In The Matter Of:

GORDON SAYLES v.

URBAN AMERICAN MANAGEMENT CORP., et al.

DR. MICHAEL GERLING

October 7, 2026

Karen Perlman and Alan Bowin

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK - CIVIL TERM - PART 57

- -X

GORDON SAYLES,

Plaintiff,

- against -

URBAN AMERICAN MANAGEMENT CORP., PUTNAM HOLDING COMPANY, LLC, BSREP UA 3333 BROADWAY LLC, SCHINDLER ELEVATOR CORPORATION, CENTENNIAL ELEVATOR INDUSTRIES INC, ESSENTIAL ELEVATOR, LLC, NEW YORK CITY EDUCATIONAL CONSTRUCTION FUND, RIVERSIDE PARK COMMUNITY (STAGE I), INC., RIVERSIDE PARK COMMUNITY II, LLC, RIVERSIDE PARK COMMUNITY, LLC, UAB PROPERTY MANAGEMENT, LLC, CENTENNIAL ELEVATOR INDUSTRIES INC., CENTENNIAL ELEVATORS IND. CORP.,

Defendants.

- -X

INDEX NUMBER:
155149/2020

JURY TRIAL

60 Centre Street
New York, New York
October 7, 2026

B E F O R E :

HONORABLE SABRINA B. KRAUS,

JUSTICE OF THE SUPREME COURT

(Appearances are listed on the following page.)

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SENIOR COURT REPORTERS

THE COURT: We're on the record.

Good morning, everybody. I'm addressing Defendant's application for recross. Mr. -- I don't actually think it's the kind of thing where consent trumps the Court's discretion.

MR. CASCONE: It never does.

THE COURT: It's up to the Court to determine whether that's proper or not. So I'm asking you to make an offer of proof because I don't really see a basis for it.

MR. CASCONE: The topics of him not hiding anything about the names of the doctors and his scrubbing of the Facebook account, that came up on redirect. His thoughts about not gathering evidence in the ten years, that came up on redirect. And my final avenue of questioning, which would be the last 30 seconds, would be about his conversations with Dr. Gerling and why he claims to have been terrified about surgery. Again, less than three minutes.

MR. KULLER: I didn't cover any of that.

THE COURT: Okay. I -- the application for recross is denied.

Second, I issued a decision last night. My decision was based on my impression that the notice of intention had not been accompanied with physical delivery of the films which counsel then -- plaintiff alleges was

actually physically delivered. Is that disputed?

MR. KULLER: I have them to mark up.

THE COURT: I'm just -- I'm asking Counsel.

MR. SCHIFERL: Is it disputed --

THE COURT: -- that you received the films along with the notice?

MR. SCHIFERL: I'm sorry. I thought your order laid bare and clean that they had the obligation to prove that they were produced to us in discovery.

THE COURT: No. No. No. The statute doesn't require that. The statute just indicates that -- basically what the statute does, it eliminates the need for them to call a foundational witness to lay the foundation for the admission of the film. And what it requires is that you received it in advance.

When I read the papers, I didn't understand that along with the notice, the films were actually delivered to you. So do you dispute that along with the notice the films were actually delivered?

MR. SCHIFERL: There's -- there's sub-issues here too.

THE COURT: But that -- wait. Before we go to your sub-issues, Counsel, I just asked you a yes-or-no question. Do you dispute that along with the notice of intention the films were actually delivered?

MR. SCHIFERL: We did get the films.

THE COURT: Okay.

Go ahead.

MR. SCHIFERL: It's clear, there was no affidavit from any doctor that these are the records.

THE COURT: They don't need -- it's one or the other. Either they have to get it to you in advance -- that's the first option, as I laid out in my decision, or it's option number two, that it comes from -- with the physician's affidavit. If you have it in advance, they're not required to have the affidavit.

MR. SCHIFERL: In advance of trial?

THE COURT: So to be fair, I did do a little digging to see what "in advance" means. It doesn't actually say "in advance." It just says that you have to have received them.

But I did do a little research to see if there is any case law that determines when you have to receive them. And there is -- there is no -- no requirement that they be received a certain amount of time in advance other than, you know, the notice of --

MR. SCHIFERL: Other than, of course, fairness of the opportunity for the other side to take them and have them -- our experts armed with them to review and then do a report --

THE COURT: But the statute presumes that the receipt does give you that option.

MR. SCHIFERL: And the reports of which are due a certain amount of time before trial. So it puts the defense, in this case, in a trick bag when we're trying to follow the rules.

And, you know, if -- if the order of the Court is they're coming in, we would note our exception because we were deprived of the opportunity to have them, to give to our experts to then -- us comply with rules to timely get expert reports to the opposition.

THE COURT: Okay.

MR. SCHIFERL: That is just -- Judge, that is fairness and impartiality --

THE COURT: Okay. So --

MR. SCHIFERL: -- whatever there is of that.

THE COURT: So I've already granted leave for you to supplement those reports in connection with the exhibits that have come in. You've had them for some time and I'm not going to stop you from responding.

MR. SCHIFERL: Okay.

THE COURT: So that is that.

I'm going to leave for a little bit later the issue of the radiology debate you have going on because that pertains to Defendant's witnesses. We don't need to address

that right away.

We have another problem.

MR. KULLER: A problem?

THE COURT: Yes.

MR. KULLER: Is it a juror?

THE COURT: Yes, it is a juror.

Yesterday, at the end of the day, Juror Number 4 advised the officer that he knows one of the doctors.

MR. KULLER: We did this in jury selection.

MR. McCRORIE: We even said -- jurors have said, "I know a doctor," but that's fine.

MR. SCHIFERL: Who?

THE COURT: So perhaps we should bring in -- but he's not here yet right.

MR. McCRORIE: Who is Juror Number 4 again?

THE COURT: I was only told that his name is Jean Pierre.

MR. SCHIFERL: I know who the juror is. That is not my question. Which doctor does he know?

THE COURT: I don't know. I don't know. And I don't know in what context he knows the doctor. So I just wanted to bring that to the parties' attention as soon as it was brought to my attention. And what I guess we could do is speak with Juror Number 4.

MR. McCRORIE: In all fairness, we gave them the

main doctors. He might have heard in the cross another doctor that was mentioned. We didn't list like every single -- it could be Demesmin.

MR. SCHIFERL: Correct.

MR. McCRORIE: We didn't give him those names. We gave them Gerling, the defense doctors.

THE COURT: So I think if we can, we should speak with him before we start.

MR. McCRORIE: We still -- we had the stuff marked tentatively. We can either -- if the Court -- we could try to put the stickers on them now, and if not the stickers, we'll put on tentative for ID.

MR. SCHIFERL: Can we stick to the topic?

MR. McCRORIE: Because then she's going to say, "Start the case" and the stuff is not marked.

MR. SCHIFERL: On this witness, when you bring him in, would Your Honor be doing the questioning? The question is "Which doctor do you know?"

THE COURT: Normally I do the questioning.

MR. SCHIFERL: That is what I --

THE COURT: I may give you an opportunity to ask any additional questions.

MR. SCHIFERL: That is what I want to know. Thank you.

MR. McCRORIE: The other thing, there was an

objection to the other day -- we put the CDs in, the films in the USB drive, the single images from each MRI film so the jury -- if the jury wants to see them at the end, they can't -- they don't have something to view a CD with --

THE COURT: They -- I think they do. Don't we have a screen?

MR. McCRORIE: But, Judge, they won't know how to get to this image.

MR. SCHIFERL: Your Honor --

MR. McCRORIE: Wait, wait. Let me, please. We would like to move not just for demonstrative. If we have a film in and there is 300 images and we're printing two or three, they can do the same or -- we'd like this as -- say this was 13, and this is just -- this is 19; it's the MRI of 4/21/21. We'd like this 19B in evidence, not just demonstrative. But we'd like it in evidence because it is in evidence, and that's what we would like.

THE COURT: Okay. So normally -- I mean, there is some discrepancy recently in the Appellate Division about this. But normally -- I don't want to say normally.

There is a school of thought that says that jurors should never be given the films to look at. Because the jurors are -- lack the knowledge to interpret the films. However, having said that, there was recently issued either this -- I think it was in 2026 -- I don't remember what

department. It's not a First Department case.

But there is an Appellate Division case that says that it is reversible error if the juror asks to see the film not to provide the film. Again, that is not a First Department case.

MR. KULLER: Sorry. Can you repeat what you just said?

THE COURT: I'm saying usually it wouldn't come up. You wouldn't give the juror an MRI or an x-ray to look at because the juror lacks the knowledge to interpret the image. However, I am aware of one recent Appellate Division case -- not in the First Department. I don't remember what department it was in -- where they held it was reversible error not to give the jurors a -- the images when they asked for it. I think it's in evidence. It can be shown to them.

Usually demonstrative evidence doesn't come in. I'm going to stick with that.

If there is a request by the jury to see a specific image, I'll address it at that time.

MR. McCRORIE: So just so we're clear, though, for things like -- for something like -- or this one, there would be -- I don't know the number. But this is a lumbar film. It shows a new herniation that came after the reason there is a new surgery.

If it's demonstrative, they're not allowed to see

it after the -- as they go into the jury room.

If both sides' doctors point to this and say it is or it isn't and they circle it, I don't see why the jury shouldn't be able to have testimony read back with the exhibit that was marked and pointed to.

THE COURT: I'll make that decision at the time it arises.

MR. McCRORIE: Understood. But if -- so --

THE COURT: Right now I'm not admitting it. Whether they will be able to view the demonstrative evidence if there is a specific request, again, I'll make that decision at the time that it arises.

MR. KULLER: You're saying --

MR. McCRORIE: Because I'll be doing the direct, we'll voice our respectful objection now to that ruling. But we'll mark them as ID with the understanding that there might be a ruling at the end that they can see it if they want. We can certainly use it on summation.

THE COURT: I have to say -- yes, I have to say it's very unusual -- I've never -- I've never had a situation where a juror requested to see a film. It could happen. It has happened.

MR. McCRORIE: I haven't tried a case before you. It always happens.

THE COURT: Is that juror here? Can you ask him to

come down?

THE COURT OFFICER: In the jury box?

THE COURT: He can have a seat here.

MR. SCHIFERL: It seems like we're in a great hurry on certain things. And I appreciate we all want to get done with this trial. I also believe that there should be an opportunity to be heard on some issues.

And we would like to be heard with regard to the issue of the request for an offer of proof -- we got your rulings with regard to Mr. Halpern, understand them. I'm not here right now to reargue them.

But one of the things, it's important we ask for an offer of proof on that issue. Mr. Shelby is ready to make one. We'd like that to get into the record. We would like to know when you will be able to do that.

THE COURT: You will not be -- I think -- I made a decision. You asked for reconsideration. I denied it. That's -- that's -- that's the record.

MR. SCHIFERL: But -- pardon. It's on. It is on.

I understand and respect all of that.

THE COURT: Okay.

MR. SCHIFERL: I have been informed by learned appellate counsel that I need to make an offer of proof on this issue.

If Your Honor is denying that, I take exception to

the denial, the ability to make an offer of proof. I just want to make sure I understand the procedure and order of things.

We did make a request for an offer of proof and there has been nothing in any record saying that it was denied. If you're now saying that you're denying it, you've done so, and we will have that in the record.

THE COURT: In your request for reconsideration you included a request to make an offer of proof. You said essentially that I was being unfair because I was allowing their witness to make an offer of proof on one issue where I didn't see relevancy necessarily, but I didn't give you that for this witness. So it is part of the record. I did deny it.

MR. SCHIFERL: Fair -- again, I'm not here to argue. I want to make sure I'm clear because I don't want to later be accused by the First Department or someone else if we have to go there. I don't think we will, but if we have to go there saying we were denied an opportunity, we didn't renew our request to make an offer of proof. That is why I'm asking Your Honor.

Thank you for the indulgence.

THE COURT: Of course.

Yes, please bring him in.

(Whereupon, Juror Number 4 enters the court room.)

THE COURT: Good morning, sir. Please have a seat. Could you please state your name for the record.

JUROR NO. 4: John Pierre Prusack.

THE COURT: Okay. Mr. Prusack, I understand that yesterday you brought to the attention of the court officer that you believe you know one of the doctors?

JUROR NO. 4: Yes.

THE COURT: And which doctor is that? Can you speak into your mic.

THE WITNESS: Mathew Wert. I think he was the orthopedist and mentioned several times.

THE COURT: Okay. Okay. And how do you know that doctor?

JUROR NO. 4: I grew up with him.

THE COURT: You grew up with him?

JUROR NO. 4: My dad saw him as a patient.

THE COURT: So when you say you grew up with him, when was the last time you would have had any direct contact with Dr. Wert?

JUROR NO. 4: In the year 2000, 2002, somewhere around there.

THE COURT: So it's been over 20 years?

JUROR NO. 4: Yeah.

THE COURT: Do you feel that there is anything about that relationship that would prevent you from limiting

your decision in this case only to the evidence that comes in, you know, in court, as opposed to saying, you know, "I know Dr. Wert was a great guy because I grew up with him and" -- you know, before -- let me ask you another question.

Up until that area of 2000, 2002, how much contact did you have with Dr. Wert?

JUROR NO. 4: I went to school with his sister. We grew up together in the same -- in the same neighborhood.

THE COURT: So did you have dinner at his house every week? Did you -- when you say, "We were in the same neighborhood," I'm still not understanding the degree of contact that you had.

JUROR NO. 4: I knew his father. His father was a podiatrist in Brighton Beach. His -- I know his nephew is an orthopedist in Sheepshead Bay, Brooklyn. My father saw him as much as 10 or 15 years ago.

THE COURT: Did you ever have any direct socializing with Dr. Wert?

JUROR NO. 4: Not since 20 years.

THE COURT: And prior to 2000, what degree of socializing did you have? Did you go to his house? Did you attend functions with him?

JUROR NO. 4: We're just family friends. I was closer so his sister.

THE COURT: Okay. Is there -- going back to my

other question, do you feel that you can commit to us that your decision as a juror in this case will be based only on the evidence that comes into the record and not in any way, shape, or form based on any prior interactions you or your family might have had with Dr. Wert?

JUROR NO. 4: I believe so.

THE COURT: Do you believe that you would have any --

Is Dr. Wert going to testify?

MR. CASCONE: No.

THE COURT: All right.

Does counsel want to ask -- does either counsel wish to ask this juror any other questions on this topic?

MR. CASCONE: Nothing from the defense.

MR. SHELBY: Nothing, Your Honor.

THE COURT: Counsel for Plaintiff?

MR. McCRORIE: No, Your Honor.

THE COURT: Thank you so much for disclosing. You can step back out.

THE COURT OFFICER: Are you ready for the jury?

THE COURT: Give me one second.

(Whereupon, Juror Number 4 exits the courtroom.)

THE COURT: I don't think that there is an issue based on that. Do Counsel agree?

MR. CASCONE: Defense agrees.

MR. SHELBY: Yes.

MR. KULLER: Can we just talk for a minute among ourselves? I got it.

MR. McCRORIE: Can we step outside, Your Honor?

THE COURT: Sure.

(There is a pause in the proceedings.)

MR. KULLER: We're going -- we respectfully request that he be excused and that the next alternate step in. The client did treat with Dr. Wert.

THE COURT: No, he didn't treat with Dr. Wert. His father did.

MR. KULLER: No, no. Our client.

THE COURT: Sorry.

MR. KULLER: Our client treated with Dr. Wert. There was a recommendation by Dr. Wert for a shoulder surgery. He didn't end up having the shoulder surgery with Dr. Wert.

You know, he went to school with his sister. He knows Dr. Wert. We think it could be prejudicial in some capacity as to why we're not calling him. And he might start thinking about certain things.

We respectfully request that he be excused.

MR. CASCONE: And we oppose that. Dr. Wert is not testifying. This juror hasn't seen him in 20 years, and he responded to Your Honor quite candidly that it won't effect

his judgment.

MR. SHELBY: We join that. And this -- this juror has no direct treatment with him. Just his family.

THE COURT: The application to excuse the juror is denied. Given that it has been over 20 years and maybe even over 26 years since he's had any kind of contact at all with Dr. Wert, given that Dr. Wert will not be testifying and his credibility will not be an issue in this case, and given the witness has 100 percent confirmed and committed to us that that old relationship will in no way impact his decision in this matter, the application is denied.

MR. KULLER: Okay.

THE COURT: All right. So are you ready to bring in the juror and present your next witness?

MR. McCRORIE: Yes. Just one minute, Your Honor.

THE COURT: All right. Are we ready to bring in the jury?

MR. McCRORIE: Yes, Your Honor.

THE COURT: Let's bring in the jury.

MR. KULLER: Sorry. One more thing.

THE COURT: Yes, sir?

MR. KULLER: I'm sorry. Just -- I have the utmost respect for the defense counsel. I'm going to respectfully remind everyone of the ruling that were made on the motion in limine in terms of precluding all references to unproven

allegations of lawsuit, fraud, RICO --

THE COURT: I mean -- all right. I don't think that's necessary.

MR. KULLER: I appreciate that.

THE COURT: Let's just go on.

MR. KULLER: Thank you.

MR. SCHIFERL: Just the unproven ones, right?

MR. KULLER: Nothing has been proven. They're all unproven.

THE COURT: I know there are some cases where there has been some workers' comp determinations, but I don't know if that --

MR. McCRORIE: That doesn't apply with him.

(There is a pause in the proceedings.)

THE COURT: Let's bring in the jurors.

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Please be seated.

Good morning. Welcome back. We're ready to hear from Plaintiff's next witness.

MR. McCRORIE: Your Honor, I guess we're going to call Dr. Michael Gerling. And we just need Plaintiff's Exhibit 2 that's in evidence, the doctor's chart.

THE COURT: That's all for you.

MR. McCRORIE: Should we get it?
THE COURT: Yeah, go ahead.
MR. McCRORIE: Thank you.
THE COURT: And the witness can step up to the witness stand.
MR. SCHIFERL: He's not in.
THE COURT: I thought he might be.
MR. SCHIFERL: You said 2?
MR. McCRORIE: We're going to put them up.
THE COURT: Good morning, sir. You can step up to the witness stand.
MR. McCRORIE: Watch the wire.
THE COURT OFFICER: Watch your step.
THE CLERK: Please raise your right hand. Do you swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?
THE WITNESS: I do.
THE CLERK: State your first and last name; spell it for the record.
THE WITNESS: Michael Gerling, G-e-r-l-i-n-g.
THE CLERK: State your address, please.
THE WITNESS: 740 Park Avenue, New York, New York 10021.
THE CLERK: Thank you.
THE COURT: You may be seated.

DR. M I C H A E L G E R L I N G,
having been first duly sworn/affirmed by the Clerk of the Court, took the stand and testified as follows:

THE COURT: And you may inquire.

Can we give counsel the mic, please.

MR. McCRORIE: Thank you. May I inquire, Your Honor?

THE COURT: You may.

DIRECT EXAMINATION

BY MR. McCRORIE:

Q. Good morning, Dr. Gerling.

A. Good morning.

Q. Dr. Gerling, you are the first doctor to testify, so we're going to be asking you to define a lot of medical terms. And whether I ask you to or not, if you think it's a term a layperson or a non-doctor or a non-spine surgeon would know, please define it for the jury as the first doctor.

So we have to ask you the first question -- I ask you to direct all of your answers to the jury.

Are you duly licensed to practice medicine in the state of New York?

A. Yes. Since 2006.

Q. And are you also duly licensed to practice medicine in the state of New Jersey?

A. Yes.

Q. Can you please -- I'm going to say as succinctly as you can, but please don't leave out any accolades or positions you've held.

Can you please tell the jury starting with college, going to medical school, residency, fellowship, can you give them your educational and work background?

A. Yes. So I grew up in Canada. And my first move to America was for college. I went to UC Berkeley in California. I was there for four years.

Then I went to medical school in San Diego at UC San Diego for four years. After which I applied to the field of musculoskeletal medicine called orthopedics.

So in order to do that, you have to do a residency, which is a training program which teaches you how to operate, how to treat, diagnose problems with the musculoskeletal system.

So I went to New Orleans for that. I was there for five years. At Ochsner Clinic. And thereafter you can go into practice as an orthopedic surgeon, or you can go for what's called a fellowship, which is a more advanced specialty center training within a field. And most of the time people that want to specialize will do that.

And so I had the honor to go to Cleveland to work with one of the godfathers of spine surgery Henry Bohlman for a year as a fellowship. He was famous for having developed surgery on the front of the neck. And I learned basically treatment of

trauma, spinal trauma, and degenerative disease. So those are the two major focuses there.

And I worked at the VA Medical Center, which is one of the original trauma centers for spinal cord injury in the nation. And in MetroHealth, which is one of the largest regional trauma centers in the nation. It is the largest trauma center for spine in the nation. And so I had a really extensive training in spinal trauma.

Thereafter, I came to New York City for my first job. I was hired at SUNY Downstate, State University of New York in Brooklyn. I worked there for four years.

Over the four years, I became the chief of spinal surgery there. I was the head of research. And thereafter, I was hired to enter into the Level 1 trauma center called Lutheran Medical Center at NYU. So NYU in the city and Lutheran Medical Center in New York -- in Brooklyn.

I became the chief of spinal surgery there. I was there for 14 years. NYU -- I was there for 14 years from -- you know, I don't know the exact years. But -- but the -- I believe I started with NYU around 2010.

I took Level 1 trauma call every other night for a long time for many, many years. I became known for spinal surgery, both degenerative and traumatic processes, obviously. I took a lot of trauma, trauma call. My practice grew quite a bit.

I expanded into Manhattan, the city. Expanded into

New Jersey as well.

Eventually, I shifted a lot of my practice to New Jersey, where I do the majority of my surgery now. I was recruited to be the director of musculoskeletal surgery at the Hudson Health System, which I recently started, I believe, in 2024. So I oversee all musculoskeletal care, including orthopedics, neurosurgery, rehab medicine, pain management, et cetera.

I -- I have been involved in academics throughout my career. Henry Bohlman, my mentor, was one of the original gurus of academics.

Out of 75 people he trained, I believe 57 of them became chairmen of departments and presidents of societies. So it was very academically oriented.

So I, throughout my career, have been working with residents, fellows, training them clinically but also doing research.

I've published over 50 papers that are peer reviewed in major journals. Some sentinel papers that are quoted quite frequently.

I've written many, many chapters in textbooks and frequently on panels for academic societies, teaching other fellows and other spinal surgeons.

I'm board-certified, which is a certification you get after you're finished with your training. So after you

initially complete your training, you do a written test. And if you pass that test, which not everybody does -- about 30 percent of people fail it -- they -- the test only really makes you board eligible.

After you're in practice for two years, you then submit your cases to the board and the American Board of Orthopedic Surgery then reviews them. You then actually sit with experts in the field, and they review your cases with you and look at your results and look at the actual outcomes of what you do. And then they determine whether or not you can be board-certified.

So in 2008, that's the first time I was in practice for two years. I was board-certified right away.

Q. In what area?

A. In orthopedic surgery, with a specialty in spine.

And then after my ten years, you have to recertify. I recertified again until now. And I just was accepted again to be recertified again.

So throughout the course of my career, I've been involved in academics. As I said, I -- you know, I was the president of the Brooklyn Orthopedic Society. I was the chairman of education at the Cervical Spine Research Society, which is the international most renowned society in spine, which I'm very proud of that.

And I regularly present and am involved in the American

Academy of Orthopedics.

I was the president of the Federation of Spine Associations, which is where all of the major spine societies come together and create a forum for education for other spine -- spine surgeons. So we put on an actual educational seminar and whatnot as well.

So I've been very involved in those societies. That's certainly the most -- my most proud crowning achievements in my career.

Q. Dr. Gerling, can you please explain the difference between being a board-certified orthopedic spine surgeon and tell them what the difference is if you're an orthopedic surgery or a sports injury orthopedic -- what are general orthopedics as opposed to spine surgeons? What do they do?

A. Well, if you -- if you think of it as an umbrella, like for example you might say that somebody is -- you know, that they're going to go to a restaurant. Right? Like restaurants are all different types, but then a type of restaurant might be a French restaurant, right?

So in orthopedics, just like in other fields, there are specializations; there are a lot of different subcategories. So the -- the field has become so specialized now that there are people that only do scoliosis in children, for example. There are people that only do reconstruction of the ankle and bunion surgery. So, you know, there are foot-ankle specialists. There

are hand specialists. There are sports medicine doctors that really don't do anything other than taking care of athletes and fixing shoulders and knee sprains and things like that.

So somebody can be a general orthopedic surgeon, in other words, that they try and do a variety of things within every field. And that's -- that's something that is reasonable. It's very rare nowadays, though, for those people to do general orthopedics but also do high level, more complex procedures.

So if you -- if you were a generalist, it's not common for you to do complex spinal surgery, for example.

So really, most people that specialize do a fellowship, and you can do a sports fellowship, as I did a spine fellowship. You can do total joint replacement, hand -- all of those different subspecialties have fellowships.

And so I -- I'm a spine expert. I do general orthopedic-type assessments on patients. I can treat their shoulder. If I think that something is wrong with the shoulder, I will treat it. I will inject it. I will send it for therapy. I don't operate on it because that's just not my specialty.

But I -- so sports guys -- I would send it to a sports guy to operate on a shoulder injury or a reconstruction person to do a knee replacement on somebody if I felt it was necessary.

Q. And as you refer out extremities for surgeries, anything other than the spinal, do you accept referrals from sports orthopedic doctors if they're treating an extremity but

there is a spine issue that needs an assessment of whether or not surgical -- surgery is indicated?

A. Exactly. I mean, I've never heard a sports person doing a spine surgery. So the sports people would refer to me after they've done their workup, and they probably would have sent the patient to conservative management and whatnot. And if they believe the patient really has failed, they would send the patient to me; I would see the patient and then do the surgery.

Q. Could you please describe for the jury your current practice, if it has a name, locations, and where the locations are, and what you do?

A. Yes. Well, the formal name is New York or the -- NY Orthopedics; that's in New York. And in New Jersey, it's Gerling Institute NJ.

You have to have separate entities for the different states. That's just state rules.

I -- I have my main office in Manhattan, where I see the majority of my New York patients. I do have a satellite office in Queens as well that I go to occasionally, once a month.

In New Jersey, I have three offices that I go to mostly. One of them in Clifton, New Jersey.

I -- I see a large volume of patients in my practice. The majority of them are either traumatic or degenerative. I do have a name for traumatic injuries, having been, you know, in

the positions that I've been in and the type of training that I had, and the care that I give those patients.

So probably 80 percent of the patients that I see have had some type of injury to their neck or back of their spine, have some type of fall, or they hurt themselves at work or fell down the stairs; they slipped; they picked up something heavy and injured their back, something like that.

Q. Motor vehicle accidents as well?

A. Motor vehicle accidents, on-the-job injuries. You know, obviously with an amount of laborers and whatnot, people who -- sanitation workers who lift 12 tons of garbage every day, you can imagine how many people -- first responders and whatnot, they get injured every day, you know.

I think 60 people in New York get hit by a car every day. Pedestrians. So you can imagine in a city like this, how many people are constantly injuring their spines. And not all of them need surgery. Only a small percentage of them need surgery.

Q. Dr. Gerling, how many spine surgeries -- not an exact amount, an estimate, do you perform on a yearly basis or whatever basis you can tell us, the frequency?

A. It varies from year to year. I don't know the exact number. It's anywhere between 250 and 600.

Q. And you said the types of cases you treated. But specifically to this matter, does your office and did your

office, since at least 2021, accept work accident cases and all of the rules and procedures that are in that separate system of work accident cases? Do you accept the coverage for that?

A. Yes.

Q. Same as motor vehicles, correct?

A. Yes.

Q. And in your practice, if people either at a work accident or a motor vehicle accident have a lawsuit in connection with that and they're coming to court, do you -- have you testified in court in New York, New Jersey, in your career?

A. Yes. I would guess somewhere around 2012 or so, you know, once I've been in practice for a while. At some point I was asked to testify in a trial. I'm not sure exactly what year. But around 12 years ago, maybe. And so I was asked to testify. I -- I ended up being an expert in that case. And thereafter, I just started testifying whenever I was asked to. And I testify about six times a year.

Q. Okay. And is that mostly on behalf of your patients?

A. It's only on behalf of my patients really.

Q. I'll say you and any other doctor who comes before a jury, are you paid for your time away from practice? In other words, what would you be doing today if not asked to testify here on behalf of Gordon Sayles, your patient?

A. I canceled, I think, three or four surgeries to be here today.

Q. Okay. And what is the rate you're being paid to be here today?

A. I believe it's $8,000.

Q. And did -- you and I met two weeks ago with Mr. Kuller in your office, in New York City, correct?

A. Yes.

Q. And did we meet again this morning, prior to you testifying?

A. Yes.

Q. To discuss the issues, the evidence, things like that?

A. Yes.

Q. When we met two weeks ago, did we ask you to help assist us with getting demonstrative evidence to teach the jury the issues in this case, the injuries in this case, the conditions Mr. Sayles has?

A. I believe that was the purpose of the visit, yes.

Q. And I'd like you to assume that defense counsel, on opening, said that we were part of some corrupt team, you and I and Mr. Kuller, a corrupt team on a fake case. Okay?

A. Okay.

Q. And that we work hand in glove together. Okay?

A. Is that true?

Q. Well, I'd like you to assume that.

A. Did he say that?

Q. Let me ask you this. I assume -- I've been practicing

over 35 years. Prior to two weeks ago, did you and I ever meet, ever even meet each other or talk to each other?

A. No. I'm sorry. I never even heard of you. I'm sorry.

Q. Now I am hurt.

In 35 years, have you ever treated a patient of yours that was a client of mine, whether I was trying a case with someone, for someone? Has that ever occurred, as far as you know?

A. I don't think so.

Q. And have you -- had you ever met Mr. Kuller prior to us walking into your office, making an appointment, walking into your office after hours so that we can prepare for the testimony in this case?

A. No. That's the first time I ever saw him.

Q. And in terms of working with you, have either of us ever been in an operating room with you looking over your shoulder and saying "Oh, please operate on that part"?

A. No.

Q. And -- so your records are in evidence as Plaintiff's 2. They're over to your right. And certain diagnostic films are in there as well. You can refer to your records. They're in evidence. You can technically even read from it.

But can you please -- did we ask you to at length go over your notes so that it can go quicker -- the testimony?

We'd asked you to review your file?

A. Yes.

Q. Can you just tell the jury -- and you can if you need it, it's several hundred pages, when -- when did Gordon Sayles first become a patient of yours?

A. February 23, 2021.

Q. Regarding that note, there is a lot of notes, a lot of visits. In that note, the first note, and maybe even the last or one of the last, we're going to go over those in detail. We might go over some parts of other notes and put them up there. But can you please tell the jury -- we're going to start defining some words. We'll do a couple of them.

What does a history mean when you take a history from a patient? What does that mean medically?

A. I mean, I would just like to say also, because you asked me to stop and define things and make things clearer for people who are non-doctors, like when we talk about my notes and I'm referencing my notes, these are notes that I create for all of my patients in my practice. Everybody who's been to a doctor knows that they take notes and keep records of what is said. Right? That is normal. That is part of normal practice.

We do that so that we can -- we can keep track of things and remember, keep -- keep facts straight. Primarily so that we -- so that we can make sure that we understand the reason why we make certain diagnoses, the history of patient's

treatment, to keep us fresh, and just as a record. Okay?

It also helps us when we make recommendations to reflect on everything that we've known in the past. So it's very important for clinical care.

Q. Okay. So first, just -- we'll go through a couple of definitions. What does "history" mean? PMH, what does that mean?

A. So the past medical history. That's standard part of -- of the visit that you have with a doctor. It's basically where they ask you about your problem, why you're there, and then also to -- so it's your history. Right?

Past medical history usually includes all of the other problems, not just the problem you're in the office for. So let's just say that you have an injury but you have a blood pressure issue. We would -- that's part of your past medical history. It may not be part of your visit or -- like one of the more driving issues that brought you to me, but it is a part of your history. So that is what we put in the past medical history.

Q. And what does "EMR" mean in medicine or medical records?

A. The electronic medical record, that is EMR. Electronic medical record. That's simply the systems that we typically use now to keep track of all of our records. It's where we enter the notes of your visit. Where we try to store all of the data

on you as a record. It's like a file.

Q. On an EMR -- for instance, your notes are in evidence, every note is approximately or exactly 18 pages. Do you change the history? Do you keep asking the patient every time they come in, "What is your past medical history?" "What is your history?" Or with EMR, do notes travel to the next note?

A. Well, of course every time you come in, we do a fresh history on you to find out the update on what's happened and -- and, you know, if there are any new medical problems, new allergies, new surgeries you may have had, whatnot.

So all of that stuff is discovered. It's written down again. There are things that are translated from note to note just -- just because that's the way the system works.

So, for example, your name and your date of birth, all of these basic demographic issues would automatically be transferred.

When I -- when I look at my EMR system, there -- I could go in and look at like the mechanism of injury that we originally put in or the mechanism of your problem. Like -- so if you said that you hurt your back lifting a box at home on a certain day, it would be in the mechanism of injury. I could go in and change that. But I don't typically even look at that section. I just do the updates on -- and so -- so some of that stuff will transfer to the new notes.

Q. Okay. And what is mechanism of injury?

A. What is it?

Q. Yes.

A. So it's the -- the way you -- because I -- I -- I treat a lot of people who have -- it's not necessarily mechanism of injury. It could be mechanism of illness.

So you could have woken up with neck pain two weeks ago and have pain shooting into your arm from it. You could have, as I said, lifted a box. It's the way that you first felt the onset of your symptoms. Or the way it happened.

So if you tripped and fell and landed on your head, that would be a mechanism that you hurt yourself.

Q. And in medicine, objective and subjective? What does it mean regarding an examination of a patient? And what does it mean such as looking at diagnostic films? What is "objective" and what is "subjective"?

A. Subjective means it's something that you say, something that you experienced and you perceive and you tell me. So it's not something that I can directly observe. It's something that you are telling me that you have experienced. So you might say, "I've been having these symptoms."

The objective is something that I can actually measure and observe directly.

So it might be looking at an MRI film. It might be examining you and like -- doing certain physical examination tests on you. Those would be considered objective.

Q. And when you say "certain tests," when we get to the testing, you can tell us what you mean.

What about findings on an MRI that you're actually looking at and pointing at?

A. Those --

Q. There is no fracture here. A fracture on a bone, that is obvious. Is that objective? Subjective?

A. Right. So when we look at a diagnostic study, objective. It's something that we can measure, it's something that we can actually see. And -- and I can measure the outcome of it.

Q. And --

A. Or a radiologist would be looking at it, and they're making an objective assessment of that.

Q. Is there -- is -- can different radiologists have different findings? Are they subjective to the radiologists to some degree?

A. Well, I mean, just like any -- any field of medicine, the way somebody records their findings or the way they test for things will be different from practitioner to practitioner.

So if ten different spine surgeons saw Gordon in the office, they may have documented things very differently. There is an ER doctor that saw him. There is -- you know, there is a pain management -- whatever it is. Different people will document in their own style or whatever they think is relevant.

But a good quality practitioner knows what they're looking at, and they'll be consistent in whatever it is that they measure so that they can -- they can have a pattern of practice which then works.

So even though it's an art and everybody has their own way of -- of sort of expressing it in their notes, it -- it is -- it is something that is -- that works and it is the way that we perform our clinical duties.

Q. I promise we'll get to the note. But you are the first doctor.

Can you please tell the jury -- and I'll only talk about the types of testing that you'll be showing them or that you did on Mr. Gordon Sayles.

Could you tell the jury the difference between x-ray, MRI, and CT scan, otherwise known as CAT scan?

A. So an x-ray, which is also called a radiograph, it's where beams of radiation shoot through your body and are captured on a film. Okay? And the reason that you see the skeleton and you see the shapes of bone and whatnot is that the more dense the material is that the x-rays are passing through, the more likely they will -- those minerals or contents will stop the x-rays from getting through.

So x-rays are very useful for looking at hard surfaces like bone or implants, things like that. So they're used to typically to see the shape of the bones, to look for broken

parts of bones, to see the configuration, the deformity or, you know, the positioning of the bones and stability.

MRIs are performed with a magnet. So the magnet shoots through your body and then it is detected. And the way the magnet works is it actually excites the molecules and the molecules then emit energy which is detected. So it's really a fascinating technology.

The advantage of that is that it's very good at looking at soft tissue. So, for example, if you do an x-ray, you can't really see the nerves in the soft tissue. Like a muscle might be a little hazy, but it's not really very well seen.

But an MRI, when it shoots through you, the muscle is very different than, for example, a blood vessel, it's very different than a -- another like ligament structure, for example. That is why MRI are so practical for looking at soft tissue thing, discs, disc herniations. That is why they're more diagnostic for that, more better.

CT scans are similar to x-rays in the sense that they use radiation and they shoot beams through you. But they -- they're very similar to MRIs in the sense that they send a slice of radiation through you so that when you're looking at an x-ray -- I mean a CAT scan, it's actually slices just like an MRI, because it sends magnets through as a slice. You're looking at slices of the tissue, and CAT scans you're looking at slices that is done with radiation. So it is again looking at

bone and implants and things like that.

Q. You -- as a board-certified spine surgeon, do you order films, and when you get the films, do you interpret them yourself separate and apart from an outside radiologist interpreting? Are you qualified to do that, and do you do that?

A. A hundred percent, that is what I do all day long. You know, I think of the difference between a radiologist and a surgeon, that -- the radiologist looks at things all day long, and they make calls. We look at things all day long and then we make calls, and then we actually go and look at it and cross-reference it.

So there is like -- if you were window shopping and you were looking at things from the outside all of the time, you say, "So that looks like a nice shop, a nice shop." But I actually look into the window and then go into the shop. And I actually can put my hands on things.

So I actually have a hands-on view to correlate with what I look at on imaging. So that -- I think that uniquely qualifies you to interpret MRIs.

Q. And do you do that on a daily basis?

A. Yes.

Q. MRIs and interpret them?

A. Yes.

Q. You said that you've worked in -- I heard you say you've worked in emergency rooms; it was part of your trauma

center, as you said?

A. Yes.

Q. Trauma 1 on call.

In any of the trauma centers you worked at in your own practice or anywhere you ever worked, have you ever had on staff a non-doctor Ph.D. biomechanical expert to help you determine the mechanism of an injury? Has that been anywhere you ever worked? Hospital? Office?

A. No.

Q. Getting back to your office and the history, do you utilize everyday physicians assistants?

A. Yes.

Q. And does the physician assistant in your office see the patient first? Take their history? Write it down? And then you come in almost every visit? Is that how it goes?

A. A lot of the visits. I have a nurse practitioner too. I have medical assistants. I have a lot of different people helping me.

Q. And going to the first note, the mechanism of injury, does your note -- were you -- first, were you aware of an error in your notes as to the mechanism of injury going all the way back to the beginning?

A. Yes.

Q. And did you become aware of that recently? A while ago? When did you become aware of it?

A. I believe recently. I don't remember when I became aware of it.

Q. Okay. And did anyone ask you to change it, or was it just noted?

A. No.

Q. Did you have at your disposal, during the course of your treatment, all of the initial records from the hospital, the emergency room, Mr. Sayles's accident report, and all of the doctors he saw in the beginning where he gave the mechanism of injury and the number of falls -- number of floors involved?

A. I don't know when I first had access to it. But I have seen them, yes.

Q. Okay. And did you take the mechanism of injury, or was it -- the initial visit, was it a PA? Was it you?

A. A combination. You know, I don't know exactly. It's been a long time. But I -- the custom of my practice is to have some -- some initial information in the chart when I see the patient. So whether it's the PA or the nurse practitioner or medical assistant with me -- and my medical assistants are excellent. They've been with me for a long time.

They try to sort of populate the chart with general information about the patient so I don't go in there completely blind.

I do verify most of the issues with patients. You know, "Oh, you fell off a building?" you know, "You" -- "You got

hit by a car?" Whatever it is. And -- and, you know, I don't necessarily spend a lot of time because I just want to know the general mechanism. How it's clinically relevant, you know, whether the bus that hit them was blue or red or whatever it was, these details don't necessarily make a difference clinically for me.

What is relevant is the fact that they landed on their head, that they landed on their feet. It is -- it is -- there is some relevance to that.

The -- at the end of the day, I -- I think the mechanism of injury is important to take note of. But it's not -- it's really not heavily weighted when it comes to making clinical decisions on a patient.

Q. You talked about different types of mechanism of injury. What is an acceleration-deceleration injury or mechanism?

A. It means that you -- it means that your body is moving in a certain direction very quickly and then it comes to a stop. A sudden stop.

Q. What was the mechanism of injury noted on the first and continued through?

A. The -- the --

Q. You can read from it. It's in evidence.

A. Right. That Mr. Sayles was on an elevator that dropped several floors. I believe four floors.

Q. That is the -- what's in all of the other records? What is it in your notes on the first visit?

A. That he was inside an elevator at work when it fell from the 23rd to the 9th floor on May -- on May 11, 2018.

Q. Okay. And what were the injuries noted -- that's the first note that is in -- that is the first thing that is noted? What are the injuries noted?

A. That he had injuries to his neck and back. The neck pain radiated to the left shoulder. That his back pain radiated to the left lower extremity.

Q. And did you know, during the course of your treatment, in fact, other doctors were treating him, that he also was claiming injuries to his left shoulder, the extremity, and being treated for that?

A. Yes.

Q. What, if anything, did Mr. Sayles tell you about any prior medical history on the first visit?

A. That he had had a prior injury on the job, I believe.

Q. Can you just read it exactly instead of --

A. Okay.

Q. Just the first note. We're going to do this one in detail and maybe the last. But --

A. "Previous fall at work in 2015, with injury to his low back. He underwent physical therapy. And was back to 75 percent" -- "and was" -- "was back to 75 percent with

persistent mild back and left leg pain. And that the new accident made the pain significantly more severe."

Q. So he told you about the back pain on Day 1?

A. Yes.

Q. The previous back pain --

A. Yes.

Q. -- from the 2015 accident?

And did he tell you anything about any prior neck pain?

A. No.

Q. Any prior shoulder pain that was medically significant, meaning there was an injury that he treated, things like that?

A. No, I don't believe so.

Q. We did it in jury selection, but would you agree that every human being at one point has had neck pain, back pain, to some point in their life even if it was mild?

A. Yes.

Q. Okay. And you had -- at least on that first date, you hadn't done any testing, but you knew about some findings of the MRIs back in 2018, correct?

A. Yes.

Q. What is a -- when you say -- and we're only going to be speaking about neck and back, so spine.

What is a -- it could be cervical or lumbar strain and sprain? What does that mean when the doctor writes that?

A. Well, formally, if you stated something is sprained,

like a sprained ankle, it's when you injure the supporting structures of a joint, when you -- when you somehow injure soft tissue and -- and you have some experienced pain, maybe some instability, whatnot. That is a -- that would be a sprain.

A strain is typically a word formally used for a muscle-type pain. We usually use those terms to describe an injury before we have any concrete evidence of an underlying structure that is injured.

So, for example, if you -- if you broke a bone in your neck, and you had neck pain but we didn't have an x-ray, we didn't have any evidence yet to show that the bone was broken but you said that you had severe neck pain, the initial thing we would call it would be a sprain or a neck sprain. And then we would get the x-ray and say, "Oh, no, it's not a sprain. The patient has a fracture in the bone in their neck."

So it's a more non-specific term that we use before we have more concrete -- concrete evidence of what is underlying the problem -- the underlying problem.

Q. So I'm going to have you read what the main findings were. But can you please tell the jury what does this mean, "diagnosis prognosis" in medicine and spine medicine?

A. So a diagnosis is -- is exactly what we think you have. So let's just say that you came in and you had been blowing your nose, sneezing, and had a fever, the diagnosis might be that you have a cold. It's -- it's the medical -- it's -- it's as

precise as you can be in making a medical diag- -- a medical determination of what the person has. So that is the diagnosis.

So at first you would be very vague because you don't have data to support it. You might say it's a sprain. But once you get an MRI and you see oh, it's actually pain coming from a disc herniation, it's no longer -- it is technically -- you know, it's probably some spraining in there, but the -- the primary diagnosis becomes herniation.

Prognosis is -- is what the outlook is or what the expected outcome would be from the -- from the injury, sort of the diagnosis.

So, for example, if you had an amputation of your leg, the prognosis of the leg coming back is very poor. You know, so you don't expect it to come back because it's been amputated.

Q. In diagnostic findings or medicine -- but in diagnostic findings, what do these words mean: "Mild," "moderate," "severe"?

A. I think most people are familiar with those expressions in the medical world. They're very similar.

So when something is mild, it's less bothersome. It's not -- it's something that you might be able to live with. It's something that is -- it might not be as distressing.

A moderate -- a moderate issue is something that is distressing, that really impairs your ability to perform certain abilities. It is something that is -- you know, you may require

treatment for it in order to live with that.

Severe is something that really needs to be addressed, you know, in a much more tight timeframe. It would -- it would obviate more extreme interventions in order to try to get rid of it.

Q. Again, could you please tell the jury what "herniation," "bulge," or "protrusion" means? In general, because you're going to say the words and you can go in more detail later, but just in general.

A. Well, bulging is just like you would imagine it to be. It's when something pushes outward. So in the spine, a lot of times you'll hear a bulge. The discs are actually a soft jello core with an outer fibrous rim. Just like in a tennis shoe or whatnot that has like a little gel insole, and the insole has gel, and it has an outer framework around it. When you push pressure on it, it pushes outward. You would expect that. Just look a Nike Air shoe. You put pressure on it; you expect it to bulge outwards. It's a response to some type of force or a pressure on the structure.

So it is quite common for people to have bulging of their discs. And it is something that happens more and more the older you get. They slowly become more and more lax and start bulging out more and more.

So typically, when people use the term "bulge," they're referring to that phenomenon of the disc pushing outwards. It's

not necessarily attached to an injury. It could be a natural phenomenon.

When people say a "protrusion" or "herniation," they're usually referring to some asymmetry or some abnormal pushing outward.

So if you have an injury to a disc, and now you have a -- you've put enough force on it that it actually damages that outer fibrous ring around the gel, it will push outwards, just like if you blow up a balloon, you know how the balloon will sort of pop out, and certain parts of the balloon will stretch out sooner. As you blow it up, it blows up more and more evenly. That is what happens with a disc. When you put a lot of pressure on it, some part of it will give out, and it will push outwards. And as it pushes outwards, it's not symmetric. It is a more focused event. And we call that a protrusion or a herniation. So as it pushes outwards, we call it herniation.

Q. You said herniation or protrusion or bulge can be -- I think you used the word "degenerative." Can it also come from trauma?

A. Yes. The protrusions and herniations typically do come from trauma.

Q. Can you tell the jury what "symptomatic" and "asymptomatic" mean?

A. So if you have --

Q. In medicine.

A. Right. If you feel something, then it would be a symptom. If you don't feel something, it's not -- you don't have a symptom. So it's asymptomatic; it means that you're not having a symptom.

Q. Whether a herniation, bulge, or protrusion is caused by trauma or preexisting degenerative condition, does it always come with symptoms?

A. No.

Q. Can it be asymptomatic?

A. Yes.

Q. And can trauma cause asymptomatic conditions to become symptomatic?

A. Yes.

Q. Can you please tell the jury one more definition, "radiculopathy"; what does that mean?

A. So -- so in the -- in the spine, you have nerves that come out of the spinal cord. So if you want, I can use -- it might --

Q. We're going to do that in just a little bit. Can you state generally, and then we're going to go through the notes, go through some tests, and actually have you explain the anatomy of the tests and your opinions.

A. So you're going to see later that the -- that the neurologic system has different parts to it. You know, everybody knows you have a brain and you have a spinal cord.

And what comes out of the spinal cord is called nerve roots. And the Greek word for nerve -- for roots is rad -- radic, I think. And so we -- we adopt a lot of Greek expressions and Greek words in medicine.

So "opothy" is something that is -- that is considered sick, a sickness of something.

So if you say that something has sickness, you usually you would say "opothy" at the end of it. So radiculopathy is sickness of the nerve root.

So if you pinch a nerve root in the spine, it's common for you to have what is called radiculopathy, which means that the nerve is -- is irritated or sick, and it's not functioning normally.

Wherever that nerve goes -- let's just say that the nerve is used to feel sensation in your outer thigh and your shin. If that nerve is sick, it may not be able to do its job and feel that area. So it would create numbness in that area.

If the nerve is inflamed, it will create, typically, a pain or a different -- an abnormal sensation in that same area, that same distribution. So the nerve is supposed to connect your foot to your brain to tell you that you feel something there. If it's inflamed, it might tell you that there is pain there or that there is a weird sensation there. That's -- that would be abnormal nerve function. So it's called radiculopathy. It can be pain; it can be numbness.

If the nerve root is supposed to innervate a muscle, so it would typically be associated with firing a muscle which would then move your leg or your foot or your arm. That muscle may not be able to function as well because it doesn't have the signals from the brain to tell you to move that muscle. So that would translate to weakness.

So if you have radiculopathy, the nerve root is not working properly, you may have numbness; you may have weakness; and you may have pain or some weird sensations in the area where the nerve root normally is.

Q. So your initial working diagnosis or your main findings, can you read it, read the first two lines?

A. So during the initial visit, we said that the patient had a cervical strain but that we wanted to rule out a disc herniation. That means that -- that we highly suspected, based off the history and the physical examination, that the patient had something wrong with the nerve that was causing the symptoms that he was having. So I said, "cervical strain rule out herniation with left sided radiculopathy."

Q. What does left-sided radiculopathy tell you before even getting a test, as opposed to bilateral or right sided?

A. It just supports the notion that we -- we believe that the symptoms that he was complaining of were being caused by a nerve root being irritated or pinched or damaged on its left side on his left side.

Q. Okay. And did you subsequently come to learn that all of his main complaints, even from the ER on, were all left sided, left-sided shoulder, left-sided leg, left-sided radiating pain both down the arm and the leg, from the beginning?

A. Yes.

Q. Can you tell the jury the second finding initially suspected?

A. Lumbar disc herniation with left sided radiculopathy.

Q. And at that time you had the opportunity of an MRI report?

A. Yes.

Q. And do you subsequently attain MRI films when available from a patient and interpret them yourselves, and do you order new MRI films when you start seeing a patient?

A. We try to gather as much data as we can within reason. So sometimes things are old. We still like to look at them. If they're available, we look at them, just to see -- to have context and whatnot, and see what's there.

And if they're outdated, we will typically order updated imaging.

Q. You have a section for whether or not they've ever had surgery in their life.

Was surgery noted previous to Mr. Sayles coming in to your office on that date? I'm going right in order, first note, main findings, surgical history.

A. Mm-hmm. I'm sorry. You're asking whether the patient had surgery in the past?

Q. Yes. Any surgery. It says -- I'm looking at your first note --

A. Yes.

Q. -- main findings surgical history, it says cyst removed from his neck. A cyst?

A. Yes.

Q. Okay. Does -- does a cyst removed from your neck have anything to do with herniated disc issues, or is that a subcutaneous issue?

A. Yeah. Superficial.

Q. What does it mean?

A. It's nothing to do with the musculoskeletal system.

Q. Were any other surgeries noted other than a cyst being removed from his neck any time in the past?

A. No.

Q. Just go through -- you can read it, the history that you took yourself, history of present illness, initial patient visit?

Just so we're clear, I'm on your first note, Doctor.

A. Yeah, I -- I was in the other section. I'm back to it.

Q. Okay.

A. Yes.

Q. So --

A. So -- so he -- so I'm going to read exactly what I wrote. That "Gordon Sayles is a 57-year-old who presents today with neck and low back complaints with a pain in the back being the most severe."

Q. Just go -- just a little slower for the court reporter.

A. "The symptoms began as a result of an elevator accident May 11, 2018. They've been present for two and a half years and becoming progressively worse."

Q. Just stop there.

What does the word "progressively" mean in terms of disc issues? And why is that significant, if it is?

A. Well, just as -- as you have worsening symptoms, that's progressively worse, it means that -- that they -- that they are getting -- that the symptoms are advancing, that they are more severe over time. It is quite common for people to have a progression of their symptoms.

Q. Okay. Continue please, Doctor.

A. That they have -- "He is currently having difficulty working full time. At the time of the accident, he was working as a New York City buildings inspector in a position that required" -- "that did not require lifting. That he requires assistance with activities of daily living, including chores, lifting, and similar tasks for which he relies on his family. And the symptoms have impaired his ability to sleep normally."

Q. Okay. We're not going to go through each of the

findings. But when you go to -- did you do a physical exam?

A. Yes.

Q. And to both his neck and his back?

A. Yes.

Q. And going to those -- just taking everything in order, neck specific findings, what, if anything, was significant?

A. Well, that he had --

Q. If there is a word like "occipital," please define it, so I don't have to stop you.

A. I'm sorry. Where --

Q. Neck specific findings. It starts with "the patient's neck pain is."

A. I'm sorry. I thought you were talking physical exam.

Okay. So his -- he had neck pain that he rated 6 out of 10. So we always ask people to use a scale from 1 to 10, where 10 would be the most agonizing pain you could have and 0 being no pain.

Q. I'm going to do this to make maybe it go quicker.

MR. McCRORIE: If I can have Dylan -- it's in evidence -- I don't know the pages. Plaintiff's --

THE COURT: You have to click on the bottom one.

MR. KULLER: Thank you. I appreciate the help.

THE WITNESS: Can we take a break?

THE COURT: Now?

THE WITNESS: Yes.

THE COURT: We're going to take a five-minute break.

MR. McCRORIE: You can shut that off then.

THE COURT OFFICER: All rise.

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

(Whereupon, a recess is taken.)

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Please be seated.

Continued direct examination.

MR. McCRORIE: Great. I'm not going to go through everything in the notes.

BY MR. McCRORIE:

Q. So you stated the neck finding. Let's just do this. There is a pain rating that speaks for itself.

What are occipital headaches that the patient was complaining about regarding the neck pain? Occipital?

A. They're very typical symptoms that patients have when they have an injury to discs in the neck. So the back of your neck, the muscles react, and you feel pain shooting into the back of your head.

Q. The -- what is -- what does it indicate when you write "patient reports clumsiness of the hands," and right after that,

"worsening of balance including instances of tripping, stumbling," with regard to neck pain?

A. Well, when you have some type of pressure on the spinal cord, it's very common that people start feeling clumsiness in their hands. We call that myelopathy.

Earlier I was saying radiculopathy is sickness of the nerve root. Myelopathy is when you have sickness of the spinal cord.

So if you have a disc that is damaged in your neck, as in this case, and it's pressing on the spinal cord, it's quite common for people to start feeling like they're losing sensation or function of their fingers, that they start feeling clumsiness, dropping things, difficulty with coordination, zippers, buttons, things.

And the same thing is true with your feet. So your balance can be off. And as we saw with examining Mr. Sayles, he had poor balance. So it's really quite common for those people to start feeling as though they have difficulty balancing when they walk.

Q. You've treated Mr. Sayles consistently from February of 2021 through present, correct?

A. Yes.

Q. Have there been multiple instances in your notes -- we're not going to point them all out -- where he has tripped or fallen and reported it to you over the time period?

A. I think so.

Q. Okay. Well, it's in there. We'll point it out.

Just going to the back findings, I would like you to -- I would like you to assume there are 362 pages of your notes. I'd like you to assume yesterday Mr. Sayles was cross-examined by one of the defense attorneys, the attorney for Schindler, and he was cross-examined, and he said to Mr. Sayles, "You told Dr. Gerling you can't do anything," and I've searched through PDF, both the words "can't" and "anything," and they do not exist in your record.

But let's go to this record. It says here the patient cannot walk more than a block without pain. The patient cannot stand more than five minutes without pain.

Did he state that to you?

A. Yes.

Q. Did he ever state to you, ever, "I can't do anything"?

A. I don't recall him saying that.

Q. And I asked you to look over your notes. Did you find it in the 365 pages either the word "can't" or "anything"?

A. No.

Q. Or anything referencing like that "I can't move," "I can't do anything"?

A. No. I mean, I think that, you know, when people have severe pain, he -- he had 9 out of 10 pain. If anybody's ever had that, I mean, it can stop you in your tracks. You know, so

you'll have moments where you have agony; you'll have moments when you don't have agony. Certainly, we know that he could get dressed and groom himself and things like that, so he had moments where he could do that. But it will stop you from doing things.

Q. He was working, though, he told you, right?

A. Yeah. So it will stop you from doing things. And it will -- and certainly, you know, you could say I can't do anything like -- just, you know, feeling as though you're really --

Q. But he didn't --

A. -- stifled in your life.

Q. Doctor, but you said he could say it. Is there anywhere in your notes where he said, "I can't do anything" or does it state exactly what I just read to you?

A. It does -- it does not state anywhere in the notes that he cannot do anything.

Q. So prior neck and back history, what does it state right there? The patient was what? You've already defined the word.

A. Sorry. Prior -- where are you?

Q. Prior neck and back history, it says the patient was asymptomatic in the neck prior to the accident?

A. Correct. And it says that the patient had a history of back symptoms prior to the accident, a fall at work in 2015,

treatment prior to this accident included physical therapy.

Q. Okay. So we don't have to go through it. You've told them what diagnosis is.

When you state "assessment" or "plan" in your notes, that mean what you are thinking it is and what the plan is, correct?

A. Yes.

Q. On page 5, please?

THE COURT: Can I just ask one question?

MR. McCRORIE: Yes.

THE COURT: There are portions of the notes where instead of like the regular type, it's italicized and in a different -- in a different font or color. What is the significance of that? Like here, under "physical exam," it says in regular type "no, patient is alert and oriented," but then underneath, it has other information in italics.

THE WITNESS: So in this, it looks like they're -- some of the notes almost hazier, almost muted, and other parts where it looks like it's bold. This -- where it's bold is just -- they're like the normal findings that you would have, and when there is something that is abnormal, if it was color, you would see it would actually be in red.

THE COURT: That would be red if it was the original?

THE WITNESS: It would normally be red. But because it's printed in black and white, it looks like it's just muted. If something is abnormal, it would typically jump out at you in a different color.

THE COURT: Understood.

So where it is in italics, it is abnormal?

THE WITNESS: Yes.

THE COURT: Okay. Thank you.

Sorry to interrupt. Please continue.

MR. McCRORIE: No, no, of course, Your Honor.

BY MR. McCRORIE:

Q. I note very briefly, you talked about the -- did you define the cervical, lumbar, and thoracal or thoracic -- did you do that yet? Do that at the anatomy.

Let's do this. What is a "straight leg raise test," and what does "positive" mean, as opposed to "negative" in medicine and in testing, it could be different than in regular English?

A. So. When we perform physical examination, there are a lot of different things that we do in order to try and make a diagnosis to gather data about the person's problem. You know, just like if somebody thought that you had an infection, they might take a sample of the tissue and culture it. Right? We do different things to try and gather information on physical examination. For example, we'll ask you to move your neck.

We'll feel your neck to see if there is spasm and tenderness, which he had. In the lower back same thing.

We also examine the neurologic system. And one of the things that is found to be highly correlated with radiculopathy is called a "straight leg raise," where you actually tension the nerve by pulling the leg up in a straight position.

It's a physical exam test. It's been done long before the invention of the MRI. It's thought to be associated with disc herniations, compressing a nerve root, or some type of stenosis on an irritated nerve root. And so even before the advent of an MRI, people would have surgery based off of a test like that.

Q. Okay. And so when it states a straight leg test is positive or a Romberg test is positive, "positive" means what? It means bad?

A. It means that it's abnormal. It means that it's -- it has the finding that you would expect in somebody who had a pinched nerve. So he had a straight leg raise that really supported the diagnosis that, yes, the symptom in his leg was being caused by radiculopathy.

Q. And you've -- we talked about this in preparation. What is a "Romberg test"? You told me what it was. What significance, if any, does it have? And what was the result?

A. Well, Romberg is a test that we do -- some of these tests just have a person's name who invented the test. So it

doesn't have a like a logical name to it.

But Romberg is where we test the balance of a person by having them stand with their feet together and look up with their eyes closed. And -- and in this case, it was positive, meaning that he had poor balance, that it showed that he was not able to sustain it.

Q. And only because -- I know I said -- we're just going to go back one page to the bottom, cervical spine exam. You told the jury he had spasm. You noted when the person has spasm, right? It says it right there?

A. Yes.

Q. "Cervical spine has limited range of motion due to tenderness to palpation and spasm," correct?

A. Yes.

Q. Do you palpate the spasm? And what does that mean? Can you feel it?

A. Yes, it's something that you actually feel. Everybody has experienced a spasm somewhere. It's -- for example, your calf might have a spasm, and you feel it, and the muscle is tight and it hurts. It's involuntary. You don't control that. It's something that you definitely don't want to have.

It's very common when people have an injury in the spine, that the spine protects itself by spasming, so. It tightens up the structures around it to try to keep it stable.

Q. When you say you can't control it, you can't fake a

spasm, correct?

A. No.

Q. So you, the doctor, feel it. So does that make it objective or subjective?

A. Objective.

Q. And what does spasm indicate to someone when you're -- when they've been complaining? What does it indicate to you, as a spine surgeon, when they've been complaining of two and a half years of radiating neck pain down their left arm and they haven't yet had the MRI test? What does that indicate to you?

A. It supports the notion that there is an injury to that area. And that that area could be correlated with the symptoms he's having.

So in this case, he had symptoms that are really pathognomonic or very characteristic of somebody who has a radiculopathy. And the fact that he had these findings in his neck supports the fact that he has a disc injury or some type of injury in the neck that is causing the -- the nerve to be pinched or irritated.

Q. And you noted the same in the thoracic and lumbar, in the low back?

A. Yeah. So, for example, it could be a disc herniation. It could be a broken bone that's pressing on the nerve. It could a lot of different things that are in there, and you would

have a spasm, and you would have tenderness.

Q. Okay. Let's go to page 5, quickly.

MR. McCRORIE: Sorry, Dylan.

BY MR. McCRORIE:

Q. You ordered tests after the first visit on Mr. Sayles, correct?

A. Yes.

Q. Just tell the jury the names of the tests, the body part, and then we'll move on to something else.

A. So we -- we ordered a new MRI of the cervical spine in order to determine the source of the radiculopathy and the pain in the neck.

And a new lumbar MRI to determine the source of the radiculopathy. And because there had been a prior MRI that showed a herniation, we wanted to see an update on the status of the spine.

Q. Very briefly, what is the purpose of a board-certified spinal surgeon or any surgeon doing what is called serial MRIs, taking MRIs every few years when there has been a trauma? What is the purpose of that?

A. Well, it's a way of following the progress of some type of issue. So just like you'd go back and check in, well, you're checking in by looking and seeing what's in there to see if anything got worse or if there is progression.

Q. Is there any other way to see what is going on, whether

or not a disc has progressed or it's broken down?

A. It's the -- it's the main, primary weigh that we use.

MR. McCRORIE: Page 6, please.

BY MR. McCRORIE:

Q. Still on -- okay. I want to ask you, you have a section called -- it's --

MR. McCRORIE: On the top, please.

Q. You have a section called "causation." This is not the part -- we're only going to do it on this one. We're not going to ask you your opinions yet. This is just from your note.

What did you, on the first visit, state the causation of the neck pain was and the neck injury?

A. It says, "As the patient was asymptomatic in the cervical spine prior to their injury, it is my professional opinion, within a reasonable degree of medical certainty, that the injuries above, recommended treatments above, and resultant disability are directly causally related to the above-stated accident."

Q. And would that causation change if it was an understanding elevators don't hit the bottom -- would that change if it went from 23 floors to 9 or 10 down to 4 and abruptly stopped? Would that change your opinion?

A. No.

Q. And what is "spondylolisthesis," spelled -- if the court reporter needs -- it's up there?

A. It's when the bone is shift.
Q. And where did he have spondylolisthesis?
A. In the neck.
Q. Regarding the causation of the lumbar injury and symptoms, if you go to the bottom, from the very first visit, understanding he told you about prior back problems, prior back injury, and prior back pain, what did you say the causation was from the beginning of your treatment through today to his lower back?
A. That -- that it was a severe exacerbation of a preexisting condition.
Q. What does "exacerbation" means?
A. It means it gets worse. So you had a problem in your shoulder and you were living with it and it's fine and, all of a sudden, you have a fall, and you have a severe, dramatic worsening where you now have a rotator cuff tear, that would be an exacerbation.
Q. Would that indicate to you that he both had an exacerbation of old injuries plus new injuries from the condition, the trauma, the accident?
A. Yes.
Q. And you didn't make an opinion about the shoulder; another doctor was treating him for the shoulder, correct?
A. Yes.
Q. Or was going to.

If you just go to the first note on the 6/15, it's the very next note. Four months later. Your notes are in evidence. We can see each note is around 18 pages. How many times you've seen him, but it's a few times a year, correct, that you see him?

A. I believe so.

Q. You don't see him monthly?

A. No.

Q. And maybe around times of surgery, you see him more often. But otherwise it's four, six months, things like that?

A. It's pretty common.

Q. Okay. So you had ordered an MRI, true?

A. Yes.

Q. And you had -- did you interpret the MRI yourself to the neck?

A. Yes.

Q. Did you interpret the MRI yourself to the back?

A. Yes.

Q. So -- okay.

When you ordered the MRI, your notes are in evidence, and you're the only one who knows -- I would like you to assume that there is a facility called Lenox Hill Radiology. A pretty well-known facility throughout the city, right? A lot of people send their patients there?

A. It's probably the largest in the nation.

Q. Okay. And you don't -- so you ordered these MRIs from Lenox Hill Radiology, true?

A. I ordered the MRI. I didn't dictate that the patient go to Lenox Hill Radiology.

Q. Okay. There is -- yesterday, the -- Mr. Sayles was cross-examined as to whether or not you, Dr. Gerling -- your name is on the report ordering the March 2021 lumbar MRI, whether you wanted that compared -- the attorney said -- to another MRI. But the report says radiograph.

Tell the jury again if there was a radiograph taken in 2014 of Mr. Sayles's lumbar spine?

What is a "radiograph"?

A. It's an x-ray.

Q. Okay. So that is what the report says. So did you even know whether or not he had an x-ray to his back in 2014? You knew about the 2015 accident, right?

A. Yes.

Q. If -- if Lenox Hill says that they're comparing it -- there is no comparison on the report, but they say they're going to compare it to a 2014 radiograph. Was that significant to you that there was a radiograph in 2014 to his back, knowing that he already told you about the other stuff?

A. It's -- just it's normal. If somebody has back pain, if they have back pain, it's not unusual for them to, at some point, get an x-ray.

Q. But you didn't order a comparison to it? Would any -- would a spine -- would you ever order a comparison of an MRI to an x-ray?

A. We don't order any comparisons from -- from radiology facilities. We will order new studies. And if they have in their record a prior similar study, they may put in there that they do a comparison. They may look at the two and compare them to say whether or not they think things have changed.

It's unusual though to have an MRI report say that they used an x-ray for comparison. I haven't seen that before. So I'm not sure why they did that. But it's -- it's really not relevant to me.

Q. Okay. Can you tell the jury, when treating spine and if there is multi trauma, if someone has injuries to extremities, the shoulder and the neck, what is the differential diagnosis and what does that -- those terms mean when dealing with someone who is complaining of shoulder pain or neck pain after a jolting injury?

A. I'm sorry. Sorry.

Q. If you could turn the ringer off.

A. You know, it was off. I think though it's break-through when my daughter calls me.

Q. I had to also shut mine off. It happened yesterday.

So -- so -- I'm sorry. The question was differential diagnosis, someone claims a jolting injury --

A. Right.

Q. -- acceleration, deceleration. They previously had right shoulder pain and neck pain; they complain of just shoulder pain.

(Whereupon, the court reporter seeks a clarification.)

Q. Just what is the differential -- what do you do as a spine surgeon or an emergency room doctor when someone is complaining of shoulder or neck?

A. Well, it's extremely common. People complain of extremity symptoms that are from an injury to the extremity, or it could be from neurologic symptoms, the radiculopathy causing symptoms in the extremity. So somebody has a herniated disc and they may present with just leg pain first, you know, or arm pain first.

So it's really standard and normal when somebody has shoulder pain to think, okay, is this coming from a nerve pain, or is it coming from an underlying structure in the shoulder that's been injured?

Sometimes it's both. I mean, if somebody has a substantial injury, it's not uncommon to have injuries to both structures.

Q. And before we have you talk about MRIs, anatomy, whether it's the spine, the knee, the back, the shoulder, what does the word "degeneration" mean as it relates to bones,

ligaments, and every body part?

A. Degeneration is the natural aging process of any structure in the body. Right? So, you know, as your body ages, parts of the structures will -- will age and they will have some type of wear and tear.

Joints in the musculoskeletal system very classically will wear down just like any mechanical things, just like a car or whatnot, an appliance. As things have daily wear and tear, they start accumulating aging, which will translate to some type of breakdown of the structure.

So in discs, they will start having some height loss. They'll start losing fluid content. They may start pushing outwards or bulging. They may have spurs or whatnot.

Q. Is that desiccation, when the water or the water content loses its height in a disc?

A. Yes. So that is part of the normal aging process. But of course the normal aging process is relative to daily wear and tear. If you have a more substantial wear and tear, i.e., an injury, it's really quite common for that site to age at a much more accelerated pace of course.

Q. Does degeneration equal pain and symptoms?

A. Not necessarily.

Q. And can trauma make previous degeneration symptomatic? If it was asymptomatic, can it make it symptomatic?

A. Yes.

Q. Depending on the person's age, depending on their particular degeneration in one body part or the other, can the level of degeneration make someone more susceptible to receive an injury than other people?

A. Yes.

Q. And does every human being walking the earth over the age of -- in their 20s, 30s have degeneration in their body?

A. Yes.

Q. In their discs?

A. It's normal.

Q. In their spine?

A. Yes.

MR. McCRORIE: If we can -- with the Court's permission, I'm just going to hand the doctor the model, and we'll put up 1. It's just for ID. It's not evidence, Your Honor. It's the anatomy of the spine on consent.

Can I hand this to the doctor?

Thank you, Officer.

(Handing.)

(Whereupon Exhibit 1 was published to the jury.)

THE COURT: And the Court notes that the diagram is being displayed as well.

BY MR. McCRORIE:

Q. These are both for demonstrative purposes, we discussed that we're going to be using them.

I'd like you slowly, succinctly, to tell the jury the anatomy of the spine, the bones, the nerves -- you said you wanted to do it before. I would like you to talk to them about -- because they're going to be seeing MRI and x-ray films that kind of look like the diagram up there. And tell them what sagittal, axial, nerve root, disc, you can use -- and whatever you're doing, tell the record what you're doing, but explain to the jury, please.

A. Okay. Well, it's a lot. Right? You can see it's relatively complex.

But the reason that it's confusing is that normally when you see a skeleton, there is a ribcage, and there is a brain, a head. Right? And there is legs. In this case it's the pelvis with the tailbone. And then the entire spine from the base of the skull all the way down to the pelvis. Okay?

The spine has bones in it that are separated by joints. And obviously the reason for that is to give us flexibility. If it was all one bone, then you would have -- you would be stiff. If you didn't have bone, you would be limp, and you wouldn't be able to support yourself and stay upright. So this is the body's compromise.

And the joints between the bones are typically a disc in the front, and then in the back are two joints called the facet joints.

So if you look at the diagram, the model up here, it's

on the screen, the cartoon on the right side, you can see actually a cross section where it's actually sliced through the spine at different levels.

The term cervical is there. Cervical is a very common term. It's used for the part of the spine that is above the ribcage. Okay? So we call that the cervical spine.

The part of the spine where the ribcage is coming off the spine has a different structure to it because of the ribs. So we call that the thoracic spine. So that is what you would consider your upper back.

And then below the ribcage, those discs do not have the structure of the ribs on them. They do not have the support and the stability that the ribcage gives them. So those are called the lumbar spine. Okay? So you've heard those terms before.

In the diagram up above, you can see an example of a cervical spine level, and the one below on the right is a lumbar spine level.

So if you slice through it in cross section, in the cervical spine, you can see the disc in the front. And if I touch it -- I don't know if I can use a cursor, no? No. But --

Q. Describe it because we don't have you --

A. Right.

In the front you can see the sort of pink ring structure that has jello -- it has jello in the middle of it

that looks gray. Okay. That's the disc.

And it's normally sort of a jelly bean-type shape, allowing for a space immediately behind it which is called the spinal canal.

And that spinal canal behind it has a yellow structure in it. That yellow structure is the spinal cord. And the -- the spinal cord normally has space around it in order to allow it to have cushioning and for when you move, for the spinal cord not to get damaged.

Q. If I could just ask you, this just for -- the spinal cord, the solid spinal cord is connected to the brain, yes?

A. Yes.

Q. And it goes from the brain down through the bottom of the spinal -- the spinal --

A. Correct.

Q. Okay. If you could tell the jury, just because we see a lumbar vertebrae, a cervical vertebrae, can you tell them what the "cauda equina" is and whether or not the spinal cord remains a full spinal cord down the whole spinal cord, or does it do something else?

A. So once it gets down further -- this diagram does not show it very well. If you look on the left side, there is a skull, and then can you see the yellow spinal cord coming out of the skull. This is a side view of the entire spine. So if you took a saw and cut through the spine here, like this

(indicating), and you were looking at it from the side, you're seeing the bones that have been cut in half, and you're seeing a transsection through the middle of the disc, right? So you're -- that pink structure, that is the disc is being cut in half.

And so you're looking at -- you can see the spinal cord coming down. And as it goes down, you can see that the bones -- each one has a number and a letter on it.

So when they have the letter "C" in the front, that's because they're part of the cervical spine.

And to help us identify the individual spots where there could be a problem, and in order for us to all be on the same page, when we're describing something, we want to individually name each bone. So the way we do that is by numbering them.

So from the top, the very top bone in the cervical spine is the C1 bone. And as you go down, you go -- it goes all the way down to C7, which is the bottom bone in the cervical spine.

Then it switches to thoracic spine. And you can see it in the beginning of the name for the bone. So the T1 would be the first bone at the top of the thoracic spine. Okay.

And as we go down the thoracic spine, they're numbered all the way through T12 because there are 12 ribs and 12 bones.

And then we enter the lumbar spine. So the L1, L2. L1

is the first lumbar bone and it progresses down to L5. Okay?

And the spinal cord, as it passes through that area, it actually ends. So when you're very young, the spinal cord goes all the way down to your tailbone. As you grow into adulthood and your spine grows, the spine cord actually -- it -- it -- it doesn't grow in the same way. So because it doesn't continue growing, it doesn't keep up with where the bones go.

So it actually ends around L1, L2 in the adult. So in the adult, your spinal cord doesn't actually go all the way down to your tailbone. It stops around L1 and 2. And then thereafter, it is just nerve roots that are coming out of it.

So up higher than -- like where the spinal cord is, the spinal cord has nerve roots coming out of it. So if you look at the cervical vertebrae in the top right diagram where you can see the pink disc that is a ring, you see the spinal cord down below. You can see a nerve root that is gray coming out to the sides on either side.

If you want to use the cursor to show that.

So that is the nerve root that he's outlining right there.

In the lower spine, when you get past the spinal cord, those nerve roots are still coming out of the spinal cord, and it's called the cauda equina, and it comes down and passes out the holes in the lumbar spine.

Q. Latin for "the horses tail." And it looks like a

horses tail rather than a full spinal cord on the MRI, true?

A. Yes.

Q. Okay. So the spinal cord is solid up at the top, connected to the brain, and there -- lower it's like a wispy horse's tail. Is that the reason that you can give a woman during child birth an epidural without fluoroscopy, they're not going to sever the spinal cord, right? There is no cord. But up top, if you're going to do epidurals, you need fluoroscopy x-ray to make sure you don't pierce the spinal cord. True?

A. Yes. And if you look at the diagram on the bottom right, where you see the lumbar vertebrae, so you can see that it's considerably bigger. It's a big pink ring with a jello nucleus in the middle of it. And behind it is a cut through the spinal canal. And you can see that there really is no spinal cord there. It's the nerve roots now. It looks like spaghetti. It's passing through, and it cuts in transsections, so you're seeing the spaghetti passing through the lumbar spine. And then it exits out those holes called the "foramen."

Q. If that disc that you're looking at on either the right side or cervical herniates out past the pink and presses on either the left or the right exiting nerve root, is that what causes radiculopathy?

A. Yes.

Q. And if the cervical vertebra is -- if the herniation leaks out and it actually compresses the spinal cord, is that

what causes myelopathy?

A. Yes.

Q. Can someone have both myelopathy and radiculopathy pressing the cord in one or both of the exiting nerve roots from a herniated disc?

A. Yes.

Q. Is that what Mr. Sayles had?

A. Yes.

Q. And can a disc herniate to the left, right, or behind, be herniated but not touching anything and therefore no symptoms?

A. It can.

Q. So because we're going to move to MRIs soon and this is what MRIs look like, correct? Sagittal view. We have the side where you can see the discs and the bone, true?

A. Sagittal view is the view on the left side where you can see looking from the side.

Q. And the axial view is if you --

A. Yes.

Q. -- took a slice of each level -- I don't know how it does that, but it takes one level and moves down, takes the next level and keeps going down --

A. Correct.

Q. -- as if you're looking down someone's head?

A. Correct. There are slices on the right side that is

somewhat what the MRI looks like in the axial.

Q. To save time we're going to show the jury some limited views but the views that show your findings, correct?

A. Yes.

Q. How many views on a typical MRI are there? Cervical-lumbar? How many pictures are taken?

A. It depends on the area that's being imaged. They can -- they can create anything that they want. In general, there is normally four different series that are done. Two of the sagittals and two of the axial series. And within each one, there is somewhere between 10 and 15, normally, slices through the spine.

Q. With hundreds of images, correct?

A. Yes.

Q. And the MRI, for those having been in one, it's a circular -- it's taking a picture in a 3D fashion and going around, correct?

A. Yes.

Q. Such as if -- if my elbow was a herniation, and we're behind here, on some views you're going to see it, because it's taking a picture then moving, taking a picture, then moving, but on some views -- like an eclipse -- you won't see it, correct? You won't see it the same? It appears different as you get to different -- they call it "slices," true?

A. Right. So as you slice through a structure, you

sometimes get the slice right through an abnormality, but sometimes you'll be on one side of it, and you won't see it. You'll be on the other side of it, and you won't see it. It's only when you go through it that you'll see it.

So the slices are not continuous, they're discrete slices, just like if you can imagine a cake that has a little baby in it, like the Mardi-gras indication that have the little baby in it. If you slice the cake, and somebody is going to get the baby -- I don't know if somebody has ever seen that. But you don't necessarily see the baby when you're doing the slices. Sometimes you have to eat the cake to find the baby inside of the slice, if that makes sense.

Q. I'm going to -- is there anything else -- we can always come back to it.

Is there anything else to tell the jury about the anatomy of the spine? Did you tell them -- I think you told them the bones.

What are the discs referred to when you say C4-5, C6-7, L4-5; why is the determination of two, letter and number?

A. So I was saying before that in order for us to be able to have a discussion and make diagnosis about individual sites within the spine, we have to name each structure. Right? And so naming the bones, we name them by the numbers in order, all the way from C1 to C7.

The disc between a bone or the joint between bones will

be named according to the bones it's in between. So if it's the disc between the C2 and the C3 disc -- C2 and C3 bone, we call it the C2-3 disc. If it's the disc between the C4 and C5 bones, we call it the C4-5 disc.

Q. So is there anything else -- you can put the model down and keep it next to you if you need it.

MR. McCRORIE: I'm going to move to a different -- for the anatomy and the conditions, if you could put up 4 -- it's for identification only -- cervical radiculopathy.

Thank you. I can hang it on there.

Thank you, officer.

(Handing.)

BY MR. McCRORIE:

Q. Okay. As succinctly as you can, we now see this is an illustration of radiculopathy. You can tell them what they're seeing on the right and why the person's arm is colored from all the way up at the neck all the way down to the hand.

A. So this is a -- an illustration of a radiculopathy caused by a disc herniation. On the right side is a view from the transsection or the cross section of the area where the disc is damaged.

You can see that normal round structure of the disc but then there is a rupture through it where some of the gel material is pushing backwards. And it's pressing on that nerve

root. That's why it says -- it's sort of red. This because it's showing inflammation of the nerve root. That nerve root, in this particular example, goes down the arm, okay. This is very typical.

So if you look at the structure on the left side, it's showing the distribution where the patient might have the pain, the numbness, the weakness.

So they feel those symptoms and experience those symptoms in the arm even though the disc is causing the symptom in the neck.

Q. Is it common for the radiating symptoms to not occur immediately for 24 hours, weeks later, days later?

A. Yes.

Q. And once a disc is either asymptomatic and aggravated or if torn traumatically, does the fluid come out like a water balloon, or can it come out over time, days, months, years, and it can come out in differing degrees?

A. Well, there are a couple of different factors here. One is the amount of pressure that is exerted on the structure. So when that disc is coming out and pressing on the nerve, it causes pressure.

And so if the -- if some of the disc comes out and it presses on the nerve, it may stop the nerve from transmitting some of the information through it, like some of the fibers may not be able to function.

If it presses harder and harder over time, which it often can, you'll have more and more progression of symptoms, just like he had a progression of his symptoms.

And the other thing is that not only is there pressure, but there is also inflammation. We talked about that earlier. So the actual gel inside of the disc is very irritating. And it irritates the nerve. So it can actually burn it.

So even if it's not pressing on the nerve, even being beside the nerve over a course of time, the irritation from the enzymes inside of the disc can start inflaming the nerve root and causing radiculopathy.

And, obviously, as you have inflammation, you're going to have swelling. The more swelling you have, the tighter the area will get, and the harder it is for the signals to get through the nerve, and the more likely you'll have a radiculopathy.

So a lot of different things are coming into play. You will have the direct pressure. You have the inflammation, which is causing chemical irritation and causing difficulty for signals to get through and causing symptoms. And then you have the inflammation causing swelling which, in and of itself, can cause secondary pressure on the disc, that can be delayed as well. And over time gets worse and worse and worse.

Q. I'm just going to show you another illustration. It's demonstrative only. You discussed the differential diagnosis.

You said the shoulder and neck are common.

THE COURT: It's Number 3. And we're just going to go -- that is Number 3. But just move to Number 2 for a second and come back.

(Whereupon Exhibit 2 was published to the jury.)

Q. And you used the word "dermatome" before. So you have this illustration, if you wanted to go back, discussing dermatome. But we're going to go back to the cervical radiculopathy versus the neck. Tell me what dermatome means?

A. Right. So this -- this cartoon gives you a description of where the patient will feel radiculopathy based off of which nerve is being pinched. So it's not exactly identical in every patient. There is variation between patients. But this is very, very typical.

So if you have a C5-6 disc herniation pressing on a nerve, you will feel the symptoms in the shoulder and trapezial area, where that blue area is to the left. That is common. There is variation. There definitely is difference between different people. But this is very typical.

And these maps of where the nerves are distributed are called dermatomes. Okay. So the derm is your skin, right? Your dermis. And "ome" is saying it's the region of the skin where it's affected.

So -- so in this case, the shoulder, you can see is affected by the C5-6 disc herniations and also C4-5 disc

herniations. So they would cause a neck pain and then it radiates into that area.

Q. And are those levels -- was Mr. Sayles affected by those levels?

A. Yes.

MR. McCRORIE: Okay. Just go to the radiculopathy for the neck please, Dylan.

It's the next one.

BY MR. McCRORIE:

Q. So this is -- you described it before. But if someone has a 5-6 up there -- I think that is the one it is -- the nerve root, they will feel -- they can feel pain where?

A. In the shoulder area.

Q. And if they also have a shoulder issue, would they feel pain in both? And would it go, you know -- could it feel -- in the beginning stages, first the neck, then the shoulder, and then back to the neck, and then both?

A. Yeah. I mean, there are different presentations. Everybody kind of has a different mechanism of injury. So depending upon what structures are pressed on or damaged, you can have more symptoms from that area first. It's very, very common for people to have a shoulder injury and a radiculopathy coming from the neck. It's very common for people to feel shoulder pain first that's coming from a radiculopathy from the neck. So these are all different scenarios.

Q. And if radiculopathy starts in the neck and goes down to the hands, does that tell you it's coming from the neck or the shoulder, those -- that specific symptom?

A. Well, there are a lot of symptoms that are more characteristic of a disc herniation in radiculopathy than of a joint injury. So, for example, when you injure your shoulder, you don't typically have numbness. Okay. That is typically something that is a neurologic finding.

If you have pain going past the elbow, that is not typically coming from the shoulder.

Now, there are differences; different people have different things. But more commonly, when you have an internal shoulder problem, it will be on the outside of your shoulder area going down your arm, toward the elbow but not past the elbow.

Q. We're just going to show you a very simple one we've talked about with you.

Lumbar radiculopathy. What does the word "sciatica" mean? And is it synonymous with radiculopathy?

A. So sciatica is a non- -- typically, a more laymen's term, a non-medical term. It's a general catchphrase for neurologic symptoms and usually neurologic pain. It is typically associated with a radiculopathy that goes into the legs.

And when you have a radiculopathy going into the legs,

just like the shoulder dermatomes we saw before, the legs have the same thing. They have dermatomes as well.

And the most common areas that are affected are usually the outer thigh, going down to the anterior, the shin, and the top of the foot, just like what Mr. Sayles had.

And so this illustration on the right side shows the distribution somebody might have of pain from a sciatica going down the buttocks, the back of the leg, to the calf, to the foot. That is a more common S1 dermatome symptom.

The reason it's red is because that is sort of where the person might feel numbness or pain.

Q. And it would start at the top and go to the bottom, it doesn't skip. It's like electricity, right?

A. There is a -- there is a variation from person to person. It's not a hundred percent with every person.

Q. From the very first visit through today, did you know that Mr. Sayles suffered from diabetes well before he saw you?

A. Yes.

Q. Did you know that he suffered from diabetic neuropathy?

A. I know he had been diagnosed with that in the past.

Q. And can you tell the jury the difference -- the -- he described the diabetic neuropathy is down in the foot, like a fuzzy feeling coming up, and it's like the foot is asleep, and the radicular pain is like electric pain going down his leg?

A. Correct. They are different.

Q. Can you tell the jury what the difference is, and what about his complaints made you call it lumbar radiculopathy?

A. Well, I mean, there are a variety of things. First of all, the complaints themselves are more characteristic of radiculopathy. And then also the physical exam findings are more characteristic of a radiculopathy. And, you know, diabetic neuropathy typically is bilateral. Okay. It --

Q. And in this case, that is the case. He told you he had bilateral it's in the -- a lot of the records, bilateral diabetic neuropathy?

A. Right. But he did not have symptoms in his left side. It was -- his symptoms were more characteristic of a unilateral radiculopathy.

Q. Understood.

A. Right.

And so if it was diabetic neuropathy, that would -- this would be an unusual presentation for a neuropathy.

Q. In fact, the diabetic neuropathy was in his feet, not his arms, not his hands. It had nothing to do with his cervical or arms, correct?

A. Correct. And diabetic neuropathy does not normally present this way.

Q. Just before we have you do the interpretation of the films and a little later on the opinions, you have reviewed all of the records in this case that at least that we gave you or

that the client has given you over the course of time, correct?

A. I believe so --

MR. SCHIFERL: Objection, Your Honor. None disclosed about review of other records.

THE COURT: Sorry? I'm sorry?

MR. SCHIFERL: None disclosed with regard to review of other records that were not his.

BY MR. McCRORIE:

Q. You're a treating physician --

THE COURT: I don't understand the objection. Are you objecting to the question?

MR. SCHIFERL: Correct.

THE COURT: Are you rephrasing your question?

MR. McCRORIE: Yes.

THE COURT: Okay.

MR. McCRORIE: Yes, Your Honor.

BY MR. McCRORIE:

Q. Did you review the records of the initial emergency room? I said it before; you said yes. The accident report, just what he complained of, what he first felt, Dr. Mian, Dr. Demesmin, that's it, maybe other things but just those for the purpose of the question.

Did you look at those --

A. Yes.

Q. -- University Pain --

A. Yes.

Q. And were you aware, as indicated on his accident report before he went to the emergency room on the date of the accident, that after the elevator bounced -- nothing happened but it bounced on the floor before he -- it says right here, it bounced on Floor 15, then he went to 14, and then it dropped down to the 4th floor?

MR. SCHIFERL: Just for the record, when he says "it says here," is that Exhibit 9? I can't see.

THE COURT: He's reading off of 9A, which is --

MR. SCHIFERL: Thank you, Your Honor.

MR. McCRORIE: Sorry about that. I didn't want to put this one up.

BY MR. McCRORIE:

Q. In any event, his injuries as described within an hour or two of the accident, before the emergency room, are "neck, left shoulder, left arm, lower spine, and lower left leg." And he signed it on 5/11/18 before going to the emergency room. You're aware of that, correct?

A. Yes.

MR. McCRORIE: And if you could just pull up -- this would be emergency room I think it's.

MR. KULLER: 1.

MR. McCRORIE: It's what?

MR. KULLER: 1.

MR. McCRORIE: Plaintiff's 1 in evidence.

(Whereupon Plaintiff's Exhibit 1 was published to the jury.)

MR. McCRORIE: If you can just go -- we'll start on page -- we won't go through everything. Page 25.

BY MR. McCRORIE:

Q. Are you able to -- let me see what page that is.

MR. McCRORIE: 25. Page 25.

So if you can make that larger, Dylan, on the top and then I'll figure out where I'm at. Even larger. Okay.

BY MR. McCRORIE:

Q. Do you see, this is emergency room. Do you -- you said you worked in emergency rooms, correct?

A. Yes.

Q. When the emergency room talks about someone's cc or if they write "chief complaint," what do they do in an emergency room when someone comes in? And they're calling this Trauma 4. You said you worked in Trauma 1, 2, 3. But they're calling this Trauma 4. What is the chief complaint when speaking about chief complaint?

A. It means that the worst thing that they're complaining of.

Q. And in your review of the record, what is the worst thing he was -- when I say "he," Mr. Gordon Sayles was complaining about throughout the emergency room?

A. Well, he had a few things he complained of. But he complained of back pain, arm pain after an injury.

Q. Okay. And that says "lower back pain and arm pain." What does arm pain tell you?

A. It's very non-specific.

Q. Okay.

A. It's meant to be, though. This is just a global, vague comment. So -- so -- it gives people perspective. That's all.

Q. And in this one, it's pre-assessment note in something called "triage." And it's a nurse he's speaking to. It says Nurse Ballard?

A. Correct.

Q. At least there it says "lower back and arm pain after dropping 5 flights in an elevator," yes?

A. Yes.

MR. McCRORIE: 27, please. Two more pages.

BY MR. McCRORIE:

Q. And in your -- you said your notes have it, but have you seen medical notes from the emergency room, from other doctors that have incorrect information, just they took the history wrong and it's not --

A. Yeah. I mean, just -- there is some difference in the way people recorded it.

Q. Okay. In any event, this one -- this is actually the doctor doing this. And he says that Mr. Sayles was doing

maintenance on the elevator. Do you see that?

A. Yes.

Q. Okay. Mr. Sayles never told you he was doing maintenance on that elevator, did he?

A. I don't think so.

Q. It says that he fell five floors and stopped on the 10th floor and his body jolted. Do you see that?

A. Yes.

Q. And here, instead of arm pain, it is saying "lower ack" -- back, I presume -- "left shoulder and left leg pain." Do you see that?

A. Yes.

Q. Okay. And on the bottom, it talks about "left-sided pain. Left-sided pain and back pain." Is that -- can you tell what part of the body they're talking about when they say "left-sided pain"?

A. Yes.

MR. McCRORIE: The next page, page 28.

BY MR. McCRORIE:

Q. This entire note --

MR. McCRORIE: If you can make it bigger, please, Dylan.

Q. -- was read yesterday except for one line, they read the whole line. And it says that he was -- it says a lot of things.

But it says, "DM presenting with diffuse back pain and left shoulder pain after an elevator mishap." What does "diffuse back pain" mean?

A. It means it was spread out.

Q. This one also says that he works as a maintenance worker at the building.

And then it says he was in an elevator, which was on the 14th floor, and it felt like it free-fell, and it stopped somewhat abruptly on the 10th floor.

Do you see that?

A. Yes.

Q. Is stopping abruptly what you meant before in mechanism of injury, meaning an acceleration deceleration?

A. Yes.

Q. Does it make a difference when an elevator feels like it's free-falling, going faster than it should and it stops abruptly whether it's 10 floors? 4 floors? 5 floors? Can they all cause injury, strain, sprains and other things?

MR. SCHIFERL: Objection. Foundation.

THE COURT: Sustained. It's also a leading question.

BY MR. McCRORIE:

Q. Here it states, "Two of the five people in the elevator fell to the floor, fell down." Do you see that?

A. Yes.

Q. That is the part that wasn't read yesterday. But that is what happened. It stopped abruptly, and two of the people in the elevator fell down.

Mr. Sayles didn't tell you he fell down. He says he braced himself, correct?

A. I believe so.

Q. And can an emergency room doctor -- I think this is an attending. Can he ever know that other people in that elevator didn't treat -- didn't go somewhere else, didn't go to their own doctor? It says they didn't come to the hospital by ambulance?

MR. CASCONE: Objection. Calls for speculation.

MR. SCHIFERL: And --

MR. McCRORIE: I --

MR. SCHIFERL: Please, let me object, Counsel. As well --

MR. McCRORIE: Yes.

MR. SCHIFERL: As well foundation.

THE COURT: The objection is sustained.

Can I ask -- can I interrupt to ask one question?

MR. McCRORIE: Yes, Your Honor.

THE COURT: On the earlier page we were looking at, I think it was page 25, it said the patient was unable to self report. Can you tell us what that means?

Maybe you want to show it to him.

MR. McCRORIE: 25?

THE COURT: Yes. It was where you started, where you -- further down. Further down. Yeah. There.

What does that mean "patient unable to give self report"?

MR. McCRORIE: It's under "pain screen," right?

THE WITNESS: Are you asking me?

THE COURT: Yes, please.

THE WITNESS: I'm not sure. I -- it could mean different things.

Usually what it means is that the patient is not conscious or that they're not able to describe their injury or their pain. But it contradicts because it says that above that "Are you having pain?" "Yes."

So maybe -- maybe the patient -- maybe they were asking questions that the patient didn't know the answer to and said, "I don't know." And they clicked that box or checked a box that says didn't --

MR. McCRORIE: Your Honor, above that it says "low back pain and arm pain." And it says exactly how and why he was feeling that.

THE WITNESS: It contradicts because it also says "Are you having pain?" "Yes."

So maybe it's just that the patient didn't have a good answer for what the triage nurse was specifically asking him. Maybe what the characteristic of the pain was.

And he said, "I don't know," so she just clicked that.

THE COURT: Thank you.

MR. McCRORIE: 30, please.

Thank you, Your Honor.

30. Right here. The evaluation, please. Can you make it a little bigger -- yeah. That's fine. Right there.

BY MR. McCRORIE:

Q. It states, "He feels better after meds. Pain worse at left lower back." Do you see that?

A. Yes.

Q. Is that consistent with later on having left sided radiculopathy, left sided herniated disc?

A. Yes.

Q. The imaging that was taken, did you -- that is radiographs, correct?

A. Yes.

Q. They don't typically take MRIs in a hospital, do they?

A. Not typically in the emergency room.

Q. Okay. Okay. Just so -- it's -- the ED diagnosis is low back pain.

MR. McCRORIE: If you could just move it up a little bit.

Q. And there could just be confusion, but there was some cross-examination how he was not given prescriptions.

MR. McCRORIE: Can you move it up, right there.

No. Down. Sorry.

BY MR. McCRORIE:

Q. When the hospital says "prescriptions" and they tell him to take it more than once a day, "RX 1 tab orally three times a day cyclobenzaprine five days," did they give him a prescription for cyclobenzaprine and ibuprofen?

A. Yes.

Q. And did they also administer that in the -- in the hospital? In fact, right above when we were reading "feels better after meds," it says -- it starts the note, true?

A. Yes.

MR. McCRORIE: Okay. And 33, please. Just in the middle.

BY MR. McCRORIE:

Q. The pain screen, at least is low back pain. That's a thing they do. You do it too. They ask him scale of 1 to 10, and it states 9. It says "aching, it was sudden, and it is constant." Do you see that?

A. Yes.

Q. Okay.

MR. McCRORIE: Page 43.

BY MR. McCRORIE:

Q. Here I'm just going through these, it could be -- it always says who it is somewhere. It could be a nurse. It could be an attending. It could be a resident. Right? But whoever

they are, at different times, there is different pain scores.

And each person is asking him -- what does "MS" mean? It says "MS comments," if you know? Right there. It's okay.

The note after it says patient -- "PT complaining of low back pain status post being in free-falling elevator that dropped" -- I am -- it says D5, but I said five stories, "before coming to an abrupt halt. Elevator did not hit bottom. Patient denies fall."

Do you see that?

And that is something that you had and considered over the course of your treatment?

A. Yes.

MR. McCRORIE: Page 58. Just up -- yeah, right there. Thanks.

BY MR. McCRORIE:

Q. It is just the history again talking about being in an elevator, dropping five stories, coming to an abrupt halt.

And then we'll go to 63.

And then just one more after that. Okay.

So here -- I don't know if we can see who is -- again, it was all different times. So 1514 would mean 3:14, correct?

A. Yes.

Q. And if he got out of the hospital at 6:55, that would mean 6:55 p.m. at night. It is what it is. The record speaks for itself. But he was there for a period of time.

This note here talks about -- at 3:15 -- "diffuse back pain and left shoulder pain after elevator mishap." Again it says he works at the building. This one says, "The elevator was on 14th and felt like it free-fell and it abruptly stopped at 10th floor." Okay. It says the same thing. "Two of the five people fell down."

And then one last one, page 65.

MR. SCHIFERL: Is there a question -- just objection as to reading.

THE COURT: I mean, the document is in evidence. He is permitted to read from the document.

MR. SCHIFERL: Yeah.

MR. McCRORIE: Or I have to do it later.

BY MR. McCRORIE:

Q. Page 65. Right there.

This is the -- either -- it says "cc fall, was doing maintenance on an elevator. Fell five floors and stopped on tenth floor. Body jolted. Complaining of lower back" -- "ack pain left shoulder and leg pain."

Is what you're seeing here the mechanism of injury, a free-falling elevator or a falling elevator, or it felt that way in an abrupt halting stop and a jolting of his body. Is that consistent with the injuries and the causation that you've already discussed just to his neck and his back, the things that you treated him for?

A. Yes.
Q. Okay.
MR. McCRORIE: Two more notes, Dr. Mian, in evidence 3, in evidence as 3.
(Whereupon, Exhibit 3 was published to the jury.)
BY MR. McCRORIE:
Q. Did you also review the initial treating sports orthopedic or general orthopedic's doctor's notes, the one he saw beginning May 24, 2018, the first treating physician after? Did you look at those?
A. I believe so.
Q. Okay, sir, do you see it here, May 24, 2018, work-related injury, neck, back, left shoulder; do you see that?
A. Yes.
Q. Okay. If we just go to neck pain. It says it's radiating, and there it's both extremities, but the left is more than the right.
Do you see that?
A. Yes.
Q. In myelopathy, something that you said he has, the disc touching the cord and the exiting nerve root -- you said that before, true?
A. Yes.
Q. We're going to show the jury that in a moment, the disc touching the cord.

A. Yes.

Q. Does that typically go down both arms when it's touching the middle of the cord, and does mostly on the left indicate that he might have both myelopathy and radiculopathy?

A. It can mean that, yes.

Q. What is "paraesthesias and numbness on both upper extremes, left more than right"?

A. Paraesthesias is when you have abnormal sensations. And numbness is when you have no sensation or a loss of sensation.

Q. And would those things we discussed, the radiculopathy and myelopathy, would someone have difficulty turning their head and potentially staying asleep and getting comfortable?

A. Yes. These notes are consistent with the diagnoses that I made. They all make sense.

Q. And the low back left lower extremity radiating pain, do you see that?

A. Yes.

Q. The same thing, paresthesia?

A. It all makes sense that it would all agree with the diagnosis that I ultimately made.

Q. Understood.

The next page, and this -- he was complaining of difficulty walking two to three blocks. Didn't he say he couldn't do it, just has pain or difficulty?

Did he ever tell you that he can't walk or can't walk certain distances without pain?

A. He said that he started having symptoms when he walked more than a block.

Q. And you knew he was working and walking, correct?

A. Yes.

Q. Past medical history, this is the first doctor he saw. He told him about a work-related injury, injuries to his back in 2015, his left leg, and his left foot.

It says here he even had two injections to his low back back then. Do you see that?

A. Yes.

Q. And he had "PT," which means what?

A. Therapy. Physical therapy.

Q. And then it says the cyst from 2013.

And then it talks about hypertension, hyper cholesterol, the other things that aren't orthopedic.

It says then he was on gabapentin. That is something for diabetes, true? Or it can be?

A. It's for neurologic symptoms.

Q. And he was on that before?

A. Yes.

Q. He was on that when he saw you, true?

A. I -- I don't recall. I have to refer --

Q. I'll state it's in your records. He's still on it?

A. Okay.
Q. He's been on it --
A. Okay.
Q. -- since before 2015. Okay. Is that fair?
A. Yes.
Q. Additionally, you've prescribed him things in addition to the gabapentin that he takes. We'll get to that maybe later, right? Specifically for his back or neck, true?
A. Yes.
Q. Okay. This is the doctor, he continues seeing him for a few visits, even does an MRI to the back and the shoulder, the left shoulder. Do you remember that? You've seen the reports and the film?
A. Yes.
Q. Okay. And then he saw him on the last note February -- August 30th, if you would just go to that, it's the last note. Okay. August 30th.
And do you see interspersed between all of these notes he was actually attending physical therapy for those three body parts with Dr. Mian for those period of months? Did you see that? The records?
A. Yes.
Q. Okay. So August 30th, he's still having the radiating pain to both extremities, with paresthesia and numbness in the neck, still having difficulty bending and sleep at night and

lower extremity. Still having all of the complaints of pain.

MR. McCRORIE: And if we go to the end, he's diagnosed the last page -- the last page -- so just move off of it. Very last where the doctor's signature is.

So right there, from the top.

BY MR. McCRORIE:

Q. He was at least diagnosed with a SLAP tear. That was from an MRI. And his diagnosis then, without -- there's no cervical MRI at that time -- is cervical strain, thoracic strain, low back syndrome, and then herniated bulging disc, and left shoulder that another doctor will talk about that.

The plan, what is that medicine? And you can say the name of it indo- --

A. Indomethacin.

Q. Yes. What is that?

A. It's a very strong anti-inflammatory.

Q. Why does someone get anti-inflammatory if they have herniated discs or disc problems or radiculopathy?

A. It's a very potent pain reliever. And as we were discussing earlier, when the nerves are inflamed, it causes pain, it causes swelling. And it then causes more compression of the nerves. So anti-inflammatories are one of the go-to medicines to try and bring down the swelling, decrease the pain.

Q. And you said that you accept work accident cases in this case. I don't want you to get into detail. But the

doctor -- he's doing therapy, but he's requesting permission, authorization to do physical therapy or more.

In your -- when you deal with work-accident related cases, do you need permission or authorization to do all of your work?

A. Most of it, yes.

Q. Okay. He sends him out or wants him to go to a pain consult to a Dr. Nasar Shahid. And he recommends the plan, MRIs, it says "C spine," "T spine," that means what? Cervical and what?

A. Thoracic.

Q. And he discusses treatment options concerning surgery to the shoulder, correct?

A. Yes.

MR. McCRORIE: And the next note, that will be the last one before we have him doing the findings. Exhibit 5. It's University Pain Medicine Center. It's Dr. Demesmin.

(Whereupon, Exhibit 5 was published to the jury.)

BY MR. McCRORIE:

Q. So he's at Dr. Demesmin, August 10, 2020, six months or so before -- if I'm doing the math right, before he sees you.

And what is a pain management doctor as opposed to an orthopedic doctor?

A. Pain management doctors are not surgeons. Typically, they are typically either anesthesiologists or rehab doctors

that have -- that do injections and implant stimulators and other types of devices to manage pain.

Q. It's noted in some of the doctors -- some of them it's not -- and it's there -- are there -- it's not -- are there contraindications or risks associated with diabetics when getting injections or surgery that aren't there for non-diabetics?

A. Yes.

Q. What are the risks of -- for diabetics regarding injections if we -- we'll see it maybe in some records. What are the risks?

A. Well, the -- you know, I do injections. Injections are very common and it's one of the principal treatments that pain management doctors do.

The main ingredient is a steroid that decreases inflammation. Steroids are very potent, and they have a lot of side effects. And they can have complications. In diabetics, diabetics are more prone to having infections than -- than nondiabetics.

Q. And just so you note, I want you to continue with that, but we'll handle it. He's only had a few recently but I'll have you explain what type of injections you do and what the purpose of epidurals are.

But please continue with what you're talking about with diabetes.

A. So they have a higher risk of infection than an average person because the immune system doesn't work as well. So there is a higher risk of infection any time you penetrate the skin.

Steroids blunts your immune system. They bring down inflammation. They slow down your immune system. So of course when you have a diabetic getting an injection with something that blunts the immune system even more, they're at higher risk of an infection than the average person.

They also have higher risk of having problems with their blood sugar levels. That is one of the more common things, that they feel as though their sugar is poorly controlled after a diabetic injection.

So steroids in the injection will normally sort of live within the area that you inject it, but some of it gets into the bloodstream. That is why a lot of times they'll describe their sugars going up. So you can have problems with sugars going up.

Bless you.

MR. McCRORIE: Someone sneezed.

BY MR. McCRORIE:

Q. Epidural injections and other pain management injections, but epidurals, why is that recommended as sometimes conservative care before considering surgery?

A. There are certain types of issues that will -- will benefit from the injection. It doesn't always work, but it can help people just by bringing down the swelling.

Q. Do you do it postsurgery in --

A. Sometimes.

Q. Okay. If we can go back to Dr. Demesmin.

All right. So here, we see the note. This one gets it right. It's a housing building inspector, talks about the accident. It says, "He was at work when an elevator which dropped eight stairs," again -- people -- do you see that? "It dropped eight stairs causing him to fall" -- this one says, "fall in the elevator causing an injury to his back. He immediately felt pain in the neck, low back, and left shoulder."

Do you see that?

A. Yes.

Q. And Dr. Demesmin at the end does the examination. He wants him to have epidural injections.

Are epidural -- we just saw a lumbar injection and we just saw the needles.

Do lumbar injections need to be done under fluoroscopy? And what about cervical? What is fluoroscopy?

A. They don't have to be, but they're ideally done under fluoroscopy.

Fluoroscopy is like an x-ray machine that you can use to -- to be very precise, where you're putting the needle and you can see the needle in the spine, and you can see exactly where you're putting it, so it's more precise.

Q. And so on his assessment there is a word that is

not -- we haven't used yet. I may say it wrong. "Lumbago cervicalgia," what does that mean?

A. It means back pain neck pain.

Q. "Cervical facet syndrome," what is that, sir?

A. Facet is the joints in the back of the spine, there are disc joints in the front and facet joints in the back.

Q. And it continues 6 and 7, same thing for the lumbar.

And when we go -- when we go down to he says "medical necessity." He says his plan is "included but not limited to physical therapy, orthopedic, neurological evaluation."

What is the neurological part of an evaluation, given what he's complaining about? Is that for the left shoulder? Neurological evaluation? Or is that something like yourself?

A. It's usually someone such as myself who does orthopedic spine surgery.

Q. Okay. Because if it's just a shoulder tear, be it a SLAP a labrum, that does not involve neurological symptoms at all?

A. Correct.

Q. And imaging studies and interventional procedure he wants, yes?

A. Yes.

Q. Let's do this. We'll see if we can do it with -- if you can just describe what you see. First, we're going to look at -- it's?

MR. McCRORIE: The hospital record is 1, correct?

MR. KULLER: Yes.

THE COURT: New York Presbyterian is 1.

MR. McCRORIE: So we have discs or sometimes USBs as the films, but we're going to show you a film. It will be demonstrative for now.

So the -- but I'll call it -- 1 is the New York Presbyterian record that we were reading from. 1A would be their disc or their radiological USB. And this would be just 1 -- it will be 1B and C, just for identification.

Can you just pull up it's 12A -- 12A. Yes.

(Whereupon portions of Exhibit 1 were published to the jury.)

BY MR. McCRORIE:

Q. We talked about x-ray. We talked about MRI. What is this? And it's hard to see. Up in the right. It's taken on 5.11.18.

THE COURT: Can you just identify for the record what you are going to be specifically referring to as 1B and C?

MR. McCRORIE: It is -- this is the lumbar x-ray. And the next one would be the thoracic x-ray, referenced in the emergency room as 1.

THE COURT: Thank you.

BY MR. McCRORIE:

Q. These are demonstratives. But they are the real films. Okay, Doctor?

What are we looking at right there, and what can we see because it's a radiograph?

A. It's a lumbar x-ray.

Q. And what else are you looking at there? The hips? Something else?

A. That is the pelvis at the bottom. And the ribcage at the top.

Q. Anything medically significant that you see?

A. No.

Q. Can you see the discs either the -- can you see the cauda equina? Can you see any of that on an x-ray?

A. No. You can just see the space where they are between the bones, but you can't see the actual disc itself.

MR. McCRORIE: Okay. Why don't we go to the next one, C.

(Whereupon, a portion of Exhibit 1 was published to the jury.)

BY MR. McCRORIE:

Q. Okay. So what -- what are we looking at here? This is --

A. This is the upper back, the thoracic spine.

Q. And what does it cover? Is that the ribs we're looking at and the back?

A. Yes. It's where the ribcage connects to the spine.
Q. How high up are we talking here?
A. It's from the base of the neck to the -- to the middle of the back.
MR. McCRORIE: Okay. So now we're going to move to Plaintiff's 18 in evidence, the Stand-Up MRIs taken up on the same date, August 13, 2018.
THE COURT: I don't think Plaintiff's 18 has been marked into evidence. That might have been one of the things you worked on with my court attorney when I wasn't here, but it was never done on the record.
MR. McCRORIE: That is what we were doing before we put the sticker -- and I think that Your Honor ruled that they're in. We can mark them now but --
MR. KULLER: It's the Stand-Up MRI.
THE COURT: Sorry. When was 18 admitted into evidence?
MR. McCRORIE: The other day you told to us agree what's in.
THE COURT: Right.
MR. McCRORIE: We put stickers on them.
THE COURT: We need to put it on the record is my point. On this record, we have not yet admitted it.
MR. McCRORIE: That's understood. You called the jury. We were going to mark it all. That's fine.

MR. SCHIFERL: I think Your Honor is correct. Us attorneys had talked about it. Your Honor hasn't passed on it.

THE COURT: I'm not saying it can't come in. I'm saying we should mark it into evidence officially on the record.

MR. KULLER: It's 18.

MR. SCHIFERL: Hold on.

MR. KULLER: It's Exhibit 18. It's the Stand-Up MRI film and we're now based on the ruling this morning officially moving into evidence. It was served with the notice of intention.

THE COURT: Okay.

MR. KULLER: Thank you.

MR. McCRORIE: We'll need all of the films, and we'll have to put stickers on them.

THE COURT: All right.

18 is in evidence, and I guess we'll mark it in evidence afterwards.

MR. McCRORIE: I'm sorry about the way it happened, Judge.

THE COURT: Okay.

MR. McCRORIE: I'll keep notes here.

BY MR. McCRORIE:

Q. I'm just going to show you a single view of

August 13, 2018. It will be 18A but it's not in evidence. It's demonstrative for the jury.

MR. McCRORIE: Can you -- yeah, that's it if you can make that bigger.

(Whereupon Exhibit 18A was published to the jury.)

BY MR. McCRORIE:

Q. So before we saw that anatomy, if you ever needed it back we have it. This is what is called the "sagittal view," correct?

A. Yes.

MR. McCRORIE: Pull it back just a little bit, Dylan.

BY MR. McCRORIE:

Q. So -- on each film or each slice, it's always gonna to have the client's name -- my accent, gonna.

It's always going to have Gordon's name, it has his date of birth there, and it's usually indicating where it was taken. But so what does it say here? When was this MRI taken?

A. Where?

Q. No. When? On the bottom, do you see the bottom right?

A. August 13, 2018.

Q. And up on the top left it says "IM7/13 SE: 102" does that mean Image 7 Slice 13, Section 102 -- Series 102?

A. Yes.

Q. And this is what you're talking about on an actual film

or CD, there will be many of these. And it will tell you which one you have, correct?

A. It is the seventh slice out of 13 images. So there are 13 slices to the spine. That is the seventh.

Q. Okay. And looking at this image, you've seen this image and all of the images we're going to show you before --

A. Yes.

Q. -- as his surgeon?

What, if anything, that is medically significant do you see on this film in relation to what we're here discussing the issues with of Mr. Sayles?

A. You can see the discs that are pushing backwards. So this is looking from the side, you can see the bones and the discs in between them.

If you look at the disc there at the top, the top three discs that are there, they are relatively normal. They have jello in the middle. That is gray with the black rim around them.

So the slice -- the slice is through the middle of the disc. So it's like a donut which has jello in the middle, and then it's got the fibrous rim on the outside. So when you slice it in the middle, you see the jello and the rim on either side. So you can see that it stops at the back of the body. It leaves lots of space behind it for the nerves.

(Senior Court Reporter Karen Perlman was replaced

by Senior Court Reporter Alan Bowin.)

(Transcript continues on the following page.)

Q. And with the Court's permission, if you -- if you need to stand up ..., but can you show us what, if any --

Why don't we do this --

THE COURT: I think there's a way for him to do that, right? There's a way for him to use the cursor himself? Maybe with the --

MR. KULLER: There's a way to do that? Okay, so what should I hit? It says: "DCM, Part, Judge, Reporter."

THE COURT: You need to give him (indicating) the mouse. Then he can use it to show you what he wants to show.

MR. KULLER: May I approach?

THE COURT: Am I right? No?

THE WITNESS: I'm not sure.

THE COURT: No, that's (indicating) not working. All right. Sorry.

Q. Okay. We'll try to --

If you stood up, are you able to point to it?

A. Does anybody have a pointer?

Q. That's, like, old school.

THE COURT: Yeah, or a light? Sometimes people use, like, a -- I'm going to find out.

THE WITNESS: Are you able to use the cursor

from down below there, with the mouse (indicating)?

MR. KULLER: I can use it --

THE WITNESS: I mean, if you want, I can stand over there (indicating).

MR. McCRORIE: He (indicating) has it.

MR. KULLER: But the doctor's saying, if he sits here (indicating) ...

(Device handed to Mr. McCrorie.)

THE COURT: Yeah, perfect. Thank you.

MR. KULLER: The other option would be for the doctor to sit here (indicating), right?

THE COURT: There is a way to do it.

MR. KULLER: Okay. Let's -- that's the first -- I'm sorry.

BY MR. McCRORIE:

Q. Is this the first MRI taken in connection with Mr. Sayles' case, that you're aware of?

A. Yes.

Q. Shortly after the happening of the accident?

A. Yes.

Q. Okay. Do you -- like we said before, is there degeneration on this MRI?

A. There is some signal change within the discs in the lower spine that shows some aging; age-appropriate aging, I'd.

Q. And "age appropriate" means somebody in their mid-fifties, late fifties?
A. Yes.
Q. What are the findings of the -- certain discs there?
A. So, if we look at the bottom three discs that look like black -- okay? -- they're darker.
So, if you use --
Who's controlling the mouse? Are you controlling it?
You can see the bottom three discs, right?
So go to the bottom one.
(Image modified.)
A. No, not those; above them.
(Image modified.)
A. Not those ones. Keep going up.
(Image modified.)
A. That one that's right above you right now.
So that disc right there, that is the bottom disc. You could see that it's pushing backwards just a little bit on the right side there.
So, in the canal, that white streak behind the discs, which is on the right side of the spinal bones -- okay? -- right there (indicating), see how it's pushing outwards there? Okay. That is less severe than up

above where you could see the disc --

The next one above. If you go to the one above there ...?

(Image modified.)

A. Keep going up.

(Image modified.)

A. See that disc right there (indicating), how it's pushing backwards?

And then, above it, the next disc above, you can see, it's pushing backwards. And also, that disc is not really flat anymore. You see how it's sort of leaning forward a little bit? So it's not -- it's not horizontal.

So it's not -- it's not in its normal position and it's pushing backwards.

This is the cut through the relative middle of the spine, so it's not the area that we're as concerned about, because the nerves have lots of space in the middle there. You can see the white space behind those discs where there's -- where the nerves live?

Q. I'm going to try do this, before we get to -- there's a lot of notes; we're not going to go through them all. Did Mr. Sayles continue to complain to you about radiating pain to his low back and his -- to his low back, first?

A. Yes, and going down the left leg.
Q. In addition to the first MRI you ordered in March of '21, did you continue to order subsequent MRIs, even through today?
A. Yes.
Q. Has that been more than one?
A. Yes.
Q. I'm just going to talk about: Did you do -- order -- one in July of 2023, and have you even ordered them this year?
A. Yes.
MR. McCRORIE: With the Court' permission, we can put it up, but I'd ask that the doctor step down and I can put up films here (indicating) and have --
THE COURT: Is there any objection?
MR. SCHIFERL: As long as I can go stand and see, as well.
THE COURT: Yes.
(The witness stepped down and entered the well of the courtroom.)
MR. McCRORIE: I'll put it here (indicating)?
THE COURT: Yes, you may.
(Item placed on easel.)

MR. McCRORIE: These are total demonstrative. We talked with counsel, Judge; these are not going into evidence, but there are --

THE COURT: Understood.

MR. McCRORIE: Okay. I'm going to put something up, and it's Gordon Sayles' lumbar spine findings. If we could keep the other one up ...? When I say, "the other one," the exhibit that was just up, the 2018. Make it bigger.

(Image modified.)

BY MR. McCRORIE:

Q. I'm going to now put one -- I think it's the third MRI, July 14th, 2023. Please tell the jury --

MR. PETROZZO: Your Honor, I only ask that they describe what image and what series it is, so that we know, for the record.

THE COURT: Agreed.

I'm sorry. One of the jurors is not able to see based on where the witness is standing.

Q. Okay. So I don't know ... Okay.

(The witness repositioned himself.)

THE COURT: Also, we need to make sure that the witness will be heard by the reporter without the mic.

Q. Okay. So we're looking here at 7/14/23. Just so

-- the sagittal image is 8 of 17; the axials are 15 of 29, 16 of 29, 21 of 29, and 22 of 29. Okay?

Please tell the jury --

You can compare it, if you'd like, to the original MRI and please tell the jury: Did the herniations that were diagnosed in 2018 get bigger, get smaller, something else?

A. So, if we compare the MRI from 2023 to the MRI from 2018, you can see that there -- this disc here (indicating) has completely degenerated. Okay? You could see the swelling in the bone; you could see that it's shifting forward and it's pushing backwards more.

At the level below, at the L4-5 level, it's pushing backwards and pinching the nerves quite severely. Okay?

So, over the course of time, as the symptoms progressed and they got worse and worse and accelerated worse and worse, this area here (indicating) has really accelerated; it's -- it's degenerative.

(Item placed on easel.)

Q. That's demonstrative. This is still demonstrative, but these are the same images without the illustration (indicating). This would be 19-A. The same images.

If the Court would permit, with this red marker

(handing), can you please tell the jury: What are the findings? Where is the herniation? Maybe you can put an arrow and compare it to the 2018 ones again?

A. All right.

So, again, this (indicating), this disc here -- this is the L3, -4 and -5. Okay? This disc (indicating) is -- is now swelling and it's almost lost all of its height --

Q. Can you speak a little louder?

A. -- lost all of its height and it's shifting forward and it's pushing backwards. If we slice it through the middle, then that's -- those are the images that we see here (indicating) in cross-section. So we can see that the -- the disc is pushing backwards. The nerve roots that we saw that looked like spaghetti before -- okay? -- are all compressed together.

THE COURT: I'm sorry. Can I pause you just for one moment? Thank you.

(Pause.)

MR. SCHIFERL: Your Honor, for the record, are these the same images?

MR. McCRORIE: Yes, without the illustration. Yes, they are the same images that were on that board, without the illustrations around them; just the images. Exact same image.

A. And when we look at the disc in cross-section, you could see that the disc is pushing backwards now and that there's very, very little space for the exiting nerve roots and for the actual nerves that are passing through. This is a slice (indicating), and then the slice immediately below it (indicating) is here on the right side. This is slice 16 of 29. It's -- it's -- the nerves are being completely crushed and the facet joints here have started degenerating as a reaction to the -- the underlying problem with the disc.

When we go to the disc below (indicating), it's pushing backwards. This is substantially worse than it was in 2018. You could see that it's getting worse; it's progressing; it's pushing backwards.

When it's sliced in cross-section here (indicating), at the L4-5 disc, you can see it pushing backwards where it's ruptured here and it's pushing on the nerve roots. It's pushing down here (indicating). Rather than that kidney-bean shape, the natural kidney-bean shape that I had shown you earlier, which is the normal shape, you could see that the disc is herniated here (indicating) and pushing backwards on the nerve roots.

(Image placed on easel.)

Q. Okay. We're just going to now move from the

lumbar, and I'm going to put up -- this is now with the illustration, but the images -- it's 4/21/21, the first MRI you ordered, cervical. It's image 8 of 13 on the sagittal and on the axial, 15 of 27, 16 of 27, 18 of 27, 19 of 27.

Please tell the jury what they're seeing here.

A. So this (indicating) is a cartoon depiction of what you're seeing on the MRI sagittal view. This is the view looking from the side, 4/21/21. This is the MRI where you could see, in the normal disc, the disc stops at the back of the bone; there's lots of space around the spinal cord. Okay? So that's normal. This is looking at the C7-T1 level.

When we go up to where the herniation is, at C4-5, you could see it pushing back and that there's a narrowing of the space where the spinal cord is; again, at the C5-6, a narrowing of the space where the spinal cord is.

When we cut it in transection, we get the axial images that are on the right side here (indicating). This is -- these are -- the cuts through the C4-5 disc. Okay? This is the C4-5 disc pushing backwards, where the nerves are. Again, instead of the disc looking as though it's a kidney-bean shape to make space for the spinal cord, instead, the disc is pushing downwards.

And it's even more dramatic on the image 16 of 27; you could see it pushing backwards and instead of having space around the spinal cord, the spinal cord is being crushed.

So, normally, you would see white space around the spinal cord here, but instead, the spinal cord is no longer round; it's more of a -- of a, um -- almost like a teacup shape, because it's being compressed.

This (indicating) is the spinal cord in the neck. Here you can see, at the C5-6 level, it's not quite as severe, so there are some spaces here where there's -- where there's white fluid and the spinal cord. It's starting to get pressed in the image 18 of 27 --

Q. Why don't I do this: It's the same images. It's 19-B. There's no cartoon.

(Item placed on easel.)

Q. If you'd just show it to the jury ...?

A. Yeah.

Q. And if the disc is touching the cord on any of these images, please put an arrow there.

A. Right.

So you can see here (indicating), the disc is pushing backwards. Here (indicating), this is the normal, kidney-bean shape of the disc, okay? But instead, everything here (indicating) is abnormal discs.

They're pushing down on the spinal cord so there's no space around the spinal cord. So the spinal cord is being compressed. That is a very typical, characteristic finding of somebody that has the symptoms that Mr. Sayles had, where you have the spinal cord-type symptoms from the spinal cord being compressed like that.

And so, when we say the patient has a cervical disc herniation with myelopathy, this is very typical, where the spinal disc -- the disc -- is pushing backwards; it's herniated backwards, it's pressing on the spinal cord; and the manifestation, or the way the patient feels and the symptoms, is what their -- you know, their functional level is affected by that.

So the spinal cord is not functioning normally. That's why he's getting the shooting pain into his arm, and getting the clumsiness and the balance problems that he was having.

Q. And if we could just -- we'll call it "19-C"; there's a split image up top, on the screen (indicating), and it's showing -- higher level up. It's in image 7 of 13 on the left, 13 of 27 on the right.

Is that showing, not totally normal, but a disc not touching the cord on the right?

A. Exactly. So that's above where the injuries are.

Q. Okay.

A. You can see, the two discs below are pushing backwards. That's a cut through a disc that's not herniated, and you could see the spinal cord right below it (indicating) with space around it. It's almost like an oval shape. It's not like a teacup shape. It is not being pushed on or compressed.

Q. And that tool on the left (indicating) in the DICOM reader of the MRI, that tells you the level you're at, from the sagittal to the axial; correct?

A. Right. So that yellow line is showing you what disc level it's cutting through, to show you the axial image. So that's a level where the spinal cord has lots of space to breathe and function.

Q. Okay. Now we're going to go to the level you're showing them, where you just pointed out --

Again, go to the next image -- it's 19-D, like David -- and that's going straight through. And please compare what we saw on the right to what we just saw -- what we're looking at now. It's also 7 of 13, series 5; and on the right, it's image 16 of 27, series 7.

A. So you could see, the yellow line is cutting through the C4-5 disc, and you could see that now there's no space around the spinal cord, and the spinal cord is not round and oval-shaped anymore; it's being

pushed on.

Q. Is that called "cord compression" in your notes?

A. Yes.

Q. Does that cause -- that exact finding -- myelopathy?

A. Yes.

Q. And does the radiculopathy -- is that seen in there? Can you see radiculopathy?

A. Well, you could see that the space where the nerve is exiting, right here (indicating) -- that there's almost no space for the nerve to exit. So -- and here (indicating) it's narrowed, as well. Okay? So that would cause the radiculopathy.

Q. Okay.

A. So this (indicating) is the left side and that's the right side (indicating); you can see "L" and "R."

Q. Did you -- I'll have you step -- sit -- back (indicating) just for the remainder.

(The witness resumed the stand.)

Q. And it's in your notes, but for brevity, did you perform surgeries to Mr. -- I don't think we'll have time to do it before, but did you perform surgeries on Mr. Sayles, to either part of his body that you were treating?

A. Yes.

Q. Which parts of the body did you perform surgery on?

A. We did the cervical surgery in the neck, where we took out those two bad discs and then put in implants to stabilize the bone.

Q. And did you also do it to any other part of his body?

A. In the lower back, the discs that we showed that were damaged, we actually -- we removed the 3-4 disc and put in implants to stabilize the bone there.

Q. And before doing the lumbar surgery, in addition to the 2021 films, you ordered the films you just showed the jury before doing a surgery to remove that disc -- those discs.

A. Yes.

Q. What is "-ectomy" in surgery and medicine?

When you say, a "lumbar discectomy and fusion," what does that mean?

A. It's removal of that. So "ectomy" -- a "discectomy" means, I removed the disc.

Q. And the acronym for cervical --

"ACDF," what does that mean?

A. It's an anterior cervical discectomy and fusion.

So "anterior" means coming from the front (indicating); "discectomy" -- or: "Cervical" means in

the neck (indicating), so "anterior cervical" means, we go through the front of the neck (indicating); "discectomy" means, we take out the disc; and "fusion" means that I put something in to stabilize that bone together.

Q. And did you have a particular order -- we can go through the notes but -- they're in evidence and we got to -- which surgery did you do first, and what was the date of it?

A. We did the cervical surgery first in order to get rid of the most dangerous issue, which was the cervical myelopathy.

Q. And could --

I think there's time to do the first surgery.

A. Okay.

Q. With permission of the Court, I'll have you step down again. But can you find your cervical operative report so we can make this go quicker? And tell me when you have that.

A. I -- I don't need it. I've read it; I know what it says.

Q. Okay. So why don't you step down.

(The witness stepped down and entered the well of the courtroom.)

(Item placed on easel.)

Q. This is demonstrative only (indicating). It just states on it: "Gordon Sayles 9/28/22 cervical spine surgery." So -- and the only image on it is a postsurgical film dated 3/11/26. It's an X-ray, radiograph.

MR. SCHIFERL: Is this -- what's on the screen (indicating), is that --

MR. McCRORIE: Yeah.

THE COURT: So you're aware, I now have it so that the witness can do the pointing from the witness' chair, if that helps. I know how to do that now.

MR. McCRORIE: You can put it up on ...

(Image displayed.)

MR. McCRORIE: Yeah.

Q. Okay. So you have it right in front of you.

Loudly, so the court reporter and her Honor can hear you.

A. So this (indicating) is really spooky. It doesn't -- the difference between this and real life is that you can see Gordon's face here, but normally, we would have drapes and everything would be sterilized and we would have a protective drape here. So, normally, I wouldn't be looking at his face.

This (indicating) is the tube coming out of his

throat, where he got intubated by the anesthesiologist. So he's completely asleep and he has a tube that's breathing for him. Okay?

So, after he's asleep and we've prepared the skin, we get all our instruments ready, we get ready to start the procedure, we make an incision on the front of the neck in order to get to where those discs are inside the neck.

Q. Is that the anterior part of what you said before?

A. Yes. So this (indicating) is the front, anterior; it's the cervical spine.

And so what we do is, we make an incision; we dissect through the tissues. There are quite a few structures, you know, in the front of your throat; we have to protect those structures and go between them, navigate between them. That's called a "surgical approach."

So, in order to get to the front of the spine, I cut the skin; I cut through the overlying muscle, called the "platysma"; and then I'm able to see the throat, where you can see the larynx and the pharynx. And on the outside, we'd be able to see the jugular vein and the carotid artery. Those are structures that we protect and move to the side in order to get an access

to the spine.

So you can imagine: Going through that space, we take our time and we --

Q. I don't want to rush you, Doctor, but can you also tell the jury what "loop magnification" is? Are you using just your eyes? Are you using --

A. Yeah. I use a binocular-type vision, so I'm looking at it three-and-a-half times magnification.

And so, once I'm actually past all of those structures and I've protected them with a retractor, I now can see the very front of the spine.

This (indicating) is sort of a cross-section of what it looks like, where the retractors are inside, moving the larynx and the pharynx to the side; the esophagus that you swallow through to the side; on this side (indicating), protecting the vessels: the jugular and the carotid.

So now I have a channel between the skin and the actual discs, the target that we want to operate on. So, once I have that -- that sort of exposure, then I remove the disc. So we actually pull out the disc, pull it back off of the spinal cord -- you could see here (indicating), that's a very, sort of, reasonable depiction of that -- and as we pull it backwards, we now have a gap there. Okay? There's a hole.

And this is the same procedure that would be done at the C3-4 level as at the C4-5 -- okay? -- the same exposure and in -- the same process of pulling the disc backwards.

Once I have the disc out, now I have -- it's almost like when the dentist drills out a cavity. You don't just remove the actual sick, or infected, tooth; you also have to clean up the remaining tooth and make space to put in a filling.

So we clean up the area, get it prepared, and then -- if we left it empty, you'd have -- it would almost be like taking out the cartilage in a knee and having somebody walk around on it. You have to stabilize it and help it heal in that position.

So we would -- so what -- what I did and what we normally would do is then fashion a space for a cage to be put in that then stabilizes the bone. That is a very, very standard, you know, way of holding the bone together, keeping it from collapsing, keeping the alignment and everything the way you want it to be. The bone then can heal in that position and can stabilize and he can safely move his neck and not -- and not be worried about the -- you know -- the bones collapsing and having more problems with his nerves.

After we --

THE COURT: Counsel, we need to wrap it up for lunch.

MR. McCRORIE: Okay.

Q. If you can just tell them what the fusion part is, if you're able to wrap it up ...? Otherwise, we'll have to continue. But if you can ...

A. Literally, it's almost over.

So, after these cages are in, in order to stabilize this segment and to hold the cages in place, we put a plate on the front. And this (indicating) is the actual X-ray of Gordon's neck from 3/11/26, so the cages are in place; there is a plate on the front that is held in position by these screws; those screws stabilize the bone so that the bone could heal together.

This is a cartoon of it here (indicating).

Q. But part of the purpose of the disc is movement of the neck?

A. Yes.

Q. Does that limit, to some degree, movement of the neck permanently, when you take the discs out and then fuse the bone together with a biomechanical cage?

A. Right. So the -- of the six discs in his neck, we removed two of them, so two of the discs will not move anymore; these are completely stabilized (indicating). So he's lost the motion from those two

levels -- between the bones at those two levels.

Q. And does that -- do you guarantee someone will be pain-free and symptom-free after?

A. No.

Q. Should it, hopefully, take away, pretty immediately, the radiating symptoms that occur?

A. Yeah. It typically helps the spinal cord very quickly. Patients frequently wake up in the recovery room saying, "Wow, I feel a significant difference." That's, I'd say, 90-plus percent.

MR. McCRORIE: I don't know if that's a good place, your Honor, before we suspend.

THE COURT: Yes.

All right, we'll break for lunch until 2:15. Enjoy your lunch.

Remember not to discuss the case.

Thank you.

COURT OFFICER: All rise.

(The jury left the courtroom.)

THE COURT: And then, for the doctor:

Just please don't discuss your testimony with anybody during the lunch break.

Thank you.

THE WITNESS: So -- I'm sorry -- the Court reopens at 2:15 or we're supposed to restart --

they're supposed to come at 2:00 and we start at 2:15?

THE COURT: We'll all start at 2:15, but the courtroom -- I don't know if the courtroom will be open at 2:00. Maybe. 2:00, 2:15.

All right, thank you.

THE WITNESS: And then we go until 4:30?

THE COURT: Yes, unless we don't finish you by 4:30, and we might go a little bit longer.

The record's closed.

(Discussion off the record.)

(Luncheon recess.)

(Continued on next page.)

A f t e r n o o n S e s s i o n:

COURT OFFICER: All rise. Jury entering.

(The jury entered the courtroom.)

THE COURT: Please be seated.

Continued direct examination.

(The witness entered the well of the courtroom.)

MR. McCRORIE: Judge, may I keep them down here (indicating)? I'll finish with these, so we can put them up?

THE COURT: Okay.

MR. McCRORIE: With the Court's permission -- I think they took this (indicating microphone) again. Talking too much.

THE COURT: I mean, you can't do it digitally -- what we're doing -- now that we can point out?

MR. McCRORIE: No, it's the --

THE COURT: You don't have that digitally?

MR. McCRORIE: He won't be able to mark it.

THE COURT: All right.

MR. McCRORIE: It's just going to the back surgery and some radiological.

DIRECT EXAMINATION CONTINUED

BY MR. McCRORIE:

Q. First off, did we have lunch together and did we buy you Pret a Manger, in addition to the fee we're giving you?

A. Yes.

Q. Okay, just checking.

All right. These (indicating) are demonstrative.

And did you -- just like you did for the neck surgery, did you put in for authorization to perform a back surgery on Mr. Sayles after -- sometime after -- those July 2023 MRIs that you went over with the jury already?

A. Yes, we did.

Q. Okay. I'm going to put up this demonstrative only. It's in two parts. It says: "Gordon Sayles 10/11/23 lumbar spine surgery."

(Item placed on easel.)

Q. Okay. And just like before, the only film on it would be a postsurgical X-ray of 3/11/26; a demonstrative only.

Loud enough for everyone, please.

A. Okay. So, again, these are (inaudible).

(Whereupon, the reporter informed the Court that he was unable to hear the witness clearly.)

THE COURT: Chris, can we give the witness a lapel mike?

THE CLERK: Yes.
(Microphone handed to witness.)
THE WITNESS: Can you hear me? Is it on?
COURT REPORTER: It could be louder, I think.
(Pause.)
THE WITNESS: Is that better?
COURT REPORTER: It is.
THE COURT: Yeah. I can hear you.
Can you hear?
MR. McCRORIE: Yes. It's working.
THE COURT: Right. I think we're good; yes?
A. Okay. So there are different ways to do this surgery. This (indicating) is the way I do it; it is a very common way to do it.

The idea is similar in the neck in the sense that we're trying to get rid of the pressure on the nerves and then, after we've, sort of, taken the pressure off the nerves, we have to stabilize the area.

In this case, because there was so much advanced inflammation and the spine was starting to fall forward and collapse, in order to properly take the pressure off the nerves and have a lasting result, we would normally lock the level together.

So, similar to the neck, we have to approach the

spine. Once we get to the spine, we have to remove the pressure and then we stabilize the spine; so, in this case, making two cuts on the outside here (indicating) and then exposing each side of the spine separately. These (indicating) are the facet joints we looked at earlier. This is looking at the back of the spine. The muscles and everything are retracted right now. We, basically, make a window and open up the area where the nerves are that are being compressed, that go to the leg. And this is at the L3-4 level; we already showed you the MRI that showed the degeneration and herniation at that level.

Here (indicating), you could see the disc being pulled out, so we're making space for those exiting nerves.

We then go into the disc space and clean out the disc space, clean out all of the excess bone and cartilage, and things like that, that are in the disc.

And then we, with this shaver, make space for our interbody spacer -- that spacer is similar to what we put in the neck -- to keep the bone from collapsing, to keep the bone from rubbing together, because if you didn't put anything in there, it would just be a loose joint, with bone rubbing on bone; it would be very uncomfortable.

Once we've cleaned up the space and we've been able to insert our interbody spacer, we then start putting in implants in the back, which stabilize the bone. These screws (indicating) hold the bone in place, lock the bones together. Similar to in the cervical spine, where he had the plate that locks the bone together, in this case there were screws that mount into the bone and then we lock the bones together with these rods and caps (indicating). It's almost like an internal frame that holds everything still.

And then we put bone graft on it.

And then -- and then here (indicating) you could see that we did a decompression here: we opened up the space for the nerve at the 4-5 level, took out disc -- the disc herniation. And again, the only -- the level that we fused was the L3-to-4 level. And that's really what it looks like.

This (indicating) is the actual X-ray of the lumbar spine --

Q. I'm going to put that up.

A. -- from March 11, '26.

Q. I'm going to put that up as 36-B -- A. I'm sorry.

MR. PETROZZO: Can you describe what cut this is?

THE WITNESS: Yes. This is a lateral X-ray of the lumbar spine.

MR. PETROZZO: Excuse me.

Your Honor, can I specifically ask what film and the series?

MR. McCRORIE: It's an X-ray. There's no series. It's just a radiograph.

MR. PETROZZO: From when?

THE WITNESS: I'm going to tell you.

So this is a lumbar X-ray, lateral view of the spine -- of the bones. You -- and --

THE COURT: Wait. I'm sorry. Before you continue:

Did we sufficient identify the demonstrative exhibit to your satisfaction, counsel?

MR. McCRORIE: I -- I said -- yes. I thought 36-A -- so 36 is the CD of the X-ray of 3/11/26; 36-A, demonstrative at this point.

THE COURT: What is --

What constitutes 36-A?

MR. McCRORIE: Lumbar postsurgical X-ray; one of them.

THE COURT: And is there a date, or anything else that's specified, so that we can identify that?

MR. McCRORIE: 3/11/26.

THE COURT: All right.

Are you good, counsel?

MR. PETROZZO: Yes.

THE COURT: Okay, thank you.

A. Yeah. So this (indicating) is looking at it from the side; you could see the interbody spacer that I put in, and the screws with the rod. This is his back.

This is actually the actual postoperative film. It's not a -- it's not a demonstrative aid; it's the actual film.

Q. Before we put up the next one, can you tell the jury: What is "adjacent-level breakdown"/"adjacent-segment breakdown," what does that mean in lumbar surgery, and do you tell patients the risk of same?

A. Well, when the spine has an injury to it, has a surgery to it, it's now lost this segment; just like in the neck, he lost two segments. The bone doesn't move here anymore (indicating). So the normal loads and shock-absorption and movement in that area is gone, so this (indicating) will not move again.

So then, when you do move, the other areas of the spine have been moved more in order to get you through your range of motion; they have to absorb more shock; they have more wear and tear than they normally would. So, when you have a fusion in your neck or your back, we

will -- you know, we -- we will oftentimes see accelerated problems at the levels beside it, and that's called "adjacent-segment degeneration" or "adjacent-segment disease."

Q. I'm going to say, four years post-surgery -- maybe it's less than that, three; I didn't do the math, but: -- does the hardware that you put in -- unless there is a new revision surgery, does it stay there for life?

A. Yes.

Q. Okay. And did you have indications of adjacent-level breakdown, after doing his back surgery, that concerned you and that we can see on radiograph and MRI?

A. Yes.

Q. Okay. And is one purpose of the surgery --

You said, they get immediate relief with the neck pain. Is that the same -- the radiating -- with the back? When he first got the back surgery, was he doing good immediately thereafter?

A. People do feel relief of the nerve symptoms when you take the pressure off the nerve, yeah.

Q. Can someone go on a plane two weeks, three weeks, four weeks after getting the cervical surgery?

A. Yes.

Q. Do you give them cervical and lumbar braces and collars to wear after the surgery?
A. Yes.
Q. You, in fact, indicate, they should wear them as little as possible, more so in the beginning and then move around, so they can get into physical therapy.
A. Just as needed.
Q. I want you to watch what I do:
Can someone raise their left (demonstrating) hand if they've had a cervical fusion?
A. Yes.
Q. Can they also reach out with it (demonstrating)?
A. Yes.
Q. Can they stand?
A. Yes.
Q. So I'd like you to now, in discussing adjacent-level breakdown and any concerns you have -- your record is there; I'm not going to go through everything, but we're now going to do 36-B. It's another view.
(Item placed on easel.)
Q. And I'm handing you the red marker (handing).
If you could show the jury what, if any, tilting, retrolisthesis, anterior listhesis, whatever those words are -- tell us what you see on these films and what they

indicate to you three-and-a-half-plus years post-surgery.

A. These views are very concerning.

This is the X-ray of the lumbar spine from 3/11/26, so this is a couple years after the surgery. The disc that looked normal before now has a collapse on one side, where the bones are rubbing on each other, and there's substantial height loss. You could see that on the lateral, as well.

So this disc here (indicating), it did have a herniation with the original injury. When we did the surgery, it was not as severe as the level above, and therefore, we elected not to include it in the surgery. But it is breaking down pretty rapidly. The fact that it's already bone on bone and it's collapsing and it's -- and it's causing more nerve symptoms suggests that -- that -- that he, unfortunately, is going to have progressive symptoms and that it will require more aggressive treatment.

Q. The herniation you showed the jury that got larger -- you said "significantly larger" -- from 2018 to 2023, can a patient manipulate that, fake that, exaggerate that, in any way?

A. No.

Q. Can a patient fake or exaggerate the bone on bone

you're showing the jury or the collapsed disc that you're calling "adjacent-level breakdown"?

A. No.

Q. Did you, in fact, request authorization to do further MRIs, after seeing this X-ray, to determine whether or not he was a candidate for revision surgery?

A. Yes.

Q. I'm going to now put up ...

MR. McCRORIE: I just need the number for ... 31-A.

31, your Honor, is an MRI, dated April 30th, 2026; I believe, at Lenox Hill Radiology. And then this (indicating) would just be the demonstrative, 31-A, MRI film.

(Item placed on easel.)

MR. PETROZZO: Again, can I just have the cut, series, and image?

THE WITNESS: Yes.

So this is a lumbar-spine MRI from 4/30/2026. On the left side, this (indicating) is the sagittal --

THE COURT: Wait, wait. Now -- I'm sorry. We needed to identify the image specifically, first.

Counsel ...?

MR. McCRORIE: Me? I thought he had the

doctor identifying it.

THE COURT: The doctor started on the testimony. He started on the testimony. Can we identify specifically ...

MR. McCRORIE: Image 12 of 20 on the sagittal view, image 23 of 32 on the axial view.

THE COURT: Thank you.

MR. McCRORIE: Thank you.

Sorry.

BY MR. McCRORIE:

Q. Continue, Doctor. And please, so we could move it along, tell the jury any adjacent-level breakdown you see on here (indicating), any changes that concerned you, and whether or not you put in for permission to do a revision of the fusion?

A. Yes.

So, um, at the level that we did our surgery before, you could see that there is a lot of space available for the nerves behind it (indicating). Okay? At the level below (indicating), you could see, the disc is pushing backwards and it's pinching the nerves in that area. Okay? That's at the L4-5 level. And the height is lost, so the normal height of the disc now is collapsed at that level.

If we cut it in transection at that level, where

the disc is pushing backwards, you could see again that there's almost no room for the exiting nerves because it's collapsed; and then you could see here (indicating) that the nerve roots are being compressed -- okay? -- in the midline.

So this (indicating) is -- this is adjacent-segment disease; it is something that is not going away with conservative management. We've tried to treat it and -- and so that is something that we put in for, a revision surgery, where we'd literally take out these implants here and do the same surgery at this level as was done up above.

Q. Did you put in for the surgery, right after reviewing the MRI and the X-rays, who you were supposed to put it in for?

A. Yes.

Q. Did you just get authorization?

THE COURT: Can I speak with counsel for a moment?

(Whereupon, the Court and all counsel entered the Court's robing room.)

(Pause.)

(Whereupon, said parties re-entered the courtroom.)

THE COURT: Back on the record.

The witness can have a seat, and I will have continued direct examination.

(The witness resumed the stand.)

MR. McCRORIE: Thank you, your Honor.

BY MR. McCRORIE:

Q. Doctor, are you going to do a surgery on Mr. Sayles, based on the X-rays, based on everything you've told us?

A. Yes.

Q. And what is the surgery you're going to perform on his lumbar spine?

A. A revision L3-4/L4-5 lumbar fusion.

Q. And not in detail: What does that entail with the current hardware that's there? Are you extending it? Are you taking it out? What does it entail? Very briefly.

A. We're going to take out the implants, clean out the level below, the way we did the -- before, and then fuse it together with implants.

Q. And I'm not going to have you read it; I'm not going to even put it up. But, when you're performing surgery on a patient, or asking them to consider it as one of the options, do you, in fact, read to them/tell them the risks, and both the risks of regular general-anesthesia surgery plus a diabetic?

Did you -- you note that in your notes, what the risks are?

A. Yes.

Q. Okay. Are some of them that you've commented -- that you write down and tell him: paralysis, death?

A. Yes.

Q. Brain damage?

A. Yes.

Q. Not coming out of the anesthesia?

A. Yes.

Q. Okay.

Very briefly, this can go up on the screen ...

This is 28 in evidence.

(Image displayed.)

Q. It's the disc and it is the cervical MRI of 9/2/25.

Looking up at image 7 of 13, series 3, of September -- September 2nd, 2025, that's a few years post your cervical surgery; and you did it on a different view earlier, but is the disc in that area still off -- is it off the cord, where you did the hardware?

A. Yes.

Q. And that you could see -- and that's --

The solid gray line down the middle is the spinal

cord, and that's, in fact, the brain, where it's connected --

Correct?

A. Yes.

Q. -- above it.

And because we can see white on both sides, that means, in that view, in September of '25, it's not touching the cord; it's -- we don't know about the axial view for exiting nerve root, but it's not touching the cord; true?

A. Correct.

Q. Okay.

MR. McCRORIE: If you could just go to 32 ...?

(Image displayed.)

MR. McCRORIE: 32 -- this will be 32-A, demonstrative only. Maybe -- I'm sorry; 28. It's 32 in evidence.

(Image displayed.)

Q. Okay. Now, this is taken August 6th, 2026. Did you also -- did Mr. Sayles also relate to you and exhibit signs of adjacent-level breakdown of the cervical spine, just like he was complaining of complaints of progressive pain to the lumbar spine?

A. Yes.

Q. And where we see the distraction there (indicating), is that where your two levels of hardware was put in?

A. Yes.

Q. Okay. The level above that and the level above that appear to now have material in that black area; is that true?

A. Yes.

Q. What is that material that is now in the --

Is that the spinal canal, where it is?

A. Yes. It started pushing into the spinal canal.

Q. Okay. And what does it mean, the fact that it wasn't there in '24, '25, post-surgery and now there is disc material on the levels above the two levels you fused?

A. It means the patient's developing adjacent-segment disease.

Q. Okay.

MR. McCRORIE: If we could just go to the next one, it's 29; it's 32-B for demonstrative only.

(Image displayed.)

Q. That is the level above the level you fused, and what is that there (indicating)? What does the black disc on the top appear to be doing to the cord in the middle?

A. It's starting to push backwards.
Q. And finally, number 30, which is just side by side ...
(Image displayed.)
Q. Now, the level straight above where you fused -- the two levels -- is now appearing to touch, or begin to touch, the cord; true?
A. Yes.
Q. Is that adjacent-level breakdown?
A. Yes.
Q. Can that be manipulated, faked, exaggerated, in any way?
A. No.
Q. Was it there the year before or the year before that?
A. I don't believe so.
Q. Okay.
MR. McCRORIE: That's it, and we don't need anything ...
Q. Before getting to the opinions: Did you review the two reports of the defendants' examining physicians, one a spine surgeon named Ira Chernoff? Did you review his report?
A. Some of it.
Q. Did you review the diagnosis, and do you agree

with what he says in the "Diagnosis"?

A. From what I recall, yes.

Q. Okay. And did you also review the report of Jerry Lubliner, the sports-orthopedic doctor?

A. I did, a long time ago. I'd have to refresh my memory on that one.

Q. Okay. So we don't have to go to a note, in each and every note -- was there ever a note where -- or a visit -- and... Okay, I count around 24 visits. It might be a little more; it might be a little less. But was there ever a visit where Mr. Sayles did not make a complaint of pain or discomfort to his neck or his back?

A. No.

Q. And were there some times it was more to the neck, less to the back, depending on when a surgery was, or something like that?

A. Yes.

Q. Okay. So we don't have to go through each of the notes, at any time they progressed, you noted it and you note whatever he's relating to you on each date; right?

A. Yes.

Q. It's in evidence, so we'll leave that.

Prior to your first surgery to his neck in September of 2022, did you, approximately in April of 2022, suggest -- I know you can't mandate it -- did you

suggest that he stop working full time?

A. I believe I did.

Q. And what would --

Would you expect someone with -- well, just take the cervical -- someone with eventual myelopathy, disc touching the cord -- by the end, would you expect him to be able to continue working, pain-free and --

MR. McCRORIE: Well, withdrawn.

Q. It is the myelopathy that causes the clumsiness and the falling?

A. Correct.

Q. And why did you suggest he stop working as a city inspector in April of 2022, understanding that you were going to perform surgery soon thereafter?

A. He had, um, clumsiness, balance problems, severe symptoms requiring medications, and -- and therefore -- and he did seem to be getting worse with time -- and therefore, I felt that he would be better off if he wasn't doing anything strenuous and he was protecting himself. He could have a fall on the job. He was exposing himself to risk.

Q. And was there ever a time you said, "Stay home, do nothing, lay in bed"; or did you tell him to -- he could -- go about his business, just not do the work or strenuous activity?

A. Well, we try to have people -- unless they are -- unless they're unable to -- to, um, use a cane, we do ask people to be active and try and exercise, to keep their neck and back stable and as strong as possible.

Q. I'm going to ask you opinion questions, so you can give your opinions and then you'll be cross-examined.

So I want to -- I'm going to ask you --

First, I'm going to give you a set of facts. I'm only going to do that once. It will be the same set of facts for all of the questions I ask you other than when I ask you to assume preexisting -- okay?

(No audible response.)

Q. I'd like you to assume that Mr. Gordon Sayles, on the date of the accident, 5/11/2018, has the date of birth -- I'm not sure -- I have the math here but I think it's wrong -- a date of birth of 9/6/1963 --

MR. KULLER: 9/8.

Q. 9/8/1963.

And then, on -- prior to coming to you, in November 2015, he had an incident of a dog, you know, scaring him, attempting to come towards him, where he fell backwards, injured his back and his foot. The foot had an ulcer to it, but his back -- I just want you to focus on it -- he had an injury to his back that he

attended physical therapy for, and I think it said in one note, had two injections.

Okay?

A. Yes.

Q. Low back.

I'd like you to assume, simultaneously, he had diabetes before 2015, he has diabetes now, and has, admittedly, experienced something called "bilateral neuropathy," which, he says, is a "fuzzy feeling" down in his feet, coming up (indicating) from the feet, with a sensation.

I would like you to assume, there was no work-accident case, no lawsuit for that case, that he treated for his back; and eventually, in November of 2017, he was cleared by the City of New York to return to work, in full capacity, as a New York City Building Inspector and that he, in fact, did return to work as a New York City Building Inspector, I think, in January of 2018, with unrestricted -- with no restrictions.

I'd like you to assume he, admittedly, said he would have some back pain, lingering, but it did not impair his ability to work, walk, do anything with his job.

I'd like to you assume, then, on May 11th, 2018, he was in an elevator and it abruptly dropped four

floors; it stopped abruptly, or halted abruptly; it jolted his body; several people in the elevator fell to the floor; he was holding onto a rail; it jolted his body, both neck, back -- forget the shoulder for now, but he did complain of shoulder pain, having held onto the rail when the body was jolted.

I'd like you to assume, his immediate complaints after, to his employer, within an hour or so, was neck, left shoulder, back, lower-left leg.

I'd like you to assume, he went to the emergency room, and everything you've told the jury -- everything you read and all the findings in the emergency room -- were there. It's mostly back, shoulder, this left-sided arm pain, things like that. Everything that was -- we discussed.

I'd like you to assume that he sees a sports-medicine orthopedic, Shahid Mian, and everything we read you, including all the notes we didn't read you; that he attended physical therapy from May 2018 through August 2018; that he had radiating pain going down his left arm that he had never had before.

I'd like you to assume that he did not have the radiating pain to his left leg, that it -- you know -- after going back to work, he had some pain to his back but not radiating.

I'd like you to assume, he had the MRIs you went over, even the ones you didn't order, back in 2018, with all of the findings as you found them to be and that you noted in your record.

And I'd like you to assume that, prior to seeing you, in addition to maybe some other doctors -- there was a Dr. Wert, but that was for the shoulder; that was in September of '20; that's for the shoulder -- that he saw that pain-management physician we read you and that you knew about, Dr. Demesmin, University Orthopedic, where they said he should see a doctor for the neurological pain and see an orthopedic for the shoulder.

I'd like you to then assume, he came to you on February 23rd, 2021; all of your treatment that you testified about and even all the treatment you didn't testify about, that you did it all, and any medications that are in there that you prescribed, that all of that occurred --

Okay?

A. Yes.

Q. -- as well as all of the testing that you ordered.

And these are the questions and the way we have to ask it. I'm going to ask you if you have an opinion;

you state, "Yes." I'm going to ask you, then, what the opinion is. After you give the opinion, I'm going to ask you your basis, the way we have to do it. Okay?

So the first question is: Do you have an opinion, with a reasonable degree of medical certainty, as to the cause of the radiating symptoms down Mr. Sayles' leg, specifically the left leg, after the accident of May 11th, 2018?

A. Yes.

Q. What is that opinion?

A. That he had lumbar disc herniation causing radiculopathy.

Q. And did the acc --

Do you have an opinion as to what caused the symptom of radiation, assuming he didn't have that radiation on a constant level as it was indicated thereafter?

What was the cause of the symptoms of radiation down his lower back?

A. The nerve being compressed.

Q. Okay. What is the cause? Was it --

A. The accident that caused an exacerbation of his lumbar condition.

Q. Okay. And is, in fact, that mechanism of injury consistent with these types of injuries, as a spine

surgeon, that you've seen often?

A. Yes.

Q. Do you have an opinion, with a reasonable degree of medical certainty, as to the cause of the ongoing symptoms that got progressively worse, eventually causing the need for a lumbar surgery in -- when -- in October of 2023? Or whatever -- yeah.

A. Yes. It was the accident in the elevator.

Q. What do you base that on?

Or: Give the basis for this opinion and the last opinion. Is it the same basis?

A. Yes.

Q. Okay. Please give the basis. I don't know if you're going to have to do it each time, but this -- I do need the basis in the record.

A. Well, based off my -- my expertise and injuries to the back; based off of the history of his -- his precondition, his ability to work, um, with full, unrestricted activities prior to the injury; the clinical history from the other doctors and the emergency room that he went to; based off of our physical examination findings; based off the intensity of his symptoms and the findings on imaging films; and then, ultimately, the findings of disc herniation during surgery.

Q. Do you have an opinion, with a reasonable degree of medical certainty, as to the cause of the cervical symptoms; again, in that hypothetical that he has not had cervical shooting pain down his arm, ever; had not been to doctors for that, ever?

Do you have an opinion, with a reasonable degree of medical certainty, as to the cause of the cervical symptoms, including the radiculopathy, that he experienced after the accident of May 11th, 2018, such as the ones relayed to Dr. Mian, through today?

A. Yes. I believe it was the elevator accident.

Q. Can you please state the basis for that opinion, for the record? And please tell the jury.

A. The same -- the same rationale as the injury to the lumbar spine: based off of my experience in the field; based off of the history that the patient had, off of the other providers' experiences with him; based off of my, um, physical examination; and, ultimately, the imaging films and diagnostic testing.

Q. Do you have an opinion, with a reasonable degree of medical certainty, as to the cause of the need for the cervical surgery?

A. It's the same.

Q. When you say, "the same," for the record, it's the same opinion?

A. Yes.
Q. And the same basis?
A. Yes.
Q. Okay. If there's any basis that's different, please tell the record; we would need to know. Okay?
A. Yes.
Q. Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not, in the future, beyond the date of this trial, Mr. Sayles will continue to experience symptoms of pain, radiation and further breakdown, whether you do the surgeries to the back or not?
A. I believe he will.
Q. And what is the basis of that opinion, and for how long do you have an opinion he'll experience that?
A. Well, he's had chronic symptoms and he has adjacent-segment disease and, um, he has not been responding to conservative management, so it's my belief that the symptoms are going to be permanent. He has permanent loss of motion at those joints that were fused in the neck and the back, as well.
Q. Okay. Just so we're clear, I don't know -- I think I asked it for one body part, but is it -- and if it's not, tell us -- is it the same opinion for both the neck and the back, going into the future, as to your

opinion as to whether or not he will have symptoms, both neck and back, given the current breakdown?

A. Yes.

Q. For what period of time for both body parts? So I don't know which one -- opinion -- you gave it on, but is it for --

A. For both the neck and the back.

Q. Okay. Is that the same basis that you just gave?

A. Yes.

Q. I don't want to put words --

That's it?

A. Yes.

Q. I don't want to ...

Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not the accident -- you know, I know it was in your notes earlier, and it's been in your notes -- as to whether the accident of May 11th, 2018 aggravated, exacerbated, whatever word you choose to use, Mr. Sayles' previous conditions to the lower spine?

A. I believe it did.

Q. Okay. And what do you -- what do you base that on?

A. The same rationale. I -- you know, I -- I've seen these types of conditions get worse and exacerbated

through injuries, in my practice on a daily basis; he had a history that's consistent with that, and based off of all of our imaging, diagnostic analyses.

Q. Do you have an opinion, with a reasonable degree of medical certainty --

MR. McCRORIE: Withdrawn.

Q. Is the surgery to the lumbar spine scheduled? We stepped in the back, but is it scheduled?

A. I'm not sure.

Q. Did Mr. Sayles come to you recently?

He testified, it's scheduled for November twenty-something.

A. I believe he did, and we discussed it again.

Q. Okay. And let me just see ...

With a reasonable degree of medical certainty, is the future surgery warranted, based on the breakdown you physically showed the jury in both the X-ray of March of '26 and the MRI in April of '26?

A. Yes.

Q. And is --

Regarding his neck -- I'm not saying that's scheduled; I'm not saying that's happening right now -- do you have an opinion, with a reasonable degree of medical certainty, as to whether or not --

Given the breakdown we just -- you just -- showed

the jury and the fact that the disc above the operative fusions is now beginning to touch the cord, do you have an opinion, with a reasonable degree of medical certainty, as to whether or not the cervical spine will require future revision surgery and further fusion?

A. I think it's highly likely that it will.

Q. And what do you base that on?

A. The natural history of these disorders. Given the fact that he has a two-level fusion and that the disc is, um, degenerating adjacent to the surgery, and given the fact that he's still symptomatic, it's likely.

MR. McCRORIE: Just give me a moment.

(Pause.)

Q. Sixty-three now, but do you have an opinion, with a reasonable degree of medical certainty, as to whether or not, after the back surgery -- so after October of '23 through today -- whether it would have been advisable for him to go back to work as a New York City Building Inspector?

A. Not with his current symptoms and neurologic problems.

Q. And did you relay the symptoms as they got progressively worse from --

They originally get better in the beginning; correct? Some of them.

A. I believe so.
Q. And did you --
So have you ever told him, or cleared him, to go back to work -- as his surgeon -- with a -- prior to today?
A. I don't believe so.
Q. And how about currently, beyond the date of this trial? Sixty-three. A lot of people are going to work till 65. But do you have an opinion as to whether or not he should go back to work, given the level of breakdown in his spine?
A. I don't believe so.
Q. And ... hang on.
(Pause.)
Q. Did you -- I'm not going to ask you to comment on it; he's going to be testifying tomorrow: Did you review the life-care plan of a board-certified physiatrist, a PM&R -- physical medicine and rehabilitation -- doctor, Dr. Barry Root?
A. Yes.
Q. Do you agree with the plan? We won't get into what it is, but do you agree with it?
A. Yes.
Q. Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not, beyond the

date of this trial, Mr. Sayles should see an orthopedic spine surgeon and follow with one regularly, either yourself or another doctor?

A. Yes; I think he should.

Q. Do you have an opinion, with --

And what is the purpose --

When someone is still feeling pain to the neck, back, has had surgery to both body parts, needs future surgery to each body part, what is the purpose of following with a board-certified spine surgeon at least once a year?

A. To -- to supervise the -- the status of his back, to try and optimize his -- his symptoms, to respond to any new symptoms, do diagnostic testing in that response; any future surgeries or future issues can be managed by that person.

Q. Is there any way to do diagnostic testing without a surgeon ordering it, or -- not a surgeon, a doctor?

A. Yeah. You should have a doctor supervising him so they can do them.

Q. And what types of testing would you anticipate he would need, going forward into the future --

MR. McCRORIE: Withdrawn.

Q. Given -- you said the pain would be permanent; correct? Rest of his life? Yes?

A. Yes.
Q. Would he also need X-rays, MRIs, going forward, in the future?
A. Yes.
Q. What is the purpose of --
You've already told us, there have been many done up until now. What's the purpose of checking out, every few years, the neck and back once it's been fused and even re-fused?
A. Well, um, as the spine has ongoing problems, we would supervise to make sure that the -- that he does not have any neurologic deficits, intractable pain that's not controlled, indicating for any surgeries that may be necessary to try and reduce his symptoms.
Q. Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not, first, postsurgical physical therapy will be advised for Mr. Sayles (indicating) if he has either the neck or the back surgery?
A. Yes; it will be.
Q. What is the purpose of physical therapy for someone with the spinal conditions that Mr. Sayles has?
A. To optimize his recovery.
Q. What is the purpose of home therapy when physical -- when regular supervised therapy may either

stop, for one reason or the other? What is the purpose of teaching the patient home physical therapy?

A. To minimize their symptoms and -- and minimize the -- the ongoing problems in his spine.

MR. McCRORIE: I'm going to save the time:

Q. Your notes indicate, he's currently getting prescriptions for pain, or for inflammation. Going into the future, beyond the date of this trial, do you have an opinion as to whether or not Mr. Sayles will require prescription medication for his -- specifically -- for his neck and back pain, symptoms, spasms, etcetera?

A. Yes; he will continue to need them.

Q. Is the basis -- what is the basis for this, and if it's the same, you can say.

A. It's the same.

Q. Okay. And you already said you reviewed the plan of Dr. Root and you agreed with it.

A. Yes.

Q. And lastly, on your very last note, if it states, "The patient will return to our office following the procedure for an initial postoperative consultation," does that tell you whether or not your office scheduled it? If it says that --

A. That was -- that was the plan during the visit. I just don't know specifically --

Q. Oh.
A. -- what -- what has happened in terms of logistics.
Q. Let's be clear: Did you tell the patient, in the last visit, that ...
THE COURT: What did you tell the patient?
MR. McCRORIE: Yeah.
Q. What did you tell the patient?
MR. McCRORIE: I didn't want to go to the other thing, Judge.
A. Yeah. I -- I told -- we -- we discussed the plan, the surgical options for his lower back, and made a plan to perform the surgery.
Q. Okay.
MR. McCRORIE: Nothing further. Thank you.
MR. SCHIFERL: Your Honor, just a point of clarification: You were reading -- counsel was reading from a record. What is the date of that record?
MR. McCRORIE: The date?
THE COURT: The last note?
MR. SCHIFERL: Yes.
MR. McCRORIE: The last note is -- they're all -- they're long, so ... October 1, 2026.
MR. SCHIFERL: Thank you.

THE COURT: Cross-examination?
MR. CASCONE: Can I go?
THE COURT: You may.
MR. CASCONE: All right.

CROSS-EXAMINATION

BY MR. CASCONE:

Q. Dr. Gerling, do you have a file on Mr. Sayles (indicating) with you today?

A. Yes.

Q. Do you have it in front of you (indicating)?

A. Do you mean the court -- the court file?

Q. I'm talking about your personal file, all of your paperwork dealing with your patient, Mr. Gordon Sayles. Do you have that with you today?

A. No. I have the court -- I was told that everything was already submitted to the court, so I didn't bring a separate file. We submitted this file; this file was then submitted to the court.

Q. So we've established, this isn't your first time testifying in a court in New York; correct?

A. Correct.

Q. You've been cross-examined by other defense lawyers in the past; correct?

A. Yes.

Q. And, on average, you testify about six times a

year in court?
A. Yes.
Q. And you know that every time you're in court, a defense attorney asks you to bring your original medical file with you -- on a patient; correct?
A. Well, normally, we have a discussion and I find out whether or not I need to; and in this case, I was told that it was already in the court.
Q. So who told you not to bring Mr. Sayles' documents to court?
MR. KULLER: Objection.
A. The plaintiff's --
THE COURT: Overruled.
I'm sorry; you can answer the question.
A. The plaintiff's counsel.
Q. All right. So you were told by plaintiff's counsel not to bring the documents on Mr. Sayles to this courtroom; correct?
A. No, not -- not in that way.
Um, I actually did have them printed, and I normally do bring them. Unfortunately, I did not go to my office today and I had not brought them home with me. And so, when I called the attorney and said, "Do I need to print a new version of it to bring," because I would have had to try and do that at home, he said, "Don't

worry; we have it in the -- in the court already; you already had it submitted." So, instead of being late for court, I just came.

Q. But you got into arguments with other defense attorneys at trial, in front of judges, on this same exact topic: that you need to bring your original documents to the courthouse.

Is that a "yes" or a "no"? You've been in prior arguments with lawyers about this.

A. I -- I don't remember having arguments with anybody about that, no.

Q. Does anything in the documents in front of you now, documents that the attorneys did ask you to bring to court, talk about a blood workup that Mr. Sayles had to undergo for your upcoming surgery?

A. The "blood workup"?

Q. Yeah, the -- the --

There's a preop; correct? You just don't -- you don't have a patient just come in, lay down and you start operating. There's got to be a pre-workup; yes?

A. A "pre-workup"? Do you mean a medical clearance?

Q. Yes.

A. I don't do those in my office.

Q. So you don't have any documentation with you today to show us that there was a premedical clearance

for this surgery that's happening in November.
A. No. That would be in the hospital chart.
Q. Okay. So the answer to my question is no, you don't have it with you today; correct?
A. I don't know if it's in this file right here (indicating).
Q. You charged the plaintiff's team $8,000 for your testimony?
MR. McCRORIE: Objection as to "team."
MR. CASCONE: It's what --
MR. McCRORIE: Yeah, I do object.
THE COURT: You could rephrase, I guess.
MR. McCRORIE: Yeah.
Q. You ever play team sports in high school?
MR. McCRORIE: Judge, I object, because of his opening, to the word "team." That includes the word "team."
THE COURT: All right. The question about whether the witness has played team sports is stricken --
MR. CASCONE: Okay.
THE COURT: -- and I'm asking you to rephrase the other question.
Q. Did the defense call you for trial today?
A. Yes; they requested that I come to trial.

Q. Okay. So you're working with me today. You're working with the defense team.

A. Honestly, you know what? I don't know who called, to be honest. I -- I was told that I was being -- that I was, um, being scheduled to testify today. I had assumed it was on behalf of my patient and I would assume it was on behalf of the plaintiffs [sic].

Q. So you think, perhaps, that you were called to this courthouse to help the defense defeat the plaintiff's case?

MR. McCRORIE: Objection.

THE COURT: Overruled.

A. No.

Q. Of course not. You always come to court to testify for the plaintiffs' side; yes?

A. Well, I have done defense in medical malpractice cases, but I've, um, really only testified in court on behalf of my own patients when my patients require an expert to testify to their injuries.

Q. Okay. I don't want to keep you here any longer, but we both know -- we know exactly -- what you're saying at trial. So you say "patient"; we say "plaintiff." We say "litigant" and then you say "patient." So I don't want to go back and forth because that's going to make an argument between us. Okay? So

we both know what we're talking about.

You're testifying today on behalf of a plaintiff, someone that's suing for money. You understand that; correct?

A. Of course.

Q. Okay.

Now, your name is associated with over 700 active lawsuits right now. Is that accurate or inaccurate?

MR. McCRORIE: Objection.

THE COURT: What is the basis of the objection?

MR. McCRORIE: That he's associated with 700 lawsuits?

THE COURT: Meaning, referenced in the papers filed in court?

MR. CASCONE: Yes.

MR. McCRORIE: Okay.

THE COURT: Okay.

A. I don't know if that's true. I mean, I have been in practice for 20 years. These -- this case has been open for -- what? -- for eight years? So I don't know. I mean, I see thousands of patients a year.

Q. Okay. And we're going to get into that: your purely medical treatment and then the ones that overlap with lawsuits. Okay?

So you have no reason to doubt me when I tell you that if someone was to do a computer search in the courthouse, your name would come up in 700 active lawsuits. My question is: Do you have a reason to doubt me?

MR. McCRORIE: Objection.

A. I have no idea --

THE COURT: I'm sorry.

What was the basis for the objection?

MR. McCRORIE: The other things they said that didn't come true?

THE COURT: What?

MR. McCRORIE: Nothing.

Withdrawn.

MR. SCHIFERL: Can we not have the comments of counsel?

MR. CASCONE: Come on. I'm not doing that to them.

THE COURT: All right. It's going to be a long afternoon, gentlemen.

The objection is withdrawn.

The witness may answer the question.

A. I -- I have no idea. I mean, if I see a patient in the office and they have an injury, even if I don't operate on them, and if they're involved in a dispute,

then I assume that I have to submit paperwork that would then document what I saw and what their injuries were or what -- what they need. Um, so whether or not I go to court, whether or not I have to testify, I may be asked to submit a paper saying, "Yes, I saw this patient and this patient had these injuries."

So it doesn't shock me that there would be, you know, a hundred patients a year that I've seen that have something that they're -- that they're involved with, with the courts. It doesn't shock me. Patients get hit by cars; car accidents, workmen's comp, whatever it is.

Q. Um-hmm. You just said you "may" have to submit a report. You know that you must submit a report to get into the courthouse; correct?

A. No. In what context are you referring to?

Q. Every time you're working with a litigant, somebody that's suing, you understand that they have a lawyer and that everything -- when you create a document, it's eventually going to get to me, the defense attorney, and to the jury (indicating); correct?

A. No. The majority of my patients are not involved in litigation.

Q. That's great, and you say that every time, but that's not what I asked you.

So I'm going to separate your patients that don't

have lawsuits and the hundreds -- 700 times you are involved in litigation, okay? So let's keep that separate, because every time that you try to mix 'em, I have to separate them again. Okay?

You understand what I'm getting at; correct?

A. What are you trying to explain? I'm trying to understand your point.

Q. We've been through this before.

A. We have?

Q. Yes.

A. When?

Q. Okay. So, if you're in the medical lane (simulating) and you step into the litigation lane (simulating), sometimes things overlap; correct?

A. I've never heard of this analogy that you're using before. I mean, obviously, I'm in court right now, so, yeah, this is legal.

Q. Yes. So when you give a diagnosis as to whether somebody has a herniation, as a doctor, it shouldn't concern you how the herniation came to be; correct?

A. Well, that's not true. No.

Q. You would give the same treatment to a herniated disc whether it was congenital, meaning somebody was born with it, if someone developed scoliosis, if someone had degeneration due to obesity, or behavioral, such as

being in the work force, a laborer, or a trauma; correct?

A. That's not necessarily true.

Q. Well, don't you speak on these topics to various groups?

A. Yes.

Q. You lecture; don't you?

A. Yes.

Q. You lecture live; correct?

A. Yes.

Q. And you lecture on the radio, on podcasts; correct?

A. I've been on, I think, one podcast, like, maybe five, six years ago? I can't recall.

Q. Ken Rosato. You were on that podcast, right? Mornings with Ken Rosato?

A. I've been interviewed on, like, a morning show, if that's what you mean. I -- I don't know if it's a podcast, but, okay. It was an interview; it wasn't a lecture.

Q. But you explained, at least to Mr. Rosato, that spinal pathology could come from congenital causes -- they were born with it -- behavioral; someone's obese, perhaps; behavioral, if they're in the labor -- they're in construction, bending a lot; painting, which causes

them to look up (simulating); crouching down (simulating); people that are installing carpets (simulating); and then trauma.

Trauma is just another way someone can injure their spine; is that fair?

A. Trauma is an injury to the spine.

Q. But you treat all of it; correct?

A. Yes.

Q. So, if you're going to do a surgery on someone's lumbar spine and you do a discectomy -- you're going to pull out the disc material and then you're going to fuse the spine -- it doesn't matter to you if that was trauma or age-related degeneration; am I correct?

A. I -- I don't know what you mean by does it "matter" to me. Can you explain what you mean by whether it matters to me?

Q. Yes. Do you take any additional steps?

If you look at the spine and you say: "You know what? This is caused by degeneration; this guy is 70 years old; his spine is degenerated," as opposed to, "This guy was hit by a New York City bus," it doesn't matter to you; you want to make the patient pain-free; correct?

A. Yes.

Q. You're not giving any better treatment to someone

that sustained a trauma than to somebody who is complaining of pain because of normal wear and tear; is that fair?

A. Yes.

Q. Okay. That was the point I was trying to make. So it doesn't really matter to you, as a surgeon, the cause of the pathology. Your goal is to take away the pain; yes?

A. Yes.

Q. Okay. Unless you're involved in a lawsuit. That's when you step out of your medical hat (simulating) and you put on your lawyer hat (simulating); and that's why you come in and tell us causation: because it doesn't matter in your practice what the cause is, it only matters when you're in the courthouse. Is that fair?

A. No.

Q. I heard a very impressive resumé this morning. As professionals, we have a resumé; we call it a "CV." Correct?

A. Yes.

Q. When was the last time your CV was updated?

A. I don't know. My executive assistant does that. I assume, within the last couple months.

Q. Okay. Have you made any recent changes to your

CV?

A. No. It depends what you mean by "recent."

Q. Let's say, within the last three years, have you made any changes to your curriculum vitae?

A. Yes.

Q. What changes have you made to your professional resumé?

A. Well, as I said earlier, I switched jobs; I became the Director of Spine at a system in New Jersey. I moved most of my practice there.

Q. Why did you do that? Why did you move most of your practice from New York to New Jersey?

A. I think, maybe 2018, I started seeing patients in New Jersey. Um, it's a completely different practice environment; I really liked it. I started expanding. I had three offices there over the last five years, six years. I think -- actually, 2020, I think I opened my Clifton office. And I like it. It's -- it's a different practice environment, so I started seeing patients there; I started doing surgery there; I started operating there --

Q. Um-hmm.

A. -- and I'm part of four different hospitals there. Um, I have a much larger patient base there.

Q. Um-hmm.

A. So that's the reason.
Q. That's it? That's the only reason?
A. Um, that's the reason why I practice there.
I mean, I -- I took that job because it's a far more prestigious job; it's far better paid; it's -- it was -- it was an upgrade.
Q. Okay. Did it have anything to do with you losing your privileges --
MR. McCRORIE: Objection.
Q. -- to practice in New York; in any of the New York hospitals?
MR. McCRORIE: Objection.
THE COURT: Overruled.
MR. McCRORIE: Can I approach?
You ruled on it.
THE COURT: I --
MR. CASCONE: I'm not mentioning --
THE COURT: I ruled on something else.
MR. McCRORIE: Can we approach?
You never let us approach. We'd like to approach because this is important.
THE COURT: You can approach.
MR. McCRORIE: Okay, thank you.
THE COURT: Step into the back.
(The following proceedings were held in the

Court's robing room, with the Court and all counsel present:)

THE COURT: Yes, counsel?

MR. McCRORIE: So, Judge, the only issue with letting that question come out: He's never been suspended in New York.

What he wants to do is -- there were these RICO cases. He got --

MR. CASCONE: Why don't you ask me?

MR. McCRORIE: Just listen.

MR. CASCONE: I never mentioned the word "RICO." I have a court order --

(Simultaneous speaking.)

THE COURT: Gentlemen, you have to speak one at a time.

Let me hear from counsel and then I'll hear from you.

MR. McCRORIE: New York University approached him when he had the RICO cases. They were talking to him about getting sued for RICO. No one suspended him. He's never been suspended in New York. He's never been -- anything that comes --

THE COURT: Counsel, right now, the question is --

MR. McCRORIE: Has he been suspended?

MR. SCHIFERL: No.

THE COURT: No. The question is: "Was part of the reason you moved to New Jersey because you lost privileges in any New York hospital?"

MR. McCRORIE: Did he say the word "suspended"?

THE COURT: No. He said, "lost privileges [sic]," and I don't see a problem with that question.

MR. McCRORIE: He didn't lose privileges, and it's all --

THE COURT: I don't know the answer to that question. I don't know if he --

(Simultaneous speaking.)

THE COURT: Wait, counsel. Once I'm speaking, then you wait.

MR. McCRORIE: Yes. I'm sorry.

THE COURT: That's okay.

MR. McCRORIE: I'm sorry.

THE COURT: So I don't know the answer to the question. The doctor could say "yes" or the doctor could say "no." The question itself --

I mean, I would -- I would agree that it would be my hope that if counsel is asking such a question, he has a good-faith basis to do so.

MR. CASCONE: Of course I do.

THE COURT: Okay.

MR. CASCONE: And it has nothing to do with RICO.

THE COURT: Okay. And we're not talking about RICO, which is what the ruling was limited to.

MR. McCRORIE: If his answer -- the GEICO case -- it's a GEICO lawsuit.

MR. KULLER: And it was in our papers.

MR. McCRORIE: It was in the --

THE COURT: Counsel, no one's asking about a lawsuit.

MR. McCRORIE: Yes.

THE COURT: The only -- the only question is whether he partially moved to New Jersey -- part of the motivation for that was loss of privileges in a New York hospital. That is the question.

MR. McCRORIE: So, okay. The only way --

And he didn't lose privileges, but the only way to respond --

THE COURT: I mean, I don't know the answer to that.

MR. McCRORIE: -- is to talk about the lawsuits that were --

THE COURT: No. It's a yes-or-no question.

MR. McCRORIE: Okay.

THE COURT: I'm not asking him to talk about the lawsuits, and we have specifically said that he can't bring up the lawsuits. This is not referencing the lawsuit.

MR. CASCONE: So as not to waste any time, I have his deposition transcript where he says: "I was suspended. I had to give my money back for Medicare fraud."

I have the transcript; I'll have it e-mailed to the Judge and to you right now.

MR. McCRORIE: Okay.

MR. CASCONE: I have it all in the transcript where he admits: "I was suspended."

MR. KULLER: Can I see the transcript?

MR. CASCONE: Can you see the transcript?

MR. KULLER: Yes.

MR. CASCONE: Of course, you can see the transcript.

Do you think I would ask these questions, as an officer of the court for 30 years, if I didn't have a basis?

(Simultaneous speaking.)

MR. McCRORIE: Suspended his medical license? I don't know if that's true.

THE COURT: Privileges.

MR. CASCONE: You just said he was never suspended. You just said he never lost privileges and I'm telling you he did.

THE COURT: I've given you an opportunity to approach. I still feel that my position on the question is right. The question is okay.

MR. CASCONE: Thank you.

THE COURT: Let's go back.

MR. McCRORIE: If he's going to be questioning him on the deposition, can we get it sent, like you said?

THE COURT: Are you questioning him on it?

MR. CASCONE: Yes.

THE COURT: Okay. All right.

MR. CASCONE: I'll get to my phone and I'll have my secretary e-mail it to everybody right now.

MR. PETROZZO: So we just need a minute.

THE COURT: Do you want to take a break?

MR. PETROZZO: Well, he has to send it.

THE COURT: Okay, we'll take a five-minute break.

(The following occurred in open court, with all said parties again present:)

THE COURT: We're going to take a five-minute break.

COURT OFFICER: All rise.

(The jury left the courtroom.)

(Recess.)

THE COURT: On the record.

MR. McCRORIE: Judge, Mr. Cascone has agreed -- we're waiting for the -- he said something about "Medicare fraud." We're waiting for the transcript to come in. He's shown us the transcript; it's here (indicating). It says that while a lawsuit was pending against him, they suspended his privileges. It then says the lawsuit was dismissed, but he had already left. He resigned -- it says, "I resigned."

The lawsuit is the RICO, the GEICO. They -- they suspended him when the lawsuit was -- he was having a discussion with them. He left. He resigned. And it says: "Was the lawsuit dismissed?" "Yes." It's right here (indicating).

There's nothing about Medicare, unless it's later on.

MR. CASCONE: It is later on, and the transcript I have doesn't even mention the word "RICO." Your order was, "Don't mention 'RICO.'" I'm not mentioning "RICO."

THE COURT: Well, I mean, my order was that

he can't be cross-examined on any allegations pertaining to litigation that was pending where those allegations had not been substantiated.

MR. McCRORIE: Yes.

THE COURT: But I'm not sure if I contemplated, in issuing that ruling, or if anybody brought up to me, that an interim suspension might be an issue.

MR. KULLER: It's my understanding from reading that testimony -- and he cleared it up later on -- that it wasn't a suspension because of this GEICO lawsuit, which was specifically cited in our papers; and I specifically cited to this GEICO lawsuit and Dr. Gerling when we filed our papers. This GEICO lawsuit got filed against him. While it was going on, he ultimately resigned from NYU-Langone; and it was a direct result of the lawsuit, which has since been dismissed.

So this whole line of questioning is about unproven allegations from a GEICO lawsuit that's now been dismissed as and against Dr. Gerling, so --

THE COURT: Well, it's not -- it's not an unproven allegation if he was suspended and --

MR. KULLER: He wasn't suspended.

MR. CASCONE: He said "yes," he was.

MR. KULLER: No, he didn't. He says "resigned." He said it --

MR. McCRORIE: (To co-counsel) I was doing the argument.

Even if he was, if it's based on a RICO suit, a GEICO suit, this is what the hospital's doing. There 15 years. They started -- not them. When I say "they," the tradesmen started suing all of the main doctors and then the -- the -- NYU, if they did suspend him, suspended him because of the RICO stuff. It's -- it's bordering on criminal; it says, "You're on a scheme with the doctors and the lawyers and the patients to do fake --

THE COURT: Yeah, I'm familiar with the allegations.

MR. McCRORIE: I know, but it was dismissed against him.

THE COURT: Right. Okay, but the point is, if the hospital -- I've not yet -- and I've dealt with a number of these -- I've not yet seen a situation where a hospital has suspended the privileges of a doctor based on a pending RICO suit --

MR. CASCONE: And may I --

THE COURT: -- and -- and -- so that's not an unproven allegation; that's something -- and if he

resigns because of a suit, that's also not an unproved allegation. The unproven allegations that can't be referenced is the very criminal conduct you're alluding to and the allegations in that complaint.

MR. McCRORIE: Only way for him to explain why he resigned is because they were bringing baseless RICO -- not just against him; it was against a bunch of doctors. And if his hospital, because they couldn't make heads or tails of it, wanted him to stop doing --

I think this would be highly, highly prejudicial. It stems from a lawsuit that was dismissed.

THE COURT: Okay.

MR. McCRORIE: It's like losing your law license, suspended, because someone accuses you of something really, really horrific and then it's dismissed and you get your law license back. He didn't. These are privileges at a hospital that didn't like their name in the paper.

THE COURT: That's fine, but it is not impermissible to question him about being suspended if he was actually suspended, and it is not impermissible to question him about being resigned --

MR. CASCONE: Thank you.

THE COURT: -- if he actually resigned. What is impermissible is to question him about any of the allegations in the RICO complaint.

MR. CASCONE: And I won't do that.

MR. McCRORIE: But how can he explain it? He has to explain it.

THE COURT: I guess he -- you know, that's --

MR. McCRORIE: It's not right. It's not right, but we take exception. It's really not right.

THE COURT: I note your exception for the record.

MR. McCRORIE: And before we go, can we have -- we still don't have the transcript. Before he starts, can we have the transcript?

THE COURT: I thought you did.

MR. McCRORIE: No, no. We don't have it yet, still. It's an e-mail; it should be here.

THE COURT: You should have it.

Did we get an e-mail? No.

MR. McCRORIE: We can wait as long as it takes.

MR. SCHIFERL: I got it at "15:35."

MR. SHELBY: Yeah, me too.

MR. CASCONE: Two transcripts. One is the

trial transcript and one is the deposition transcript.

MR. KULLER: I don't have it.

MR. McCRORIE: I got it.

MR. KULLER: You got it?

MR. McCRORIE: Yes.

THE COURT: You might not be on the e-mail, Mr. Kuller.

Somebody's sending it to him.

(Pause.)

THE COURT: All right, are we ready?

MR. McCRORIE: Can I just read?

The Court, in the trial transcript, is ruling on something about the "suspended"; I just want to see it. This is -- one was a deposition; one is the court in a trial. So --

We just got this. I just ...

THE COURT: This is not really intended to be discovery.

MR. McCRORIE: What?

THE COURT: This is not discovery, right?

I mean, this is being provided to you because he's going to question him. So you can look at what he's questioning him about, but I don't want to take a half-an-hour for you to read two transcripts and digest them. So I'd like to continue.

It's a quarter to four. At this point, we're definitely bringing back the witness tomorrow, so --

MR. CASCONE: And I only have five minutes and then I'm moving on to a different topic.

MR. McCRORIE: Is it --

It doesn't appear to be mentioned at the trial, unless I'm missing it, but ...

I wrote the word "suspended"; I wrote --

THE COURT: Can you show him the portion of the transcript you want to reference? Thank you.

MR. McCRORIE: Judge, can we just put on the record what he had to say at the deposition?

He says --

THE COURT: Wait. Are you referencing the deposition transcript?

MR. McCRORIE: Yes.

THE COURT: Okay.

MR. McCRORIE: Yes. So before you --

This is page 11.

MR. CASCONE: May I interrupt for just one second?

I do my crosses very quickly. I don't reference deposition transcripts unless I'm confronted with --

THE COURT: Understood.

MR. CASCONE: -- a statement. I don't plan on reading a transcript --

THE COURT: Right.

MR. CASCONE: -- unless the doctor fights me on it.

THE COURT: I don't think the doctor's going to lie.

MR. CASCONE: No.

MR. McCRORIE: Okay, this is page 11. It says -- page 11, line 10, to the bottom:

"Question: What happened to the privileges? Were they suspended or revoked?

"Answer: I resigned.

"Question: Before you resigned, were the surgical privileges suspended for any period of time?

"Answer: Yes. You know, it's complicated. Because I had a lawsuit that's recently dismissed, the lawsuit made allegations about me which forced NYU to do an investigation and suspension. During that process I resigned.

"Question: You mentioned a lawsuit" --

THE COURT: All right, I get the point.

MR. McCRORIE: But he has to explain the civil RICO lawsuit that they --

THE COURT: He -- he does -- he does not have to explain it, but he can choose to explain it if he wants to. But the defense cannot inquire about it.

MR. McCRORIE: This is prejudicial.

THE COURT: Counsel, I made my ruling. Have a seat. Let's continue the trial, okay?

MR. McCRORIE: Yes.

THE COURT: Thank you.

(Mr. McCrorie was seated at counsel table.)

MR. McCRORIE: The doctor is outside.

THE COURT: Yeah. Let's bring the doctor in.

(Pause.)

(Continued on next page.)

MR. McCRORIE: So we don't get into any -- can I redirect that an insurance company was suing him and that case was dismissed against him, an insurance company for liability was suing?

MR. SCHIFERL: The witness is here, Your Honor. The witness is here.

MR. McCRORIE: You ruled --

THE COURT: Wait. Wait.

Doctor, please step out.

It was really inappropriate to ask about that in front of the witness.

MR. McCRORIE: And I'm sorry to do that. It's just --

(Whereupon the witness leaves the courtroom.)

THE COURT: I am not going to limit you on redirect. However, if you open the door, that can be problematic.

Why don't we see how your witness handles the questions? I think your witness is probably quite capable of handling the questions. He seems like he's doing a good job.

MR. McCRORIE: I don't think so. These were alluding to criminal charges that --

THE COURT: Nobody is going to ask him about criminal charges. They're going to ask him -- the questions

are was part of the reason because you were suspended for privileges. He can say "yes" or "no."

"Did you resign?" "Yes" or "no." That's it.

And if he wants to talk about why, he can talk about why. If you want to ask him about why, you can ask him about why, but by doing so, it might open the door.

MR. McCRORIE: I'm allowed to use the words liability company that sued you and the case was dismissed.

MR. CASCONE: No.

MR. McCRORIE: Why wouldn't I be?

THE COURT: You can just say it was a lawsuit that was dismissed. But if you bring up the lawsuit, you will be opening the door, Counsel. That's all I'm saying. I wouldn't do that if I were you, but it's up to you.

Are you ready?

Do you want to brings the doctor back in.

THE COURT OFFICER: Should I bring the jury in.

THE COURT: Why don't we wait until the doctor is back in.

(Whereupon, the witness enters the courtroom.)

THE COURT: Are you good with water, Doctor? Yeah? Okay. You can have a seat -- well, if you want to stand.

You can bring in the jury.

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom at this

time.)

THE COURT: Okay. Please be seated.

Continued cross-examination.

MR. CASCONE: Can I have the last question read back please? I'll ask it again.

THE COURT: I think you were asking about his reasons for relocating to New Jersey, and he discussed some of those reasons.

CROSS-EXAMINATION

BY MR. CASCONE:

Q. Okay. So before we took our break, you gave the jury the reasons why you're not doing a lot of your work in New York anymore. And I asked you are those the only reasons. And then we took our break.

Do you remember having that conversation with me just a couple of minutes ago?

A. I do.

Q. Let me give you another opportunity.

You like New Jersey better; you having more customers in New Jersey.

Are there any other reasons why you're no longer practicing at Lenox Hill Hospital?

A. No.

Q. Okay. I'm looking at your resume from 2024. And it indicates that you're the attending orthopedic surgeon at

Lenox Hill Hospital. Was that accurate in January of 2024, that you were the attending orthopedic surgeon at Lenox Hill Hospital?

A. I think my privileges were --

Q. Let me ask you --

THE COURT: Wait.

Q. That is a "yes" or "no."

THE COURT: No.

MR. CASCONE: No?

THE COURT: No. When he's in the middle of an answer, you need to wait until his answer is done. If at the conclusion of his answer, you have some application to the Court, you can do so.

MR. CASCONE: I apologize.

THE COURT: It's okay. Go ahead, sir.

BY MR. CASCONE:

Q. Go ahead.

A. At some point at the end of 2023 or beginning of 2024, I don't know exactly when, my privilege from NYU -- I mean, from Lenox Hill had expired. And I hadn't done a case there in -- I don't know. I've done one or two cases there the entire time I was there. And so there was debate in my practice as to whether or not it was worth continuing to be an attending there. The privileges expired, and I did not renew them.

Q. So I just want to be crystal clear. Your privileges

expired on their own, and that's the reason why you're no longer the attending orthopedic surgeon at Lenox Hill Hospital?

A. I -- I don't remember exactly when they expired, but they did -- I -- I needed to renew them in order to continue -- I need to go back and go through the whole process again.

Q. Sir, you were suspended from Lenox Hill Hospital; isn't that true?

MR. McCRORIE: Judge, can we approach with this? It's --

MR. CASCONE: I'm talking about Lenox Hill Hospital, and I'm trying to move this as quickly as I possibly can.

MR. McCRORIE: Can we approach?

THE COURT: You can approach. Do we need to just break for the day? I really don't know what else to do with you guys.

You can't approach in front of the witness. Obviously, we're going to have to go off the record, and I'm going to to have to excuse the witness and the jury again.

MR. McCRORIE: I will just show you --

THE COURT: You want to have a discussion off the record in the robing room? Is that what you're asking for, Counsel?

MR. McCRORIE: No.

THE COURT: I'm not sure what you're asking for.
MR. McCRORIE: Can we just -- here.
THE COURT: You want to consult with your adversary, that's fine.
Off the record.
(Whereupon, a discussion is held off the stenographic record.)
MR. McCRORIE: Can we approach?
THE COURT: I don't think this is a conversation that we should be having in front of the witness, do you?
MR. McCRORIE: No. I'm just going to show you -- I'm not going to say anything.
THE COURT: I really don't know do you want to go in the -- back on the record.
MR. CASCONE: Can we break for the day?
THE COURT: I kind of think that that is the best thing to do at this point, honestly.
MR. McCRORIE: It's just -- it says NYU, not Lenox Hill.
THE COURT: Agreed. That is what we previously discussed.
Are so he's talking --
MR. McCRORIE: -- about something else.
THE COURT: -- about something else.
MR. McCRORIE: Yes.

MR. CASCONE: Can I move on?

MR. McCRORIE: I'm just showing him he's saying Lenox Hill. That's all.

MR. CASCONE: What do you want me to do, Your Honor? Just tell me.

THE COURT: I really don't know what you all want to do. Why don't you continue along the lines we thought you were going to continue on because it sounds like you sort of went on a different track.

MR. CASCONE: I don't think so, but I'll try to get back on track.

THE COURT: Well -- why don't you do what you can do, and then if we need to have a break to complete it, we'll try that. Okay?

MR. CASCONE: Yes.

THE COURT: Okay.

BY MR. CASCONE:

Q. Have your attending privileges ever been suspended in any New York Hospital?

A. Yes.

Q. Okay. Is that one of the reasons why maybe you favored Jersey over New York, because you were --

A. No.

Q. -- suspended here in New York?

A. No.

Q. Why didn't you include that when I gave you the chance twice? I asked you, "Anything else about New York maybe you think the jury would like to know about you?" And you didn't take --

A. Because that is --

Q. You didn't take my opportunity.

A. No. That is not the reason.

Q. So you being suspended in New York is not a big deal. Is that what you're telling us?

A. I'm not following your line of logic. You asked me why I was doing cases in New Jersey. I have a long track record in New Jersey. That's where my practice was -- was basically based. And as I said, I had a tremendous opportunity there that I had been transitioning to.

The fact that I had disputes with my old institution over certain matters that if we have to discuss, will probably be problematic, but I had -- I had disputes with them and --

Q. Problematic for you, right?

THE COURT: No, no, no, no, no. No. Let him finish his answer, please.

Were you done with your answer, Doctor?

THE WITNESS: No.

THE COURT: Okay.

A. The fact that I had -- that I had disputes in New York made it an easy decision to be there. It made -- but it wasn't

the reason why I was transitioning there. I transitioned there eight years before.

Q. Let's cut to the chase. I'm challenging your credibility. I'm not trying to do a character assassination. I don't believe what you told this jury is truthful. So I'm attacking your credibility. Okay?

You understand this, being in court as often as you are, correct? I'm permitted to do this?

MR. McCRORIE: Objection.

THE COURT: The objection --

Q. You understand that, right?

THE COURT: The objection to the question is sustained.

Next question.

BY MR. CASCONE:

Q. So when you say things to this jury involving a lawsuit and asking my client to pay money, I have a right to challenge your statements. You understand that, correct?

A. Yes.

Q. Okay. And part of my challenge is to whether or not you're telling us the truth, the whole truth, and nothing but the truth; you understand that, correct?

A. Yes.

Q. So when I asked you something that I feel is important, like your privileges as a doctor, and you tell us one thing and

then I have to confront you with something else and you change your answer, that damages your credibility.

MR. McCRORIE: Objection.

Q. Would you agree?

THE COURT: Sustained.

The jury will disregard the question.

MR. McCRORIE: And the privileges as a doctor --

THE COURT: What? No, no, no.

MR. McCRORIE: Okay.

THE COURT: Objection sustained. That's it. There is no more commentary.

Next question.

BY MR. CASCONE:

Q. In your dispute, you had to return money to your patient, correct?

A. I don't know what you're referring to.

Q. Part of the reason why you were suspended, this whole suspension thing we're talking about, whether or not you allowed things to expire or you resigned or you were suspended, you had testified about this previously, correct?

A. I don't know what you're specifically referring to.

Q. Okay. The name of the case Juan Rosario versus Burnside Trucking in the Southern District of New York, right here, in March of 2024 -- you explained some of this situation that we're talking about.

You said, quote, "It's very complicated," close quote.

MR. McCRORIE: Give a page number if you're quoting.

MR. CASCONE: Page 10, line 10, through Page 11, line 25.

THE COURT: Just give me a minute to get it up, please. Okay.

MR. CASCONE: And, Your Honor, you may be looking at two transcripts. One of the transcripts -- the one I'm specifically referring to right now is the case of Juan Rosario. I provided you with another transcript I'll be talking about later. I believe it starts at Page 10.

THE COURT: I'm there.

MR. CASCONE: Okay.

THE COURT: You can proceed.

BY MR. CASCONE:

Q. So in that sworn deposition, I believe you testified -- tell me if you don't remember or if I'm getting it wrong -- that you had no privileges in New York hospitals. Is that accurate? That you had no privileges in any New York hospitals?

A. I don't remember the time -- I don't remember the timing of that deposition. When was that?

Q. It was on March 22nd of 2024.

So at that time, in March of 2024, is it true that you

had no privileges in any New York hospitals?

A. I think that's correct. Yes.

Q. Okay. Now, the fact that you had no privileges in any New York hospitals, are you telling us that it had no bearing on you shifting your practice to New Jersey?

A. Yes. I had been doing it for six years, seven years, as I said.

Q. So it was just a coincidence that you lose all of your privileges in one state and you move everything to another state?

A. You're mischaracterizing it. But I --

Q. Correct me.

A. I already had all of my patients in New Jersey. I already had everything in motion. I was already transitioning there when I resigned from NYU.

Q. So you resigned? It didn't expire; you resigned?

A. No, we weren't talking about NYU before.

Q. Okay. That's where I got the hospitals wrong?

A. Yes.

Q. One you let expire, and one you either were suspended from or you resigned. Is that fair? I just want to make sure I'm clear.

A. Yes.

Q. Okay. Now, whether you were suspended or you let it expire or you resigned, you had to return money to patients; is

that correct?

A. No. I don't know what you're talking about. Which patients? You're making it up.

Q. I'm making it up?

A. Yes.

Q. I'm lying?

A. What patients are you referring to?

THE COURT: Wait, wait, wait, wait, wait, wait. So the way this works is he is going to ask you questions; you're going to answer the questions. Okay?

Next question.

BY MR. CASCONE:

Q. So the CV that I just read from that you're the attending orthopedic surgeon at Lenox Hill Hospital, is that New York or New Jersey?

A. New York.

Q. Is that still accurate? Are you still the attending orthopedic surgeon at Lenox Hill Hospital?

A. No, as I said before.

Q. Okay. So my other question was did you update your CV to reflect that you're no longer -- that you no longer have any privileges in New York hospitals?

A. It has been updated. I don't know when it was updated.

Q. Was it updated to make it more accurate to let your patients know that you no longer have privileges in any New York

hospital?

A. I've never had a patient look at my CV before.

Q. Why do you have a CV?

A. Why do I have a -- a resume? Why does any anybody have a resume?

Q. You really want to ask me questions? You're not going to like my answers.

THE COURT: All right. Please, let's -- really, can we just move along, Counsel?

MR. CASCONE: Sure.

THE COURT: Next question.

BY MR. CASCONE:

Q. You have a CV to advertise yourself. Is that fair?

A. I've never used my CV to advertise myself.

Q. Then why do you have a CV?

A. Everybody maintains a CV. I'm -- I'm an academic guy. I work at hospitals in administrative positions, of course I have a CV. Everyone has one.

Q. Of course.

So just tell us, why do you have a CV?

A. I just answered that exact question.

Q. You said, "Of course...everyone has one." But I'm not talking about everybody else. I'm just talking about you now. Why did you --

THE COURT: I'm going to strike the question and

ask you to move to the next question.

BY MR. CASCONE:

Q. Do you know a Thomas Kolb?

A. He had a very famous radiology center that he sold to Lenox Hill.

Q. Kolb Radiology, correct?

A. Yes.

Q. Is Kolb Radiology still in business?

A. I don't know the workings of his company. I think he sold it.

Q. Did you ever work with the firm called Subin & Associates?

A. What do you mean --

MR. McCRORIE: Objection.

A. What do you mean by "worked with"?

THE COURT: Sustained. The objection is sustained.

BY MR. CASCONE:

Q. Have you ever testified on behalf of the law firm called Subin & Associates?

A. I have. A couple of times.

Q. When was the last time that you worked with Subin & Associates?

A. What do you mean by "worked with"?

THE COURT: The original question "worked with" was objected to and sustained. The question that you were

allowed to proceed with was whether he has testified for Subin. He has.

Next question.

MR. CASCONE: Okay.

MR. McCRORIE: I didn't object --

THE COURT: No, you didn't object. But -- but the witness didn't like the phrasing, and I had wanted him to stick to the phrasing --

MR. McCRORIE: Understood.

THE COURT: -- that I thought was okay. So let's go.

BY MR. CASCONE:

Q. You're being paid $8,000 today, yes?

A. Yes.

Q. Who's paying you $8,000?

A. The plaintiff's counsel, I believe.

Q. So are you working with Plaintiff's counsel today?

MR. McCRORIE: Objection.

A. I -- I don't --

THE COURT: Sustained. I'm sorry. The objection is sustained.

Next question.

BY MR. CASCONE:

Q. Okay. When was the last time Subin & Associates, the law firm, paid you to work on their cases?

MR. McCRORIE: Objection.

THE COURT: Sustained.

BY MR. CASCONE:

Q. Subin & Associates is no longer in business, correct?

MR. McCRORIE: Objection.

THE COURT: Sustained.

Move on, Counsel.

BY MR. CASCONE:

Q. What about Asher & Asher, that law firm, have you ever worked with them before?

A. Who?

Q. Asher & Asher?

MR. McCRORIE: Objection.

THE COURT: Sustained.

A. I don't know who that is.

Q. You mentioned Dr. Root, the guy we're going to talk to tomorrow. You've worked with him before, correct?

A. Dr. Root? I'm sorry. Who is that?

THE COURT: The life care planner, right?

MR. CASCONE: Yes.

A. Before seeing a life care planner, I have never heard his name before. And I don't even recognize it now, honestly.

Q. Counsel asked you about ten questions that you reviewed Dr. Root's -- the life care planner -- plan, and you read it in detail and you've agreed with everything that's in there. That

Dr. Root.

A. I don't know him.

Q. Have you ever heard of him before?

A. No.

Q. So the first time you heard of Dr. Root was when you read his report for this trial. Is that fair?

A. I think so. I don't recall ever hearing his name before.

Q. Okay.

A. I don't think I've ever met him.

Q. I didn't ask you if you ever met him. I asked if you knew of him.

THE COURT: You have to respond verbally, sir.

THE WITNESS: Sorry?

THE COURT: You were shaking your head no, but I need a verbal response:

THE WITNESS: What is the question?

MR. CASCONE: Okay. I'll rephrase the question.

THE COURT: Okay.

BY MR. CASCONE:

Q. You were asked by Mr. Sayles's attorneys if you reviewed the report of Dr. Root, and whether or not you approved it and/or agreed to it.

Do you remember those questions?

A. Yes. I answered that question.

Q. You answered yes, so you -- let's establish that. You read Dr. Root's report thoroughly and you agreed to all of it, yes?

A. I didn't say that.

Q. So then elaborate. Tell me what you agree to and what you don't agree.

A. I don't recall. I didn't memorize it. It's been a long -- I -- I did review it. I did agree with the majority of it. A lot of it -- I mean, I agreed with what was pertaining to my own subspecialty. And it's -- it's about the patient's life care plan.

I don't do life care plans. So what I'm familiar with, that's related to my practice, in other words, how often he would see me, imaging in the future, whatnot, I agree with those things, those aspects of it.

Q. Do you have Dr. Root's plan in front of you?

A. I don't think so.

Q. So how can we know tomorrow when Dr. Root testifies what you agreed to and what you didn't agree to --

MR. McCRORIE: Objection.

Q. -- if you don't know --

THE COURT: It kind of sounds like you're whispering "objection," not into a microphone, so if you would, nice and loud, say it.

MR. McCRORIE: Sorry?

THE COURT: It almost sounds like you're talking to yourself. But the objection is sustained to that question.

MR. McCRORIE: Sorry.

THE COURT: Next question.

BY MR. CASCONE:

Q. When is the last time that you looked at Dr. Root's report?

A. It's been a while. That's what I'm saying. I don't have a fresh memory of it.

Q. So if the jury is told tomorrow that you approved the plan, how do we know what portions you approved and what portions you didn't approve?

A. Exactly what I just said a couple of minutes ago, when I said that I -- I am familiar with the parts of the plan that pertain directly to me. But in your question earlier, you said that you agree with every word in it 100 percent, I --

Q. I never used the word 100 percent.

THE COURT: Wait, wait, wait.

A. Whatever word you used, you know what I mean. In its entirety.

Q. Yes.

A. I'm paraphrasing. I don't recall all of the aspect of his care plan that don't pertain to my specialty, but I do recall the ones that are relevant to what I would know and are part of my specialty. And those are the things that I mentioned

a couple of minutes ago when you asked me about it.

Q. You were seemingly able to stay with long hypothetical questions. "I want you to assume A, B, C, D, E, F, G, H, I, J." Do you remember that? And you just nodded along and you said, "Yes, I agree with everything you just said."

So, Doctor, you'll agree to anything the plaintiffs say to you at this trial, won't you?

MR. McCRORIE: Objection.

THE COURT: Overruled.

A. No. I agreed that I would assume what he told me to assume, which is what I'm being instructed to do. So I, of course, said yes, I will assume that, if I'm being instructed to assume something.

Q. But then you gave conclusions based on those assumptions. Do you know any of those assumptions to be true?

A. I believe most of them I was familiar with and that I know to be true, yes.

Q. Okay --

A. Stuff that I know as a clinician, taking care of the patient, yes.

Q. So some of what you agreed to, you don't agree with?

A. I -- I was asked to -- I was -- I was asked to assume, and I agreed to do so.

Q. So the $8,000 -- is it 8500 or is it 8,000? 7500 or don't you know?

A. I believe $8,000 is my fee, yeah.

Q. Were you given a check today? Is it something that we can look at?

A. No, it wasn't given to me.

Q. Now, how do you come up with $8,000? Is that for a half day's testimony? Is that for a full day's testimony? Is that based on an hourly rate?

A. Probably ten years ago -- I don't think I've ever raised my fee. Probably 10 or 12 years ago, when I was asked to testify, I asked around to all of the spine surgeons I knew. And I asked, "Have you ever testified? If you have, okay, well, how much do you charge?" That's how I set my fee. Because I wanted to be fair. I don't want it to be too much or too little. I wanted to be fair.

If I'm canceling my surgeries for the day, I think that it's reasonable to be reimbursed for that. I have a practice with a lot of overhead. And if I'm canceling surgeries and if I have to move them around, it costs a lot to me. Sometimes I'm not able to redo them again. So that's how I set my fee.

And actually, obviously, everybody knows there's been a lot of inflation in the last 12 years. $8,000 probably -- it probably is something that should be revised at some point, quite frankly.

Q. I guess -- thank you for all of that. I'm not attacking you on the amount of money. I just asked you is it

$8,000 for a morning? $8,000 for a full day? Does it get adjusted is what I'm getting at?

A. That's normally what we charge, $8,000 to appear in court.

Q. Is that for a half day or is that for a full day or something else?

A. It's usually for a half day because I don't normally run over like this. This is very long testimony.

Q. Yes. I agree. So if $8,000 is fair for a half day, are you expecting another $8,000 for the afternoon session?

A. I mean, you're asking me billing questions that I haven't thought about yet. I'm sorry. I'll figure it out after we're done.

Q. You're not just going to accept $8,000 for today are you?

MR. McCRORIE: Objection.

THE COURT: Overruled.

A. You know, I oftentimes -- I sometimes don't even look at -- usually don't even see the checks. So, yeah, I mean, I'm sure that I will tell my assistant, "Hey, we ran over, please send them a bill for the remainder."

Q. Okay. And then if you come back tomorrow, you're going to have your assistant send a bill for tomorrow's testimony too, correct?

A. Probably. I mean, if I have to cancel in the morning

patients that are on route to my office, an entire office full of patients, and we have to scramble and we lose all of this face with all of these patients, all of these patients that need surgery need to have some type of care, and suddenly they've been waiting all of this time to see me, and they're called on route to the office, or maybe they even arrive to the office and they're told that you're canceled because you took all day to questions --

Q. I took all day?

A. Yeah.

MR. McCRORIE: Objection.

THE COURT: The witness -- the witness should be reminded that direct examination of the witness took until after 3:00 o'clock. Okay. So I don't -- let's just take it from there. Let's go again.

Next question.

BY MR. CASCONE:

Q. So $8,000 for the morning. $8,000 for the afternoon. Another $8,000 for tomorrow. That's $24,000 you're going to make off of this trial. Correct?

A. I don't know that to be true.

Q. All right. What about your review of the reports in preparation of trial? That is additional time you're given, correct?

A. If I do extra work, I usually, just like any attorney

or other professionals, I bill for my time.

Q. Good. We're in agreement. You deserve to get paid for your time.

A. Thank you.

Q. That is not why I'm asking the questions.

So it's $8,000 in the morning, $8,000 in the afternoon, tomorrow is another $8,000. That is $24,000 right there.

Then there is additional money you're going to make from your review of the records. So that is where my next question is going.

How much extra money did you make from just reviewing records in preparation for your testimony?

A. I have no idea. I normally don't. I -- if I have to cancel my practice to -- to do legal work --

Q. You're giving me the -- you're answering whys. And I'm not asking why questions. I'm just asking factual questions. I know you know how to do this. And if you're going to complain about how long I'm keeping you, just answer my question so we can get out of here.

MR. McCRORIE: Objection.

THE COURT: The objection is sustained. There was -- there was no question there.

Sir, is it your testimony -- I think what the lawyer is asking you is you don't bill for reviewing records?

THE WITNESS: No. As I said a minute ago, I answered that question.

THE COURT: He's just asking how much you bill. That's the question.

THE WITNESS: I think $700 an hour.

BY MR. CASCONE:

Q. So it's 8,000 flat fee. 8,000 flat fee. 8,000 flat fee. An additional $700 per hour for the review of records. Are you with me so far? "Yes" or "no"?

A. Yes.

Q. Are you with me?

A. I understand -- well, I'm not with you in the sense that I don't agree with you, but I understand what you're saying. It's not complex.

Q. I know it's not complex. I don't know why you're arguing with me then.

THE COURT: Gentlemen, next question, please.

MR. CASCONE: All right.

THE COURT: Thank you.

BY MR. CASCONE:

Q. You prepared twice with the lawyers, right? Two weeks ago and then again -- no? You're looking at me like I'm speaking a different language.

THE COURT: All right. Could we please not have any commentary either from Counsel inquiring or from the

witness, and just limit ourselves to asking a question and providing an answer. That would really be looked upon with favor by the Court.

MR. CASCONE: I'm sorry, Your Honor. I'll try to do better.

THE COURT: Thank you.

BY MR. CASCONE:

Q. Did you meet with the plaintiff's lawyers in preparation of your testimony for this trial? "Yes" or "no"?

A. Yes. One time last week or the week before. And then on the way here today we had a conversation about the logistical things.

Q. Okay. So a week before, when you spoke to the other lawyers, did you charge them for your time then?

A. I don't know.

Q. Maybe yes, maybe no; you don't know?

A. I don't know. I didn't talk to my assistant about it. She made an appointment for them. They came in. We met for a short period of time. I don't even think we met for an hour. I'm not sure how long we were together.

Q. How much do you make per year, approximately, for trial work? If you do this six times a year, approximately how much do you make from your work in the courtroom?

A. I mean, it's really rare that I testify for more than a half day. So six times a half day. So six times eight. What

is that? 46? No. Six times eight is $48,000.

Q. Plus the prep time, plus the $700 an hour?

A. If I -- if I need to do the -- the hourly work that I do. But I -- you know, that's not normally very extensive. Because I don't -- I already know my patients. And I -- it's my own chart. I'm just coming in testifying to the contents of my chart.

Q. Okay. And you realize that when you testify at a trial like this, oftentimes there are other lawyers that are coming to watch you, correct?

A. I don't know.

Q. You're not saying that you're turning down the courtroom work, are you?

A. That is by no means the way I govern my practice. I have no desire to come to court. This is not fun.

Q. But you do it six times a year, and you get paid each time, correct?

A. Each time I have to cancel a day of work and have all of my overhead and my practice churning away while I cancel my patients that have been waiting a long time for surgery, yes.

Q. Are you under a subpoena right now?

A. I'm sorry?

Q. Are you under a subpoena right now?

A. I have no idea.

Q. You came here voluntarily, transactionally. You come

in; you get paid. You do so willingly. Yes?

A. Yes.

Q. You're not court ordered to be here. You're not under a subpoena; you came hear willingly?

A. Correct.

Q. Okay. And you do that at a minimum six times a year, yes?

A. I don't know if it's a minimum. I'm sure I had years where I testified less. I'm saying on average I think it's about that.

Q. And sometimes it's up to ten times a year, correct?

A. I have no idea. I don't keep track of that.

Q. Why don't you just say, "I'm not coming to court. I'm done with this. Don't bother me. Don't ask me to come to court. I hate it. I want to be a doctor and a doctor only"? Why don't you say that to the lawyers that asked you to come here?

MR. McCRORIE: Objection.

A. Because --

THE COURT: Overruled.

A. Because I couldn't look in the face of my patient that got injured by your client and say, "I'm not going to tell the courts about their injury, about the treatment that I had to do because I don't have the time." I don't do that. Instead I say, "Okay, yes, I'm willing to testify for you."

Q. You get referred patients that are already involved in litigation on a regular basis, correct?

A. I mean, I see patients that -- that have litigation. Most of the time when I see them I'm not aware of the fact that they have litigation until later. Like with Gordon, I didn't know about it until later.

Q. Okay. Wait a minute.

His accident happened in 2018. He comes to you in 2023 for the first time, correct?

A. I -- no '22.

Q. '22?

MR. McCRORIE: '21.

A. '21.

Q. Years after his accident, he comes to you and you take a detailed history from him. And you're telling this jury when you first talked to him, you don't ask him, "Do you have a lawyer"?

A. No. He's a workmen's compensation patient that had an on-the-job injury. I treat him like any other patient. I -- you know, I govern whatever needs to be governed within the workmen's compensation world in terms of filling out the paperwork for it. The vast majority of those patients are not involved in any type of lawsuit. It's -- workmen's compensation patients get injured on the job. They're injured workers.

Q. A vast majority are not involved in litigation. But

there are plenty that are. Is that fair?

A. I'm sure there are.

Q. Well, you testify at least six times a year. You've got to know it's not like out of the ordinary that one of your patients has a lawsuit. You're coming to actual court four times a year, and you hate it apparently.

MR. McCRORIE: Objection.

THE COURT: Sustained.

BY MR. CASCONE:

Q. When a patient of your comes in, you know where they're coming in from, whether it's from another doctor, whether a lawyer referred you this patient, yes? I'm trying to be fair with you.

MR. McCRORIE: Objection.

A. Fair with me?

THE COURT: Sustained as to the comment.

Q. Yes.

THE COURT: Just answer -- again, eliminate the comment and limit yourself to answer the question.

You can answer the question, Doctor.

A. Most of the time we know they're referred to us or they found us on the internet or from another patient that told them about us, their physical therapy office where they're sitting in the room with other patients and they say, "Who is your doctor? My back is killing me. It's not getting better."

You know, most of the time we know the source. But not always. I mean, a lot of times patients come in and they say -- they say, "I don't remember the person that referred me." So, I mean, yeah, we -- we try to keep track of that stuff. But we don't always know.

Q. All right. How about with Mr. Sayles? Mr. Sayles was in an elevator accident in 2018. And he comes to you in 2021, almost two years after the accident. You meet with him. You care about him. He's your patient. He complains to you about pain. You, as a good doctor, want to take away his pain, yes? Yes? You want to take away his pain?

A. What kind of question is that, honestly?

THE COURT: So --

Q. Well --

MR. McCRORIE: Judge, can we object?

THE COURT: No.

MR. McCRORIE: Come on.

THE COURT: What happens is the witness is objecting.

So, sir, if your lawyer wants to object, he's going to object. You just need to focus on answering as directly as possible the question that is asked to you instead of this sort of argumentative situation that you both have going on with each other. Okay?

So let's just try it again, gentlemen.

Let's -- can you re-ask your question.

A. The answer is yes.

Q. Okay. Good.

When you met with Mr. Sayles, you asked him, "What are you doing here? Why are you seeing me?" Is that fair?

A. Yes.

Q. That is the history, "What happened to you? What brought you to me?" Yes?

A. Yes.

Q. And he told you that "I was in a horrific elevator accident" or something to that effect, correct?

A. Yes. We know the history.

Q. You wrote down in your records that we looked at earlier today that he told you that he fell in an elevator 13 stories. Whether or not it was accurate, you found out later, when you wrote it down, in your mind you thought your patient fell 140 feet, yes?

A. I don't remember what I was thinking then.

Q. It's in your record he fell 14 stories, yes?

A. It does say that.

Q. When you say, "It does say that," it sounds like you're removing yourself from your own records.

You're not disavowing your own records, are you?

A. No. I just don't think that I wrote that in. I think my medical assistant wrote that in.

Q. But you spoke -- you spoke with Mr. Sayles. So you have your record in front of you. And you see, "Oh my goodness, you fell 140 feet." You don't have that conversation with your patient?

A. No, I didn't think he fell. I thought that he was in an elevator that fell.

And I actually believe that that was a typo that it was 13 -- the 13th floor to the 9th floor.

But even if it was two floors, a free-fall from 10 feet is enough to injure someone the way he was injured. So it doesn't matter whether it was 110 feet or if it was 20 feet or if it was 10 feet. It was a substantial fall that he had symptoms from.

Q. You were asked by Plaintiff's counsel about the mechanism of injury. And I want to just go over that for a second with the jury.

When we talk about the mechanism of injury, it's basically does it make sense, does the story make sense that he was injured in this way. Yes?

MR. McCRORIE: Objection.

Q. Is that fair?

THE COURT: What is --

A. Yes.

Q. Okay. It's fair?

THE COURT: All right. Wait. I'm sorry.

What was the basis of the objection.

MR. McCRORIE: The Appellate Divisions decision.

THE COURT: I mean, I don't know what that means, Counsel.

The objection is overruled. The question and answer stand.

Next question.

BY MR. CASCONE:

Q. So as a doctor, you want to take a complete history from your patient, correct?

A. Yes.

Q. And you want to take an accurate history from your patient, correct?

A. Yes.

Q. So if somebody told you, "I just fell off the Empire State Building, and I'm walking in here, I fell off the Empire State Building, and I fell and hit my heels on the ground, and it felt like I hit a brick wall," would you just put in there "My patient fell off the Empire State Building onto the concrete floor"?

MR. McCRORIE: Objection.

THE COURT: Overruled.

A. If they told me that they fell off the Empire State Building and then they hit a brick wall, yes, I would write it down.

Q. Would you put anything else in the record?
A. I'm sorry?
Q. At that point, would you put anything else in the record? Like flag it? Like maybe this person doesn't have the mental capacity to agree to a surgery? The person is obviously crazy? Would you have any kind of notation in your record at that point?
A. If the patient fell off the Empire State Building and landed on the floor, yeah, I would think that I would probably think, "Are you sure?" I probably would second-guess that.
Q. Okay. So a fall of 140 feet, did you question Mr. Sayles at that point? Did you say anything like, "Are you sure you fell 140 feet and hit a brick wall?"
A. Honestly, I don't remember the exact conversation.
Q. Does it matter what the history is? You're going to put in your history whatever the guy tells you, right?
A. We try to take a history -- the history is what they tell us, yes. We try to take an accurate history.
Q. But didn't we already establish that it doesn't matter if he tripped and fell over his own shoelaces, he had an accident in a car, he got attacked by a dog. It doesn't matter to you. You're his doctor; your job is to take away his pain. Is that fair?
A. It -- we do our best to help people and --
Q. Right?

A. Yes.
Q. You only get into trouble when you come into our lane, the legal lane, and you come into court and try to convince a jury that the story that he tells you is true --
MR. McCRORIE: Objection.
Q. -- it has nothing to do with your treatment?
MR. McCRORIE: I didn't realize the question wasn't over, but objection.
THE COURT: Sustained.
MR. CASCONE: Your Honor, it's 4:30. I'm losing my voice. Can we break until tomorrow?
MR. McCRORIE: Can we go further? Even if he'd have to come back so that we can cut the time that he's going to be here, not for our money, for the patients, can we do that?
THE COURT: We'll go for another 15 minutes.
MR. CASCONE: Can I get a drink? Can I have a little water?
THE COURT: Of course.
MR. McCRORIE: Thank you, Your Honor.
BY MR. CASCONE:
Q. Now, I just asked you questions about your evaluation of your patients. You made sure that your patient is somewhat telling you an accurate story about what happened, correct? It's important that he's somewhat accurate?

A. What do you mean by "you make sure"? I don't know what that means.

Q. You would inquire if you had any doubts as to the veracity of the story being told to you by a patient, correct?

A. You mean inquire with the patient? What do you mean by inquire?

Q. All right. Years ago, unrelated to this case, we had an opioid crisis. And doctors were on high alert to make sure that they weren't giving out opioids to people who were drug addicts who were claiming "I have pain." There were checks and balances that were put in place.

You understand what I'm talking about, correct?

A. I don't know what checks and balances you're referring to.

Q. You have to make sure that you're not prescribing people medication who don't really need it --

MR. McCRORIE: Objection.

Q. -- is that fair?

A. I follow --

THE COURT: Again, you are very soft-spoken on the objections, so it's very easy to miss it, especially because they're going so very fast. Did you intend to assert an objection to that question?

MR. McCRORIE: Judge, I'm trying to let it go. I don't want to keep interrupting.

THE COURT: Either object or don't object.

MR. McCRORIE: I object to the opioid crisis and the question --

THE COURT: Right. It's a hypothetical. The objection is overruled.

You can -- I don't know if you did already answer the question. You might have.

Okay. The question and answer stand.

MR. CASCONE: Okay.

BY MR. CASCONE:

Q. You operated on an Napoleon Aquino, correct?

A. Correct.

Q. You know where I'm going to go with this, Napoleon Aquino?

A. I don't know what you're referring to.

Q. He was referred to you by the Subin Law Firm. Do you remember that?

A. No.

Q. If I told you that the Subin Law Firm referred their client Napoleon Aquino to you, would you have any reason to doubt me?

A. I don't know.

Q. You performed surgery on Mr. Aquino without even doing an MRI --

MR. McCRORIE: Objection.

Q. -- is that accurate?
A. Yes.
THE COURT: Basis of the objection?
MR. McCRORIE: Objection.
THE COURT: I'm sorry?
MR. McCRORIE: I'm just objecting, Your Honor.
THE COURT: The objection is overruled.
MR. McCRORIE: He says he doesn't know. Okay.
A. So Napoleon --
MR. CASCONE: Wait a minute until the judge gives you an instruction. I don't know what is happening.
THE COURT: Nothing is happening.
MR. CASCONE: Okay.
THE COURT: We're all good.
A. So Napoleon Aquino is a patient of mine that I'm familiar with because he -- he had a bullet fragment in his leg and needed to be diagnosed with a CT scan, which is the standard of care for people who can't get an MRI. So he could not get an MRI. We ordered a CT myelogram on him.
(Senior Court Reporter Karen Perlman was replaced by Senior Court Reporter Alan Bowin.)
(Transcript continues on the following page.)

Q. And you did surgery on a cervical spine, and you fused C6 to C7.

MR. McCRORIE: He was in the middle of the answer, I think.

Q. I'm sorry. Did I interrupt you?

THE COURT: Were you in the middle of an answer?

THE WITNESS: No, I finished.

THE COURT: All right. We're all good.

Continue with your next question.

A. I heard your question.

THE COURT: Yes.

A. So I don't know what level I did; I don't recall. That sounds correct. It was a one-level ACDF.

Q. But was it not determined that he did not have the legal capacity to consent to a surgery because he was committed to a mental hospital?

MR. McCRORIE: Objection.

A. No.

THE COURT: Sustained.

The objection is sustained.

MR. McCRORIE: And move to strike, please.

THE COURT: You can't move to strike a question. You want to move to strike his answer? The answer is stricken.

Q. Okay.

THE COURT: All right.

Q. We spoke about "mechanism of injury," and we've established that a mechanism of injury is a way to explain how an injury was caused; is that fair?

A. Yes.

Q. A herniated disc, have you ever referred to it as a "jelly donut"?

A. I mean, I used that analogy earlier in order to explain to the jury what it would look like in the sagittal plane, when it's transected in the middle.

Q. And a herniation is a protrusion of the gelatinous material of the disc; yes?

A. Yes, it usually is.

Q. Okay. And in Mr. Sayles, you told the jury that he sustained, not one, but two cervical herniations as a result of the elevator incident two years earlier; yes?

A. Two years before my initial consultation?

Q. Yes.

A. Yeah. It was more than two years, but, okay, yes.

Q. More than two years. I'm just ...

Now, the mechanism of injury to cause -- a herniated disc in the cervical spine could occur from a direct trauma on the head (indicating), causing the

bones of the cervical spine to come in contact with one another (simulating); is that fair?

A. That is one mechanism of herniation.

Q. Right. So we see ceiling-collapse cases: something falls on the head, presses the spine down violently (simulating), and causes the jelly to shoot out (simulating) of the disc material; yes?

A. That does happen sometimes, yes.

Q. Okay. And that's a mechanism of injury; yes?

A. Yes.

Q. Another way that the gelatinous material can herniate from a cervical disc is a violent flexion and extension, like you would see in a rear-end accident; correct?

A. Motor vehicle accidents, not just rear-end.

Q. Right, something that caused the neck to go back and forth (simulating).

A. Or twist, yes.

Q. That was my next one: Or twisting, a violent twisting of the neck.

A. Yes.

Q. Okay. Which one of those happened to Mr. Sayles (indicating) in the elevator, or the two years before you first saw him for the first time? Did he get hit on top of the head with a shopping cart that went flying in

the air (simulating)? Did he -- did his body levitate violently from the floor of the elevator and hit the ceiling of the elevator when it crashed down (simulating)?

MR. McCRORIE: Objection.

Q. Was it a twist (simulating)?

THE COURT: Sustained as to form.

Q. What was the exact mechanism of injury that caused two disc herniations in Mr. Sayles' neck?

A. Axial loading.

Q. So did he get hit on top of the head (indicating)?

A. No.

Q. It was the sudden hitting of the brick wall and the feet that sent a shock wave all the way up the spine, causing those two herniations.

A. And he probably, during the process -- aside from the shock and axial loading -- also probably snapped his head one way or the other, somehow. I mean, it's not going to be that simple; it's obviously complex.

Q. Your answer for every hard question, it's complex; right? You do that every trial?

MR. McCRORIE: Objection.

THE COURT: Sustained.

Q. You didn't see a video of the inside of the

elevator; correct?

A. No.

MR. McCRORIE: Objection.

THE COURT: Overruled.

Q. So you're just making this up, that he probably violently moved his neck. You didn't see a video, you weren't there, and never spoke to an eyewitness.

MR. McCRORIE: Objection as to all of it and "violently moved his neck."

THE COURT: I didn't quite catch all of that, but I do agree.

Objection as to form is sustained.

Q. Where are you getting this from, that he violently twisted his neck?

MR. McCRORIE: Objection.

THE COURT: Overruled.

A. I didn't say he violently twisted his neck.

Q. Then how are you competent to tell this jury a mechanism of injury to the cervical spine if you didn't see the accident, you didn't speak to any eyewitnesses to the accident, there's no records of him violently twisting his neck?

It's just -- you just said, that "probably" happened. And you know, from being in court over and over again, the Judge requires "within a reasonable

degree of medical certainty." We're not at a barbecue; you can't just say, "Probably, maybe this happened." You're in a court of law and the Judge (indicating) has rules. It's within a reasonable degree --

MR. McCRORIE: Objection.

Q. -- of medical certainty.

MR. McCRORIE: Objection.

THE COURT: Sustained.

The jury will disregard the question.

Q. You don't know the mechanism of injury, do you?

A. I actually, in front of everybody here, already said that I believe it's axial loading. Everybody knows that he fell numerous floors, at a high speed, and came to a stop. That's axial loading.

Q. When you say, "everyone knows," how does everyone know?

A. Because it's been not only testified upon today, it's in every medical record; it's in -- it's in the court system; it's an accepted mechanism of injury for this case.

Q. That's what he told everyone after he started a lawsuit; correct?

MR. McCRORIE: It's been determined, your Honor.

Objection.

MR. CASCONE: It hasn't been determined by anyone.

THE COURT: All right.

MR. CASCONE: The jury will determine --

THE COURT: All right, that's enough. That's enough. We're done for today.

MR. CASCONE: Okay.

THE COURT: You know? All right.

I'm sorry, Doctor, for the inconvenience. I'm sure it's not easy for you, but I have to ask you to come back tomorrow morning at 9:30.

All right, the jury is excused. Have a lovely evening.

Please remember not to discuss the case.

I'll see you tomorrow at 9:30.

COURT OFFICER: All rise.

(The jury left the courtroom.)

MR. SCHIFERL: I would like the admonishment on the record for the witness.

THE COURT: You mean, that he's not supposed to talk to anybody about his testimony --

MR. SCHIFERL: Yes.

THE COURT: -- between today and tomorrow?

MR. SCHIFERL: Yes.

THE COURT: Okay.

Doctor, you're not supposed to talk to anyone about your testimony between when you leave and you come back tomorrow.

The witness also wanted to ask the Court a question.

THE WITNESS: Well, I need to reach out to my patients and cancel a lot of people. I'd like to know when I'm expected to be done.

THE COURT: There's (indicating) your -- they're the people you have to ask.

THE WITNESS: I have to let them know.

THE COURT: Counsel -- sir, when the lawyers who called you first -- when we were doing the schedule, they told me: "Dr. Gerling is going to be all day. In fact, if we don't finish him all day, I'll be" -- you know -- "we might not finish." And I said: "No, no, no. I've had Dr. Gerling; he's a half-day witness."

This is what the plaintiffs who brought you here have done; they kept you on the stand until three o'clock. I have no idea how long the cross is going to be, but the cross is going to be substantially shorter than the direct, and normally it's the other way around.

So I can't --

THE WITNESS: Should I cancel my morning or should I cancel the whole day tomorrow?

THE COURT: I really hope you'll be out of here by lunchtime. I would assume you'll be out of here by lunchtime.

Is it fair to say that Dr. Gerling --

MR. SCHIFERL: I don't understand what's going on. I mean, first of all, it's not for the witness to bargain with your Honor.

THE COURT: He's not arguing.

MR. SCHIFERL: I said, "bargain with"; I didn't say "argue."

THE COURT: He's not trying to bargain with me. He has responsibilities and he's trying to plan for them, just like we all would.

MR. SCHIFERL: And I appreciate that with the best of them, your Honor, but if your point --

THE COURT: Can I just ask: Do we need all of this to be on the record?

MR. SCHIFERL: No.

THE COURT: Thank you.

MR. SCHIFERL: I just wanted the admonishment on the record.

THE COURT: I just wanted to let the reporter go.

(To reporter) We're off the record for today and we're done with you. Thank you so much.

(Discussion off the record.)

(Whereupon, the matter was adjourned to Thursday, October 8, 2026, at 9:30 a.m.)

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