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

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MOAZZAM R. GILL,

Plaintiff,

-against- Index No. 706989/2020
JURY TRIAL

SIGFREDO VALLADARES-LOPEZ AND
FLEETWASH, INC.,

Defendant.

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Supreme Courthouse
88-11 Sutphin Boulevard
Jamaica, New York 11435
May 29, 2025

B E F O R E:

HONORABLE NICOLE McGREGOR-MUNDY,
Justice of the Supreme Court

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

LAW OFFICES OF MICHAEL LAMONSOFF, PLLC
Attorneys for the Plaintiff
32 Old Slip, 8th Floor
New York, New York 10005
BY: JASON LESNEVEC, ESQ.

MULHOLLAND MINION DAVEY McNIFF AND BEYRER
Attorneys for the Defendants
374 Hillside Avenue
Williston Park, New York 11596
BY: KEVIN McNIFF, ESQ.

DALILA CUMMINGS, RPR
MONICA JENKINS
Senior Court Reporters

THE CLERK: All rise. Queens Supreme Court part 7 is now in session. The Honorable McGregor Mundy presiding.

THE COURT: Good morning. You may all be seated. Off the record.

(Whereupon, a discussion was held off the record.)

Please call in the case.

THE CLERK: This case is on for trial, Index Number 706989 of 2020, Moazzam R. Gill versus Sigfredo Valladares-Lopez & Fleetwash, Inc. Counsel's, please state your appearances for the record?

MR. LESNEVEC: Good morning, Your Honor. Jason Lesnevec from the Law office of Michael Lamonsoff on behalf of the Plaintiff Moazzam Gill. Good morning, Your Honor.

THE COURT: Good morning, Counsel.

MR. MCNIFF: Kevin McNiff Mulholland Minion, 374 Hillside Avenue, Williston Park, NY 11596. Attorney for the Defendant. Good morning, Your Honor.

THE COURT: Good morning, Counsel. Okay. Counsel are we ready to proceed?

MR. MCNIFF: We are.

THE COURT: And, Counsel, you may call your, actually, excuse me, who's going to be testifying today?

MR. MCNIFF: Dr. Berman.

THE COURT: Okay. Let's bring in the jury.

(Whereupon, the jury entered the courtroom and

upon taking their respective seats, the following occurred:)

COURT OFFICER: All rise. Jury entering.

THE CLERK: Do all parties stipulate to the presence and proper placement of the jurors; Counsel for the plaintiff?

MR. LESNEVEC: I do.

THE CLERK: Counsel for the defense?

MR. MCNIFF: I do.

THE COURT: Everyone maybe seated. Good morning, jurors. Welcome back. I hope everyone had a relaxing and hopefully enjoyable holiday weekend. We're going to continue with the trial at this time.

Counsel, you may call your next witness.

MR. MCNIFF: Thank you, Your Honor. Defendant's call Arnold Berman.

THE COURT: Please bring in Dr. Berman, please.

(Whereupon, the witness entered the courtroom and took the witness stand.)

THE CLERK: Please raise your right hand. Do you solemnly swear or affirm that the testimony you shall give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE CLERK: You maybe seated. In a loud, clear

voice state and spell your name?

THE WITNESS: Arnold T. Berman, MD. B-E-R-M-A-N.

THE CLERK: And please state your business address for the record?

THE WITNESS: 1700 Paoli Pike, Malverne, Pennsylvania.

THE CLERK: Thank you.

THE COURT: You may begin.

MR. MCNIFF: Thank you, Your Honor.

DIRECT-EXAMINATION BY MR. MCNIFF:

Q Good morning, doctor.

A Good morning.

Q Are you a physician licensed to practice medicine in the State of New York?

A Yes.

Q When did you become licensed?

A I think it was about 1980.

Q Can you tell the Court and Jury about your educational background, training and experience?

A Yes. I graduated from South Philadelphia High School, received a Chemistry degree from Temple, MD degree from PCOM Medical College, Philadelphia. Following that I did a surgical internship in orthopedic surgery residency.

I had additional fellowship training at Presbyterian Hospital, New York Columbia Presbyterian and also at Mass

General. I came back to ^ /HAPB /REUPB and I was made professor and chairman of Department of Orthopedic Surgery, the position I had for about 30 years.

Q Are you still practicing?

A Practicing a lot less but still practicing and enormous practice experience. I spent about 90, 95 percent of my time in practice all those years. I did have a responsibility for teaching residents and students.

We had a residency. I directed 25 residents that I trained total over 125. They're all board certified and, um, I did a lot of other teaching and got the highest teaching awards you could get, Block Award and some other awards for teaching, um, medical students, residents and practicing physicians.

Q Are you board certified?

A Board certified orthopedic surgeon.

Q What does it mean to be board certified?

A You have to graduate medical school and take at least one year of surgical internship, four years of orthopedic surgery residency. At the end of the residency you take a written exam.

You are able to practice one location for two years and end of those two years you take an oral exam. If you become board certified, passing those tests, you become board certified.

Q Doctor, have you ever had any disciplinary issues?

A I had about 25 years ago one incident on a license renewal with a clerical error and it was so recognized as a clerical error. Unfortunately I was responsibile for what my staff does.

Of course I took the responsibility. It was a $250 fine but I've never had any other problem with my license. I never had loss of license, never stopped practicing, never had anything like that.

So, it was, um, I'm told by people involved it was very minor, small fine and I paid it. I wasn't going to, you know, burn my secretary for it and let her pay the fine. Obviously, I accepted the responsibility although I had nothing to do with it but I accepted total responsibility for that.

Q Okay. And you've practiced since then continuously?

A Never interfered with my practice, had nothing to do with the practice. It was a clerical error and it was so recognized as such and I was fined.

Q Have you testified before?

A Yes.

Q Approximately how many times?

A Many times, um, workman's compensation there's a lot of testimony there do with various aspects. So, I would say that alone would be several thousand other type of testimony like this would be much less.

Q Okay. Have we ever met before this case?

A No.

Q All right. And did we speak on the phone in preparation of your testimony?

A Yes.

Q Did we speak last night?

A Yes.

Q Approximately how long?

A I don't know, 10 minutes maybe.

Q Did we go over your report?

A Yes.

Q Are you being compensated for your time here today?

A Yes.

Q How much are you being compensated?

A Ask me to check on that, I think I'm getting $4,500.

Q Okay. And were you compensated for the preparation of your report and the examination of the plaintiff and your review of the medical records?

A Yes.

Q Do you know how much that was?

A I think it was about $500.

Q Okay. Can you tell us approximately the present time what percentage of your practice is devoted to seeing people who have claims in accidents?

A I would say main thing I do is see independent medical evaluations for work-related injuries. That's what I do mostly.

I also see other kinds of situations like this one and, um, I would say recently it's been maybe 5, 10 percent my normal practice but until about 10 years ago I had an enormous practice working round the clock with a full staff, full group of residents that I had the responsibility of training, about 25 attending board certified orthopedic surgeons that I was responsible for and, um, but, um, then I did very few independent medical examination over the last several years. Over 10 years I would say, um, I've seen far fewer patients for treatment.

Q And did you examine the plaintiff in this case at the request of the defendants, correct?

A Yes.

Q When did that evaluation take place?

A That was December 22, 2011 to 2021.

Q And you prepared a report following the examination, right?

A Yes.

Q You have that with you?

A Yes.

Q Please feel free to review your report to refresh your recollection. Now, Doctor, as far as the evaluation, do you take a history, review medical records and perform a physical examination?

A Yes.

Q You did that in this case, right?

A That's right.

Q As part of the record review, did you review records from the surgeon who did the left shoulder surgery, Dr. Touliopoulos?

A Yes.

Q You reviewed the hospital records for the surgery?

A Yes.

Q And now, you performed a physical examination of the plaintiff, correct?

A I did.

Q And can you explain to the Court and Jury what the physical examination consisted of generally first, then we'll get into the specifics?

A Too many parts to an examination. One is the history and the other is the hands on physical exam. The history of course is very important. It's the patient tells you and we accept that as accurate and that's the history.

The sequence of events, treatment they had, how they're doing and so on. The physical exam is kind of to verify the history to see if there's a basis for pain that they maybe having or basis for some other complaints.

So, to verify that you conduct a hands-on examination where we do what we call objective testing. There's two kinds of evacuation. One is subjective, what the patient tells you

and then it's very important to listen intently and the other is the physical examination, that's the objective aspect.

Objective meaning out of control of the patient. Subjective is under total control of the patient. Objective is totally out of control of the patient. That's done by medical science.

We do things that have measurements, reflexes, atrophy, whether or not there's atrophy, and they're using their legs correctly, muscle testing, see if they're strong or weak, see if they have sensation or loss of sensation.

Reflexes to see if they have a pinched nerve or anything like that. That's the objective part. The subjective part is they tell you. The objective part is what you measure on examination.

Q Okay. You want to go through the history with us, Doctor?

A Yes. The history was that it was a 47-year-old male who had no problems. He was an Uber driver and he was okay initially. He had this automobile accident and the date of the injury was December 4, 2019.

The date of my, the date of the operation that we'll talk about was about a year later and about a year after that was my evaluation of the patient. So, I examined the patient December 22, 2021 and the history was that he was a 47-year-old who was injured on December 4, 2011.

This was an automobile accident and injured three parts, left shoulder, his back and his neck and he was treated conservatively, went to the emergency room, wore a neck collar and had whole variety of conservative non-operative treatments including physical therapy, psycho, um, neuropsychology, orthopedic surgery and neurology, pain management and physical therapy.

Specifically he received physical therapy 2, 3 times a week for 2 years and was still going at the time I saw him. He had chiropractic treatment for 2 years and wore a low back corset and he had neck injections and low back injections, Cortisone type injections to his neck and back called Epidural injections for low back had two of those, three to his neck.

And the MRI's and X-rays were also done. The orthoscopic surgery was eventually performed and it was determined that he had a rotator cuff abnormality and few different abnormalities.

He underwent the surgery and had the rotator cuff repair and stabilization and some other aspects of the surgery. The patient also underwent surgery for the neck, incision in the front to take out the disc and to fuse the neck where there is a problem with the disc.

And this was done and at level C5, C6 in the midportion of the neck right about this level and that was done 12/21/20. So, injury was December 2019. The surgery was December 2020,

and my evaluation was December 2021.

Q And you performed the physical examination part of it as well, right?

A Physical examination which of course is the objective part. Subjective part is what the patient tells us. The objective, what you measure, what you observe utilizing medical science and subjective is totally under the patient's control which is very important to listen to history intently.

And then you have the objective part that's totally out of the patient's control. You take measurements of various kinds to see based on medical science what's the problem and what should be done about it. So, that's the process.

Q All right. So, let's go through your physical examination. You did among other things range of motion tests; is that correct?

A Yes.

Q Take us through the range of motion testing?

A So, range of motion means you ask a patient to move different directions. We don't take the arm or shoulder and move it for the patient. The patient moves it. It's called active range of motion.

So, here we're talking about the left shoulder. So, the left shoulder, this is called flexion up in the air. This is called external rotation behind the head. This is called rotation behind the back to the side. And you go through that

and do it about three times routinely for every patient to make sure there's consistency.

And, um, that's what was done here. Now, in the process we try to determine whether or not there is any special science we call them to indicate serious abnormalities and they have names, named after the people many years ago who identified them, the names but the test we're talking about is an, if you lift the arm up, somebody has a problem with the rotator cuff, you come up to about here will be painful.

You go further, will be painful. So, we try to identify the patient moving in different directions and where they have pain and what it means. So, the patient does all of these things.

Then we do some other testing measurements. Everybody doesn't do it but some of us do and we tape measure, measure the circumference of the arm in this case because you want to make sure that there's enough muscle bulk that they could function normally.

So, we measure the circumference, see if there's any atrophy or wasting from loss of motion. There was none here. Then we do strength tests. We have a special device called Jamar Test, squeeze it.

It has a straining gauge on it. You squeeze it. You read it. The patient will squeeze it. You will see in here it was good. It was good strength, 75 pound on the right, 70 on

left which would be normal for a right-handed individual.

This is completely normal. That's a good sign. The range of motion I talked about was full range of motion. Patient already had surgery on the shoulder, left shoulder but had a good recovery, had a good job technically, had a good job rehabilitation wise and patient was doing well.

Could do this, this, this, and this. We discussed and I documented all that in the report. Then we do special tests. If you lift the arm up here and it hurts, it's an impingement where the ball, the ball and socket hits the main part of the shoulder.

So, that called an impingement. That's one of the main things this patient had. It's something you're born with and it was there and it was identified and patient had it treated. By the time I saw the patient, the patient was fine already, had the surgery, had rehabilitation, had the result you hoped for the excellent result.

So, that's the reason we do these surgeries and conduct these kinds of procedures is so patients get better. Everybody doesn't get better. This patient got better and had good strength on strength testing, had no atrophy on circumference measurements, had no problem with range of motion and had good strength 75 pounds is a pretty good grip on the right and the left 70 pounds, pinch, 12 pounds on the right and left which is good for a right-handed individual.

So, um, the patient had surgery, excellent result. Patient was doing well. There were some minor complaints, mild pain that you would see almost after almost any kind of significant surgery.

It's orthoscopic where little holes were made and you look inside with a scope. It started out many, many years ago, many decades ago looking into the bladder, cystoscope. Now it's evolved into arthroscope for almost all the joints of the body.

The patient had on my examination, pretty good examination. It was, I didn't really find any abnormalities of any significance and there was an injury. There was treatment and there was full recovery, the way it supposed to work out.

Doesn't always work out but in this case she had a very good result.

Q Okay. The injuries were resolved?

A They were, yeah.

Q Is that your opinion within a reasonable degree of medical certainty?

A Yes.

Q And did you have an opinion within a reasonable degree of medical certainty as to whether the plaintiff can return to work?

A Yes.

Q What was your opinion?

A I didn't think there was any problem. I think that the

employment history was it, um, working as an Uber driver. He was working for a long period of time. I didn't have the information whether he was working or not working but he was certainly able to work and he had good strength, good motion in his shoulders where it required and his other joints required for driving were all good.

Q Now, Doctor, you mentioned the surgery that was performed the orthoscopic surgery; have you performed that type of surgery?

A Yes.

Q On how many occasions?

A I don't know, um, over a thousand for sure.

Q You also mentioned you talked a little about atrophy; is atrophy objective?

A Very objective. I measure with tape measure to see if one side is equal to the other side and right side should actually be a little bit bigger in the right-handed individual.

Q That means he's using the muscles equally?

A Means he's definitely using equally and it's subjective using them equally it maybe yes, then we measure it and are using them equally, had good strength, the measurements are good. So, we know that they're using them normally.

Q Did you know whether there was any fraying in the operative report from Dr. Touliopoulos anywhere in the shoulder?

A There was. There was, you know, the shoulder is a ball

and socket joint, big ball, almost as big as your wrist, your hand when it's a clinched fist. It's not quite but it's a big ball, bigger than a golf ball and smaller than a baseball.

Okay. And it's attached to the different parts of the shoulder with muscles. The shoulder is a unique joint because the shoulder has a lot of motion. Obviously if you adjust ourselves but it doesn't have a lot of stability.

So, you give up the stability for the motion. When you have the motion and in her case it was, it was a, um, a good result that she had from the orthoscopic surgery and it was essentially normal.

Q Is fraying degenerative?

A Fraying is degenerative. When you look inside of the shoulder joint or any other joint you could actually see the structure and the labrum is like a washer. It sits inside the shoulder joint.

You have one in the knee also called the meniscus but the shoulder it's called the labrum and you could tell if there's wear and tear on it versus an injury by fraying and how it actually looks.

All the descriptions say it was fraying of it which means it's a wear and tear type situation as opposed to a big sharp tear.

Q Okay. Um, Doctor, how long did the evaluation take approximately?

A I don't know. I don't measure that but, um, the ladies that take care at my office and run my office tell me I spend about a half hour with the patient. I spend maybe about a half hour before I see the patients because there's a lot of records that goes along with this type of evaluation.

I spend about an hour and a half, two hours after the evaluation reviewing all records and dictating a report. It's about a two and a half hour process.

Q Okay. And Doctor, I know we talked about some of the records that you reviewed from Touliopoulos but did you review any other records?

A I saw the various imaging records, imaging pictures of the MRI's, saw the operative notes that were carried out and, um, they were, they were the main parts of the examination. The MRI's are something like X-rays.

It's about 70 years old now. And the difference between MRI and X-ray is that the MRI you could see soft tissues. An x-ray will show the bone. So, these two guys got a Nobel Prize for it. They deserve it because they'll show water on it, whether or not you have fluid in the joint, will show soft tissues, whether or not it's torn or not torn.

And the MRI of course is critical to everything we do. We use them all day long because it gives us so much information, almost as much as operating on a patient. So, the MRI's were done of the shoulder and then of the end of the neck,

cervical spine.

And this patient, um, was 47. That's not really old but we know from experience that if you're an active person and the 40's you start to develop these degenerative or wear and tear type findings of the shoulder for example.

And, um, when you have that, you could see that on the MRI. So, there was no new injury. There was no acute injury. What we saw there were two things on the MRI.

MR. LESNEVEC: Objection, Your Honor. Can we approach? It's outside the scope of disclosure.

THE COURT: Approach. I didn't hear what he said.

(Whereupon a discussion was held off the record.)

THE COURT: The objection is sustained.

Q Doctor, we're going to move on to, you also reviewed a verified Bill of Particulars; is that right?

A Yes.

Q That's a legal document?

A Yes.

Q Does that set forth the claims?

A Yes.

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

THE COURT: Any cross-examination?

MR. LESNEVEC: Yes, Your Honor. Thank you.

CROSS-EXAMINATION BY MR. LESNEVEC:

Q Good morning, Doctor.

A Good morning.

Q Now, when you examined Mr. Gill that was not as your patient, correct?

A Correct.

Q You agree, you conducted your examination on behalf of the defense and the defendants in this case, correct?

A Yes, independent but for the defense.

Q You consider this independent you say?

A I said it's called an independent medical examination, that's what it's called, yes.

Q By the way, um, your examination of this patient was that of a man or woman?

A Was a man.

Q Okay. I heard you referring to she, I wanted to be certain. When you wrote your report you did this examination of Mr. Gill, you Knew that was on behalf of the defense, correct?

A Yes.

Q The defense was the one who asked you to do the medical exam, correct?

A Yes.

Q You knew that from the Bill of Particulars, the legal proceedings that you reviewed, right, you knew that Mr. Gill was the plaintiff, right?

A Yeah. I mean in a sense it's the same as any other

examination that you take a history, you do the examination and you review the records but that's correct.

Q Now, the vast majority of times you come to court and you testify, you do that on behalf of the defense; is that correct?

A Yes.

Q How many defense medical exams are you doing now in a given week?

A Varies a lot but I would say between two and four a week.

Q Now, you've done up to 10 in a week in the past, correct?

A Yes. Usually it's in range I said but I've done as many as 10 a week and as few as none a week.

Q And how much do you charge to testify in court?

A I, um, I work with an organization where I get paid a certain fee and they handle everything and you said for coming in here today?

Q Yeah.

A For what I'm getting paid is I believe $4,500.

Q You testified in the past you earned $5,000 to come to court and testify, haven't you?

A Well, I just said 400 -- $4,500.

Q My question is, Doctor, you've made more than that testifying in court before, haven't you?

A It varies a lot. It varies a lot. It varies on jurisdiction. It varies on all kinds of things but typically, that's about the range about $4,500 that I got.

Q And if you could, Doctor, you testified many times before, right?

A Yes.

Q If you could just answer my questions with a yes or no or tell me if you can't do that?

A Yes.

Q Is that okay with you?

A Yes.

Q And how much did you get paid to review the legal records that you talked about, the Bill of Particulars?

A About $500. I can't be sure but it's about that.

Q You don't document that anywhere in some type of bill?

A I think my bookkeeper and certainly my wife does but I'm not sure. I don't document that, no.

Q How long ago were you paid for that review of those records?

A I don't know.

Q Your defense medical legal work is not just performed here in New York, correct?

A Right.

Q You agree with me that you are pretty popular in other states as well for this type of work, correct?

A Pennsylvania, New Jersey and New York.

Q Three different states where you do this type of work; is that correct?

A Yes.

Q You've done it on behalf of defendants in Pennsylvania, New Jersey and New York; is that correct?

A Yes.

Q Has your medical legal work been profitable for you over the years?

A You know, medicine --

Q If you could with a yes or no?

A All you have is time --

THE COURT: One second.

A The answer is yes.

Q And how many years have you been doing this defense legal work?

A Most of my career I didn't do any of it but around the time I had a very serious illness unfortunately -- excuse me.

THE COURT: One second. You have to speak one at a time, Gentlemen. I think he was trying to answer the question, Counsel.

Q I know what he's about to get into, if you could answer yes or no, how many years have you been doing this type of work, just state the years, Doctor?

A I started gradually.

Q Doctor, if you can't answer it I will move on.
A I'm happy to answer all of your questions. The answer is --
THE COURT: One second, Doctor. I'm going to have the reporter re-read the question to you. Just answer it. Madam Court Reporter, can you please read the last question?
(Whereupon, the requested portion of the record was read back.)
A I started about 15 years ago.
Q And how much have you made from this medical legal work over the 15 years?
A I don't know. I don't know. I think whatever it was charged by me and my office. I'm told there was standard fees. There was nothing out of line.
Q Are you familiar with Professional Medical Evaluations PC?
A Yes. That's when I first started doing these.
Q Okay. It's a yes or no. If you could just answer yes or no?
A Yes.
Q Because I want to keep it flowing, okay?
A Sure.
Q And you owned that company at one point, correct?
A Yeah. It was the arm of my practice is what it was.

Q The arm of your practice meaning you set up that company just to perform these legal medical exams, correct?
A Yes, primarily workman's compensation.
Q Didn't you form that over 30 years ago, yes or no?
A Yes.
Q And that was you formed it simply for these legal medical exams, yes or no?
A Yes, for workman's comp back then.
Q The company was formed in 1991; is that true?
A Yes.
Q Now, that wasn't the only company you owned that did these defense medical exams, was it?
A Well, we had --
Q It's the only one?
A Not the only one but there were two, one was the one you mentioned. The other was that was for Pennsylvania. I was told we had to got a separate one to do in New Jersey and New York and that was called Professional Medical Evaluations.
Q Well, there was also Comprehensive Medical Assessments?
A Right. Right.
Q Correct?
A Yes.
Q That was another one of your company's that you owned to do this type of work, correct?
A It was a corporate name. You have to do it in a

corporation. That's what it was.

Q If you could answer yes or no?

A Yes.

Q You were the principle owner of Comprehensive Medical Assessments?

A Yes.

Q You were the principle owner, you owned it?

A Was my practice, was, was.

Q And that company received a steady amount of requests for medical legal exams over the years, true?

A Yes.

Q In fact you weren't the only ones performing these exams, the company was so busy there were other doctors that you hired to perform those exams, correct?

A Yeah.

Q Yes or no?

A These 125 residents that I trained wanted to do it so I said fine.

Q Yes or no?

A Yes.

Q You've done this before where you've testified and cross-examination, the attorney had told you to limit yourself to yes or no answers before, right?

A Sometimes, sometimes no.

Q Okay. Now, you also owned Metropolitan Orthopedic

Consultants?

A Right.

Q Well, was more than two, isn't that true, yes or no?

A Well --

Q Yes or no, Doctor, did you own more than two company's that did this legal medical work, yes or no, Doctor?

A Yes, the answer is yes.

Q How long did you own that company for, Metropolitan Orthopedic Consultants?

A I don't remember. It was, um, probably several years. It was, there was formed for it in New Jersey and New York the other was for Pennsylvania, um, I don't recall the number of years. It was a while.

Q That company performed almost all of it's examinations on behalf of the defense, correct?

A Not 100% but close to that, yes.

Q You've also performed defense medical exams on behalf of a company called IMS?

A Yes.

Q And you've performed these defense exams on behalf of a company called CSG, correct?

A Yes.

Q That's Consolidated Services Group, right?

A Yes.

Q Now, the companies that you owned over the years, they

performed these exams at 15 different locations; is that correct?

A Well --

Q Yes or No.

A Yes. I know, yes, is the answer to that. I'm happy to --

Q If you can't answer yes or no, that's fine. You had 10 different locations in Pennsylvania, correct, yes or no?

A Yes.

Q You had seven different locations in New Jersey where you did defense exams, correct?

A They're available locations but the answer is yes. They weren't utilized much but they were available, so, the answer is yes.

Q You had 5 different locations you used here in New York City for the defense exams, correct?

A Yes.

Q Where were those located?

A One in each of the 5 boroughs.

Q Manhattan, Brooklyn, Staten Island, Bronx and Queens?

A Yes.

Q Now, the fact that you owned all these defense medical exam companies and you derived income from that, that doesn't affect the validity of your opinions that you give in court, yes or no?

A I been around a long time. Nobody could tell me what to do. Nobody's going to push me around and they all know it. So, they know if their going to get an exam by me, it's going to be legitimate and 100% and if they want me to do it, fine.

Sometimes they don't like what I write, sometimes they do, doesn't matter to me. They have to know that what I give them is 100% accurate 100% of the time. That's what I've been doing.

Q Isn't it true your company Comprehensive Medical Assessments grossed millions of dollars over the years?

A It did.

Q It did. In fact in 2016 your company grossed 3 million dollars for doing these defense exams, correct?

A Not for me but for all the various people who are involved in doing these exams.

Q It grossed 3 million dollars that year, correct?

A Grossed.

Q And it grossed that same number in 2017 too, didn't it?

A Correct. Not for me but all the other people doing the work.

Q You didn't see any of it?

A Oh, I saw it. I saw it, yeah, sure, I did fine.

Q You did fine. You've seen millions of dollars from your business over the years?

A I only got paid for what I did. I didn't get paid for

putting the company together or working with other people. What I got paid was what I did with my own two hands. That's what I've always done in all my years of practice.

Q Now, Comprehensive Medical Assessments was so profitable you were able to sell that company, correct?

A Yes.

Q You sold it for profit, right, yes or no?

A It was a profit more of a merger but it was a profit.

Q Now, almost all of your work that you do now is spent on these medical legal exams; is that correct?

A Almost all, not all but almost all.

Q You've never come to court and testified that a person who was injured sustained an injury that was related to the accident in court, right?

A I do it all the time. That's 90 percent of the workman's comp exams that I do are legitimate injuries. I just say they want to know how I would treat it.

It's based on my experience, this operation, this operation, no operation or something else. So I just whatever the questions are I answer them.

Q Now, you testified earlier some of the first questions was about a clerical error on a license renewal application?

A That's correct.

Q You remember those questions?

A That's correct.

Q Isn't it true you also previously testified in court it was actually a late application to the Pennsylvania State Board of Medicine?

A It was --

Q Yes or no?

A No. It was a renewal, can't be answered yes or no. It's a serious question and I have the right to answer it. It was --

THE COURT: Doctor, he said either yes or no or if you can't do a yes or no, say I can't answer it yes or no, Sir.

A I can't answer it yes or no.

THE COURT: Counsel, are you going to be reading from this?

MR. LESNEVEC: Yes, we will.

THE COURT: One second.

MR. MCNIFF: Can you direct me to where?

MR. LESNEVEC: I will but I will lay a little foundation first.

THE COURT: One second. Approach for a quick second, please.

(Whereupon, a discussion was held off the record.)

(Whereupon, Senior Court Reporter Dalila Cummings began recording the following proceedings:)

THE COURT: Members of the Jury, you are about to hear the lawyer for plaintiff read portions of a document referred to as -- is it a transcript or EBT?

MR. LESNEVEC: A transcript from a trial proceeding.

THE COURT: It is a transcript. At some point before this trial began, the witness, under oath, testified and answered questions put to him by lawyers. A stenographer recorded the questions and answers, and transcribed them into the document which the witness later -- did he sign this?

MR. LESNEVEC: No. This is from trial.

THE COURT: And transcribed them into a document. The portions of the transcript that you will hear are to be considered as if the witness were testifying from the witness stand.

CROSS-EXAMINATION

BY MR. LESNEVEC:

Q Doctor, do you recall testifying at a jury trial in Kings County on June 7, 2018?

A I don't recall.

Q The name of the case was Dexter James versus Noson Kopel -- N-o-s-o-n K-o-p-e-l. Do you remember testifying in that case, Doctor?

A No.

Q When you testify in court, you raise your hand and you swear to tell the truth, don't you?

A Always do.

Q Every time, right?

A Every time.

Q And so, directing your attention to page 325, line 11, do you remember being asked the following questions and giving the following answers?

THE COURT: One second.

MR. McNIFF: Objection, Your Honor. Can we approach?

THE COURT: Sure.

(An off-the-record discussion was held away from the jury.)

THE COURT: Members of the Jury, we are going to take a five-minute comfort break. During this break, please do not discuss this case with anyone, including the fellow jurors. And do not speak with the doctor, attorneys, witnesses. If anyone attempts to speak about this case, please notify my officer, who will in turn notify me. We are going to take a five-minute comfort break at this time.

Off the record.

(An off-the-record discussion was held.)

THE COURT: Doctor, let me remind you you are

still under oath. So you cannot discuss or speak to anyone, not the attorneys or anyone.

THE WITNESS: Of course. Thank you.

(A short recess was taken.)

THE COURT: On the record.

Counsel, you are requesting a readback of certain questions and answers with the witness on the stand?

MR. LESNEVEC: Yes, Your Honor. It is of the portion that I asked the doctor did he file a late application to the Pennsylvania state board of medicine. Couple questions ago.

THE COURT: Could we have that read back from the court reporter? And just for the record, Dr. Berman is not on the stand or in the courtroom at this time, nor the jury.

(The reporter reads back the requested portion of the proceedings.)

MR. LESNEVEC: I'm offering this line of questioning that I have highlighted to the Court page 325, line 11 through 15 to impeach the testimony he just gave because he gave a very different answer back at the trial on June 7th, 2018.

THE COURT: One second. Counsel, the Court was just inquiring, as inquired, that from the read back, the witness attempted to elaborate or explain his answers. So

that was my encouraging you, but you indicated to the witness that you did not want an explanation or elaboration to his question; that you wanted a yes or no answer. Correct?

MR. LESNEVEC: Yes.

THE COURT: And you want to say anything else before I ask counsel for his position?

MR. LESNEVEC: Judge, the question was posed to him before, and he answered it with a yes at this prior trial, which I cited on page 325. The fact that he's now testifying he can't answer that with a yes or no is in conflict with his testimony he's given before on under oath. So I'm offering to impeach him.

THE COURT: Counsel.

MR. McNIFF: Your Honor, as you point out, he was not permitted to explain, so he cannot be impeached on an answer that's been cut off. He has to be able to explain an answer, give the final answer, and then you can determine whether it is inconsistent. We have two issues here. I submit none of this is inconsistent based on testimony of the clerical error, but the first problem here we have to analyze is whether it's inconsistent. He's been cut off. There was no inconsistency.

THE COURT: So you are objecting. You have an objection?

MR. McNIFF: I do. That is my objection.
THE COURT: Sustained. Please bring the jury back.
Doctor, just be reminded you are still under oath, sir.
THE WITNESS: Yes, Judge.
THE COURT: Please bring in the jury.
THE COURT OFFICER: All rise. Jury entering.
(The jury enters the courtroom.)
THE CLERK: Do all parties stipulate to the presence and proper placement of the jurors? Beginning with the counsel for the plaintiff?
MR. LESNEVEC: I do.
THE CLERK: Defense?
MR. McNIFF: I do.
THE CLERK: Thank you. Jurors, you may be seated.
THE COURT: Everyone may be seated.
Counsel, you may proceed.
MR. LESNEVEC: Thank you, Your Honor.

CONTINUED CROSS-EXAMINATION

BY MR. LESNEVEC:

Q Doctor, on your direct testimony earlier today you testified that this was a clerical error; is that correct?

A It's my understanding.

Q Okay. Isn't it true that, Doctor, that it was not a

clerical error. In fact, it was because you filed false biannual registration?

A No. It's a hundred percent wrong what you said. And it's misleading and dishonest what the facts were. If you want to know the facts --

Q I'm sure counsel --

A If you want --

THE COURT: One second.

A Go ahead. If you want the facts, I'm happy to tell them to you and the jury.

Q I'm sure that counsel will follow up with the facts.

A Well you --

THE COURT: Doctor, Doctor, you have to let the attorney speak. One at a time for my reporter's sake. Okay, sir.

Q Do I have it correct that you were disciplined? Yes or no?

A I was given disciplinary motion with no effect of my license, no effect of my practice, no effect on anything, because it was a clerical error, and it was a clerical error by my staff. And I accept the responsibility for it. And it has absolutely nothing to do with my practice or anything else. This is strictly a clerical error, that he is going to try to make it into something big.

Q Doctor, my only question was whether you were

disciplined?

A In a limited -- extremely limited way that had no significance on my practice and effect to me seeing patients, operating, not for one day or for one minute.

Q So in this case you examined Mr. Gill, correct?

A Yes.

Q Which company did you do that on behalf of?

A This was an independent medical evaluation, and as far as I'm concerned it was totally independent. I work with a company that makes these arrangements called IMX.

Q It was IMX?

A Yes.

Q Okay. Now, the report that you signed in connection with your exam, that was typed, correct?

A Yes.

Q Did you type that?

A Did I what?

Q Did you type that report yourself?

A No. I told you it was IMX.

Q IMX typed your report?

A Yes. I couldn't type if I had a gun to my head. I can't type.

Q Now, you saw Mr. Gill one time; is that correct?

A Yes.

Q Was on December 22nd, 2021?

A Yes.
Q So it was two years after the collision; is that correct?
A Yes.
Q And that was over three years ago from today?
A Yes.
Q Correct. Now, when Mr. Gill came to see you, he told you that he injured his left shoulder, correct?
A Yes.
Q He told you that he injured his neck and back, correct?
A Yes.
Q Did he tell you that he had vision problems?
A He did. I put it in the report.
Q IMX put it in the report?
A No, I put it in the report. They only type what I dictate. They don't put anything in the report. Do you understand?
Q Did Mr. Gill tell you that he was experiencing headaches when he saw you?
A If it's in the report means he told it to me.
Q Is it in the report, sir?
A Yes.
Q Did he tell you he had daily lower back pain?
A Yes.
Q Did he tell you that that back pain would travel into

his legs?

A Yes.

Q Did he tell you that it would make his legs numb?

A Yes.

Q And he told you about the surgery to the neck? You mentioned that, right?

A Excuse me.

Q He told you about the surgery he had to his neck?

A Yes.

Q That was due to a herniated disc?

A Yes. Had nothing to do with this.

Q That was to fix a herniated disc, correct?

MR. McNIFF: Objection.

THE COURT: Basis?

MR. McNIFF: Beyond the scope of this examination.

MR. LESNEVEC: He testified --

MR. McNIFF: Shoulder.

MR. LESNEVEC: He testified about it on the direct.

MR. McNIFF: Not in connection with his examination. This is beyond the scope of his evaluation.

THE COURT: Overruled.

Q He had the surgery to fix the herniated disc, correct?

A Yes. Long before I saw him. I had nothing to do with this so.

Q I understand.

Now, Mr. Gill had told you that his left shoulder pain had improved after the shoulder surgery; is that correct?

A He I put in the report.

Q But that he still had some pain; is that correct?

A Yes.

Q And he was still actively treating with doctors when he came to see you; is that correct?

A I'm not sure if it was regular treatment, but he was still seeing some doctors, yes.

Q He told you that he had an eight out of ten lower back pain?

A Yes.

Q He told you that he had a five to six out of ten neck pain; is that true?

A Yes.

Q He told you about his headaches, right?

A Yes.

Q And it was causing ten out of ten pain in his head?

A Yes.

Q Now, I want to make sure I have this correctly. Was Mr. Gill injured in the collision, in your opinion?

A Well, I think it was my opinion based upon what he told me. I've been listening to patients and believing them my whole career. If he said he was hurt, I accept that. However --

however, it has to be verified by an examination. So I accept the fact that he was injured, but I also accept the fact that he required this examination, and that the examination showed he was okay. And my overall evaluation indicated that just what I said in the report. He had this longstanding impingement syndrome that is very well documented in the records, irrefutable, and as a result, that was his problem. Had nothing to do with this injury.

Q Which medical records said that he had a longstanding impingement syndrome?

A You could --

Q Which records?

A The x-rays.

MR. LESNEVEC: Objection.

THE COURT: Is it the same objection as previously?

MR. LESNEVEC: Yes.

MR. McNIFF: He just opened -- he just asked him the question.

MR. LESNEVEC: I did not ask about x-rays.

MR. McNIFF: You just asked what document.

THE COURT: Can you repeat the last question, please.

(The reporter reads back the requested portion of the proceedings.)

MR. McNIFF: That's the question.

MR. LESNEVEC: An x-ray does not say something, Your Honor. There's nothing written on an x-ray. It's a film.

MR. McNIFF: That's the question.

THE COURT: One second.

MR. McNIFF: He's objecting to his question.

MR. LESNEVEC: I'm objecting to his answer about x-rays that he never reviewed.

THE COURT: Counsel, you asked the question. Doctor, you may answer the question.

THE WITNESS: Can you repeat the question, Your Honor?

THE COURT: Can you please reread the question.

(The reporter reads back the requested portion of the proceedings.)

A Well, the medical records included all the radiologic reports. And the way they wrote them is a description in medical language that's longstanding. It is nothing new here. There are many things here that prove it's old. Many things. Including the fact that this problem with the roof of the shoulder joint -- the acromion -- is something he was born with. And he had a minor injury. He was treated and he got better.

Q Doctor, you never actually reviewed any x-ray films of Mr. Gill, did you?

A I reviewed all the x-ray reports, yes.
Q I didn't ask if you reviewed the reports?
A No. They were --
THE COURT: One second. Doctor, let him ask a question, and then you can answer.
Q I asked if you looked at an actual screen that showed the images on an x-ray. Did you do that?
A They weren't available. So I could only look at the reports. My experience --
THE COURT: Doctor. Doctor --
MR. LESNEVEC: Your Honor.
THE COURT: -- you answered the question. You can't go beyond the question that was asked, sir.
Q Did you look at any of Mr. Gill's MRI films up on the screen of his left shoulder, Doctor? Yes or no?
A They weren't available so I couldn't look at them.
Q Doctor --
A Same for the x-rays.
Q You realize that those were taken two weeks after the accident? The MRI to the left shoulder. You know that, right?
A Yeah.
Q And you saw him two years after the accident, correct?
A Right.
Q You were never given those films, were you?
A All I could do is ask for them and --

Q Okay.
A In this setting --
Q And Doctor --
A -- either you get them or you don't get them. Did I ask for them? Yes.
Q And did you get them?
A No.
Q To this day you still have not seen the MRI to his left shoulder, have you?
A I saw the reports.
Q I didn't ask about the reports, Doctor.
A No.
Q I asked about the actual image on the screen. You still haven't seen them, have you?
A No.
Q Doctor, did you ever review intraoperative photos from the surgery of the left shoulder?
A None were available as part of medical records.
Q What is an intraoperative photo?
A An intraoperative photo is when you are doing an operation, especially with arthroscopy, there is a camera hooked right into the arthroscope, which is amazing. And as you take a look at the arthroscope, through the scope you can take pictures. As many as you want. And you just keep taking as many pictures as you like. So the photos were taken, but in

this type of evaluation, lots of times there's limited information. And you can't get any more information. I looked at all the information that was made available to me, and that was not made available.

Q Intraoperative photos during an arthroscopic surgery are pretty common, aren't they?

A They are done in every arthroscopic case. And sometimes they are of value, and sometimes they are very little value, but they are done as a routine.

Q And did you ever request the intraoperative photos from the surgery to Mr. Gill's left shoulder, Doctor?

A I requested all of the records. Whenever you are doing an independent medical evaluation there's always deficiencies in the records, and the only thing I can do is request them. And I always request them. And there are lots of records here, and I looked at them all. And I put them all in proper weight, but I didn't get them all. I should add, no matter how hard you try, lots of times you can't get them all.

Q Any idea why the Defense withheld the intraoperative photos from you?

A Excuse me?

Q Any idea why those photos were withheld from you?

A They weren't withheld. Nobody's doing anything out of line that you are implying. Nothing is being withheld from me. These are all legitimate hardworking people. Okay. Sometimes

they are available, sometimes they are not. You are dealing with big hospitals. You are dealing with people who keep records, and if they have them, they have them. If they don't have them, they don't have them.

I looked at everything they gave me, and it's an inch and a half of records that I have in my briefcase here. I looked at everything available. I always ask are you sure you gave them all. And of course they said they gave them all to me.

Q Did the defense attorney tell you that during your phone call you had before coming in?

A What?

Q Did you have this conversation about you having all the records during the phone call with Defense Counsel?

A No. The only conversation I had with him is speaking to me last night, briefly today. And his question had to do with the report. We only talked about the report.

Q Can you tell me when the preexisting conditions in Mr. Gill's left shoulder started? What date?

A It's impossible to tell the date. Obviously it is a wear and tear condition. He's 47 years old. Hardworking guy. And these things take many years, if not decades. And it's from repetitive motion as you keep moving your shoulders. Especially if you are a hardworking guy, you are going to have the ball and socket go up against the roof of the shoulder joint called the

acromion. And that irritates it from normal usage. Normal usage. And as a result, you have these abnormalities, and that's what he had. He didn't have a new injury. He had these abnormalities that are obviously longstanding and chronic, on the MRI.

Q And of all the records that you brought with you in your bag today, do any of those records indicate that Mr. Gill had left shoulder pain before the crash?

A They didn't indicate yes or no. So there's no way to tell.

Q Did you see any complaints of pain in the left shoulder in these records, Doctor, before the accident?

A That doesn't mean too much. Plus --

MR. LESNEVEC: With a yes or no, Judge.

THE COURT: Doctor, if you can, just answer yes or no to the question, sir.

A The answer is no, but --

Q It's no?

THE COURT: Yes or no.

THE WITNESS: It doesn't surprise anybody Your Honor.

THE COURT: Just yes or no, sir.

Q You did not see any complaints of shoulder pain before the accident, in the records, right?

A Right. Doesn't mean it wasn't there. But it wasn't in

the records.

Q Mr. Gill was how old on the date of the crash?

A Forty-seven years old when I examined him.

Q So forty-five on the date of the crash, right?

A Yes.

Q Was Mr. Gill a weightlifter before this crash?

A He didn't tell me he was, if he was.

Q Did he perform any heavy construction before the crash?

A He did some construction. From what he told me about his work history was a little bit different. He worked as an Uber driver, and he wasn't actually working when I saw him. I assume that kind of work has some lifting, carrying suitcases and so on. But I don't have anymore details on what I just said.

Q Where in your report did you write that he did some construction?

A No, I said things. Like he was doing work construction. What he was an Uber driver. Then I said my assumptions an Uber driver, yes, it lifts suitcases and now the car -- and he's, you know, doing fairly heavy work. Many other fields have heavy work too. Construction was one of them, but he was an Uber driver.

Q And Uber driver is not heavy work or heavy lifting, is it?

A Well, if you had a big suitcase and your driver had to

lift it up and put it in the trunk of the car for him, it would be heavy. For you it wouldn't be heavy. For him it would be heavy. These drivers, in my experience, because I have taken a lot of them, they do lifting.

MR. LESNEVEC: Objection, Judge.

A And hurt themselves.

THE COURT: One second, Doctor.

Basis.

MR. LESNEVEC: The objection is to other patients. He's talking about other people at this point. We are focusing on Mr. Gill.

THE COURT: Sustained.

Q Only limit your answers, Doctor, if you can to Mr. Gill.

A I was only talking about Mr. Gill.

Q In your opinion, was the left shoulder surgery necessary?

A It was an elective operation, which means it was not a hundred percent necessary. Means it is a choice. There are many ways to have treated it. That was one way to treat it.

Q In your medical opinion, Doctor, within a reasonable degree of medical certainty, did he require that left shoulder surgery? Yes or no?

A I think it was an option. It could have been treated conservatively, not operatively. Because he didn't have that

much conservative treatment. I think ordinarily he would have much more conservative treatment if he was my patient. I would say let's try this, this, and this. If that didn't work, we would do the surgery. I'm not sure he had full measure of treatment. I don't think they did anything wrong, but there's a choice.

Q You reviewed the records that he did try physical therapy to the left shoulder before surgery, right?

A He had physical therapy. He had other measures.

Q That's conservative?

A But the question is it is a matter of judgment. I'm an experienced treating orthopedic surgeon. How much is conservative treatment before you say you have to get operated on? Looking at this case, if it was me, I would have treated him longer, and little bit differently with conservative treatment without surgery. But it's an art of medicine. He could treat it any way he wants. And I don't think he did anything wrong, but it was a choice. It is a clear choice. He didn't have to have the operation. This was an elective procedure.

Q In your judgment, do you believe that Mr. Gill was less than truthful to you when he saw you?

A Of course.

Q Did you feel that he was exaggerating to you?

A Of course not.

Q I'm sorry?
A Of course not. He was a totally legitimate guy. Just asking him simple questions he gave me the answers.
Q And you have no reason to believe that he was lying to you about that, right?
A Of course not.
MR. LESNEVEC: All right. I have no further questions. Thank you.
THE COURT: Thank you. Any redirect?
MR. McNIFF: Thank you, Your Honor.

RE-DIRECT EXAMINATION

BY MR. McNIFF:

Q Good afternoon, Doctor. You did an exam of his neck in connection with this examination, right?
A Excuse me.
Q His neck. You performed an examination of his neck, correct?
A I did put it in the report, but I believe I stated the remainder of the examination was conducted and it was normal. I didn't go into any details in the report about his neck because he didn't have any complaints about his neck.
Q Okay. The information that you received about his neck either came then from him or his doctor's records, right?
A Yes.
MR. McNIFF: Okay. Thank you, Doctor. I have

nothing else.

THE COURT: No further questions?

MR. McNIFF: Yes, Your Honor, no further questions.

THE COURT: Thank you. Doctor, you may stand down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Counsel, do you have --

MR. McNIFF: Can we approach for a second?

THE COURT: Yes.

MR. McNIFF: Thank you.

(An off-the-record discussion was held away from the jury.)

THE COURT: Okay. Members of the Jury, it's that wonderful time of the day when we have our lunch break at this time. Please do not discuss the case with anyone including your fellow jurors. If anyone attempts to discuss the case with you or speak with you please notify my officer, who will in turn notify me.

Everyone have a very nice lunch break. It looks like it is a nice day outside. I will see everyone back here at 2 o'clock sharp. Have a good lunch.

THE COURT OFFICER: All rise. Jury's exiting.

(The jury exits the courtroom.)

THE COURT: Have a good lunch, everyone. See you

back here at two.

Off the record.

(An off-the-record discussion was held.)

(A lunch recess was taken.)

(Whereupon, the following was recorded and transcribed by Senior Court Reporter Monica Jenkins.)

(Continued on next page.)

* * * * *

THE COURT: Are we ready to proceed?

MR. MCNIFF: Yes.

THE COURT: We're going to call your next witness, Dr. Stolove, right? What is Dr. Stolove's first name?

MR. MCNIFF: Catherine.

THE COURT: Please bring in the jury.

(Whereupon, the jury entered the courtroom and upon taking their respective seats, the following occurred:)

COURT OFFICER: All rise. Jury entering.

THE CLERK: Do all parties stipulate to the presence proper placement of the jury? Beginning with Counsel for the plaintiff?

MR. LESNEVEC: I do.

THE CLERK: Counsel for the defense?

MR. MCNIFF: I do.

THE CLERK: Be seated.

THE COURT: Everyone maybe seated. Counsel, you may call your next witness.

MR. MCNIFF: Thank you, Your Honor. Defense calls Dr. Catherine Stolove.

(Whereupon, the witness entered the courtroom and took the witness stand.)

THE CLERK: Please raise your right hand. Do you solemnly swear or affirm the testimony you shall give will

be the truth, the whole truth nothing but the truth?

THE WITNESS: I do.

THE CLERK: You maybe seated and in a loud, clear voice state and spell your name?

THE WITNESS: Sure. My name is Catherine Stolove, C-A-T-H-E-R-I-N-E S-T-O-L-O-V-E.

THE CLERK: Ma'am, please state your business address for the record?

THE WITNESS: It's 111 East 75th Street, Suite 1B, New York, New York 10021.

THE CLERK: Thank you.

THE COURT: Good afternoon, Doctor. You may proceed, Counsel.

MR. MCNIFF: Thank you, Your Honor.

DIRECT-EXAMINATION BY MR. MCNIFF:

Q Good afternoon, Doctor.

A Good afternoon.

Q Doctor, can you tell us about your educational background, training and your experience?

A Sure. Absolutely. Sure. Absolutely. So, I earned my bachelors degree at Tufts University. I studied both biology and Spanish. After that I pursued my Masters in general psychology at the New School For Social Research.

I always had a big interest in where biology and psychology overlap. After I earned my Masters I moved on to

Columbia University where I earned a PhD in clinical psychology and at that time I also began to study neuropsychology.

So, I had to fold that into my training. So, my degree is in clinical psychology but then I also got additional training in neuropsychology in order to have this be my specialty.

I did my pre-doctoral residency at Rusk Rehabilitation at NYU Langone Hospital. There I spent 6 months on the inpatient unit working with people who had acute brain injury. So this is people who had traumatic brain injury, people who had strokes, people who had brain infections, brain tumors, any number of kind of catastrophic brain event that might land them the inpatient unit.

So, there I learned to do cognitive assessments in an inpatient capacity. I also did psychotherapy. I did cognitive remediation. I also spent 6 months on an outpatient unit. So, that's a little bit down the line after somebody comes out of the hospital.

And there I also worked with traumatic brain injury patients. Again, I also worked with patients who had stroke, patients who had tumors, any number of conditions doing psycho therapies, doing cognitive remediation, doing really in dept neuropsychology assessment.

I also was able to in my time on the outpatient unit work at the brain injury day-treatment program which is a

program that's designed to take groups of people who have suffered moderate to severe brain injury and really focus on rehabilitation and helping them re-enter society as much as possible.

And I was able to also work as part of their concussion clinic at NYU Langone so with patients who had mild traumatic brain injury or concussion which is a very different process.

After I finished my pre-doctoral residency, then I moved on to do a post-doctoral fellowship and this is required to really get specialized training in neuropsychology. This is a 2-year fellowship.

I did that at Columbia University Medical Center. I did that in the Epilepsy Division of the Department of Neurology but it wasn't just epilepsy patients because we know that things like traumatic brain injury, stroke, brain infections, all of these things can lead to epilepsy.

So, I saw patients that had extensive brain disorders and brain trauma and there I focused specifically on neuropsychology assessments. So, that's what I did day in and day out for two years. I was also able to do other things like go into the operating room to do intraoperative mappings where we would wake people up during craniectomy's do testing for them while they're getting procedures like tumor resection.

And that's a great way to really learn a lot about the brain as you see it up close and personal. After my two year

fellowship at Columbia Medical Center I was then hired by Mount Sinai Hospital to work on the inpatient, basically brain injury unit.

So, again similar to Rusk that was people who had traumatic brain injury, who had brain infections, strokes, any number of conditions. So, there not only was I responsible for patient care, neuropsychological assessment, doing bedside psychotherapy, doing cognitive remediation therapy but I also joined the faculty.

I was responsibile for training pre-doctoral interns as well as students who had just gotten their PhD and was in their residencies as well as post-doc's doing their two-year training process.

After a while I left the hospital and I entered private practice but I maintained my faculty status at Mt. Sinai Hospital. So, I'm currently on their faculty and I participate actively in training their doctoral students and their pre-doctoral residents and post- doctoral fellowships.

That's something I continue to do actively. I give seminars. I supervise them on all different kinds of cases, again, traumatic brain injury whether it be brain infections, strokes, any number of things that might cause cognitive impairment.

And then aside from that I am currently in full-time private practice seeing patients in both a clinical respect and

then also doing medical legal work.

Q So, you are a neuropsychologist, correct; just explain the field in general, not with respect to what you did, tell the jury about a little what that encompasses?

A Sure. Absolutely. So, in neuropsychology basically the goal is to take someone's who's experiencing any type of cognitive problem, whether its memory complaints, difficulties with attention, any number of things that people might have in terms of thinking skill problems and our job is kind of to be detectives to investigate to see what might be at the root of those problems.

Other times people come to us, they know what the problem is. They know they have a brain tumor or they know they have epilepsy. Our job is to see how the brain is functioning in order to be able to make recommendations for treatment and ways that can improve functioning across the board.

So, my job involves when someone comes to see me, there are a couple of key components. The first is that I do a thorough review of the available medical records and you know this spans general health, it spans any kind of images that someone might have had.

It's really is not just within neurology. It's really looking at the whole system and the medical records, somebody's health history, their surgical history, all different aspects of how they have been from a health perspective.

Next thing I do is a very thorough interview with someone to look at all aspects of their history and that really goes all the way back to the very beginning. I ask people about their mother's pregnancy.

We ask them if they were premature, any complications if they had any infections in childhood, seizures in childhood, surgeries in childhood. I also ask about how they did in school to see if there's any possibility of a learning disability or possibility of ADHD which could carry on into adulthood and affect somebody's functioning.

I ask about their occupational history. I ask about the language they speak. I ask about their life currently. I ask about what they do each day, what, how they manage their finances, how they travel, all different aspects.

So, I do a really thorough interview that kind of gets to the heart of somebody's functioning both in the past, how they're functioning today. Another key part of what I do is observing behaviors.

So, what can I tell as a psychologist about this person from the way that I'm interacting with them. So, we know that there are a lot of different things that happen in the brain, different processes that can be represented outwardly.

If people have damage to the part of the brain where the language centers you are going to see that in their communication, you know, they might have a slur. They might

speak slowly. They might trip up to the words. They're trying to find, you know, if people have damage maybe to the front part of their lobe, the frontal lobe, front part of the brain.

Maybe you are going to see really distractibility, have a hard time focusing. They can't keep up with what you are doing or they turn and they grab their phone or doing something else or have say lots of emotionability, ups and downs.

They might have a temper, might get angry. There are so many things that we as neuropsychologists are trained to look out for in the process, not just language, not just how they're interacting with you but, you know, do they need frequent breaks, um, what they're saying, does it make sense.

Are they speak logically, is it illogical. Do they answer the question you are asking or do they veer off somewhere else, seems like they're not understanding what you said. How does their mood seem.

That's a big part of what we're trying to look at as clinical psychologists. Do they seem like they're very depressed and they're slow and they're having a hard time expressing themselves or does it seem like they're incredibly anxious and nervous and on edge or does it seem like they're pretty even keel throughout the evaluation.

So, behavioral observations, that's something I'm doing from the time somebody walks into my office until the time that they leave. Then lastly I'm doing a very in depth evaluation

with a lot of tests.

This goes on for a number of hours and the idea with the evaluation is to take a tour of the brain to visit all the different regions and see how each of these regions is functioning.

So, there are a number of types of tests that I give people. Primarily its pencil, paper based tests we use some stimuli things we might manipulate blocks and things like that but also tests I'm doing with a person, sitting face-to-face with the exception of maybe one computerized test.

Everything I do with a patient, I'm sitting with them and I'm observing them for hours. So, not only do I get a lot of information in terms of what the data tells me, I get a lot of information in terms of what I'm seeing with the person.

Now, these tests that we give people, they have been developed with a ton of research over many decades and there's a set of classical tests that neuropsychologists tend to give. We also use the same tests.

We all know about these tests and the way that the tests are developed is that they create them. They create the items. They create the questions. Then they go out to the population and they give these tests to thousands of people.

And once they give it to thousands of people, they're able to get an idea what we call norms. That's really where the average person is going to perform, most people perform and of

course some people will have very strong performances on some tests and some people will have lower performances on some of the tests.

And there are a number of things that can cause those lower performances but really the idea is that you get these norms for people that depending on their age and where applicable, you know, how long they went to school in some cases.

We get as specific as we can to know exactly, you know, how someone that is 65 years old should be functioning on a test of vocabulary. So, we know when we make these interpretations they're very much rooted in science and they're rooted in data because these are studies that have been done over decades in order to get these norms.

So, the tests, that's the final part. So, I'm able to weave together the medical history. I weave together somebody's self report. I weave together what I observe. I also finally put in what I see in this extensive data that covers a lot of cognitive territory.

Q You ever testified before?

A I have not. This is my first time.

Q Um, did you ever meet me before this case?

A No.

Q Did we speak on the phone last night?

A We did for about an hour and a half.

Q Did we go over your report and your tests?
A Yes, we did.
Q Are you being compensated for your time here today?
A Yes.
Q How much?
A 3,000 for today.
Q And were you compensated to prepare your report and do the evaluation and everything that went into that?
A Yes, it was 4,600 for that.
Q Okay. If you weren't here today, what would you be doing?
A I would be testing patients. I would be writing reports or combination of the two.
Q And you mentioned part of your practice is related to this type of work, right, seeing plaintiff's in lawsuits?
A Yes.
Q What percentage of your practice relates to that?
A So, about 60 percent of my work is in that kind of practice but in addition I'm also part of a group practice. It's a psychiatry practice but it employs, we have a team of psychiatrists, psychologist and there's a range of services and I am a neuropsychology that's on the staff there.

And I accept Medicare so I primarily see individuals over the age of 65 and that comprises the bulk of my clinical practice that's the other 40 percent of the work I do.

Q Okay. When did this evaluation take place?

A On the 24th of February of 2025.

Q Okay. And do you have your report with you?

A I do.

Q Please feel free to refer to your report to refresh your recollection if you need it.

A Thank you.

Q Part of what you do, I think you told us earlier, is you take a history?

A Yes.

Q Can you tell us about the history that you took from the plaintiff in this case?

A Yes. Absolutely. So, do you mean biographical history or of this incident?

Q Biographical first?

A Sure. Absolutely. So Mr. Gill let me know he was born in Lahore Pakistan. He told me his first language is Urdu. He began to learn English at age 5. He told me he's also fluent in Spanish.

He told me that he finished high school and he won the green card lottery around age of 17, came here to the United States, that he had done a number of jobs, the most recently of which was being an Uber driver.

Um, he let me know that he's married and that he has children and that following the accident, he said that his,

there was a separation with his wife and that there was minimal communication and contact at that time.

And he told me he was living with a friend in Long Island and that this friend helped him with certain activities of daily living and he let me know also that he was not currently working.

Q Okay. And did you take a medical history?

A Yes. Medical history, he let he know that he took medication for hypertension but he denied prior loss of consciousness. He denied prior psychiatric history, prior psychiatric treatment, taking any kind of psychiatric medication.

Q Did you perform a test on the plaintiff you mention earlier?

A Yes, I did.

Q Now, can you explain the test in general to the jury, the test that you performed?

A Yes. Absolutely. So, as I mentioned before, when we do a comprehensive neuropsychological evaluation, the idea is to really get a glimpse of how all the different regions of the brain are functioning.

So, there's a bunch of different domains that we're going to look at. The first is we look at general intellectual function and this is pretty much divided into right and left hemispheres.

So, intellectual functions that's mediated by the right hemisphere, going to be visual facial skills, so, your ability to look at additional stimulus to understand the different parts that comprise to put together shapes to make puzzles to understand how any kind of visual stimulus fits together and how to work with that.

Now, in the left hemisphere when we think about intellectual functioning, for most people that's where language is located and so here we're talking about a number of different functions with language.

We're talking about someone's vocabulary. We're talking about their ability to come up with words really quickly, to find the words they want to use and basically to be fluid and fluid in language.

Now, here I want to mention an important caveat that pertains to my work with Mr. Gill and that's something in neuropsychology in general, and that language is really, really key and really important and that's something that we assess and consider carefully.

That's because if English is not someone's primary language, then it's not fair to test that person in English because if they perform poorly and you compare them to other people who might have had English as their native language.

So, then you're going to sloth them into a category saying something like they have a exceptionally low vocabulary

or low average of vocabulary when that's not fair because, you know, for people who weren't born and raised in an English speaking country and English is not their primary language, it's basically not a fair or valid assessment.

So, Mr. Gill is fluent in English, very proficient as a matter of fact but I did not administer tests of language to him to assess things like vocabulary and fluency because that wouldn't be a valid indicator.

Had I, you know, were fluent in Urdu, then I would have absolutely done that but unfortunately we are limited to the tests we have. I gave only two tests. I will mention those a little later.

The two tests that really relied on language, these were basic memory tests. I will explain a little about that, why these can be used and populations of people who for whom English is not their first language.

So, language is an area we usually assess in detail but in this evaluation as I said, we did not. Then the next area of the brain that the tests look at is what we call the frontal lobes.

Now, this area of the brain is what separates us from other animals, what makes humans human so it's really among other things, is responsible for the ability to pay attention, to sustain attention, to be doing two different tasks at the same time to keep track of what you're doing, to solve problems,

to monitor yourself and be able to catch yourself when you make a mistake, to be able to inhibit the impulses that you have to do something, you kind of have self control.

All of that is located here in the frontal lobes. So, we give tests of attention, the ability to just focus and concentrate on something and then we also give tests of these other capacities are what we call test switches.

You can go between two different things, problem solving, can you take a task you've never seen before and figure out a strategy, a good way to get it done.

Can you inhibit your impulse to say something. We look at a lot of different executive functions as well in testing. Then, the next big area of assessment is called basically learning and memory.

Now, the area of the brain that mediates learning and memory we call the mesial temporal lobe. It's very deep down here in the brain, very primitive structures because we know animals also have to learn and remember.

So, these are primitive structures in the brain. You might have heard of a structure called hippocampus one bilateral side. So that's really responsibile and plays a big role in being able to learn information and then later to come back and recall that information.

So, I give several tests of learning and memory both visual learning and verbal learning because as I said we have

the two hemispheres. So, for verbal learning here's where I mention those two tests we did in English.

Verbal learning, I give a test that's rather simple. It's just 10 basic words that are not overly complicated, you know, some words we're saying like wagon or lemon or foot. So if looks at somebody's ability when I say those words and repeat them and I repeat them and I repeat them, how well are you able to kind of strategize and think about what you've learn and think about how to add more information again.

The second verbal learning test is very basic story, short story, things simple, not too complicated, something to the effect of on Friday January 10th in San Diego California there was, to that effect, a short story.

So again, somebody who's fluent and proficient in English, should not be especially challenging. Then with each of these verbal tests then later, you know, you will come back 20 or so minutes later and then ask the person, you know, what do you remember from the list of words.

What do you remember from the stories in order to test their memory because it's not just encoding the information, it's holding on to it. Then I also administered a test of visual memory.

So, this involves, you know, like show you a figure that has a lot of details on it. You sit and you copy the figure and then I will come back later and say, okay, give a

blank paper, what do you remember of that figure.

And I actually gave two verbal memory tests and two visual memory tests. We did one figure, then we did another one that was a page that had 6 different basic shapes and this test not only are your ability to remember the details of the shape but also remember the spacial location, where it is on the page.

And then the last main domain that I looked at in testing is mood because we all know that mood can affect your thinking skills and if you are feeling particularly depressed, feeling particularly anxious, that's going to have a bearing on the data.

So, with anyone we assess, we have to make sure we know how they're feeling, how they're doing so we can comment on that aspect. You know, as I said, we look at medical history. We look at, you know, all of these different things can basically impact how someone is functioning today and mood is another essential one for us to look at.

So, those are the main domains we look at in a comprehensive neuropsychological evaluation.

Q Before you administer the test, do you give any instructions?

A I do. Yes. Absolutely. So, I inform, I give a little bit of background, what we're going to be doing, that we're going to be doing a lot of different tests. Some of them will be puzzles. I ask to remember some things.

Um, I also let people know, every person who comes to see me, it's very important to try their best on all the tests and I also let people know that one of the things we're going to be looking at is their effort.

And that's not just through me looking at them and observing their behavior, it's also baked into the test. There are tests that are measures of effort. I inform someone that the tests will be assessing your level of effort and there are statistical, there are mathematical ways that tests are able to determine if you're giving anything less than 100% of your best effort.

Q Okay. Um, before we get into the specific tests, you did review records as part of your evaluation, right?

A Yes.

Q That include the emergency room records?

A Um, hum.

Q For cognition, Dr. Busuchio who testified already in this case?

A Um, hum. Yes.

Q Let's now move to the actual test that you ministered, okay, can you can we go through them and please tell us first what's the first test that was administered?

A So, the first test that I administered that day was a test of executive functioning and it's a very basic test and it has a line that has triangles and squares alternating. There

are 5 sequences and I just asked Mr. Gill to just copy it.

This is a really simple task that most people can complete without any problem and they can make sure there are 5. On this one Mr. Gill went on and put 7 which is when somebody does something like that while they're also counting, that's something that we rarely see.

It's a very rare way to respond to this first task especially because it's relatively easy in comparison to other tasks.

Q And can we go to the next test you administered?

A Um, hum. Should we go test by test or domain?

Q Domain is fine?

A Sure. Okay. So, as I said, you know, I won't be talking about language. That's not an area that I assessed, um, aside from my behavioral observations of observing how Mr. Gill interacted with me.

And in those, everything was normal. I did not notice any word finding difficulties. I didn't notice any stutter, any difficulty articulating words. I didn't notice anything to me that would be indicative of brain injury.

So, the next area that I looked at when we're talking about intellectual functioning is that visual facial processing that we see happening throughout the right hemisphere. Now, on, in this domain, I'm going to refer back to my data here. All right. So, test of visual processing, what I asked Mr. Gill to

do was one of the tasks involved taking three dimensional blocks looking at a pattern and using the blocks to construct a pattern.

And most of these tests start really easy and they get more difficult. That's because we want to allow a lot of room for people who have a lot of trouble with the tests and for people who are quite capable with the tests.

So, on this task of building blocks, Mr. Gill's performance was at the 9 percentile. That means 91 percent of people who took the test in the normative sample, people pulled from the population, 91 percent of people performed better than he did.

That puts his score in the low average range. There was another test that I gave him where it's basically some puzzles, a matrix as a shape missing. You have to look at it to figure out the pattern.

This is another one that's harder as we go along. On this one his performance was in the below average range at 5 percentile meaning 95 percent of test takers performed better that where he did on this test.

And I also give him a test where he had to look at pieces of a puzzle that were printed on the page, 2-dementional and he had to assemble them in the mind to figure out how they fit together.

On that one his performance was in the low average

range at 16 percentile, meaning that 84 percent of test takers performed better than he did. So, all and all when we take those three tests together, it gives a perceptual reasoning score on a perceptual reasoning index at percentile in the below average range meaning 94 percent of people who took this test did better than Mr. Gill did.

Also in the visual facial domain I give him as I mentioned before, a test that's details he had to sit and copy the figure and try to, it's not a hard test, not overly complicated.

It's just making sure that you get everything in the figure and then it looks reasonably similar to the one that you see on the page and here his performance was in the 5 percentile.

And that's in the below average range, meaning 95 percent of people scored better than him. I also gave a test that shows a bunch of lines on a dial that has numbers on them. He has to look at the lines and figure out what the angle is.

That one his performance was in the average range, 26 to 50 percentile. Here his performance was consistent with what we would expect for somebody his age. Now, moving, we covered language, we covered visual facial moving to frontal, frontally mediated functions.

First of all it processes speed. This is basically how quick the mind fires, how rapidly things are moving, how quickly

are you able to perceive stimulus, how quickly you can respond to that stimulus.

I gave him two tests here and one is basically transcribing numbers to symbols. So, there's a key with numbers and symbols then down below you have to write in the symbols. You go as fast as you can. You have a limited amount of time.

Here his performance was in the exceptionally low range at the first percentile and that means that 99 percent of people performed better than him on this test. There's another one you have to scan above the symbols, try to find two that match and cross them out.

It's the same idea. Here you are trying to go fast as you can. You have a limited time to do it. Here his performance was below the percentile in the exceptionally low range and I think it is and I'll take a pause here with the data that say that it bears mentioning here, that these scores, both the visual facial scores and the processing speeds scores are inconsistent with aspects of what Mr. Gill told me about his functioning in day-to-day life.

He told me that he drives himself short distances, that he drives locally. Now, somebody with the processing speed below the first percentile who is so slow, that's inconsistent with the ability to drive a car, to respond rapidly, to pay attention to what's going on around you.

Also, these aspects where his visual facial processing

was quite low, that's also inconsistent with the ability to drive a car, to be on the road, to perceive where the other cars are, to know how to park, to know how to be safe on the road.

His performance on the test that I give him, gave him, was not consistent with what he reported that he's able to do in his day-to-day life. So, moving on in terms of executive functions, there's another test I gave.

This looks at something called working memory. So, in day-to-day life this includes things like if somebody gives you a phone number, can you remember it. We don't do that as much any more but code to sign in to something.

Can you hold information in your mind and manipulate, use it, be able to basically repeat it. Here, I had a board with different cubes affixed and I asked him to copy me in pointing to the cubes.

Again this starts very easy and then gets more complicated. His performance on this was in below average range at the 5 percentile which means again that 95 percent of people that took this test did better than he did.

I gave him a second condition where I ask him to repeat, to reverse, I mean reverse the order that he touched the cubes in and here his performance was also in the below average range at the 5 percentile.

When we combine these two scores for the test overall, that puts his performance in the exceptionally low range at the

first percentile for working memory. Now, in addition to that first test that I described, the one with the alternating triangles and squares, I also asked him to draw a clock and this is a seemingly simple task but give us a lot of information and here he was able to do just fine.

He was able to draw the clock. He placed the numbers accurately. He had the hands accurately. This is inconsistent with his performance on other tests; for example, the one where I asked him to copy the shape and draw the shape where his performance was at a 5th percentile.

But then when I asked him to draw a clock, his construction was normal and it was detailed and it included all of the relevant parts. Here we have inconsistency with the data. That doesn't really make sense.

I also gave him a test that looks at a couple of different aspects of executive functioning. Now, on the first part of the test, he looked at a page that had numbers scattered about in circles, had to go quickly as he could to connect the numbers.

It's a pretty easy task, almost like connecting the dots, what we do when we are kids and his performance here was at the 14th percentile, in the low average range meaning he was slower than 84 percent of people that took the test.

Also importantly, one of the things that I looked at, not only do I look at how much someone can do, I look at

different aspects. Do they make mistakes. Do they, you know, start to go one direction but then stop.

And here Mr. Gill had three, what we call near miss. This means that maybe he was at 2, started to go toward 7, went back maybe later was at 7, started to go towards 11. These are very rare errors.

People rarely on this very simple task make those kinds of mistakes. So, for the index for the near miss errors, his performance was below the first percentile and in the exceptionally low range, meaning that's a very uncommon error that we don't see often.

Now, after this first task just connecting the numbers the task gets a little bit harder. Here the numbers, there are two numbers, two circles for each number, different colors, you have to switch between the two colors.

Not only do you have to go fast to connect the numbers in order too, you have to remember which color you were just on, remember to go to the next one, try to keep that in mind. On this one Mr. Gill actually did really well.

His performance was in the average range which is exceptionally rare for somebody to perform more poorly on the easy trial and then also after that to perform well on the more difficult trial.

So, you know, an analogy, this is if somebody was lifting weights and they were unable to lift up a 5 pound

weight, then they move on to picking up a 20 pound weight with no problem at all.

On this he did make two color errors which is also pretty rare. That puts his performance in the below average for the errors but he was able to perform the task in a way that was much more rapid than it was the first and easier trial.

Now, moving on to the next domain, that is, um, verbal memory. So, again, I'll let you know that I gave him a list of words. This was 10 words, basic words and I repeated it four times and looks to see not only, you know, how much can he learn ultimately, but how does he learn over time.

Does he learn a little bit more with each repetition and here he performed very well. He learned all 10 words by the fourth trial. His overall performance was in the high average range.

That means, it was at the 75 percentile which means that it was better than 75 percent of people that took the test. And this is worth mentioning because in moderate to severe traumatic brain injury, this is an area where we see people have trouble learning new information; especially when growth memorization where I'm giving unrelated words, you try to remember them.

This is an area where we see difficulty in moderate to severe brain injury. This is an area where we may see difficulty in the days to weeks after a concussion also known as

a mild traumatic brain injury but we do not see any cognitive symptoms persist in concussion beyond 3 months.

So, there's no reason to believe that this would be an area of difficulty besides the fact Mr. Gill performed very well on this task.

(Whereupon, Senior Court Reporter Dalila Cummings began recording the following proceedings:)

DIRECT EXAMINATION

BY MR. McNIFF:

Q Doctor, if I can just jump in here for a second.

You mentioned mild, moderate, severe brain injury. Can you just go through those different categories for the jury.

A Sure. Gladly. Absolutely. So there are a number of factors that classify a brain injury, and the most basic one is what we call a Glasgow Coma Scale. Now, this is something that is determined basically right when someone has an injury. So the paramedics at the site of an injury will take the Glasgow Coma Scale, and then again when somebody gets to the emergency room they will take the Glasgow Coma Scale. There was a possible 15 points.

There are three different things that they are looking at here. The first is somebody's ability to open their eyes. Do they open their eyes spontaneously or are they completely unconscious. There is a range within those two. If they open their eyes in response to a stimulus or somebody's verbalizing.

Another one is motor functioning. Is somebody able to move? Are they able to follow commands.

And then lastly, we have someone's ability to verbalize. Are they able to respond to you, to answer your questions or again, are they completely unconscious where they are not able to. Or are they moaning or saying things that don't make sense.

So those three indices make up the 15 points. If somebody's 13 to 15, that's called classified. If we have other signs and symptoms and factors, which we will take about a little bit later. That's classified as a mild traumatic brain injury or a concussion. Anything that's below that is going to be classified in terms of somebody's ability to respond to a stimulus to open their eyes to follow commands, that's going to be classified as a moderate to severe brain injury.

Now, there are two other factors that separate a mild traumatic brain injury, a concussion from a moderate to severe traumatic brain injury, and that is that in order to be classified as mild, you have to have a loss of consciousness under 30 minutes. So this is actually surprising to some people. You can lose consciousness for 29 minutes and it's still a concussion. It is still a mild brain injury.

And you can also -- the other part is post traumatic amnesia. That's basically what a period of time where you cannot remember what happened after the accident. So in order for somebody to be classified as mild, this can be up to 24 hours of post traumatic amnesia. That's still a concussion. That's still a mild injury. Sometimes surprising to people you can have that amount of memory loss and it's still classified as mild.

Q Can we go back to the test now?

A Yes. Absolutely. So I mentioned the list learning

test that he performed very well on that. Conversely, on the story memory test -- this is the easy one. Basic details. His performance was in the low average range at the 90th percentile. Here, we have a big discrepancy between types of verbal memory. He's able to learn words on a list, but he's not able to learn details on a story, which is not really consistent with anything that we see. It just doesn't make sense, not for concussion or for other types of brain injury conditions, and in terms of the follow up later. I asked Mr. Gill what he can remember. I read a list of words a while ago. I repeated it several times. What can you remember of those words? And there, his recall was in the average range. So he was actually able to remember he remembered five out of ten, which is consistent with other people his same age.

Then I did a different kind of memory task. This one is called recognition. Where I gave him ten words that were on the list, ten words that were not on the list. And here his performance was actually much lower. It was in the exceptionally low range. Below the second percentile.

Again, this kind discrepancy for something like a concussion doesn't make any sense that someone would be able to be spontaneously recall words at a rate that's consistent with their peers, but then recognition which is actually, arguably a lot easier, he was not able to recognize the words and differentiate between the words that he had seen and had not

seen. So this is another aspect of the data that doesn't make sense.

Now, on the story recall, his performance was in the average range of the 25th percentile. So he was able to spontaneously recall enough details for this story to be consistent with other people his same age.

Now I also sometime later said do you remember the figure that I had you copy? Can you please draw what you can remember of that figure? His performance was in the low average range of the 16th percentile, meaning 84 percent of people performed better than he did on that test.

As I said, I gave two visual memory tests. The second one he had to look at a page that had shapes, draw the shapes accurately, and put them in the correct location. Here he had his scores for learning were lower than we would expect. Lower than the average range. They ranged from exceptionally well on the second trial. I showed him this three times to the below average on the first and third trial which basically shows that he's not taking any information or that's the depiction that he's giving.

When I came back, and said 25 minutes later what do you remember of those shapes? He remembered 100 percent of what he had learned, but he hadn't learned very much to begin with. But most importantly, I also gave him a recognition trial. So I showed him a number of shapes he had not seen and I showed him a

number of shapes that he had seen, and this is arguably a much easier task. Here his performance was in the exceptionally low range than the first to second percentile. Again, this doesn't make sense given the history of the injury. This is not something we see in concussion, and would not expect to see on testing.

Now, mood. That's the next area that I assessed. I gave Mr. Gill a test of a measure, basically, of depression -- depression symptoms. And there is a caveat that I want to give along with this and that is that typically we give what's called symptom validity test. These are tests that have some true symptoms that people who are depressed or anxious or have other types of emotional dysfunction, there are some true items that we see often, but there are also some very uncommon items and we look to see how consistently people respond with the items that are not very commonly endorsed and how much they are responding consistently.

Now I looked in my library of tests to see if I can access a symptom that we test in Urdu. I was not able to access one in Urdu. I did not want to give a symptom validity test that's entirely in English. As I said before, number one, I don't think that would be a fair test to give in written form, especially when it's getting into a lot of complex potentially, culturally dependent questions.

So I didn't give him a symptom validity test and I

don't have that data to relate, but I did give a depression measure that looks at symptoms of depression. And on this he did endorse severe symptoms of depression. We don't unfortunately have this symptom validity data to say whether he was responding in a way that is likely straightforward or whether it is indicative of exaggeration of symptoms.

Q Is that self-reported?

A It is, yes.

Q What does that mean?

A So that means it's a subjective measure. That's important to clarify. So this is a questionnaire that I gave him to complete on his own where he read the items and basically indicated how often he may have felt this in the past one to two weeks. So it's completely his reading of it and his own response. And yes, that's --

Q Okay. Can we continue then with the test?

A Yes. So those are all of the domains of the test results with the exception of effort. And I'm happy to move on to that if you would like.

Q Yes. We can move on to effort.

A Yes. Absolutely.

Q First, can you tell them a little bit about what effort is?

A Yeah. Yeah. So a really key part in neuropsychological evaluation is looking at somebody's effort

and engagement and motivation. It's easy enough for someone to come in and just pretend that they can't do anything on the test, and pretend that they have impairments. So in my field in neuropsychology, there are a number of measures. We call them performance validity measures. And the idea here is that they are designed to look at the degree, the amount of effort somebody is expending, how engaged they are in testing.

Now, there are two different types of performance validity measures. One is called stand-alone measures. The other one is called an embedded measure. And I will explain each.

Now a stand alone measure is a test that's been designed to look difficult, but it's actually quite easy to complete. Most people are not good at being able to determine or discern what, for example, a brain injury looks like. And so, it's not so easy to say, oh, this is a test that would be easy to complete or this would be a test, it would be difficult to complete. So often times when someone is not -- all of the time when someone is not giving good effort we pick that up on these validity tests.

So the stand-alone measures, again as I said, they are designed to look at like any other test that I gave here and they are in a bunch cognitive domains. These are memory tests. They are tests of attention. They are tests of working memory of processing speed. And we scatter them throughout the testing

across the course of the evaluation so we can look at how much effort someone is giving in each domain and how much effort they are giving from the beginning to the end of the evaluation.

Now the second type of performance validity test is called and embedded measure. Now these are statistically derived. They are mathematical equations that we use to take from the tests that were already given to see patterns of how people perform. And we are able to determine from those patterns just how I explained to you a while ago there are certain things that are inconsistent that we very rarely see. The equations are able to see patterns of people's performance to say this is not consistent; this doesn't make sense; this doesn't add up. It's not something we see if the population of people who are giving true effort.

Now we know just from clinical practice from our training, from everything that we learn as neuropsychologists at the very beginning that what we do that we have to give effort tests in every single evaluation that we do. That includes, as I said, I accept Medicare. I see a lot of people over the age of 65 who come to me with concerns of dementia. I still look at effort tests. I need to make sure they are trying their best, otherwise my tests aren't telling me anything. They are not giving me information. Even people who come to me who are scared that they have dementia, they have no reason to fake bad on the test. I still look at their effort to make sure that

they are giving me their very best performance.

Now, we know through our clinical training and standards that the average number of effort tests, stand alone and embedded on a clinical exam is five. And in this kind of context a medical legal exam at least six to eight are given. I can't go into specifics for what these tests look like because in my field this is something that obviously has to remain protected, and we have to protect the sanctity, so the directions don't get out so people don't know how to past the test. But I will give you an example of basically what this looks like. It looks like any other test. Maybe I'm asking you to look at some pictures, remember them, maybe asking you to do something as quickly as you can. But the key is that it's works in seamlessly with the other tests, and you are not able to tell the difference between a performance validity and another test.

And also there is no way to determine from the regular test that I give what the mathematical statistical equations are to figure out how we detect when somebody is giving poor effort. As I said before, in a medical legal case we have a minimum of six to eight tests. And in my evaluation of Mr. Gill I gave 13 different indices. I gave three stand-alone measures, and then there are three other tests that are embedded. And so, that gives us 13 total measures. And of these 13, Mr. Gill was below the threshold of failing on 12 of 13 measures.

Now we know that sometimes the question is asked can

people fail these because they are depressed. Can people fail these because they are anxious or because they are tired? And the answer is no. The way that these tests are normed, a lot of research goes into these tests and we have been able to see that not only can people pass them when they were anxious, not only can people pass them when they are depressed, not only can people pass when they are tired, or when they were in pain, but the way that they are normed is that we not only give the test to people in the general population, we also give the test to people who have severe neurological disease and disorder. We give the test to people who have been in a coma after a traumatic brain injury. We give them to people who have had skull fractures from gunshot wounds. We give them to people who have had terrible strokes. We give them to people also with learning disabilities. We give them to tons of neurological populations. And we see that threshold of where people pass and where people fail. And we know that people with severe neurological injury and disease are able to pass these tests.

There are only three circumstances in which people do not pass these tests. The first is when somebody has what we call intellectual disability. This term used to be called mental retardation. We don't use that term anymore. We say intellectual disability. It means the same thing. It means having an IQ below 70. And these are individuals who need support throughout life to function, to live.

The second group of people that don't pass the effort test are people with advanced dementia. People that have Alzheimer's disease, not just early, but late -- later on Alzheimer's disease, people who can't go out on their own, people who need a lot of support to be safe.

Third group of people that we see that don't pass these effort tests are people who have an incentive to not pass them. Who have a possibility of secondary gain if they can make themselves look cognitively impaired and basically look as if they are failing tests.

Now, I think it's worth mentioning that we know in research because I mentioned these three groups of people that don't pass these tests. We have seen that among people who have intellectual disability, people who have an IQ of 60 to 69, which is quite low functioning, they fail 44 percent of effort tests trying their best. People with advanced dementia, people with Alzheimer's disease, people in nursing homes, people that can't do much of anything for themselves, they fail 83 percent of the effort tests when they are engaged and they take them.

Now Mr. Gill, he failed 12 out of the 13. He failed 92 percent of the effort test, which means his performance was worse than someone with intellectual disability of IQ 69 and below. And his performance was worse than somebody with advanced Alzheimer's disease, like living in a nursing home and being completely dependent from most activities and daily

living.

So basically what that shows us is that we are not able to look at any of his scores across the evaluation, and say that any of them is credible, because without the establishment of good effort, of adequate effort even, we can't say that there's any evidence of any kind of decline or impairment.

Q Okay. Can you take us through the process of determining whether a person sustained a concussion?

A Yeah. Absolutely. So as we established before, concussion also known as mild traumatic brain injury, this is something that is diagnosed based upon the characteristics of the time of the injury. This is not something that's diagnosed down the line. It cannot be diagnosed a week later when you have a headache. It can't be diagnosed a month later when you say that you are having trouble remembering things. It's diagnosed specifically based upon characteristics of things that happened at the time of the accident.

Now, the standards of what is accepted in the field of from the American Congress of Rehabilitation Medicine, there are six criteria for concussion. All of these basically are things that are determined the day of an injury, and they all basically are routinely examined in any ER visit or any trip in the ambulance there or aspects are evaluated throughout. And I will explain what those are.

The first criterion is mechanism of injury. There has

to be establish that there is an injury to the head, that somebody hit their head on something, that their head hit something, that they were close to a blast like a grenade going off. There has to be a mechanism of injury.

The second is there have to be clinical signs. Now there is a difference between signs and symptoms. Symptoms are what somebody reports. It's subjective. It's what somebody says about what they are experiencing. Signs are something that a medical professional can see.

The second criterion is these signs. Acute signs. So these are things of consciousness. These are things that paramedics would be able to see, and that in the ER they would be able to determine loss of consciousness. This includes amnesia for the event. This includes altered mental status. So somebody's confused. They are dazed. They don't know where they are. Often they start speaking in gibberish or they don't make sense or they don't know what happened or what's going on. And another one is what we call neurologic signs. People can have a seizure after a concussion. People can have tonic posturing, which is stiffness. And people can have what's called ataxia -- balance problems, difficulty walk. Those are the signs. That's criterion two.

Criterion three are the symptoms that somebody reports. Now this can be altered mental status. Somebody can say I feel confused. I feel dazed. I feel out of it.

And then we have physical symptoms. We have cognitive symptoms. We have emotional symptoms. Physical symptoms include things like light headedness. This includes headache. This includes blurry vision. This includes sensitivity to light. Sensitivity to noise. The cognitive symptoms. Somebody might be telling you that they feel confused. That they feel like they are processing slowly or that they are not able to remember.

And then emotional symptoms. Sometimes we see people have a strong emotion reaction that's not common for them. Something that's uncommon. Maybe somebody's really irritable immediately following a concussion or somebody is emotionally acting in a way that they wouldn't be normally acting. So that's criterion three. The mechanism of injury, we have the clinical signs and we have the symptoms that somebody reports.

Criterion four is laboratory findings and examination. So somebody is taken to the emergency room, and they make them try to perform all different kinds of things say walk, watch them when they are walking. They look to see their eye functioning. So basically this is to see if there are any ocular motor problems, eye movements, difficulty with balance, difficulties with coordination. There are blood tests to look for biomarkers of concussion.

Often times in an emergency room when a provider is particularly worried there might be a concussion or a brain

injury, they can give a blood test. So that's criterion four.

Criterion five is neuroimaging. So often times when patients come into the emergency room, and they are complaining of a head injury, they are sent for a CT scan to look at the brain. This is to see if there are any recognizable, obvious signs of brain injury whether that be skull fracture, whether that be a bleed in the brain. Any number of things that can happen.

And then the last criteria for a concussion is that it cannot -- the symptom and the signs cannot be due to anything else. So there are other things that can look like a concussion. One is intoxication. There are certain drugs and alcohol people might use that can give them similar symptoms, similar signs.

And another one is a medical condition. People can have seizures. It can look like this. Somebody might have a stroke. It can look like a concussion. Right.

And one of those factors also is basically motivation to feign a concussion or to feign an injury. That's one of those criteria. Importantly, there are all six of these criteria. Importantly, criterion one is always necessary. Mechanism of injury. It can be criterion one, mechanism of injury combined with seeing something abnormal on a CT scan. It can be mechanism of injury combined with clinical exam, so the doctors are seeing something or the signs -- they are showing

these signs. They are showing amnesia. They are showing coordination problems. But you can never arrive at the diagnosis of concussion just through mechanism of injury and self-reported symptoms alone. Those two don't meet the criteria for concussion. There has to be these other factors.

Q Does Mr. Gill meet the criteria for a concussion?

A Based upon his medical records in the emergency room, he denied loss of consciousness, and the emergency room -- the emergency room records state that there was no head injury. But if we are being generous and we see he did indeed strike his head during the accident, none of us was there, none of us is able to say with certainty if we are being generous, and we say he did strike his head. In addition to that, we have that he arrived in the emergency room. We know that in the ambulance he had a Glasgow Coma Scale of 15. That's his perfect -- all of us in the room right now have a Glasgow Coma Scale of 15 or as far away from a coma as it gets. And that's how Mr. Gill was at the scene of the accident.

In the emergency room he reported light headedness. He reported headaches. Again, this falls under that self-reported symptom category. There were no clinical signs. There was no loss of consciousness. There was no amnesia for the event. There was no tonic posturing. There was no seizure. There were not documented ocular motor problems. There was not illogical speech. There was not disorientation. He did not appear to not

know where he was. He did not appear to be speaking incoherently. So we have none of these clinical signs on the CT scan. There was nothing found indicative of any kind of brain injury whatsoever. And also we cannot rule out this other possibility. The criterion six of there being something else causing symptoms.

Q Is the answer no?

A My answer is there's no evidence that Mr. Gill sustained a concussion.

Q And can you tell us what the normal course is for a person who sustains a concussion?

A Yeah. Absolutely. We actually know a lot about concussion from recent research. It's not so much a mystery what happens in the brain when there is a concussion. It's something called the neurometabolic cascade. A whole series of physiological events whereby there is a total shift in the normal balance of ions and neurochemicals in the brain. So we know that there are fluctuations in levels of potassium, calcium. We know these excitatory neurotransmitters are admitted and that there is what we call excessive metabolism excessive activity. We know that after that there is a crash. It's called an energy crisis. All the while we know that there's abnormal transmission of a transmitter called acetylcholine -- a-c-e-t-y-l-c-h-o-l-i-n-e. And that is really key in learning and memory.

While there is this dysfunction in acetylcholine, that is the prevalent hypothesis for why somebody has difficulty paying attention, realizing what's going on, remembering things, taking in information. But most importantly, we know that mild traumatic brain injury, we know that in concussion that this almost immediately, the neurometabolic cascade, it starts to resolve. So we see this spike in changes in the brain in terms of the chemicals in the brain, but then immediately it starts to get better. So there's no lasting damage in a concussion or a mild traumatic brain injury.

In fact, that's what largely separates mild traumatic brain injury or concussion from moderate to severe traumatic brain injury. But we know that due to these chemical changes, due to these events, that there can be -- there absolutely can be physical symptoms, and there can be cognitive symptoms. However, these tend to resolve within days to weeks. And what the research shows us is that studies have been done with thousands of individuals that have concussions. People in sports. People in accidents. All kinds of things. What the research shows us is that by the three-month mark, these symptoms resolve on their own. It's just a matter of basically the brain achieving that balance that it had before. And everything returns to homeostasis or the state where it was before.

Now what the research shows us is that there are only

three groups of people that continue to report symptoms three months after concussion. And these groups of people are basically people that have psychiatric problems from before. So things like depression or anxiety, and also then we also have people with the opportunity for secondary grain. People who have the opportunity to maybe benefit from this. And basically, those are the main two that we have. People who have psychiatric difficulties, and then we have people who have potential for secondary gain.

Now comparing a concussion to a brain injury, in terms of lasting effect or trying to say moderate to severe brain injury comparing a concussion on a mild TBI to a moderate to severe brain injury is kind of comparing a bruise to a compound fracture. A bruise goes away. It's something we know. The process we know that the blood dissipates. We know a bruise goes away. We don't expect to have long term physical consequences from a bruise.

Now compound fracture, that's more complicated. We know there might be lasting symptoms or basically lasting effects of a compound fracture. So a concussion or mild TBI is not a compound fracture. It's like a bruise. It goes away.

THE COURT: One second. Counsel, approach, please.

MR. McNIFF: Sure.

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

away for the jury.)

THE COURT: You may continue.

MR. McNIFF: Thank you, Your Honor.

CONTINUED RE-DIRECT EXAMINATION

BY MR. McNIFF:

Q Now, Doctor, do you have an opinion within a reasonable degree of neuropsychological certainty as to whether Mr. Gill sustained any kind of traumatic brain injury as a result of the accident?

A I do. My opinion is that he did not sustain any injury.

Q And what is the basis of that opinion?

A The basis of that opinion is that he did not meet the currently accepted standards -- the criteria for concussion. But even if he did meet the currently accepted criteria for concussion, that we wouldn't expect to see any deficits beyond the three-month mark.

Q Okay. Do you have an opinion within a reasonable degree of neuropsychological certainty as to whether Mr. Gill can work?

A There is no -- based upon my testing, there is no valid or reliable evidence that Mr. Gill has any neuropsychological cognitive deficits or that there are any barriers to him returning to work.

MR. McNIFF: Thank you, Doctor. I have no further

questions.

THE COURT: Thank you.

Members of the Jury, at this time we going to take a brief comfort break to give everybody a little comfort. During the very brief break please remember do not discuss this case with anyone. Do not discuss among yourselves, and do not talk with the parties, witnesses or attorneys.

So we are going to take a brief comfort break. All right.

THE COURT OFFICER: All rise. Jury exiting.

(The jury exits the courtroom.)

THE COURT: Off the record.

(An off-the-record discussion was held.)

THE COURT: Please bring the jury.

THE COURT OFFICER: All rise. Jury entering.

(The jury enters the courtroom.)

THE CLERK: Do all parties stipulate to the presence and proper placement of the jurors? Beginning with the counsel for the plaintiff?

MR. LESNEVEC: I do.

THE CLERK: Defense?

MR. McNIFF: I do.

THE CLERK: Thank you. Jurors may be seated.

THE COURT: Everyone may be seated.

Counsel, you can proceed with cross.

MR. LESNEVEC: Thank you, Your Honor.

Good afternoon, Doctor.

THE WITNESS: Hi.

CROSS-EXAMINATION

BY MR. LESNEVEC:

Q How many years ago did you graduate with your PhD?

A 2019.

Q So that was a little over five years ago?

THE COURT: You have to say yes or no.

THE WITNESS: I'm sorry.

A Yes.

Q And your first job -- I'm not talking about fellowship or internship, but your first career after graduating, you started in 2022; is that correct? Private practice?

A For private practice. But I had seven years -- I can explain if you --

Q I am going to try to make it as quickly as I can. So if you can limit to the question I'm asking, just answer the question. Okay. The attorney will get to follow up with you to ask you more questions after me, just so you are aware. This is your first time you said?

A Yes.

Q But you have been in private practice since 2022?

THE COURT: Yes or no.

A Yes.

Q Did you send your resumé to the defense attorneys in this case?
A Yes.
Q And is that the most up-to-date resumé that you have?
A Should be.
Q It is dated April 3rd, 2025. Do you have any updates that you needed to do that?
A No.
Q Now, are you currently treating patients diagnosed with TBI? Traumatic brain injury?
A I don't treat. I just assess.
Q How frequently are you prescribing medications to any of your patients?
A I don't prescribe.
Q How frequently do you administer cognitive therapy in your private practice right now?
A I don't treat. I just assess.
Q How many patients do you assess on a weekly basis right now?
A Between three and four.
Q And what percentage of those patients were injured due to head trauma in a motor vehicle accident?
A I would say, currently, five percent or fewer.
Q So you basically perform screenings or assessments, right?

A Not screening. Just comprehensive neuropsychological batteries.

Q Batteries? At this point have you diagnosed any patients with traumatic brain injury before?

A Psychologists don't diagnose. As I said earlier, that's something done by the medical personnel based on the characteristics.

Q Let me ask it this way. How many of those that you have talked to were diagnosed by someone with traumatic brain injury?

A How many?

Q Yeah. What percentage?

A In private practice only?

Q In private practice that you are doing right now.

A I would say since 2022, maybe ten.

Q You've published before; is that right?

You have to answer yes or no.

A Yes.

Q How many of your publications are on traumatic brain injury?

A None.

Q How many of your publications discuss treating cognitive deficits?

A None.

Q When you examined Mr. Gill that was not as a patient,

right?

A No.

Q And you conducted your exam on behalf of the defense and the defendants in this case, correct?

A Yes.

Q How many defense exams of plaintiffs have you performed?

A Ever?

Q Ever.

A It would have to be, maybe, three hundred.

Q How did the defense get in touch with you in this case?

A Through JEC Disability.

Q What is that?

A It's an organization that connects firms with experts. They have a panel of experts.

Q How did you get involved with that?

A Through my former mentor, now colleague who does medical legal work. Who connected me with the organization.

Q Did you approach your colleague and say I want to get into medical legal work or --

A No. It's something that I trained doing from the second year of my PhD program. So I started -- I added this type of work into my other training in 2015.

Q What was your interest in getting involved with medical legal work for defense?

A It's another avenue where neuropsychology is used and where you can practice neuropsychology, and I like to keep -- diversify my practice to be engaged in different avenues.

Q Did you speak to any of the defense attorneys or anyone on their team before you wrote your report in this case?

A No.

Q How many times did you speak to anyone from the defense or the defense firm before today?

A Just once. Yesterday.

Q So first time you found out that you were going to testify was yesterday?

A Oh. I'm sorry. I thought you meant spoke to over the phone. I was contacted over a month ago.

Q So how many times -- again, I will ask, how many times have you spoken to anyone from the defense, defense attorneys, defense firm in this case?

A There have been e-mails about the date for trials. So maybe a total of five e-mails.

Q How did you know who your assignment was here?

A Can you clarify?

Q How did you know what you were going to be testing Mr. Gill for or what to do or why you were being sent here?

A It's very standard neuropsychological IME. So when you see someone here, as I mentioned before, you are doing all these different steps, taking all of this history. You come without

bias to test somebody, and you incorporate all of these different elements to access whether or not there's any evidence of cognitive impairment.

Q But how did you know what you would be assessing for? Did anyone ever reach out to you and say hey we would like you to assess Mr. Gill? How did that come about?

A I was informed -- the e-mail through JEC Disability that I would be hired and provided with medical records and told that I would be performing a neuropsychological IME.

Q And you knew at that point that you were being hired on behalf of the defense firm, right?

A Yes.

Q Did you bring copies of any of these e-mails to court with you today?

A No.

Q Were you asked to bring anything with you today by the defense?

A No.

Q Did you bring --

A I brought a copy of my report.

Q What about any of the bills or any of the copies of payments for yourself? Did you bring any of that?

A No.

Q Did you discuss with the defense what your testimony would be today before you testified?

A As I mentioned earlier, we spoke yesterday for an hour and a half.
Q Did you discuss your testimony?
A We discussed what would be covered today. Yes.
Q Your testimony, right?
THE COURT: Yes or no.
A Yes.
Q Was there any discussion of types of questions that I may be asking you today?
A Not that I recall.
Q So this is your first time testifying in court, and you didn't ask what might the questions be on cross-examination?
A I have been to court before. I have observed this type of trial. This type of testimony.
Q How many times have you done that whereby you have gone to watch and see what happens?
A I have gone to two trials, and I have also watched plenty virtually.
Q You were sent legal records to review as a part of this case; is that correct?
A Yes.
Q Now if a patient is not sent to you by a defense attorney or a defendant, do you still ask the patient for the legal pleadings?
A Can you repeat that.

Q So in the 40 percent of your practice, not the non-legal work, are you still asking those patients if they have a case to show you the legal pleadings?

A We clarify in our reports, meeting face-to-face. Also, it's for clinical purposes, not for forensic purposes.

Q So that's a no? You don't ask those other patients?

A Do I ask them if they have legal proceedings?

Q Do you ask them for their legal pleadings? The Bill of Particulars that you reviewed?

A When I see people in clinical context?

Q Yes.

A No.

Q You don't do that when it is a legal context?

A I don't ask for the Bill of Particulars. It's provided to me.

Q And who provided the Bill of Particulars to you in this case?

A Defense through JEC Disability.

Q How many times before today have you reviewed legal pleadings like the Bill of Particulars?

A I don't know that I would be able to say how many times. I don't think -- I don't know. I wouldn't be able to estimate.

Q You were also given Mr. Gill's medical records, right?

A Yes, I was.

Q And you examined him, right?
A Yes.
Q And you were paid for that work; is that right?
A Yes, I was.
Q And how much was the total for all that work?
A Forty-six hundred.
Q To testify or for reviewing the -- doing the exam?
A The exam. Forty-six hundred.
Q How much were you paid in connection with this entire case?
A The entire case would be seventy-six hundred.
Q You saw Mr. Gill one time?
A I did.
Q And you saw him just a few weeks ago, actually?
A Yes, I did.
Q February 24, 2025?
A Yes, it was.
Q So, that's five years after the crash, right?
A Yes.
Q You have no personal knowledge of what his symptoms were during the first five years, right?
A Beyond the medical records, no.
Q You have no personal knowledge of that, right?
A Not beyond the medical records.
Q What was Mr. Gill's demeanor like when he came to you?

A He, I noted in my report, was mildly dysphoric, which means signs and symptoms a little bit depressed, seemed a little bit down. That was his demeanor.

Q He made complaints of pain to you?

A He did.

Q He complained about his left shoulder?

A He did.

Q He complained about numbness in his legs?

A Yes.

Q Did he tell you whether or not he planned on getting any other surgeries?

A I don't recall. If he did, it's in my report.

Q You could refer to your report, page 2, if you could. Towards the top.

A Yes. It says here lower back.

Q He intends to get lower back surgery; is that what he told you?

A That's what he told me on the 24th.

Q Did he tell you whether or not he wanted to continue the physical therapy?

A I would have to refer back.

Q You can refer.

A I recall now. He said his prescription had expired and he was hoping to get another.

Q He would continue with physical therapy?

A He would like to, yes.
Q Was he doing physical therapy at home when he saw you?
A I cannot recall if he told me he was doing exercises at home.
Q Take a look at your report on page 2.
A Yes.
Q He told you that he was doing therapy at home?
A Yes, he did.
Q Did he tell you whether or not he was using any medical devices?
A He said he was using some -- for pain, cold packs, patches. Things like that.
Q Was he taking any medication at the time that he saw you?
A He said he was using Baclofen, cyclobenzaprine, escitalopram, sumatriptan.
Q Did he report having headaches to you when he saw you?
A Yes.
Q What did he tell you about that?
A He told me that he has headaches on a regular basis.
Q Did he mention any difficulty with his ears?
A He said that he has tinnitus, chronic.
Q What is that?
A It is a ringing -- a buzzing or ringing in the ear.
Q Did he report any difficulty with memory to you?

A Yes, he did.
Q What did he report?
A He told me he leaves his stove on. He told me he now has to set a timer for daily prayers. He said he is prone to forgetting people's names.
Q Did he tell you whether or not he had any friends that would help him?
A He said that he lives with a friend but that a lot of his friends have ceased to contact him and he's not associated as he once was.
Q What about doctor's appointments? How did he tell you he kept track of those?
A He told me he relies on calls and reminders from the doctor's offices.
Q From the doctor's offices?
A Yes.
Q Did you ask him about his ability to sleep at night?
A I did. He told me that he has a lot of sleep difficulty. His sleep is interrupted. That he doesn't get enough sleep.
Q What was his work history before the crash?
A He had worked for Uber. He was an Uber driver.
Q How frequently was he working?
A He told me he was working full-time. Regularly.
Q Now, did you find out any of the details regarding the

severity of the crash we are here for?

A Can you clarify what you mean by severity.

Q Yes. Did you get any of the details of the crash? Let me start with that?

A The details that I got from the medical record said that he was able to get out of the car and ambulate, walked around the car, got back in, called 911. I don't have details about the shape of the automobile, if that's what you are asking.

Q Do you know what types of vehicles were involved in the crash?

A I do. He said a commercial van that rear-ended him as he was going 40 miles per hour on the highway.

Q And did you review Mr. Gill's hospital records?

A I did.

Q And they noted head pain in his records; is that right?

A Yes. They noted headache.

Q Headache. Head pain as well?

A I don't recall if there was -- if it used both of those terms specifically, but.

Q When was last time you reviewed those records?

A Yesterday.

Q Did it report complaints of dizziness in the hospital records?

A I know there was light headedness. Possibly dizziness,

as well.

Q Complaints of headaches, dizziness, memory problems, those can all be signs of a traumatic brain injury, can they?

A They can.

Q Now, you had mentioned Mr. Gill scored lower than average on most of the tests, right? That you administered?

A Yes.

Q Below average, right?

A Yes.

Q You mentioned he scored first percentile on a couple of the tests, right?

A Yes.

Q So that means that 99 percent of test takers scored higher than him?

A Yes.

Q Processing speed index test, right?

A Yes.

Q Just briefly, what was that again?

A That's basically how fast you can do a task that's not difficult.

Q And that was first percentile?

A Yes.

Q The symbol search test, just briefly what was that?

A Symbol search you scan a row of symbols, try to see if two match. One that matches another, you cross it. If not, you

cross out no.

Q And again, he scored very low on that test?

A Yes.

Q First percentile?

A Yes.

Q It is your position no brain injury, right?

A There's no evidence of traumatic brain injury.

Q No evidence of any head injury. In fact, is that your testimony?

A I can't say that there wasn't an injury. I wasn't there at the time. I can't say there was not a head strike. What I can say is that he does not meet the criteria for mild traumatic brain injury or moderate or severe brain injury.

Q Did you find Mr. Gill to be credible?

A Credible in what way?

Q In his complaints to you?

A Well, as I mentioned before, he failed 92 percent of the effort test that I gave him. So I did not find him to be a credible reporter in his presentation.

Q Now, his complaints about forgetting names or forgetting that he left the stove on, I think you mentioned, did you believe that he was making that up?

A Well, it's not about believing or not believing. That's his subjective report.

Q Did you find him to be lying about that?

A I don't use the word lying. It's not a usefully term in my field.

Q You did find him to be less than credible about that?

A About his self-report? It's not really a true or false. It's his subjective experience. So it's not facts or not a fact.

Q So you have no position on whether or not he's credible in those complaints to you?

A My job doesn't involve judging credibility of what somebody tells me. My job is to look at the objective performance, what the data says on testing, so I leave in somebody's self-report as part of what I used to make my conclusions. So I can't tell you that he has pain or doesn't have pain or forgets things or doesn't forget things. That's not part of the scope of my practice.

Q His complaints about headaches, do you believe he was credible about those complaints?

A Again, it's not about believing or not believing. That's not part of the scope of my practice. That's judging whether somebody has headache or not.

Q The medications, the Gabapentin, the sumatriptan that he was taking, why was he taking those?

A I'm not a medical doctor. I can't comment on prescription medications.

Q Do you have an opinion as to whether or not Mr. Gill

was taking those for some reason other than cognitive injuries?

A Again, I'm not a medical doctor. I can't comment on prescription medications.

Q The ringing in his ear, you testified about that, right? Mr. Gill.

A You asked if he had ear problems, I said he had.

Q Did you find him to be credible about that?

A It's the same as the head --

Q Is that --

THE COURT: One second. Counsel, you have to let the doctor finish her answer.

MR. LESNEVEC: I apologize.

THE COURT: Then you ask the question.

You want to finish your answer, Doctor?

THE WITNESS: Thank you.

A It's same with the headaches. It's completely subjective. It's his self-report. It's not in the scope of my practice to judge whether or not he has ringing in his ears.

Q Ringing in the ears can be considered a cognitive deficit, can it?

A No. Cognitive means thinking skills. Ringing in the ears has nothing to do with thinking.

Q Do you have any opinion as to whether or not the tinnitus in his ears has anything to do with this crash?

A That's a question for a medical doctor. I don't treat

diagnosis or deal with ringing in ears.

Q You are aware that Dr. Busuchio testified in this case?

A I am.

Q When did you first learn that?

A I'm trying to think back. Honestly, I can't recall when I learned about it. It was likely last week sometime.

Q Who did you learn that from?

A I believe -- I'm really trying to remember. It might have been -- I had access to her records, so I knew that she had evaluated Mr. Gill, and maybe -- I think maybe asked Ms. McCarthy if she had testified so I would know.

Q Who is Ms. McCarthy?

A On the defense team.

Q She's on the defense team?

When did you speak to her?

A I e-mailed with her last week.

Q And she e-mailed you that Dr. Busuchio had testified?

A I asked for the transcript.

Q Of Dr. Busuchio's testimony?

A Yes.

Q Did you read that testimony?

A I did.

Q So you are aware that she diagnosed him with mild traumatic brain injury?

A Yes, I am.

Q And you also saw that in her records, right?
A Yes, I did.
Q And so you are aware of the tests that Dr. Busuchio performed, right?
A Yes, I am.
Q Did Dr. Busuchio misinterpret the diagnosis here?
A Well, brain injury is not diagnosed after the fact. It is something diagnosed based upon the characteristics and things that are observed at the time of the injury. Not after the fact.
Q Again, I asked you did she misinterpret the finding of traumatic brain injury?
A Based upon the fact that Mr. Gill did not meet criteria for traumatic brain injury, in my opinion that's a mischaracterization of his case and presentation.
Q Was that because Mr. Gill attempted to alter the test results in her testing?
A Well, she did not perform sufficient effort testing, so I don't think there's any way to say that the data she obtained in her evaluation of him was indeed valid.
Q Do you have an opinion as to whether or not Dr. Busuchio missed something in her analysis?
A She didn't administer -- she administered one effort test. She reported the score. She did not report any other scores on effort testing. And that's far below what people give

in clinical practice.

Q Was she asked during the trial -- because you read the transcript -- was she asked about effort tests?

A She was.

Q And administered those?

A She was.

Q What was her testimony about that?

A She said she administered a rate 15, described how that was given. She said there was another embedded measure called digit span, which she said he passed, but she didn't describe that in her report. She didn't talk about what his score was on that test. She also said that she could tell that he gave good effort because there was a trial to a computer test that she gave him, and that he passed the trial. So he got on to the real test, but all tests that we give have trials. That's not an effort test. An effort test is something with sufficient data and research to back it up. So we understand the psychometrics and how it's interpreted.

Q Do you doubt Dr. Busuchio's credibility?

A Credibility? Can you say more about that.

Q Did you find that she gave credible testimony in this case?

A I think that her interpretation of her data is not consistent with the standards in our fields. And in our field -- and I think that based upon her evaluation she does not

have valid or reliable evidence of brain injury in Mr. Gill's case.

Q Do you know how long Dr. Busuchio has been practicing for?

A Twenty plus years she said.

Q Do you know how many patients she has treated over the years?

A I believe she said thousands.

Q Have you ever met Dr. Busuchio?

A I have not.

Q Are you aware that Mr. Gill's friend came to court and testified in this case?

A No.

Q You weren't given that testimony?

A No.

Q I want to you assume that his friend testified he observed some of the very symptoms that you documented in your report. Is it your position that his friend came in here and lied?

MR. McNIFF: Objection.

THE COURT: Basis?

MR. McNIFF: She's never met or evaluated the friend. Or she's not in position to offer testimony about someone else's credibility.

THE COURT: Sustained. Sustained.

Q Mr. Gill didn't score in the first or second percentile on all the testing; is that true?
A Yes.
Q He actually scored higher on some, I think you said, and lower on others; is that right?
A Yes.
Q On the second part of the color trails test, I think you said he scored 34th percentile?
A Yes.
Q And he actually scored 34th percentile in the immediate memory index test as well, right?
A I believe so. I can look back at the data.
Q Page 10 on the 4th paragraph.
A Yes.
Q 34th?
A 34th percentile.
Q Okay. So again, some scores were higher, some scores were lower, right?
A Yes.
Q Is it your position that he gave more effort on tests where he had higher scores?
A No. My position is that this entire set of data is rendered invalid by the fact he gave insufficient effort.
Q Even though he scored higher on other tests? Yes or no?

A He scored higher on some tests.
Q Is it your position even though he scored higher on other tests?
A I'm sorry. Can you repeat?
Q The fact that he scored higher on some tests and not others, you are saying he's faking across the board? Yes or no? Or he's not giving --
A When people fake they tend to fake selectively. They tend to think about what a brain injury might look like and they are selective in where they decide.
Q So it's your position that Mr. Gill selected to do worse on some tests, rather than others; is that right?
A It's what the data suggests.
Q Why did he do that?
A People often try.
Q Why did Mr. Gill do that? Do you have a position?
A I don't know. That's completely subjective. That would be a question for him.
Q When you obtained the history from Mr. Gill, he told you that his left shoulder surgery had improved his range of motion to some extent?
A Yes, it did. Yes.
Q Did you find that he was trying to magnify or inflate any of that information he gave you?
A In what way?

Q Was he being obstructive about that or less than honest about that when he said he had improvement after the shoulder surgery?

A Again, I'm not there to evaluate his honesty. I'm also not giving him a physical exam. I don't know about his range of motion. It is his subjective report.

Q Mr. Gill told you after his lower back surgery that the numbness went away in one of his legs, right?

A He did.

Q Did you find that to be credible?

A Again, I didn't give him a neurological exam, so I didn't check to see his sensory perception in his legs.

(Whereupon, the following was recorded and transcribed by Senior Court Reporter Monica Jenkins.)

(Continued on next page.)

* * * * *

Q Do you have any evidence at all Mr. Gill had suffered a head injury before this crash?

A I do not.

Q Have you seen any records at all that showed he had a prior accident or injury before this crash?

A I have not.

Q Any records to show he prior headaches before this crash?

A No.

Q Any records to show that he had tinnitus in his ear before this crash?

A No.

Q That's because there are none, right?

A I don't know if there's evidence exists. Nobody's given me those records. They might exist. I can't say.

MR. LESNEVEC: Thank you, Doctor.

THE COURT: Any redirect?

MR. MCNIFF: Yes, Your Honor.

RE-DIRECT-EXAMINATION BY MR. MCNIFF:

Q You were asked questions about the tests that were administered by Dr. Busuchio a couple minutes ago by plaintiff's counsel and you also mentioned about a certain industry standards; can you just explain that to us, any significance of that, how that works?

A Yeah. Absolutely. Well, I think I said this in the

beginning but there are certain tests that neuropsychologists are familiar with. These are the tests that we see during training, tests we practice administering while we're learning how to do this.

And there's a reason why there are tests that are the strongest that the validity, reliability and also there's a standard across the field. In her exam, Dr. Busuchio, in her exam of Mr. Gill gave him one test that I am not familiar with.

I have never seen this test. I don't know any neuropsychologists who have ever administered this test or seen this test themselves called neuro tracks and it's from the sounds of it, it's a test where you sit somebody in front of a computer, you leave and they do the tests themselves.

I don't know how long it takes to administer that's basically time I miss out. As I mentioned before, the importance of the behavioral observations working with patients, seeing the patients, how they perform things, that's not possible with the computerized test.

Also, this test, because it's something we don't regularly use and a lot of us have never heard of, we can't assume has the same strong psychometric properties as the tests that we use regularly and then also in addition in her evaluations with him, the primary test she gave was this neuro track computerized.

She only did 20 minutes face-to-face testing with him.

That's a small fraction of the time a neuropsychologist typically spends sitting and observing a patient.

Q Can you also explain to the jury about your involvement assessing and working with people with brain injuries throughout your career?

A Of course. Yes. Yes. Um, I have worked with people with traumatic brain injury from very early in my clinical training and as I mentioned before, you know, that started as early as when I was in my third year of my PhD program, 5th, 6th year PhD program, pre-doctoral residency, post-doctoral fellowship and then also my current work.

So, it's been many, many years across many settings, inpatient, seeing people with acute injury, outpatient, again, working in rehabilitation day-treatment program helping people eventually try to re-enter the world and then also, um, you, know working one-on-one in cognitive remediation and therapy testing of all of that.

MR. MCNIFF: Thank you, Doctor. No further questions, Your Honor.

THE COURT: You may stand down, Doctor.

THE WITNESS: Thank you.

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

THE COURT: Do you have further witnesses?

MR. MCNIFF: No witnesses, Your Honor. Defense

rests.

THE COURT: Okay. Members of the jury, we are done for today. So, we are going to resume the trial next week Tuesday, June 3rd at 10 o'clock a.m. sharp. I'm going to ask everyone to please be mindful of your fellow jurors' time.

Everyone please get here on time. So, everyone have a good weekend and I will see everyone on Tuesday, June 3rd at 10 a.m. sharp. Everyone have a lovely evening. Get home safely and a good weekend.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exited the courtroom.)

THE COURT: Okay. You may all be seated. Any motions?

MR. LESNEVEC: No.

MR. MCNIFF: No, Your Honor.

THE COURT: Okay. All right. Off the record.

(Whereupon, the trial was adjourned to Tuesday, June 3, 2025 at 10 a.m.)

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