Exhibit 12

Q. Have you ever testified in any cases that I was actually the attorney on the trial?

A. Yes. This is the third case.

Q. Okay. And that would be over the course of your entire practice?

A. This is my -- going into my sixth year, yes, my whole entire practice.

MR. BRODY: I'm sorry, I missed that. Going into my sixth year?

THE WITNESS: This is my third time testifying for over six years of practice.

MR. BRODY: Six years of practice.

THE WITNESS: Yeah.

Q. And there's been questions about testifying on behalf of Alex Bespechny's office. Do you recall you ever have any surgical cases referred to you from them?

A. I mean I don't particularly remember if it's from any kind of attorneys but I know we get requests for a narrative I do maybe from Mr. Bespechny but I couldn't discriminate.

Q. How often do you testify on a yearly basis?

A. I think I have done a total of five testimonials.

Q. Five --

A. Of my own patients. I don't testify for -- just testifying for attorneys. Only my own patients.

Q. Now, with the Court's permission and if you could

briefly, Doctor, you could just step down. I'm going to ask that you go over a little bit of the anatomy of the spine from the prospective of a spinal surgeon.

Thank you, Doctor.

A. I don't know if anyone --

THE COURT: Doctor, I'm going to ask you to step right over there so that the court reporter can hear everything that you're saying. Thank you.

THE WITNESS: No problem.

A. So I don't know if anyone went over the spine model with you while you guys were here. But our anatomy of the spine divides from our cervical area which consists of seven vertebrae in the cervical spine. They are usually first letter will be C. C1 through C8 even through it says C8 it usually refers to a nerve not the vertebrae. It only refers to -- there's only seven cervical vertebrae.

Then from that point on it's what we call the midback, the thoracic area, it start with T1 through T12. So there is 12 thoracic vertebras. Then it divides into the lumbar area which we call usually the lower back. Then it divides into, as you can see, L1, L2. Sometimes a doctor refers you have a disc herniation between L1 and L2. So usually L1 is the lumbar. It stands for lumbar. And basically you have five of them. So from one to five.

Then it continues into the sacrum which is this part

right here and it also divides into five parts. And then you have your coccyx which is your tailbone.

So between each vertebrae, as I always even in my office, I always go over the anatomy with the patient so they have a better understanding of what is going on with them. Between each vertebrae there's a disc. It's a cushion. It's something that gives us that -- the air mass bubble that we have in our spine. And from each point, between either vertebrae, you have this nerve that comes out and gives innervation whether it's to your upper extremities, whether to your abdomen muscles or to your lower extremities.

In this case we are dealing with a lumbar spine so we are going to concentrate on the lower back. In this case the area we have is the disc that gives innervation to our lower extremities. So the nerves are named by the nerves that are located between let's say L1-L2. So the nerve would be L1. So that's the nerve that comes out of here. And the disc, if God forbid it herniates, it usually irritates the nerve on the exit and usually people feel the symptom down their legs. It's called radiculopathy.

In this case the way it's described, you know, the herniated disc that's pushing on a nerve, it's like an electrical bulb that we have and we have somewhere a broken wire, sometimes it's blinking, then it goes off. So that blinking part is let's say our disc herniation that interrupts

the electrical current. In this particular case it's the nerves to get to our muscles and that's why you feel the pain because the nerve feel gives us the motor function as well as the sensation.

Q. And while you have the model, can you explain to the jury what the lamina facet joints and the foramina are?

A. Sure. If we look at -- I wish we had just one piece of the -- but the way we look at our vertebrae is the actual vertebrae I call it the bottom of the floor. If you can see better here, these are walls and the lamina is our roof. The little windows that we have in our house in this particular area is where the nerve comes out, it's called foramina, all the fancy words that you can describe.

Q. And the facet joints?

A. The facet joints is basically, as I told you, we have multiple vertebras in our spine. The facet joints are our little joints just as the same joints we have in the elbow, the shoulder or the knee. But these are the tiny joints that connects each vertebra to each other and provides us with a range of motion.

MR. GERSHON: Thank you, Doctor.

Q. Now, Doctor, during the course of your treatment, did you have occasion to review any records?

A. I was able to review some physical therapy records, yes.

Q. Did you review any hospital records?

A. I think -- I don't remember but I think I saw the ER report.

Q. And did you also review the MRI report and film?

A. I reviewed the MRI report. I also always review my own films.

Q. Okay. And Doctor, if you have -- you have your office notes with you?

A. I do.

Q. Okay. And are those notes kept in the ordinary course of business?

A. I can't even hear you, sir.

Q. Are those records kept in the ordinary course of business?

A. Yes.

Q. And is it the ordinary course of business for you to keep those notes?

A. Absolutely.

Q. And are those notes made contemporaneously with seeing the patient?

A. Yes.

MR. GERSHON: At this point subject to whatever we will discuss, I am going to ask that that be marked as Plaintiff's Exhibit 7 into ID.

THE COURT: Do we have something else? It will

be Plaintiff's 7. Let's mark it.

Any objections, counsel?

MR. BRODY: For ID, no.

THE COURT: Okay.

MR. BRODY: I would like to see it. I haven't seen it.

(Whereupon, Dr. Lerman's medical records was marked as Plaintiff's Exhibit 7 for identification.)

MR. BRODY: Your Honor, I don't want to waste time. As we go along if I see something, I will bring it to the Court's attention.

THE COURT: Okay.

COURT OFFICER: Plaintiff's 7 for ID so marked.

MR. GERSHON: Thank you.

Q. Doctor, I'm going to ask you questions and if you need to refer to your notes that have been marked Plaintiff's 7 for ID, please do.

A. Sure.

Q. Can you tell the members of the jury when was the first time you saw Mr. Iglesia?

A. I have initial encounter was on April 2, 2014.

Q. Just tell us about that.

A. Do you want me to read it from here?

Q. Yeah, you could read it or --

MR. BRODY: Well, he can't read it unless it's in

evidence.

THE COURT: That's correct.

Q. Well, you can read from it and then just tell the jury.

A. Patient came in at the time he was a 23-year old male. He was referred to me by Dr. Reyfman who's a pain management doctor for back pain and pain in his neck and his back pain was shooting down both his lower extremities, his left greater than right. At that particular point patient had already received three to four months of physical therapy and two lumbar epidural injections. He still continuously had pain.

I examined the patient, patient did not have any previous accident, patient never had previous low back pain or any radicular symptoms. Again, I am referring to the radicular symptoms is the pain I mentioned to you guys before that's kind of shooting from your lower back down the legs, usually that's radicular symptoms. He also had some numbness on the left side more than on the right side.

Examined the patient, noticed patient had some weakness in his lower extremities. I'm reading it. His sensory was decreased a little bit in his bilateral lower extremities, range of motion was deceased and his strength. The most important, in my eyes, is the strength. Usually you grade the strength from a one that you're not able to move at all to five which you can move. For someone 23-years old you should have

five out of five strength if not five plus. In this case his lower extremity muscles were about four out of five, so about one grade of strength decrease. So that doesn't happen for no reason. He did have tenderness to touch on palpation. And then we went on to reviewing his MRI's.

After review of his MRI we noticed the patient had disc herniations at L3/L4, L4/L5.

MR. BRODY: I ask the doctor to talk a little slower.

THE WITNESS: I'm sorry. Sure. Sure.

A. We noticed the patient had disc herniations at L3/L4, L4/L5 and L5/S1. So at this particular point I'm a surgeon, I have a patient in front of me, I have to do the best for the patient. So at this point you're not going to go and operate on all the bad levels the patient has, especially on a 23-year old. You're not going to be doing a fusion especially if it's a non-emergent fusion.

So I had a long discussion with the patient. I said you should go back to Dr. Reyfman and figure out where the pain is coming from because even though there's three levels, I will not do anything until I figure out exactly which one is bothering you the most. So we sent him for a discogram. A discogram --

Q. Doctor, before we go into the discogram, at that point on the first visit he had actually brought his lumbar films?

A. Lumbar MRI's.

Q. And at this time with the Court's permission I'd like to ask you to step down and I'd like you to go over the MRI's and show us what you saw on the MRI's.

A. Sure.

Q. Doctor, I'm going to hand these up to you. And if you tell us which one you pick, whatever one you want to use first, and we'll mark it for ID.

A. We can start with the sagittal view.

THE COURT: Well, we'll mark it into evidence first because for ID they can't see it.

MR. GERSHON: Okay. So I'd like to mark that into evidence then as 5A.

MR. BRODY: I have to compare that to the original. I have to pull out which one of the originals that's supposed to be a blowup of.

MR. GERSHON: It's -- Your Honor, it's taken right from there. Just in an effort to get done with the doctor, it's literally right off the film.

THE COURT: What would you like to do, counsel?

MR. BRODY: I don't know. Does --

THE COURT: I thought you said that you were in agreement in bringing these demonstrative evidence --

MR. BRODY: Well, can you pull out which one he has chosen to blowup?

MR. GERSHON: My concern is by the time we do that, we're going to end up --

THE COURT: Well, he has an objection and I don't have a --

MR. GERSHON: Come on.

MR. BRODY: But you've had these films. Just pull out the one that you say it is.

Q. Doctor --

MR. BRODY: Maybe the doctor can find it.

THE WITNESS: Let me see if I can help you out.

MR. GERSHON: That would be great.

THE WITNESS: That's all you have here?

MR. GERSHON: Judge, this is what I was concerned with. Can we take a five minute --

THE COURT: We are going to take a five-minute break.

THE WITNESS: I found one of the MRI's.

THE COURT: You don't need to?

MR. GERSHON: No, not right now. We will start with the axial. Thank you, sorry guys.

THE WITNESS: Right here.

THE COURT: Counsel, would you like to compare the photos?

MR. BRODY: I'd like to compare it. I'd like the original marked and then the big one can be marked. I

don't know what? As a subset?

THE COURT: Doctor, can you show him the blowup?

MR. BRODY: We can say on the original x-ray number 17 or 22.

THE COURT: So this will be 17A?

MR. BRODY: So an x-ray --

THE COURT: The x-ray is already in the record?

MR. BRODY: It's number 16 out of 22 and 17 out of 22 of February 27th.

THE COURT: But the films are marked as what, counsel?

MR. BRODY: I know but there's multiple films.

MR. GERSHON: Well, let this film be marked as 5A and he'll identify for the record the particular slices he's referring to.

MR. BRODY: That's fine. We can do that.

THE COURT: Is that acceptable, counsel?

MR. BRODY: That is acceptable, Your Honor.

THE COURT: So it's admitted as 5A part of the 17 slice -- I mean slice 17 of 22.

MR. BRODY: Sixteen and 17.

THE WITNESS: Seventeen and -- 16 and 17.

THE COURT: Thank you.

THE WITNESS: Sorry.

(Whereupon, a blow up axial view of the MRI film

of Michael Iglesia was marked as Plaintiff's Exhibit 5A in evidence.)

COURT OFFICER: Plaintiff's 5A in evidence.

A. Exhibit number 5A. So this is us -- you mind if I grab the model?

Q. Please.

A. So as I explained to you this is an MRI of the -- my patient Michael Iglesia. And in this particular area I think this is probably one of the most important shots. This is what I always look at. I don't always look because -- sagittal views are of the side. So these are slices.

Q. Doctor, what exactly is an MRI, like how it's done?

A. An MRI is a -- it's a spinning magnet that gives us an imaging of our soft tissue as well as liquid. So in our case this soft tissue would be the muscle as well as the disc and nerve endings also is soft tissue. X-ray is good for the bone, fractures or any type of organ, if you're looking for any kind of bony disturbance. In this particular case an MRI gives us a better picture of the soft tissue and see if there is any kind of disc which is a soft material versus nerve which is also soft material.

So the view here is called an axial view. It's pretty much if we are looking into the canal, like into the tube into the patient and we see as the slices are done as if you're slicing up a salami, so this is how you see it. So you can see

how every nerve exits in each direction and you can see if there is any interruption of that particular nerve.

So in this picture we can see -- that's what I'm talking about the view that we are looking into the canal. This is our discs, this is our left side, this is our right side, and this is the area we should have for our nerves that exit on each side that gives us innervation to our lower extremity muscles.

So looking here you should have a nice round picture. In this particular case which is L4/L5 you can see how there is something dark that comes down here and it gives us more of a flat top instead of a nice round picture. That's that disc herniation. But even more important patient came in even before looking at the MRI, patient came in saying I think I have biliteral lower extremity radicular symptoms or pain, but the left is worse than the right. And here it goes -- you can see in this particular area on the left side you don't see here this little thing is the nerve that tries to exit. Over here this dark part almost looks like it's torn and it's more on the left side, that's the disc herniation. That's more on the left side. And that's why I think axial views is probably one of the most important views and I always look at the MRI myself.

Q. Doctor, do you want to take a look at the sagittal?

A. I don't need to. I think this is enough.

Q. All right. Okay. Okay. Let's just move on with it.

So Doctor, based on your review of the MRI, reviewing

the sagittal and the axial, what was your impression in terms of diagnosis?

A. I mean, as I mentioned earlier, patient had multiple pressure on the L3/L4, L4/L5 and L5/S1 even though I noticed there is more with disc herniation on the left side, it's still not enough of a conclusion to say to me yes, let's go, I'm ready to operate, I know exactly where it's coming from. I'm not a cowboy, I'm a doctor and I don't know exactly where the pain is coming from.

So I referred him back to Dr. Reyfman to see exactly which of these it was coming from. I had an idea of where it was coming from. I still want to make sure and give a young man another chance to see if we can avoid the surgery. Try to do something of a minimal discectomy and at the same time see which particular level is causing the problem.

Q. And did you refer him to Dr. Reyfman?

A. I referred him back to Dr. Reyfman, yes.

Q. And can you tell us what is a discogram and what were the findings?

A. Discogram is when the patient is laying flat, he doesn't know exactly which disc is being injected. But doctor who's a pain management doctor injects fluid with a little bit of a dye. Under the fluoroscopy, which is an x-ray, a light x-ray picture that they take, as he injects into the disc he looks at the patient's reaction, he doesn't ask do you have

pain, you don't have pain, but he looks for a reaction. So L3/L4 he was normal. But at L5/S1 patient is in excruciating pain as well as the dye can be seen on the x-ray it came out. So it was noticed, it showed the fact that there was an annular tear.

Q. Doctor, I know you are a busy surgeon and we have you for just the afternoon which is why I tried to skip through that --

MR. BRODY: Objection.

THE COURT: Counsel, no comment, please. No colloquy.

Q. You mentioned that -- you said that the L5 -- you said that the dye came out at the L5/S1. Which was the abnormal?

A. L4/L5.

Q. And is this discogram, how is this important then an MRI?

A. This is a physical finding that you see right there and then. And it's done with the patient being present with you and you see the reaction of the patient which is concordant pain and dye coming out meaning that there's nothing encompassing that disc or usually -- I don't know if anyone showed you the picture of the actual disc, what it consists of. This consists of the nucleus pulposus and the annulus fibrosus which is a whole bunch of fibers wrapped around, and that's what gives us the cushion, the air mass bubbles for us. So if that annulus --

the wraparound ruptures, the nucleus stuff inside starts to come out.

So the same concept here. If you inject something into the disc inside, if there's normal annulus with the wraparound, the dye will stay inside. If there's a rupture, it travels out.

Q. And so it's not just the patient reporting pain, it's also you can -- the tester can see, and in this case Dr. Reyfman, can see on the fluoroscope; correct?

MR. BRODY: Objection, it's not --

THE COURT: Sustained.

Q. Can that be visualized?

A. It can be visualized.

Q. And -- in terms of -- in terms of discogenic pain or determining where it's coming from, how is that different from an MRI?

A. As I mentioned earlier, even though on the MRI you can see multiple disc herniations, I would never decide just on the MRI. I would pick -- I would do the random studies which are done by pain management to figure out exactly from which particular disc the pain is coming from which nerve endings around the disc are compromised.

Q. When someone is having this procedure done, do they know what level is being injected?

A. I mentioned that earlier. Patient has no idea.

MR. GERSHON: Judge, at this time I ask, and forgive me ladies and gentlemen of the jury, just two minutes if the jury go out so we can find that film so we can look at the sagittals.

THE COURT: Okay. Take a recess.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

(Whereupon, there was a recess taken.)

(Whereupon, a blow up lumbar sagittal view of the MRI film of Michael Iglesia was marked as Plaintiff's Exhibit 5B in evidence.)

(Whereupon, x-rays was marked as Plaintiff's Exhibit 6 in evidence.)

(Whereupon, an x-ray board was marked as Plaintiff's Exhibit 6A in evidence.)

(Whereupon, an axial view of Plaintiff Michael Iglesia's lumber spine was marked as Plaintiff's Exhibit 5C in evidence.)

(Whereupon, illustration boards of Michael Iglesia's lumbar spine were marked as Plaintiff's Exhibits 7A and 7B for identification.)

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE CLERK: Doctor, you're reminded that you are still under oath.

THE WITNESS: Yes.

Q. Thank you.

Doctor what's the exhibit you're looking at now? What is it? What is it labeled?

A. So exhibit number 5B.

Q. What is that?

A. And we're looking at that sagittal view that I briefly explained before is our view from the side. This is us looking from the side. And you can see the slices are done in a vertical manner from left to right.

So in this particular -- why this view is important is looking at these views this is -- are L3/L4 disc, L4/L5 disc, L5/S1 disc. So even not being a spine surgeon you can see that something is going on here, something is going on here, and something is going on here. And that's the reason why I mentioned before that after reviewing the MRI I saw three issues, not only did I see it but the radiologist who read the report as well saw that there's three problems in his back and that's the reason why I had to send him to Dr. Reyfman back to identify which out of these particular levels was causing the problem.

Q. Now, Doctor, when you said there was something going on, just show the jury on the film what shouldn't be happening at the L4/5 level?

A. I mean, first of all, if you look at these two,

they're a little bit darker than the other one. Why is it darker? Because water or anything that has water in it lights up on the MRI. We can see this, this is fat tissue. Fat tissue has some water and it lights up. Water has discs in it, it lights up. But in this particular area there is still some water here but you can see that there's some almost like a little bump in the back and that's what people read as herniations this bump and bump. But these two levels look darker and that's what they call desiccation or something that ruptured and water comes out. Because when it lights up, water lights up on the MRI, it's bright.

Q. Thank you, Doctor. You can sit down and take that down.

So before he came back to you, Doctor, you mentioned that he had a discogram and that he also had a discectomy?

A. Yes.

Q. What is a discectomy as performed by a pain management specialist?

A. The disc --

MR. BRODY: Your Honor, this is all repetitive. We had the pain management specialist and he explained exactly and demonstrated what it was and now I am looking at the clock too, this is just repetitive at this point.

MR. GERSHON: Your Honor, I'm just asking him one question.

THE COURT: Okay. One question. Very good.

Q. What is the discectomy as performed by a pain management person?

A. There's multiple levels of discectomy. One is what we call microdiscectomy is when the small tiny little tube gets down to the disc and through with a tiny small very very small instrument we remove loose fragments of the disc. If there's more of a mini open discectomy, you actually are to open in the back but that's done by a spine surgeon, you remove the muscles and get down to the area and then you remove the disc.

Q. And as a spinal surgeon is that an accepted procedure?

A. The microdiscectomy is something that you want to -- basically you're trying to exhaust all the methods of treatment before you can move on to the next level of surgery because, again, as I always tell my patients as much as I love to do surgery, that's the last stop.

Q. Okay. So after the discogram -- positive discogram and the discectomy did Mr. Iglesia come back to you?

A. He came back to me. Next follow-up visit -- even though I think I told patient to come back to me in like a month so, yeah, I told him to come back two weeks after he gets -- at least after a discectomy but he came to me I think he had a discectomy on the -- the 9th of April and he came back to me nine days later because he was in excruciating pain in his lower back. So not only did they not help him, it actually got worse.

Q. And just tell us briefly about that visit and what was the determination that you made?

A. After long discussion with the patient going over the findings that I received from Dr. Reyfman directly, and in his operative report, as well as examining the patient which physical exam did not seem to be changed at all, he still had that weakness in his lower extremity as well as the numbness, we talked about what are the next options. So physical therapy, check, he already had that. Epidural injection, he already had that even microdiscectomy. So at this point I said you can continue doing physical therapy or the last option here is the pain is out of proportion because at this point, you know, I have the MRI findings, I have the findings from the -- from the pain management, but the final -- you know, how the patient feels, is how the patient feels.

So I always tell the patient if it debilitates, the next option is surgical intervention. In this particular case, because it's not only disc herniation but it's also a discogenic pain, meaning the pain is coming from there, typically the gold standard not would be just to come in and take out the loose fragment on the disc but actually you have to come in and secure it with screws and a rod and then open up the area for the nerve.

Q. Okay. And Doctor, was surgery done?

A. The surgery was performed.

Q. And can you tell us how it came about that the surgery was done and then we are going to talk about the surgery?

A. Actually we usually do planned surgeries. So we -- on that date we spoke about the surgery but we never determined the date. But I think on the 23rd of April patient called my office saying he's in excruciating pain, he cannot tolerate this pain any more.

So I said -- it was actually Wednesday because Thursday we operated at Nassau University. I said go to my hospital where I'm going to be the next day and you are going to be evaluated by my staff. They are going to take you in and try to give you IV steroids and see how you feel. That was done in the morning. I saw the patient. He was not getting better. Again, the discussion of surgical intervention came back and that's when the decision was made to receive the surgical intervention.

Q. Doctor, at this point with the Court's permission I ask that you step down and just please explain to the jury about the surgery, okay.

A. Sure.

Q. Please. And I have some -- and you can use the model and I have a couple of illustrations that have been marked as Plaintiff's 7A and 7B for identification purposes.

Will this help in assisting in explaining the surgery?

A. Yeah. I can show them what is going on.

Q. Just that these pictures --

MR. BRODY: Objection, Your Honor. First we had a sidebar and there will be an instruction about what we are seeing here.

Q. Okay. Doctor, this is obviously not the patient. It's an illustration of the patient. This is an illustration based on the operative report to help you in assist in explaining what the surgery is to the jury; correct?

A. Yes.

MR. BRODY: Well, it's based on the diagram, the anatomy. It's not based on the operative report. The items that were added to it indicate what the operation is.

MR. GERSHON: Well, the anatomy is there.

MR. BRODY: I understand. But it's not the plaintiff's anatomy. It's a general --

THE COURT: Is that correct, Doctor?

THE WITNESS: I'm not sure what are you asking.

Q. It's not the patient's anatomy?

A. No, it's not.

Q. The procedure that's shown is based on the operative report in this particular case?

A. The only thing is the incision. There was two small -- two incisions made on the side. The picture shows here one incision.

THE COURT: So in other words, this is not the

patient that you're looking at. This is a rendition of what an operation, such as this, would look like?

THE WITNESS: That's it.

Q. Okay.

MR. BRODY: Thank you.

THE WITNESS: Well said.

THE COURT: Very good.

Q. Can you explain to the jury from the beginning to the end how this is done?

A. Absolutely. So in Michael's case we had to make two small incisions in the back in a similar fashion but on each side. So not only he has one, he has two incisions. We go in between the muscles.

Q. I'm sorry, I don't mean to interrupt you but is he under general anesthesia?

A. Patient comes into the operating room, he's being fully intubated. They connect him to the neuro monitoring team. It's basically the electrodes or needles that once the patient goes to sleep it's to monitor the nerves. Throughout the whole entire procedure someone else, not only the visualize, but someone else tells us if we are close to the nerve and what's under the screws, are the screws too close to the nerve or not. So basically it's another method of precaution to prevent patient from damaging the nerves or God forbid paralysis.

MR. BRODY: Objection, the question was was he

anesthetized.

THE COURT: Sustained.

A. Okay. Patient --

THE COURT: You have to ask a question.

Q. Okay. So just let's start with the beginning of the procedure now. Go ahead.

MR. BRODY: Was he anesthetized?

Q. Was he anesthetized?

A. I mentioned the patient was intubated and anesthetized. So the tube was place down the patient's throat. He went to sleep, and afterwards all these electrode things, the patient was placed in the prone position. He's laying down on the table face down and an extra comes in to identify the area where we are going to be operating. L4/L5 is being identified on the x-ray, marked out as well. Then you make two incisions on each side. You go into the muscles to get to the area of L4/L5, you take another x-ray. So the most important thing is to identify the correct level.

Once the correct level is identified, we proceed with our decompression what's called. Decompression is when we burn that -- the roof that we have of our house is the lamina. So we are opening up this lamina to be able to -- if someone is pushing us from the floor, which is a disc herniation, now we can open up something from the top. So now it has more room to flare up and nerve will be free.

Q Can you show on the model where that would be, Doctor?

A Sure. So if this is patient laying prone -- so once we get to the L4-5 area right here, we shave this bone out to be able to get into this canal and see if the nerves are compressed. We move the nerve out of the way and we move fragments.

Once we complete one part of the procedure, which is depression or opening up of the nerve, we proceed -- because you have to really shave a significant amount of bone to be able to get into that far disc that I showed you, the little thorns.

You have to shave a significant amount of bone out of that. We don't want to leave the patient unstable. We have to proceed with the placement of the screws and the stabilization of patient's spine.

So, you find those -- the walls of our little spine that I showed you before with an X-ray in place. You actually take the x-rays through the entire procedure.

You make screw holes and then you direct these screws. And that's where the patient -- you monitor the little needle that comes in place -- comes in, because once we place our screws, now we take a little rod and test each screw to make sure there is no perforation, no communication with the canal. And it -- God forbid it is touching the nerve, because the nerves exit on each side.

So, basically you have a couple of millimeters to the

side to be able to do that. Once you secure with screws -- these are the actual X-rays of the patient. This is our view from front to back. These are the X-rays that were done. And this is actually done from the side.

Q Doctor, if you are going to refer to the X-rays, if you can, show us -- these are post-surgical X-rays? Could you put this one up.

A Let me finish with the.

So, once you place the screw, now you have to connect it with the rod, because placing a screw, we still have an unstable spine. So -- and another reason why you do two sides to the screw, because we have multilevel directions of our spine.

If this would be up and down, we would be okay with one side. But because we have the rotational factor, we don't want the patient to rotate and God forbid pull the screws out.

You secure the two sets of screws on each side. Then you connect it with rod. Once you put the rod in, you take a special device called an extractor, you put it down and then you open up even more area. And then you tighten down these buttons or caps.

This is how it looks from the side. And to show -- where is the X-ray?

Q Those right there.

Doctor, those are post-surgical X-rays taken in your

officer; correct?

A Yes.

Q What is the date of those X-rays?

A 6/19/2017.

MR. GERSHON: Just let the record reflect that that is marked 6 A, that exhibit.

A Look at Exhibit A. This is the X-ray that was done from the summer. You can see this is the view from the side or the lateral view. That shows L4-L5, a great placement of the screws. Hardware perfect. Same thing here.

You can actually also see this is what we here to achieve, the lateral fusion. We place bone here so that the bone grows from one to the side.

The bony bridge is that fusion. If you don't have this bony bridge it would be screws -- just the screws. These screws will pull out over time.

So, the goal here is to get natural fusion because placing the bone on each side, that nerve turns into bony bridge.

What is significant here in this X-ray that was taken three years postoperatively, is L-5 S-1, you start seeing the white line which shows degenerative change or some arthritis.

In someone who is twenty-five, twenty-six years old you should not be seeing this line. It's called adjacent level disease.

Adjacent level disease is when you have fusion on one level, the other little joints that I showed you before, which are called the facets, they start over working, doing overtime.

So now you start seeing some degeneration in this particular level.

Q Anything else, Doctor, with that?

A No, that's it.

Q Thank you. You can go back to your seat.

Doctor, since the accident, Mr. Iglesia has come in to your office for numerous follow-up visits; correct?

A Yes.

Q And I am just going to rush through it quickly with you.

A Sure.

Q What was the first operative visit?

A If you don't mind, I will refer to the date from my notes. The next one, May 9, 2014.

Q I am just going to ask you to tell us anything significant about that or anything you want to mention and we will just --

A The significant part is I think the surgery was a great success because the patient did not have symptoms anymore, he had no pain going down his legs.

He was still complaining about back pain but it was explained to the patient that the surgical intervention is

not -- the back pain is something that will be there for the rest of his life.

It's the radicular symptoms and weakness that the patient experiences in his leg, and the most important thing in a young individual is to get his function, which is full strength.

And in this particular visit, almost what, two weeks after the surgery, he got full strength back as well as no pain going down the legs.

That pain was there, but it's -- A, it was part of the normal post-operative routine, and B, it's not the reason why you do surgery.

Q What was the next post-op visit?

A September 26, 2014.

Q What is the significance about that?

A Again, same thing. I am very happy with the patient getting full strength back. And the radicular symptoms improved but, again, range of motion was decreased, and it was discussed with the patient prior to surgery, as well as the back pain was still there and stiffness, which I think it was getting worse with the weather changes.

Q And, by the way, it would be safe to say based on the treatment, there was some -- when Mr. Iglesia had pain, he would complain about that, but he also told you when he was feeling better?

A Yes, absolutely.
Q When was the next time you saw him?
MR. BRODY: What date were you referring to?
MR. GERSHON: We were referring to 9/26/14.
Q Doctor, moving on to January --
MR. BRODY: The next visit?
MR. GERSHON: Yes.
Q Moving on to January 23, 2015, which was the next visit, could you tell us if there is any changes or it's pretty much the same?
A Significant improvement in his low back and radicular symptoms. They are still there, some back -- low back pain, but was a significant improvement.
Q When was next time you saw him?
A October 16, 2015.
Q Now, can you tell us about that visit? And I will ask you to focus on the second paragraph in the report.
A I can't hear.
Q I will ask you to focus on the second paragraph in the report and just tell us what his situation was at that point on October 16, 2015?
MR. BRODY: May I see that one, Your Honor? I don't have that.
MR. GERSHON: That's not true. I showed him --
THE COURT: If he wants to see it, don't tell me

what you think about it, just show it to him.

(Pause held.)

THE COURT: Can we continue?

MR. BRODY: Yes.

Q Doctor, tell us about that?

A Significant improvement with his radicular symptoms but low back pain still present, and on a scale from one to ten, it's about six.

Q So, in spite of the fact that he was having pain, you felt the surgery was successful because the radicular symptoms had gone away?

A Absolutely and the strength. The strength improved as well, which is -- as well as the sensation. So, I think it's a great success.

Q And let's go to the next visit, February 24th, 2016.

A Still decreased range of motion and stiffness that was pretty much the main complaint.

Q I am sorry?

A Decreased range of motion and stiffness. That was the main complaint.

Q And at that point, did you indicate anything about him being able to go back to work?

A If you don't mind, I will take a look.

Yes, I actually said the patient can return to light duty. Anything that can allow him to sit for thirty minutes,

stand for thirty minutes, alternate.

Q During this post-surgery, are you aware of the fact that he went back for physical therapy?

A Yes.

Q And are you also aware of the fact that he cleared him for light work, and he actually found a job?

A Yes, I know that.

Q You saw him again on May 4, 2016; correct?

A Correct. Let me just confirm with the date.

May 4th, 2016, yes.

Q And was that pretty much the same, no radicular symptoms, but still back pain stiffness, loss of motion?

A Same thing.

Q And then again on August 26, 2016, you saw him again; correct?

A Yes.

Q And just tell us about that visit?

A Actually, the patient came in earlier than six months because he had increased low back pain.

Q And --

A Still no radicular symptoms. Pain level went up to seven.

Q Seven out of ten?

A Yes, on a scale of one to ten, one being no pain, ten being pain out of proportion.

Q You saw him again on October 19, 2016?

A October 19, 2016, yes.

Q And lastly -- the last time you saw him, you saw him on June 19, 2017; correct?

A Let me just double-check. June 19, 2017, correct.

Q And why don't you tell the jury, first of all, in your own words about that visit the last time you saw him about his pain, whatever he was experiencing.

MR. BRODY: What day are we talking about?

MR. GERSHON: We are talking about June 19, 2017.

A As I mentioned earlier, I mean the significance of that visit is we did another X-ray to make sure that his hardware is in place. And the lateral masses, a/k/a the bony bridge on both sides to create a natural fusion was intact but patient still had stiffness and back pain.

But the most concerning to me was the adjacent level, L5-S1, the white line, the little arthritis that a twenty-six year old kid who has that white line there, that's what we call adjacent level degeneration.

Once that level is blocked out with the screws and locked in with the fusion -- yes, the patient feels great and his radicular symptoms are improved, but you also have to be weary of the other level below or above starting to work overtime.

It's like -- let's say we have six of you here pulling

a boat and one of you leaves, now it's five of you pulling the same boat. You are putting extra strength into it and there are much more chances of hurting yourself because the force is distributed not among six, but among five of you.

So, it's the same story in your lower back. Once one level is knocked out, the other guys start working extra time.

Q I am going to talk about that briefly in a second and then I will wrap up.

On the date of the last time you saw him, you took -- you did a range of motion test; correct?

A Correct.

Q And how is that done? Do you use anything to do that?

A There is a special thing, it's called a goniometer that tells you the degrees the patient flexes or extends, instead of trying to figure out with the eye.

You put it against the patient and do it together with the patient's flexion and it shows his degree of range of motion.

Q Could you tell the members of the jury, looking at your report, what his range of motion was and what would be a normal finding for a young man his age?

A I cannot read from my notes?

Q Just look at it and you can just refresh your recollection. That's absolutely --

A I will try to summarize the best possible way.

One second. So, just to summarize, his range of motion of his lumbar spine decreased about fifty percent. I mean, for someone his age, it's significant.

Q What is flexion?

A Flexion in this case was forty.

Q And --

A Forty-five, sorry.

Q What is normal?

A You can get up to ninety, eighty to ninety.

Q And, by the way, flexion is just bending forward?

A Yes, bending forward.

Q What is extension?

A Extension is extending backwards.

Q What is normal extension?

A Normal, about twenty.

Q Twenty?

A Yes.

Q What was it here?

A Ten. About fifty percent, as I mentioned.

Q And side bending, what was that?

A Side bending is when you just -- I am sorry. I will get up.

So, you do all range of motion. Flexion, extension, side bending to each direction, and rotation.

Just to summarize again, about fifty percent was

decreased.

Q Doctor, based on your review of the records, based on your looking at the discogram, the MRI, actually going in during the surgery, and seeing the disc, which you did -- you saw the disc on surgery; correct?

A Of course, yes. You have to be able to see the disc when you do decompression you move the nerve out of the way.

Q When you went in, did you see herniation?

A Yes, you see the annulus tear with herniation.

Q That was L4-L5 you took out?

A Yes, absolutely.

Q You mentioned this adjacent disc. Could you tell the members of the jury, what the significance of that is, because I want you to assume for my purposes that you know that my client's radicular symptoms, as you said --

MR. GERSHON: He is not here as an expert. He is here as a treating physician.

THE COURT: That's correct. Sustained.

Q Doctor, with respect to the adjacent disc, what is your prognosis in the future?

A If it is going to continue with the rate that it's going right now, patient will have another spine surgery.

Q And doctor, could you -- and why is that?

A Because as I mentioned earlier, the over working of the disc will eventually deteriorate that disc because we saw

some herniation in the MRI, even though it was not torn, but it was already starting the process from the MRI that we saw.

Now that we have an extra stress on that particular level, we don't know exactly when it's going to happen, but within the next ten to fifteen years it's pretty much inevitable.

And then you have to extend the fusion down a level below. I know it sounds like a domino, but that's the game. It can be a domino effect almost.

Q And did your opinion take into account the fact that Mr. Iglesia presently is like twenty-six years old?

A Absolutely.

Q What you saw at L5-S1, is that a normal finding in a twenty-five, twenty-six year old?

MR. BRODY: Objection.

THE COURT: Sustained.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty whether the injuries sustained in this accident were brought on by the accident that occurred on December 17, 2013?

A Patient did not have any injuries before. Patient never suffered from any back injuries. So, according to all the findings and everything, yes.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty whether Mr. Iglesia's injuries are

permanent?

A Absolutely they are permanent.

Q Doctor, could you tell us what the cost of this type -- what type of surgery do you anticipate he is going to need with a reasonable degree of medical certainty, and what is the cost of that surgery?

MR. BRODY: Objection to the second part of that question.

THE COURT: Compound.

Q What type of surgery?

A You have to go in now, you have to go in and take out the hardware, put the new hardware in at that level below and extend the fusion.

Now you have to put in a rod. You can't -- if you are going to take out screws from the level above, you still have those wholes and they can create a fracture.

So, you have to go in, remove the screws, put the new screws in, which is a bigger size and then extend the rod all the way down to S-1, because you have to do decompression at the level below.

Q What is the cost of the surgery?

MR. BRODY: Objection.

THE COURT: Foundation.

Q Doctor, do you perform these surgeries?

A Yes.

Q And do you know what the cost of these surgeries are?
A It can run up to one hundred fifty thousand dollars, I mean, because of the revision and hospital stays and everything.
MR. BRODY: Objection. That's not responsive.
THE COURT: Sustained.
MR. GERSHON: I have no further questions.
MR. BRODY: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BRODY:

Q Doctor, we have met today for the first time; correct?
A Yes.
Q You know who I represent in this action; correct?
A Yes, I guess.
Q You have testified before; correct?
A Yes, I did.
Q And I am looking at the clock and I know we both want the same goal, to finish everything at a reasonable hour so you don't have to come back; correct?
A I guess, yes.
Q I would appreciate it if you can answer the yes or no question with a yes or no.
A Unless I can't.
Q If you can't, please let me know.
A Absolutely.
Q So I don't want to argue over a little point. We both

agree anything in the world is possible?

A Of course.

Q That's always an answer and we banter with other doctors, not with you.

A I don't know.

Q You wouldn't know. Withdrawn. Forgive me for jumping around because I have a tendency to do that.

Before you stood up and you said, this and this and flexion and extension, and those were the observations you made in what he could and could not do; correct?

A Yes.

Q This is based upon him telling you what he could or --

A Yes, me examining him. I try to tell him bend forward, bend --

Q You tried to tell him -- because it's a passive examination?

A Yes.

Q It's not active in any way that you can see if he can go forward more than he says; correct?

A I mean, it's not really passive. It's active. Passive would be me --

MR. GERSHON: Objection. I would like the witness to be allowed to answer the question. He was half --

MR. BRODY: If I --

MR. GERSHON: Objection.

MR. BRODY: I want to move fast, Your Honor.

THE COURT: Don't be argumentative. I heard your objection. Okay, sustained.

You can finish.

A Active range of motion is a patient doing it for you. Passive is when you pretty much are doing it for the patient if he is unable to.

Q I reversed it; correct?

A Yes.

Q I am a lawyer, not a doctor; correct?

A Yes.

Q Doing my best here.

A Absolutely, yes.

Q So, it's an active movement and it's limited by pain; is that correct?

A Limited by pain.

Q You would never ask a patient to go beyond a -- where patient says it hurts; correct?

A Of course.

Q When you do these examinations with him and you determine the degree of flexion and extension, the patient stands up, you tell him to bend over and he bends over and he goes this far; correct?

A You --

Q I am just saying, if he goes this far, then you would write down, you would record what he is --

A I always tell my patient to push until they start having some pain.

Q I said that. But if you tell them that and the patient does this, you would record what it is; correct?

A Yes, if he feels the pain. You also look at the different signs, someone cringing their face.

Q If the patient does this, you would record that too; right?

A I would -- again, I would reassure -- if I'm not satisfied with the findings, I would probably then do a passive and see how much I can do actually.

Q You are not going to push him past when he says, I am in pain?

A You can see the signs and symptoms of the patient. You can't -- it's a body as a whole, so I treat --

Q Again, if you can't answer my question, please tell me.

Are you going to push a patient beyond where a patient complains of pain?

A Absolutely not.

Q In your practice, in your history, have patients ever feigned this extension, flexion, rotation testing? What I mean feigned, they didn't do their full amount?

Do you know that to be true ever?
A I'm not really understanding your question.
MR. BRODY: I will withdraw that.
Q Do you know there was a lawsuit in this case?
A I knew about it like when Mr. Gershon contacted me.
Q When was that?
A A couple of weeks ago.
Q Prior to that, you never knew the patient was suing for his injuries?
A I had no idea.
Q He never told you?
A He never told me, no.
Q When he contacted you a couple of weeks ago, what date was that? Was that in '17?
A It was -- no, it was already 2018. A couple of weeks ago.
Q When was the last time you saw the patient before this last visit?
A I can tell you right now. June 19, 2017, was the last visit.
Q June 19th. Who arranged that? Did your office make the appointment or did he make the appointment?
A I have no idea. I don't follow these things.
Q But it wasn't an appointment that you were aware of? He came up on your schedule?

A Just like anything, you get the schedule for the day.
Q By the way, your partner is doctor -- you own this practice? You are one of the owners of the practice?
A Yes, I am.
Q How many partners are there?
A There is three partners.
Q Who are they?
A Dr. Avanesov, Dr. Saleehin, Dr. Ruotolo and me.
Q There are four altogether?
A Dr. Avanesov is part of Advanced, and we are part of Total Orthopedics.
Q Explain that. Who is Advanced?
A Advanced is Dr. Avanesov and Dr. Saleehin.
Q What does Advanced do?
A It's the same thing, spine surgery. Dr. Avanesov and the others. I am part of Total Orthopedics.
Q Dr. Avanesov is part of Total as well?
A Yes.
Q One of them assists you on the surgery; is that correct?
A Correct.
Q Who was that?
A Dr. Karen Avanesov.
Q And how much did you get for this surgery?
A I have no idea.

Q You don't know how much the surgeries are? Your office takes care of that?
A Usually the billing, yes. I am trying to be a doctor.
Q How much are you being paid for being here today?
A Six hundred dollars an hour.
Q I must have missed that. Six hundred an hour beginning when?
A From the review of records, the travel time and everything. Everything that I am missing out from my work.
Q Had you billed anything prior to arriving today?
A Did I what?
Q Have you billed any of your time before you got here today?
A Not yet.
Q How long did it take to you review records?
A I don't remember. You have to keep track of all these things.
Q What do you do, put time sheets in for the office to --
A No. I let them know I reviewed this for how many hours.
Q Do you recall what you told them?
A I haven't calculated the time yet, no.
Q Can you approximate for us how much time you spent reviewing records?

A Two hours maybe prior, meeting with Mr. Norm, another hour, three hours plus time travel here, and being away from practice, missing a full day of work.

Q How many hours?

A Maybe like ten hours.

Q Ten hours?

A Yes.

Q Mr. Norm, you mean counsel?

A Yes.

Q And you remember you met with him when?

A What?

Q When did you meet with him?

A Two trials before. When did we meet for this?

Q For this case?

A At my office in Brooklyn.

Q Did you have these X-rays there with you?

A I had X-rays.

Q These?

A Yes.

Q When is the first time you saw these blow-ups?

A The cartoon blow-ups?

Q The big ones. Today is the first day?

A No. The MRI I saw visually myself. The cartoons -- this is my first time.

Q Cartoons, what do you mean?

A The drawing ones. Not, the actual MRI films.
Q The illustrations?
A Yes.
Q Cartoons is a little kid hitting things over the head.
A Pardon me.
Q Do you have any idea if you were paid cash for this surgery?
A No.
Q Who paid you the -- who paid the office?
A I have no idea.
Q You don't attend to that kind of stuff?
A No.
Q Dr. Reyfman -- I'm not good with names. You will excuse me.
How many patients have you had, shared patients with him? He referred to you or referred to him?
A I don't remember. I don't recall the exact number. But --
Q Approximately in this last year?
A Maybe ten, top.
Q Could you approximate for your practice -- you have been practicing six years?
A Maybe total sixty.
Q A total of ten --
A I don't have -- I don't have the number.

Q I am asking you for an approximation. It could be more?

A Maybe. Maybe less, maybe more.

Q That would be directly to you or to your practice referred to you?

A To the practice.

Q Are there other patients that he may have referred to Dr. Avanesov?

A Maybe.

Q You don't know?

A I don't keep track of these things.

Q You testified this will be the third time you testified for this firm?

A With Norm, yes.

Q How many times have you testified in total in the six years --

A Five.

Q How many times have you been working on a case or a patient that you never got to testify on because the case either settled or was disposed of? How many of those medical/legal situations were you in?

A I have no idea. We work at level one trauma which is an intersection of major highways of the Long Island Expressway and the Wantagh Expressway.

So, we have patients helicoptered into us from

accidents all the time.

Q I don't mean to interrupt. I'm not asking you how many cases.

I am asking, the cases that you have worked on that will be going to trial, but never make it to trial, so you have prepared, you have reviewed, maybe you spoke to the lawyer, but the case settled, it never went --

A Five times with -- the times were the only time I testified and I prepared for the trial.

Q I am not asking when you testified. I am asking the cases that you were involved in that never -- you never testified in?

A I have never had-- what you are saying is if I prepared for trial but it never went to trial? I never had any of --

Q I am saying, patient has been in an accident, maybe lawyers contacted you, you were going to be coming in to try the case, and then the case settles, you don't have to come in?

A I don't know.

Q You don't know?

A I have no idea. I don't recall any cases that I prepared for and I never went to trial.

Q Okay, that's fair.

Doctor, pain is a subjective complaint; correct?

A Correct.

Q When I did this with Dr. Reyfman -- I assume -- I know you are not a detective, you are a doctor.

Earlier in response to one of the questions you said, I am a doctor, I can't tell you for certain anything about a question that was being asked.

Do you recall that? Before, today, in response to Mr. Gershon, one of his questions?

A Maybe, yes.

Q You said, I am only a doctor.

A Right. Right. Right.

Q And I know you are not a detective.

A Okay.

Q So, if a patient comes in and they complain to you that they had pain, you note that; don't you? You write it down?

A Yes.

Q That's what you are supposed to do; correct?

A Absolutely.

Q And it is a subjective thing, and I have dealt with this jury. Subjective means plaintiff tells you that?

A Absolutely, yes.

Q So, the plaintiff can say, I am in pain eight out of ten, or I am in pain four out of ten, whatever it is, you write it down?

A Absolutely.

Q And that goes into your consideration of how you are going to address the treatment of that patient; correct?
A Correct.
Q And the objective is to do the best you can. I would assume that the patient can be as pain free as possible?
A Absolutely.
Q And as functional as possible?
A Absolutely.
Q And they're not exactly the same concepts?
A Yes.
Q People can still have pain and be functional?
A Yes.
Q They can still work and do things; correct?
A Yes.
Q Also, with respect to pain and discs, some people can have what's called a herniated disc and not feel pain; is that correct?
A Correct.
Q And the pain -- it would depend on where it is, it would depend on the level of impingement on the nerve; fair statement?
A Yes.
Q Some people can have a herniated disc for years and not even know it; correct?
I don't want to go to the possible word. Is it

correct?

A It's -- I don't want to say, it's possible. I don't want to say -- I am going to say I cannot answer yes or no. Depends on where it is.

Q Besides the pain that this gentleman was complaining about with respect to the back, he also complained about pain in other areas; is that correct?

A Yes.

Q And, in fact, the shoulder, he had shoulder pain, neck pain?

A Yes.

Q Leg pain and other areas, but you're a spine surgeon so you address the spinal area; correct?

A Yes.

Q And maybe seeing other people for the other areas; correct?

A Probably.

Q You said that before he went to P.T. Do you know what kind of P.T. he went to?

A You mean --

Q Let's go before the surgery.

A I think he was doing manipulations there as well as electrodes.

Q That's modalities, types of it. But do you know that he was doing it?

A The patient told me that, yes, he was doing it.
Q I am sorry.
A I also reviewed the reports of the physical therapy place.
Q Which physical therapy place?
A I forgot the name of the place.
Q Were you aware he went four days a week to physical therapy and to two different physical therapy places on the same day?
A No, I was not aware of that.
Q Were you aware that on some of those days, not only did he do two physical therapies on the same day, but he also did acupuncture at the same time.
A I know he was doing acupuncture, but I don't know if it was same day or not.
Q Do you know where?
A No idea, no.
Q Do you know, during the time he was also getting chiropractic treatment?
A I was aware of chiropractic treatment, but not sure which days. But, yes, he mentioned that.
Q Did you know which parts of his body he was getting chiropractic treatment for?
A I know part of back was one of them as well.
Q Part of the back?

A Yes.
Q Was he also getting it for other areas?
A Not sure.
Q How about the acupuncture?
A I think he was getting acupuncture to his back, but I don't know any other areas.
Q And the physical therapy, do you know if he got physical therapy for other areas?
A I know for the back.
Q That's what you know?
A Yes.
Q I am asking, do you know for other areas. That's a no answer.
A Yes. No.
Q I notice in your reports that the -- besides the lumbar situation, there were cervical disc problems; correct?
A Yes.
Q And you put them in many of your reports. What was the cervical area that you noted?
A Can I read from here?
Q You can refresh your recollection with it.
A He had multiple disc bulges from C2-3 to C6-7.
Q You don't know if this is associated with this accident?
A It was part of the accident. I mean, after the

accident, he started having these symptoms.

Q Did he complain of symptoms after -- did you say he never complained before about the cervical area?

A I don't have it here.

Q Is there any record that you said that he never complained about the cervical area?

A No, I don't have --

Q So, your statement just now is conjecture? It was I you assuming; correct?

A Cervical was not too much a problem. It was mostly the lower back.

Q That wasn't my question, whether it was a bigger problem or smaller problem, but if you have it in all of your reports.

A Yes.

Q You have it there, so, I mean, it must be something that you put down?

A Absolutely.

Q And it said bulges; correct?

A Yes.

Q Now, which MRI -- let me back up a minute.

You told us about your background as an orthopedic surgeon and you had some specialty training; is that correct?

A Correct.

Q What is the specialty training that you had, without

going through whole thing all over --

A It was a spine surgery fellowship.

Q And are you a diplomate in surgery?

A Board certified.

Q Are you diplomate in surgery?

A I'm not sure --

Q Board certified -- with what organizations are you a member of?

A A.A.O.S.

Q What is that?

A American Association of Orthopedic Surgeons.

I am a member of the A.O.A., which is the American Osteopathic Association.

Q Are you a D.O.?

A Yes.

Q And can you tell the jury what a D.O. is?

A Absolutely. At some --

Q The short version.

A I don't know how short it can be. I just want everybody to -- a doctor of osteopath in the medical -- a D.O. and an M.D. are the two different ideas that at some point were one and then split into two.

Medical doctors went into more of an approach with drugs and this and that, and osteopaths also added the part which involves body manipulation.

So, you take all the same classes, you get exactly the same license.

As a matter of fact, as of 2016, there are no more boundaries for a D.O. or M.D. for residencies. Before there was a D.O. residency and an M.D. residency.

At this point there is -- an M.D. and D.O. can go to the same.

We take one extra class in medical school which is manipulation or treatment of the musculoskeletal problems by addressing muscle energy or --

Q I don't want to come back --

A Basically, we have an extra class.

Q And prior to 2016, there were boundaries between the two?

A As a matter of fact, in the '80's, in California, they take --

Q In New York. We are only in New York now.

A They took all the D.O. and converted them to M.D.

Q In New York, prior to 2016, were there boundaries between the two disciplines?

A Different D.O.'s can go to M.D. residences, but M.D.'s cannot go to the D.O. residences.

Q As we move forward here, do you, as a routine, send patients back for a discectomy?

A No.

Q In this case, did you advise him to have the discectomy or was it Dr. Reyfman who did that?
A I advised him to go back to Dr. Reyfman for a discogram and possible --
Q That's not my question. I know you are very intelligent.
MR. GERSHON: Objection. Objection. I am going to object and ask him to please let him the doctor answer.
THE COURT: Sustained. Sustained. Not responsive.
Q I asked about the discectomy, Doctor, not --
A I did send him for discectomy myself.
Q You did?
A Yes.
Q And after the discectomy, did you send -- you referred him back for a discogram?
A They are part of the same procedure. All in one procedure.
Q The discogram -- Dr. Reyfman was --
A It's all done at the same time. You do the discogram and then you do the discectomy of the particular level.
Q That's not what I --
A I'm not Dr. Reyfman.
Q He did the discectomy and then at another time he did the discogram -- and forgive me, the annuloplasty?

A Yes.

Q Those two were done at the same time, but a different time with --

A I'm not Dr. Reyfman. I don't know which -- it can all be done in one shot.

Q When you were examining -- during the course when you saw him, did you note whether he had any atrophy in his legs?

A He did not. Lucky -- knock on wood, he did not.

Q That would be important? That's why you knocked on wood.

A That would be a chronic problem. That would be an irreversible problem.

Q It also is lack of use or the muscle wasn't being fed?

A Sometimes if you don't get the appropriate -- when the muscles are not working enough, that's when it starts to die out.

Q He didn't have that?

A No, he didn't have that.

Q Do you know if he had been working prior to seeing you but sometime after the accident? Do you know if he did any work?

A Right after the accident?

Q Not right after the accident but sometime after the accident. When did you first see him?

A I saw him first to be exact April 2, 2014.

Q April 2nd?
A Yes.
Q And the accident was December 2013?
A Accident was December 17, 2013, yes.
Q How did he come to see you? Do you know, was he referred by somebody?
A Yes, Dr. Reyfman.
Q Reyfman is the one who referred him to you?
A Yes.
Q Do you know how he came to see Reyfman?
A I have no idea, no.
Q By the way, did you ever see Mr. Moreno during the course of this timeframe?
A Yes.
Q Where did you see him for --
A I was an assistant in the case with Dr. Avanesov. We are partners.
Q Do you know how Mr. Moreno came to see you?
MR. GERSHON: Objection. Beyond the scope.
A I have no idea.
THE COURT: Overruled.
Q You assisted at this surgery too?
A Yes.
Q And Dr. Avanesov assisted at Mr. Iglesia's surgery?
A Yes, absolutely. We always work together.

Q You both were in the surgery --

A We are two surgeons, spine surgeon present in every case.

Q Do you have your operative report?

A I do.

Q I have -- I got off track. Hold on a second.

When I talked about your -- you had specialized training as an orthopedic surgeon. There are other specialties in the area that deal with people with these kinds of traumatic injuries, one way or another.

For instance, the radiologist would be someone who looks at films; is that correct?

A Yes.

Q Do radiologists have special training?

A Yes.

Q A radiologist has additional courses or classes or training that an orthopedic surgeon would not have; is that correct, generally speaking?

A Yes. I mean, it's a different field. Absolutely.

Q And what does a radiologist do?

A They read films.

Q And there is a radiologist who read the MRI; is that correct?

A Yes.

Q The February 27, 2015 MRI that we have pictures of

here; correct?
A Correct.
Q And do you know -- have you seen the radiologist's report on that MRI?
A I have seen the portal because all images come up and you can look at the report.
Q I thought you reviewed all records before coming here, you said, and that would include, I assume, the radiology report?
MR. GERSHON: Objection.
A On the day of the surgery, I definitely look at the report of the --
MR. GERSHON: Can we approach.
(Discussion held off the record, at the bench.)
Q By the way, in response to questions earlier to counsel, you said there were some problems in the area. I don't know exactly the word you used, but there were some problems on three levels, and you said that the radiologist even pointed that out.
Do you recall saying that?
A Yes.
Q So, you did read the radiologist's report to see that the radiologist pointed it out; correct?
A Yes.
Q And that's one of the things you looked at, among

other things, in assessing what the patient was suffering from or what plan of treatment would follow; correct?

A Correct.

Q That was taken at -- the radiology report in question refers to 2/27. It's the one you just testified to the MRI about; correct?

A Correct.

Q And so, the MRI's are here, you reviewed them, you have testified about them, correct?

A Correct.

Q And you have read the radiologist's report at some point?

A Correct.

Q By the way, it was taken at Stand Up Brooklyn Radiology. Do you have access -- can get online and see the film there?

A Any facility of Stand Up MRI, everyone has a portal.

Q In your office you have the capability of just getting on your computer --

A Even on my phone.

Q Let me just finish the question so she can get it.

A Sure.

Q You have the capability of accessing all the radiologists' reports and films at any of these facilities?

A Correct.

Q And you have just said, even on your phone you can do it?

A Correct.

MR. BRODY: Your Honor, may I have this marked for identification.

MR. GERSHON: I consent to it going into evidence.

(Whereupon, the item referred to was received and marked Defendant's A in Evidence.)

Q In this radiologist's report, the radiologist was Dr. Winter; correct?

A Yes.

Q I will read -- can you find anywhere in this report where he said he has herniated discs at L-2 L-2,3 L3-4 or L5-S1? Does the word herniated disc appear in this report?

A L3-4, L4-5, L2-3. The posterior bulging discs within the thecal sack.

(Continued on next page.)

Q. My question is does the words herniated disc or herniated nucleus pulposus or HNP appear in this report?
A. No, they do not.
Q. They do not.
And specifically at the L4/5 level it's posterior disc bulging abutting the ventral fecal sac he says; correct?
A. Correct.
Q. Now a bulge is pretty much what it says. It's part of the disc itself, it's just sticking out a bit?
A. The bump as I showed you on the picture.
Q. The bump.
A. Yeah.
Q. But that's a bulge?
A. Everyone reads it differently. Again --
Q. I'm not asking how it's read.
MR. GERSHON: Once, again --
MR. BRODY: Objection. Not responsive.
THE COURT: Sustained.
Q. I'm asking is there a difference between --
MR. GERSHON: So --
THE COURT: It's sustained. So it's not responsive. So he can continue. He's not going to continue with his answer.
Q. Is there a difference in your practice, in orthopedic practice and spine surgery, between what's called a bulge and

what's called a herniated disc?

A. Everyone reads it differently. That's why I always read my own reports. And that's why --

MR. BRODY: Not responsive again, Judge.

THE COURT: Sustained.

Q. I'm asking the question in the practice of orthopedics and surgery is there a difference from the term bulge and herniated disc?

A. There is a difference, yes.

Q. There is a difference; correct?

A. Yes.

Q. A bulge is not a herniated disc; correct?

A. Correct. That's the reason why we sent for discogram.

MR. BRODY: Objection, it's not responsive the last part.

THE COURT: It's struck.

Q. And the impression of this radiologist on February 27th on the MRI's that you were showing said -- and I'm going to read, Your Honor, okay, at 2/3, 3/4 and L5/S1 -- I beg your pardon, that should have been L2/3. L3/4 and L5/1 of posterior sub ligamentous disc bulges at the L4/5 level this posterior disc bulging abutting the ventral fecal sac.

Next line, in the neutral sitting position there is a slight kyphotic angulation at L2/3. Kyphotic means?

A. Lordotic is a normal position of the spine. If you

can raise the model, that's the curve you should have. Kyphotic is the other way.

Q. And often that is congenital; is that not correct?

A. No.

Q. It's not congenital when you have a -- what is scoliosis?

A. Scoliosis can be based on two -- it's on --

Q. All right. When you're talking about lordotic, the normal lordotic, the curve spine, it curves; is that right?

A. Correct. Kyphotic deformity is not a normal deformity of the normal spine.

Q. Is everybody born with an appropriate lordotic curve to their spine?

A. Usually, yes, unless there's some deformity.

Q. Well, there are anatomical differences among people too; right? That can come from birth; correct?

A. Not particularly at L2/L3 though.

Q. So you're not aware of that in your practice?

A. Of what?

Q. Of anatomical differences among people.

A. Of course there is anatomical differences.

Q. In fact, when people get older, sometimes they lose that lordotic curve, don't they?

A. It can either get worse or less, yes, due to arthritis.

Q. Well, you used the word desiccation before. That's the loss of water in the disc?

A. Absolutely.

Q. And the aging process causes desiccation; correct?

A. Absolutely.

Q. And that's why you refer to a young man with desiccation as not normal; correct?

A. Correct.

Q. So we know how this works. I know something about your field. Not much. Just a little.

MR. GERSHON: Objection.

THE COURT: Sustained as to the comment.

Q. Okay. And the flexion position the lumbar curvature demonstrates --

A. You want me to read it?

Q. Go ahead but nice and loud and slow. You talk too fast.

A. In the flexion position the lumbar curvature demonstrates accentuation of the kyphotic angulation with a vex meaning the top at L2/L3.

Q. So that's two -- that's a two, three and then there's a three, four, and then there's a four, five; is that correct?

A. Correct.

Q. And the disc that had the -- that was fused was L4/5?

A. Correct.

Q. So that's two discs above this observation was noted; correct?

A. Correct.

Q. You don't disagree with this?

A. I don't disagree with it.

Q. All right. Next one. In the extension?

A. In the extension the lumbar curvature becomes lordotic with relative strengthening at L3/L4.

Q. Okay. And this is February 27th, this is two months after the accident. Do you think these findings were as a result of the accident, the curvature, the lordotic, what he's saying in these two paragraphs?

A. Curvature is not an issue here at all.

Q. All right. Whatever he's saying in these two paragraphs, do you think this was caused by the accident?

A. No, I'm not concerned again with lordotic, kyphotic.

Q. Okay. So it preexisted the accident; correct? Fair statement?

A. Maybe.

Q. All right. Doctor, do you have your operative report with you?

A. Yes, absolutely.

Q. Where did this operation take place? Nassau University Hospital?

A. Nassau University Medical --

Q. And is the medical report part of the hospital record?
A. Yes, it's part of the hospital record.
Q. Routinely a surgical operative report is part of a hospital record; correct?
A. And my chart as well, yes.
Q. And your chart as well.
MR. BRODY: Your Honor, I offer the operative report into evidence. We do have subpoenaed the Nassau county records here.
MR. GERSHON: No objection. At this time I offer his records which were marked for identification.
THE COURT: So it's B in evidence.
MR. BRODY: Thank you.
THE COURT: Let's mark it, please.
(Whereupon, Nassau University Medical Center medical records was marked as Defendant's Exhibit B in evidence.)
MR. GERSHON: Why don't you mark the whole hospital record and use your operative report in the meantime.
MR. BRODY: Here's the operative report in the meantime.
COURT OFFICER: So marked.
THE COURT: Did we mark it already?
THE WITNESS: I have it.

MR. BRODY: Excuse me, is B going to be just for the operative or the whole Nassau county record? The whole records. So then can we make the operative report itself B1 because I want to refer to that though more than I refer to the hospital --

THE COURT: Sure. It could be B1.

MR. BRODY: And this could be B.

THE COURT: Sure.

(Whereupon, an operative report was marked as Defendant's Exhibit B1 in evidence.)

THE COURT: Counsel, I'm giving you five minutes.

MR. BRODY: Sorry, Your Honor?

THE COURT: Five minutes.

MR. BRODY: To finish?

THE COURT: Well, we're going to close in five. Whether you finish or not the Court has to lock up.

MR. BRODY: It's 4:24 I have --

THE COURT: We close at 4:30. I'm giving you a five-minute warning.

MR. BRODY: I know but he did over an hour-and-a-half.

THE COURT: So then the doctor has to come back. That's all I can tell you.

Q. Doctor, will you look at your operative report?

A. Sure.

Q. It's dated 4/24.

A. Yes.

Q. Forgive me, I have to focus with these glasses.

The preoperative diagnosis was L4/5 annular tear with intractable low back pain and lumbar radiculopathy; do you see that?

A. Yes.

Q. That's before the surgery, that's what you put down as the preoperative diagnosis; correct?

A. Correct.

Q. You didn't put down herniated disc there, did you? Yes or no, Doctor?

A. No, no, no.

Q. You didn't put that down as a preoperative diagnosis; correct?

A. Annular tear is considered to be part of the disc --

Q. Well, we've had two lessons from two different doctors of what an annular tear is. And I understand it's the thing around the side which holds the gel which is the nucleus in its place; right?

A. Exactly.

Q. And it could be a partial annular tear, a small annular tear, it could be annular tears; right?

A. Yes.

Q. People can live with annular tears without pain;

correct?

A. Yes, absolutely.

Q. People can go years with annular tears and not even know they have it; correct?

A. That's where the discogram comes in, yes.

Q. Okay. And you can have annular tears from normal exertion or exercise too as well I suppose, can you?

A. Not in a 23-year old.

Q. How about repetitive movements?

A. Again, not in a 23-year old.

Q. All right. Do you know what kind of sports this 23-year old entered into?

A. At that time he was not playing any sports.

Q. Do you know what sports before the accident he had entered into --

A. Not that I know of, no.

Q. -- for the first 22 years of his life?

A. No, I don't have anything --

Q. You don't have any information about that; right?

Do you know what kind of work he was doing prior to the accident?

A. He was a driver.

Q. No, he wasn't driving. He was a passenger, sir. Do you know what passenger on what?

A. A delivery truck.

Q. Do you know what he delivered?

A. I don't remember.

Q. Do you know how many times the loads he would pick up or not pick up or bring in or bring out, do you know any of that?

A. No, I don't have it documented here but it never bothered him before.

Q. Whether it bothered you or not, did you ask him, did you ask him what his activities were?

MR. GERSHON: Objection to the form. He didn't say bothered. He said it bothered him.

THE COURT: Overruled. If I overrule, you don't continue, counsel.

MR. GERSHON: No, it's just --

THE COURT: It's okay.

Q. All right. So I -- just because of the time, you did this surgery; correct?

A. Correct.

Q. You explained the surgery in medical terms that I don't understand. But you do --

A. I try to do it in layman's term.

Q. But there are parts of a body and instruments and things are moving that you put in here that we don't understand.

A. Yeah, I showed them --

Q. I understand. I'll wait till a movie comes out.

MR. GERSHON: Objection.

THE COURT: Sustained to the comment.

MR. BRODY: Withdrawn.

Q. At the end of the day you have a postoperative diagnosis; correct?

A. Yes.

Q. And postoperative means after the surgery; correct?

A. Yes.

Q. And your postoperative diagnosis is one L4/L5, annular tear with axial low back pain and lumbar radiculitis; is that correct?

A. Correct.

Q. Radiculitis means the pain that's transferred down; correct?

A. Correct.

Q. And that's again the pain being transferred down is a subjective symptom, correct, plaintiff tells you?

A. Besides the straight leg raised test that shows you the pain.

Q. In one of your reports later on it says straight leg was negative but I don't want to go through that. I don't have time. Unless you want to come back, sir, then I will go through every one of those reports with you.

A. Let's go.

Q. Two, neuro compression on the right side general

endotracheal. Now the trachea is up here, isn't it? (indicating)

A. Anesthesia that's general endotracheal.

Q. I see, so I misread the line.

So what am I looking at number two postoperative diagnosis neuro compression on the right side --

A. Neuro compression.

Q. On the right side?

A. Yes.

Q. Was it on the right side before the surgery or was it the left side?

A. He had symptoms mostly on the left side but surprisingly the disc was worse on the right.

Q. And I thought you said specifically the left was greater than the right?

A. Exactly. It happens.

Q. Again, in this postop diagnosis -- and I don't want to quibble with you what annular tear means, do you use the words herniated disc, herniated nuclear pulposus, HNP, which means herniated nuclear pulposus, are they ever here as a diagnosis?

A. No, I didn't need it.

THE COURT: Okay. It's 4:30. Would you like the doctor to come back?

MR. BRODY: Can I think about it and I'll let counsel know?

THE COURT: At this point ladies and gentlemen of the jury please come back tomorrow Thursday at ten -- at 9:30 a.m. Thank you.

COURT OFFICER: All rise.

MR. BRODY: Well, before the jury leaves maybe we can have a word?

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

THE COURT: Come back at 9:30. Thank you.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

(Whereupon, Court is recessed and the case adjourned to Thursday, February 14, 2018.)

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