

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS : CIVIL TERM : PART 7

-----X
MOAZZAM R. GILL,

Plaintiff,

-against-

Index No. 706989/2020

SIGFREDO VALLADARES-LOPEZ & TRIAL
FLEETWASH, INC,

Defendants

-----X
Supreme Courthouse
88-11 Sutphin Boulevard
Jamaica, New York 11435
May 22, 2025

B E F O R E:

THE HONORABLE NICOLE MCGREGOR-MUNDY,
J U S T I C E

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

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Attorney for the Plaintiff
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BY: JASON LESNEVEC, ESQ.

Mulholland Minion Davey McNiff & Beyrer
Attorney for the Defendants
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New York, New York 11596
BY: KEVIN MCNIFF, ESQ.

FRANCINE SPAULDING, VICTORIA BIFULCO
Senior Court Reporters

1 THE CLERK: All rise, come to order.

2 THE COURT: Good morning everyone, please be
3 seated. On the record, please bring in the jurors. Call
4 the case in.

5 THE CLERK: Queens Supreme Court -- all rise,
6 Supreme Court Part 7 is now in session with the Honorable
7 Nicole McGregor-Mundy presiding. This is case on trial
8 Index 706989/20, Moazzam Gill against Sigfredo
9 Valladares-Lopez & Fleetwash, Inc.

10 Let the record reflect all counsels are present.

11 MR. LESNEVEC: Good morning, your Honor. Jason
12 Lesnevec, Law Office of Michael Lamonsoff on behalf of the
13 plaintiff, Moazzam Gill who is present in court.

14 THE COURT: Good morning, counsellor.

15 MR. MCNIFF: Kevin McNiff, Mulholland Minion,
16 374 Hillside Avenue, Williston Park, New York, 11596
17 attorney for the defendant. Good morning, your Honor.

18 THE COURT: Everyone may be seated. Are you ready
19 to proceed?

20 MR. LESNEVEC: Yes, your Honor.

21 THE COURT: Please bring in the jury.

22 THE COURT OFFICER: All rise. Jurors are
23 entering.

24 (Whereupon, the jury entered the courtroom.)

25 THE CLERK: Do all parties stipulate to the

1 presence and proper seating of the jury?

2 MR. LESNEVEC: I do.

3 MR. MCNIFF: I do.

4 THE COURT: You may all be seated. Everyone may
5 be seated.

6 Good morning members of the jury, welcome back. I
7 hope you all had a relaxing and or productive last few
8 days. We will continue with the trial at this time.

9 Counsel, you may call your next witness.

10 MR. LESNEVEC: At this time, plaintiff calls
11 Dr. Matthew Kalter.

12 THE COURT OFFICER: Witness entering.

13 THE CLERK: Raise your right hand. Do you swear
14 or affirm the testimony you are about to give shall be
15 truth, whole truth and nothing but the truth?

16 THE WITNESS: I do.

17 THE CLERK: State and spell your full name and
18 address for the record.

19 THE WITNESS: Dr. Matthew Kalter, 496 Smithtown
20 Bypass, Suite 200, Smithtown, New York 11787.

21 THE CLERK: Witness has been sworn, your Honor.

22 THE COURT: Proceed counsel.

23 EXAMINATION BY

24 MR. LESNEVEC:

25 Q Good morning.

1 A Good morning.

2 Q Have we ever met before today?

3 A No.

4 THE COURT: Please keep your voice up so we can
5 all hear you, sir.

6 Q Is the green light on the microphone?

7 Have we ever met before?

8 A No.

9 Q We spoke on the phone yesterday?

10 A Correct.

11 Q How long did we speak for?

12 A Ten minutes.

13 Q What did we discuss?

14 A General prep for the case.

15 Q Have you ever testified in court before where my office
16 was representing the injured person or the plaintiff?

17 A No.

18 Q How many times have you testified this year in court?

19 A Zero.

20 Q This is your first time?

21 A Correct.

22 Q How many times have you testified, if you can estimate,
23 over your career?

24 A Ten times.

25 Q Give us a brief history about your educational

1 background?

2 A Yes, I did my college at Muhlenberg College in
3 Allentown Pennsylvania. I went to Ross University School of
4 Medicine, did my training at Stonybrook University Hospital, a
5 fellowship in pain management in Annapolis Maryland.

6 Q So you are a medical doctor?

7 A Correct.

8 Q When did you graduate from medical school?

9 A 2002.

10 Q What is your field of practice?

11 A Physical medicine in rehabilitation by general practice
12 pain in medicine.

13 Q Tell us about the field of pain medicine?

14 A Yes, it encompasses a wide amount of things. It can
15 include orthopedics as well as spine care. But anything that
16 causes pain we treat with multiple different ways with
17 medications, physical therapy, as well as injections and
18 procedures.

19 Q Are you board certified?

20 A Yes.

21 Q What does it mean to be board certified?

22 A Basically, you have to do a curriculum and pass an
23 examination to -- that are up to date in all the current
24 information.

25 Q What are you board certified in?

1 A Physical medicine, rehabilitation as well as pain
2 management.

3 Q How is physical medicine and rehabilitation different
4 than pain management, if at all?

5 A Physical medicine is generally rehab or basically where
6 people are involved in more physical therapy or treating joint
7 pain. Where as pain management includes more of the procedural
8 aspect of injections and medications.

9 Q Do you hold a residency?

10 A Yes.

11 Q Can you tell us about that?

12 A Yes, residency at Stonybrook University Hospital which
13 involved treating people with spinal cord injuries and different
14 injuries where people rehab from. Then I did a fellowship in
15 pain management which involved a year of learning procedures and
16 injections for pain management.

17 Q Are you affiliated with any hospitals?

18 A Yes.

19 Q Which hospital?

20 A Plainview Hospital, St. Catherine's Hospital,
21 St. Joseph's Hospital, as well as Northwell.

22 Q What are your duties and responsibilities in terms of
23 those affiliations?

24 A Basically, I am on staff there. I don't do a ton of
25 work there but if there is a pain consult or if one of my

1 patients are in the hospital I go there.

2 Q How long have you been in private practice for?

3 A Since 2007.

4 Q Has that been continuously in the field of pain
5 management and physical rehabilitation?

6 A Correct.

7 Q Do you also perform surgeries or surgical procedures of
8 any sort?

9 A Minimally invasive spine procedures, yes.

10 Q Tell us more about that?

11 A Yes, there are different ways to treat pain and back
12 pain. There is certain procedures which can treat disc pain as
13 well as joint pain, involves multiple different types of
14 minimally invasive procedures.

15 Q Are you familiar with a discectomy procedure?

16 A Yes.

17 Q Tell us generally about that procedure; what is a
18 percutaneous discectomy?

19 A Basically a lot of people have problems with their
20 herniated discs pushing on the nerves. What this does is
21 basically without having a full blown surgery, we got in with a
22 needle and remove a small piece of disc and it takes the
23 pressure off the nerve.

24 Q How many of those disc operations have you performed
25 over your career; if you could estimate?

1 A 40 to 50.

2 Q What about injections, have you performed any
3 injections?

4 A Yes, I have performed epidural injections, discectomy
5 injections, multiple joint injections.

6 Q Approximately, how many epidural or joint injections
7 have you performed over your career?

8 A Four to five thousand.

9 Q How is it that you obtain your patients or find
10 patients to treat?

11 A Multiple different ways. My number one referral source
12 is just other patients that had good care and happy with their
13 care. You get referrals from multiple physicians and other
14 specialties.

15 Q If you were not here today, what would you be doing?

16 A I would be working in my office.

17 Q Are you being compensated for your time here?

18 A Yes.

19 Q How much?

20 A \$4,000.

21 Q \$4,000?

22 A Yes.

23 Q Are you familiar with a patient named Moazzam Gill?

24 A Yes.

25 Q Have you treated that patient?

1 A Yes.

2 Q Where did you treat him at?

3 A I treated him at an office in Bellrose at Premier
4 Physical Medicine and Rehabilitation.

5 Q As part of treating Mr. Gill, did you review any --
6 collect records from Mr. Gill?

7 A Yes.

8 MR. LESNEVEC: If I can have these marked.

9 THE COURT: It has to be bound. I will give you
10 big clips because that is kind of a mess. We will put it
11 neatly and then put the rubber bands around it.

12 We will mark this as Plaintiff's 18, for
13 identification purposes.

14 THE COURT OFFICER: Plaintiff's 18, has been
15 marked for ID.

16 (Whereupon, Plaintiff's Exhibit 18, was marked for
17 identification by the Reporter.)

18 Q If you would take a look at Exhibit 18.

19 A Yes.

20 Q Take a look through the records and let me know if you
21 recognize them?

22 A Yes, I do.

23 Q What do you recognize Exhibit 18 to be?

24 A These are my records of treating Mr. Gill.

25 Q Are those also records from Premier Physical Medicine

1 Rehabilitation?

2 A That's correct.

3 Q Are those accurate copies of the records from your
4 office?

5 A Yes.

6 MR. LESNEVEC: I would ask they be admitted in
7 evidence.

8 THE COURT: Any objection?

9 MR. MCNIFF: No objection.

10 THE COURT: What was previously marked for ID will
11 be entered into evidence as Plaintiff's 18.

12 THE COURT OFFICER: Plaintiff's 18, has been
13 marked into evidence.

14 (Whereupon, Plaintiff's Exhibit 18, was marked in
15 evidence by the Reporter.)

16 THE COURT: You may proceed.

17 Q Doctor, do you work along side other doctors at Premier
18 Physical Medicine and Rehabilitation or have you over your last
19 couple years of working?

20 A There are other doctors that work in the office. I
21 don't work with them.

22 Q Do they have a separate role than you?

23 A Yes, they do general physiatry where I specialize in
24 pain management.

25 Q What is the difference between physiatry versus pain

1 management?

2 A Physiatry is general rehabilitation, they do the basics
3 of physical therapy and certain medications. But, I am more
4 trained in pain management, I can do more of the procedural
5 aspect.

6 Q Physical therapy being the more exercise component,
7 pain management being more your administration of injections and
8 medicines?

9 A Correct.

10 Q Who is the physiatrist that treated Mr. Gill at Premier
11 Physical Medicine and Rehabilitation?

12 A I believe it was Dr. Raj Tolat, R-A-J, T-O-L-A-T.

13 Q Is he still practicing?

14 A I believe he is retired now.

15 Q What did Mr. Gill come under your care for?

16 A For pain management.

17 Q Do you know when he first presented to you, did he
18 describe why he was there or how he was injured?

19 A Yes, he stated he was involved in a motor vehicle
20 accident and he was having neck and back pain.

21 Q When was the first time you started the treatment?

22 A August 27, 2020.

23 Q During that initial visit -- I just want to focus on
24 that visit, did you take a history from him?

25 A I did.

1 Q Did he describe his complaints to you?

2 A Low back pain which radiated to his bilateral legs, as
3 well as neck pain which was radiating to his left arm.

4 Q If you could, just keep it slow because the reporter
5 has to type everything down.

6 When you say bilateral legs, radiation to the bilateral
7 legs, what does bilateral mean?

8 A Both legs, left and right.

9 Q By time came he came to see you, was he already
10 treating with physical therapy?

11 A Yes.

12 Q Do you know how long he had been treating with physical
13 therapy before he came to see you.

14 A It looks like his initial treatment was on December 11,
15 2019.

16 Q Going back to August 27, 2020 when you saw him, did you
17 perform an evaluation of him?

18 A I did.

19 Q What did that consist of?

20 A Examination of his neck and back.

21 Q Did you perform a range of motion testing for instance?

22 A I did.

23 Q Tell us about that? What did you, what were the
24 results?

25 A I examined the cervical spine, there was flexion of 35

1 degrees, normal is 50; extension was 25 normal is 60. Bilateral
2 tilt of his neck was 15 degrees and normal is 45; that was
3 bilateral, which is both sides. Lumbar spine range of motion
4 with flexion was 70 degrees, normal is 90; extension was 10,
5 normal is 30; and, lateral tilt, bilateral, both sides was 15,
6 normal is 40.

7 Q What did the results of that testing mean to you in a
8 medical sense?

9 A That the patient was significantly limited in range of
10 motion in both the neck and back.

11 Q Can you tell us then, for example, flexion at
12 30 degrees, what does that mean?

13 A Of the spine?

14 Q Yes, what does the flexion test look like?

15 A For the neck, it is basically going like that.

16 Q For the flexion of the neck you asked the patient to
17 bend their head down?

18 A Correct.

19 Q With their chin towards their chest?

20 A Correct.

21 Q What was his ability to bend his head down?

22 A Flexion was 35 degrees.

23 Q 35 out of?

24 A Out of 50 which is normal.

25 Q What about extension; how is that test performed?

1 A Extending, putting your head backwards.

2 Q What was the result of that?

3 A That was 25 degrees.

4 Q Out of a possible?

5 A 60.

6 Q How is it that you measure these -- how do find out
7 what is going on?

8 A There is a device called a goniometer which checks the
9 angle of how far the patient can do that maneuver.

10 Q You were using that during the testing?

11 A Yes.

12 Q What about the lower back, tell us how those tests are
13 perform?

14 A Lower back flexion is basically bending forward with
15 your back, that was 70 degrees, normal is 90. Extension is
16 bending backwards, it was 10 degrees, normal is 30. Lateral
17 tilt is bending side-to-side and on both directions it was
18 15 degrees and normal is 40?

19 THE COURT: Doctor, I'd ask you to speak a little
20 slower so the reporter can get what you are saying and we
21 can all get it also, sir.

22 Q In your medical opinion at that point when you first
23 saw him, did you believe he was exhibiting signs of
24 radiculopathy?

25 A Yes.

1 Q What is radiculopathy?

2 A Radiculopathy is basically radiating pain, from the
3 neck it radiates down the arms, from the back it radiates down
4 the legs.

5 Q Did you find that to be significant medically speaking,
6 did he have those symptoms?

7 A Yes, because it does indicate nerve compression.

8 Q Can you describe what is nerve compression?

9 A Basically something pushing on a nerve, usually it is a
10 disc that is out place that pushes on the nerve and causes the
11 pain to radiate down one of the extremities.

12 Q You continued -- are you still treating him now?

13 A Yes.

14 Q You have treated him consistently since 2020 until now?

15 A Correct.

16 Q Throughout that time, did you have an opportunity to
17 review any of Mr. Gill's MRI films?

18 A I did.

19 Q Which MRIs did you review; the neck, the back or both?

20 A Both.

21 Q Was your treatment primarily focused on neck, the back
22 or both?

23 A Primarily focused on the lower back.

24 MR. LESNEVEC: Your Honor, I have spoken to
25 counsel, I will put Exhibit 2 on the screen which is the

1 lumbar MRI film of December 18, 2019.

2 THE COURT: That is fine.

3 Q Are you able to see Exhibit 2, that I put up on the
4 screen?

5 A Yes.

6 Q If you need to step down during any of this, you can do
7 that with the Court's permission.

8 THE COURT: Do you need to step down, Doctor, so
9 you can point.

10 Q Can you tell us what we are looking at in Exhibit 2.

11 A Basically, this is the lumbar spine which is your lower
12 back, this is your tailbone, these are the bones in between the
13 discs, these white areas here are the discs. And, the area of
14 problem are these two lower discs which is 4/5 and 5/1. You can
15 see the spine, all of these discs are coming up to this area and
16 these are fine, these last two here are pushed out of place and
17 pushing on the spine. The nerves are coming out.

18 Q For the record, is that L4-5 and L5/S1?

19 A Correct.

20 Q There are various levels to the spine, correct?

21 A Yes.

22 Q What does it mean in that those levels are L4-5 versus
23 L5/S1?

24 A The level of the spine they correlate to different
25 parts of the body. So L4-5 and L5/S1 generally radiate further

1 down the leg.

2 Q How did the disc at L4-5 and L5/S1 appear?

3 A They are herniated which means they are pushing off on
4 the nerves.

5 Q Are you able to show us I guess the spinal cord as
6 depicted here?

7 A That's here.

8 Q So, basically the white line that goes along the discs
9 down into the back?

10 A Correct.

11 Q The fact those discs at L4-5 and L5/S1 are indenting or
12 pushing on them, what does that mean in a medical sense?

13 A The nerves are compressed and that's why he is getting
14 those symptoms.

15 MR. LESNEVEC: I don't have any questions as far
16 this exhibit, your Honor.

17 Q Did you review that MRI with Mr. Gill?

18 A Yes.

19 Q Based on your review of that MRI, what was your
20 recommendation to Mr. Gill in terms of future treatment?

21 A Recommendation was for him to continue his physical
22 therapy, I did give him some medications. But, I recommended
23 that he undergo an epidural injection.

24 Q Did you administer that injection?

25 A I did.

1 Q Approximately, how many injections did you administer
2 to Mr. Gill throughout your time you treated him?

3 A It was seven injections and a procedure.

4 Q I will go into the procedure in more detail in a
5 minute. Approximately, how many times did you see Mr. Gill over
6 the years?

7 A Eighteen times.

8 Q Which years did you treat him?

9 A 2020 up until the present.

10 Q So, 2020 to 2025?

11 A Correct.

12 Q How frequently were you seeing him over the years?

13 A Every two to three months.

14 Q Did you continuously check his range of motion
15 throughout the times you saw him?

16 A I did.

17 Q How is he just generally progressing, in a general
18 sense over the years?

19 A Generally the range of motion was pretty stagnant, did
20 not improve much but his pain level waxed and waned.

21 THE COURT: I did not hear.

22 A It waxed and waned, it gets better and worse.

23 Q What does that mean, waxed and waned?

24 A Like certain times where the pain level was good and
25 certain times the pain level was worse depending on treatment.

1 Q Are you aware he had a cervical fusion surgery to his
2 neck?

3 A Yes.

4 Q That was December 21, 2020, are you aware of that?

5 A Yes.

6 Q What is an EMG test?

7 A It stands for electro myogram. It a nerve conduction
8 test as well. What it checks for is how significantly a nerve
9 is compressed and what levels are compressed.

10 Q How does it check for that?

11 A There are two parts to the test. The EMG portion
12 basically you put needles into muscles to check the function of
13 the muscle and then there is a nerve conduction part where you
14 see how fast the nerve is functioning.

15 Q Did Mr. Gill undergo an EMG test?

16 A He did.

17 Q Do you know when he underwent that test?

18 A February 13th of 2020.

19 Q What were the results of that test?

20 A It showed nerve compression in the left C8, which is
21 the cervical spine; and, left L4 levels which is the lower back.

22 Q That test was positive for neck and the back?

23 A Correct.

24 Q What did that mean to you in a medical sense he had
25 positive findings for the neck and the back on the EMG test?

1 A It correlated with the other findings of his
2 examination as well as the MRI.

3 Q Did you prescribe Mr. Gill any medication for his pain
4 or treatment over the years?

5 A I did.

6 Q What did you prescribe?

7 A Meloxicam, which is an anti-inflammatory;
8 cyclobenzaprine, which is a muscle relaxer; and gabapentin which
9 is a nerve pain medication.

10 Q Why is it that you prescribed those specific
11 medications?

12 A Meloxicam, I feel helps decrease inflammation which
13 would help his pain level. Muscle relaxer basically relaxes the
14 muscle and helps them increase the function and also releases
15 pain. Gabapentin helps with radiating radicular pain which he
16 was having.

17 Q How frequently was that prescribed to Mr. Gill over the
18 years by you?

19 A He was on it pretty much on a continuous basis. So,
20 every visit I would renew it.

21 Q What, if any, side effects does those medications have?

22 A Meloxicam can bother the stomach if it is not taken
23 with food or if someone is very sensitive to it; the muscle
24 relaxer cyclobenzaprine can make you fatigued and sometimes
25 dizzy; gabapentin, as well, can cause fatigue or dizziness.

1 Q Now, is Mr. Gill also treating with physical therapy at
2 Premier Physical Medicine and Rehab throughout the years you
3 were treating him?

4 A Yes.

5 Q Do you know how consistently he was treating with
6 physical therapy?

7 A I believe it was three or four times per week.

8 Q You had mentioned that you administered injections?

9 A Yes.

10 Q You said it was seven?

11 A Seven, yes.

12 Q Can you tell us what types of injections were you
13 administering?

14 A They were generally lumbar epidural injections.

15 Q What is an epidural injection?

16 A It is basically putting a steroid which is an
17 anti-inflammatory along with an anesthetic lidocaine putting it
18 under an Xray in the area where the nerves are being compressed
19 to get the swelling down.

20 Q When you say it is done under Xray, what does that
21 mean?

22 A Basically a fluoroscope, which is a live Xray, as we do
23 the procedure we localize the area so it shows exactly where the
24 needle goes.

25 Q Is that basically to help you see where you are

1 injecting the solution?

2 A Correct.

3 Q What, if any, results did Mr. Gill see from the
4 injections?

5 A He received temporary partial relief.

6 Q Were those injections to the neck, back or both?

7 A The ones I administered were to the back, the lumbar
8 spine.

9 Q I want to move to the year 2024, specifically, that was
10 when you performed the procedure?

11 A Yes.

12 Q How is Mr. Gill progressing in a general sense that
13 year in 2024 prior to the procedure?

14 A He was having continuous radicular pain which means his
15 pain was radiating from his back down both of his legs which was
16 fairly significant.

17 Q Why is it that you recommended, I think it was a
18 discectomy?

19 A Correct.

20 Q Why was that recommend by you?

21 A I felt that we tried the epidurals a few times. And,
22 as mentioned, again, he was getting partial relief and was
23 coming back so I felt the percutaneous decompression was a more
24 of a permanent procedure.

25 Q Is that a surgery?

1 A It is a minimally invasive surgery.

2 Q When did you perform that?

3 A June 20, 2024.

4 Q Was he administered anesthesia for that surgery?

5 A Yes.

6 Q Was it general or local or something else?

7 A General.

8 Q What is general anesthesia?

9 A Basically the patient is completely out as we do the
10 procedure meaning they are not responsive.

11 Q They are unconscious?

12 A Correct.

13 Q Was that performed at a surgery center or somewhere
14 else?

15 A Surgery center, yes.

16 Q Who, if anyone, was present with you when you performed
17 that operation?

18 A An anesthesiologist and a nursing assistant and a Xray
19 tech.

20 Q Can you take us through the step-by-step procedure how
21 is that perform?

22 A Yes, basically, first the anesthesiologist who
23 administers his medication and makes the patient comfortable.
24 We clean, prep the area to make it sterile. We set up the X-ray
25 machine to localize the area where the problem is. We put a

1 small needle to anesthetize the area where we are going and then
2 once we localize area, we will put a small nick with a knife to
3 cut the area of where we are going to go and then a larger
4 needle goes through that nick and goes right into disc under
5 X-ray. Once we in the disc, we put basically what looks like a
6 scissor to remove some pieces of the disc through that larger
7 needle.

8 Q What is the purpose, medically speaking, for removing
9 those portions of the disc?

10 A Basically the hope is we taking pressure off the disc.
11 The disc is pressurized so if we remove a small piece, we hope
12 it sucks back up and takes some pressure off that nerve.

13 Q So, when we looked at Exhibit 2 of the lumbar MRI film,
14 when you speak of relieving pressure, are you talking about the
15 discs where we saw the indentation onto the spinal cord or
16 canal?

17 A Correct.

18 Q How long did that procedure take to perform?

19 A Approximately, 45-minutes to an hour.

20 Q Did you tell Mr. Gill to limit his activities in any
21 way or give him post-operative instructions after that surgery?

22 A Yes, basically I told him he could perform sedentary
23 activity he can walk and do normal things but no heavy lifting
24 or anything strenuous.

25 Q You obviously continued to see him after the procedure?

1 A Yes.

2 Q Can you tell us generally how he has been progressing
3 after the procedure?

4 A He did get significant relief in his right leg, his
5 right leg pain almost completely resolved. He continued to have
6 low back pain and continued to have left leg pain, I'll be it
7 slightly improved.

8 Q When was last time you treated Mr. Gill?

9 A The last time I saw him was in April and I did perform
10 an epidural injection at that time.

11 Q April of 2025?

12 A Yes.

13 Q How was he doing at that point when you last saw him?

14 A Again, the right leg the pain was completely resolved.
15 He continued to have moderate, low back and left leg pain.

16 Q So, you administered the injection at that point?

17 A Correct.

18 Q Why did you administer the injection?

19 A I wanted to get further improvement of the left leg
20 pain.

21 Q Did you make any recommendations to Mr. Gill in term of
22 his ability work through your treatment?

23 A I am a consulting doctor so I really don't discuss as
24 far as percentage or disability but I did recommend that he
25 continue sedentary activity.

1 Q What is sedentary activity?

2 A Basic walking, basic daily activities without lifting
3 any greater than 10 to 15 pounds.

4 Q Mr. Gill have any prior accidents or injuries that you
5 are aware of?

6 A Not that I am aware, no.

7 Q In all of the records that you reviewed or kept, is
8 there any prior accidents or injuries noted anywhere?

9 A No.

10 Q Are you aware of any prior medical treatment that
11 Mr. Gill had prior to this accident?

12 A I am not aware of any, no.

13 Q Have you formed an opinion with a reasonable degree of
14 medical certainty as to the cause of the herniated discs that
15 you pointed out at the L4-5 and L5/S1 levels?

16 A Yes, the only indication that I would have is it would
17 be related to the accident.

18 Q Why is that your opinion?

19 A As far as the history is concern there was no notation
20 of any prior pain of the neck or back and herniated discs are
21 common to happen after an accident like that. You would need
22 force to cause a herniation like that. So, the assumption it
23 was related to that.

24 Q Have you formed an opinion with a reasonable degree of
25 medical certainty as to the permanency of the herniated discs in

1 the lower back?

2 A Yes, I feel it going to be a chronic condition, I don't
3 think it will resolve completely. Although, we can continue to
4 treat and improve his pain level.

5 MR. LESNEVEC: I don't have any further questions.
6 Thank you.

7 THE COURT: Any cross?

8 MR. MCNIFF: Yes, your Honor. Thank you.

9 CROSS-EXAMINATION

10 BY MR MCNIFF:

11 Q Good morning.

12 A Good morning.

13 Q We never met before?

14 A No.

15 Q You mentioned your educational background and you said
16 Ross University School of Medicine?

17 A Correct.

18 Q Where is that?

19 A A combination of Dominica as well as rotations in the
20 tri-state area.

21 Q Physically were you in the United States doing medical
22 school or were you there --

23 A Partly there and partly here, yes.

24 Q Okay. You mentioned a couple of minutes ago about the
25 anesthesia that was done for the percutaneous discectomy?

- 1 A Yes.
- 2 Q You said general anesthesia?
- 3 A Yes.
- 4 Q Are you talking about the patient being intubated?
- 5 A Yes.
- 6 Q Did you prepare an operative report for this?
- 7 A Yes.
- 8 Q Do you have that with you?
- 9 A Yes, I do.
- 10 Q As part of the anesthesia that was administered was one
- 11 percent lidocaine administered?
- 12 A No, that's a local. Yes.
- 13 Q That's a local?
- 14 A Yes.
- 15 Q Then it says intravenous sedation?
- 16 A Yes.
- 17 Q Is that IV?
- 18 A Yes.
- 19 Q Is that like propofol?
- 20 A It could be propofol, it could be fentanyl.
- 21 Q That is administered by the anesthesiologist?
- 22 A Correct.
- 23 Q That is monitored during the procedure, right?
- 24 A Correct.
- 25 Q Does this say that the anesthesia was propofol or

1 fentanyl?

2 A It does and I don't include the anesthesia -- that is a
3 separate anesthesia report which I don't have.

4 Q But your operative report doesn't mention the
5 intubation part; is that correct?

6 A That is correct.

7 Q At least according to the operative report, the
8 anesthesia used was IV sedation?

9 A That is what is stated, yes.

10 Q Are you familiar with the website that you have at
11 Premier?

12 A It is not my office so I don't look at that.

13 Q You mentioned before you are a consultant. You were
14 not the treating doctor in this case or --

15 A I am the treating pain management.

16 THE COURT: Doctor, let the attorney finish his
17 question, sir.

18 Finish counsel.

19 Q Were you only a consultant?

20 A Yes.

21 Q You were not a treating doctor treating him for the
22 physical therapy aspect of this?

23 A Correct.

24 Q That was done by Dr. Tolat?

25 A Correct.

1 Q Back to the website. You are not really familiar with
2 the website?

3 A I don't look at it. It is not my office.

4 Q So let's talk generally about what happens when
5 somebody comes into you as a consultant. Is the first thing
6 that you do is take a history from the patient?

7 A Yes.

8 Q Would you agree with me that the history is important?

9 A Yes.

10 Q Would you agree with me it important for a number of
11 reasons?

12 A Yes.

13 Q One is you use it to from differential diagnosis?

14 A It helps in that, yes.

15 Q Differential diagnosis is the list of possible causes
16 of a condition in the patient; is that fair?

17 A Correct.

18 Q Generally speaking, you put the most likely cause at
19 the top and the least likely cause at the bottom?

20 A Correct.

21 Q Then what you want to do when you get this information
22 is that you document it, right?

23 A Yes.

24 Q You document it for a number of reasons, true?

25 A Yes.

1 Q You document it because you want to have an accurate
2 history in your notes?

3 A Correct.

4 Q You want to have a complete history in your notes?

5 A Yes.

6 Q You want to have a thorough history in your notes?

7 A Yes.

8 Q And you are doing that because if you go back in time
9 and you want to look at the records you want know what is going
10 on back then?

11 A Correct.

12 Q If another physician were to look at the records, this
13 way they can look at them and say what is going on with the
14 patient at some point prior, true?

15 A Correct.

16 (Whereupon, the following was recorded by Senior Court
17 Reporter Victoria Bifulco.)

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1 CROSS EXAMINATION

2 BY MR. McNIFF:

3 Q You record in your practice all the pertinent,
4 positive findings, true?

5 A I try to, yes.

6 Q Okay. Part of what you do when you take a history is
7 you are relying on the patients who come in to see you to be
8 truthful, right?

9 A Correct.

10 Q You want an accurate history from them; is that
11 right?

12 A Yes.

13 Q Then part of what you do as part of this evaluation
14 is you perform a physical examination, right?

15 A Yes.

16 Q And would you agree with me in general that parts of
17 the physical examination have a subjective component; is that
18 true?

19 A Yes.

20 Q All right. Just like pain is subjective; isn't that
21 right?

22 A Correct.

23 Q When a patient reports pain to you, you don't know
24 whether that is real or not just from what they say; is that
25 right?

1 A That's correct.

2 Q Okay. So part of the physical examination, does that
3 include an observation generally of the patient?

4 A Yes.

5 Q Okay. And you look at them to see if they are in any
6 kind of distress, right?

7 A Correct.

8 Q Okay. You can do this also by asking them a pain
9 scale, I think you mentioned that before, right?

10 A Yes.

11 Q That's zero to ten?

12 A It's one of the scales, yes.

13 Q One of the scales is the happy face to the crying
14 face, true?

15 A Yes.

16 Q In your records did you record a pain scale for the
17 plaintiff?

18 A I don't believe I did that, no.

19 Q Okay. So generally speaking, you perform tests on
20 patients to see if you can correlate the subjective complaints
21 of pain to findings, correct?

22 A You correlate the examination of the patient along
23 with the testing results, yeah.

24 Q By the way, you mean you don't do any independent
25 investigation into a patient to see what kind of person they

1 are?

2 Not that we expect you to do that, but you don't do
3 that, right?

4 A No.

5 Q You are relying on them in that meeting in that
6 setting in the office to be honest, true?

7 A Correct.

8 Q Doctor, in this case did you review other than in
9 preparation of your testimony other doctors' records outside
10 of Premier and potentially outside of MRIs?

11 A The only things that I reviewed were Dr. Tolat's
12 notes, Dr. Golzad that we mentioned prior, as well as the test
13 results of the MRIs.

14 Q So that is Premier at an MRI facility, right?

15 A Correct.

16 Q And you didn't review any other doctors' records
17 outside of Premier?

18 A No.

19 Q Okay. Generally speaking, Doctor, part of the
20 physical evaluation includes what you told us before range of
21 motion testing; is that right?

22 A That's part of the examination.

23 Q And you ask a patient to move in different directions
24 like you explained, flexion, extension, right?

25 A For?

1 Q For lumbar spine, essentially bend over; is that
2 correct?

3 A Correct.

4 Q And you are relying on the patient to be accurate
5 with you when they feel pain, right?

6 A Yes.

7 Q And then sometimes you will do different tests to
8 determine if there is some kind of nerve root pathology like a
9 straight leg raise; is that right?

10 A Correct.

11 Q You did that in this case, right?

12 A I did.

13 Q Did you do any type of compression tests on the
14 spine, the cervical spine?

15 A Yes.

16 Q And when you did the straight leg raise, you recorded
17 your findings, right?

18 A Yes.

19 Q Much like you did the range of motion testing; is
20 that right?

21 A Correct.

22 Q Can we go through some of your notes, Doctor?

23 A Yes.

24 Q Can I direct you to November 18, 2021?

25 A Yes.

1 Q So you take a history from him at that time; is that
2 right?

3 A Yes.

4 Q And then you do a review of systems and that's kind
5 of a history as well, right?

6 A Yes.

7 Q You ask the patient about specific questions; is that
8 true?

9 A Yes.

10 Q And you ask him questions about bowel, bladder
11 changes, true?

12 A Yes.

13 Q Balance issues, right?

14 A Yes.

15 Q And falls, correct?

16 A Yes.

17 Q And that's relevant to your assessment in part
18 because you are trying to figure out if he truly has a
19 neurologic issue because they can be signs of one; is that
20 true?

21 A Signs of severe compression, yes.

22 Q Absolutely. I mean, if you are incontinent of
23 bladder or bowel, that is an emergency, would you agree?

24 A Yes.

25 Q That has to be operated on immediately, true?

1 A Yes.

2 Q But balance issues and falls may not be an emergency,
3 right?

4 A Could be, could not be.

5 Q Right. Okay. And in this case he denies bowel,
6 bladder, balance or fall issues, true?

7 A Correct.

8 Q Then you perform a physical examination in November
9 of 2021, true?

10 A Yes.

11 Q And you also assess whether he is alert and oriented
12 times three, right?

13 A Yes.

14 Q Times three means alert and oriented to person,
15 place --

16 A Time.

17 Q And time.

18 A Yes.

19 Q Okay. And that, no problem, right?

20 A No.

21 Q You also did the no apparent distress; you look at
22 him and see how he is doing, right?

23 A Yes.

24 Q And at least visually there is no apparent distress,
25 right?

1 A Correct.

2 Q Part of your physical examination, do you fully look
3 at the patient?

4 They are appropriately disrobed and you look at them
5 or you don't do that?

6 A Yeah, we do a general assessment. Absolutely.

7 Q You also do test motor strength testing in the upper
8 and lower extremities, right?

9 A Correct.

10 Q And that's important because that could also be a
11 sign of a neurologic issue, right?

12 That's part of figuring out if what the patient is
13 telling you is correct, true?

14 A Correct.

15 Q You are also concerned about the severity; isn't that
16 true?

17 A Yes.

18 Q The scale is essentially zero to five; is that
19 correct?

20 A Yes.

21 Q The lower the scale, the bigger the problem, the more
22 urgent the problems, would you agree?

23 A Yes.

24 Q Can you explain to the Court and jury what the muscle
25 strength tests are for the upper and the lower extremities,

1 Doctor?

2 A Yeah. I mean, basically it's asking them to push
3 against you for resistance or lifting the muscles on their
4 own. That tells us what the number is.

5 If they could lift on their own, it's a three, at
6 least a three. If they are pushing against you with their
7 full resistance, it's a five out of five.

8 Q Got it.

9 In this case when you did the testing in November of
10 2021, the muscle strength that you found was five/five which
11 is completely normal, right?

12 A Full strength, yes.

13 Q And you found full strength in both the upper
14 extremities and the lower extremities, true?

15 A Yes.

16 Q Okay. And you also check sensation, and that's
17 important because it's also evidence of a neurologic issue,
18 that's something with the spinal cord if you have decreased
19 sensation.

20 You would agree with that, correct?

21 A Right.

22 Q Is that a pin prick test?

23 A Yeah, or basically touching the area and asking if
24 they feel it.

25 Q Are you kind of poking them a little to see what

1 their sensation is like to correlate what the complaints are
2 with the physical findings, right?

3 A Correct.

4 Q And you did that in November of 2021 and his
5 sensation was intact; is that right?

6 A That's correct.

7 Q So that's normal, right?

8 A Yes.

9 Q And you also checked reflexes, right?

10 A Yes.

11 Q And that's on a scale, and two plus would be normal,
12 right?

13 A Correct.

14 Q And the purpose of testing the reflexes, that's a
15 separate test for neurologic issues as well, right?

16 A Yes.

17 Q Because if you have decreased reflexes, again,
18 depending on the severity, you may have an emergency; is that
19 right?

20 A Correct.

21 Q And in this case when you tested in November of '21
22 his reflexes, they were completely normal; is that true?

23 A Yes.

24 Q Okay. Can we go to January 27, 2022?

25 A Okay.

1 Q All right. At that point you take a history; is that
2 right?

3 A Correct.

4 Q You actually ask him about his neck during that
5 visit, right, it's the last sentence in the history of present
6 illness?

7 A Yes.

8 Q All right. And he reports to you at that point in
9 time that the neck pain has resolved, right?

10 A Yes.

11 Q And, again, you do that examination that we just
12 talked about, review of systems, right?

13 A Yes.

14 Q And, again, you don't see bowel or bladder issues,
15 right?

16 A Right.

17 Q But balance and fall is the same thing, no problem,
18 right?

19 A Correct.

20 Q You checked muscle strength again in January of 2022,
21 and at that point that is still five/five, right?

22 A Yes.

23 Q Arms, legs, the muscles that you tested, normal,
24 right?

25 A Yes.

1 Q Sensation, normal?

2 A Yes.

3 Q And reflexes, normal?

4 A Yes.

5 Q So you do a physical examination of the cervical
6 spine during that visit, right?

7 A Yes.

8 Q And you palpate the area, Doctor, is that what you
9 do?

10 A Yes.

11 Q By palpate, we mean touch the area to find out what
12 is going on; is that right?

13 A Yes.

14 Q And there is no cervical paraspinal tenderness,
15 right?

16 A Correct.

17 Q You check your cervical range of motion too?

18 A Yes.

19 Q And that's, what, flexion, extension?

20 A And bending.

21 Q And tilt?

22 A Yeah.

23 Q And that's normal, full range of motion, right?

24 A Yes.

25 Q He comes back when, July 2022; is that the next note

1 you have?

2 A I did an injection on him in June of 2022.

3 Q Your next evaluation is that July?

4 A July 14, 2022.

5 Q Okay. Is that the same thing, review of systems is
6 normal?

7 A Yes.

8 Q The physical examination, muscle strength is normal,
9 sensation is normal?

10 A Yes.

11 Q Reflexes are normal?

12 A Yes.

13 Q Okay. You check the cervical spine again, no
14 tenderness, right?

15 A Correct.

16 Q You do range of motion testing for the lumbar spine,
17 right?

18 A Yes.

19 Q Decreased, true?

20 A Yes.

21 Q Okay. That's a subjective component, again, you are
22 relying upon the patient to be accurate with you; is that
23 right?

24 A Yes.

25 Q Do you have another note from August of 2022?

- 1 A August 25, 2022.
- 2 Q Okay. And the review the systems, same thing,
3 correct?
- 4 A Correct.
- 5 Q Normal. No cervical complaints, right?
- 6 A No.
- 7 Q The physical examine, muscle strength is normal,
8 right?
- 9 A Yes.
- 10 Q Sensation is intact, right?
- 11 A Yes.
- 12 Q Reflexes is normal?
- 13 A Yes.
- 14 Q You see him again in October of 2022?
- 15 A October 13, 2022.
- 16 Q No cervical complaints, right?
- 17 A Nothing noted.
- 18 Q So he is not complaining about his neck?
- 19 A No.
- 20 Q Again, no balance issues, no falls right?
- 21 A Correct.
- 22 Q Muscles are normal, right?
- 23 A Yes.
- 24 Q Sensation is intact, true?
- 25 A Yes.

1 Q And his reflexes are completely normal, right?

2 A Yes.

3 Q You see him again -- you told us about these
4 visits -- April of 2023, right?

5 A I did a procedure April 6, 2023, so I am on April 27,
6 2023.

7 Q He had no cervical complaints, right, he is not
8 complaining about his neck?

9 A No.

10 Q Physical exam we have motor strength is normal,
11 correct?

12 A Yes.

13 Q Upper and lower extremities, right?

14 A Yes.

15 Q His sensation is in tact and his reflexes are
16 completely normal, right?

17 A Yes.

18 Q And, again, these are the physical examinations that
19 you are doing to test his muscles, right?

20 You are asking him to push as hard as he can, right?

21 A Yes.

22 Q And you are assessing his ability to push, and you
23 are saying it's normal, right?

24 A Yes.

25 Q Do you see him again September of 2023?

- 1 A September 7, 2023.
- 2 Q And at that point no complaints of cervical pain,
3 right?
- 4 A No.
- 5 Q No issues with balance or falls, right?
- 6 A No.
- 7 Q And his muscle strength is normal, right?
8 His sensation is normal and his reflexes are normal,
9 right?
- 10 A Correct.
- 11 Q You see him again January 24, right?
- 12 A January 11, 2024.
- 13 Q All right. No cervical complaints, right?
- 14 A No.
- 15 Q And the physical exam is the same, right, it's all
16 normal?
- 17 A Physical exam is not completely normal but the review
18 systems is normal.
- 19 Q The review systems is normal?
- 20 A Yes.
- 21 Q Muscle strength, five/five, normal, right?
- 22 A Yes.
- 23 Q Sensation is normal?
- 24 A Yes.
- 25 Q Reflexes are normal, right?

1 A Yes.

2 Q So we are there again March 24 -- I'm sorry, March 7,
3 2024.

4 Do you have that note?

5 A Yes.

6 Q He does not have any neck complaints at that point,
7 right?

8 A No.

9 Q So the last neck complaint was July of 2022 then,
10 right, so far?

11 We haven't come across a neck complaint?

12 A Yeah. I was basically treating for his lower back.

13 Q But you ask him how he is, right?

14 A Yeah.

15 Q You are a pain management doctor, true?

16 A Yes.

17 Q You are asking him do you have any complaints, do you
18 have any pain, right?

19 A Yes.

20 Q And if he told you that, you would certainly note it,
21 right?

22 A Yes.

23 Q And you would treat it, wouldn't you?

24 A Yes.

25 Q And, again, this visit is motor strength or his

1 muscles are normal, his sensation is intact, and his reflexes
2 are normal, right?

3 A Yes.

4 Q In May of 2024 you see him again, and we have the
5 same results, right?

6 A May 16, 2024.

7 Q No cervical complaints, muscle strength is normal
8 sensation is in tact and reflexes are normal, right?

9 A Yes.

10 Q Same is true in November of 2024, right?

11 A November 7, 2024.

12 Q Okay. We have the same results, no neck complaints.
13 The physical exam with regard to his muscle strength is
14 normal. Sensation is in tact, and his reflexes are normal,
15 right?

16 A That's correct.

17 Q And at that point you do the straight leg test, and
18 that's negative bilaterally?

19 A Yes.

20 Q So at that point there is no evidence at least
21 according to the straight leg test that he has any pathology
22 in the lumbar spine at that moment in time; is that correct?

23 A Correct.

24 Q Then you see him again in February of 2025; is that
25 right?

1 A February 27, 2025.

2 Q And I think you told us you saw him one more time
3 after that, right?

4 A One epidural after that. Yes.

5 Q Okay. All right, Doctor.

6 MR. MCNIFF: You know what, thank you very much.

7 I don't have any further questions.

8 THE COURT: Any redirect, counsel?

9 MR. LESNEVEC: Yes, your Honor.

10 THE COURT: Go ahead.

11 MR. LESNEVEC: Thank you.

12 REDIRECT EXAMINATION

13 BY MR. LESNEVEC:

14 Q Doctor, you were asked about the difference between
15 consultant versus treating doctor.

16 Can you just go over that and tell us exactly what
17 your role was with treating, Mr. Gill.

18 A Yes. I am just focusing on the pain management
19 aspect of what treatments I can give him in the pain
20 management field, mainly procedural and injections that would
21 help the patient.

22 Q How is that different from the physiatrist role or
23 someone who is administering physical therapy?

24 A Physiatrist is involved in the physical therapy, more
25 the location process, more functional process of the patient

1 getting better on a daily basis, and there is more of a
2 general overview of the patient.

3 Q You were asked questions about subjective components
4 to the testing that you performed such as the range of motion
5 testing; do you recall that?

6 A Yes.

7 Q How many patients have you treated over your career,
8 ballpark?

9 A Ten thousand.

10 Q Out of all those patients that you have treated, did
11 you find in any way that Mr. Gill was exaggerating during any
12 of the testing?

13 A No.

14 MR. McNIFF: Objection.

15 THE COURT: Basis?

16 MR. McNIFF: I'm not sure of the correlation.

17 It's a form objection.

18 THE COURT: Can you read the question back,
19 please?

20 (Whereupon, at this time, the last question was
21 read by the reporter.)

22 THE COURT: Sustained.

23 Do you want to rephrase?

24 MR. LESNEVEC: Yes, Judge.

25 Q Did you find that Mr. Gill was exaggerating at any

1 point when you were treating him, Doctor?

2 A No.

3 Q Why not?

4 A I have done this for a long time. I usually have a
5 pretty good idea whether a patient is exaggerating or not.

6 Q Did you find that Mr. Gill was giving less than full
7 effort during any of the testing that you administered?

8 A No.

9 Q You were asked a lot of questions about, first it was
10 balance and falls, right?

11 A Yes.

12 Q Do you remember those questions?

13 A Yes.

14 Q How if -- first of all, why were you testing for or
15 asking the patient about balance or falls?

16 A Yeah. Those questions indicate that there is severe
17 compression which could indicate an emergency.

18 Q And did you find that Mr. Gill needed emergency
19 surgery?

20 A No.

21 Q The fact that he denied balance or falls, how did
22 that factor into your analysis or your review of the MRI
23 films, if at all?

24 A It doesn't change what I see on examination and what
25 I see on his MRI findings. It just tells me there is no

1 significant condition that would warrant surgery immediately.

2 Q You had said that he denied bowel and bladder issues,
3 true?

4 A Yes.

5 Q What did that mean to you in the medical sense that
6 he denied that?

7 A That there is no significant emergency. We didn't
8 need to take him to the hospital at that time.

9 Q And why are you asking these questions or documenting
10 this in your records that you are denying bowel or bladder
11 issues or balance or falls?

12 Why is that, doctor?

13 A In light of the fact that if an emergency does
14 happen, I document it to myself and anyone that looks at my
15 chart to see there wasn't any issues at the time.

16 Q You mentioned that he was alert and oriented times
17 three?

18 A Yes.

19 Q What does that mean?

20 A If there is any significant neurological component or
21 brain component that would effect his orientation.

22 Q Why did you document that?

23 A Again, because that would indicate a more severe
24 condition that would need immediate attention.

25 Q And motor strength, five out of five, you documented,

1 Doctor?

2 A Yes.

3 Q What does that mean?

4 A Means that his muscle is at full strength.

5 Q And tell me how that is tested, or how did you check
6 for motor strength?

7 A Basically ask him to push against me with resistance
8 and each muscle component.

9 Q How long does that testing take?

10 A Ten seconds.

11 Q And the fact that he had five out of five motor
12 strength during these tests that were performed on these
13 various dates, how does that, if at all, impact your analysis
14 of his herniated discs at L4/L5 and L5/S1 that you pointed out
15 to us?

16 A It doesn't.

17 Q Why not?

18 A Because, again, he could still have nerve compression
19 and radicular signs with full motor strength.

20 Q There was questions about his sensation being intact,
21 correct?

22 A Same aspect. It wouldn't change my diagnosis and
23 treatment.

24 Q What did that mean when you say the patient's
25 sensation is in tact?

1 A Those things would happen over a chronic period of
2 time where it was compression. You could still have nerve
3 compression that was significant without that being positive.

4 Q Did you ever diagnose Mr. Gill with any muscle injury
5 or muscle issue specifically?

6 A No.

7 Q Reflexes are normal. I think you testified about you
8 checked his reflexes?

9 A Yes.

10 Q What does that mean?

11 A Again, it would be a significant -- if the reflexes
12 were effected if would be a significant neurological
13 condition, specifically brain condition that would warrant
14 immediate attention.

15 Q And why did you document his reflexes?

16 A Just to state there was nothing significant that
17 needed medical attention.

18 Q Does that change your analysis in any way of the
19 herniated discs in the lower back that you pointed out that he
20 had normal reflexes?

21 A No.

22 Q Okay.

23 MR. LESNEVEC: Thank you.

24 I have nothing further.

25 THE COURT: Doctor, you may leave the stand now.

1 (Whereupon, at this time, the witness exits the
2 stand.)

3 THE COURT: Members of the jury, we are going to
4 take a comfort break at this time, so we'll take about a
5 ten-minute comfort break.

6 Remember those admonitions I gave you.

7 During the break, please do not do any research
8 about the case. Do not discuss anything related to the
9 case with anyone, including other jurors.

10 Do not speak with the attorneys, parties or
11 witnesses.

12 If anyone tries to discuss this matter with you,
13 please tell the officer who will then in turn notify me.

14 We are going to take a brief comfort break.

15 THE COURT OFFICER: All rise. The jury the is
16 exiting.

17 (Whereupon, at this time, the jury exits the
18 courtroom.)

19 THE COURT: Come back at twelve o'clock.

20 MR. LESNEVEC: So the Court is aware, my next
21 witness is coming at two o'clock.

22 THE COURT: You are done for --

23 MR. LESNEVEC: Yes, I'm done for the morning
24 session, so I told the next witness to come back right
25 after we finish lunch.

1 THE COURT: Do you have anything else before
2 lunch?

3 MR. LESNEVEC: Not with the jury.

4 THE COURT: I wish I knew that when they were
5 still here.

6 MR. LESNEVEC: I'm sorry. I didn't want to
7 interrupt.

8 THE COURT: I am going to tell my officer that
9 they can go to lunch and they can come back at two
10 o'clock.

11 MR. LESNEVEC: Thank you, Judge.

12 (Whereupon, at this time a lunch recess was
13 taken.)

14 * * * * *

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

16 * * * * *

17 THE CLERK: All rise. Come to order.

18 Queens Supreme Court Part 7 now in session, the
19 Honorable McGregor Mundy presiding.

20 THE COURT: You may all be seated.

21 MR. McNIFF: Good afternoon, your Honor.

22 THE COURT: Good afternoon.

23 Are we ready to proceed, Counsellors?

24 MR. LESNEVEC: Yes, your Honor.

25 MR. McNIFF: Yes, your Honor.

K. Busuchio - Plaintiff - Direct

1 THE COURT: Please bring in the jury.

2 THE COURT OFFICER: All rise. The jury is
3 entering.

4 (Whereupon, at this time, the jury enters the
5 courtroom.)

6 THE COURT: You maybe be seated.

7 THE CLERK: Do all parties stipulate to the
8 presence and proper seating of the jury?

9 MR. LESNEVEC: I do.

10 MR. McNIFF: I do.

11 THE COURT: You may all be seated.

12 Everyone may be seated.

13 Counsel, you may call your next witness.

14 MR. LESNEVEC: Thank you, your Honor.

15 At this time the plaintiff calls Dr. Kim
16 Busuchio.

17 (Whereupon, at this time, the witness takes the
18 stand.)

19 THE COURT OFFICER: Watch your step. Walk all
20 the way around and remain standing.

21 THE WITNESS: Thank you.

22 THE CLERK: Good afternoon. Please remain
23 standing.

24 Raise your right hand.

25 Do you swear or affirm to tell the truth, the

1 whole truth, and nothing but the truth, under penalty of
2 perjury?

3 THE WITNESS: I do.

4 D R. K I M B U S U C H I O, a witness called on behalf of
5 the Plaintiff, after having been first duly sworn by the
6 Clerk of the Court, took the witness stand and testified
7 as follows:

8 THE CLERK: In a loud and clear voice, please
9 state your name, spell your name and state your business
10 address.

11 THE WITNESS: Kim, last name, Busuchio,
12 B-U-S-I-C-H-I-O. My address is 55 West 39th Street,
13 Suite 15N, New York, New York 10018.

14 THE CLERK: Thank you.

15 You may be a seated.

16 The witness has been sworn, your Honor.

17 THE COURT: Thank you.

18 You may proceed, counsel.

19 MR. LESNEVEC: Thank you.

20 DIRECT EXAMINATION

21 BY MR. LESNEVEC:

22 Q Good afternoon.

23 A Good afternoon.

24 Q Have we have met before today?

25 A No.

1 Q We spoke on the phone yesterday; is that correct?

2 A Correct.

3 Q How long did the phone call last for?

4 A Not long, maybe 20 minutes.

5 Q What did we discuss?

6 A My treatment and assessment of Mr. Gill.

7 Q Have you ever testified in court before where I was
8 one of the attorneys asking questions?

9 A No.

10 Q What about my law office, have you ever testified
11 where my law office represented someone that was injured in a
12 case?

13 A I don't believe so.

14 Q Can you give us a brief history about your
15 educational background?

16 A Sure. In 2004 I graduated with my clinical
17 psychology degree from Fairleigh Dickinson University. That's
18 in Hackensack Teaneck, New Jersey.

19 During my training at -- during my Ph.D. training,
20 that was for my doctorate program, I did my internships and
21 externships in neuropsychology. I did that at Kessler,
22 U.M.D.N.J., which is the University of Medicine and Dentistry
23 in New York.

24 And the V.A. I worked with Gold War Vets at the V.A.
25 that came back with traumatic brain injury. And I did

1 research and assessment for traumatic brain injury and
2 rehabilitation.

3 I then went on to do my internship in neuropsychology
4 at Rusk Rehabilitation Institute which is at NYU.

5 I did a year of inpatient and outpatient rotation
6 specializing in assessment and traumatic brain injury,
7 concussion, head injury, and cognitive rehabilitation related
8 to those injuries.

9 I then did a two year post doctoral residency at JFK,
10 Johnson Rehabilitation Institute. That's in Edison, New
11 Jersey. I did a year of inpatient rotation and year of
12 outpatient rotation specializing in assessment of traumatic
13 brain injury, head injury, head trauma, concussion and
14 cognitive rehabilitation related to those injuries.

15 I was then the clinical director of neuropsychology
16 at a private practice in Manhattan from 2007 to 2021. Again,
17 that's an outpatient facility specializing in traumatic brain
18 injury, concussion, post concussion syndrome, and cognitive
19 deficits, rehabilitation related to those injuries.

20 And I have been at the current center, the Center of
21 the Comprehension Concussion Center of New York which was a
22 another private practice in Manhattan specializing in
23 traumatic brain injury, assessment and cognitive
24 rehabilitation.

25 Q So are you a neuropsychologist?

1 A Yes.

2 Q Can you just tell us what the field of
3 neuropsychology encompasses?

4 A Yeah. Neuropsychology is assessment of brain trauma
5 and the cognitive deficits related to the brain trauma, so any
6 type of injury to the brain and cognitive deficits, and what I
7 mean by that is attention problems, memory difficulty,
8 processing speeds, spatial skills, verbal functioning, any
9 motor skills, any cognitive ability that could have been
10 effected due to a head trauma or head injury.

11 Q Can you tell us about any research you performed or
12 any publications you have published?

13 A Yeah. Throughout my graduate studies my clinical
14 psychology degree in neuropsychology for my Ph.D., I did
15 numerous research publications and presentations, specifically
16 at neuropsychology presentations and also the International
17 Neuropsychology Association which is a premier neuropsychology
18 journal.

19 Q How long have you been in private practice now,
20 Doctor?

21 A Since 2007.

22 Q That has been continuous until now?

23 A Yes.

24 Q If I have it correct, you worked at two different
25 offices since then?

1 A Correct.

2 Q What was the first one?

3 A Center for Cognition and Communication.

4 Q And what was your position there, your title?

5 A Clinical Director of Neuropsychology.

6 Q What were your duties and obligations as clinical
7 director there?

8 A So I oversaw the entire program of neuropsychology.

9 What I mean by that is I did an evaluation and
10 clinical review on all the patients that came in with a brain
11 injury referred by other physicians, physiatrists,
12 neurologists, and then determined if that patient needed
13 treatment.

14 If they did need treatment, I would implement the
15 treatment plan and oversee the treatment throughout the course
16 of treatment, and then reevaluate the patient throughout the
17 treatment to determine progress and adjust the treatment plan
18 if needed.

19 Q If you were not here today in court testifying, what
20 would you be doing?

21 A I would be treating patients.

22 Q And how frequently are you treating patients now,
23 Doctor?

24 A So every day. I specialize in seeing new patients,
25 doing follow up with patients that are in the rehabilitation

1 program, but I do that all day.

2 Q And are you being compensated for your time here
3 today?

4 A Yes.

5 Q How much are you being compensated?

6 A \$7,500, but not just to be here today, but also all
7 my review of records, reviewing -- I actually treated him at
8 the other center that I was at too, so I had to review the
9 records from the Center of Cognition along with the records
10 that I treating him incurred.

11 Q So you are currently treating Mr. Gill?

12 A Yes.

13 Q So I want to back up.

14 When you treated him first, that was at the Center
15 for Cognition and Communication?

16 A Correct.

17 Q Where are you treating him now?

18 A At the Comprehension Concussion Center of New York.

19 Q Can you just tell us generally about the different
20 parts of the brain?

21 A Sure. So there is different lobes of the brain. We
22 have the frontal lobe.

23 We have a parietal lobe.

24 We have the temporal lobe and we have the occipital
25 lobe.

1 Those are different areas of the brain and different
2 functions for those areas of the brain.

3 The frontal lobe would be specializing in -- that's
4 where we have attention and executive functioning, even
5 emotional dysregulation. Irritability, frustration, that's
6 more of the frontal lobe.

7 The parietal is more visio spatial skills or
8 perception.

9 Then you have the occipital lobe that is responsible
10 for our visual system and you have the temporal lobe which is
11 memory.

12 Q What happens when there is damage to one of those
13 parts of the brain or structures?

14 A Yeah. So when a patient has a head injury or
15 traumatic brain injury, that -- those areas of the brain, they
16 are all connected, so we have neurons in the brain that are
17 all communicating with each other. And if one area or areas
18 of the brain that have specialized neurons for a specific
19 cognitive ability is not functioning properly, we are going to
20 have impairments and that's going to show up in a patient's
21 life.

22 Q Now, in terms of your treatment of Mr. Gill at the
23 Center for Cognition and Communication, that office, did you
24 keep records in terms of the treatment that you gave to Mr.
25 Gill?

1 A Yes.

2 MR. LESNEVEC: Your Honor, I would like to have
3 this marked.

4 THE COURT: Okay.

5 We are going to mark this document as
6 Plaintiff's Exhibit 19 for identification purposes.

7 (Whereupon, at this time, Plaintiff's Exhibit 19
8 was marked for identification.)

9 THE COURT OFFICER: Plaintiff's Exhibit 19
10 marked for identification.

11 Q If you could take a look at those, Doctor, and let me
12 know when you are finished.

13 A Yes.

14 Q Do you recognize those?

15 A Yes.

16 Q What is Exhibit 19 you have there?

17 A These are the records from the Center of Cognition
18 and Communication.

19 Q Are those accurate copies of those records?

20 A Yes.

21 MR. LESNEVEC: I would ask they be admitted into
22 evidence.

23 THE COURT: Any objection?

24 MR. McNIFF: No objection, your Honor.

25 THE COURT: What was previously marked as

1 Plaintiff's Exhibit 19 for identification purposes will
2 be entered as Plaintiff's Exhibit 19 in evidence.

3 (Whereupon, at this time, Plaintiff's Exhibit 19
4 was marked into evidence.)

5 THE COURT OFFICER: Plaintiff's 19 has been
6 marked in evidence.

7 MR. LESNEVEC: Thank you.

8 Q Doctor, when is the first time you saw Mr. Gill at
9 the Center of Cognition and Communication?

10 A January 10, 2020.

11 Q Is how was he referred to your practice?

12 A Dr. Tolat who is a physiatrist.

13 Q And so Exhibit 19, there is some documents at the
14 very top.

15 Can you take a look at the first page of Exhibit 19?

16 A Sure.

17 Q I think it's the top one there.

18 You see it has the name of my law office on that
19 page?

20 A Yes.

21 Q Do you know why that's indicated on that page or how
22 that comes into the records?

23 A Yeah. The administration at the Center for Cognition
24 and Communication fills this form out so it will have the
25 attorneys' information and it also has Dr. Tolat's

1 information.

2 Q And what did Mr. Gill come under your care for
3 specifically?

4 A For assessment. Dr. Tolat referred the patient to
5 our center for assessment of the cognitive deficits,
6 attention, memory processing speed deficits, and for me to
7 assess and treat if necessary.

8 Q Did you take a history from Mr. Gill on January 10,
9 2020?

10 A Yes.

11 Q Was that for the purpose of diagnosing and treating
12 him?

13 A Yes.

14 Q What was the history he gave?

15 A On 12/4/19 he was driving, and he was rear ended by a
16 commercial van.

17 Q And in terms of any complaints, did he make
18 complaints to you of any pain or injuries?

19 A Yes. So he had head pain, especially in my expertise
20 I deal with the cognitive defendants, but I'll talk about
21 everything that he spoke to me about.

22 He talked about concentration and memory difficulty,
23 headaches, dizziness. He talked also about ringing in the
24 left ear. He talked about sound sensitivity, light
25 sensitivity, and anxiety and depression.

1 These are all post concussive symptoms. It is under
2 the umbrella of post concussive syndrome. There is physical,
3 there is cognitive and there is emotional, so he had all of
4 them.

5 Q What is post concussive syndrome?

6 A After a patient has a head trauma or traumatic brain
7 injury, they can develop post concussion syndrome, which are a
8 constellation of symptoms that are persistent that don't go
9 away and require treatment.

10 In his situation with post concussive syndrome, it's
11 an umbrella of symptoms. So you could have cognitive,
12 physical and emotional symptoms and behavioral.

13 Cognitive symptoms is what I treat. The attention,
14 the memory, the processing.

15 Dr. Tolat was also treating the pain, the head pain,
16 neck pain, back pain for the patient.

17 And then the emotional symptoms, he had depression
18 and anxiety which he was in treatment for also.

19 Q How old was Mr. Gill when he first start treating
20 with you?

21 A Forty-five.

22 Q Did he give you any more specific details about
23 whether he struck his head in the accident or anything of that
24 nature a?

25 A Yeah. He was rear ended by a commercial vehicle and

1 he struck the left side of his head on the window and his left
2 shoulder. He had a change of mental state at the time of the
3 accident. He felt dazed, confused, disoriented; and he was
4 taken by ambulance to the hospital at that point.

5 Q Did Mr. Gill report to you whether or not he lost
6 consciousness?

7 A He denied loss of consciousness to me, but you don't
8 have to lose consciousness to have a head injury and
9 concussion.

10 Q Why is that?

11 A The change of mental state at the time of the
12 accident, feeling dazed, confused, disoriented; and a patient
13 doesn't even know if they lost consciousness at times. A
14 patient can lose brief consciousness and not even know.

15 He told me he didn't lose consciousness, but he was
16 feeling dazed, confused and disoriented.

17 The fact that he struck his head, and he had head
18 pain in the hospital which was documented also and headaches
19 and dizziness in the hospital.

20 Q Did you administer any tests of Mr. Gill on the first
21 day you saw him on January 10, 2020?

22 A Yes.

23 Q What tests did you administer?

24 A Neuropsychology tests, test of memory, attention,
25 processing, spatial skills, motor skills, executive

1 functioning.

2 Q And if you could just -- I would like to go through
3 it because I think you did various tests, right?

4 A Correct.

5 Q Can we go through those individually?

6 A Sure. So there is a computerized testing that's on
7 the first page. That's the neuro tracks computerized
8 assessment. That's a test that's on the computer.

9 Mr. Gill is asked to go through each different test
10 for each domain. What I mean by that is, for example, memory,
11 I will test his verbal memory, his visual memory, and what I'm
12 looking for as a neuropsychologist is what areas of the memory
13 is he impaired in.

14 Is he having trouble acquiring information, storing
15 it or retrieving it?

16 So I am able to tell that based on the data that I
17 get from the computer.

18 Also attention. People say attention and
19 concentration, but it breaks down into sustained attention,
20 divided attention, selective attention. I think I have things
21 like multitasking that we do on a daily basis shifting from
22 one task to another.

23 I am able to determine what areas specifically he had
24 trouble with. Processing speed, how quickly he can perform a
25 task. Executive function are things that every day we do in

1 terms of planning, organizing, problem solving, without even
2 thinking about it. Those are areas that are tested also.

3 And verbal functioning. Word finding. Trouble
4 having the tip of the tongue, knowing what you want to say and
5 just can't seem to get it out.

6 So those are all the type of skills that I look for.

7 Q And how did he perform on those test that day,
8 Doctor?

9 A He had significant deficits in specific areas, but
10 then there are other areas where he was preserved in. Which
11 is very typical with a concussion profile, traumatic brain
12 injury profile.

13 You are going to get areas that were not damaged,
14 were not effected, and then you are going to get areas of
15 impairment. And that's exactly what I saw with his profile.

16 So the areas that were impaired or the areas that I
17 implement treatment for to rehabilitate.

18 Q What were the areas of impairment that you found in
19 testing him?

20 A Specifically, fluctuating attention and focus. I
21 spoke before about attention, sustaining his attention, he was
22 unable to do that. He was in the less than the first
23 percentile in a lot of areas of what we call visual scanning
24 focus. Concentration.

25 That was one the of big areas and that's going to

1 effect memory because if you can't attend to something, you
2 are not going to be able to remember something.

3 He also had difficulty with spatial skills, so I
4 spoke about before he had difficult with perceptual skills,
5 for example, there would be a building on the computer on the
6 screen, and you would have a red pillar that moves, and he has
7 to determine where he was in relation to that building.

8 Is he in the front of the building? Is he on the
9 side of the building?

10 So he had difficulty with that.

11 Q Did you find that any of the deficits that you found
12 in Mr. Gill pursuant to the testing to be significant
13 medically or neuropsychologically?

14 A Yes. So I implemented a treatment plan to work on
15 initial acquisition of memory, so, again, remember I mentioned
16 before that memory, you could either have a retrieval problem
17 or acquiring information.

18 He had difficult learning the information and then
19 attention, focus and spatial skills.

20 Q Now, did any of these tests check for or test for
21 exaggeration of the symptoms?

22 A Why he.

23 Q How did that work? How did they test for
24 exaggeration?

25 A So I gave -- we have stand alone measures of test

1 effort they call them in neuropsychology. And then you also
2 had embedded measures on the testing.

3 Then there is a number of different ways a treating
4 doctor could determine whether a patient was putting forth
5 full effort, not only the testing, but in the treatment also.
6 On the testing itself I gave a test called the Ray 15. He
7 did -- he passed that test. This is a test that looks like a
8 memory test. So I am going to give him a sheet. A, B, C,
9 one, two, three, circle, triangle, square. There is 15 items
10 on there, and I ask him to try to remember as many as he can
11 on the sheet.

12 So based on the instructions it appears to be a
13 memory test. So any patient that is trying to exaggerate or
14 make more of their symptoms would not pass that. He passed
15 it. He did very well on that test.

16 Q Were there any other tests that is any type of
17 embedded measures to check for that?

18 A Right. So the computer itself has a tutorial before
19 we even begin the test.

20 And, again, a patient that's not putting forth effort
21 is not going to pass the tutorial. You are not going to get
22 on to the actual regular test.

23 And then there is throughout the other tests, there
24 is tests what we call the digit span, which he was able to --
25 that's more of an embedded measure. That tests auditory

1 attention, working memory, and he was able to pass all those
2 tests.

3 (Whereupon, at this time, Senior Court Reporter
4 Victoria Bifulco was relieved by Senior Court Reporter
5 Francine Spaulding.)
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1 Q How many times over your career have you administered
2 these tests?

3 A Thousands.

4 Q How many different patients have you treated for
5 cognitive deficits or brain injury over your career?

6 A Thousands.

7 Q Did you form an impression of Mr. Gill or his injuries
8 after his initial test on him and evaluating him that day?

9 A Yes.

10 Q What was your impression?

11 A A head injury, post-concussion syndrome and cognitive
12 deficits related to the head injury of post-concussion syndrome.

13 Q Is post-concussion syndrome a type of traumatic brain
14 injury or is that considered traumatic brain injury?

15 A Yes.

16 Q Are there different severities of traumatic brain
17 injury?

18 A Yes, there are.

19 Q Can tell us about that?

20 A Sure. In this case, I would consider Mr. Gill having a
21 mild traumatic brain injury. So you have mild, moderate and
22 severe. In his case it is mild.

23 Again, also the cognitive deficits, he had areas of
24 preservation and areas of weaknesses. So, it is the areas of
25 weaknesses, I was rehabilitating. But, in terms of his injury

1 itself, this is called a mild traumatic brain injury, that
2 post-concussion syndrome then developed.

3 Q Can you give us an example in a different case of let's
4 say severe traumatic brain injury; what are those symptoms like?

5 A Severe a patient would be taken to the hospital and
6 there would be bleeding in the brain. They would need brain
7 surgery to, you know, to evacuate any pressure or blood in the
8 brain. That would be a more severe brain injury. Then there is
9 the moderate where a patient might have significant
10 post-traumatic amnesia they can't remember a lot of events
11 surrounding the accident.

12 Q Just tell us in term of the treatment you recommended
13 from that point moving forward?

14 A So the treatment after I identified he did have
15 cognitive deficits, which was consistent with his complaints
16 which is why Dr. Tolat referred him to us, I implemented a
17 treatment plan to work on rehabilitating those areas and getting
18 him better.

19 Q Was that cognitive therapy of some sort?

20 A Correct.

21 Q How frequently was he treating cognitive therapy
22 thereafter?

23 A He had 18 sessions.

24 Q That was at the Center of Cognition and Communication?

25 A Correct.

1 Q Over what time period was that?

2 A From January of 2020 until April of 2021.

3 Q During that period, what type of cognitive therapy was
4 given to him?

5 A So, it is computer based therapy. So, I implemented a
6 treatment plan to work on those areas of sustained and divided
7 attention, the spacial skills and the acquisition of memory.

8 Q How did he perform throughout the 18 sessions of
9 cognitive therapy?

10 A So, he made steady improvement across the sessions
11 which is another way you can determine if a patient is putting
12 forth effort. When you see progress in treatment when you are
13 rehabilitating those areas, you would expect to see a gradual
14 improvement over time across those sessions.

15 Now, with him, the pandemic, it was the time of the
16 pandemic, so there were some breaks in treatment for him and he
17 also had some surgeries that he had to deal with. But, when he
18 was able to do the sessions, I did see progress.

19 Q That was over the course of approximately a year and a
20 half?

21 A Correct.

22 Q Can you explain to us more about the symptoms that he
23 complained about or that you noticed during that time in terms
24 of the post-concussive symptoms?

25 A Yes, like I mentioned before, he had pain, neck, back

1 pain, headaches, dizziness, numbness, difficulty walking,
2 standing, balance problems.

3 Then, specifically, with what I was treating for,
4 attention, concentration, memory. For example, he would forget
5 things like doctor's appointments. Even putting it in his phone
6 he would forget to look -- he would hear the alarm and forget
7 what he put the alarm for. That is very specific. He would
8 have his friend help him make food in the house and he would
9 have to do frozen food because he could not do the cooking. He
10 would have to have another friend help pay his bills.

11 So, this is how it affects his daily life in terms of
12 what I was treating him with.

13 Q Earlier did you mention issues with anything with his
14 hearing or ears?

15 A Yes. So, he was seeing Dr. Tolat, the physiatrist who
16 noted left ear ringing, tinnitus, also light and sound
17 sensitivity. Then he also had post-traumatic headaches, severe
18 post traumatic headaches. That was not only documented in
19 Dr. Tolat's records but that was documented further along when
20 he saw a neurologist, Dr. Golzad.

21 MR. MCNIFF: Objection.

22 THE COURT: Basis?

23 MR. MCNIFF: Records are not in evidence.

24 MR. LESNEVEC: The records of Dr. Golzad are.

25 THE COURT: What were they?

1 MR. LESNEVEC: The last exhibit, Exhibit 18.

2 THE COURT: Dr. Kalter?

3 MR. LESNEVEC: Dr. Tolat and Dr. Kalter. It was
4 the same facility.

5 MR. MCNIFF: I thought she said Dr. Golzad.

6 THE COURT: Can you please read back the last
7 response madam court reporter.

8 (Whereupon, at this time the testimony was read
9 back by the court reporter.)

10 MR. MCNIFF: Can we approach?

11 (Whereupon, an off-the-record discussion was held
12 at the bench.)

13 THE COURT: The objection is sustained as to the
14 witness' reference as to Dr. Golzad.

15 MR. LESNEVEC: Sure.

16 Q Just sticking with the records which we have in
17 evidence from earlier today from Physical Medicine and
18 Rehabilitation, Dr. Tolat, did you review those records?

19 A Yes.

20 Q Did you review them years ago when you were treating
21 Mr. Gill?

22 A Yes.

23 Q In terms of complaints, you were mentioning light
24 sensitivity, and tinnitus. Can you describe what your
25 understanding was from those records?

1 A Dr. Tolat noted the patient had light sensitivity and
2 sound sensitivity, very common with post-concussion syndrome,
3 blurry vision, which is the visual disturbance that he described
4 and also the left ear ringing and then the post-traumatic
5 headaches.

6 Q Did you find those complaints to be significant in your
7 analysis of neuropsychology?

8 A Yes.

9 Q How is that?

10 A Again, that's the constellation of symptoms of
11 post-concussion symptoms. Those fell within the physical range
12 and that's what he was being treated with Dr. Tolat, the
13 physiatrist, and then Dr. Tolat referred him to me for
14 rehabilitation of the attention in the memory and the
15 processing.

16 Q How does blurry vision relate to traumatic brain
17 injury?

18 A Yeah, just like we mentioned before, there are
19 different lobes of the brain. Again, that is the occipital
20 lobe. So, all different areas of the brain are connected
21 through neurons. So, if one specific area of the brain get
22 affected, it affects the transmission of communication from
23 other neurons. So, that could be affected -- the visual system
24 can be affected.

25 Q What about -- so, tinnitus, what is tinnitus?

1 A Tinnitus is ringing in the ears. So, a patient might
2 come in and say I can't stop this ringing. Buzzing, sometimes
3 they say a buzzing sound. Again, that is the inner ear.

4 Q How, if at all, does that relate to post-concussive or
5 traumatic brain injury?

6 A That is a symptom that is, that can develop if you have
7 what we call chronic post-concussion syndrome.

8 Q Now, after a period of time in 2021, you were still
9 treating him?

10 A Correct.

11 Q Did you perform any repeat testing on him?

12 A Yes, in March of 2021 was my repeat?

13 Q Was that March 8th?

14 A Yes.

15 Q What test did you administer during that time?

16 A The computerize testing but also paper and pencil test
17 of assessing attention, memory, processing, spacial skills,
18 verbal functioning.

19 Q How did he perform on repeat testing?

20 A So, he had, again, areas of preservation, areas of
21 weaknesses. As a treating doctor, I am able to look from
22 session to session to how he is improving. Some days he did
23 better, some days he did not do as well. That is normal with
24 progression of a concussion.

25 So, it is almost like a zig zag in terms of the

1 progress. Any day a patient could not perform as well as
2 others. But, in his situation he was making progress in
3 treatment but on re-evaluation, I did notice he was still having
4 fluctuating attention and processing speed deficits and areas of
5 executive function.

6 Q What did that mean to you in a neuro-psychological
7 sense?

8 A That he continued having residual cognitive deficits
9 even after the course of treatment.

10 Q Did your impression change at that point after the
11 second repeat test?

12 A No, the diagnostic impression was still head injury,
13 post-concussion syndrome and cognitive deficits.

14 Q Did you have a chance to review Mr. Gill's hospital
15 records from Long Island Jewish Hospital?

16 A Yes.

17 Q Was there anything in those records you determined to
18 be significant in terms of your analysis in neuro-psychology?

19 A Yes.

20 Q What was that?

21 A The fact is that we talked about post-concussion
22 syndrome and that does develop over time. But on the day that
23 he went to the hospital, on that very same day, he had
24 headaches, dizziness and there was documentation of head pain.

25 Q Why did you find that to be significant?

1 A Those are all the neurological symptoms that are
2 associated with post-concussion syndrome that are associated
3 with traumatic brain injury, concussion, and head trauma.

4 Q Now, was he diagnosed specifically with a concussion in
5 the emergency room?

6 A No.

7 Q Does someone need to be diagnosed with a concussion in
8 order to suffer from post-concussion syndrome?

9 A No.

10 Q Why not?

11 A Not in the hospital. They will be diagnosed over time
12 if those symptoms persist. So, you would be diagnosed with a
13 concussion, which is a mild traumatic brain injury; and, then
14 you develop what you would call a post-concussion syndrome.
15 But, that typically develops over time. But, you don't have to
16 be diagnosed in the hospital with concussion.

17 Q After Mr. Gill finished treating at the Center of
18 Cognition and Communication, are you aware of treatment that he
19 got neuro-psychologically thereafter?

20 A So, he was seen for another neuro-psychological
21 evaluation in 2022, that was from Dr. Counts (phonetic); and,
22 then again I saw him in 2024.

23 Q Could you tell us when did you see him in 2024?

24 MR. MCNIFF: Objection. Can we approach?

25 (Whereupon, an off-the-record discussion was held

1 at the bench.)

2 THE COURT: You can proceed.

3 MR. MCNIFF: Withdrawn. Thank you.

4 Q So, Doctor, can you tell us about when you saw him in
5 2024?

6 A December 27, 2024 I did I another neuro-psychological
7 evaluation. Again, I was at the new center at that point. So,
8 I went from the Center of Cognition and Communication; and, I
9 saw him again in 2024 at the Comprehension Concussion Center.
10 Again, I did a clinical interview, determined what areas he
11 continued to still having deficits in and I then performed a
12 neuro-psyche evaluation.

13 Q What, if any, complaints did he make to you in 2024
14 when you treated him?

15 THE COURT: I am sorry, I did not hear.

16 Q What, if any, complaints did he make to you in 2024
17 when you treated him?

18 A Memory difficulty, organization difficulty, processing
19 speed, attention and concentration.

20 Q In terms of treatment that December 27, 2024, what, if
21 any, treatment did you provide?

22 A So, after that evaluation I implemented a treatment
23 plan going forward to help him address those areas that he had
24 difficulty on the testing. In acquisition of memory, attention,
25 focus, processing speed.

1 Q So, did you test him again in December of 2024?

2 A Correct.

3 Q That was another round of testing such as what you did
4 before?

5 A Correct.

6 Q Can you tell us about those tests specifically from
7 December of 2024?

8 A Correct. So, there was a computer portion of the test
9 and then the paper and pencil. Again, I tested all areas, all
10 cognitive domains of memory, attention, processing speed,
11 spacial skills, executive functioning and determined that he had
12 significant residual deficits at that point in areas of
13 fluctuating attention of focus, processing speed, acquisition of
14 memory.

15 Q Again, did you test for any type of exaggeration of
16 symptoms?

17 A Yes.

18 Q How did you do that?

19 A Again, I gave him what is called a Rey 15 items test.
20 Again, he passed that. He was definitely performing full effort
21 on the testing. And, again, I had treated him since, so I had
22 seen his progress in treatment also.

23 As a treating doctor I am able to take a look from
24 session to session to determine if a patient is benefitting from
25 treatment and improving in treatment.

1 Q So, how was he by December 2024? Was he improving,
2 staying the same, getting worst?

3 A Right, again, there was gap, he did not have treatment
4 for a while. He stopped in 2021 and then was under the care of
5 other doctors from 2022 until 2024. So, he still had
6 significant residual deficits at that point, but I was treating
7 him for that year and half prior so I did know him very well, I
8 knew his deficits. So, I was able to implement the treatment
9 plan going forward to help him with the residual deficits he
10 had.

11 Q Did you ever review the brain MRI films or diagnostic
12 tests for Mr. Gill?

13 A I did not.

14 Q Do you ever make any recommendations in term of going
15 to work for your patients?

16 A No.

17 Q Are you aware of any prior injuries Mr. Gill had to his
18 head?

19 A No.

20 Q Are you aware of any prior cognitive deficits he had
21 before the accident?

22 A No.

23 Q Are you aware of any other accidents he was involved
24 in?

25 A No.

1 Q Are you aware of any prior cognitive therapy or
2 treatment that he had before this car accident?

3 A No.

4 Q Do you have an opinion within a reasonable degree of
5 neuro-psychological certainty as to what the cause of Mr. Gill's
6 cognitive deficits and his traumatic brain injury was?

7 A The 12/4/2019 work related accident.

8 Q Why is that your opinion?

9 A Because he sustained a head injury, traumatic brain
10 injury, concussion and developed post-concussion syndrome and
11 those were the cognitive deficits that were sequelae or as a
12 result of the head injury or traumatic brain injury.

13 Q Within a reasonable degree of neuro-psychological
14 certainty, do you have an opinion with regards to the permanency
15 of the cognitive deficits and traumatic brain injury?

16 A At this point they are permanent.

17 Q Why is that your opinion?

18 A Like I mentioned before, I could see progress in
19 treatment and at some point in treatment, rehabilitation turns
20 to what we call maintenance treatment because they begin to
21 plateau in treatment.

22 At that point, I changed the treatment course from
23 rehabilitation to maintenance and teaching strategies to get
24 around deficits and that's where he is right now.

25 Q Are you recommending any type of future care for him?

1 A The future rehabilitation would be to maintain the
2 gains he made and also continue teaching him strategies so that
3 he could function better in his overall life. He is not going
4 to get better in terms of the residual cognitive deficits at
5 this point but I can teach him ways to get around, and to cope,
6 and to manage those skills. For example, like use calendars,
7 writings things down for himself, cueing himself, things to help
8 get around those.

9 Q How long would you recommend that he continue the
10 cognitive therapy or any type of maintenance therapy?

11 A So, I tapered treatments down. So, right now he had 14
12 sessions since December with me now in the new center. And,
13 again, that is over the course of say five months, five or six
14 months now. So, I would do once a week, and then once every
15 other week, and then once monthly for a few years.

16 MR. LESNEVEC: Thank you, Doctor, I have no
17 further questions.

18 THE COURT: Any cross?

19 MR. MCNIFF: Thank you, your Honor.

20 CROSS EXAMINATION

21 BY MR. MCNIFF:

22 Q Good afternoon, Doctor.

23 A Good afternoon.

24 Q Have you ever testified before?

25 A Yes.

1 Q Approximately, how many occasions?

2 A I would say over 18 years, approximately, 60 times.

3 Q When you testify, is it connection with a patient,
4 right?

5 A I am a treating, doctor, yes.

6 Q With a patient in a lawsuit; is that fair?

7 A I am a treating doctor.

8 Q My question is not clear, I apologize. When you have
9 testified those 60 times, I want to know if you testified for a
10 patient in connection with the lawsuit; yes or no?

11 A If they had lawsuit, I was testifying.

12 Q You did come into court like today?

13 A Correct.

14 Q And the plaintiff's counsel asked you questions?

15 A Correct.

16 Q In those cases where you testified about 60 times, they
17 were in connection with a lawsuit?

18 A If they had a lawsuit, yes.

19 Q Now, Doctor, when the patient comes to see you, is the
20 first thing you do is sit down and talk to them?

21 A I do a clinical interview with the patient, yes.

22 Q Is that when you ask them how are you?

23 A No, it is a little more specific than that. I ask
24 about their cognitive --

25 Q In general, that's what you are asking them?

1 A About what happened to them.

2 Q And they explain that to you?

3 A Correct.

4 Q Part of it you elicit symptoms from them?

5 A Not elicit, I ask what happened to them and then they
6 tell me what happened.

7 Q Okay. When they tell you what happened, do they make
8 complaints to you about their condition?

9 A Correct.

10 Q Are those complaints subjective?

11 A Yes.

12 Q In this case, you did that with Mr. Gill?

13 A Correct.

14 Q You had a clinical interview?

15 A Correct.

16 Q And you asked him about what is going on and why you
17 are here, right?

18 A Correct.

19 Q And, he told you about his symptoms?

20 A Correct.

21 Q And you noted them, right?

22 A Correct.

23 Q And, they are subjective; would you agree with that?

24 A That is what the patient reported, correct.

25 Q Then you would administer a test, you told us about the

1 test in general, right?

2 A Correct.

3 Q And, again, this is generally speaking, you mentioned
4 among other tests, is it the Rey 15?

5 A Correct.

6 Q And you did a number of other tests; is that right?

7 A Correct.

8 Q Can you just explain for us the different tests in a
9 general way, you know, it is a pencil and paper, right?

10 A Pen and paper and a computer.

11 Q The NeuroTrax, is that the computer?

12 A That is the computer portion.

13 Q And tell me generally first about the computer portion,
14 you sit, is that what happens, a patient sits at the computer
15 and goes through the test?

16 A Correct.

17 Q The pen and paper portion you put that in front of them
18 and they perform different functions?

19 A Correct.

20 Q This is generally speaking, they are matching up
21 symbols; is that one of the tests?

22 A Symbols search and symbols match, correct.

23 Q Are they looking at the patterns of either numbers or
24 letters or that part of test generally?

25 A On those specific tests but there are a number of other

1 tests I give.

2 Q But those tests generally ask a patient to perform
3 certain tests, right?

4 A Correct.

5 Q You mentioned the term full effort a number of times,
6 right?

7 A Correct.

8 Q I think you told you us you test for that?

9 A Correct.

10 Q Would you agree that generally speaking the test
11 require full effort from the patient in order for the results to
12 be valid?

13 A Say that again.

14 Q Sure. Generally speaking, does the test require full
15 effort from the patient in order for the results to be valid?

16 A That's what I interpret, correct.

17 Q But, it does require that part from the patient to
18 actually give full effort?

19 A Correct.

20 Q I just want to go through some of the tests with you.
21 Do you have your report?

22 A Yes.

23 Q So, the test administered I guess this is the first
24 visit, January 20th?

25 A January 10th.

1 Q Of '20, right?

2 A Yes.

3 Q You administered a number of tests and the first one is
4 called the Mindstream Scientific Cognitive Assessment Test,
5 correct?

6 A Correct.

7 Q Is that the same or different from the NeuroTrax?

8 A That is the same.

9 Q That is the computer test?

10 A Correct.

11 Q Does that test require full effort from the patient in
12 order to be valid?

13 A Correct.

14 Q You also -- you administered WAIS, W-A-I-S, IV Digit
15 Span Test, true?

16 A Correct.

17 Q That test also requires full effort from the patient in
18 order to be valid?

19 A Correct.

20 Q You administered the WAIS-IV Simple Search?

21 A Correct.

22 Q Once again, it requires full effort from the patient,
23 true?

24 A Correct.

25 Q There are three or four, or five more tests, whatever

1 it is, they all require full effort from the patient?

2 A Correct.

3 Q You are interpreting the results of the test in
4 connection in part with the effort given by the patient?

5 A Correct.

6 Q You administered tests during your second visit; is
7 that right; or re-testing?

8 A Correct.

9 Q Are the tests the same that are administered or do you
10 change the test?

11 A Most of them are the same. There might have been a few
12 additional sub tests.

13 Q What do you mean by sub tests?

14 A All of them are sub tests. Every test I give is a sub
15 test.

16 Q You said additional sub test, what do you mean --

17 A You asked --

18 THE COURT: No, no, you have to let the attorney
19 ask his question and finish. Then you answer because the
20 reporter can only take one person down.

21 Were you finished your question, counselor?

22 MR. MCNIFF: I finished.

23 THE COURT: Do you need it to be repeated by the
24 reporter?

25 A I remember the question. I found the sub test that I

1 was talking about. It is called the verbal fluency, F-A-S.

2 Q That's a new test that was administered?

3 A That was a new sub test that was administered.

4 Q Does that test require full effort from the patient in
5 order for the results to be valid?

6 A Correct.

7 Q Then you had, I guess, a third round of tests in 2024;
8 is that true?

9 A Yes.

10 Q When you performed your third round of tests in 2024,
11 did you modify the sub tests?

12 A They appeared to be the same.

13 Q So, those test require full effort from the patient in
14 order to be valid?

15 A Correct.

16 Q If a patient were not to give full effort, the results
17 of those tests may not be valid, true?

18 A I would not be able to interpret the results if they
19 did not put full effort. That is why I am able to assess if
20 they did.

21 Q Right. If they didn't, the results would not be valid
22 because you could not provide a valid interpretation?

23 A Correct.

24 Q In general is my question, true?

25 A Correct.

1 MR. MCNIFF: Okay. Thank you, Doctor.

2 THE COURT: You are finished?

3 MR. MCNIFF: Yes, your Honor, no further
4 questions.

5 THE COURT: Any redirect?

6 MR. LESNEVEC: Yes, your Honor, thank you.

7 REDIRECT EXAMINATION

8 BY MR. LESNEVEC:

9 Q Doctor, did you find that Mr. Gill gave less than full
10 effort during any of your tests?

11 A No, he gave optimal effort. Not only the tests but the
12 treatment I gave him.

13 Q Tell us more about how he gave optimal effort during
14 treatment and the testing?

15 A Right. So, not only do I give the test that I was
16 referring to, the Rey 15, there is a number of embedded measures
17 in the test itself like the digit span that I spoke about
18 before. And, the patient doesn't even know that these are tests
19 of effort. So, if the patient was exaggerating or not putting
20 forth full effort, they would fail those tests. Especially when
21 they appear to be memory test.

22 Also, there is a number of different ways as the
23 treating doctor, because I see him over years, is watching his
24 progress from treatment session to treatment session. If
25 someone wasn't putting forth full effort, they would not

1 improve. They would do poorly across the board on these tests.

2 The other way you can tell is the areas of preservation
3 and the area of weaknesses on evaluation. Someone that is not
4 putting forth effort would be impaired across the board because
5 they don't know what is a test of effort and what is a cognitive
6 test. But, when you have areas of preservation, that means the
7 patient is putting forth full effort because the areas of the
8 brain that were not damage, they are doing well on the tests.
9 The areas that were injured, are the areas on the neuro-psych
10 that are showing up as impairments.

11 Q In terms of the sub tests, I know there was one
12 additional sub test that you gave the second round. Why do you
13 stick to the majority of the same sub tests?

14 A Right. So, I look at his baseline and then I want to
15 see on the re-evaluation how he improved or what areas he is
16 still having difficulty based on the baseline when I gave him
17 after treatment and then I reevaluate him to determine if there
18 is progress in those areas and then if there is any further
19 treatment that needs to be done.

20 MR. LESNEVEC: All right. Thank you, Doctor.

21 THE COURT: You may stand down, Doctor, thank you.
22 Counsels, please approach.

23 (Whereupon, at this time a discussion was held at
24 sidebar.)

25 Okay. Members of the jury, good news, today you

1 will have an early out. So, you will hear those
2 admonitions one more time. Please, do not -- during this
3 break, please do not do any research on any topic about
4 this case. Do not discuss anything related to the case
5 with anyone, including your fellow jurors. Do not speak
6 with the parties, the attorneys or any witnesses. If
7 anyone attempt to discuss this matter with you, please
8 notify my court officer who will in turn notify me.

9 So, today like I said, you have an early out. Get
10 home safely, have a relaxing evening and see you back here
11 tomorrow morning at 10:00 a.m. sharp. Have a good evening.

12 THE COURT OFFICER: All rise. Jurors exiting.

13 (Whereupon, the jury exits the courtroom.)

14 THE COURT: Off the record.

15 (Whereupon, the trial was adjourned until May 23, 2025, at 10:00
16 a.m.)

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