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

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JEAN ORLANDO TALLEYRAND,

Plaintiff,

Index No.
502930/2014

-against-

COWAN EQUIPMENT LEASING, LLC, GREGORY GRAHAM, GUILLARD TALLEYRAND, AND MARJORIE ANN FERRER,

Defendants.

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December 4, 2018
360 Adams Street
Brooklyn, New York 11201

B E F O R E:

HONORABLE PETER SWEENEY,
Justice, and a Jury

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

For the Plaintiff:
LIAKIS LAW, P.C.
65 Broadway
New York, NY 10006
By: NICHOLAS LIAKAS, ESQ.

For the Defendants Cowan Equipment Leasing, LLC and GREGORY GRAHAM
LEWIS, BRISBOIS
77 Water Street
New York, NY 10005
By: JAMES T. WHALEN, JR., ESQ.

NORA CAMPISI, SCR
Senior Court Reporter

THE COURT: All rise, jury entering.

(The jury enters the courtroom at this time.)

THE COURT: Good morning, good morning, have a seat, thank you. Thank you all for getting here on time, I appreciate it. So we are all ready to go. Do we have the doctor in the hallway?

MR. WHALEN: Right outside.

THE COURT: So we are going to get right going.

Just so you know, today we are going to finish today 1:00. I don't know if I told you that, but I hope that is good news.

All right, are we ready?

MR. LIAKAS: Yes, your Honor.

THE COURT: Please call your next witness.

MR. LIAKAS: At this time plaintiff calls Dr. Michael Gerling.

COURT OFFICER: Please remain standing, face the clerk, raise your right hand.

M I C H A E L G E R L I N G, M.D., called as a witness on behalf of the Plaintiff, after having been first duly sworn/affirmed, took the witness stand and testified as follows:

THE CLERK: You may be seated. In a loud clear voice can you give your name and business address for the record.

THE WITNESS: Yes, it is Michael G-e-r-l-i-n-g 506 Fifth Avenue in Brooklyn 112t17 -- no, 11215.

THE COURT: Thank you. Good morning, Doctor. Counsel, whenever you are ready.

MR. LIAKAS: Thank you.

DIRECT EXAMINATION

BY MR. LIAKAS:

Q Good morning, Dr. Gerling?

A Good morning.

MR. LIAKAS: Now, I just want the Court to be aware, I set an alarm here, your Honor, so if my phone goes off, it is not a call.

THE COURT: All right.

MR. LIAKAS: I set an alarm.

THE COURT: My phone will probably go off before yours.

Q Okay. Dr. Gerling, you are a medical doctor, correct?

A Correct.

Q What is your specialty?

A Orthopedic spine surgery.

Q What does that mean?

A It means that after finishing medical school I went to an orthopedic residency program for five years, which is a musculoskeletal specialty base, we take care of injuries and problems with the bones, the joints, anything in the bones and

joints and muscles in the extremities.

Q While we are on the topic, can you tell us about your education and your background?

A Yes, so I graduated from UCC, San Diego Medical School in the year 2000. After that I went to a residency for five years in Ochsner Clinic in New Orleans, which is the orthopedic residency I mentioned. Then after that I did a one-year fellowship at Case Western in Cleveland, which is a specialty center for spine surgery with Henry Bowman, who is a famous sort of leader and educator in the field, and that was a year of specialty training only in spine surgery, and it really only focused in degenerative and traumatic injuries to the spine. So, that is one of the first places in North America that had a spinal cord injury center, and it also had, is a major magnet center for trauma for five different states, so it is a huge pool of trauma and degenerative patients for you to sort of learn higher levels of sort of understanding of that field.

Q Now, are you a part of any professional societies or memberships?

A Yes. So after finishing my residency in 2005, I did the fellowship in 2006. Then I came to New York, at that point I became an academic full time attending at SUNY Downstate for four years. During that time, I initiated my academic career and I joined lots of societies, including the Cervical Spine Research Society, which I am a full fledged member, and board

member. And then the academy, American Academy of Orthopedics, the Lumbar Spine Research Society, North American Spine Society, numerous societies. And I have active roles in all those societies, including being on the committees for research for presentation, the program committees in order to set the program for the meetings. I am on the instructional course lecture committee for the, for example, the Cervical Spine Research Society, meaning I am actually giving that course tomorrow, it is an all day course in Scottsdale, and some -- I am very involved, I am the president elect of the Federation of Spine Associations, which is the, it is the overriding body from the American Academy of Orthopedics that governs education for orthopedic surgeons. So I am -- I run the program for the orthopedic society, specialty there for spine surgery, and I am very involved in that society as well.

Q Do you publish anything with regard to the neck or back, cervical, lumbar spine?

A Yeah, regularly all I do is spine in my practice, and all I do academically is spine. I am regularly presenting podium presentations on my research. I have two presentations on Saturday in Scottsdale at the Cervical Spine Research Society, and numerous other ones given by some of our research fellows during the week. So I am engaged as an NYU professor, an associate professor. At the Scoliosis Research Foundation, we do a lot of research, we present papers and also publish

them.

Q Tell us about your current practice?

A Okay, so, since 2006 when I moved to New York, I was at SUNY Downstate for four years. At the end of that I was the chief of spine surgery there, and actually the chief of their orthopedic research at that point, and then I transferred to NYU, what is now called NYU Brooklyn. Back then it was called Lutheran Medical Center, which is a level one trauma center as well. And at Lutheran Medical Center, I was there for four years as their chief of spine surgery, and then it became NYU. But over the course of that four years, I was already at the NYU faculty in the city, I was already operating and doing my research in the city at NYU. And so now I basically am all NYU, because NYU took over that hospital. I am still the chief of spine surgery there, I continue, my group continues to take calls. I am the, one of the founders of my group. Then I have a junior partner that works under me. We take the spine only call in the level one trauma center. So half of all of the call goes to us.

So my practice is comprised of a lot of trauma, probably 80 percent of the patients I see during the year are trauma related patients, which is they slipped and fell on ice, or whether they fell down the stairs, whether they fell off a roof as a construction worker. Some type of injury could include lifting a really heavy box, something like that,

throughout their back, but some form of injury to the back, and so about 80 percent of the patients I see, I don't know how many patients I see a year, probably in the thousands.

Q And what types of conditions do you treat, like you said, it's a lot of trauma, do you do wide spectrum?

A Yeah, within the spine I do a wide spectrum, because I do see degenerative problems, so you do see some deformity, people who have cricking and twisting of their spine, or shifting of the bones and joints. But I do everything from the skull base all the way down to the tailbone. So if you had a fracture in your lower back, I would fix that. If you had degenerative process in your lower back I would fix that. The same thing within your midback, your thoracic spine, or your cervical spine, which is your neck, so any type of spinal problem you have in the neck.

The only thing that I don't do is tumors that are actually in the spinal cord itself. And there are people that specialize in that. And I don't do primary tumors, which are also something I believe should be somebody who specializes and only does primary tumors, because it is a very different type of surgery. If somebody had a liver tumor that then became metastatic and went to the spine, I can take care of that. So that is not a primary tumor, a primary tumor. If you have some other type of condition, like a melanoma, now it goes to the spine, that is metastatic, I can take care of that.

Q And you mentioned you were the chief of spine at a level one trauma center, what is a level one trauma center?

A There are centers that are distinguished as level one by the American College of Surgeons, that have a certain compliment of providers that can take care of any type of trauma problems. So if somebody is in a high level car accident and they have substantial injuries, they would have to go to a level one trauma center, because they may have bleeding inside their head, a problem with their spine, they may have a tear of their spleen, all those things. We have emergency personnel that are capable and qualified to manage those problems. You have to be at a level one trauma center for those things.

Q You have seen thousands of patients, correct?

A Per year.

Q Per year. Have you ever testified before?

A Yes, I only testified when I am -- one of my patients has some type of issue in Court they would need me to take care of, to manage. I, so like, for example, today, my -- I am only here because, you know, Jean is my patient and I need to be here for him. But I don't do any type of expert testimony except for in malpractice cases, even though I haven't gone to trial on any of those. I have done some depositions, both for the defense and for plaintiffs. So in other words, if somebody is suing a doctor, I may defend the doctor, or I may be the person who is on the side saying, no, look, there's really something wrong,

you -- the patient needs -- the patient wasn't treated properly because of this.

Q And being here today, obviously you are taking time away from your practice; are you being compensated for your time here?

A Yes.

Q Do you know what your rate of compensation is?

A $8,000 is my usual rate.

Q Now, what is a doctor-patient relationship? Before we talk about Jean specifically, let's talk in broad terms, a doctor-patient relationship?

A It is an -- it is actually, I believe that is a legal term, but it is, basically is the -- it is the relationship that a patient has with their treating doctor. Aside from the privacy issues or the fact whatever they say is private, the relationship is just I am the person that would be taking charge of their care for the type of problems that I treat, so I am responsible for that person's spinal problem, and if I can't manage the problem, I really need to help them find somebody who can.

Q Now, you said responsible for the care, were you responsible for the care of Mr. Jean Talleyrand, in his neck and back specifically?

A Yes, from the point that I initially saw him until the current time, so he continues to be one of my patients.

Q When did you first see Mr. Talleyrand, and I will remind you, I know you have your notes with you, you can refer to them, I will mark them, so long as -- do you have them in front of you?

A Yes, this is my clinical chart.

MR. WHALEN: Deem them marked, Judge?

THE COURT: All right, his chart will be, what are we up to, Plaintiff's Exhibit --

THE CLERK: Four.

THE COURT: Plaintiff's Exhibit 4.

MR. LIAKAS: Thank you.

THE COURT: We are marking it for identification at this point, correct, or you want to mark it subject to redaction?

MR. WHALEN: Subject to redaction, I am fine with that being deemed marked.

THE COURT: Received in evidence subject to redaction.

Q Again, Dr. Gerling, you can refer to those notes you have in front of you. Can you tell us when did you first see Mr. Talleyrand?

A On October 21st, 2015.

Q And on that date, did he give you a history?

A Yeah, a history is when a patient speaks to you. You ask them questions, they tell you, they answer the questions and

try to explain what is going on with them, or why they are having their symptoms. And that is a necessary part of every visit, because you want to, you really want to understand what the scope is of the issue. And a lot of times you know you can diagram, or have a very strong notion of what a person's diagnosis is by their history, because things, some things are very characteristic. And on that day, I did take a history on him. Excuse me, I'm trying to turn my phone off.

Q I am going to point you to the first note, can you tell us, tell us -- I'll have it up for the ladies and gentlemen of the jury, what was the history Mr. Talleyrand gave you?

A That he had had multiple injuries, including his neck, back, and extremities when he had been in a car accident on 7/28/13. But after the accident he had gone to the emergency room by ambulance, that he had severe radiation of pain to the right hand, interfering with his activities of daily living. Activities of daily living are things you do during your daily activities that sort of you need to do. So for example, eating, preparing food, getting dressed, washing yourself, brushing your hair, doing chores, some of those are relatively simple things, some of them are easier than other things. But those are considered activities of daily living.

I noted some specific ones he said he had difficulty doing, including bathing, grooming, dressing, chores, grocery shopping, similar types of tasks. He said that he couldn't bend

or lift without severe symptoms, that he had not been able to work because of the symptoms.

Q Now, let's break it down for a second. Mr. Talleyrand comes to you and obviously this accident was in July of 2013, you saw him in October of 2015. So at this point, he had had treatment, fair to say?

A Yes.

Q And he comes to see you, this is the history that he gives, what is the significance of -- let's break it down piece by piece. This history with regard to radiation, severe radiation to the right hand, what is the significance of that in an orthopedic spine setting?

A Well, when we say that, that is a summary of a patient. What we document in the history is not necessarily -- it is certainly not every single word we said to each other, but we will ask questions in order to understand what the patient -- what their symptoms are, and what they are describing. And so what that really means is that from what he was describing, it sounded as though he had neck pain radiating down from the neck to the right hand, that it -- in other words, that he didn't feel like he just had a problem in the right hand, but in fact it was radiating to there, and that would be characteristic of a neurologic type problem if it radiates like that; it is not always, but it is characteristic of that.

Q I am going to ask you, Doctor, if you can indulge me

for a second, step down for the use of the model, if it would assist you and tell us what exactly you mean, how the structure of the spine comes into play, when we are talking about radiating pain down the right hand?

(The witness stepped down from the witness stand)

A Okay, so this does help me. So this is actually very weird to look at at first, but if you think about this as just being purely the bones and discs in the structures of the spinal column itself, the orange part is the part of the chest where actually ribs come out of it. Normally you might see a skeleton, it would have ribs here. The red part, which is the lumbar spine, which is the lower spine, which is below the ribs and just above the pelvis, the pelvis, the sacrum right here, the bottom of the spine is blue, and that is the base that connects with the pelvis, it is a part of the pelvis. The lumbar spine is red, the thoracic spine is orange, and then the cervical spine is above the area where the ribs are. The cervical spine, as you can see, is a relatively short area, primarily seven bones in most people, and it is yellow in this particular model.

This model shows discs in between the bones. This is a relatively reasonable depiction of the way things are, you know, it is pretty close to being anatomic for a normal person. There are variations from person to person, it is very representative.

What you also see is a red structure here, which is the

artery that runs along each side of the spine within it. That is not the famous ones that you hear about from the movies, like the carotid or the jugular, it is not that. This is a different artery, called the vertebral artery. There are the yellow things coming out of the spine, called nerve roots. So when the brain forms, it actually has a spinal cord that runs through the spinal column down to the upper part of the lumbar spine. But the way that that spinal cord works, is by sending out signals through nerves to different parts of your body. So if your brain says I want to move my right arm, it would send a signal down the spinal cord through the nerve root out to the muscle, which would then make the arm move. And so that is how everything is controlled. If you pinch or irritate a nerve, then that nerve will usually have have different types of symptoms or manifestations. It is somewhat different, depending how it is irritated or pinched. If it is just inflamed, then usually it is more like a painful sensation in the area where that nerve root controls. So that nerve root controls sensation to this part of your arm, it is called a dermatome, in that because it is the skin, the dermis, that area is what nerve is innervated, by that nerve. So if you touch your skin there, the signal goes through that nerve to the brain and the brain says, oh, somebody is touching, you know, it is touching the area of the skin on the arm or the hand.

Likewise, if you inflame that nerve, you will feel pain

along the distribution of where you normally would feel the sensation. Whereever that nerve goes, you kind of, your brain would think, okay, something is burning my hand, even though it is just inflammation of the nerve root. We call that radiculopathy, because it is the nerve root. Radic is Greek for root, and opathy means sickness. Radiculopathy is when the nerve is being irritated or pinched.

And everybody knows that if you cross your legs in a certain way, or sit on the toilet seat too long, that you can, your nerve can go to sleep, so your foot can go to sleep or your arm can go to sleep, if you lie in a certain way. That is because the nerve is being pinched, or one of the nerves is pinched. It can be pinched down low, or pinched up in the spine. And most of the time when you feel that, you just feel numbness, because the nerve is sort of unable to send a signal through.

Numbness can be a sign of radiculopathy as well, if the nerve is being pinched. And also, if you feel weakness, because you just physically can't move the muscle, that can be caused by a nerve root being pinched as well, because it can't send signals to the muscle to make that muscle move. That would be weakness caused by the nerve being pinched. We would call that a radiculopathy as well. Most of the time there is a blend, or there is some mixture of those things.

And to make it even more complicated, the spinal cord

can get irritated and pinched too. So if the spinal cord gets pinched, then it is not just one simple nerve root, it can be a whole spectrum of nerve roots. So instead of having one clean dermatomal distribution of your pain or your numbness, it may be your whole hand, it may be your whole arm, it may be your whole right side. It depends how the spinal cord is being pinched or irritated.

So when you have something wrong with one of these discs in the spine and it is pushing backwards, or pinching, if it is pinching the spinal cord, you may have a diffuse, we call diffuse pattern of numbness or weakness. Some people may say it is non-anatomic. What they really mean by that it is diffuse, spread out all over the hand or the leg, or something. And so that would be symptom of the -- sort of being pinched.

But oftentimes, as in the case of this case, the spinal cord and the nerve root kind of are both being irritated or pinched, so it can have a mixture of those two things that -- the radiculopathy type symptom. But also you can have that diffuse kind of problem with weakness or numbness called myelopathy. Myelopathy is where the spinal cord has some effect from something inside of the spinal canal, if the spinal cord is being irritated, or has some abnormality or sickness, we call that myelopathy. Because it is, myelo is the Greek word for spinal cord and opathy is sickness. So myelopathy and radiculopathy are the two types of problems you can have in the

spine, from the nerve root being irritated or damaged.

(The witness resumed the witness stand)

Q Doctor, at this point, before we get into your examination, your clinical examination of Mr. Talleyrand in October of 2015, you said he obviously had a course of treatment. You took his history, we know he went to the ER by ambulance for care. So I want to show you some of those records, we can talk about the significance, if you find it, at all?

A Can I step down?

Q You certainly can, if it is easier for you to see.

(The witness stepped down from the witness stand)

Q I want to take you to the hospital record of Mr. Talleyrand. So now, he was taken by ambulance to the hospital. I want to just focus on this portion right here. Tell us, when he went to the hospital what did he complain of?

A Well, he clearly had chest pain. When people complain of -- so after an accident if you complain about chest pain, if you complain about chest pain, people are really going to worry that you are having a heart attack, right, that is what this means, is that he was complaining of chest pain. And they said rule out myocardial infarction, which means a heart attack.

So, there is such a thing as a, it is called a distracting injury or distracting symptom, and it can be distracting for the patient, and also for the provider. So if

you, let's just say a truck ran over your foot and shattered all the bones in your foot, that would be extremely painful, as most people would understand, right. But if you also had an injury to your left arm, because you, you were ripped around, you struck the truck with your arm, maybe you also injured your back at the same time.

It is well-known that if you have a severe symptom, a distracting injury, that providers have missed, and oftentimes do miss other types of symptoms or problems. So in fact, we are trained as doctors to try and examine those parts, despite the fact they may not be the primary symptom or complaint that day. So if there is something that is significant, like chest pain, it oftentimes is the primary complaint, despite the fact there may be other symptoms or problems.

Q I am going to talk to you about in a second, he does have other symptoms. I want to show you the second page of the hospital report where he makes complaints. I want you to assume that Mr. Talleyrand testified that he was sitting in a stopped motor vehicle leaning forward, talking to his brother and his cousin, and the tractor-trailer, unexpected to him, unanticipated, a tractor-trailer came from behind him and struck the back and side of their car. His head was thrown backwards into the passenger seat, and the head rest, and he presents to the hospital with these complaints. What is the significance of these complaints in the context of what I just told you now in

that hypothetical? You can certainly use this if you like?

A They report, they are describing the accident, MVA means a motor vehicle accident, he complains of back pain, and abdominal pain. That he had been vomiting since the accident, that he was sitting in the back seat of a car with the seatbelt on when they were struck. So what are the significance of these things? Well, clearly this was a -- was not a small injury, it affected multiple parts. Vomiting is a very characteristic complaint of somebody who has a head injury, or concussion. Abdominal pain can come from vomiting, it can come from injuries to the abdomen and an accident. You can get injured by a seatbelt, there are a lot of different ways you can injure your abdomen in an accident. And then the back pain could be from the accident, from the accident damaging the back as well.

Q I want to take you to the ambulance call report. I want you to take a look at this one section here. Mr. Talleyrand's chief complaint at the scene of the accident, coupled with the vomiting, coupled with the fact that his head went backwards and struck the seat, this is what his complaints are, what is the significance of "I feel dizzy"?

A Well, when people have dizziness, nausea and vomiting after striking their head against a seat, or having some type of head injury, that is really a concussion until proven otherwise. It suggests that he had a some type of injury to his head. It doesn't -- it is not the only thing we would use to diagnose

that, but it does suggest that.

Q Now, what is the -- I want you to assume, Doctor, that after the accident occurred Mr. Talleyrand was kept in the hospital for two days, okay, and when he was released, the hospital told him to follow up with his primary care doctor. Why would that be something that is important and significant in terms of his release at the -- with those instructions?

A Well, first of all, if he was kept for two days they were clearly concerned about something, they thought something significant had happened, something severe, and they thought that he would be unsafe if he was sent home. So that is the portion that is the logical reason for why he would be in the hospital so long, because they would send him home otherwise.

But the follow up with the primary care doctor is what one would do if somebody has an injury that needs to have follow up. And so they clearly knew that he had some type of injury, they felt that it was significant enough to keep him in the hospital for two days, and they felt he needed followup with a professional as an out-patient.

Q I want to take you to that follow up with the professional as an out-patient, I want to take you to the notes of Silver Needle Acupuncture, we are going to go through them, if you can look?

MR. WHALEN: Just for the record, I have no problem, let's deem them marked whatever is next.

MR. LIAKAS: Right. You want me to actually --

MR. WHALEN: Deem them, just say we are looking to Silver Needle records, which are deemed in evidence.

MR. LIAKAS: Without the number, we don't have the number.

MR. WHALEN: Let's get the number.

MR. LIAKAS: Do you know what the next exhibit is? Do we have an evidence list over there?

COURT OFFICER: Yes.

MR. WHALEN: Just for the record.

THE COURT: All right, we will figure out the number later. Right now, you are agreeing that this should be received in evidence?

MR. WHALEN: Yes, I agree, Judge.

MR. LIAKAS: The record from Silver Needle Acupuncture.

THE COURT: So they will be received in evidence.

Q I want to take you to the presenting complaints and pain diagram that was present on the initial evaluation at Silver Needle Acupuncture. If you can tell me, what do you see here with regard to the area of pain, what are the significance of those areas being complained about, having complaints of pain two days after the accident?

A Well, what day was he discharged from the hospital?

Q He was discharged from the hospital on the 29th -- the

30th, I am sorry?

A Okay, yeah, so he went --

Q 29?

A That is a very quick follow up that he was able to do after being discharged, because you have to get organized, find out where you're going to go to treatment. Because he was complaining of neck problems, back problems, and problems in his right arm, we already know about some of these, he had had some type of head issue in the hospital. Now it seems like it is a neck issue, his low back, and then his right knee.

Q Now, I want to take you to the second page of this same examination, physical examination, you see where it says physical evaluation, neck, restricted motion?

A Yes.

Q What does the restricted motion tell you in a clinical setting?

A Well, it also says pain scale 9 to 10.

Q What is the significance of that?

A Would be on a 10 point scale. So what they were saying, that he had severe pain in his neck, with movement of the neck.

Q And what does that tell you in a clinical setting?

A He said it was sharp and stabbing, the type of pain was sharp, stabbing pain in the neck area.

Q What does that tell you as a doctor in a clinical

setting?

A That is very strong support for the fact that he presented with a severe neck complaint, neck condition. And in the lumbar part back there it, it says that he had pain 10 out of 10, in the lower back, it was also, it was sharp and stabbing.

Q What does that tell you about his lumbar spine?

A That he had an injury to his lumbar spine as well.

Q Now, with someone with restricted range of motion, is that consistent with someone who just underwent a traumatic event?

A Yes. That is typically because the body is trying to protect that part. So patients will have reflexive spasm of the muscle. People have had stiff necks before, that is a spasm of the neck muscle, right; you have a spasm in your low back, it is very stiff, the body is, it is a reflex the body is using to try and protect it.

So if you think about the notion of the body, you know, of evolution and trying to -- the body trying to save your life, if you were in a battlefield injury, and somebody stabbed you in the spine, or you had a severe injury in the spine, well, your spine might be unstable, right, and your survival may depend upon the spine's ability to regain that stability. And so the spine tightens down those muscles to try and stabilize it, even though that is not the best for mobility, it may be the best to

save your nerves and your spine; the stability, that is a reflexive response.

Q Everything we have seen so far in the initial examination done just a few days after, is that consistent with that, with -- consistent with a traumatic event happening a few days before?

A Yes.

Q I wanted to take you the next page of the same examination done August 2, you can see his complaints; you can see some of his other complaints. What are the significance of these complaints that we see on the first examination?

A Well, he had tingling in the right hand, and difficulty rising to walk from sitting. So these are symptoms similar to what I had discussed earlier. Tingling is not a typical symptom of somebody who has an injury to skin or a joint, it is something that is more typical of a neurologic type symptom, tingling like your foot wakes up after it is asleep. That is a neurologic tingling, that suggests he had something neurologic happening in the right hand.

Q Now, few days later Mr. Talleyrand presents to Bayview Medical Care PC, a physical therapy office after seeing the acupuncturist. He presents to Bayview Medical Care, he is examined by another doctor, okay. And this doctor, I will bring up his notes, also did a physical examination, this was on 8/5/17?

MR. WHALEN: Just --

MR. LIAKAS: I will give you more. These are Bayview Medical Care PC records. We will deem them marked Plaintiff's Exhibit, I think we are up to 6?

MR. WHALEN: Thank you.

Q Now, we will go to the second page of this examination. I want to ask you again, can you tell me what the significance of this finding is, that Mr. Talleyrand had numbness in his right fingers, again, or a separate doctor, separate day, separate evaluation, those are his complaints, what is the significance of that?

A Well, it supports the picture that he has some type of neurologic problem. It supports the notion that he has neck pain causing that numbness, because those things typically go together. So it is not the only way that you can have numbness in the hands, but we try to put things together. We are, we are making a diagnosis, so we try to put all of the different building blocks together to support or rule out a diagnosis.

And when somebody has consistent complaints of numbness in the hand, then it is again something pointing to a neurologic type problem. If they also complain of neck pain, and then it suggests it could be coming from there.

Q Now, I want to take you to the diagnosis by that doctor upon completion of that physical exam on the 5th of August 2013, and you see some of the diagnoses that we have here are related

to concussions and to the cervical and lumbar spine. Are these fair diagnoses as you see them based on his complaints, based on the history that was given?

A Yes, all consistent with the complaints, the lumbosacral injury. So that is sprain strain of lumbosacral spine, that means that they don't have more data to know what is happening in the spine, but they know there is an injury there. And the sprain or strain means either a ligament or muscle or something has been damaged in there, so that's an appropriate early diagnosis. Rule out radiculitis means they think there could be some nerve type symptoms coming from the lower back going through the leg. They said cervical sprain strain, meaning that they believe there is something injured in the neck. Rule out radiculitis means that they believe there is a cervical nerve type problem, causing the symptoms in the arm. They think there is an upper back injury, they think there may be a problem in the right arm, and in the right leg.

So at this point they sort of have a lot of data. They have -- he also has post traumatic headaches, so that headache often times is associated with a concussion that somebody had recently, but it also is associated with neck type pain too. If you have a neck problem it oftentimes feels like you have a headache from it, or it oftentimes presents just with a headache. It is all consistent with what we have seen.

Q I want you to assume at this point Mr. Talleyrand

begins a course of therapy, acupuncture and conservative care, and is treating in therapy and acupuncture 3 to 4 times a week and that lasts for a period of about nine months?

A Yes.

Q Within that same period, he is referred to a physical medicine and rehabilitation doctor, I will pull up his note here at St. Dominick's Medical Services PC, we will deem those marked as Plaintiff's Exhibit No. 7. So I want to take you, this is now three months almost removed from the accident. He is referred to this doctor for an evaluation. I want to just go over the chief complaints and the history of present illness as it was given on that day to this doctor?

A Okay, so the doctor is describing a motor vehicle accident, the accident that we were discussing today from July 28, 2013, with injuries to the neck, the right shoulder, the right arm, the right lower limb, and the lower back. It describes the same things I described, the history is consistent there. That he developed high blood pressure during the course of this accident, that he had started acupuncture, that he had some benefit from the conservative treatment. That means the non-operative type treatment. Conservative treatments are like acupuncture and chiropractic care, physical therapy. He had some benefit, which is typical from those type of treatments, but he still continued to have pain and numbness, or sensory symptoms, and that is the reason why the patient was sent to his

office, to rule out the root type problems.

Q And were Mr. Talleyrand's complaints on that day of the accident consistent with what you have said before, with regard to nerve --

A Yes.

Q -- or cord irritation?

A Yes, so all these things, again, are consistent. He is complaining of acute sharp neck pain radiating to the right arm, and the numbness in the hand, weakness in the right arm. That he has a constant low back pain radiating to the right leg with numbness in the lower part of the legs when he stands.

Q Now, after this chief complaint was done and the history of present illness was done, Mr. Talleyrand came with his complaints, this doctor did a full examination, a physical examination. I want to highlight some points from that physical examination; what is the purpose of a motor examination?

A Motor means that you are testing the actual muscle strength. So the motor, the motor skill is a physical use of the muscle. So we test the muscles to see whether or not the brain is able to send signals through the cord, the nerves to the muscle, and activate that muscle. If it is not quite going through that well, or not going through completely, the muscle will be weaker than normal. So a motor weakness should be 5 out of 5. So if you test the muscle, a person should have full strength. If it is -- in this case, there was some weakness in

the lower extremity, 4 plus out of 5. That means that he detected some mild weakness, which is exactly how he described it.

What he did, in the upper extremities he found some mild weakness as well in the right arm, in the wrist flexors, and the right elbow as well. So those are all characteristic of having some -- that goes along with the numbness that he had been describing, his seeing some evidence of nerve issues; it is something, it is not severe, it is mild at that point.

Q Now, what about the musculoskeletal examination, what is the purpose of this type of examination?

A So they are trying to actually see if they can reproduce symptoms in the joints themselves, by examining the joints themselves. So just like you would examine the knee by pressing on it or twisting it and moving it to try and figure out if all the different parts are intact, or had been damaged. The same thing is true when the -- when you are testing the spine. They are compressing the head down, which is the compression test, it is called. And if you have a problem with the disc when you press on it, it will reproduce those problems, because the disc is sensitive. He had very little rotation. So he was -- he had difficulty moving his head, looking side to side, or bending. And he felt that there was some stiffness or tenderness in the muscles themselves, which gets back to what we were talking about earlier, about the reflexive reaction the

muscles have. Then he did a straight leg raise testing, which is a test that we do to see whether or not the nerve root in the low back is being pinched, because it is being pinched and tethered when you lift the leg. That nerve root can't move the way it normally does, and it will actually make the symptoms worse, it will exacerbate them. When it is positive it is a pretty good sign or symptom for the fact he had something going on with the nerves in his lower back.

Before the days of MRI, that was considered one of the major tests that they would do, to determine if a person had a disc problem and needed surgery, so this is a very, very -- it is considered to be a very strong finding.

Q Now, I want you to assume, as Mr. Talleyrand continues his conservative care, and continues acupuncture, and chiropractic treatment, physical therapy, the symptoms are not getting better. In fact, the symptoms are either staying the same, some days getting worse, and he presents to a spine surgeon. I want to take you to those notes, and that note is dated February 7, 2014, this is New York Spine Specialists, we will deem them marked as 8, I believe we are up to 8, Plaintiff's 8?

THE COURT: All right.

THE CLERK: Eight.

Q Now, I want to take you to again, when Mr. Talleyrand comes in, there is a history taken, he lets the doctor know

about his complaints, and some physical examination is done. So let's talk about the physical examination and the history that was given by Mr. Talleyrand on this day, if there is any clinical significance to what you see here?

A Well, the symptoms that day were similar. He -- this is now -- this is not -- this is almost a year, no, it is six months later now. So that day the patient was -- you know, he told them about the car accident where his symptoms began, that he, he had -- it says patient has no -- has not had prior neck or back injury, that they weren't able to work, that the patient's symptoms were interfering with their ability to perform daily activities, that they had had physical therapy, warm packs, he describes the type of therapy and non-operative care the patient had before he came. He also complained of low back pain, the neck pain was radiating to the right upper extremity and bilateral -- and the back pain was relating to both legs. He had numbness, tingling and dysesthesia d-y-s-e-s-t-h-e-s-i-a, that is a symptom where you are having abnormal sensation rather than normal sensation.

Q What does that mean?

A It is a neurologic, these are all neurologic symptoms, these are not things that are caused by a joint being damaged, like the knee, or something like that. This is a neurologic type finding. That severity of pain was 8 out of 10 in the back, and in the neck it was 8 out of 10, and the symptoms were

constant at that point. That when he did things like lifting and carrying, they got worse.

Q I want you to assume in 2007 Mr. Talleyrand testified in 2007 he was involved in a motor vehicle accident, received physical therapy for about two and-a-half months for neck and back pain, that pain after two-and-a-half months completely resolved, he had no findings that would indicate ongoing pain or symptomatology, and he was able to work, didn't miss a day of work. Would you consider that to be a prior neck or back injury?

A From -- so what was the date of that accident?

Q 2007?

A Yeah, so, you know, I think that I, as a medical professional that treats patients that have spinal injuries all the time, I would consider it an injury, yes. You know, if I hadn't gone to medical school I --

MR. WHALEN: Objection, he gave his opinion, no, not if he hadn't gone to medical school.

THE COURT: I'm sorry.

MR. WHALEN: The answer is if hadn't gone to medical school, he did go to medical school.

THE COURT: Just answer the question.

MR. LIAKAS: I think he was answering the question.

MR. WHALEN: I think he finished his answer, Judge.

Q When someone comes and presents to your office and you

do your history and ask them about prior instances, what is the usual course of practice in your office?

MR. WHALEN: Objection, your Honor.

THE COURT: Well --

MR. LIAKAS: His office.

THE COURT: All right, well, his whole office or just him?

MR. LIAKAS: They are one and the same.

THE COURT: All right, fair enough. You can answer the question.

A So when a patient comes to our office and they, they report that they have had -- that they have some type of symptom, we always ask them if they have an injury from an accident, and whatever their history is, we also ask them, if you have any other prior disorders or injuries or problems or whatnot, that is not a simple one liner question, it is a conversation, but it can be at times a simple question that we are not dwelling on, because it is not really that clinically relevant. But we will ask something like have you had any type of prior disorders or problems with your neck or back. We may ask, we may use the word injury, if you had a specific injury. There is no set protocol for the way we would ask it. If we have -- if it is relevant, if it means something to us, then we may delve into it deeper and have a full conversation about it.

But, like, for example, if a patient came to you soon

after a problem started but that problem had been going on for three years, that would be relevant. So in other words, the problem got worse two weeks ago, but if in fact he had had this problem, multiple episodes over the course of the last five years, that would be significant. So that is something we would have a deeper conversation about, right. We would document more detail on it. If it is something that is simple, like a disorder, and if we use the word, if we say disorder, and they say, no, we move on if we don't think they have had a significant problem with their neck or back before the start of these symptoms or this current episode.

Q Now, I want to move to the second page of this examination that we see six months after the accident where again this doctor does a motor examination and some neurological testing. Can you tell us what is the significance of the findings on this examination, if any?

A Well, what is significant is that these symptoms, these findings that are noted by this doctor, are consistent with the prior reports. All of these reports seem to correspond. The doctor found that the patient had weakness in the right elbow, just like the last doctor had found that he had weakness in the wrist on the right side. These are typically felt to be characteristic radicular type findings, in the sense that these muscles that are weak, all are controlled by a similar nerve root. So when you have a biceps and a wrist extensor weakness,

that is characteristically felt to be coming from the C6 dermatome, or myotome, which is the muscle group. So it is characteristic, this is the characteristic picture of somebody who has a radiculopathy.

Q So if you are doing just this examination, and you get these findings --

A Yes.

Q -- what is your initial inclination as to a diagnosis, what are you thinking the problem is just based off of this?

A Well, this person has numbness in the C6 area, in this nerve root, C5-6, in the nerve root area, and they have weakness in the C5-6 area, that is very characteristic of a radiculopathy. Radiculopathies are caused by neck problems most of the time, disc herniation, especially in a person who is relatively young. So your thought pattern as a clinician is this is a cervical disc herniation, this is something, if something started suddenly with an injury, then your natural assumption is this is a neck injury whereby the nerve is being pinched, most of the time by a disc herniation, and it is causing the nerve not to work properly.

Q Now, at some point in time -- we will go back to your examination, this is all prior to you even seeing Mr. Talleyrand, correct; and at this point in time Mr. Talleyrand presents to you, an orthopedic surgeon for a consultation, and this is down the road. Now, I want you to assume that between

April of 2014 up until the time that he saw you, he was not doing therapy, he was about nine-months or -- I am sorry maybe about a year gap where he was not doing any therapy in a clinical setting. When you are treating patients, do you always offer them therapy in a clinical setting or are there other options?

MR. WHALEN: Objection, other options --

THE COURT: Well, you can -- does physical therapy have to be administered in an office or are there other alternatives? You can answer the question.

A So, there are a lot of different non-operative treatment techniques. We try to get somebody in to a professional to have professional physical therapy, that is considered one of the pillars of treatment. Anti-inflammatory pills are something that we try to get them to use. Sometimes they can't tolerate it, or sometimes they can't afford it, but in our area of practice, we try to get them on some type of medicine and some type of professional physical therapy.

But in parallel with that, it is expected they try to do things at home. And there are studies that show that your benefit from home type exercises and treatments, if they are actually explained and taught to you, are equal in terms of their efficacy, equal in terms of their ability to help you to actual physical, formal therapy in the office. So that is why when somebody is having therapy, we tell them, no, you just

don't go to physical therapy, you also should be doing treatment at home using ice and heat at home. You are only in therapy a couple of times a week for an hour. You should be doing exercises at home or stretching, or something at home. That is actually a very normal process. It is a structured home exercise program that is administered by physical therapists and our office as well. When they are seen by us, it is well accepted if they are plateauing or not really getting a significant change from their therapy, that they just continue to do things at home at -- on their own. That is, sometimes that is a choice they make. Sometimes they are forced not to go to therapy, for one reason or another, to go to therapy, and sometimes it is -- sometimes it is just something they prefer, because it is more efficient for them, or it works for them, or they feel like, you know what, this is just as good. There are a lot of different reasons why they would have a home sort of therapy, home exercise program.

Q Let's go back now, you can have your seat. I'm sorry to keep you standing for so long.

(The witness resumed the witness stand)

Q Let's go back to your initial note. You gave us the history, told us Mr. Talleyrand complained of radiation to his right hand in the initial, then you did your physical examination?

A Yes.

Q What are your findings upon your physical examination?

A That day in the office we focused primarily on the cervical spine, because that was by far the worst issue. We found that he had restricted range of motion, he had something called, in the neck, he had something called a Spurling sign, which is when you manipulate or move the head in certain ways you are able to compress the nerve a little bit more and make the symptoms worse, that is called a Spurling sign, and that is considered to be very specific to patients that have nerve root compression in the neck. So if you have a nerve that is already kind of pinched and irritated, and now you move in such a way you irritate it more, that makes the symptoms worse, we call that a Spurling sign. He had one of those.

Then we tested his balance, which was unsteady that day. We also tested his pelvic stability when he was standing on one leg, that is called a Trendelenburg test. That was positive as well on the left side. He had hyperreflexia in his upper extremities on both sides, which is a sign of the spinal cord being irritated.

Q Tell me about hyperreflexia, what is the significance of that, how does it tell you, or indicate to you as a clinician that there is a spinal cord irritation?

A Well, it suggests that the spinal cord is not doing its job of repressing the normal reflex that somebody would have, so the spinal cord represses your reflexes, sort of calms you down

so you don't do things automatically. If you don't have that function, your spinal cord is not -- it is not, it is not doing its normal job, and so it is significant. It is only one finding out of multiple findings that you may have that all support the diagnosis that there is something happening with the spinal cord. In this case, there was also a pathologic reflex, which is called the Hoffman sign bilaterally. He also had clonus, those are all pathologic reflexes, meaning they are not normal reflexes. If you did that reflex on a baby, they would have those findings. And the reason they have those findings is the spinal cord hasn't developed properly yet in order to repress those findings. If you have pinching or irritation of the spinal cord, you will have those findings. So clonus, Babinski, Hoffman, those are all characteristic tests. And if you have more than one of them, it is even more support for the fact that something is there. And in this case he had multiple findings that all supported the fact that there was something irritating or something had changed in his spinal cord function.

He had balance problems, that is characteristic. He had the abnormal reflexes, the hyperreflexia, he also had the Hoffman sign and the clonus. Those are all things that all fit together in one puzzle. And then he also had weakness of his grip in his inner osseous muscles in the right, and the right biceps muscle, just like what had been found by the other spine surgeon who examined him in the past. So these are all

consistent findings. This weakness of grip in the osseous is also considered a sign of something being irritated in the spinal cord, and that is something that we call myelopathy, which we were talking about earlier.

Q At this point you commented on the level of disability of Mr. Talleyrand based on history, based on the fact he had done therapy, acupuncture, chiropractic therapy, he's seen physical medicine doctors, he's seen other spinal surgeons, and you commented on his level of disability. What did you find it to be?

A Well, I said he had total disability. I didn't go into it in any detail, I said he is totally disabled at this time. He had a labor type job before, and can't perform that job any more.

Q And on that visit, on the initial visit, did you have any recommendations with regard to future treatment or care or intervening measures for Mr. Talleyrand?

A Yes. We recommended that he have surgery on his spine, after reading the MRI of the cervical spine that showed that there was cord -- the spinal cord was being impinged by a disc herniation.

Q We will get to that in just a moment. Before we do, I want to take a detour for a second. Obviously, throughout the course of your treatment you were treating Mr. Talleyrand's neck and his back, correct?

A Yes.

Q Can you tell us, because we will focus on the neck, can you tell us what is the status of his back, what's the problem there, and what is his prognosis for the future?

A So, during his initial visits we really focused on his neck, which was the, at the time his primary complaint and his main problem. We took note of the fact that he had severe back pain, but we were not -- we were not focusing on it in our care until after he had had his neck, you know, had surgery on his neck, and we -- and I believe it was in March of 2016. So about two and-a-half months after his surgery, was it two-and-a-half? Yeah, just a little over two months after his surgery, that is when we started spending more time focusing on the problems in his lower back when we did a more thorough look at his problem.

And certainly when we examined the spine more, in more detail, we found that he had restricted range of motion, that he had some spasm and tenderness with deep palpation, that he had restricted range of motion of the thoracic spine.

So over the course of his care with me, he has had consistent complaints of back problems. These complaints are consistent with his providers that he had before me, they are consistent with the symptoms that he complained of at the time of the accident and they continue to be active and significant today, as we have treated him all the way through. Well, I mean he is currently still a patient, but all the way through his

June 29th, 2018 visit. So he has continued to have consistent complaints. The treatment he has had thus far has not been able to eradicate it adequately.

When we first read his MRIs from 2013 of the lumbar spine, we agreed with the radiology reports that he had some type of abnormality. It looked like there was an abnormality at the L5-S1 disc, it is in my notes, and we followed it. Over time, he continued to have severe symptoms, and those symptoms, as we had treated the neck, became more of a focus of our care. We did order, as what we -- as customary and practice, additional MRIs in order to follow the problem and see whether or not anything was evolving or changing in the spine.

It did appear with time that the L3-4 disc became more -- that it became more severely effected, but it still at this time, was not considered -- you know at this point we didn't find that it was appropriate to indicate a surgery for him. But he certainly at this point has a consistent history with a consistent problem on examination that is, that is, that warrants additional care, which I believe is ongoing. He warrants physical therapy, pain management evaluations, and he warrants continued follow up in my office, but at this time we don't have a target for surgical intervention.

Q At this point I want you to assume Mr. Talleyrand has undergone two lumbar epidural steroid injections, would that be consistent with what you are saying that he needs continued

care, as his injuries evolve in his lower spine?

A Yes, those are appropriate, and I believe that he will require more.

Q Now, within a reasonable degree of medical certainty, can you tell me in the context of Mr. Talleyrand not missing a day of work before this accident, not having any complaints of back pain aside from 2007, two months of therapy, but being pain free relatively for years before this accident, can you tell us within a reasonable degree of medical certainty what is the competent cause of his clinical condition to his lumbar spine?

A It is the accident from 2013.

Q Now, I want to shift back, because we just went on the detour, I want to shift back to the complaints Mr. Talleyrand had with his neck, and your recommendation for surgery. Now, after the first visit, you recommended, you said, surgery; what type of surgery was that?

A Well, we discussed the fact that he would require removal of the discs in his neck that were irritating the spinal cord. When you remove them it is like drilling out a cavity, you can't just leave them empty, it would be like removing the cartilage in your knee without putting in an implant or something to your knee. The way we do it is remove the bad disc, put in a filling and a plate, that is called a fusion. Basically we take away that joint, put a -- put in an implant to hold the bone in the proper position, and then some bone

grafting material to try and help the bone heal in that position so he will have a permanent solution to the problem with that disc. That is called an ACDF, anterior cervical discectomy and fusion.

Q Before we delve into the actual procedure that you did and how you did it, I want to talk about how you came to the conclusion that Mr. Talleyrand would benefit from the surgery. So I would like to show you his MRIs and we can deem them marked, the 2013 MRI deemed mark as Plaintiff's 8?

MR. WHALEN: Nine.

COURT OFFICER: Nine.

Q And the 2015 cervical spine MRI as Plaintiff's 10. If you would like to step down, you certainly may.

(The witness stepped down from the witness stand)

Q Dr. Gerling, I have here a side by side of two of Mr. Talleyrand's MRIs, one was taken immediately after the accident in 2013, and the second was ordered by yourself, as you know, prior to just before having the surgery.

So can you tell me, just based on this, what do we see, what is the function of this MRI, and what is this telling us, with regard to Mr. Talleyrand's neck?

A So, first of all there are a couple of things I need to say. An MRI is something that is -- maybe you know, it is foreign to most people. Let's try to understand what it is. It is like a slice through your body, okay. So sort of like if you

were looking at a slice of a piece of ham you got from the market, you can see a ring of fat, maybe a piece of bone in there, you see the muscles, all that stuff this is similar to that. It is like a slice through your body. And they have different planes that they will slice you in in order to try and see the different structures in your spine.

So an MRI helps us look at the different soft tissue structures. It can also show us some of the more bony hard structure as well, but it doesn't have as much detail in the actual bone as other types of studies do. But it is considered the principal test that we use in order to evaluate nerve type problems, because it shows us the nerves really well, okay.

And in this particular case, when I saw the patient this MRI was not a fresh MRI, it had been done two years prior. And in normal practice, if I had received this MRI in 2013, and I was evaluating him, that MRI would have been sufficient for me to treat him, okay. It is not the highest quality MRI in the world, there are MRIs that are so detailed that you can see every single little atom, like there are some that are not even really in normal practice, that are used for experimentation, probably a hundred times stronger than this MRI is. So I just want you to understand that this is not a high quality MRI, but it is a sufficient MRI in order to treat somebody. It is something that in my usual practice, I could rely on to indicate somebody for surgery, as I did during his first visit, and it is

something that I frequently would use to guide my surgery. So, if I see a structure inside the spine touching the spinal cord, then I would then -- I would be able to use this MRI to plan the surgery to remove that structure, okay. So that is what an MRI is used for.

And in this case, the MRI was from 2013. I knew that there was a problem in the spine, and it -- it went along with what I found on my history and my physical examination. That is why I felt comfortable talking about surgery with him during that initial visit. It had been a long time since his accident happened, he had significant symptoms, he had sufficiently severe findings on examination as well, that all correlated with the findings on his MRI, so it was very clean, okay.

The reason I ordered a second MRI was purely just because I wanted to make sure there was nothing else that dramatic that had, had happened since the first MRI that might change the plan, okay. And in this case there wasn't anything substantial that changed.

Now, on the initial MRI you see this is looking from the side, these are the bones in the neck, that are similar to the bones in the cartoon here. (Indicating) If you slice through the bones, which are just -- if you can imagine a slice through the bones in the neck here with a disc in between. So these are the discs, if you look at them in the midline, okay. And then behind the discs, inside the canal is this round canal

that contains the spinal cord that goes through it, and that is what this structure is, that is in gray in the MRI. And that white stuff around it is just fluid, it is the space in the spinal canal, around the spinal cord in the model here. In the cartoon it is actually dark. The cartoon is not perfectly reproducing the MRI, but it is a very reasonable depiction to help you sort of conceptualize and understand what the MRI shows, okay.

The MRI shows a cut through the middle of the disc, and that disc contains a sort of an outer shell called the annulus, and then inside a pulp, sort of like a core or the nucleus of the disc, okay. And when a patient has a herniation, it means that this outer shell kind of gets damaged, and the inner pulp is moving in that direction, and pressing outwards inside that area that is damaged, that is called a herniation. So if the disc is pushing outwards in an area that is abnormal, we call that a herniation. If it is just sort of gradually losing fluid and it's just aging, which some people would say is a degenerative process, that is the aging process, then we expect the height to lessen, we expect things like the fluid or the pulp inside the disc to slowly be going away; as it gets older, it is getting old and drying up, that is why you will hear some radiologists saying that the disc is bulging outwards, that is it is almost like it is sagging, okay. It is pushing outwards, that is something more of a circumferential problem. In other

words, it is happening in the even manner around the entire disc.

So in this MRI, to get back to it, now that we sort of know what we are looking at, we see the discs in between the bones, and we can see the discs pushing backwards into where the canal is. Where the white water is surrounding the spinal cord, at the C5-6 level, you can see a some black matter, everything that is on the right side of my pen right now, is not supposed to be there, that is disc that is inside the canal. (Indicating)

We look at the disc above, the C4-5 disc, we can see a little bit pushing back in the canal as well, okay, but it is obviously much more severe at the C5-6 level. And the spinal cord that is coming down, you can see that as the spinal cord gets to the C5-6 disc, it actually is pushed a little bit and it changes its shape a little bit at that level. That is because the disc is pressing on it. We call that impingement, and it is shifting the spinal cord, and you can see that as the spinal cord is moving, that there is less space between behind the spinal cord as well, that the actual caliber of the spinal cord is less, okay. So that is nerve, that disc is pressing backwards where that spinal cord is, okay, and that is sufficient to cause irritation of the spinal cord. Discs cause irritation of the spinal cord and nerve roots in two different ways. One is by pressing on them, and the other is through the

chemical process of a disc that is damaged, because the disc can leak out enzymes that then burn and irritate the nerve or the area and that can cause that thing we are talking about, the radiculopathy we were talking about before. It is not just pressing on the nerve, it is also irritating it. That is why many studies that have been done on discs have found that the smaller disc herniations have a similar amount of pain as bigger disc herniations. In other words, there is not a strong correlation between big disc herniations and pain. So you can have a smaller disc herniation and have just as much pain.

Okay, in the follow-up MRI that was done in 2015, it really wasn't very different. Again, the spinal cord had this sort of disc that is pushing out. It does look like it is still touching, the disc still looks like it is touching the spinal cord. You still see the C4-5 disc pushing backwards.

Now, I can tell you that discs pushing backwards in the canal can look fresh, or they can look old. In this study from 2013 this disc isn't just a black mass that is pushing backwards in the canal where the spinal cord is, it also has this little brightness in it. That brightness is called an annular tear where there is some type of fluid. Just like you see the fluid around the spinal cord is white, it is where there is some type of fluid or swelling inside that disc, that is a finding that is characteristic of a fresh herniation, okay. So this spinal cord -- this disc right here in 2015, still appears to have that

little tear in it. When we look at the 2015 report, I mean films, you can still see it pushing out in the canal, so that disc was still there, okay, it hadn't gone away. But the point of getting this MRI in 2015 was to make sure that we didn't miss something that might also be a target for treatment during surgery.

The other thing that should be noted is when you do an MRI, and you do the slices that are like this, you also do slices like slicing a banana. Those are called axial cuts, and those cuts are different. And there are different ways to make those cuts. You can cut it like straight across, or the technician can cut it at an angle, one way or the other. And also, those cuts are not continuous, there is a gap between each cut. Just like this cut is one cut, the next cut will be a couple millimeters over. So for that reason we do cuts in different planes, to try and make sure that we don't miss anything, because you can easily miss something. If something was sitting just like this, and one cut was on -- in front of it, the other cut was behind it, then that would not show up, right. If you then did a cut from the side, you might catch it at that point and see it. Okay, so MRIs are not perfect, they don't catch every single problem, but they are excellent at showing us pathology.

If you can also imagine if somebody made a cut through the nerve, the disc, it was at an angle such as this, that you

may see the disc pushing backwards, but you may see a lot of fluid and a lot less deformity of the spinal cord than if you did a cut in line with where that disc is pushing on the spinal cord, right. See, sometimes we will see that those discs, those cuts vary in terms of the angle that they are performed. And they also can vary because they may not be at the exact same level, when you get the second MRI. So this cut right here may be just a little bit like a millimeter or two different than the cut that is done in 2013.

Q Just looking at this, can you explain to me, I may not be understanding fully if I am just looking at this as a layperson between 5 and 6 on '13, and 5 and 6 on the '15 MRI, the '13 MRI looks bigger to me; is there any explanation medically for that?

A Well, there are a couple. First of all, this cut may be more centered on the -- where the actual disc is herniated, so it may be catching it at a better spot where you can see it better, or see a, the full size of it better than the other thing is. These things do change over time. And so, as you can imagine, if you took a joint and you smashed the joint, well, the body tries to heal it. And at first it will appear like a big mass of fluid and irritation, and there may be blood, things like that, but then over the course of a year or two the body is working to try and repair it and trying to do damage control. So the MRIs can change from year to year. That is the reason

why we will get serial MRIs sometimes on people to see how things are going, see if it is getting worse, just like we did in the low back, in his low back.

But so this MRI from 2015 still shows the disc herniation and still shows an impinging on the spinal cord, but it doesn't appear quite as bad as the 2013. And I think the reason for that is just it is probably not the exact cut. And also, the spinal cord -- the body can try to absorb a part of the disc.

Q Now --

A It might be just a little bit absorbed or contracting a little bit or generating.

Q At that point, if the body is reabsorbing this disc to some degree, does that mean that Mr. Talleyrand's symptoms should be going away, does that correlate 1-to-1?

A It can; I mean, it is up to the patient, you know, some patients do get better, and if they don't get better that is why when -- we do surgery. So we look to see they will get better, we hope they will get better, that is why we send them to physical therapy. If we knew nobody gets better from this, we wouldn't say suffer for 2 or 3 years, we would say, okay, let's do surgery today, we give them a chance, we try, to do the therapies. Like when he saw the other spine surgeon, the other spine surgeon said no, go back and try some more therapy, see if you can get better, because, yes, it can get better. In this

case, it didn't get better, and the nerve type problems, can get better, or they can stay the same, but in this case they stayed the same. If anything, they seemed to progress. So the -- so that is a product of damage to the nerves and spinal cord, or, and/or ongoing irritation and impingement on the spinal cord and nerves.

Q You also mentioned the other side, the axial. Can you tell us where you are looking, you said it sliced like a banana?

A Yes.

Q I have the diagram here. And again, the same marking, the last --

MR. WHALEN: The last illustration wasn't marked, Judge.

MR. LIAKAS: I marked the individual --

MR. WHALEN: The MRIs.

MR. LIAKAS: They are just --

MR. WHALEN: Just for purposes of identification, we call the last illustration Plaintiff's 10.

MR. LIAKAS: Sure.

MR. WHALEN: 11, if --

THE CLERK: We did 10, 11, up to 11.

MR. WHALEN: 11 for ID.

THE COURT: Fair enough, it will be deemed marked for identification as Plaintiff's Exhibit 11.

Q Now --

MR. WHALEN: Correct, now he is putting up another one.

MR. LIAKAS: Plaintiff's Exhibit 11, 12, I am sorry, will be the axial cut MRI from 2013; 13 will be the axial cut of 2015, and the overall diagram will be marked for identification, not as evidence.

COURT OFFICER: 11 is ID, 12 is what; ID.

MR. LIAKAS: Those are are evidence.

COURT OFFICER: 12 and 13 and evidence.

MR. LIAKAS: Right.

MR. WHALEN: 11 ID, and this is 14 for ID.

MR. LIAKAS: 14 is ID as well.

Q You mentioned the axial, can you tell us what are we looking at?

A Now we are talking about the cuts where the MRI is actually cutting through the spine like a banana. So you are looking at the -- this in the cartoon here, you are looking at the spine from sort of like from below actually, you can see the annulus of the disc with the pulp in the middle and the space where the spinal cord lives behind it, then the bones in the back of your neck. So this is the bump, the spinous process is the bump you feel when you touch your back, you can feel the bone there, okay. This is the bump on the back. So this ring right here around the spinal cord is the canal, and around the spinal cord is this fluid, and the disc itself is being sliced

just like in this cut here called an axial cut, okay. And again, it is not perfect, it is not a sharp sharp image, but it does show the disc herniation at C5-6 pressing on the spinal cord. There is no fluid between the spinal cord and the disc at the center portion right here, and you can see that the spinal cord has flattening on the front of it, so the spinal cord is being pressed on, okay. This cut is likely going, like I said, directly across the area where the spinal cord is being pinched, okay. So the spinal cord has some defamation on it and it doesn't have fluid around it the way it naturally would.

When we go to the 2015 MRI, and you look at the disc itself, you can see this disc, this cut really isn't through the disc, this cut is actually at an angle, that is why there is some bone, that is why sort of, the disc of is sort of cut off there, almost like it is, as if it is slicing through the disc, as in the exhibit, was this 10?

Q This would be 11?

A On Exhibit 11, where I was describing if you have a cut that is going across where the disc herniation is pressing on the spinal cord, it will be much more helpful than a cut that is at an angle. And in this particular view on 2015, the disc is not -- it is not a clean cut through, it actually looks, like at some point it exits the disc and goes into the bone, so it is a slight angle. And I don't think that we can rely on purely this image to to describe the extent to which the spinal cord is

being irritated or impacted. In this study there wasn't a great cut taken that caught that perfect view where the spinal cord is being irritated. It does show, however, the nerve root going into the right arm being pinched. And so if you look at the cartoon you can see the disc pressing down on the area where that nerve is exiting the spine. So it would explain why he had -- and that is the C6 nerve that goes into the biceps muscle, and the wrist extensor, so it all still fits together very well in this 2015 MRI. But it doesn't illustrate on the axial cuts a great cut where you are pinching the spinal cord. But certainly there was nothing in this study that showed us we should do something at a different level, and we decided to focus on this disc during our surgical treatment.

Q Now, all this is leading up to your eventual recommendation for the ACDF surgery you explained before?

A Yes.

Q Now, before going into the surgery, you understood that Mr. Talleyrand is hypertensive, meaning his blood pressure, and you had to discuss the risks and the benefits of the surgery with him. Can you tell us what are some of those risks and benefits of him getting this anterior cervical discectomy and fusion surgery?

A So, I mean, I think that it will be easier for people to understand, some of them, if we actually show them the surgery, you can see what things are happening, and you can

understand why you would have certain risks and dangers. I mean, because of course with -- when you have anesthesia.

Q Let me stop you for a second. It will be marked for identification Plaintiff's 15.

A Everybody knows that anesthesia is common, and everybody knows that anesthesia has some risks. The sicker you are the more risk there is, the bigger the surgery the more risk. There is a lot of different things that weigh into the risks of surgery from an anesthesia standpoint. It is not uncommon for a person who has labile blood pressure issues. So his blood pressure shot up when he went to the emergency room. Blood pressure that is not controlled in a regular scenario is going to be really hard to control in the scenario where -- in the surgical field, and the dangerous thing about blood pressure when you do spine surgery is that if the blood pressure goes up it can cause bleeding, because as the vessels have more and more pressure on them, and if they had, just clot off a little bit from the surgery, now that clot can be pushed out, and they can actually have bleeding. And I have seen it, even this year, I mean, it does happen when blood pressure shoots up. So having a blood pressure problem is definitely a risk of a medical risk with anesthesia that can lead to death, it can lead to bleeding in the wound that can cause permanent changes to the -- to your swallowing or to your airway. It can cause, problems with -- you can have a stroke, or some type of problem in your brain

because your pressure shoots up, and those are all the reasons we try to control the pressure before the surgery. But even in a normal person you can have a stroke or have your blood pressure shoot up. In his case it is just high risk.

Now, when we do the surgery we have to cut the skin, we then have to pass through the different tissues, and that is called a surgical approach, to get to the spine. So here we are looking at a slice through the cross section, through the area that I am operating on.

Q Fair to say, same kind of position?

A Just like a slice through the spine. And so you can see the spine, just like I described before with that disc, that is our target. Now we have these retractors that are holding the tissue to the side. If you look at the different structures that are inside here, you can imagine what the risks are of surgery. This shows -- this is the carotid and the jugular. You can have massive, lethal bleeding from that. You can have a problem with your swallowing. It is not uncommon for patients to have difficulty swallowing after the surgery. You can have a problem with your airway with the place where the air goes down to the lungs, and that is the patient has a tube inside their airway during the surgery, because they have the respirator. When you take that tube out now they have to breathe on their own after the surgery. If there is bleeding in this area or swelling, it can compress the airway and stop them from being

able to get air into their lungs. So that can be a risk of surgery.

Aside from that, there are lots of little nerves in the neck that can get damaged and can cause problems to there. For example, control of their breathing with the vagus nerve, which is right here. And then once we get down to the spine, there is the spinal cord and the nerve roots. It is possible for them to have worsened symptoms, or worsening damage to the spinal cord or nerves from the surgery, it can happen. It doesn't happen as often, and certainly if a person has experience and they do it regularly it shouldn't happen that often, but it can happen.

The biggest problems, though, and the most common problems with the surgery occur with the actual disc itself, okay. So, the biggest most common problem is that we take out the disc but it doesn't alleviate all the pain, okay.

So you would like to say that the surgery is going to completely heal you of all your problems, but one of the biggest most common things with the surgery is that even though we take away one of the sources of your problem, you still have other things that are bothering you, or you still have other problems, so you can continue to have the neck pain, and those nerves can have some permanent changes that don't go way. You can also -- you are doing, you are taking away the cartilage, now you are putting in an implant, you are putting in screws and a plate on the front of the spine that looks just like in this depiction

here, and it is actually shown in his true postoperative x-ray there, that plate can come out, it can get loose, it can push backwards and press on the breathing tube. It can tear a hole in the esophagus, if these screws back out, and that happens to people. If the bone doesn't heal together eventually that will happen because over time, as it moves, those screws will eventually get loose, the plate will eventually get loose, eventually the hardware will fail. So you need to heal, that is why we call it a fusion. And if the bone doesn't heal together, you have what is called a non-union. In other words, the bone didn't unite together. And when that happens, you will have irritation and pain in that area, because it is something inside a joint that is hurting you, and you will also have risk of these implants getting loose and coming out.

Q Now --

A This is the surgery that we actually performed on him, where we actually took out the disc, just like it is shown here, you put in the plastic implant. We put in these pins that hold it open, while we are putting in that implant, and then we put in the screws, and the plate. Now, that this is not the true size of the plate, obviously. The size of the plate is closer to the size in this x-ray that is on the board. It is probably around a half inch in length, it is about 2 or 3 inches thick, but this is the actual disc filled with the filling. You can see the markers on the little plastic implant and the actual

screws and plate.

Q Just for the record --

MR. WHALEN: Just for the record, Judge, the doctor was referring to an x-ray taken on July 1, 2016. It is in evidence.

MR. LIAKAS: Yeah.

MR. WHALEN: It is deemed marked in evidence as Plaintiff's 16.

Q Now, intraoperatively you had an opportunity to actually see this disc; is that correct?

A Yeah.

Q And you have your operative report up there, I would like you to take a look at the operative report. Tell the ladies and gentlemen of the jury what it was that you saw as you were inside of Mr. Talleyrand's neck looking at this disc?

A Well, it said I removed the disc, that the posterior disc herniation was visualized, excised. That means I removed it, and sent out to pathology. So I, with my eyes, saw the disc in the canal, where -- the disc, the herniation, where the spinal cord and nerves are.

Q Now, after the surgery, I notice that you say you put in what is called a drain. Why would you put a drain on Mr. Talleyrand, can you tell us what that is?

A So, after you do a surgery, you are going to take out your retractor and close the tissues together and have it heal.

But you can have ongoing bleeding that goes on inside there, and I was talking about that earlier. If you have an accumulation of blood there it can press on the structures and cause a life-threatening situation. So when we put a drain in it is basically like a little plastic tube, or a plastic conduit by which blood can come out of the wound. So in this case the type of drain I used is a little tube that comes out of the skin, and it attaches to a bulb that is sucking on it, and any fluid that accumulates in there will then go through the tube and into the drain, and so it gets pulled out of the wound. So it is to make sure there is no accumulation of blood. We pull that drain out after we believe that he is out of risk, and do away with it. Then the skin heals at the site where the drain is coming out.

Q Now, at some point in time -- thank you so much, you can have your seat for the time being.

(The witness resumed the witness stand)

Q By the way, Dr. Gerling, where was this procedure performed?

A At Lutheran Medical Center.

Q And when Mr. Talleyrand was released from Lutheran Medical Center after the surgery and after the drain was implanted, what were your instructions to him?

A To return to the emergency room if he has difficulty breathing, or if he can't swallow, that he needed to wear a collar and be cautious about the way he moves his head, that he

shouldn't lift anything heavy, that he should return to our office in two weeks for evaluation. We give him instructions about how to manage the pain. Patients typically will have pain on the back of their neck, that radiates into the top of their head and down into their shoulders, that is normal postoperative pain. They have pain in the throat itself where the incision was made and where the pressure was placed on the throat and on the structures inside the neck. So when he eats for the first week we ask them to eat a pureed diet because it is soft and it can go through the swollen and painful parts, and it is easier to swallow. If you have certain liquid-y type substances, it can go into your lungs by accident because you have swelling, that then deforms the structures in your throat and can allow the fluid that you are swallowing to go in the wrong pipe. So we are very careful about their diet post-op. Then they return to our office in two weeks.

Q And in two weeks, or sometime near two weeks, did Mr. Talleyrand return to your office for his first postoperative visit on January 26th of 2016?

A Yes.

Q And what did you find upon examination on that day that he came in?

A I found that he had appropriate postoperative symptoms. That he complained -- I am sorry.

Q Go ahead?

A That he complained of --

Q Didn't mean to cut you off?

A Dysphasia, which is the abnormal swallowing, which is normal post-op, that he complained of spasms in the neck going -- and ongoing numbness in the right arm. So in other words, that numbness was still there, that he had some improvement of the neck symptoms that he had before the surgery. So it sounded like we had at least gotten some part of the problem, we had gotten rid of some part of the problem. He was wearing his hard collar, he was taking the narcotic and the Valium medication, the muscle relaxer we gave him from the surgery, and that his wife was still helping him with his daily activities. He said he still had his low back pain and he was wearing his back brace for it.

Q The ongoing numbness of the right upper extremity, that is your note there?

A Yes.

Q What is the significance of that, if anything?

A Well, it didn't just spontaneously go away. When you cross your legs, your foot falls asleep, you uncross them your foot wakes up. That can happen right away after the surgery, sometimes it takes years to come back, sometimes it doesn't come back at all. The longer the compression is there, the more likely it will be permanent. This has been, it had been two years, over two years since the accident. So, so at that point,

it was, you know, it was unclear how much of his symptoms he would get back.

Q Now, going to your neurologic exam on that day, meaning post-operatively, your first evaluation after the surgery, what did you find neurologically with regard to Mr. Talleyrand, if anything, that is of significance?

A Nothing new.

Q So he still had the same neurologic deficits?

A Yes.

Q What was your recommendation at that point for Mr. Talleyrand?

A That he should, that he should continue with the collar, go to physical therapy, do his home exercise program, take medications, that he could go to his pain management doctor, Dr. Valerie, if he continued to have symptoms, if he needed to.

Q What is the purpose of this postoperative physical therapy?

A To help him with the possible operative pain. They have a lot of spasm, they -- it is very irritating and painful to have spine surgery, so the therapist helps you with that.

Q And you saw Mr. Talleyrand again in March of 2016?

A Yes.

Q And was he still complaining of neck pain?

A He still had his similar symptoms, he also said his jaw

and face on the right side was bothering him.

Q Is there any significance to that?

A I don't think so, unless he was swallowing, he was irritating his jaw by swallowing when he was trying to change his mechanics of swallowing. I don't think that is something that is a really common, an obvious correlation with the surgery. He still had his back pain, he wasn't able to work, return to work.

Q Doctor, as you continued to follow Mr. Talleyrand through 2016, up until the present time, obviously, he has this hardware in his neck between the C5 and the C6 levels, what is the long-term effect of having that hardware there?

A Well, it is similar to what I said before, the bone has to heal together. So, if you -- if the bone successfully heals together, then the hardware sits there, and is stable and shouldn't move. So the metal in your body itself shouldn't cause long-term problems in and of itself. The only problem is when the bone doesn't heal, and the screws now start becoming loose and the hardware loosens and fails, that is when you have -- you have to go back in and make, you know, a revision surgery and adjust it. If it heals, the long-term effect of the hardware itself, is that it just sits there once the bone heals, it is not necessary.

Now, the overall effects of the surgery, including the hardware and the fusion are that you do not have any motion at

that level, so you have removed that joint, you have lost that joint forever, so you are no longer the way God made you in that area, you are the way that the surgeon made you for the most part at that level.

Q I want to show you --

MR. WHALEN: 17.

Q The postoperative x-ray, 7/1/16, which will be marked as Plaintiff's 17, and received in evidence?

MR. WHALEN: ID.

MR. LIAKAS: The board will be ID, these are his x-rays. We will do the board as ID, Plaintiff's 16.

MR. WHALEN: 17.

MR. LIAKAS: 17, I am sorry.

Q Currently, these are the x-rays taken of Mr. Talleyrand's neck post-op, this is what he is left with in his neck is that fair to say?

A Yes.

Q Now, you were mentioning the fact that this hardware is going to have some effect on him in the future, can you tell us what you mean in the context of adjacent segment syndrome?

MR. WHALEN: Just objection to the way the question was formed, because the doctor actually testified the hardware will just stay, so if he wants to ask him another question about the future --

THE COURT: See if you can rephrase it a little

different.

Q Sure. You said the hardware will sit there. At some point will there be any need for Mr. Talleyrand to have future surgery to the cervical spine?

A So, assuming that the disc healed normally and that there are -- the hardware doesn't fail, so that that level has now put to rest, and there is no more problem at that level, you now have a site that is stiff, there is no joint there, so the normal day-to-day wear and tear on the discs around it, is inevitably higher because the activity and motion and normal function of that one disc is lost, so the brunt of your daily activity is now borne by the other discs. So, we -- when those other discs have an accelerated degenerative problem in them we call that adjacent segment disease. So as you have more problems at the adjacent level, the disc, because it doesn't have the normal protection from the joint below, the disc above starts wearing down, that is called adjacent segment disease. The plate itself can shift slightly upwards, and as we see, if you don't mind me approaching the x-ray.

(The witness stepped down from the witness stand)

A As we see, the plate here has a good distance from the adjacent disc, but as the disc heals this plate is in proximity to that other disc, so it is possible that the plate itself is somehow effecting the disc as well. It is not obvious from this x-ray that that is happening. But the problem with the adjacent

level is more dramatic in his case because we know that he already had a problem with that adjacent level coming into the surgery. And so now he has that problem with the adjacent level, combined with the fact that he has this problem, this stiffness and loss of motion at the disc below. So he is more likely than the average person to have a problem at this level above.

Q How about putting this in context with the fact Mr. Talleyrand still has weakness and numbness, as we said, I saw in your notes in his right upper extremity, putting that in context with the adjacent segment syndrome, and the need for possible revisions in the future, is Mr. Talleyrand at a greater risk than the average person for needing a revision surgery?

MR. WHALEN: Objection, your Honor, he just testified to that.

THE COURT: Well, you can answer the question.

A So, there are two reasons why he is at higher risk than the average person who has this surgery. The average person that has this surgery, this is, this surgery is done on a relatively high volume basis in America, this is not some obscure surgery, it is just as common as knee and hip replacement, it is really common. But the majority of these surgeries are performed on people that have a degenerative process, those patients that are having this, and particularly the ones that are studied in all the big studies that are

published, are not a group of patients who had whiplash, okay. So the fact that he had an injury to the neck, and had one disc that we thought was severe enough to take out, doesn't preclude him from having problems at other discs, in other levels. And we know he had something at the C5-6 level, to begin with. I didn't think that it it was significant enough to remove with the surgery, but we know that he had it to begin with, and the fact that he had ongoing symptoms after the surgery ongoing neck pain that even today he continues to have significant symptoms in his neck, suggests that it wasn't just that disc that was a problem, that there were other structures in the spine that were damaged. We know that, but it just all fits together and supports that.

So he is not the guy who had surgery and feels good post-op, and now we are worried, like we are asking what his risk is for having surgery in the future. This gentleman is the guy who had an an injury, we damage controlled treating one level, and he still has residual leftover pain, and we obviously didn't get all of the problem out of his neck. So he has more to do, he has more problems in his neck. He is not that characteristic person where we would, you know, where we would look at the chances of him having another surgery in the future. He is at much higher risk of having a revision surgery in the future, probably between 10 and 15 years after his first surgery.

Q Is that within a reasonable degree of medical certainty that Mr. Talleyrand is at much higher risk of needing this revision surgery?

A Yes.

Q I want you to assume that the defendants have hired an expert to come in and tell us that the MRIs that we see from 2013, 2015 show a degenerative process, meaning that the accident didn't cause these injuries, it already existed in Mr. Talleyrand's neck even before the truck hit him. I am resting on this diagram -- I want to show you the axial cuts here?

A It -- actually the best cut is the -- it is easier to --

Q Sagittal?

A This one.

Q Okay, sorry. Do we have the number on this, so we will be using the sagittal model of the MRIs?

A I think was 11.

Q 11, very good memory?

A I think you said that, because I asked before.

Q Why would that theory fail?

A Okay, so why do I not think that this is a degenerative process?

Q Correct?

A First of all, we all know that as we age that the body doesn't discriminate, right. From left to right or different

parts, if you have wrinkles, you don't just have wrinkles on one side of your face, it is a part of your body, it is genetic aging. So people who have arthritis in their spine that is significant arthritis at a young age, typically have arthritis at multiple levels, it is more widespread. The characteristics in this disc herniation at C5-6 are not typical of an arthritic problem. There is a bright tear in the disc that we see on both '13 and '15 MRIs, that's an acute change. Arthritis or degenerative changes that occur over time naturally are more characteristic of a dark disc, because it has lost water, and a disc that is bulging circumferentially, and is not as focused as this disc was in terms of its effects on the body. So this really effected the right side. The disc on the MRI is, has a bright spot in it. To me, that looks like a fresh disc herniation, it does not look characteristic of a degenerative problem.

Q In a degenerative process, correct me if I'm wrong, you would expect widespread problems along the entire spine, in this that is not what we see here?

A That is one of the reasons why I would say this is less likely to be degenerative, it is not -- it is possible to have one spot that is degenerative, it is possible, but it is just not common. That is, I mean, that is just speculative to say that this is degenerative when it -- you know, based on the fact there is a disc that is pushing backwards in the canal. The

characteristics of the disc in this MRI, are not a typical bone spur from arthritis. The characteristic of this disc herniation are of an -- of this finding on the MRI are of a disc herniation.

Q So you don't see any bone spurs or osteophytes, or anything of that nature?

A I don't think that we are looking in this MRI that is pressing on the spinal cord is due to a bone spur or an arthritic change in the disc.

Q Now, Doctor, is it fair to say the C5 and C6, that level in the disc that sits in the middle of that level, C5-6 disc is a member of our natural body, just we are born with it?

A Yes.

Q And can you tell us just briefly, the function; that disc has a function, correct?

A Yes.

Q What is the function, just briefly, of that disc?

A It is a joint, so it gives you mobility.

Q Now, does Mr. Talleyrand have any function at that joint as a result of this accident?

A No, the joint is not there anymore.

Q Will that be permanent?

A Yes.

Q And is that significant?

A Yes.

Q And will Mr. Talleyrand, within a reasonable degree of medical certainty, require additional care to his cervical spine?

A Yes.

Q And within a reasonable degree of medical certainty, for the sake of brevity, all these questions will be within a reasonable degree of medical certainty, will he require revision surgery to his cervical spine?

A I believe that he will have a revision surgery, and likely between 10 and 15 years from his initial surgery.

Q And within a reasonable degree of medical certainty, Dr. Gerling, what was the cause of Mr. Talleyrand's clinical condition to his cervical spine?

A The accident in 2013.

Q Thank you very much, I have no further questions.

THE COURT: All right, we will take a very short break, five minutes, ladies and gentlemen, okay.

COURT OFFICER: Rise for the jury.

(Whereupon, the jury leaves the courtroom at this time.)

(Whereupon, a recess was taken at this time)

COURT OFFICER: Rise for the jury, jury entering.

(The jury enters the courtroom at this time.)

THE COURT: Have a seat, thank you.

All right, have a seat, Doctor, thank you.

(The witness resumes the witness stand)

THE COURT: Whenever you are ready, Mr. Whalen, you may start your cross-examination.

MR. WHALEN: Thank you, your Honor. Thank you. With the Court's permission my paralegal, and plaintiff's permission, my paralegal is going to help me as we will use some things on the Elmo, so that is her purpose, Marielle.

CROSS EXAMINATION

BY MR. WHALEN:

Q Good afternoon, Dr. Gerling?

A Good afternoon.

Q You and I have met before; correct?

A Yes.

Q A number of times, correct, 3 or 4?

A Really?

Q Yeah?

A Well, on, maybe because we had to repeat the -- I think we had only done one thing where you were deposing me, right, but it was one patient, multiple visits or something.

Q I think two or at least?

A Maybe, but it was the same patient, right.

Q Okay, so and we spoke in the hall before this; correct?

A Yes.

Q We have some common interests, fair to say?

A Yes, fair to say.

Q Prior to testifying here today, did you meet with Mr. Liakis and go over your testimony?

A Yes.

Q And when was that?

A Over the weekend, and then this morning I met with him briefly.

Q And with regard to the medical illustrations, was over the weekend the first time you saw those or were those presented to you before for your approval or your consideration?

A Oh, I think they were probably before when they were being -- when they were produced, yeah.

Q You testified on direct examination that this type of spinal procedure has become a pretty common procedure, is that fair to say?

A Yes.

Q That it is done on a frequent basis now; correct?

A It is a much more common surgery; in the last 30 years it has been very popular.

Q And you, yourself, do a lot of these surgeries; correct?

A Yes.

Q And specifically the fusion surgeries, correct?

A Correct.

Q And it is typical for a patient that after this surgery they can be a -- they can have the surgery in the morning and be

discharged in the afternoon, or sometimes they can have the surgery in the morning and be discharged the next day; correct?

A Yeah, I mean, it depends, it depends on the scenario, but as far as, you know, popular belief, actually we are having a symposium on this tomorrow, some surgeons believe that you have to watch the patient for four hours, minimum after the surgery, some six hours. Some believe you have to keep them overnight. It also depends on how you do the surgery, because bleeding issues, some people are more -- they leave the patient bleeding more than others, so they need to watch them longer.

Q You outlined for the jury a lot of the risks that are associated with this surgery in your testimony. Fair to say that none of those risks came to the moment in this instance?

A Well, no, some of them did. He didn't get complete relief from the surgery, which is a one, he didn't have -- he didn't have one of the major complications from anesthesia, he had just appropriate postoperative symptoms, yes.

Q So, all those risks, such as death and bleeding and all those things, didn't come to fruition in this case?

A That's true.

Q It was a successful surgery to the extent that none of those risks came to fruition?

A Correct.

Q And the length of time -- you do this surgery how many days a week, do you perform surgery?

A It depends on the week, how many. Some weeks I only do 1 or 2 surgeries, some weeks I do 8. I would say the average is six cases a week, but I do a whole variety of cases on a variety type of patients.

Q Understood. You gave us the different areas, different treatment of the spine. When I am asking you questions let's keep it to the fusion, surgical fusion or lumbar fusion, okay, or 1 or 2 levels would be fine?

A Okay.

Q How many of those do you do in a year?

A I don't know the exact amount, I would say probably 200 to 220, if you combine cervical and lumbar, I would say that is reasonable to assume.

Q Okay, fair enough, so approximately, just using the 200 number, 50; I know there is 52 weeks in a year, but it's faster if there is 50 weeks a year, that would be about four a week, is that fair to say?

A Right, assuming I don't take vacation.

Q I expect you would take a vacation. And you are compensated for your surgery on each and every one of those surgeries; correct?

A No.

Q Some you do for free?

A Yeah, I have charity cases. I have cases where I, you know, I don't participate with the insurance, I am not going to

get paid for them, for sure.

Q For the vast -- most of them, fair to say you get compensated?

A Yeah, in various, you know, levels. Some, some it's menial, it is a minimal amount, sometimes it is a good amount, so yeah, you win some, you lose some.

Q Fair to say, that your patient population for this type of surgery varies from some very young people to some older people, would that be fair to say?

A Absolutely, yeah.

Q Let's identify that a little more, people in their twenties, fair to say?

A Yes.

Q And people in their, what would old be, 60s or 70s?

A 90, 95.

Q Still doing this type of procedure, correct?

A Yes.

Q And you would term the operation itself, not the symptomatology, but the operation itself, as a successful procedure; correct?

A You mean globally, in general?

Q Yeah?

A Yes, in general, yes.

Q You were pleased in your operative report with the disc placement in between the two vertebrae; correct?

A The execution of this surgery, yes.

Q Yes, and how long did this surgery take for the point in time for -- of you being involved in this, not the anesthesiologist?

A I don't know, but it would have been less than two hours.

Q You said that the disc that was removed was sent for pathology; is that correct?

A It should have been, yes.

Q I think you said it in your operative report?

A That's correct.

Q It was sent to pathology?

A That is what I would have asked the scrub tech to do when I take the disc out.

Q You send it to pathology to see what?

A Well, actually, traditionally, the pathologist would, you know, the pathologist would look at everything, including if we take a screw out, they would even say we have to look at that. But that is changed a lot recently. NYU actually doesn't want us to send disc any more to identify it as disc. The most, the most significant time we send things for pathology is when we are not quite sure what is going on, like, for example, if we are certain there is infection, or a tumor something like that. Most of the time in this scenario it is sent to pathology just out of routine.

Q Do you know the pathology results for this particular disc?

A No.

Q Do you know if the pathology results said that this disc was suffering from degeneration?

A No, I don't, I don't recall seeing the report.

Q Most of your patients, the great majority of your patients go back to their normal daily activities of living, would that be fair to say?

A Well, I really don't know the proportion of them that do.

Q Some of your patience who have had a cervical discectomy and fusion go back to strenuous activities?

A Certainly, I mean there are patients that do extremely well.

Q Even patients in their 60s or their 70s go back to, you know, extreme activities?

A I can't think of any of my patients that do extreme activities after the fusion surgeries, but I mean there are there are precedents out there where people do, sure.

Q Some younger patients go back to strenuous activities too; correct?

A Yes.

Q Some professional football players have had this type of surgery correct?

A Yes.
Q Professional golfers have had this type of surgery, correct?
A Are you -- oh.
Q Not --
A You are not pointing at him?
Q No?
A Yes, yes.
Q And even people in their 60s go back to strenuous activities or sports activities, that you are familiar with like skiing and hockey and things like that, correct?
A Yes.
Q Do you know what Mr. Talleyrand did for a job before he came to you?
A I have, I have some memory of it, I think that he does, I want to say that he did some custodial work, he worked for -- he did physical things on the job. I don't remember exactly. I know that at some point in my notes I took note of the fact he worked in some supervisory activity at some point, but my understanding was that he had a physical role in his job where he had to do work, physical work with his hands.
Q By the way, when a patient comes to you with their complaints, you rely on their truthfulness; is that correct?
A Yes.
Q And when Mr. Talleyrand came to you with his complaints

he told you that there had been an accident, which he was involved in, in 2013; correct?

A Yes.

Q It is in your notes, and he told you that that accident involved a truck, correct, I believe?

A I don't think so.

Q Okay, do you know anything else about that accident, about the amount of damage in the vehicles or lack of damage or anything like that?

A I, I mean, I know that there was a truck involved, not just because you just said it, I know that there was a truck involved, but going back to when I was evaluating him, I didn't know that there was a truck involved, I just knew that he had been involved in a motor vehicle accident, and that he had injured himself in an accident.

Q You were relying on him and some of the medical records that you later saw, such as were displayed to you at Kings County Hospital as to the fact there was a motor vehicle accident, but the extent of the forces, fair to say, you have no idea what they were that were involved in this accident?

A My -- what I know is that they were sufficient to injure him, but I don't -- but I wouldn't know the particular loading of the car, and certain angles, or -- and I don't think anybody truly knows exactly what direction, you know, these loads occur in, because the patients are in different positions

in the car. And if they are sitting forward and they fall backwards, if they are, if they are twisting in a certain direction, all of those things impart different loads on a patient, different forces.

Q But you didn't question Mr. Talleyrand about how he was seated except for the fact he was seated with a seat belted driver; correct?

A No, I don't believe that I did. I would have questioned him to ask him how he got injured in the accident, yes.

Q And you don't know, again, the extent of the damage, if any, to the vehicle he was in?

A No.

Q You are relying on Mr. Talleyrand for the forces that were involved in that accident to reach your conclusion that this accident was the cause of his surgery; correct?

A Well, the, not entirely. We use the history, as well as the clinical findings. And I mean it is a big clinical picture, right, it is somebody who is working, who can no longer work. It is a person that had a herniation in his neck, he had a, significant objective neurologic findings and objective findings on examination, he had subjective findings as well. It is not all -- it is not all -- it is not all something that you read on a piece of paper. Some of it is coming out of his mouth for sure, but if it all fits together, it is quite sophisticated

for somebody to be able to make it all fit together, if it is not true.

Q How about the fact that he was involved in a 2007 accident where he had complaints of neck pain, you were aware of that at a point in time in your treatment; correct?

A Yes.

Q You weren't aware of that, I don't believe, on your first visit. By the time your second visit came around in December, you became aware that there had been a prior 2007 accident, correct?

A Yes.

Q And Mr. Talleyrand told you that after that 2007 accident, he went to physical therapy, and he got better; correct?

A I am looking at my December 2015 note. You know, I don't know exactly how many of those details I had available to me that specific day.

Q I thought I got out of your notes on that December that he had a 2007 accident, and it was resolved; I'll withdraw the question?

A Well, on the note I said that I reviewed an MRI, MRIs from the 2007 accident, and found that there were no herniations present, I don't see.

Q You -- actually, Doctor, you didn't review MRIs from the 2007 accident. Counsel and I have agreed upon that because

the MRIs from the 2007 accident weren't available, okay, so let me move on to --

MR. LIAKAS: By stipulation. Can we approach?

THE COURT: You want --

MR. WHALEN: By stipulation, we agreed the MRI were not available.

MR. LIAKAS: Well, can we approach and we will --

THE COURT: Quickly.

(Whereupon, an off-the-record discussion at side bar was held between counsel and the Court.)

(In open Court:)

THE COURT: All right, so ladies and gentlemen, you just heard some testimony concerning certain MRIs that were taken back in what year?

MR. WHALEN: 2007.

THE COURT: 2007. Now, the films were not available for Dr. Gerling's review, all right, so any testimony that he gave you concerning what those MRIs allegedly showed, has to be completely disregarded by you, okay. So all that testimony concerning what he just said about the MRIs has to be stricken from the record. You must remove any concept of what he testified from your minds.

MR. LIAKAS: Your Honor, can we clarify with regard to the report?

THE COURT: Well, look, next, let's go.

Q On your first visit with Mr. Talleyrand, your first office visit was on October 21st, 2015; correct?

A Yes.

Q Some 27 months after the accident; correct?

A Yes.

Q On your first visit, did you have occasion to review the Kings County Hospital records?

A At the time I prepared this note, I don't believe that I had those records.

Q You know, though, you have since in the course of your treatment of Mr. Talleyrand, reviewed the Kings County Hospital records, correct?

A Yes.

Q You know that there is no loss of consciousness, no LOC, is one of the notes, you reviewed also?

A Yes.

Q Mr. Talleyrand, he told the hospital staff that he didn't lose consciousness, correct?

A Right.

Q He was kept in the hospital because of his chest condition, correct, they were concerned about his heart, his lungs, and his blood pressure; correct?

A I don't know that that's true.

Q You know that he thereafter started treatment with an acupuncture facility, some of the records were put up, Silver

Needle Acupuncture, correct?

A Yes.

Q And also Bayview Medical physical therapy; correct?

A Yes.

Q And did you review the records of Bayview physical therapy?

A I believe so.

Q And you noted the diagnostic interpretation was right leg, right ankle, right arm, right shoulder, neck and back pain?

A I believe we reviewed it earlier here, yes.

Q All of the above, though, correct?

A I believe so.

Q And he was also at the time being treated by Dr. Jacques, you saw some of his records, for his hypertension; correct?

A Yes, I believe so.

Q As to blood pressure, which you were also concerned about at the time you did your surgical intervention; correct?

A Correct.

Q And it was still something he was suffering from, it is a life-long condition, hypertension, is that fair to say?

A It can be.

Q Let me withdraw it. Lifelong once it starts?

A It can be. If you lose weight sometimes it goes away, there are ways it can go away but.

Q You are aware while he was attending physical therapy at Bayview, which he attended from August of 2013 until April of 2014, as counsel indicated on direct, some nine months of physical therapy, okay, that during that period of time, his complaints of neck pain went away?

A I don't recall that.

Q I'll just take a moment to show you some of the records?

A Should I approach?

Q Let me get it up first, if you can't see it you are welcome to come down?

THE COURT: I don't think he can see it. Doctor, you can certainly step down.

(The witness stepped down from the witness stand)

Q I am going to show you from the -- these are in evidence, Judge. From the physical therapy notes, the first note dated 8/7, August 7th, 2013, if I can get it up on this, that will be great.

MR. LIAKAS: Say the date again, I am sorry.

Q 8/7 2013. Can you see the date? If you can't, you can look right here, doc, it might be easier to see on that?

A Can we focus it? You want me to- right here. It goes up and down. It is only one way. Okay, I can try to read it on the page.

Q You can read it on the page, certainly we can see on

the page, I am just showing it for the jury, there is a complaint, the complaints of the patient are listed above?

A Yes.

Q And it states there on his initial, neck, midback, lower back, right shoulder, right knee right ankle, right elbow, right wrist, right arm, right leg?

A Yes.

Q All of the above; correct?

A Yes.

Q And --

A Those are the sites where he had his pain.

Q And then he is given certain modalities, physical therapy modalities which we don't have a physical therapist here, certainly they look like heat and cold, and some stretching and other physical therapy things, correct?

A Well, the note here doesn't really document therapy, I don't think, yes.

Q Here, treatment?

A I don't know if that is the plan or I assume that was what was executed or taken out, but I don't know, HP, I am not sure what those are.

Q Neither am I?

A Yeah.

A He is getting treated.

Q He is getting treated, he does -- so on 8/8 he follows

up on 8/12?

A Similar course.

Q I will take it down, we'll have to do it old school.

(The witness resumed the witness stand)

Q I am going to tell you, I am not going to show you all the records, I am going to tell you that there were ten visits in August -- you can resume the stand. In August of 2012, one visit in September of 2012, 14 visits in October, ten visits in November, and then we get to December. And during those periods of time I will ask you to assume the records reflect the treatment of all those areas that he was complaining about on the initial visit. Then we get to December, actually, the first visit in December, the first three visits are December 4th, December 6th, and December 9th. I am going to tell you that he had complaints of neck and lower back pain on all three of those visits, okay?

A Yes.

Q I am going to show you part of the record, December 12th, December, it is either 11 or 12, December 11th or 12th, it is 11; December 11th, December 12th, December 16th, okay, the complaints of neck pain, he doesn't have any anymore, correct, according to that, the physical therapy treatment notes?

A Those days he was complaining of his back more, I mean, we don't know --

Q Well --

A -- if he complained of neck pain because they didn't check it off. We just know they were treating that site; I am not sure.

Q I ask you to assume right up until that date, as I said, all those physical therapy appointments that he did up until that point in time, he had received treatment because of complaints of his neck, and now we are in the second week in December, and there is no more complaints of pain to the neck or treatment to the neck, according to the physical therapy notes, correct?

A They didn't check the box, I don't think that this is a real note that I can rely on to know whether or not he had neck pain.

Q Can you rely on the notes where he said he did have neck pain?

A Honestly, I don't think you can -- you can -- that is not a narrative, that is just a box that was checked. I mean, reasonably speaking, they were, they were treating the neck during those visits where they checked the box for neck, and they were treating the back and the visits -- on the visits they checked the box for back. I think that is really the way they do it. It is hard to know from that note.

Q For the record, I ask you to take a look at the physical therapy notes, okay, for complaints and treatment dated

December 17th, 2013, December 23rd, December 28th, December 29th, December 30th, December 31st, January 6th, January 8th, January 9th, January 14th, January 16th, January 23rd, January 24th, January 30th, January 31st, February 10th, February 14th, February 18th, February 20th, February 28th, March 12th, March 21st, March 26th and the last note of April 10, 2014, and this is my copy, doc, there is -- you know what I am going to ask. There is no complaints of neck pain and no treatment to the neck though; correct?

A I will take a look at them.

Q Sure.

A Yeah, I mean, so I would certainly agree that these notes don't reflect an obvious complaint or treatment of neck, but I don't believe that these are narrative or complete, or make any strong statements that there is no neck pain.

Q Would your testimony be the same for the treatment he received beforehand at the occasions that he was treating for the neck, and that they checked off neck, to indicate that, well, maybe there isn't any strong reason to believe the neck is damaged?

A These are not -- these are not narrative notes, they are not, I don't even know what person is filling these notes out, they are not signed. I guess at the bottom it says signature of physical therapist, but it is including all three visits for that. I don't know if that is the treating physical

therapist. These are not really notes that I would rely on other than to say that clearly he was being treated at a physical therapy office on those dates. So he was having what we consider conservative care for spinal disorders. I mean, it is certainly validates he had a significant lumbar injury.

Q Okay?

A It doesn't invalidate that he had a cervical spine problem.

Q So I would assume -- maybe I shouldn't assume anything, I assume then the contra is indicating when he was treating for the neck you wouldn't rely on those notes to reflect that he was actually receiving treatment for the neck in the early stages of physical therapy?

A Well, as I said, I think that if it indicates on that, what you showed me, that they checked a box for neck, and then checked the types of treatment, I would say that it is reasonable to assume that the patient was getting care at that site that day, but I just don't believe that that, that that is a note I would rely on to know the extent of the symptoms the patients were having in any one particular area. They could have had blood pressure problems that day, but they weren't complaining or treating that site; you know what I mean.

Q Sure, and I think if it was one entry that may or may not be the case, but these were 26 --

MR. LIAKAS: Objection.

Q -- separate entries, you understand that, right, Doctor?

A Yes.

Q So, would it be fair to say, if you were relying on these notes only, that that note, those notes in the physical therapy records indicate resolved cervical sprain or strain?

A As I said, not at all, and I didn't say I would rely on those notes for understanding whether or not he had neck problems. And he wasn't solely treated for neck sprain or strain, he was treated for neurologic problems that I wouldn't expect them to be treating --

Q So are we saying that the Bayview area physical therapy, you told us the gold standard for treatment is physical therapy, on your direct examination, physical therapy and home therapy are the things most people should do to get themselves better; correct?

A Those are the first, it is the gold standard for things we try first for neck and back problems, absolutely.

Q And, but it is your testimony -- this is the last time I'll go into this, I'll move on. It is your testimony we can't rely on the physical therapy notes from the physical therapist or from the facility that reflect no more treatment for neck pain, correct, we can't rely on that, that is your testimony?

A My testimony is that I don't think that that note really sufficiently rules out the fact that the patient had a

neck disorder at the time, it just indicates that, it appears to indicate, and it is not even really a great indication, but it appears that it indicates that they were being treated for the lumbar spine during that three-month period that you just pointed out; maybe thought that was more effective, that was something that was helping more, something that they could have more effect on.

Q This spine model is an indication of a normal spine, is that fair to say?

A Yeah, it is similar to the actual normal spinal column, yes.

Q With an exception of the colors?

A And everything else being ripped out, yes.

Q And the rubbery things in between are the discs; correct?

A Yes.

Q And the outer shell, as you told us, is the annulus fibrous?

A Yes.

Q The disc material is inside, correct?

A Correct.

Q And these are the vertebrae that are -- that the discs are in between the vertebrae, correct?

A Correct.

Q These vertebrae are, and discs are very healthy

vertebrae and disc, correct?

A Well --

Q If you want to hold it, you can --

A You can't -- they are not discs, they are not discs, they are just rubbery things.

Q They are not discs?

A It is meant to be a depiction of a typical disc, it is not something that we would -- we don't normally hold a spine in front of it to diagnose a degenerative problem, right.

Q Correct?

A We usually would use a study. If we get an MRI of that thing, we might be able to see some characteristics.

THE COURT: We have to make some ground -- Doctor, I am going to ask you to focus on his question, try to answer his question so we can move along, all right.

THE WITNESS: Sorry.

Q These vertebral bodies, they are -- this is the end plate, fair to say?

A Yes.

Q On this side?

A Yes.

Q These are smooth, because that is how a normal healthy disc vertebra would appear, correct?

A I guess so, yes.

Q Plaintiff's 11, the illustration for identification, in

11, in the 2013 MRI findings this doesn't look at all like the model, correct?

A I think it looks similar.

Q That is bone growth, isn't it, looking at C4 on the end of each of them, correct?

A Not substantially, no, what you are pointing at is the normal epiphysis of the bone.

Q This isn't normal-looking disc vertebral body, is it, C5?

A I mean, yeah, it has some, I mean contouring to it, it certainly doesn't look like C4, it doesn't look like C6, it doesn't look like C3, it looks different, you are right.

Q This is degeneration that has occurred over time, isn't that fair to say, indicating on C5, what looks like a tooth has been pulled out of somebody's mouth?

A You are pointing to a cartoon, that is not an accurate depiction of the patient's -- that is not an accurate depiction of the patient's bone.

Q So this illustration is a fraud, is that what you are telling me?

MR. LIAKAS: Objection, your Honor.

THE COURT: Well, all right, so this illustration does not accurately show what it purports to show, Doctor?

THE WITNESS: No, that is not what I meant.

THE COURT: Okay.

A What I mean to say is that the way that cartoon appears there. It is not -- it is the best that the cartoon artist could do to reproduce what appears on the MRI above, and it is similar, but it is not exactly the same. And the MRI, MRI, as I said earlier, is not used to delineate bone, it is not considered to be a great source for delineating where bone is, and to distinguish where the bone is. So in the actual MRI film above, everybody can see that it is difficult to make out where the bone starts and ends at the C5 bone. On the cartoon, the bone is a completely different color than the tissue around it and it is much more obvious, right.

Q Looking at C5 in the MRI finding, these two teeth pointing down, certainly not flat there, is it, yes or no?

A It is not supposed to be flat.

Q So, this is incorrect, right here 7, 6, 5, not supposed to be flat, these are flat, though, right?

A If you look at all the discs above none of the epiphysis, or the bony shape, they are all arched, they all have an arch that is normal.

Q Looking at the MRI, this certainly, certainly doesn't look a lot sharper, the MRI of 2015; correct?

A It sure does, yeah.

Q And these discs, C3-4, C4-5, C5-6, C6-7, fair to say that there is desiccation of those discs; correct?

A I think that it is age appropriate.

Q So, age appropriate degeneration; correct?
A Yeah, so it is what you would expect to see in somebody's MRI that is his age.
Q You told us, looking again at the MRI, of 2000 -- November 2015, this is the spinal cord, correct?
A Yes.
Q And you like this one better, though, with the spinal cord in the 2013; correct?
A Well, no, I was -- I don't like it better, I just think -- I don't know what you mean by like it better.
Q You said you could rely on this one, can you rely on the 2013 -- can you rely on the 2015 also?
A I believe, I believe that the 2015 depicts what was going on in the disc in that exact cut, I think it is reasonable.
Q You talked about a little bit about disc herniations and broad based disc herniations, what is the difference between a broad based disc herniation and acute herniation, or is there a difference?
A I think that you can describe an acute herniation as being focal or broad based, so they are not different entities necessarily, they are not mutually exclusive.
Q Could you use the term that he has a broad based herniation to reflect a degenerative condition also?
A Not typically, no.

Q Stenosis, that is another word that is connected with degeneration; correct?

A Not necessarily, I mean stenosis just means narrowing of a space, it doesn't --

Q The narrowing of a space over time is degeneration; correct?

A Not necessarily.

Q You are saying, you are being very careful in saying not necessarily, but it could be; correct?

A Right, so if you had -- I can, of course, think of scenarios where that's true, but it is not true in this case.

Q Spondylolisthesis is a degenerative term; correct?

A There are about 5 or 6 different types of spondylolisthesis.

Q But it is a degenerative term, not if there is 5 or 6, it is a degenerative term?

A There is traumatic etiologies of spondylolisthesis as well.

Q And there is degenerative findings of spondylolisthesis, correct?

A There are degenerative types of spondylolisthesis as well, yes.

Q We have disc bulges which can occur as a result of degeneration, correct, yes or no?

A Yes.

Q Spondylolisthesis which can occur as a result of degeneration, correct?

A It can, yes, but not in this case.

Q And stenosis which can occur as a result of degeneration; correct?

A But not in this case, yes.

Q And broad based disc herniations which can occur as a result of degeneration; correct?

A People don't typically use the word that way for degenerative problems, no.

Q You saw Mr. Talleyrand again after the operation -- by the way, when you saw him the first time, you didn't prescribe any medication, correct?

A So we discussed appropriate use of analgesic medication, yes.

Q What does that mean?

A It means appropriate use of analgesics. So we discussed the fact that he should be using them, how to use them, and what the risks are of using them.

Q And the analgesics that you were discussing would be Ibuprofen?

A All the different types of medications yes.

Q What are they, Ibuprofen is Advil, right?

A Ibuprofen is, yes.

Q You saw him again post-op on January 26, 2016, you had

a couple, I believe it is 1 or 2 more visits in 2016; correct?

A Yes.

Q Okay, and then you didn't see him again until this past summer, correct?

A No, April of 2018.

Q Okay, and in April of 2018, you were asked to see him to prepare, to participate in a life care plan; correct?

A I don't know that that's true, I don't think so, I don't do life care plan.

Q To give your treatment and the cost of treatment that would be necessary for him in the future; correct?

A I don't believe so.

Q You did a letter to that effect which, to counsel's office which stated that he will need in the future this and that?

A I don't believe I did at that time.

Q You didn't do that?

A No, not at that time.

Q In 2018?

A In April of 2018.

Q So you had no participation with counsel in the preparation of the costs of future surgery in 2018, with regard to Mr. Talleyrand?

A No, that is not what I said.

Q Okay?

A What I said is in this visit in April of 2018, I did not. The purpose of that visit, first of all, was to see him, and I did not, to my knowledge, I don't recall or have any indication that I participated in a life care plan at that time. I saw him again in June.

Q Or any --

A Of 2018.

Q Okay?

A And I believe that I prepared the narrative summary which you are referring to, which at some point, in the summer, I was asked. So in August I prepared a narrative summary, so that would have been two months after that visit in June.

Q So in August of 20018, you were asked by counsel for the plaintiff to opine as to the costs involved in Mr. Talleyrand's future care; correct?

A They requested that I do a narrative summary of my opinion of the his issues that he had had from the beginning until the end of my treatment with him, and to opine or to discuss what I thought his future held and whether -- and to make recommendations of what I think the costs would be that I can estimate. I certainly didn't do a life care, I don't do life care plans.

Q I think you told us in your direct testimony that the long -- there are no long-term effects of the hardware that is in Mr. Talleyrand's body, right?

A Well, the metal itself, to our knowledge, does not cause a long-term effect from the actual metal ions or the particles in it, it is just the stiffness in the joint, the loss of the joint that really has long-term effect, yes.

Q And the metal itself, you have had thousands of patients who have had metal in various parts of their spine over the course of your career, correct?

A Yes.

Q The metal itself has not created any kind of problem in and of itself, the metal, correct?

A It -- only when it loosens or gets out of place. It is not the actual presence of metal in their body, right.

Q And Mr. Talleyrand has a one level fusion as we know, correct?

A Yes.

Q Would it be fair to say some people even with two levels of fusion achieve, because the body accommodates the same flexion, extension, and rotation that they had before their surgery?

A In some people they do, yes, they can get back to the similar functional range of motion, but they don't have the same physiologic, if you measure the range of motion in their neck at those levels, there would be no motion.

Q At that, those two levels or one level, whatever it is; correct?

A Correct.
Q But the range of motion could be as it was before the surgery?
A Before the surgery, in the injured state, yes, but not as it was before necessarily the accident.
Q You have no scheduled appointments with Mr. Talleyrand; correct?
A I don't have my schedule in front of me, I don't know when his next appointment is.
Q At your 2018 visit, you didn't prescribe him any medication, correct?
A In June we recommended a CAT scan of the cervical spine, and recommended analgesic medications for the neck and back. In April we again had discussed the CAT scan of the cervical spine with analgesics for the neck and back.
Q And the CAT scan would be for the purposes of verifying the hardware was in place, as you verified in the past?
A And the bone had healed, because that would be one explanation why he was having so much pain, that he has a non-union.
Q Your x-ray that you took post-op accident, though, showed the bone healing, correct?
A No, that was -- it was too soon after the surgery to know whether the bone healed.
Q And how long does the bone take to heal typically?

A Between 6 and 12 months.
Q And you have not taken any x-rays or CAT scans of him, is that what you are saying?
A Right, so you don't have a postoperative CAT scan that, to prove that the bone healed, and until proven otherwise post-op, we are concerned it didn't heal.
Q You stated earlier in your direct examination, that the discs can heal, a herniated disc can heal on its own; correct?
A They can, yes.
Q So, now having seen the physical therapy records where he stopped treatment for his neck, physical therapy treatment in December of 2013, do you have an opinion with a reasonable degree of medical certainty as to whether or not any damage done as a result of this car accident could have healed itself?
A I don't believe so.
Q But you don't know, because you hadn't -- you didn't see him for another two years, correct?
A Well, and I don't think those notes really reflect a true history of the patient, it is just a box checked on what site they treated that day.
Q You have not ordered any further MRIs, correct?
A No, the CAT scan is the study we ordered.
Q When you did this surgery, you had to -- I don't think it is the right word, but grind down the end plates of each of the vertebrae that the medical device was inserted into,

correct?

A Correct.

Q That was to take down any bony growths or protrusions which would interfere with the smoothness of the implant; correct?

A No, it is because the bone, the shape of that bone, that dome-y shape isn't the same shape, as the implant we put in, we have to fashion it so it fits a nice, clean fit, like carpentry.

Q You had to clean up the vertebrae, fair to say?

A We remove, we remove bone in areas in order to make it fit the size of the implant that we are putting in, so it is a nice, clean fit for stability.

Q It is fair to say in irritating, for lack of a better word, both of the end plates it also promotes healing more quickly, correct, bone growth?

A We try to make the bone, we try to lessen it up -- so we can -- so the bone heals, that is correct.

Q Just a second, doc, I think I am done.

You understand from your review of the medical records in Mr. Talleyrand, that he had has a history of hypertension; correct?

A I don't know what history prior to his accident he had, I just know about the exacerbation at the time of his accident.

Q And exacerbation is something on a prior condition,

correct, an aggravation of a prior condition, correct, that is what exacerbation is?

A I don't know, I don't know what was there before the accident, I just know that in the trauma of the accident that he developed severe high blood pressure.

Q And that was reflected in the Kings County Hospital records; correct?

A I believe in more than just that, but it was reflected in those records, yes.

Q I have no further questions, thank you, Doctor.

THE COURT: Redirect examination.

REDIRECT EXAMINATION

BY MR. LIAKAS:

Q While we are on the topic of hypertension, I want you to assume, Doctor, Mr. Talleyrand did not have any complaints or treatment or any mention in his medical history of hypertension before this accident, okay. Now, is it possible for a traumatic event to ignite a hypertensive response?

MR. WHALEN: Objection.

THE COURT: All right, you have to rephrase the question, counsel.

Q Assuming that Mr. Talleyrand had no complaints of hypertension, had no treatment, no medication before this accident, and then with a truck collided with the car he was a passenger in and he struck his head on the seat back behind him,

he began to be hypertensive, does that fit, is that possible?

MR. WHALEN: Objection, is it possible.

THE COURT: All right, if you want to get right to the question I will permit the question.

Q Yes?

THE COURT: Does he have -- within a reasonable degree of medical certainty.

A It is well-known that --

THE COURT: Well, go ahead, let's have a clear question.

Q Do you have an opinion with a reasonable degree of medical certainty, whether or not the hypertension in the absence of any prior hypertension could have been caused in this accident?

A I believe that his blood pressure went up because of the stress of the accident, I don't know the impact that would have on a long-term basis. But on -- at the time of the accident, I believe that the accident caused his blood pressure to go up.

Q And Mr. Whalen asked you about, could this be degenerative, could these conditions be longstanding, but he didn't ask you about Mr. Talleyrand specifically. Now, you mentioned before, why specifically Mr. Talleyrand, what we see on those MRIs is traumatic in nature, is that fair to say?

A Yes.

Q And in part of diagnosing that, I want to ask you, if I can find it, when you are in your office looking at MRIs, do you look at the Plaintiff's 11, do you look at the actual MRIs or are you looking at a cartoon?

A We look at the MRIs.

Q I figured.

MR. WHALEN: We stipulated to that.

Q But the MRIs itself, what are those primarily showing you as a doctor?

A He has a clinical disorder consistent with trauma. Whether or not there is some degenerative changes that are age appropriate, it is normal in his age group to have mild degenerative changes, and I believe that there are mild degenerative changes in the neck that are appropriate. But it is very reasonable to assume, with a medical degree of certainty that the pain that he has, the syndrome that he has was brought on by the traumatic herniation of the disc at that level. It is reasonable to assume, within a medical degree of certainty that the pain syndrome, the neurologic problems that developed, were caused by the accident, and that herniation in his neck.

Q And Mr. Whalen also mentioned a few dates where in December, starting in December, 11, I believe, Mr. Talleyrand was not receiving care to his neck in therapy, do you remember that part?

A Yes.

Q Now I believe he said December 11th, December 12th, December 16th, December 23rd, December 26th, December 31st, January 6th, January 8th, January 9th, and I can continue all the way to April 10th, and he said there was no treatment to his neck. I want to show you what has been marked, it is in evidence, the records from the acupuncturist who was treating Mr. Talleyrand on all those dates, all 26 of those dates, can you tell me, in all 26 of those days that Mr. Whalen mentioned is there treatment to Mr. Talleyrand's neck?

A These notes are similar to the physical therapy notes in the sense that they are boxes that are checked, the therapist, the acupuncturist was treating the neck and the back on all of these dates.

Q Thank you. And --

A In January -- in December, in January, and February, in March and in April.

Q All of the dates Mr. Whalen had mentioned, correct?

A Yes, well, I don't know if those are exactly the same dates, but in the same time period.

Q And, Dr. Gerling, you were also asked, well, do professional athletes have this surgery, right?

A Yes.

Q This surgery can treat multiple conditions, fair to say?

A Yes.

Q And it can treat radiculopathy, as you said, it could treat myelopathy; correct?

A Yes.

Q Now, I want you to assume, for the sake of the argument here that Mr. Talleyrand is not very good at basketball but he plays for the New York Knicks, that is why -- he plays for the knicks, okay, and he has a traumatic event that causes myelopathy and radiculopathy, and a traumatic herniation in his neck, and has continued pain, spinal cord pain and symptoms of spinal cord damage, even after he has this fusion. Now, in that setting, a professional athlete, assuming Mr. Talleyrand plays for the Knicks, could that be a career ending injury?

MR. WHALEN: Objection.

THE COURT: You can answer the question.

A He would not be allowed to return to his sport with the clinical picture that he has, and with the ongoing care and symptoms that he has had and findings that he has had after this surgery, up to the current date. So as he sits today, he would not be allowed to play. So he did not have a resolution of his symptoms from a focused small -- certain problem that was treated, healed, and then could allow him to return to whatever it is, his activity that he was doing before. In his case, he had severe injury that is complex, it is not simple. He is not a 20-year old basketball player that is in incredible shape, that -- or a football player that is in incredible shape that

gets hit all the time and can bounce back. He is not the same person, and he is, his --

THE COURT: All right, Doctor, you answered.

A So it is not, it is not the same scenario, and I do not think he can go back.

MR. LIAKAS: Thank you, very much.

THE COURT: Recross.

RECROSS EXAMINATION

BY MR. WHALEN:

Q You know what is coming, the acupuncture progress notes from January 16th, I didn't go back to December, up and through April of 2016, there are boxes at the top, do you agree, Dr. Gerling?

A Where it says complaint, yes.

Q Complaints, and do you agree in all those entries, I will hand them to you in a second, lower back, back pain, LBP, correct?

A I don't know what you mean, can you --

Q That is checked off, lower back pain?

A Do you mean at the top and in the body?

Q Yes?

A Yes.

Q Midback pain, MBP is not checked off, correct?

A I, I would love to give you the benefit of the doubt on that.

Q Is it checked off or not?

THE COURT: Simple question.

A It doesn't say midback pain, it says MBP, I don't know what that is, I am not sure.

Q Is it checked off?

A MBP is not.

Q How about NP, neck pain, is that checked off?

A Not checked off.

Q All of them reflect the same treatment he got, that they state he is not treating for his neck pain anymore, it is resolved, according to the records?

A They actually support the notion that he still had neck pain, he complained of neck pain.

Q Any treatment checked off for neck pain, NP, you can look through them?

A If NP means neck pain, then this note suggests that he was not getting acupuncture for his cervical myelopathy.

MR. WHALEN: Thank you very much, Doctor. I have nothing else.

MR. LIAKAS: Last question.

THE COURT: Go ahead, it better be related to this.

MR. LIAKAS: It is.

REDIRECT EXAMINATION

BY MR. LIAKAS:

Q I would like to publish this?

MR. WHALEN: Well, I would like to publish mine too.

MR. LIAKAS: The same thing.

THE COURT: You can publish it tomorrow.

Q Right under patient name, it says complaints, what box is checked for all those dates?

A So as I said, it is clear from all of those notes that he was complaining of neck pain, but it doesn't -- it is not clear from those notes that he was getting acupuncture care for neck, it is not clear one way or the other, but acupuncture is not used to treat myelopathy, and cervical disc herniations, okay.

MR. LIAKAS: Thank you.

THE COURT: All right, thank you very much, Doctor. All right, counsel come up.

THE WITNESS: Are my notes to be left?

THE COURT: Yes.

MR. LIAKAS: Yes we are going to mark them.

THE COURT: They have to stay, thank you.

(Whereupon, the witness stepped down)

(Whereupon, an off-the-record discussion at side bar was held between counsel and the Court.)

(In open Court:)

THE COURT: All right, so ladies and gentlemen, as I indicated to you this morning, we are done for the day.

So tomorrow we are going to come back, we are going to reconvene, we have two more witnesses for tomorrow, I believe, but we are not going to start until 10:30, so please be here ready to proceed by 10:30. Okay, thank you again for getting here on time, today, thank you.

COURT OFFICER: Rise for the jury.

(Whereupon, The jury leaves the courtroom at this time)

THE COURT: Gentlemen, I will see you tomorrow.

MR. WHALEN: See you, Judge

(Whereupon, the Court recessed and case adjourned to December 5, 2018)

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