

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS : CIVIL TERM : PART 43

-----X

CHERYL BLUE : INDEX NO.:
25605/09

PLAINTIFF :

- against - :

FORESURE TRANSPORT, INC., d/b/a :
FORESURE TRANSPORT, PINE RIDGE FARMS, :
LLC, ERNESTO GARCIA :

DEFENDANTS : TRIAL

-----X

360 ADAMS STREET
BROOKLYN, NEW YORK 11201
APRIL 13, 2012

BEFORE: HONORABLE MARK I. PARTNOW,
JUSTICE, AND A JURY

APPEARANCES:

LAW OFFICES OF JAMES McCRORIE, P.C.
Attorney for Plaintiff
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New York, New York 10119

FABIANI, COHEN & HALL, P.C.
Attorney for Defendants
570 Lexington Avenue
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BY: THOMAS J. HALL, ESQ.

JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

1 COURT OFFICER: All rise, jury entering.

2 COURT CLERK: All jurors are present. You may
3 be seated.

4 THE COURT: Good morning, ladies and
5 gentlemen. I am sorry for the delay, but as I told you
6 we can't get started until all nine of you are together.

7 I understand one of the jurors showed up a
8 little late this morning. Try to show up on time next
9 time, if you can.

10 If you recall yesterday we were in the middle
11 of the plaintiff and about to start cross examination of
12 the plaintiff, but for the convenience of the witnesses
13 we are going to call a witness out of turn now.

14 The plaintiff is going to call a doctor to
15 testify. Counsel, call your next witness.

16 MR. MCCRORIE: Plaintiff calls, Dr. Paul
17 Brisson, B R I S S O N

18 D R. P A U L B R I S S O N, having been called as a
19 witness by and on behalf of the Plaintiff, having first been
20 duly sworn, was examined and testified as follows:

21 COURT CLERK: In a loud, clear voice please
22 give your name and office address.

23 THE WITNESS: Paul Brisson B R I S S O N 51
24 East 25th Street, sixth floor, New York, New York 10010.

25 COURT CLERK: Thank you. Please be seated.

1 THE COURT: Counsel, you can proceed.

2 MR. McCORIE: For the record, there has been
3 a stipulation into evidence and for the record we will
4 state it. 2B and C are blow ups of certain portions of
5 the Woodhull Hospital record. The MRI of Ms. Blue from
6 -- the cervical, is number 4 in evidence from 11/8/08.
7 Also from November of 2008 is the lumbar MRI and left
8 shoulder MRI. That is all part of Plaintiff's 4.

9 Plaintiff's 4 was the actual film.
10 Plaintiff's 5 is an actual film. Plaintiff's 6 is an
11 actual film.

12 Going back to Plaintiff's 4A, B and C are blow
13 ups of certain images of the cervical film. 5A is the
14 blow up an image of the lumbar film. Number 7 is the
15 Brooklyn Hospital records from October 10th, 2008.
16 Number 8A and 8B are blow ups and Dr. Brisson actually
17 brought the x-rays and the CD is here.

18 I failed to mark Dr. Brisson's file. I guess
19 that would be 16 or any portions --

20 THE COURT: Counsel, I don't understand the
21 last thing you are telling me.

22 MR. McCORIE: Well, just do it this way.
23 Going in the next order, Plaintiff's number 9 are the
24 office notes of Dr. *Ilyce Maranga, chiropractor, RN.

25 Plaintiff's 10 is the notes of Angelic

1 Physical Therapy. Plaintiff's 11 is the notes of Dr.
2 Hannanian. Number 12th are the notes of Dr. Jeffrey
3 Kaplan. Number 13 are the procedure notes and office
4 notes of Dr. Kushnerik. Plaintiff's 14 is the complete
5 hospital record of Downtown Hospital regarding the
6 cervical surgery. Plaintiff's 15 is the complete
7 hospital record of Roosevelt Hospital regarding a
8 shoulder surgery. Then number 16 would be a portion of
9 Dr. Brisson's file that will be going into evidence.

10 THE COURT: That is all in evidence without
11 objection; is that right, counsel?

12 MR. HALL: Yes, your Honor.

13 THE COURT: Thank you.

14 MR. McCORIE: May I proceed, your Honor?

15 THE COURT: Yes.

16 DIRECT EXAMINATION

17 BY MR. McCORIE:

18 Q. Good morning.

19 A. Good morning.

20 Q. Doctor, if you can please speak in a loud voice.

21 The ceilings are high and direct your responses so the jury
22 can hear you.

23 Can you tell the jury if you are licensed to
24 practice medicine in the State of New York?

25 A. Yes, I am.

1 Q. When did you become so licensed?

2 A. In 1993.

3 Q. Are you currently employed?

4 A. Employed, yes.

5 Q. Do you have your own practice?

6 A. Self-employed, that is really the word. Yes.

7 Q. How long have you had your own practice?

8 A. Since 1993 as well.

9 Q. Where is your current practice?

10 A. The address I stipulated to before is my office
11 which is on 25th Street, Manhattan. And I do perform spinal
12 surgery at New York Downtown Hospital.

13 Q. In September of 2009 and a period of time before
14 that, was your office address at another location?

15 A. It was.

16 Q. Can you tell the jury the location and any other
17 doctors that were within that office?

18 A. The location was on 56th Street 160 56th Street on
19 the east side. Dr. Kaplan worked in that location, Dr.
20 Crone worked in that location, Dr. Boppa worked in that
21 location, Dr. Write worked in that location.

22 Q. Despite the fact that they worked at that location,
23 were they part of your practice and were you part of theirs?

24 A. Independent practitioners.

25 Q. Does your practice accept work related accidents

1 and all the special rules and procedures that come along
2 with it accepting those?

3 A. Yes, I did.

4 Q. How about the same with motor vehicle accidents,
5 does your practice accept motor vehicle accidents and all
6 the special rules and procedures that come along with
7 billing and treating a patient with that type of care?

8 A. Yes as well.

9 Q. As distinctly as you can without leaving out any
10 accolades or accomplishments, can you please tell the jury
11 your educational and professional background starting with
12 college going through internship, residency and taking us to
13 where you are currently and because you are the first
14 medical witness testifying, when you get to words like
15 internship, fellowship, residency, if you don't mind
16 defining them? I would be appreciate that.

17 A. Very well. I am from Canada, Montreal, so college
18 in Canada is a little different than what you think it is
19 here, but, the equivalent of college I did a small college
20 in Montreal, a small private college.

21 I went to the University of Montreal for medical
22 school, a french university. I graduated in 1979 and after
23 that I did my internship year at the McGill Teaching
24 Hospital. McGill in Montreal is an English university,
25 so-called and I did various rotations in hospitals,

1 pediatric hospitals, Schreiner Hospital and so on and so
2 forth.

3 Q. If you don't mind keeping your voice up because the
4 feeling is I don't hear you fully.

5 Define internship and residency.

6 A. Internship is essentially a year that is done by
7 obligation. In order to have the right to practice after
8 your medical education you have to do an internship to
9 obtain a license. So when it comes to internship from
10 Canada, internship in the United States is the same.

11 Upon completion of my internship, I practiced as a
12 family practitioner in a remote location in Canada called
13 the Magna Islands.

14 I was a family practitioner a hundred miles away in
15 the middle of the ocean, essentially. The Magna Islands are
16 north of Prince Edward Island. I was one of five general
17 practitioners taking care of a large remote community.

18 I came back to Montreal in 1983 to do a residency
19 in orthopedic surgery. So residency is a medical indication
20 meaning it is the definition of the years of training to be
21 a specialist. In my case orthopedic surgery.

22 Somebody can do a residency to be a cardiologist,
23 can do a residency to be an internist or whatever. My
24 residency was orthopedic surgery and this was done at McGill
25 Teaching Hospitals, four years 1983, 1987. 1988 I came here

1 in New York City and did a year a spinal surgery fellowship
2 at the Hospital for Joint Disease.

3 So fellowship in a context of medical education,
4 again, is the year that one does by virtue of choice, not by
5 virtue of training requirements. And my choice then was to
6 be a spinal surgeon or involving spinal care.

7 I did a year of spinal surgery training at the
8 Hospital for Joint Disease and I had already planned a
9 second year which I did in Buffalo with Dr. Simmons, very
10 well known to this day at Buffalo General Hospital, another
11 fellowship. I did two of those years and then came back as
12 a house officer at the Hospital for Joint Disease from 1989
13 until 1997, actually.

14 Q. You stated that you did your fellowship in
15 orthopedic spinal surgery, do surgeons that typically do
16 shoulders, knees, ankles and other joints, can they do
17 spinal surgery as well or is it a speciality within the
18 field of orthopedics?

19 A. Certainly speaking from myself -- I cannot picture
20 myself doing anything other than spinal surgeries. So if
21 arthroscopic is doing shoulders or knees, I cannot see
22 myself doing arthroscopic.

23 Q. How many spinal surgeries do you perform on a
24 yearly basis currently?

25 A. About 100, 150 or close to 200.

1 Q. Do you do anything other than spinal surgery?

2 A. No.

3 Q. Are you board certified?

4 A. Yes, I am.

5 Q. Tell the jury what you are board certified in and
6 explain the significance, if any, of the board
7 certification?

8 A. So board certification is another voluntary
9 program, if you want, although frankly it is required more
10 and more by all sorts of agencies in the public. It is what
11 is a certification to a level of training and competency in
12 terms of practice and ability to sit and do exams and
13 essentially pass them.

14 So I and like any other board certified physician,
15 we have to first pass this exam which in my case, in the
16 case of orthopedic surgery, is a practice base. You show
17 what you did two years. At one point you do a written exam
18 and you have an oral exam. And every ten years thereafter
19 you have to recertify. And I did one recertification nine
20 years -- eight years ago and I will have another one coming
21 in a year or two.

22 Q. Do you hold any positions at any hospitals within
23 New York City?

24 A. At New York Downtown I have the directorship in the
25 spinal surgery division.

1 Q. Other than being director in spinal surgery at New
2 York Downtown, in your current practice, can you tell the
3 jury what types of patients you see?

4 Do you see trauma patients, patients that don't
5 have trauma; what type of patients do you see?

6 A. I see, essentially, the whole gamut of what would
7 be spinal care with certainly the exception of pediatric
8 spinal problems, which often are deformity type problems.
9 So I take care of people that have sequelae from trauma. I
10 take care of people that have spinal problems, pinched nerve
11 problems, weakness and so forth. And the gambet is quite
12 wide.

13 It is all sorts of reasons for their problems,
14 whatever brings them to the office I will be dealing with.

15 Q. And so just so we are clear, I asked you the
16 question about accepting work related accidents and motor
17 vehicle accidents, do you also see many other types of
18 cases?

19 A. Oh definitely.

20 Q. Have you ever testified in court before?

21 A. Yes, I have.

22 Q. And on the times you testified in Court, how does
23 that come to be?

24 A. Just about exclusively for the patients that I took
25 care of.

1 Q. Okay, as opposed to being retained, some other way
2 to review a file?

3 A. As example, that is correct.

4 Q. Have you ever testified in Court on behalf of a
5 patient who you operated on that happened to be a client of
6 mine?

7 A. Yes, I have.

8 Q. Can you tell the jury in the 15 years of my
9 practicing how many times that has occurred?

10 A. Once.

11 Q. Can you tell the jury when this was?

12 A. In the autumn of last year.

13 Q. Before autumn of last year, despite the fact that
14 you were seeing Ms. Blue since 2009, had you and I ever met
15 each another prior to testifying in October of 2011 for some
16 other patient?

17 A. No.

18 Q. Since August of 2011, from the time you knew that
19 this case was going to come to trial, did you and I met
20 again other than August 2011 regarding Ms. Blue's case?

21 A. Yes, we have.

22 Q. Approximately on how many occasions did we meet to
23 prepare and go over this case?

24 A. We met on two occasions.

25 Q. On the first occasion what, if anything, did we

1 speak about or review or plan for trial?

2 A. We met a few weeks ago and we reviewed the medical
3 material that I happen to know and you provided me with some
4 additional pieces of information.

5 Q. And in addition to that, what you just testified
6 to, did you look at Ms. Blue's MRI films and specifically
7 pick out certain images from those films that would be
8 instructive to the jury to explain whatever you wanted to
9 tell the injury about her condition?

10 A. Yes, we have.

11 Q. Did you compare those enlargements to the
12 originals?

13 A. Yes, we did.

14 Q. Are you being paid, as are all doctors that come
15 before the jury will be, for your time away from your
16 practice having been called on whenever the trial was going
17 on?

18 A. Yes, I am.

19 Q. Okay and how much are you being paid and what does
20 that entail? Why are you being paid?

21 A. The stipend is \$10,000 and it means all the time
22 and the effort required for the testimony and preparation
23 and including changing office practices. Tomorrow for
24 example I will be seeing patients all day, as an example.

25 Q. How many patients are you going to now see tomorrow

1 on Saturday?

2 A. I believe the day is over 46.

3 Q. Prior to coming before the jury, did you review all
4 of the available medical records in this matter?

5 A. Yes, I have.

6 Q. Okay and I believe the office note portion and
7 whatever portion, other portion Mr. Hall would like in, but
8 the office note portion would be in evidence, so you can
9 read from it, so if you need to read from it, look at your
10 notes and tell the jury when did Ms. Blue first become a
11 patient of yours and how did she become referred.

12 A. Mrs. Blue first came to the office September 21,
13 2009 at the request of Dr. Kaplan.

14 Q. Okay, can you just go to your office notes in front
15 of you?

16 A. Yes, I did.

17 Q. Because you are the first doctor, when we say you
18 took a history in the medical field or the context of
19 medical treatment, what does history mean?

20 A. Well, I am sure you know anyway, but history in
21 this case is the taking of a questionnaire where you try to
22 obtain all the facts as they are, and try to understand from
23 the information obtained the events that occurred to an
24 onset of condition, traumatic or not.

25 What happens is whether in manifestations,

1 repercussions, response to treatment, failure to respond to
2 treatment, it all comes. That is what a history contains.

3 Q. So, we are clear in September 21, 2009, you also
4 told the jury your office was within the same facility or
5 office of Dr. Kaplan, just in your separate practice?

6 A. Correct.

7 Q. At that time, did you have the availability of all
8 Ms. Blue's medical records in addition to her history having
9 been treated by Dr. Kaplan for the last year?

10 A. I had availability for some records, but not all of
11 them.

12 Q. Can you tell us the history that was relayed to
13 you?

14 A. They were described to me as while in a motor
15 vehicle accident and apparently on a work assignment, that
16 in particular, vehicle two was hit by a large motor vehicle.
17 Apparently it was a large truck. And she points out to me
18 immediately the experience of unpleasurable whiplash, some
19 neck whiplash, resulting in her neck symptoms.

20 Q. Let me stop you there. That is a word that many
21 people know, what does it mean medically, whiplash?

22 A. You know, when you are whipping a large a stick
23 back and forth, that is sort of easy. In medical
24 terminology or setting, whiplash refers just about
25 exclusively to neck injury. It's when your head is whipping

1 and lashing from a sudden deceleration or sudden
2 acceleration and that applies to a certain degree of force
3 to have this quick motion that is not entirely under your
4 control.

5 Q. We are not going to do this for each note, but just
6 with this first note, would you continue on with the history
7 that she told you in that 11 months after the accident?

8 A. She mentioned to me by way of occupation she was a
9 legal editor. She had essentially cervical pain right from
10 the get go, but within months she had increased symptoms and
11 at that point was getting more and more intolerable. She
12 had headaches and associated insomnia.

13 Q. Like inability to sleep?

14 A. Yes. It got to a point where even walking was
15 problematic at some moment, at some exacerbation phase. She
16 had developing forearm pain as well numbness to her fingers,
17 gradually developing during this period of time from the
18 date of accident to the moment that I saw her.

19 Even though she is right hand dominant she had
20 difficulty dealing with her task or occupation. It requires
21 a fairly detailed use of both upper extremities and that was
22 becoming a problem and came to the left upper extremities.

23 She rated her pain anywhere from between five and
24 ten. And in a physician's office, the doctors will ask you
25 what is the pain, what is your pain level and it is hard to

1 refer to what is a personal experience or symptoms, but we
2 try to put a subjective comment to an objective level. We
3 say what is your pain, zero meaning no pain, ten the worst.
4 Hers was five on that day.

5 Q. Did you say subjective, objective, in medical
6 terms, what does that mean?

7 A. Simplest form, subjective means you the subject
8 tell me the information based on the a question or a fact.
9 Objective means that as the objective, the observer will
10 note some details, some note, some findings that are either
11 from what you are told or what I can examine and notice.

12 Q. Continue please, Doctor. You were continuing with
13 the history?

14 A. Yes, she mentioned as well that she had lower back
15 pain from this particular incident. And had occasionally
16 weakness in her left lower extremity, but the main concern
17 was the neck. And she pointed out to the fact that
18 activities of daily living many of them were provoking more
19 symptoms, make matters worse, in other words.

20 Q. Was it your understanding, despite it never being
21 noted in your notes, that she was also being treated by Dr.
22 Kaplan and other doctors for a left shoulder tear and was
23 actually operated opted on?

24 A. I was aware of the fact that other physicians were
25 involved in her care.

1 Q. Okay, when you dealt with her and you said here
2 that her main concern was the neck which was your focus as a
3 spinal surgeon in treating Ms. Blue?

4 A. Well, the focus was directed to the area, the
5 symptoms, that lead to most significant limitations for her,
6 in her case, which comes with spinal problems, the neck and
7 arm condition that we just discussed.

8 Q. Okay, did you do any examination on that day?

9 A. Yes, I have.

10 Q. What did you find on the examination?

11 A. I found that she had, in essence, pain in the neck
12 on palpation to touch. That she had at that point some
13 degree of inflammation, but not excessive due to fact that
14 her Spurling test -- that is a special neck test.

15 Q. Spurling?

16 A. Where I squeeze the cervical roots, the nerve if
17 you want, that was not provoking sharp pain like it being
18 with some patients. Otherwise, though, she did have
19 weakness in the left arm. Her hand grip was definitely
20 weaker than what it should be. She also had difficulty
21 extending her wrist on the left side.

22 Q. Doctor, what does diffuse tenderness mean, both the
23 word diffuse when it says that medically or any doctor and
24 then tenderness as it relates to the neck?

25 A. Diffuse means that you have the white area with

1 palpation will cause symptoms that are instilled in pinpoint
2 areas. Wide. Tenderness is exactly that, when you press
3 the area the patient describes more symptoms.

4 Q. Did you have an opportunity on that visit to
5 actually look at her MRI films and the reports with the
6 films?

7 A. Yes, I have.

8 Q. Okay as well as x-rays performed by Dr. Kaplan?

9 A. Correct.

10 Q. To the neck. Again, you looked at x-rays of her
11 neck and back and the MRI, that is it, correct?

12 A. Correct.

13 Q. Tell the jury when you looked at the x-rays you can
14 also include the MRI and I want you tell them what you found
15 then you can define words like spondylosis when you get to
16 them?

17 A. So the films reported or discussed --

18 Q. Which films, if you can just tell us?

19 A. I have on my note November 8th, 2008 for plain
20 x-rays they were executed by Dr. Kaplan in his facility.

21 Q. November 8th, 2008 you have MRI of the cervical
22 spine; is that correct, as well as plain x-rays, but there
23 is no date?

24 A. That is right. I stand to be corrected. MRI
25 November 8th, x-ray I am not certain about the date. About

1 thereabouts.

2 Q. Regardless of what date, what did you see when you
3 looked at them as well as what may have been noted, what did
4 you see?

5 A. Plane radiographs radiographs in general are good
6 to see the bone structures and there is still very useful
7 even though we have modern imaging methodologies. When it
8 came to the cervical x-rays, it showed that the cervical 5
9 and 6 -- we name a disc by virtue of the bone that it is
10 sandwiched between. Cervical 5 and 6, what we call
11 spondylosis. Spondylosis is the disc narrowing bone spurs
12 at that particular level.

13 Q. Spondylosis is caused by trauma?

14 A. No.

15 Q. Is spondylosis a typical finding in a man or woman
16 of 53, 54 years old?

17 A. It is common and actually expected almost.

18 Q. In addition to the spondylosis, what else was
19 found?

20 A. The C6-7 level, therefore second disc had to some
21 degree similar findings, just not as much as cervical 5 and
22 6. Then I had the opportunity to look at the MRI of the
23 cervical spine, the MRI dated November 8th, 2008. What I
24 talked to you about before. MRI's are good to show soft
25 tissue and they show the relationship of the soft tissue

1 among themselves because each cervical tissue has a certain
2 look compared to another one to the point also with bone.
3 That showed that she had herniations, mass effects, as I
4 like to call them.

5 Q. M-A-S-S

6 A. Yes, in other words, tissue occupying in an area
7 that doesn't belong. A cervical 5 and 6 and cervical 5 and
8 6 and 7, the ones we just talked about.

9 Q. What is secondary straightening of the normal
10 cervical lordosis mean?

11 A. That is that a description that the radiologist or
12 in our case even ourselves can make. We have a normal
13 alignment of the cervical spine, for example. So when
14 somebody has an active spastic condition, presumably in this
15 case, you end up with losing that posture.

16 Q. What do the words cervical disc herniation with
17 myelopathy and lumbar disc herniation without myelopathy?

18 A. Disc herniations can have repercussions and in this
19 case, in her case, it did for the arms so you end up with
20 numbness and weakness that I talked about. That is the
21 myelopathy I am referring to.

22 Q. Myelopathy meaning what?

23 A. Myelopathy refers to dysfunction of the neuro
24 system and the one without myelopathy meaning refers to the
25 lumbar because many lower lumbar areas refer to the fact

1 that the back pain or the disc abnormality as noted doesn't
2 have the same repercussions on the neurological system as it
3 did in the cervical area.

4 Q. Tell the jury these two words first, then we will
5 get to what it was. What does diagnosis mean and what does
6 prognosis mean?

7 A. Well, diagnosis is a term that describes the sort
8 or medical conclusion you would come up with after obtaining
9 information that is available, meaning history, physical
10 examination, imaging information and others. You end up
11 with a diagnosis. Progress is a term that describes what we
12 believe is the potential outcome. In other words, the hope
13 of recovery or not, improvement or not. The prognosis is a
14 stipulation, a comment about the outcome.

15 Q. Did you ask Ms. Blue if she ever experienced or
16 ever had any trauma to the neck or back before?

17 A. Yes, I have.

18 Q. Okay what, if any, past history did she relay to
19 you?

20 A. None really.

21 Q. And what was your diagnosis and prognosis at least
22 on the visit?

23 A. The diagnosis was cervical disc herniations with
24 nerve pinching problems. She had associated weakness and
25 the prognosis, in my view, was poor because of the duration

1 of symptoms. Meaning, from date of the accident which was
2 in 2008, October to what was, approximately, one year after
3 the accident in her first visit. Therefore, the prognosis
4 just by virtue of clinical time was poor. And even
5 discussed at the first consultation by the operation of
6 surgery.

7 Q. Were you aware that in addition to medication in
8 addition to physical therapy for the approximate year before
9 that she had actually undergone cervical epidural injections
10 into the neck with Dr. Kushnerik and had not had relief?

11 A. I was aware of the fact that she had from date of
12 the accident active care.

13 Q. Were you aware that she had not be working other
14 than one day since the accident?

15 A. I was made aware of that, yes.

16 Q. What was your opinion at that time whether or not
17 that I was visible for her to go back to work at this point?

18 A. Based on the symptoms described and confirmed by
19 the physical examination I didn't believe she could do it
20 and that is the reason why she was the not. She didn't have
21 the capacity to work.

22 Q. What would prevent her from doing it?

23 A. I am sorry, sir.

24 Q. What would prevent her -- assuming what I am
25 holding is something called an Edgar document, it would be

1 required for her to sit for eight hours comparing this
2 document to another one with her head down, what would
3 prevent her with cervical herniations and the medications
4 she is on and concentrating on such a document?

5 A. Well, that is what I understood. Also is the fact
6 that she had very sort of time consuming, almost tedious
7 type of work where she had to be very careful reading her
8 material for these -- I believe these documents are
9 financial documents and they have to be compliant and that
10 requires attention and that is exactly the type of activity
11 and posture this would produce more symptoms in a case of
12 head flexion and arm numbness.

13 It would be hard for me, at least, to imagine that
14 she could concentrate and do her work well.

15 Q. I want to go through the second note and would the
16 Court's permission I will have you step down, but if you can
17 go to the second note, the second time you saw her on
18 October 14, 2009?

19 A. This is correct.

20 Q. Okay, did you take any further history, record on
21 the symptoms, you don't have to go through the whole thing
22 if anything was additional and also first tell us that?

23 A. Yes, I mean, I obtain additional details to the
24 history. For example, this note reflects epidural
25 injections that counsel was mentioning before, which is a

1 common used treatment modality for pain when it comes to
2 spinal pain.

3 And there was also a better description possibly on
4 her part also with regard to the finger numbness, arm
5 infection as to the neck pain while she stood with her head
6 forward.

7 Q. Did you take any imaging studies yourself on this
8 date, if so, what did you find?

9 A. Yes, I have. And the x-rays were regular x-rays
10 again were with a focus on dynamic instability. We ask her,
11 we asked the patient to flex and have an x-ray in the flexed
12 position and ask the patient to extend. We have an x-ray
13 done in the extended position. And we had that x-ray done
14 and the findings were that the cervical 4 and 5 had a
15 rotation that exceeded the normal.

16 So she had, radiographically at least, evidence of
17 cervical instability.

18 Q. Does assessment equal diagnosis in your notes?

19 A. Pretty close. The answer would be yes.

20 Q. What was your assessment on this second day?

21 A. Assessment was injuries resulting in instability at
22 cervical 4-5 and the disc herniations C5-6, C6-7 with the
23 weakness to the arm that we talked about.

24 Q. Did you make any recommendations regarding surgery
25 at that point?

1 A. Yes, I have.

2 Q. What were the recommendations to the surgery?

3 A. The surgery was to address the disc herniations at
4 C5-6, C6-7 and address the instability at C4-5.

5 Q. Are you permitted to just do surgery on her or do
6 you have to seek authorizations and get someone else's
7 approval and permission?

8 A. Yes, in the context of she presented -- she had a
9 compensation case, you have to subject a package for review.

10 Q. You are also agreeing when you take a compensation
11 matter to accept the compensation rate?

12 A. Yes.

13 Q. Is that rate significantly lower for both treatment
14 and surgery than it would be if someone had a private
15 benefit or say Donald Trump walked in and wanted to have his
16 neck operation, is it different?

17 A. Yes, there is indeed prescribed fees that would not
18 be considered customary in other settings, correct.

19 MR. McCRORIE: Okay, with the Court's
20 permission, I would like the doctor to come down?

21 THE COURT: Doctor, you can step down. That
22 is fine.

23 THE WITNESS: Thank you, your Honor.

24 Q. Doctor, I am going to put a model up if the
25 court officer wouldn't mind getting the easel, please.

1 THE COURT: I don't think the model is going
2 to go on the easel.

3 MR. McCRORIE: I have other illustrations we
4 are going to use. Illustrations that are not in
5 evidence, they are demonstrative only and I will refer
6 to them.

7 Could you please using the model and this
8 illustration of the cervical spine.

9 THE COURT: Is that in evidence or is that
10 just for demonstrative purposes?

11 MR. McCRORIE: Demonstrative.

12 THE COURT: That is fine.

13 Q. Can you use the model and the board up here called
14 anatomy of the vertebral column to explain to the jury
15 anatomy first of the spine, the lordosis, what an axial view
16 and sagittal view is. As much as you can tell them about
17 the spine.

18 A. Okay, well, what you have in front of you is a
19 classic depiction that we often, even use ourselves, to
20 explain to patients or to instruct students to what would be
21 considered normal anatomy, at lease in a schematic way.

22 So, what you have on this particular easel
23 demonstrating is a lateral view and the back view of the
24 whole spinal structure. C1 through S1. Cervical 1
25 to sacral 1.

1 Based on what we just discussed before, what I
2 would point out to you is the fact we have natural curves in
3 our spine, so we tend to have a cervical lordosis, meaning a
4 curve toward the back. A thoracic psychosis, you tend to
5 have a little rounding formed in the thoracic spine, which
6 is the mid part of our spine. We tend to have a lumbar
7 lordosis, lower down, the sway that you are aware of.

8 Q. Is that on the model, is that depicted basically
9 what the spinal looks like?

10 A. Yes, this is depicted. This is a classic way to
11 present and appear and what this depicts to some degree to
12 what we are talking about, lordosis circle, lordosis lumbar,
13 thoracic psychosis.

14 What counsel has asked me before and also when we
15 comment on films and when see images, we like to point out
16 the type of views. So if we were to see an x-ray from the
17 side, we call that the sagittal view. If we've looked down,
18 and the view through the arm is called the axial view. It
19 is important when it comes to MRI's, we tend to look at
20 axial view quite a bit. Sometimes we have a coronal view or
21 frontal view.

22 One of the other things that is important to bring
23 to your attention is these little red plastic --

24 Q. Yellow?

25 A. Yes. Yellow here depicts nerves. So, what is good

1 to retain is that there is a tight intimate anatomy between
2 the bone and the nerves. It doesn't take too much to get
3 nerve compression and here you have the exit point where you
4 can picture inside, especially if we have the axial views,
5 that things can get pretty tight fast if we have what is
6 called the mass effect.

7 Q. Okay, now if we can go to Plaintiff's 8 in
8 evidence, I just want to have you explain to the jury what
9 they are looking at. Obviously this is Ms. Blue.

10 A. Yes, it is.

11 Q. The date is on there is whatever the date is, but
12 it is a view of her before the surgery, correct?

13 A. Yes.

14 THE COURT: For the record, what exhibit is
15 that?

16 MR. McCRORIE: 8.

17 Q. Can you tell the jury when you said that you did
18 these stability views on October 29, 2009 or whenever the
19 second visit was, October 14, what they are seeing here,
20 what it shows you?

21 A. So what you are looking at is a sagittal, side
22 view, cervical points, cervical spine x-rays, the bone
23 x-ray. You look from the side and in this case we are doing
24 the dynamic study referred to before as flexion extension.

25 And what that x-ray added in terms of information

1 compared to what I believe was known before, is that yes,
2 you have cervical 5-6, cervical 6-7 to lesser extent showing
3 narrowing. Cervical 5-6 bone spurs and so forth, but if you
4 were to do a little geometry exercise and do the angulation
5 between cervical 4 and 5, you would realize that the arc of
6 rotation is excessive.

7 Normally we have a certain arc of rotation and in
8 her case it was double the normal.

9 Q. Again, even the disc space narrowing, would that be
10 caused by a car accident or is that something that you
11 already talked about, spondylosis?

12 A. These changes were present before.

13 Q. Okay, I am going to hold up Plaintiff's 4B, again
14 the actual films are in evidence and so before we tell the
15 jury about the films, an MRI comes maybe 16 to a view, we
16 are looking at one view, correct?

17 A. What counsel is telling all of us is the fact when
18 you look at the film and it is possible for you to see that
19 there is multiple small images and they correspond to the
20 part of the spine, in this case, that was sliced. It is a
21 technology that slicing the body form.

22 So what counsel is trying to tell all of us is that
23 two of these slices were identified for demonstration
24 purposes.

25 Q. If you can tell the jury, if you can put these back

1 and tell the jury what they are seeing, what view this is
2 and point out everything from the round part, the line
3 coming down and what we are looking at?

4 A. So you are looking at the sagittal, side view, MRI.
5 So we talked about that before, the MRI shows more, shows
6 more of what? Shows more of soft tissues and different soft
7 tissues have different densities.

8 So that is how we worked this through. So for
9 example, you have this particular dark degree of density
10 that's the muscle nuba. What he was pointing out is the
11 cerebellum, the back part of your brain.

12 Q. I want to go back to the illustration for a moment
13 and in the illustration coming from the skull what is the
14 yellow line and what would be the black around the yellow
15 line be?

16 A. Looking at that it refers to the spinal cord and
17 space around the spinal cord. So what you have depicted
18 here in this long gray tube lighter than the muscle is the a
19 spinal cord itself.

20 Q. Is the spinal cord connected to the brain?

21 A. Yes, otherwise we wouldn't be able to do much.

22 Q. And the little yellow the nerve endings that are
23 coming out, this is the spinal cord, are those nerve endings
24 what goes out on branches to our arms our legs, back up to
25 our brain?

1 A. Yes, it is the main table that brings all the
2 feelers that we need to act, move and so forth.

3 Q. One more point for the jury, the spinal cord
4 appears to be thick at the top and trail off at the bottom
5 and we can show them here a cervical as opposed to a lumbar,
6 what is the cordus equinus as opposed to the full spinal
7 cord?

8 A. What really happens somewhere in the high low mark
9 area of the spinal cord, the main cable stops and really
10 leads to this series of little nerves we call nerve roots
11 and that is what you see here. And somewhere somehow
12 someone said they like the term, it has to stick and that is
13 why we call it cordus equinus, horse tail. It looks like a
14 horse's tail. You have a dense bunching of lumbar and
15 sacral roots that innervate the leg and the bottom part of
16 our body.

17 Q. What would happen if the thick full spinal cord up
18 in the cervical region were severed to any degree?

19 A. Severed to any degree? Severed is a bad word. One
20 would have definitely some form of paralysis or serious
21 impairment, but it can be compromised and have dysfunction,
22 arm weakness, for example, numbness, like Mrs. Blue has.

23 Q. Okay, so one last thing going to -- the pink in
24 between the brown, can you tell the jury which is the bone
25 which is disc and talk about the end plate of each in the

1 illustration first?

2 A. So from the illustration point of view the pink
3 here refers to the disc. So the disc is the area of the
4 spine that allows us to have some motion, otherwise we would
5 be living as bamboo sticks and the disc is a flexible
6 structure, but its content has to remain where it supposed
7 to be, if it comes out, you have a herniation and may or may
8 not have resulting neurological compromise from that, if not
9 pain alone.

10 Q. When you say, "comes out", is that into the spinal
11 canal passing the end plate of the bone?

12 A. It could factly come out in any direction, but the
13 dorsal extrusion or protrusion which is the commonest is the
14 one that leads to neurological problems.

15 Q. Is there a ligament holding the disc in place in
16 between the spinal canal and the where the disc is being
17 held in?

18 A. Yes, there is actually two main ones. The first
19 one is called annulus and the annulus is the tough mesh that
20 holds the jelly part of the disc together.

21 Q. Pointing the axial views of the disc?

22 A. Annulus around here and you have another one that
23 is the, I believe, the sort of whitish portrayed here --
24 correction, the gray portrayed hear. That is the so-called
25 posterior longitudinal ligament. That is another touch

1 structure. Things are usually contained by those
2 structures.

3 Q. Things are contained where they are supposed to be
4 by annulus and posterior ligament?

5 A. Correct.

6 Q. The middle part or nucleus pulposus of the disc,
7 what is that?

8 A. That is your jelly part. That is what we call
9 jelly for all intents and purposes nucleus pulposus, it's a
10 discus structure that allows a little motion within itself
11 some we can move our body and have head turning and flexion
12 and so on and so forth.

13 Q. Which we call that jelly, is it a tough jelly, a
14 hard jelly?

15 A. Unfortunately it hardens up over time, we talked
16 about that, but generally it is relatively soft.

17 Q. What we are going to do is go back to Plaintiff's
18 4B and if you could explain the jury -- what I will have you
19 do, you if you don't mind, is to do just the C levels,
20 writing in here C1 through 7 on the bone.

21 Let's see where the vertebrae are?

22 A. One is little hard to see but it is just -- you
23 have to the dorsal ring and the front ring here. But here
24 is C2, C3, C4, C-5, C 6 and c7.

25 Q. Just so it is clear, you said that the C4-5 disc

1 would be the disc between the forth and fifth vertebra,
2 correct?

3 A. Yes, a disc is named by the sandwiching bone.

4 Q. And can you tell the jury what we are looking at C
5 5-6 and the difference in the disc space as it looks above
6 and below?

7 A. Well, counsel has it the wrong way, 5-6 is right
8 here.

9 Q. I am not a doctor.

10 A. It is narrower, the disc on this particular image
11 shows a lot of darker signals, it is almost black compared
12 to the one --

13 Q. By signal you mean --

14 A. MRI signal. In other words, okay, this white
15 signal versus a gray signal versus a black signal, I'm
16 referring to the depiction the images on the films that I
17 get to see in the office. So that particular disc is not
18 having its normal signal compared to the ones say above C4
19 for example. It is darker and it is narrower. C6-7 to
20 lesser extent has the same findings. C4-5 from a hydration,
21 from a water content, doesn't look so bad.

22 Q. And although C4-5 has a hydration content, if the
23 disc, in fact, coming out past the end plate, if one were to
24 cover that white what we call contiguous material --

25 A. Yes, it looks from this view it is bunching out, it

1 is not where it should be, contained as well as it should
2 be.

3 Q. We are going to put up 4A, although it is the same
4 date, November 8th, it appears to look different, can you
5 tell the jury what T1 image is compared to a T2 image in
6 MRI's?

7 A. MRI technology is one of the these marvel of modern
8 of science and engineering. The scientist behind it won the
9 a Nobel Prize. I don't pretend to understand the spinical
10 hydrogen atoms, like technology implies.

11 What you have is modulation that captured the
12 spinic energy in a way. The T2 weighted image points out a
13 water signal, so whatever structure that has water will show
14 up bright on the MRI and that's what you have.

15 The T1 is more for soft tissues like bone edges and
16 things like that. This one is the one that we use often and
17 I think it is a little more illustrative and it is also a
18 good one to show disc herniations.

19 Q. Almost if someone were to hide behind the telephone
20 pole and keep moving a little to the left or right, you
21 would see a bigger view of them, could you explain to the
22 jury while the person is in the MRI machine, how it takes a
23 picture, moves takes a picture, because I would like you to
24 explain how you see things different in one view that you
25 don't see on another view?

1 A. Well, what counsel is putting up here that you have
2 a different weighted image and that can be completed with
3 technology.

4 A. Again, it is focused on a different type of the
5 structure, we can see ligaments better on this particular
6 imaging than we would have here.

7 Q. Now we are looking at 4A for the record?

8 A. The technology is slicing the body -- virtually
9 slicing the body. I am not sure if you want to get into
10 that, but the point here is that as we have a slice at a
11 particular point of the newer canal we see some exchange he
12 is in the disc. These are not so bad here, but then we were
13 to look at this particular one as we see that the C5-6 and
14 C6-7 have disc herniation, loss of disc containment, for
15 example.

16 Q. And if you can can you circle those two disc
17 herniations is that you speaking of?

18 A. So that is C-5 six and that is C6-7 (Witness
19 complies.)

20 Q. So we are clear, on this view if you were on cover
21 the end plate of disc those anything that extend out into
22 the spinal canal would be called herniation?

23 A. Yes yes. I think even from your viewpoint you can
24 see well that there is loss of containment there compared to
25 what normal should be.

1 Q. Okay less go to 4C and now look at the axial view
2 dated the same date and tell the jury what they are looking
3 at describing the full circle around the spinal cord in any
4 time it appears that the disc is touching the spinal cord?

5 A. Well here you have the axial look, the look down
6 view. And this one here points out to the relationship that
7 you have, the spinal cord, nerve canal and disc or bone
8 area.

9 The best way here to approach is probably to look
10 at normal or near normal. In here you have the white signal
11 that the space, that the loose space, the neural canal has.
12 You need to have a loose space.

13 Q. Write normal on this view?

14 A. You have a nicely shaped spinal cord.

15 Q. Indicated with an N, the normal.

16 MR. McCRORIE: I am telling the Court reporter.

17 A. It is a nicely shaped spinal cord. We think about
18 it as round, but it is a little more oval, it looks like it
19 is in tact.

20 Q. One other thing which might be confusing, how does
21 the MRI get different views in terms of looking down?

22 How does it get the down look? How does it bypass
23 one view? I know you already you don't know the exact
24 technology.

25 A. I know the slicing concept. In other words, these

1 white lines you have on this particular vignette reflect
2 corresponding slicing levels. So, the computer related to
3 -- the computer attached to MRI machine will slice our body
4 a different levels a different points and that is what the
5 resulting vignettes or images are.

6 Q. Why don't we do this to speed it up. If you feel
7 you have to tell the jury tell them, show them a disc that
8 is being that is abnormal on the axial view?

9 A. You know if you were looking, for example, at this
10 particular set of images here you see that this particular
11 disc has lead to some change in the spinal cord that's
12 vignette 11.

13 Q. Write changes if you want to?

14 A. Or 12 even changes. So that is the cervical disc
15 4-5. There is some changes that are not as impressive at
16 the other levels, but there is some changes.

17 Q. You said at 4-5?

18 A. Cervical 4-5.

19 Q. So the jury is clear, this one you circled the mass
20 effect on 4B on 4-5?

21 A. That is cervical 4-5 compromise.

22 Q. We are going to move off cervical just so we can
23 move along. I want to put up a lumbar view and those films
24 are here, 5A for identification. Tell the jury -- now they
25 know they are looking a sagittal view, can you show them any

1 abnormality, if any, that you found and see on the lumbar
2 film?

3 A. Yes, I think the first one I would strike me as
4 worth mentioning is lumbar L5 S1 where you see again is some
5 degree of loss of containment of the disc.

6 Q. If you draw a line from end plate to end plate?

7 A. I was going to do that. This line here, so you can
8 see, there is some form of bulging.

9 Q. Just so the jury is clear, you talked about the
10 cordus equinus or horse's tail, at one point it goes from
11 solid to trailing off, is that actually a good view to see
12 that?

13 A. Yes, the lumbar roots, the little spaghetti strands
14 you see that.

15 Q. How would somebody receive a lumbar epidural during
16 pregnancy without any fluoroscopy?

17 A. It is like trying to spear a spaghetti string while
18 it is being cooked, so it is a hard thing and the same thing
19 here.

20 Q. Just use this illustration to discuss how a
21 cervical epidural injection is done and if you need to go
22 back to the film?

23 A. Well, I think it is this is good view because it
24 points out the cervical segment and an epidural on the
25 cervical segment are a little trickier and you need to be a

1 little more careful on this. You are putting a needle in a
2 very small space. It is a virtual space. It is a called
3 epidural and you don't want to pierce the dura. The dura is
4 the sack that contains the neural tissue. It has a fluid
5 that, we call the cervical spinal fluid, the watery fluid,
6 but you don't have much more to go to spear the spinal cord
7 itself, that would be a bad thing and worse would be
8 throwing medication into it. That is catastrophic.

9 Q. Dr. Kushnerik's epidural procedure records are here
10 as 13, but as we hold up one view of it it looks like there
11 is a hypodermic needle in there.

12 Is that the epidural needle being shown through
13 something called fluoroscopy so the doctor can see where he
14 is going?

15 A. Yes, so people who do these things safely, as hers
16 was done, use complete technology. A little bit like a
17 camera view of what we are doing when they put a needle in
18 the space, when you put the medication in.

19 Q. Doctor, did their come a time that you got an
20 authorization for the surgery to do what you requested on
21 the second visit for Ms. Blue?

22 A. Yes.

23 Q. When did you do that surgery?

24 A. The surgery was executed 04/28/2010.

25 Q. Pull the surgical report out of your file please if

1 you don't have it handy, Doctor, I will get it for you.

2 A. Do you mind maybe?

3 Q. So why don't we do this.

4 Can you explain the jury the type of surgery using
5 this illustration and what type of implants were put into it
6 and I will get the record.

7 A. So as you heard, Mrs. blue was defined as having
8 three cervical problems. Two of them were disc herniations,
9 one of them with instability.

10 The purpose of the surgery is to get safely to the
11 bone, to the bones, cervical 4-5 and 6 and 7. Have the
12 exposure required to proceed to discectomy and implantation
13 of six implants.

14 Q. Tell the jury when you use a term like discectomy,
15 if you don't mind before you sit down, what procedure was
16 done and you now have the record, there is an operative
17 report?

18 A. So Phase I is access surgical incision and access
19 the epidural space. I mean, we have the God given anatomy
20 that makes it possible to reach the cervical bones safely.
21 That doesn't take away the fact that you are next to the
22 windpipe and next to the esophagus the feeding tube or next
23 to the carotid artery, which is the one that goes to the
24 brain.

25 I mean, there are some pretty important structures

1 there, having access to the bone. The next step is to do
2 the discectomy. The discectomy entails removing the damaged
3 disc material and do it in such a way that you are safe.
4 That is where you are getting close to the spinal cord and
5 the neurological structures.

6 So that is the so-called neurological phase that
7 people are so concerned about. Those surgeries have a certain
8 element of risk.

9 Q. So once the disc is removed, in this view it is
10 hollowed out, what do you then do and how long does this
11 procedure take?

12 A. Okay the discs are removed and in her case she had
13 three discs removed and that is subsequently followed by
14 implantation. In other words, you remove from top down the
15 tissue that is either weak or damaged by the cervical 4-5,
16 or relating mass effect C5-6 C6-7, but you have to fill the
17 space that you would -- that existed before because the disc
18 was there, you fill it with an implant and it is now a
19 fairly common technology used that they called a Peek
20 implant. It is a polymer or orthopedic plastic, if you want
21 to call it that.

22 That implant is filled in its hollow portion with a
23 bone phase, because ultimately you want the bone to take
24 over in healing. And all of this is held in position by
25 applying an anterior cervical plate. You don't want

1 implants to move, you want bone fusion and keep the anatomy
2 that is reconstituted with a normal alignment as much as
3 possible.

4 Q. Are you doing this with your eyes; how do you see
5 what you are seeing?

6 A. Okay, the first phase the access, pretty much. All
7 this work when it comes to the discectomy is done from a
8 microscope and the actual implantation of the cervical plate
9 is done with my own eyes.

10 The whole process in a case like hers -- I cannot
11 recall how long it took for her, but traditionally it takes
12 over three hours.

13 Q. And she was under anesthesia, correct?

14 A. Yes.

15 Q. I am going to hold up and put up 8B in evidence,
16 tell the jury what they are looking at?

17 A. You are looking at a side x-ray, the resulting
18 effect, if you want, from the spinal surgery. What you have
19 here is a side view that shows the cervical plate, the
20 attachment of the cervical plate to the vertebral body to
21 the bones.

22 These little dots are markers in the implant. The
23 implants are radiolucent, if we didn't have little markers
24 in there we would not know where they are. So these are
25 implanted at the manufacturing stage and when we do the

1 x-rays we can see where they are. And this particular view,
2 for example, here and here, this one maybe here. You are
3 starting to see the bone starting to ossify. So you have
4 the resulting effect with implant cervical fusion C4-5,
5 C5-6, C6-7.

6 Q. For how long will that three level plate system
7 been in Ms. Blue?

8 A. The rest of her life.

9 Q. I am going to show you Plaintiff's 8A and that
10 would be compared to the views, the other side views we
11 took, in Plaintiff's 8A, what view is this and is this one
12 before and after?

13 A. Well, yes, this is the front view before the
14 surgery. This is the front view after the surgery. For the
15 assessment of the fusion, that is the only one we had
16 before, it is easier to work with. That is, I suppose, an
17 illustration by counsel of the fact that she had an implant
18 in her body and it is there to stay.

19 Q. Prior to having you sit down Doctor, did you have
20 an opportunity prior to rendering the opinions regarding or
21 final prognosis regarding Ms. Blue, did you have an
22 opportunity to review all the available records including
23 her initial hospital record and emergency room record?

24 A. Yes.

25 Q. Okay, that is in evidence as Plaintiff's 2. Were

1 you aware her chief complaint to the EMS, having been taken
2 right from the car put on to a long board, was my neck and
3 head hurts?

4 A. I am aware of this, yes.

5 Q. When she got to the emergency room, and we can go
6 through it looking at Plaintiff's 2B, first what does triage
7 mean?

8 A. Well, emergency rooms are very busy places and you
9 have to prioritize care. Some people have real emergencies,
10 some people have lesser problems, that is what triage does.

11 You have to use your best judgment based on
12 criteria to put somebody ahead because of the severity of
13 the medical condition versus another type of injury where
14 you would have somebody wait longer.

15 Q. This one is called an emergency physician record,
16 they have a form for MVA, and MVA meaning what?

17 A. Motor vehicle accident.

18 Q. Okay if you take this highlighter, Doctor, where is
19 her injury and when did it occur according to the physician
20 that is seeing her after the accident?

21 A. So that is sort of a templated form. I see this
22 like you are now injury to neck, is what is reported and
23 that is, I suppose, her talking to the triage nurse or the
24 physician and that is at the facility and occurred just
25 prior to arrival.

1 Q. Indicating with a highlighter, the location of her
2 most significant complaints?

3 A. Head and neck.

4 Q. At the time noted you don't have do it, it is right
5 there as 5:20 and if you could circle down here indicates
6 memory loss or highlight headache and back pain for ROS,
7 what does ROS mean?

8 A. Review of system.

9 Q. So they indicated at least at that time she had
10 memory loss, headache, neck pain; can you see that, can you
11 highlight that?

12 A. Whatever is circled is indeed what has been
13 identified.

14 Q. What are her associated symptoms right up here?

15 A. Dazed is what is circled.

16 Q. What does it say she remembers prior to coming to
17 the hospital?

18 A. She remembers the impact and she remembers coming
19 to the hospital.

20 Q. This is just an illustration, it talks about
21 flexion, hypertension and it has a brain moving within a
22 space, can you explain that to the jury, what happens during
23 a whiplash like injury, the head is whipped back and forth?

24 A. To some degree her brain was suspended in the
25 cranium in the skull. So when you have a severe

1 deceleration accident there is little bit of suspension in
2 the brain going one way or the other.

3 Q. Just show the jury, please.

4 A. (Witness complies).

5 Q. When we talk about whiplash, it doesn't have to
6 involve that but does it often involve that?

7 A. The whiplash event led to the neck injury that we
8 talked about and some degree of brain dysfunction depicted
9 on the ER assessment.

10 Q. There is an "X" over here on the bottom of the
11 head, can you just please highlight the "X"?

12 A. Yes and the "X" points out to the left proximal
13 area of the area that hurt the most this day.

14 Q. The written notes indicate headache initially was
15 diffuse, six out of ten, then gradually became more
16 localized to the left mastoid process; is that the left
17 mastoid process?

18 A. Yes.

19 Q. Can you please above this when you look at this
20 physical exam when someone tells the emergency room do
21 doctors typically do a head, neck and systems exam
22 regardless of what you are coming in for?

23 A. Yes, especially in this case, you make sure of the
24 level of consciousness and so on and so forth.

25 Q. If you like, you can highlight and go over what is

1 checked off, I want you to tell the jury what the words
2 vertebral point tenderness, muscle spasm and pain on
3 movement, tell them what each word means?

4 A. Vertebral point tenderness points out to the fact
5 that palpation at certain points of the spinous process, for
6 example, the bony spikes we feel when put our hand in the
7 back of our neck is tender. Muscle spasms are felt. You
8 feel the muscles being tight, tender. And the fact that she
9 when moves her neck has more motion than normal.

10 Q. Is muscle spasm, a word you used before, objective
11 or subjective, meaning can a person fake a muscle spasm or
12 exaggerate it?

13 A. No, it is subjective.

14 Q. Ok, so the doctor feels that when they note it?

15 A. Correct.

16 Q. Let's go to the back, the next page, when they
17 examined Ms. Blue's back, can you indicate what they
18 indicated here with the line?

19 A. Okay, it is somewhat analogous. Vertebral point
20 tenderness, low back area spinous process, the bone you can
21 feel that is tender to touch, she had tenderness reported.

22 Q. What does CVA mean?

23 A. I am not sure what it means in this case.

24 Q. Okay.

25 A. Muscles spasms were reported as being indeed

1 present.

2 Q. And this circle, can you highlight the circle,
3 those are marks made by the physician?

4 A. Yes. What we are looking at in these markings here
5 on this body diagram is pointing out what is lumbar, for me
6 at least.

7 Q. At least in the clinical impression, what does
8 clinical mean in those terms?

9 A. It is the resulting judgment to what they say in
10 the emergency room. It is what the diagnosis is or
11 assessment, like I call it.

12 Q. What is the clinical assessment, MVA sprain of
13 what, when it says neck and lumbar, what does lumbar mean?

14 A. Lumbar is low back, neck and cervical.

15 Q. Just highlight those, please.

16 A. We are talking about lumbar, we are talking about
17 neck, cervical in this case, we talk about and explain and
18 mention the fact that she had MVA.

19 Q. Going to down to the x-rays, could you tell us what
20 part of her body was x-rayed and what does head CT mean?

21 A. They did x-rays in case of trauma. You want to
22 make sure you don't have fracture or things of that sort in
23 her neck, so she had cervical x-rays, she had lumbar sacral
24 x-rays, low back x-rays. The findings were that she had a
25 straight cervical x-ray in terms of the alignment.

1 We talked about that, she lost the sway that
2 normally exists in the neck.

3 Q. So the actual highlighted and circled by the doctor
4 says straightening of the cervical lordosis, correct?

5 A. Yes, correct and referring to the cervical segment,
6 correct.

7 Q. Is that consistent with trauma?

8 A. It is consistent with some event. It is consistent
9 muscle spasms and in this case trauma was involved.

10 Q. Okay and the head CT, what is a CT?

11 A. Well, because I suppose the physicians took note of
12 some mental change in function, so they wanted to make sure
13 she had no brain injury and they asked for plain CT of the
14 brain.

15 Q. Let's go to the x-ray reports from the hospital
16 there's both a cervical AP view and they did lateral views,
17 lumbar sacral view, it is here on a disc, but by report,
18 what does the impression of both the cervical lumbar and
19 what if any medical significance does that have.

20 MR. McCRORIE: I am sorry, 2C is a larger
21 version of what is in evidence.

22 A. So, one they rule out actual fractures, but they
23 rule in what we have been talking about, the fact that she
24 had muscle spasm and that is inferred because the cervical
25 spine lost its lordosis. We have a straightened cervical

1 spine.

2 They talked about the findings that we discussed,
3 the spondylosis. In this case they used the word spondylo
4 lordosis, which literally means the same, at least to me it
5 does, narrowing of the disc space of the spurring.

6 Q. What do they call minimal disc spacing?

7 A. Again, it is a term describing a varying from
8 normal where the disc space is narrowed a little bit. We
9 know C6-7 is not as changed as C5-6.

10 Q. What about the lumbar spine, only because there is
11 a word there uterine fibroids and some other terms, tell the
12 jury what was found?

13 A. They pointed out the fact that for the most part
14 the bony relationship in the lumbar segment was within
15 normal limits.

16 Q. Okay, what does that mean, degenerative uterine
17 fibroids in the pelvis, lumbosacral graphs are otherwise
18 within normal range?

19 A. The uterine fibroids refer to a gynecological
20 issue.

21 Q. Just before we have you sit down too, in evidence
22 Plaintiff's 7, are you aware that Ms. Blue three days before
23 this accident was in an incident where she was assaulted,
24 punched in the arm and had a sprain to the right wrist and
25 punched in the right shoulder?

1 A. I was made aware of that eventually.

2 Q. You have seen the actual report?

3 A. Yes.

4 Q. It is in evidence, but it indicates a punch to
5 right arm today complaining of pain to same. Color pink in
6 skin, warm to the touch.

7 I wanted to go to the record portion where they did
8 a physical exam. If you can with this highlighter indicate
9 where the neck exam was and what it is indicates?

10 A. This is a typical medical -- again, it is a
11 templated form. There is a word, in the neck --

12 Q. What does supple mean in the neck?

13 A. Yes, I was going to get to that. What we see here
14 and I agree with gentleman, I would interpret that as being
15 supple implying that the neck has no range of motion, no
16 particular tenderness and you don't have suppleness if you
17 are having spasms and then after that there is a zero to bar
18 which means negative something, but after that I cannot tell
19 you what it is.

20 Q. Just so we see that it is negative something.
21 Right above it does that state 53 year old here with pain in
22 right shoulder and right wrist status post assault, negative
23 head pain; is that what that states?

24 A. Correct.

25 Q. So a line with a question means she was

1 experiencing no head pain three days before the time she was
2 in the emergency room getting a CT scan for head pain?

3 A. Correct.

4 Q. At least suppleness of the neck is inconsistent
5 with three days later there being spasm, pain on movement
6 and vertebral point tenderness?

7 A. Very much so.

8 Q. You can have a seat, Doctor.

9 Is taking a history and writing the word whiplash
10 is that what is known as the mechanism of injury?

11 A. In this case, yes.

12 Q. I meant just when you take a history and you write
13 how it happened, if someone fell, what is mechanism of
14 injury?

15 A. Well, it is just that whiplash, we use as a
16 diagnosis as well as in the cervical spine, but literally
17 she experienced whiplash to cause her trauma. Whiplash is
18 neck pain, occipital pain, mastoid pain.

19 The disc herniations happened because of a
20 whiplash, but it is not a whiplash disc herniation --

21 Q. I want to get some definitions, then we do some
22 opinions and you are done, but what does degeneration mean,
23 medically, as it relates to the spine?

24 A. Degeneration in the spinal context, spinal care
25 context, is a term describing changes from normal anatomy.

1 And that changes occur normally as we get older. I have
2 disc generation for certain because I reached this famous
3 threshold point.

4 Q. Meaning age?

5 A. Thank you. Meaning disc narrowing. Meaning
6 dryness of the disc. Meaning that when you look at a disc
7 in an MRI it is dark instead of being white, watery.
8 Meaning bone spurs that occur as we get older. Yes, that is
9 disc degeneration, the condition we hear about a lot.

10 Q. Does disc degeneration equal herniation?

11 A. No.

12 Q. Can you have a herniation and have it be
13 asymptomatic?

14 A. Yes.

15 Q. Tell the jury what asymptomatic means?

16 A. Means that you don't have symptoms. You have
17 almost like a radiographic diagnosis, but no clinical
18 diagnosis. No symptoms.

19 Q. Can trauma cause the previously asymptomatic disc
20 herniations to become symptomatic?

21 A. Yes.

22 Q. Can trauma cause a previously asymptomatic
23 degenerative disc disease, like spondylosis, that doesn't
24 have herniations can that cause a herniation superimposed on
25 the previous weakened spondylosis?

1 A. Yes.

2 Q. The more degenerated a spine is, could you agree,
3 the less trauma is needed to cause a herniation?

4 A. Generally speaking, yes.

5 Q. When you were with the microscope looking in Ms.
6 Blue's -- in her spine, did you actually note and visualize
7 herniations and tears to the annulus?

8 A. Yes, I did.

9 Q. If someone had such herniations prior to an
10 accident and they were symptomatic, would you expect being
11 the level they were that you showed the jury and saw with
12 your own eyes, would you expect that person to have some
13 complaints in the 50 some odd years prior to the accident
14 some to some physician?

15 A. Yes.

16 Q. How about if she was actually before a physician
17 within 72 hours of the accident, would you expect that
18 someone, that she would complain of neck pain to a
19 physician?

20 A. I would think so. I would say yes to that.

21 Q. Would you expect her neck to be supple within 72
22 hours if she had a herniation that was pressing out into the
23 canal, multiple herniations, but actually indenting as it is
24 on the axial view?

25 A. I would expect her to have symptoms and complain

1 about it.

2 Q. Okay, I am going to ask you your opinions with
3 regard to the cause of Ms. Blue's herniations and
4 conditions.

5 I would like you to first assume that there was
6 testimony, but there will be testimony by Mr. Garcia, that
7 he was driving a 53,000 pound truck and that Ms. Blue was
8 sitting within a stopped vehicle in front of this truck and
9 whatever the degree of impact was, it caused the vehicle in
10 front of it to be thrown four feet forward, it caused the
11 transmission gear to break on the vehicle because the driver
12 was on the break at the time.

13 MR. HALL: Note my objection for the
14 foundation.

15 THE COURT: I will allow it subject to
16 connection.

17 MR. HALL: Thank you.

18 Q. I would like you to further assume that the rear
19 bumper, rear bumper shock was replaced on the vehicle and
20 that the metal was dented underneath the bumper, that may
21 have even looked not so damaged at the scene, it was
22 replaced within a week of the accident.

23 I would like you to assume that the trunk latch of
24 that trunk of that vehicle was broken. I would like you to
25 further assume that Ms. Blue was in the emergency room and

1 picked up by ambulance immediately after the accident, never
2 got out of the vehicle and when she was taken out of the
3 vehicle was strapped down in a long board and it is even
4 indicated she was unable to sign because she was strapped
5 down when they came in they got there.

6 I would like you to further assume she convalesced
7 at home and tried to go to work a week later, went to Dr.
8 Maranga and on November 7, 2008, had a complete physical
9 exam that indicated reduced range of motion to the neck,
10 reduced range of motion to the back, reduced range of motion
11 to the left shoulder, associated pain -- I am only going to
12 be asking you about the neck and back. And that was as a
13 result -- and that after the date of the accident until
14 today she has had all the medical care that you have
15 testified about and all the medical care with you including
16 the epidurals to the neck and back, any other injections,
17 medication, physical therapy and that she's is in condition
18 she's in that you operated on.

19 Do you have an opinion within a reasonable degree
20 of medical certainty as to the need, first, for that surgery
21 that you did to her neck?

22 A. Yes, I do.

23 Q. What is your opinion as to the need and cause of
24 the surgery?

25 A. That it is based on a trauma.

1 Q. What did you base that opinion on?

2 A. On the fact that she had no prior history of
3 medical care for such problems.

4 Q. Do you have an opinion knowing what you know and
5 having the hospital record and having not seen any other
6 record in a 53 years of any other treatment and seeing what
7 you see on the films, seeing what you saw on the operation,
8 do you have an opinion as to the cause not of the
9 spondylosis, of herniations that are within her neck that
10 were operated on?

11 A. Yes, I do.

12 Q. What is your opinion as to the cause of the
13 herniations?

14 A. Again, the cause is due to the trauma that we know
15 about.

16 Q. I would like you to assume in a hypothetical world
17 that herniations were there, but were asymptomatic; is that
18 possible?

19 A. Yes, it is.

20 Q. So I would like you to assume that herniations were
21 there in the hypothetical world, out there, this is not your
22 opinion, but they were there and that as a result of the
23 truck hitting the back of the car and her head doing the
24 whiplash like motion, that from that point on she had
25 symptoms that hadn't stopped until today, in that

1 hypothetical do you have an opinion within reasonable degree
2 of medical certainty as to whether or not the accident where
3 the 53,000 pound truck hit the car and caused her neck to do
4 that, whether or not that was the cause of aggravating of a
5 preexisting previously latent and asymptomatic herniation?

6 A. I agree that is the cause. The trauma is the
7 cause.

8 Q. What is latent mean?

9 A. Latent means a condition that is not manifested and
10 that eventually comes about due to all sorts of
11 circumstances.

12 Q. Absent the motor vehicle accident, do you have an
13 opinion whether Ms. Blue would require any of the treatment
14 that she has undergone from the emergency room until today?

15 A. Nothing indicating to me based on history she would
16 have needed any care for her neck.

17 Q. If I took out any of the questions in that
18 hypothetical or the actual question about let's say for
19 instance the man's transmission didn't break or didn't get
20 that bumper replaced, but there was an impact how ever light
21 or heavy with the truck and the car that was stopped causing
22 Ms. Blue's neck to whip back and forth, would that change
23 your opinions on any level?

24 A. No.

25 Q. Do you have an opinion within a reasonable degree

1 of medical certainty as to whether or not Ms. Blue will
2 require future medical care beyond the date of this trial?

3 A. Yes, she would need future care.

4 Q. And for what period of time would you expect and
5 you can tell us the categories, that Ms. Blue would require
6 future medical care?

7 A. I think it is logical to assume because we have a
8 history to also base judgment on, that she will need care
9 for pain relief. She will need care for flexibility in her
10 neck and need improvement of range of motion and she will
11 need medical opinions of various stages to assess the
12 cervical fusion and to assess the other areas of the
13 cervical spine lumbar spine, based on history.

14 Q. I am sorry to do this to you, and the jury I want
15 to back up. I only did the neck.

16 Do you have opinion within a reasonable degree of
17 medical certainty as to the cause of Ms. Blue's lumbar
18 herniation?

19 A. Yes.

20 Q. What is your opinion with regard to her lumbar
21 herniation?

22 A. The opinion is also the symptoms are triggered by
23 the trauma that we know about.

24 Q. You mentioned pain management, are you treating Ms.
25 Blue for pain management in her shoulder and even ongoing

1 back conditions or are you a surgeon waiting to see if the
2 surgery is going to be done?

3 A. Literally --

4 Q. Or some combination?

5 A. To a point literally I don't consider myself a
6 surgeon who is interested only in surgery, but my role, my
7 involvement for Ms. Blue has been in the cervical area.
8 That was the most important area. Other people have been
9 involved in lumbar, shoulder and pain management.

10 Q. Without going through every single question, would
11 your opinions be the same as the cervical; in other words,
12 could the lumbar herniation have been there before in the
13 hypothetical world and be asymptomatic, she just didn't
14 complain about it?

15 A. Yes.

16 Q. And given her history, is it your opinion that it
17 is caused by the accident based on her prior history?

18 A. Same answer, yes.

19 Q. Okay are you aware of Ms. Blue's current treatment
20 by the doctors where they are requesting, prior to
21 considering back surgery, spinal cord stimulator and
22 rhizotomy?

23 A. I am aware of that.

24 Q. We will have other doctors discuss that. Let's get
25 back to the future medical opinion, please.

1 You said she might need medicals, you said therapy
2 or maintenance, let's go to your specialty first.

3 Do you have an opinion within a reasonable degree
4 of medical certainty as to whether or not she should
5 continue, given the symptoms she is still having, to see a
6 orthopedic surgeon, spinal surgeon, specifically spinal
7 surgeon, into the future, such as yourself?

8 A. Yes.

9 Q. What is your opinion -- I know it is tedious, but
10 we have to do it this way.

11 What is your opinion?

12 A. Generally speaking, patients of spinal surgery need
13 follow-up at reasonable intervals. I could see a patient
14 like Mrs. Blue requiring -- she would require visitation at
15 least once a year with an x-ray probably at the same
16 frequency or at least every two years and depending on the
17 symptoms, MRI's would be in need on average every two, three
18 years.

19 Q. Okay, so what is a cost, if it wasn't a
20 compensation case? I would like you to assume there would
21 be an instruction that after this trial that Compensation
22 gets all their money back, I would like you to assume that
23 and in the future, what would it cost someone to come to a
24 follow-up visit whether it be yourself or the general area,
25 a spinal surgeon, for a follow-up visit with the x-rays at

1 least once a year? Separating out the cost.

2 A. For a visit of the office is usually \$150 to \$200.
3 X-rays up to \$300, I suppose. MRI's, I will speak for what
4 I believe is the general cost in New York City at \$1,200 is
5 what I know about.

6 Q. When you say depending on symptoms, you are aware
7 that Ms. Blue still had had symptoms both in the shoulder
8 and the back, correct?

9 A. I am aware of that correct.

10 Q. Was surgery a success in the neck?

11 A. I believe so.

12 Q. Medical success?

13 A. I believe it was.

14 Q. Does Ms. Blue still exhibit symptoms in the
15 cervical region post surgery?

16 A. She has one persistent very difficult problem and a
17 few others that are not so severe. The severe one is the
18 spasm. The left trapezius muscle group with limitation in
19 the range of motion, especially when it comes to turning her
20 head.

21 Q. What is the trapezius muscle, where is that?

22 A. It is a shoulder muscle that gives us the swing
23 shaping of our shoulder, if you want.

24 Q. Ms. Blue is currently 56 years old, again, I note
25 tedious for what period of time would you recommend with a

1 reasonable degree of medical certainty, she continues to at
2 least check out her neck once a year with a spinal surgeon
3 and back?

4 A. My opinion she would need frequent visits, at least
5 once/twice a year.

6 Q. When you said \$300, would that be \$300 for the
7 neck, \$300 for the back in terms of series of x-rays?

8 A. Most likely, yes.

9 Q. Does Ms. Blue still have what is -- what are
10 radicular symptoms, radiating symptoms, where do they come
11 from, the disc herniation, cervical disc herniation?

12 A. When we talked about the yellow string on the
13 plastic model, they are the nerves that reach the part of
14 your limbs. She has a little bit of numbness left in her
15 left hand, compared to what she had before surgery. It's
16 better, but she has some left.

17 Q. Did the surgery take away the -- it is noted in
18 your notes, the electric-like symptoms?

19 A. It certainly took away a lot of the sharp, very
20 severe symptomology. She is now left with some residual
21 numbness, which by the way is fairly common after such
22 condition.

23 Q. Does that have to do with -- I am holding up
24 Plaintiff's 4A, the fact that you actually took out the disc
25 materials and actually -- I am holding up 4C, took the disc,

1 the disc was no longer there pressing where it was pressing
2 and now the peak implant?

3 A. The persistent numbness has more to do with the
4 duration of the compression on this neural tissue that
5 existed until the point of surgery.

6 Q. The three screws, bars, in her neck, do they limit
7 her motion?

8 A. To some extent, yes.

9 Q. And the spasm that you said in the trapezius
10 muscle, are you aware that she goes for weekly injections to
11 attempt to break that spasm as well as therapy to try and
12 loosen up the motion?

13 A. I am aware of that.

14 Q. Would you have any opinion as to whether or not
15 that should continue until the spasm which hasn't broken
16 since April of 2010, breaks, if it does?

17 A. It has been a very difficult problem for her and I
18 anticipate will need care for this until it gets better, if
19 it does.

20 Q. Can trauma cause previously asymptomatic
21 spondylosis or degeneration to now advance?

22 A. Yes.

23 Q. In fact, do you have an opinion as to whether or
24 not the truck hitting Ms. Blue had an affect on her
25 previously asymptomatic spondylosis, whether or not it will

1 continue to progress despite the fact that you have done the
2 fusion?

3 A. Well, she is at risk of having problems in the
4 future, so the answer is yes

5 Q. When you state in your notes that she is not ready
6 for vocal rehabilitation, what do those words mean?

7 A. They apply to the fact that based on my
8 understanding of her level of competency and work history,
9 but mainly based on the symptoms she has now, she will not
10 be able to attend any vocational program.

11 It would be the sentiency in her occupation, and
12 would be the type of neck spasms that would make it
13 impossible for her to do that at this time.

14 Q. Given her previously being asymptomatic as a result
15 of the accident and given any knew traumatically caused
16 herniations and issues you have told the jury about, would
17 you expect someone with Ms. Blue's condition to have pain
18 upon sitting for a period of time?

19 A. She has already and the answer is yes.

20 Q. How about standing for a period of time?

21 A. Same applies.

22 Q. Bending her neck or back to any degree?

23 A. She as limitation, range of motion definitely
24 provoking pain.

25 Q. Are her conditions permanent given the time they

1 have been going on, in your opinion, are they permanent
2 conditions?

3 A. My opinion is that they are permanent.

4 Q. Within a reasonable degree of medical certainty, is
5 Ms. Blue facing the prospect of any further surgeries of the
6 spine, neck or back?

7 A. To some degree yes.

8 Q. What is your opinion as to whether or not she
9 requires same?

10 A. Surgery?

11 Q. Yes.

12 A. Moderately likely.

13 Q. And what is it -- when you fuse discs whether it is
14 one level, two levels, three levels, what happens to the
15 levels above and below, what can happen?

16 A. When can happen due to the change in mechanics you
17 can have an accelerated wear of those discs, therefore,
18 resulting in symptoms, neurological problems. It is always
19 a problem.

20 Q. Are you aware to date of the amount of -- under the
21 compensation rates, you have been compensated by another
22 entity for Ms. Blue's care?

23 A. I believe it is --

24 THE COURT: I don't understand the question.

25 Where are you going with that?

1 Q. I have the bills?

2 THE COURT: Well, why don't you move the bills
3 into evidence.

4 MR. McCRORIE: Okay, the bills have come to
5 approximately \$24,000 in treatment.

6 A. Yes counsel asked me before to do summations,
7 \$23,330.72

8 Q. If is this was a private matter, such as in the
9 future, how much would that number be?

10 A. Higher.

11 Q. A lot higher?

12 A. It would be higher.

13 Q. Okay, can you put on the record -- I don't know if
14 I did this -- please bear with me then I will be done, your
15 objective basis, rather than -- not Ms. Blue's history, can
16 you tell the jury any of the objective basis you have for
17 telling them her herniations were caused by the accident?
18 So anything objective, seeing the discs findings, just for
19 the record?

20 A. Well, we had objective weakness in the arm.
21 Objective numbness in the arm. Objective loss of range of
22 motion of the neck. We had spasms to the neck. We had two
23 disc herniations proven. One level with cervical
24 instability and a patient who did not have any clinical
25 improvement in one year from the date of trauma.

1 MR. McCRORIE: Okay, I have nothing further.

2 THE COURT: Thank you. Counsel, You can
3 proceed

4 CROSS EXAMINATION

5 BY MR. HALL:

6 Q. Good morning.

7 A. Good morning, sir.

8 Q. You have testified in Court before?

9 A. Yes.

10 Q. Okay and you said generally in the past it has been
11 for patients under you care, correct?

12 A. Correct.

13 Q. And, in fact, do you recall testifying back in
14 February of this year on behalf of a patient by the name of
15 Jesus Solis?

16 A. Correct.

17 Q. Right, that was in New York County, correct?

18 A. I believe so.

19 Q. All right, do you recall being cross-examined, by
20 your understanding, by my partner Steve Cohen?

21 A. I remember that session, correct.

22 Q. Okay and in this case did Dr. Kaplan also testify
23 on behalf of Jesus Solis?

24 A. I cannot say. I am not sure.

25 Q. Did Dr. Kaplan have any involvement in Jesus Solis'

1 care and treatment?

2 A. I believe so.

3 Q. Did you get Jesus Solis as a patient through
4 referral from Dr. Kaplan?

5 A. Correct.

6 Q. Can you tell the jury, I know that will be
7 approximation, about how many times per year you testify
8 either in a courtroom like this or Workers' Compensation
9 Board hearing or some other type of medical hearings?

10 A. Well, compensation board hearing once to twice a
11 month. Usually once a month and Court hearings like this
12 one, all this here is an average one to two times a year.

13 Q. And is there is a difference between how much you
14 charge for compensation board hearings opposed to
15 testifying in Court cases like this one?

16 A. Compensation board hearings are, again, court
17 appointment fees. I don't determine the fees.

18 Q. And your typical rate for testimony in Court is
19 \$10,000?

20 A. Correct.

21 Q. What percentage of your patients, Dr. Brisson, are
22 involved in litigation?

23 A. I cannot tell you, sir.

24 Q. But more than Ms. Blue, you have at least we know
25 about Mr. Solis, there are others?

1 A. There are others.

2 Q. Yes?

3 A. Yes. That is the way of life in this part of the
4 world. There are others. The exact percentage I cannot
5 tell you.

6 Q. More than ten percent?

7 A. I think it would be probably as an orthopedic
8 surgeon involved in an accident case, ten to fifteen
9 percent.

10 Q. Okay, ten to fifteen percent of your patients have
11 active cases in litigation, at some point in time during
12 your care and treatment, correct?

13 A. Quite possible.

14 Q. And do you ever get patient referrals from lawyers?

15 A. Direct referrals?

16 Q. Yes.

17 A. Some lawyers will sometimes send patients to my
18 attention, correct.

19 Q. And about how many a year, if you can estimate for
20 us?

21 A. I cannot tell you that.

22 Q. In connection with cases for your patients that are
23 in litigation, do you prepare reports for lawyers if you are
24 asked?

25 A. If I am asked then the answer is yes.

1 Q. Do you get paid for that?

2 A. I do get paid.

3 Q. How much do you get paid for your reports?

4 A. Anywhere from \$500 to \$750.

5 Q. Per report?

6 A. Per report.

7 Q. How many such reports do you write per year, if you
8 can estimate for us?

9 A. I cannot say for certain, but probably that two
10 reports a month or so, two to three reports a month.

11 Q. Now if you had to estimate and I am going to ask
12 you to, based upon your testimony on behalf of patients who
13 are in litigation, between the Court testimony and the
14 reports that you write for the lawyers who asked for them,
15 what percentage of your income does that represent?

16 A. Less than five percent.

17 Q. You testified earlier, before you testified here
18 today, you met with Mr. McCrorie twice, correct?

19 A. Correct.

20 Q. Now, are you going to be paid for the time that you
21 spent with Mr. McCrorie preparing for you testimony in
22 addition to the 10,000 you being paid to appear here?

23 A. You mean today, no it is all inclusive.

24 Q. Everything is included in that \$10,000?

25 A. Yes.

1 Q. How long did you meet with Mr. McCrorie on those
2 two occasions you sat down?

3 A. I would say both times approximately four to five
4 minutes.

5 Q. So about an hour-and-a-half in total?

6 A. Approximately.

7 Q. Okay do you write any reports for Mr. McCrorie on
8 behalf of Ms. Blue?

9 A. I am not certain. I believe not.

10 Q. Did you want to check your file?

11 A. Yes, I believe the only thing I have on Mrs. blue
12 is the office notes.

13 Q. Okay, you didn't write a formal report at the
14 request of Mr. McCrorie for Ms. Blue?

15 A. I don't believe so. I really don't. It would be
16 here, but I don't have it.

17 Q. Do you recall for Mr. Solis when he testified back
18 in February, do you write a formal written report for him?

19 A. I did, I think, for him.

20 Q. Trolman, Glaser and Lichtman; is that correct?

21 A. You know better than I.

22 Q. I have the transcript right here, if I told it was
23 for Mike Madonna -- excuse me David Corley at Trolman,
24 Glaser and Lichtman; does that reflect your recollection?

25 A. Again, I don't really remember the names and types

1 of case. I just remember that I did a report.

2 Q. Do you know if you have any other cases with
3 Trolman, Glaser & Lichtman?

4 A. I couldn't tell you.

5 Q. Do you have cases with more than one or two
6 lawfirms?

7 A. Oh, all over the place. I just don't know.

8 Q. Dr. Brisson, how long are your typical visits with
9 the patients?

10 Why don't we focus on Ms. Blue. Typically, how
11 long were your visits with Ms. Blue in your care and
12 treatment, each office visit?

13 A. When they came to me?

14 Q. Yes.

15 A. They certainly vary, but you know, quite frankly
16 after a bit of time with her easily 20 to 30 minutes.

17 Q. Okay, all right, I am going to show you what I have
18 in my hand, a fax from your office and actually has
19 appointments listed for Ms. Blue for December 12th 2011, 15
20 minutes. January 25 2012, 15 minutes. March 7, 2012, 15
21 minutes. April 11, 2012, 15 minutes.

22 A. Counsel, that is a scheduling system. That does
23 not reflect the time spent with her.

24 Q. You are saying that the minutes and the start time
25 here doesn't reflect how much time you spent with them?

1 A. Probably I can tell you also they waited a long
2 time from --

3 Q. I am not asking for what she can tell me -- I am
4 asking you to tell me if you spent more than 15 minutes
5 listed in your records, yes or no?

6 A. Sir, scheduling is 15 minutes --

7 Q. You are saying you spent more than 15 minutes with
8 her on those visits?

9 A. Definitely with her. Easily.

10 Q. And we are talking about the rates you are getting
11 paid before with Mr. McCrorie, am I correct that for the
12 visits Ms. Blue made to your office she was charged anywhere
13 from \$49.26, for example, for the January 27, 2010 visit; is
14 that correct?

15 A. She is prescribed compensation --

16 Q. I am asking you what was paid for the visit? You
17 charged and paid an amount of money, it was \$49.26; is that
18 correct?

19 A. I will answer the question if you let me.

20 Q. I am asking for yes or no; is that correct?

21 A. Yes, it is correct.

22 Q. All right, then for a visit on October 14, 2009 you
23 charged and were paid \$71.49, is that true?

24 A. Correct. I suppose. You have it.

25 Q. You don't have it in your file?

1 A. I can pull it out if you want to ask me questions
2 about these things.

3 Q. Is that your billing summary?

4 A. Correct, statement of account.

5 THE COURT: What is your question, Counsel?

6 Q. I don't know what you are checking. You believe
7 what I said is correct, so.

8 A. I was waiting for additional questions on the
9 matter. I am ready.

10 Q. You are ready. Am I correct that for the x-rays
11 you charged and were paid \$171.21?

12 A. This one for some reason I don't have listed here,
13 so.

14 MR. HALL: May I approach the witness, your
15 Honor?

16 THE COURT: Yes.

17 A. That is the compensation rate for x-rays?

18 Q. I am not talking about what the rate is.

19 You charged and were paid \$171.21 for the x-rays,
20 correct?

21 A. Yes.

22 Q. All right, now you talked about different rates
23 when a patient like Ms. Blue comes in and you are getting
24 paid \$50 bucks a visit opposed to \$150 or \$200 a visit, is
25 the standard of care that you render any less?

1 A. No, not at all.

2 Q. You get the same treatment as a patient like Ms.
3 Blue whether or not you are paying 50 bucks for the visit or
4 \$150 or \$200 a visit, correct?

5 A. Yes.

6 Q. So in the future if Ms. Blue comes back to you and
7 says, you know what, I was paying 50 bucks before it is all
8 I really can afford, are you going to turn her away?

9 A. I never did that, I don't know why I would do that
10 now.

11 Q. In the future going forward, you would treat her at
12 the same rate you are treating her now, correct?

13 A. I would have a normal conversation like we have in
14 the office and we deal with private patients.

15 Q. Okay, if you decided, you know what, I have been
16 treating Ms. Blue, I put a three level fuse in her neck, I
17 feel a commitment as a doctor, an obligation of a doctor to
18 continue treating her, if she said, I can only continue to
19 pay the 50 bucks a visit, you some accept that?

20 A. I can assure you if that is the case I will do
21 that.

22 Q. Concerning the 170 bucks, Doc, that is all I can
23 afford, you would do that, right?

24 A. I am telling you I would take care of her the same
25 way I would before. I wouldn't change anything.

1 Q. I want to go back to the MRI cost for a moment when
2 Mr. McCrorie asked do you know what the standard fee is for
3 an MRI, do you know what Ms. Blue paid for her MRI's?

4 A. I don't. I mentioned what I thought I knew, but I
5 don't.

6 Q. When was the last time you checked, just generally,
7 as to how much an MRI costs?

8 A. Because sometimes private patients tell us how much
9 they pay at a facility. I don't really now, \$1,000 to
10 \$1,200 many times.

11 Q. Before you came here today, did Mr. McCrorie and
12 you discuss fact that you were going to be testifying or
13 asked to testify about future medical care costs?

14 A. There was discussion about future medical costs,
15 but not MRI's as such.

16 Q. Isn't an MRI part of future medical care? You just
17 testified it was, yes or no; isn't it?

18 A. It is, but not the rates. Rates are what I know
19 from my patients in the office.

20 Q. As you are sitting here today, you cannot tell us
21 -- you can't tell this jury how much Ms. Blue will have to
22 pay in the future for an MRI, can you?

23 A. Well, I am faced with these people all the time --

24 Q. Doctor, please, yes or no. You cannot tell them.
25 You didn't make any calls or do any research into this

1 before you took the stand, did you?

2 A. About the topic, no.

3 Q. You understand, right?

4 A. No.

5 Q. You didn't, right? You pulled the number out based
6 upon something that you had heard about some time in the
7 past and you didn't follow up before you took the stand
8 today, correct?

9 A. I see patients every day. The answer is not so up
10 in the air. I don't run an MRI business, I am not going to
11 give you a rate that I don't myself charge.

12 Q. That \$1,200 rate, you cannot state with any type of
13 certainty that is what she would have pay in the future,
14 correct?

15 A. It would be very likely, sir.

16 Q. I am not asking for likely, you can't say with any
17 certainty, can you?

18 A. Certainly in sense you are asking me, no.

19 Q. Thank you. Let's go back to this issue of
20 certainty, there is also discussion of future surgery and
21 you were reflected for a minute after Mr. McCrorie asked you
22 a question and you said that it was moderately likely,
23 correct?

24 A. Correct, sir.

25 Q. Can you sit here and state to this jury within a

1 reasonable degree of medical certainty Ms. Blue is going to
2 need future cervical surgery?

3 A. As I said, moderately lightly.

4 Q. I am not asking you to explain your answer again, I
5 am asking you to answer my question, Doctor.

6 Can you say within a reasonable degree of medical
7 certainty that Ms. Blue will require further surgery, spine
8 surgery in the future, yes or no?

9 A. The answer is no.

10 Q. Now, Mr. McCrorie elicited on direct examination
11 that you had treated a patient and a client of his by the
12 name a Daniel Breen (phonetic) correct?

13 A. Correct.

14 Q. And that --

15 MR. McCRORIE: I didn't mention the name under
16 HIPPA. I would say that is the name, but we shouldn't
17 be talking about the name.

18 MR. HALL: You are correct. That is my fault.
19 I apologize.

20 THE COURT: That is stricken from the record.

21 Q. Mr. B?

22 MR. McCRORIE: The name is out there.

23 Q. You testified in that case back in October of last
24 year; isn't that correct?

25 A. Correct.

1 Q. And in that case the care and treatment for Mr.
2 Breen included a discectomy and fusion also, correct?

3 A. Yes.

4 Q. That was also cervical spine, correct?

5 A. Yes.

6 Q. And Mr. McCrorie had gone through the same type of
7 education of the jury in that case with regard to the
8 physiology of the human spine?

9 A. To a logic stand, correct.

10 Q. Same thing with regard to the care and treatment of
11 what the surgery entailed, same thing?

12 A. Correct.

13 Q. Mr. McCrorie paid you \$10,000 to testify in this
14 case as well, correct?

15 A. Correct.

16 Q. In that case the referral actually came from a
17 different doctor, a Dr. Hauskinecht, correct?

18 A. You would know better. I cannot recall.

19 MR. McCORIE: I will stipulate.

20 MR. HALL: I certainly would.

21 Q. Mr. McCrorie will stipulate Dr. Hauskinecht is
22 another doctor who you get patients from by way of referral?

23 A. Very few. I know him, but I don't get many
24 patients from him.

25 Q. Are any of the patients, other than the person we

1 are talking about just now, involved in personal injury
2 litigation?

3 A. (No response.)

4 Q. The Hauskinecht referrals?

5 A. I operate as follows. The answer is no.

6 Q. Other than this one?

7 A. I cannot answer the referral part as you are
8 describing it to me. The sources of the patients are all
9 walks, all types.

10 Q. You are not saying that Dr. Hauskinecht hasn't
11 referred other litigants to you, that could be true?

12 A. No, no, Dr. Hauskinecht has referred other
13 patients, personal injuries in the past. The answer is yes,
14 but he doesn't refer much to me to begin with.

15 Q. Okay, but the cases he does refer to you tend to be
16 personal injury cases?

17 A. I don't know. I cannot recall for certain.

18 Q. You just said he referred other plaintiffs of
19 personal injury cases to you in the past?

20 A. If you understood this, that is not what meant. I
21 said a patient comes from various sources. Has Dr.
22 Hauskinecht refered cases to me that have personal injury
23 history, the answer is yes.

24 Q. Right, okay, that is what I thought I heard.

25 Now, do you have any current patients who are

1 clients of Mr. McCrorie other than Ms. Blue?

2 A. I don't know. I don't think so.

3 Q. Now, Doctor, am I correct that your first visit
4 with Ms. Blue was on September 21, 2009, correct?

5 A. Correct, sir.

6 Q. You were seeing her at the request of Dr. Kaplan,
7 correct?

8 A. Correct.

9 Q. You used to share an office with Dr. Kaplan; is
10 that right?

11 A. Correct.

12 Q. I think on direct examination Mr. McCrorie elicited
13 an answer that back in 2009 you were sharing an office back
14 then, correct?

15 A. Correct.

16 Q. Now, for how long did you share an office with Dr.
17 Kaplan?

18 A. I arrived there in January 2007 and left in October
19 of 2010.

20 Q. And since October of 2010, you have been in your
21 current office, correct?

22 A. Correct.

23 Q. How about before you shared an officer with Dr.
24 Kaplan, where was your practice before that?

25 A. At the office I am at now.

1 Q. Okay, and what years was that?

2 A. 2000 to January 2007. 2000 to 2007.

3 Q. From the 2000 to 2007 time period, did you share
4 those offices with any other doctors?

5 A. It was a gentleman by name a Dr. Keisman that
6 worked there and for a while Dr. Wright.

7 Q. Is that Dr. Arden Keisman?

8 A. Yes.

9 Q. What was his specialty?

10 A. Pain management.

11 Q. Did you and Dr. Keisman have a relationship where
12 you would refer each other clients or he would refer you
13 clients and you might refer him clients?

14 A. He referred to me. I referred to him very little.

15 Q. Other than Ms. Blue, Dr. Kaplan has referred other
16 patients to you in the past; is that correct?

17 A. Yes, Dr. Kaplan has referred to me, yes.

18 Q. He has referred quite a few patients to you in the
19 past?

20 A. In the past more than now he did.

21 Q. Again, we know that Jesus Solis was at least one of
22 the other patients that he referred you, right?

23 A. Dr. Kaplan is an orthopedic surgeon. I saw quite a
24 few patients from him.

25 Q. And many of his patients were involved in personal

1 injury actions?

2 A. Correct. Probably higher percentage than
3 otherwise. The answer is yes.

4 Q. How many referrals per year and I guess I will
5 break it down. You said not as much as before back in the
6 day when you were getting more referrals from Dr. Kaplan,
7 about how many a year were you getting, Dr. Brisson?

8 A. Probably maybe two to three a week.

9 Q. Okay and when Dr. Kaplan was referring you two to
10 three patients a week, how many of those patients were
11 personal injury litigants?

12 A. They were compensation cases versus no fault or
13 whatever.

14 Q. Whatever, there was an accident involved there was
15 some kind of proceeding, either court proceeding, comp,
16 no-fault; what was the percentage?

17 A. Pretty high, probably 90 percent.

18 Q. 90 percent of those referrals back when you were
19 getting two to three a week, those people had some sort of
20 legal action going, correct?

21 A. Quite likely, correct.

22 Q. How about now currently, how many referrals do you
23 get from Dr. Kaplan presently on a weekly basis, since you
24 broke it down that way?

25 A. Less now. I probably get one case or two a month

1 maximum.

2 Q. Okay, so that is anywhere from 12 to 24 cases a
3 year now from Dr. Kaplan, correct?

4 A. If so many, but okay.

5 Q. Okay, what percentage of those current referrals
6 from Dr. Kaplan are involved in some type of injury case,
7 same percent?

8 A. Got to be the same percent.

9 Q. 90 percent?

10 A. I would think so.

11 Q. Now, when you first saw Ms. Blue, you were talking
12 about taking a history, you took a history from her when she
13 first came to see you, correct?

14 A. Correct.

15 Q. All right, and you said the history was important,
16 correct?

17 A. Correct.

18 Q. And can you tell us why taking a history from a
19 patient that you are seeing on referral for the first time
20 is so important?

21 A. Because it is the basis of a good patient physician
22 relationship. In order to treat well you need to have, the
23 best you can, accurate facts, especially when it comes to a
24 patient's symptoms.

25 Q. Okay and the word whiplash that appears in your

1 report from your first office visit, that was a phrase used
2 by her to describe what happened to her?

3 A. Well --

4 Q. Or did you characterize it as something else?

5 A. Whiplash is a medical diagnosis, so I probably used
6 it.

7 Q. Based upon what she told you in terms of what
8 happened in that motor vehicle accident?

9 A. Of course.

10 Q. Now, I am not sure if I heard this correctly on
11 direct examination, but I think you said you saw her like 12
12 months after the accident; is that correct?

13 A. Well, September 21st 2009 is the initial
14 consultation with me and she got involved with this motor
15 vehicle in October of 2008, so it is almost a year. Is 51
16 weeks.

17 Q. Actually, the accident happened in March of 2008?

18 A. Is that correct?

19 MR. McCORIE: No, October. The accident
20 happened in October of 2008.

21 Q. Okay, I am sorry.

22 All right, so you saw her about a year after the
23 accident?

24 A. 51 weeks after, correct.

25 Q. Her complaints at that time were with the neck and

1 the back, at least for what she was seeing you for?

2 A. Neck, back, left arm.

3 Q. You said with regard to the neck complaint at that
4 time they were at five out of ten on a scale of one to ten?

5 A. It was subjective pain rating five over ten.

6 Q. From zero to five you characterize that as what
7 type of pain?

8 A. It is zero to five, five is getting there, but zero
9 to is five usually manageable pain. It is moderate paint.
10 It is not severe pain.

11 Q. When you go from five to ten, how does that
12 characterize, six to ten?

13 A. You get into a range where a patient, at least
14 subjectively, is pointing out to more issues regarding to
15 the pain experience.

16 Q. What would an eight out of ten be?

17 A. Counsel pain is a personal experience. Eight out
18 of ten is a way for the patient to express to us some the
19 severity of their experience.

20 I mean, some people have eight over ten and don't
21 look that bad. Some people have five over ten are rarely
22 functional. That is a subjective area. Eight over ten in
23 normal parlance is significant pain.

24 Q. Now, do you know if Ms. Blue received any medical
25 treatment in connection with her lower back in the

1 year-and-a-half in the year between the accident and when
2 you first saw her?

3 A. I believe other consultants have been involved in
4 pain management there.

5 Q. Were those records made available to you?

6 A. I am aware that some of them were made available to
7 me afterward.

8 Q. Did you see Dr. Kaplan's record?

9 A. Yes.

10 Q. Now, in the time leading up to the accident, the
11 years leading up to the accident, are you aware of whether
12 or not Ms. Blue had any medical care and treatment in
13 connection with the neck and lower back?

14 A. History-wise, I am not aware of anything.

15 Q. When you say history-wise, you mean from what she
16 told you, correct?

17 A. What I know from the moment I met her the answer is
18 I don't know of anything that existed before.

19 Q. The moment you met her she told she hadn't had any
20 prior care treatment for her neck and back?

21 A. That is what I heard.

22 Q. You talk about in your direct examination the
23 assault that occurred about three days before the accident,
24 correct?

25 A. Correct.

1 Q. Now, the first time you were made aware of that was
2 when?

3 A. That was recent. That was a week ago.

4 Q. So in your history it doesn't reflect that,
5 correct?

6 A. Correct.

7 Q. Ms. Blue didn't tell you about that?

8 A. I was not aware of it. The answer is correct.

9 Q. So, if we were talking about before, you were
10 talking about neurologic conclusions, that someone who had
11 the kind of degenerative condition that Ms. Blue had in her
12 neck and back with the type of -- even a very light impact,
13 it could be activated by something as light as a very light
14 impact, correct?

15 A. Correct.

16 Q. How about something very light like being punched
17 in the arm very forcefully?

18 A. It could certainly create it too.

19 Q. And being shaken?

20 A. That is an event that could do it too.

21 Q. When you first saw Ms. Blue on September 21, 2009
22 your impression was that she had cervical disc herniation
23 with myelopathy and lumbar disc herniation without
24 myelopathy, correct?

25 A. Correct sir.

1 Q. Myelopathy, from what I wrote from the record, was
2 numbness in her arm or at least one of the symptoms was
3 numbness in her arms?

4 A. Weakness as well.

5 Q. And weakness. When you talk about the weakness and
6 numbness in her arm, was that based upon her complaints to
7 you or something else?

8 A. No, no, this is based on physical examination. The
9 objective sign that we obtained while examining her.

10 Q. So in the examination you were manipulating her arm
11 or something?

12 A. Testing the muscles strength.

13 Q. Okay, it wasn't from one of the films, it was from
14 your manipulation of her arm?

15 A. Yes, the films cannot tell me if the patient is
16 weak or not. That is from a clinical examination.

17 Q. Is there anyway or have you seen in the past a
18 person effect the results of that type of clinical
19 examination when they either tell you something about
20 numbness or don't quite perform to full capacity?

21 A. It is always possible. I have seen it in the past.

22 Q. Your clinical examination of her, which is what you
23 base the numbness and myelopathy, that can be manipulated by
24 the patient, correct?

25 A. The answer is yes.

1 Q. Thank you.

2 Now, we are talking about the November 8, 2008 MRI
3 of -- MRI's I should say of the cervical lumbar spine, you
4 had a change to see those during your first consultation,
5 correct?

6 A. Correct.

7 Q. And then in your narrative report of September 21,
8 2009, you note that you reviewed the cervical spinal MRI
9 films, they showed spondylosis at C5-6, right?

10 A. Correct.

11 Q. You also note that x-ray by Dr. Kaplan which she
12 had taken some time earlier, that demonstrated spondylosis
13 at C5-6 and C6-7, which was advanced, correct?

14 A. Correct.

15 Q. Okay and then when you saw Ms. Blue again on
16 October 14, 2009, that is for a follow-up after that, right?

17 A. Correct.

18 Q. All right, and your notes from that follow-up visit
19 you indicate that you had the opportunity to review that MRI
20 again -- I guess you actually did review it again, correct?

21 A. Correct.

22 Q. You wrote on it note that MRI shows spondylosis
23 which is severe at C5-6 and C6-7 with narrowing or disc
24 space, correct?

25 A. Correct, sir.

1 Q. You also took x-rays that day, correct?

2 A. Correct.

3 Q. Those showed severe spondylosis and narrowing,
4 right?

5 A. Yes, sir.

6 Q. Okay and again you testified -- and I don't want to
7 beat a dead horse, the narrowing is part of the aging
8 process in the spine, correct?

9 A. Yes.

10 Q. Drying out the discs, correct?

11 A. Correct.

12 Q. I am 45 years old, I am not going to guess how old
13 you are, we have those types of conditions going on in our
14 spine?

15 A. We do, both of us.

16 Q. I am not going to guess the ages of the jurors, but
17 that is that part of the normal aging process, correct?

18 A. We fall apart, sir.

19 Q. How old was Ms. Blue when you first saw her?

20 A. 54.

21 Q. So the spondylosis that you saw, you would agree,
22 is not unexpected in a woman of that age?

23 A. Garden variety, if you want to call it. The answer
24 is that spondylosis along with our history. I can't say
25 anything about the patient.

1 Q. That didn't make her any different than another 53
2 year old you might have seen, right?

3 A. I meant what I said. If I just look at this
4 without knowing any history I cannot comment on the fact
5 other than there is narrow bone spurs and so forth.

6 Q. And I think you agree and I believe you testified
7 on direct examination that that spondylosis was present in
8 Ms. Blue's spine prior to the accident of October 2008,
9 correct?

10 A. It is definitely a developmental aging process.

11 Q. Type of degenerative arthritis of the spine,
12 correct?

13 A. That is one way to put it.

14 Q. Not brought on by trauma?

15 A. No. We said that also.

16 Q. Spondylosis is a condition of the spine that can
17 get progressively worse, correct?

18 A. With regard to radiographs, what do you mean? Tell
19 me, that is all I am asking.

20 Q. If the condition gets progressively worse so that
21 you might come to a point in time that spondylosis can
22 continue to develop in a person's spine to the extent that
23 they might start feeling symptoms, correct?

24 A. Spondylosis can. The answer is yes.

25 Q. That is fine. That is all I want.

1 A. Yes.

2 Q. Thank you.

3 A. I would like to say more, but --

4 Q. And the spondylosis as it develops can result in
5 pain and that can happen even without trauma, correct?

6 A. But, the point is that --

7 Q. I am asking you it can happen without trauma?

8 A. If that is a question the answer is yes, it can
9 happen without trauma.

10 Q. Thank you. You said in part when you were giving
11 your opinion before, that your impression that the injuries
12 to Ms. Blue's cervical spine were due to the work related
13 motor vehicle accident was based at least in part upon the
14 history she gave you concerning her onset of symptoms,
15 correct?

16 A. That is right.

17 Q. Okay, now going back to the MRI films of the lumbar
18 spine in the initial office notes when September 21, 2009,
19 you note that the lumbar spine MRI showed no nerve root
20 impingement, correct?

21 A. Correct, sir.

22 Q. Would you agree that MRI's are diagnostic tests
23 that can show nerve root impingement or irritation?

24 A. It shows a relationship -- well and if there is
25 impingement I would normally see it.

1 Q. Are there are also clinical tests for nerve root
2 impingement?

3 A. Correct.

4 Q. And can you explain what the clinical tests for
5 nerve root impingement are?

6 A. In which part of the body?

7 Q. How about the lumbar spine, that is what we are
8 talking about now.

9 A. Without complaints of weakness, numbness to the
10 lower leg, more often than not, weakness of the dorsiflexion
11 of the foot. Weakness in the big toe flexion. Weakness in
12 the -- the push off from the ground. Numbness to the top
13 of the foot or bottom of the foot. And you can have what we
14 call a positive straight leg raising test, when we lift the
15 leg you have a shooting pain indicating sciatic distribution
16 of the pain.

17 Q. What are you looking for when you perform the
18 straight leg raising test?

19 A. You are looking for the effect of tension on the
20 nerve. If the nerve is inflammed then you put all the
21 tension it will react and give you additional pain symptoms,
22 so it is a sign of inflammation.

23 Q. So, if it is positive you would say that reveals
24 tension root signal; is that correct?

25 A. Correct.

1 Q. And what does that mean?

2 A. Again, it would mean that if the nerve has
3 somewhere in its section an inflamed area because when you
4 put that nerve on the tension the pain is reduced. There is
5 a lot of reason for this. That is why I am putting it in a
6 generic way.

7 Q. Okay, on September 21, 2009, after the initial
8 consultation with Ms. Blue, you did a straight leg raising
9 test, correct?

10 A. That is right.

11 Q. And the straight leg raising test failed to reveal
12 any tension root sign, correct?

13 A. Correct.

14 Q. The clinical test that you did on September 21,
15 2009 was negative for nerve root impingement, correct?

16 A. Correct.

17 Q. The MRI that was done on November 8th, 2008 was
18 also negative for nerve root impingement, correct?

19 A. Correct.

20 Q. We can have bulges and herniations without
21 necessarily having a lost of containment which would cause
22 pain, correct?

23 A. I agree with that.

24 Q. That would go for also there may be bulges and
25 herniations that don't cause the nerve root irritation,

1 correct?

2 A. Right.

3 Q. Now, in terms of the Woodhull Hospital x-rays, do
4 you have a copy of the x-rays?

5 A. I want to --

6 Q. I want to focus on the lumbar spine.

7 THE COURT: What is the exhibit you are using
8 now?

9 MR. HALL: That is exhibit Plaintiff's 2C.

10 Q. Now that x-ray report that was taken in the
11 hospital immediately after the accident shows there was no
12 fractures or dislocations in the lumbar spine, correct?

13 A. Correct.

14 Q. And the intervertebral disc space in the lumbar
15 vertebral body were all normal, correct?

16 A. In terms of the relationship, yes.

17 Q. What does it mean that the intervertebral disc
18 space and lumbar vertebral bodies were all normal in height?

19 A. Means that you have normal configuration. That is
20 sort of God has given to us in terms of disc heights.
21 Lordosis is position of bone. It is one layer of knowledge.
22 It doesn't give you disc tissue appearance, it gives you a
23 bone relationship. That is a good start.

24 Q. All right, the x-ray report doesn't mention any
25 condition in the lumbar spine that might cause or suggest

1 instability, correct?

2 A. They didn't do flexion extension, but we don't see
3 any displaced bone in this way.

4 Q. The impression that is lumbar sacral spine
5 radiographs within normal range, right, other than those
6 other things we talked about that were gynecological and not
7 related?

8 A. The answer is yes to your question, sir.

9 Q. Now, your initial September 21, 2009 recommendation
10 you said you were already leaning toward spinal surgery,
11 correct?

12 A. Correct.

13 Q. That was after seeing Ms. Blue once?

14 A. Yes, but knowing that she had --

15 Q. Yes, you wrote that after seeing her once, right?

16 A. Yes, the answer is yes.

17 Q. And next at the follow-up on October 14, 2009, you
18 mentioned that she failed conservative treatment, correct?

19 A. Yes.

20 Q. That is the assessment?

21 A. Yes.

22 Q. Surgery is warranted in this case, right?

23 A. Correct.

24 Q. That was your assessment, conclusion, after having
25 seen her twice, correct?

1 A. Based on history, yes.

2 Q. Now, when you mentioned that she had failed
3 conservative treatment, would you agree that before you
4 proceed onto a spinal surgery with a patient, you would
5 attempt to address the symptoms of the problem in the spine
6 through other measures first?

7 A. It was done by the other people.

8 Q. I am Just asking you if you would agree with that?

9 A. But I am only one type of doctor.

10 Q. I am not asking what you did.

11 I am just saying would you agree that is the way it
12 is generally done?

13 A. That is what happened to her, the answer is yes.

14 Q. You would agree first to try conservative care
15 before moving onto spinal surgery, correct?

16 A. She had it for one year.

17 Q. Please, this goes so much faster if you can answer
18 yes or no.

19 A. Yes.

20 Q. True, right?

21 A. Yes.

22 Q. So that would be medications, right?

23 A. Yes.

24 Q. Physical therapy?

25 A. Yes.

1 Q. Even injections?

2 A. Yes.

3 Q. Okay, so that's the course you would actually
4 follow before you would actually progress onto a surgery,
5 correct?

6 A. Was all done. The answer is yes.

7 Q. Now, you saw her again on January 27, 2010,
8 correct?

9 A. Yes, sir.

10 Q. And again, it looks like you had taken x-rays at
11 the prior visit, correct?

12 A. You are suggesting I took x-ray that day or the one
13 that was done before?

14 Q. That wasn't the one at the prior visit, you took
15 x-rays at a prior visit?

16 A. The x-ray I am referring to sir, the one that dates
17 October 14.

18 Q. That's what I meant. You refer to the x-ray you
19 had done at her last consultation, the prior one?

20 A. Yes.

21 Q. And you note that it showed severe spondylosis at
22 C5-6 and C6-7, right?

23 A. Yes.

24 Q. There was anterior and posterior osteophyte
25 formation, correct?

1 A. Yes.

2 Q. What is an osteophyte?

3 A. Bone spurs. Bone overgrowth.

4 Q. And do those occur over time?

5 A. Same process. Same aging process. They occur over
6 time.

7 Q. You get to a point where they are noticeable, it
8 takes a fairly lengthy period of time?

9 A. Yes.

10 Q. And again your assessment was she had failed
11 conservative treatment options and then your plan was at
12 that point starting to discuss cervical surgery, correct?

13 A. Correct.

14 Q. All right, now at that point you note in your plan
15 as well I do not feel that the patient will improve unless
16 surgery be performed, correct?

17 A. Correct.

18 Q. You also said that she would definitely, in your
19 view, benefit from a decompression anteriorly with fusion,
20 correct?

21 A. Correct.

22 Q. That was your opinion?

23 A. Yes, sir.

24 Q. After that on March 1, 2010, you note indicates
25 that Ms. Blue called in order to attempt to schedule

1 surgery, correct?

2 A. You have it. I take your word for it.

3 Q. Okay, then she comes in again March 15, 2010,
4 correct?

5 A. Correct.

6 Q. All right and I am looking at the imaging studies
7 part, Doctor, it says you say, I had the opportunity to
8 review the x-rays that were done in the past, so I am not
9 quite sure which ones they were, do you know which ones?

10 A. Same ones we are referring to since the beginning.

11 Q. The ones for Dr. Kaplan or the ones that you did?

12 A. I did flexion extension views and he had regular
13 x-rays done.

14 Q. Okay, which ones are we talking about here?

15 A. Both series.

16 Q. Okay, looking at all the x-rays and you noted
17 instability at C4-5, correct?

18 A. Yes.

19 Q. The other two levels we have been talking about
20 C5-6 and C6-7, there was spondylosis and narrowing, correct?

21 A. Correct, sir.

22 Q. But you don't note any instability there, correct?

23 A. In those two levels, no.

24 Q. Yes?

25 A. No.

1 Q. At the end of that note the plan is for anterior
2 cervical discectomy and fusion, correct?

3 A. Correct.

4 Q. At all three levels?

5 A. Yes.

6 Q. During your career, you spent a lot of time seeing
7 patients with herniated discs, correct?

8 A. Yes.

9 Q. And you operated on people with herniated discs,
10 correct?

11 A. Yes.

12 Q. And in this case you operated on Ms. Blue to remove
13 a disc which you felt that was the source of her pain and
14 other symptoms, correct?

15 A. And as well as deal with the instability, yes.

16 Q. What about disc removal without fusion, do you do
17 those as well?

18 A. In cases of cervical spine -- the answer to this
19 question is that it can be done in specific situations, not
20 hers.

21 Q. Well, could you explain to us why you didn't go
22 that way with her?

23 A. Referring to cervical or lumbar?

24 Q. For cervical the surgery that you did, why you went
25 the fusion and not simply the discectomy?

1 A. One side had small disc herniations, cervical,
2 affecting the root at the exit point. We call that
3 enunciate disc herniation. You can do a small dorsal window
4 opening as a treatment, that will work well. When you have
5 central disc problems like she had, wide based like she had,
6 in addition instability, that treatment would not be
7 recommended.

8 Q. So?

9 A. It is based on this case, the imaging has a lot of
10 bearing. It is based on the history, plus the imaging here
11 in terms of a decision and plan of which methodology to use.

12 Q. All right, so it was your opinion based upon all
13 the factors that you need to go with fusion as opposed to
14 just a discectomy, correct?

15 A. Historically, discectomies without fusing the
16 cervical spine were done, they were proven not to give good
17 results. As far as I know, nobody does that.

18 Q. No one does discectomies?

19 A. Sir, listen to me, I don't know of anybody who does
20 that.

21 Q. Would you agree that the discectomy with fusion is
22 highly invasive?

23 A. No, because it's the right treatment. Invasive,
24 would mean I did more than I had to do. It is the right
25 treatment. It is an invasive treatment.

1 Q. That's what I'm talking about. You showed the jury
2 you cut open the neck, correct? Doctor just follow me here,
3 you cut down the neck, correct and you have to move the
4 windpipe over to access the spinal cord, correct?

5 A. Correct, to access the point --

6 Q. That is invasive; is it not?

7 A. It's an open surgery.

8 Q. Right. You have been doing this procedure based
9 upon what I heard on your direct examination since about
10 1989; is that correct?

11 A. Long time --

12 Q. Is that correct?

13 A. That is correct.

14 Q. 1989, right, that is 22 years, right?

15 A. Correct, sir.

16 Q. All right and I think you testified on direct that
17 you do about 100 or 200 of those a year; is that correct?

18 A. At the beginning I was not doing that many, but
19 that is pretty much the average I do now the last couple of
20 years.

21 Q. If you was a little less in the beginning, even if
22 you take out a few, that is thousands of surgeries, correct?

23 A. Yes, it sounds like it, correct.

24 Q. Many times. If it was 200 a year for 22 years it
25 is 4,400 surgeries?

1 A. I didn't do that many. I did thousands, yes.

2 Q. Does a patient's age potentially affect the success
3 of --

4 A. You were talking this way. Let me get it again.

5 Q. I am sorry. I apologize.

6 A. Does a patient's age affect the likelihood of
7 success of the procedure?

8 A. To some degree, in general, yes, but at her age
9 group we are still in a good zone to have good outcomes.

10 Q. She was 53 or 54 at the time, that is still a zone
11 -- age zone for a good outcome, correct?

12 A. Surgery has a place if indicated, yes.

13 Q. There are other factors that might affect the
14 likelihood of success with this surgery with other medical
15 issues?

16 A. Related or unrelated. You have to clarify your
17 questions, sir.

18 Q. Other than unrelated medical issues?

19 A. Smoking, for example, is a bad one. If the patient
20 that is not her, by the way, if she was having rheumatoid
21 arthritis, that would be a problem. Steroid dependency.
22 Some people have bowel disease and need to take steroid.
23 That would that be a bad thing.

24 Medical condition in general can have unfavorable
25 success. That is spinal surgery and everything else.

1 Q. Did you anticipate when you requested the authority
2 to do the surgery on Ms. Blue that it would lead to
3 improvement of her conditions?

4 A. Yes.

5 Q. And that was certainly one of the goals, correct?

6 A. I wouldn't do it otherwise.

7 Q. And you wrote again January 27, 2010 that you did
8 not feel she would improve until surgery was performed, in
9 fact, right?

10 A. Because we had a history --

11 Q. I am just asking --

12 A. The answer is yes.

13 Q. You also wrote that she definitely would benefit
14 from the procedure in your view?

15 A. Right.

16 Q. So the goal was to stabilize her neck, correct?

17 A. Yes.

18 Q. Try to address some of this neck pain, correct?

19 A. Yes.

20 Q. Some of the numbness in her left fingers, correct?

21 A. Correct.

22 Q. Based upon the people that are in your practice you
23 have some patients who are litigants, involved in lawsuits,
24 and some that aren't, correct?

25 A. Correct.

1 Q. Have you performed the discectomy and cervical
2 fusion on both some of the patients that are involved in
3 lawsuits and those that are not?

4 A. Correct.

5 Q. And you find there is a difference between the
6 degree or quality of recovery between the patients who are
7 involved in personal injury litigation opposed to those who
8 are not?

9 A. There is a different perception of outcome, yes.

10 Q. You said there is a difference of the perception of
11 outcome, does that have anything to do with the term of
12 malingering?

13 A. No, it just has to do with the sentiment of
14 wellness after. I don't think malingering. Malingering you
15 create -- at least for me, you create and make up symptoms.
16 I think it is more like the level of satisfaction or the
17 existence of symptoms versus complete dissipation.

18 Q. When you say sentiment, you mean -- again, what
19 people's sentiment would be in a postoperative course of
20 care while you are following up, what they are telling you
21 about their symptomology, correct?

22 A. To some degree, yes.

23 Q. Whether or not surgery has actually cleared up or
24 helped to alleviate the symptoms they were complaining about
25 before the surgery?

1 A. The way they look at their outcome, in general.

2 The answer is yes.

3 Q. Because those people who were involved in personal
4 injury litigation have a stake in the outcome of their
5 lawsuit, correct?

6 A. You say it.

7 Q. I am not just saying it. You know what malingering
8 is, Doctor?

9 A. She is not malingering.

10 Q. I am not talking about anybody in particular here,
11 I am talking about the notion. The notion is -- isn't
12 malingering a medical term?

13 A. It is a term to describe people who create and
14 amplify symptoms.

15 Q. So that is recognized in the medical community,
16 that that does occur? There is a test for malingering,
17 correct?

18 A. There are some attempts to try and identify those
19 patients, correct. They are not the greatest.

20 Q. If it didn't happen, there wouldn't be a test to
21 try to identify people who are involved in malingering,
22 correct, it goes on?

23 A. I don't disagree with you on this one.

24 THE COURT: Counsel, how much longer are you
25 going to be?

1 MR. HALL: Maybe 15 or 20 more minutes.

2 THE COURT: All right, let's keep going.

3 Q. How about the term secondary gain, you heard of
4 that term as well?

5 A. Yes, I did.

6 Q. That is basically the same thing or similar to
7 malingering, correct?

8 A. I don't know if it the same thing, but it implies
9 an intention --

10 THE COURT: By the way, if any members of the
11 jury need a break just raise you hand. You have to let
12 me know, okay?

13 A. It implies an intention to considerations that I
14 even as a physician would not know sometimes.

15 Q. Because the person making the complaints, the
16 subjective complaints, might be so convincing that you
17 couldn't even tell?

18 A. Well, that is one aspect certainly, and many
19 others.

20 Q. Okay, now you did that surgery on April 22, 2010,
21 correct?

22 A. Correct.

23 Q. And then in your experience, does recovery take
24 time or is it like immediate?

25 A. It takes time.

1 Q. Okay, so because of that fact, you continued to see
2 Ms. Blue and follow-up, correct?

3 A. Correct.

4 Q. All right, let's take a quick look at few of your
5 records. And what was going on in post-op June 2, 2010,
6 that visit; are you there?

7 A. Yes, I am there.

8 Q. That visit we are about five weeks out, correct?

9 A. She had surgery in April, yes.

10 Q. And you saw her for an urgent consultation,
11 correct?

12 A. That is what it says, yes. I don't recall, but I
13 am reading like you do.

14 Q. You take these notes contemporaneously with your
15 visits?

16 A. Yes.

17 Q. It says here that is what happened on June 2, 2010?

18 A. No question.

19 Q. Urgent consultation, correct?

20 A. That is what it says.

21 Q. That is what it says. So that's the impression you
22 had, she was showing up because she had an urgent complaint,
23 correct?

24 A. Correct.

25 Q. And her complaint included sharp stabbing pain to

1 the left trapezius muscle and intermittent, correct?

2 A. Correct.

3 Q. She told you she had numbness that had come back in
4 her last two fingers and the ulnar aspect of her arm,
5 correct?

6 A. Correct.

7 Q. The ulnar aspect of your arm, just for the jury
8 benefit?

9 A. Distribution extending to last two digits, fourth
10 and fifth digit. Forearm, same area.

11 Q. At the end of your visit with her you day you had
12 an assessment which was of residual cervical radiculopathy
13 and myelopathy, correct?

14 A. Correct.

15 Q. Five weeks out. Please turn to July 12th, 2010.

16 A. I am there.

17 Q. You beat me. All right, we are about ten weeks out
18 after that point, correct?

19 A. Correct.

20 Q. And Ms. Blue continued to complain of residual pain
21 located at the base of her neck and into her shoulder
22 bilaterally, correct?

23 A. Correct.

24 Q. She noted lots of pressure at the base of her neck,
25 correct?

1 A. Correct.

2 Q. She did have residual tingling and numbness in the
3 finger tips of her left hand, correct?

4 A. Correct.

5 Q. And your assessment, again, was she continued to
6 complain of muscle spasms and pressure to the base of her
7 cervical spine, correct?

8 A. Yes.

9 Q. All right let's go to July 26th, 2010, please, 12
10 weeks out at that point, correct?

11 A. Yes, sir.

12 Q. And in your assessment after visiting with with
13 that day you said she suffers from muscle spasm and residual
14 cervical pain, correct?

15 A. Correct.

16 Q. Okay, June first, 2011, at this point about 13
17 months out, so a little over a year, correct?

18 A. Yes, sir.

19 Q. All right and the first paragraph you are talking
20 and you say result after spinal surgery is painful spasm in
21 the left trapezius muscle group, unchanged in spite of
22 aggressive pain management therapeutics, correct?

23 A. Correct.

24 Q. You also say the patient as well points out to some
25 numbness to the tips of her left fingers that is sort of

1 reminiscent of prior symptomology, correct?

2 A. Same distribution, yes.

3 Q. Prior symptomatology prior. Means before the
4 surgery, correct?

5 A. Correct.

6 Q. Last office note doctor January 25, 2012 we are
7 about 21 months out at this point, correct?

8 A. Yes.

9 Q. And when you saw her for follow-up consultation
10 that day she continued to complain of persistent unrelenting
11 muscle spasms many in the cervical spine, correct?

12 A. Correct.

13 Q. The spasm is pain, right?

14 A. A spasm is a muscle tightening. It can be painful,
15 in her case it is. It doesn't have to be painful.

16 Q. She is having spasms again in her cervical spine?

17 A. That is what she has.

18 Q. Movement of her neck provoked pain, range of motion
19 was limited, correct?

20 A. Correct.

21 Q. Then, again your assessment was persistent neck
22 pain that is associated with stiffness and spasm, correct?

23 A. Correct.

24 Q. Doctor, are you familiar with a company by the name
25 of K2M?

1 A. Yes, I am.

2 Q. What is K2M?

3 A. A medical implant company.

4 Q. What do they do, make prostheses that are used in
5 surgical procedures?

6 A. They make the peek, they make the plate, they make
7 what you saw in the x-ray.

8 Q. And you are familiar with company by the name of
9 Interpore Cross International?

10 A. Yes, I am familiar with that.

11 Q. What is Interpore Cross International?

12 A. It is another implant company.

13 Q. Now, you own shares of K2M, correct?

14 A. No.

15 Q. You don't, you owned shares of K2M back in 2004; is
16 that right?

17 A. 2004 or 5, I did. The company was sold a year a
18 half or two ago.

19 Q. Well, let's go back to 2008, in 2008 did you own
20 shares in K2M?

21 A. I did.

22 Q. How many shares of K2M did you own back in October
23 of 2008?

24 MR. McCORIE: Objection.

25 THE COURT: Is there any relevance into this?

1 MR. HALL: Yes, your Honor. Subject to
2 connection.

3 THE COURT: I will give you some leeway.

4 Q. How many shares of K2M did you own in October of
5 2008?

6 A. Little over 95,000, I think.

7 Q. 95,000 shares?

8 A. Yes.

9 Q. This is a company that makes implants that you use
10 in your fusion surgeries, correct?

11 A. Yes, but I used other implants too, but in this
12 case I used K2M.

13 Q. Did you use K2M for this surgery?

14 A. Yes.

15 Q. You remember Dr. Keisman that we talked about?

16 A. Repeat.

17 Q. Do you remember the Dr. Keisman that we talked
18 about?

19 A. Yes, I remember him, yes.

20 Q. You shared office space with him for a number of
21 years, correct?

22 A. Correct, sir.

23 Q. Okay, isn't it true that in February of 2009 Dr.
24 Keisman filed a lawsuit on behalf of the United States of
25 America and other states including New York under the

1 federal and New York State false claims act?

2 A. He did.

3 Q. Okay.

4 MR. McCORIE: Objection.

5 Q. Isn't it true that this lawsuit claimed that
6 you were paid kickbacks to use the surgical hardware made by
7 Interpore and an K2M.

8 MR. McCORIE: Objection.

9 THE COURT: I will allow it, yes or no?

10 A. The answer is that this claim --

11 Q. No, did he not file that lawsuit?

12 A. He did, sir.

13 Q. Okay, thank you.

14 He did not make a claim in that lawsuit on behalf
15 of the State of New York and the United States of America
16 that you violated the New York and Federal False Claims Act
17 because you were paid kickbacks to use the surgical hardware
18 made by Interpore interest K2M?

19 MR. McCORIE: Objection to claims. Why don't
20 we asked what happened --

21 THE COURT: I will allow --

22 MR. HALL: He can ask about the outcome. You
23 can ask about the outcome.

24 Q. Wasn't that one of the claims, yes or no? Was that
25 claimed in the suit?

1 A. You know, I think you should know at least how I --

2 Q. Doctor, this jury should know that I am asking you
3 a question.

4 THE COURT: Don't argue with the witness.
5 Doctor, just answer the questions posed by the attorney.
6 Plaintiff's attorney will have an opportunity to
7 redirect.

8 MR. HALL: Thank you.

9 THE WITNESS: Your Honor, I found out about all
10 this about a month ago --

11 Q. Doctor, please, is that the claim in the lawsuit?

12 A. Again -- I guess, I do know now. A month ago I
13 didn't know? I didn't know until then.

14 Q. I don't care when you knew you were being sued.

15 A. I care when I knew.

16 Q. I bet you do, Doctor. You are being sued.

17 MR. McCORIE: Objection.

18 A. I am not sued anymore.

19 THE COURT: Your comment is stricken from the
20 record.

21 A. I am not being sued anymore, sir.

22 THE COURT: I want to get this done before
23 lunch, so Doctor, please listen to the question and if
24 you are able to answer it answer it. If you are not
25 able to answer it tell me.

1 THE WITNESS: Okay, your Honor. Thank you.

2 Q. I am asking you a very, very simple question, if
3 you can answer it yes or no that is fine.

4 You found out about it a couple of months ago,
5 fine.

6 I am not asking when you found out, I am asking you
7 part of the lawsuit if I had in February of 2009 by Dr.
8 Arden Keisman, with whom you shared office space for many
9 years, it is claimed that you were paid kickbacks to use the
10 surgical hardware made by Interpore and K2M, yes or no?

11 A. It was his claim.

12 Q. Doctor, did you ever tell Dr. Keisman that
13 Interpore paid you tens of thousands of dollars a year as a
14 consultant, yes or no?

15 MR. McCORIE: Objection.

16 THE COURT: Sustained.

17 Q. Did you ever tell Doctor --

18 THE COURT: Counsel, what he told somebody
19 else? I am going to sustain that.

20 Q. Were you paid tens of thousands of dollars a year
21 as a consultant to Interpore, a company whose implants you
22 put in your patients' necks?

23 THE COURT: I will allow it.

24 A. 2003, 2004.

25 Q. You were a consultant then?

1 A. Yes, I was a consultant.

2 Q. In 2003 and 2004 are you putting Interpore
3 prosthetics into your clients' necks?

4 A. I don't think they had neck implants. Probably
5 not. I don't recall.

6 Q. Did you use Interpore products for lumbar spine
7 surgeries back then when you were a consultant for them?

8 A. I probably did.

9 Q. Did you have written contract which provided that
10 Interpore was going to pay you for quote, unquote consulting
11 work back then?

12 A. Correct.

13 Q. And isn't it true that you did very little or
14 probably no consulting work?

15 A. That is not true.

16 Q. You actually did consulting work pursuant to that
17 contract?

18 A. I did.

19 Q. That was on behalf of the medical device company
20 who manufactured the implant that you put in your patients'
21 spines, correct?

22 A. Correct.

23 Q. Now, back then were surgeons paid based upon the
24 volume of Interpore products that they used in a particular
25 year?

1 A. Absolutely not.

2 Q. So, you deny that claim?

3 A. Of course.

4 Q. Isn't it true that once you claimed to Dr. Keisman
5 you were only getting \$20,000 a year and other surgeons who
6 were doing less surgeries than you were getting \$80,000 to
7 \$100,000 a year doing surgeries?

8 MR. McCORIE: Objection.

9 THE COURT: Sustained.

10 Q. Back in 2003, were you paid \$60 to \$80,000 in
11 consulting from Interpore pursuant to your contract?

12 A. 2003, probably yes.

13 Q. How about 2004?

14 A. I think it stopped. I cannot tell you when I
15 stopped. I stopped around that year.

16 Q. Up to that point you were making about \$60 to
17 \$80,000 doing consulting for this company?

18 A. For only two years, I believe.

19 Q. Do you know a gentleman by the name of Gary Perez?

20 A. Sure I do.

21 Q. Who is Gary Perez?

22 MR. McCORIE: Objection.

23 THE COURT: I will allow it.

24 A. Gary Perez is an implant rep.

25 Q. Implant rep who used to work for in Interpore,

1 correct?

2 A. I don't think he worked -- you are asking -- he
3 wasn't working for Interpore. He is an independent guy.

4 Q. Really, Gary Perez was never an employee of
5 Interpore?

6 A. I don't believe so.

7 Q. What about K2M?

8 A. He is not employed by K2M either.

9 Q. He is salesman who sells their products to you?

10 A. Correct.

11 Q. Dr. Keisman, did you attend a meeting with Perez
12 after he had started selling K2M products in order to talk
13 about receiving shares of K2M?

14 A. No.

15 MR. McCORIE: Objection.

16 THE COURT: I will allow the answer to stand,
17 but let's limit the questions in that area.

18 Q. Did there come in time which you did become a
19 shareholder in K2M?

20 A. Yes.

21 Q. Again, you were a shareholder owning about 90,000
22 shares of K2M stock back in October of 2008, correct?

23 A. I would say so, correct.

24 Q. Now, Doctor, you wouldn't do a surgical procedure
25 on one of your patients unless you thought it was medically

1 necessary, correct?

2 A. You spoke so fast. Can I have that again?

3 THE COURT: Repeat the question.

4 Q. Doctor, you wouldn't recommend a surgical procedure
5 for one of your patients unless it was medically necessary,
6 would you?

7 A. Correct.

8 Q. And your own personal economic benefit plays no
9 role in your assessments or recommendations; am I correct?

10 A. Correct.

11 Q. What about here in the case of Ms. Blue, back in
12 October of 2009 you had 95,000 shares of K2M stock, correct?

13 A. That is correct.

14 Q. All right, then in Ms. Blue's procedure -- you
15 actually have the New York Hospital record available there,
16 the surgical record?

17 A. No.

18 MR. McCORIE: It is in evidence thought.

19 MR. HALL: This is in evidence. This is my
20 copy.

21 Q. Operating room implant log form. Can you run down
22 the list of surgical implants that you put in Ms. Blue's
23 neck?

24 MR. McCORIE: For the record, it is in
25 evidence, deemed in evidence as 14.

1 A. We have bone graft material, we have implants, K2M
2 spacers, spacers, three level blades, the screws.

3 Q. All right, so in the operation on October 22, 2010
4 on Ms. Blue's cervical spine you put in three seven degree
5 spacers, correct?

6 A. Correct. Three seven degree orthotic spacers, yes.

7 Q. Who manufactured them?

8 A. K2M.

9 THE COURT: Counsel, I am not limiting you,
10 but how much longer are you going to be?

11 MR. HALL: Five minutes.

12 THE COURT: Okay, let's keep going.

13 Q. All right, in addition to those three seven degrees
14 spacers manufactured by K2M, you put in one three-level
15 plate, correct?

16 A. Yes.

17 Q. Who manufactured that?

18 A. K2M.

19 Q. In addition to that, you put in eight self-starting
20 screws, correct? K2M also?

21 A. Correct.

22 Q. So, let me get that straight now. After seeing Ms.
23 Blue on two occasions you recommend a highly invasive
24 surgical spine procedure, you undertake this procedure which
25 involves a three-level fusion, correct?

1 A. Correct.

2 Q. And includes implantation of three spacers, a plate
3 and eight screws, right?

4 A. Correct.

5 Q. And all of those implants were supplied by K2M, the
6 company in which you owned shares at the time, right?

7 A. It is an innovated company, the answer is yes.

8 Q. By the way, did Ms. Blue execute a consent form for
9 the surgery?

10 A. Yes.

11 Q. And it is known as a informed consent form,
12 correct?

13 A. Yes.

14 Q. And what are some of the medical risks or issues
15 that are in the consent form?

16 A. Essentially, everything, but I don't know which one
17 you are referring to.

18 Q. A risk of complications, correct?

19 A. Infection, neurological injuries, failed fusion, so
20 on.

21 Q. Did you ever disclose to Ms. Blue before the
22 surgery that you own stock in the company that provides the
23 implants that you were putting in her neck?

24 A. I do. I don't know about her, but I do.

25 Q. Do you have any evidence that you disclosed to Ms.

1 Blue that you owned 90,000 shares in the company whose
2 medical devices you were putting in her neck?

3 A. Don't point at me this way.

4 I know patients were informed of my association.
5 It was started around this time. I don't know if she
6 herself got it.

7 Q. That is the question before --

8 A. The answer --

9 Q. Did you inform her, did you give her the
10 opportunity to know that information before you went in and
11 did the surgery?

12 A. I don't know about her.

13 MR. HALL: I have nothing further. Thank you.

14 MR. McCORIE: Real briefly.

15 REDIRECT EXAMINATION

16 BY MR. McCORIE:

17 Q. Doctor, do you know if the doctors or the New York
18 State Workers' Compensation Board that authorized your
19 surgery as medically necessary has any stock in K2? Anyone
20 who said from the Workers' Compensation Board of the state,
21 you need to do this surgery, you got authorizations to do
22 it; do you know if they own stock in K2?

23 A. I don't know.

24 Q. But your surgery was found to be authorized and
25 medically necessary, the same one you did and put in for,

1 correct?

2 A. Correct.

3 Q. Are you aware either through your employees telling
4 you or the New York Post articles that Dr. Keisman was sued
5 for sexual harassment and using for pornography in your
6 office and then you kicked him out of your office?

7 A. I saw it --

8 MR. HALL: Objection. Hearsay.

9 Q. Did the employees in your --

10 THE COURT: There is an objection.

11 MR. McCORIE: I will withdraw the question.

12 THE COURT: The question is withdrawn.

13 Q. Did the employees in your office sue Dr. Keisman
14 for sexual harassment?

15 A. You bet they did.

16 Q. Did you kick him out after your employees said,
17 this Dr. Keisman is a little crazy, he is touching us, he is
18 doing things to us?

19 MR. HALL: Objection.

20 THE COURT: Sustained.

21 Q. Okay, did you kick Dr. Keisman out of your office
22 on your own?

23 A. I own the office half and half. In order to
24 protect reputation I left because he was uncontrollable.

25 Q. But, there was a lawsuit involved where you made

1 him leave?

2 A. He sent how many lawsuits and he lost everything,
3 four, five, six --

4 Q. Is that what happened, because I want to move on.

5 Is it a lawsuit against you or did he report you to
6 the United States -- New York State blah, blah, blah?

7 A. Dr. Keisman reported me to the New Jersey attorney
8 who was involved with these issues regarding physicians and
9 conflicts of interest and that was dismissed October last
10 year.

11 Q. Okay, so regardless of those issues, you told the
12 jury -- you were being asked questions about malingering and
13 secondary gain, you started to say it, you have been
14 practicing medicine for years and you said you haven't seen
15 it before, what is your opinion as to whether or not Ms.
16 Blue is exaggerating, either the bars you put in her neck or
17 exaggerating anything about her symptoms?

18 A. She is not.

19 Q. The spasm that she has been getting 50 some odd
20 injections for to try to break up the spasm for, is that
21 something she can exaggerate or fake, the palpable spasm?

22 A. It is there. It is not exaggerating. It is there.

23 Q. Do you consider her malingering to any degree?

24 A. Never did.

25 Q. Would you have expected when you asked her her

1 medical history whether or not she has ever been injured
2 before, due to her neck or her back or whatever, would you
3 expect that she would say by the way, I was assaulted three
4 days before and I wasn't injured to my neck or back; is that
5 something you expect she would tell you if all she
6 complained about being punched in the right arm and being
7 diagnosed with a wrist sprain, would you expect that she
8 would bring that up to you?

9 A. I mean --

10 Q. If you asked about her neck or back history?

11 A. I mean, she didn't have any history. She didn't
12 mention it to me. That is all I can say.

13 Q. If she did injure her neck so badly that she needed
14 a neck surgery or back spinal cord stimulator from this
15 assault where she only complained about her right arm and
16 her right wrist, would you expect she would be able to go to
17 work like she was coming home from when this truck lightly
18 tapped the back of her car hard enough to throw the car four
19 feet forward?

20 Would you expect that if she was so injured from
21 the assault on the arm that she couldn't go to work?

22 A. Exactly. The answer is no.

23 Q. Again, you were ask asked did you also do a
24 cervical fusion on the client, we mentioned his name, did
25 that client fall 18 feet from a scaffold, have a brain

1 injury, was unconscious at the bottom of a scaffold and did
2 he require a cervical fusion from herniations after he
3 resolved the brain injury?

4 A. Yes.

5 Q. Did he also break his hand so badly after four
6 surgeries he couldn't make a fist?

7 A. Correct.

8 Q. But he also required the cervical fusion, did you
9 get any kickbacks for doing the cervical fusion to Mr. B.
10 after he fell 18 feet and was unconscious at the bottom of
11 his scaffold?

12 A. Dr. Keisman is a liar. I never had a kickback in
13 my whole life.

14 MR. McCRORIE: I have nothing further.

15 THE COURT: Anything, counsel?

16 MR. HALL: One.

17 RE CROSS EXAMINATION

18 BY MR. HALL:

19 Q. Doctor Keisman -- I'm sorry.

20 A. Don't make that mistake again.

21 Q. I don't mean any disrespect about that.

22 Dr. Brisson, you said that Dr. Keisman's action
23 against you was dismissed; is that what you said?

24 MR. McCRORIE: The one from New Jersey.

25 Q. The one from New Jersey, the one I was talking

1 about.

2 A. Yes.

3 Q. Isn't it actually true that it was voluntarily
4 dismissed without prejudice; isn't that correct?

5 MR. McCORIE: By Dr. Keisman.

6 Q. Is that correct, it was voluntarily dismissed
7 without prejudice?

8 A. That is a legal --

9 Q. I am asking you.

10 THE COURT: Counsel, that is a legal term.

11 A. Come on.

12 Q. Have you ever seen the stipulation --

13 THE COURT: First of all, let's --

14 A. Don't throw things at me, sir.

15 THE COURT: What do you want to say

16 (Pause in the proceedings)

17 THE COURT: Counsel, the reporter cannot get
18 down everyone speaking at the same time.

19 MR. McCORIE: Dr. Keisman withdrew these
20 claims that he made.

21 MR. HALL: Voluntarily without prejudice.

22 THE COURT: Is that your stipulation, Counsel?
23 That is the stipulation. It is stipulated to. Thank
24 you.

25 Thank you, Doctor. You can step down.

1 Counsel, come up a second.

2 (Whereupon, an off-the-record discussion was
3 held.)

4 THE COURT: All right ladies and gentlemen, we
5 are going to recess for lunch.

6 I ask you to return to Court promptly at two
7 o'clock.

8 Remember all my admonitions. Don't discuss
9 the case with anybody. Don't let anybody discuss this
10 case with you. Have a pleasant lunch. Thank you.

11 * * * *

12 (At this time, a luncheon recess was taken,
13 and the trial adjourned to 2:00 p.m.)

14 * * * * *

15 CERTIFIED TO BE A TRUE AND ACCURATE
16 TRANSCRIPT OF THE MINUTES TAKEN IN THE
17 ABOVE-CAPTIONED PROCEEDING.

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