SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS : CIVIL TERM : PART 73

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RUBY SARWAT,

PLAINTIFF,

-against-

Index No. 14792/15
Trial

FIVE STAR CARTING, INC. And EDWIN FLORES,

DEFENDANTS.

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Supreme Courthouse
360 Adams Street
Brooklyn, New York 11201
September 28, 2018

B E F O R E:

HONORABLE PETER SWEENEY,
J U S T I C E, and a Jury

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

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* * *

FRANCESCA CIOFFI, CSR, RMR
Senior Court Reporter

THE COURT OFFICER: Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Good morning, ladies and gentlemen. As you know, when we left off yesterday, we were on the plaintiff. I think we will finish with the plaintiff very shortly and we have our second witness out in the hallway so we're ready to proceed.

So, counsel, I believe we were up to you. So if you have any questions, feel free.

MR. FEEHAN: Would you like me to wait until she gets her water?

THE WITNESS: No, that's okay. When I came in I need it.

THE COURT: All right.

THE WITNESS: Thank you, sir, for worry about me. Thank you.

RECROSS-EXAMINATION

BY MR. FEEHAN:

Q Ms. Sarwat, good morning.

A Good morning, sir. How are you?

Q I'm all right.

A Good, sir.

Q Do you remember testifying during your testimony you indicated --

A Sir, can you please, if you don't mind, speak little

bit? I can't.

Q Absolutely. I can be loud.

A Is thank you so much.

Q Do you remember yesterday counsel asked you some questions about your relationship with your husband and perhaps why you weren't speaking on the day of the accident?

A Sir, this is my personal matter, please. It's really like a long story. I don't want to be discuss with in front of anybody's.

Q And I'll be honest with you, I apologize for having to ask.

A Sir, please. This is really my personal.

MR. ROSENBERG: Let him ask.

THE WITNESS: Okay.

A Okay, sir.

Q It's unfortunately part of the job and I have to ask you some questions.

A Sir, go ahead.

Q I'll be as brief as I can.

How long have you been having problems with your husband before this accident?

A Sir, when I marriage, I try my best to keep this marriage.

Q Ms. Sarwat, I don't want to upset you.

A Please, let me finish. I try my best to keep this

marriage. Almost 22, 23, I try, I don't know how long I do. I know the first when I came this country, what he done, what all these things. I don't want to be sure take off my clothes in front of everybody to show, please.

I have very tough time from him and we come from Pakistan, we don't have it easy to do the divorce and all these things. I go through lot of things because my family and everyone is said it's okay, it's okay, it's okay. It's not okay.

They telling me the culture. I said 1993, I am over here. I adopt the culture over here. I am not in Pakistan. I work tough, I run the house, I pay the mortgage, I do the grocery, drop off the kid, everything. (Crying.)

THE COURT: All right.

Q Are you okay? You want to take a break?

A I tell you to don't start with me.

THE COURT: Ladies and gentlemen, we will take a short recess, okay? Five minutes.

THE WITNESS: I ask you please don't start. I beg you to don't start.

(Whereupon, a brief recess was taken, after which:)

THE COURT: Ms. Sarwat, would you like to get up and go outside for a moment and collect yourself? Feel free. You don't have to stay there. You can go to the ladies room or go out in the hallway.

MR. ROSENBERG: Judge, while we're waiting, I asked one question in response to Mr. Feehan's questioning about, "How come you didn't tell your husband that you were in an ambulance?"

THE COURT: Right, and you brought up the fact that they were not getting along.

MR. ROSENBERG: So which is how we got that. Could we end this line of questioning? What is the purpose of this? To torture her?

THE COURT: Obviously not, counsel. Look, he's entitled to inquire. I don't know how many more questions you have in this area.

MR. FEEHAN: I didn't get an answer, first of all, to my one question that I asked.

MR. ROSENBERG: What was the question?

THE COURT: Counselors, you want to go forward with the doctor? We will put her on afterwards.

MR. ROSENBERG: I think she wants to get it over with, Judge.

THE WITNESS: Sir, I'm sorry.

THE COURT: Look, if she can go forward shortly, sure, but that's your problem, counsel; you have a doctor.

MR. ROSENBERG: I know.

THE COURT: It's 11:00.

MR. ROSENBERG: Ask her.

THE WITNESS: Sir, let's finish.

THE COURT: Okay. Are you sure you're going to be able to go forward.

MR. ROSENBERG: Ms. Sarwat, just answer exactly. He asked you a very easy question: How long have you had problems with your husband? Give him a time frame of how long and we will be done with this.

THE COURT: He didn't ask you the nature of the problems or --

THE WITNESS: Sir, is memories me. Everything is came in my --

THE COURT: I think you'll be a lot better off if you just answer the question, okay, and don't go on and on and on, all right? And you'll be off the stand much quicker.

THE WITNESS: Okay. I'm sorry.

THE COURT: Don't apologize.

THE WITNESS: I'm sorry for everybody. I can't control it.

MR. FEEHAN: It's fine. I will try to make it as easy as possible; I know it's bad. If you just answer what I ask you, it will be easier for you I hope.

THE WITNESS: Okay, I'm sorry.

(Whereupon, a brief recess was taken, after which:)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: All right, counsel, you may proceed.

Ms. Sarwat, just again, just listen very carefully to his questions. When you answer, just answer what he's asking you; no more, okay?

THE WITNESS: Okay. Sure, sir.

THE COURT: Go ahead, counsel.

RECROSS-EXAMINATION (CONTINUED)

BY MR. FEEHAN:

Q Ms. Sarwat, would it be fair to say you have had problems with your husband since the beginning of the marriage?

A Yes.

Q Are you still married?

A Yes.

Q Are you legally separated?

A I don't file the separation. I live separate.

Q You live in different locations currently, correct?

A Yes.

Q Was your husband ever physically abusive to you?

MR. ROSENBERG: Objection. Really?

THE COURT: Yes, I'm going to --

MR. FEEHAN: Physical condition is an issue.

A Sir, I don't have any -

MR. ROSENBERG: Don't say anything.

THE COURT: Come up, counsel.

(Whereupon, an off the record discussion was held at the bench, after which:)

THE COURT: Ladies and gentlemen, I ask that you step out in the hall for a quick second.

(Whereupon, the jury exits the courtroom.)

THE COURT: Go ahead, counsel.

MR. ROSENBERG: Before he does, let me state my objection to the question.

This whole line of questioning, whether or not she was physically assaulted by her husband --

THE COURT: Again, I guess the record already reflects that the jury is not present. Go ahead.

MR. FEEHAN: To be clear, your Honor, you want me to ask it in a general sense?

THE COURT: Ask her whatever you want.

EXAMINATION BY

MR. FEEHAN:

Q Ms. Sarwat, were you ever physically assaulted by anyone that caused an injury to you?

MR. ROSENBERG: Objection.

A No.

THE COURT: Were you ever physically assaulted by your husband? Yes or no? Can you answer the question?

THE WITNESS: No.

THE COURT: You can't answer the question or your

answer is no?

THE WITNESS: I don't want to be answer this question.

THE COURT: You have to answer the question, ma'am.

MR. ROSENBERG: Answer the question.

THE WITNESS: Sir.

Q The answer is yes or no, ma'am.

A He slap me in the face.

MR. ROSENBERG: Okay. So good, bring the jury in and let her say that. That's outrageous that he would ask that.

THE COURT: Counsel, relax.

Is that it, ma'am? He slapped you in the face?

THE WITNESS: Yes.

THE COURT: He never threw you on the ground and hurt your back or anything?

THE WITNESS: No.

THE COURT: That's on the record so now we don't have to go into it, okay? You want to -- go ahead.

MR. FEEHAN: Can I ask one further question?

THE WITNESS: Sir, I want to ask why are we --

THE COURT: What's the question?

MR. FEEHAN: Did she fall as a result of it?

THE COURT: Fair enough.

Q Ma'am, when he slapped you, did you fall?

A No.

MR. FEEHAN: All right.

THE COURT: Do you have any other questions for her, counsel?

MR. FEEHAN: I don't.

THE COURT: So do you have any recross?

MR. ROSENBERG: No, Judge.

THE COURT: So, bring the jury back in and you'll just say I have no more questions and you'll say you have no questions and we will hear from the doctor.

In the meantime, somebody can go out and get the doctor.

MR. ROSENBERG: Judge, rather than have her walk in front of the jury again, can we have her -- he'll say he has no further questions and we're done?

MR. FEEHAN: I don't have to say it at all. I can say it now if you like.

THE COURT: Well, no. All right. So you want her to step down?

MR. ROSENBERG: Yes.

THE COURT: You can leave the stand. Nobody has any more questions for you. You're done.

(Whereupon, the witness stepped down from the stand.)

THE COURT: Why don't you get Dr. Merola?

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Ladies and gentlemen, both attorneys had no further questions for the witness so we're up to our next witness.

Please call your next witness.

MR. ROSENBERG: Plaintiff calls Dr. Merola.

A N D R E W M E R O L A, M D, called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, was examined and testified as follows:

THE COURT OFFICER: In a loud, clear voice, state your name and business address for the record.

THE WITNESS: Andrew Merola, M-E-R-O-L-A, 567 First Street, Brooklyn, New York 11215.

THE COURT: You may inquire, counsel.

DIRECT EXAMINATION

BY MR. ROSENBERG:

Q Morning, Doctor.

A Morning.

Q Doctor, I'm calling you Doctor but tell the jury what your occupation is.

A I'm an orthopedic reconstructive spinal surgeon.

Q And, Doctor, are you licensed in the State of New York to practice medicine?

A Yes, I am.

Q Any Board certifications?

A I am Board certified in orthopedic surgery.

Q And how long have you been Board certified?

A Since 1998.

Q Doctor, how long have you been a doctor?

A I graduated medical school in 1990. I did an internship and a residency at SUNY Downstate Kings County Hospital; that was five years. I did a year fellowship in spinal reconstructive surgery after that. And I've been practicing as an attending surgeon here in New York City since 1996.

Q Doctor, do you have affiliations or hospital privileges?

A Yes, I do.

Q Tell the jury what hospitals.

A Mount Sinai Hospital and New York Hospital.

Q And, Doctor, approximately in any given year in the past few years, approximately how many spinal surgeries do you do a year?

A Several hundred per year.

Q And can you tell the jury generally what that -- what types of spinal surgeries they are?

A So, they are surgeries that involve either reconstructing the neck or the lower back areas. They're surgeries that involve a whole host of problems, either

fractures or infections or tumors and in some cases, it's birth defects, those kind of things.

So, any kind of structural abnormality or problem involving the neck or the back.

Q Doctor, you and I, have we ever met before?

A Yes.

Q In the past since 1996, how many times have our paths crossed?

A I would probably say four or five times.

Q When is the last time that you and I have crossed paths?

A I don't remember precisely but maybe last year.

Q Doctor, can you tell the jury did there come a time --

MR. ROSENBERG: By the way, Judge, I move that this doctor be deemed an expert in spinal surgery.

MR. FEEHAN: No objection.

THE COURT: So, the Court will permit the doctor to express his opinions in the field of orthopedic surgery.

MR. ROSENBERG: Thank you.

Q Doctor, did there come a time where you were referred a patient by the name of Ruby Sarwat?

A Yes.

Q Can you tell the jury when that was?

A It was October 9th of 2015.

Q And do you have notes?

A I do.

Q You can't read from them but you can look at them and refresh your recollection if you need to recall.

Doctor, tell the jury who referred Ms. Sarwat to you.

A Her pain management physician, Dr. Leon Reyfman.

Q And when did Ms. Sarwat come under your care or come for the first time to your office?

A October 9th, 2015.

Q And at that time, did you examine her?

A Yes, I did.

Q Tell the jury, first off, did she make complaints of pain and if so, what they were and if you examined her and what the examination entailed?

A Sure. Her major problem was pain in her back that was radiating or traveling down into her legs and her feet. And that was pain that was significant enough to interfere with her normal day-to-day activities, particularly activities that required her to bend at the waist or otherwise put pressure on the lower back.

Q One question I forgot to ask you, Doctor, if you could back up a second.

Are you being paid to take time out from your practice to come to court?

A Yes, I am.

Q Do you come regularly as an expert to court, Doctor?

A I have a regular practice so I only come to court when I'm asked by my patients to come in.

Q Were you asked this time around?

A Yes, I was.

Q And how much are you being paid to come in?

A We will generate a bill based on $650 an hour for time away from the office.

Q In order to be here today, tell the jury what did you do with your schedule today?

A So, I basically had to clear today's schedule to be here.

Q Doctor, generally speaking, about how many patients do you see in either a month, a year, any way you can quantify that?

A Sure. So, I do several hundred surgeries per year; barring any vacations, I'm generally working pretty much the entire week. Mondays I have office hours. I have office hours on Fridays. Tuesdays, Wednesdays and Thursdays I'm in the operating room and generally on weekends, based on whoever is in the hospital, we will be following those patients in the hospital.

I generally treat somewhere in the neighborhood of about 75 or so patients per week. Those are both patients -- inpatient surgeries and office visits in the hospital in the -- in my private office as well.

Q Doctor, did you review records from -- for Ms. Sarwat?

A Yes.

Q Tell the jury what did you look at?

A Well, she had been referred by the pain physician and she had been doing physical therapy. So I had an opportunity to look at the pain management physician's notes of course and the physical therapy notes that she was doing therapy at Dr. Coyne's office.

She had come in basically because it was a surgical consultation regarding potential surgery to the lower back as a consequence of a failure of what we call conservative treatment.

Q Can you explain to the jury what conservative treatment is?

A Conservative treatment is that kind of care that's first started when patients have, for example, a traumatic injury, your body has an opportunity to heal from trauma and often times it takes some time to do that. So you start with a course of physical therapy.

The physical therapy is not helpful if the physicians notice that the condition is getting worse. The next portion of conservative treatment would be for local pain management where you would actually have the administration of certain special medications into the area where the injury is in order to decrease one of the consequences of an injury called inflammation.

Those medications are generally steroids and those steroids have a way of completely blocking the chemical effects of the inflammatory process from a traumatic, for example, disc herniation. If the body has not been able to heal through those nonsurgical procedures, then patients are oftentimes referred for a surgical consultation.

So in general, conservative means nonsurgical but it can also mean up to and including special types of injections that are administered through the skin into the area of the injury.

Q And, Doctor, you mention the word herniated disc. Can you tell the jury generally what that means?

A Sure. So, if you think about your spinal column, your backbone, it's not one side of bone, it's multiple bones that are stacked up on top of each other and in between the bones, there's a piece of cartilage that holds those bones together, and that piece of cartilage is called the disc.

There's an inside portion of the disc which is very jelly-like, so the disc is very squishy and there's an outside portion of the disc that's made of these bands of very tough fibers so it prevents the bones from moving around in an abnormal way and also holds that jelly-like material inside.

Q Doctor, I'm going to show you if I can a diagram.

MR. ROSENBERG: Judge, can I approach to get the tripod?

THE COURT: Sure.

Q You can come off so you can point.

THE COURT: Before you show it to the jury, we should have a little discussion about it, counsel.

MR. FEEHAN: You have a question?

MR. ROSENBERG: My question is can he come off and show the jury?

THE COURT: Come up here.

(Whereupon, an off the record discussion was held at the bench, after which:)

Q Doctor, let me show you a copy of what's here and ask you does that or those diagrams, do those show the disc that you just told us about?

A They're a description of the surgical procedure and there's an illustration of discs within the illustration, correct.

Q And do those discs accurately depict or show what you were just talking about with respect to the disc spaces?

A Yes.

MR. ROSENBERG: Okay.

THE COURT: Do you have any issue, counsel? Any voir dire?

MR. FEEHAN: I don't, but is he offering it?

THE COURT: You're just using it for demonstrative purposes?

MR. ROSENBERG: I'm offering it into evidence.

MR. FEEHAN: I just asked a question.

MR. ROSENBERG: I offer it into evidence.

THE COURT: Any objection?

MR. FEEHAN: No objection.

THE COURT: So we will mark the exhibit as Plaintiff's Exhibit 6 and it will be received in evidence.

MR. ROSENBERG: With no objection? I didn't hear.

THE COURT: Yes, it's being received in evidence.

(Whereupon, the aforementioned document was marked as Plaintiff's Exhibit 6 in evidence as of this date.)

THE COURT OFFICER: Exhibit 6 so marked.

Q Doctor, can you show the jury about the discs? If you could just show the jury presurgery. I know we're going to get to postsurgery but can you point to what you were discussing the jury about the discs spaces?

A So, on the lower right-hand corner of this illustration, you can see the bones of the lower back are depicted as being stacked up on each other and each one of them has a number and here you have the third lumbar bone, the fourth, the fifth and then what's known as the sacrum, so they're all stacked up on top of each other.

And in between each of the bones, you can see this light blue area, that light blue area is that particular piece of cartilage called the disc and it sits or is sandwiched

directly in between the bones, once again, to hold those bones together and prevent them from moving around in a bad way and to absorb shock and motion in between the bones.

Q Doctor, on a normal person -- when I say "normal" someone that does not have a herniated disc -- can you explain to them how that compares to someone that does have a herniated disc? What it looks like that's different?

A The disc is sandwiched in between the bones which means that all of the disc material has to be within the borders of those bones. And the reason that that disc material needs to be within the borders of all those bones is directly adjacent to the bones and the area where the disc is are the nerves that travel down into your legs and your feet. So, those nerves are traveling through your spinal canal before they get down into where your legs and feet are.

So, if disc material is herniated or sticking into the spinal canal, the consequence of that is that it would put pressure on the nerves that then travel down into your legs and your feet.

Q Okay. Have a seat for a moment.

A (Complying.)

Q Doctor, after Ms. Sarwat came to you, did you examine her?

A Yes, I did.

Q What else did you do as part of you examination?

A Well, of course a physical examination to test the body parts that were told to me to be painful and causing a problem. And then in order to correlate that physical examination with what was going on on the inside, I also reviewed some nerve testing that had been done as well as an MRI film that had been done.

Q Okay. Not just a report but the film?

A The film itself, correct.

Q Doctor, can you tell the jury just generally speaking about MRIs?

A So, an MRI is a way of taking an image of the inside portion of your body using a very special type of magnet, and that magnet is able to generate an image of the internal anatomy of your body so that we can get basically a relatively decent picture for what things look like on the inside.

Q And tell the jury in your experience as a reconstructive spinal surgeon, do you rely on that, do you not? Explain to them a little bit about that reliance or nonreliance.

A So, the MRI itself is important because it will help you to confirm the diagnosis of the patient's condition. So in other words, after you've spoken to the patient about what's bothering them and you've done a physical exam, you are just about 99 percent positive of what the problem is and that's the diagnosis of their condition.

The MRI is there in order to confirm the diagnosis that

you suspect based on the examination and the other thing that the MRI does is it will tell you whether or not there might be something else causing that particular problem.

For example, when you're dealing with a patient that has a disc problem that you suspect the problem is from a disc causing a nerve problem, the MRI will tell you if indeed is a disc herniation or is it something else like an infection or tumor or a fracture or something like that.

So, the MRI confirms your physical findings and the MRI also makes sure that there isn't something else that could possibly causing the problem.

Q Doctor, generally speaking, the gold standard if I may, for lack of better word, do you rely a hundred percent on the MRI? Does the radiologist MRI differ in opinions? How does that work?

A One of the things about MRIs are is it's an image or a picture or a photograph of what the inside portion of your body looks like. So, any time you're looking at an image, that image is subject to interpretation. There are adjectives that we use to describe the image.

For example, if a radiologist reads a film, what that means is the radiologist looks at the image and then gives you a verbal description of what they see based on their interpretation. So, I will look at the film itself so that I know what I have seen based on what I also see on the patient

during the physical exam. Now, I'm also able to take that information and combine it with what I know things look like at actual operation or surgery.

So, MRIs are helpful in once again confirming the diagnosis that we make, in making sure that we don't have another problem causing the condition but ultimately what's actually happening inside the body is based on what the -- what we would call surgical findings which is really what's happening inside that patient that you would otherwise directly visualize during a surgery.

Q Let me ask you this: Who would be in the best position to see what's there to be seen? Would it be the doctor or surgeon, the radiologist, both, or something else?

A The best person to be able to actually see what the problem is would be the operative surgeon who's physically touching, looking at, and removing that particular problem.

Q Okay. Doctor, in your practice since 1996 or earlier than that, have you seen herniated discs during your operations?

A Yes.

Q About how many times?

A Thousands of times.

Q And, Doctor, can you tell the jury how does one sustain or get a herniated disc?

A So, disc herniations can come from a variety of different causes. Sometimes disc herniations can come just

through the normal wear and tear and aging process. Sometimes disc herniations can come from an excessive lifting issue. Sometimes herniations can come from a sudden increase in abdominal pressure, for example, a sneeze or a horrible coughing or horrible vomiting can cause sudden increases in intra-abdominal pressure which could pressurize a disc and result in herniations, and herniations can also come from traumatic causes.

Q Doctor, can you explain to the jury what type of force is needed? I know you mentioned some examples but is there a certain amount of force that's needed to herniate a disc? How does all that work?

A So, everybody is different. Everybody's cartilage is a little bit different. For example, the cartilage on the tip of your nose, every one of us has a different nose and the tips of all of our noses feel a bit different because it's the cartilage in your nose that's making the tip of that nose.

So, there is no specific number that we can say this is the number beyond which herniations will occur. It's individualized based on the patient. What has to happen for the herniation to occur is that the disc has to become at least pressurized to the point where the fibers of that outer covering tear to the point where that jelly-like stuff that's on the inside can now make its way out.

So, there has to be some point at which those fibers

fail and in so failing cause that jelly-like substance to leak outward, and it's that leaking outward that's the herniation itself.

Q Doctor, motor vehicle accidents, in your experience in treating people with spinal injuries, have you ever seen someone herniate a disc as a result of a motor vehicle accident and if so, how often?

A Yes, I have seen motor vehicle accidents herniate discs and it happens with relatively frequency to patients who are involved in motor vehicle accidents.

Q Can you explain to them in a motor vehicle accident -- let me try it this way.

Doctor, I want you to assume that there's been testimony by Ms. Sarwat that she was stopped at a traffic light and felt two hits to the rear of her SUV Lincoln Navigator by a garbage truck. I want you to assume that there was an -- there was no significant property damage to the rear other than some damage to the rear bumper of the vehicle.

With those assumptions, Doctor, do you have an opinion whether or not someone could herniate a disc in such an accident like that?

A Patients can herniate discs under those types of accidental conditions, yes.

Q Doctor, can you explain to the jury the significance of low impact rear-end collisions, high impact rear-end collisions,

medium impact rear-end collisions? Can you tell them about the force or forces that are required or not required and how people herniate discs?

MR. FEEHAN: Objection.

THE COURT: Yeah, I'm going to at this time sustain the objection.

MR. ROSENBERG: I'll rephrase it.

Q Doctor, can you discuss with the jury in your experience -- let me back up a second.

Doctor, do you have any experience and have you ever taken any classes in biomechanics or physics?

A Yes.

Q How many?

A Specific classes quite a few, plus part of orthopedic surgery is biomechanics.

Q Doctor, can you tell the jury -- I want you to discuss in a high impact case, do people necessarily herniate discs?

MR. FEEHAN: Objection.

THE COURT: Well, I'll let him answer that question. Go ahead.

A People don't necessarily have to have a herniation given the particular type of impact that occurs which means that patients who have high impact type accidents don't necessarily have to herniate, no.

Q Okay. Have you seen people herniate discs in high

impact cases?

A Yes, I have.

Q Have you seen people herniate discs in low impact cases?

A Yes, I have.

Q Have you seen people herniate disc in medium impact cases?

A Yes, I have.

Q Generally speaking, is there a way of quantifying or telling the jury that you need X speed or X amount of damage to a car to herniate a disc?

MR. FEEHAN: Objection.

THE COURT: Now you have to lay a foundation if you want to ask him that question.

MR. ROSENBERG: I'm sorry?

THE COURT: You're going to have to lay a foundation with the doctor before I'm going to allow him to answer that question.

Q Doctor, do you have any experience in your training in on-the-job experience with respect to motor vehicle accidents?

A Yes.

Q Doctor, do you have an opinion as to what force is necessary to herniate a disc?

MR. FEEHAN: Objection.

THE COURT: Sustained.

Q Doctor, I want you to assume that Ms. Sarwat was involved in a low to medium rear-end impact motor vehicle accident.

MR. FEEHAN: Objection.

MR. ROSENBERG: I'm not done with the question yet.

THE COURT: Yes, it's in a hypothetical question. You can answer. Go ahead, let him finish.

Q I want you to assume that Ms. Sarwat was involved in a low to medium impact rear-end collision to the -- involving her vehicle while she was stopped.

Doctor, with that assumption, do you have an opinion whether or not Ms. Sarwat could herniate a disc as a result of that?

MR. FEEHAN: Objection. Can I approach?

THE COURT: Come up.

(Whereupon, an off the record discussion was held at the bench, after which:)

Q Doctor, have you ever treated patients involved in low impact rear-end collisions to herniated discs?

A Yes.

Q Have you ever treated patients for medium impact collisions from motor vehicle accidents?

A Yes.

Q Have you ever treated people with herniated discs involving high impact rear-end collisions?

A Yes.

Q Doctor, can you tell the jury did you elicit a history from Ms. Sarwat when she came to visit you?

A Yes.

Q Can you tell the jury what was significant, if anything, in the history that you obtained?

A The most significant thing in the history that I got from the patient was that she began to develop the symptoms, that is, the complaints and the problems with her lower back including the pain radiating down into the legs and feet after an accident which occurred in July of 2015. July 9th of 2015.

Q Did you find out what she did for a living?

A She was a driver.

Q And anything else that you got out of the history from Ms. Sarwat when you initially saw her?

A That she had, as we said, tried conservative treatment after the accident occurred. Was actively doing that treatment including up to having had several of these specific injections to the lower back called epidural steroid injections and that she was specifically coming to see me because her pain management physician was concerned that her condition had not shown the type of improvement that he would otherwise have liked to have seen.

Q Did you make recommendations after seeing her at that time?

A After examinations and reviewing all her treatments and of course her diagnostic imaging studies, yes, I did make a recommendation.

Q What recommendation did you make?

A The recommendation was to remove the herniation in the lower part of her back that was compressing or putting pressure on her nerves that were resulting in damage to the nerves.

By removing the disc herniation itself and by stabilizing the lower back, the key term being stabilization, we can prevent the condition from continuing to progressively get worse.

Q Doctor, after that recommendation, did you see Ms. Sarwat again?

A Yes.

Q When did you see her again?

A My next visit with the patient was actually when we had her prepared and ready to have the surgery the day of the operation where we once again reviewed her condition, how she was feeling, her physical exam and then prepared her for the actual surgery itself.

MR. ROSENBERG: Judge, I'm going to offer another board into evidence.

THE COURT: Any objection?

MR. FEEHAN: No objection.

THE COURT: So, we will mark this board as

Plaintiff's Exhibit 7 and it will be received in evidence without objection.

(Whereupon, the aforementioned document was marked as Plaintiff's Exhibit 7 in evidence as of this date.)

THE COURT OFFICER: Plaintiff's 7 in evidence so marked.

Q Doctor, I'm going to show you a copy of what the jury sees and ask you what does that show?

A This is a description of the reconstruction that is the rebuilding of the lower back and the stabilization procedure that's undertaken after the disc is removed.

Q Did you perform an operation on Ms. Sarwat?

A I did.

Q What date was that?

A December 16th of 2015.

Q Where was it is done?

A At New York Presbyterian Hospital in lower Manhattan.

Q Doctor, what part of her spine did you operate on?

A The least part of -- lowest part of the spine known as the L-5, S-1 segment.

Q Can you tell the jury generally how many of these operations to that part of the spine have you done before Ms. Sarwat's surgery?

A In the 20 some odd years that I have been practicing prior to that surgery, of course I'd done maybe a thousand or

more of those.

Q Doctor, can you tell the jury or describe for the jury -- I know this is somewhat later in the operation -- can you tell them earlier in the operation what you did?

A Sure.

Q Can you take them through it?

A Sure. So, this is an operation that involves the lowest most part of your back and it's the portion of your lower back that attaches to your pelvis where your hips and your legs are. Every operation that you do involves being able to see the area that you need to see in order to be able to do the surgery, and that's known as an approach.

So, the patient undergoes a general anesthetic so that they are put to sleep before the procedure. They're then positioned on a special table that positions the lower portion of their back in such a way that we can work on that area. After they've been put to sleep and positioned and they've been surgically prepared so that they are prepped in a sterile fashion, you can then start what's known as the approach.

The approach involves making an incision in the lower part of the back so you can move the muscles of the lower back out of the way because there are large muscles in the lower part of your back that are covering the bones of the lower back. So, we need to move those muscles away so we can actually expose the bones that are the subject of the procedure.

Q Doctor, let me stop you for a second and ask you if you could look.

Do any of those pictures on that board that I'm showing you now which is a copy of Plaintiff's 6 in evidence, do any of those show that part of the surgery?

A Yes.

Q Can you tell the jury which one?

A Sure. The upper left-hand portion of the illustration demonstrates the area of the incision; it's in the lower part of the back. The lower portion of the illustration demonstrates the moving aside of the muscles that cover the muscles and the bones of the lower back.

There's an image of the actual incision itself which is a photograph of the lower back of the patient in the middle portion of the illustration.

MR. ROSENBERG: I'm going to offer into evidence another board.

THE COURT: We will mark this other board as Plaintiff's Exhibit 8. Any objection, counsel?

MR. FEEHAN: No objection.

THE COURT: 8 will be received in evidence.

(Whereupon, the aforementioned document was marked as Plaintiff's Exhibit 8 in evidence as of this date.)

Q Doctor, I'm going to show you another board, a copy of what I'm showing the jury now as soon as I step out of the way.

Do any of those depictions illustrations show what happened next during the surgery?

A Yes.

Q Can you explain them?

A On the left-hand portion of the illustration is an image that shows the spinal canal opened; in other words, the roof where the covering of the canal has been removed. That's a procedure known as a laminectomy.

Q Let me stop you for a second. Is that actually what you see is what is illustrated?

A Yes.

Q Okay. Go ahead, I'm sorry.

A And you are actually directly looking at the nerves in the lower part of the back that then travel down into the legs. And the reason that you want to see those nerves is you need to move those nerves out of the way in order to remove the herniation because the herniation is directly impinging upon or putting pressure upon these nerves and it's important to be able to visualize everything very clearly so you don't damage those nerves while you are moving them out of the way to remove that herniation.

Q Doctor, let me interrupt you for a second.

The herniation just to go back for a second is where this piece, that shock absorber or blue thing is pushed out?

A Correct, it's where that shock absorber light blue

piece of material that we're looking at on the illustration is now. The portion of that material is inside the spinal canal on the actual nerve roots themselves.

Q So I think -- I don't think we covered this yet but what did you see with your eyes when you lifted that cover off her spinal canal? What is it that you visualized?

A What I visualized -- what was described in the operative report was a large herniation, in other words, a large piece of disc material that was actually compressing the nerves themselves.

Q Doctor, if you could tell the jury in your experience, you described it as large; what does that mean? Large versus small versus medium? What's the significant, if any, of that?

A Sure. I mean, the significance of large is that there was a quite a bit of pressure on the nerves themselves. In fact, large herniations have a tendency to displace or push the nerves out of the way because it's -- the herniation is taking up room that the nerves would otherwise normally take up.

So in that sense, that description means that there was a significant amount of disc material inside the canal.

Q What is the significance to Ms. Sarwat of that herniation? In other words, what does it produce? Does it produce -- what are the symptoms of that?

A So, the symptoms of that are pain in the back because the disc is no longer working properly and also pain traveling

down into the legs with neurological deficits to the legs and those neurological deficits; that means that the nerves are not working properly. These are the nerves that are responsible for giving you the ability to walk and, in fact, her left leg was weaker than her right leg and there was a lack of sensation and reflexes.

So, that disc material compressing those nerves is causing damage to those nerves which then causes those neurological problems to occur. By removing that disc and by stabilizing the condition, our goal is to stabilize, is to take this area and prevent it from causing any more damage.

Q Doctor, tell the jury if someone does not take care of that herniation, what would happen?

A So, in patients that have nerve damage in terms of sensation loss, reflexes loss or weakness, in cases where herniations are producing pressure, the longer that pressure is there, the more damage occurs as time goes on and then eventually, you can incur what's known as a drop foot or you would be dragging that foot because the muscles that those nerves are working are no longer getting the proper signal that they need in order to maintain your normal ability to walk.

Q Now, I know you used the word surgery stabilizers that have nerve involvement. Does it grow back, does it get better? Does it get worse? Explain the significance of time with stabilization.

A So, nerve tissue -- so, surgeries that are done on nerves are important in the sense that nerves are the type of organ in your body that does not have a great potential to recover. So, when nerve tissue is lost and/or damaged, that material can't really grow back well.

If you break a bone, you can heal a fracture. If you cut your skin, the skin can heal of course with a scar but it can heal. If you have damage to a nerve or nerve tissue, that nerve tissue and those nerves are unlikely to regrow or grow back. There's also nothing from a surgical perspective that we can do to repair those nerves because they're extremely small structures that involve very sensitive chemical processes that occur within the nerve that just don't always regenerate.

So, the consequence of having these types of neurological problems and the reason for doing the stabilization is to preserve whatever function you have so that you can continue the ability to basically walk.

Q What, if any, impact does it have on pain?

A So, pain -- your nerves do several different things. Number one, your nerve feels. That's how you know you're wearing a pair of pants; you can feel the pants on your leg.

The nerve that goes into your leg will move a reflex. If you've ever seen anybody tap on a knee, you know if you jerk your knee, that's a reflex that's maintained by a nerve. The ability to move your leg and your foot up and down and walk is

the muscles that the nerve is working so that you can walk. The other thing that the nerve does is it feels pain, like if you get stung by a bee, you know you were stung because there's a pain sensation from having been stung likewise if your burned or whatever painful stimulus you may have.

On the inside of the spinal canal, the pain fibers in the nerve are very sensitive and the herniation first affects the pain fibers. It then later starts to affect the sensory fibers, the muscle fibers and the reflex fibers. Now, when those pain fibers are damaged, they're working, they're firing, they're telling the brain there's pain in this nerve. What happens is that there is an imprint that occurs within your brain and your spinal canal and that's called a neurogenic component of pain.

So, that neurogenic component of pain goes along with a nerve root injury. So by taking the pressure off we hope that we take some of that away by not having any more pressure on the nerves but you can have a -- you can have residual nerve pain from the compression and the injury.

Q Okay. Doctor, let me continue the operation. What is next thing that you did?

A So once we have the herniation removed and the nerves are now free from pressure, we basically need to rebuild or reconstruct the lower back and that starts by inserting special views into the bones so we can now hold those bones in place

from preventing them from moving in an abnormal way. Because the disc is no longer holding the bones and maintaining them in a normal fashion, we don't want the bones to collapse and then cause more damage to the nerves.

So, in order to prevent that from having screws, we insert these special screws and you can see that there's on the left side of the illustration a diagram of how the screws are inserted from the back to the front and the upper --

Q Can I see which board you're looking at?

A Sure. (Complying.)

MR. ROSENBERG: Judge, I'm offering this into evidence.

THE COURT: All right. So, we will mark this exhibit as Plaintiff's Exhibit 9 and Plaintiff's Exhibit 9 will be received in evidence without objection.

(Whereupon, the aforementioned document was marked as Plaintiff's Exhibit 9 in evidence as of this date.)

Q These are the screws that you're talking about?

A Correct. So, on the left side of this illustration is an illustration of the screw placement into the L-5 and S-1 bones from front to back and the upper right-hand portion of the illustration is kind of a cut away for what that looks like so that you can get the idea for where those bones are holding on to the -- what we call the vertebral bodies or the bones of the lumbar spine.

Q And how many screws or holes are put in?

A Four.

Q Okay. What did you do next?

A The next thing to do is to replace the area where the disc has been removed by inserting a special device called a cage. It's basically like a shim you would put under a piece of furniture to maintain the furniture level; it's a shim and it's placed in between the bones.

It's sized to take up the appropriate amount of space between the bones so that they are normally spaced and it adds into the area where those bones will now grow together to form what we call a fusion or a stabilization through solid bone growth between two previously separated bones.

Q Let me stop you for a second. Do you have a board that illustrates what you're talking about that's up there?

A I do. It's this one.

Q Okay. The piece that's inserted that you're telling us about, is that in the left side?

A That's on the left side of the illustration and it's a charcoal gray on the illustration itself.

Q Okay. In this cage that you talked about, what is that?

A That's the replacement or the shim that's inserted between the bones.

Q What did you do next?

A And then the next thing that's done is that the screws themselves are locked together by affixing each screw with a rod so now the rods are joining the screws in order to hold everything together to give the entire lower back an opportunity to heal together as one piece of bone.

Q Doctor, is that meant to be permanent or does that come out or something else?

A That is permanent.

Q By the way, can you tell the jury what is the longevity? How long does that last, that apparatus?

A So, this is a mechanical reconstruction of the human body. It's not -- it's made up of titanium metal and carbon fiber plastic. So these mechanical reconstructions alter the way your body now functions because now you are -- you're part mechanical, right? So, you're still part human but you're also part mechanical.

So, when mechanical reconstructions are taken, these kinds of things are monitored over time by surgeons who do these surgeries to look for what we call an adjacent segment of problem which means a wearing down of the actual fusion process itself from the normal wear and tear that happens as you live your life and go through the normal aging process.

So, the general longevity of these kind of procedures is in the neighborhood of about seven to ten years.

Q Then what do you have to do?

A At that time, based on the imaging studies, you can image the areas that are worn down and then you need to reconstruct those areas which essentially means mechanically fusing the areas that are attached to your primary fusion. That's a revision procedure.

Q I'm going to get back to this in a second but just jumping ahead for a second, I want you to assume that Ms. Sarwat has a life expectancy of 34.4 years.

Do you have an opinion if Ms. Sarwat should live to 34.4 years how many future revision surgeries she will need?

A These things, as I say, have a life expectancy of about 7 to 10 years. So you'll see in about 10 years at least or at most that this will break down and require revision.

Now, at that point in time, as you get older, your overall demands change and you have less demands and less stress and indeed patients with these problems as they get older have a tendency to have more difficulty with their activities of daily living, so their stress also changes over time.

So, with a 34-year-old, if one anticipates life expectancy, you're guaranteed at least one surgery and likely -- most likely to have also a second at some point in time.

Q What did you do next during the surgery?

A After the surgery is completed and you've stabilized everything, you then have to reverse that process of exposure which means you basically have to sew the muscles and the skin

back together again in order to give everything that's on the outside now a chance to heal.

Q Was Ms. Sarwat admitted to the hospital for a period of time and if so how long?

A Yes, I believe this admission for Ms. Sarwat lasted about five days or so.

Q When is the next time you saw Ms. Sarwat?

A So, I saw her for her postoperative visit in January. So we did the surgery in December and I had seen her in January of 2016.

Q When you saw her in January, did you make complaints of pain and if so, what were they?

A So at that time, she did not have any new symptoms or complaints, she was healing from the effects of the surgery. She did have some redness around the area of her incision and I had prescribed some medications for her.

Q When did you see her again?

A So, the next time I had seen her was that area of redness that she had around the incision was responsible for a condition we call a dehiscence. A dehiscence is an opening up of the incision so the area that was previously sewn together had now started to open and so I admitted her to the hospital in order to revise the incision and to explore the fusion.

Q How long was she admitted that time?

A I believe she was in for about the same amount of time

if not a bit more.

Q Did you operate on her again?

A I did, yes.

MR. ROSENBERG: Judge, I'm offering this board into evidence.

THE COURT: Any objection, counsel?

MR. FEEHAN: No.

THE COURT: We will mark this board as Plaintiff's Exhibit 10 and it will be received in evidence without objection.

(Whereupon, the aforementioned document was marked as Plaintiff's Exhibit 10 in evidence as of this date.)

Q Doctor, I'm going to give you a copy. Can you tell the jury what Plaintiff's 10 in evidence shows?

A Sure. That's an illustration of the second surgery which is the dehiscence of the incision and then a revision of the incision with what's known as an exploration.

So basically, we remove the area of the closure that was not healing and then we clean out the entire area to look inside to make sure that there's nothing on the inside that's causing a problem with the healing.

We place some special drains to absorb any excess fluid that might be there and then we reclose the entire area using a little bit of a different kind of a closure technique in order to reinforce the closure to provide it with some extra healing

capacity, if you will.

Q What, if anything, does that closure performed in the second surgery do with respect to a scar?

A Well, in the primary closure that's done, we generally use a stitch that runs underneath the skin so there's no visual external stitches so you have a tendency to decrease overall scarring.

In cases such as this, we then use another type of stitch that's placed outside the skin in order to give it extra strength for the healing process, so you have a tendency to have a greater scar formation with this type of incisional closure.

Q Permanent?

A Yes.

Q Doctor, can you tell the jury this dehiscence, is that -- explain to them is that something that is a risk or is this something common? Explain to them about that.

A So, a dehiscence or a breakdown of the surgical incision is something that's one of the known complications -- potential complications of surgery and it happens in the neighborhood of four to five percent of cases.

And essentially, it means the skin needs an extra type of closure in order to stimulate the growth factors that are involved in stitching that skin.

Q Doctor, when is the next time you saw her?

A So, this procedure was done on January 13th of 2016.

We had a hospital stay after that. And then I saw her back in the office on February 12th of 2016.

Q And on February 12th, did she make complaints of pain or make complaints to you and if so, what were they?

A That was her standard postoperative visit; that was her second postoperative visit. There were no new complaints at that time and at that time, the incision itself was healing well.

Q When is the next time you saw her?

A I then saw her in June of 2016.

Q What complaints, if any, did she make and what did you do?

A The majority of her symptoms were what we call mechanical axial pain; that's pain in the back area. It's pain that is generated by activities like bending and lifting and twisting. Surgery was helpful in terms of decreasing the shooting component of the pain going down the legs but she did have some residual symptoms, most of which were pain related in the back.

Q Doctor, can you tell the jury when someone has this type of surgery, the first surgery where the cage is put in and the screws, Doctor, what effect does that have on someone's range of motion and can you -- let me back up.

Tell the jury what is a range of motion.

A Range of motion is the ability to move a body part like

your fingers. If you take your finger and you bring it all the way down to here, that's the range of motion of all the joints in the finger and you can measure that. The same holds true for your spine.

So in your lower back, if you think about the range of motion of your lower back, what kinds of positions can you put it into? You can put it into the position where you bend backwards or look towards the sky; that's called extension. That's typically around 60 degrees of bending backwards.

You can bend forwards to put on your shoes and touch your toes, and that's some -- typically in the area of somewhere around 80 degrees or so. You can also bend side to side, both the left side and the right side and in your lower back; that's about 40 degrees to each side and of course you can also rotate. So, you can see something coming from off your shoulder, you can rotate your torso either to the right or to the left.

Rotation is generally 80 degrees because you should just be about able to get your entire body off to one side to see what's happening from the side should you have to do that. So, those are the standard rages of motion for your lower back and those ranges of motion are based upon the ability of those bones that are in your lower back to what we call articulate with each other. So, there are joints that sit in between those bones. And when you're moving in those positions, those joints are also moving.

Now, there are five bones that articulate together to attach yourself to your pelvis. So, in a patient that has a fusion, you have removed the section of the articulation, right? The joint that occurs between your lumbar spine and your pelvis. So, part of the stabilization process is you sacrifice some of the range of motion because now you don't want that area to move because if it moves, it continues to cause more damage.

So, the effect of a fusion because it is a stabilization is to totally restrict the range of motion in the lower portion of your lumbar spine.

Q What type of restriction in terms of degrees or any other way you can describe it?

A I mean, I could tell you I have some range of measurements that I made on the patient in actually July of this year of the lower back.

Q Tell the jury what that was in.

A So, in measuring the patient's range of motion, her lumbar extension which is backward bending was 10 degrees. Her forward bending was up to 40. Her right bending was to 40. And her left was to 40 as well. Rotations were a bit restricted.

In fact on the right side, it was only to 35 degrees. And on the left side it was 40 degrees. So on the right side it was a bit less than half of normal and on the left side it was just half of normal.

Q Doctor, is that -- can you describe to them what the

difference is between subjective and objective testing?

A So, subjective is based on what the patient tells you; that's subjective. It's based on the patient's telling you something.

Objective is based on something that the patient doesn't have voluntary control over; for example, a reflex. If you test a reflex, that reflex actually lives inside your spinal cord. So, you don't really have voluntary control over what happens with a reflex because it's something that's just happening inside the cord itself.

Withdrawal responses -- for example, when you withdraw from pain, you don't have to think about withdrawing from pain; it's else an automatic response that your body does. It's protective, right? You don't want to have to sit there and go, "My hand is on fire; I need to move my hand." No, it automatically happens, right?

Spasm in a muscle is reflective. In other words, that's automatic it's not under your voluntary control. Spasm happens because a muscle in your body wants to prevent a body part from going into a position that causes pain. So, these kinds of automatic responses that your body generates are what we call objective physical findings. It's something that you can feel on a patient and measure that are not based upon a patient's actual voluntary control.

Q When you took Ms. Sarwat through her range of motion

testing in July of this year, was there any component of that that was objective?

A So, when you measure a range of motion, the way to measure that range of motion so that you know exactly what the patient is capable of doing or not doing is you have your hand on their muscles.

So, you are basically ranging the patient; you're taking them through what's known as a passive ring of motion because you're putting the patient into a range but you're also feeling their muscles. You don't want to of course take them beyond the limit where there is spasm because that's going to hurt them, so you really need to know where that spasm is happening. And when you feel spasm, you know this is as far as the body can possibly do because I feel a spastic muscle.

What does a spastic muscle feel like? It feels like a Charlie horse; it's like a rock-hard portion of your muscle. If you're experiencing it, it hurts in the area where the muscle is in spasm. So, when you measure the range, that's what you're doing; you're feeling the muscles and taking the patient through the range of motion based on where they experience that, what we call palpable spasm.

Q Where you feel it?

A Correct.

Q Doctor, let me jump ahead for a second and ask you with respect to the future, will Ms. Sarwat ever get any better on

her range of motion than what you saw on this July?

A No, so this is 2018. We did surgery back in '16, that's several years ago, and we fused the lower part of her spine purposefully so these ranges of motion are permanent.

Q What will the aging process do, if anything, with respect to the range of motion?

A The normal aging process is going to have, as we said, a wear and tear effect. It happens as time goes on so the functionality of her range of motion will, as a consequence of that aging process, gradually decrease as time goes on.

Q Doctor, is that the last time you saw her was in July of this year?

A Yes.

Q When did you see her before that?

A We were in communications with each other so we could monitor her treatment with Dr. Reyfman. I had several conversations with her and my last in-office visit with her was in 2016.

Q When in 2016?

A June.

Q And your conversations with Dr. Reyfman, when did they take place?

A So, one of the things that I had done for Ms. Sarwat was as part of that monitoring process, I got some postoperative imaging studies on her.

MR. FEEHAN: Objection, your Honor. Can we approach?

(Whereupon, an off the record discussion was held at the bench, after which:)

Q Doctor, let me ask you I think on Plaintiff's 6 in evidence --

A I can see it.

Q -- the top right?

A Yes.

Q Was that something that you ordered?

A Yes.

Q When was that taken?

A That X-ray, that was -- looks like was taken 2015.

Q Okay. And would that be what it would look like today?

A No, it would look different today.

Q How would it be different?

A You'd start to see some of these mechanical changes occur at the joints above the area of where the X-ray is.

Q Okay. What was the purpose of taking that postoperative X-ray?

A You want to get a baseline image for what things look like so you can follow it over the course of time.

Q And, Doctor, can you explain to the jury after having done the first surgery and visualizing what was there to be seen, someone with a large herniation such as what Ms. Sarwat

had, explain to the jury whether or not this condition of a herniated disc would be something that someone could actually walk around with for any period of time.

A So, this kind of a nerve compression causing sensory problems and weakness to the legs, the operation was done so that you could walk because had it not been done, if this were long standing, you would have lost that capacity to walk.

So basically, someone wouldn't really be able to be up and walking around and functioning in any kind of a normal sense with that kind of pressure on their nerves.

Q Can you explain to the jury -- do you have an opinion one way or another whether or not Ms. Sarwat's herniated disc at L-5, S-1 was traumatic in nature?

A I do.

Q If so, can you explain to the jury how you arrive at that opinion?

A Sure. So, two things. In number 1: The surgical findings demonstrated that the disc itself was quite large and easily removable. Discs that are longstanding, in other words, had been sitting there for a long period of time don't really come out that easy and you need to do some surgical tricks to get them out which sometimes involves chiseling things away and drilling things and doing other stuff which was not necessary in this case; that's number one.

Number 2: Discs that produce, as I indicated before,

the kinds of physical problems that the patient was having can't be longstanding because otherwise, she wouldn't have been able to walk around with that kind of a herniation.

Q Doctor, I want you to assume that before July 9th, 2015 that Ms. Sarwat was a limo driver that drove 50, 60 hours a week; I want you to assume that.

Would someone be able to do that with that type of a herniation that you visualized?

A No.

Q Doctor, did you know that Ms. Sarwat was a limo driver?

A Yes.

Q And, Doctor, do you have an opinion based upon the fact that Ms. Sarwat -- I want you to assume that Ms. Sarwat had no prior complaint of lower back pains ever. I want you to assume that Ms. Sarwat was driving 50, 60 hours a week again before this accident happened.

With that assumption, do you have an opinion whether or not Ms. Sarwat would be able to drive a limo had she had this injury before July 9, 2015?

A I do.

Q What's that opinion and what do you base it on?

A My opinion is that she would not have been able to do that type of work. I base it on my 20 plus some odd years of experience, my personal treatment of the patient, my review of the records and of course, the operative findings of the disc

herniation that I was able to look at.

Q Doctor, when you removed the disc, what significance did that have in terms of your observations whether or not this was traumatic in nature or long-standing or something else?

A As I said before, it was an easily removable large herniation producing significant nerve root compression that went along with the history that she gave me of the accident occurring in July of 2015.

Q So, with a reasonable degree of medical certainty, I think you've answered it but let me make sure that we have this.

Do you have an opinion as to whether or not Ms. Sarwat sustained a herniated disc at the L-5, S-1 with impingement on a nerve as a result of the July 9, 2015 motor vehicle accident?

A Yes.

Q And what is your opinion?

A My opinion is that she sustained a disc herniation at L-5, S-1 with significant impingement to the L-5, S-1 nerve roots.

Q Do you have a reasonable degree of medical certainty -- Doctor, what is the future of -- I know you talked a little bit about Ms. Sarwat needing revision surgeries.

What does the future hold with a reasonable degree of medical certainty for Ms. Sarwat in terms of her daily activities?

A So, daily activities are one of the kinds of things

that as you would anticipate after having had a reconstruction and fusion with some residual neurological loss. Those activities of daily living have a tendency to progressively get worse as the normal aging process occurs over time.

So, that's something of course that would need to be addressed with the patient as she ages and gets older.

Q Do you have an opinion whether or not Ms. Sarwat will need assistance, with a reasonable degree of medical certainty, in the future?

A Yes.

Q And tell the jury what that opinion is and what do you base it on?

A So, based on my experience and treating patients that have had these conditions and of course even seeing other patients that are older who have had these conditions who come into the office for care and treatment and opinions, we know that these patients over the course of time do develop a requirement for assistance.

It's one of those things that it's important to be able to decrease stress and strain on their back; it helps maintain their independence and it's part of their future treatment process.

Q Doctor, I know that you're not a fortune teller but with a reasonable degree of medical certainty, do you have an age at which you predict Ms. -- again, with a reasonable degree

of medical certainty -- that Ms. Sarwat will need some home care or assistance?

A I think a reasonable age to predict these things as occurring is in middle to late 60s.

Q And tell the jury in your experience doing this for as long as you have been and seeing the older patients now, what would be the progression?

A You progressively see deterioration in function as time goes on in older patients.

Q In your specialty, are you familiar with the costs that are involved with respect to spinal surgeries?

A Yes.

Q For the future medical care as it relates to your specialty, can you quantify what the cost would be for a spinal revisions?

A Spinal revision, because it's a redo procedure, it involves a longer hospital stay and it also involves different kinds of implants and bigger post operative team, you're looking at $125,000 cost for revising these procedures.

Q Is that the physician cost, hospital cost, total cost?

A That's total cost.

Q And this would be times two?

A Based on what we previously said and know about a patient who's got this 34 year life span, God willing, yes.

Q Doctor, what would be the cost associated with other

stuff, other medical stuff that would go along with spinal revision such as --

MR. FEEHAN: Objection to form.

THE COURT: All right. Other medical stuff that goes along with it.

Q They don't like the word stuff.

THE COURT: You can use the word "stuff" counsel. Not that eloquent, but we will let it go.

Q What other medical costs would be entailed other than the spinal revisions such as would that be costs associated? Would you recommend physical therapy? Would you recommend other things?

A Patient of course would have therapy and continued pain management afterwards, yes.

Q I know we're having another doctor come in this afternoon but in your experience for Ms. Sarwat, do you have an opinion whether or not she'll need pain management for the rest of her life or not?

A I do.

Q Tell the jury what that opinion is.

A She would involve what we call chronic or long term pain management.

Q I didn't hear that; the door was closing.

A I said she would require chronic or long term pain management.

JUROR NUMBER 1: That would be for the rest of her life, correct?

THE WITNESS: Yes.

Q Doctor, in terms of medications, again with a reasonable degree of medical certainty, would she be required to take medications for the rest of her life, prescription medication?

A That would be under the auspices of the pain management physician, yes.

Q Doctor, did you place like -- in July when you last saw Ms. Sarwat, did you ever place any restrictions on what she could do or can't do?

A So, my counseling and advice to the patient is that she could perform those activities that she felt comfortable doing. She should avoid excessive repetitive motion to the back and of course try to avoid activities that required bending, lifting, and twisting.

But otherwise, she was allowed to perform activities on an as tolerated basis which means let your body be your guide; it has a very good way of telling you what your tolerances are. So if you can do something and tolerate doing it to within reasonable comfort, it would be okay.

Q Doctor, it may be repetitive but I'm going to go there for a couple of more questions. With a reasonable degree of medical certainty, do you have an opinion if Ms. Sarwat, as a

result of this motor vehicle accident, permanently lost the use of a body organ, member function, or system?

A Yes.

Q What is your opinion and what do you base it on?

A My opinion is based on my experience, my treatment of the patient, my review of the records and diagnostic studies that she has lost functions of the musculoskeletal system, lower spine, and neurological system L-5, S-1 nerve roots.

Q Permanently?

A Yes.

Q With a reasonable degree of medical certainty, do you have an opinion whether or not as a result of this motor vehicle accident that Ms. Sarwat was involved in that she sustained a significant limitation of a use of a body function or system and if so, what is your opinion; what do you base it on?

A Yes, I do, and I base that opinion of course on my experience and my treatment of the patient, my review of the records, and this is with respect to her musculoskeletal system and neurological L-5, S-1 nerve root.

Q The word "Significant", Doctor, tell the jury what do you mean by that; what is significant?

A It's a loss of sensation reflexes and weakened and loss of motion to the lumbar spine, and this is significant because it's outside the range of what's anticipated to be normal for age.

Q How far outside is Ms. Sarwat?

A Significant. Significantly outside the normal range.

Q Doctor, with a reasonable degree of medical certainty, do you have an opinion whether or not as a result of Ms. Sarwat's motor vehicle accident, whether or not she sustained a permanent consequential limitation of use of a body organ or member and if so, what is your opinion; what do you base it on?

A Yes, I have an opinion, of course, that's based on my experience and my treatment of the patient as I've indicated beforehand, and this is with respect to her musculoskeletal system and her neurological system as well.

Q With a reasonable degree of medical certainty, Ms. Sarwat's motor vehicle accident, do you have an opinion whether or not Ms. Sarwat will have a scar to the back of her -- to the back where you operated on her twice?

A Yes.

Q And what is that opinion and what do you base it on?

A My opinion is she has a permanent scar of her lower back and that's based on the actual fact she has a scar on her lower back.

Q How big is it?

A I have not measured the incision itself but I can tell you that based on of course my operative report and my procedure itself, this is about at least four and a half to five inches worth of midline lower back skin incision.

Q And would it be fair to say that what she has now, the look of it now, will it get better or worse over time or stay the same?

A It should stay the same over the course of time.

Q Doctor, do you have an opinion, with a reasonable degree of medical certainty, as a result of Ms. Sarwat's motor vehicle accident, that she sustained a medically determined injury that prevented her from performing her usual customary daily activities for 90 out of 180 days immediately after that accident?

A Yes.

Q Tell the jury.

A She sustained an inability to perform her work and duties after the accident.

Q For how long?

A I don't remember the exact amount of time but it was significant and it was one of the reasons that her pain management physician sent her to me because she was unable to work.

Q Would you be upset if I told you I don't have any more questions?

A Not at all.

THE COURT: All right; thank you, counsel.

We will take a short break before we hear cross-examination.

(Whereupon, the jury exits the courtroom.)

(Whereupon, a brief recess was taken, after which:)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Mr. Feehan, whenever you're ready.

MR. FEEHAN: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. FEEHAN:

Q Good afternoon, Dr. Merola.

A Good afternoon.

Q Let me introduce myself to you. My name is Jim Feehan; I represent the defendants. And unless I'm mistaken, I never met you before, correct?

A Yes.

Q You testified this morning about your fee for appearing here today and you indicated it's based on $650 an hour, is that right?

A Yes.

Q Have you already sent a bill for your appearance?

A No.

Q How many hours do you anticipate billing him for?

A I guess it depends on how long I'm here for today; hopefully not that many hours.

Q I would hope so, too.

You indicated that the first time that you saw Ms.

Sarwat you conducted a physical examination?

A Yes.

Q In addition to reviewing some records and the MRI films?

A Yes.

Q How long does it take you to do a physical examination in those circumstances?

A It depends. I mean, it's hard to give you an exact number because sometimes exams are easier to do than others. I mean, this was a decently comprehensive examination involving the neck and back and then I had to review the diagnostic studies and then speak with the patient, so I don't know. I wouldn't want to guess a time; I don't really base it on time.

Q I guess my question really goes to the actual exam itself. If you're doing whatever it is you do in the exam as opposed to talking to her about your findings and those kind of things, how long does the exam take?

A It depends. I mean, a reflex can take a minute or so to elicit a response and you're eliciting multiple reflexes, you're testing muscles, you're examining gait, you look at range of motion; it adds up.

Q Do you remember how long hers took?

A No.

Q When you first saw Ms. Sarwat -- just to backtrack for a second, you brought your file today, Doctor?

A Yes.

Q Did you receive a subpoena for your records from my office.

A I don't know.

Q Somebody else in your office take care of those matters?

A Yes.

Q I have here some records that were received pursuant to a subpoena.

MR. FEEHAN: And I'm going to move those into evidence, your Honor.

THE COURT: Show it to counsel.

MR. FEEHAN: (Complying.)

MR. ROSENBERG: Okay.

THE COURT: So, the records will be marked as Defendant's Exhibit B and will be received in evidence without objection.

(Whereupon, the aforementioned document was marked as Defendant's Exhibit B in evidence as of this date.)

Q Doctor, just so you're aware, what the subpoenaed records include are your office visit notes, the operative reports from the two surgeries, and I believe just two telephone conversation notes, okay?

A Yes.

Q And the MRI report as well, all right?

Now, the file that you have, do you have anything further in that file?

A So, I have everything that you've listed inclusive of the last follow-up that was in July of 2018.

Q That too?

A I have two MRI reports because I have the one that was pre-op and I have the post-op.

Q Okay.

A And EMG. Did we say EMG?

Q That is not here.

A I have that as well.

Q Those are not in evidence. And they were not provided pursuant to the subpoena.

Relative to your first witness with Ms. Sarwat on October 9 of 2005 -- please feel free to refer to your notes -- did you take a history from her at that time?

A Yes.

Q Did she tell you during the course of taking that history that she had been involved in a prior motor vehicle accident?

A No.

Q Is that something you typically want to know?

A If there's a significant course of treatment they're after, yes.

Q Did she provide you with copies of medical records from

that prior automobile accident?

A No, I haven't seen any records regarding any prior accident at all, no.

Q Assume for the purpose of my question we had testimony yesterday that she had treatment following an earlier automobile accident for a course of month and a half, two months. Would you want to have looked at those records?

MR. ROSENBERG: Objection, that's not what she said.

THE COURT: I don't remember what she said so you can ask it in the hypothetical way. I assume that said that.

Q Assume that she said she had treatment for a period of months; would you wanted to have looked at those records?

A If she had conservative treatment for a period of months and then was back to working, it would be irrelevant to really look at those records. No, they wouldn't make a difference.

Q Wouldn't make a difference to you?

A Correct.

Q Okay. But nevertheless, she never provided you any records?

MR. ROSENBERG: Objection. Asked and answered.

THE COURT: Fair enough.

Q So, fair to say, Doctor, you don't know anything about

that prior automobile accident?

MR. ROSENBERG: From 2002?

THE COURT: You can answer the question.

You don't have any idea of what, if any, medical treatment she had following that accident?

THE WITNESS: That's correct.

THE COURT: Okay.

Q Doctor, you indicated earlier during your testimony that something as simple as coughing could cause a herniated disc, correct?

A Yes.

Q Could you herniate a disc sitting in a chair sitting down?

A You can herniate if you have an increase in your abdominal pressure. It overloads the anulus, yes.

Q Are there other factors that can cause low back problems?

A Low back problems in general?

Q Yes.

A There are multiple factors that can lead to low back problems.

Q Would obesity be one of those factors?

A Obesity is kind of an interesting thing because there has really never been any clear clinical correlation to obesity and spinal disorders because patients' bodies have a tendency to

accommodate whatever their particular body habits happens to be.

Q How about a sedentary life-style?

A Sedentary life-styles can lead to deconditioning but in and of themselves are not known to produce herniations.

Q Doctor, you gave an opinion that the accident of July the 9th of 2015 caused the disc herniation at plaintiff's L-5, S-1 vertebrae, correct?

A Yes.

Q Does now knowing about that earlier motor vehicle accident change that opinion in any way?

A No.

Q But you don't know anything about that accident, correct?

MR. ROSENBERG: Objection.

THE COURT: No, overruled. You can answer. You can answer yes or no.

A Based on everything that I discussed, the herniation that I removed, the appearance of that herniation, the ease of which that herniation was removed and the neurological deficits the patient had, I would tell you that any prior issues, if there were at all any prior issues to her back, had no relevance on this particular injury.

Q Would you agree with me there could have been a prior issue with respect to her lower back that was exacerbated by the accident of July 9th and caused that herniation?

A There was nothing that I saw that led me to see there were degenerate issues that were activated or exacerbated by this particular accident.

Q Doctor, on each of your visits with Ms. Sarwat, you create office notes, correct?

A Yes.

Q Is it fair to say that it's only that last note that you had on July 23rd where you put in writing that she needs the revision surgeries?

A That's where we indicated in writing that revision is one of those things that's the rationale for continuing treatment, yes.

Q In your experience in the initial part of your treatment of her, did you know that in those types of procedures, revisions would be necessary?

A That's part of the informed consent process, of course, when we discuss and it's in her operative report where I say informed consent. We look at the realistic goals and expectations of surgery and then potential surgical complications, one of them being the fact that mechanical reconstructions require these revision surgeries in the future. Yes, of course.

Q It says you discuss the possibilities. It doesn't say specifically that a revision would be necessary, does it, in any of those earlier records?

A You never say never and you never say always. But certainly more likely than not in patients who have mechanical reconstructions.

Q Did you write that in any of the earlier records?

A It's part of their discussion, it's part of my normal practice.

Q I'm asking if you actually wrote it the way you wrote it in the July 23, 2018 note.

A No, it was more specifically outlined in the July 2018 note.

Q Prior to that July 2018 visit, you hadn't seen her in two years, correct?

A Correct.

Q Doctor, as you sit here today, the testimony that you gave relative to your belief that at some point the implant will fail and necessitate a revision?

A There's mechanical breakdown in the area where the fusion is that will necessitate a future surgery.

Q You can't tell us when that's going to happen, right?

A Within seven to ten years.

Q You don't know the date?

MR. ROSENBERG: Objection.

THE COURT: You can answer.

MR. ROSENBERG: Is he looking for May 9th?

MR. FEEHAN: I'm looking for a no.

MR. ROSENBERG: You're looking for what?

MR. FEEHAN: For him to say no.

THE COURT: Come on, let's go. Next.

Q Are you going to answer the question?

THE COURT: You don't know the date that she will have that surgery, correct?

THE WITNESS: No, I do not have a specific date.

Q Have you scheduled the surgery at this point?

A No, I have not.

MR. FEEHAN: Thank you, Doctor.

THE COURT: Thank you.

Any redirect?

MR. ROSENBERG: I promise.

REDIRECT EXAMINATION

BY MR. ROSENBERG:

Q Doctor, can you tell the jury again about obesity? I know you started to explain to them.

What effect, if any, does obesity have on herniated discs?

A So, everybody has a particular body morphology to them, right? So certain patients are built in certain ways. Some of us are taller or skinnier or thicker or wider or shorter. So, there's a habitus that you have based on your genetics and your bones and your joints and your lungs and your organs, and all of these things accommodate to whatever that particular habitus

happens to be.

So, patients that are skinny and short have spinal conditions and spinal problems and patients that may be taller and bigger can have spinal conditions and spinal problems; we see it across the spectrum. There's nothing specifically that means if you are or are not of a particular body mass index, you have any particular predisposition to having a disc problem, per se.

Q Doctor, I want you to assume for a second that in 2002, Ms. Sarwat had a car accident, that she received less than a month's worth of physical therapy to her neck. Would that --

MR. FEEHAN: Objection. That's not the testimony.

MR. ROSENBERG: I'm asking him a hypothetical.

THE COURT: Go ahead.

Q With that assumption, Doctor, would that have any effect on the herniated disc that you saw and took out of Ms. Sarwat's lower back?

A No.

Q Explain it to them; is there any correlation?

A No correlation at all.

Q Would someone be able to walk around with that kind of a herniated disc had she had that a week before this accident happened without seeking medical treatment?

A Not with the particular kind of herniation that she had at L-5, S-1; no.

MR. ROSENBERG: I have no other questions.

THE COURT: Anything else?

MR. FEEHAN: Nothing.

THE COURT: Thank you very much, Doctor.

THE WITNESS: Thank you, your Honor.

(Whereupon, the witness stepped down from the stand.)

THE COURT: Ladies and gentlemen, it's 1:00 or thereabout. We will take our lunch break and see you at 2:15.

(Whereupon, the jury exits the courtroom.)

(Whereupon, a luncheon recess was taken.)

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

THE COURT OFFICER: Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Good afternoon, everyone. We're all set; we have the witness in the courtroom.

Mr. Rosenberg, please call your next witness.

MR. ROSENBERG: Plaintiff calls Dr. Reyfman.

L E O N R E Y F M A N, M D, called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, was examined and testified as follows:

THE CLERK: Please state your name and address for the record.

THE WITNESS: Leon Reyfman, 2279 Coney Island

Avenue, Brooklyn, New York 11223.

THE COURT: Okay. Counsel, you may inquire.

MR. ROSENBERG: Thank you.

DIRECT EXAMINATION

BY MR. ROSENBERG:

Q Good afternoon, Doctor.

A Hello.

Q Doctor, I'm calling you Doctor; tell us are you licensed to practice medicine in the State of New York?

A Yes, I am.

Q How long have you been so licensed?

A Since 2004.

Q And, Doctor, do you have a specialty?

A My specialty is anesthesia and pain management.

Q And can you tell the jury just briefly your credentials?

A Sure. I finished medical school in 2002. Completed residency in anesthesia at SUNY Downstate in 2006 and I completed a year of pain management fellowship at St. Luke's-Roosevelt Hospital in 2007. I'm Board certified in anesthesia and pain management.

Q I don't know if I asked Dr. Merola this: Can you tell the jury what is to be Board certified? What does that mean?

A Board certification means that the physician must finish accredited residency and fellowship, then sit for a

written and oral exam. Upon successful passing of both, then the appropriate Board, in this case American Board of Anesthesiology, will grant a Board certification status.

Q Doctor, do you teach now and if so where?

A Yes, I am on faculty at SUNY Downstate Medical Center. I work as a director of pain management. I teach residents and fellows. I also have hospital privileges at Mount Sinai and Beth Israel of Brooklyn.

Q Doctor, before I forget, before today, have you and I ever met before?

A No.

Q Have we ever talked before?

A No.

Q Doctor, in order to be here today, if you weren't here, what would you be doing?

A I would be seeing patients.

Q And in order to be here today, were you -- you're not coming for free -- how much do you charge?

A I'm being compensated an hourly rate of $425 an hour.

Q Doctor, can you tell the jury with respect to your specialty, what is it that you do?

A I treat patients who have pain. My subspecialty, I treat primarily patients who have spine conditions; patients who have neck, midback, lower back pain.

I also see patients who have pain in their joints,

shoulders, and knees. And I also treat patients who have nerve damage neuropathies. Most of my patients that I treat have some form of pain because of problems from their spine.

Q And I was just going to ask you if you can quantify for the jury what percentage of your patients have spinal pain?

A Probably about 80 percent.

Q Doctor, do you do surgeries?

A I do minimally invasive spine surgeries, yes.

Q Can you describe for them what types of surgeries?

A My specialty or my training is to deal surgeries that are minimally invasive, disc decompression procedures, spinal cord stimulators, morphine pumps. Those are the most common surgeries that I perform of my peers in my specialty.

Q And how long have you been doing that?

A Since 2007.

Q Doctor, did there come a time when you came upon a woman by the name of Ruby Sarwat?

A Yes.

Q And how did it come about that she came to your office?

A She was referred to me by Dr. Coyne on August 3rd, 2015.

Q And when she came to you, did you get a history from her?

A Yes, this was a 43-year-old female who was involved in a car accident. She was injured on 7/9/2015. She primarily had

complaints to her neck and lower back as a result of the injury.

Q And, Doctor, did you find out what she did for a living?

A She was a limo driver and this happened when she was driving dropping off a passenger in New York City and she was hit by a moving garbage truck. That's the history I obtained.

Q Doctor, when Dr. Coyne referred her to you, did you speak with Dr. Coyne about Ms. Sarwat?

A I'm not sure.

Q And when she first came to you, can you tell the jury did she make complaints of pain?

A Yes, she did.

Q What is it that she said?

A She said that she has lower back pain, that was also swelling in her left foot. She described pain on the scale of 9 out of 10, 10 being the worst. Constant sharp, aching pain, pain was worse when she was sitting, standing, walking and bending.

Q And what treatment, if any, did you do for her?

A She was receiving physical therapy treatment from Dr. Coyne. I examined her with -- we discussed various treatment options, medications and possible injections into her neck, her lower back. She was given prescription for Norco which is Vicodin some people know it as, and we use the medication for patients in moderate to sever pain.

She receive prescription and given information about lumbar steroid injection.

Q What is it you told her about that? You said you gave her information?

A Yes.

Q What information?

A Information about injection, lumbar epidural steroid injection.

Q Can you tell them what is that?

A Lumbar steroid injections I use for patients who have physical therapy, have had former pain medications and they continue to have progressive neck or back pain. Steroids are very strong antiinflammatory medication so it's mostly symptomatic treatment. It's to inject steroid in the area of a problem, in this case it was L-5, S-1 to reduce inflammation and irritation in her lower back.

Q Did you review MRI reports, EMG reports? Tell the jury what records you reviewed.

A I have reviewed the MRI of lumbar spine which was performed on 7/20/15 which was consistent with L-5, S-1 disc herniation which was protruding by 3 millimeters. She also had a nerve test --

Q Can I interrupt you for one second?

A Yes.

Q That 3 millimeter, can you tell the jury in your

medical opinion what significant --

MR. ROSENBERG: By the way, Judge, I never offered him as an expert in his field of pain management.

MR. FEEHAN: No objection.

THE COURT: We will permit Dr. Reyfman to render his opinion in the field of pain management as it applies to this case.

Q Doctor, the 3 millimeter herniation, what significance -- what does that mean?

A The space where the disc are and the nerves, blood vessels is called epidural space; it's a fairly narrow space in the area of 5 to 6 millimeters. So, 3 millimeter protrusion is a 50 percent of that space is occupied by that herniated disc.

Q And is that small, medium, large?

A It's large.

Q Doctor, did you review EMG reports?

A Yes, she had an EMG done performed in 2015 which was consistent with bilateral L-5, S-1 radiculopathy.

Q Can you tell them what radiculopathy is?

A Radiculopathy by definition is constellation of symptoms, someone having lower back pain shooting down lower extremity with numbness pins and needles. Physical exam findings consistent with neurological deficits such as muscle weakness, loss or decreased reflexes and also diagnostic test such as EMG and/or MRI that shows she has a protrusion that

impinges on the nerve that result in nerve damage.

EMG is a test to perform to see if there's any form of impingement and if there is, to specify the location; in this case it was L-5, S-1.

Q When was the EMG done?

A It was done in October of 2015.

Q And can you tell them for those that have not had an EMG how is it done?

A This test has two components to it; it's called nerve conduction velocity. We use a nerve stimulator. We shock various areas of arms or legs, depends where it's being performed along the nerve distribution. And we record the wave length of nerve stimulation on a computer.

The second part of the test is taking a small needle and inserting it into various muscle groups that are innervated by that nerve. And we also look for muscle contraction which also gets recorded on a computer and through a software analysis, we can determine whether there's impingement or not.

Q Can you also tell the jury that test, is that test painful, is it not?

A It's uncomfortable.

Q The patient is not anesthetized when they undergo that test, are they?

A No.

Q Doctor, why was she sent to you?

A Because she's been having a lot of back pain, neck pain. She had already several weeks of physical therapy. And she was in a lot of pain.

Q And after you saw her that first time, did you see her again after that?

A Yes.

Q Approximately altogether how many times have you seen her?

A We have altogether about 49 visits.

Q And on what schedule did you see her?

A Approximately once a month every two to three weeks on occasion.

Q Doctor, let me jump back for a second and ask you approximately how many patients do you see in a week?

A I see personally 150 about patients or so.

Q And ultimately, did Ms. Sarwat undergo these injections?

A Yes, she had two epidural steroid injections performed by me.

Q When were they done?

A They were done in October and November of 2015.

Q And, Doctor, can you tell the jury mechanically how is it done? How do you give someone that type of shot?

A Sure. Usually this procedure is performed either in office surgery suite or surgery center or hospital. Most often

they perform under local anesthetic.

So, the way it's typically done patient will come into the procedure room, will lie down on their stomach. We take X-rays as we do these injections so we can see the needle progress to someone's spine on the screen. The skin gets clean with iodine to avoid infection. We take a needle with lidocaine which is numbing medication. We inject the skin, that part usually stings for a few seconds, and through that numb area, we use three and a half to five inch needle and we advance it to the point where we know we're in the right spot by taking multiple X-rays. And then once we know we're in the right position, we inject steroid.

Q And that is something you're watching on the screen?

A That's correct.

Q What are the risks to that?

A Risk of spinal injections are infection, damage, and bleeding. Most often patient will complain of headaches or some back pain afterwards. There's small chance of causing damage but we take every precaution to avoid such. Those are the risk factors.

Q And the actual endpoint of where the epidural goes in, is that -- where in the spine -- is it in the canal?

A It's exactly in epidural space, epidural canal.

Q Doctor, altogether, let me jump ahead. Presently, is she still under your care?

A Yes, she is.

Q Let me jump to the end and then we will go back for a second. In the future, will she continue to be seeing you or another pain management doctor?

A I would strongly think so, yes.

Q And for how long?

A For her lifetime.

Q Doctor, tell us in your practice as a pain management doctor, have you seen patients before that have had spinal fusions?

A Sure.

Q How often is that that you see this patients?

A On the average once a month.

Q Okay. And how often in your practice do you see them on a week on a month or a day?

A I see them every month; depends on what type of treatment they're receiving.

Q I'm asking total. When patients come to you, what percentage of the patients have spinal -- have had spinal fusions?

A Out of the total, I see probably 15 to 20 percent had some form of spinal surgery.

Q And generally speaking, those people that have had a spinal fusion are going to require a pain management doctor for the rest of their life?

A Most often, yes.

Q Doctor, after those injections, did they work?

A No. She only reported very mild temporary relief after the two epidurals.

Q And so what is it that you did with those results?

A I gave her referral to see Dr. Merola who's a spine surgeon to discuss surgical options.

Q Why is it that you thought at that point in time that was best?

A This was a patient who already had approximately three or four months of physical therapy. She had -- she required a lot of pain medications. She had two injections. And she still had significant amount of pain in her lower back. And I thought the right thing to do would be to have her explore surgical options to see if this problem can be fixed.

Q What type of medications is it that you gave Ms. Sarwat?

A She took -- we trial various medication; muscle relaxants, we try antiinflammatories, we try narcotics such as Percocet, Vicodin. We gave her medication called Gabapentin that be use commonly for nerve pain.

So we did trial several regimens of medication and she still had pain. She also reported drowsiness with medication, so she wasn't happy the way this medication made her feel.

Q And ultimately, after you referred her to Dr. Merola,

did you ever talk to Dr. Merola about Ms. Sarwat?

A Yes, I have.

Q And what is it that you discussed? What did you say to him?

A We spoke primarily after her first surgery where she had infection in her spine which required second procedure. We discussed various treatment options and I think we both agreed that surgery would be appropriate in this case to help the pain.

Q And, Doctor, based upon the history you got from Ms. Sarwat and based upon the treatment you rendered for Ms. Sarwat, do you have an opinion whether or not this accident, this motor vehicle accident that she was involved in on July 9, 2015, was that the competent producing cause of her pain and her injuries?

A Yes, I believe that the accident --

MR. FEEHAN: Objection to form.

THE COURT: Hold on a second. Come up.

(Whereupon, an off the record discussion was held at the bench, after which:)

THE COURT: Rephrase your question.

Q Doctor, do you have a medical opinion, with a reasonable degree of medical certainty, as to what the cause of Ms. Sarwat's pain is?

A Yes. In my medical opinion, I believe that the accident of 7/9/2015 resulted in her symptoms.

Q What do you base that opinion on?

A This was a woman who was functional; she had no prior injuries or prior complaints of neck and lower back pain until this injury.

Q Doctor, I already asked you if you knew what she did for a living.

Doctor, I want you to assume for a second that Ms. Sarwat was working 50, 60 hours sitting in a limousine driving clients. Would someone with that type of job be able to do that type of sitting for those prolonged periods with that type of 3 millimeter impingement?

A I highly doubt that somebody would be able to drive and work having large herniated disc in the lower back in their lower back.

Q Doctor, what do you base that opinion on?

A Based on my -- based on the history that I obtained, based on the physical exam findings, based on the radiological studies as well as nerve tests.

Q Radiological studies that you're referring to is the MRI?

A Yes.

Q And the EMG?

A That's correct.

Q What else have you done for her -- I don't want to go through 49 visits. I don't think they want to listen to 49 visits.

A Sure. So after she had surgery, she resumed physical therapy after the scar healed. She did require less medication at some point. We also -- I also performed a lumbar facet injection. Facets are the joints that run from the base of the skull all the way down to the tailbone.

The function of the joints is to give mobility and flexibility of the spine. When somebody looks down or rotates their spine, that's how their joints work. Oftentimes, after surgery, after fusion, these joints get inflamed. And what I did is I injected her lower back joints in both sides after which she had little relief. Then we continued pain medications.

Q When were those injections from that facet done?

A Early 2016 I think. Then for about a year and a half or so, we just manage her with pain medications. Then we spoke to her about an option of --

Q Can I interrupt you for a second?

A Yes.

Q Tell the jury what are the risks in long term use of pain medications.

A Primarily with all opiates, there's risk of dependency, tolerance and addiction. Unfortunately, opiates can cause side effects such as drowsiness, diminished reflexes and rash; those are common but mostly concerned about addiction.

Q I'm sorry, go ahead?

A In 2017, we spoke to her about considering spinal cord stimulator; it's a device that be use for patients who's had back surgery and they still have persistent back pain.

So we did a trial. What it's performed it's done in the surgery center setting or hospital. Patient do get anesthesia for they're somewhat asleep for it. We insert two electrodes on top of their spine and we stimulate a certain area of somebody's spinal cord that's responsible for lower back pain and leg pain.

Q Can I interrupt you for a second?

A Yes.

Q When you say you insert it, this is not on top of the skin?

A No, no, it's deep into the spine. So it's right on top of the spinal cord; it's very deep.

Q I'm sorry.

A So, she had that procedure done and usually the trial lasts a week and during this week, we monitor patients to see how well they respond to it. In her case, she had no relief. In fact, she just didn't like the way she was feeling. She had some heart palpitation so we removed those leads and we kind of back to Square 1 with pain medications unfortunately. That's really the story of Ruby's long term pain management treatment.

Q When is the last time you saw her?

A I saw her recently last week. It was 9/26.

Q And you're still seeing her on an approximately monthly basis?

A Yes.

Q And when you -- tell the jury is there a reason why you see her monthly as opposed to every six months or every year?

A We want to see how she responds to her treatment, medications, and see if she develops any other complaints or issues. Narcotics are not refillable in New York State so the patients will need to come in on a monthly basis and overall, we like to see to make sure there's no worsening of her condition that we need to address.

Q Doctor, can you tell the jury about the prognosis? What does the future hold for Ms. Sarwat?

A She is what we call chronic pain patients. After six months after treatment after initial insult, anyone that has pain, this really becomes a chronic issue. She had done a -- everything possibly could be offered from pain management standpoint, rehabilitation and as well as surgical standpoint.

She will need ongoing treatment with pain medications. She will need further diagnostic tests, CAT scans X-rays MRIs. There is definitely a role for more injections. There is possibility that she may need additional surgery because of her condition. As she gets older she will need help at home.

Right now, even her age now, she has difficulty performing her activities of daily living. Grocery shopping,

meal preparation, personal hygiene; they're already affected now. And I think as she gets older, she will be need more help with home health aide and our goal is to provide care to her to avoid to -- to make her as functional as possible.

Even now she works a little, as much as she can, so she's doing everything possible to move on with her day.

Q And, Doctor, did you review Dr. Schuster's life care plan?

A Yes, I did.

Q Was there anything in that life care plan that you disagreed with?

A No.

Q The costs that were associated in that life care plan as it concerns pain management, were those costs appropriate?

A Yes, they were.

Q And for the future, other than what you've told us already, if I want you to assume that life expectancy charts in the books she has 34.4 years should she live to her full life expectancy, will she get worse over time?

A Unfortunately, I think she will get worse as she ages.

Q Doctor, did you have an opportunity to look at the 2017 MRI?

A Yes, I have.

Q Is that in your records as well?

A Yet, it is.

Q Can you tell the jury is there anything significant in that?

MR. FEEHAN: Objection, your Honor.

MR. ROSENBERG: It's in evidence, Judge.

THE COURT: All right. Read back the question.

(Whereupon, the referred to question was read back by the Reporter.)

THE COURT: In what?

MR. ROSENBERG: In the 2017 MRI.

THE COURT: While --

MR. FEEHAN: Your Honor, I'd like to approach.

THE COURT: Come up.

(Whereupon, an off the record discussion was held at the bench, after which:)

THE COURT: Ladies and gentlemen, two minutes please; step outside.

(Whereupon, the jury exits the courtroom.)

THE COURT: What is this, Defendant's B?

MR. ROSENBERG: Defendant's B, yep.

THE COURT: All right.

MR. ROSENBERG: Judge, I --

THE COURT: Relax. Let's go on the record.

You're making an objection, counsel, correct?

MR. FEEHAN: I am, your Honor.

THE COURT: So state your objection for the record.

MR. FEEHAN: The objection for the record is that the MRI that's being referred to, my office was never given an authorization for that MRI previously. I was unaware of it until today.

I spoke to counsel about it. He said he wasn't going to inquire about it in the first place. I looked at the subpoenaed records for Dr. Merola's office earlier today before I questioned him and I did not see it in there. It's apparently there now.

There was a second set of Dr. Merola's records on the table when I returned after the lunch break. I don't know where this came from, quite frankly.

THE COURT: All right.

MR. ROSENBERG: Here's the best part, if I may.

THE COURT: Go ahead.

MR. ROSENBERG: This is in a subpoenaed record room. There's one staple that went through this entire packet of papers. Clearly, Mr. Feehan didn't look at it closely enough because it's here and it's attached and this is not my copy.

THE COURT: Hold on a second, all right? I don't care what came in on the subpoenaed records, all right? That doesn't make the MRI report admissible, number one.

I'm just -- when you offered these records, you're the one that offered them, correct, Mr. Feehan?

MR. FEEHAN: I did, your Honor.

THE COURT: We're talking about Defendant's Exhibit B, correct?

MR. FEEHAN: Correct.

THE COURT: And you're claiming when you offered them in evidence, the MRI report was not in there?

MR. FEEHAN: I did not see it. I looked through it and I did not see it in there looking for it.

THE COURT: Okay.

MR. ROSENBERG: You care to look at it, Judge?

MR. FEEHAN: There's no question it's there now.

THE COURT: Let me see.

MR. ROSENBERG: Sure. (Handing.)

MR. FEEHAN: Your Honor, it doesn't change the fact it's never been exchanged and shouldn't be a part of this case.

THE COURT: Counsel, when you offer it and he doesn't object and it becomes in evidence, it becomes a problem. If you objected, you're absolutely right; I would have pulled it out in two seconds, it's not admissible the way it was offered.

But if you offered it and it went in without objection, then I have a problem. Well, you know, I see multiple staples that have been removed and whatnot here.

MR. ROSENBERG: Judge, not in the main packet.

THE COURT: What?

MR. ROSENBERG: Not in the main packet.

THE COURT: What's the main packet? This?

MR. ROSENBERG: No. The bulk of the papers, Judge, is where it's in. That's his subpoena too. That's not my subpoena.

THE COURT: When you offered these records, counsel, was the staple here or not?

MR. FEEHAN: There was a staple, yes.

THE COURT: Look at the staple in the middle of the package.

THE COURT OFFICER: (Handing.)

MR. FEEHAN: There was a staple.

THE COURT: I only see one staple in the middle. So, I'm just wondering how he could have stuck in or how someone could have stuck in an MRI report if there was a staple similar to that when you saw it.

MR. FEEHAN: Your Honor, when Dr. Merola was on the stand, I went through with him page by page referring to what was there.

THE COURT: Let me see.

THE COURT OFFICER: (Handing.)

THE COURT: I'm sort of stumped, counsel. I don't see how it's possible, to be honest with you. I don't. But you can give me a suggestion and I'll listen. But there's

one staple that holds all these records together, all right? I don't see any other staple marks by the MRI report where -- and I just can't fathom that someone could have stuck the MRI report in.

If you want to give me an explanation as to how you think that's even possible -- take a look, counsel.

MR. FEEHAN: Judge, I don't have an explanation. I'm not going to be able to come up with one for you. I literally sat there with Dr. Merola and I went through each one of his notes and I --

THE COURT: Maybe you didn't see it. My view of this is the MRI report had to be in those records since they're all stapled together and it couldn't have been inserted in those records afterwards, all right? So maybe you didn't see it.

Given that, what can I do? You know, it's in evidence, you offered it; he didn't object. Unless you think I have grounds to reconsider your objection, I don't know. I mean, again, Mr. Rosenberg, that MRI report should not be in evidence if he objected.

MR. ROSENBERG: He's the one that offered it. I didn't offer it, Judge.

THE COURT: Well, that's sort of the problem that we're at, all right? So, I have to make a ruling. My ruling is going to be that the MRI report was in that

packet, there's no possible way where it couldn't have been and unfortunately, you just didn't see it, so....

But then again, you know, where's the prejudice if he wants to renew his objection? You know?

MR. ROSENBERG: Renew his objection? Judge, it's in evidence. I'm not agreeing that it be withdrawn out of evidence. And I'll take it one step further. I'll bet you if I go through Dr. Coyne's records that are in evidence also, I'm going to find a copy in there as well.

So, Judge, I'm not withdrawing my consent to that coming into evidence. I can't undo the hands of time. That's ridiculous and you know, Judge, I take offense that someone is sort of insinuating that I'm the one that stuck that into the packet. He should have read the file better. Clearly that was there.

I have Dr. Merola's records right here, by the way. I have what he had. It's sitting here. He left it here and there's another copy right here.

MR. FEEHAN: And the doctor said he had a copy of it.

THE COURT: I remember when he was about to question him on the MRI report, you came up, we had a sidebar and he indicated that he would not go into it.

MR. FEEHAN: By agreement, that it wasn't part of the case.

THE COURT: What's that?

MR. FEEHAN: By agreement, that it wasn't part of the case. Therefore, there's no prejudice to taking it out of the exhibit at this point because it's not part of the case.

MR. ROSENBERG: No, it doesn't work that way. You're the one that offered it.

THE COURT: That is the problem. Off the record.

(Whereupon, an off the record discussion was held, after which:)

THE COURT: We're in recess for a short second.

(Whereupon, a brief recess was taken, after which:)

THE COURT: Where are we? It's in evidence. Are we conceding?

MR. ROSENBERG: It hasn't been marked in evidence.

THE COURT: All right.

MR. FEEHAN: As to Dr. Merola's records, I will withdraw my objection because it's also contained in Dr. Coyne's records. My problem is at this point, I'm going to put a radiologist on the stand, he's going to be crossed by Mr. Rosenberg as to the fact that he has never seen or reviewed that MRI or that MRI report; neither has ever been provided to my office.

Today is the first day I found out about its existence. I don't have a problem necessarily with Dr.

Reyfman testifying about it today. My concern is that my doctor is going to be subject to collateral attack because he hasn't seen it when nobody on the defense side ever knew it existed before today.

MR. ROSENBERG: Judge, if you want me to respond to it, I'll respond simply by saying I didn't offer it into evidence. It's the same thing.

THE COURT: I understand that. But now, I mean, here's the potential problem that I see. You now have an expert on the stand who's an expert in pain management, all right? And you want him to do what? Read materials that are in evidence?

MR. ROSENBERG: Yeah.

THE COURT: And then what?

MR. ROSENBERG: And offer his opinion as to what it means.

THE COURT: All right.

MR. ROSENBERG: He's a medical doctor.

THE COURT: Did you serve a report for this doctor?

MR. FEEHAN: No.

MR. ROSENBERG: No, he's a treating doctor.

THE COURT: I know he's a treating doctor. That's another issue, counsel. Did you serve an expert exchange for him where you spoke about this MRI?

MR. ROSENBERG: No, Judge.

THE COURT: So, there's no report where he discussed this MRI, all right?

MR. ROSENBERG: Judge, I don't have to exchange a narrative report on a treating doctor.

THE COURT: You don't?

MR. ROSENBERG: You do not.

THE COURT: That's a new one on me.

MR. ROSENBERG: Okay.

THE COURT: That's a new one on me.

MR. ROSENBERG: Is that what Mr. Feehan is arguing, that I have to --

THE COURT: I mean, where's the notice that you have an expert that -- just because he's a treating physician, he can get any expert opinion he wants under the sun? Is that what you're saying?

MR. ROSENBERG: He's a medical doctor. You want me to lay the foundation and ask him how many MRI reports he reads a day? He reads thousands.

THE COURT: At the end of the day, I always thought if you want to put a treating physician on the stand, of course you can and there's certain liberties you have, such as opinions on causation and permanency that don't have to be in his report.

But certainly the injuries have to be in his report and I think if there's X-rays in his report, he has to

mention them I think.

MR. ROSENBERG: Just so we're clear for the record, Judge, is it your understanding that a treating doctor that comes in for the plaintiff has -- the plaintiff's attorney has to serve a narrative report for that doctor?

THE COURT: Yes, under the trial rules.

MR. ROSENBERG: I take exception to that because that's not --

THE COURT: We will see.

MR. ROSENBERG: Judge, also in addition to that, Mr. Feehan is being disingenuous to this Court because there's another subpoena here from Complete Radiology in the subpoenaed records room.

THE COURT: By the way, I'm not saying necessarily a narrative report but some sort of report setting forth the nature of the injuries and everything else.

MR. ROSENBERG: Judge, he accepted the Complete Radiology. It's here.

THE COURT: What is it? 202(h)? Let me look it up. Hold on a second. What are the rules of medical exchange? Anybody know that cite, Mr. Appellate Guy?

MR. ROSENBERG: If I had to get --

THE COURT: 202.17.

By the way, was there a request for -- here, read this. Read this. Let me go look this up. (Handing.)

THE COURT: It's really 207.17 mostly (b).

"(b): At least 20 days before the date of such examination -- " okay, all right.

"At any time after joinder of issue and service of a Bill of Particulars, the party to be examined or any party may serve on all other parties a notice fixing the time and place of examination."

And it goes on and on.

Now (b): "At least 20 days before the date of such examination or on such other date as the Court may direct, the party to be examined," that would be you, "shall serve upon and deliver to all other parties the following which may be used by the examining medical provider: 1: Copies of the medical reports of those medical providers who have previously treated or examined the party seeking recovery. These shall include a recital of the injuries and conditions as to which testimony will be offered at trial referring to and identifying those X-rays and technicians reports which will be offered at trial including a description of the injuries, the diagnosis, and prognosis. Medical reports may consist of completed medical provider Workers' Compensation or insurance forms and provide the information required by this paragraph."

So you're quite right, Mr. Rosenberg, you don't have to serve a narrative report; it's simple service of

medical reports will do.

Then it goes on: "And you must also provide the following: Duly executed and acknowledged written authorizations permitting all parties to obtain and make copies of all hospital records and such other records including X-ray and technicians reports as referred to and identified in reports of these providers who have treated or examined the party seeking recovery."

Again, so I'm going to go look it up right now. So if you want to call a doctor to testify, you have to serve a report from that doctor, doesn't have to be a narrative, all right, and if he's going to make reference to X-rays or any other technicians report, it has to be set forth in that report. That's my reading of the rule and not only do you have to do that, you have to provide authorizations.

So now the question is: What if you don't? Is that grounds to preclude the testimony from that doctor as to eliciting any testimony concerning that X-ray report or MRI?

MR. ROSENBERG: If you look it up, you're going to find cases that say that authorizations --

THE COURT: Did you give him an authorization for the MRI? He said you didn't.

MR. ROSENBERG: I gave him authorization for all --

THE COURT: He said you didn't.

MR. ROSENBERG: Judge, he subpoenaed it; it's here. Yes, the answer is yes. He had an authorization.

THE COURT: Did you get an authorization for this?

MR. FEEHAN: I got a trial subpoena authorization after the case --

THE COURT: You got a trial subpoena. So let's say the authorization component perhaps is complied with, did you ever get a medical report from Dr. Reyfman setting forth what his testimony is going to be regarding the plaintiff's injuries and what he's going to say in connection with any X-ray or --

MR. FEEHAN: No.

MR. ROSENBERG: That's not --

THE COURT: I'm going to go look it up. You're saying you don't have to do that?

MR. ROSENBERG: I didn't say that yet.

THE COURT: All right.

MR. FEEHAN: I'm going to be to but I --

MR. ROSENBERG: His office records are four inches thick. His narrative report is in there.

THE COURT: Quit yelling; I'm trying to keep calm.

My question is very simple; listen to my question: Did Dr. Reyfman indicate anywhere in any report in this pile of records, that I guarantee there are pile of reports over there, that he read this MRI and somehow indicated what his

testimony was going to be concerning this MRI? Yes or no?

MR. ROSENBERG: Read it, yes. I don't know if he said what his testimony would be.

THE COURT: Show me what you got. Show me, show me.

MR. ROSENBERG: Okay.

THE COURT: And that was served on him, by the way. Not just came in pursuant to the subpoenaed records.

MR. ROSENBERG: You know what, Judge? Go look it up and you're going to find exactly what I said. I don't have to give him any more than an authorization. And he got authorizations for the MRIs, he got them during Discovery and he got them for a trial authorizations.

I'll rest on that and I'll tell you that the cases for treating doctors say just that. I don't have to give him a 3101.

THE COURT: I understand you don't have to give him a 3101.

MR. ROSENBERG: That's correct.

THE COURT: Okay.

MR. ROSENBERG: Yep.

THE COURT: I understand that a hundred percent but you have to give him a report that complies with this section.

MR. ROSENBERG: Okay.

THE COURT: You say you don't?

MR. ROSENBERG: I don't.

THE COURT: Let's see what the law says.

MR. ROSENBERG: Okay. Go ahead, go look it up. Go ahead.

MR. FEEHAN: Can I be heard?

THE COURT: Yes.

MR. FEEHAN: My objection to it is that that particular MRI is July of 2017. This was already on the calendar. I couldn't have gotten authorization for it before that. It didn't even exist.

THE COURT: All right. So the point is?

MR. FEEHAN: I have never been given an authorization for it.

MR. ROSENBERG: First of July 2017, it wasn't on the calendar.

MR. FEEHAN: You have the date?

MR. ROSENBERG: The case was marked final.

THE COURT: Find out when you gave him an authorization for it.

MR. ROSENBERG: I gave him an authorization for it.

THE COURT: Show me. You'll have proof of that.

MR. ROSENBERG: No problem.

THE COURT: All right, get that.

MR. ROSENBERG: Judge, so I'm clear, is he denying

he didn't get an authorization for Dr. -- for Dr. Reyfman and Complete Radiology?

MR. FEEHAN: I got an authorization for Dr. Reyfman.

MR. ROSENBERG: What about Complete Radiology?

MR. FEEHAN: After the time that the new MRI was taken.

MR. ROSENBERG: Judge, he got trial authorizations for them as well.

THE COURT: So in other words, trial authorizations wouldn't have done him much good in getting the films in time for his radiologist to look at the films, correct?

MR. ROSENBERG: Wrong. He got the trial authorizations a year ago.

THE COURT: After the case --

MR. ROSENBERG: The Note of Issue was filed.

THE COURT: Take a recess.

(Whereupon, a brief recess was taken, after which:)

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Sorry for the delay, ladies and gentlemen, but every once in a while, we have to discuss things.

So, we're ready to go. So go ahead, counsel, continue your examination.

MR. ROSENBERG: Sure.

DIRECT EXAMINATION (CONTINUED)

BY MR. ROSENBERG:

Q Doctor, do you have the 2017 MRI report?

A Yes, I do.

Q Can you tell the jury what significance, if any, you gleaned from that?

A There is still a L-5, S-1 disc herniation that's slightly less than it was before, 2 millimeter protrusion. There's also an L-5 bulging disc that's protruding by 3 millimeters at L-3, 4 which wasn't present in 2015.

Q Okay. And, Doctor, on conclusion of that MRI report item number 5 --

A Okay.

Q -- can you read that to the jury?

A Sure. "Extensive postoperative changes are seen related to posterior paraspinal musculature of mid/lower lumbar spine and metallic artifact with prior surgery seen within the subcutaneous soft tissue."

Q And what does that mean, "extensive postoperative changes"?

A These are muscular changes, that the muscle have undergone changes such as inflammatory chronic inflammatory changes.

Q Causally related from this accident?

A Yes.

Q Doctor, before I forget, with respect to home care that we talked about a little bit, I'm going to ask you if you can -- do you have a copy of the vocational rehabilitation expert's report in your file?

A Yes, I do.

Q And can you turn to the page near the end for support care?

A Yes, I see it.

Q I know earlier I asked you just in lump sum because we're going to have the vocational rehabilitation expert I think Monday afternoon.

But with respect to home health care, I know you said you agreed with the report in its entirety but specifically in your experience as a pain management doctor, can you tell the jury is that reasonable, age 65 to 78, 8 hours a day?

A I think it's very reasonable. At least they'll be able to cover majority of her daytime with help of others to get her more functional.

Q Then actually progresses in age 70 to life, do you agree with the particular part detailing 12 to 14 hours a day?

A I think it's reasonable.

Q Okay. Doctor, let me ask you, and it may be a little bit repetitive, I apologize.

Doctor, with a reasonable degree of medical certainty,

do you have an opinion whether or not Ms. Sarwat sustained a herniated disc at L-5, S-1 with impingement from the July 9th, 2015 motor vehicle accident?

A Yes, I do have an opinion, which is she did sustain a herniated disc at L-5, S-1.

Q And what do you base that opinion on?

A Based on her symptoms, presentation as well as diagnostic studies MRI which was performed in 2015.

Q Doctor, with a reasonable degree of medical certainty, do you have an opinion whether or not Ms. Sarwat sustained a permanent loss of use of a body organ member function or system and if so what is your opinion?

A My opinion is she did develop loss of use of her lumbar spine. She was injured three years ago. She underwent extensive course of treatment. She still have progressive disability and chronic pain. I believe there's significant loss of her lower back function.

Q You used the word and I'm going to ask you now another question and I'm going to ask you what significant means.

Can you form an opinion or do you have an opinion with a reasonable degree of medical certainty whether or not Ms. Sarwat sustained a significant limitation of a use of a body function or system as a result of this motor vehicle accident of July 9, 2015?

A Yes, she did develop significant limitation or loss of

function of her lumbar spine based on the previous answer. She had extensive treatment, she had lumbar surgery followed by complication. A number of procedures and she still today shows significant limitation of her lumbar spine.

Q Doctor, I didn't ask you this but have you recommended Ms. Sarwat to try and undergo again the neurostimulator?

A No, I did not.

Q Is there a reason why?

A She had it done last year and she didn't show any improvement during the trial.

Q Doctor, with a reasonable degree of medical certainty, do you have an opinion whether or not as a result of this motor vehicle accident whether Ms. Sarwat sustained a permanent consequential limitation of a use of a body organ or member and, if so, what is that opinion?

A She did sustain permanent loss, permanent damage to her lumbar spine.

Q Doctor, with a reasonable degree of medical certainty, do you have an opinion whether or not as a result of this motor vehicle accident, that Ms. Sarwat sustained or was prevented from performing her usual and customary daily activities for at least the 90 out of 180 days immediately following this accident?

A Yes.

Q What's the opinion?

A She did have limitation in her activities of daily living from the accident till present.

Q And let me ask you: You said from the day of the accident till present, and what about the future?

A And the future as well.

Q Would it be fair to say forever until she dies?

A That's reasonable, yes.

MR. ROSENBERG: That's it. I don't have any other questions.

THE COURT: Thank you.

Your witness, counsel.

MR. FEEHAN: Thank you.

CROSS-EXAMINATION

BY MR. FEEHAN:

Q Good afternoon, Dr. Reyfman; how are you?

A How are you?

Q How you holding up?

A I'm okay.

Q Good. Just a while ago, you testified that the plaintiff never made any prior complaints to the neck or back, is that right?

A Speak up a little? I'm sorry. Can you repeat your question?

Q Sure. You testified earlier that prior to this accident, the plaintiff had never made any complaints to her

neck or back, is that correct?

A That's correct.

Q If I told you that there's been testimony in this case yesterday by the plaintiff that she injured her neck previously, would that surprise you?

A Her main focus of treatment was to her lower back. I mean, if there is any obviously records, that would be good to know obviously.

Q If the testimony was that she was involved in a prior motor vehicle accident, would you want to have seen those records?

A If there was a significant damage of course.

Q Were you provided with those records?

A No.

Q Were you aware of the prior accident?

A No, I was not.

Q You took a history from the plaintiff, correct?

A Yes, I did.

Q On the first time that you saw her?

A That's correct.

Q And she gave you what her prior medical history was, correct?

A Yes, she did.

Q And your notes, you don't note that she told you about the prior motor vehicle accident, correct?

A That's correct.

Q Doctor, if you would take a look at your first office notes from 8/3 of 2013. On the third page of that under the second paragraph, second bold heading where it says "Cervical Radiculopathy"?

A Yes.

Q Were you recommending that the plaintiff undergo cervical epidural injection?

A Both cervical or lumbar which were provided to her information during this office visit, yes.

Q So, she was complaining of neck pain as well when she first saw you?

A That's correct.

Q Did you ever do that?

A No.

Q Why is that?

A She had more disability, more pain because of lower back.

Q Did the neck pain ever go away?

A As my last visit, she -- I have to review all my chart but as of my last visit, she only had lower back pain.

Q When was the last time she complained to you of neck pain?

A As I said, I would have to go through each --

Q Go ahead.

MR. ROSENBERG: Judge, at this point, I'll object because there is no claim in this case for cervical. If he wants to, then I'll be happy for him to go into that.

THE COURT: Well, you want an answer, counsel?

MR. FEEHAN: I would like to know when the last time she complained was.

THE COURT: Okay, give us an answer to that question.

A As of 11/28/2016, there were no complaints of neck pain.

Q You indicated that you saw Ms. Sarwat a couple of weeks ago?

A Yes.

Q When was the last time you saw her before that?

A 9/5.

Q You testified earlier that one of the -- as a pain management doctor, someone prescribing medications, one of the things you worry about is dependency?

A Yes.

Q Has there been any sign of dependency in this case?

A No.

MR. FEEHAN: I don't have anything else, Doctor; thanks.

THE COURT: Okay. Any redirect?

MR. ROSENBERG: There is.

REDIRECT EXAMINATION

BY MR. ROSENBERG:

Q Doctor, I want you to assume that Ms. Sarwat had a motor vehicle accident in 2002; 16 years ago. I want you to assume that she received approximately less than a month of physical therapy only for her neck. Does that change your opinion in any way with respect to her lower back?

A No.

MR. ROSENBERG: I have no other questions.

MR. FEEHAN: Nothing else.

THE COURT: All right. Thank you very much, Doctor.

THE WITNESS: Sure.

(Whereupon, the witness stepped down from the stand.)

THE COURT: All right, counsel, I'm assuming we're done for the day?

MR. FEEHAN: We are.

THE COURT: So, ladies and gentlemen, we have no more witnesses for today. But the case obviously is not over. Monday you're off in the morning, Monday is my motion day just so you know, so you can take the morning off.

But we do have a witness for the afternoon. So we're going to start about 2:00 Monday afternoon, okay? So we're getting there.

So, have a great weekend. We will see you Monday afternoon.

(Whereupon, the jury exits the courtroom.)

(Whereupon, Court is recessed and the case adjourned to Monday, October 1, 2018 at 2:00 p.m.)

* * * * * * *

CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE ORIGINAL STENOGRAPHIC MINUTES TAKEN OF THIS PROCEEDING.

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FRANCESCA CIOFFI, CSR, RMR
Senior Court Reporter

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