SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER
----------X
LUZ PELAEZ-MORONTA,

Plaintiff,

-against- Index No. 52610/2017

MAVIS TIRE SUPPLY, LLC and CHRISTOPHER LITTLETON,

Jury Trial

Defendant.
----------x

Courthouse
White Plains, New York

May 9th, 2022

BEFORE:
HON. CHARLES C. WOOD,
Justice of the Supreme Court

APPEARANCES:

OMRANI & TAUB, P.C.
Attorneys for the Plaintiff
488 Madison Avenue, 20th Floor
New York, New York 10022

BY: JAMES FORDE, ESQ.

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BY: HOWARD S. SHAFER, ESQ.

MR. FORDE: We're going to premark these medical records starting with Number 17. Exhibit 17 is ASC Urgent Care.

(Whereupon, at this time Plaintiff's Exhibit 17 was marked into evidence.)

MR. FORDE: Exhibit 18 is National Neuro Labs.

(Whereupon, at this time Plaintiff's Exhibit 18 was marked into evidence.)

MR. FORDE: Exhibit 19 is New York Spinal Institute.

(Whereupon, at this time Plaintiff's Exhibit 19 was marked into evidence.)

MR. FORDE: Exhibit 20 is Stand-Up M.R.I. of Yonkers.

(Whereupon, at this time Plaintiff's Exhibit 20 was marked into evidence.)

MR. FORDER: Exhibit 21 is Mercy Medical Center.

(Whereupon, at this time Plaintiff's Exhibit 21 was marked into evidence.)

MR. FORDE: Exhibit 22 is White Plains Chiropractic.

(Whereupon, at this time Plaintiff's Exhibit 22 was marked into evidence.)

MR. FORDE: Exhibit 23 is Dr. Alladin's records.

(Whereupon, at this time Plaintiff's Exhibit 23 was

marked into evidence.)

MR. FORDE: Exhibit 24 is W.M.C. Physical Therapy.

(Whereupon, at this time Plaintiff's Exhibit 24 was marked into evidence.)

MR. FORDE: Exhibit 25 is Ardsley Secor Volunteer Ambulance.

(Whereupon, at this time Plaintiff's Exhibit 25 was marked into evidence.)

MR. FORDE: Exhibit 26 is New York Spine.

(Whereupon, at this time Plaintiff's Exhibit 26 was marked into evidence.)

MR. FORDE: Exhibit 27 is M.R.I.'s and reports from 2015.

(Whereupon, at this time Plaintiff's Exhibit 27 was marked into evidence.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time the sworn jurors entered the courtroom, and took their respective seats.)

THE COURT: Have a seat, everyone.

Good morning. Welcome back, ladies and gentlemen of the jury. I'm sorry for our delay this morning. We needed to premark some of our exhibits, and make sure our tech in this courtroom is compatible with what we were using upstairs. So, we should be ready to go.

I'll ask Mr. Forde to call his next witness,

please.

MR. FORDE: Thank you, your Honor.

The Plaintiff calls Dr. Angel Macagno.

THE COURT: Dr., come on up.

THE COURT OFFICER: Place your left hand on the bible, raise your right hand and face the Judge.

D R. A N G E L M A C A G N O,

called as a witness on behalf of the Plaintiff, having been first duly sworn, was examined and testified as follows:

THE COURT: Have a seat.

Just state and spell your name for the record, and give us your business address, please.

THE WITNESS: My first name is Angel. Last name is Macagno, M-A-C-A-G-N-O. I'm a spinal surgeon; an orthopedic surgeon. I'm board certified. I specialize in spinal surgery. The address 671 Merrick Avenue, Westbury, New York.

THE COURT: Dr., we're dealing with the masks, as you know. Speak into the microphone as best you can. It's probably better to slow down just a little bit as well. The jurors are out there straight ahead of you, behind Mr. Forde. So, project your voice to the back of the courtroom.

The lady right in front of you has to take down everything you say. Speak slowly and clearly, as best you can.

Thank you.

Mr. Forde.

MR. FORDE: Thank you, Judge.

DIRECT EXAMINATION

BY MR. FORDE:

Q Good morning, Dr. Macagno.

A Good morning.

Q Dr., are you currently licensed to practice medicine in the State of New York?

A Yes. Since 2012.

Q 2012.

Where did you go to medical school?

A I went to medical in Argentina. I went there in 1988. Medical School's name is National University of Cordoba.

Q And where did you -- Did you do an internship here in United States?

A Yes. I did my internship and residency both in orthopedic surgery.

Q And where did you do that?

A Downstate Medical Center, in Brooklyn.

Q And can you describe your area of specialty as far as orthopedic surgery?

A I'm board certified in orthopedic surgery. So, I

specialize in spinal surgery.

Q Spinal surgery?

A Spinal surgery.

Q Any other types of surgery that you specialize in other than surgery of the spine?

A I'm board certified in orthopedic surgery. It's not what I do normally in my practice.

Q And have you -- Do you have any hospital affiliations currently?

A Yes. I have in N.Y.U.; New York University, with the Hospital for Bone Diseases, Bellevue Hospital, in Long Island with Mercy Hospital, and San Francisco Hospital, Winthrop Hospital, and New Jersey Hudson Regional Hospital.

Q And are you board certified in orthopedic surgery?

A Yes, in orthopedic surgery.

Q What does that mean to be board certified?

A Board certified is one requirement in this country. After you finish your residency and you do your fellowship, then you start your own practice. Then you have to pass an exam, where you're going to present cases and be reviewed in the specialty that you are applying. In order to pass exam, you have to be trained first. You're going to be tested by written exam and by peers.

Q Do you have any kind of academic appointments or teaching experience?

A Yes. I'm a clinical assistant professor or orthopedic surgery at N.Y.U.

Q And how long have you been a clinical assistant professor at N.Y.U.?

A Since I finished my fellowship. Probably in 2013.

Q And any other clinical professor appointments that you have with any other hospitals?

A No. The Hospital for Spinal Surgery.

Q Spinal Surgery.

Have you done any kind of publishing or written any type of articles with regard to the area of your specialty?

A Yes. I have chapters I have written. I have multiple articles written.

Q And specifically with regard to injuries of the spine caused in motor vehicle accidents, have you had any type of research or writing experience as far as those types of injuries?

A Not specifically with motor vehicle accidents. But I have in cervical spine, I've published articles, the outcomes and the injuries of the cervical spine. But not specifically with car accidents or motor vehicle accidents.

Q Those are as far as articles are concerned?

A Yes.

Q What about in the course of your medical practice, have you had occasion to treat and perform surgery on individuals

that injured their neck or back in motor vehicle accidents?

A Yes, I did.

Q And approximately, how many, if you can give us a number?

A I don't know. I've been doing this for many years. I cannot be specific as to how many are related to motor vehicle accidents. But I've been doing this for years, but I can't give you a specific number.

MR. FORDE: Dr., I'd ask that Dr. Macagno be qualified as an expert in the field of orthopedic surgery.

MR. SHAFER: No objection, your Honor.

THE COURT: Very good. The doctor is qualified to give testimony in the area of orthopedic surgery.

Q Now, Dr., in the course of your medical practice, did you come to treat a lady by the name of Luz Pelaez?

A Yes, I did.

Q And do you remember when you first began to treat her?

A Can I check my records?

Q Did you bring your chart with you today with regard to this particular patient?

A Yes, I have.

Q And would it help your testimony in order to refer to that chart?

A Yes. In order to be accurate, yes.

MR. FORDE: Your Honor, may he?

THE COURT: Sure.

Q You can look at your chart.

MR. SHAFER: Your Honor, I would just ask that he not read from the chart.

THE COURT: To the extent that you can give testimony from your memory, please do. If you need to refer to your notes, by all means do so.

THE WITNESS: Fantastic.

Yes. I saw her for the first time on January 22nd, 2019.

Q At that point when you saw her, did you take a history of the patient?

A Yes.

Q What was your -- What was the history that you took from her at that point? What had she been doing before she came to you?

A She was a patient involved in a motor vehicle accident years before; 2018 (sic). I have to check in order to give you the exact date. She was a restrained passenger that was involved in a motor vehicle accident.

Q And her previous course of treatment before she had come to you, were you aware of what her prior treatment had been?

A Yes. She had extensive conservative treatments. Physical treatment, multiple medications, injections.

Everything was endured in the previous treatment.

Q So, approximately how long had she can been under consistent conservative care?

A I think shortly after the accident for many years.

Q As far as the conservative care that she received, are you aware whether she received any evaluations from a neurologist?

A She had an E.M.G. done. I believe so, yes.

Q The were you aware of whether she had seen any other orthopedic surgeons before you?

A I'm not aware. Or I do not recall. I'm sorry.

Q So, at the point and time when she came to you for treatment, had she been recommended to you for potential surgical options?

A Yes. Normally patients that come to us for surgery is because they consulted with other treatment.

Q And when you say the patient was referred to you, was that you personally or was it a medical group that you belong to?

A I do not recall about this patient.

Q Back in 2018, 2019, were you affiliated with the New York Spine Institute?

A Correct.

Q And what is the New York Spine Institute and how are you associated with it?

A I'm basically an employee there. I'm part of the group. We were -- Currently we have four spinal surgeons and one neurosurgeon and two orthopedic surgeons. It's a private group that's not affiliated specifically with any hospital. We have multiple hospitals that we perform surgeries.

Q So, you are basically an employee of the New York Spine Institute?

A Correct.

Q Now, just as far as your testimony here today, are you being compensated for your time to come to court to testify?

A Yes.

Q And is that compensation directed to New York Spine Institute or directed to you?

A To New York Spine Institute.

Q Do you know what the New York Spine Institute bills for your time to come to court?

A I think at this time it's $15,000.

Q Is that money that you receive? As part of that, do you get paid $15,000 to testify?

A I'm receiving about 30 percent of that money.

Q And what is that meant to compensate for, as far as your testimony in court?

A Basically my time. I have to stop seeing patients.

Q And as far as the scheduling and billing for your time, is that all done through the New York Spine Institute?

A Correct.

Q You don't handle any of that personally?

A No.

Q Now, before coming here today, Dr., did you review any kind of records with regard to the treatment of this patient?

A Yes, I did.

Q What did you review?

A I reviewed basically my own records, reports, some images, and some records from the Westchester Medical Center, and some records from the radiology images. I don't remember the name.

Q When she came to you originally in 2019; early 2019, did you have an opportunity to review any M.R.I. films that had been taken previously?

A At that time, she had M.R.I. performed, but I had only the reports. I didn't have the M.R.I. personally.

Q Were those reports from 2015, shortly after the accident?

A Yes.

Q Do you have those reports as part of your chart?

A Yes.

MR. SHAFER: Just to be clear, we're talking about 2015?

MR. FORDE: Yes, Mr. Shafer.

Just for the record, we have marked as Exhibit

Number 27, the M.R.I. CD of 2015, and these are the reports that accompany them, which are all part of Exhibit 27.

Q Okay. All right. So, Dr., the officer has handed you some M.R.I. reports from December of 2015.

Are those the reports that you reviewed when you originally saw Miss Pelaez?

A Correct.

Q And can you tell us what significant findings there were with regard to the cervical spine?

A Basically she had a -- There were significant disc herniations at C5-C6 level and C6-C7, there were the most significant. There was another disc herniation at C4-C5. And multiple level disc bulges.

Q And as far as the lumbar spine, what significance findings, if any, were there on the M.R.I. reports from 2015?

A She had disc herniations with compression of the nerve routes, and there were disc bulges at L4-L5.

Q Now, were you aware of whether Miss Pelaez had any kind of prior history of neck or back pain or trauma, or anything before November of 2015?

A I do not. I'm not aware that she had any trauma before. I know she had some treatments for muscle spasm in the neck or neck pain with a chiropractor one time, at least in my records or what I reviewed. She had one time in the past.

Q And how long before 2015, did she have that muscle

spasm and treatment from the chiropractor?

A I think years before. But I don't have the exact date.

Q So, once you had an opportunity to review the M.R.I. reports, what else did you look at as far as evaluating this patient in January of 2019?

A Well I did a complete physical exam.

Q And were what were the results of your physical exam when you did that?

A She had significant muscle spasm in the neck and lower back. She was tender to palpation. She had decrease range of motion of both of them. And then she had positive signs for irritation of nerves, and degeneration in the cervical and lower spine.

Q That was at an exam that you did yourself personally by examining her body; her neck and her back?

A Correct.

Q So, as far as January of 2019, what was your main area of concern as far as her spine?

A I was concerned mostly for the neck at that time, because she was having increasing weakness in her extremities and significant signs of nerve compression with irritation of the nerves that were in her muscles in some movement and sensation with the other extremities.

Q Now, how old was this patient when you evaluated her?

A The first I think she was 50 or 51 years old. No, more

than that.

Q She was in her early 50's?

A Yes.

Q Now, as far as the M.R.I. findings from the 2015 M.R.I., were there any indications of any kind of age related changes, degeneration or arthritis, or anything like that that showed up on the M.R.I. films from 2019?

A As per the report. I never reviewed the films. Yes, there were changes for arthritis.

Q Would that be considered at all unusual with regard to an individual in their early 50's?

A Yes. Absolutely.

Q Would you expect to find arthritic changes or degenerative changes in someone in their 50's?

A Yes.

Q Is that out of the ordinary, or is it abnormal for someone to have any kind of degenerative changes in their spine?

A It's pretty common. We start having changes at 38 years old. At 50 years old, we're going to find changes.

Q So, it wouldn't be unusual to show signs of arthritis at the age of 51; would it?

A Correct.

MR. FORDE: I want to make sure everybody can see the screen.

Well, if the witness can step down, your Honor,

with the Court's permission.

THE COURT: Dr., if it would be helpful, by all means, step down.

(Whereupon, at this time the witness complied.)

Q Dr., while you are scrolling through the images, can you just generally tell us what we're looking at, what the jurors are looking at the screen?

A This is one of the most important images. This is basically the cervical spine. This image we're seeing the patient from the side. We can see this is the front. Okay. This is the front of the neck. This is going to be the back of the neck. This is your brain. The face is going to be here.

This is what we call vertebrae. They're bones in the neck. In between the bones are going to be the discs. This is what we care right now in this moment. This is a really important structure. This is the spinal cord.

The spinal cord gets all the information from the brain to the arms. If you have an injury of your section of the spinal cord, you are going to get paralysis or you're going to die. We cannot fix spinal cord.

This is an image we're looking for. You're going to see white space in the front and the back of the spinal cord. This white space is basically fluid. It's a fluid that's produced from the brain and going all the way down to the tailbone inside the spine. This is the most important part.

Nothing should be coming vertebrally and compressing this.

This is okay. This is a small disc bulge. This is not so significant.

But you can see here, you can see this compression of the spinal cord. And this one is less.

Q Dr., while you are scrolling through, just so we're clear, the lighter areas in the column, those are the bones?

A The lighter area. This gray, these are bones.

Q Those are the bones.

And the darker areas that are in between the bones, those are the discs?

A Those are the discs.

Q Okay.

A And I want to try to see how this system works.

And now this is the M.R.I. for the spine as we're seeing it, is the relationship between the last spine that was in here. And this view is going to be like we're seeing the patient from the top. And this is the same structure as here. We can see this is going to be spinal cord, and this is what we talked about is all the fluid around, and the disc is going to be this.

There is nothing coming from the disc and compressing the spinal cord. And this is the spinal cord -- coming from the spinal cord.

When we go down, we have a small disc herniation of

this. We're not concerned. This is not so significant either.

But when we come here, this structure. That is pretty clear that this basically is the gel. The disc is like a structure. It's a soft structure. It's a cushion between vertebrae. And inside, you're going to have a gel.

When you have an injury, the gel is going to come out. That is what we don't want. And that means in one side the gel is not really cushioning. In time, it's going to compress of the spinal cord and compress the nerves and it's going to cause pain.

In the next one, you have another disc herniation. That's not so significant. Mostly on the right side.

But this is our main finding here. This is disc compression. That's a real disc herniation.

Q Let's focus on the cervical area. Based upon the patient's history that you had at that time, did you have a conclusion with a reasonable degree of certainty as to whether or not these herniated discs were related to the accident she had in November of 2015?

A Yes, I do believe so.

Q Why is that?

A Because first in the symptoms, the images are showing something that is new, that is not chronic, it's not formed spurs that you can see that exist in other images. This is a soft tissue injury. That this corresponds to something that is

acute.

The other side the symptoms are the history of not having an injury before that's not significant; not having trauma, or not having -- We don't have any images before the accident to compare. But she didn't have significant injuries of the neck.

The other part the symptoms referred by the patient are totally consistent with my exam. And the exam; the physical exam did bear out that she's having some new injury to the nerves.

Q So when somebody has an injury to a specific disc in their cervical spine, will that cause symptoms that you can trace back to an injury at that disc?

A Correct, in general. In general, this is anatomy. This is not perfect. This is not mathematics. But in general, in your body, every nerve is going to take sensation to a specific place of the arm. For example; an upper extremity. At the same time you're going to have comprise muscles that would result in weakness that is specific for that nerve.

Q And so the exam; the physical exam that you did of Miss Pelaez, was that consistent with the traumatic injuries that you see on this M.R.I.?

A Correct. Absolutely.

Q Now, you also have on that disc, I believe, the lumbar spine?

A I don't know if you have it here.

MR. FORDE: Your Honor, can my office assistant approach and help him?

THE COURT: Sure.

Q There we go.

A This is the view that we've seeing before.

Q Just so we're clear, at this point now on that same disc, what part of the body Luz Pelaez are we looking at here?

A This is the lower body. This is called the lumbar spine. This is lower part of your spine. This is going from the lower thorax to your buttocks. Basically goes to your buttocks here. This is called sacrum. This is the last bone. There is no real disc you can see.

This is the last disc in your lower spine. It's called L5-S1. This other disc is called L4-L5. And you can see the two discs what we call -- they have what we call black disc disease. Because basically the color that we are seeing on the M.R.I., you always have people who have black, because this is color. The color means that something happened to the disc. Mostly trauma, because there are two discs compromised that came out. That means when you have white image like this disc that we can see on the M.R.I., those disc are pushing full of water; full of cartilage that are going to make this disc bulge.

When you have the gel coming out, you're going to have those discs going to be stiffer. They're going to be hard.

It's not going to be cushions. That's going to give you more pain.

At the same time, this is the disc -- This is level we're talking about. This is the disc that's black.

And the last one, they have the same thing that we talked about before. This is the disc herniation. But it's not so significant that you can see. Also the left here. But there is a disc herniation coming out and compressing the nerve too. There is a black disc, plus a disc herniation.

Q So, the lower disc that you were pointing at there, those discs are black because of trama?

A Correct.

Q And how do you distinguish between that and the other discs above it that appear to be, for lack of better term, healthy?

A The other disc looks not so bad. When you see the white like this, it's okay.

But another disc herniation in L1-L2. This is the other image.

But if you see spine disc completely with arthritis, you're going to see everything black. It's not that you have one disc with arthritis and the other is good and the other is bad. It's all going to be complete.

Q That's my question. So if it's a purely degenerative spine, that's basically riddled with arthritis, all the discs

would be black; correct?

A Correct.

Q And these ones; only the lumbar ones, were only the ones that were herniated by trauma, those are the ones that look different?

A Correct.

Q Did she have -- I guess maybe if the witness can take the stand again. We'll get a different image up. You can go back up to the stand.

(Whereupon, at this time the witness complied.)

Q Okay. Now, Dr., did she also have any M.R.I.'s performed after that initial set in 2015?

A Yes, correct. She had some M.R.I.'s done after that.

Q Do you know with when the next set of M.R.I.'s were done?

A I do not recall. In 2020. But I should check my records.

Q You can look at your notes?

A She had a M.R.I. of the lumbar spine on June 19th, 2020. This is what I have here. I think there was a M.R.I. of the cervical spine too, but I'm not sure about that.

Q Okay. While we're waiting for those images to come up. So, after your initial evaluation of her in January of 2019, did you make a determination as to whether or not she was a candidate for surgery?

A Yes. I discussed with the patient. She was a candidate for surgery. She it already exhausted conservative treatment. I didn't believe she would benefit from more injections or physical therapy. She was deteriorating. One of the options at that time was surgery.

Q So, at that point, did you believe that was her only option to have the surgery?

A There is one of the options. I always talk to the patient. Does she have a concept to do surgery. But at that time doing more conservative treatment, that's her option. Does she continue conservative treatment. I don't think it was going to work. But yes, the option; the final option would be surgery at that time.

Q If she had just continued with conservative care; the physical therapy, more pain injections, things like that she had been doing for three or four years, would she have gotten better in your estimation?

A I don't believe so.

Q Dr., I'm going to impose upon you again to go over to the laptop and look at the other M.R.I. studies that have been marked into evidence.

A She had a M.R.I. of the cervical spine -- A M.R.I. of the cervical spine and a M.R.I. of the lumbar spine from 2020.

Q And the one on top is from July of 2018?

A Yes. July 8th, 2018.

Q If we can take a look at that one please, Dr.
A I think this is the M.R.I. that we saw before.
Q This one was from July of 2018. July 8th, of 2018?
A Correct.
Q All right. So, now that was about three years or so after the ones from 2015.
And that was taken before you saw her; correct?
A Correct.
Q And did you review that M.R.I. when you saw her in January of 2019?
A Yes. This is the M.R.I. that we already saw in the previous time.
Q This one is from July 8th of 2018?
A 2018. The other one was 2015. Correct. I'm sorry about that.
Q Did you have this one available when you evaluated her in 2019?
A Correct.
Q So, what findings, if any, are there of significance in this M.R.I., which was taken about three years later?
A First, this M.R.I. is much better quality than the other one. We can see much better what is going on. We have the same bulges. It's a little bigger, the disc C5-C6. This is what we're talking about.
This is a significant disc herniation we can see what I

described before, compressing the spinal cord. This is significant compared with the other M.R.I. And the disc in the lower is getting bigger too. And we have the disc involved that was no significant is getting worse too. But C5-C6 is still the worse one.

Q And those the images from the top down?

A Correct.

Now we can see how to compare. This is going to be 3-4. Not so significant. 4-5 still having changes, mostly slipping forward. If you can see, we call that anterolisthesis. That is basically when one disc slips forward over the other.

Q I want to stop you there. Anterolisthesis?

A Correct.

Q And what does that mean?

A That means that the disc is slipping forward.

Q Is that because of the instability of the disc?

A That is one of the reasons, the disc injury, correct.

Then C5-C6 is a slipped disc. It's getting bigger. There is more compression. It still exists. It's losing a little bit of white because some years have passed between the first and the second.

And then C6-C7 has a bigger disc, mostly on the right side. That means the changes are getting worse.

Q And the progression of this condition compared to the M.R.I. of 2015, would that be just because of the aging process,

or is that the nature of a traumatic injury like this?

A Well, in trauma injuries normally -- there are two things can happen. That's why we don't rush to do surgery immediately. The discs could get better over time. But most of the time when you have these injuries they're going to get worse. That's what happened here.

Q And how is the aging process come into play as far as an older patient as opposed to a younger patient?

A Basically when we see the first images, that white side of vertebrae, that disc, that's leaking. That is something new that is sometimes acute. Even discs over time, we can see here after four years or three years, start getting darker and not so white because it's the aging process of the injury that we saw before. Okay. It's still white there. But it's still telling us it's a new injury.

Q All right. Dr., the use of M.R.I.'s to look at the discs and evaluate them, is the M.R.I. a completely exact science or is that just a road map?

A No, it's not exact science. You have a difference if you have two people reading M.R.I.'s. You are going to have different thinking what is going on. But in general speaking, we know what is going on in these cases. It's the most accurate tool for describing the injuries at this time.

Q And the M.R.I. results do they have to be compared and correlated with the patient's clinical symptoms?

A Absolutely.

Q You can take the stand now.

(Whereupon, at this time the witness complied.)

Q All right. Dr., do you also have any kind of E.M.G. studies or any other diagnostic testing available to you to evaluate this patient?

A Yes, there was an E.M.G.

Q While you are looking, can you explain what an E.M.G. is?

A An E.M.G. basically is a study that is taking the compromised or integrity of the nerve, where we have the compression. The nerve is like a cable. Same thing. We have the wires inside and insulation around it. It's a cable same thing. And the impulses; the nerves generated by the brain through run through there like the cable. It's the same.

Q I mean, the nerves -- if I can interrupt you for a second. The nerves that run from your brain down your arm, it's like that electrical wire that's right there?

A Absolutely.

Q It's exactly the same thing?

A Correct. It's the spinal cord, as we saw before, the structure is in the middle. And from there, they're coming out at every level.

The images; there are multiple kind of images. But in general, they take the integrity of the cord how the nerve is

working. If you have an interruption, if you have a slow down, the impulse; the electrical impulse is moving around that.

Q And so, the E.M.G.'s that you had an opportunity to review, did they assist you in any way in determining whether or not there was any impact on her nerves to her neck and back?

A Yes. In this case, absolutely. She had injuries of the nerves in the neck and the lower back.

Q Okay. As far as the E.M.G. testing, can you describe how it's done, physically?

A There are multiple ways to do it. I'm not specialized in images. The most accepted one is you put needles in the different segments that we're talking about. Like the body is a map. If they want to check the C4 in the neck, in the neck, I have to put the needles, that is pretty bothersome for the patient, in the muscles that they're going to be generated by that section. And if there is some slow down in the impulse means that there is an injury of that neck.

Q So, would it be correct to say that there is electricity that is passed through the nerve?

A Correct.

Q And then it's recorded?

A Correct.

Q Okay. If there is a slow down of the electricity, that means there is damage to the nerve?

A Correct.

Q Can a patient fake a test like that?

A No, it cannot fake it. It's an objective test.

Q Is there anything that is in control of the patient when they have the electricity pass through the nerve?

A No.

Q All right. So now based upon on your exam, you determined that surgery would be her best option. Is that correct?

A Correct.

Q What type of surgery would you consider?

A Well, in this case, due to the age of the patient what we call anterior cervical discectomy and fusion. Basically we remove the nerve. We place something to replacing the nerve. In this case, I used cages; titanium cages. And the idea is for the bone to grow and make the levels together. We eliminate the nerve.

Q So, the disc was going to be taken out and replaced by something?

A Correct.

Q And when you say anterior. What do you mean by an anterior surgery?

A That's the front. We do it from the front of the neck.

Q Instead of the back?

A Correct.

Q Why don't you do it from the back?

A Well, the back is not indicated for this kind of injuries. We do it from the back for other kinds of injury, for patients that are paralyzed, bigger surgeries, bigger compressions.

In this case, we didn't need to go through it. We can do it from the front. Technically, it's less dangerous. It's still a big surgery, but less dangerous surgery than going from the back.

Q What are the potential risks of this type of surgery where you enter through the neck?

A The most common risk of this first, patient is going to be raspy. Going to have difficulty swallowing. That's always happening for two or three days. But it could be horsiness. Patient could change their voice. This is important if you are singer because you need to be aware that could happen. Most of the time it's temporary, but there are cases it happens forever. That means it changes your voice.

You can have nerve injuries because you're working around the nerve. You can have vascular injuries. In front of the neck, there are dangers there. You can cut arteries, veins. You can have bleeding. You can have paralysis. During any surgery, there are people who die. That is strange for this, but it could happen.

There are multiple, multiple kind of nerves there. If you cut a nerve that is called glossopharyngeal nerve, you're

going to have the tongue go towards one side. That is a really bad complication. You can have problem swallowing forever. Scar tissue inside. I'm talking about the scar in the region. These are more or less some of the risks.

Q When was your last -- Withdrawn.

How many times did you see her before you did the actual surgery?

A I think three times. Three times.

Q And at your last preop discussion, can you tell us when that was?

A That was on March 26th, 2019.

Q As far as did you make any notations as to whether she either had or had not had any kind of significant improvement with conservative care?

A I have to check my record. Evidently, if she had improvement, I would not do the surgery.

Q Well, if you can find your note from that.

A Is it the last note before the surgery?

Q Yes. March 26th of 2019.

A I have it here.

Q Okay.

A What is your question again.

Q The question was whether you made any notes as to her level of improvement with conservative care?

A Yes. In my history of present illness, I wrote down

she tried conservative treatment. Meanwhile the treatments were performed, there was no significant long-term improvement. Symptoms continue to persist.

Q At that point and time, what was -- The contemplated surgery was to which disc space?

A C4-C5 and C5-C6.

Q C4-C5 and C5-C6?

A Correct.

Q Now, did you schedule her for surgery at that time?

A Well, she was already scheduled.

Q Oh, at that point?

A Yes. This was her preop visit. I always see my patients before the surgery just to answer questions or go over the surgery more in detail.

Q When did you actually do the surgery?

A I did the surgery on April 1st, 2019?

Q And where did you do the surgery?

A I think I did it on Long Island, Mercy Hospital.

Q Okay. Do you have your operative report from that surgery?

A Yes, I have it with me.

Q Can you find it?

A Yes, I have it.

Q Okay. Now also, Dr., did you have an opportunity to review any illustrations or diagrams that explain the surgical

procedure that you had done?

A You're talking about before the surgery or after the surgery?

Q After the surgery?

A Yes.

Q And do you have a copy of that representation that you looked at that; the illustration?

A Yes, I have a copy.

Q Did you have an opportunity to compare the illustration with your operative report, and for the purposes of reviewing whether it was a true and accurate representation of the procedure itself?

A It's pretty accurate.

Q Is it anatomically correct as far as the procedures you did and the parts of the body you did the surgery on?

A Correct. It's pretty accurate. It's the same levels.

MR. FORDE: Your Honor, I'd like to have a copy of that illustration marked into evidence.

MR. SHAFER: Brief voir dire, your Honor?

THE COURT: Sure.

VOIR DIRE EXAMINATION

BY MR. SHAFER:

Q Good morning, Dr.

A Good morning, sir.

Q You said pretty accurate?

A Yes.

Q In what way is it not accurate?

A Let me see. The cages are not the same -- how is it -- same type of cages. You have like 20 cages on the market. But this is the cage that we use. It's the same type of cage. Industry wise, it's not the same cage. They are pretty similar one to the other.

Q Is it not similar in any other way?

A No. It's what we do.

MR. SHAFER: No objection, your Honor.

THE COURT: Okay. That will be Exhibit 28.

(Whereupon, at this time Plaintiff's Exhibit 28 was marked into evidence.)

MR. FORDE: Your Honor, I have an enlargement of that image that I'd like to have marked at 28A.

THE COURT: Okay. We'll deem it marked so we don't have to stop.

MR. FORDE: With the Court's permission, can the witness step down, and bring your operative report with you.

DIRECT EXAMINATION CONTINUED

BY MR. FORDE:

Q So, Dr. Macagno, if you could, go through your operative report, and explain what it is, how the surgery took place from when you brought her into the operating room and what you did?

A It's pretty much shown here. This is pretty much of what we do on a regular basis.

This kind of surgery, we do an approach on the right side. I prefer the right side because I'm right handed. If you ask me why on the right side, because I'm right handed.

We go through the spine. We have to move a structure not shown here. This is pretty much how we saw on the M.R.I.

This is the cut coming from the top. This is the difference. This is the spinal cord. This is the disc. Same thing that we saw before. But we didn't see all the structures in the middle, in the way down to the spine.

You have -- This is the tube. The patient is breathing through that. This is the trachea where she would breath. This is the esophagus. That's where we swallow. Okay. This is going to the first part of the digestive system. This is the structure that could be damaged. And you have arteries. This is the carotid artery. That is really important.

We move everything to the side, and we get to the spine. We see the spine. This is going to be spine. And this is the same view that we have before; seeing from the side. This is the disc with the disc herniation compressing spinal cord.

What you do from the front, with a removal of the disc, we use tools. It's basically carpentry work. We're basically carpenters doing this. We do everything with a microscope

because everything is really tiny.

We remove the disc in the middle, all the way back to the spinal cord. We remove the disc herniation, and then we're going to replace it with the cage; the titanium cages. These cages are impacted. That means we don't want the cages to come out. That is why we put a plate in the front. You can see this is in the front, with tiny screws. That is going to pull everything together.

Q So now when you first -- And if you need to look at your operative report, you can. When you did the incision and you looked at the areas where the discs were herniated, could you actually see the disc impinging on the nerves?

A Correct. When we get to this, this is the disc. Okay. And the disc herniation is going to come on the back of the disc. When we get to the back, normally we see a hole in the disc. We some material coming through there. Remember, we see everything with a microscope.

When we remove them, we can see the spinal cord actually. And sometimes you can see what is happening is the spinal cord is compressing.

Q So, can you actually see it with your eye? You can see the disc pushing on the nerves?

A Sometimes, yes. Multiple sometimes, yes.

Q In your operative report, did you indicate whether you can actually see the impingement of the disc onto her actually

nerves?

A Yes. A disc herniation was evident at this level indenting dura and compressing nerve roots. That happened with the disc C4-C5. The disc below -- That was disc below; C5-C6.

Q What about the disc between C4-C5?

A The disc herniation was evident at this level indenting dura compressing nerve route and removed completely.

Q Okay. Now, on the bottom of the diagram of the board, you are using certain tools that look like the hammer and those kind of things. Those cages that you are talking about, what are those? Are those cages filled with anything or is it just metal?

A It's filled with some substance inside. We use bone that is basically cadaver bone. It's people's bone. It comes in a package. Some people are still using bone from some patients. I prefer not to use it because it's very painful to remove it from the left hip. It's a substance that's going to make the bone grow, easier or faster. I use Trinity.

Q You use Trinity?

A Trinity. At the time, we used Trinity. We changed it now for a better substances.

Q So, this substance that goes inside the cage, that's a foreign substance?

A Correct.

Q And you mix it with bone?

A Correct.

Q And I think you said it was a cadaver bone?

A Correct. We use cadaver bones.

Q You basically take bone from a dead person?

A It's coming from people, because it sounds really scary, because if you have a piece of bone from dead people. It's coming in really containers already. It's already prepared.

Q Right. So it's processed?

A It's processed cadaver bone, correct.

Q And what's the purpose of mixing that material with the bone material and putting it inside the cage?

A Everything is trying to make -- Because surgery is your own bone is going to grow. These cages have a hole inside. The old bone is going to grow through that cage to this bone, and forming just one; the same bone. That bone there helps to grow the bone of the patient. Helping the bone to grow.

Q And that plate, the X-ray that's on the right side at the bottom, the white area in the middle, is that the plate that you put in to secure the area of the fusion?

A Correct. You can see here on this side, after we put the cages, those cages have nothing -- no screws in these cages; bone to bone. That means you have to put secondary support. We put the plate in the front with the screws. And using this case, we put six screws in.

Q This plate that's put in there, is that meant to permanent?

A Everything we put in there, we do with an idea of it being permanent.

Q So those vertebra; C4-C5 and C5-C6, those vertebrae are not going to be able to move anymore. Is that correct?

A Correct. Because we removed the disc.

Q So, once you do a surgery like that, what happens in the future to the disc above and below the surgery?

A Well, it's described as deferent labor desist. That is, we know that it will increase the pressure in the top and bottom levels. We know that patient that have this kind of this surgery have 2.5 percent chances per year to have the level below or above having problems that need surgery because they increase the pressure of those levels.

Q Is it common for someone like Miss Pelaez to need surgery; future surgery on the areas below and above because of that adjacent pressure?

A In her case, yes. I'm pretty sure she's going to because the level below, as you saw on the M.R.I., C6-C7, it was level that was already sick; has a disc herniation. That level tends to give surgery or tend to get worse in a short period of time. A short period of time for us is five years for example. I'm almost sure she's going to have another surgery.

Q Why didn't you fuse all of the cervical vertebrae at

the same time?

A Well, really the same thing that always happens. You could. But over the years with experience, at the beginning when you get out of medical school and residency, you want to fix everything, and you put all the screws and you fuse everything. And basically it's not the same results.

It's a bit different between two levels and three levels, because it's an increase of risk of complications, surgical time. In this case, I discussed it with the patient that she could have a cervical fusion once at different levels. And the other thing is she's a Jehovah Witness or something like that. A Jehovah Witness. It's more risky of having a blood transfusion with the patient. It's more risk of complications.

Q I'm sorry. I didn't understand. Because she's a Jehovah Witness?

A She cannot receive blood transfusions.

Q Oh, blood transfusions.

It's because of the increase risk of bleeding and she wouldn't be able to get blood?

A Correct. There is a multiple reasons why I decided to do two and not three or four discs.

Q All right. Dr., you can go back.

(Whereupon, at this time the witness complied.)

Q All right. Now, based upon the surgery that you did, were you happy with the result as far as how the surgery went?

A Yes. I think the surgery was pretty good and she had a complete fusion. We didn't have any complications. It was as I expected.

Q As a result of the surgery, did that mean she was cured and never have any future complaints?

A No. She's going to have. These kind of patients, as I always discuss before surgery with the patient, these surgeries don't do miracles. Patients are going to have neck pain. They're going to need physical therapy and exercises pretty much for life. In her case specifically, she has another disc with injuries that she has higher chances to have new surgery in the future compared with other patients.

Q All right. So -- And with regard to her lumbar spine, did you make a determination at any point as to whether or not either should have or is a candidate lumbar surgery like this?

A Sure. She's a candidate for a fusion surgery too for lumbar surgery.

Q Have you scheduled for surgery as far as that's concerned?

A No, not that I know of.

Q Once you did the surgery, did you see her postoperatively?

A I saw her multiple times after surgery for care.

Q What would say the follow-up reports as far as your examinations, how was she doing postoperatively?

A She had significant improvement of the nerve compressions that we were looking at for the surgery to improve the function of the arms. Unfortunately, she had some residual neck pain that would require more injections and more treatment.

Q And after you did the surgery, are you aware any course of physical therapy or pain injections or anything like that?

A Well, normally we prescribe physical therapy for six weeks. That she had for sure. And she had treatments for pain management. They gave her multiple medications for chronic pain. She had some headaches that were secondary to the muscle spasm that were in the back of the head. And she improved temporarily with some injections. I think she got in the neck she got injections. But she's going to need more treatment, yes.

Q Where did she have the -- Post surgery, where did she have the neck injections; the nerve blocks?

A I don't recall right now. I saw it this morning. I think she had it at Westchester Medical Center.

Q Okay. So now, Dr., based upon your treatment of this patient, your initial exam, your review of her history, did you draw the conclusion with a reasonable degree of medical certainty in the field of orthopedic surgery as to whether this motor vehicle accident from November of 2015, caused the problems to her neck?

A Yes, I do believe so.

Q You said that they're related?

A Yes. Correct.

Q And the restrictions that she had at the time you treated her and the restrictions that she has now, do you have an opinion with a reasonable degree of medical certainty as to whether those restrictions are significant and permanent in nature?

A Yes, they are significant and permanent.

Q With regard to her lumbar spine, same question. Based upon your exam, the prior history, and the diagnostic testing that you looked at and your treatment of her to date, do you have an opinion as to whether the injuries to her low back are directly related to the motor vehicle accident?

A Yes, I do believe so.

Q And with regard to those injuries to her lumbar spine, do you have an opinion whether they are significant and permanent in nature?

A Yes.

Q And what is that opinion?

A That they are permanent. Even if she gets surgery or not surgery, she would have significant restriction secondary to those injuries.

Q Now, the placement of the metal plate that you put into the spine, did you have a chance to check the alignment of that plate the way you put it in?

A Yes. We see with X-rays after the surgery.

Q As far as the placement of the plate, was it in good cervical alignment?

A Yes.

Q Did you bring any kind of a model to show what that model looks like?

A I have a model here.

MR. FORDE: May I?

Actually, could I publish it to the jury?

MR. SHAFER: Can I see it first?

No objection.

THE COURT: Okay.

(Whereupon, at this time the object was displayed to the jury.)

Q So, Dr., what the jury is looking at this moment, what is that that they're looking at?

A It's pretty much similar that we saw before. Instead of all the cervical spine, there is only three vertebrae brace there. You can see the cages with the plate in the front and the screws.

Q And that's similar to the type of plate that you put into Luz Pelaez' neck?

A Yes. A different brand, like we discussed before. But it's the similar plate. It's more or less the same.

Q Now, as far as this surgery that was performed, do you

-- did you get paid for the surgery or did New York Spine Institute get paid for the spine surgery?

A Yes.

Q Do you know how it was paid?

A I think this particular patient was a lien.

Q And what does that mean?

A The patient paid cash in advance for the surgery.

Q And is there any amount of money that is owed to New York Spine Institute for the surgery as far as you know?

A Well, I think the system before I get there to New York Spine Institute, if that's the case, either the patient cannot pay everything because the amount is significant. Part of it is paying in front, and the other part -- After the surgery, it depends on the result. It's going to be paid after.

Q So, part of the surgery is paid for on a lien basis in some manner and there's some amount that's still due to New York Spine Institute?

A Correct.

Q Again, that's the financing of the surgery, is that money that you are directly paid because of that?

A No. I get percent of the surgery.

MR. FORDE: Okay. Thank you, Dr. I have no further questions.

THE WITNESS: You are very welcome.

THE COURT: Let's take our morning break at this

time. Ladies and gentlemen, let's take ten minutes. Do not discuss the case.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, at this time the sworn jurors exited the courtroom.)

THE COURT: Dr., feel to stretch your legs. If you go in the hallway, you may not discuss your testimony with anyone.

I think Mr. Shafer is going to want to look at your file.

MR. SHAFER: Yes, your Honor.

(Whereupon, at this time a brief recess was taken.)

THE COURT OFFICER: Jury entering. All rise.

(Whereupon, at this time the sworn jurors entered the courtroom, and took their respective seats.)

THE COURT: I remind you that you are still under oath.

Mr. Shafer is recognized for cross-examination.

MR. SHAFER: Thank you, your Honor.

CROSS EXAMINATION

BY MR. SHAFER:

Q Good morning, Dr.

A Good morning, sir.

Q My name is Howard Shafer. I represent the defendant in this case. I'm going to ask you some questions.

You and I have never met before?
A Correct.
Q We did not have an opportunity to discuss this case?
A Correct.
Q But you did have an opportunity to discuss the case with the attorney for Miss Pelaez; correct?
A Briefly, yes.
Q And that was when?
A This weekend.
Q And New York Spine Institute, that's the name of your entity?
A Correct.
Q And you work for them?
A Yes.
Q Do you have an ownership interest in it?
A No. I'm just an employee.
Q But that's not part of National Neuro Labs; is it?
A No.
Q And you're not affiliated with National Neuro Labs; are you?
A Correct.
Q Now, that surgery that you described just before, you don't normally do that on people who are involved in motor vehicle accidents; correct?
A No, not necessarily.

Q In fact, you perform that surgery on people who are not involved in motor vehicle accidents; correct?

A Correct.

Q I think you told us you couldn't tell us, but can you tell us what percentage of the people that you treat were involved in motor vehicle accidents versus not being involved in motor vehicle accidents?

A I do not know.

Q And you wrote a report. Before I get to that, how are records kept at New York Spine Institute?

A Electronically.

Q Okay. Epic?

A We're switching to Epic. E.M.R., we call it.

Q So, can you tell me specifically how do your notes get into the patient's chart?

A Basically we dictate it in the system.

Q You dictate in the system?

A Correct.

Q Once records go into the system and are signed, they shouldn't change; correct?

A Unless we an put addendum; correct.

Q And how would an addendum be registered?

A It's going to say addendum.

Q It's going to say addendum. Okay.

I'm going to ask you to take a look -- With the Court's

permission, I'm going to hand up what was exchanged as a notice of expert witness exchange, pursuant to CPLR 3101 (d).

Specifically, I'm going to ask you to take a look at your the 9/22/20 report. Do you see that?

A Yes.

Q Is there a section called discussion?

A Yes.

Q And there is a two-line paragraph, then a one-line paragraph, and then followed by another one-line paragraph; correct?

A On discussion?

Q Right?

A Yes.

Q Am I correct?

A Correct.

Q Okay. And the first two-line paragraph reads:

"Based on the history and clinical evaluation the patient's current spinal symptomology is directly related to the motor vehicle accident sustained 11/6/15."

Did I read that correctly?

A Correct.

Q Based on the history, when you say history, what do you mean by that?

A History of personal illness. What happened, what happened before I saw the patient related to the accident.

Q So, the history of what happened before the accident and what any findings were before the accident, would be important; correct.

A Yes. This is important, correct.

Q But you're relying on the information patient gave you and any information you were able to gather with regard to the patient's history before the accident in order to draw your conclusions; correct?

A Correct.

Q The second paragraph, which is a one-line paragraph reads, "prognosis guarded"; correct?

A I don't know where that is.

Q You see the section that says discussion?

A Discussion; not his present illness.

Q We're back to discussion.

A Correct.

Q So, there was a two-line paragraph, then a one-line paragraph and followed by another one-line paragraph; correct?

A Correct.

Q And the second one-line paragraph or the second paragraph, which is one line says "prognosis guarded"; correct?

A Correct.

Q And the third paragraph, which is a one-line paragraph reads, "Patient is temporarily totally disabled"; correct?

A Correct.

Q And that is as of 9/22/20; correct?

A Correct. In the narrative.

Q Okay. Now, Dr., I'm going to hand you, with the Court's permission, I'm going to hand to you what has been received in evidence as Plaintiff's Exhibit's 19, which contains your 9/22/20 narrative report. I'll tab it so you can flip to it.

Do you see that discussion section, Dr.?

A Uh-huh. Yes.

Q And do you see that third paragraph, which was a one-line paragraph, has now become a three-line paragraph; correct?

A Correct.

Q And is there an indication of an addendum?

A No, there is not.

Q Do you know how the one-line paragraph could have become a three-line paragraph?

A Yes, I know. This is the not the regular part of the record. This is a narrative. This is not going to the insurance. This is the narrative. Narratives are different part of the record. We have something that is going to be used here that is going to have a secondary person that's taking of that for errors, grammatical errors, and that can be corrected. We don't need to do addendums on narratives because they're not -- There are two narrative; the first one and second, and

the corrected one. But they are narratives. They are not dictated during the patient. Specifically, they're dictated after. And they're not going to go to the insurance. They're not going to be billed or nothing like that. They have to be revised, and they have to be corrected mostly for grammatical errors or for wrong phrases, or anything like that.

Q Well, Dr., adding two lines is not a grammatical error; is it?

A Correct. Yes, because it was something to be added. It's a narrative, and you can correct it. In this case, these are narratives.

Q Well, does this narrative -- Can I have that back, please, Dr.?

Does that narrative, as you call it, Dr., indicate when it was signed?

A What's the question? I'm sorry.

Q Sure. Does that narrative, as you call it, indicate when it was signed?

A Yes. It's a narrative; the final narrative.

Q And that was signed electronically by you; correct?

A Correct.

Q And it was signed electronically by you on October 11th, 2020, 10:08:15 p.m.; correct?

A Correct.

Q Okay. So, Dr., so what you are saying is even though

it was signed, even though it was signed, somebody went back in and made changes?

A Correct. That system that we use in the past permitted you to do that in this kind of records; narratives.

Q And not change the signature page?

A Not change. That's why we're changing to avoid those problems. We're moving to Epic now. This will not allow you do that.

Q But if I didn't have two different copies of the same narrative, I wouldn't know it was changed; correct?

A Correct. Whoever was sending the initial one is not the corrected one.

Q I'm going to stick with your 9/22/20 narrative report, Dr. And on page two, you say "I have personally reviewed all studies today, including interpretation of actual images"; correct?

A Correct.

Q And the December, 2015, films do not appear on that disk; correct?

A Correct.

Q You told us at least the report of 2015 films was part of your chart; correct?

A Correct.

Q So, I believe -- Do you still have the exhibit?

So, marked in evidence or rather received in evidence

as Plaintiff's Exhibit 19 is the chart from the New York Spine Institute.

I'm going to ask you to take a look at this chart. Take your time, and point out the December, 2015, film reports in the chart from your office.

A What date, please?

Q You indicated that the reports of December, 2015, films were part of your chart?

A My regular chart, yes.

Q And pursuant to subpoena, your office supplied a complete copy of your chart, which was received into evidence as Plaintiff's Exhibit 19. I'm going to ask you to please pull the December, 2015, film reports out of Plaintiff's 19.

A What's the date again? December --

Q The film reports were from December, 2015? December 18, 2015, and December 11, 2015.

A I don't have those reports. I'm trying to find them.

Q Take your time, Dr.

A I don't know where the reports are.

Q They're not in there; correct?

A Not in these paper, no.

Q Can I have that back, please?

Does New York Spine Institute have a medical record coordinator?

A They have people in charge of medical records, correct.

Q Okay. Do you know somebody named Christian in that department?

A Yes.

Q And would it be fair to say that Christian would not have sworn that this was a complete copy and accurate copy of your chart if it wasn't; correct?

A Well, I don't understand your question.

Q You have no reason to believe Christian to be dishonest; correct?

A No, absolutely not.

Q So, you made reasonable inquiry and concluded that this was a complete copy of the chart. That would be accurate; correct?

MR. FORDE: Asked and answered, your Honor. Objection.

Q While you were looking at those records, you didn't see any records from Dr. Sutera; did you?

A I do not recall.

Q Do you want to take another look?

A What's the name of the doctor?

Q Sutera, S-U-T-E-R-A.

A I don't see anything.

Q Okay. I think you told us that you believe that Dr. Sutera saw her one time before the accident; correct?

A I do not recall saying specifically with Dr. Sutera. I

don't know who she saw.

Q But you believe she was seen one time for a neck complaint before the accident; correct?

A Yes. If that's a chiropractor.

Q Correct.

A Correct, yes.

Q So, I'm going to refer you again to your 9/22/2020 narrative report?

A Uh-huh.

Q And you have a section called history of present illness; correct?

A Correct.

Q And on the third line of that paragraph reads:

"Symptoms began status post a motor vehicle accident sustained on November 6th, 2015".

Do you see that?

A Correct.

Q Did I read that correctly?

A Uh-huh.

Q Yes?

A Correct.

Q And the last sentence in that paragraph says:

"Denies history of present spinal symptomology".

Correct?

A Correct.

Q And then the last line or the next paragraph reads:

"She is still complaining of posterior neck pain radiate to bilateral shoulders. Mostly related to muscle spasms".

Did I read that correctly?

A Correct.

Q And the next paragraph, second line reads:

"The pain is exacerbated by prolong standing and sitting."

Did I read that correctly?

A Correct.

Q Do you come to testify in court for anybody other than your patients?

A No.

Q You told us that the fee for New York Spine Institute for your testimony here today is $15,000?

A Correct.

Q Have they been paid?

A Say that again?

Q Have they been paid?

A I believe so.

Q Have you seen a check?

A I did not.

Q Have you in fact been paid?

A Say that again?

Q Have you been paid?

A No, I did not.

Q You have not been paid.

I'm going to ask you to take a look at the National Neuro Labs record, which has been received in evidence as Plaintiff's Exhibit 18. And I tabbed a page that I'm going to take you to.

Now, Dr., I'm going to take you through this range of motion testing.

A Okay.

Q Is range of motion testing something that's commonly used in medicine?

A Correct.

Q What is range of motion testing?

A It's testing the different movements that a part of the body can be done. Could be the cervical spine, could be elbow. And you have the normal, extreme range of motion against the one that you're going to compare it to when you examine the patient.

Q Okay. And is there indication whether there was range of motion testing of the cervical region?

A Yes.

Q Okay. And normal for flexion, extension, lateral flexion and rotation is 45 degrees; correct?

A This is as per this chart, correct.

Q But that's fair to say that's the base line they're

using?

A That's the base line of Dr. Debi. This is not my chart.

Q I understand it's not your chart. This is an indication of a normal level; correct?

A This is his indication of what is reading here. That doesn't mean it's correct.

Q And can you show us what is flexion mean? Can you demonstrate it for us, Dr.?

A Say that again.

Q Can you demonstrate flexion of the cervical region for us?

A This is flexion.

Q It's like looking down?

A Correct.

Q And can you demonstration extension for us; cervical extension for us?

A Correct. It's going to be like this.

Q And lateral flexion?

(Witness indicating.)

Q And rotation?

(Witness indicating.)

Q And the indication here is that the normal range of motion is 45 degrees; correct?

A This is the indication of his normal range of motion,

correct.

Q And based upon that and using a goniometer, Dr. Debi found flexion, extension, lateral flexion and rotation of 40 degrees; correct?

A Correct.

Q So, a five degree difference; correct?

A Correct.

Q And did she do a range of motion testing of the shoulder?

A Yes.

Q And she has an indication of normal range of motion of the shoulder; correct?

A As per her chart, correct.

Q And she has her exam results?

A Say that again. I'm sorry.

Q She has her exam results there; correct?

A Yes, correct.

Q And they're all normal; correct?

A As per the chart, correct.

Q And in the lumbar region, she did flexion extension range of motion testing?

A Correct.

Q And an indication that 90 degrees is normal?

A Correct.

Q And she found 70 degrees?

A Correct.
Q And she indicated that lateral flexion range of motion testing was done?
A Correct.
Q And that the normal level was 30 degrees?
A Correct.
Q And she found 20 degrees on left and 20 degrees on the right?
A Correct.
Q And she also did elbow range of motion testing; correct?
A Correct.
Q And according to her normal levels in her examination, they were all normal; correct?
A Correct.
Q And she did similar range of motion testing for the wrists?
A Correct.
Q And found all levels to be normal?
A Yes.
Q Range of motion testing in the hip; correct?
A Correct.
Q All levels to be normal; correct?
A Correct.
Q And range of motion testing of the knee she did;

correct?

A Correct.

Q And normal levels; correct?

A Correct.

Q Same with the ankle; correct?

A Correct.

Q Okay. Now, what is manual muscle testing?

A I don't know what you are referring to. She has it written someplace.

Q Turn to the next page.

A Okay. Yeah, this is muscle strength, I believe. So, that is what we want to say there.

Q Muscle strength testing?

A Correct.

Q Manual muscle strength testing; correct?

A Correct.

Q Can you test muscle strength manually?

A Correct. It's the way that you do it.

Q Okay. And she did manual muscle testing of the neck; correct?

A Yes.

Q And if -- A normal level would be five over five; correct?

A Correct.

Q Okay. What does that mean?

A I don't know, because I don't know what she refers to when she says muscle testing of the neck. You cannot compare to that with a limb. Muscle strength is strength is done for a limb; for extremities. I'm not really sure what she said about the neck.

When you do muscle testing, you are compare one and the other. Patient changes. Muscle testing. I don't know about the muscle testing of the neck by the doctor who did this, because I don't know what he's talking about. I'm not sure.

Q Okay. But you're familiar with muscle testing?

A Of course. I do it everyday in the office.

Q And a result of five over five means what?

A Normal.

Q Normal.

Okay. And there is at the top right corner there, it's got the date of the accident; right?

A Correct.

Q 11/6/15?

A Correct.

Q And then it has date of consultation? Do you see that?

A Yes.

Q 1/18/16?

A Correct.

Q And she did muscle testing; manual muscle testing of the neck, the trunk. What's the trunk, Dr.?

A I believe it's the thorax.
Q The hip; correct.
A Correct.
Q The knee?
A Correct.
Q The ankle?
A Correct.
Q The foot?
A Yes.
Q Toes?
A Yes.
Q Hallux?
A Yes.
Q Scapula?
A Yes.
Q Shoulder?
A Yes.
Q Elbow?
A Yes.
Q Wrist?
A Yes.
Q Fingers?
A Yes.
Q Face?
A I have no idea what's the face. It says face. It says

normal.

Q But all indicate to be normal; correct?

A Correct.

Q And do you know that Dr. Debi is a neurologist?

A I do believe she's a neurologist.

Q And the spine or the disorders of the spine can have an impact on muscles of the other parts of the body; correct?

A Correct.

Q You don't see an indication of that here; correct?

A Correct.

Q Now you described for us your professional training; correct?

A Correct.

Q You did a residency. You did an internship. You did a residency; correct?

A Correct.

Q There is a board certified in orthopedic surgery; correct?

A Correct.

Q Is there a specialty certification in spinal surgery?

A Not specifically. But in fellowships, I did two fellowships in spine.

Q And radiology is also a specialty; correct?

A Correct.

Q Radiologists do internships?

A I believe so, yes.
Q And they do residencies?
A Yes.
Q And there is a board certification?
A I think so, yes.
Q Okay. And what is the specialty of radiology?
A Radiologists are basically everything related to diagnostic testing. That includes X-Rays, M.R.I.'s, electrons. That's the specialty related to radiology. They sit down with different kinds of machines. They do it by myself and read what is going on there.
Q So, they specialize in the taking and interpretation of radiological films?
A Yes. Correct.
Q Like M.R.I.'s?
A Correct.
Q Like X-rays?
A Correct.
Q And you're not a biomechanical engineer; are you?
A No, I'm not a biomechanical. In one part in my research extension, we do biomechanics. But I'm not an engineer.
Q You're not a biomechanical engineer?
A Yes.
Q So, you couldn't sit here and calculate forces for us?

A No. I'm not a biomechanical specialized person.
Q Now, the spine is composed predominantly vertebrae and intervertebral discs; correct?
A Between other structures.
Q And the head supported by seven cervical vertebrae?
A The neck is composed of seven cervical vertebrae.
Q A young person's intervertebral discs have a gelatinous consistency. Would you agree with that?
A Correct. An old person too.
Q And would it be fair to say, Dr., that gelatinous consistency -- Withdrawn.
And intervertebral discs normally are hydrated; correct?
A What.
Q Hydrated?
A Correct.
Q And it would be fair to say the gelatinous consistency or hydration in the intervertebral discs decrease with age?
A Of course.
Q All spines degenerate; correct?
A Correct.
Q Are you familiar with the term stenosis?
A Correct.
Q What is stenosis?
A It's a closing of some space.

Q Could that be an indication of degeneration?

A If we're talking about in general or are we talking about the spine?

Q In the spine?

A In the spine.

Q Is that an indication of degeneration?

A It could be a part.

Q And are you familiar with the spurring, Dr.?

A Yes. I know.

Q What is spurring, Dr.?

A Spurring is when the body is starting to get older. Or when you have a trauma in one disc, you're going to have your body trying to compensate. The body is pretty smart. It's trying to do what we do with a fusion. It's trying to -- When you have abnormal movement, when you're getting old, it's trying to fuse that space, and trying to get formation or form that will try to fuse one body part or the other in the spine.

Q But you're not saying that spurring is only caused by trauma; are you?

A It could be caused by trauma in one disc. Because if you're unstable, for example, or if the disc is moving abnormally. Because we were born with the process there, you can have spurring in one disc, yes.

Q But spurring doesn't occur overnight?

A No. Absolutely not, correct.

Q Spurring occurs over years; correct?
A Correct.
Q Are you familiar with the uncovertebral spurring?
A Say that again.
Q Are you familiar with the term uncovertebral spurring?
A Uncovert --
Q U-N-C-O --
A Oh, yes.
Q Are you familiar with that term?
A Yes.
Q Can that be an indication of degeneration?
A Correct.
Q And what is a osteophyte, Dr.?
A An osteophyte is synonymous of spurring. Osteophyte is a bone formation that is coming from the body that is abnormal.
THE COURT: Mr. Shafer, how much more do you have?
MR. SHAFER: I've got a bit, your Honor, unfortunately.
THE COURT: We're going to break for lunch at this time.
Ladies and gentlemen, do not discuss the case. Be back here at two o'clock.
THE COURT OFFICER: All rise. Jury exiting.
(Whereupon, at this time the sworn jurors exited the courtroom.)

THE COURT: Dr., once again, you cannot discuss your testimony with anyone.

(Whereupon, at this time a luncheon recess was taken.)

* * * * *

Certified to be a true and accurate transcription of the within proceedings.

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SUSAN L. GIAMPICCOLO
Senior Court Reporter

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