerves sort of take the signal from the facet joint and then travel to the spinal cord and then send a signal up to your brain that you are experiencing pain.

You can inject medicine around that medial branch nerve that will then numb the nerve so it doesn't conduct the signal to your brain that you are having pain, so it helps with both diagnosis as well as treatment for the pain to determine if you are having pain coming from those joints as well.

Q. What effect, if any, is noted did it have on his Percocet use?

A. After both the epidural injections for the radiating pain and the medial branch blocks for the axial pain, we were able to bring his use of the Percocet, when he was previously taking roughly three to four daily, we were able to drop it down to approximately one to two a day just used for like break-through pain if you are doing something more active.

Q. And roughly a month later, if could you just look at the note, did his Percocet use have to increase again?

A. Yes.

He reported to me that the injections were starting to wear off and he was requiring up to roughly three daily for pain control rather than the one to two he had been utilizing.

Q. I'm going to now have you jump to October 28, 2013.

A. October?

Q. 28th, 2013.

A. Okay.

Q. Up until that time, had Mr. McManus been on Percocet and Flexeril?

A. Yes.

Q. And you have already indicated that you did epidurals, faucets, lumbar, trigger point injections, and sacroiliac injections at least to this point, correct?

A. Yes.

Q. Can you tell the jury in the plan what the consideration of radio frequency ablation is?

A. Radio frequency ablation is at that medial branch never that we injected the medication around it. Again, it's sort of used for diagnosis as well as therapy.

If the pain returns, some patients will go in and we will almost think of a hot poker down around and directly on that nerve. Heat it up to 90 degrees Celsius, and then what that does it denatures the nerve. Essentially it cuts it and prevents it from conducting very much longer period of time.

It's a procedure that is done for patients who don't necessarily want to try to go through serial injections, or if the injections do not last longer than say a couple of weeks.

Q. In that date you noted injections are wearing off and you had told them about that, correct?

A. Correct.

Q. If it's in your note. Did you explain that to Mr. McManus?

A. Yes.

Q. What, if any, referrals to other specialists did you

make on October 28th, 2013 after having tried all of those other things you discussed?

A. With any patient there is different routes of treatment, and injections being one route, and you initially start with conservative treatment, if that doesn't help you then you go on to injections for treatment or more invasive treatments, and if they don't provide long-term relief or if some patients don't like the idea of getting injections all the time, and I completely understand that, so I always -- whenever a patient comes in, I always say we have multiple different options. "You are responding to the injections, we can continue injections. We can do nothing, which is I mean always an option. That's never the one that is chosen, or we can also go down another road and get another opinion on the matter from a surgeon to see if surgery could be necessary for a more permanent solution to the pain rather than continuous treatment."

Q. Is a Board Certified PM&R physician treating Mr. McManus for pain management, what was the surgical -- did you discuss the surgery with Mr. McManus that you were sending him out for an opinion for?

A. Yes.

I mean, I always generally will talk to patients. I'm not the surgeon that will be performing it, but I'm aware and well educated on the different surgeries available to the lumbar spine.

They go from minimally invasive ones, where you go in with a camera, to pull out pieces of disc for more severe problems to the spine.

They can go in with what's called a micro-discectomy. We actually cut, go down, pull out portions of the disc.

To a more severe surgery where you go down an actually do a laminectomy, which is taking the piece of the bone on the back out, which it's there to provide support, but by taking it out it's freeing up some of that space where the nerves will be flowing, and then since you are pulling that bone out and interrupting the structure of the spine, then you need to go in and actually put some screws and plates to support the spine. That's called a lumbar laminectomy discectomy and then fusion. The fusion is the plates.

Q. What was he being sent out for?

A. Once he was sent out he was recommended by both Dr. Merola and Dr. Brisson.

MR. FABIANI: Objection.

Hearsay.

THE COURT: Sustained.

MR. MCCRORIE: Dr. Brisson's records are here and we can put them into evidence.

Q. Did you send him out for a surgical opinion?

A. I sent him out for a surgical opinion.

Q. Did you get a copy of the recommendation?

A. Yes.

Q. Who did you send him out to?

A. He has been sent out to see Dr. Brisson, and then, as this is a pretty severe sort of life-altering surgery, he was quite apprehensive and scared about it. I always recommend to everybody, I mean, if I was having major surgery I would want a second opinion.

He was sent for a second opinion with another surgeon, Dr. Merola, as well.

Q. Are each of those physicians, Dr. Merola and Dr. Brisson, are they physicians your office, both you and Dr. Kaplan, refer patients to if a surgery is to be considered?

A. They are some of the surgeons, that, yes, we refer patients to.

Q. Did you discuss yourself with Mr. McManus the risks of the surgery that was being considered?

A. Yes.

Q. What were the risks, as you relayed to Mr. McManus before he got the second opinion, what were the risks of the surgery that you understood he was being recommended for?

A. Surgeons often don't like to spend a whole lot of time with patients, so I often field many of the questions regarding surgeries, regarding risks, regarding what they can expect. Surgeons will be in and out and don't really give a chance for questions often if the patient isn't really prepared for it.

So, we discussed the surgery. We discussed the risks, and he asked me what the risks of a lumbar fusion would be as was related to Mr. McManus that the surgeons we were recommending an L-4/5 and L-5/S-1 --

MR. FABIANI: Move to strike.

THE COURT: Sustained.

The last answer about what other surgeons recommended is stricken from the record.

Q. As part of your treatment of a patient who is sent out for a surgical opinion, is it your medical duty to know the surgery he is being considered for a pain management patient?

A. I feel it's my duty to do it and it makes me better to be able to discuss it with the patient and to be knowledgeable of the surgeries.

Q. Don't tell us what the doctor said, what information did you give him about what type of surgery, what risks were you going over with Mr. McManus?

A. I mean, as with any surgery --

Q. What's the name of the surgery you told him the risks of?

MR. FABIANI: That I object to.

I have no objection to the other question. That question I object to.

Q. As part of your diagnoses and treatment --

THE COURT: Sustained.

Rephrase it.

Q. What is the name of the surgery you discussed with Mr. McManus?

MR. FABIANI: Objection.

THE COURT: Overruled.

Q. Don't tell us what anyone else recommended, what did you tell him?

A. We discussed a surgery that's called an L-4/5 -- a two-level fusion of L-4,5 and L-5/S-1.

As I stated before, he is quite concerned about the dangers of the surgery, so he asked me what the risks could be involved, what to expect, and I mean the risks, as I told him, involved in any surgery initially you worry about infection because you are cutting through the skin, going down to bone, taking bone out.

During the surgery they have to monitor the spine.

THE COURT: Sustained. Sustained.

MR. FABIANI: Can we approach on this, please?

THE COURT: Step up.

(Discussion at bench.)

THE COURT: The objection is sustained.

Q. Do you have knowledge as to whether or not the recommended surgery was authorized?

A. Yes.

Q. Did Mr. McManus have the surgery?

A. He did not.
Q. This was back in 2013, correct?
A. Correct.
Q. After Mr. McManus made a decision to not have the surgery, he continued to treat with you?
A. Yes.
Q. From that point on, did you continue the course of treatment that you were administering beforehand?
A. Yes.
Q. Did you give him further epidurals?
A. Yes.
We would do epidurals periodically as his pain would return and the injections would wear off.
Most recently, a few weeks ago, I gave him another injection.
Q. Okay, so in 2017 you have given him epidural injections?
A. Yes.
Q. To your knowledge, did there come a time when Mr. McManus, in your treatment of him, was once again considering the back surgery?
A. Yes.
Q. Did there come a time, once again, that surgery was authorized if he were to choose to have it?
A. Yes.

Q. Do you know when that was in relation to today?
A. I believe it was a few months ago with Dr. Merola.
Q. Did Mr. McManus choose to have that surgery?
A. He was quite scared of going on with the major back surgery; and, like I said before, we sat in the office and discussed the different options for treatment and as he was --
Q. Just your treatment.
A. Just my treatment.

The epidurals continued to give him functional improvement of life. He was able to return back to some employment, a different position that was less straining to his spine.

He elected to proceed with going forward with more conservative, with injections, at the present time.

Q. The injections that you performed this year, was that before or after he made the decision, once again, to not have the back surgery?
A. I believe it was after.
Q. Okay.

If you say his pain was exacerbated, what does that mean as a physician?

A. Exacerbation just means made worse. Different things can make things worse. So, if the patient comes in and says "my pain is worse," something will exacerbate it.
Q. Doctor, in your notes, the many notes over the years,

you talk about, say if it says, I will give it for example, 7 to 8 out of 10 on the VAS pain scale; what is that?

A. VAS pain scale is called visual analogue pain scale. It's just a scale where one end of the scale is a zero and there is a happy face, and that's the actual scale, it has a happy face on it and the whole other end of the scale is a frowning face and there is a 10.

I tell a patient, I say: "Okay, 10 being the worst pain you ever felt, zero being no pain at all, where along this scale is your pain today" and they tell me.

Q. Did there come a time after you performed, after the first EMG/NCS did you perform any others?

A. Yes.

Q. How many have you performed, if you know, up until today?

A. I think there has been three.

Q. So three over the last five years?

A. Correct.

Q. Has the result been any different or what was the result on the second and the third? You already told us about the radiculopathy.

A. On the second one he was still only showing right-sided complaints on the EMG. That doesn't mean there aren't left-sided complaints, but the EMG just, again, defines severity. You could still have a moderate radiculopathy without any damage showing to

the muscle.

Like I said before, the nerves are being kinked, sort of like a water hose. There is still enough signal getting through. You may not see any damage in the extremities even if there is pain.

On his last EMG he did start to develop both right and left findings in the pin portion of the exam in the musculature, so he had some progression when compared to his prior EMG.

Q. I will have you jump to February, 2015. We are jumping to get closer.

THE COURT: This is February?

MR. MCCRORIE: Yes, 2015. February 11th.

A. Okay.

Q. On that occasion did you note that he was able to cut medication down?

A. Yes.

Q. What caused the medication to cut down.

A. An epidural. Lumbar epidural.

The prior epidural he noted improvement in his pain down to a 2 out of 10 with medication. 4 to 5 without medication.

Again, he was cutting his pain down from three a day down to one to two. We were recommending trying to provide more injections to try and bring his -- wean off the opiate medication as much as possible.

Q. Just going a little slower, he was able to cut the medication down from three to one to two following what?

A. Following the injection, the epidural.

Q. So the injections were helping him, and the medications was helping him; would you agree?

A. Yes.

Q. What is -- he still has residual symptoms, what do those words mean?

A. Like I said before, the way we would determine if another injection may be necessary is if you still have residual symptoms. You still have, although the pain may be reduced, it's not to say it's gone. There is still sort of pain. Like I said the fire is not put out.

So, another injection can hopefully throw some more water on the fire to try to bring the pain level down further. There is still room for improvement, although there was some improvement already.

Q. Do me a favor, if you can, why don't you just read the three sentences, I believe, read the history in February of 2015 just up to the last one.

A. "Patient is a 37-year old male who presents with back pain. Continues noting improvement following prior epidural improvement noting improvement in pain down to a 2 out of 10 with medication, four to five without.

He has been able to cut medication from three a day

down to one to two a day following the injection.

As he still has residual symptoms, and would like to avoid surgical intervention as well as wean off of narcotics, he would like to proceed onto an additional injection in the hopes of bringing his pain level down to a zero to two without medication and without the need to proceed onto surgery."

Q. Did you find Joseph to be what's known as a "compliant" patient?

A. Yes.

Q. Did Joseph listen to your recommendations and your admonitions about the narcotic drug use?

A. Yes.

Q. I'm just going to state, it's in the next note. Did you ever write: "His pain is waxing and waning between a 7 and 10." What does that mean, waxing and waning?

A. It means throughout the day or weeks the pain will get worse or better depending on activity generally, and that's why people who use medication appropriately when the pain gets worse, it's sort of "as needed." When the pain is better, they will not need it.

Depending on the activity, the pain can either go up or down.

Q. January 21, 2016, an epidural was performed and you wrote this -- it's on all of your reports, but I want you to explain it. "Lumbar disc displacement --

MR. FABIANI: What date was this?

MR. MCCRORIE: January 21st, 2016.

Q. "Lumbar disc displacement without myelopathy, lumbosacral."

What does that mean? If you can explain.

A. Myelopathy is direct cord damage or cord impingement where you will start to see some symptoms relating to cord damage.

You will start to see upper or spasticity or tightening of the limbs. It's more of a surgical emergency if you start to have myelopathy rather than without myelopathy means you are having the pain, but you are not having the actual cord damage.

So, essentially, spinal cord damage, it's a more serious condition.

Q. Looking at the plan, it's noted that it started some time in the fall of 2016.

What are the medications Mr. McManus has been on today, in January of 2016, and for some time before.

Can you list them?

A. Yes.

Q. And the milligrams, just so it's in the record?

A. He takes --

THE COURT: This is on January 2016?

MR. MCCRORIE: And currently.

A. Yes.

Q. What is his current medication regiment?

A. He is taking Percocet 10 325. That's 10 milligrams of oxycodone combined with 325 milligrams of acetaminophen.

He is taking cyclobenzaprine, 10 milligrams and Gabapentin 300 milligrams. He is taking the Gabapentin twice a day. He is taking the Flexeril, generally, just at night, and then the Percocet he will use it up to twice a day as needed for pain.

Q. Down from what it had been?

A. Right.

Q. As noted for quite some time?

A. Yes, it waxes and wanes. It's not always two tablets. That's essentially an average. That is the appropriate way to use it. I don't like patients who come in and say: I have to take four a day. That means they are not using it appropriately. The appropriate way to use it is on days say you are out doing something, it might start to hurt your back, you come back, it's hurting a lot more, than you use it.

You are sort of relaxing on vacation, you don't need it, you don't take it.

Q. So, you have already told the jury before, earlier in your direct, what the Cyclobenzaprine or Flexeril was, or the Percocet or the oxycodone and acetaminophen together, what is Gabapentin; is that a narcotic?

A. Gabapentin is not a narcotic. It's actually an old

medication that used to be used decades ago for seizures that they found that as one of the effects of the medication it also helped with nerve pain. It's a numbness shooting pain from anything. Could be from radiculopathy. Could be diabetic neuropathy saying it was caused from the nerves.

Oftentimes I really like to use that in combination with other medications. Again, to try to, everything in the goal of trying to take patients off of sort of addictive medications an onto other medications that can help and maybe don't have quite as many side effects or addictive property.

Q. Whether it was the fall of 2016 or in notes of 2017, what is right-sided fluoroscopically guided trochanteric verser hip injection.

What is that?

A. Can I use the model?

Q. Of course. I will hand you up the model, just for ease, using Plaintiff's 31.

A. So, this is the pelvis, and, like I said, this is the coccyx. This is the pelvic bone or the hip. This is the femur. This is the bone that he fractured and now the intramedullary rod is in.

At the femur you have something called greater trochanteric protuberance, which is right here. Which is sort of that or between the head of the femur, after the neck of the femur, and where it curves down.

This, and everybody can sort of feel it, you could actually feel it on your hip. As it sticks out there is something on top of it called a bursa.

A bursa is just a fluid-filled sack. It's consistency almost like egg yoke, but then it has a covering of it and it's put there to act so there is smooth motion of muscular tendons over joints.

Every joint in the body will have a bursa.

That bursa or fluid-filled sack can become inflamed due to trauma, due to overuse, due to sometimes arthritis, bony growth that can grow out sort of around the bursa and it could become inflamed.

When it does that it is very painful. Laying on your side patients will often come in and say "I can't sleep on my right side it hurts too much."

Walking, because it's sole purpose is to sort of improve the fluid motion of the tendon over that region, walking becomes very painful.

Touching it, you could all feel your own, touching it would become exquisitely painful. When that happens treatment for it is often, I mean initially with physical therapy oral anti-inflammatories, if that doesn't work then you can do an injection into the joint where you go down, you generally are using fluoroscopy or sometimes you can just go in blindly, but you get a better result generally if you use an x-ray machine.

You put the needle, you go directly down to bone.

So you are feeling bone and you are seeing it on x-ray. Then you pull it back a little bit, inject a little bit of dye in to make sure you are in the bursa. Then you inject Lidocaine combined with -- Lidocaine is an anesthetic combined with a steroid in that area to bring the inflammation down.

Q. I would like you to assume Dr. Kaplan went over x-rays with the jury and I'm holding up 17D showing them where that region was with no bony growth and taking them through the years of 2014 and 2016, the most recent is November, it's 21D. You pointed out that that was bony growth that wasn't present at the time of the accident.

Do you see where I'm pointing to with a cycle?

Is that the area where you injected the trochanteric?

A. Yes.

I mean, the bursa covers the whole region. You see a diagram of it. It's sort of a long, sort of sliver, kidney-bean shape joint that encompasses the whole joint.

Yeah, if it gets inflamed at any region it could spread and that's the region into the bursa where we inject it.

Q. You did that on more than one occasion?

A. We have done it on more than one occasion and presently we have requested an additional injection.

Q. Just taking January 12th, 2017 if your note says: "The reason for the procedure is right-sided trochanteric

bursitis".

Can you tell us what that means "the trochanteric bursitis."

Unfortunately, after lunch we will do the opinions. I'm pretty much done with the treatment.

A. Trochanteric bursitis, like I said, you have the greater trochanter bursa, which is the fluid-filled sack, that we were discussing before, and the bursitis is inflammation of that fluid-filled sack.

So trochanteric bursitis is just the description of inflammation of the trochanteric bursa.

Q. Did Mr. McManus report these injections were helpful?

A. Yes.

Q. Currently, do you still see Mr. McManus on the approximate monthly basis?

A. Yes.

Q. What is the reason for seeing a patient on an approximate monthly basis when you are prescribing narcotic pain medication and was under active pain management treatment?

A. Because opiates are a very serious drug. The CDC, Center for Disease Control, recommends monthly medication management. That's for multiple reasons.

One is because you want to assess the patient's pain to make sure that the medication is still necessary.

Two is to check for compliance to make sure there is no

diversion and patients are actually taking it and not selling it or giving it to family or any number of reasons.

THE COURT: Mr. McCrorie, we have to break for lunch now.

MR. MCCRORIE: Of course.

THE COURT: Members of jury, we will break for lunch now. 2:15. 2:15.

Let's start promptly at 2:15.

Thank you very much.

Have a pleasant lunch.

(Jurors exited the courtroom.)

(Whereupon, there is a luncheon recess taken and the case adjourned to 2:15 p.m.)

AFTERNOON SESSION

(Whereupon, court resumes.)

(Jurors entered the courtroom.)

THE COURT: You may be seated.

Members of the jury, I hope you had a pleasant lunch and got your rest and we are ready to go.

Dr. Grimm.

(Whereupon the witness resumes the stand.)

THE COURT: Mr. McCrorie.

MR. MCCRORIE: Thank you, Judge.

DIRECT EXAMINATION (Cont.)

BY MR. MCCRORIE:

Q. When is the last time you examined Mr. McManus in the office?

A. In the office, it looks like May 2nd, 2017.

Q. In the future, do you expect Mr. McManus to come for a follow-up visit?

A. Yes.

Q. When?

A. I'll expect approximately monthly visits.

Q. Just taking that last visit I think we were on, taking that last visit we were on, can you just told us the medication was on, can you tell us what were his complaints of pain on the last date?

A. He stated that he returned to work.

At work he was standing for long periods of time, working as a security guard at a financial-necessity position. Quite a lot of standing and sitting, which had been exacerbating his pain.

I stated that he continue utilizing Gabapentin, which helped with his radiating pain.

He reported the medication had helped he said.

He reported that prior epidurals had reported greater than 60 percent improvement in his radiating pain.

The pain has now since exacerbated and he was

describing pain radiating down his right rather than his left lower extremity, all the way to his feet.

We discussed that he received an authorization for an additional epidural injection. He wished to proceed.

He also described that the right hip pain, right trochanteric bursa pain at his hip, had gotten worse and returned.

He was asking if we could request another trochanteric bursa injection.

He stated he was utilizing approximately one Percocet daily for his pain that he would take after he worked his workday.

Q. Part of your review in rendering diagnosing and treatment, did you review the St. Barnabas record from St. Barnabas Hospital noted in Dr. Kaplan's notes, but did you do it as well?

A. I flipped through it.

Q. How about the Lubin Center?

A. Yes.

Q. Did you look at the discharge and the typed notes in the hospital record?

A. Yes.

Q. Did you consider, prior to rendering a diagnosis, the notes of the first surgeon, Dr. Mark Klion?

A. Yes.

Q. And did you consider the office notes you said you reviewed of Dr. Merola and Dr. Brisson?

A. Yes.

Q. And Dr. Bharam?

A. Yes.

Q. Actually, in this case I will give you a hypothetical in something else.

I would like you to assume that Mr. McManus was 34 years old on the date of the accident.

On the day of the accident he fell into what's called a flocculator tank and fell approximately 18 feet into the tank.

I would like you to assume he was in St. Barnabas Hospital after having received two morphine injections in the ambulance.

That he was diagnosed with a, in multiple areas, mid-femur comminuted femur fracture as well as up by the hip-part of the femur fracture, okay?

I would like you to assume that he was hospitalized for a period of 1/30/2012 to 2/3/2012, most of that time being bed-bound in the hospital.

I would like you to assume he was then transferred to the Lubin Rehabilitation Center at the Montefiore Hospital Center 2/3/2012 to 2/14/2012; okay?

A. Okay.

Q. Which he had inpatient physical therapy during that

time.

I would like you to assume that on the second visit with Dr. Mark Klion, he noted back pain and discomfort, and that he was not yet weight bearing, but was moving around and attempting to do physical therapy, okay?

A. Okay.

Q. I would like you to assume that prior to the date of the accident Mr. McManus testified he had previously was asymptomatic entirely in his whole 15-year career as a steamfitter.

That he had been a steamfitter for approximately 15 years.

That I would like you to assume further that Mr. McManus had, other than minor treatment with a chiropractor only, he never had an x-ray to his back.

Never had an MRI to his back, nor had ever seen a doctor for his back excluding a chiropractor to see him four or five times for an accident, motor vehicle accident in 1999. No claim for follow-up other than that treatment that I just mentioned.

Do you have that so far?

A. Yes.

Q. I would like you to further assume Mr. McManus started treating with Dr. Kaplan in late April, 2012.

He was referred to you after complaining of back pain

and hip pain and leg pain on the right side to Dr. Kaplan, and was referred out for an MRI, the first MRI of his life he testified to, Mr. McManus, okay?

A. Yes.

Q. That MRI was to the lumbar spine.

He came back and it's what you interpreted for the jury here today, as you interpreted, an L-4, L-5 herniation, okay?

A. Yes.

Q. Was there any L-5/S-1 as well?

A. Yes.

Q. I would like you to assume that all of your treatment and diagnosis and testing occurred, as it did, you testified it did, I'm going to be asking you questions only about the back, all right, not the femur or the hip.

At the end I'm going to ask you about the trochanteric bursitis only with regard to the hip, okay?

A. Okay.

Q. So the first question is: Assuming no symptoms, that he is asymptomatic before the accident.

Do you have an opinion with a reasonable degree of medical certainty, as to the cause of the herniations that you interpreted and diagnosed in the L-4, L-5 and L-5/S-1 -- first do you have an opinion?

A. Yes.

Q. All of your opinions must be stated with a reasonable

degree of medical certainty.

If at any time you couldn't, whether we asked that question or not, both myself and Mr. Fabiani, you need to tell the record that, okay?

A. Okay.

Q. What is your opinion with reasonable medical certainty as to the cause of the herniations under those facts?

A. Based on my training --

Q. Well, first we need the opinion. Then I will ask you your basis.

A. With a reasonable degree of medical certainty, I can determine that the herniations can be causally relate to the accident on that day.

Q. The accident of January 30th, 2012?

A. January 30, 2012.

Q. Now, tell the jury what is your basis -- that's the herniations that you discussed with the jury at the two levels?

A. L-4,5 and L-5/S-1.

Q. What is your basis for having the opinion that the herniations were caused by the accident?

A. Well, based on my medical training, my medical expertise, my evaluation of his diagnostic testing, my discussions with him of his symptoms, asymptomatic prior/symptomatic post, and also of his responses to treatments after the accident is how I came to the medical opinion with a

reasonable degree that it could be causally related.

Q. I want to change the hypothetical, and I want you to assume as a hypothetical only, okay.

So you need to assume it's true.

I would like you to assume it's true that Mr. McManus had a preexisting asymptomatic herniated disc that he didn't know he had on the date of the accident.

MR. FABIANI: Objection.

THE COURT: Step up.

(Discussion at bench.)

THE COURT: The objection is overruled.

Q. So, doctor, just assume, for the purposes of this question, as you told the jury can it happen.

Assume that Mr. McManus had a preexisting asymptomatic herniation, okay?

A. Um-hum.

Q. You've got to say yes or no.

A. Yes. Sorry.

Q. Sorry, I know it's late.

The same facts occurred, the same accident occurred and that the same time he was complaining about back pain to Dr. Klion and then he saw Dr. Kaplan, yourself, and all other treatment that you testified to, okay?

A. Yes.

Q. In that scenario, do you have an opinion with a

reasonable degree of medical certainty as to whether or not in that hypothetical scenario the accident aggravated or activated a preexisting latent asymptomatic condition of the spine and made it become symptomatic?

MR. FABIANI: Objection.

THE COURT: Overruled.

A. Yes.

In that hypothetical, with a reasonable degree of medical certainty, it certainly is possible that the -- it certainly can be related to a preexisting herniation, just like we spoke before, wasn't causing any problems was just there, and the accident aggravated it, caused that jelly to push out and aggravated a previously asymptomatic herniation and now it has become symptomatic due to the accident.

Q. Without taking the time to -- you have seen the photos -- did we show you the photos of Mr. McManus at the bottom of the tank?

A. Yes.

Q. So a fall that far, 18 feet, if there was a preexisting asymptomatic herniation could it cause that herniation to get bigger or move onto a nerve?

MR. FABIANI: Objection.

THE COURT: Sustained. Sustained.

Q. Is the mechanism of injury, an 18 feet fall, is that consistent, the mechanism of injury with a traumatic injury?

MR. FABIANI: Objection.
THE COURT: Overruled.
THE WITNESS: Yes.
A. That mechanism of injury can certainly cause, again, uneven pressure on the disc, jelly pushing out, can cause a herniation.
Q. To this hypothetical, regardless of whether it was preexisting or caused by the accident, do you have an opinion with a reasonable degree of medical certainty as to the cause of all of the symptoms to Mr. McManus' lower back, the radiating symptoms and the pain symptoms that you have testified to in your records regardless of whether it was preexisting or caused by the symptoms after the accident, do you have an opinion as to the cause of it?
MR. FABIANI: Objection.
THE COURT: Sustained. Sustained.
Q. Do you have an opinion as to the cause of his symptoms to the lower back?
MR. FABIANI: Objection.
THE COURT: Overruled.
A. Yes.
Q. What is that opinion as to the cause of the lower back symptoms?
A. With a reasonable degree of medical certainty, I find that the accident caused the symptoms related to the fall because

he didn't have symptoms before it, and he had symptoms after it, so the cause and effect and everything, it's sort of like a puzzle, everything goes together, and all the pieces fit together in pointing to an aggravation of the nerves and the herniation related to the trauma sustained from his fall.

MR. FABIANI: I move to strike the answer.

THE COURT: Overruled.

Q. Do you have an opinion with a reasonable degree of medical certainty as to the cause of the need for the interventional pain management that you administered to Mr. McManus including the epidurals, the facets, the trigger blocks to the lower back?

A. Yes.

Q. What is your opinion?

A. With a reasonable degree of medical certainty I find that the reason for treatment is directly related to the accident.

Q. What is the basis of your opinion?

A. The basis of my opinion is my training, the review of his diagnostic procedures, my visits with him, and then his responses to treatment.

Q. Earlier on in your exam I asked you if you knew other steamfitters or treated other steamfitters and what steamfitters do.

Do you treat other construction trades as well as

steamfitters?

A. Yes.

Q. Did you ever make any recommendations to Mr. McManus as to whether or not he can return to work as a steamfitter performing the manual labor he performed before January 30th, 2012 for approximately 15 years?

A. Yes, I recommended he should not return to that position.

Q. With a reasonable degree of medical certainty into the future, would you expect, and we are just going to speak about the low back, would you expect a man with the injuries you diagnosed Mr. McManus to have, to have pain upon squatting?

A. Yes. I would expect injuries of that kind to have pain with squatting.

Q. What about kneeling?

A. Yes, significant pain.

Kneeling places strain on the spine, you are going to have some pain.

Q. I'm just going to go through a few more; lifting?

A. Like I said before, like any type of strain, like in a bowel movement or lifting, you are straining and that could put pressure on the jelly that can aggravate the condition.

Q. What about climbing ladders or scaffolds or things like that?

A. Again, that involves straining, compression on the

spine, it can aggravate the condition.

Q. With a reasonable degree of medical certainty, do you have an opinion as to whether or not after the date of this trial Mr. McManus will continue to experience pain to the region of the lower back in the form that you testified to?

A. Yes, to a reasonable degree of medical certainty I find that he will continue to experience pain to his lower back.

Q. For what period of time into the future with a reasonable degree of medical certainty is it your opinion that he will continue to have pain in his lower back?

A. With a reasonable degree of medical certainty I feel he will likely have pain indefinitely.

Q. When you say "likely indefinitely," what is your opinion having treated him for five years through the interventional pain management and the rest of the treatment, will he or will he not with reasonable certainty?

A. With reasonable certainty he will have pain indefinitely requiring treatment for the rest of his life and it will progress.

Q. What is the basis of your opinion?

A. The basis of my opinion is my training, my review of his records, my review of diagnostic studies, his history, his treatment, and response to treatment thus far.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. McManus, beyond the

date of this trial, whether it's medically recommended that he continue to see a pain management, PM&R doctor, such as yourself, into the future?

A. Yes.

Q. What is your opinion as to whether or not that he should or shouldn't do that?

A. I recommend he continue to seek treatment with either myself or some other pain management physician on a monthly basis.

Q. For what period of time do you recommend with reasonable certainty that Mr. McManus continue to see a pain management, PM&R physician?

A. He will require it for lifetime. Lifetime duration.

Q. What is the current cost of a visit with a PM&R physician, such as yourself, in the Tri-state area in New York?

A. My office charges for the visit only $250.

Q. You state a monthly -- what are the prescriptions, what are the -- what is the length of the prescriptions you write to Mr. McManus?

A. Again, for the opiate medications, the State of New York and the CDC and the Federal Government only allows monthly prescriptions. The other medication refills can be placed. If patients are on a steady dose, then refills can be administer if they are still under titration or if something has changed and we need to adjust it. Then I can give monthly if they are on a

steady dose and some refills can be placed.

I generally like to monitor patients on any medication every couple of months.

Q. So, if it is monthly, that would be 12 times a year. If Percocet was once a day instead of twice a day, could it go to every 60 days ever?

A. It could. Generally, again, any patient on opiates I would like to see monthly, but, yeah, if he was taking it very sparingly and we were able to come down, then we could possibly stretch it out.

Q. Six to twelve times?

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to into the future whether or not he will continue to be on and be prescribed pain medication similar to what he has been prescribed for some time now?

A. Yes.

With a reasonable degree of medical certainty I find that he will require these medications in the future.

Q. For instance, currently Flexeril or a muscle relaxer?

A. Yes.

Q. We talked about generic and brand name.

I want you to be as conservative as you can, can you tell the jury with a reasonable degree of medical certainty, do you have an opinion as into the future of whether or not he

should be on Flexeril or something similar, but currently the drug is called Flexeril or cyclobenzaprine?

A. Yes.

With a reasonable degree of medical certainty, I find he will be on it. He has spasms daily and it often helps at night when you sort of can't adjust your body because you are asleep, the muscles often tighten up and the spasms will get worse overnight.

So oftentimes the patients need sort of anti-spasm agents at night to help them sleep so that the back doesn't sort of spasm overnight to any greater degree.

Q. What is the current cost, and, again, make it the generic, you could site the reference if you want, the cheapest you could find Flexeril.

What is he currently doing?

A. He is on cyclobenzaprine. Again, generally taking it nightly, and it's roughly $1 -- it is $1 a pill, according to "Good RX", which is a website you could look up medications on. $1 a day.

Q. For the generic?

A. For the generic.

Q. Would the brand name be more experience or less expensive?

A. If you were to go with a brand name it would be more expensive.

Q. $1 a day for what period of time taking a 10-milligram muscle relaxer?

A. Based on his treatment up to this point, they also say look at the past to predict the future. He has been taking it daily.

Q. With reasonable degree of medical certainty?

A. With reasonable degree of medical certainty, he will need it daily.

Q. For what period of time?

A. Throughout his lifetime.

Q. The Percocet or generic version of Percocet, currently you testified he was two times a day?

A. Yes.

Q. What is the cheapest for that, meaning non-brand name as cheap as you can get it, even if you have to purchase it out of country to ship it here?

A. Currently he is waxing and waning he is averaging roughly two a day. Some days, as we go through his records, sometimes he needs 0/1/2 sometimes he has been up to 3. On average he is using two a day, which is appropriate, because he is using it for exacerbations.

It's generally available at -- the cheapest you could find that for using Good RX I found was $1.50 a pill.

Q. For what period of time into the future with a reasonable degree of medical certainty?

A. He will need it for his lifetime with a reasonable degree of medical certainty.

Q. The drug known as Gabapentin is a neuropathic pain reliever, the non-narcotic that he is currently taking once a day.

Do you have an opinion with a reasonable degree of medical certainty as to whether he should be continually to take and be prescribed a non-narcotic, such as Gabapentin?

A. Yes.

Q. Neuropathic pain?

A. Yes.

Q. What period of time into the future?

A. With a reasonable degree of medical certainty, I find he will require it for his lifetime.

Q. What is the cost of that one pill per day?

A. One tablet is a $1.25.

Q. Again, generic version?

A. The brand name is Neurontin, and it's much more expensive.

Q. Do you have an opinion with a reasonable degree of medical certainty, I would like you to assume Dr. Kaplan already talked about it, I don't know if he talked about the back, but do you have an opinion with a reasonable degree of medical certainty as to whether or not into the future Mr. McManus should have x-rays with any regularity to his lumbar spine?

A. Yes.
Q. What is your opinion?
A. X-ray to the lumbar spine with a reasonable degree of medical certainty should be performed once yearly.
Q. At what cost?
THE COURT: Once what?
THE WITNESS: Once a year.
Q. At what cost?
A. An x-ray is $250.
Q. Is your basis the same as it was for the others?
A. Yes.
Q. Do you have a opinion with a reasonable degree of medical certainty as to whether or not into the future Mr. McManus should have any further lumbar MRIs?
You testified he had two in the last five years. Should he have any going into the future?
A. Yes.
Q. With what regularity, if at all?
A. As it's important, as we discussed earlier, myelopathy. He has shown some progress already. It's important to evaluate that from time to time.
I think once a year would be an overkill and a waste of resources, but I think unless he has some sort of -- if his progression starts to get worse and he does start to display he may need it sooner, but I think it is important to monitor it

every three years.

I think that's a reasonable time frame.

Q. What is the current cost of the lumbar MRI, understanding you say it's every three years.

What does it cost today?

A. $1,500.

Q. For what period of time is your opinion with reasonable medical certainty that he would require an MRI every three years?

A. For his lifetime.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not he should be under the diagnostic test known as an EMG/never conduction studies, you testified he has done three since the accident.

Do you have an opinion as to whether or not he should have future EMG nerve conduction studies?

A. Yes.

Q. What is your opinion?

A. Again, at a minimum I think he should have them performed every three years to evaluate for progression.

If his condition is worsening, then they may be performed more often than that, but, again, just based on his past he has shown some progression already. We should evaluate it every three years.

Q. For what period of time into the future, doctor -- I know it's tedious, doctor.

A. For his lifetime.
Q. What is the current cost of the EMG nerve conduction study today to the lower back?
A. $3,000.
Q. Do you have an opinion to a reasonable degree of medical certainty, understanding he said "no" to the surgery twice, do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. McManus should undergo any further lumbar epidural injections?
A. Yes.
Q. What is your opinion as to whether or not it's recommended medically with reasonable certainty that he should or shouldn't?
A. That again based on his treatment previously, he has been undergoing three a year approximately based on his response to it.
So going forward he will likely undergo a minimum of three a year, and if his condition progresses, as we discussed before, we can safety do up to six a year if it gets worse.
Q. For what period of time, doctor?
A. Lifetime.
Q. What is the basis of that with regards to the epidural injection?
A. Basis is his treatment thus far, and how it has helped him symptomatically helped him return back to work.

Helped him reduce reliance on medications, although he still needs them.

It's helped improve his quality of life and functionality.

Q. Did I ask you for what period of time into the future he should have x-rays? I know you said the cost, what period of time?

A. Lifetime.

Q. That's once a year?

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not physical therapy would be recommended or his recommended to Mr. McManus just for the condition to the back alone?

A. Yes.

Q. What is your opinion with a reasonable degree of medical certainty as to whether or not he should be in physical therapy supervised or formally?

A. I feel he should undergo supervised therapy two to four times a month to help with preventing sort of that progression we are talking about, and also to help him keep focused on a home exercise program as well. It's important to combine both structured physical therapy with a professional with the home exercise program.

Two to four times a month I feel is reasonable.

Q. Do you have an opinion with a reasonable degree of medical certainty -- withdrawn.

What is the current cost of the physical therapy session?

A. Depending on what's done, generally, it's $100.00 to $150 a session.

Q. Say it one more time, I'm sorry.

A. 100 to $150 per session.

Q. For what period of time into the future, in addition to what you said was his home therapy program, should he be undergoing formal physical therapy at two to four times a month?

A. Lifetime.

Q. I'm sorry, it's late, we are all tired.

Did I ask you the current cost of the epidural injection?

A. The cost for -- my office charges for my service $1,500 for an injection.

Q. And does that even include the facility and the rest of it?

A. That doesn't include the facility.

MR. MCCRORIE: Thank you for your patience, doctor.

I have nothing further.

THE COURT: Cross-examination?

THE WITNESS: Judge, I don't know if it's the

Dominican coffee running through me, but could I --

THE COURT: Why don't we take a ten-minute break.

(Jurors exited the courtroom.)

(Whereupon, a recess was taken.)

(Jurors entered the courtroom.)

(Whereupon, court resumes.)

THE COURT: Mr. Fabiani, you may inquire.

MR. FABIANI: Thank you.

CROSS-EXAMINATION

MR. FABIANI:

Q. Good afternoon, Dr. Grimm.

Feeling better now?

A. I'm ready.

Q. I will try not to keep you up there long enough that you need to make another emergency run to the men's room.

You and I have never met before, correct?

A. Correct.

Q. I'm going to -- you testified that you have been cross-examined or testified at trial three times.

This is your fourth time; correct?

A. Correct.

Q. Do you know the procedure on cross-examination if I ask you a question that calls for a yes or no answer, just answer it yes or no.

If you can't answer it yes or no, simply say "I can

answer the question yes or no", and then I will either rephrase the question or we will move onto another question, okay?

A. So if it's not or yes or no or more complicated than a yes or no --

Q. Just say "I cannot answer that question yes or no", and we will deal with the consequences of thereafter?

A. Gotcha.

Q. You have been affiliated with Dr. Kaplan since 2011.

So about six years; is that correct?

A. Correct.

Q. Dr. Kaplan's office, I think you testified, they take work accident cases as part of the practice?

A. As part of the practice, yes.

Q. Is that a large part of the practice?

A. I would say, for me, it's just the nature of pain management, probably 60 percent, and then I have 40 percent of Medicare or major medicine, that type of thing.

So it's a significant part but definitely not all.

Q. As part of that practice, Dr. Kaplan gets referrals from lawyers of patients who are -- have been involved in accidents and are involved in lawsuits as a result of those accidents, correct?

A. Yes.

Q. In this particular case, Mr. McManus, who was referred to Dr. Kaplan by the lawyer that was handling his work-accident

case, correct?

A. I actually don't know. I guess I wouldn't know where he came from. If you are telling me that -- I don't know.

Q. I will ask Dr. Kaplan when he is here tomorrow morning. If you don't know, you don't know.

A. I can't assume. I don't know for sure.

THE COURT: Don't assume.

THE WITNESS: I don't know.

Q. Under no circumstances do I want you to allow me to put words in your month.

A. Okay.

Q. I want your testimony to be your testimony, not my testimony, Mr. McCrorie's testimony, but your testimony, okay?

A. Good.

Q. The first time you ever saw Mr. McManus was some time in 2012 the accident; in May of 2012, correct?

A. Yes.

Q. But when he was referred to you, he was referred by Dr. Kaplan who had seen him some time earlier, correct?

A. Yes.

Q. And the office records, which you have in front of you, indicate that Mr. McManus was first seen by Dr. Kaplan April 30th, 2012, right?

A. Yes.

Q. That's approximately, actually to the day, three months

after the accident, correct?

A. Yes.

Q. Now, and he gave doctor -- the plaintiff gave Dr. Kaplan a medical history, correct?

A. Correct.

Q. That's what appears in the subjective transcription of Dr. Kaplan's April 30th notes?

A. Yes.

Q. Now, when you started treating Mr. McManus some time thereafter, did you review the history that had been provided to Dr. Kaplan by Mr. McManus?

A. Yes, I looked it over.

Q. And you testified on direct examination that you reviewed certain portions of the St. Barnabas Hospital record; is that correct?

A. Yes.

Q. What portions of the St. Barnabas Hospital record did you review?

A. Primarily, I mean, I am sort of looking for bullet points as hospital records that are filled with medications and that. I usually look at the surgeries, what was done. Sometimes medications. So those type of things.

Q. Were you provided with an entire copy of the hospital record?

A. I believe -- I most likely was. I can't recall right

offhand, but I imagine.

Q. Do you know when you were provided with a copy of the St. Barnabas Hospital record?

A. Likely in our chart, yes.

THE COURT: Likely in what?

THE WITNESS: It was in our chart.

I believe it was in our chart on the first date, and I reviewed it.

Q. My understanding is that you brought your entire chart with you here today; is my understanding incorrect?

A. I brought what my assistant printed out for me. St. Barnabas is not in here. I believe it's on the CD.

Q. Your office was served with authorizations. We are calling upon your office to provide us with copies of everything in the hospital chart. I can represent to you, in your office chart, I can represent to you that we did not receive a copy of the St. Barnabas Hospital record.

A. Okay.

Q. When we received the records from your office.

Do you know why that is?

A. I do not know. I am not in charge of records and I don't have my computer in front of me here to tell you everything that is in it.

Q. Do you know what else was in your office record that wasn't produced to us when we asked for it in the discovery

aspect of this case?

A. I would imagine everything was provided to you.

Q. Well, you mentioned that you read part of the Lubin Rehabilitation record; correct?

A. Yes.

Q. We didn't receive any of the Lubin Rehabilitation record from your office.

Are you sure it's in your file?

A. I'm not.

MR. MCCRORIE: Objection.

THE COURT: Sustained.

MR. FABIANI: There was two questions.

MR. MCCRORIE: Authorizations were provided for all of the hospitals.

MR. FABIANI: That's not the issue, Mr. McCrorie, and you know that's not the issue.

MR. MCCRORIE: Objection to that.

THE COURT: Sustained. Sustained.

Step up.

(Discussion at bench.)

THE COURT: The objection is sustained.

Q. As I sit here today, to the best of your recollection, what were the contents of the office file that was maintained in your office that are not part of the chart that you have in court with you?

A. To the best of my knowledge I was given my office notes, Dr. Kaplan's office notes, procedure reports, diagnostic studies, prescriptions, and I believe that's it.

Q. Were you given any procedure reports from St. Barnabas Hospital?

A. No.

Q. The only procedure reports that you have are the procedure reports that came from doctors seen by Mr. McManus since you began treating him, correct?

A. I mean procedure reports in the chart that I brought are my procedures.

Q. I understand that.

A. Yes.

Q. In Dr. Kaplan's. Aren't there also copies of reports from Dr. Bharan.

A. Not in my chart that I was given to bring, just Dr. Kaplan. My assistant printed out our office notes in our office. I have those available to me, but I didn't bring it. They didn't print it out.

Q. Are you looking at 21 or 21G when are you looking at it?

A. I am looking at 21G.

Q. Let's look at 21.

A. Okay.

Q. Which is what Dr. Kaplan identified as the full office

records.

THE COURT: You are talking about Plaintiff's Exhibit 21?

Q. Is that 21 right there?

A. This is 21.

MR. MCCRORIE: 21G is in evidence, Judge.

We didn't put it in, the record, subject to redaction.

MR. FABIANI: Subject to me reviewing. I haven't had a chance to do yet.

THE COURT: We are looking at 21 now; is that right?

Q. We are talking about 21 are reports and procedures from Dr. Bharan in there?

A. I am not sure. I haven't reviewed it. I would have to find them.

Q. We will come back to this.

A. Okay.

Q. I will withdraw the question.

A. Okay.

Q. Put 21 away, please.

Let's look at the St. Barnabas Hospital record, please.

You will note that I identified a couple pages that I was going to be asking you questions about.

A. This one or this whole thing is St. Barnabas?

Q. The whole thing is the record. The pages are the ones I put on a slant so you could easily find them.

A. Gotcha.

Q. Could you tell the ladies and gentleman of the jury what I asked you to look at?

A. Okay.

Q. The first page you are looking at now.

A. The first page: Document Review Report from St. Barnabas Hospital.

Q. Does that contain the patient history?

A. Yes, "History details."

Q. "History details" that's information that is obtained from the patient by either the admitting nurse or emergency room first upon admission, correct?

A. Yes.

Q. Could you read to the ladies and gentlemen of the jury, just briefly, what that paragraph, the initial intake history detail says?

A. "I fell. Patient is a 34-year old male with no significant PMH, past medical history. Though has fractured both ankles in the past. Presents status post fall through a hole at work today with a height of about 25 feet. Patient reports he fell more on his right leg, and that is where the pain is most. Patient reports no LOC, loss of consciousness, and does remember the entire incident. Patient reports no numbness and tingling of

the extremities. Patient reports no chest pain, neck pain or abdominal pain".

Q. Would you agree with me that at the time Mr. McManus was admitted to St. Barnabas Hospital, notwithstanding the fact that he had been given morphine, that he told the people in the emergency room that he remembered the entire incident; correct?

A. According to this report it states that he remembers the incident.

Q. You can then turn to next page "MS/neuro/lymph" where it talks about "musculoskeletal".

You got that?

A. Okay.

Q. Could you read the musculoskeletal comments?

A. Yes. "Positive swelling. Positive ecchymosis. Positive tenderness at right ankle. Positive ecchymosis and tenderness at right, tib/fib and femur. Positive distal pulse. Moving toes. Sensation intact. Capillary refill at two seconds."

That's it.

Q. What is the medical significance of "positive distal pulse?"

A. Positive distal pulse is checking to make sure that the arteries are intact.

Q. Positive distal pulse is a good thing; correct?

A. Yes.

Q. Moving toes, what's the medical significance of that?
A. There is not paralysis of the nerves and he is able to move his toes.
Q. No injury to the nerves other than able to move his toes?
A. I wouldn't say "no injury", but the motor nerves are intact.
Q. They work?
A. Yes.
Q. And I don't believe ecchymosis was defined.
What is ecchymosis?
A. Bruising.
Q. Black and blue?
A. Yes.
Q. And where did they, again, where did they note black and blue?
A. At the right ankle, at the right tib/fib femur.
Q. If you can now move to the next one I tagged.
A. Okay.
MR. MCCRORIE: You can refer to the page on the bottom.
MR. FABIANI: This is page 12 of 194 at least on this version I have. I have noticed sometimes when they printout the pages they don't print out the same.
Q. Does yours say page 12 in the bottom?

A. In the gray little box it says: "Page 12 of 194."
Q. Right, okay.
What is this, what did I just ask you to look at?
A. The page.
Q. What is the page?
A. St. Barnabas Hospital documents reviewed report.
Q. This is another report?
A. Yes.
Q. There is a general complaint, a chief complaint, right. What's the chief complain?
A. "My right leg hurts."
Q. What's the next category, "additional HPI?"
A. "34 year old male."
Q. Stop for a second.
What does "HPI" mean?
A. History of present illness.
Q. Can you read that to the jury, please?
A. "34-year old male brought in by BIB, brought in my EMS as trauma alert after falling from construction site through a hole from about 20 to 25 feet high.
As per patient he landed on his right side mostly and denies LOC, loss of consciousness.
Patient admits to pain in his right leg mostly. More proximal area. Patient with Glasgow Coma Score, GSG, 15.
Admits to having previously broken both ankles when

younger, about 15 to 20 years ago, at different times.

Patient given 10 morphine for pain on the field."

Q. GCS, Glasgow Coma Score, tell the ladies and gentlemen of the jury what that is?

A. It's been a long time since I was in residency. I know it's a scale to determine cognition or alertness. Don't ask me much more about that.

Q. Would you agree with me, 15 is the top Glasgow coma score, meaning that you are alert, oriented.

A. Yes. Glascow, G-L-A-S-C-O-W, Coma Scale.

Q. Is the word on the top of the next page musculoskeletal?

A. Yes.

Q. Under the heading?

A. Yes.

Q. Can you read to the ladies and gentleman of the jury what is said there?

A. "Leg pain."

Q. What is the next musculoskeletal notation?

A. It says: "Negative." And it says: "No arm pain. No neck pain. No back pain. No stiffness."

Q. So, at least as when he was admitted to the emergency room on the day of the accident, plaintiff was suffering no back pain; is that correct?

A. I would say at the time they were taking this picture

in time, he had no back pain.

Q. Okay.

You had an opportunity to review the St. Barnabas record before you came here today.

Where in the St. Barnabas Hospital record does it make mention of plaintiff suffering any back pain?

A. I don't believe there is any specific mention of back pain.

Q. There is no mention in the entire St. Barnabas record of any back pain, correct?

A. Not of back pain, just leg pain.

Q. Let's move onto -- we can put that away for a moment?

MR. FABIANI: May I approach, your Honor?

THE COURT: Yes.

Q. I have given you Plaintiff's Exhibit 17, which is the record from Lubin Montefiore Medical Center.

How long was plaintiff in Lubin?

A. Approximately two weeks.

Q. February 3rd to about February 14th?

A. Yes.

Q. You reviewed portion of that as part of your care and treatment of Mr. McManus?

A. Yes.

Q. Not the entire thing?

A. I mean I flipped through it.

Q. Where, could you tell us, where in the Lubin Medical Records from Montefiore Lubin Medical Rehabilitation Facility where plaintiff was February 3rd to February 14th, 2012 if there is any mention of any back pain?

A. Not that I have seen.

Q. There is no mention of any back pain in the entire 11 or 12 days that Mr. McManus was in the rehabilitations facility, correct?

A. Correct.

Q. Let's take a look at Plaintiff's Exhibit 20 in evidence, which is Dr. Klion's records?

A. Okay.

Q. Dr. Klion was plaintiff's original treating orthopedist, correct?

A. Yes.

Q. Dr. Klion is the man who operated on plaintiff's leg, correct?

A. Correct.

Q. Dr. Klion was the man who treated plaintiff postoperatively until he came under the care of Dr. Kaplan at the suggestion of his lawyers, correct?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A. He was treating with him before he saw Dr. Kaplan, yes?

Q. Dr. Kaplan testified that he was referred to him by his

office?

A. Okay.

Q. Now, when for the first time in Dr. Klion's notes, is there any mention of any back pain?

A. I see some complaints of back pain on January 30th, 2012.

Q. Take a look at the top, January 30th is the day of the accident?

A. Sorry. Okay, March 29th, 2012.

Q. What does Dr. Klion note about Mr. McManus complaints of back pain?

A. He is also complaining of lower back discomfort "possibly from his sedentary position."

Q. What does that "possibly from a sedentary position" mean?

A. From what I understand, his pain is worse when he is sitting.

Q. Does that mean Dr. Klion is saying he has back pain is because he has been sitting too long?

A. I wouldn't necessarily say that, but I would ask Dr. Klion that.

Q. In Dr. Klion's records, does he talk about when he thinks the plaintiff will be able to return to normal activities?

A. "At the present time he will remain non-weight bearing over the next four weeks. He will then start a progressive plan

of weight bearing. Including toe touch to partial weight bearing over the next four weeks. At approximate 12 weeks, if there is good healing, he will start weight bearing as tolerated. He was given a prescription for Percocet for pain control.

His prognosis for full return to activity is potentially asked for months postop."

THE COURT: At one month postop.

THE WITNESS: Four months., "FOUR" for "FOR".

THE COURT: Not the number 4.

Read that again.

THE WITNESS: Asked for months. I guess he is asking for multiple months.

Q. I just asked you to read what it was.

What was the date of that?

Was that February 28,2012?

A. Yes.

Q. So, would you agree with me that at least as of February 28th, 2012 Dr. Klion was considering that the plaintiff had a potential ability to return to full activity, correct?

MR. MCCRORIE: Objection.

THE COURT: Sustained.

Sustained.

I guess there is either a typo there or this is subject to different interpretation.

It's been repeated to me twice.

It doesn't have a specific time period for return, but it does say "FOR months".

Can we agree that is what it says "FOR months."

MR. FABIANI: Right "for months."

THE COURT: Okay.

Q. Is there anything in Dr. Klion's records in which he indicates that he is of the opinion that the plaintiff, that during the course of his treatment, the plaintiff would not be able to return to full activity at some point in the future?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A. I don't see anything like that, no.

Q. So, at least as of the time that Dr. Klion last saw plaintiff, which was at the end of March, 2012, there was no doctor who rendered a prognosis that Mr. McManus would not be able to return to full activity; correct?

A. This is quite early in his treatment, so I don't see how anybody can render any type of opinion.

MR. MCCRORIE: Objection.

Q. That was yes or no.

THE COURT: The answer and the question will stand.

Next question.

Q. Then after he left Dr. Klion he came to Dr. Kaplan's

practice at the recommendation of his lawyer; correct?

MR. MCCRORIE: Objection.

Asked and answered.

THE COURT: Overruled.

THE WITNESS: Yes, from what you told me.

Q. Now, in the April 30th, 2012 notes of Dr. Kaplan, I would ask you to turn to that note.

THE COURT: This is reference to Plaintiff's 21.

THE WITNESS: Okay, April 30th, got it.

MR. FABIANI: May I approach again?

THE COURT: Yes.

MR. FABIANI: I don't know if the pages are out of order.

THE COURT: Yes.

MR. MCCRORIE: I have no objection to showing him what you have, John.

Q. Let's look at the one you have right there.

MR. FABIANI: It's not in the same place as the one that I have, which probably means it's in there twice, but that's okay.

Q. Could you read what Dr. Kaplan wrote starting with that sentence -- the word "he" right there.

A. "He did have a motor vehicle accident in 1999 for which he was treated for low back and neck pain by a chiropractor. This essentially resolved."

Q. So, a couple of things.

He told Dr. Kaplan that he had suffered, that he had been in an automobile accident in which he had suffered neck and low back injuries, correct?

A. Correct.

Q. And he -- did he also relate that to you, that he had been in an automobile accident back in 1999 in which he had suffered neck and low back injuries?

A. I don't recall. It's not in my note.

MR. MCCRORIE: Objection to the word "injuries".

THE COURT: Overruled.

THE WITNESS: I mean I don't remember. It's not in my note. I would imagine we discussed it. I usually go over prior records with the patient.

Q. Did you have any records from the prior treatment to Mr. McManus' low back from back in 1999?

A. No.

Q. I'm going to ask you to assume that in his cross-examination Mr. McManus gave the following testimony.

MR. FABIANI: It's at Page 91?

THE COURT: What date was this?

MR. FABIANI: May 25th.

THE WITNESS: I thought I wasn't supposed to assume.

MR. MCCRORIE: No, he is telling you to.

What page?

MR. FABIANI: Page 91.

THE COURT: I'm missing this.

I hope the jury is missing it too.

Nothing has been asked here, has it?

Anything? It must have been funny.

Maybe I should hear it. I like funny things, especially this time of the day.

THE WITNESS: I was making a bad reference to earlier when I said "I could assume," and you said I don't want you to assume anything, and then I said to Mr. Fabiani "I thought you didn't want me to assume."

It's getting late.

THE COURT: What page?

MR. FABIANI: 91 in the transcript I have.

THE COURT: What line?

MR. FABIANI: Starting at line 9.

Q. It says:

"QUESTION: Okay, you testified on direct examination that I think you said it was 1995, but I'm not 100 percent sure, that you had visited a chiropractor for several visits?

"ANSWER: Yes.

"QUESTION: When was that again?

"ANSWER: I believe it was in 1995.

"QUESTION: And was that for low back problems?

"ANSWER: No, that was not for low back."

Then the answer continues discussing the nature of the accident.

Is that testimony that Mr. McManus gave under oath, on that witness stand, that he did not have treatment for low back pain when he saw that chiropractor, inconsistent with what he told Dr. Kaplan about his prior medical history?

MR. MCCRORIE: Objection.

THE COURT: Sustained.

Q. Dr. Grimm, would you agree that the testimony that Mr. McManus gave that he did not see --

MR. MCCRORIE: Objection before the question comes out, your Honor.

THE COURT: No, no.

Step up, please.

(Discussion at bench.)

THE COURT: The objection is sustained.

Q. What information, if any, did you obtain regarding the prior treatment that Mr. McManus had had for his low back?

A. For his low back I believe he had just been on medication for pain at my initial visit.

Q. Prior to, I'm asking you about the prior incident that is referred to in the records of him having received chiropractic treatment to his lower back some time in the past before this

accident.

What information did you obtain about that condition, injuries, whatever it was?

A. That he had had a few sessions of treatment by a chiropractor that had resolved and had not bothered him since.

Q. You just testified that it had resolved; correct?

A. According to the records.

Q. Well, the record doesn't say it was resolved. The record says it was "essentially resolved"; doesn't it?

A. Yes.

Q. There is a difference between having resolved and something eventually having been resolved?

A. Yes.

Q. "Essentially" is an adverb that modifies that means it's not completely resolved?

A. I think he hasn't had any treatment of that up to that point.

Q. Yes or no, Dr. Grim, "essentially resolved" is somewhat less than having resolved, correct?

It means there is still some residual, correct?

A. I wouldn't describe it as having some residual.

Q. Let me put it this way: "Essentially resolved" means it wasn't completely resolved, correct?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A. I'm not an English major, so for me reading that, if it were any other patient coming into see me and I read that it essentially resolved, I would think that they weren't having any issue with it.

Q. Wouldn't that be it didn't completely resolve then?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

THE WITNESS: I would, again, if it was any patient coming in, I would think it was essentially resolved; that it wasn't bothering them.

Q. Dr. Grimm, you would agree with me that it's important that medical conditions and medical history be accurately recorded in medical records, correct?

A. Yes.

Q. And choice of words is, I mean notwithstanding our current administration, choice of words is something that is important when writing something; correct?

A. Yes.

Q. And you would agree with me that someone made the decision to write the words that it was "essentially resolved"; correct?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

THE WITNESS: That's what's in the report, yes.

Q. That person could have just as easily written it was

completely resolved or it was fully resolved, if, indeed, it was completely or fully resolved, correct?

A. I mean, I would ask Dr. Kaplan that question what he was referring to as "essentially resolved".

Q. I guess we will have that opportunity tomorrow.

Let's go to the June 11th, note.

A. Okay.

Q. You have that June 11th, note?

A. Yes.

Q. That's where you talk about the present illness, correct?

A. Yes.

Q. Then you talk about the past medical history?

A. Yes.

Q. And in the past medical history there is an indication of lumbar radiculopathy, correct?

A. Yes.

Q. And you explained that on direct examination as being a computer glitch that that's how lumbar radiculopathy made its way into the past "medical history section," correct?

A. It was my unfamiliarity with the EMR on how that was in there.

Q. That was an unfamiliarity that occurred in June of 2012, correct?

A. Yes.

Q. You have been treating the plaintiff from May of 2012 to the present; correct?

A. June of 2012.

Q. I'm sorry, June of 2012.

Dr. Kaplan saw him in May.

A. Yes.

Q. Is it your testimony that in the entire five-year period that you have been treating the plaintiff, you were never able to figure out how to operate the computer in your office so that lumbar radiculopathy was not in the past medical history, but was in the history of the present illness; is that what you are telling us?

A. I mean I could show you because, again, I'm the only person in my office who is most technically proficient at computers, and no one was able to really tell me anything. I was a learning curve on using the EMR.

If I have to I could bring all my patients in up to a certain point where I finally figured out where to find the diagnosis code to put in the plan because my office manager, Dr. Kaplan, dictates everything.

I was the one who uses EMR now the way it's supposed to be meant. That was sort of my work around to get a plan in the assessment and the plan because for some reason on the EMR if you have something in the past medical history it allows you to click on it when you do an "Assessment" and "Plan" and write a plan

under it.

I have now since learned how and where to find the ICD-10 and ICD-9.

ICD-10 is the diagnosis codes that Medicare uses for diagnoses, so I can't remember the exact date. I figured it out.

If you need me, I could bring in multitude of examples where I have made this same error for months and months and finally fixed it. This is not the first time I have been questioned about this on depositions.

Q. Here is the question, Dr. Grimm:

This is the only place in your medical records where past medical history is mentioned, correct?

A. Yes.

Q. The subsequent -- every subsequent report, which pretty much has the same format, the little headings in green and then all the words filled in afterwards, there is nothing about past medical history, correct?

A. Yes.

Q. So the only record that we have looking at your records indicates that Mr. McManus had a past medical history, meaning before the accident, of lumbar radiculopathy. That's what the record says, correct?

A. That's what this says and it's in error.

Q. Okay.

Are there any other errors in the medical records at

all?

A. Yes.

Q. What other errors?

A. I have mistakenly had "right" and "left" wrong a couple of times. I think some things have been carried forward. That's the downside of electronic medical records.

Q. I noticed there was mistakenly right for left but it was corrected on many, many occasions, right?

A. Yes.

Q. This was never corrected, yes or no?

A. There was no addendum put in, no.

Q. On direct examination you testified about the diagnostic studies, the MRIs that were ordered, I believe, by Dr. Kaplan back in 2012?

A. Yes.

MR. FABIANI: Let me just see which exhibit numbers they are.

Q. You testified that -- I'm not going to put them up. I want to pull them out.

You testified that there was evidence on those MRIs from May of 2012 of the degeneration of the discs at L-4, L-5 L-5/S-1, correct?

A. Correct.

Q. You can't tell by looking at that MRI how long the degenerative process had been, the degeneration had been in

progress, correct?

A. Correct.

Q. You are not a neuroradiologist, correct?

A. My wife is.

Q. You are physical medicine?

A. My wife is a neuroradiologist.

Q. But she is not here testifying?

A. She is not.

Q. You testified on direct examination that it's your opinion that the disc herniations that are shown on this MRI, were caused by the accident; is that the testimony you gave?

A. With a reasonable degree of medical certainty I can find that it was caused by it.

Q. So that means that it's your opinion that the disc herniations did not exist on January 29th, 2012, correct?

A. With a reasonable degree of medical certainty, I find that the trauma is forceful enough of a fall of 20 feet to cause those herniations.

Q. I understand that you are testifying that the trauma was sufficient to have caused those herniations; but what I'm not hearing is, that the trauma in this particular case actually did cause the herniations; am I hearing this correctly?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

A. It's my opinion that they caused it. If I were a

betting man it's my opinion that they caused it.

Unless you have an MRI of before and after, there is no guarantee.

Q. Exactly.

MR. MCCRORIE: Objection.

THE COURT: Overruled.

Q. In order to determine whether a condition is caused by a traumatic event with a herniated disc, you should have a before and after film to contrast, correct?

A. I disagree with that statement.

Q. You said that disc herniations can occur over the course of time, correct?

A. Generally a herniation, there will be some type of trauma.

Q. You said it could be such a trauma as sneezing?

A. Bulging, protrusions, but a herniation in a 35-year old at that time, again, you are going through the annulus fibrosis, everyday wear and tear, can cause bulges and degeneration, generally will not cause a herniation.

Q. You said that the herniation can be asymptomatic, correct?

A. Correct.

Q. You also said that herniations, if they are not impinging on a nerve root would not cause any pain or discomfort, correct?

A. Correct.

Q. I think you said that many, many, many, many, many, people of over a certain age are walking around with disc herniations that are not impinging on anything; and, therefore, are asymptomatic, correct?

MR. MCCRORIE: Objection.

THE WITNESS: Correct.

Q. Now, can you testify with a reasonable degree of medical certainty that the disc herniations that are shown in that MRI, the May 2nd MRI, were not the result of -- were not instigated by the trauma of the auto accident back in 1995 or 1999, and then progressed over time; can you testify to that?

THE COURT: Let's get some clarification on this date, 1995 or 1999. That's the one accident. There was only one accident; is that correct?

It's just that the dates are confused. Sometimes it's referred to as '95 and sometimes '99. It's the prior automobile accident.

MR. FABIANI: Right. I think Dr.Kaplan testified it was 1999,the plaintiff testified it was 1995.

As far as we know there was only one automobile accident either in 1995 or 1999.

Q. Yes or no, can you?

A. I don't think that is a yes or no question.

Q. You drew the little bulges there?

A. Outlined.
Q. Outlined the little bulges there?
A. Herniation. Bulge would stay within the annulus fibrosis.
Q. Have you seen the actual views, by the way?
A. Yes.
Q. Do the actual views show any nerve root impingement?
A. They show foraminal encroachment.
Q. They do not show nerve root impingement; do they?
A. Again we are taking one picture at a time, no pressure on it.
Q. The ones you saw did not show any nerve root impingement; correct?
A. Correct.
Q. They showed encroaching on the foraminal opening, but they did not impinge on the nerve root?
A. I think at some level they had. I would have to review it or look at it.
Q. You would agree with me that unless the disc, the bulge or herniation, whichever it is, is impinging on a nerve root, it's not going to be causing any pain or radiology; correct?
A. I would disagree vehemently with that. The nerves could become inflamed and swollen. That's what could give you inflammation; and that's why even if the nerve is not sitting on it, if it's already inflamed it could cause pain and then it

could get worse with straining, with maneuvers like a straight-leg raise on physical examination.

So, I mean, when it's actively inflamed you could have pain even without impingement. That's when I talk about putting out the fire.

Q. In order for it to become inflamed, it must have been injured by some mechanism, correct?

A. Yes.

During the trauma, you hit that doughnut, the jelly pushes out, comes out, hits the nerve and then pulls back.

Q. Then the nerve is?

A. Aggravated, inflamed, and injured.

Q. Back in January of 2012 is what your testimony is that the nerve was injured?

A. At some point.

Q. You don't know exactly when?

A. I don't know exactly when.

Q. The darkened area L-4/L-5, L-5/S-1, it's a little darker than the other discs, correct?

A. Correct.

Q. Is that a sign of a drying out?

A. Yes.

Q. That's a sign of what's called desiccation, correct?

A. Yes.

Q. Desiccation is something that takes place over time,

correct?

A. Correct.

Q. There is greater dessication at L-4,5 than there is at any of the other discs, correct?

A. L-4,5 and L-5/S-1.

Q. I meant L-4,5 L-5/S-1?

A. Correct.

Q. It's darker there?

A. Correct.

Q. Then when we get to 2017, the L-4/L-5 and L-5/S-1 discs are darker than the other discs as well?

A. Yes.

Q. Although the other discs are starting to darken; aren't they?

A. I would want to see the comparison again.

Q. Sure.

MR. FABIANI: I'm holding up Plaintiff's Exhibit 35D, and Plaintiff's Exhibit 35B.

35B is the 2012.

35D is the 2017.

Q. You can compare the two. Let's let the doctor look, and then we will show the jury?

A. It would also depends on -- looks like these are done at different locations, correct?

Q. I believe this was done at --

A. Lennox Hill.
Q. And this one was done at East River, I think.
MR. FABIANI: Is that right East River?
MR. MCCRORIE: They might have changed their format.
THE WITNESS: If different magnets are used, it could have a little bit different effect on the images.
I will give you that these images do look a little darker, but there was also a different magnet, so it could have had -- that could be related to the magnet.
Q. But you would agree with me that the discs on the 2017 at the levels above 4, 5 and S-1 appear to be darker than the discs in --
A. I think that it's related to the images because these lower discs, just the contrast is uniform from the L-4/5,L-5/S-1. I would attribute that to the different magnets being used.
Q. Not to the desiccation of the discs above L-4,5?
A. I mean, I would want a comparison. Again, there is not that. It's sort of not comparing the same thing.
Q. You would like a comparison study because it would enable you to be more exact in your analysis of what the condition is, correct?
A. I mean, yes.
I could just say looking at that, the colors are different, but it's completely different magnets that were used.

Q. You are unable to tell by comparison to the colors to the colors in the earlier one to the colors to the colors in the later one as to whether there is any desiccation.

Is that what you are telling us?

A. You could see that there is desiccation, you just can't tell -- I mean, you are asking about progression of the dessication of colors.

You can't tell -- I mean, herniations are pushing out, so you are measuring, not measuring shades.

Q. Would you agree with me that when there is a traumatic herniation of a disc caused by a blow, that that causes immediate pain?

A. Not always.

Q. Sometimes they don't cause immediate pain?

A. Again, you could have the traumatic blow, and it misses the nerve root, it's not going to cause immediate pain or it could just weaken the annulus fibrosis.

Q. Let me ask the question this way:

If you have a traumatic incident that causes a herniation, that touches on the nerve root enough to inflame it or damage it, you would feel immediate pain; correct?

A. You should feel pain on a traumatic herniation directly impinging on a nerve.

Q. So, if there was a herniation that occurred on January 30th, 2012 as a result of a trauma that impinged upon

the nerve sufficient enough to inflame it and injury it, plaintiff should have noticed the pain, correct, yes or no?

A. No.

Q. You testified about the future medical care you believe Mr. McManus is going to need, correct?

A. Correct.

Q. I think you testified as part of it the past history is an indication of what the future will bring, correct?

A. Yes.

Q. You testified, let's start with the current cost of an office visit is $250 per visit, correct?

A. That's the charge for patients if they are coming in paying cash, they are charged $250.

Q. That's not what you got paid for the visits you had seen --

MR. MCCRORIE: Objection.

THE COURT: Overruled.

Q. That's not what you have been paid, correct?

MR. MCCRORIE: Can we approach?

THE COURT: Approach.

Step up.

(Discussion at bench.)

THE COURT: Overruled.

MR. MCCRORIE: Exception.

Q. Dr. Grimm, may I ask the question this way:

As part of the work accident system, you are paid a lower amount for your visits than the $250 you just quoted to the jury, correct?

A. I agree. I go into an order to accept Workers' Comp. for patients. You have to.

THE COURT: Just answer.

THE WITNESS: Yes.

Q. How much per visit have you been paid for the visits that Mr. McManus had over the past five years?

MR. MCCRORIE: Continued objection.

THE COURT: Hold on a second.

Step up again.

(Discussion at bench.)

THE COURT: You may continue.

MR. MCCRORIE: So I don't have to keep saying it. I have a continued objection.

THE COURT: Continued overruled if it's the same question.

MR. FABIANI: It's the same question as to each and every one of these treatments.

THE COURT: Overruled.

Q. How much less than $250 a visit did you accept in full treatment for the treatment you have been rendering for Miss McManus over the five years?

A. We agreed to the contract Workers' Compensation

depending on the complexity of the visit, it could range from 65 to 150 to 175. I think on average, just for the visit alone, not including injections, trigger points, it's around $100, I believe. You would have to check with my billing department. They are the ones who -- I just work there.

Q. When you performed x-rays on Mr. McManus in your office -- I will rephrase the question.

Were x-rays taken of Mr. McManus at your office?

A. I believe Dr. Kaplan took x-rays.

Q. Do you know how many x-rays he took in the past five years?

A. I do not.

Q. Would you agree with me under the Work Accident System, the fee that Dr. Kaplan received for the x-rays that he took was his than $250 per x-ray?

MR. MCCRORIE: Objection.

THE COURT: Overruled.

THE WITNESS: I don't know that what they get. I don't really take many x-rays.

Q. You testified Mr. McManus is going to need x-rays on his lumbar spine once a year for the rest his life.

He is 40 now. We are looking at a lot of x-rays into the future?

A. Yes.

Q. God willing.

A. Yes.
Q. How many x-rays of his lumbar spine has he had since the accident?
A. He has been treating with the surgeons, spinal surgeons. So generally they would be the ones taking the x-rays of the spine. I don't believe in exposing him with too much radiation, so I generally deferred x-rays of the spine at that time as he was treating with the surgeon for them.
Q. You are the doctor managing the care of his low back?
A. Managing the pain.
Q. Of his low back?
A. Yes.
Q. And you testified that notwithstanding him having visited with Dr. Brisson and Dr. Merola, that he has declined to have back surgery, correct?
A. Correct.
Q. As far as we know for now for the foreseeable future, whatever issues Mr. McManus has with his back, you are the man, correct?
A. Correct.
Q. Let's go back to the question then:
Since you have been managing his back since June of 2012, do you know how many lumbar x-rays he has had?
A. Again, since he has been treating under their care, I have, again, I'm not going to take an x-ray of his back when he

has already gotten one at the surgeon's office. So I believe every time he sees the surgeon he likely has an x-ray. I don't know how many he has got.

Q. I get that you don't want to over-radiate him. That's commendable. I get it.

My question is: Is the doctor managing his low back, who referred him to Dr. Brisson and Dr. Merola, who has copies of reports from Dr. Brisson and Merola in your file because he came back to you to talk about treatment alternatives for his back, how many times did Dr. Brisson and/or Dr. Merola and your office x-rays his lumbar spine since June of 2012?

A. I don't have that number.

Q. Do you know whether it's been more than once a year?

A. It very well could be.

Q. Do you know whether it's been less than one a year?

A. I would -- I am not sure.

Q. If you were to check in your records and see the reports from Dr. Brisson and Dr. Merola, wouldn't they indicate to you whether he had gone over any x-rays?

A. They don't forward their x-rays to my office on a timely basis, so it's difficult to get records from other offices.

Q. You have them now?

A. Some of them.

Q. You don't know if you have all of them?

A. We generally don't have every office visit. We get recommendations for surgery. They are following him for surgery. At that time they are the ones taking the x-rays.

Q. Is it your testimony that --

A. Now, if I was taking it over, and they are no longer seeing the surgeon, then I would be the one managing that portion of that treatment.

Q. How many times did plaintiff see Dr. Brisson?

A. I don't have that direct number.

Q. How many times did he see Dr. Merola?

A. Again, I don't have that number right offhand.

Q. There is no way by looking at your file you could tell us?

A. No.

Q. Let's see: Mr. McManus had a lumbar MRI in 2012, correct?

A. Yes.

Q. I think that is May 2nd, 2012?

A. Yes.

Q. He had another set of lumbar MRIs in January of 2017, correct?

A. Correct.

Q. Who ordered those two sets of MRIs?

A. The first one was by Dr. Kaplan, and, I believe, the last MRI was Dr. Merola.

Q. Dr. Merola did report to you that he ordered an MRI and you were furnished with copies of those MRIs?

A. Actually Joseph reported to me that he had received an MRI and we contacted Lenox Hill Radiology where he had the MRI done for copies of the MRI.

Q. As far as you know sitting up here today, in the five years since this accident, Mr. McManus has had two sets of lumbar MRIs, correct?

A. Yes.

Q. That's one every five years, right?

A. No. That would be two, right.

Q. Well, one every five years?

A. Two in five years.

Q. Well, five year gap between the two?

A. Okay.

Q. Am I wrong, is my math wrong?

A. That's correct.

Q. You could say it?

A. Two in five years.

Q. You won't get punished if you agree with me.

As far as the EMG and NCS testing that you have done, how many of those have you done in the five years you have been treating Mr. McManus?

A. We have done three.

Q. Three of them?

A. Yes.
Q. You quoted for Mr. McManus on direct examination that the cost of them is $3,000 each, correct?
A. Correct.
Q. You would agree with me, however, that under the Work Accident Compensation System you were paid less than $3,000 for each EMG/NCS study that was done, correct?
MR. MCCRORIE: Objection.
THE COURT: Overruled.
THE WITNESS: I think it's somewhere in the range of 1600 to $2,000.
Q. It's between a half or a third off of what you quoted as the retail rate, correct?
A. Yes.
Q. That's a negotiated rate?
A. Well, I wouldn't call it negotiated.
Workers' Comp. says if you want to see Workers' Comp. patients you will accept these rates. If you don't want to see Workers' Comp. patients, then you will not accept these rates.
Q. You don't send a bill to the patients for the difference from what you receive from Workers' Comp. and what you would like to get paid in an ideal world, correct?
MR. MCCRORIE: Objection.
THE COURT: Overruled.
THE WITNESS: Not that I'm aware of.

Q. Don't let me give you any ideas.
A. I got my billing office. I just work there.
Q. So you accept the fee that is paid by Workers' Comp. in full and final satisfaction of your charges for the EMG and the NCS, correct?
A. Yes.
Q. And with respect to the lumbar epidural injections, I think you testified that in the five years since you began treating Mr. McManus, you have given him 11 epidural injections?
A. Approximately. I would have to count.
Q. You quoted, you said that you charged $1,500 for that, correct?
A. Yes.
Q. That's not what you get paid, is it?
A. Somewhere between 1,000 and $1,100.
THE COURT: I don't think he charged 1500. The fee is 1500 approximately in calculating going forward, not that he charged that. You could ask him how much he charged.
THE WITNESS: My office.
Q. Right?
A. The fee is what my office has determined.
Q. But you accept in payment for the services rendered either $1,000 or $1,100, whatever the Work Accident System allows you to be paid, correct?

A. Because there is a multitude of Workers' Compensation patients. It's kind of like a higher volume. You accept what the fee is on their fee schedule like Medicare.

Q. If after this case is over, and Mr. McManus comes to you and asks you to perform the same treatments and render and do the same examination, but Workers' Compensation is no longer paying for it, it's your testimony that you are going to charge him more than you are currently getting paid by Workers' Comp. for the services that are being rendered?

A. My office is going to charge him more. If it were up to me, I wouldn't. We would charge $250, and we have patients who are Workers' Comp. that are no longer covered who are now cash payment and they do pay that amount.

Q. They do pay that much?

A. Yes.

Q. Let's talk about physical therapy.

Is Mr. McManus currently under going physical therapy?

A. I believe I haven't gotten any authorization, so I believe he is doing a home exercise program.

Q. When was the last time Mr. McManus actually had a formal physical therapy program?

A. I think we actually may have got some authorized at some point recently. I don't know exactly a date; but it's been some time.

Q. 2014?

A. I'm not sure.
Q. I think we have physical therapy records in evidence, and I think the last date is 2014 unless I'm missing something.
THE COURT: Mr. McCrorie, do you want to stipulate on this?
MR. MCCRORIE: Sometime in 2014.
THE WITNESS: I can agree to that.
THE COURT: 2014.
Q. What type of home exercise program is Mr. McManus currently engaged in?
A. I mean, I give my patients stretching exercises to do. I advise them of closed-chain exercises and what that means is exercises that keep your feet sort of fixed in one position on either a bike or an elliptical or open chain, which means the feet are coming off the ground which can cause pounding to the joints in the back.
So discussing for the back only, those type of exercises primarily.
Q. Do you know whether Mr. McManus is currently performing those exercises; and if so, at what rate?
A. He's told me he is doing it. I usually recommend, I mean, three to five times a week for 15 minutes to a half hour is usually what I recommend. I hope he is.
Q. You think physical therapy is necessary above and beyond the home exercise program just to make sure that the home

exercise program is being followed, correct?

A. There are some things that can't be done or equipment we don't have at home. Sometimes modalities are helpful in the form of electrical stimulation to the muscles which can help. Modalities of ultrasound can help, acupuncture, therapy, just solely a home exercise program cannot fulfill, but you work with what you have.

Q. Have you recommended Mr. McManus join a gym?

A. I don't know if I specifically recommended it, but I think it's probably a good idea if you are able to financially afford it.

Q. You think joining a gym would be a good idea?

A. Everybody should join a gym.

Q. Do you have an interest in a gym. I am being facetious.

One last topic and then we are done.

On direct examination and then again on cross-examination, you testified that it's your opinion with a reasonable degree of medical certainty that the herniated discs that appear on the MRI of May 2nd, 2012, were caused by the fall into the tank on January 30th, 2012, correct?

A. Yes.

Q. Then you were asked a hypothetical in which you were asked to assume that the herniated discs preexisted the fall, but were asymptomatic and you were asked: Could the fall have

activated those preexisting herniated discs, correct?
A. Correct.
Q. And you testified, correct me if I'm wrong, you testified that, yes, under those circumstances the fall could have activated previously asymptomatic herniated discs, correct?
A. Yes, in that hypothetical.
Q. That's not your opinion; correct?
A. If I were to choose --
Q. Yes or no, that's not your opinion?
A. That's not my opinion.
Q. That's not your opinion that the herniated discs were preexisting and that they were aggravated or activated on January 30th, 2012, correct, yes or no?
A. With all the puzzle pieces, that's what I have concluded. That's my opinion.
Q. So the answer to my question that it's not your opinion that they were aggravated is: Yes, that's correct, they were not?
A. Yes.
Q. They were caused --
A. With a reasonable degree of medical certainty.
Q. Gotcha.
MR. FABIANI: That's it.
THE COURT: Redirect?
MR. MCCRORIE: Yes, your Honor.

REDIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Dr. Grimm, do you have any idea after a jury renders a verdict whether a plaintiff continues to get Workers' Compensation benefits?

A. They do not.

Q. So, did you, did I ask you to review the lifecare plan report as well as the costs that the defendant's lifecare planner, Jane Mattson, performed?

MR. FABIANI: Objection.

Way beyond the scope.

THE COURT: Sustained.

Q. Is $250 to $600 a visit the cost to see a physiatrist in the New York State, Tri-state region?

A. Yes.

Q. Is $1,750 the average cost of an MRI. I understand you guys can get it for $1,500, but is 1,750 that is the average cost of an MRI?

A. Yes.

MR. FABIANI: Your Honor, may we approach on this? I don't want to really interrupt, but I have to.

THE COURT: Step up.

(Discussion at bench.)

MR. MCCRORIE: I will withdraw.

THE COURT: Thank you.

Q. I would like you to understand Mr. McManus said if authorization was granted he would like physical therapy; if, assuming at the end of this case, authorizations will not be required.

Do you still have the opinion that he should be in a formal physical therapy program?

A. Yes.

Q. Can you tell the jury why a herniation does not have to occur immediately?

Can it occur days or weeks later?

A. The herniation can be present.

As we stated earlier, it hasn't hit the nerve root or the nerve root is just -- the body is a malleable thing.

If you start to strain, you start to walk, you start to walk around, that herniation can strike and hit up against the nerve, and, at any point, can cause aggravation. That's why you hear the patient say: "Oh, my sciatica is acting up." There is aggravation.

Q. What effect does, if a disc is herniated or the annulus is torn, what effect does movement have upon the squeezing out of the jelly or the movement of the jelly, movement of the body as someone gets up and is moving about?

A. There is a medical term for it "neurogenic", N-E-U-R-O-G-E-N-I-C, "claudication", C-L-A-U-D-I-C-A-T-I-O-N.

What that means is with ambulation it starts to put

more pressure on the disc and then as the longer you walk, the more the disc herniation can protrude and come into contact with an inflamed nerve or it could inflame the nerve and you could get the radicular symptoms.

Q. Could you go to your initial note, 6/11/2012, the one that had the past medical history?

A. Okay.

Q. Past medical history is located only on the initial note?

A. Yes.

Q. On almost all medical records, correct?

A. Yes.

Q. Had Mr. McManus been undergoing lumbar radiculopathy, as it states up in the notes here, since his accident for five months approximately, yes or no?

A. Yes.

Q. Okay, do you see where it says "past surgical".

It says "right", approximately, ma'am, "right femur fractures intramedullary rodding," he had that before the accident in the past surgical history?

A. No.

Q. When you wrote that down, was that a mistake, was it the same, an electronic medical record that you needed to note?

A. It was the same medical record, yes.

Q. You weren't trying to say prior to this accident he had

a rod in this leg, even though that's what it says?

A. Correct.

Q. Could you go to Dr. Klion's notes. It's in evidence. You have it there.

A. Yes.

Q. Dr. Klion's note. Dr. Klion wrote a note, dictated that he had an error in his note of 2/28/12, it's the 1st note on Page 1.

A. Yes.

Q. Do you see that in the certified record?

A. Yes.

Q. He said that his note did not accurately reflect the patient's condition on the physical examination and that you should refer to the typewritten notes, okay?

A. Yes.

Q. I would like you to assume that Joseph testified that that particular doctor, nice guy that he was, wasn't paying particular attention to his back, okay?

MR. FABIANI: Objection.

THE COURT: Sustained.

Q. Let me ask you this: Dr. Klion, who wrote that thing that says: "His prognosis for full return to activity is potentially 60 for months post off, "FOR".

He then wrote he requires physical therapy at this time on 2/28.

On the hand-written notes of 2/28 in addition to what he wrote, he wrote that: "Joseph was able to squat, have a normal gait, and was able to hop without leg pain, single leg hop."

Do you see that?

A. Yes.

Q. The same note that he referred to that had errors in it?

A. Yes.

Q. Do you believe that Joseph would have a normal gait when he had not been ambulating for those two months?

MR. FABIANI: Objection.

THE COURT: Sustained.

Q. Could Joseph have a normal gait wearing a cast on this leg?

MR. FABIANI: Objection.

THE COURT: Overruled.

THE WITNESS: No.

Q. Could Joseph have a normal gait -- withdrawn.

With a cast on his leg, could Joseph's squatting have a cost over where the intramedullary rod was?

A. No.

Q. Could Joseph, do you believe, medically, single-leg hop without pain on that date?

A. No.

Q. Do you believe Joseph could have had full range of motion on the right less than a month after the rod was put into is his --

MR. FABIANI: Objection.

THE COURT: Sustained.

Q. Is it noted each time in your file, each time you did a straight leg?

MR. FABIANI: Objection.

THE COURT: Sustained.

I don't remember any reference to that.

Q. You referenced in an answer that you could feel pain on a straight leg.

MR. FABIANI: I don't remember that in the answer.

THE COURT: Sustained.

That may be part of the records, but it came out of his mouth during cross.

THE COURT: Ask another question.

MR. MCCRORIE: I will, your Honor.

Q. Does your opinion remain the same that the accident caused the herniation?

A. Yes, to a reasonable degree of medical certainty, I find that.

Q. That it caused the symptoms?

A. Correct.

Q. But for the accident, would he have needed all the

treatment you did?

A. With a reasonable degree of medical certainty, I do not feel that he would have required that treatment.

MR. MCCRORIE: Nothing further.

MR. FABIANI: Nothing further.

THE COURT: That concludes your testimony finally. Now you could have all the Dominican coffee you want.

Thank you.

Enjoy your vacation.

THE WITNESS: Thank you.

(Witness excused.)

THE COURT: Counsel, step up.

(Discussion at bench.)

THE COURT: Members of jury, we are done for today, 10 tomorrow, 10 o'clock.

I had to fight for that for you now, 10:00.

Have a very, very pleasant evening.

See you tomorrow 10:00 a.m.

(Jurors exited the courtroom.)

(Whereupon, the case was adjourned to June 2, 2017 at 10:00 a.m.)

Certified to be a true and accurate record of the within proceedings.

_____

Dina Ludwicki CSR, RPR
Senior Court Reporter