SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: CIVIL DIVISION - PART IA-13

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ARDIANA GASHI,

Plaintiff,

-versus-

Index # 302761-2010

VICTORIA VOGEL-BLUMENTHAL,

Defendant(s)

----------x

August 1, 2014
851 Grand Concourse
Bronx, New York 10451

B E F O R E : Honorable FERNANDO TAPIA,
J U S T I C E

APPEARANCES:

BERGMAN, BERGMAN, GOLDBERG & LAMONSOFF
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BY: FRANCIS J. SCAHILL, ESQ.

Victoria Efferen

Senior Court Reporter

(Whereupon Plaintiff's Exhibit 11, illustrative board, marked in evidence as of this date)

(Whereupon, Plaintiff's Exhibit 12, fusion surgery disk, marked in evidence as of this date)

(Whereupon, Plaintiff's Exhibit 13, set of x-rays from Doctor Lattuga, marked in evidence as of this date)

(Whereupon, Plaintiff's Exhibit 14, model of the skeleton, marked for identification as of this date)

THE COURT: Bring in the jury, please.

(Whereupon, the jury enters the courtroom)

THE COURT: Have a seat, folks.

Thank you very much, ladies and gentlemen for being on time. Sometimes things happen and you know this does not happen like on TV where if it is an 8:30 program it starts at 8:30. There are a lot of other things that take place.

We are going to resume the testimony. Remember what I said yesterday that Miss Gashi is not going to testify first today. We are going to take a doctor, a medical professional out of place because if we don't get him today, the likelihood is that we will not get him to testify. Once we complete with the doctor's testimony on direct and cross, then we'll have Miss Gashi take the stand again and resume. Just to make it clear as to what is before us.

That being the case, I want to wish you a good morning. Ready to go to work?

(Whereupon, the jury responds affirmatively, en masse)

THE COURT: Let's go to work. Mr. Fields, please.

MR. FIELDS: At this time the Plaintiff calls Doctor Sebastian Lattuga.

S E B A S T I A N L A T T U G A, M.D., having been called as a witness on behalf of the Plaintiff, having been first duly sworn, was examined and testifies as follows:

THE COURT OFFICER: Please have a seat. State your name and professional address for the record.

Keep your voice up, please.

THE WITNESS: Sebastian Lattuga, 2001 Marcus Avenue, Lake Success, New York 11042.

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. FIELDS:

Q Good morning, Doctor.

A Good morning.

Q I am just going to ask, Doctor, that you keep your voice up.

A Okay.

Q We have a small room here but once again as I instructed prior witnesses, if I cannot hear you back here I assume that the last juror in the box can't hear you either.

A Yes, sir.

Q I ask you to keep your pace slow enough because we have a court reporter so try to keep it slow, okay.

A Yes, sir.

Q You have given us your full name and address, can you give the ladies and gentlemen a brief history about your educational background.

A Yes, I am a board certified orthopedic spinal surgeon. I went to medical school here in New York State, Stonybrook University and went on to do a residency in orthopedics at Stony Brook Hospital and Stony Brook as well and went on to do a spinal fellowship at the University of Miami, Jackson Memorial Medical Center. I am the chief of spine surgery at North Shore Franklin Hospital. My practice is in the New York Metropolitan area, I keep several offices here and I am licensed since 1991 to practice medicine here in New York State.

Q Tell us what it means to be board certified?

A Board certified is a process of accreditation that occurs, there is a board that oversees the education of every specialty of medicine, so there is a board that sits in Chicago that dictate exactly what type of education an orthopedic surgeon should have, what the training is, how much surgery, how many

years it takes. They oversee all of that and you have to pass written exams throughout. There is two or three exams, I forget now and you do an oral exam. When you are all done, you do the oral exam and then you get board certified after your oral exam. That was initially in 1998 and then every 10 years you have to recertify.

So in 2008 I recertified as an orthopedic surgeon and I have been practicing ever since.

Q Doctor, is every physician who practices in the field of orthopedics board certified?

A Again, no, you have to pass the test.

Q But you can still be a doctor and not be board certified?

A Yes, sir.

Q And still practice?

A Yes, sir.

Q Can you tell the ladies and gentlemen what it means to hold a residency?

A Yes.

Q You said you had a residency?

A You guys watch TV, the doctors, you go to medical school but you graduate with an M.D. but you are not a doctor yet, you have to sort of learn your craft. There is so many different areas of medicine and I am an orthopedic surgeon and so that's the specialty of medicine that you might know as if you

break your leg they put you in a cast, that's what an orthopedic surgeon is. We do sports medicine, arthroscopy, spinal surgery.

So what happens, you graduate medical school and go through a training program, it is generally five years of where you learn your craft. It is really an art, surgery. Little by little you are given more and more responsibility and there is learning, book learning, there are tests and then you actually practice surgery along with an experienced surgeon and little by little you graduate your residency and apply for that board certification process.

In this case I did a residency at Stonybrook. It took me five years which includes the internship and went on to do my fellowship in spine surgery.

Q And what is a fellowship, Doctor?

A So, orthopedic surgery is that whole specialty of medicine that deals with the things that I mentioned to you, in orthopedics there are sub-specialties, different sub-specialties. For example, spine surgery is a sub-specialty, hand surgery, sports medicine, pediatrics, we put the braces on the kids with the crooked legs. Basically those are all sub-specialties. To get sub-specialty accreditation or a separate diploma, you have to do a fellowship so you spend, I spent another year and a half actually just only doing spinal surgery with adults and pediatrics and even though I did spine surgery in my residency, the whole time, that one year and a half was basically I lived in

an operating room and I got to operate with all the famous doctors in the country, learning all the great things that you need to pass on to become a surgeon. So that's what happens.

Q You told us that you are currently the chief of surgery at Franklin Hospital?

A North Shore Franklin Hospital.

Q What does that mean?

A The chief's obligations they are mostly administrative so, for example, there are other spine surgeons in my hospital that I am responsible for credentialing to make sure they are capable to do surgeries and are allowed to do surgeries in our hospital. There is a residency teaching program which we have our own, I teach the residents, I am in charge of that residency for spinal surgery and I also interface with some of the national agencies that are involved with hospital oversight. It is administrative things, administrative duties mostly, it is not that interesting but that's what I have to do.

Q How long have you been in private practice?

A Since 1998.

Q That's been continuous?

A Yes.

Q And continuous as an orthopedic surgeon?

A Spine surgeon, yes.

Q With the specialty in spinal surgery?

A Yes, only spinal surgery.

Q Doctor, approximately how many surgeries would you say --

THE COURT: Hold on, we need a break. One of the jurors is having a problem.

(Whereupon, the jury exits the courtroom)

(Whereupon, a brief recess was held)

THE COURT: Okay, let's resume. Mr. Fields.

Q How many surgeries would you say you performed on any given year?

A On any given year?

Q Correct.

A Over 300.

Q What percentage of those approximately are spine surgeries?

A All of them.

Q Very good.

MR. FIELDS: Your Honor, at this time I offer Doctor Sebastian Lattuga as an expert in the field of orthopedic surgery.

THE COURT: He is a treating physician at this point.

Any objection?

MR. SCAHILL: No objection.

Q Are you being paid for your testimony here today?

A Yes.

Q And can you tell us how much?
A 600 an hour.
Q And you anticipate being present here for this trial for how long?
A Hopefully I will be out by lunch, but I might be here all day.
Q Can you tell us what the basis of that fee is?
A It is usual and customary medical/legal fees for testimony, keeping with what I believe are appropriate fees for being out of the office and not seeing patients and not being able to operate.
Q How did you get here today, Doctor?
A I drove here.
Q Is my office at all involved in or has it participated in the arrangements of your transportation?
A No.
Q Very good. Now, did there come a point in time, Doctor, that the plaintiff in this case Ardiana Gashi came under your car?
A Yes.
Q And, again I see you have a chart with you?
A Yes.
Q I ask in the course of your testimony if you need to look at the chart to refresh your recollection, I have no issues with that. We have certain records in evidence including your

own, but if there is something else in addition, please refer to that.

A Okay.

Q And, can you tell us just generally speaking, Doctor Lattuga, what did Miss Gashi come under your care for?

A She was involved in an accident in August of 2009 where she injured her neck and back and she came to see me for a spine surgical evaluation with respect to her neck and back.

Q Keep your voice up a little bit.

A Sorry.

Q Before we move further Doctor, I brought with me what appears to be a model of the spine.

MR. FIELDS: Permission to approach, your Honor?

THE COURT: Yes.

Q I am going to hand this to you. We marked it for identification purposes as Plaintiff's Exhibit 14.

THE COURT: For ID?

MR. FIELDS: Yes.

Q Doctor Lattuga, do you recognize that model?

A Yes.

Q What do you recognize that to be a model of?

A The model of a human spine.

Q Looking at the model of the human spine, is that anatomically correct?

A Yes.

Q If I ask in the course of your testimony to utilize the model, again, Plaintiff's Exhibit 14 for identification, could you do so?

A Yes.

Q And do you think it will assist you in explaining your testimony?

A Yes.

Q And is it your opinion that it would assist the ladies and gentlemen of the jury in understanding some of the concepts and terms about what you are here to testify for?

A Yes.

Q I am going to ask you to use that at any point in time of your election to explain anything that may come up.

Generally speaking Doctor, explain to us what it is that we are looking at.

A This is a -- do you mind if I stand?

THE COURT: You can stand.

MR. FIELDS: You can take it off the hook.

A This is a model of a spine, everybody noticed that there is a spine. The spine is divided into three different parts, you would say your neck, your middle and lower back, but the doctor words or the medical expressions for that would be cervical spine, thoracic and lumbar spine which is analogous to neck, middle and lower back.

The cervical spine being the neck has seven segments,

usually the thoracic has twelve segments and the lumbar has five segments. When I say segments I am referring to the bones. They are bones. The spine is a column of bones separated by a structure called an intervertebral disc and one disc between each vertebrae. They are individually numbered from the top down. Cervical starts with one, C1 to 7, T1 to 12, L1 to L5.

The disc between each vertebrae is named accordingly so the disc that's between the first lumbar vertebrae L1 and the second lumbar vertebrae, L2 would be called the L1/2 disc. That's how we call it.

The main function of the spine is twofold. The first function of the spine is it supports your arms and chest cavity, helps to hold that all together otherwise you would sort of collapse like a worm. So we are vertebrae and we have vertebrae that supports the body and allows you to move your heart and lungs through space or else it would collapse. It is a structure that's important for movement and mobilization.

The second main function of the spine is to act as a conduit or a tunnel for the spinal cord and the nerves. The jury all knows like if you break your spine you could be paralyzed and the reason is they are intimately related. In fact, the vertebrae of the spine has a tunnel that carries the spinal cord and the nerves down from the top to the bottom and then at every level between each vertebrae the nerves come off and go to the arms.

For example, the cervical spine sends nerves to the arms. The lumbar spine sends nerves to the legs and so they are intimately related. So the spine is important for those two functions. To repeat, stability and mobilization and as a conduit for the nerves.

We talk about the spine getting injured right, or damaged or some process occurring, not only could it affect your mobility and your ability to move, right because that's important in maintaining that function, but also you can damage the nerves, you can have nerve dysfunction. So you will see if I am asked about doing a physical exam, when I examine someone's spine I am examining both those properties, not only am I examining how they move, but I am doing a neurological test where I am testing the nerves to see how they work.

That's an overview of how the spine works.

Q Take a step back for a second.

You testified that the spine is a conduit for the spinal cord and the nerves, what essentially is the function of the nerves?

A So the nerves are like electrical cables and what they do is carry information from the brain to your extremities. For example, so if you close your eyes and you feel the chair you know you are feeling the chair and the reason why you don't have to look, you can close your eyes and feel because the nerves bring the information of sensation back along that conduit like

an electrical cable through the arm, along the nerve, into the spine, up the spinal canal, into the brain. And the brain takes that information and processes it and you process it so you know that you are touching the chair, you are not touching a piece of ice and you are not touching a sharp pin. You know that not by looking at it, but because that information contained in your brain through the receptor of the nerves.

Q To be specific, how does that relate to pain?

A So, to the extent that -- so then the nerves carry information, right in both directions, so if you think that you want to move your -- you know I am from Brooklyn -- pinky finger, you move your pinky finger. You touch like I said a piece of ice with your pinky finger, you get sensation back to your brain that it is ice, not something sharp, right? If you have dysfunction of that nerve, one of the things that you could feel if you went too hard on that sharp object you could prick your finger and that would hurt, right? And so that information is all carried along that nerve so if there is any damage to that nerve along the pathway like an electrical cable, you can elicit those same sensations, even though you are not touching something sharp, you can feel pain because the knife which is like a wire is broken and is sending faulty information to the brain and the brain picks it up as pain when really it is just being pinched or it is frayed or compressed.

So the brain does not know that, it just knows that the

signal that goes back to the brain is disordered and it reconstructs that as a symptom like pain or dysfunction or loss of sensation or loss of strength because it is not carrying signal to the arm, there is not enough signal so there is no motor strength in the arm. That's the way that dysfunction of the nerve could be manifested. The doctor word for that dysfunction is radiculopathy. You will hear that, radiculopathy.

Q Just looking at the model itself in terms of its orientation, can you tell us based upon the human anatomy which is the front and which is the back?

A So the front of the spine is where the big squares are that's called the vertebrae and this would be the front, this would be the back. If you feel the back of your neck you feel the bumps on the back of your neck, you feel the bones of the spine, you are touching the spinous process, the tip of the spine. Between the two is the spinal cord and the nerves.

Q Thank you very much. Let's talk about Doctor, certain pathology or disc dysfunction?

THE COURT: Is the doctor going to make reference to the spinal model now?

MR. FIELDS: Yes.

THE COURT: I want to make sure, I don't want his view to be blocked from the jury.

MR. FIELDS: Yes, yes.

Q Doctor, are you familiar with the term herniated disc?

A Yes.

Q Can you tell us what that means?

THE COURT: Remain standing, Doctor.

A What happens, from the jury's prospective, I spoke to you about the way it ought to be, the way God made you, the way it is normal, but through the course of living on the earth you can get a change in the normal anatomy and the normal position of the vertebrae and the structures around the spine.

For example, if you get into an accident you could fracture one of these vertebrae, to give you an example, and that fractured vertebrae would create dysfunction at the area where the break is. Those vertebrae are important in supporting the spine, so if that was broken, then it would not support the spine any more, it would move too much and create pain. That broken fragment might actually pinch the nerve, right, so that's one example.

Another example is the disc, the intervertebral disc, it has a normal structure and function but it could become disordered or abnormal as a result of trauma, let's say hypothetically. So the normal structure of a disc which from your prospective it looks like it is like an orange, it has a tough outer cover and a jelly like inner layer and that structure is in between one bone and the other. If there is, hypothetically some

trauma to the area, you could disrupt that disc, you can damage that disc, you can tear the rind of the orange and some of that jelly like material can leak out. That's what this model represents. You see the red structure protruding out away from the disc, it is red and that is meant to represent and it is adequate representation of a herniated disc, that's a word that you are hearing for the first time.

So some of that material can herniate out, it can leak out from its original position. You might say what is the big deal, it went from one spot to the other. Here is the big deal. If it goes out and comes to press up against the nerve, then it could cause disorder or dysfunction to that nerve and that nerve impulse strength going to the leg, the sensation coming back your reflex or pain can be affected by a herniated disc.

Also, locally that disc was supposed to be between the two vertebrae, so what happens when it moves? It actually weakens the bond between the two and moves excessively. It is called instability, it is a word that you will hear when I discuss the surgery and that could occur anywhere along the spine that there is a disc from top to bottom. So that's a herniated disc.

Q Again, when we talk about the discs, can you explain to us what the function of these discs are?

A The two primary functions of the disc are stabilization of the motion segment and I just mentioned that to you. If this

disc is between that bone and that bone and it gets broken, what is going to happen is that bone and that bone will move too much because they don't have the structure or the support. It acts like a bushing or a motor mound -- for the guys, I am a little bit of a chauvinist -- it binds one to the other.

The displacement of the disc can compress the nerve or the spinal cord, so it can move like I said before and once it presses the spinal cord or the nerve, it creates symptoms such as pain or neurological dysfunction.

Q Thank you, Doctor. Now, when a physician wants to look into the inner workings of the spine on a particular patient, ordinarily how would an orthopedist such as yourself go about doing that?

A Two tests that we usually use, or three tests that we use are called diagnostic tests. So a diagnostic test is different than a clinical test such as listening to the heart or the lungs, hypothetically it is something that we could look inside. X-rays we all know what x-rays are. CAT scans are super x-rays and the best test is called an MRI. An MRI is a diagnostic test that helps us to look inside people and get a picture of the inside without having to open someone up. It is a very powerful tool for looking at spinal -- lots of diseases, but spinal diseases.

Q Let's talk about x-rays.

A Okay.

Q Typically in the diagnosis of some type of dysfunction in the spine or conditions of the spine, how are x-rays typically used?

A X-rays are very important. You know a lot of patients say oh, I don't need an x-ray, you have an MRI now. That's not true. X-rays give us a lot of information about the bones. X-rays show bones, that's one of the best tests for looking at the bones. Like I described to you before, you can have an injury or a process or an accident and damage the bones of the spine. It is very important, it is not less important than the disc, so the x-rays give us good information about the bones and then also the relationship of the bones.

So, as you saw in the model, one bone is supposed to be right on top of the other bone, so even though you cannot see the intervertebral disc on an x-ray because it is soft, not bone, you can see the relationship of one bone over the other. So if there is a dysfunction of the disc or damage to the disc, you can see it change in the relationship between one bone and the other.

So we look at things like alignment, the height or the distance between one and the other, the actual bone itself to see if there is a crack or a fracture. All of that is available on a plain x-ray.

Q How about a CAT scan?

A CAT scan is just like an x-ray, has the same quality and image of bone except we get it in three dimension, an extra

dimension. A CAT scan takes a picture all the way around you and the computer redoes the image in three dimension. We do three dimension CAT scans now where you can see the whole vertebrae from the top, from the side and then you can reconstruct it to see a 3D image and rotate the image on the screen.

CAT scans are very important because they give us very clear detail, it is like a high def TV for bone. Often times, the bone is important obviously, it is an important part of the spine.

Q On the flip side, Doctor, how useful is an x-ray or a CAT scan to an orthopedist such as yourself in diagnosing some of the non-bone structures in the spine just like the discs?

A It is less important, obviously. That's why I was saying I did mention before that the MRI is the most powerful tool in looking at the spine because it does not only show the bone, but it shows the discs, it shows the nerves, the spinal cord, the ligaments, all the soft things, soft structures of the body that were intimate to the spine working well.

They compliment each other but you know the gold standard, the best test is the MRI, but the other tests are important as well.

Q So, Doctor, did there come a time in your evaluation of Miss Gashi that you had the opportunity to look at hospital records from Lawrence Hospital which are in evidence as Plaintiff's Exhibit 4?

A Yes.

MR. FIELDS: If I may approach, your Honor?

THE COURT: Please.

Q I am going to hand you Plaintiff's Exhibit 4. Looking at that document, Doctor, do you recognize that to be the Lawrence Hospital record that you reviewed?

A Yes.

Q And just quickly taking a look through that hospital record, is there an x-ray test report that is contained in there?

A There is a neck x-ray.

Q Yes, correct. Do you see it?

A Yes.

Q And do you see the portion of the neck or cervical spine x-ray report that identifies what they call an impression?

A Yes.

Q Just generally can you tell us what an impression is?

A It is a summary of the radiologist, the doctor that reads the x-rays, that's all he does, so he makes a report on all of his x-rays and dictates everything he sees, but then at the end he writes an impression and the impression part is his final analysis. So he writes, "no evidence of fracture or malalignment."

Q I want to direct your attention to the paragraph just

above where the word impression appears. Do you see that?

A Yes.

Q And can you just read for us what that says?

A There is reversal of the normal lordosis.

Q What does that mean, Doctor?

A So the spine as I showed you before has a curvature, it is not straight like a pipe, it has curvatures so each part of the spine, the cervical, the thoracic and lumbar have their own nerve curvatures so the spine or the cervical spine usually has a certain C shaped curve and that's normal in everyone. In this particular case it says that there is a reversal of the normal lordosis. So that normal curvature that you ordinarily would see on an x-ray if you took it, if you did not have a spine problem was not present and was actually abnormal, there was a reversal, it went the other way. That suggests, what does that mean, the suggestion of that is that's indicative of some process occurring, pain, or perhaps a disc problem, but it is not normal to have a reversal of lordosis and it is indicative of something. We cannot be exactly sure, but something is disordered is the word I would probably use.

Q Moving to the next portion of that line it indicates -- and again referring to the impression portion -- that there was no evidence of fracture or misalignment. What does that mean?

A So, you can have a reversal of the lordosis because you have a fracture or dislocation. It is a displacement, dislocation

means one bone would move away from the other, right? So those two things he did not see.

So, what this is suggesting and it is ultimately proven by the MRI is that there is probably a disc injury, that's what it suggests, but it does not, it is not conclusive to that, but it is suggestive for a disc injury.

Q Would it be fair to say that's essentially ruling out that there was a fracture in any of the vertebrae in the cervical spine?

A Or dislocation.

Q Dislocation, okay. Again, looking at this cervical x-ray report from Lawrence Hospital, I want to ask you have you ever heard the term loss of height?

A Yes.

Q And in terms of the structures of the spine, what does that mean?

A Well, again it is an overall impression the radiologist would make or orthopedic surgeon would make when looking at an x-ray. Is there a correct line of the vertebrae, is there the right spacing between each vertebrae because remember that disc as I showed you is between each vertebrae so sometimes there could be a loss of height from one vertebrae to the other which could be indicative of age related changes, arthritis or something like that.

So, there are other processes, many, many other

processes which I have not discussed, not to confuse you that could affect the spine. So what you are saying is there is no mention of a loss of height here.

Q What is the significance of that? There is no mention of loss of height here in this x-ray report?

A There is no evidence of arthritic or degenerative, age related changes to the spine.

Q Thank you. Again, I think if you go to the back of the Lawrence Hospital record, if you leaf to the back of the Lawrence Hospital record, the discharge summary, I am not going to ask you to find it yourself because we have the record in evidence under Plaintiff's Exhibit 4, but there is a notation in the report, in the record itself that indicates that the plaintiff, Miss Gashi has a neck injury that was noted to be a cervical strain. What does that mean?

A The emergency room doctor is trying to give, we have to give what is called a diagnosis. So a diagnosis is a description of what exactly is wrong. Not that the patient came in and had neck pain, but what actually happened. So the word strain as you can imagine is a medical expression that's used to characterize a soft tissue injury of the spine, meaning or it could be ligament injury of the knee as well, it could be of the knee as well, but in the spine it could refer to ligaments, discs, muscles around the spine.

Q Would it be fair to say that it is a generic term?

A Very generic, it applies to any of those, it could be any of those and they are all different injuries but it could be any of those injuries that it is referring to.

Q Now, again, referring to Plaintiff's Exhibit 4, in that record, Doctor, there is an ambulance call report. In the call report which was issued and documenting what was happening while Miss Gashi was being transported to the hospital in the ambulance, in that report there is a notation that indicates that she has a pain scale of an eight. Can you tell us what a pain scale is?

A Yes, a pain scale as you would imagine if you go to speak to a patient and I say, does it hurt you and you say, yes it hurts me. And how much does it hurt you and the answer ordinarily would be a lot, but that's not easy to communicate from one doctor to another or a patient to another. So we actually ask you to rate it from zero to 10. So we always say 10 is the worst pain that you could experience, a woman having a baby, even though you are a guy, we say that a woman having a baby that's a 10. If that was the worst pain you could experience, how would this compare in terms of pain and that's how we do it with zero being no pain. That's how we objectively quantify the degree of pain a patient is experiencing by asking them to rate it on a scale of one to 10.

Q What is the significance of a pain scale reporting of a an eight?

A That's a significant, that's a lot of pain. That's how I would characterize it.

Q Doctor, you did testify that you had an opportunity to review the Lawrence Hospital record including what would be the ambulance call report. Within that record, did you note anything that stated that Miss Gashi was complaining of neck pain?

A Yes.

Q And is that contained in the ambulance call report?

A In the ambulance report, yes.

Q And had she not had any neck pain would there have been any reason to do a cervical x-ray?

A No. I mean I think it is clear both by the ambulance record and the nursing record and by the facts of, that they actually took an x-ray that Miss Gashi did actually indeed complain of neck pain as a consequence of the accident.

Q Miss Gashi testified on her discharge from the hospital she was given a cervical collar to wear?

A Yes.

Q And is that consistent with the type --

A It is customary when someone gets a sprain or a strain to use that word again, to protect that body part by limiting the motion because it hurts when they move it, so by limiting the motion you can help to alleviate the patient's discomfort, that's the goal of the collar.

Q Let's fast toward a little bit, Doctor. When was it for

the first time that Miss Gashi came under your care?

A 5/3/10.

Q And when Miss Gashi presented to you on that day, what did she tell you about the condition of her neck and back?

A That she still had and this was 5/3/10 so it was many months after her accident, she had eight out of 10 pain in her neck radiating into her upper extremities as well as lower back and lower extremities and radiating, for the jury, the word radiating means the pain starts here and shoots down the arm or shoots down the leg, that's radiating pain. And that's important because that's usually the pain of a pinched nerve, so that's why we document it that way. She complained there was numbness, she had less sensation, tingling and the word is dysesthesia which is the doctor word for a funny sensation like she picked something up, it did not feel right when she picked it up. Those were her complaints to me when she came in.

She said she had difficulty lifting, carrying, bending. Her daily activities were interfered with because of the pain that she was experiencing. She stated that she did not have any of these symptoms just prior to the accident.

Q And what significance did you draw on the fact that upon your initial consultation with Miss Gashi that she was reporting no prior symptoms at the time of the accident?

A Well it is significant when you take a history, it is important that you ask a patient, you say it hurts, you say for

how long and obviously it is an important question. Also why it is important is because she had a prior accident. So she could have had that pain every day for five years, that is one kind of a patient. A patient that has pain, you know, just for the last eight months, that's a different kind of a patient. When I say a different kind meaning it tells a different story as to what the treatments might be potentially.

So it is important to sort of get that history and sort that out at the beginning if you can.

Q Now you testified that when Miss Gashi presented to you at that time she was exhibiting, she was complaining of radiating pain?

A Yes.

Q Clinically what is that indicative of?

A Radiating pain is pain that often suggests a herniated disc. Just so you know, chest pain you can have chest pain that radiates up into your jaw, that could be a heart attack. Not all radiating pain comes from a pinched nerve, but radiating means it starts at one area and the patient feels the pain migrate, in this particular case because we are talking about her spine, she is complaining about neck pain. That radiating pain is consistent with the word radiculopathy. Remember I mentioned that to you, the word radiculopathy means sick nerve, it is a Latin word meaning sick nerve. From your prospective, sick meaning that the sensation is disordered, there is pain in that

nerve root distribution, there is a loss of sensation, there could be weakness or loss of reflex, any of those things constitute a radiculopathy from a clinical prospective.

Q And how about the significance of her having reported numbness?

A Again numbness as I described to you is one of the functions of the nerve. When you touch something with your finger it has to bring the proper information back to your brain to know what you are touching. If you cannot feel it right that maybe means, it does in this case, that the signal going back to the brain is interrupted, so there is some evidence of nerve dysfunction.

Q And at the time of that initial examination, was there a pain scale that was reported?

A Eight out of 10.

Q Did you deem that to be medically significant at that time?

A Yes.

Q Now Doctor, at the time of your initial examination did you take a history?

A Yes.

Q And tell the ladies and gentlemen of the jury what is a history and why it is important?

A I believe I alluded to it before when I said a history is sort of telling the patient, you ask the patient to tell you

their story so you the doctor can help to arrive at a diagnosis. It helps you to formulate your thoughts about what is wrong with the patient.

So what is wrong with the patient, I need to hear the whole story before I decide, so I need to know, for example, what the history regarding this particular injury is.

Q The history that was provided by Miss Gashi was?

A She was involved in an accident on 8/20/09 and that, since that time to the time she saw me, approximately nine months later she continued to have the pain as she described.

Q What did she tell you about her prior medical history?

A That she did, indeed, have a prior accident in 2006 where she had similar injury to her neck and back which was treated and it responded to the treatment and that she was, as a consequence of that treatment, she no longer had any significant symptoms.

Q Very well. In addition to taking a history, Doctor, did you perform some kind of a physical examination at that time?

A Yes.

Q Tell us what it was that you did?

A The spine exam that I described to you before is in two phases; the first is the range of motion. I will give you the numbers. The neck is examined as follows:

Three parameters that we examine, flexion which is chin to chest, extension, chin as far back as it goes and left and right turning which is lateral rotation. On that day she had restricted range of motion in flexion where normal would be 70, her finding was 45. Extension, normal was 45, her finding was 10. And left and right turning where normal is 80 degrees, her finding was 35 degrees. There was tenderness and spasms noted. I put my hand on the patient to see if there is any pain when you touch it over the specific areas of the neck that you believe were involved and the answer is yes, she did have that finding.

She also had a spasm which is very, these are very common findings when you have a spinal injury. You find these spasms which are involuntary muscle contractions, it is the Charley horse in the middle of the night that you cannot break, that happens in a muscle after an injury and the spine as well and I noticed that spasm.

Q The spasm, is that in medical terms deemed to be an objective finding?

A Yes.

Q And can you explain to us what that means?

A Well, findings are considered to be objective or subjective, so subjective is what the patient tells you. So you hear, they tell you something and you take it at face value what they are telling you. Objective tests are where a patient is not directly involved or minimally involved and the result of that

test.

So, for example, spasm they don't control that, it is an involuntary muscle contraction. Range of motion, let's say the elbow, you may move the elbow from one extreme to the other and measure the degrees. That's predominantly an objective finding. The patient can have an influence, but for the most part the doctor can get an objective reading on what it ought to be.

Q The range of motion that you performed on Miss Gashi that day I think you indicated flexion, extension and right left rotation?

A Yes.

Q The limitations that you had found in performing those range of motion tests, did you deem them to be medically significant?

A Yes.

Q In terms of limitation?

A Yes.

Q And by the way, did you use any type of an instrument at that time in performing those range of motion tests?

A A goniometer.

Q Is that a medically accepted method in measuring range of motion on a particular patient?

A Yes.

Q As well I think your record indicates that you performed some type of an inspection of Miss Gashi?

A I mentioned that before, the inspection percussion and palpation. She had positive findings in both respects as well as the spasm.

Q I think there is an indication that she had some tenderness?

A Yes.

Q What does that mean?

A Well essentially you put your hands on the patient's neck or lower back, depending on what area you are examining and you press on that area and look to elicit very specific types of tenderness, not that it hurts anywhere, it has to hurt in a certain area. If it hurts in that area, that's consistent with a spinal injury.

Q And the spasm, if there is positive noted spasm?

A Similarly, if you find spasm in the appropriate area of the body that's consistent with the injury, it is consistent with the injury.

Q Was that the case with regard to Miss Gashi?

A Yes.

Q And in terms of the subjective complaints that Miss Gashi had, were they consistent with your objective findings that you found during the course of your testing?

A Yes.

Q By the way, the various range of motion tests that you performed I think you indicated flexion, extension, right and

left rotation, those are measured against the norm; right?

A Yes.

Q Okay.

A And I quoted the norms.

Q And again there were varying percentages of degrees so let's take, for example, the flexion test you performed?

A Yes.

Q I think you noted that there was 25 degrees on flexion with 70 degrees being normal. What does that mean to have a normal range of motion of 70 degrees on that particular test, if you could demonstrate that for us?

A Well 70 degrees would be, so you would have the patient bring the chin down to their chest fully. For the average person, the norm on a goniometer would be approximately 70 degrees. In her case it went from having the patient look towards the midline, it would be 25 degrees into flexion so that was an abnormal finding.

Q How are these norms set?

A They are set by the guidelines, for example in the Worker's Compensation Guide, doctor guides for normal ranges of motion for people. I mean plus or minus several degrees is considered to be, you know, these are the normal values.

Q Is it fair to say that the norms that you described in your examination, your range of motion exam those are universally accepted?

A Yes.

Q In addition to the physical examination, did you conduct a neurological examination?

A Yes.

Q And can you tell us what that consisted of?

A So, as I described to the jury before the nerves are intimately associated with the spine, so you look for dysfunction in the nerve when you think there is a spinal injury. In this particular case, the pertinent abnormalities with respect to the cervical spine showed weakness of flexion and extension of the wrist, so your ability to lift your wrist up and down is controlled by your brain through your cervical cord and the nerves. If you get dysfunction, you will get dysfunction of the upper extremity function.

In her particular case she had a weakness of bringing the wrist up and down and that's consistent with the radiculopathy. That was one finding.

Also sensation, we examined the sensation over the upper extremities and that was found to be abnormal in the C6 distribution. Again, it was consistent with the cervical injury.

Q How is sensation measured in terms of this neurological exam?

A Again, it could be measured with the tip of your finger, with the tip of a reflex hammer, anything that has sort

of an edge to it that you are able to elicit, can you feel this? Yes. Can you feel this? No. Does it feel the same way as the other way? Is it sharp or dull? You examine -- it is across the entire upper and lower extremity.

Q Are these neurological exams known to be objective types of tests?

A Yes.

Q Were the objective findings on your neurological exam consistent with the subjective complaints that Miss Gashi made when she came to you at that time?

A Yes.

Q Now, at the time of your initial examination of May 3, 2010, Miss Gashi brought with her her cervical and lumbar MRI films; correct?

A Yes.

Q And at some point in time you had an opportunity to review those films?

A Yes.

Q And, as an orthopedic surgeon, Doctor, at that time how experienced were you in interpreting MRI films or studies?

A Well, we are very experienced. It is part of our board certification. To get board certified you have to be proficient in reading x-rays, MRIs, CAT scans. If you cannot read an MRI, then you cannot get board certified.

Q I believe within your report you indicated for that

particular exam date you had reviewed an MRI report concerning those MRI studies; correct?

A Yes.

Q And without telling us what the findings were, when you reviewed the cervical MRI film taken of Miss Gashi which I believe is dated October 30, 2009 --

A Yes.

Q -- were your findings consistent with that of the originally reviewing radiologist?

MR. SCAHILL: Objection, your Honor.

THE COURT: Re-ask the question.

MR. FIELDS: Okay.

Q Let me ask you something, Doctor, when you reviewed the cervical MRI film, did you reach an impression or a diagnosis?

A Yes.

Q Can you tell us what that was?

A Miss Gashi had a herniated disc at C4/5 and C5/C6.

Q And you had a report in which a prior radiologist had as well reviewed that film?

A Yes.

Q And were your findings consistent?

MR. SCAHILL: Objection, your Honor.

THE COURT: I will allow that.

THE WITNESS: Yes.

Q I believe you indicated that during your neurological

exam you found there to be sensation decreased at the C6 level?

A Yes.

Q And how does that relate to your MRI film interpretation where you found there to be a herniation at the C4/5 and C5/C6 intervertebral disc levels?

A It is consistent with injury at that disc level.

Q How about the lumbar spine, when you reviewed the lumbar spine, did you reach a diagnosis?

A Yes.

Q What was that?

A That she had a bulging disc at 3/4 and 4/5 with the foraminal disc component in each level.

Q Foraminal disc, tell us anatomically what is the foramina?

A Can I bring the model up?

The foramina is the little tunnel where the yellow structure comes out which is supposed to be the nerve. Sometimes it is a circle, the disc, so it can herniate here which is the way you see it which is anterior or directly back into the spinal canal. They call that a central or paracentral herniation and it could herniate right in that little tunnel, the foramina. It could be a small herniation but create a lot of pain because it is a small area, there is not a lot of room for the nerve to be displaced. So, that's a foraminal disc herniation.

Q Doctor, just very briefly, we have in evidence --

THE COURT: You want to douse the lights?

MR. FIELDS: I think it is clear on the wall unless there is difficulty by the jurors.

THE COURT: If any of the jurors have difficulty seeing what is going to be projected on the wall, raise your hand.

(Continued on following page...)

THE COURT: Do me a favor, sir. Take a seat. Pull it right next to him so you won't block the jurors.

Can everyone see? Okay. All right. If you want to stand, do whatever.

Q. Now, doctor, I'm going to show you, again, what we have in evidence. I'm referring to the cervical MRI film of October 30, 2009 in evidence under Defendant's C. Okay?

MR. FIELDS: May I approach, your Honor?

THE COURT: Please.

Q. Dr. Lattuga, I'm going to hand you the laser pointer. I would ask you to be careful with it, please, and utilize it during the course of your examination.

I'm looking at the cervical film as shown and, I believe, having reviewed this with you before, I found Image 6 to be most useful, if it will run. I just got to load it. Here we go. I might just use the disc.

THE COURT: Jurors, if at any point you want to stand up and stretch, you could do that. You are not wedded to the chairs. Every so often I stand up, too. It gets crampy.

Q. Now, doctor, again, looking at Defendant's C, more particularly the October 30, 2009 cervical MRI taken of Ms. Gashi which is following the August 2009 accident.

Do you recognize what is shown there?

A. Yes.

Q. Can you just tell us what it is that we are looking at?

A. This is one of many images of the cervical MRI. That's the neck MRI. You are taking -- a MRI reconstructs images of the inside of the body and they are printed as slices. So if you saw the original photo, you had a lot of little pictures. What that was was slices from one side to the other because just like in this model, you saw the disc was on one side, so you may have a slice of the MRI on the other side and you would say there was no herniated disc, so you need to examine the entire spine.

So this is almost the midline to give you some orientation. This is the brain here. This tunnel, this looks like a tube at the top going down the middle is the spinal canal. You remember I told you that the spinal has a canal with which the spinal cord and nerves run, well that is it, and each square structure is the vertebrae, the bones, and you could see the gray structure in between is the intervertebral disc. That's what it look likes.

So the normal alignment - and in this area, that's this disc in this part. MRI -- this disc is relatively normal, shows that the vertebrae is directly over this vertebrae with the disc in between and there is a very smooth posterior border.

If you look at the one below in contrast, what you see is a couple of things. You see square vertebrae. You see the disc, structure of the disc which by the way is not as thick as

that one because some of this has leaked into the spinal canal. It is protruding or herniated in that direction. It has a little bump.

This is only one cut. If you follow it, you will see it all along and in your brain you have to say I see it on all of them, it is herniation. So here it is, that herniated part of the herniation there.

Q. What level are you referring to?

A. That's C-4, 5, the one right below 5,6 has similar findings with some narrowing, etc.

So this is, you know, one of several images. You can't just look at one. This is good for you the jury because it's easy for you to see or fairly easy for you to see. There is protrusion at C-4,5; C-5,6.

Q. This thick white line that runs to the center of the film --

A. That is the spinal cord.

Q. Okay. What is the significance of the fact that that material from the disc seems to be pushing into the white area?

A. Again, that's what we have been discussing the whole time about, you know, nerve damage or impingement on a nerve or irritating the nerve. That is what the source is.

Q. Okay. You told us that in your, after your initial examination you determined that there was a C-4,5; C-5,6 herniated disc with radiculopathy?

A. Yes.

Q. And would that be the cause of the radiculopathy?

A. Yes.

Q. That would be material that is pushing into the spinal column area?

A. That as well as the instability created as a consequence of the herniation.

Q. Okay. Now, doctor -- I will turn this off for a second.

Doctor, can you tell us what a prognosis is?

A. It is a doctor's educated guess. It is not the right word, but it's an educated guess, but it is really not a guess. It's a thoughtful prediction of what might occur in the future based on what the diagnosis and the circumstances around the diagnoses are.

Q. When a patient sustains a traumatically herniated disc, what's the various prognoses that you might give to the patient?

A. Well, early on the prognosis is actually pretty good. Most people that get herniated discs are treated successfully with things like medicine and therapy, you know. It's the patients that have persistent pain for -- you know, it's arguable for 3 to 6 months, those patients, the prognosis goes down substantially.

Let's say for every hundred people you see, a herniated disc within a week or two of their accident more than 90 percent

of the people get better without surgery, but if you take that same group of people at six months, you know, if you have six months or longer of pain that has not gone away or is getting worse, the percentages of those people that need surgery is much higher.

Q. Now, doctor, when you talked about the herniated, when the material inside, I think we call it the nucleus pulposus, that gelatinous material inside of the disc itself --

A. Yes.

Q. -- it escapes the disc, okay. What happens to it?

A. Well, it depends where it goes; right, but it can go -- but if it goes into the direction of the nerve, can come to life against the nerve or the spinal cord. It does not dissolve away. Like some people thinks it goes away or a chiropractor can push it back into place. That is not true. It can't happen.

What happens is either that you treat the symptoms and the symptoms resolve with the treatment, but the disc is still there or the patient has surgery and you can remove it, but --

Q. That brings me to my next question, doctor.

So if the material never makes its way back into the disc itself, I guess it's been extruded out, how does one typically feel better if the material is escaped permanently?

A. Well, a big part of pain from the herniated disc is not only from the compression, but the body as a consequence of the

compression gets an inflammatory response, so that's why if things like Advil and Motrin help people with pain or knee pain. If you stop the inflammation, they have less pain. It might not be zero, but it reduces the pain.

Q. And you understood that Ms. Gashi had a car accident on August 2009. According to her history she was asymptomatic before that accident and you saw her on May 3, 2010 which is roughly about nine months following the accident and she, according to your records, seem to have consistent and continued complaints of pain and radiating pain and numbness from her neck region.

Now, doctor, at that point in time in terms of the prognosis that you gave, get better, get worse, stay the same; at that point in time what was Ms. Gashi's prognosis?

A. Well, it was, you know, guarded to poor. So guarded would mean I was concerned that she might not get better and poor meaning you know, she might not get better at all. So somewhere in between that. Really if the patient is having pain from a herniated disc that lasts eight months and it has been consistent for eight months, like I said, a lot of those patients end up having surgery because the pain just continues to get worse, so I was concerned on that visit.

Q. What was your discussion with Ms. Gashi at that time?

A. Precisely you discuss -- you know, she is coming to me for surgery, so I discuss surgery as an option. I always have

an alternative to surgery, you know.

Q. What were those?

A. Those were continue to do physical therapy, continue to have injections, continue to just take medicines or just live in pain.

Q. When you say injections, what are the injections?

A. Like steroid injections in the spine.

Q. Do these steroid injections typically provide permanent relief?

A. Generally it's temporary.

Q. What did Ms. Gashi decide to do?

A. She had a prior lumbar low back injection. She had an adverse reaction or unwanted reaction. She wasn't happy with it. She really didn't want to do more injection. You can always take another injection. She didn't want to do anymore injections. She had already been doing -- she had been seeing Dr. Cruz for, you know, eight months doing physical therapy, you know, two or three times a week. She didn't want to keep going to therapy forever.

She had this 8 out of 10 pain, had weakness of her upper extremity, loss of sensation. She was willing to at least hear surgical options. We reviewed it with her, then ultimately she decided and proceeded to go down that road.

Q. When you say went down that road, that would be for surgery?

A. She had surgery, yes.

Q. What type of surgery did you discuss with Ms. Gashi at the time?

A. It would be cervical discectomy infusion.

Q. Can you just briefly tell us in general terms what that means?

A. So --

Q. You can use the model, if you want.

A. So if the process, if the disease process that creates pain is a herniated disc or disc that is displaced, moved from one place to the other is now pinching the nerve and part of the process is this instability that is created meaning that there is bone that moves too much, then the operation that is generally recommended for herniated disc in her neck is called anterior cervical discectomy infusion operation in the hospital under anesthesia.

An incision is made by me in the neck. What I do during the surgery is remove the damaged disc, visualize the spinal cord and nerve, make sure there is no remaining disc, rebuild or reconstruct that segment with implants made of titanium that stay in forever.

Q. I have before us, it's in evidence under Plaintiff's 11. I have a poster board and I'm going to ask that you take a look at that.

If you can, doctor, if you can step down to your right

and looking at -- look at Plaintiff's 11. Doctor, do you recognize the illustration that is shown?

A. Yes.

Q. Okay. And can you tell us what is shown in that illustration?

A. So this is an illustration of the cervical spine, the central component of the surgery.

Q. The surgery that you --

A. That I performed on Ms. Gashi, and it has some of the essential relevant features that I will be explaining to you, what was wrong with her.

So basically this is an image of her skull. It shows the relationship of the herniated disc, the skull where it is in the neck and the spinal cord. This is a blow up of it.

THE COURT: Doctor, can step a little more to the side so Juror Number 1 can see?

A. This is a blow up of the above illustration showing a cross section of the vertebrae. This one labeled C-4, the disc herniation with its protrusion or herniation displacing. That is the ligament impinging upon the dura which is the cover of the spinal cord. That is the disc which is C-4,5 and then similarly has the same process in C-5, 6. You could see it's impinging on the dura which is the cover which has many, many nerve roots very, very sensitive to pain.

So what the operation is, it is an incision on the

front of her neck done under anesthesia. Once I make the incision, I mobilize the vital structures so the breathing, swallow tube is brought to the side, the carotid artery and the jugular vein are brought to the other side.

Q. How do you do that?

A. Once you get underneath the skin, I could see those structures, right, and then use surgical instruments to sort of manipulate those structures. It is called a retractor. It's a stainless steel instrument you put in. You are able to move the esophagus and larynx out of the way and the other vessels the other way.

Once I do that, I have that moved, we put in a self-restraining retractor. It stays in to hold it so my hands are free so I can do the important part of the work.

And what this is meant to represent in this box here is what I'm doing, removing all of the disc material and this is a grasping device used to grasp the disc. It is kind of like -- it's kind of like crab meat or lobster meat. It comes out in pieces. The end of the bone has to be removed as well.

I'm actually -- my vantage point, I'm looking straight down the tunnel in the microscope. I'm looking down straight from the front. I'm actually looking at the spinal cord and the nerves.

Once I'm sure and, again, I'm looking microscopically there is no longer any compression on the nerve or that I've

alleviated compression not only on the spinal cord, but on the nerve roots depicted here exiting, you see the relationship as they come out, then I know that I completed the first part of the operation which is called decompression. You have to take the pressure off the nerve.

Now we have to address the issue of stability. If you recall, I said the other big problem with having a herniated disc is that the spine is unstable and so we use implants like we do in other parts of the body made of titanium so they are MRI compatible. They last forever. They don't cause any significant reactions and that is applied to the --

You know, once I put a spacer to fill the gap in the bone, then I put this plate and it screws in and screws into place. There are two in each vertebrae and for her, it's done at two levels, so it's not only here, but a second level which is the one below it. You cannot really see it. That stabilizes the vertebrae. That is the operation.

Q. And when you say anesthesia, is that under local --

A. General anesthesia.

Q. Which means what?

A. She is brought into the operating room by the anesthesiologist. She's put to sleep, put a tube down your throat. We have all seen it in the movies. That does the breathing for you, that keeps the patient perfectly still so I can do the operation safely as possible.

Q. Now, doctor, before we move forward. We do have a video that somewhat illustrates in motion how this procedure was done.

Can you tell the ladies and gentlemen what an E. M.G. or electromyography is?

A. E. M.G. is a test that is -- it's one of several tests that can test for radiculopathy, the doctor's words that I explained for the function of the nerve root.

Q. And did you send Ms. Gashi for an E. M.G. test before you performed the surgery?

A. I believe I did not.

Q. Okay. Was there any particular reason why not?

A. The patient had -- I didn't send her because the patient essentially had pure very positive signs of radiculopathy, so an E. M.G. test we do because sometimes we are confused. It's a nice test to document radiculopathy other than me doing an physical exam with respect to the nerve functions. But sometimes you could have nerve dysfunction not from a herniated disc in the neck. You could have it from a wrist injury or some other injury.

When it's not clear, it is very a powerful tool to distinguish between other diseases that cause pinch nerve like symptoms, but in this case because she had a positive MRI, positive objective findings of dysfunction, positive objective finding of essential -- sorry -- dysfunction, it was all

consistent with the exact level that was on the MRI. I felt there was more than enough radiculopathy to indicate the surgery.

Q. Okay. Prior to performing this surgery, did you discuss with Ms. Gashi what the risks of the surgery were?

A. Yes.

Q. What were they?

A. So any surgery that requires anesthesia, there is always risk of death with general anesthesia due to cardiac dysfunction, blood clots, etc. etc.

So, you know, risk of death. Specifically spinal surgery it is a risk that it does not work, that the patient can have persistent pain, that the nerve does not ever recover. They could have more pain than they had before depending on how it heals. It can create scarring.

They could have more nerve dysfunction. It could be weaker than it was before. The patient could even be paralyzed, you know, unfortunately. That does not happen very often, but that is a risk of surgery. Even if the doctor does everything right, patients could be paralyzed.

Bleeding can occur at the time of the surgery or a few days later. Infection can occur subsequent to the surgery. All those are risks that we can reduce. We cannot make it zero. There are real risks that happen to people.

Q. Were the noted benefits discussed with Ms. Gashi at

that time?

A. The main benefit of the surgery would be to reduce the pain that she was having and to hopefully improve some of the neurological dysfunction, like lost of sensation and motor function.

Q. Okay. Now, how long was the procedure, the anterior discectomy fusion that you performed?

A. About an hour.

Q. And while you were actually inside of Ms. Gashi's spine, how are you visualizing structures?

A. I think I mentioned it before. I had an illustration up. Once everything is exposed, then I'm looking directly down the front of the neck down into the spinal canal. I have an operating microscope that we are using to enlarge the picture, and it gives me a firsthand visualization of the herniated disc, which in this case I confirmed was compressing the spinal cord and the nerve and I'm also able to confirm adequately that I removed the entire disc or majority of the disc that I believe is creating the problem at the time of surgery.

Q. After the surgery, did you have occasion to take x-ray studies?

A. Yes.

Q. Is that conventionally done? Is that usually done?

A. Yes.

Q. Well, we have -- doctor, I'm going to direct your

attention to Plaintiff's 13. I'm going to hand you the films. I will let you go through them doctor.

I want you to select which one or which films you find most appropriate in discussing how Ms. Gashi presented diagnostically from an x-ray after the surgery and, again, there is a light box right beneath you, the smaller one.

THE COURT: Let's see if we can set up that shadow box.

COURT OFFICER: Yes, Judge.

A. So this was the x-ray of Ms. Gashi taken after surgery.

THE COURT: Doctor, once again, you have to be mindful of Juror Number 1.

A. This is an x-ray taken after surgery. It's the side-view of the lateral view of her neck. You could tell it's after surgery because implants are in. You could see the plate and the individual grafts that are put in at 4, 5, 6 that represents the side-view, and then the front to back view would be this one where we could see the front to back view of the plate. You don't see the grafts as well because they are hidden by the plate. That is what we take post-operatively for several months until we see that everything is healed.

Q. Thank you, doctor.

THE COURT: You could give the films back to Mr. Fields.

COURT OFFICER: Yes, Judge.

Q. Now, doctor, given the nature and type of surgery that you performed on Ms. Gashi, assuming no post surgical complications or subsequent events that would aggravate the surgical areas or the areas that were addressed, how long typically is recovery from the surgery itself?

A. About six months to a year.

Q. Over the course of that six months to a year, how do you expect, how do you anticipate a patient will progress over that time?

A. Well, we look for two main things. Number 1 would be incorporation of the grafts because all of that hardware and the materials we put in have to heal properly. If they don't heal properly, the patient needs another operation. In this case she healed properly.

The second thing we look for is clinical recovery. So for those subjective complaints they were making when they came in or objective findings of neurological dysfunction, so they will say, you know, that the pain is better than it was before or that the numbness may be better. They may still have pain, but the numbness went away. We are looking for resolution of those symptoms that the patient had surgery for.

Q. In your records, doctor, there are post-operative reports dated June 10, 2010, August 3, 2010, January 10, 2011, and we also had a recent examination of July 30, 2014, which was just two days ago.

Over the course of that span of time which is considered to be post-operative, how did Ms. Gashi progress over time in a general sense?

A. In a general sense, you know, the grafts, fortunately did heal but, unfortunately, she continued to have disability referable to her surgery and her injury.

Q. Okay. I just want to direct your attention -- within each of those reports and, again, we have them in evidence. I believe your records were in evidence under Plaintiff's 7.

For the record, you indicate that in each of those post-operative examination notes that the patient has improved neck pain, however, continues to have residual pain and symptoms consistent with operative conditions.

A. Precisely.

Q. What does that mean?

A. Well, what happens is that the patient, they generally -- after surgery it's like this: They say they feel better. Doctor, the surgery helped me. I feel better than before, but I still have pain from time-to-time or I still have, you know, pain in the same areas. It's not as bad as it was before, but I feel better. That's the kind of -- I still get the numbness. I had the numbness very profoundly before. Now, you know, I feel better, but it's still not the same as it was before the accident. That is what that means to convey.

Q. Okay. Now, you mentioned that on July 30, 2014, Ms.

Gashi was examined at your office?

A. Yes.

Q. And I believe during the course of that examination it was determined, doctor, that on this, on the cervical extension test, that range of motion test that Ms. Gashi had -- I believe my math is correct -- a 77 percent --

MR. SCAHILL: Judge, I'm going to object to leading. Can we have the doctor testify as to his findings?

THE COURT: All right. You know, I understand what you are saying. At this point, I want to speed this along.

Okay. I will allow an X amount of leading.

MR. FIELDS: Just doing the math, your Honor, to make it easier.

Q. Based upon the range of motion test finding that you had, there was a 77.8 percent lost in range of motion, okay, and this is after the surgery. Can you explain why?

A. Typically what happens with the patients that have herniated discs, they lose motion as a consequence of everything that I told the jury before, disruption in the -- bones don't move as well. They lose function. So me doing the fusion or me operating and doing the fusion, I'm not improving their motion. What I am doing is fixing their spine in a specific location so they are not further doing damage to the nerve. That is why

they get improvement of the nerve symptoms and some of the pain, but as a consequence of their herniated disc in and of itself and the subsequent surgery, the patient suffers permanent loss of motion.

Q. Now, doctor, is it fair to say the primary purpose of the surgery, of this type of surgery is to alleviate pain?

A. Pain and neurological dysfunction.

Q. That would be the weakness?

A. Weakness, numbness, pain, reflex changes.

Q. And according to your notes, doctor, how did she fair in those areas post-operatively?

A. Continues to have those disabilities.

Q. To what extent as compared to before the accident?

A. Essentially the same.

Q. Now, doctor --

A. Four out of five function of the muscle group, four plus out of five which is the same as the first visit, lost of sensation in C-6. You know, she was subjectively a little bit better, but she still has that finding.

Q. What about the pain post-operatively?

A. She says the neck is better. You know, still has some back pain, but has less neck pain before the surgery like I characterized before.

Q. All right. Now, doctor, can you tell us are you familiar with a medical term by the name called adjacent segment

syndrome?

A. Yes.

Q. Can you tell us what that is?

A. Adjacent segment decompensation is basically a concept if you have a disc injury.

Right, so the body is a machine, right? So if you use the body as a machine, if you have disruption in one part of the machine, it can affect the other part of the machine.

So I guess an example is like if your drive train is out of whack, it can knock out your transmission. You can't have a normal transmission if you do damage to one part of the car.

The spine is the same way. If you have an injury to discs or have surgery, it affects the mechanics, biomechanics of the spine. It can accelerate or even create new problems at the adjacent level and so those patients often need to have other treatment because of the adjacent segment condition it's called.

Q. How does that relate to your prognosis of Ms. Gashi post-operatively?

A. Well, post-opt in a patient that has disc injury like this, you have to say there's potential this could get worse, meaning not only the area with the herniated disc, but it can create adjacent problems or if you have surgery, it gets worse even though you are feeling better for a while or might require another operation. Because we did one operation doesn't mean

you won't need another. In fact, it's frequent that it occurs. Adjacent segment decompensation you need to address that with the patient as part of the conversation about surgery and other options.

Q. Okay. Before I finish with you, doctor, we did have an opportunity to go over an illustrated video; is that correct?

A. Yes.

Q. And when you looked at the video, doctor, did you determine that the video would be useful in understanding the surgery that you performed?

A. Yes.

Q. Okay. And if you want to just narrate what we are seeing as it plays through because I'm going to play it through once. It's quite quick. Tell me if there is any point you want me to stop.

A. Sure. So this is an illustration of the spine here with the muscles adjacent to the spine. Is it playing?

Q. Play it?

A. Yeah, please. So it shows pointing to damaged area of the disc, the disc protruding out. It is herniated. This is looking down the spinal canal, compressing the spinal cord displaying the nerve root. The surgery is removing that fragment of disc or taking the pressure off the spinal cord and then the space is being opened up. We are putting in the implants which act as a spacer between the two vertebrae.

Q. This was down at two levels, correct?

A. Correct.

Q. There were two implants?

A. Yes, one at 4, 5 and one would be at 5, 6 and then that heals together subsequent so that becomes one functioning unit.

The most important thing for the injury are these two are one bone. We didn't gain any motion as a consequence of that. What really is the most important thing is that the relationship of this bone and this bone is now it's stable. It's not subject to injury and the nerve is not going to damage because these two bones are moving back and forth, you know.

Q. How essentially is that bone infused together?

A. It's a natural process which you do by stimulating it you know, cutting the bone like I mentioned, cut part of the bone away and prepare the surface for these implants and the body just naturally heals them together.

Q. By the way, in this surgery, was there any bone grafting done?

A. Bone grafting, it's actually done now as -- the answer is yes. It's done as a product that you actually buy and they insert it.

Q. So it is no longer harvested from other parts of the body?

A. Not from the hip. It is manufactured.

Q. This material that is manufactured, where is it placed

in relation to the implant?

A. The grafting material?

Q. Yes.

A. It's in this disc or this ring.

Q. It's stuffed around the implant?

A. Yes, in and around this implant.

Q. Okay. We will continue to play.

A. This is the application of the plate.

Q. How are those -- I assume there is a drill that you use?

A. A drill.

Q. Okay.

A. Drill, tap, screw for the carpenters. It's really a great operation. It helps lots of people. It really solves the problem of pressure on the nerve and instability.

Q. Thank you. Now, doctor, based upon all of your examinations and all of your findings, including those findings -- I will withdraw that.

At the conclusion of your surgery, did you reach some type of post-operative diagnosis?

A. Yes.

Q. What is it essentially, a post-operative diagnosis?

A. Well, what are my thoughts after I did the surgery.

Q. How is that different from a diagnosis reached by looking at MRI film?

A. The difference is what I found. It's different between me speculating this is what I believe is wrong based on all of the findings and then post-opt diagnosis what I found.

Q. Is it possible that those two can be different?

A. Yes.

Q. Why is that?

A. Because actually looking inside you get to see if that is direct evidence. There is no more telling evidence than that.

Q. What is your post-operative diagnosis?

A. Traumatically induced disc herniation at the C-4,5 and C-5,6?

Q. Were those consistent with the diagnosis you reached by looking at the actual MRI films?

A. Yes.

Q. And so do you currently have an opinion within a reasonable degree of medical certainty as to what the cause of Ms. Gashi's pain was?

A. It was from the herniated disc she sustained in this accident.

Q. And, by the way, the hardware and the implants that you put into Ms. Gashi's cervical spine, are those permanent?

A. Yes.

Q. Okay. They are not coming out, right?

A. No.

Q. Now, at some point in time, Dr. Lattuga, did you have an opportunity to look at some MRI films that were taken from Ms. Gashi's 2006 accident?

A. Yes.

Q. And do you recall what those films showed?

A. Some bulging at similar levels.

Q. Okay. Those were discs at the C-4,5, C-5,6 level?

A. Yes.

Q. And based on the fact that after the 2006 accident and the films that you reviewed that you found some bulging discs there, how were you able to see that Ms. Gashi's pain is causally related to the 2009 accident?

MR. SCAHILL: Objection, your Honor.

THE COURT: No. I will allow it. I will allow it. If you can.

A. Yeah. I mean, there are several components to that. I was able to see the '06 MRI. I think -- I don't think the damage was as severe. I believe that this accident certainly aggravated that prior condition. I got to review the records from the hospital, Dr. Cruz's records, my own discussion, all of which confirmed there is no significant history of continuous neck problems after that injury of the older injury.

So it's true there was underlying, there is an underlying condition, but this accident was an aggravation of that prior condition and in my estimation, the MRI, it looked

like it got worse, so I believe that, you know, the current pain and need for surgery was related to the accident, this accident here.

Q. So the presence of the 2006 MRI, the presence of bulges in the 2006 MRI films, that doesn't change your opinion with regards to causation in this case, correct?

A. Correct. It's -- you know, it aggravated her prior condition.

Q. Now, Ms. Gashi presented yesterday and testified and she noted a scar which was a surgical scar on her neck. We measured that to be two quarter inches by about an eighth to an quarter of an inch wide.

Is that consistent with the type of scarring that one would sustain following the surgery?

A. Yes.

Q. And, at this point in time, now over four years post surgery, would you expect that scar to improve anymore?

A. No.

Q. Now, as Ms. Gashi grows old, she gets into her golden years, how do you expect over time Ms. Gashi is going to present physically? And, again, we will limit your response solely to the neck region.

A. Well, I mean, we spoke about the adjacent segment problem. We spoke about, you know, she continues to have some symptoms. So, you know, there is a concern that she is going to

have some significant continued symptoms that might require further treatment, even may be another operation.

I mean, you know, you can't -- you know, we don't have a crystal ball. I would say more likely than not she is likely to have significant consistent persistent symptoms requiring further treatment.

Q. Within a reasonable degree of medical certainty will Ms. Gashi continue to have some degree of pain in her neck?

A. Yeah, for sure, because she is -- four years later she still has pain, so, I mean, although she feels better, she still has pain.

Q. How about the limitation?

A. Limitation is permanent.

Q. The last question. Doctor, the surgery itself, do you have any idea what the cost of that surgery was?

A. Total cost of surgery can exceed $100,000.

Q. How about in this case?

A. It's about 60,000 or something.

Q. What went into those surgical costs?

A. Hospitalization, anesthesiology fees, pathology fees, hospital fees, the bed fees, the implant fees, the surgical fees. There are a lot of fees.

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

THE COURT: All right. Fine. We are going to

break for lunch now. I know we had a long day. I told you to get ready to work today.

I will give you an extra 20 minutes. Enjoy. Come back at 2 o'clock. Get ready to work. Enjoy your lunch.

COURT OFFICER: All rise please. Jury exiting.

(Jurors leave the courtroom.)

THE COURT: Doctor, don't speak about the testimony with anyone please, okay.

(Witness leaves the courtroom.)

(A luncheon recess is taken.)

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

COURT OFFICER: All rise. Jurors entering.

(Jurors enter the courtroom.)

THE COURT: Doctor, come up and take the stand here.

Folks have a seat. You enjoyed your lunch today? Was it very good? Where did you go eat?

JUROR NUMBER ONE: We went to the Spanish restaurant over there. Soup.

THE COURT: Was it good?

JUROR NUMBER ONE: Yeah.

THE COURT: Okay. Now I know where to go.

All right. Thank you, very much. Okay. Having said that, we are going to now have, Mr. Scahill, your cross-examination, sir.

MR. SCAHILL: Thank you, your Honor.

THE COURT: Thank you.

CROSS EXAMINATION BY

MR. SCAHILL:

Q. Good afternoon, doctor.

A. Hi.

Q. How are you?

Doctor, you mentioned that you first saw Ms. Gashi on May 3, 2010, correct?

A. Yes.

Q. And Ms. Gashi was referred to you by her attorney, correct?

A. I don't know that to be true, sir.

Q. Well, on your intake form you have a space that says referring doctor?

A. Yes.

Q. There is no referring doctor, correct?

A. Yes. I mean, it's filled out in -- the patient fills it out and it's written -- N.A. is written.

Q. Would it be fair to say that she was referred to you by her attorney?

A. No, sir, not necessarily. She could have been referred by a friend or reputation.

Q. Do you normally in the course of your practice get referrals from attorneys?

A. I can.
Q. Have you testified in the past?
A. Yes, sir.
Q. You have testified on a regular basis in the past; is that correct?
A. Yes, sir.
Q. You testified at least six times a year in personal injury litigation, correct?
A. On behalf of the patient that I operated on, yes.
Q. Is it fair to say at least 50 percent of your practice is devoted to accident cases?
A. Yes.
Q. Would it also be fair to say that you obtain a substantial income from referrals from lawyers and testifying in personal injury cases? Is that fair to say?
MR. FIELDS: Objection.
THE COURT: That is fair game.
A. Not necessarily. I would not characterize it that way, but 50 percent of my practice has to do with patients that have been injured in some manner and so that's obviously a significant portion of my income. They are not all necessarily referred by attorneys. Often times I get -- the majority of my patients are referred by physicians or through other mechanisms, so that's a more accurate way to characterize those relationships.

Q. When you first saw Ms. Gashi, were you aware that she was involved in a personal injury lawsuit from the accident of August of 2009?

A. That she was involved in a car accident which I would presume there might be some litigation, yes.

Q. So is it fair to say when she came to you, you were aware that she was involved in litigation?

A. You know, again, I can't answer that yes or no, but there are people that see me that are involved in accidents that are not suing anybody so, you know, I could say the majority are, but I didn't know specifically whether she was or was not.

Q. Well, you stopped treating her at sometime in 2011. Ms. Gashi testified January of 2011 was the last time that you saw her before Wednesday?

A. Yes, sir.

Q. Is that fair to say?

A. Yes, sir.

Q. When you saw her on Wednesday, it wasn't for purposes of treatment, it was for purposes of your testimony here in court, correct?

A. Probably, yes.

Q. Absent this testimony in court, you would not have seen her and you told her after January of 2011 come back to me as needed, correct?

A. Not necessarily. Frequently patients will see me after

their litigation is over or several years after an accident because they may have some symptoms related to their spine. Everything I mentioned to you before about, you know, patients having ongoing symptoms, they may need to see a doctor. I mean, obviously one of those doctors they may see in the future if their symptoms became more symptomatic, so that is accurately characterizing the relationship that I have with Ms. Gashi.

Q. As to this patient, your contacts with this patient, your contact with this patient ended in January of 2011, correct?

A. That is the last time I saw the patient.

Q. Absent this lawsuit she would not have come back to you at this time; is that fair to say?

A. I disagree. She may have come back. I mean, I answered your question already. She came back, you know, for whatever reason and we documented her exam on that visit, but she may have easily come back for just for her symptoms. Many, many patients come back for their symptoms.

Q. Doctor, it's your testimony that Ms. Gashi suffered a herniated disc in the accident of August 20, 2009 that ultimately led to your surgery; is that correct?

A. It's my opinion that she did have a herniation on that MRI that aggravated her prior condition which I mentioned in my testimony and it was that accident in 2009 which aggravated the condition that ultimately led to the pain and suffering and the

need for surgery.

Q. Now, part of your opinion, your diagnosis, is based on the history given to you by Ms. Gashi, correct?

A. Yes.

Q. In fact, the history that is given to you by the patient is an important part of your diagnosis, correct?

A. Yes.

Q. In medical school you're taught to take a thorough and accurate history, correct?

A. Yes.

Q. And was Ms. Gashi open and honest with you in giving her prior medical history prior to your examination and treatment of this patient?

A. I believe so.

Q. You mentioned she revealed to you she was involved in a motor vehicle accident in 2006 where she injured her neck; is that correct?

A. Yes.

Q. And also her back?

A. She was involved in a prior car accident where she injured her neck and back, yes.

Q. As a result of that accident in 2006, she had surgery on both of her knees. You are aware of that, correct?

A. Yes.

Q. Did she reveal to you she was involved in another car

accident in 2001 where she also had a serious injury to her neck and to her back?

A. I'm aware there was a prior accident, yes.

Q. Did she reveal that to you was my question.

A. I don't recall.

Q. You have in your chart a patient questionnaire. When Ms. Gashi first comes in, am I correct that she did not indicate in that patient questionnaire in her responses that she had an accident in 2001 where she had a serious injury to her neck and back?

A. Yes.

Q. And am I also correct that you never reviewed any of the records from 2001?

A. Yes.

Q. So, doctor, making a determination and -- withdrawn for the moment.

Am I also correct that other than what you discussed with Mr. Fields, you never reviewed any of the records from 2006 regarding her treatment for her neck and her back?

A. Other than reviewing the MRIs.

Q. You never got the records of her treating physician from 2006?

A. No.

Q. You never got the records from her treating physicians from the 2001 accident?

A. No.

Q. And are you aware --

A. I did ask, but I understand they are not available.

Q. Well, we will get into that in a second.

Are you aware that she had filed two lawsuits claiming serious injuries to her neck and her back from the 2001 accident and the 2006 accident?

A. I mean, not the specific details, but I'm aware that she was involved in the accident in 2006 and I presume there was some litigation involved in that, but I don't know the details of that.

Q. Are you also aware she filed a lawsuit, in fact, a lawsuit seeking recovery of $3 million from the accident of 2001?

MR. FIELDS: Objection.

THE COURT: All right. Sustained. I don't want to go into that. Mr. Scahill, let's deal with the facts of this case. I will allow you to go into the prior, the fact that she brought a prior lawsuit. Let's not go into the specific collateral issues.

Q. Were you aware of that doctor?

THE COURT: Once again, the objection was sustained with respect to that, okay. Do not answer it. Okay.

At this point, disregard any reference, jurors, to

any amount that was in issue with respect to that prior lawsuit. Okay.

Q. You had indicated earlier that you felt the 2006 MRIs diagnosed the Plaintiff with disc bulges; is that correct?

A. Yes, sir.

Q. Now, are you also aware that she had a prior MRI in 2001 of her cervical spine?

A. I wasn't able to see any records of 2001.

Q. Am I correct, doctor, in order to form a definitive diagnosis, you as the physician, scientist, want to have all of the records you possibly can before you come to an impression and a diagnosis, correct?

A. I mean, not necessarily. I mean, the '06 MRI is a more recent MRI. It would contain the information. It would show me the nature, status of her spine. At that point that is really more important than looking at the 2001 MRI. I mean, it would be nice to review, but, you know, the 2006 MRI would encompass those things that had occurred prior, so that to me is sufficient for making an analysis as to how severe the prior, along with the history might have been, the prior accident might have been.

Q. In radiology, in medicine, there is such a thing as base line tests, correct?

A. Yes.

Q. It is yes or no. Would you agree that it would have

been helpful to you in forming an opinion that you would have had access to the base line test that was taken in 2001?

A. Not necessarily.

Q. I ask you to review with me the base line test, the MRI test that was taken in 2001. You said the 2006 films showed disc bulge. I would ask you to review with me the 2001 films and these were taken at Yonkers Imaging.

MR. SCAHILL: This is part of Defendant's Exhibit A, your Honor.

THE COURT: Okay. All right.

MR. FIELDS: Objection. If we can--objection.

THE COURT: Excuse me. This is in evidence; isn't it?

MR. FIELDS: No. Everything was subject to redaction, so we can just remove that.

THE COURT: Oh, wait. Wait a minute. Hold on. Hold on. Hold on.

MR. SCAHILL: This part of the 2001 court file.

MR. FIELDS: I understand, but we still have evidentiary issues, your Honor. So if we can --

THE COURT: Hold on. Just clarify. Come in the back, please.

MR. FIELDS: Well, if we can take it off.

THE COURT: Can we click that off, please?

(Whereupon, the following proceedings occurred in

the robing room on the record among the Court and counsel, out of the hearing of the jurors.)

MR. FIELDS: Your Honor, this is on the issue of whether Komar K-O-M-A-R V Showers which serves the legal proposition that the MRI report inclusive in a business records constitutes inadmissible hearsay it's not and it should have -- Wagman which is much more on point --

THE COURT: When he brings it up. I want to look at it at that point.

While he's looking it up, just cite this Komar case.

MR. FIELDS: Well, there was some discussion concerning whether the MRI report that is contained in the business record of a treating physician or a physician itself will constitute, would be admissible and the case K-O-M-A-R V Showers, 227 AD 2D 135 Appellate Division First Department indicates and I will read from the cite if you want me to, otherwise --

A report of a physician which was a medical record and interpretation of MRI film as opposed to day-to-day business entries of treating physician did not constitute business record, was not admissible in an action arising out of an automobile accident. That is citing McKinney's CPLR 4518.

I believe we are still waiting on counsel to pull

up Wagman V Bradshaw which I thought I had, your Honor. I do apologize.

MR. SCAHILL: Judge, Wagman is a Second Department case from 2002. The cite is 292 AD 2d AD 4 and Wagman dealt with an objection by the Defendant of a Plaintiff attempting to put in MRI reports without giving the Defendant the opportunity to review the films and the Appellate Court felt that it is reversible error to permit an expert witness to offer testimony interpreting films when the films were not in evidence.

That is not the case here. Here it is Plaintiff's surgeon on the stand. I'm cross examining the Plaintiff's surgeon with the Plaintiff's prior medical records. I can't see how that is an impermissible use of the Plaintiff's own medical records.

Number 1, I served in May of 2012 3122-A with those records. Number 2 we stiped these records into evidence. We stipulated to allow them to be into evidence. They are part of the court file from the 2001 litigation. They were referenced in a decision from a Judge in this courthouse. They are also part of the Plaintiff's records from Superior Medical Services which have also been stipulated into evidence. So for that reason, I think this is clearly proper cross-examination.

MR. FIELDS: Again, your Honor --

THE COURT: What does Wagman say?

MR. FIELDS: Again, citing to what counsel just stated.

THE COURT: How would you interpret Wagman? We already has his interpretation.

MR. FIELDS: Again, what counsel indicated, cited to in the body of the decision, it's reversible error to permit an expert witness to offer testimony interpreting diagnostic film without production, receipt in evidence of the original films. We don't have the original films.

MR. SCAHILL: I'm not asking for expert testimony. I'm asking was he aware that the Plaintiff had an MRI in 2001 and she was diagnosed with disc bulging. I'm not asking him to interpret anything.

MR. FIELDS: Since 4532-A which concerns the introduction of the film itself is not governed by 3122 that is a business record exception allowing those records into evidence, the case says in the following paragraph applies only to the actual film scan or strip resulting from one of the specified medical tests and, again, I underscore a written report by non-testifying health care professional interpreting MRI films such as an MRI report herein is not admissible in evidence. Such a written report is patently inadmissible hearsay as the preparer of the report is unavailable for cross-examination.

If you wanted to put the film in and have Mr. Lattuga, Dr. Lattuga testify, that would be perfect. That would be governed by 4532-A, but I don't believe that 3122-A allows introduction of the report as a business record under Komar V Showers as cited to under Wagman V --

THE COURT: Read that section about the summary, the report being hearsay again, once again for the record.

MR. FIELDS: Since CPLR 4532 applies only to the actual film, scan or strip resulting from one of the specified medical tests, a written report by a non-testifying healthcare professional interpreting MRI films such as MRI report herein is not inadmissible hearsay in evidence, is not admissible into evidence. Such a report is patently inadmissible hearsay as the preparer of the report is unavailable for cross-examination.

THE COURT: Well, let me look at this. I think dispositive on the issue, let's look at this even more succinctly from the standpoint of this doctor.

If we ask Dr. Lattuga to testify about, you know, from this report, he doesn't have -- there's no way he can actually testify other than the fact that --

MR. SCAHILL: I am just asking him if he is aware.

THE COURT: If you are going to say are you aware -- okay. Make a proffer of the question you would ask.

MR. SCAHILL: That is what I'm going to ask. I'm

also asking him if he is aware of the report from the 2006 films. I'm also going to ask him is he aware of the affidavit that was filed by the Plaintiff's treating physician in this court with respect to her injuries in 2001.

THE COURT: I think you can ask that, but I don't think you can show it on the wall.

MR. SCAHILL: Why not?

MR. FIELDS: Subject to redaction. That is why I wanted to go through the records to make sure none of the records that have been included contain inadmissible documents.

THE COURT: No. Listen. Hold on, because Dr. Lattuga is in no position based upon that report to testify as to whether he agrees or disagrees with that impression.

MR. SCAHILL: I am asking if he's aware that the impression was made.

THE COURT: That is one thing if you are saying listen, are you aware that there was an MRI report, an MRI that was conducted that was done on so and so if he says I assume yes, I am. You know, okay. Do you go beyond that? You could not possibly go beyond that. You know why? Because at this point --

MR. SCAHILL: I'm not asking him to interpret it. I'm asking was he aware.

MR. FIELDS: I just don't want the contents of that report being testified to, so --

THE COURT: I think that, you know, that you are within your right. Are you aware there was a report from -- the guy says yes. If you go on to -- but depending on whether he says yes or no, then you are precluded, then you cannot go into that because then he is no position to testify about that.

MR. SCAHILL: I would rather not get interrupted during my cross constantly. I'm also going to question him -- I'm making a proffer of proof here.

I'm also going to question him on the affidavit that was filed by her doctor in 2002 with respect to the summary judgment and all of the findings of that doctor.

MR. FIELDS: But that is a report prepared for the purposes of litigation. It is not a business record.

MR. SCAHILL: It is an affidavit from her treating doctor. How can I not?

MR. FIELDS: Because that's no different than a narrative report. It is governed by Komar V Showers and its progeny.

Your Honor, if a narrative report from a treating doctor, okay, that was included in any one of these business records, it would not be admissible. In fact, there is one such report from a 2001 doctor. I think it's

Dr. Kleinman or something that's addressed to the attorney, Ms. Gashi's attorney that is not admissible because he wrote it for the purpose of the lawsuits.

MR. SCAHILL: Judge, it is an affidavit from a doctor that her doctor submitted in this court as part of the court file. I'm certainly allowed to question him on what that doctor had to say about her condition ten years prior to his treatment.

MR. FIELDS: It is not a business record.

THE COURT: You know, see, again --

MR. SCAHILL: It is an affidavit.

THE COURT: It may very well be an affidavit, but the procedure of laws here are very stringent, okay, they are, with respect to that. They are.

I think at this point what we have is a situation where we have a person who is going to sit there, he or she, he's going to be expected to answer certain questions that he says well, listen, there was an affidavit submitted. How would I know why the doctor actually wrote it?

MR. SCAHILL: These were his findings.

THE COURT: It was the other doctor.

MR. SCAHILL: Well, I'm cross examining him.

MR. FIELDS: Do you have the actual reports that the doctor wrote?

MR. SCAHILL: I have his affidavits.

MR. FIELDS: Your Honor, I have no objection to the reports that he wrote because that is a business record, but the affidavit that he submitted to --

THE COURT: Hold on. The reports -- well, how is that report then different if you are saying you have no objection then to the MRI report?

MR. FIELDS: Because the MRIs are governed under Wagman Bradshaw. MRI reports can't come in.

THE COURT: But now we are splitting hairs. At some point we can go so far, but we can't go completely. On the other side, he says MRI reports should go in. You are saying at this point because Wagman controls at this points he says MRIs, but now he says he wants to be, wants to be able to inquire if there was. You would have no objection to the reports from the doctor if he has any reports?

MR. FIELDS: But he is willing to submit the affidavit of that doctor which was prepared for the lawsuit.

THE COURT: Okay. The affidavit is --

MR. FIELDS: That does not constitute a business record.

MR. SCAHILL: It is a court record.

MR. FIELDS: It doesn't matter.

MR. SCAHILL: How does it not matter? I subpoenaed the court file. You could use anything in that file. You could take judicial notice this was part of the file.

MR. FIELDS: It didn't -- you can't circumvent the rules of evidence just by bringing the court file which includes things that are otherwise inadmissible. There are tons of stuff in any given court file that you can't bring in. Just because it is in a court file doesn't make it admissible.

THE COURT: It doesn't mean that.

MR. SCAHILL: It is an affidavit from her own doctor.

THE COURT: What does the affidavit say?

MR. SCAHILL: Detailed all of his treatment and diagnosis of her from the accident of 2001.

THE COURT: But he does not have the reports to substantiate.

MR. SCAHILL: They are in evidence. All of the records are in evidence.

THE COURT: Are the reports in evidence?

MR. FIELDS: They are subject to redaction.

THE COURT: Okay. Bring the reports -- if you go with the report, confront him with the reports, okay. Look at the reports.

Doctor, if the reports from the treating doctor, the one who wrote the affidavit -- remember, an affidavit is a conclusion which was supposedly culminated by his treatment of this lady dealing with her.

Now we come to this, but if you are going to show the end product which is the affidavit, obviously he is not in a position to be able to disagree or agree because he's saying, you know what, I have nothing to look at. If you have the report, bring the report.

MR. SCAHILL: This is cross-examination.

THE COURT: I believe that cross-examination should be as much lateral or have as much leeway because, again, it is cross-examination, but by the same token we have rules of rules of evidence that are going to say listen, it may appear to be unfair, but these are the rules that we got at this point.

We got a guy sitting up here. You are going to tell him about this MRI report. If you are going to ask him, are you aware this report was -- he says, yes. If he says no, okay, fine. If he says no, fine, you move on. If he says yes, well, you still got to move on because you can't inquire because you are going to inquire of certain things that he has not seen.

MR. SCAHILL: I disagree, Judge. I'm also going to use her affidavit, everything that she says in her

affidavit.

THE COURT: Well, she is here. Sure.

MR. FIELDS: That I don't have issue with.

MR. SCAHILL: Come on, Judge. We will never get out of here. It's 3 o'clock.

THE COURT: Gentleman, there is only one person who determines when we get out of here and what time we start. That's me.

MR. SCAHILL: Understood. I didn't mean to be disrespectful.

THE COURT: I understand that.

At this point, I know we are getting into rules of evidence that we are dealing with.

Mr. Scahill, once again, I'm allowing you as much leeway as you are entitled to on cross-examination, but we do have those rules and we are going to have to deal with them. Her affidavit, she is here. She is fair game.

MR. FIELDS: I concede that, your Honor.

(Whereupon, the following takes place on the record in open court.)

(Continued on the next page.)

THE COURT: Objection sustained.

Q Doctor, we were talking about the baseline MRI that was taken in 2001. Were you aware that Miss Gashi had a baseline MRI in 2001?

A As I said I never had access to those records, I did not know or not know that she had an MRI.

Q Were you aware that she was treated for over two years in 2001 as a result of the accident in 2001 and that she had unrelenting, constant, severe neck pain from 2001, were you aware of that?

A Again, I don't know the specific details of that accident other than she was involved in an accident and she was treated for her neck and back.

Q These are records that are in evidence. You talked about an EMG earlier. An EMG is a test that is given to patients to test whether they have radiculopathy; is that correct?

A Yes.

Q Were you aware that she had an EMG in 2001 which showed that she had cervical radiculopathy?

A Again, I was not privy to having any of these records in 2001.

Q I am going to show you the records that are in evidence from superior Medical Services and her EMG results. I ask you to take a look at these. This is a test that was done on May 31, 2001, a nerve conduction test. There is an impression, an

interpretation. It indicates there was evidence consistent with left C7/C8 and C8/T1 nerve root dysfunction and irritation as seen in radiculopathy.

Would that be indicative of a serious injury to someone's cervical spine?

A Again, not necessarily. It depends on the duration of it and also this is not the same level where she injured what we are currently discussing at this point. She had surgery at C5/C6, this is C7/C8 and C8/T1. It is a positive finding and relevant to that circumstance, but the fact that she was asymptomatic prior to this --

Q This is in 2001?

A Yes, but the fact that it resolved means that it was a transient finding and resolved wasn't a permanent finding, it related to that first accident.

Q I ask you to take a look at the records from her treating neurologist from 2001. Were you aware that she treated with a neurologist by the name of Doctor Peter Kwan. Was that brought to your attention?

A No.

Q Were you aware that the neurologist from 2001 diagnosed this plaintiff as totally disabled as a result of the 2001 accident?

A Again, I did not have access to the records.

Q The answer to that question, you were not aware that

she was previously diagnosed as being totally disabled from an automobile accident 10 years prior to the time that you saw her?

A Again, I know that she had an injury.

Q That's a yes or no, Doctor.

A Well I cannot answer it exactly yes or no because if she was involved in an accident and she did sustain an injury to her neck and back and she was treated for a significant period of time, which I do know then it is not unusual that she would be disabled during that time period, so that's why I would de facto know that existed based on the history of that.

Q I asked you before --

MR. SCAHILL: Withdrawn.

Q You testified earlier this morning that if an individual had an injury that persisted over a lengthy period of time that would be indicative of someone who had a serious injury to their neck or their back if they had a lengthy time of treatment; is that correct?

A I may have used those words. Again, the fact that she was treated for and had complaints of neck and back meant that was significant, the follow through is that resolved and she had a subsequent accident in 2006 which was treated and also resolved. They were both significant. And then this current accident aggravated the prior condition. It is all consistent with what I said.

Q I am going to show you an affidavit that was submitted by the plaintiff herself in a lawsuit in 2001 describing her condition.

A Okay.

Q When we talked about Miss Gashi being open and honest with you, she did not reveal to you the 2001 automobile accident; correct?

A It is not mentioned in my record.

Q So, this is the plaintiff's own description of her condition in 2001. At that time she was known by her maiden name which is Krasniqi. She indicated that she filed this case for serious and personal injuries sustained in a motor vehicle accident in April of 2001. Do you see that, Doctor?

A Yes.

Q And paragraph four describes the accident and she put in her affidavit that as a result of that motor vehicle accident in 2001 she sustained painful and permanent injuries to her neck, mid back, lower back and she described what those injuries were. Disc bulge at C4/C5, a disc bulge at C5/C6. Those are the two levels that you did the surgery on; correct?

A Yes.

Q She is also describing all of the symptoms and diagnoses that she had back in 2001. Did she reveal any of this to you?

A Not specifically.

Q You told us earlier that she did not even mention the 2001 accident. In 2001 she filed an affidavit in this courthouse saying that she had injuries to the disc at C4/5, C5/C6 specifically the disc that you operated on nine years later. Are you also aware that she indicated that she treated at Superior Medical Services and she underwent MRI evaluations and the MRIs that were done in 2001 revealed the disc bulging and all of the findings that are listed there?

MR. FIELDS: Objection.

MR. SCAHILL: This is the plaintiff's own affidavit, Judge.

THE COURT: I will allow it. Mr. Scahill, you have to ask your question. I think you are going on to a narrative. Ask the question, allow for the answer and then proceed.

Q Were you made aware of any of these findings or her treatment at Superior Medical Services which included MRI evaluations to the neck and to the back which showed significant pathology?

A Again I did not have access to those records. I was aware that she was involved in a 2001 accident.

Q Were you aware that she treated at Superior Medical Services for a year and she received continuous treatment and physical therapy to alleviate what she described as constant and persistent pain that she was experiencing in her neck, mid back

and lower back?

A Yes, I am aware that she was treated for neck and back problems from the 2001 accident.

Q Are you now aware of that?

A Well --

Q You told us that she did not mention the 2001 accident to you?

A Yes.

Q Are you now aware of that?

A My recollection is refreshed by your posting of the information, but I was aware that she was, in preparation, when I did preparation for this trial, I was aware that she was involved in, like I said before, two prior accidents, one in 2006 which she wrote in her own handwriting and a prior accident, both of which resolved.

Q Would it be fair to say that your opinion as to whether or not she sustained a herniated disc from the accident in 2009 would have been more enlightened if you had all of the records that she did not give you or reveal to you, is that a fair statement, that's a yes or no?

A Not necessarily. I mean to the extent I believe I answered the question I have a recent follow up MRI subsequent to that which gives me great insight as to what the potential injury was before that.

Q We will talk about that in a minute. When you said on

direct examination when Mr. Fields was talking to you, you said if someone had a prolonged period of excruciating or serious pain from a neck injury, that's more indicative of a structural problem with the disc than a minor sprain or strain, is that a fair statement?

A That's your statement. You have to read the record exactly to see what I said in response to the statement. But, obviously, if someone had a prior injury and I have acknowledged in my testimony that she did have a prior injury to her neck in the 2001 -- back in 2001, repeating myself, 2006 she had a neck and back injury and the 2009 accident rather aggravated her prior condition and I think we are saying the same thing.

Q This is the plaintiff's own affidavit. Paragraph nine, the second sentence says, however the neck pain, mid back pain or lower back pain which began over two plus years ago continued to persist on a constant basis during the course of my treatment and has still not diminished in its intensity. Although the visits and physical therapy sessions with Superior Medical Services would temporarily relieve the pain I felt in my neck, mid back and lower back, it has not remedied my physical condition nor diminish the restrictions that have changed my daily way of living since the motor vehicle accident.

Is that indicative, that statement made by your patient, is that indicative of someone who had a serious condition to their neck dating back to 2001?

A Not necessarily. This is a statement that she wrote. This is not really a medical opinion. Now you are asking me to comment on what I think she meant when she wrote this.

Q This is your patient's --

A I believe it to be truthful when she wrote this, but I don't know how she felt a year after this.

Q This is your patient's own words?

A I would say to you that obviously she wrote this, it must have been truthful at the time. That's what she felt but based on the history that we have, not only my history but the other physicians taking care of her at some point this problem resolved and so then she had another injury to her neck.

Q We will get into that in a minute, Doctor.

As far as the 2001 accident, Miss Gashi also said after the accident, she attempted to perform her duties at work and the result was that she experienced severe neck pain, mid back pain and lower back pain and had to stop working. That's all indicative of someone who had a serious injury dating back to 2001; isn't that correct?

A Well again you say dating back to, I think at the time this was a significant injury as well as documented here. I don't think that you know I am lucky enough that I got to see the MRI in 2006, so I get to see some retrospective analysis of it. At some point from the history of mine and reviewing some of the records, this resolved and then was aggravated in the 2009

accident. So I think that's all consistent.

Q This affidavit is dated June of 2003, two years after that prior accident. In fact, Miss Krisniqi or Miss Gashi at that time said, I can no longer stand, walk or sit for extended periods of time without taking a break. After the accident I experienced severe pain from all the trauma including egress, getting in and out of her own motor vehicle, that's all indicative of someone who had a serious injury; is that correct?

A I believe I answered that question.

Q You refer to records regarding the 2006 MRI?

A Yes.

Q And you said that you indicated that you actually reviewed the 2006 MRI; is that correct?

A The films.

Q When were you given the films from the 2006 MRI to review?

A In preparation for testimony.

Q And when was that?

A Several weeks ago.

Q Several weeks ago you were given the MRI?

A Yes.

Q When you gave the opinion that Miss Gashi was seriously injured from the accident of 2009 you did that without the benefit of reviewing the 2006 films; is that correct?

A When, specifically are you asking me that I gave that

opinion?

Q You gave that opinion this morning to the jurors and you also gave that opinion to her attorney long before you looked at those films. Is that fair to say?

A So, it would be contemporaneous, 8/6/2013 is when I had an opportunity to review the 2006 MRI.

Q You are aware that the 2006 films indicate that the plaintiff, in fact, suffered herniated discs at the same levels that were found on an MRI in 2009, you were aware of that; correct, Doctor?

A I got to review the films but my impression was having seen the old report that was essentially consistent with the old report, you know, I read as a bulging disc at C4/C5 and C5/C6, the same level.

Q You read the 2006 report as well from the same radiologist?

A The films, sir.

Q You looked at the report?

A No, I did not see the report.

Q Are you aware that the interpreting radiologist from the 2006 films read what you said is a bulge as disc herniation?

MR. FIELDS: Objection, objection.

THE COURT: I don't want to get into specifics of that.

Let's move on.

Q Are you aware that the interpreting radiologist from the 2006 films read them as disc herniation?

MR. FIELDS: Objection.

A No.

THE COURT: He said no.

Q Did you get any of the plaintiff's medical records from 2006?

A No.

Q You are giving an opinion that all of the plaintiff's injuries were caused by the 2009 auto accident without the benefit of looking at any of her records from the 2006 accident, is that fair to say?

A Other than the MRI that I got to review.

Q So, if her records from the 2006 accident showed consistent complaints of serious neck and back pain, that would be something that would change your opinion; is that correct?

A No, it wouldn't because this accident really is an aggravation of the prior accident so that acknowledges the fact -- and I am answering your question, sir -- in my opinion, it includes the fact that she did have two prior accidents and she did injure her neck in two prior accidents. The MRI, in my estimation, showed an injury and you showed the jury and myself the 2001 report which I will take at face value, I have not see it, that there was an injury to that same level. My testimony is

consistent that the 2009 accident significantly and seriously worsened or aggravated that condition to the extent that even with all the treatment, she continued to deteriorate and ultimately needed surgery.

So I am including the fact of the relevant issues that you are bringing forth that there was a prior accident. I am acknowledging that yes there was a prior accident and she was treated for it, but, my history that I have taken from the patient, Doctor Cruz' history, the ER record all reflect no significant prior complaints of neck problems at the time of this accident.

I think that's relevant. Don't take my word for it, I take the word of Doctor Cruz and the ER record that she had no prior problem and that's how I am basing my opinion. I think it is consistent with what you are asking me.

Q I am going to show you the records from her 2006 treatment. She treated with an orthopedic surgeon, Doctor Louis Rose in 2006?

A Yes.

Q I would ask you if you had the opportunity to review any of these records. Miss Gashi was 20 years old at the time of her 2001 accident?

A Yes.

Q A 20 year old who undergoes an MRI, a finding of disc bulges to the cervical spine would be a significant abnormality

for a 20 year old; is that fair to say, Doctor?

A It is a finding.

Q Well, it is not a normal finding; correct?

A It is a positive finding that is not normal; correct.

Q And you would not expect to see any arthritis or degeneration on an MRI for a 20 year old; correct?

A I would not expect to find that, no.

Q So if there is a finding of disc bulges on an MRI in 2001, that's an abnormal finding that can be indicative of some disc injury, is that fair to say?

A That's what I testified to.

Q And if there is a finding on an MRI in 2006 of a disc herniation abutting and impressing on the spinal canal, that's a serious abnormal finding; is that correct?

A I mean I don't necessarily agree that was the finding, but if someone has a herniated disc on an MRI, that's an abnormal finding, yes.

Q You would not expect -- at the time of the 2006 motor vehicle accident Miss Gashi was 26 years old. You would not expect a 26 year old to have findings of arthritis on an MRI; correct?

A That's correct.

Q So, if a 26 year old had an MRI in 2006 that showed a herniated disc of the disc space into the cervical spine, into the cerebral spinal canal, that would be a serious finding;

correct?

A That's a positive finding.

Q That would be something that you yourself would recommend surgery for, depending on the severity of the symptoms; correct?

A A herniated disc, yes, sir.

Q That's ultimately what you did, you operated on a 29 year old plaintiff for disc herniation of the cervical spine; correct?

A Yes, sir.

Q It was your opinion that those disc herniations were as a result of an accident in 2009, not the 2006 or 2001 accident; correct?

A My opinion is that those herniations which I believe are herniations from what I thought was a bulge in the prior film, was an aggravation of the injury to those levels. So whether there was a bulge, I read as a bulge in 2006, someone else read it as something else. We both agreed there was an injury to that level, we both agreed.

Subsequent to that, she had a new injury for which she was treated conservatively, didn't respond, ultimately I recommended surgery. That second accident or third accident in 2009 was significant, was what significantly aggravated her prior condition. I think that's clear.

Q I ask you to look at the records from Doctor Rose from

2006. The date of the evaluation was July 14, 2006 and Miss Gashi complained of continued neck pain which radiates into her upper extremities. That's more than a sprain; correct? If someone has radiating pain down into their arms, that's because of an injury to the disc at one of the levels of the cervical spine; correct?

A I mean do you want me to testify what Doctor Rose's opinion was under the circumstances?

Q I am asking you a hypothetical. You talked about, earlier this morning, radiating pain.

A Yes.

Q And if someone has radiating pain it is because of an injury to a nerve at one of the disc spaces of the cervical spine; correct?

A Not necessarily. Like I described to the jury not all radiating pain is nerve relating, it could be a heart attack.

Q We are talking about someone's neck. The reason that Miss Gashi was complaining of radiating pain into her extremities in 2006 was because one of those discs was impressing on one of the nerves in the cervical spine; is that fair to assume?

A If that was Doctor Rose's opinion, he is a good doctor, I would accept his opinion as being valid. I am not making the diagnosis, so I don't feel comfortable making a diagnosis off of one yellow line on a note from 2006.

Q I will show you some additional records. Doctor Rose's

records indicated limited range of motion. You talked about range of motion evaluations that you did?

A Yes, would it be okay if I see the whole note instead of taking excerpts?

Q I can give you the entire chart.

THE COURT: Doctor, wait for the question.

Q I can give you his entire chart, but I was specifically referring to range of motion testing that was done which was limited. The doctor noted his examination of the paravertebral muscles, the musculature around the neck showed there to be severe spasm. Those were the same findings that you had; is that correct, Doctor? This is from July 14, 2006. The spasm, the limited range of motion, those are all the same findings that you had in 2010 when you saw Miss Gashi for the first the time; is that correct?

A Yes.

Q So is it correct to say that a finding -- and you indicated the limited range of motion, the spasm were all objective findings. Is it fair to say that she had the same exact objective findings in 2006?

A Doctor Rose's note, he notes that she had limited range of motion of her cervical spine.

Q In addition to severe spasm; is that correct?

A I am reading, sir, I am sorry. He also notes severe spasm.

Q Now, this persisted for an extended period of time and you said that would be indicative of someone with a serious injury. He diagnosed Miss Gashi with severe cervical spine sprain, possible cervical radiculopathy and continued to treat Miss Gashi. When she returned to him 10 days later, she continued to have significant discomfort about the neck, mid back and lower back. She has stiffness and tightness and she continued with intermittent numbness and tingling in the right upper and lower extremities.

The tingling and the numbness in the upper extremities found in July of 2006, that was because of the injury to her cervical spine disc; correct?

A If you are asking me to make an opinion on part of Doctor Rose's note, let's see what the Doctor thought, I did not examine the patient. I am only seeing the story in pieces.

Q I will show you his impression. His impression again was severe cervical spine sprain with possible radiculopathy, severe thoracic spine --

A Okay.

Q You talked about the length of treatment and the length of symptoms. A month later she returned continuing to complain of pain and discomfort about the neck, mid back and lower back and he did a further examination at that time and he showed limited range of motion, tenderness and spasm to the cervical spine. That's not someone that's improving, she is complaining of

pain and discomfort about the neck, mid back and lower back; isn't that correct, Doctor?

A That's what Doctor Rose wrote in his note, yes.

Q On every visit to Doctor Rose -- this is from September of 2006 -- his physical evaluation showed, this is two months after the accident. Again, range of motion lacking three fingerbreadths of clearance chin to sternum, that's a significant finding, right, Doctor?

A These are Doctor Rose's notes that reflect his physical findings on that date. You can scroll down to his impression and he will tell you what he thought.

Q Well, Doctor Rose for months treated this plaintiff in 2006 for radiating pain into her right upper extremities with difficulties lifting and pulling, even dressing and undressing. That's indicative of someone that has a serious injury to their neck; correct?

A I mean I would say that it was like I testified to before, she had an injury at that time and she was --

Q In December, five months after initial treatment she went back to him saying that the pain in her neck and back had yet to resolve. She had continued stiffness on the right side of her neck, has difficulty with side to side motion and increased pain. She said her symptoms have yet to resolve. She has pain with simple household chores. That's someone that has a significant injury to their neck; correct?

A And she was being treated for that.

Q Well, you said that the accident of August of 2009 was the cause of the plaintiff's injuries which ultimately lead to her surgery. The surgical findings that you had indicated that the plaintiff had a herniated disc that was impressing on her spinal canal; correct?

A Yes.

Q An individual that has a herniation in their neck, that herniation is going to progress over time; correct?

A It could.

Q And it could get worse over time with or without a traumatic a second traumatic event; correct?

A It could.

Q Am I correct that you have operated on many patients who have the exact same findings as Miss Gashi with or without a traumatic event?

A Yes, you can have a herniated disc in the absence of a car accident and need surgery, that's possible.

Q The herniated disc that was diagnosed in this plaintiff in 2006, with the medical records that I have just showed you from 2001 and 2006, those records are indicative of someone who had a serious problem with their neck long before this accident of 2009; correct?

A And that's been my answer. You asked me that question several times and I continue to give you the same answer.

In 2001 she had an accident and injured her neck and back. In 2006 she had an accident hurting her neck and back. And then in 2009 she had another accident which aggravated a prior condition and that acknowledges, right, that there is a prior condition and ultimately she was treated, she failed and she opted to do surgery.

Q Your opinion is that the 2009 accident was the cause of the surgery, is that because Miss Gashi came to you from an attorney and she had a lawsuit pending?

A No.

Q You are basing that on her medical records?

A Well, I mean it is clear she would have surgery for the first accident if it was bad enough that she needed surgery and she did not have surgery. She could have had surgery with Doctor Rose and she did not have surgery. The presumption would be and I would argue and this is what she told me and this is what Doctor Cruz' notes reflect, that she got better, that's why she did not need surgery.

So the difference with this particular accident is that this accident was significant enough, big enough to cause a significant aggravation of those prior, of that area and she tried it all again and she did not get better and this time she ended up having surgery because she did not resolve it. She was getting worse and had neurological dysfunction.

Q There is a concept in medicine Doctor known as

secondary gain; correct?

A There is a concept, I don't know if it is exclusive to medicine, but I understand what the words secondary gain mean.

Q You are taught that in medical school, you are taught about secondary gain; correct?

A I mean I could have been, I don't recall specifically recall but I do know what secondary gain is.

Q What is your understanding of the phrase secondary gain when it applies to medicine?

A Secondary gain is when someone has another reason for trying to obtain treatment, you know, whether it is that they are going to the doctor to say they are sick when they want painkillers, they really want the painkillers or they say their back hurts so they don't have to go to work. Obviously, you are all smart people, you know that people do things like that.

Q And a lawsuit --

A That's what he is conveying.

Q A lawsuit is another --

A That's another example of why someone may want to do something like that.

Q Now you talked about the hospital records?

A Yes.

Q The diagnosis from the hospital back in 2009 was strain of the neck and back; correct?

A Yes.

Q And you said that diagnosis, I am going to pull up the hospital record.

MR. SCAHILL: Which is in evidence, your Honor, as Plaintiff's Exhibit 4.

Q This is the impression from the hospital record. Strain of the neck and back. Now an individual that has a strain of the neck and back, that could be something that resolves itself in a short period of time; correct?

A Yes.

Q And with or without conservative treatment; is that correct?

A Possibly, yes.

Q Now, are you aware that Miss Gashi's complaints at the hospital centered on her back?

A Her neck and back.

Q Well, are you aware that the majority of her complaints dealt with her back?

A My impression was you just saw the circle neck and back right there, that's what was circled, so that would not be my interpretation.

Q I am going through the records with you. I will ask you were you aware of certain findings. This was her initial complaint and her chief complaint was pain to her mid upper back and right side?

MR. FIELDS: Objection, your Honor. I think it is

a mischaracterization of the evidence. There are prior triage notes and entries in the hospital record.

MR. SCAHILL: Mr. Fields can bring up anything he wants on redirect.

THE COURT: You can do it on redirect.

Q This is her hospital record from the date of the accident. It says, patient brought in on back board. That's what that means, boarded and collared?

A Yes.

Q Complaining of pain to the mid, upper back and right side. Patient driver of a vehicle that was rear ended. After that she received treatment. People in the hospital actually took care of her. You listed her pain level as 10 and the pain location was where?

A I mean you want me to read what is yellow highlighted?

Q Yes.

A Back and right side.

Q There was no mention of the neck there?

A In the beginning, the prior note.

Q This is the hospital record from the date of the accident. The pain level is 10 and the pain is her back and right side?

A Yes.

Q Again she was seen, the hospital record notes her pain level continued to be a 10. Where is the pain location at that

time, Doctor?

A Well, again it says back and right side if you are asking me to read what is yellow?

Q Yes.

A Back and right side.

Q Is there any mention of her neck?

A There was in the rest of the record, just not here.

Q You talked about that she had a pain level of eight which was excruciating pain. The hospital record noted her appearance and there is a finding there. What does that finding say, Doctor?

A What part of this would you like me to read?

Q Under general appearance.

A Mild distress.

Q Is that indicative of someone that has had a serious injury that requires surgery after the accident?

A I mean it does not say normal, it says the patient was in distress.

Q When every entry in the hospital record other than that initial diagnosis point to her complaints of back pain and right sided pain, were you aware of that?

A I mean I reviewed this record, I think that you know it. To me it appears slightly incomplete. It is clear that from the ambulance record that she had neck and back problems, she had a collar and they discharged her with a collar. Why would they

discharge her with a collar if the problem was the lower back? They took an x-ray of the neck. Why did they only write lower back? They x-rayed her neck and gave her a collar for the neck and you are suggesting that it was only her lower back. It is clear that there was a neck problem.

Whoever was doing this was doing it very quickly and maybe they were busy and not spending a lot of time writing. The big picture is she complained about her neck and back here, she complained about the neck and back and this reflected she had neck and back injury. We went over the x-ray and we know what the discharge was, they sent her home with a collar and that's to me what it suggests.

Q You talked with Mr. Fields about the difference between subjective complaints and objective complaints. Subjective someone can say I feel nauseous and objective is if someone is vomiting, that's an objective sign?

A For the most part, correct.

Q As part of medicine you are asked to develop a differential diagnosis; is that correct?

A Yes.

Q Is it fair to say that the differential diagnosis in this case is that Miss Gashi had long standing, chronic injury to her disc that required surgery after degeneration, after multiple years of radicular pain, is that a fair description of a differential diagnosis?

A No, sir, that's a mischaracterization of a differential. A differential is when you don't know what the diagnosis is, you don't know if it is tuberculosis or pneumonia. Here we know there is an MRI that's a positive herniated disc and clinical findings of neurological dysfunction and x-rays so we know what the diagnosis is. It is cervical radiculopathy. As to your theory that you suggested in your question that there was some degenerative phenomena, though it is upon that someone could undergo degeneration, it is clear here why Doctor Cruz' record and my record and my history that she was not having significant symptoms at the time of the accident and it is my opinion and continues to be my opinion that this accident aggravated the prior conditions that you so well elucidated to the jury and but for this accident in 2009 she would not have a surgery.

By the way, nobody wants spine surgery. It is not like a face lift or anything.

Q I understand, Doctor.

A You don't have surgery because you might get something, especially spine surgery when the risks are being paralyzed or dying.

Q You can have surgery for a long standing condition that had nothing to do with this motor vehicle accident?

A Yes, but clearly that's not what happened here.

Q I ask you to take a look at the 2009 MRI and the 2006 MRI and we could talk about the findings.

A Okay.

Q The disc spaces that you operated on are shown on this MRI; correct?

A Yes.

Q And the disc in this MRI are herniated, they are impressing on the canal; is that correct?

A What MRI is this, sir?

Q I am asking you, you said that you are conversant in MRIs, you see that space right there, you see that space right there, that impression, that is a herniation on the spinal canal; is that correct? It shows a herniated disc at two different levels, the levels that you operated on?

A You cannot ever or would I ever read an MRI in one sheet in one film like this. In order to give an adequate reading of an MRI for it to be medically plausible, you have to have the entire MRI.

So, I had the opportunity to review that MRI that I gave an opinion on, so I got to see the entire MRI, I could show the jury. It is not appropriate for me to look at a film like this absent of the content and give any opinion whatsoever.

Q You did not answer my question. Isn't it in fact that the discs that are shown on this MRI show herniations into the spinal canal that are impinging on the spinal canal that would require surgery?

A You cannot give an opinion based on one cut like this,

that is not medically plausible. No radiologist would look at one film and make an opinion. You have to look at the entire film. It is like on an EKG, it is like saying look at this one little line of an EKG and the doctor saying the patient is having a heart attack. The cardiologist would say, I have to look at the entire thing. You are asking me to look at one sheet without a time and without a date and I could not, I certainly couldn't tell you if the patient needed surgery.

Q Let me show you another film.

Does this show the exact same thing, discs that are protruding into the spinal canal?

A This is a different sequence, a different stir image, it is a different formatting.

Q Does this show the exact same thing?

A You cannot give an opinion based on one film.

Q I just showed you the film above.

A Yes.

Q And the discs were impressing on the film above into the spine canal at two different levels. They are now impressing into the spine canal on two different levels in this MRI?

A You are pointing to the thoracic spine not the cervical spine.

Q We are talking about the disc spaces is the discs that are impressing on the spine canal; correct?

A I cannot answer your question yes or no.

Q Well, Doctor, this MRI that you see here was taken of the plaintiff after her August of 2009 accident, this MRI was taken in 2010, October. I am sorry, in 2009, October 30, 2009. The MRI that I showed you first was taken in September of 2006. They are exactly the same findings, Doctor.

A Is that your opinion as a radiologist, sir?

Q Well taken.

But even a layperson can show that they have significant pathology in the 2006 MRI. Would you agree with that?

A For me to do a proper reading of an MRI, you have to have the entire MRI. It is not appropriate for me to give you an opinion on one particular cut on an MRI when I have not had an opportunity to have the whole MRI up. So I cannot answer your question yes or no, but I did review this in its entirety in 2006 and I do believe there is a disc injury at C4/C5, C5/C6, the same levels that I operated on. But I think the MRI that was done three years later was worse and I believe that accident aggravated those prior disc injuries. It is pretty clear.

Q Can we at least agree that this sequence of the MRI that was done in 2006 shows a herniation into the spinal canal?

A That's your opinion, I read it when I looked at it. I looked at the entire MRI, I read it as a bulging disc. You, with your credentials, you read it as a herniation. That's fine. Okay, I think the 2009 looks worse and was has aggravated the

prior condition.

Q If there was a finding in 2006, if you took that same patient and you went back and took an MRI three years later, remember you could have the exact same findings that Miss Gashi has here without a motor vehicle accident; correct?

A That's completely speculative.

THE COURT: Let's not argue. Next question, Mr. Scahill. Next question.

Q In order to progress you said the MRI film in 2009 was worse than the MRI film in 2006. Did you compare the two?

A Yes.

Q Did you put them up side by side and compare them?

A Yes.

Q Did you see a progression of the pathology at the disc space at the two levels that you operated on?

A Yes, it is my opinion that it looked a little, it looked worse. I will quantify it, I think that more importantly than just the MRI because that's what I was talking about the whole time, that her clinical findings, that she got worse even though she did treatment, she did not get better so she ended up having surgery. My opinion is that second accident aggravated the prior disc injury that she had.

Q It is actually the third accident.

A The third accident aggravated the prior accident.

Q My question to you Doctor, is that these findings could

have occurred with or without the 2009 motor vehicle accident, the progression of the disc degeneration and disc herniation that was found in 2006, is that fair to say?

A I cannot answer that yes or no, but I can tell you that we don't operate on an MRI.

THE COURT: He said he cannot answer it yes or no.

MR. SCAHILL: Nothing further, Judge.

THE COURT: Thank you, Mr. Scahill.

Any redirect?

MR. FIELDS: Very briefly, your Honor.

REDIRECT EXAMINATION

BY MR. FIELDS:

Q Good afternoon, Doctor, once again.

A Good afternoon.

Q During the course of Mr. Scahill's cross examination there was some discussion about the hospital record where he referred to the complaints that Miss Gashi had made as being related to her back. Do you recall that?

A Yes, sir.

Q And I just want to direct your attention to the second page of the EMT or the ambulance call report and you see the portion where it says body part?

A Yes.

Q And can you just read that to the ladies and gentlemen

for us?

A Body area number one, neck, lower right leg, back upper.

Q Thank you. Just so we are all clear, Doctor, the ambulance call report would contain information about Miss Gashi's condition including her complaints while she was in the ambulance right after the accident?

A Yes, sir.

Q Let's fast forward a little bit Doctor. I am going to show you what was the intake or the original triage record from the hospital, at Lawrence Hospital. Upon Mrs. Gashi's admission to the emergency room and referring to the first page, I just want you to look at the section that appears below the letters HPI.

A Yes.

Q You see that?

A Yes.

Q Can you read for that what that says?

A It says location of pain, neck, back, lower, there is a diagram.

Q Let's talk about that. There is a diagram on this. Tell us what the diagram is?

A It is a head diagram of the front and back of the head.

Q And are there any notations or notes or anything

inscribed on that particular diagram?

A There is an area that is highlighted at the base of the skull and to the right and it is basically Miss Gashi's neck and the right side of her neck and that's, they check that off as that's the specific area where she was pointing to where the pain was.

MR. FIELDS: May I publish this to the jury, your Honor?

(Whereupon, the exhibit is published to the jury)

Q Doctor, before we go any further, just going back to the ambulance call report, just for the record, there is a portion of the report that is identified under what they call a narrative. Can you just read for us the first sentence that contains what the patient's complaints were?

A Unidentified 29 year old female sitting in her vehicle complaining of neck, back and leg pain.

Q Thank you. I am going to return these up there so we can keep them together, Doctor.

Now, Doctor, during the course of your cross examination you were referring to these MRI studies that we were shown both during the course of my examination and Mr. Scahill's examination you were referring to them as slices. What do you mean by that?

A Well, like I showed the jury the model of the spine how that red piece was sticking out to one side, the MRI, the way it

is formatted it slices through the body so if the slice went through the body on the side where there was no herniation you would not see a herniation. So just to put up one picture and say do you see a herniation and have me answer no, then there is no herniation, that's not accurate.

For me to say there was or was not a herniation at that level, I would have to see all the slices from one side to the other and the other slices that go through the other way as well, otherwise I would be giving an opinion without all the information and I would not be accurate.

Q Thank you, Doctor. Now, you were shown a report from Doctor Rose, several reports from Doctor Rose and Doctor Rose is affiliated with Throgs Neck Physical Therapy, that's his office, and there was some discussion about the range of motion tests that were performed. Do you recall that?

A Yes.

Q And by the way, you were aware that Miss Gashi had received physical therapy following that 2006 accident?

A Yes.

Q Now, I am going to refer to Defendant's Exhibit D which is a reevaluation performed at Doctor Rose's office and within the record appears to be the last date in which there was a range of motion test performed by the physical therapist. I am going to direct your attention to the second page. More specifically, Doctor, I just want you to take a look at the range of motion

test findings that are set forth concerning the cervical spine. Do you see them?

A Yes, sir.

MR. SCAHILL: Judge, could we get a date on this report?

THE COURT: Yes.

Q Could we get a date on this report, Doctor?

A 10/24/06.

Q Do you see the two findings on the range of motion test?

A Yes.

Q And can you tell the ladies and gentlemen of the jury as of 10/24 of 2006, what Miss Gashi's range of motion test finding was on flexion?

A 45 degrees.

Q And based upon your set for the normal of 70, if my math is correct, we can agree, Doctor, that's about a 36 percent deficiency?

A Yes.

MR. SCAHILL: This is in 2006?

MR. FIELDS: Yes, 2006, correct.

Q Flexion is what, again?

A Chin to chest.

Q And extension, what was the finding?

A 40 degrees.

Q From your stated norm?
A My stated norm is 45 degrees.
Q If I told you if my math is correct that that's an 11 percent deficiency on extension, I would be correct, yes?
A Yes.
Q Now I want to fast forward Doctor and let's fast forward to after the 2009 accident when you first see Miss Gashi. Again, I believe that was May 5, 2010?
A Yes.
Q Or May 3?
A May 3, 2010.
Q And can you tell the ladies and gentlemen of the jury what your finding was on flexion testing?
A 25 degrees as opposed to 45.
Q So if my math is correct, that's a 64.3 percent deficiency?
A It is more restricted.
Q So, Doctor, my question is, as a matter of opinion, would you say that a patient who goes from a 36 percent deficiency on flexion to 64.3 percent, that is a loss that would be medically significant?
A Yes.
Q Again, that's consistent with your opinion in this case that she suffered an aggravation?
A That's an aggravation.

Q Again, Doctor, that does not include any information that we may have after 10/24/2006 as to whether Miss Gashi improved even more; correct?

A Yes.

MR. SCAHILL: Objection, your Honor. That's purely speculative.

THE COURT: Well, all right. He already answered the question. Redirect does not mean recross indeed, okay.

Q Let's go back to your extension test of May 3, 2010.

A My finding was 10 degrees as opposed to 40 degrees.

Q When you say as opposed to 40 degrees, that's what Doctor Rose, by his office found in October of 2006?

A Yes.

Q And if my math is correct based upon Doctor Rose's extension test for the cervical spine, that was only an 11 percent deficiency or a loss in the total range of motion?

A Yes.

Q And based upon your finding, Doctor on the extension test, if you found there to be a 10 out of a 45, we could agree that your stated finding was that she suffered a 77.8 percent deficiency or a loss?

A It was worse.

Q Or limitation?

A Yes.

Q Would you deem that difference or that change to be

medically significant?

A Yes.

MR. FIELDS: Thank you.

Q Doctor, on cross examination there was a reference to Doctor Kwan's neurological report, do you remember that?

A Yes.

Q And somewhere in that report it indicated that at that time it indicated that Miss Gashi seemed to be totally disabled?

A Yes.

Q And when there is a reference in a chart that someone is totally disabled, from a medical standpoint does that automatically assume or state that the patient's total disability is permanent?

MR. SCAHILL: Objection, your Honor.

THE COURT: He is not speculating. You Have to withdraw it or reword it.

MR. FIELDS: I will withdraw it.

Q What is the relationship between a finding that someone is totally disabled or someone that sustained an injury that's permanent?

MR. SCAHILL: Objection.

THE COURT: I will allow it couched that way.

Q What relationship, if any?

A You can frequently make someone totally disabled for a

temporary period of time and so it is not unusual, I think that was my answer, that you can have an injury and be totally disabled for a period of time and you respond and you get better and your disability is no longer there and you can go back to work or your regular activities, so.

Q It does not necessarily mean --

A It does not necessarily mean that you are totally disabled forever. It is not that type of a classification.

MR. FIELDS: Nothing further.

THE COURT: Mr. Scahill, recross?

MR. SCAHILL: Yes.

RECROSS EXAMINATION

BY MR. SCAHILL:

Q Do you know what the instructions were to Miss Gashi when she left the hospital that day on August 20, 2009?

A I don't have a specific.

Q Do you know how long she was in the hospital for?

A I believe it was a better part of the day.

Q Actually five hours. This is the instructions that she was given. Wear soft collar for a few days removing at bed time, moist heat to neck and back, use muscle relaxant or Vicodin for pain as needed. Would that be the instructions that you would give to someone who had a sprain or a strain?

A Yes.

Q Is it, in fact, true that absent this lawsuit that a

proper diagnosis for Miss Gashi from the auto accident of August 20, 2009 that she had a sprain or a strain that required limited treatment?

A That's not correct, sir.

MR. FIELDS: Objection.

THE COURT: I will allow it.

Q That's not correct, that's what you said, Doctor?

A That's not correct, what you said.

Q Did you say that was not correct what I said?

A That's not correct.

MR. SCAHILL: Thank you, nothing further.

THE COURT: Okay, you can step down, Doctor. Ladies and gentlemen, that's it for today. We worked hard today. We are going to work on Monday again, so don't you all jump up at the same time now.

Monday at 10:00 we are back here. I want you to remain, okay. Thank you. Enjoy your weekend.

(Whereupon, jury exits the courtroom)

(Whereupon, juror number one Amanda Torres remains)

THE COURT: It came to my attention from the court officer that you wanted to speak to the lawyers and me.

JUROR: My question to you was the evidence that was shown today, obviously we will be able to see it as a whole when we deliberate?

THE COURT: That which is in evidence will be made available to the jurors.

JUROR: No further questions. I don't want to go into further details until it is needed.

THE COURT: No problem, thank you.

JUROR: Have a good weekend all.

(Whereupon, the juror exits the courtroom)

(Whereupon, the case is adjourned until August 4, 2014)