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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FRANCINE SPAULDING, VICTORIA BIFULCO
Senior Court Reporters

THE CLERK: All rise, come to order.

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

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

Let the record reflect all counsels are present.

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

THE COURT: Good morning, counsellor.

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

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

MR. LESNEVEC: Yes, your Honor.

THE COURT: Please bring in the jury.

THE COURT OFFICER: All rise. Jurors are entering.

(Whereupon, the jury entered the courtroom.)

THE CLERK: Do all parties stipulate to the

presence and proper seating of the jury?

MR. LESNEVEC: I do.

MR. MCNIFF: I do.

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

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

Counsel, you may call your next witness.

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

THE COURT OFFICER: Witness entering.

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

THE WITNESS: I do.

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

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

THE CLERK: Witness has been sworn, your Honor.

THE COURT: Proceed counsel.

EXAMINATION BY

MR. LESNEVEC:

Q Good morning.

A Good morning.
Q Have we ever met before today?
A No.
THE COURT: Please keep your voice up so we can all hear you, sir.
Q Is the green light on the microphone?
Have we ever met before?
A No.
Q We spoke on the phone yesterday?
A Correct.
Q How long did we speak for?
A Ten minutes.
Q What did we discuss?
A General prep for the case.
Q Have you ever testified in court before where my office was representing the injured person or the plaintiff?
A No.
Q How many times have you testified this year in court?
A Zero.
Q This is your first time?
A Correct.
Q How many times have you testified, if you can estimate, over your career?
A Ten times.
Q Give us a brief history about your educational

background?

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

Q So you are a medical doctor?

A Correct.

Q When did you graduate from medical school?

A 2002.

Q What is your field of practice?

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

Q Tell us about the field of pain medicine?

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

Q Are you board certified?

A Yes.

Q What does it mean to be board certified?

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

Q What are you board certified in?

A Physical medicine, rehabilitation as well as pain management.

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

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

Q Do you hold a residency?

A Yes.

Q Can you tell us about that?

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

Q Are you affiliated with any hospitals?

A Yes.

Q Which hospital?

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

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

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

patients are in the hospital I go there.

Q How long have you been in private practice for?

A Since 2007.

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

A Correct.

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

A Minimally invasive spine procedures, yes.

Q Tell us more about that?

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

Q Are you familiar with a discectomy procedure?

A Yes.

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

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

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

A 40 to 50.

Q What about injections, have you performed any injections?

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

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

A Four to five thousand.

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

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

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

A I would be working in my office.

Q Are you being compensated for your time here?

A Yes.

Q How much?

A $4,000.

Q $4,000?

A Yes.

Q Are you familiar with a patient named Moazzam Gill?

A Yes.

Q Have you treated that patient?

A Yes.

Q Where did you treat him at?

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

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

A Yes.

MR. LESNEVEC: If I can have these marked.

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

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

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

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

Q If you would take a look at Exhibit 18.

A Yes.

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

A Yes, I do.

Q What do you recognize Exhibit 18 to be?

A These are my records of treating Mr. Gill.

Q Are those also records from Premier Physical Medicine

Rehabilitation?

A That's correct.

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

A Yes.

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

THE COURT: Any objection?

MR. MCNIFF: No objection.

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

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

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

THE COURT: You may proceed.

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

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

Q Do they have a separate role than you?

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

Q What is the difference between physiatry versus pain

management?

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

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

A Correct.

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

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

Q Is he still practicing?

A I believe he is retired now.

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

A For pain management.

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

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

Q When was the first time you started the treatment?

A August 27, 2020.

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

A I did.

Q Did he describe his complaints to you?

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

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

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

A Both legs, left and right.

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

A Yes.

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

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

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

A I did.

Q What did that consist of?

A Examination of his neck and back.

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

A I did.

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

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

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

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

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

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

A Of the spine?

Q Yes, what does the flexion test look like?

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

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

A Correct.

Q With their chin towards their chest?

A Correct.

Q What was his ability to bend his head down?

A Flexion was 35 degrees.

Q 35 out of?

A Out of 50 which is normal.

Q What about extension; how is that test performed?

A Extending, putting your head backwards.
Q What was the result of that?
A That was 25 degrees.
Q Out of a possible?
A 60.
Q How is it that you measure these -- how do find out what is going on?
A There is a device called a goniometer which checks the angle of how far the patient can do that maneuver.
Q You were using that during the testing?
A Yes.
Q What about the lower back, tell us how those tests are perform?
A Lower back flexion is basically bending forward with your back, that was 70 degrees, normal is 90. Extension is bending backwards, it was 10 degrees, normal is 30. Lateral tilt is bending side-to-side and on both directions it was 15 degrees and normal is 40?
THE COURT: Doctor, I'd ask you to speak a little slower so the reporter can get what you are saying and we can all get it also, sir.
Q In your medical opinion at that point when you first saw him, did you believe he was exhibiting signs of radiculopathy?
A Yes.

Q What is radiculopathy?

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

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

A Yes, because it does indicate nerve compression.

Q Can you describe what is nerve compression?

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

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

A Yes.

Q You have treated him consistently since 2020 until now?

A Correct.

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

A I did.

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

A Both.

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

A Primarily focused on the lower back.

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

lumbar MRI film of December 18, 2019.

THE COURT: That is fine.

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

A Yes.

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

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

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

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

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

A Correct.

Q There are various levels to the spine, correct?

A Yes.

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

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

down the leg.

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

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

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

A That's here.

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

A Correct.

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

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

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

Q Did you review that MRI with Mr. Gill?

A Yes.

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

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

Q Did you administer that injection?

A I did.

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

A It was seven injections and a procedure.

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

A Eighteen times.

Q Which years did you treat him?

A 2020 up until the present.

Q So, 2020 to 2025?

A Correct.

Q How frequently were you seeing him over the years?

A Every two to three months.

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

A I did.

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

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

THE COURT: I did not hear.

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

Q What does that mean, waxed and waned?

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

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

A Yes.

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

A Yes.

Q What is an EMG test?

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

Q How does it check for that?

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

Q Did Mr. Gill undergo an EMG test?

A He did.

Q Do you know when he underwent that test?

A February 13th of 2020.

Q What were the results of that test?

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

Q That test was positive for neck and the back?

A Correct.

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

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

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

A I did.

Q What did you prescribe?

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

Q Why is it that you prescribed those specific medications?

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

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

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

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

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

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

A Yes.

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

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

Q You had mentioned that you administered injections?

A Yes.

Q You said it was seven?

A Seven, yes.

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

A They were generally lumbar epidural injections.

Q What is an epidural injection?

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

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

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

Q Is that basically to help you see where you are

injecting the solution?

A Correct.

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

A He received temporary partial relief.

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

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

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

A Yes.

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

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

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

A Correct.

Q Why was that recommend by you?

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

Q Is that a surgery?

A It is a minimally invasive surgery.
Q When did you perform that?
A June 20, 2024.
Q Was he administered anesthesia for that surgery?
A Yes.
Q Was it general or local or something else?
A General.
Q What is general anesthesia?
A Basically the patient is completely out as we do the procedure meaning they are not responsive.
Q They are unconscious?
A Correct.
Q Was that performed at a surgery center or somewhere else?
A Surgery center, yes.
Q Who, if anyone, was present with you when you performed that operation?
A An anesthesiologist and a nursing assistant and a Xray tech.
Q Can you take us through the step-by-step procedure how is that perform?
A Yes, basically, first the anesthesiologist who administers his medication and makes the patient comfortable. We clean, prep the area to make it sterile. We set up the X-ray machine to localize the area where the problem is. We put a

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

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

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

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

A Correct.

Q How long did that procedure take to perform?

A Approximately, 45-minutes to an hour.

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

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

Q You obviously continued to see him after the procedure?

A Yes.

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

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

Q When was last time you treated Mr. Gill?

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

Q April of 2025?

A Yes.

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

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

Q So, you administered the injection at that point?

A Correct.

Q Why did you administer the injection?

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

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

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

Q What is sedentary activity?

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

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

A Not that I am aware, no.

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

A No.

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

A I am not aware of any, no.

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

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

Q Why is that your opinion?

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

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

the lower back?

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

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

THE COURT: Any cross?

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

CROSS-EXAMINATION

BY MR MCNIFF:

Q Good morning.

A Good morning.

Q We never met before?

A No.

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

A Correct.

Q Where is that?

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

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

A Partly there and partly here, yes.

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

A Yes.
Q You said general anesthesia?
A Yes.
Q Are you talking about the patient being intubated?
A Yes.
Q Did you prepare an operative report for this?
A Yes.
Q Do you have that with you?
A Yes, I do.
Q As part of the anesthesia that was administered was one percent lidocaine administered?
A No, that's a local. Yes.
Q That's a local?
A Yes.
Q Then it says intravenous sedation?
A Yes.
Q Is that IV?
A Yes.
Q Is that like propofol?
A It could be propofol, it could be fentanyl.
Q That is administered by the anesthesiologist?
A Correct.
Q That is monitored during the procedure, right?
A Correct.
Q Does this say that the anesthesia was propofol or

fentanyl?

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

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

A That is correct.

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

A That is what is stated, yes.

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

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

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

A I am the treating pain management.

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

Finish counsel.

Q Were you only a consultant?

A Yes.

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

A Correct.

Q That was done by Dr. Tolat?

A Correct.

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

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

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

A Yes.

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

A Yes.

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

A Yes.

Q One is you use it to from differential diagnosis?

A It helps in that, yes.

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

A Correct.

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

A Correct.

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

A Yes.

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

A Yes.

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

A Correct.

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

A Yes.

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

A Yes.

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

A Correct.

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

A Correct.

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

CROSS EXAMINATION

BY MR. McNIFF:

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

A I try to, yes.

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

A Correct.

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

A Yes.

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

A Yes.

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

A Yes.

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

A Correct.

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

A That's correct.
Q Okay. So part of the physical examination, does that include an observation generally of the patient?
A Yes.
Q Okay. And you look at them to see if they are in any kind of distress, right?
A Correct.
Q Okay. You can do this also by asking them a pain scale, I think you mentioned that before, right?
A Yes.
Q That's zero to ten?
A It's one of the scales, yes.
Q One of the scales is the happy face to the crying face, true?
A Yes.
Q In your records did you record a pain scale for the plaintiff?
A I don't believe I did that, no.
Q Okay. So generally speaking, you perform tests on patients to see if you can correlate the subjective complaints of pain to findings, correct?
A You correlate the examination of the patient along with the testing results, yeah.
Q By the way, you mean you don't do any independent investigation into a patient to see what kind of person they

are?

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

A No.

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

A Correct.

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

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

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

A Correct.

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

A No.

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

A That's part of the examination.

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

A For?

Q For lumbar spine, essentially bend over; is that correct?
A Correct.
Q And you are relying on the patient to be accurate with you when they feel pain, right?
A Yes.
Q And then sometimes you will do different tests to determine if there is some kind of nerve root pathology like a straight leg raise; is that right?
A Correct.
Q You did that in this case, right?
A I did.
Q Did you do any type of compression tests on the spine, the cervical spine?
A Yes.
Q And when you did the straight leg raise, you recorded your findings, right?
A Yes.
Q Much like you did the range of motion testing; is that right?
A Correct.
Q Can we go through some of your notes, Doctor?
A Yes.
Q Can I direct you to November 18, 2021?
A Yes.

Q So you take a history from him at that time; is that right?
A Yes.
Q And then you do a review of systems and that's kind of a history as well, right?
A Yes.
Q You ask the patient about specific questions; is that true?
A Yes.
Q And you ask him questions about bowel, bladder changes, true?
A Yes.
Q Balance issues, right?
A Yes.
Q And falls, correct?
A Yes.
Q And that's relevant to your assessment in part because you are trying to figure out if he truly has a neurologic issue because they can be signs of one; is that true?
A Signs of severe compression, yes.
Q Absolutely. I mean, if you are incontinent of bladder or bowel, that is an emergency, would you agree?
A Yes.
Q That has to be operated on immediately, true?

A Yes.
Q But balance issues and falls may not be an emergency, right?
A Could be, could not be.
Q Right. Okay. And in this case he denies bowel, bladder, balance or fall issues, true?
A Correct.
Q Then you perform a physical examination in November of 2021, true?
A Yes.
Q And you also assess whether he is alert and oriented times three, right?
A Yes.
Q Times three means alert and oriented to person, place --
A Time.
Q And time.
A Yes.
Q Okay. And that, no problem, right?
A No.
Q You also did the no apparent distress; you look at him and see how he is doing, right?
A Yes.
Q And at least visually there is no apparent distress, right?

A Correct.

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

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

A Yeah, we do a general assessment. Absolutely.

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

A Correct.

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

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

A Correct.

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

A Yes.

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

A Yes.

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

A Yes.

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

Doctor?

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

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

Q Got it.

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

A Full strength, yes.

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

A Yes.

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

You would agree with that, correct?

A Right.

Q Is that a pin prick test?

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

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

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

A Correct.

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

A That's correct.

Q So that's normal, right?

A Yes.

Q And you also checked reflexes, right?

A Yes.

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

A Correct.

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

A Yes.

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

A Correct.

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

A Yes.

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

A Okay.

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

A Correct.

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

A Yes.

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

A Yes.

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

A Yes.

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

A Right.

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

A Correct.

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

A Yes.

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

A Yes.

Q Sensation, normal?
A Yes.
Q And reflexes, normal?
A Yes.
Q So you do a physical examination of the cervical spine during that visit, right?
A Yes.
Q And you palpate the area, Doctor, is that what you do?
A Yes.
Q By palpate, we mean touch the area to find out what is going on; is that right?
A Yes.
Q And there is no cervical paraspinal tenderness, right?
A Correct.
Q You check your cervical range of motion too?
A Yes.
Q And that's, what, flexion, extension?
A And bending.
Q And tilt?
A Yeah.
Q And that's normal, full range of motion, right?
A Yes.
Q He comes back when, July 2022; is that the next note

you have?

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

Q Your next evaluation is that July?

A July 14, 2022.

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

A Yes.

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

A Yes.

Q Reflexes are normal?

A Yes.

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

A Correct.

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

A Yes.

Q Decreased, true?

A Yes.

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

A Yes.

Q Do you have another note from August of 2022?

A August 25, 2022.
Q Okay. And the review the systems, same thing, correct?
A Correct.
Q Normal. No cervical complaints, right?
A No.
Q The physical examine, muscle strength is normal, right?
A Yes.
Q Sensation is intact, right?
A Yes.
Q Reflexes is normal?
A Yes.
Q You see him again in October of 2022?
A October 13, 2022.
Q No cervical complaints, right?
A Nothing noted.
Q So he is not complaining about his neck?
A No.
Q Again, no balance issues, no falls right?
A Correct.
Q Muscles are normal, right?
A Yes.
Q Sensation is intact, true?
A Yes.

Q And his reflexes are completely normal, right?
A Yes.
Q You see him again -- you told us about these visits -- April of 2023, right?
A I did a procedure April 6, 2023, so I am on April 27, 2023.
Q He had no cervical complaints, right, he is not complaining about his neck?
A No.
Q Physical exam we have motor strength is normal, correct?
A Yes.
Q Upper and lower extremities, right?
A Yes.
Q His sensation is in tact and his reflexes are completely normal, right?
A Yes.
Q And, again, these are the physical examinations that you are doing to test his muscles, right?
You are asking him to push as hard as he can, right?
A Yes.
Q And you are assessing his ability to push, and you are saying it's normal, right?
A Yes.
Q Do you see him again September of 2023?

A September 7, 2023.
Q And at that point no complaints of cervical pain, right?
A No.
Q No issues with balance or falls, right?
A No.
Q And his muscle strength is normal, right?
His sensation is normal and his reflexes are normal, right?
A Correct.
Q You see him again January 24, right?
A January 11, 2024.
Q All right. No cervical complaints, right?
A No.
Q And the physical exam is the same, right, it's all normal?
A Physical exam is not completely normal but the review systems is normal.
Q The review systems is normal?
A Yes.
Q Muscle strength, five/five, normal, right?
A Yes.
Q Sensation is normal?
A Yes.
Q Reflexes are normal, right?

A Yes.
Q So we are there again March 24 -- I'm sorry, March 7, 2024.
Do you have that note?
A Yes.
Q He does not have any neck complaints at that point, right?
A No.
Q So the last neck complaint was July of 2022 then, right, so far?
We haven't come across a neck complaint?
A Yeah. I was basically treating for his lower back.
Q But you ask him how he is, right?
A Yeah.
Q You are a pain management doctor, true?
A Yes.
Q You are asking him do you have any complaints, do you have any pain, right?
A Yes.
Q And if he told you that, you would certainly note it, right?
A Yes.
Q And you would treat it, wouldn't you?
A Yes.
Q And, again, this visit is motor strength or his

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

A Yes.

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

A May 16, 2024.

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

A Yes.

Q Same is true in November of 2024, right?

A November 7, 2024.

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

A That's correct.

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

A Yes.

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

A Correct.

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

A February 27, 2025.

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

A One epidural after that. Yes.

Q Okay. All right, Doctor.

MR. McNIFF: You know what, thank you very much. I don't have any further questions.

THE COURT: Any redirect, counsel?

MR. LESNEVEC: Yes, your Honor.

THE COURT: Go ahead.

MR. LESNEVEC: Thank you.

REDIRECT EXAMINATION

BY MR. LESNEVEC:

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

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

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

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

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

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

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

A Yes.

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

A Ten thousand.

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

A No.

MR. McNIFF: Objection.

THE COURT: Basis?

MR. McNIFF: I'm not sure of the correlation. It's a form objection.

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

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

THE COURT: Sustained.

Do you want to rephrase?

MR. LESNEVEC: Yes, Judge.

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

point when you were treating him, Doctor?

A No.

Q Why not?

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

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

A No.

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

A Yes.

Q Do you remember those questions?

A Yes.

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

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

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

A No.

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

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

significant condition that would warrant surgery immediately.

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

A Yes.

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

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

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

Why is that, doctor?

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

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

A Yes.

Q What does that mean?

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

Q Why did you document that?

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

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

Doctor?

A Yes.

Q What does that mean?

A Means that his muscle is at full strength.

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

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

Q How long does that testing take?

A Ten seconds.

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

A It doesn't.

Q Why not?

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

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

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

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

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

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

A No.

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

A Yes.

Q What does that mean?

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

Q And why did you document his reflexes?

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

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

A No.

Q Okay.

MR. LESNEVEC: Thank you.

I have nothing further.

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

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

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

Remember those admonitions I gave you.

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

Do not speak with the attorneys, parties or witnesses.

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

We are going to take a brief comfort break.

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

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

THE COURT: Come back at twelve o'clock.

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

THE COURT: You are done for --

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

THE COURT: Do you have anything else before lunch?

MR. LESNEVEC: Not with the jury.

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

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

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

MR. LESNEVEC: Thank you, Judge.

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

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

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THE CLERK: All rise. Come to order.

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

THE COURT: You may all be seated.

MR. McNIFF: Good afternoon, your Honor.

THE COURT: Good afternoon.

Are we ready to proceed, Counsellors?

MR. LESNEVEC: Yes, your Honor.

MR. McNIFF: Yes, your Honor.

THE COURT: Please bring in the jury.

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

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

THE COURT: You maybe be seated.

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

MR. LESNEVEC: I do.

MR. McNIFF: I do.

THE COURT: You may all be seated.

Everyone may be seated.

Counsel, you may call your next witness.

MR. LESNEVEC: Thank you, your Honor.

At this time the plaintiff calls Dr. Kim Busuchio.

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

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

THE WITNESS: Thank you.

THE CLERK: Good afternoon. Please remain standing.

Raise your right hand.

Do you swear or affirm to tell the truth, the

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

THE WITNESS: I do.

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

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

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

THE CLERK: Thank you.

You may be a seated.

The witness has been sworn, your Honor.

THE COURT: Thank you.

You may proceed, counsel.

MR. LESNEVEC: Thank you.

DIRECT EXAMINATION

BY MR. LESNEVEC:

Q Good afternoon.

A Good afternoon.

Q Have we have met before today?

A No.

Q We spoke on the phone yesterday; is that correct?
A Correct.
Q How long did the phone call last for?
A Not long, maybe 20 minutes.
Q What did we discuss?
A My treatment and assessment of Mr. Gill.
Q Have you ever testified in court before where I was one of the attorneys asking questions?
A No.
Q What about my law office, have you ever testified where my law office represented someone that was injured in a case?
A I don't believe so.
Q Can you give us a brief history about your educational background?
A Sure. In 2004 I graduated with my clinical psychology degree from Fairleigh Dickinson University. That's in Hackensack Teaneck, New Jersey.

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

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

research and assessment for traumatic brain injury and rehabilitation.

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

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

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

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

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

Q So are you a neuropsychologist?

A Yes.

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

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

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

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

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

A Since 2007.

Q That has been continuous until now?

A Yes.

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

A Correct.
Q What was the first one?
A Center for Cognition and Communication.
Q And what was your position there, your title?
A Clinical Director of Neuropsychology.
Q What were your duties and obligations as clinical director there?
A So I oversaw the entire program of neuropsychology.

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

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

Q If you were not here today in court testifying, what would you be doing?
A I would be treating patients.
Q And how frequently are you treating patients now, Doctor?
A So every day. I specialize in seeing new patients, doing follow up with patients that are in the rehabilitation

program, but I do that all day.

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

A Yes.

Q How much are you being compensated?

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

Q So you are currently treating Mr. Gill?

A Yes.

Q So I want to back up.

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

A Correct.

Q Where are you treating him now?

A At the Comprehension Concussion Center of New York.

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

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

We have a parietal lobe.

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

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

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

The parietal is more visio spatial skills or perception.

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

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

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

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

A Yes.

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

THE COURT: Okay.

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

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

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

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

A Yes.

Q Do you recognize those?

A Yes.

Q What is Exhibit 19 you have there?

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

Q Are those accurate copies of those records?

A Yes.

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

THE COURT: Any objection?

MR. McNIFF: No objection, your Honor.

THE COURT: What was previously marked as

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

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

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

MR. LESNEVEC: Thank you.

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

A January 10, 2020.

Q Is how was he referred to your practice?

A Dr. Tolat who is a physiatrist.

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

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

A Sure.

Q I think it's the top one there.

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

A Yes.

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

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

information.

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

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

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

A Yes.

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

A Yes.

Q What was the history he gave?

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

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

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

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

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

Q What is post concussive syndrome?

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

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

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

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

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

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

A Forty-five.

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

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

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

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

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

Q Why is that?

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

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

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

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

A Yes.

Q What tests did you administer?

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

functioning.

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

A Correct.

Q Can we go through those individually?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So he had difficulty with that.

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

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

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

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

A Why he.

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

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

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

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

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

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

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

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

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

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

(Whereupon, at this time, Senior Court Reporter Victoria Bifulco was relieved by Senior Court Reporter Francine Spaulding.)

Q How many times over your career have you administered these tests?

A Thousands.

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

A Thousands.

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

A Yes.

Q What was your impression?

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

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

A Yes.

Q Are there different severities of traumatic brain injury?

A Yes, there are.

Q Can tell us about that?

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

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

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

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

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

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

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

Q Was that cognitive therapy of some sort?

A Correct.

Q How frequently was he treating cognitive therapy thereafter?

A He had 18 sessions.

Q That was at the Center of Cognition and Communication?

A Correct.

Q Over what time period was that?

A From January of 2020 until April of 2021.

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

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

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

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

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

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

A Correct.

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

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

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

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

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

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

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

MR. MCNIFF: Objection.

THE COURT: Basis?

MR. MCNIFF: Records are not in evidence.

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

THE COURT: What were they?

MR. LESNEVEC: The last exhibit, Exhibit 18.

THE COURT: Dr. Kalter?

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

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

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

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

MR. MCNIFF: Can we approach?

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

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

MR. LESNEVEC: Sure.

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

A Yes.

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

A Yes.

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

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

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

A Yes.

Q How is that?

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

Q How does blurry vision relate to traumatic brain injury?

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

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

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

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

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

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

A Correct.

Q Did you perform any repeat testing on him?

A Yes, in March of 2021 was my repeat?

Q Was that March 8th?

A Yes.

Q What test did you administer during that time?

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

Q How did he perform on repeat testing?

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

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

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

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

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

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

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

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

A Yes.

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

A Yes.

Q What was that?

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

Q Why did you find that to be significant?

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

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

A No.

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

A No.

Q Why not?

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

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

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

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

MR. MCNIFF: Objection. Can we approach?

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

at the bench.)

THE COURT: You can proceed.

MR. MCNIFF: Withdrawn. Thank you.

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

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

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

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

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

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

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

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

Q So, did you test him again in December of 2024?
A Correct.
Q That was another round of testing such as what you did before?
A Correct.
Q Can you tell us about those tests specifically from December of 2024?
A Correct. So, there was a computer portion of the test and then the paper and pencil. Again, I tested all areas, all cognitive domains of memory, attention, processing speed, spacial skills, executive functioning and determined that he had significant residual deficits at that point in areas of fluctuating attention of focus, processing speed, acquisition of memory.
Q Again, did you test for any type of exaggeration of symptoms?
A Yes.
Q How did you do that?
A Again, I gave him what is called a Rey 15 items test. Again, he passed that. He was definitely performing full effort on the testing. And, again, I had treated him since, so I had seen his progress in treatment also.

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

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

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

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

A I did not.

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

A No.

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

A No.

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

A No.

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

A No.

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

A No.

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

A The 12/4/2019 work related accident.

Q Why is that your opinion?

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

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

A At this point they are permanent.

Q Why is that your opinion?

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

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

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

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

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

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

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

THE COURT: Any cross?

MR. MCNIFF: Thank you, your Honor.

CROSS EXAMINATION

BY MR. MCNIFF:

Q Good afternoon, Doctor.

A Good afternoon.

Q Have you ever testified before?

A Yes.

Q Approximately, how many occasions?
A I would say over 18 years, approximately, 60 times.
Q When you testify, is it connection with a patient, right?
A I am a treating, doctor, yes.
Q With a patient in a lawsuit; is that fair?
A I am a treating doctor.
Q My question is not clear, I apologize. When you have testified those 60 times, I want to know if you testified for a patient in connection with the lawsuit; yes or no?
A If they had lawsuit, I was testifying.
Q You did come into court like today?
A Correct.
Q And the plaintiff's counsel asked you questions?
A Correct.
Q In those cases where you testified about 60 times, they were in connection with a lawsuit?
A If they had a lawsuit, yes.
Q Now, Doctor, when the patient comes to see you, is the first thing you do is sit down and talk to them?
A I do a clinical interview with the patient, yes.
Q Is that when you ask them how are you?
A No, it is a little more specific then that. I ask about their cognitive --
Q In general, that's what you are asking them?

A About what happened to them.
Q And they explain that to you?
A Correct.
Q Part of it you elicit symptoms from them?
A Not elicit, I ask what happened to them and then they tell me what happened.
Q Okay. When they tell you what happened, do they make complaints to you about their condition?
A Correct.
Q Are those complaints subjective?
A Yes.
Q In this case, you did that with Mr. Gill?
A Correct.
Q You had a clinical interview?
A Correct.
Q And you asked him about what is going on and why you are here, right?
A Correct.
Q And, he told you about his symptoms?
A Correct.
Q And you noted them, right?
A Correct.
Q And, they are subjective; would you agree with that?
A That is what the patient reported, correct.
Q Then you would administer a test, you told us about the

test in general, right?

A Correct.

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

A Correct.

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

A Correct.

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

A Pen and paper and a computer.

Q The NeuroTrax, is that the computer?

A That is the computer portion.

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

A Correct.

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

A Correct.

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

A Symbols search and symbols match, correct.

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

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

tests I give.

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

A Correct.

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

A Correct.

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

A Correct.

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

A Say that again.

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

A That's what I interpret, correct.

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

A Correct.

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

A Yes.

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

A January 10th.

Q Of '20, right?
A Yes.
Q You administered a number of tests and the first one is called the Mindstream Scientific Cognitive Assessment Test, correct?
A Correct.
Q Is that the same or different from the NeuroTrax?
A That is the same.
Q That is the computer test?
A Correct.
Q Does that test require full effort from the patient in order to be valid?
A Correct.
Q You also -- you administered WAIS, W-A-I-S, IV Digit Span Test, true?
A Correct.
Q That test also requires full effort from the patient in order to be valid?
A Correct.
Q You administered the WAIS-IV Simple Search?
A Correct.
Q Once again, it requires full effort from the patient, true?
A Correct.
Q There are three or four, or five more tests, whatever

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

A Correct.

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

A Correct.

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

A Correct.

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

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

Q What do you mean by sub tests?

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

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

A You asked --

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

Were you finished your question, counselor?

MR. MCNIFF: I finished.

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

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

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

Q That's a new test that was administered?

A That was a new sub test that was administered.

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

A Correct.

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

A Yes.

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

A They appeared to be the same.

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

A Correct.

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

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

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

A Correct.

Q In general is my question, true?

A Correct.

MR. MCNIFF: Okay. Thank you, Doctor.

THE COURT: You are finished?

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

THE COURT: Any redirect?

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

REDIRECT EXAMINATION

BY MR. LESNEVEC:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT OFFICER: All rise. Jurors exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Off the record.

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

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