SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF BRONX : CIVIL TERM : IA-35

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FELICIA WATSON,

Index:
31065/2020E

Plaintiff,

-against-

OLR ECW HOUSING DEVELOPMENT FUND COMPANY, INC., OLR ECW, L.P., OMNI NEW YORK, LLC, And RELIANT REALTY SERVICES, LLC,

Defendants.

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TESTIMONY
Dr. Angel Macagno

851 Grand Concourse
Bronx, New York 10451
December 11, 2024

B E F O R E:

HONORABLE RAYMOND FERNANDEZ,
Justice of the Supreme Court

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

FOR THE PLAINTIFF:
HARRIS, KEENAN & GOLDFARB, PLLC
233 Broadway, 9th Floor
New York, New York 10279
BY: SHERI HOLLAND, ESQ.
SETH HARRIS, ESQ.

FOR THE DEFENDANT:
PERRY, VAN ETTEN, ROZANSKI & KUTNER, LLP
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BY: JEFFREY VAN ETTEN, ESQ.
PATRICK DOWNEY, ESQ.

Maggie J. Klasen
Senior Court Reporter

(Whereupon, the item referred to, Plaintiff's Exhibit 13, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 14, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 15, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 16, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 17, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 18, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 19, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 20, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 21, was received in evidence.)

(Whereupon, the item referred to, Plaintiff's Exhibit 22, was received in evidence.)

COURT CLERK: Good morning. This is case on trial, index number 31065 of 2020E. Felicia Watson versus OLD ECW Housing Development. Appearances remain the same.

THE COURT: I think we have one new addition. Counsel, you're my new addition.

MR. HARRIS: Seth Harris, Harris, Keenan & Goldfarb, for the plaintiff.

THE COURT: Good morning, Mr. Harris.

MR. HARRIS: Good morning, Your Honor.

THE COURT: Okay. Are there any issues for the record before I bring this jury in?

MS. HOLLAND: No.

THE COURT: Thank you, Ms. Holland.

Mr. Van Etten, any issues for the record?

MR. VAN ETTEN: No, Your Honor.

THE COURT: Okay. I have alerted counsel earlier, off the record, that Juror Number 6 called to advise that he will not be here. The excuse he gave was something about being the only one at his place of employment who could go in today.

With the consent of counsel, I'm subbing in Alternate Number 2 to fill in place instead of Juror Number 6. So now, we are proceeding forward. We only have one alternate. I will address the jury about punctuality and about their duty to be here when they come out.

Jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: All right. Everybody, have a seat,

please. Okay. So I had told you when we were last here, on Monday, about the importance of being on time. Okay? This seems to be becoming an issue, and I have to talk to you about it. Okay? It is disrespectful to me, and to all of the lawyers, and to the parties that are on trial here for you to be late. Okay? I'm not looking at anybody, specifically. You are required to be here. Okay?

Another thing is, this is your job until this trial has concluded, so if there are any issues where maybe your boss calls you and tells you have to go to work, you come here, and you give a note to my court officer that says what your boss told you. I'll call your boss myself. This is your job. Okay? I need everybody's head to nod. All right? And you have to be on time. Okay?

It's very important. I have been sitting up here since before 10:00 a.m., very patiently. And now we're getting underway, it's almost 11:00. We're going to hear from our first witness. All right? Thank you.

Ms. Holland, do you have a witness?

MS. HOLLAND: Yes, the plaintiff calls Dr. Macagno.

THE COURT: Somebody's got to get him.

COURT OFFICER: Please remain standing. Sir, raise your right hand.

A N G E L M A C A G N O, M D, a witness called by and on behalf of the Plaintiff, upon being duly sworn,

took the witness stand, and testified as follows:

COURT OFFICER: In a loud, clear voice, please state your full name and your title for the record.

THE WITNESS: First name Angel. Last name Macagno, M-A-C-A-G-N-O. My title is -- I'm a doctor -- medical doctor.

COURT OFFICER: Very good, Doctor. Take your seat. Thank you. And speak into the microphone, please.

THE COURT: I'll just repeat what my officer said. You're going to want to speak right up on this microphone. Okay?

Okay. Counsel, you may inquire when you're ready.

MS. HOLLAND: Thank you. Good morning.

Good morning, ladies and gentlemen.

DIRECT EXAMINATION

BY MS. HOLLAND:

Q Dr. Macagno, can you please tell the jury what type of doctor you are.

A I am a surgeon -- an orthopedic surgeon, board certified in orthopedic surgery. I specialize in spine surgery.

Q And where were you born, Dr. Macagno?

A Argentina.

Q I want to talk to you about your educational background and experience as a physician. Please tell the jury about your educational background.

A I completed medical school in Argentina. The name is National University of Córdoba School of Medicine. I finished in 1988. Then I did my residency in orthopedic surgery. I was orthopedic surgeon there. And I work many years in different hospitals and clinics in orthopedic surgery in Argentina.

Q Okay. Now, there came a point when you moved to the United States; is that correct?

A Correct.

Q So let's talk about the process you went through when you came to the United States in order to practice medicine here. First, tell the jury when you moved here.

A I think that was 2021.

Q 2021?

A I think we move in 2000 because my son was born in 2020. He was one year -- actually, in 2001.

Q To be clear, you moved here in 2001 --

A One.

Q -- is that correct?

A Yes, correct.

Q Now, by that time, you had been practicing as an orthopedic surgeon in Argentina for, approximately, how many years?

A 15 years.

Q Okay. So, now, you came here in 2001. Explain to the jury the process you underwent in order to practice medicine

here in the United States.

A It's a long process. You have to go multiple steps in order to practice here. The first one, you have to -- they have to study your credentials in Argentina. They look for everything, just to be sure you are a doctor -- a real doctor. That take time. It's a process that take time because you cannot bring it, they have to request everything. Then you have to take exams that -- they are mandatory for medical students here, also. Okay? They are called USMLEs. They are -- you are -- in that time, were four. I think, now, they're three. You have to study for that. They are long exam done on computer.

When you pass those exams, you can apply at the medical school. You don't have to repeat it, but you have to apply for residence because you start from zero. Okay? What is the process that is complicated for the big surgeries, one of the most difficult to get for a foreign -- I'm Latino American. It's, like, really difficult. Okay? That is why I start working in -- Miami was my first part in Miami Children's Hospital. I start working in research investigation.

I have -- it's not how you do it, but they offer me, because I already trained, what we call a fellowship in the spine. I was with a group in spine, really well known. I started working with them for one year. It was a fellowship. I can operate, but --

Q Let me stop you at this point. I want to make sure the jury knows what time period we're talking. Okay?

So to be clear, you came here in 2001, and you underwent a background check and an examination process to confirm that you were an actual doctor, is that correct?

A Correct.

Q And then you applied for an internship/residency here, in the United States; is that correct?

A That was -- yes, that's correct. But, first, I did the fellowship. That is not the normal thing to do -

Q Okay.

A -- but I was offered that.

Q Let me just stop you then, to make sure we're clear.

Before you did the residency and internship here, in the United States, you worked at a hospital in Florida and, at that point, you did a fellowship studying spine surgery; is that correct?

A I was doing surgery. I was assisting in surgery, yes.

Q Okay. So you were assisting in spine surgery at a hospital in Miami; is that correct?

A Correct, correct.

Q Now, I have the benefit of having your CV in front of me.

And, just to speed this along, am I correct that you were doing the spine fellowship between 2007 and 2008, and again

in 2013 and 2014?

A Well, that -- the regular process for America, mostly, is do the residency and then the fellowship.

Q Okay.

A In my case, I tried to get more points doing the first fellowship that was offered, and then I did the residency.

Q Okay. And then you went and continued to do the fellowship, again, between 2013 and '14?

A Correct, I did a resident -- full residency. They'll take anything, five years. That is one year internship, and four years residency. I did it in Kings County Hospital here, in Downstate Medical Center, in Brooklyn. And then I did another fellowship in NYU with Dr. Errico, where they were accepted there, and I did the second fellowship in spine there.

Q Okay. So just so we have the time periods correct, you did the internship and residency at Downstate in Brooklyn between 2008 and 2013, and you also did your spine fellowships before and during those -- your residency; is that correct?

A Correct.

Q Okay. Now, are you licensed, currently, to practice medicine?

A Yes, I'm licensed.

Q And where are you licensed to practice medicine?

A Currently, I have a license in New York State and New Jersey.

Q Okay. Now, I just want to go back a second. You did mention that you practiced as an orthopedic surgeon when you were practicing in Argentina; is that correct?

A Correct.

Q And when you were a practicing surgeon for 15 years, approximately, in Argentina, what types of body parts did you do surgery on when you were practicing in Argentina?

A First, I did trauma. That is, basically, fracture or accident. I did sport medicine. That was arthroscopy, shoulder, a knee. And then the recon, that is hip replacement, knee replacement. This is in general.

Q Okay. You just mentioned that you did sports medicine when you were a practicing surgeon in Argentina; is that correct?

A Correct.

Q And that would include the treatment of injuries to knees and shoulders; is that correct?

A Correct, yes.

Q And did that also include performing surgeries to knees and shoulders while you were practicing in Argentina?

A Correct.

Q Okay. Now, let's fast forward. We're back here, in the United States, and you've completed the fellowship as a spine surgeon here in the U.S.

Are you board certified?

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

Q Okay. Tell the jury what it means to be board certified in orthopedic surgery.

A When you finish the fellowship, you are legally authorized to start doing surgery. Okay? I can do surgery in orthopedics, is what I did. I can do fractures. I can do -- and by that, basically, I was doing the spine because my fellowship was spine. But then you want to get the board certified, that is the top of what you can get. That is a specialization. Okay? It doesn't matter if it's orthopedics, you have to go through a process that take, like, two or three years.

You have to do a number of surgeries. You cannot pick surgeries. Every surgery you do is going to go to be evaluated, and then you have to take a big exam, also. There are two parts. Okay? When you do the cases, they're going to -- you have to present it, and you have a panel of doctors that are going to ask you questions, is it well done, do they agree or not agree. And then you have to do another part, that is a multiple choice questions.

Q Okay. And to be clear, when you say that you're board certified, you had to go through all of those steps in order to be certified by the American Board of Orthopedic Surgery; is that correct?

A That's correct.

Q And you just mentioned that, as part of the process, you had to present your cases to the Board in order to be certified.

What do you mean by "you had to present your cases"?

A Well, you have to go, first, in the hospital -- I was working in two or three hospitals. You have to go to the hospital medical records, put all the notes that you did for a case, the operative report, show the MRIs, x-rays, the results. If there were complications, you have to talk about the complications and -- because you cannot pick the case. You have to actually discuss the case with them. They are going to ask you questions.

Q And to be clear, when you say you have to discuss the case, you have to present to the Board proof of surgeries, right, that you have performed as an orthopedic surgeon; is that correct?

A That's correct.

Q Okay. So when you say "cases", you mean the surgeries that you have performed; is that correct?

A That's correct.

Q And when you were applying to be board certified, you presented evidence of surgeries that you did to the spine; is that correct?

A Correct.

Q And, approximately, how many surgeries did you have to

present proof of as part of your board certification?

A I don't remember a lot of time, because it changes over the years, but you had to present, I think, it was 50 cases in six months or something like that. It was the minimum. But, usually, more -- you have to present more. But the minimum, I think, was 50 in six months. I could be wrong, but it's about that.

Q Okay. So, approximately, 50 spine surgeries.

You had to present proof that you did these surgeries in order to become board certified; is that correct?

A Well, it's not only spine surgery. Any orthopedic -- because it also defined orthopedic surgery. I was speaking of spine, but I had other cases -- the trauma cases that I had to present, also.

Q Now, are you affiliated with any hospitals. In other words, do you have hospital privileges?

A Yes.

Q And what hospitals do you have privileges with?

A Here, in Manhattan, with NYU Langone, with NYU Orthopedic Hospital, that used to be Hospital For Joint Diseases. I work in Bellevue. It's part of the program as part of the teaching process. I work in Long Island in -- sorry -- Mercy Hospital, San Francisco Hospital, and Winthrop Hospital, that is part of NYU now. And New Jersey, I work in Hudson Regional Hospital, and a surgery center that is called Palisades

Surgical Center.

Q Okay. And to be clear, in order to have privileges at a hospital, you have to go through a screening process by the hospital in order to be able to work and do surgeries at a hospital; is that correct?

A That's correct.

Q All right. Now, are you familiar with a medical group known as New York Spine Institute?

A Yes, this is where I work for. It's a private institute.

Q Okay. So you are affiliated -- you're a doctor at the New York Spine Institute?

A I'm an employee of New York Spine Institute.

Q Okay. And can you tell the jury, approximately, if you can put a number on it, how many spine surgeries have you performed in your career, if you can put a number on it?

A So, we operate a lot. When you start operating ten years ago, maybe, you are doing much less. But lately, it's, like, maybe 300 a year but -- I don't know. Now, I'm slowing down. I'm getting old and tired. Yes.

Q I didn't hear what you just --

A Now, I'm slowing down a little bit because I'm getting old and tired. Yes.

Q Okay. But, approximately, 300 spine surgeries a year; is that correct?

A Yes.

Q Okay. Now, by the way, do you do any teaching as a physician? Do you teach anywhere? Do you teach anyone?

A My position at NYU is a clinical assistant professor in orthopedic surgery. We teach fellows, residents, not only in surgery, we have to give talks, and we have a specific calendar that we have to do. At the same time, I was invited to be part of the doctors at Bellevue. When they give me the privileges, it was, you know -- it was -- since I did trauma, I go and do, sometimes, surgical there just -- it's a teaching process for Bellevue, but it's general trauma.

Q Okay. So just to be clear, as a professor -- withdrawn.

As a doctor, in addition to treating patients, you also teach doctors who are residents in the field of orthopedic surgery; is that correct?

A Correct.

Q All right. So we're here today to talk about Felicia Watson.

Felicia Watson is a patient of yours; is that right?

A Correct.

Q And we asked you to come in to testify on behalf of Ms. Watson, and explain to her -- excuse me -- explain to the jury the treatment that you administered to her.

That's why you're here today, right?

A Okay. Yes.

Q Now, did your medical group charge our office -- our firm a fee for you to come here today?

A Yes, they charged.

Q And what was the fee charged by your medical group?

A I'm not totally sure how much they're charging now.

Q Are you not sure? You don't know?

A Not sure because it's not the fee that's going to come to me. I get a percent or -- I'm just an employee, as I said.

Q Oh, okay. All right. Fair enough. Let's now talk about Felicia Watson. I'm sorry, I forgot to ask you this question.

Approximately, how many times have you testified before coming here today?

A Not many times. This is not my job. They call me multiple times to do it as part of business. I only testify for patients that I do surgery. Probably ten years, I would get a number 10, 15 times. Not many times.

Q Okay. So you only testify for patients of yours who you performed surgery for; is that correct?

A Correct.

Q And is this is the first time that you're testifying for a patient represented by our firm?

A I do believe so, yes.

Q Okay. We've never met before this case; is that

correct?

A Correct.

Q All right. So, now, let's talk about Felicia Watson. Okay? We have your file, Doctor, and it's marked in evidence as Plaintiff's Exhibit -- just give me one second. I believe it's marked as Plaintiff's Exhibit 3. Give me a second.

MR. VAN ETTEN: It's 3.

MS. HOLLAND: It's 3. Thank you, Mr. Van Etten.

Q We have your file marked as Plaintiff's Exhibit 3.

But you brought a copy with you here today; is that correct?

A Correct.

Q Okay. So -- all right. Give me one second. One second. Okay. All right.

Now, am I correct, Doctor, that your treatment of Felicia Watson was for the injuries to her cervical and lumbar spine?

MR. VAN ETTEN: Objection.

MS. HOLLAND: I'll rephrase it. I'm just trying to move it along. That's it. I'll try it again.

Q What body parts did you treat Felicia Watson for?

A Specifically, the neck and the lower back.

Q Okay. And, ultimately, did you perform surgery on her?

A On the cervical spine, correct.

Q Okay. Do you recall the date of the surgery, meaning

the month and the year?

A I don't, but I have it. It's --

THE COURT: Doctor, you can't look at anything.

THE WITNESS: Okay.

Q Do you recall the month or the year?

A I don't remember. I'm sorry. Like '22 -- I don't know a specific year. Yeah, I don't remember exactly.

MS. HOLLAND: All right. I can do one of two things. I can have the doctor go through Plaintiff's Exhibit 13, which is the NYU Langone records, that contain the operative report, or I can just show him my copy of the operative report to refresh his recollection.

Are you okay with that?

MR. VAN ETTEN: I have no problem, Sheri. It's just, Ms. Holland, that he was looking at his chart, which isn't marked. That's why I had the problem. That's all. So I have no problem showing him -- yeah, whatever you want.

MS. HOLLAND: Can we just deem this marked as Plaintiff's Exhibit 23 for identification. And we'll just mark after, with the Court's permission. We deem this marked Plaintiff's 23 for identification.

(Whereupon, the item referred to is marked Plaintiff's Exhibit 23 for Identification.)

Q Does that refresh your recollection as to the date of her cervical surgery?

A Yes.
Q And what was the date?
A December 30, 2022.
Q Okay. December 30th, 2022; is that correct?
A Correct.
Q Okay. Now, before I ask you some questions about the individual visits that you had with Ms. Watson, I want you to explain to the jury the anatomy of the spine.
A Okay.
MS. HOLLAND: And with the Court's permission, may the witness step down from the stand, and use this anatomical model to describe or explain to the jury the anatomy of the spine?
THE COURT: Just keep him near a microphone.
MS. HOLLAND: Sure.
MR. VAN ETTEN: May I, Your Honor, walk to the side?
THE COURT: Yep, wherever you can see.
Watch your step, Doctor.
Q Okay.
A This is, basically, a full spine. Okay? This is what we use. It's a complete model. This is the pelvis, what we have here. And here, is going to be the head. And this is the spine. We start from the head, all the way down to your buttocks. Okay? That is here. I have three parts that are the

most important. One is the cervical, that is the neck. One is the thoracic, that's is the middle back, where the ribs are. And then there this is the lumbar, this is the most important, this is lower back. Then you have the last part, that is a sacrum. That is not so important for what we talk here. Okay?

There are two -- in general, there are two -- there are two most -- let me put this straight. Two more important components here. You have, in the all the spine, up to down, bones parts, bones, that are called vertebrae. Okay? That is the white stuff here. Okay? They are solid. They're, like -- I always say we're carpenters. They're good. They're really solid. And then the middle, you have a cushion, that is the disc. The disc is, like, cartilage, and inside, you have a gel. You move to the disc. And you squish it in just to a bone. You have pain, or it will be bone against bone.

One part that is important, you can see here, it's the most important part of the spine. It's behind the bodies. These are what we call the spinal cord. The spinal cord is really sensitive. And if you get injured, you're going to die or get paralysis. We cannot fix it. Okay? It's behind. You cannot see, but this yellow thing, here, it's going to be behind the discs. And these yellow things are coming from the spinal cord out of the nerves. And they bring all the information to the arms and the legs. Okay? That is going to be the most important part when we do surgery. Okay?

Q Okay. Now, you mentioned that there are nerves. Those in the yellow pieces that are sticking out?

A Uh-huh.

Q Okay. What do the nerves come out of? Do they come out of holes inside of the spinal process?

A Yes. You have the bone, you have the disc. Okay? And if the bony part there, it's like a hole where the nerve is coming out. When the nerve is compressed, for example -- this is an example. It's not real. It's a disc herniation. Okay? The gel of the disc came out. When the disc herniation compressed enough, is when we have problems, the sciatic pain, the shooting pain to the leg. That is most important part.

People think the most important part is the lower back pain. No, it's not. Lower back pain is not so important. Everyone is going to have it at least during their lifetime. And you almost never do surgery for lower back pain. Okay? The problem is when the nerves are compromised is when you start having problems.

Q Okay. So let me just, while you're still up there, make sure we're clear.

You mentioned, and I think the anatomical model shows, what a herniated disc looks like; is that correct?

A Correct. It's for teaching purpose because, normally, a disc is going to come -- the posterior part of the disc when we're seeing the real MRI. Okay? This is really strange to see

a herniation, here, on the side. It exists, but it's one percent maybe. The disc will usually come from the back. The gel is going to come out in the back of the disc.

Q Okay. And when the jelly comes out and it makes contact with the nerves, that's when you have, I think you said, the problems; is that correct?

A The what?

Q When the jelly comes in contact with the nerves, that causes what?

A That causes nerve pain. Okay? But it's not only the compression because that is what I'm trying to explain all the time. You can have a disc herniation, okay, and not necessarily compressing significantly on the nerve. But when the disc herniation break, you release a lot of chemicals there. It's a cascade, that we call. That means, sometimes, you don't have a disc that is terrible, compressing the nerve. Because there is something compressing, but the nerve is going to have pain without so much compression because there is a cascade of chemicals that is going to irritate the nerve.

Q Okay. So let me just make sure I understand what you just said.

Are you saying that a person could have a herniation, and not actually feel pain or have issues with the nerves? Is that possible?

MR. VAN ETTEN: Objection.

THE COURT: Overruled.

A Absolutely, yes.

Q Okay. And why is that possible, that you can have that and not --

A Because -- because, as I always say, people -- I always explain, even on -- with my students. We don't do surgery in models, MRIs, images. You do surgery in people. And that is the part, the most important. Everyone check MRIs, "Oh, you should" -- I see MRIs that are terrible sometimes, but the patient is okay. What, you going to do a surgery? Okay? And there are MRIs that are not so terrible, and the patient is miserable. That is when you do other things.

Q Okay. So you decide to do surgery based upon the complaints made by the patient, what you see when you examine the patient, as well as what's on the MRI?

A Well, I use everything. The see the images, the MRI. I'm never going to do a surgery basing off reports. Sometimes a patient bring me a report and say, "I know I need surgery based on what other people said." I got to see what is going on. It's got to be consistent with the complaints and my physical exam.

Q Okay. All right, Doctor. You can have a seat.

A Thank you.

Q I will take this. Thank you.

THE COURT: Watch your step, Doctor.

Q Now, I just want to ask you. To be clear -- and you may have said this. I apologize.

When you have a herniated disc, and it does compress upon the nerves, and you have the cascade of circumstances that you just described, that can cause pain and other symptoms depending on where the compression takes place; is that correct?

A That's correct.

Q All right. Now, can you tell the jury what happens to the spine, naturally, as we get older.

A When we get older, it's every part. The body is getting older, also. We call it arthritis. That is a natural process. We use that -- unless you have an accident, you're going to start at 38 years old having evidence of arthritis in your spine. It's not -- you don't need to be 70 or 90 like people think. 38, you start having some changes, that they're going to get worse over time.

Q Okay. So here's my question about that.

Can a person, as they age, develop changes in their spine, but those changes do not cause them any type of symptoms?

MR. VAN ETTEN: Objection.

THE COURT: Don't lead.

MS. HOLLAND: Sure.

Q What is the result, if any, of arthritic-- withdrawn.

What is the result, if any, of changes that happen to a person's spine as they age?

A Well, it changes and the symptoms are going to be different. First, they are going to be slow growing, okay, because it's a slow process. It's nothing that happens in one day. Okay? You're going to start mostly, based on arthritis, you will have lower back pain, middle back pain, neck pain. Not so much if you take some of the meds. Okay? But, over time, could happen. Okay? But it's difficult to happen one day to the other. Normally, it's going over time, getting worse.

Q Okay. All right. Now, if a person -- withdrawn.

Okay. We talked about a herniated disc. Okay? What can cause a herniated disc?

A Most of the time, it is going to be trauma.

Q Okay. When you say "trauma", what do you mean by that?

A Trauma is going to be -- could be from -- it's a stress situation on the disc that is going to produce some changes in the disc. Okay? So the situation could be a car accident, a fall on the street, rugby players, football players. It doesn't need to be something terrible, neither. As I said, you are getting older, minor traumas can cause a disc herniation. I see, all the time, people turning and then they get a disc herniation from that. It doesn't need to be a bad -- anything bad.

Q Okay. All right. Now, we're ready to talk about your visits with Ms. Watson. All right? I'm going to direct your attention to your file, okay, that you have in front of you.

And, again, it's in evidence as Plaintiff's Exhibit 3. The records are marked in evidence as Plaintiff's Exhibit 3.

MR. VAN ETTEN: May we just approach, please, for a second, Your Honor.

THE COURT: Yes. Please, come up.

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

THE COURT: We're going to take a quick bathroom break. All right?

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: Doctor, you'll be permitted to leave the stand. I remind you that you're under oath. Do not discuss your testimony with anyone. Okay?

THE WITNESS: Thank you.

(Whereupon, a short recess was taken.)

THE COURT: Very good. Jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: All right. Everybody just come right in and take your seats. Okay?

Ms. Holland, when you're ready.

MS. HOLLAND: Yes.

Q Okay. So, Dr. Macagno, we are going to actually mark your file as Plaintiff's Exhibit -- deemed marked as

Plaintiff's 24, for identification -- for ID only.

THE COURT: Got it. So we're up to 24. Thank you. So marked.

(Whereupon, Plaintiff's Exhibit 24 was marked for Identification.)

Q Okay. Are you ready, Dr. Macagno?

A Yes.

Q Okay. Let's do it. All right.

So, what was the first date of your visit with Ms. Watson?

A I saw her for the first time on March 30, 2021.

Q Okay. And what is a history, Doctor?

A Say it again. I'm sorry, Counsel.

Q What is it meant when a patient provides a history or a doctor notes the history in his record?

A Well, the first part is what happened to her, how this pain started, chronic, acute, did she fall, what is the mechanism of when -- as to the patient's recollection, okay, what happened to her that start with this kind of pain or problem.

Q Okay. So what history do you note in your March 30th, 2021, note, which is contained in Plaintiff's Exhibit 3?

A At the time, she was 47 year old. She was a status post home accident on August 24, 2020. The day of the accident, the patient was at her bathroom of her apartment when part of

the ceiling fell over her, impacting the patient on her head and back, knocking her down to the floor.

Q Okay. Was there a note that she had lost consciousness?

A In the note, it said loss of consciousness was positive.

Q Okay. And what were her complaints to you, Doctor, when you saw her that day?

A She was complaining of neck pain radiating to bilateral upper extremities, and lower back pain radiating mostly to the right lower extremity.

Q Let's about that for a second. She was complaining of neck pain radiating to her bilateral upper extremities with numbness and tingling.

What does that mean, essentially?

A Well, the -- what I would think is it's not numbness and tingling. The patient never is going to say that. They normally say presentation, they describe in different ways. It could be a burning pain, it's pretty unspecific. But, basically, give you an idea that could be a compromise of the nerve in the neck or the lower back after her description. Okay? It's an inflammation or something of the nerve, that is radiation of the pain, numbness, tingling, everything we talk about.

Q Okay. So the -- but I'm saying, your note indicates

that she had bilateral, meaning it was going down both her arms; is that correct?

A Correct.

Q And with respect to her back, what does your note indicate?

A That she had pain more radiating to the right lower extremity.

Q Okay. By the way, Doctor, I'm looking at your note from that date, and it states, in the first paragraph, she is also complaining of minimal back pain and lower back pain radiating mostly to her right lower extremity, to the groin and anterior thigh.

Do you see that sentence?

A Yes.

Q Okay. Now, where it states she's complaining of minimal back pain, is that accurate?

A No, it is not. It's, like -- that is a dictation. It's a terrible system. That should be middle back pain, and lower back pain.

Q Okay. When you say that's dictation, meaning, it was a dictation -- a glitch when you were dictating the note?

MR. VAN ETTEN: Objection.

MS. HOLLAND: Withdrawn. I'll try it again.

Q You said that that's not accurate as a result of dictation. Can you explain to the jury, quickly, what you mean

by that?

A Around this time -- okay. We use electronic medical records. Okay? They go around and change them over time. Some are better, some are worse. Everything is trying to make things faster, okay, and clearer. At that time, we started using dictation connected to the system. It's a learning process, also. Okay? You don't have anyone to proofread your notes. Whatever you dictate, you see something wrong, you change it, but sometimes, it's going to be missing. You're going to see something that is not making sense.

Q Okay. Now, during this first visit, after she explained to you what happened to her and how she was feeling, did you examine her?

A Yes, I examined her.

Q And tell the jury about your examination.

A Basically, my exam was mostly related to the neck and lower back. I didn't examine any other body parts.

Q Okay.

A The neck, that is related to the cervical spine I shown on the model, there was evidence of muscle spasm. The range of motion was painful. It tender palpation, and the range of motion was decreased. I put some numbers there with the normal range of motion numbers to know, over time, what's going on. It was significant. She was in pain at that time.

Q Let me stop you at this point. Now, you said that when

you examined her neck, you noted that she had muscle spasm; is that correct?

A Correct.

Q Okay. Tell the jury how you determined that she had muscle spasm, and the significance of the presence of the muscle spasm.

A Everyone can know what is a muscle spasm. When you touch the muscle and it's tight, mostly in the back and you're going to touch the neck. Everyone, "It's hurting here, and it's really stiff." And you touch that, you know it's there, that's a muscle spasm. And this is the way that the body -- the body is really smart. The body -- you have an accident, the body will try to do is limit your movement just to not to keep injuring yourself. Okay? Like, we put the brace. The moment -- what the does, muscles spasm. But they're really painful, but that is what the body does, to limit your movements, giving you muscle spasm.

Q Okay. And you noticed that she had loss of range of motion; is that correct?

A Correct, it's related.

Q Okay. And, just briefly, what do you mean -- what is range of motion and the significance of loss of range of motion in a person's spine?

A Well, the range of motion is not so important in reality. Okay? It's mostly legal parts with patients that are

having injuries in work -- it's a reality. We will not talk about that. In Workers' Comp, a work injury, car injuries, you have to do the range of motion. Okay? And it's so -- if it's reduced or it's limited, it becomes, basically, like a muscle spasm. Okay? You're not going to do range of motion when a patient has a fracture. There's no way. And you're not going to push the patient to do the range of motion. That could change from one patient to the other, but, yes, it's important to note that she had limited range of motion because of the muscle spasm.

Q Okay. Now, again, noting in your section of your report under neurological exam, for the upper extremities, it says the ligament was examined, Spurling sign positive.

Can you tell us what that means.

A The ligament -- not at all. It's the dictation. Spurling sign is the first part of the exam of the neck. And you -- what you try to do with the maneuver is irritate the nerve that is compromised. Okay? And then what you do is turn the head -- the patient's head, when you do that, turn the head to one side, make him bend the head and compress. And when you do that, you irritate the nerve. And that patient, if it's real, what she's feeling, she's going to have a shooting pain. They don't like you a lot. They're not going to like you a lot either way, but that is what the Spurling sign is, trying to reproduce the pain.

Q All right. So, just to be clear, when you made reference to this ligament being examined, that was a dictation issue --

A Correct.

Q -- problem? But the Spurling sign was a positive result; is that correct?

A Correct.

Q All right. Now, I also note that in your report, under that examination of her upper extremity, you have weakness, right biceps, right brachial radialis, and right triceps.

What does that mean?

A The nerve -- the body is like a map. Every nerve is going to go to a different place, and it's going to give you different symptoms. Okay? It's not so perfect. Perfect -- people -- a human body, you have variations. But, basically, you have a full nerve in the neck that is --

THE COURT: What?

COURT OFFICER: There was a noise outside.

THE COURT: Okay. Thank you. Continue, Doctor.

A You have a full nerve, for example, compressed, that is a nerve that is going to be the fifth nerve, between C4 and C5. I will explain that. It's going to give you muscles radiation to the arm and to the shoulder. It's going to give you some weakness in the biceps. It's like a map. Every nerve is going to go to different places. Okay? That is significant. In this

case, the muscles affected are concordant with the images that I saw in the MRI. I'm sorry.

Q I'm sorry. So you said the muscles -- the issues that she was having with the muscles in her arms directly relate to what you saw in the MRI films? Is that what you --

A Correct.

Q -- said? Okay. Great. Now, you also examined her back and her lower extremities as well; is that correct?

A Correct.

Q And in that same note, this is page 2 of the 3/30/2021 note, it states, reversal sick positive, right lower extremity.

What does that mean?

A No. What it means is -- the term is la seg. That is the name -- a French name for a maneuver that we perform. La seg is equivalent here, in the United States, to straight leg raising. Okay?

Q Let me just stop you for a second. Am I correct where it says, reversal sick positive, again, that's a dictation problem?

A Absolutely.

Q Okay. Instead, you meant it -- what you said was a la seg test?

A La seg, it is in French.

Q Okay. And that's the equivalent of straight leg raising test; is that correct?

A It's equivalent. It's a little more complete, but it's equivalent, yes.

Q Tell the jury what a straight leg raising test is, and the significance of it, including your findings in this case.

A We do test not only for diagnosis, we do tests just to try to confuse the patient, just to be sure they are not lying to us. Okay? We do it all the time. A patient that really -- you're touching one patient to another. A straight leg raise is basically lying down in the bed, you raise the leg straight. That is going to -- if the patient had a sciatic inflammation, it's going to -- he's going to complain of significant burning pain or to the tip of the toes, that is what a straight leg test is for.

Q Okay. And what were your results in this case when you performed the test on her?

A It was positive.

Q Okay. So there was an indication that she was having the radiating pain from her back down her leg; is that correct?

A That is correct.

Q All right. In addition, you noted in your examination of her lower extremities that she had parentheses anterolateral aspect right thigh and weakness.

What does that mean?

A It's just a fancy name for changes in the sensation of the patient. Okay? You're going to describe different, if she

feels, like, fine. When you touch and you can play with the other side, it is going to like feel less or it's going to feel like a burning sensation, that is part of sensations. It's part of nerve also, sensory part.

Q Okay. And you noted that she had weakness in the leg, as well; is that correct?

A Correct.

Q Now, these symptoms -- withdrawn.

The results of your examination of her neck and back, and these tests that you performed on her, did you consider that information in coming to any conclusions during your evaluation of her that day?

A Well, as I -- the symptom that the patient complained are consistent with the MRI images, my physical exam, and I do believe, with the mechanism of the injury, yes.

Q All right. So let's talk about the MRI images.

Did you have an opportunity to look at MRI images for her neck and her back during that visit?

A Yes. I saw MRIs from 2020 of the neck and lower back. Images.

Q And where were they taken?

A They were taken at Stand-Up MRI.

MS. HOLLAND: Okay. Now, Your Honor, with the Court's permission, may the witness show the images to the jury, and point out his observations? These images are in

evidence as Plaintiff's Exhibit 17.

THE COURT: Mr. Van Etten?

MR. VAN ETTEN: Yeah, I just -- I -- yes. I guess I'll just save it for cross, Judge. I'm just confused what --

THE COURT: Show the witness, please, quickly.

MS. HOLLAND: Okay. So what we are going to do, Your Honor, we are going to use Plaintiff's 21, which is a thumb drive, with all the films from Plaintiff's 17.

THE COURT: We're going to make it so you can see, I promise.

Q Doctor, you will have to come down and pick out the images you want to show the jury.

THE COURT: Mr. Van Etten, anywhere you can see.

MR. VAN ETTEN: I'll end up moving. I'll see where they end up, Judge.

MS. HOLLAND: 2020, we will show the cervical spine first. The cervical spine from September of 2020.

MR. VAN ETTEN: Your Honor, the court officer pointed it might be difficult for the jurors to see through the witness.

THE COURT: We'll find out. Okay. You good? You good? You can slide -- we're good.

A This is basically --

THE COURT: If you can't see, you'll tell me. And

if you can't hear, you'll tell me. Very good.

Is there a question?

MS. HOLLAND: Not yet.

THE COURT: Thank you. Wait for a question, Doctor.

Q So, Doctor, we have up on the screen Ms. Watson's cervical MRI images taken on September 18th, 2020; is that correct?

A Correct.

Q Okay. Now, on the -- from the perspective of the screen facing the jury, the image on the left side of the screen is what? And what is the image on the right side?

A That one, there?

Q Yes.

A Okay. This -- I will explain a little bit, really, what an MRI is. Okay?

Q Okay.

A MRI is a really nice study, don't produce radiation. You are not in danger if you are pregnant or anything like that. It let's us see the soft tissues more than the bone. CAT scan, x-rays, CT scans are for bone. Here, we see soft tissues. It is a pretty excellent study. And what we see here is simplified. It's like, on this side, what we see is the cut -- the neck cut from the side. Okay?

Q Okay. And just to be clear, Doctor, we're talking

about the image that's on the right side of the screen?

A I'm moving the cursor, there. This is going to be the front of your neck. This is going to be the back of your neck. Okay? These white stuff is fat. Everyone has fat in the back. This is part of your brain. Okay? And this black thing, there, is the spinal cord. That is scary. But this is 3D imaging. You are -- it's not a static image. On this side, we're seeing the side. And on the other side, we're seeing the patient from the top. Okay? And this is going to be the mouth. This is the back of the neck, and this is black stuff, here, is going to be the disc, and the spinal cord. It is same thing.

Q To be clear, we are talking about the image, now, on the left side of the screen?

A Can you see the cursor, there?

MR. VAN ETTEN: So the jury's left and right is confusing.

THE COURT: Can you see? Let's clarify.

MR. VAN ETTEN: I think the witness was pointing to the right side of the screen, as it's there, but it's actually the left side to the jury.

THE WITNESS: I'm pointing with the cursor. I think you can see this on there.

THE COURT: So the cursor is on the left side. What, Doctor?

THE WITNESS: Whatever you -- it's going to be left

side for them.

THE COURT: Okay. So when you do left or right, it's for them. Okay?

THE WITNESS: Okay. This is going to be the left side, this is the lateral neck. We see from the side. Okay? And it's pretty clear, this gray stuff, here, are the bones. It's pretty nice. It's square. And the black things are the discs. Okay? And the discs, as I said, are cushion. It's a soft tissue. And, here, you can see the same, but this is going to be the disc, and this is the spinal cord. Okay? This is nice.

And the good thing is when I point, here, you can see -- you can see that line, that is, like, a purple line there, it is telling me what level I'm cutting on the other side. That is why we can count where the injury is. Okay? And if you can see, here, this is a high cut. The discs, no one give numbers to the disc never. I don't know why we don't name the discs. It is really confusing. That means -- when you see -- you say C3-C4, it's the disc that is between the vertebrae 3 and the vertebrae 4. Don't ask me why. It would be easier to say disc 1. C is because of cervical. C3-C4 is the disc there. This is what I mean. This is the C2-C3 disc. This is C3-C4. Okay? And they're going back.

This is the most important thing because this is

where you're going to see -- if I can do it because it's not moving good. You can see, here, you don't want the disc to come out backwards. Okay? It can come to the front. We don't really care, but the spinal cord of the nerves are there. Okay? It doesn't need to be something terrible that is coming out, but if it is compressing, you get symptoms. Okay?

You can see this is C3-C4, and it is touching the spinal cord. It shouldn't. You should be everything white around because the white stuff is fluid, and the spinal cord has more space, like here, for example, and it's white all around. It's not disc. Okay? Nothing is compressing. It should be like that. But if we're going down -- if I can do this. This is -- okay. Now, you can see. This is the level C3-C4. Now, you see the other side, that the disc is contacting the spinal cord. There is no white stuff anymore around the spinal cord. Okay? That is a disc herniation. Some people call it disc bulge. It's -- it doesn't mean that this bulge is less than a disc herniation. I will explain. That means we have a disc herniation, there.

Q What level is this, Doctor?

A This is C3-C4.

Q Okay.

A And then I can keep going down, if I can. This is C4-C5, the next level, and you can see the disc is also

contacting the spinal cord. Okay? This kind of contact could give mostly radicular symptoms, like we said, numbness, tingling. But if it compress more, it's going to give more significance in stuff like you can lose your balance, pee yourself. It's worse. Okay? This is not severe, but it's contact.

And then we can -- this is C5-C6, that is also contacting the spinal cord. Okay? It is not really white around. I cannot move it really good, but it's the idea. If we go down, you see, again, you have all white around the spinal cord. It is not a significant disc herniation. Okay?

Q And what level is that?

A This is C6-C7, down.

Q Okay. So just to sum it up, you see herniations at C3-4, C4-5, and C5-6; is that correct?

A Those are the worst levels, correct.

Q Okay. Now, while you're here, Doctor, and with the Court's permission because I'm going to have to put in another thumb drive. Okay.

Did you have an opportunity to review an MRI of the cervical spine that was taken of Ms. Watson in 2019?

A Yes.

Q Okay. Now, that is in evidence as Plaintiff's Exhibit -- Plaintiff's Exhibit 18.

MR. VAN ETTEN: May we approach now, Judge?

THE COURT: Come on up.

(Whereupon, a discussion was held off the record.

(Whereupon, the following discussion takes place at sidebar among the Court and Counsel, outside the hearing of the sworn jurors.)

THE COURT: Okay. We're outside the presence of the jury. We're in the robing room. Mr. Van Etten made an objection, asked for a sidebar, and here we are.

Mr. Van Etten, please.

MR. VAN ETTEN: Yes, Your Honor. Ms. Holland, during her direct examination, has now asked the doctor if he had reviewed a May 24, 2019, MRI film from Stand-Up MRI. The doctor's records do not contain that report in them. The doctor's records do not reference that MRI at any time. The doctor has not been identified as an expert witness to testify to any review of other records that are not part of his chart, as it applies to his treatments as a treating physician.

So since we have not been given any disclosure for the doctor, as it applies to what his thoughts may or may not be on the films, I'm objecting to him testifying to them because we were unaware that he was going to do so. As we have previously noted, this was an issue that is on various parts of the court record about trying to get those films. They were changed with us yesterday afternoon by plaintiff's

counsel, thank you very much, around 4:00. So I don't know when he may or may not have reviewed them. That part of foundation was not addressed.

But the fact remains, they are not in his record, he's not there. He just testified previously that based on his findings and the MRIs that he saw, that's where he made his initial diagnosis. In that first impression, that first report, it only references the 2020 -- September 18, 2020, cervical lumbar film, not the 2019 films. So he didn't talk to them. It's not in his initial testimony. We are caught by surprise, and if they wanted him to review that, they should have disclosed him as an expert.

MS. HOLLAND: All right. So, he's a treating physician. Counsel is free to cross-examine him as to when he actually saw the film. In fact, I'm going to ask him that question, again, just to make it clear. And I think once he gives his answer, that's going to, frankly, put this issue to bed. Next, like I said, he's a treating physician. He is here to testify about the his evaluation of the plaintiff. And all of the issues that counsel is raising can be dealt with on cross-examination.

We don't have to serve expert disclosure on a treating physician. His records and his testimony and his evaluation of the plaintiff speak for themselves. There is no prejudice here. Okay? I think that's what counsel is

trying to allege. There's no prejudice here.

They were aware of this MRI film throughout discovery. They had an authorization for the release of the film and the report. And to suggest that they just got it last night -- we served it as part of our responsibilities under the CPLR when we subpoenaed records to our office. They were aware of this film. They had it. They have their own experts. They are not prejudiced, ultimately, on the contents of this CD.

MR. HARRIS: They asked us to stip it in, this film.

THE COURT: Okay.

MR. VAN ETTEN: Just to finalize the part on the record here, Judge. Plaintiff put in the New York Spine Institute records, and they're in evidence. This film is not in those records. The subpoenaed records from that institute are here, as well. Those films are not in those records. They did not disclose this expert for the purpose of looking at those films.

To Ms. Holland, I add, she was not here at the earlier part of the trial, I believe, when we had the issue about the dispute on those films, so she may not have known. But we did not get the authorization for the 2019 films until we started the trial a week ago because we had never gotten an authorization prior to the date of incident. So

no, we did not get it. That's why we got to see those films for the first time last night.

THE COURT: To be very fair with you, Mr. Van Etten, you did not get that authorization because it was deemed waived. And the Court, in the interest of justice, ordered them to be disclosed.

MR. VAN ETTEN: Correct, Judge. I get that. I appreciate that. But, Judge, my point is, here, if they're now telling me that those records are out there and they had been there, yet we fought to get these things -- and again, it was an issue of waiving. If this is a doctor that's coming in to testify onto those records, and it's not in his records, and it's not referenced in his records, how would we be aware of the fact that he ever reviewed them?

THE COURT: He's going to testify right now, subject to cross-examination. So you have you exception. I will permit this line of inquiry subject to the proper foundation. Okay, Ms. Holland?

MS. HOLLAND: Okay. I understand.

THE COURT: Very good. So we'll go back out there and we'll do that.

MR. VAN ETTEN: Thank you, Judge.

(Whereupon, the following takes place in open court, in the presence of the sworn jury.)

THE COURT: You may resume.

Q Dr. Macagno, as the treating physician for Ms. Watson, okay, do you have access through the web -- the internet to the records of Stand-Up MRI when you're in your office?

MR. VAN ETTEN: Objection. Leading.

THE COURT: Can we just ask that a different way, Ms. Holland.

MS. HOLLAND: Sure.

Q What, if any -- withdrawn.

How -- withdrawn.

During your treatment of Ms. Watson, how did you access her Stand-Up MRI records?

A They are two ways. The most common is the patient bring the CD. But some places -- some systems, Stand-Up, Lenox Hill Radiology, they have a website when you can access the images directly from the web.

Q Okay. And when you say you can access the images and records directly from the web, the person who can access those images, with the permission of the patient, is a patient's treating physician; is that correct?

A Yes. In this case, yes.

Q So in this instance, did you have access to the website of -- withdrawn.

Did you have access to the digital files of Stand-Up MRI for Felicia Watson as her treating physician?

MR. VAN ETTEN: Objection. Can we get a timeframe,

please.

Q During the time that you treated Ms. Watson, right, starting in March of 2021, up until today, did you have access to the digital files of Stand-Up MRI, as part of your treatment of Ms. Watson?

A Yes.

Q Okay. And did that include the May 24th, 2019, cervical MRI?

MR. VAN ETTEN: Objection.

THE COURT: Overruled.

Q Did you have access to the May 24th, 2019, MRI, the one that we're going to ask you about?

A Yes.

Q Okay. Did you have an opportunity to review that MRI during your course of treating Ms. Watson?

A I don't remember during the course of treatment, but I reviewed now, yes.

MR. VAN ETTEN: I renew my objection.

THE COURT: Sustained. Sustained.

Q Okay. Did you have an opportunity during your evaluation of Ms. Watson to look at the MRI images before May -- before August 2020?

A Yes, I saw them.

Q Okay. And when was it that you saw the images?

A For sure, as I remember, in preparation for this trial.

Q Say again?
A In preparation for this trial, I downloaded the images.
Q Okay. Did you see the images before preparing for trial?
A I do not recall.
Q You don't recall? Okay.
MS. HOLLAND: Well, Your Honor, these images are in evidence, Your Honor.
THE COURT: Sidebar. Stop.
(Whereupon, a discussion was held off the record.)
Q Thank you, Dr. Macagno. We're going back now to the 2020 MRI that I have on the screen from September 18th, 2020. Okay? You told us about the herniations that you observed at various levels.
Do you have an opinion, okay, based upon your examination of the plaintiff and your examination of these films, whether or not the herniations that you observed on these films were caused by trauma?
A Yes, to a reasonable degree of medical certainty. Yes.
Q Okay. And the trauma being, as described by the client, the collapse of the ceiling and her fall; is that correct?
MR. VAN ETTEN: Objection.
THE COURT: Overruled.
A Yes.

Q Okay. All right. Now, let's go to the lumbar films. Lumbar, yes. All right.

THE COURT: We'll move this TV a little to the jury's left. Okay. Good now? All set.

Q Okay. Let me know when you're ready, Dr. Macagno. Are you ready?

A I'm ready.

Q Okay. All right. Up the screen, we have images of the plaintiff's lumbar spine taken on September 18th, 2020?

A Yes.

Q Okay. Can you tell the jury what we're looking at.

A It's pretty similar to what we seen before, but it's going to be everything bigger because it's lower back. This image here, on the left, I think your left, the marking there, is going to be the lower back seen from the side. Okay? This is fat. Everyone has fat there. And the belly is going to be here. We don't care. It's not part of the MRI. And the same thing, we have the other cross image, on the other side, that is being seen from the top. Okay?

It's pretty similar, but it's bigger, everything. With a big difference, if you can see in this image, seen from the top, it's not the spinal cord anymore. You see small dots. These dots are nerves. Okay? It's a big, big difference. That means you cannot get paralysis for anything happening here, but you can damage nerves. Okay? We are going to go -- what I see

here, basically, the last two discs are the discs compromised.

Oh. Other thing. This is going to be your sacrum. This is going to be your funny bone, the coccyx, your buttocks, are going to be here. This is the last disc, that is called L5-S1, and this is the most common disc that is injured accidents. Okay? Basically, she's got pretty good discs in every level, but she has a problem at that level, that is C4-C5. I don't if it's not clear, but you can see that vertebrae on top, it looks like it's slipping forward. It is not significant, but it's evident. You have all the bone in the back are pretty aligned. Okay? One, one, one, one. When you get here, it looks like it's slipping forward. That has a name, that is anterolisthesis or spondylolisthesis. Okay?

The last disc is a disc that is not really working pretty good. We call it black disc because we see like that in the MRI. Okay? It's a little but stiff. And you have this on two levels. Let me see. They are not terrible, but they are pressed. Okay? This is basically what she has in lower back, compromise of the last two discs of the lower back.

Q And you said compromised. That's L4-5 and L5-S1; is that correct?

A Correct.

Q Okay. And the compromise -- the herniations, what are they?

A Well, the herniations, here, you cannot see really

good. It's more because they're bulge/herniation in the back. They're in the back. Okay? They're in the back. This bony, per se, that is the deformity. It's not only the disc herniation, it is everything is closing. If you can see the space where the nerves are, that is tiny. But when you go up -- down, this is a greater space. You have all the nerves nice. You go there, this is what happens with spondylolisthesis, the nerves are, like, starting to get compromised there. Okay? This is called -- one of the terms is spondylolisthesis. And we will go up, as it gets big. Okay? All the nerves are nice there.

Q Okay. So my question to you, Doctor, these herniations at these two levels, do you have an opinion as to whether or not those herniations were traumatically induced?

A Yes. They -- yes.

Q Okay. And what is your opinion?

A That -- the same thing that I said before, most in this case, you can see that all the other discs -- this is not great. Okay? All the other discs are great. Okay? And you have brought in the last two discs, that is mostly trauma.

Q Okay. Thank you, Doctor?

A You're welcome.

Q And, Doctor, just so it's clear. When you say something is traumatically induced, can you tell the jury what you mean by that.

A Well, as I said before, that's doesn't need to be a terrible trauma. It could be a twisting injury. Mostly in the spine, that when we are getting older, it's here to -- you hurt it, a bending injury, twisting is pretty bad for the disc. Okay? Or could be trauma, car accident. This is trauma.

Q What about falls?

A Falls include everything. A fall on the buttocks, for example, is going to be do an actual strength and it's going to compress the disc and make the gel to come out. But the rotational component is pretty bad for your disc.

Q Okay. Rotational injuries to the back and falls to the back can cause damage to the spine; is that correct?

A Correct.

Q And herniations; is that correct?

A Correct.

Q Now, you may resume your seat, Doctor. Now, Doctor, I believe we touched on this earlier when I was asking you questions, generally, about the spine. Okay? And we talked about what happens as people age.

And you explained to the jury your spine starts to change when you age; is that correct? Like other parts of our body?

A Correct.

Q Are you familiar with the term degeneration when we talk about the spine?

A It's arthritis. It similar as arthritis.

Q Okay. So degeneration is a name for arthritis in the spine?

A Yes.

Q Okay. So can a person have degeneration in the spine -- withdrawn. I will try that again.

When a person has degeneration in the spine, what changes, if any, do you see in the spine? If you're seeing degenerative changes, what do you see?

A I want to first, I'm sorry, correct myself. Arthritis is the degeneration in all of the spine. Okay? Because it does not have preference for one disc. The spine usually changes. Basically, what you are going to see is the bones getting -- the disc getting stiffer. It starts forming what we call osteophytes, a funny name. They're pieces of bone that they're growing around. Okay? Not so much cushion between vertebrae, that produce pain. The bones are getting weaker. That is osteoporosis, but it's helping with this.

Q Okay. And you gave us an example, right? You have bones in your spine, that's one thing that can happen during degeneration.

And there can be other changes in the spine as a result of degeneration; is that correct?

A Yes. Well --

Q Okay. I know, I'm sorry. It might be obvious. Here's

my question. I want to make sure it's clear with the jury.

Can a person have degenerative changes, like you just described, and not feel any type of symptoms or pain? Is that possible?

A Yes.

Q Okay.

A Absolutely.

Q Okay. And if a person -- withdrawn.

In Ms. Watson's case, she was in her mid 40s at the time this accident happened. Did you see on any of the films whether or not she had any evidence of any degenerative changes in her spine?

A It's a mix that is suspected. Okay? 40-something years old, you are going to have some changes, like, arthritis, but it's a mix of changes. Okay? Because the change is generated by age. Back changes generate from some traumatic injury. Okay? That is a mix of changes in the MRI.

Q Okay. You can have degeneration, no symptoms, and then you can have a trauma, and that could further damage the spine and cause symptoms; is that correct?

MR. VAN ETTEN: Objection.

THE COURT: Can we ask it a different way.

MS. HOLLAND: Sure. Okay. I think I covered it. I hope the jury's got it.

MR. VAN ETTEN: Objection.

THE COURT: Sustained.

MS. HOLLAND: Okay. I'm just thinking out loud. Okay. Okay.

Q Now, the first visit, you looked at films, you examined her, you spoke to her, did you come to any conclusions, okay, as to whether or not, number one, all of her symptoms and your findings were causally related to the trauma that she told you she experienced back in August of 2020?

A Yes. As I said before, yes. I do believe it is causally --

Q It's causally related; is that correct?

A Right.

Q Okay. And what was your recommendation for treatment? Let's start with the cervical spine.

At that point, what was your recommendation for treatment?

A Well, the patient normally come to see you after. You're a spine surgeon. No one comes to see the spine surgeon. No one wants to be cut. Everyone is going to go to the primary doctor, physical therapy, get treatment. It includes multiple types of treatment. Then the patient come to see me, she have changes. She starts having symptoms, mostly in the arms, with weakness. And then it's not an emergency to do the surgery. That is the first thing that we discuss with the patient. It is not -- because I hear all the time, oh, you don't do surgery,

you can get paralyzed. That doesn't exist.

And they give the options of treatment. Okay? This include keep doing physical therapy, if you feel better. You learn -- when I do there -- change activities. We teach how to use and not to hurt herself. You can do medications. I don't recommend for a long time. And you can do injections as part of the treatment, and you are a candidate for surgery. But it is the same. These are the red flags for surgery. This is not an emergency. You don't need to rush or do anything at this moment.

Q Okay. Well, did you come to a conclusion, by the time you saw her in March of 2021, what she should do, given the treatment she had thus far, with respect to her cervical spine?

A Everything that I said before. Okay? All the treatments or surgery. The only thing I do, the surgery. If she decides to do the surgery, it's okay, because she's a candidate. But if not, she did the right thing. She will think of keep doing conservative treatment.

Q Got it. Okay. And with respect to her lumbar spine, what was your conclusion based upon that first visit?

A She could be a candidate for surgery also if the symptoms are getting worse.

Q Okay.

A What I mean, symptom getting worse, we explain to the patient, the leg weakness, shooting, that not the lower back

pain. Okay? Not only lower back pain.

Q Okay. All right. So now, I want to just move on to go through, just generally, her treatment, including the surgery. Okay?

Am I correct that after this first visit in March of 2021, you went on to see Ms. Watson over the next couple of years, actually up until very recently, in 2024?

Am I right about that?

A Yes.

Q Okay. So now, let's take the cervical spine first, and we'll deal with the lumbar spine. Okay? I had an opportunity to review your records. Your next visit with her was in November of 2021.

And at that visit, what was your recommendation, at that point, in terms of her doing the cervical surgery?

A The same thing. She came to see me with the conservative treatment, it started getting worse, came to discuss surgery. Nothing changed. The surgery, at that time, was an anterior -- the proposal, and I explained to her, an anterior cervical discectomy and fusion, C4-C5, C5-C6, possible C3-C4, that they are the worst three levels there.

Q Okay. So am I correct, ultimately, you performed surgery on her at those levels; is that correct?

A Yes.

Q And I think you mentioned earlier that surgery took

place the following year in December of 2022.

Am I right about that?

A Yes.

Q Am I correct?

A Yes, you're correct.

Q Okay. And just to be clear, during that one year period of time between November of 2021 when you saw her, and when you did the surgery the following year, there was scheduling and preoperative testing and all of those --

MR. VAN ETTEN: Objection.

THE COURT: Can you ask it a different way, please.

MS. HOLLAND: Sure.

Q What was going on during that one-year period of time?

A When you request surgery, it starts a process. Okay? I have no idea about the other parts of the process. I do the surgery. And then there's a lot of people involved in this. There's going to be insurance, there's going to be surgeon coordinators that are requesting papers to start talking to the patient, start deciding dates, and then presurgical -- sometimes patients cannot do surgery. It's not an emergency. They have to take time, family to help, or work to do, so they start organizing everything. It's paperwork, basically.

Q All right. So now, let's talk about the surgery object.

Do you have the operative report in front of you,

Doctor?

A I have it, yes.

Q Okay. Let me know when you're ready.

A Ready.

Q Okay. Number one, where did the surgery take place?

A Where.

Q Where, yes.

A At NYU Langone, main hospital.

Q Okay. And to be clear, those records are in evidence, Doctor, as Plaintiff's Exhibit 13. And I will represent to you that the surgery took place on December 30th, 2022, and she was hospitalized overnight, based upon those records. Okay?

My first question is, what was the procedure that you performed on her?

A We discussed it before. We did an anterior cervical discectomy and fusion, C4-C5 and C5-C6, last two levels.

Q Okay. That was my first question. What is an anterior cervical discectomy and fusion?

A Well, this is probably the -- sounds scary, but it's the most common procedure performed by spine surgeons in United States. Okay? But it sounds scary because you are going to cut your neck, literally. You have to make an incision in the front of the neck. But it's the less dangerous part of the neck. It's scary. Women normally hate us because of the scar. This is the first thing that this patient asked. But you're going to

get a small incision. I normally do it on the right side -- it doesn't matter what side you cut -- because I'm right handed. That's preference. A small incision. They call it laser. It's not really a laser. It doesn't exist, laser, that you burn something. You use a microscope. When you do the incision, you do this under a microscope. Everything is really tiny inside.

If you press, you cannot cut here because this is the trachea, you have that thing here. But if you go in the side, you feel a hole. That's where we go. If you press, you can know because painful. The spine is right there. The spine is not here. Here is the muscles. And they then we go in. We retract everything that you have to retract, and go and see the spine and clean the front.

Q Okay. All right. And I want to get into what you did, more specifically, during the surgical procedure.

My question is, the anterior cervical discectomy, is just generally the process is to remove part of the spine and fuse it together; is that correct?

A That's the name, anterior, we go up -- cervical because it is the cervical spine, discectomy because we remove the disc, and fusion because the final process is fuse the spine.

Q Okay. Now, I want you to explain and I want you to use, with the Court's permission, okay, I have a -- an anatomical --

THE COURT: Don't show it to the jury.

MS. HOLLAND: I held it the wrong way. I apologize. I have a board. It's an anatomical display of what takes place during this surgical procedure. I ask the doctor, with the Court's permission, to utilize the --

THE COURT: What's that marked as?

MS. HOLLAND: I didn't mark it. It's an old --

THE COURT: Peel that off and mark it for ID.

Yes?

MR. VAN ETTEN: Can we approach first on that.

THE COURT: Of course.

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

THE COURT: Okay. We are going to take five minutes. Okay? Everyone can use the restroom. Do not discuss the case. All right?

Doctor, you are permitted to step off the stand. You are under oath. You may not discuss your testimony with anyone. Okay?

THE WITNESS: Okay. Thank you.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: Just five minutes, guys.

(Whereupon, a brief recess was taken.)

MR. VAN ETTEN: So, Your Honor, we were just about to possibly mark for identification at least two boards for this witness to describe to the jury. The first board,

which we're removing the prior marking from -- I believe it's from a different patient, obviously.

MR. HARRIS: Different patient?

MR. VAN ETTEN: A different person.

THE COURT: It's -- I can't see. Can I see?

MR. VAN ETTEN: I will it to show you, Judge. It's a board that say C5-C6 and C6 --

THE COURT: All right. I disagree that that's a different patient. It's a medical diagram.

MR. VAN ETTEN: The reason I'm saying that is twofold, Judge. When you go into -- here's what I'm saying, Judge.

When we get a foundation to have a medical art -- piece of demonstrative evidence, you have the doctor say that he reviewed. He reviewed it from the records, the films, anything like that, so it fairly and accurately depicts what it's showing that to show the jury. For example, there are herniations shown in this that are at different levels than other areas. Because those are herniations that were involved at C5-C6 and of C6-C7. These are different levels and they are going to be different manifestations from the MRIs or whatever was used for that other person, which I'm assuming is patient.

So that is an improper and unfair demonstration to be utilized because I do not believe that this piece of

documentation was from Ms. Watson's records, her films, or anything like that, that would provide a proper means of allowing this to be -- even as an exhibit for ID, to be shown to the jury because it would be misleading.

The second one is also for an apparent anterior lumbar discectomy and fusion. I mean, we haven't reached that yet, and I'm not sure which levels we're going to go with, but I'm going to have the same issues --

THE COURT: Can I see it, please.

MR. VAN ETTEN: Sure. As it applies to that --

THE COURT: What's the issue with this one?

MR. VAN ETTEN: Listen, there are different surgeries that can be done. I mean, I guess if we go through foundation, we have to do an offer of proof. The doctor may not decide that this surgery, if any, is going to be done. It may change. That would not accurately reflect the surgery because he might have to go in there and have to do something different. It could be less levels, more levels. It's speculative to have this also used as a piece of demonstrative evidence for identification.

THE COURT: All right. Okay. Thank you, Mr. Van Etten. As I stated off the record, and I will state for the record, it is my job to make sure that this jury understands and is processing information that's being presented to them.

And, as I've said, Ms. Holland you do have a foundational issue with this before you're going to be permitted to use it, okay, to make sure that there is no confusion. All right?

MS. HOLLAND: Yes, I'm aware, Your Honor.

THE COURT: Very good. So your exception is noted, Mr. Van Etten. And we will see how this plays out, based on the foundation. Okay? And, just, Ms. Holland, hard stop at 12:50.

MS. HOLLAND: 12:50, okay. Sure.

THE COURT: Jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: Okay. Welcome back. Quickly take your seats, please. Thank you. It's almost lunchtime. All right?

Okay. Ms. Holland, when you're ready.

MS. HOLLAND: Sure.

Q Okay. So, Dr. Macagno, I want to ask you some questions, more specifically, what you did during the cervical surgery. And I've marked as Plaintiff's Exhibit 25 for identification this --

(Whereupon, the item referred to is marked Plaintiff's Exhibit 25 for Identification.)

THE COURT: Just to him first.

Q This poster board. Okay? And will this poster board aid you in your description, generally, of what takes place during an anterior cervical discectomy and spinal fusion?

A Yes. It's approximately what we do, yes.

Q Okay. Now, just to be clear, in this board, just for the purposes of the record, refers to the anterior cervical discectomy and spinal fusion done at C5-C6 and C6-C7. And, in this case, you did the fusion at C3 -- I'm sorry.

A C4-C5.

Q And C5-C6; is that correct?

A Correct.

Q But the fact that you did it at different levels, despite that, does this board still aid, generally, in what takes place during an anterior cervical discectomy and spinal fusion?

A Yes. It would be the same for every level.

MS. HOLLAND: Okay. Your Honor, with the Court's permission, may the doctor refer to the board in explaining what he did during the surgery?

THE COURT: He may, over objection.

MR. VAN ETTEN: Thank you.

Q Do you need your operative report with you?

A I --

Q You will be able to explain without the report?

A Yes. Absolutely.

Q Okay. Thank you. Okay.

A Okay. This is pretty much what we do. It's -- we don't do this part anymore. Forget it. In the past, we used a bone from the patient. Some doctors or all doctors --

MR. VAN ETTEN: Objection.

THE COURT: Overruled. Continue, Doctor.

A All doctors still use it. We don't use it anymore. Forget about that. That is a no. This is the neck. Okay? Everyone has it. This is more or less the incision that I talked to you. Okay? We do incision that is -- we don't use anymore. These incision are terrible. This is more steady and they are better. We make a small incision, about one inch, in the anterior part of the neck. Okay?

And, as I said, the spine is right here. That means we have to get to the spine, and we put retractors. We put something so the spine is -- we cannot hold anything with the fingers. Okay? We put specific protectors, metal, just to see this. And we see it with a microscope because that is really tiny, tiny. The next step, as it's shown here, is remove the disc that we are going to -- that disc, really, we don't cut it with a knife. The disc, we take it in pieces. This and this, they are not working anymore. There's nothing there. Okay? And what is behind is the spinal cord. This is where the procedure is -- it had to be terrible to give you paralysis

because, of course, it's in the back. Not everyone is as scared of paralysis. No, we don't touch the spinal cord. We remove the disc. It's going to be bone and bolts, okay, we decompress the nerve. I'm sorry.

Q You said "we decompress the nerve"?

A Correct.

Q What do you mean by that?

A We -- we are carpenters. It is a carpentry procedure. You remove the disc, and when you remove the disc, they -- we the nerve. We see that in every kind of compression, but we cannot fix it. People ask me, "can you do something to the nerve?" Nothing. The nerve cannot be touched. It's going to recover over time, hopefully. And then this is the same thing that we see from the side. Okay? The surgery is the same.

We remove the disc, and when you remove the disc, the compression of the spinal cord or the nerve is going to come out. It's going to be flat. You see it with a microscope. Now, you have to put something there because the hole. Okay? In the past, we used to use bone. We don't use it any more. We use titanium. Titanium works really nice with bone. It's what we use in football players. Actually, with two levels of this surgery, the results are so nice that you can keep playing contact sport at professional level. One or two levels is okay. More than two is not.

Then what we use, I think you can see there, in the

back, we put -- no bone. This is bone. We don't use a bone anymore. We use metal cage. It's tiny. We pick the size inside. Everyone say, "how you know?" Well, we measure it, and we have 50 cages. We use the one that is specific for that patient. That cage is impacted. And then what -- what you do to avoid problems, that cage coming out, because in the past we didn't have technology, you have the cage and then you have to use a collar for six months, one year. Terrible.

What we use now is a plate. That is a titanium plate also. And we -- there are 20 different types of plates, and we put a screw and attach it to the bone. Okay? It is a carpentry process. Yes, it sounds like it. But this is for safety because you don't want anything to come out. Okay? This is a procedure that you -- you're going to be walking home the same day or -- you'll be walking the same day. Sometimes, you have to stay in the hospital. But, normally, now, we do it outpatient. They go home almost all the time. And then you ge to close. That's it. That's the process.

Q Okay. So, thank you, Doctor.

A You're welcome.

Q You can put the board right there. Okay. You said some things to the jury, and I guess I will make sure that we understand the process. Withdrawn. I'm going to try that again. Okay? Okay.

Here's my first question. The reason you removed the

disc is because the disc is compressing on the nerve; is that correct?

A It's not a completely -- nobody knows the reason. The disc has multiple functions. One of the functions is cushioning. That is one of those. There is no cushioning anymore.

Q It's not cushioning anymore?

A No, because nothing there. The cushion part, that is the gel, came out, and is compressing the nerve. That's why. The other part, you cannot leave pieces of this because you want -- a fusion cannot be soft tissue. It has to be bone against bone. But, yes, the most important part is they compress the nerve.

Q Okay. You removed the disc to stop compressing against the nerve. And then you put a metal cage where the disc was located between the two bones; is that correct?

A Correct.

Q And can you explain the reason why you put the cage there. How does that lead to the fusion part?

A Well, there are different kinds of cages. Technology is incredible now. We are making cages with 3D printers now. But, normally, the cages have a hole in the middle, okay, as a part. We put some products to help, but the idea is the bone grow and fuse one bone with the other to the cage. Okay? This is the idea.

Q Okay. Now, so that's what we mean by fusing the spine together; is that correct?

A Correct.

Q Okay. And then to secure that cage, you have to put a plate and screws; is that correct?

A Correct. In this case, that's what happened.

Q Okay. And here's my last question before we go to lunch. Okay?

When you performed this surgery, Doctor, what is -- is the purpose of the surgery to, sort of, cure the person or -- like, what is the purpose of the surgery?

MR. VAN ETTEN: Objection to form.

THE COURT: What is the purpose of the surgery?

Q What's the purpose of the surgery?

A The purpose of the surgery, in this case, is to avoid the patient keep losing the function of the arms. That is one of the most important part. As I said before, you don't do this surgery to alleviate neck pain. I have, all day, patients coming, "I'm in pain." It's not going to get better. There's no indication. It's the wrong indication. It's been done, but it shouldn't. The idea of the surgery is to decompress the nerve and try the nerve to recover life, to recover strength, or not to get to a point where you are going to lose the function of the arm.

Q Okay. So to be clear, the surgery does not repair the

damaged nerve.

Am I correct about that?

MR. VAN ETTEN: Objection.

THE COURT: Sustained.

MS. HOLLAND: Withdrawn. I will try it again.

Q What is the effect of the surgery, if any, on the damaged nerve?

MR. VAN ETTEN: Objection.

THE COURT: I'll allow that one.

MR. VAN ETTEN: Description of the nerve?

THE COURT: I'll allow it.

A I think I explained it before. We cannot fix nerves. There's no way. You can give somebody medications, but you cannot fix nerves. If know, we're making people that is paralyzed work. We are not there. But we decompress the nerve and we try -- the nerve is going to recover by itself. But the patient has to do their own part. Okay? Go to the gym, recover th muscles, try that route. That is the function. We cannot fix nerves, not yet.

MS. HOLLAND: Okay. Your Honor, it's 12:52. I think it's a good time.

THE COURT: Very good. Ladies and gentlemen, we're going to take lunch at this time. We'll be back here at 2:00 p.m. Okay? Do not discuss the case with each other, with anyone at all. All right? Keep an open mind. I'll

see you at 2:00 p.m. Good. Thank you very much.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: Doctor, you will be permitted to step down. You remain under oath, and you are not to discuss your testimony with anyone. Okay?

THE WITNESS: That's correct.

THE COURT: Very good. Thank you. We stand adjourned until 2:00 p.m. Thank you, all.

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L U N C H E O N R E C E S S

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

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THE COURT: Jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: Take a seat. Go ahead. You guys can sit right down. Okay? You guys came back right on time. I really appreciate all of you, and we're going to get right underway. All right?

Ms. Holland, the witness is yours.

Doctor, you remain under oath. Okay?

THE WITNESS: Sure.

THE COURT: Go ahead, Ms. Holland.

CONTINUED DIRECT EXAMINATION

BY MS. HOLLAND:

Q Now, Dr. Macagno, you just described for the jury before lunch the surgery that you performed on the plaintiff back in December of 2022.

Am I correct that in the year of 2023, you continued to see the plaintiff both for her neck and her back?

A Yes, correct.

Q Okay. And you've documented your visits in your file; is that correct?

A Correct.

Q Okay. And just in summary, if you can, over the course of 2023, did the plaintiff -- when she would come to see you, did she continue to make complaints regarding her neck and radiating pain into her arm?

A Yes, she continued. It's pretty common. It's kind of a -- pretty common in these kind of surgeries. Neck pain is pretty common, as I said before, it's muscle spasm. It's not going to get better until we can recover the neck muscles. And she has some numbness -- residual numbness in the arm. That is expected. We're waiting for the -- you know, the nerves. Is this going to recover or not completely?

Q Okay. Now, as part of your follow-up treatment with her, this is now in 2023, did you order x-rays of her cervical spine?

A Yes.

MS HOLLAND: Now, Your Honor, with the Court's permission, may the doctor show the x-rays of the plaintiff's cervical spine that were taken at Lenox Hill Radiology in 2023? They are in evidence as Plaintiff's Exhibit 19, and then the thumb drive is in evidence as Plaintiff's Exhibit 22. And the thumb drive is actually in the computer.

THE COURT: Very good. Yes. Thank you. And you all let me know if you can't see or if there's any issue.

We're good? All right.

Q Doctor, before you begin, I just have to ask a question. First, we're looking at cervical spine x-rays that were taken at Lenox Hill Radiology of Ms. Watson on March 19, 2024; is that correct?

A That's correct.

Q Okay. And just so it's clear, there were x-rays taken of her also in 2023; is that correct?

A That's correct.

Q Okay. So can you tell the jury what we're looking at in the x-ray from March 19, 2024.

A Well, it's -- this is how it looks after the surgery. Actually, more rapidly because, normally, it doesn't look so straight, but this looks really nice. This is -- you can see this -- in your left side now, okay, here, it's a lateral view. We see from the side. Okay? Like, we see them before, we see this one. This is the brain. The shoulder is going to be here. This is the spine.

In x-rays, the disc, you cannot see anything. They see black. Okay? It's nothing there. These are discs. These are the two discs that we replaced with titanium cages. Okay? And you can see the cages inside. Okay? And then in the front of the spine is going to be a plate. It's really nice because we have really small plates with the screws. Really, the screws are really tiny, tiny, tiny. There are six screws. We're going

to see in the front there, because one screw is behind the other. And the good thing, the spinal cord is going to be in this canal that is here. We don't touch the spinal cord for these surgeries. Okay?

And this is the same view, but seen from the front. Okay? And we can see the same, the cage. Okay? You can see the screws there, one, two, three, four, five, six. And that -- this is almost two years after surgery. That is going to be the last x-rays.

Q Okay. Just to be clear, the view that you were just speaking of, that would be to the jury's right, as you're looking at it; is that correct?

A This is -- the right is going to be the AP, seen different from the front. The left is going to be seen different from the side. We always request that.

Q Okay. All right. Thank you, Doctor.

A You're welcome.

Q You can have a seat on the stand.

Now, I want to switch gears and now talk about her back. Okay? I want to go back to that first visit in March of 2021 when you first saw her. And we've established that you continued to see her from March 2021 up until today. Okay?

A Correct.

Q All right. Now, let's talk about her back. Okay? At some point, did you make a determination that she was a

candidate for lumbar surgery?

A Correct.

Q Okay. Do you recall when that was, Doctor?

A Well, since the first day, I discussed that. I didn't say that she -- that she have to have the surgery, but we discuss it, that if -- well, the patient also understand if not improvement with conservative treatment, she could be a candidate for lumbar surgery in the future because she have the symptoms. Okay?

Q And I want to direct your attention, specifically, Doctor, to your note from October 2022.

Do you have that in front of you?

A I'm looking for it.

Q October 24th, 2022. Let me know when you're ready.

A I'm looking for it.

Q You know what, just for --

MS. HOLLAND: May I just help the, Doctor, or just show him my copy with Mr. Van Etten's permission?

MR. VAN ETTEN: No problem.

Q Okay. Doctor, I'm going to show you my copy so you don't have to look for it.

A Okay.

Q I'm directing your attention to your October 2022 note.

A Okay.

Q Okay. And that is, again, from Plaintiff's Exhibit 3

from your records. You just told the jury that, at the first visit, you opined or you concluded that she could become a lumbar surgical candidate if she didn't improve. Now, we're in October of 2022.

What was your conclusion as to whether or not she was -- had reached the point that she was a candidate for lumbar surgery?

A It's the same -- it's another dictation, but this is same thinking. Patient is getting worse. She's still a candidate for lumbar surgery. It's not an emergency, as I said before, but the symptoms are getting worse. Okay?

Q Okay. Now, over the course of 2023 -- okay. You've just talked about her back in late 2022. Over the course of 2023, right, she just had the cervical surgery during the early part of 2023.

My question is: Were you focusing on her neck, her back, both, or something else?

A Well, it's a post-op for the neck, but you always ask for the back if something really terrible is happening, the patient has something that could become an emergency. If not, it's going to be the focus in the post-op of the neck.

Q Okay. So I now want to bring your attention -- we're now through 2023 and into 2024. Okay?

A Okay.

Q You saw your client, or Ms. --

THE COURT: Watson.

Q -- Watson, in April of 2024, and you saw her recently in November of 2024; is that correct?

A Correct.

Q Okay. Let's talk about that. Okay? But I'm still talking about the back, and just for ease, I'm going to hand you your November 12th, 2024, note.

A I have it here.

Q Oh, you have it in front of you?

A Yeah. Absolutely. Thank you.

Q Perfect. Okay. All right. Again, talking about the back, were you of the opinion still, as of November 2024, that she was a lumbar surgery candidate?

A Absolutely, yes.

Q And what surgery is she a candidate for? What type of surgery?

A It's going to be a posterior fusion, a lumbar fusion.

Q Okay. Now, I have what's been marked as Plaintiff's Exhibit for identification -- Plaintiff's Exhibit 26 for identification. I'm going to show this to you.

(Whereupon, the item referred to is marked Plaintiff's Exhibit 26 for Identification.)

Q And my first question is, would this aid you in your description of the steps generally taken for a lumbar fusion surgery?

A Well, this is going to be -- there are two kinds of surgeries there. One for the front is not going to be for her. It's not necessary for her. And the one for the back is going to be the surgery we perform, yes.

Q Okay. So the portion of the exhibit that addresses the posterior lumbar fusion, would that aid you in your description to the jury of what that surgery entails?

A Okay.

Q Would that aid -- my first question is, would this help you explain it to the jury?

A Yes, it's pretty -- it's, as I said before, it's more or less what we do, correct.

MS. HOLLAND: Okay. With the Court's permission, may the witness refer to that portion of this exhibit so he can explain what a lumbar fusion consists of.

MR. VAN ETTEN: Renew my --

THE COURT: Over objection, yes.

MR. VAN ETTEN: Thank you.

THE COURT: To be clear, ladies and gentlemen, he's using this part of the chart as relevant to this plaintiff. Okay?

THE WITNESS: Yes, this is not --

THE COURT: Hold on. Wait for a question. Wait for a question.

Q Okay. Can you explain, using the chart, generally, the

steps that are involved in a posterior discectomy fusion in the lumbar spine.

A Okay. This is -- we're going from the back. Okay? We make an incision. There's many ways to do it. I still do it the old way. I open, I don't use robots or anything like that. I don't believe in those. What you have to do, you can remove the disc from the back. Okay? You don't need to load from the front. I leave the front. It's more a dangerous surgery for other cases, not this. When you go from the back, it's pretty --

THE COURT: One second.

THE WITNESS: Sure.

THE COURT: You can't see? We can just address that.

Sorry to interrupt your testimony, sir.

A Okay. Here we go. We go from the back. Okay? We make the incision without the use of drill. Okay. It's carpentry to remove the bone. And we can remove the disc from the back. Okay? The same thing that we do it from the front in the ACDF, but this is more -- it's bigger, the space. Then the idea of the surgery was to remove the disc. We replace it with -- this is wrong, but we use, again, titanium cages, technology advance. And then around the cage is going to be a little bone. The bone is coming from that peep hole. Okay? That bone should grow. It's going to take six months to one year. It doesn't

mean -- we cannot keep the patient laying down in bed six months to a year. Then that is why we use this, in fact. They are screws. We use four screws. Titanium screws. They hold altogether for the patient to be able to start walking the next day. Okay?

Q Okay. So now, have you finished explaining what the surgery consists of?

A Yes.

Q Okay. Thank you, Doctor. You can take your spot back on the stand. Thank you.

A You're welcome.

Q All right. Now -- I'm now taking you, Doctor, still at that most recent visit in November of 2024. Okay? You just told us what your recommended surgery would consistent of.

When you saw Ms. Watson in November of 2024, what complaints did she make to you?

A Well, the most important things are the lower extremities symptoms, that they are getting -- the weakness is getting worse compared with the previous. Okay? So still have numbness, tingling, straight leg raise positive, but the weakness is getting worse. That mean the pathology is getting worse.

Q Okay.

A The range of motion is still limited, probably worse than before, but these are mostly the problems that I would

indicate to surgery.

Q Okay. And with respect to her neck and her upper extremities, how was she doing that day when you saw her?

A Well, on this day, she was refusing to proceed with surgery. She has resolution -- almost resolution of symptoms of upper extremities. She has some residual numbness, tingling in one of the arms. Of course, the neck pain is going to have intermittent neck pain, we know about that and we discuss it. But, overall, is doing better.

Q Okay. Great. So now, I have a couple more questions for you and then I'm done. Okay?

A Okay.

Q Here's my question: With respect to the injuries that she sustained, both to her neck and to her back, you've told the jury that, in your opinion, they are causally related to the accident that's the subject of this lawsuit.

My next question is: In your opinion, are her injuries permanent, both to her neck and to her back?

MR. VAN ETTEN: Objection to form of that question, please.

THE COURT: Ask it a different way, please.

MS. HOLLAND: Sure.

Q Here's my question: With respect to the injuries she suffered to her neck and to her back, in your opinion, are her injuries permanent?

A Yes, both with surgery or without surgery are going to be permanent.

Q Okay. And with respect to your last evaluation of her, in your November 2024 report, you note that for her prognosis, it's guarded.

What does it mean when you have the prognosis guarded?

A Guarded means that patient is going to do, overall, better, is not going to be in a wheelchair, is not going to be in a terrible pain, but is going to be having problems for -- she's going to have limitations, she's going to have residual pain, and maybe some residual weakness. It's going to do better than before, but it's guarded. We have to see how she's acting in the future.

Q Okay. Now, in light of the fact that your opinion is that her prognosis is guarded, do you have an opinion as to whether or not this guarded prognosis will have an effect on her enjoyment of life?

MR. VAN ETTEN: Objection.

THE COURT: Overruled.

A Yes, it's going to change ways to do -- to advance life. Okay? There are going to be limitations. We're going to teach her what things -- teach her what things she cannot do anymore. For example, when we talk to the patient, do not BLT. It's easy to remember. Do not bend forward, do not lift weights -- significant weights, you know, constant for a job.

And try not to twist as much as possible. That is in general. Okay? But, yes, she's going to have limitations. She's not going to be able to do or perform activities that she was used to perform before.

Q Okay. Now, Doctor, I want you to assume that there's going to be a witness that's going to come in here, a Dr. Ali Guy, and he's going to testify about the need for future medical treatment for Ms. Watson. Okay?

Here's my question, okay: In your opinion, would Ms. Watson benefit from additional medical treatment, including evaluations by a doctor, periodic evaluations of -- excuse me. Evaluations by a doctor, periodic diagnostic studies, the benefit of an additional surgery, both to her cervical spine and to her lumbar spine, okay, pain management, okay, with a pain management doctor.

Would you agree that she will need those types of medical treatment in the future --

MR. VAN ETTEN: Objection.

Q -- would benefit from that?

THE COURT: Overruled.

A She -- yes, this patient -- in general, first, no physical therapy, but exercising, swimming pool, whatever, have to pay for that, gym, it's forever. You cannot stop that. You're not going to do okay. X-rays, not so much, but MRIs every one year or every two years are recommended, mostly if she

starts experiencing new symptoms. We know every time that we do a fusion, after -- well, we normally tell her what the book says, that patient has 2.5 percent chances per year to have the level above or below the fusion damaged. Okay? That means it's going to be about 25 percent in ten years. This is in general. You have patient before or after.

Q So just to be clear, you're saying based upon the studies, right -- medical studies that the levels in the spine above and below the areas that were fused will start to be affected?

MR. VAN ETTEN: Note my objection.

THE COURT: Overruled.

A Correct, that's what I explained, yes.

Q Okay. Is that called adjacent segment syndrome?

A Yes, adjacent segment disease, we call it.

Q Okay. And how are the levels above and below the areas that have been affected by the trauma, how and why are they affected as time goes on?

A The fusion is going to effect it because the stress -- I'm going to fuse these two segments, I'm not going to use these two discs anymore. That mean the stress on that is going to be transferred to the other levels. The 2.5 percent is referring to patient that they are healthy , okay, that they don't have any other problem. Patients that have other discs with problems, remember, have disc with the disc herniation, probably

is going to be shorter time.

Q And, I apologize --

MS. HOLLAND: I apologize, Mr. Van Etten, I don't know if I asked this question. I have to do it. Okay?

Q With respect to her lumbar condition, okay, is it your opinion that her lumbar condition, the herniations, her symptoms, the need for surgery, is it your opinion that it's causally related to the accident that occurred on August 24th, 2020?

MR. VAN ETTEN: Objection.

THE COURT: Overruled.

A Yes, it's -- both, I do believe, are related, yes.

Q Okay. I wasn't sure if I asked that question. Thank you very much, Doctor.

A You're very welcome.

Q Doctor, thank you very much. Thank you.

THE COURT: Very good. Mr. Van Etten, when you're ready, your witness.

MR. VAN ETTEN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. VAN ETTEN:

Q Hi, Doc. How are you doing?

A Good.

Q I think -- I'll tell you what, since this is up on the screen, I'm going to start with that right now, so we can start

there, and then maybe we can save some time.

That is an x-ray from seven months ago -- eight months ago, correct?

A Correct, yes.

Q Okay. And I think you said that showed a really good job there?

A So lucky, yes. It looks good.

Q I think you said "perfect" even, correct?

A It's lucky. It doesn't show like that all the time.

Q And you've taken some other MRIs since this surgery, and they're in your chart.

And there have been no complications from this surgery?

A Correct.

Q And that's because you did a good job?

A Our work, yes.

Q Yeah.

A Was lucky.

Q You're proud you did a good job, right?

A It's solid work.

Q Okay. When you just talked, though, at the end about the segmental issues and everything else like that and you gave some percentages, you're talking about a revision surgery, correct?

A Yes.

Q Okay. And revision surgeries do not happen every time

you do a fusion, true?

A Correct.

Q In fact, it's ten percent or less of the time, true, typically with the neck?

A No, the numbers are 25 percent -- the chances are, if the disc is healthy above or below, 25 percent every ten years.

Q And at this point, to our knowledge, the discs are healthy above and below?

A We don't know.

Q We don't know?

A Well, no, what was the question again? I'm sorry.

Q They're healthy right now?

A No, they're not healthy. She still has the disc herniation a level above, but it didn't get worse. She doesn't need surgery.

Q So, exactly, it hasn't changed?

A It hasn't get worse.

Q And if it doesn't get worse, she doesn't get a revision, fair?

A Not at this moment, correct.

Q All right. So you can't say right now whether she will or will not get a revision? You can't see into the future, fair?

A Correct.

Q Okay. That's the easy part. I've got a couple more

things to start asking you.

By the way, that would apply to the lumbar spine, too, because, in fact, she hasn't even had a lumbar surgery, correct?

A Correct.

Q But you were asked by Ms. Holland, would she need a second surgery, even though she hasn't had a first, and you said I guess she might, right?

A I don't think we were talking about the lumbar spine.

Q Okay. So the lumbar, you don't think she would need a second surgery?

A No, it's -- the same thing apply. I don't think she asked me that question before. That's what you're asking me.

Q So until she gets a lumbar surgery, you would agree you can't opine that she might need a revision surgery because she's hasn't even had the first surgery, fair?

A Correct, yes.

Q Okay. All right. Now, the first time you saw Ms. Watson was on March 20th, I believe it was, 2021.

Do you have that there?

MS. HOLLAND: March 30th.

Q March 30, right?

A Yes.

Q And I believe Ms. Holland asked you if you took a history of her -- from her?

A Uh-huh.

Q Do you have that one with you there, Doc?
A I have it with me.
Q Thank you. And just so everybody knows, it's Dr. Macagno, correct?
A That's correct.
Q I said it wrong yesterday and I told you I'd say it right when I met you this morning.
A Correct.
Q All right. So you took a history of her on that first visit, correct?
A Yes.
Q And that date is March 30, 2021, correct?
A March 30, 2021, correct.
Q And in your chart that you brought, which has been marked as -- for identification, you have a different document that's on the cover sheet of that from February of 2021, don't you?
A Yes, I saw that.
Q Right. And is that, like, an intake sheet for her?
A Normally, when the patient is coming in, they give it, or they have an appointment or something, they make them fill out a paperwork. I don't check that paperwork ever. This is the first time I saw it.
Q Okay. But that -- and, again, you said before you didn't know how much was being charged to the attorneys to be

here because that's part of the business --

A Correct.

Q -- right?

So is that part of the business, that they do something like that?

A It's in the office, the patient, yes.

Q Because -- but doesn't that say that New York Spine Institute has a lien?

MS. HOLLAND: Objection.

THE COURT: Sustained.

Q Does New York Spine Institute --

MS. HOLLAND: Objection.

THE COURT: Hold on. Let him ask the question.

Q -- have an interest in the outcome of this litigation?

MS. HOLLAND: Objection.

THE COURT: Doctor, do you know?

THE WITNESS: Absolutely not.

Q Okay. Thank you. And are there various people identified on that initial intake sheet? Right? I think it's the first page, Doc. First page.

A No. It's because of the physical therapy that referred the patient to me.

Q And are Ms. Watson's attorneys identified on that sheet, as well?

MS. HOLLAND: Objection.

THE COURT: Can we approach, please?

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

(Whereupon, the following discussion takes place at sidebar among the Court and Counsel, outside the hearing of the sworn jurors.)

THE COURT: Go ahead, Ms. Holland.

MS. HOLLAND: Okay. I have an objection to counsel making any reference to, number one, that my firm's name is on any document in this case because it's already been a ruling by this court that counselor cannot ask any witness whether or not the plaintiff was referred to a doctor by her lawyers. There would be no reason to ask this doctor about a reference to my law firm on a cover sheet, essentially, other than to establish that there's some relationship between the doctor and my law firm.

Number two, we had an off-the-record discussion just moments ago and counsel believes that he can ask this witness about whether or not the word lien and funding, as it appears on a bill, is somehow tied to Burns & Harris/Harris, Keenan & Goldfarb, and whether or not the doctor's medical group delayed treatment in this case for the year between November of 2021, and when she had the surgery in 2022, in order to seek funding. There's absolutely, number one, no evidence of that.

And number two, while we're back here, on the

separate issue of funding, I'm making an application that there be no reference to funding in this case. Okay? It is absolutely irrelevant whether or not the plaintiff took out a loan from a third-party funding company to pay for any medical treatment in this case. It's not probative of anything, okay, at all. So I'm making an application that there be no reference or no questions asked about funding, Period.

THE COURT: Mr. Van Etten?

MR. VAN ETTEN: Sure. We have a record where we were told by the witness that the first time the patient was ever seen by New York Spine was the end of March of 2021, yet his chart that he brought with him actually says that she had consulted with his healthcare group, medical group, whatever you want to call it, over a month before that on a document that says lien. And then, as I said, there are other records indicating when surgeries were being undertaken that there were funding liens and contributions being paid to that medical group in their records.

So I was inquiring of it because of the discrepancy between the dates he said she first started treating at there, and also because counsel brought up about the delay in the time for the treatments with all the machinations that had to happen and all the things that had to go on in this to set this up, and that's where I believe that there

inquiry if he knew, which was the question, whether he knew, or not, to find out what was involved in that and the issue of the lien.

I don't know, at this point, because we are not allowed to depose these doctors. I don't know. In the old days, a doctor would go and take a lien off something if somebody wasn't covered on a case, and they would take a lien against the recovery, and they would go treat the people and have a surgery, and they would have a lien against the recovery. That's why I asked the question about the lien because then there is a potential financial interest by the medical group in the outcome of this litigation, for which I would be able to inquire.

If they have a lien, that she owes them money, and they want to get paid, they have an interest in this outcome, and that is probative for credibility. And that was why I asked the question to see if he knew it. He said he had no idea about the stuff and, you know, that's where I was doing it -- basically stopping where we were because he's not the witness.

Now, I may have to subpoena somebody else for them to come in if they try to put in these records as evidence of the expenses. But as I also told you, I am concerned because she's testified under oath previously, and you're right, it might be collateral source, that she was a

Medicaid recipient, having Medicaid benefits at the time. Yet, now, I'm seeing they were paid through a legal funding entity.

That goes to the reasonable costs involved, possibly for collateral sources, but it might be something else, particularly with a lien. That's why I'm making inquiry because I don't know that and they're going to be asking the jury for past medical costs.

MS. HOLLAND: We have to deal with the issue of past medical costs and we'll have to deal with the bills before this Court, before the jury gets the case and we can deal with the bills then. Okay? Everybody who gets Medicaid -- just because a person has Medicaid doesn't mean the doctor's group accepts Medicaid. Okay?

And on the issue of whether or not she was Medicaid eligible or whether or not there's a collateral source, all of that information is delved into at a collateral source hearing. It is not proper to do this in front of this jury. Okay? So I'm renewing my application, again, that there be no further questions regarding liens and funding.

MR. VAN ETTEN: And, as I said, he said he doesn't have the knowledge and I was going to stop asking that, but I believe I had a reasonable inquiry if they had a lien on her litigation --

THE COURT: Okay.

[!EZ SPEAKER 02]: -- and they could have.

THE COURT: Okay. So I'm granting Ms. Holland's application. You will stay away from lien, you will stay away from funding, you --

MR. VAN ETTEN: Well, yeah, absolutely.

THE COURT: Stop, I'm speaking.

[!EZ SPEAKER 02]: I'm sorry, I apologize.

THE COURT: I permitted you to ask the question of the doctor, does New York Spine Institute have a, I believe you said financial interest, maybe you said vested interest, I'm not sure. I allowed you to ask that question, the witness unequivocally said no.

We're moving on.

[!EZ SPEAKER 02]: Absolutely.

THE COURT: You have your exception.

[!EZ SPEAKER 02]: Absolutely. Thank you.

(Whereupon, the following takes place in open court, in the presence of the sworn jury.)

THE COURT: The jury is going to take a five-minute bathroom break.

(Whereupon, a short recess was held.)

THE COURT: The jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: Go ahead, just right back to your seats. Okay? Mr. Van Etten is in the middle of his examination. He's going to continue now.

MR. VAN ETTEN: May I continue?

THE COURT: Please.

MR. VAN ETTEN: Thank you.

Q Okay. Ms. Watson comes to you, Ms. Holland asked you about taking a history, correct?

A Yes.

Q It's the first thing you do, basically?

A Yes.

Q History is very important for patient care, true?

A Yes.

Q Okay. Why is it important?

A Because of multiple things. As I said before, and I repeated before, it's really important because you are going to have related to injuries and the complaints of the patient are consistent with the mechanism of the injury in this case.

Q Okay. When you say mechanism of injury -- and let me just see if we can clear that up a little.

You can have mechanism of injury from trauma, true?

A Uh-huh.

Q True?

A Yes.

Q You can have, though, a mechanism of injury with a back

or spine from degenerative disease, true?

A Yes, but it's not the same. You can cut it, yes.

Q Exactly. Well, because when you say mechanism, most people think mechanical, like Ms. Holland said, a fall or you said a car accident or something like that, but back or neck problems can be degenerative, true?

A Well, to answer the question -- I'm not going to say mechanisms of injury. Maybe -- I'm sure your English is better than me, but when you talking disease, you have hepatitis, you're going to ask -- it's not spine, hepatitis. It's not the mechanism of the injury, it's the disease that is coming for some point. Okay? Not necessarily everything is going to be mechanical. When you say mechanism, mechanical. Not everything is mechanical.

Q I understand that, but what I'm talking about, you've treated patients with arthritis, correct?

A Yeah. Not anymore. Yes.

Q Okay. And sometimes -- and we'll take it as a different example because I think you said you had done other types of orthopedic surgery with replacements, right?

A Correct.

Q Hip replacements, knee replacements?

A Correct.

Q And, usually, a hip or a knee replacement, that's because degenerative arthritis gets to the point where it takes

out everything there, you've got to put a new joint in, fair?

A Correct.

Q And that's not trauma, correct?

A Correct.

Q Because that's degeneration over time, correct?

A Correct.

Q And that can happen with the back or neck, true?

A Correct.

Q Okay. So is that a mechanism -- if it's arthritis and degeneration, is that a mechanism? That's what I'm just not clear of the word. I want to make sure we're on the same page.

A That is what you call a history of patient illness.

Q You called it what?

A That is how you call it API because you don't want to ask only it happened yesterday, maybe it was happen over years, that is why it's degenerative, what you're referring to.

Q Correct. So it is important then when a patient comes in to give you an accurate history.

Would that be a fair statement?

A Yes.

Q And when you ask a patient about their history of present illness, do you also inquire if they've had prior illnesses or injuries?

A Normally, in these cases, yes, I think I ask that.

Q Okay. And that can be very relevant for you when

trying to make a diagnosis?

A Not necessary, but yes.

Q And it can also, in certain instances, help you in making a prognosis for your treatments?

A Can you repeat the question, please.

Q Sure. Let me give you a hypothetical. Let's say a person has a prior problem with the shoulder, and the shoulder is giving them lots of pain, and giving them weakness in the arm. When you examine them, would you -- and they're also telling you they have a neck problem.

Do you not have to determine the role the shoulder plays with the complaints, as well as the role of the neck?

A Those are two different things. That is history of present illness. You're trying to find out where it's -- I have a lot of patients that's coming for the shoulder today, I don't even touch it. Send them today to a shoulder specialist.

Q Right. And in this particular instance, when Ms. Watson saw you the first time, she told you she had no prior history of neck or lower back pain, correct?

A Correct.

Q And you talked about some MRIs you reviewed, correct?

A Say again.

Q You talked about MRIs that you reviewed?

A The MRIs?

Q Yes.

A 2020, yes.

Q Okay. And you are now aware today that before you saw Ms. Watson and before you saw the films from November -- sorry, from September 18, 2020, there is a prior MRI for the cervical spine?

MS. HOLLAND: Objection.

THE COURT: Sustained.

Q Well, sir, if you're seeing a patient, would you want to have their full records and history?

A No.

Q No?

A I don't need it, no.

Q Okay. Let's go to your examination then for a second, and I'll come back to that. In your examination, you found -- you did an orthopedic examination, correct, on Page 2?

A First day?

Q First day.

A Yes.

Q Okay. And you found various issues with the right upper extremity, correct?

A Correct.

Q And you talk about the ligament was examined, Spurling sign positive, and I think you said the ligament was a typo?

A Yes, we clarified that.

Q All right. By the way, the last page of that report,

you signed it?

A Yes.

Q So you reviewed this report, signed it, and didn't correct it when you did it?

A I said that, and I'll verify again, you -- sometimes you don't even know this, and you don't review all the reports because it's never going to be possible. It's a typo, yes.

Q And you also corrected on page 1 where it says she is complaining of minimal back pain.

And now you're saying that your note that you signed was an error, and it wasn't minimal back pain, fair?

A It's not making sense, correct.

Q Okay. It doesn't make sense that somebody can come in and say they have a small amount of back pain?

A No, because --

MS. HOLLAND: Objection. That's not what he said. I object to that.

THE COURT: Overruled.

Q Have you had patients come in when they're having a neck complaint, and then say they also have a small amount of back pain?

A Yes.

Q Have you had that? Yes. That's my question, yes or no.

MS. HOLLAND: Objection. I'm just going to ask --

THE COURT: Let him answer.

MS. HOLLAND: -- that the witness be able to answer the question. Thank you.

A Yes, I've had patients with that. But, in this case, you can see that the patient -- that is a typo. And if you read the note, the patient have significant neck pain related to her left upper extremities in the beginning, but also have lower back pain radiating to right lower extremity. It's not minimal. It's not reported there. It's not significant.

Q Okay. Now, Doc, going back to that physical examination, you found, as I said, certain things with the right upper extremity that were not normal.

Would that be fair?

A Correct.

Q All right. Can you tell me in your examination -- by the way, the right upper extremity, does that include the right shoulder?

A Yes, correct.

Q Okay. And did you record in that note the presence of arthroscopic portals from a prior right shoulder surgery?

A No, there's no reason.

Q Were you aware she had a prior right shoulder surgery when you saw her?

A I don't recall.

Q Well, is it anywhere in your note?

A I do not recall if I -- you asked me a question.
Q Please, look at your note and tell me.
A I don't think it's in the note.
Q It's not there, correct?
A It could be no. Yes.
Q Okay. And we have all of your visits from 2020 to 2024, and you make no reference to the right shoulder surgery that was undertaken in 2019, true?
A Correct, not there, yes.
Q And you talked about some of the weakness in the right arm, correct?
A Correct.
Q Are you aware that Ms. Watson testified that she had weakness issues before her right shoulder surgery?
A Could be, yes.
Q Are you aware that Ms. Watson, after she had the shoulder surgery, was given a note by her doctor placing her on restrictions for a year, and to be careful how much she lifted because of the weakness in her right arm?
A Okay. No, I was not aware.
Q Well, 2019 to 2020, close in time, fair?
A Yes.
Q Did you think that maybe then the right shoulder, had you known about it, would've been something you could inquire about?

A No, because I did the physical exam. Besides the spine, I was -- I'm orthopedic surgeon, and the symptoms of the patient are coming from the spine. Sometimes they are coming from the shoulder, we're aware of that, and even I sent her to the shoulder specialist. It was not the case.

Q And sometimes, though, Doctor, when patients come in, you have to distinguish between the neck and the shoulder because of how the dermatomes and the nerve root distribution goes through the arm, correct?

A Yes, but it's not the right explanation. The shoulder pain could be coming from the neck, from the shoulder, or from both.

Q Exactly.

A That is explanation.

Q And that's something you have to examine and consider as a spinal surgeon before you do surgery, right?

A That is why I examine the patient.

Q But you didn't even know she had prior shoulder problems.

A It's not related to the shoulder.

Q And I want you to assume she also told this jury on the direct examination by her attorney, that before the shoulder -- the pain she was getting before the shoulder surgery started in the neck and ran into the shoulder. Were you --

A No, it's not. It's starting in the neck and was

running between the shoulder blades. That was the thing, behind the shoulder. That is not shoulder. But I want to explain, so everyone understand, you're pointing me here. This is not shoulder. This is not shoulder pain. This is trapezius pain. It's coming from the disc herniation at this C3-C4. If I can explain about medicine, this is not shoulder pain. Shoulder pain is going to be in this part of the pain.

Q All right.

A The patient -- the way difference between shoulder and neck is going to be -- when you ask the patient in an exam, if you're having shoulder problem, she's not going to be able to raise the shoulder. If she has a neck problem, she's going to be able to do this. That is why it's not included about the right shoulder.

Q My question -- if I -- I'm not sure I understood you, so please correct me if I'm wrong. But then you said if it comes -- starts the pain here and goes this way, it's not shoulder pain, it's neck pain, correct?

A No, I didn't say that.

Q Okay.

A I say -- no, the shoulder -- pointed to the shoulder. It's nothing to do with what I said.

Q Okay. But if a person has pain starting in the neck running this way through her back, would that be a symptom of a neck problem?

A As I explained before, I said it was not clear. That is a typical pain the C3-C4 disc herniation is going to give you.

Q Okay. So if Ms. Watson was complaining of that pain before her accident on August 24, 2020, wouldn't that be part of a prior pre-existing symptomatic neck problem?

A I will ask you a question because I don't have --

THE COURT: Doctor -- Doctor --

THE WITNESS: Yeah, I'm sorry.

THE COURT: -- you can't ask him a question.

THE WITNESS: No, no, no, it's okay. But I cannot --

THE COURT: Everyone stop. Stop.

Ms. Holland?

MS. HOLLAND: Yes, I want to object --

THE COURT: Yes.

MS. HOLLAND: -- because there's a lot of pain going this way and that way, and there's no record being made of any of this, so if it's ever read back to anybody, nobody's going to know what the witness or the lawyer was referring to. That's my first objection.

THE COURT: What's your second?

MS. HOLLAND: I forgot.

THE COURT: That's okay. As to the first objection, I would agree. Let's just be -- Mr. Van Etten,

let's be better when we're saying pain starting here and radiates here, for the record, what you're reflecting -- what you're pointing to. Okay?

Q What I'm trying to tell you, Doctor, okay, in this instance, I want you to assume that Ms. Watson on the first day of testimony pointed this jury to the back of her neck up -- around midway to her neck, and said she was having pain there, and it was running down through her shoulders going down her arm into her body.

MS. HOLLAND: I object to counsel's characterization of what my client testified to.

MR. VAN ETTEN: The jury would be the ones to interpret what the witness described and showed them.

THE COURT: Okay. I will allow the question.

Doctor, can you answer?

Q Okay. Assume that. Okay? Can you assume that, yes or no?

A I don't know. It's not too clear because I cannot assume that.

Q Okay. You can --

A You're telling me this. It doesn't mean it could be this. It's another situation.

THE COURT: There's a lot of -- again --

Q Can I just ask you to assume that -- this is all I'm asking, Ms. Watson was complaining of pain in her neck before

August 24, 2020.

Can you just assume that?

MS. HOLLAND: Objection. That was not her testimony. I'm going to object to counsel's characterization of Ms. Watson's testimony.

THE COURT: Ms. Holland, your laptop is going to die. You might want to close the lid on that.

Okay. Read what she testified as to, and ask your question.

MR. VAN ETTEN: I'm going to it, Judge.

THE COURT: Okay.

Q Okay. Question -- page 118, line 4.

"QUESTION: I want to ask you some questions about your right shoulder -- about your right shoulder prior to August 24, 2020. Did you ever experience right shoulder pain before August 24, 2020?

ANSWER: I did.

QUESTION: And can you tell us where the pain was when you were experiencing the pain?

ANSWER: It was just, like, a triggering pain from the start -- that start from my neck, upper part of my neck, all the way down. It stopped to my shoulder.

QUESTION: And it was your right shoulder; is that correct?

ANSWER: Yes. Correct."

Q Page 119. Line 11.

"QUESTION: Did Dr. Babatunde send you for any type of tests to see what was going on with that area where you were feeling the pain, like the neck area into the shoulder?

ANSWER: Yes."

THE COURT: Okay. Now, Mr. Van Etten -- Doctor, listen for the question.

Q Now, having heard that, with pain at the of the neck going down into the shoulder, can you make that assumption that that is what Ms. Watson has told this jury she experienced before August 25, 2020?

A Absolutely. It's a totally different situation.

Q Okay. But she complained of pain starting in her neck, correct?

A It doesn't matter. Yes, that's what she said.

Q In your record, did she complain to you of ever having any pain in her neck, yes or no?

A I didn't understand.

Q Did she ever tell you she had pain in her neck before August 2020 --

A No.

Q That is an incorrect history that you got from her, fair?

A No, not necessarily.

Q Okay. When you came in and you made a causation

connection before, when you were asked if everything was caused, okay, you were also asked about things on how the trauma occurs that can cause a herniation.

Do you remember saying that before?

A Uh-huh.

Q Yes or no?

A Yes, I'm sorry.

Q All right. And you said stuff like twisting?

A One of the mechanisms.

Q You said twisting, fair? You said car accident, which is a big trauma, correct?

A Yes.

Q Okay. And did you ever find out anything about how Ms. Watson may have sustained an injury on August 24, 2020, when the ceiling fell?

MS. HOLLAND: Objection.

THE COURT: Can I just have it again. I'm sorry.

Q What do you know was the cause of -- sorry.

Did she twist?

THE WITNESS: May I answer?

THE COURT: If you can.

Q Did she twist, yes or no?

A I don't know. The patient is not going to remember that. If you are hit in your head, you are not going to remember. I see these patients 20 times a day. They say they

fell on their head. They don't remember it was -- and knocked down. She lost consciousness. You know, no. I'm telling you what happened when this happened, how the neck is injured, or the shoulder, whatever. Normally, it's a twist mechanism. The patient is not going to remember. The ceiling fell on her head, looking down.

MR. VAN ETTEN: Move to strike as nonresponsive because I asked him yes or no.

MS. HOLLAND: Objection.

THE COURT: That was nonresponsive. Ask the question.

Q My question is, sir: Do you have anything in your records or your memory indicating that she told you she sustained a twisting injury?

A No.

Q Okay. You don't know what the mechanism of injury was because you weren't there, fair?

MS. HOLLAND: Objection. That is not --

THE COURT: Overruled.

A Say the question again, please.

Q Sure. You don't know what the mechanism of injury was because you weren't there, fair?

MS. HOLLAND: Objection to the form of the question. Of course the doctor wasn't there. It's argumentive. Objection.

THE COURT: I'm going to overrule.

Is that a fair statement, sir?

THE WITNESS: Correct. Yeah, I was not there.

Q Okay. And you don't even know if the falling ceiling actually struck her, true?

MS. HOLLAND: Objection. It's argumentative.

THE COURT: Sustained. Now, it's getting to be much. Ask another question, please.

Q Okay. You said in your record she sustained a loss a consciousness, correct?

A Well, that is what I said is there. Yes, correct.

Q And that's because that's what she told you, correct?

A That's what we have for her.

Q I'm going to show the records from the hospital, and the prehospital care report. These are marked as Plaintiff's 1 in evidence. Doctor, looking at this, the prehospital care report, right here, I know it's tough to read.

Do you see right there where it says denies loss of consciousness?

A Right.

Q Do you see that from the day of the incident?

A Yes. That's okay.

Q Okay. So that would be indicative of lack of loss of consciousness, true?

A This is more -- whoever wrote it there, yes.

Q Yes. And are you aware it also says that in the hospital record?

A That is the hospital record.

Q This is the ambulance. There are more people that say it.

A Okay.

MS. HOLLAND: I'm going to object. I'm going to object. If counsel is going to show the doctor a hospital record regarding a notation of -- did not lose consciousness, then he needs to show the doctor the completes ER record, where it later states -- and I read this out when my client was on the stand -- okay?

MR. VAN ETTEN: Judge, can we please have the conversation --

THE COURT: Everyone stop.

MS. HOLLAND: I'll stop.

THE COURT: Stop. Stop. Can we just make this very simple? We all agree the doctor was not there that night.

MS. HOLLAND: Right. My objection is different and I apologize for the speaking objection. My objection is --

THE COURT: Can we speak then, if there's more. Let's speak -- let's have a sidebar. Okay. Thank you.

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

Q I will just do it real quick again, Doctor. I will

show you the same note, right after the no loss of consciousness. Patient has no obvious injuries or bleeding, no obvious deformities?

A Correct. Yes, the same thing that she said. Perfect.

Q Okay. And I just want you now to assume that similar notes are in the hospital record, but there is also one note that says she may have had some vomiting, and that she is not sure if she loss consciousness. So there were other notes, to be fair. Okay?

A Okay.

Q My point was, though, Doc, is you were told that there was no loss of consciousness, and you only go on what the patient tells you, fair?

A Yes.

Q Okay. And did the patient ever tell you that she had had a prior MRI on her neck before you treated her?

A It's not in the --

MS. HOLLAND: Objection.

THE COURT: Overruled. He said no.

Q Now, you are making a causative statement to this jury saying that, because of what happened, it was her injuries that you are seeing her for, were all caused by this accident, correct? That's what you --

A Say that again, please.

Q You told this jury, on Ms. Holland's question, that her

injuries you were seeing her for were all caused by this incident, correct? That's what you said?

A Yes, to a reasonable degree of medical certainty. Yes.

Q Okay. And when you saw Ms. Watson, and you looked at the MRIs -- because you said on that first date, your first impression was based upon your examination, the history you got, and the MRIs?

A And complaints of the patient, yes. Four components, yes.

Q And your records, by the way, with your company when they do it, you talk about discs or otherwise, your records show that you get discs in and they have separate little reports where they log in when you get CDs, correct?

A What?

Q Pieces of papers are served by the office people, when you get a CD, for example? I will show it to you real quick. It might be in the subpoenaed records.

How does CDs get logged into your company when you get a CD from Stand-Up MRI?

A I have no understanding from Stand-Up MRI, personally.

Q Your company, when they get a CD from Stand-Up MRI, how does it get logged into your chart?

MS. HOLLAND: Objection. There's been no evidence his company received CDs from Stand-up MRI.

MR. VAN ETTEN: I asked him --

THE COURT: Stop, stop, stop.

MS. HOLLAND: Objection.

THE COURT: I'm confused, as well. I'm confused, as well. When his medical office receives a CD from an outside the facility, the question is what procedure --

Q Do they have a sheet that says it?

A No.

THE COURT: The answer is. No move on, please.

Q And in your chart, what is in evidence, films and report from Stand-Up MRI, which had been marked into evidence as Plaintiff's 21 --

THE COURT: What's the date on those MRIs?

MR. VAN ETTEN: I'll get to that in a second. I was --

THE COURT: Go ahead.

Q Did you get multiple reports from Stand-Up MRI while you were treating Ms. Watson?

THE WITNESS: May I answer?

THE COURT: Please.

A It's not the way that it works. Like, when I log in in the system, there's two ways -- can I clarify because I think everyone is confused. There are two ways that I can see the MRI. One way is the patient, not my office, the patient bring in the CD to me, they load it, I read it personally. The other way is getting to the site. I get -- I see them and I do the

interpretation. And at the same time, I read the report because I know the report is going to be used in a situation like this or for insurance for denying surgeries. That is not a correct report. That is why I do both. Okay. Sometimes I have the report. The patient normally brings the report.

Q Okay. Do you have the report -- because you said you showed the jury the September 18th, 2020, films.

Do you have the report?

A I got it when I log in. If you let me log in, is the report there, yes.

Q Do you have it in your chart?

A I don't know if it's in my chart.

Q Can you check that, please.

THE COURT: He's looking for an MRI report from Stand-Up MRI?

Q Just identify --

A For 2021, 2020 -- 2020, you said?

Q Yes, 2020. The September 18, 2020.

A I don't think I have 2020 here, but I'm pretty sure I read it because I read it from the side.

Q Well, if it's in your report from the first visit, you did look at that, correct?

A As I said, I do my own interpretation, but I'm not -- I read the reports listed on the site because the site had both things. Yes. I know, and I remember the report because I read

it last night.

Q Okay. I will show you then Plaintiff's 14.

Is this the September 18, 2020, report that you looked at?

A Yes.

Q Okay.

A It's -- yes.

THE COURT: Okay. Wait for a question.

Q All right. Now, it identifies what it is that you're seeing, a correct, an MRI of the cervical spine?

A Yes.

Q And it tells you the techniques that's being used?

A Yes.

Q And what is the next line on that report? Right after --

A And the comparison to 2019, correct.

Q It says comparison study May 24, 2019?

A Correct.

Q So that would be a prior MRI film for Ms. Watson, correct?

A Correct.

MS. HOLLAND: So I'm going to object to this because when I tried to question the doctor about this, I got an objection.

THE COURT: Okay.

MS. HOLLAND: Okay? I got an objection.

THE COURT: I trust this is wrapping up right now. Ask your next question.

Q My question is to you, sir: That you saw -- when you first saw this patient, then on your first visit, because you said you read this, true?

A Yes.

Q Okay. That there was a prior MRI film of her, true?

A Yes.

Q And you told us earlier, by Ms. Holland, that you never reviewed those films from before until you came in here for trial, true?

MS. HOLLAND: Objection. That wasn't his answer. He said he could not recall.

THE COURT: Overruled. Overruled. Doctor?

A I don't recall reviewing them, no. But it's not important for my treatment of the patient.

Q Doc, I agree.

A I don't recall if I reviewed or not.

Q I agree with you, Doc. It may not be important for your treatment, but when you are telling this jury about causation, and there's a prior film of her neck, isn't that important if you are going to be accurate on whether it's causally related, if the prior films may or may not show something?

A Yes.

Q Thank you.

A At my review of them --

THE COURT: Doctor. Doctor. Doctor.

Q But, Doc, here's my point. Look at your report at the ends. You said on that first visit is was causally related, didn't you?

A Yes.

Q But you are hadn't looked at those films when you made that statement, did you?

A Yes, it doesn't matter. Yes.

Q You didn't look at them?

A It doesn't matter to me.

Q Okay. So when you said from day one of your treatment that it was causally related, you did not have all of the information because you didn't have those films, true?

A I do not recall if I had it, but it has nothing to do -- it's not the fils that relate -- we don't treat films, sir. We don't treat films.

Q If you can't answer it true or yes or no, please, let me know and I will rephrase.

A Okay. Whatever.

Q My question to you, though, is: On that first date when you made your first statement of causal relationship, you did not have all of the films of your patient; isn't that true?

A Could be or not. Yes.

Q Okay. And you now know that with the prior neck complaints that we just read to you and other films, that there is a prior history involving the neck, true?

A No.

Q And you were told there were no prior problems with the neck by your patient, true?

A No, because I don't have the records. The doctor request that. A lot of doctors request the neck when they have shoulder pain just to be sure. That is the point. You are telling me something that you are supposed to be doing. I'm telling you the medical part. I don't care if the patient -- the patient never have the symptom that they have in this moment. We don't treat MRIs.

Q I understand that, Doctor. But I, as I said to you before, for the purpose of your treating her, that's up to you whether you go back and look at her other films.

MS. HOLLAND: Objection. Judge, is there a question here?

Q My question to you, though, to come into court and tell everybody something about causation, don't you need all of the records?

MS. HOLLAND: Objection. This is asked and answered.

THE COURT: This is asked and answered. Mr. Van

Etten --

Q Doctor, you're are aware -- and I think you said about disc degeneration, correct?

A Say it again.

Q Disc degeneration, you're aware of that?

A Yes, it's a condition. Yes.

Q That's part of the aging process?

A Yes.

Q Are there -- and disc degeneration can't cause herniations, correct?

A Not the same disc herniation that she has here.

Q Did I ask you about this one or did I say in general, Doctor?

In general, can disc degeneration cause herniations, yes or no?

A Not this kind of herniation.

Q Doctor --

THE COURT: Doctor. Doctor --

A I understand what you're saying. It's going to be different.

Q Okay. They can cause -- disc degeneration can cause herniations, correct?

A They are called disc herniations, osteophyte complex. It's another entity.

Q Osteophyte complex is different though, Doc. That's

when you get bony growth. I'm talking -- let me ask you this, Doc.

The MRIs of the lumbar spine, they show disc desiccation, correct?

A Yes.

Q Okay. And disc desiccation, that's a drying out of the disc, correct?

A Disc desiccation, yes.

Q Right. And disc desiccation can cause a herniation, correct?

A No.

Q No?

A No, it's not related.

Q Disc desiccation doesn't cause herniation?

MS. HOLLAND: Objection. Asked and answered.

THE COURT: He said no. Next question.

Q Now, Doctor, are there other -- are there issues that people can be predisposed towards getting disc herniation?

A Say it again.

Q Predisposed, can there be congenital issues that can cause disc herniations?

A Congenital thing that cause disc herniations? There are described cases of families that they have some DNA problems that all the family have disc herniation, and need surgery when they were ten years old. There are some cases in--

Q But there are other things -- I mean, some times that you can have, if there is some type of physical ailment which causes more wear and tear, a back can wear out or you can get a disc herniation, correct?

A Say it again.

Q If you have some other part of the body -- you mentioned hips before. I think you said you've got to look at the hips.

If you've got a bad hip and it's causing a person to walk the wrong way, the disc can get infected and that can herniate, true?

A Yeah, but not a disc herniation.

Q Bulge then? Will it bulge, not a herniation. Is that what you're saying?

A No, it has nothing to do with the thing.

Q Are people that are overweight predisposed to having degeneration in their spine?

A Correct. It's a condition.

Q So that's yes, correct?

A Yes.

Q So being overweight can cause that degeneration, correct?

A Degeneration, yes.

Q And what's levoscoliosis?

A What is --

Q Levoscoliosis.

A Levoscoliosis, it's a deformity of the spine, could be that in children, that is what I like to do. Could be in adults, that is degenerative. Yes.

Q And Ms. Watson has levoscoliosis in her spine?

A Not significant, no.

Q Isn't it in the Stand-Up MRIs of her lumbar spine at L2? You have your records, can you --

A Say it again.

Q Is it in her Stand-Up MRI films at L2 that she has levoscoliosis? They're there. Do you remember that?

MS. HOLLAND: Objection.

THE COURT: Hold on. Everybody stop.

Doctor, you have the Stand-Up MRI in front of you. Take a look at it. He's asking you a question about it.

MR. VAN ETTEN: Your Honor, to speed it up, let me show you the September 18, 2020.

THE COURT: Thank you.

Doctor, look at what Mr. Van Etten is showing you.

Direct his attention to what you want him to see, please.

Q It's highlighted and underlined in red. Does that say levoscoliosis in l2?

A Yes, it doesn't mean anything.

Q Okay.

A Okay. Good. That is the name. One level is scoliosis, correct.

Q So this is another document that you possessed that showed you from the first time that you saw her that she had -- and levoscoliosis is something that you are born with, correct?

A No.

Q Does it develop over time?

A Say it again.

Q Does it develop over time?

A It could.

Q Well, how do you get levoscoliosis?

A It is one level of scoliosis. That is not scoliosis. We are going to talk -- can I talk to a doctor? Because I'm answering question that --

THE COURT: Doctor. Doctor, you have to answer the questions as they are posed.

A Levoscoliosis one level doesn't exist. I don't know who put that.

Q Well, the person, to answer your question, who put it was the MRI facility that you relied on when you made your causation diagnosis, that's who put it.

Are you aware of that?

MS. HOLLAND: Objection. Objection.

THE COURT: Ask the question.

Q Are you aware of that?

MS. HOLLAND: Objection.

THE COURT: He read it. He sees it. He doesn't agree with it. Ask a question, please.

Q Are you aware of other parts of the medical history of Ms. Watson?

MS. HOLLAND: Objection.

THE COURT: What part, sir, please?

Q In addition to -- do you know what her weight was when you first saw her?

A Say it again.

Q Do you know what her weight was when you first saw her?

A I don't know if it's there or not. I don't know.

Q In your first report, you said before that you only examined the neck and the back, but didn't you do a full workup of her?

A Yes. Let me see if we put the weight there. If you have it and want to give me?

Q I'm asking you, as her treating physician, if you know what her weight was when you saw her?

A I don't have it written here.

Q Okay. Thank you. Did you look at any other records to determine what her weight was? Because you said that someone being overweight, that can affect degeneration, true?

A Yes.

Q Okay. Did you look into that issue while you were

examining her and considering her treatments?

A I'm not talking about degeneration here, never. You're talking about that.

Q Are you aware that she had surgery for a breast reduction?

MS. HOLLAND: Objection.

THE COURT: Overruled.

Are you aware, sir?

THE WITNESS: No.

Q Are you aware that there are people that have back problems, women, who have to get breast reductions to ease the procedure on their back or neck?

MS. HOLLAND: Objection.

THE COURT: Overruled.

A It is not a yes or no question. Can I answer from the medical standpoint?

THE COURT: He can't answer.

Q Have you ever treated any patients that you are aware of that have had breast reductions because of back or neck pain?

A I don't treat that. I sent them to a medical doctor because they're not surgical. It's lower back pain.

THE COURT: He hasn't treated. Next question.

MR. VAN ETTEN: But I was -- but my question wasn't about treating.

A I know what you're saying, but I'm not going to answer

what you want.

Q But if you saw somebody with that type of problem and you thought that that could help them, you might refer them you said to somebody else to get a breast reduction to ease the pressure on the back or neck, true?

A I said before that we don't treat lower neck pain or back pain. I'm not crazy. I don't really care. We collect pain -- lower back pain or neck pain, I'm not treating that. I send to a medical doctor to treat that. We're treating nerve injuries. That is not going to give it to you.

Q Now -- okay. When -- you were talking about the recovery from the surgical spine surgery, correct?

A Uh-huh.

Q You talked about a few of the residuals that she was still having?

A Yes.

Q And when she was at NYU Langone before she was discharged, did you and your staff have to examine her?

A Yes. Could be me, could be my PAs, yes.

Q All right. The NYU Langone Hospital records are Plaintiff's 13 in evidence. All right. I'm going to show you some records from NYU Langone. With the Court's permission, I will approach you again, though I haven't asked for permission previously.

Does this look to you, even though it's in evidence, to

be Ms. Watson chart?

A Uh-huh.

Q Okay. So when she went in for surgery, it was elective surgery; is that correct?

A Correct.

Q Okay. When they examined her as part of her overall review, this is part of the discharge --

A Okay.

Q -- they addressed, in fact, obesity as an issue with her, correct?

A It's mandatory from mostly NYU, but mostly every hospital. Yes.

Q And just so the jury knows that I'm not a crazy person, it talks about past surgical history?

A Yes.

Q And what is the first one?

MS. HOLLAND: Objection.

Q Does it say breast reduction surgery?

A Yes.

Q Okay. Now, let's go to the measurements. Discharge exam by Dr. Shafford (ph.).

Do you know Dr. Shafford?

A Had to be one of the residents, a first year probably.

Q Can you tell the jury what type of examination was done of Ms. Watson by that doctor at NYU.

A After the surgery.
Q Okay. And what did he find -- or she could be a she?
A Okay. That everything was 5/5, everything was okay.
Q And that 5/5 would be motor strength and weakness, correct?
A Correct.
Q So everything on the right side and left side was completely normal after her surgery, fair?
A That means that the surgery was good.
Q That was. I think we said that before.
A Yeah.
Q And, in fact, again, there's another motor examination, also in the operative surgical post-operative note, that would be you?
A No, resident.
Q A resident would --
A Yeah.
Q And that second note, what does it say about the motor functions? Was everything normal again?
A Yes.
Q Okay. And that would be the right side, as well?
A Right and left.
Q Okay. And that note was also signed by you?
A No, this is -- I have to cosign. This is how it works at the hospital. They do the exam. I'm not even present. I

have to cosign the note because if a person calls me and says there's no red flags, everything is okay. Everything is okay. I say okay. I cosign the note saying that I agree with the resident. That's it. I was not present.

Q Don't you want to make sure that everything was fine? Do you ask the resident if everything was fine before you cosign it?

A Absolutely. They call me in the morning, and if there is a problem, we elevate it. Yes.

Q Okay. And again, the final note, again, right before discharge, the same thing, everything was normal?

A Yes.

Q So as of the date she was being discharged on December 31, 2022, there was no weakness in her upper extremity and her motor skills were normal, true?

A At the moment -- that is what is written there, yes.

Q Okay. So that means you did your job correctly?

A Probably done completely accurate.

Q And once a patient gets a surgery like she had, she has to come for follow-up visits, correct?

A Correct.

Q And you saw her afterwards, correct?

A Yes.

Q And the first thing you do, do you check to see if the wound is healing properly?

A The first time.

Q Right. And ask her questions about how she's doing, if she's having problems, anything like that, correct?

A Correct.

Q And when she gets discharged from the hospital, she gets pain meds, right?

A She gets multiple medications, correct.

Q Okay. And when she comes in on that first visit afterwards, and she is still having pain, you will prescribe pain meds, correct?

A For the first three months.

Q Okay. And do you know if you did for her?

A Say again.

Q Do you know if you prescribe pain medicines for her?

A Well, I don't have the records here, but -- normally, pain medicines, muscle relaxer, pain medicine, yes.

Q Okay. Because I -- again, maybe I'm wrong and the jury will be able to look at it.

I don't recall seeing you prescribing any pain meds after at least a month; is that fair?

A Some patients don't need it, just take Tylenol.

Q Okay. And you see her again for a follow-up visit, usually about six weeks after, give or take?

A About, yes. Yes.

Q And at that time, you evaluate the patient to see if

they can -- they are well enough to get physical therapy; is that true?

A That is what -- normally, I get the first x-ray and I ask the patient how she feels. If she's okay, I send her to physical therapy.

Q Right. And it's key for that patient to get better because as you said, to try to get as well as they can and help the nerves possibly regenerate to do physical therapy, fair?

A Absolutely not. I say physical therapy is the worst thing to happen in this country.

Q Well --

A No, I didn't say that. I said muscle strengthening programs. Physical therapy -- send a patient and say do it six weeks, they're going to pull something and get massages and there's going to be some temporary relief, but it's not what you need. And I say, you will recover when you can strengthen your muscle, that could take six months, one year, in the gym or in the swimming pool. That is what I say.

Q Okay. Let me ask you a question then, Doctor. Could you please turn to your note of February 13, 2023.

A Yes.

Q Thank you.

A Yes.

Q Do you have it? Okay. You go in there and you do the HPI again?

A Yes.

Q And the last line in that paragraph, you state patient has not begun postoperative physical therapy, correct?

A Okay.

Q Is that what you said?

A I'm trying to get it there. Six weeks -- yes, because I didn't indicate -- yes. I see the six weeks, yeah.

Q And then right on your plan, two pages later?

A Yeah.

Q Did you not say patient will restart physical therapy for the cervical spine, new referral was provided?

A Yes.

Q Because you wanted her to have physical therapy, correct?

A It's the standard of care. You asked me my personal question, and I say I don't believe it's helpful for a long time. It's not going to heal her. It's not going to improve her. It's going to be temporary relief. I think they should do it for some time, yes. I agree. And I referred six weeks, yes.

Q Your personal belief is one thing, but you made a recommendation to her; is that true?

A No. Maybe I don't explain good. I didn't say that is -- you asked me a question before that say physical therapy is mandatory. No, it's not. I don't think it's good. I think it's going to for some time. And some patients that come in say

it hurt me more, I don't want any more. And some patients come in and say it feels better, the muscles. It's not going to fix the problem, but they should try. Six weeks is the standard of care.

Q Well, throughout the rest of your records, you continually state that she was not going for any physical therapy.

Are you aware of that?

A Could be, yes.

Q Okay. So you don't think she needed physical therapy?

A If the patient said that physical therapy -- I think I don't explain myself well. It's me. It's me. It's not you. I will try to do it better. I recommend physical therapy. Some patients say I don't want to, it's a pain, it's hard to take the bus. I say try for a couple weeks and see how you do. Patients come and sit down, it hurts more, I don't like it. Okay. Do exercises at home. You don't have to have it. Okay. That is not what is going to fix it.

Q Well, on your next visit, on April 11, 2023, in your plan -- this is your plan, your note, you state it is medically necessary for the patient to attend physical therapy to continue to improve range of motion, strength endurance, and flexibility to functional limits, and to help return the patient to optimal level of function, perform activities of daily living, and for gainful employment --

A What date is that?

Q Doctor. Doctor. Doctor, let me finish my question, please.

Doctor, is that not the note that you wrote?

A May you --

Q Yes or no?

A I don't know what note. I want to read it.

MS. HOLLAND: What date?

MR. VAN ETTEN: Sure. Sorry, April 11, 2023.

A April 11th --

Q April 11, 2023, I will show it to you again, Doctor. Thank you. Sorry. That's my bad. Everything underlined and highlighted?

A Yeah, that was written by my PA.

Q Right before PA, what does it say? Cosigned by who?

A By me. I cosign sign every note. That's okay. It's part of everything, correct. Are you asking me what my --

THE COURT: Doctor. Mr. Van Etten, another question, please.

Q So, basically, then, if your PA signs a note and makes a recommendation, you don't look at it because you don't care about --

A It's not the -- it's not the wrong recommendation. You are asking me, I don't personally think. If the patient wants it, I will send. If the patient doesn't want it, I will not

send. Okay? That's not making any difference in anything. You're asking me, as a doctor, what do I believe. They can write things. They are PAs. And, yeah, I cosign notes. It's not wrong, either.

THE COURT: Mr. Van Etten, hold on. We need a five-minute break.

Ladies and gentlemen, we are going to take a five-minute break. Please don't discuss the case. Keep an open mind. Five minutes.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

(Whereupon, a brief recess was held.)

THE COURT: Before we resume, Doctor, in response to questions by Mr. Van Etten, the only correct answers are yes, no, I don't know, or I don't recall. Okay. Ms. Holland will be afforded an opportunity to ask you follow-up questions. All right?

THE WITNESS: Thank you.

MS. HOLLAND: That is, of course, assuming that Mr. Van Etten says I'm going to ask you a question. I'm going to ask that you answer it yes or no. Some of his questions are open ended.

THE COURT: Okay. Mr. Van Etten --

MR. VAN ETTEN: I will try, Judge. I usually say true or correct, instead of yes or no.

THE COURT: Fair is your other favorite.

MR. VAN ETTEN: Fair, yes, true, correct, no.

THE COURT: Be clear.

MR. VAN ETTEN: I'm trying, Judge.

THE COURT: Be clear, because if it invites a narrative, you're going to get a narrative. Okay?

MR. VAN ETTEN: I understand completely, Judge.

THE COURT: Thank you, sir.

Jury, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: Go ahead. Jump right back into your seats, folks.

Mr. Van Etten, you may resume as soon as the jurors are seated.

MR. VAN ETTEN: I will resume.

THE COURT: Go ahead.

Q Briefly, Doctor, I hd mentioned before disc desiccation and drying out of a disc. Okay?

And in your first dated report, you do note dehydration, correct?

A Of course.

Q Okay. And dehydration from a film less than a month from the incident would not have occurred overnight, correct?

A No, it's not correct.
Q Wouldn't that have taken a long time to develop, yes?
A No, it's wrong.
Q Okay. So disc desiccation and dehydration can occur in a month?
A Absolutely, yes.
Q Okay. Thank you. And when you saw the MRIs from Stand-Up MRI, right, from September 18, 2020, did you see any evidence of trauma in them?
A Say again, please.
Q Sure. When you saw the MRIs from September 18, 2020, did you see any evidence of trauma?
A I'm not sure what you mean by that.
Q Okay. Well, you know with diagnostic film studies, they can be used to diagnose when someone has trauma, fair?
A I think I -- yes. I think I understand some of the part.
Q I mean, with an MRI, if someone has had recent trauma, you will see an edema, correct?
A Well, it's correct.
Q Thank you.
A But this is --
THE COURT: Next question.
Q Will you also, if there is a significant trauma, see hemorrhages?

MS. HOLLAND: Objection as to form. What is a significant trauma?

THE COURT: Ask it a different way, please.

Q Would you also, if you had trauma, see hemorrhages?

A You could, yes.

Q Okay. Would you see subluxations, which is dislocations?

A No, they are totally different things.

THE COURT: Next question.

Q Would you see dislocations in hard films like x-rays or CAT scans?

A Absolutely. Paralyzed, yeah.

Q Okay. Would you see something called an instability of the ligamentum in an MRI if there was trauma?

A Oh, yeah. Big trauma, yes.

Q And in the MRI films that you saw from September 18, 2020, yes or no, am I correct that there was no hemorrhages, instability of the ligamentum, or edemas?

A Absolutely not, yes.

Q They were there?

A Absolutely not. They were not.

Q Okay. Thank you. Now, again, just going to the hard studies, CAT scans, or x-rays, are you aware that Ms. Watson had a CAT scan at Bronx Lebanon Hospital the day of incident?

A No, I didn't know.

Q And if I told you the record, which is before court, so we can make it go faster, was negative for any fractures or dislocations?

A Absolutely, yes. I would expect that.

Q Okay. We should have done this sooner, Doc. We should have done this sooner. Okay.

Now, is there such a thing of objective testing and subjective testing?

A Yes.

Q Can you tell the jury what objective testing and subjective testing is.

A It refers, for example, they are testing where we perform the test, and we are expecting the patient to react in a definite way. Okay? For example, straight leg raising, if it is positive, it is not going to give me pain going to the elbow. Okay? It's going to give me the pain going through the sciatic nerve. That is subjective. Okay? Reflexes could be fake, also, but it's difficult to fake reflexes. Okay? Sensory -- sensory could be faked by the patient, but it's really difficult -- but that is a defense.

Subjective is open to the patient lying or not, that you are not going to see anything. Okay? Objective is going to be not only the physical exam, but for example, diameter of the patient. That shows traumatic injuries.

Q Okay. So an MRI, an x-ray, a CAT scan, those types of

things are objective tests that you can look at and see what they show, fair?

A Absolutely, yes.

Q Okay. And, sometimes, there are tests that you administer as a doctor, like I think you said reflex tests. That's you know -- you have them sit, hammer, they go like this, or they don't move. Sometimes they don't move.

That's the one where you talked about that it could be faked or not faked, right?

A Yes. Yes.

Q Okay. And it's not just that, it could be the elbow, you do it on those types of joints, correct?

A Yes.

Q Okay. And in this circumstance, did you find evidence, at times, that Ms. Watson was exhibiting symptoms to the left side and the right side equally on her upper extremities?

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

Q Okay.

A Let me see that to be sure. I don't want to answer -- I think it was mostly one side. This is my first exam. Mostly in the right side. Okay? The weakness, yes.

Q Okay. Now, are you familiar with EMGs or nerve conduction tests?

A Yes.

Q What are they?

A They are really -- they're studies that technically measure the status of the nerve. Okay? If the nerve could have some injuries or not. They are really, really, really -- studies with great incidents of false negative. We don't use it to decide what level we're going to operate. We use it just for mostly checking if the patient have a problem in the brain or in the nerves because she can have a problem in the nerve and the EMG come back negative. You see, bigger incidents of false negative.

Q Okay. You're still treating Ms. Watson, correct?

A Yes.

Q Are you aware that she has also started some treatments with a Dr. Guy?

A I don't recall.

Q Do you know if Dr. Guy -- have you ever been given any EMGs that Dr. Guy performed of Ms. Watson?

A I do not recall.

Q The doctor that referred Ms. Watson to you, Dr. Almentero, did he do EMGs of her, and did you look at those EMGs?

A Could be. I don't recall if I looked at EMGs. No one asked for them.

Q You talked about the symptomology that you saw that you felt was consistent with C4-C5, C5-C6, with Ms. Watson, fair?

A Correct.

Q Okay. And that is a different nerve root distribution than C8-T1; is that correct?

A Correct.

Q The PMR records are marked into evidence, I believe, as Exhibit 2 -- Plaintiff's 2 in evidence. I'm going to show you the November 18, 2020, report from PMR. And I'm going to let you look at the impression here, following the EMG of Ms. --

MS. HOLLAND: I'm only going to object to this because none of this was dealt with on direct examination. It's way beyond the scope.

MR. VAN ETTEN: My cross is open.

THE COURT: I'm going to allow it.

Q Does that say that Ms. Watson had a C8-T1 radiculopathy?

A Yes, in the EMG, correct.

Q Okay. And are you aware that the EMG done at the same time that they found C8-T1 was negative -- the C4-C5, and C5-C6, as of November 18, 2020?

A I think I answered that already. It's high incidence od false negative. It doesn't mean absolutely anything. We don't use that.

Q So you don't believe that EMGs are worth while to you as a diagnostic tool?

A Absolutely not.

Q Okay.

A It's the worst thing that you can do because this is what happens.

Q Now, Ms. Holland asked you about Dr. Guy coming in and making recommendations for future care for Ms. Watson, so if he comes in and tells this jury he's relying on EMGs --

MS. HOLLAND: Objection. I object because it's beyond the scope, Judge.

THE COURT: I'm going allow the question. Ask the question and then move on. Go ahead.

Q And he says this EMG says she needs these treatments, you would not agree with that because you don't believe in EMGs, fair?

A I'm a surgeon. I'm not going to touch C8-T1, absolutely not.

THE COURT: Okay. Doctor, okay. Next question, please.

THE WITNESS: I'm sorry, my fault.

Q By the way, I looked in your first bunch of reports. The first time that you used the word -- by the way -- withdraw that, I apologize.

What's radiculopathy?

A Radiculopathy is multiple signs and symptoms that they are going to talk about, an embalmment of a nerve? Okay. A nerve distribution, specifically. Okay?

Q Okay. I've looked in your reports. And until you went

in and did the surgery -- so for when you first started seeing Ms. Watson in March of 2021, until December 30th, 2022, you never said she was suffering from radiculopathy in any of your reports; is that true?

A Of course because it's not needed. Numbness, tingling, weakness, la seg positive, all these is radiculopathy. Okay? You don't need to put the term radiculopathy. She had irritation of the nerve, and it is perfectly documented there.

Q Your diagnoses that you gave during those times, though, was a cervicalgia, correct?

A That is a billing diagnosis. It's not a diagnosis.

Q So when you're writing down the official report of your patient, and the only diagnosis is for her neck injury is of cervicalgia, that is just a billing diagnosis?

A That is a billing diagnosis. I don't even do it. The diagnosis is included in my report, what I saw.

Q These are your signed reports. You did --

MS. HOLLAND: Objection.

THE COURT: Ask a question, please.

Q Sir, are you telling me that you did not prepare these reports?

MS. HOLLAND: Objection, Your Honor.

THE COURT: Overruled.

MS. HOLLAND: Argumentive.

THE COURT: Okay. I'll allow it. Overruled. I'll

allow it. Ask you question again.

Q Are you telling me you did not prepare these reports?

A Say it again? I didn't understand the question. My report is completely there. You said radiculopathy symptoms.

Q And I'm going to show you, and Ms. Holland had talked to you about December -- October 24, 2022, report, when you were talking about the possible -- sorry -- right before the surgery of the cervical spine. And I'm looking to see where it says for the diagnosis, it has cervicalgia, correct, and then it also says -- what does it say you're the diagnosis for the back was?

A Lower back pain and not specified back pain -- that has nothing to do with the form of the report. You're trying to --

Q Okay.

A That has nothing to do --

Q It says -- all it says for a diagnosis low back pain --

MS. HOLLAND: Objection.

THE COURT: That's what it says, Mr. Van Etten. Next question, sir.

MR. VAN ETTEN: I didn't finish the --

Q And then it says unspecified back pain laterally, unspecified chronicity, unspecified whether sciatica is present.

Is that what it says in your record?

A That is billing. Someone clicking the billing thing. That's it. My exam said radiculopathy.

Q Does that say that in your --

A That is billing.

THE COURT: Everybody stop. Doctor --

THE WITNESS: I know. I'm sorry.

MS. HOLLAND: I understand. I just want to get my objection out. I'm objecting to the same question being asked repeatedly of this witness. He answered the question multiple times. Counsel asked him what it was, he said it's a billing diagnosis. I'm asking that he not be permitted to ask the same question over and over.

THE COURT: He will not ask that question again. Move on, please.

MR. VAN ETTEN: My question is, though, Your Honor, and I apologize, where it says unspecified sciatica.

Q Sciatica, we know, that is something where there's a radiation down to the lower extremities, correct?

A Yes, it's the --

Q Right. And it says unspecified, correct?

A This is diagnosis. This is a click button. You diagnose that for the computer system. That's it. You have to read my --

THE COURT: Thank you, Doctor. Thank you.

Mr. Van Etten, another question.

MR. VAN ETTEN: I'm going to keep going, Judge. Don't worry. Thank you.

Q I'm going to jump real quick because we just talked

about the back. And we talked about that Ms. Watson came back to you on November 12, 2024.

Do you have that? That's the one that was loose.

A Yes, I have it.

Q Thank you. Now, can you pull that one up right there, and go to the treatment part.

A Yes.

Q Okay. And again, we've talked about what you said before about her being a candidate for lumbar surgery when Ms. Holland was asking you. But on that date, which is less than a month ago, you discussed that issue with Ms. Watson.

And she told you she didn't want surgery, she wants to continue conservative treatments, correct?

A At this time, she want to continue conservative treatments, correct.

Q Okay. So she told this jury that she told you on November 12, 2024, she wanted surgery, either she or you are incorrect.

Would that be fair?

A No, she is a candidate for surgery.

Q No, no. But she said she wanted it, and you said she --

A I'm reading what I have in my notes. I offered surgery, and she doesn't want it yet. That's it.

Q And in that first note that you talked to Ms. Holland

about from March 30, 2021, you said she would be a candidate -- could be a candidate if her symptoms worsened, correct?

A Doesn't respond to conservative treatment, correct.

Q That's what you said?

A Absolutely, yes.

Q All right. Oh. When you said to make her a candidate -- I forgot. You were talking about her being a candidate either for cervical or for the lumbar surgeries, you had said she should go, I think, first, to have further conservative treatments before she had the neck surgery, correct?

A I think she -- well, it's an option. I gave the option. But for surgery, because I do believe she already exhausted the conservative treatment, it's getting worse, but she had the option to keep doing it.

Q Let me ask you about those conservative treatments because you also said this wasn't an emergent condition when you saw her, correct?

A Absolutely.

Q Okay. So, normally, when a patient comes in -- and I think you used the word inflammation before; is that correct?

A Yes.

Q Nerves get inflamed sometimes?

A Swollen, I said, yes.

Q Swollen and inflamed?

A Yes.

Q And one of the primary treatments that you can get is prescribing an anti inflammatory medicine, true?
A Yeah, they did it.
Q True, yes?
A Yes, they did it. Yes.
Q And anti inflammatories could be something like Naprosyn, that's an anti inflammatory that you can use?
A Yes.
Q Okay. There's lots of them, fair?
A Yes.
Q Okay. And if a regular over-the-counter -- not over-the-counter. If a prescription to, like, Naprosyn doesn't work, you can use stronger anti inflammatories, correct?
A It -- I imagine whoever prescribed that, yes.
Q Steroids can be used, correct?
A Yeah.
Q And if steroids don't work, that's when they sometimes will go to epidural steroids, correct?
A Well, it's up to the patient.
Q I'm sorry?
A It's an option of treatment. It's up to the patient. It's not mandatory, yes.
Q Okay. It's up to the patient, fair. But, in this case, other than maybe Naprosyn, are you aware that at no time had Ms. Watson ever gone to steroids or epidural injections

before she saw you?

A Did you read the first part of my note -- the first note?

Q Yes.

A Patient tried extensive -- patient is not coming to me for treatment. They're coming referred to me because they failed conservative treatment for surgery. Patient tried extensive conservative treatment, including physical therapy, anti inflammatories, muscle relaxers, pain medication, without significant improvement. That is what she tried.

Then when she see me, I say listen, this is not an emergency. This is not. You can try everything again. You can try injection. And then they ask, injection is a stupid thing. You can have complication with injection. When they talk to pain management, it's an option of treatment. It's up to you. That's what I said.

Q My point was, Doctor, if you just have -- and, again, you don't know exactly what type of antiinflammatory she was given, fair?

A It doesn't matter, yes.

Q But my point is, before you want to do surgery, particularly with a nonemergent surgery, would it not be the best option to use all available conservative means of treatment? Not saying what it was, would that not be the best practice?

A Everything is written there. Okay? Everything. I don't want to have problems. I want to get out of here. Everything is there. Don't play doctor with me. I put here that the patient underwent conservative treatment. Right here. In this country, conservative treatment is six weeks of physical therapy, fail. Anti inflammatories are not included, but I could be. Injections are not the standard of care, but I offer it to the patient. Patient exhausted conservative treatment per standard of care. She is getting worse. She is a candidate for surgery. It is not an emergency. I'm pretty clear with the patient.

THE COURT: Thank you, Doctor. That's what the report says.

THE WITNESS: Sorry.

Q Do you know if she was compliant with that conservative care? In other words, did she follow the instructions of the therapist that treated? Her did you check on that?

A No. She was referred to me by Dr. Almentero. She is referred to me because he did it.

Q Okay. Now, on your last note November 12, 2024, you indicate that Ms. Watson was only using over-the-counter medications as needed, correct?

A What date? Yes, whatever I put there is what I put there. Yes.

Q And that's because your surgery the neck was

successful, and her back pain was not so bad that she needed stronger medicine, true?

MS. HOLLAND: Objection to the form of the question.

THE COURT: Ask it a different way, please.

MR. VAN ETTEN: Sure.

Q If she was only using over-the-counter medication when you last saw her, would that be an indication to you that her pain level was not severe?

A The pain level where, in the lower back?

Q Anything you're treating.

A Yes. Who cares? Yes. Pain level is not an indication for surgery.

Q All right. And, again, I just want to go back for a preface. I apologize. We had talked about before if her symptoms worsened you said before, then she could get the lumbar surgery.

The decision to get a lumbar surgery is going to be yours and hers, fair?

A It's going to be hers. My option is offer the -- I think she's a candidate. It's her decision to have it.

Q But the recommendation has to come from you, as a spinal surgeon, to get approval to do that?

A Absolutely, yes.

Q A pain management doctor cannot recommend a surgery for

a person?

A Not surgery that we do. Sometimes, they recommend the spinal cord simulator or --

Q No, I'm sorry. Your surgeries, a fusion, a laminectomy, that's you, as a spinal surgeon, that makes those recommendations, correct?

A Yes.

Q Revisions, if they're needed, you make that decision, and she says yes or no?

A With the patient, correct.

Q Okay. And we've already heard you say what you think about physical therapy, so I won't go there about your beliefs on physical therapy.

After your surgery, did you recommend her have a visiting nurse?

A Say again?

Q Did you recommend for her to have a visiting nurse?

A Again?

Q Did you make a recommendation or referral to have a nurse come to her home after your neck surgery?

A No, but they have to. It's a protocol, mostly at NYU. They have to take a lot things, yes.

Q Okay. And for how long does that last?

A In this -- that lasts -- normally, as I said, these surgeries are going home same day. That means we check -- it

has to be four hours for her. In her case, I think she had a sleep apnea, protocol must stay overnight. That means she is checked on every four or six hours until she is discharged.

Q Right. So that's a short period of time after the surgery that she needed it and one of the reasons was because she had sleep apnea, correct?

A Correct. That's why she stayed overnight. That's a protocol.

Q And when you saw her, let's say at six weeks after, you were not recommending that she needed a visiting nurse, based on the way she presented to you, fair?

A Correct, no.

Q Okay. And do you know the last time she's had any prescription medicines given to her?

A From me, I don't know. I don't have it in the -- in this part of the chart. From my side, okay?

Q Right.

A They are, but --

Q Okay. Now --and I left off on it before we got carried away, and I apologize, about objective and subjective.

And pain complaints are subjective. Would you agree with that?

A Yes. I tell my patients all the time.

Q Again, not casting anything, but you rely on the patient to be accurate when they report that to you, fair?

A Right.

Q Okay. And when I say visiting nurses services, by the way, I may have also -- you've never recommended that she use a home health aide to help her because of the physical condition that you've observed, correct?

A I do not recall if she needed one or not. Sometimes, the patient requested, and I will tell my patient in neither way it is needed. And I will request and say you need it. If you think it's going to help, I will request it. If it's approved, it's approved.

Q So in the three years, though, from your records that you've treated her, she's never told you she needs a home health aide, and you've never recommended one to her, fair?

A I do not recall.

Q Okay. All right. And are you familiar with the term symptom amplification?

A Oh, yes.

MS. HOLLAND: Objection. Judge, this is all beyond the scope.

THE COURT: Let's see where it goes.

Q What is symptom amplification?

A Symptom amplification?

Q Yes.

A That's the term?

Q Yes.

A The patient is exaggerating the symptoms.

Q Okay. And are you familiar with the term secondary gain?

MS. HOLLAND: Objection.

A Absolutely, yes, secondary gain.

THE COURT: I'll allow it.

Q And what do you know secondary gain to mean?

A Secondary gain is to actually take advantage of a situation that is not real. Okay? And it's happening either way. It's happening to the patient, trying to trick the doctor to have surgeries just to get money, or a doctor that's implicated in the same case. Okay? It could be in either way. Or attorneys in some situations, as I'm reading the chart now -- in the newspapers now.

Q Did you ever consider whether secondary gain or system amplification had any relationship to the complaints made to you by Ms. Watson?

A No, absolutely not.

Q Would you agree with me that there are some people, and I'm not saying Ms. Watson, that will magnify their symptoms when they're engaged in litigation?

A All the time.

Q All the time. Thank you very much, Doctor. I appreciate it.

A You're very welcome.

THE COURT: Ms. Holland?

MS. HOLLAND: Yes.

REDIRECT EXAMINATION

BY MS. HOLLAND:

Q So, I'll start with -- I'm going to try to be brief, but I want to cover some of the points that he made. Let's start with the last one. He asked you about symptom magnification and secondary gain.

And I believe you said you never saw any evidence of that in Ms. Watson?

A Absolutely not. If so, I'm not going to treat her.

Q Okay. In other words, when you had been -- withdrawn.

You've been her doctor for the past three years, you've never had the impression that she was faking her symptoms; am I correct?

A Correct.

Q Okay. And, of course, you have no indication in this case that she's trying to fake her symptoms in order to get money, any indication of that?

A Not in my office, not when I examined her, not when I saw her.

Q Okay. Now, you were asked questions about the MRI from 2019. Okay? There was an MRI to her cervical spine in 2019. I tried to show it to you on direct, and there was an objection.

Do you recall that?

A Yes.

Q You had an opportunity to compare --

MR. VAN ETTEN: Objection.

THE COURT: Let me hear the question. Go ahead.

Q Am I correct that you had an opportunity to compare the 2019 cervical MRI, which was taken before the accident in this case, with the September 2020 MRI; am I correct?

MR. VAN ETTEN: Objection.

A Correct.

THE COURT: Approach.

MS. HOLLAND: Your Honor, my -- okay. This was explored during cross-examination, and I'm asking, do I have an opportunity now to ask the doctor about his comparison of those films?

MR. VAN ETTEN: Objection. Beyond scope of cross. We need to approach, Your Honor, please.

THE COURT: Please, come up.

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

THE COURT: Ms. Holland, when you're ready.

MS. HOLLAND: Yes.

Q Okay. Doctor, you testified earlier that the fact that my client had a cervical MRI in 2019 is not relevant to your opinions here today.

And one reason for that is that you didn't have the complete medical records of the doctor who ordered that MRI; is

that correct?

MR. VAN ETTEN: Objection. Leading.

THE COURT: Overruled. I will allow it.

Q Is that correct?

A Correct.

Q Is that correct?

A Correct.

Q And you are aware, sir, that the doctor to whom that MRI report from 2019 was addressed was a doctor who performed the surgery scope on my client in 2019? You're aware of that; is that correct?

MR. VAN ETTEN: Objection.

THE COURT: Overruled. I'm going to allow it.

A I'm aware now, yes.

Q As a doctor who has performed shoulder scope surgeries -- I believe you testified that when you were working in Argentina, you handled shoulder injuries; is that correct?

A Yes.

Q When a person has a problem with their shoulder, okay, why is it that a doctor would also order a cervical diagnostic study if the person is complaining of shoulder pain? Why is that?

MR. VAN ETTEN: Objection.

THE COURT: Overruled.

A Because he want to cover himself and rule out that the

patient has no cervical -- significant cervical injury that he can be missing and doing the wrong surgery. Yes.

Q Okay. Now, with respect to -- hold on one second. Counsel asked you questions about diagnoses listed in your report, cervicalgia, unspecified sciatica, and back pain.

And I believe you said that these are billing diagnoses; is that correct?

A Yes, these are EMR records. They're terrible, but they are billing diagnoses, correct.

Q I'm sorry. I didn't really understand what your --

A EMRs are electronic medical records. We now use that, they are mandatory. And the last part you write your exam, the important part, you click two buttons where you have to put the diagnoses.

Q Okay. And when you say these are billing diagnoses, what do you mean by that?

A That's the -- they're not relative to my diagnosis. This is the one that they are going to use for bill, the counter, whatever it's called.

Q Okay. So basically, in order to properly bill the provider -- the health care provider for the patient, the doctor has to push certain buttons related to the body part.

Is that how it works?

A Yes, even if they're incorrect because pushing that button that they put there, is a billing list. They should put

more, but yes. Correct. It's for billing. It's not the real diagnosis -- medical diagnosis.

Q Okay. Let's see. Oh. Let's see. You were asked several questions about prior shoulder pain, prior neck pain, and how that wasn't relevant to your diagnosis in this case.

Do you recall that line of questioning?

A Yes.

Q Okay. And I believe you testified, in conjunction with those answers, is that Ms. Watson had nerve damage as a result of the trauma she suffered; is that correct?

A It's nerve swelling, nerve inflammation, yes.

Q Okay. And that occurred because of the damage to her disc in her spine; is that correct?

A Correct.

Q So the fact that she may have had shoulder pain in the past, neck pain in the past, that radiated into her shoulder or vice versa, that had nothing to do with your evaluation of her, in light of the symptoms she presented and the MRI studies that you reviewed; is that correct?

A Absolutely correct.

Q Okay. Counsel also asked you questions about whether the MRIs that you looked at in September of 2020 had any traumatic -- I think you used the word traumatic findings, such as swelling, hemorrhaging.

Do you recall that line of questioning?

A Absolutely, yes.

Q And I believe you testified that the MRIs that you looked at did not have any evidence of swelling or hemorrhaging. I think you also said something referring to a ligament. Okay? I can't pronounce the word.

Here's my question: What is the significance, if any, okay, if an MRI that you saw in this case, in September of 2020, the fact that it doesn't have swelling, hemorrhaging, or ligament damage, is that significant?

A I will explain.

Q Okay.

A The images has -- there are images of trauma. There are images. Not the images that he said, the counselor, because this is a big trauma. We seen in the hospital, we treat them. Edema, fracture, dislocation, they are big trauma. They are basically going to be bring to the hospital in a helicopter. But a extruded disc herniation, it doesn't mean -- not every trauma has to be significant for a patient to die or have paralysis. Extruding disc herniations in the cervical spine, that means the gel is coming out, that's not degenerative. This is trauma, a small trauma, but it is an origination of the symptoms. That is the trauma that we are looking for.

Q Okay. So you are not looking for swelling, you're not looking for hemorrhaging?

MR. VAN ETTEN: Objection.

THE COURT: Sustained. Don't lead the witness, please. Thank you.

Q Okay. Okay. Okay. Counsel asked you that when Ms. Watson was discharged from the hospital after her cervical surgery, she was evaluated, and it was noted that she had normal muscle strength or lack of muscle weakness when she was discharged from the hospital.

Do you recall that line of questioning?

A Yes.

Q The fact that she may have had normal muscle strength or lack of weakness upon discharge, is that dispositive of the fact that she may be presenting today with weakness, okay, and pain?

Do you understand the question?

A She was okay at the time, and is now getting weaker?

Q Yes.

A It could happen, yes.

Q Okay. Now, why does that happen?

A Because when we do the exam, they do the exam, you're looking for something that is really, really terrible, a red flag. Something that has happened. I don't really believe we will find everything, but it's okay. It's okay. Over time, you can have irritation of other nerves or you didn't do the weakness. They expected no physical therapy, muscle strengthening, that is difficult for patients doing it also, but

it's what they want. The weakness is related to that.

You decompress the nerve, you do the carpentry. Now, you have to recover the muscles, and that is not recovered in physical therapy. You have to do active exercise, gym and swimming pool. That could happen, all the time.

Q Okay. You have to just forgive me, Doctor. I'm not quite sure if your answer was responsive to my question.

A Could be. I am really tired.

Q I'm talking about when she was initially discharged from the hospital after she had her surgery, there was an evaluation by a doctor or a PA, and they examined her for weakness, and they concluded that their examination was normal. And now, she's presenting to you, after she's had the surgery, and she's complaining of the numbness and the tingling and the weakness.

How could you have a normal muscle exam upon discharge, and then continue to have pain and weakness later on, afterwards?

A I don't have any weakness in my exam. I said the only thing that she had was a residual numbness, tingling, in the right forearm. I don't have any examples for weakness. That is subjective. Yes.

Q Okay. So you can have that type of response and still go on to have the numbness and --

A For the rest of your life, yes.

Q Okay. Thank you. Thank you, Doctor.

A You're welcome.

MR. VAN ETTEN: One?

THE COURT: One.

MS. HOLLAND: Thank you so much.

THE COURT: One last question, Doctor, before we leave.

RECROSS-EXAMINATION

BY MR. VAN ETTEN:

Q The last question she just asked you, okay, where you said no weakness but there were still some residuals. Correct, that's what she just said? Based on that, some residuals, but no weakness in your last exam from November 12, 2024, you determined she had reached maximum medical improvement with her neck, true?

A Yes, that's what I wrote.

MR. VAN ETTEN: Thank you very much.

MS. HOLLAND: Well, wait a minute.

THE COURT: Last question, Ms. Holland.

REDIRECT EXAMINATION

BY MS. HOLLAND:

Q What does maximum medical improvement mean?

A Maximum medical improvement means that, at this time, I will not make her better with any kind of surgery. That is maximum medical improvement, not that the patient is perfect

after surgery. Happens all the time, still have pain, still have -- well, that is maximum medical improvement. That is to say nothing to do with you right now, more than exercise, but no surgery for you.

MS. HOLLAND: Okay. Thank you.

THE COURT: Thank you, Doctor.

MR. VAN ETTEN: Thank you, Doctor.

THE WITNESS: Thank you so much.

THE COURT: Doctor, you are excused. You may step down. Okay?

Ladies and gentlemen, at this time, we stand adjourned. We're going to be back here tomorrow at 10:00 a.m. Again, I'm not singling out anybody. I don't even know who was late today. My officer just told me two people were late.

You notice that we started 45 minutes late, we would have been done 45 minute ago. Do you see how it's on the back end? Respect my time. I respect your time. Respect each other's time. Tomorrow, 10:00 a.m. Okay? Do not discuss the case. Do not do any research. Keep an open mind. And above all, get home safe. Okay?

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: One last thing, before we adjourn, Ms. Holland, I know you want to make a record. I will permit

you to do so tomorrow. Okay?

MS. HOLLAND: Thank you, Judge.

MR. VAN ETTEN: Thank you, Judge.

THE COURT: Anything for the record, tomorrow morning, I promise.

(Whereupon, the proceedings were adjourned until December 12, 2024, at 10:00 a.m.)

* * * * * *

I, Maggie J. Klasen, certify that the within proceedings are a true and accurate transcription of the original stenographic record.

_____
Maggie J. Klasen
Senior Court Reporter
Bronx County

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