- Dr. Labluga
- Dr. Stefanides
- Dr. Ziejewski

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

OSAM E. EBRAHEM,

Plaintiff,

v. 12 Civ. 8253 (SAS)

COACH LEASING, INC. and DEREK LESTER MORTON,

Defendants.

New York, N.Y.
August 16, 2013
10:10 a.m.

Before:

HON. SHIRA A. SCHEINDLIN,

District Judge

APPEARANCES

MORGAN LEVINE DOLAN
Attorneys for Plaintiff
BY: GLENN P. DOLAN

GALLO VITUCCI KLAR
Attorneys for Defendants
BY: MATTHEW J. VITUCCI
ALEX M. HOWARD

(Trial resumed; jury present)

THE COURT: After a great deal of difficulty and 70 minutes of crying and suffering, he pled guilty, so we will finish the summations and charge Monday morning. Then it is up to you, the deliberations.

Mr. Dolan.

MR. DOLAN: Yes, your Honor. To begin with, pursuant to the terms of the joint pretrial order, I offer the following items before me into evidence:

As Plaintiff's Exhibit 10, the St. Luke's Roosevelt Hospital emergency room chart; as Plaintiff's Exhibit 12, the St. Luke's Roosevelt Center bill; Exhibit 13, Pappas Physical Medicine & Rehabilitation chart; exhibit 14, Pappas Physical Medicine & Rehabilitation bill; Exhibit 16, Advanced Radiological Imaging, April 22, 2011 MRI report; Exhibit -- I'm sorry; 15, the Advanced Radiological Imaging prior -- April 22, 2011 lumbar MRI films; 17, the Astoria Medical Imaging, February 3, 2012, lumbar MRI and x-ray films; Exhibit 18, the Astoria Medical Imaging, February 3, 2012 lumbar MRI and x-ray reports; Exhibit 19, the Astoria Medical Imaging, February 3, 2012 left knee MRI films; 20, the corresponding report; 21, the corresponding bill; Exhibit number 22, Dr. Stefanides' chart; Exhibit number 24, Dr. Stefanides' bill, Exhibit number 25, Dr. Lattuga's chart; Exhibit number 26, Dr. Lattuga's x-ray films; Exhibit number 27, Dr. Lattuga's bill; Exhibit number 28, the

Boulevard Surgical Center chart, including operative report; Exhibit 29, an anatomic schematic of that surgery; Exhibit number 30, the Boulevard Surgical Center bill; Exhibit number 31, the North Shore LIJ Franklin Hospital chart, including the September 19, 2012 operative report; Exhibit number 32, a corresponding anatomic schematic of the surgery; Exhibit number 34, the North Shore Long Island Jewish Hospital Franklin Medical Center bill; Exhibit number 36 and 37 -- I'm sorry. Exhibits numbers 38 and 39, the anatomic models of the spine; and Exhibit number 40, for purposes of identification, the anatomic model of the knee.

At this time, your Honor the plaintiff calls Dr. Sebastian Lattuga to the stand.

MR. VITUCCI: Your Honor, I object to portions of that offer. Maybe we could --

THE COURT: I thought he said pursuant --

MR. VITUCCI: They are listed as trial exhibits. I didn't see that all of these things were offered into evidence, which is what he just did.

THE COURT: I assume the models and schematics are demonstratives only.

MR. VITUCCI: And some of the reports he mentioned I believe would be hearsay.

THE COURT: Which reports?

MR. VITUCCI: MRI reports, doctors' narrative reports,

and things of that nature.

MR. DOLAN: I'm not offering doctor's narrative reports. All of the other items were stipulated to and signed off by my adversary in the pretrial order as going into evidence. No objection to their going into evidence.

MR. VITUCCI: Your Honor, can we talk about this later and perhaps go ahead with the witness?

THE COURT: We have a lot to do today. There isn't any later. That's the problem.

Let's go with the doctor.

MR. DOLAN: If you could take the stand, Doctor.

SEBASTIAN LATTUGA,

called as a witness by the Plaintiff,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DOLAN:

Q. Dr. Lattuga, good morning. Please state your qualifications for the record. To begin with, are you duly licensed to practice medicine in the State of New York?

A. Yes. I'm licensed to practice medicine in the State of New York since 1991. I am a board certified orthopedic spinal surgeon. I received my certification initially in 1998, recertified in 2008. I'm currently the chief of spinal surgery at North Shore Franklin Hospital.

Q. Doctor, where and when did you attend medical school?

A. Medical school, SUNY Stony Brook School of Medicine, graduated 1989; SUNY Stony Brook orthopedic residency, 1995; university of Miami, Jackson Memorial Medical Center, adult and pediatric spinal surgical fellowship, 1997; and I've been in private practice here in New York and Long Island since that time.

Q. Are you a member of any professional associations?

A. North American Spine Society, American Medical Association, New York State Medical Society, amongst others.

Q. Doctor, have you held any academic positions?

A. Yes. I'm the director of the spine orthopedic residency training program. I'm also clinical assistant instructor with the Hofstra Medical School.

Q. Doctor, is it fair to say that you actually teach other doctors?

A. Yes, I do, every day.

MR. VITUCCI: Objection to the form as leading, your Honor.

THE COURT: One moment, please.

It's overruled.

Q. Doctor, have you been qualified as a medical expert in the past?

A. Yes, sir.

Q. On how many times have you been qualified as a medical expert testifying in court in say the last year?

A. Five times, roughly.
Q. And, Doctor, have you ever testified on behalf of a patient who is a client of mine or my office in the past?
A. I don't recall.
Q. Do you recall any instances where you did so in a courtroom?
A. I don't have a specific recollection.
Q. None that you recall?
A. No, sir.
Q. Doctor, when did Osam Ebrahem first come under your case?
A. May I refer to my chart?
Q. Please.
A. 4/20/12.
Q. On how many occasions have you examined him in all, approximately?
A. I saw him -- I examined him three times before I performed surgery on him. Then I performed surgery on him. And I've seen him subsequent to that perhaps three times, four times, three times.
Q. Doctor, each time that you treated Mr. Ebrahem or examined Mr. Ebrahem, did you document your findings in your office notes?
A. Yes.
Q. Is that the chart you were referring to?
A. Yes.

Q. And did you eventually prepare a narrative report with regard to this patient as well?
A. Yes.
Q. You have both of those with you?
A. Yes.
Q. And I'll advise you again to feel free to refer to those throughout your testimony as necessary.
Doctor, with regard to the report that was issued to my office, did you charge a fee for your time in preparing that document?
A. Yes, sir.
Q. What was that fee?
A. $1200.
Q. And, Doctor, do you also receive a fee for your time here, away from your patients, testifying in court today?
A. Yes.
Q. That fee?
A. $600.
Q. Doctor, is that the usual and customary charges for a physician of your qualifications in this region?
A. Yes, sir.
Q. And do you receive the same fee regardless of your findings and regardless of the outcome of this case?
A. Yes, sir.
Q. Doctor, at some point did you take a verbal history from

Mr. Ebrahem?

A. Yes, sir.

Q. And in addition to taking a verbal history, did you review documents with regard to his treatment?

A. Yes, sir.

Q. And why is that important to review documents in addition to taking a verbal history?

A. Well --

MR. VITUCCI: Objection. It assumes -- object to the form, your Honor.

THE COURT: Overruled.

A. Most of the testing comes -- test results come in document form. For example, MRI report will come in a document form. So we review those documents as part of the care and treatment of patients. So that's part of taking care of a patient.

Q. And, Doctor, the records that you reviewed, did those include the St. Luke's Roosevelt Hospital chart?

A. At some point when I was preparing my narrative, yes, I did review that document.

Q. And the records of Dr. Pappas, Dr. Stefanides, both the preaccident and postaccident lumbar MRI reports?

MR. VITUCCI: Objection to the leading, your Honor.

THE COURT: This is just time saving. Just trying to list the documents he reviewed. There is no problem.

MR. VITUCCI: Never mind.

Q. Did you review the operative reports as well?

A. Yes, sir.

THE COURT: I don't think we got an answer when he said: Did you review the records of Dr. Pappas, Dr. Stefanides preaccident, postaccident of the lumbar MRI. You reviewed all of that?

THE WITNESS: Yes.

Q. Doctor, using the anatomic models of the spine that have been marked as Plaintiff's Exhibits 39 and 38, would you please come down from the witness stand and explain the anatomy of the human spine to the jury?

THE COURT: 38 and 39 are only demonstrative.

A. It's a big question to describe the anatomy of the human spine in five minutes.

Q. I didn't give you a time limit, but five minutes would be good.

THE COURT: I would prefer four minutes.

A. The spine functions in really two capacities. Everyone understands they have a spine. But it really functions in two main roles. One is as a stabilizer of the trunk in the upper body. You all know you have bones in your legs that help to support you. For example, your thighbone is a solid structure that helps people bear weight on. Similarly, the trunk needs to have some axial support. Otherwise, you would just collapse, like a worm.

The spine, the way it's designed, I'll go through it real quickly, is functioned to provide some upper trunk support and stability -- stability, it's a big word -- and, secondarily, its main function is to house and function as a conduit for the spinal cord and the nerves.

It really has two very important roles. The way it's designed is, it is segmented into different parts, individual bones called vertebrae, separated by a structure called an intervertebral disc. It's this segmented structure, and there are seven cervical vertebrae, bones, there are 12 thoracic vertebrae, and there are five lumbar vertebrae, so cervical, thoracic, and lumbar. Neck, upper back, and lower back. Vertebrae separated by intervertebral discs. And they are segmented in such a way so that there is some flexibility with respect to the spine. You can see, there is some motion. We are able to turn and move and it gets very complicated. Part of the way it's designed this way, in a segmented fashion, is so there is some flexibility of the spinal column, and that allows us to function and move through space effectively.

The second main role, which I told you, which is a critical role, is to house -- act as a conduit for spinal cord and the nerves. The way -- if you look at the individual bones, each bone looks kind of like this. There is a heavy quadrangular structure of the bone called a vertebral body. There is this arch in the back called lamina, et cetera. Most

importantly there is a hole in the middle. That hole, if you stack one on top of the other, acts as a tunnel for the spinal cord and the nerves to travel from the brain down through the spinal cords, and at every point it sends off a set of nerve roots which help to control function in the upper and lower extremities. Again, as a conduit for the spinal cord and the nerves, what the spine is doing, it acts in a protective fashion and helps to guide the nerves in the proper direction.

The nerves, as you probably know, because it's going to come up a little bit later, the nerves will act as electrical cables that carry signals to the arms and legs. And those signals, in your own mind and body, is sensation. That's a signal that's carried along the nerves. There is motor function. You can move your arm because the signal is going from the brain through the spinal cord to the arm. There is a reflex that helps to control, and it actually controls the sensation for pain. So all those things occur as -- across each individual nerve root. And each nerve root goes to a specific area of the body which will come up later. That's the basic and overall structure of the spine.

Obviously, because it's a human living structure, it can get injured from accidents, from diseases, et cetera. That's the basis for understanding what goes on.

Q. Doctor, in terms of injuries, could you please define a disc herniation and a disc bulge and explain the distinction

between the two, if any?

A. Yes, I will. And so probably every juror heard the word herniated disc. My friend has a herniated disc. You might have a herniated disc. Not all herniated discs are equal or the same. Let me give you a little discussion -- little bit more of the anatomy of the intervertebral disc which when damaged can become a herniated disc. So, again, it was vertebrae. There is the structure between, which is the intervertebral disk and then there is the vertebrae. That intervertebral disc has a certain structure. It's defined. It looks a certain way. God made it look a certain way. As a consequence of an accident or disease, that disc can get disrupted in its normal shape. When it gets disrupted in its normal shape, then it might not function properly.

So, for example, a normal, intact disc, its purpose is to provide a little bit of flexibility because it's a tough cushioned structure. But, even more importantly is, it provides stability, meaning it actually helps to bind one bone to the other. If this happened inside you, you would be paralyzed. Paralysis happens with just a little bit of motion across the vertebrae. It's very important that those two bones are bound together and the intervertebral disc functions effectively in that regard.

If there is an injury to the intervertebral disc, then the following things can happen. Number one, if you injure the

intervertebral disc you get what's called instability. Now the bones aren't bound. They move back and forth. You are all beginning to see, you see these nerves as I described before and as I'm showing here, the relationship between the nerve, the vertebral body and the intervertebral disc, they are right next to each other. And so if you have damage to the vertebrae and it moves back, it bangs into the spinal cord. You can have paralysis. If you have migration of the disc or damage to the disc, it can migrate, touch the nerve and create problem, damage that nerve or create irritation.

In this model here, I'll open it, again, to show you the cross-section, like that. Everyone can see a normal disc kind of looks like a kidney bean. It has a little bit of a concave or scalloped surface adjacent to the nerve roots. It's really tough like -- it's got an outer tough cover like an orange and a soft inner portion called a nucleus pulposus. Let's say hypothetically that's the inside of an orange. If the outer line gets torn, then that material on the inside, that viscus material, like an orange or really like the inside of a bicycle seat, that gel, it can leak out. That's what this is meant to represent, this red structure. If you get disc material protruding out or leaking out, that's called a herniation, protrusion, extrusion. If you have just a tear in the cover of the orange and you get like a bubble forming, that might be called a disc bulge.

So everyone is making an important semantical point on this. I want the jury to really understand the difference. There is really like a spectrum of injury. It goes from, you know, just a tear of the cover all the way to a complete extrusion of the material out. Anything can happen. It can be like a little scratch to a complete rip. The disc is equally exposed to that phenomenon.

We, as doctors, make verbal descriptions of these findings. Generally, you'll see that on a report. So the doctors talk to each other. In the absence of being able to talk to each other, they will write a report. Certain doctors will then use certain words, like bulge versus herniation versus extrusion on paper, so that if I read the paper or a different doctor reads it, I can visualize the degree of the damage. That's kind of what's going on with making a distinction between a bulge or a herniation.

Q. Thank you, Doctor.

You can take your seat again for a moment. I am going to bring you the medical records that are in chronological order.

MR. VITUCCI: Objection. Which records are we talking about?

MR. DOLAN: The records identified a moment ago.

THE COURT: Are those the ones that you objected to?

MR. VITUCCI: My only objection, and we can take it up

later, they were listed as trial exhibits and I don't know what he's offering into evidence. My objection would be, he offered a whole bunch of records --

THE COURT: He read it one by one. I need for you to object one by one so I know which one we are objecting to. You want me to start with that long list?

MR. VITUCCI: I don't. I guess if he identifies it, I'll bring it up at that point.

THE COURT: All right.

You can only show a one witness exhibit at a time.

What exhibit do you want to start with?

MR. DOLAN: The St. Luke's Roosevelt emergency room chart.

THE COURT: I assume there is no objection to that.

MR. VITUCCI: No objection.

THE COURT: Let's start with that.

I don't want to go into it right now. One by one.

Q. With regard to the St. Luke's Roosevelt Hospital chart, what history was provided by the patient in terms of the mechanism of the accident on January 11, 2012?

A. Patient was hit by a bus on the driver's side door and seat. He was seat belted.

Q. Meaning this was a restrained driver, Mr. Ebrahem?

A. Yes.

Q. And what tests, if any, were conducted in the emergency

room? I'm referring to studies, Doctor.

A. In the x-ray.

Q. X-ray of what portion of the body?

A. X-ray of the left knee.

Q. And were there, in fact, complaints made by the patient of both his left knee and his lower back, including tingling going down the left leg?

MR. VITUCCI: Objection to leading, your Honor.

THE COURT: Sustained.

Q. If you could go back to the history as provided by the patient, what complaints did the patient make in the emergency room?

A. Left knee, low back, left leg, left knee, left leg.

Q. What indication is there of any symptoms going down the leg?

A. Lateral low back pain, a tingling of left lower extremity.

Q. Thank you, Doctor.

Doctor, with regard to the x-ray that was performed on the left knee, what were the findings of the radiologist at St. Luke's Roosevelt Hospital on January 11, 2012?

A. No fracture.

Q. And what indication, if any -- I'll save it for the next witness.

Doctor, what medication was prescribed to the patient or given to the patient?

A. Motrin.
Q. And what is Motrin?
A. Antiinflammatory.
Q. What is the function of that drug?
A. Decrease pain after an injury or accident and inflammation.
Q. Did the patient receive discharge instructions advising him to follow up with his doctor?
MR. VITUCCI: Objection to the leading, your Honor.
THE COURT: No. It's just not leading. He could have said, what instructions did the patient receive upon discharge.
Go ahead and answer my question. What instructions did the patient receive upon discharge?
Please watch out for leading, Mr. Dolan.
THE WITNESS: He was told to take his Motrin and see -- follow up with a doctor.
Q. And referring now to Exhibit number 13, the Pappas Physical Medicine & Rehabilitation chart.
A. Yes.
Q. When did Mr. Ebrahem first come under the care of that facility?
A. 1/24/12.
Q. Within two weeks of the accident?
A. Yes, sir.
Q. What type of treatment did he undergo there?
A. It was a physical medicine and rehabilitation facility, so

he received physical therapy.

Q. And to what areas of his body?

A. Back and knee.

Q. And referring now --

A. Pardon me. I missed the question.

Q. I didn't get a question out.

Proceeding to Exhibit 17, and they are in chronological order, what studies were performed on Mr. Ebrahem's lumbar spine at the recommendation of Dr. Pappas, if any?

A. I don't have --

Q. That's because it's an enlargement. I apologize.

I'll have you take a look at Exhibit number 18 and ask you to indicate what studies were performed on the patient's lumbar spine at the recommendation of Pappas' physical therapy?

A. Lumbar MRI.

Q. When was that study performed?

A. 2/3/12.

Q. Have you had an opportunity to review any lumbar MRIs that were performed prior to that occasion?

A. Yes.

MR. VITUCCI: Objection, your Honor.

THE COURT: You can't just say objection.

MR. VITUCCI: We have not been provided with a report summarizing the doctor's findings.

MR. DOLAN: It's not in your narrative report?

MR. VITUCCI: I have not received an addendum from this doctor with regard to his findings with regard to the MRI he just referenced, so I object to the testimony.

THE COURT: I don't quite understand. He prepared a report?

MR. DOLAN: He did.

THE COURT: But that report didn't cover an MRI he received afterward?

MR. DOLAN: It did. It covered both the preaccident MRI and the postaccident MRI.

MR. VITUCCI: If I can see that report.

THE COURT: Can you show it to your adversary.

MR. DOLAN: Pre or post?

MR. VITUCCI: Pre.

MR. DOLAN: Sure.

MR. VITUCCI: I'm sorry. I thought he was referring to, did he see the film. Are we now saying the report?

MR. DOLAN: We are talking about the reports.

MR. VITUCCI: Did he receive that report? Did he comment on it in his narrative?

MR. DOLAN: Yes, he did.

MR. VITUCCI: Can I see that. Because I'm not aware of that.

Never mind. I just saw it.

Q. Doctor, did you also review an MRI report that was performed prior to the January 11, 2012 accident?

A. Yes.

Q. And what was the date of that report?

A. 4/22/11.

Q. Doctor, if you could come down from the witness stand and, using this highlighter, demonstrate any findings, any difference in the findings between those two reports, the preaccident lumbar MRI report and the postaccident lumbar MRI report.

MR. VITUCCI: Are we just referring to the reports? We are not going to refer to the films themselves? Is that the question?

MR. DOLAN: Counsel, there is two reports on the easels.

Q. Please proceed, Doctor.

A. These are the general reports that they are describing that are generated by, in this case, a radiologist who is the kind of doctor --

THE COURT: I can't hear you.

A. Prepared by a different kind of doctor, called a radiologist, which essentially his job is to just read x-rays and MRIs and then he generates reports. It's nice as sort of an addendum to my own practice where I also read films. I'm an expert reading films. It's nice to have someone else's

opinion.

The difference between these two films, this is dated April 22, which is before his accident, and this is dated after. There is a lot of words on this. But what I want to draw your attention to specifically three different areas of the spine. As I described to you before, the spine is made of cervical, thoracic, and lumbar. Also, we reference them as C, T, and L. You see the L5-S1, L4-5 and L3-4. And each of this -- L5-S1 is the one disc between the two vertebraes. When we were referring to a specific disc, it really has two numbers. It's the disc between L5 and S1 or the disc between L4 and 5. Each disc has two numbers. The glaring difference between these two reports, sort of before or after, is, this radiologist read at 3-4, broad-based disc bulge; at 4-5, broad-based disc bulge. And it's actually broad disc bulge. Typically, it's characterized as broad-based disc bulge. L5-S1, similarly, there is a disc bulge. If you just compare and contrast that to this MRI report, which is after the accident?

Q. Referring to Exhibit --

A. Number 18. At L3-4, there is a disc herniation; and at L4-5, there is a disc herniation; and at L5-S1, there is a disc herniation. So these are two different reports and two different times, characterizing the nature of the deformation of the change and the shape of the disc in two different ways.

Classically, disc herniation is a broader, larger degree of injury or sort of worse, if you want to say it's a worse condition to have. And that's the comparison of those two reports.

Q. Doctor, how would you describe the conditions as portrayed in the preaccident lumbar MRI report with respect to Mr. Ebrahem's lumbar spine?

A. This is fairly characteristic of sort of age-related changes to the spine. And so what happens is, that if you take an x-ray or do an ultrasound, you do an MRI and look on the inside of someone, the inside of them reflects the way they look outside as well. So the same way you can look at me and say, I have gray hair, I'm losing my hair, you are about 40 something, maybe a little bit older, if you look inside of me, similarly, the MRI would also begin to show changes that are consistent with my age and the time that I spent on the earth. These are the classic, very classic reports for someone, let's say, in their forties and fifties, maybe late thirties, depending on what's going on. I like to characterize them to jury and to my patients as age-related changes, not necessarily broken or something bad, but just the way we begin to look over time on the inside. That's what this generally characterizes.

Q. How does that compare to the findings of disc herniations in the postaccident lumbar MRI report?

A. This report continues to show some of those age-related

changes in its characterization. Moderate disc degeneration, spondylosis, these are words that characterize age-related changes. But herniated discs specifically, these three areas, I feel, in this particular case, are consistent with this traumatic history, that he was involved in an accident.

Q. Doctor, are you familiar with the term exacerbation?

A. Yes. Exacerbation means make worse, something occurred and now it's worse than it was before.

Q. How does that come into play, if at all, in this scenario, where there was normal age-based degeneration in the spine before the accident and a finding of actual herniations of the disc after the accident?

A. Again, I think in this particular case, if you would say -- you would characterize this as an exacerbation, meaning something happened between these two times that created energy into the spine, put energy into the spine, created an injury. And now the discs went from being bulged to now herniated. And I think that's very consistent with the accident and the history that he has given.

Q. Thank you, Doctor. You can take your seat again.

Doctor, reviewing your chart again, once the patient went to the emergency room, once the patient began that initial course of physical therapy, once the patient underwent the MRI examinations, when he came under your care, beginning on -- I'm sorry. What was the date that he came under your care at

first?

A. 4/20/12.

Q. What history, if any, did he provide to you?

A. Similarly, that he was involved in an accident when he was driving a car. He was struck by a bus.

Q. What information did he provide to you with regard to his prior medical history, if any, throughout his course of treatment?

A. Prior medical history is that he had neck surgery back in 2011 with respect to his spine.

Q. Doctor, are you aware that the patient in the year and a half or so prior to his January 11, 2012 accident began experiencing symptoms of sciatica where he had some pain down his legs, was getting some physical therapy, and had some injections to his neck and back?

A. Yes. He also had epidurals prior to having seen me, injections.

Q. And so, Doctor, upon your first examination of Mr. Ebrahem, what were your findings back at that time, in April of 2012? I'll ask you to break it down, first, with regard to his lower back and then we will address his neck.

A. Well, on that date I examined specifically his lumbar spine. And so the exam, the physical -- there is a history. When a patient comes in, you ask him a history, what happened, what's going on. Then there is the physical examination where

you examine the patient. And so for spine injuries or spine examinations it basically revolves around range of motion and neurological testing.

So what happens is that I ask the patient to step down and I take their spine through a range of motion. I am going to stand for a second, if it's okay, just to show the jury what I will do. I'll stand next to him. And the spine, I'm talking about the lumbar spine, not the neck. I check the range of motion as follows. I ask them to bend forward. I say, bend forward as far as you can. I guide them through with my hands. Bending forward will be flexion. I ask them to lean back all the way. That's extension of the lumbar spine and I make the recording. I ask them to turn to the left, which is left lateral rotation or lateral turning, and to the right, right lateral rotation. I'll measure that compared to the normal.

His findings on that first exam were as follows: He had restricted range of motion with a flexion of 15 degrees, with normal being 90; that his extension was 10 degrees, with normal being about 40 degrees; and left and right turning, his exam was 25 degrees with normal being around 60. So he had significant, more than 50 percent loss of motion of his lumbar spine.

Another thing we do is we palpate. Palpate and percuss, means we touch the area. You put pressure on to see if it's tender, seeing if there is any muscular reaction. In

this case he had tenderness and spasm over his lumbar spine as well as something known as spasm. What spasm is, it's like a charley horse. You get up in the middle of the night, and it wakes you up from bed. In your leg it's an involuntary muscle contraction. The plaintiffs that can get spinal injuries, they can develop spasm in the area around the injury and you can feel that. You can see it and you can feel it. In this case I was able to determine that he did have spasm of his lumbar spine on that date and, again, that's an objective finding.

We examine range of motion of the spine as part of its stability and structure. We also do a neurological examination because, as I showed you, the nerves are intimately related to the vertebrae. And in this case I found he had weakness of the nerves of the lower extremity consistent with the area of the spine that was -- that we saw the injury in. For example, his quads, his quadricep muscle, which is the thigh muscle, was four out of five. Five out of five is normal. That's the way we grade muscle strength. Five out of five would be normal. His was four out of five. His hamstrings were four out of five; again, abnormal. His tibialis anterior, it's the muscle that makes you bring your foot up and down this way, four out of five. Those were all abnormal. Sensation. Remember I told you the nerve carries sensation, the feeling back to the brain from the extremity. Abnormal left L3, right L4, left L4, right and left L5. And so, again, it corresponds to specific areas

of the lumbar spine, of the low back, where the nerve is emerging. Each nerve has a number and I described it. And each one is examined during the normal course of a physical exam. And it was found to be abnormal at those levels.

He also had what's called a positive straight leg raise. A positive straight leg raise, it's another test. Essentially, if you are laying flat on your back and I grab your heel and I raise your heel off the bed, it elicits pain at a certain point. Normally it shouldn't elicit pain if you lift it up to a certain degree.

If there is any evidence of a pinched nerve, and the word that's going to come into play here is radiculopathy. Lot of fancy medical records. But radiculopathy, all that means is that it's a diagnosis of a disorder of the nerve function, whether it be motor strength, sensation, reflex, pain. If the patient has disorder of the nerve, they have a positive straight leg raise. Why is the question. When you lift the leg you're actually stretching the nerve. And that is a subtle way -- it's an old test. It's been around forever for the MRI. It helps to tell the doctor, that, yes, the nerve is being pinched somewhere in its course from the spine to the leg. So that was positive. That was a positive finding.

Those are my findings on that day.

Q. Doctor, you said there were approximately three presurgery visits, is that right?

A. Yes.
Q. And in that first presurgery visit what were your findings with regard to his neck?
A. I have no exam of his neck on that date.
Q. Because he was not complaining of his neck?
A. No.
Q. And, Doctor, ultimately what treatment did you render to Mr. Ebrahem?
A. He had surgery.
Q. When was that?
A. Surgery on 9/19/12.
Q. So the accident was in January of 2012, the surgery was in September of 2012, and you've already indicated that he was undergoing a course of physical therapy in the interim.

Can you please explain to the jury why you waited until September to do the surgery while this physical therapy was ongoing in the interim, if any reason at all?
A. Generally speaking, not in all circumstances, but in many patients that developed herniated discs is, we put them through a course of conservative treatment. You are going to hear that a lot. Let's try to treat this conservatively. Surgery is always potentially an option, but not necessarily the first option. We usually send the patients for things like physical therapy. We try different medicines. Activity restrictions, perhaps an injection. All of that we might try before doing

surgery. At some point we will say has it been successful or not. If we make -- I make the determination, well, you've had treatment for a year or six months or eight months or three months, whatever we determine to be appropriate in that case and he hasn't responded, then surgery becomes an option. That's what happened.

(Continued on next page)

Q. Doctor, utilizing the anatomic drawings that have been marked as Plaintiff's Exhibits 32 and 32A, could you again please come down, and you can bring your operative report with you if you have it, and explain the procedure that you performed on Mr. Ebrahem's lumbar spine.

Before you do so, Exhibits 32 and 32A, are they a fair and accurate representation of the procedure that you performed on Mr. Ebrahem?

A. Yes.

Mr. Ebrahem underwent a procedure that is commonly performed for severe herniated disc, not a mild herniated disc. It is called a laminectomy and a fusion.

So essentially what occurs in a procedure like that is aspects of the vertebral canal -- this ring which I showed you before, which is on the outside of the spinal canal, is removed as part of the surgical procedure to expose the nerves as they exit at different levels.

That gives me access visually microscopically to address what is called neural compression. As I described to you before, if you get a herniated disc, you get a pinched nerve, the nerve is being pinched, I have to unpinch the nerve.

How do I unpinch the nerve?

You make an incision on the patient's back, you remove muscle and bone in different areas of the spine that are blocking my visualization of the discs. I am able to deflect

the nerve roots, which are the nerves themselves, I am able to go in and remove those herniated portions of the disc which are hurting the nerves, which are compressing the nerves. That occurred in multiple levels of the lumbar spine L3, L4, L5, S1.

Then the first part of it is a laminectomy.

The second part is fusion. The word fusion is really a bad word. In general, I used the word instability before, that the spine needs to maintain stability. As a consequence of an injury, the spine can get unstable.

If the spine gets unstable, then it creates symptoms like pain and neurological dysfunction, as you saw in my exam, that he was getting weakness, right, the weak muscles.

You need to address instability. The way we address stability in the spine is by fusing the spine. This is the same kind of operation you might do on someone who has a major fracture, a dislocation.

These bones aren't lined up properly. These bones are not relating to each other properly because they have had disc injury, and the discs have been rendered unstable. So the way we stabilize it is providing a metallic scaffold, which is done with screws and rods, as you see.

And we do bone grafting. The screws only hold everything in place until Nature sort of heals everything together.

So he underwent this fusion procedure where screws are

inserted at multiple levels and rods are put in and then grafted. All of this was to realign the spine properly from the instability that was created from the accident, and getting it to heal in a relatively normal alignment.

It is not going to be the way perfectly like God made it, but it's still going to be better than it was after the accident. So that's the operation.

Q. Doctor, I understand you indicated that you made an incision and you exposed the spine.

Physically how are the -- first of all, what are the screws and rods made of?

A. These are called titanium implants.

Q. Is titanium metal?

A. Yes, it's metal.

Q. How are these physically inserted into the patient's spine?

A. So the patient is brought into the operating room, is put under general anesthesia, is rolled prone, or face down, on the operative table. Everything is prepared and draped appropriately, sterilized appropriately, and actually a large x-ray machine is brought in. It is called a fluoroscopy, which is an interoperative device we have for getting better placement of the screws.

An incision is made basically from the middle of the upper back to your buttocks area right above the crease, and then the muscle that is adjacent to all this is stripped away

using special instruments, large retractors. This is all exposed, exposing the bone with a series of retractors placed to keep the muscle away.

The individual bone is removed using a high-speed burr and high-speed instruments. Once that is done and with the microscope I have taken the pressure off the nerve, then I set about with my screws. The screws go in by drilling a hole. Each one has to be drilled. It has to be tapped. The boys might know what that is. It's basically creating a thread, because a bone is kind of like a soft rock. It is a porous stone is what it is.

You drill it, you tap it, you create the threads. Then the appropriate size, length, and diameter screw is inserted into the pedicles -- it's called a pedicle screw -- at every level.

We use x-rays to help make sure it is all lined up properly all the way down and that is occurs.

Q. Doctor, when you say it has to be drilled, do you actually have like a drill like a carpenter uses to drill through the bone?

A. Sure, yes.

Q. How are the holes then threaded as you indicated?

A. So the instruments, we use surgical instruments much like -- you know, it is craftsmanship. It is high-level craftsmanship.

So the drill is of a certain diameter. It has to be a certain diameter. It has to be drilled to a certain depth. Once that happens, you have to measure it, the depth that you drilled. And then I already know the diameter that I have drilled and a tap which is a little bit larger -- the core is the same size, but it has threads that are slightly larger than the hole that I have drilled. And then it is tapped to a certain depth, again using radiographic assistance.

And then, depending on the depth and the diameter of the hole that I have chosen to drill because of a choice, I choose the appropriate screw of depth and diameter, then the screw is inserted. And once that occurs the rod itself, it is a single rod which I contour, so it is a straight rod that I have to bend to the patient's own natural contour, that is dropped on top of the screws. The screw has an open top, like a cup, and the rod just sits on top of it.

Then we get that all lined up. It has to be appropriately lined up, and then there is a set screw. What you see here is a set screw. It is very technical for the jury, but that is inserted into the threaded female receptor of the screw and it gets inserted in the machine threaded cap.

Once you screw it in, it is actually torqued into place. If anybody knows what torque is, you have to turn it until it reaches a certain level, a threshold of energy, it is called torque. I know I am boring some people here for sure,

but the torque, it's like 50 pounds, foot pounds, etc., the exact number I don't remember, but it is all set up on the device where it actually clicks when it hits the appropriate torque for the screw diameter. That is how the screws are put in.

Q. Doctor, referring again to the MRI reports that are on the reverse side, Exhibits 16 and 18, did you rely on the findings of those radiologists in making your diagnoses and rendering your treatment in this case, at least in part?

A. Yes.

MR. VITUCCI: Objection, your Honor.

THE COURT: What is the objection?

MR. VITUCCI: The witness didn't have the prior MRI when he rendered his diagnosis and rendered treatment. I object to that question.

THE COURT: OK. He has to rephrase it to be very particular as to what he had at the time. Because the question is phrased, Did you rely on the findings of those radiologists in making your diagnosis. I don't if you have those radiologists. Can you be very specific as to what you relied on at the time of making your diagnosis, can you be more specific.

THE WITNESS: The MRI report that he is holding, the 2/3/12.

THE COURT: One MRI?

THE WITNESS: Yes.

MR. VITUCCI: Which one?

THE WITNESS: The 2/3/12 MRI.

MR. VITUCCI: OK.

BY MR. DOLAN:

Q. Referring to Exhibit No. 18, the 2/3/12 MRI, Doctor, are the findings in your operative report in any way distinct from the findings of the radiologist who interpreted the postaccident February 3, 2012 MRI?

A. They are consistent.

Q. In terms of the levels of the herniations, was there any distinction in those?

A. Well, I mean, I noted on my report that I found herniations at, segmental instability L2/3/4 and herniated discs at 2, 3, and 4.

Q. All right.

A. That is what I noted. But, you know, he also had the herniations, it is omitted, at L4/5 and L5/S1. That is what I did on this. That's what I was able to observe when I did this area here.

So I found additional damage. That is the additional damage that I found, on the operative report, in these areas, this is the L3, L3/4, L4/5 and L5/S1. These were all the areas that the MRI report showed the herniation, my defect here that is evident on the x-ray postoperatively that I examined. I

took the pressure off those nerves. In addition, I was able to find some other problems.

Q. Is it fair to say that when you went in there and looked with the human eye you found additional damage that was not detected in the MRI report?

A. Yes.

Q. Doctor, could you explain how that would be the case? In other words, in terms of rendering a diagnosis, how do you rate the findings of an MRI report as opposed to surgical findings?

A. MRIs are excellent diagnostic tools. For the most part, what you see on an MRI you should see when you open a patient up.

Obviously, once you are actually looking at it yourself, it is in 3D, it's live, it's magnified. That is a much higher degree of visualization that an image we created on a picture somewhere.

An MRI is an extremely powerful tool, but, yes there, are many circumstance, many circumstances where I will open a patient up and I will see more than the MRI showed. That's for sure.

Q. Doctor, you can take your seat. Do you want to bring your chart with you.

On how many occasions did you examine the patient in your office subsequent to the surgery?

A. Twice.

Q. When was that last occasion?
A. I am just double checking the dates.
Q. No problem.
A. 6/21.
Q. Of 2013?
A. '13, yes. Three times postop.
Q. Did you conduct a physical examination of the patient on that occasion, on his last visit at your office in June of this year?
A. Yes.
Q. What were your findings at that time in terms of range of motion and any other testing you did?
A. Range of motion showed was diminished 40 degrees of flexion, with 90 being normal; 15 degrees of extension, with 40 being normal; left and right turning 40 degrees with 60 being normal.

Abnormal gait. That is the way he walked. He had an abnormal gate. He had altered sensation L2 distribution.

Q. You gave a percentage loss of range of motion earlier for his first visit with you. How would you characterize the percentage loss of range of motion upon the last visit?
A. Approximately 50 percent.
Q. OK. Thank you. I'm sorry. The other tests that you did and the results?
A. I took an x-ray on that day, and I found the x-rays to be

satisfactory. That was essentially what the exam entailed on that date postop.

Q. Did the patient make any complaints to you at that time? Did you elicit any?

A. Yes. The patient, my notes of that day said patient was doing reasonably well considering his recent operation. He had some improvement of his lumbar pain. However continued to have residual pain and symptoms consistent with preoperative condition.

He had some chronic systems with respect to low back, his hip, six out of ten. Pain worse with lifting, carrying, and bending. That was the complaint.

Q. So he experienced some improvement after the surgery, but he also had residual complaints. What are residual complaints?

A. Oftentimes, especially with neurological injuries, patients have damage to a nerve as a consequence of an accident or an injury. You may intervene with an operation to stabilize the vertebrae, take the pressure off the nerve, but the nerve function doesn't fully recover.

I take the pressure off the nerve. I don't give them a new nerve. If the nerve was irrevocably damaged by the injury then it might note recover at all.

As you are probably, aware some spinal cord injury patients, even though you do surgery, they don't ever walk again.

Once a nerve is injured, it might recover, it might fully recover or it might partially recover. In the majority of instances they get partial recovery.

So if you get partial recovery, it means they have persistent symptoms. It didn't all go away, the numbness didn't go away or the weakness didn't go away or the pain doesn't all go away. That's what we call persistent symptoms.

Q. Is that the circumstance here?

A. Yes.

Q. Doctor, assuming that 20 years ago Mr. Ebrahem was involved in a motor vehicle accident, experiencing back pain, undergoing some physical therapy and that his symptoms ultimately resolved;

Assuming that within the last year or two before his January 11, 2012 accident as he aged into his mid 50s, he began experiencing some sciatica, undergoing some injections and undergoing some physical therapy, as well as undergoing an endoscopic microdiscectomy of his neck,

Assuming that he also underwent an April 22, 2011 lumbar MRI that diagnosed only some natural degeneration and bulges of the discs in his lower back,

Assuming that on January 11, 2012, Mr. Ebrahem was wearing his seatbelt while seated in an SUV that was stopped in traffic near the Lincoln Tunnel when his vehicles sideswiped by a 48,000-pound bus,

Assuming that his body was thrust backward and forward in the vehicle and that his left knee struck the interior of the vehicle,

Assuming that after the Port Authority police responded to the scene, he proceeded to drive his passengers to Newark Airport, dropped his car outside of a body shop, and took a taxi to Roosevelt Hospital, where he made complaints of pain to his left knee and pain in his lower back going down his left leg,

Assuming that he also went underwent an x-ray in the emergency room showing only mild degenerative spurring in his knee at most,

Assuming that within two weeks of the accident getting the first available appointment he began an initial course of conservative treatment, undergoing physical therapy three times per week for an initial stint of five months and then again after each operation and continuing after that,

Assuming that within three weeks of his accident, on February 3, 2012, he underwent a postaccident MRI study showing that what had once been mere degeneration and bulging of the discs in his spine had exacerbated into full-blown herniations since this accident,

Assuming that on February 3, 2012, he also had lumbar x-rays taken showing only mild levels of degeneration,

Assuming that Mr. Ebrahem's symptoms before and after

the accident were like night and day, so that what had once been an inconvenience and annoyance that still allowed him to work full-time had become a state of constant pain,

Assuming that Mr. Ebrahem ultimately came under your care to treat that pain, and underwent an operation in which metal rods and screws were surgically implanted to stabilize his spine,

Assuming that subsequent to the surgery he experienced relief so that his pain was no longer constant but remains intermittent and continues to be increased by motion and fatigue,

Assuming all that I have stated, do you have an opinion with a reasonable degree of medical certainty as to the competent producing cause of Mr. Ebrahem's disc herniations, spinal instability, and subsequent spinal fusion surgery?

MR. VITUCCI: Objection. Assumes facts not in evidence.

THE COURT: I will allow it. Assuming all of that, what is your opinion?

A. My opinion is that I believe that the need for surgery was related to the accident, yes.

Q. Was the accident of January 11, 2012 a competent producing cause of the disc herniations and spinal instability?

A. Yes.

Q. Doctor, but for his accident of January 11, 2012, would

Mr. Ebrahem have required lumbar spinal fusion surgery?
A. No.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to the permanency of the injuries Mr. Ebrahem sustained in his January 11, 2012 accident?
A. Yes.
Q. And what is that opinion?
A. It's permanent.
Q. Doctor, what is a progressive injury?
A. Progressive means that it gets worse with time. So, in other words, a patient comes in with a specific problem, you make a diagnosis, and then you can expect that you would say, well, this is a progressive condition. It means it's going to get worse as you get older. That is what progressive means. It deteriorates, gets worse as you older.
Q. Doctor, would you characterize the injuries Mr. Ebrahem sustained in this accident as progressive injuries that would require future treatment?
A. That it's more likely than not he's going to require significant future treatment.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Ebrahem sustained a significant limitation of use of his lumbar spine?
A. Yes.
Q. And what is that opinion?

A. He did.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Ebrahem sustained a permanent consequential limitation of use of his lumbar spine?
A. Yes.
Q. And what are the bases of your opinion that he sustained those losses of use of his lumbar spine?
A. It's based on the history of his accident, the review of the MRI, the surgical observation I made, the surgical procedure that was performed, and his subsequent recovery. All that relates to his disability.
Q. And the components of that disability, does that include the 50 percent loss of range of motion that you've described and the pain that he continues to experience?
A. Yes.
MR. DOLAN: And the photograph, please. It is going to be the last one. It is the last one.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty -- let me show it to the witness, the surgical incision -- as to whether the surgical scar is a permanent condition?
A. Yes.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Ebrahem's surgical scar down his back constitutes a significant disfigurement?

A. Yes.
Q. What is your opinion?
A. It is.
Q. Is it also permanent?
A. Yes.
Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to what future medical care Mr. Ebrahem will require as a result of his January 11, 2012 accident?
A. Yes.
Q. Did you prepare a life care plan for him in that respect?
A. Yes.
Q. Is that referenced in your report?
A. Yes.
Q. Doctor, if you could please itemize the treatment, including the frequency, cost and duration thereof in terms of what you are recommending for Mr. Ebrahem?
A. These are projections that I made with respect to his future needs. Orthopedic lumbar, to see an orthopedic surgeon five times a year, approximately $200 a visit; pain management visits once a month, $200 a visit; x-rays twice a year, $300 an exam; an MRI taken once every three years at a cost of approximately $1,000; the nerve study, EMG study every two years at $1500; medicines like Motrin, $50, I guess the monthly approximately $600 a year.

Potentially he needs an implantable analgesic pump and

catheter once the medicine stops working, a surgery facility can go as high as $75,000; it is possible he may need more surgery as a consequence of this accident, another fusion, which can cost upwards of $100,000; intermittent injections one to three times a year, which can cost $5,000; physical therapy three times a week at $125 a visit for the next two years.

He is still recovering from surgery, still needs therapy. And then once a week thereafter.

So these are all the kinds of things that you can anticipate someone like this would be required to make him feel comfortable going forward.

Q. Doctor, you indicated an opinion with a reasonable degree of medical certainty that he will eventually require additional spinal fusion surgery. Why is that?

A. Well, first of all, he hasn't fully healed. So, until he fully heals, I can't say he won't need an operation to get this operation to heal.

Secondly, patients that have spinal fusions oftentimes develop degeneration at the level above or below the site of the fusion because there is a rigid area of the spine and a more flexible area of the spine. That junction can see a lot of stress and they could develop new herniated discs as a consequence of that and require surgery. It is not uncommon that happens. It is more likely than not that it could happen.

Q. Doctor, the need for that future surgery, is that more

likely to occur sooner or later? In other words, more likely in year one or year ten?

A. Well, in his case we have to wait for him to be fully fused. I would say there is a short blip. He is healing, so I'm not anticipating it, but it is possible he could need surgery in the next six months or year to continue on this surgery.

After that once, that's fully healed, then everything I discussed is more of a long range problem it happens year six, seven, eight, nine, ten. That's when it happens.

MR. DOLAN: Thank you, Doctor. Nothing further.

MR. VITUCCI: Can we take a two-minute break.

THE COURT: We can take the full ten-minute morning recess now and we will start the cross. Unlike some issues yesterday, today I will really come back in ten minutes and we'll get started. We have three witnesses to get through. So ten minutes. So, Doctor, we will be reconvening in ten minutes.

THE WITNESS: Thank you.

(Recess)

CROSS EXAMINATION

BY MR. VITUCCI:

MR. VITUCCI: Before I begin, I would like to offer into evidence at this time Defendant's Exhibit Q, which would be the chart of Dr. Dmitiri Petrychenko, and as Exhibit R a

chart of Dr. Hazem Ali.

Q. Good morning, Doctor.

A. Good morning.

Q. Now, would I be correct in saying that Mr. Dolan just asked you to do something that you are pretty uncomfortable doing?

A. With respect to what?

MR. DOLAN: Objection, your Honor.

THE COURT: I don't know what he is talking about. Maybe the witness does. Did he ask you to do anything you are uncomfortable with?

THE WITNESS: No.

Q. Well, he asked you to take a look at some MRI reports and compare them, didn't he?

A. Yes, sir.

Q. You don't ever rely on other doctors' MRI reports, do you?

A. I use them regularly in the course of my practice. I mean, I read the films myself as well.

Q. But you always make your own assessment, correct?

A. Yes. But I do read other reports every day, and I rely on them, of course, in the course of practice.

Q. You make your own assessment of MRI films, correct?

A. When I have the films, yes.

Q. I would be correct in saying that when you first saw -- do you recognize Mr. Ebrahem back here?

A. Yes, sir.

Q. When you first saw him, you didn't make an assessment about his prior MRI because you didn't know he had one, right?

A. When I -- I did not make --

Q. Just --

THE COURT: Let him answer you.

MR. VITUCCI: OK. Go ahead.

THE COURT: Go ahead.

A. When I first met him, I just looked at the new MRI.

Q. Did you order your own MRI? Do you know?

THE COURT: I think he's checking the notes.

A. I'm checking the date on the one that I -- I don't want to speak incorrectly. I relied on the 2/13/12 MRI when I saw him on 4/20/12.

Q. So you relied on someone else's MRI?

A. Your characterization of someone else's, I relied on the MRI that the patient brought when he came.

Q. Did he bring one or not bring one?

A. I answered year question. The MRI of -- just to be clear, the 2/3/12 MRI was the one that I reviewed on 4/20/12.

Q. Now, you are here today I think Mr. Dolan went over your fee?

A. Yes, sir.

Q. So your fee for half a day is $12,500?

THE COURT: What? Did you say that?

THE WITNESS: My fee is $600 an hour. Oftentimes I

will take a retainer of that amount of money prior. I don't believe I took that retainer today.

THE COURT: But your fee for testifying here is $600 an hour, right?

THE WITNESS: That is correct.

Q. No, it's not, Doctor. Mr. Dolan disclosed your fee.

MR. DOLAN: Objection, your Honor, to the testifying form of the question.

THE COURT: The testifying -- wait a minute. I am all confused myself.

MR. VITUCCI: I am, too.

THE COURT: I am not asking about the total fee. The testifying part of it is $600 an hour, is that right?

THE WITNESS: Correct.

THE COURT: That is what he said three times. What is incorrect? You said that is incorrect.

BY MR. VITUCCI:

Q. Mr. Dolan disclosed you, in your expert witness disclosure it says court appearance, half day, $12,500, is that correct?

A. That's generally the retainer that I charge for testifying.

Q. So it is not $600 an hour?

THE COURT: A retainer is different, as you know as a lawyer, from the hourly fee. A retainer is different. You know as a lawyer "retainer."

MR. VITUCCI: I always work on an hourly fee.

THE COURT: You don't know the word "retainer"?

MR. VITUCCI: I didn't have it in my mind, your Honor, I do know the word. I'm sorry.

A. To finish answering your question, I have not received $12,500 from Mr. Dolan's firm as a retainer prior to coming here, but that is generally is what I do.

Q. If you were going to be here for a full day, you would charge a retainer of $25,000, is that correct?

A. That's correct. Again, I did not receive that amount of money, sir.

Q. What have you received? I guess that's the question, right?

THE COURT: You mean for all his work on this case?

Q. Have you received anything yet?

A. I don't believe I received anything yet.

Q. Now, Doctor, you would agree with me that you would perform a lot of surgeries, correct?

A. I am a spinal surgeon, yes, sir.

Q. I would be correct in saying that you would perform up to five surgeries a day, isn't that right?

A. Yes, sir.

Q. In addition to doing surgeries, you keep certain days for patients, is that correct?

A. Yes, sir.

Q. So on those days instead of doing five operations you see

patients?
A. Yes, sir.
Q. Would that be just a regular day, an eight-hour day?
A. I mean, it might be 8 hours, it could be 12 hours. It all depends on the day and how many patients are coming in, etc.
Q. Let's assume a regular eight-hour day.
A. Yes, sir.
Q. Now I would be correct in saying that you see up to 70 patients a day, correct?
A. I could see that many patients in 12 hours, yes.
Q. That is a lot of patients.
A. Yes.
Q. You have to have patience to have that many patients.
A. I'm sorry?
Q. Let me try to do the math. Let's assume that was an eight-hour day, and if you saw 70 patients, I worked it out on a calculator, that is six minutes a piece with each patient, correct?
A. I don't see 70 people in an eight-hour day. I could see up to 70 people if I worked 12, 14 hours, which I have by the way. But on average I see four to six people an hour, average. It depends on the circumstance, the nature of the patient.
Q. Let's assume six people an hour. So let's do the math. How much is that a person? Ten minutes, right?
A. It's ten to fifteen minutes, depending on the --

Q. In that time you do an exam of the patient right, you wouldn't see him and say, Hello, Hey, Charlie, How you doing?

You would examine them, right?

A. Just to clarify, I have a physician assistant that works with me with the patients and a nurse that works with me.

Q. I am not talking about anybody but you.

A. Just to help describe how the interaction is. It is not only me seeing the patient.

Q. OK. Let's say you have 20 people and you. Ten minutes, correct?

A. My time is about ten or 15 minutes, depending on the circumstances.

Q. That is time enough to do an orthopedic exam, isn't that right?

A. You know, again, I am doing it as well as my assistant, the other doctors that work for me. It is not only me that does the exam.

Q. There's been a lot of debate here -- in fairness to you, you weren't part of it because you are just here today -- about how long it takes to do an exam, and your testimony is ten minutes, correct? Yes?

A. It depends. Ten to fifteen minutes I think for a spinal exam is a reasonable amount of time.

Q. Thank very much for answering that, by the way. Now --

MR. DOLAN: Objection, your Honor.

THE COURT: Yes. Sustained. Please could we maybe have less drama and more questions.

MR. VITUCCI: OK. More questions.

BY MR. VITUCCI:

Q. Sir, would I be correct in saying that on your very first ten-minute exam with Mr. Ebrahem, back here, you made a decision that you were going to do surgery?

A. I mean I discussed surgery with him, certainly. I am a surgeon, so every patient coming to me I am evaluating for whether or not I think they would be a surgical candidate or a candidate for something else. So essentially that is the decision that's being posed to me. And the office is structured in a way to facilitate that decision or that recommendation.

Q. After your ten minute exam on that first visit, I would be correct in saying, Doctor, it mentions in your very first report, April 2012, he signed a consent form for surgery, right?

A. Is that true? I don't know that to be true. Where do you see that?

Q. By the way, do you have your original chart here, 4/20/2012 directed to Dr. Pappas?

A. Yes, sir.

Q. There is a lot of form language here, right? These are all boilerplate paragraphs here, right? "Past medical history,

plan", that's all boilerplate, and "overview of different treatment options discussed with this patient including surgical" blah blah blah, that is all boilerplate there, right?

A. I don't know what the word boilerplate means.

Q. It is in each and every one of your reports, correct?

A. It's the phraseology and the way that I write my reports in order to convey the sum and substance of the conversation.

Q. OK. You didn't dictate or type or have anyone dictate or type "all the risks benefits, alternatives, success and failures of surgical v. nonsurgical procedures were discussed with the patient," etc., etc.

That is in every one of your reports.

A. That is part of a standard format that I use.

Q. So you have a standard format?

A. That is correct.

Q. And you do a ten-minute exam?

A. That's not correct, sir.

Q. Now, Doctor, you do a lot of operations, you just told us sometimes five a day, right?

A. I mean, I can't characterize the word "a lot," but I am a spinal surgeon. That's what I was trained to do, and that's what I do on a regular basis.

Q. How many procedures do you do a year?

A. Approximately 400.

Q. How many have you done over your career?

A. 5,000.

Q. Are you perfect?

THE COURT: Don't even answer. Nobody is perfect. That is a silly question.

What is the next question?

BY MR. VITUCCI:

Q. Now, going back to patient visits -- excuse me. Let's go back to your initial exam of Mr. Ebrahem. That was 4/20/12. That was three months postaccident, right?

A. Yes, sir.

Q. You have your notes there so we can read along with each other. You wrote, if I am correct, that Mr. Ebrahem was injured on November 12, 2002, correct?

A. Yes, sir.

Q. That is wrong obviously, right? That is after the date you are seeing him?

MR. DOLAN: 12? You said 2.

MR. VITUCCI: No, I am --

MR. DOLAN: You said 2002.

MR. VITUCCI: I said 2012.

MR. DOLAN: Oh.

Q. I mean -- yes, 2012, excuse me.

A. Yes, obviously that's wrong.

Q. Now, when you first saw him, he didn't have a lot of records with him, right?

A. The MRI.
Q. And we are talking about the MRI that was taken in 2012?
A. Yes.
Q. Correct?
A. Yes, sir.
Q. Now, you took a history from him when you first saw him, and as part of that history you asked him if he had any prior injuries to his neck or his back, isn't that right?
A. That would be part of what I asked, yes, sir.
Q. He told you he had none, isn't that right?
A. No. He wrote that he had neck surgery. He told me he had neck surgery in 2011.
Q. Where is that? Can you show me?
A. This is the part of what the patients fill out when they come to the office. He filled this out in his own handwriting. He had neck surgery.
Q. He had neck surgery. OK.
A. He also said that he had physical therapy, warm packs, exercise.
Q. Right. So we are not here about the neck. So we don't have to worry about the neck.
A. Sorry.
Q. He didn't say anything to you, if I am correct, about having a back injury, right?
MR. DOLAN: Back injury?

A. He denied --

Q. I will take that. Back injury. He didn't tell you he had a back injury, right?

A. Not specifically.

Q. In fact, he didn't tell you he had any complaints with regard to his back before the January 11, 2012 accident, isn't that right?

A. No specific complaints.

Q. In fact, not no specific complaints, he denied having a problem before the accident that we are here about, isn't that right, Doctor?

A. He denied having any significant prior. That is a question that I ask patients.

Q. We will get to significant in a minute, OK, and your meaning of significant.

Significance has a special meaning to a doctor as opposed to a layperson, right?

A. It could.

Q. It does, doesn't it? Let me ask you this: If Mr. Ebrahem had a minor complaint about his back at some point in time, let's say -- you first saw him in April of 2012. Let's say in March of 2012 he got up in the morning and twisted his back. Would that be significant to you?

A. No.

Q. In your view a significant prior complaint could change

your diagnosis as to causal relation?
A. It could.
Q. Correct?
A. Yes, it could.
Q. Now, you would consider am I correct in saying a prior history of epidural injections to be significant, wouldn't you?
A. Yes.
Q. And you would consider a prior history of having an MRI to be significant, wouldn't you?
A. I mean, it is hard to answer that question yes or no. Having an MRI doesn't necessarily mean there is something wrong, but certainly it would be information that would be important.
Q. You would agree with me that in your report you only note significant things, right?
A. Usually, yes.
Q. You just mentioned that a prior history of epidurals would be significant, right?
A. Yes.
Q. And a prior history of having an MRI, that would be significant, wouldn't it?
A. It could be, yes.
Q. I would be correct in saying that Mr. Ebrahem didn't say any of those things to you?
A. But he did record that he had prior epidurals of his back,

yes. Similar to the way he reported that he had a prior neck problem in his --

Q. He reported that to you?

A. Yes.

Q. Initially?

A. Yes.

Q. Where is that in your notes?

A. In that same sheet. That is what I was referring to when I was showing. His prior treatments, list previous treatments. He circled epidurals.

Q. That was for his neck, correct?

A. No.

Q. Well, how can there be any reference to him having epidurals to his back if you didn't have anything recorded in your records showing that he had a prior back problem.

MR. DOLAN: Injury.

A. Well, I really can't answer that question yes or no.

Q. Is there any reason why?

A. Because I think that the history -- it is best answered with an explanation. He wrote his prior problems of neck and back in the history and physical report that he has to fill out.

In my narrative I wrote that there was no significant prior history because I didn't deem those interventions to be significant relative to why he was coming in that day. So when

a patient comes in, I'm trying to formulate a thought as to why is he here today. He could have had --

Q. He was there today meaning your first visit because he had back pain, correct?

A. Correct.

Q. He had a bad back, correct?

A. He had back pain and leg pain.

Q. You did operate on him. He had a bad back, right?

A. Yes. I believe I answered your question. He had back pain and leg pain when he came in.

Q. This trial is about whether he had a bad back before the accident, you do know that, right?

MR. DOLAN: Objection, your Honor.

THE COURT: Sustained. This trial is about the alleged accident on January 2012. That's what this trial is about.

BY MR. VITUCCI:

Q. Doctor, you would agree with me that it would be significant and you might have a different opinion if he had a course of treatment for his back prior to the accident?

A. That is significant information. I believe I answered that, yes.

Q. When you first saw Mr. Ebrahem you weren't aware that he was under a course of treatment with Dr. Petrychenko, were you?

A. Not specifically but that he was under a course of

treatment by a physical therapist and other doctors. I'm usually a third-party consult. People come to me inquiring about surgery. So I am not a primary care doctor for the spine.

Q. Do you know Dr. Petrychenko?

A. No.

Q. Do you know Dr. Hazem Ali?

A. No.

Q. Do you know that Dr. Petrychenko was giving him epidural injections into his lumbar spine before this accident?

A. Again, I don't have a specific knowledge of who gave him injections, but I am aware that he did receive injections in his spine before seeing me. And that was -- go ahead.

Q. You will agree that injections into the lumbar spine are to treat pain, correct?

A. Yes, sir.

Q. In fact, you provide that service at your medical operation, right?

A. In my office, yes, sir.

Q. And you will agree that Dr. Petrychenko was treating Mr. Ebrahem for lower back pain before this accident, correct?

A. I can't testify what the treatment, Dr. Petrychenko's treatment. I don't know what he was doing.

(Continued on next page)

Q. But you have his records, don't you?
A. If you could refresh my memory, I would appreciate that.
Q. Let me show you Exhibit Q, Doctor. Can you take a look through there?
A. Yes. It appears Dr. Petrychenko was a pain management physician who rendered epidurals to Mr. Ebrahem.
Q. He rendered epidurals to his lumbar spine?
A. Yes. And his neck as well.
Q. We are not talking about his neck now, are we? You didn't treat him for his neck, right?
A. I reviewed the record and you asked me what he did and he gave epidurals to his lumbar spine and his neck.
Q. Dr. Petrychenko mentioned in there that there was a failed series of injections, in other words, those injections didn't provide him with any relief, correct?
A. Again, I can't tell you what his opinion was relative to what his treatments were.
Q. Well, you do agree that the treatment didn't work, right?
A. I agree that epidurals did not help the patient.
Q. In fact, you cited that as one of the reasons to do your surgery, isn't that right?
A. That's correct.
Q. That the epidurals before the accident didn't work and that's one of the reasons you did your surgery?
A. That's not correct, sir.

Q. Doctor, you want to look at your own expert report. Don't you mention at the bottom of your conclusion: Patient underwent two lumbar spine epidural injections at Interventional Pain Management on October 1, 2011 and October 15, 2011, without improvement.

A. Yes. That's in my narrative.

Q. Mr. Ebrahem had a bad back before the accident, isn't that correct?

A. He had treatment for his low back and he was receiving epidurals for his lumbar spine.

Q. And you weren't aware of that treatment when you first saw him and made a recommendation for surgery, correct?

MR. DOLAN: Objection. Asked and answered, your Honor. He was aware.

THE COURT: He can answer that himself.

A. Yeah, I was aware that he had received epidurals to his back before.

Q. But you don't comment on that anywhere in your report, isn't that correct?

MR. DOLAN: Your Honor, he read it from his report.

A. You just quoted that part --

Q. In your initial records you didn't make any comment about his having seen Dr. Petrychenko --

THE COURT: You changed the question. First, you said, where in your report did you say that. Now you are

saying in your initial records. Which would you like an answer to right now, report or the initial record?

Q. Doctor --

THE COURT: You need to answer my questions if I ask you a question, please.

Mr. Vitucci, it's 12:05. We have three witnesses today. It will help if you answer my questions. Do you want to know about the record or the report right now?

MR. VITUCCI: I want to know about the records.

THE COURT: The record, not your report. Your initial record of your first meeting with this fellow, did you know about the treatment for the back?

THE WITNESS: I did know that he received epidurals and I did point that out that the patient circled he had epidurals prior to having seen me.

Q. And are you familiar with the records of Dr. Hazem Ali?

A. I'm not familiar with the records of Dr. Hazem Ali.

Q. Do you reference the records of Dr. Ali in any of your reports or records?

A. Off the top of my head I don't have a specific recollection. If you could refresh my memory, I appreciate it.

Q. I can't.

A. I don't have a specific recollection. There are so many reports.

Q. Doctor, would I be correct in saying that you mentioned the

prior treatment by Dr. Petrychenko and Dr. Ali in your expert disclosure for the first time that were served only two months ago?

A. In my medical narrative, which is a summary of the events that I prepare when asked sometimes, I mentioned the prior treatment.

Q. Doctor, you went through the other records before, the Roosevelt Hospital record. Would I be correct in saying that Mr. Ebrahem didn't mention anything about a prior problem in his lower back when he was as Roosevelt Hospital?

A. I didn't recall seeing that in the Roosevelt record, no.

Q. And you mentioned you saw the records of Dr. Pappas. Did you note in that review of records that Mr. Ebrahem had a prior accident back 15, 20 years ago?

A. There was mention of that in Dr. Pappas' record, that he had a prior car accident 15 years ago.

Q. You have no way of knowing what, if any, treatment he received in that intervening time period, do you?

A. Not specifically, no.

MR. VITUCCI: I have no further questions, your Honor.

MR. DOLAN: Very briefly.

REDIRECT EXAMINATION

BY MR. DOLAN:

Q. Doctor, how long was the operative procedure that you performed on Mr. Ebrahem, if you could estimate?

A. Approximately four hours.

MR. VITUCCI: Objection. Not the subject of cross, your Honor.

MR. DOLAN: Sure.

Q. We are talking about ten-minute exams. I want to know how much time he spent with the patient.

THE COURT: His surgery was four hours. Next.

Q. Fair to say that you spent a lot more than ten minutes with this patient?

A. Yes, sir.

Q. You've conducted more than one examination of the patient?

A. Yes, sir.

Q. A series of examinations over the last year and four months?

A. Yes. Three before surgery. Three separate visits before surgery.

Q. And then follow-up office visits after the surgery?

A. Yes, sir.

Q. Doctor, you indicated in his very first visit with you Mr. Ebrahem provided you with information that he had had prior lumbar injections and prior physical therapy. Am I correct?

A. Yes.

Q. Can you remove that page of your office notes from your chart.

A. I am not sure I understand you.

Q. I want to mark that page as an exhibit.

A. You're welcome to.

Q. We can return it to you after the trial.

A. It's easier if you keep it in the chart, because it then won't get separated.

MR. DOLAN: Let's mark the whole chart.

Your Honor, for the record, we are going to mark the actual chart, original chart that the doctor brought with him, as Plaintiff's Exhibit number 25A in evidence.

THE COURT: I can't put it in evidence yet.

MR. DOLAN: I offer it in evidence.

THE COURT: I can't do that either. I don't know if Mr. Vitucci has had an opportunity to look at every page. He can do that over the luncheon recess. I can't accept it yet. He can do it over the luncheon recess.

MR. DOLAN: I have no further questions.

THE COURT: Thank you.

That's your chart?

THE WITNESS: That's my chart from the office, but I can get it on the computer.

THE COURT: We need to keep it here.

THE WITNESS: If somebody can get it back.

MR. DOLAN: I will return it after the trial.

THE COURT: Thank you.

(Witness excused)