(Whereupon the jury enters)

THE COURT: Good morning, ladies and gentlemen of the jury.

We will continue. As you recall, we have a doctor this morning, a doctor tomorrow morning and a doctor Thursday afternoon. So the only thing we're sure of is you're not going to be here Thursday morning or Friday.

All right, counsel, call your next witness.

MR. AVANZINO: At this time, we call Dr. Andrew Davy to the stand.

D O C T O R A N D R E W D A V Y, called as a witness on behalf of People, having been first duly sworn, was examined and testified as follows:

THE COURT CLERK: In a loud, clear voice, please state your name and business address for the record.

THE WITNESS: Andrew M. G. Davy, 1513 Voorhies Avenue, Lower Level, Brooklyn, New York 11235.

THE COURT: Dr. Davy, if you hear the word objection, please try to refrain from answering unless you hear me say the word overruled.

Go ahead, counsel.

DIRECT EXAMINATION

BY MR. AVANZINO:

Q Good morning, Doctor.

A Good morning.

Q Tell the members of the jury about your educational background.

A Yes, I have a Bachelor's in Chemical Engineering from the School of Engineering and Applied Sciences at Columbia University. I have an MD degree from the College of Physicians and Surgeons, also of Columbia University.

My internship and residency was done at the Presbyterian Hospital in internal medicine and anesthesiology. I then did a one-year fellowship at the University of Rochester at Strong Memorial Hospital in pain medicine.

I'm board certified in pain medicine and I've been a full-time pain physician focusing on interventional pain treatments for about ten years.

Q Doctor, can you explain to us what the specialty of pain management is?

A Yes. My role is to alleviate a patient's pain when they have failed conservative treatment, such as physical therapy, routine medications and sub-minor injection-type treatments. I focus more now on interventional pain therapies that is geared at basically decreasing the patient's pain by at least 50 percent or more, and at the same time improving their quantity and quality of sleep, increasing their activities of daily living and ability to also earn an income.

Q Now, Doctor, you told us that you did a fellowship

beyond your residency. Just give us some background. What does that mean to do a fellowship once you complete your residency?

A Well, it's a post-doctoral fellowship, meaning that you are a full attending and you've chosen to concentrate on one specific area that we call a subspecialty where you're exposed to patients with chronic pain and you learn how to assess, diagnose and treat these conditions.

Q And you did your fellowship in pain management?

A Yes, I did.

Q Sir, you told us about being board certified. Can you tell us what that means to be board certified, in this case in anesthesiology and pain management?

A It means that the peer group, the American Board of Anesthesiology has examined you both orally and on paper and you have met a certain standard that they set. And that allows you to be a consultant or an expert in that field.

Q Now, Doctor, in addition to being board certified in pain management and anesthesiology, are you also licensed to practice medicine in the State of New York?

A Yes, I am.

Q Doctor, can you tell the members of the jury what professional affiliations you have?

A Yes. I'm a member of the American Pain Society, the American Medical Association and the International Association

for the Study of Pain. I also have membership in ISTS, which is the Interventional Spine Treatment Society.

Q Doctor, can you tell us about your employment history once you finished your fellowship?

A After my fellowship I was an associate attending at Albany Medical Center. I then took on the directorship at Providence Hospital in Anchorage, Alaska where I turned a money-losing program around in three months.

I then moved back to New York and worked both as an anesthesiologist and started my own pain practice. I was also the director of chronic pain at Mary Immaculate Hospital and St. Mary's Hospital, the Catholic Charities Group.

Q And, Doctor, in your training and in your practice, do you treat and do you see patients that have pain referable to their spinal column, to their neck and their back?

A Yes. That is the most common type of pain that I treat. I have other areas of interest including cancer pain and certain types of lymph pain, but the majority of pain that I treat now as a full-time pain medicine physician is spine pain, neck, upper and lower back pain.

Q And, Doctor, in your practice, can you give the jury some idea what the source is of most of your patients, where most of your patients come from?

A They come from neurologists, orthopedic surgeons orthopedic spine surgeons, neuro-spine surgeons, internal

medicine physicians and chiropractors as well.

Q Why do they send their patients to you?

MR. GORKIN: That's objected to.

THE COURT: Sustained.

Q Sir, you tell us they are the source. They refer their patients to you?

A Yes.

Q For what purpose, sir?

A The patients are referred to me when they have failed, as I stated earlier, conservative treatment. The patients are sent to me when the pain, the source of the pain is either not clear or the treatment interventions have not produced the results that the patient is looking for.

And so, what I do is I evaluate the patient. I focus on identifying the pain generators and then I apply the varied treatment intervention, again, geared at decreasing their pain and improving there function and sleep.

Q Sir, have you testified in court previously?

A Yes, I have.

Q And, sir, can you give the jury an idea on what kind of basis you've been called upon to testify in court over the years?

A I've been called to testify in this setting for the plaintiff. I do that about once a year. I also conduct independent medical examinations for defendants, insurance

companies and I have been asked to testify on their behalf also.

Q Sir, when you have testified on those occasions, have you been qualified as an expert in the field of anesthesiology and in the field of pain management?

A Yes.

MR. AVANZINO: Your Honor, at this time I ask that Dr. Davy be qualified as an expert in the field of anesthesiology and pain management.

MR. GORKIN: No objection.

THE COURT: Fine.

MR. AVANZINO: Thank you, your Honor.

Q Sir, are you being compensated, are you being paid for your time away from your practice to come to court today?

A Yes.

Q And at what rate or what is the -- what are you being paid for your time?

A My hourly rate is $250 an hour.

Q Sir, now in terms of the reason that we're here, the patient, Ronald Weathers, can you tell us when you came to see Ronald Weathers for the first time?

A Yes.

MR. GORKIN: Your Honor, if he's going to be, your Honor, referring to his record, just so we know that as opposed to something he remembers.

THE COURT: Okay. You're referring to your notes?

THE WITNESS: Yes.

A I first saw Mr. Weathers on August 20th, 2008.

Q How was it that Mr. Weathers came to see you?

Sir, you told us that often, most of the time you are referred your patients from other doctors. How is it that he came to see you?

A He was referred to me by Dr. Delman.

Q Can you tell us, sir, did you take a history from Mr. Weathers when he came to see you?

A Yes, I did.

Q Tell us what the significance is in your specialty for taking a history.

A In my specialty, when I see the patient, most of the time they are at the end point of whatever treatments they've been exposed to. Usually they've been told that their pain is not real and that, you know, they're not reliable in terms of reporting their pain.

So because pain is subjective, I have to get a detailed history during which I assess the patient's ability to describe their pain, their ability to identify and also participate in decreasing their pain intensity. The history also helps me to narrow down my diagnosis and identify the pain generators.

Q Sir, in this case, when you met with Mr. Weathers on

August 20th, of 2008, did you come to learn that he was 56 years of age?

A Yes, I did.

Q And did you come to learn that he was involved in a motor vehicle accident on June 23, 2008?

A Yes, I did.

Q Sir, did you learn when he was first given medical attention after the accident?

A Yes. I was able to review the emergency room report.

Q But just for purposes of this question now, just from taking the history, did you come to learn that he went to the emergency room?

A Yes, yes.

Q Did you come to learn that he went to the emergency room the day after the accident?

A Yes.

Q Now, he came to you with his complaints about his neck and his back?

A Yes.

Q Now, sir, is it unusual in your practice to find that patients who come to you with neck and back complaints having been in a motor vehicle accident do not initially get treatment that day, but rather will wait for a certain period of time?

MR. GORKIN: Objection to both, to the form and --

THE COURT: Sustained.

Q Sir, Mr. Weathers went for his first medical attention the day after the accident, correct?

A Yes.

Q Is that unusual in your practice?

MR. GORKIN: Objection.

THE COURT: Sustained.

Q Can you tell us, when somebody has complaints of their neck and their back when you see them and they give you the history and when that history involves not receiving treatment initially, what the medical explanation for that is?

A Yes, the medical explanation, especially in this case of a herniated or bulging disk, disk disease, typically the patient will describe, you know, feeling pain in their back, either a crack, a snap or a pop. And hours to days later they will develop pain radiating down the leg. This is because the body, in response to the rupturing of the disk, sends out a chemical mediator to heal the disk and this creates an inflammatory response. And that could take hours to days to develop and the patient will have pain radiating down the leg. So it's not uncommon for patients to sustain this type of injury and not be in severe pain that would necessitate a hospital evaluation. And so hours to days later, when the pain intensifies and starts to radiate, they would go to the hospital.

MR. GORKIN: Judge, we haven't established that the

plaintiff sustained any injury yet.

THE COURT: Counsel, overruled. That's been sustained. You can cross-examine on that.

Q Sir, I'm going to ask you about that initial emergency room visit. Do you have the record from Coney Island Hospital emergency room?

A Yes, I do.

MR. AVANZINO: I believe we marked that as an exhibit, your Honor.

THE COURT: Are they in evidence?

MR. AVANZINO: Yes, your Honor.

THE COURT: What number is this?

MR. AVANZINO: This is Plaintiff's 3.

THE COURT: Coney Island Hospital records.

MR. AVANZINO: Yes, the Coney Island Hospital records.

THE COURT: In evidence already?

MR. GORKIN: Yes.

MR. AVANZINO: Yes, your Honor.

Q I show you a copy of that record, sir. Now that's in evidence, this record from Coney Island Hospital. Does it indicate in the history that this is a 57 year old man, status post motor vehicle accident yesterday?

A Yes, it does.

Q And does it also describe the areas of complaint of his body that he had?

A Yes, it does.

Q Does that include his neck and his back as well as his left knee?

A Yes, it does.

Q Was an examination performed there?

A Yes.

Q And from the complaints and the examination, did the doctor in the emergency room determine that x-rays should be done?

A Yes.

Q Now, is that a common practice for x-rays to be done when somebody's taken to the emergency room with these type of complaints?

A It is not common. It is necessary when the patient complains of severe pain.

Q So it's not something that's routine, it depends on the level of complaint that the doctor feels is coming or whatever the results of his exam are?

A Yes.

Q In this case the results of the x-rays were negative. What would be the purpose of taking an x-ray of the spine, of the neck and the back?

A To rule out any acute unstable fractures that would require immediate surgical intervention.

Q So there were no fractures of the bones in the spinal

area for Mr. Weathers?

A That's correct.

Q Did the doctor who saw Mr. Weathers give a diagnosis at that point?

A Yes.

Q And what was that, sir?

A Neck and lower back pain, musculoskeletal pain and left knee sprain.

Q And was he also given pain medication at that time?

A Yes. He was given Motrin.

Q And indication to follow up with a doctor?

A Yes.

Q And all of what you saw in the emergency room record would be consistent with ultimately the complaints that Mr. Weathers had when he came to see you?

A Yes.

Q Now, sir, in addition to taking the history -- that's fine, we're done with that. Thank you.

In addition, sir, to finding out that he had been treated the day after the occurrence, you also came to find out that he had seen Dr. Delman, correct?

A That is correct.

Q And that he received physical therapy with Dr. Delman?

A Yes, he did.

Q And that the physical therapy had proven not to be

successful?

MR. GORKIN: Objection.

THE COURT: Sustained.

Q Did you come to learn that the physical therapy had proven to be not successful?

MR. GORKIN: Objection.

THE COURT: I just sustained it. Rephrase the question.

Q In obtaining the history in finding out Mr. Weathers' pain, did you come to learn from him in taking the history that the physical therapy had not been successful?

MR. GORKIN: Objection.

THE COURT: Sustained. We'll have a side bar --

What were the complaints of the plaintiff when he came before you?

Q What were the complaints that he came to see you for?

A He complained of pain primarily in his lower back and secondarily in his neck. The pain intensity on a scale that goes from zero to ten, zero meaning no pain and ten meaning the worst pain he's ever experienced, which is to him the pain intensity in the lower back at that time was a seven out of ten. At its worst it was an eight. And the neck pain at that time, six to seven out of ten and at its worst was nine out of ten.

Q Now, in addition to learning about the history of the

car accident, did you determine from the history whether Mr. Weathers, whether Ronald had any prior problems with his lower back or neck before this accident of June 23, 2008?

A Yes. He reported that in 1974 he was involved in a motor vehicle accident, but he did not sustain any injuries to his neck or lower back.

Q So then the history was that he's had no prior complaints before the automobile accident of June 23, 2008 referable to his lower back?

A Correct.

Q And that he had been able to work steadily throughout his adult life?

A Yes.

Q Sir, did you conduct an examination of Mr. Weathers?

A Yes, I did.

Q And did you also have the benefit of the MRIs that had been taken of his lower back and his neck?

A Yes, I did.

Q Sir, can you tell us whether at this point it would be of help to you in explaining to the jury to look at MRIs that are in evidence?

The MRIs are Plaintiff's 4 in evidence. If you can explain to us what the role is of an MRI in your practice.

A The MRI is used to confirm or dispute a clinical diagnosis. The clinical diagnosis is based on the patient

history and the physical examination. And the MRI is then used to correlate these findings and it would either support the diagnosis or dispute it.

Q Now, in terms of your training, I know you told us that you were trained in medical school, of course, in various parts of medicine, but you specialized in anesthesiology and your subspecialty was in pain management and you did a fellowship.

As part of your training, were you taught how to read and interpret MRIs?

A Yes.

Q And can you tell the members of the jury what role the MRIs play in your practice? In other words, how regularly do you review MRIs of your patients?

A I do review them on a fairly regular basis. Their primary role is usually when there is a conflict in terms of my clinical diagnosis or the patient's response to the treatments that I've instituted. When I did my fellowship, we routinely treated patients based on their history of radicular pain. And if they didn't respond to the treatment, then we would obtain an MRI and be more interested in looking at the film. And reason for this is that the MRIs are very sensitive tests and it can sort of mislead one in terms of correlating treatment. It will show disease when that disease is not causing any clinical symptoms in the patient.

So the clinical signs and symptoms, locating the pain generator, pressing on the pain generator, reproduction of pain, those are more useful tools in the treatments that I have to offer patients. And the MRI is a facilitator or it will help to direct treatment to other areas when the patient is not really responding to your clinical picture and your treatment.

Q And in this instance, in the case of Mr. Weathers, have you had the chance to review the MRIs on a number of occasions?

A Yes.

Q Sir, if you can, if it would help, we'll put them on the shadow box.

MR. AVANZINO: Perhaps with Court's permission, the doctor can step down and explain to us what the MRIs show.

THE COURT: Yes.

MR. GORKIN: Your Honor, may I stand over there?

THE COURT: Sure, you can.

For the record, let's just identify each MRI.

Q Doctor, before we begin the process of looking at the MRI films themselves, I'm going to ask you to just differentiate for a moment and we'll have an opportunity, if you'd like with the model, to explain to the jury about the different regions of the spine and perhaps whatever you prefer, sir, to go into that and explain.

A Sure. I think the most important concept to

understand is what the MRI looks at. You have a transverse --

THE COURT: Has this model been marked?

MR. AVANZINO: No, your Honor, it has not. So could we have that marked for identification then? There's a model and there's also --

THE COURT: You've got to ask some preliminary questions, as you know, on the model.

MR. AVANZINO: Yes.

Q Doctor, the model that you have, Plaintiff's 5 for ID that you're holding in your hands, could you describe what that is?

A This is a model of the spinal column. This is the head.

Q At the top, beginning at the top?

A The head, cervical, thoracic, lumbar, sacral.

Q Sir, can you tell us, when you say cervical, what part of the spinal column is that?

A The neck, cervical; chest, thoracic; lower back, lumbar; and the tailbone and below the hips is sacrum.

Q Would this be useful and helpful now in describing to the jury certain things about the anatomy of the spine?

A Yes.

MR. AVANZINO: With the Court's permission, can the doctor use it?

THE COURT: Go ahead.

A I'm going to explain how the MRI helps me to determine my treatment.

MR. GORKIN: We don't have a question.

THE COURT: Sustained. You can ask an open-ended question.

Q Doctor, can you explain to the jury with regard to the anatomy of the spine in using the model and since we have the subject MRI, how it correlates?

A The MRI uses magnets and the unit of magnet is called Tesla. And based on how intense the magnetism is, T1, T2 weighted image, you can penetrate deep into the tissues.

The MRI can give you a cross-sectional view, which is looking straight on, which would be this. Or it can give you a longitudinal or transverse view. And you can have cuts starting from here all the way across. So that's basically how an MRI works.

Q How is that different, if you use the model, from an x-ray, what an x-ray would show?

A The basic difference between an x-ray and MRI is the MRI allows you to see soft tissue. The x-ray will only allow you to see bone and shadows. The MRI gives you a better picture of the soft tissue, the disks, the nerves.

Q And so if you would now go on to explain the role that the disks play and the nerves, if you can explain about the spinal column.

A The spinal column is made up of vertebral bodies, spinous process is in the back. The vertebral bodies are separated by the disk and --

Q The vertebral bodies are the bone?

A The bones.

Q These are the bones. So these are the thick, white objects that we see there, quite hard because they're bone?

A Yes. And the structure is very rigid. Each level has three joints. The joint between the vertebral body is called the intervertebral joint, which is separated by the disk. And behind it, there's two joints called facet joints.

And because this is a rigid construct, rupturing any one joint will rupture the other two joints.

Now, it's important to understand the anatomy of the disk. The disk has a central core called the annulus fibrosus, which has the consistency of jello. And that allows us to run and jump. It cushions us. It's movable. It's compressible.

It is then contained by another structure called the -- the disk is the nucleus pulposus, I'm sorry. The structure that contains it is called the annulus fibrosus, which is a thicker, more rigid-type structure. And the important anatomic construct of that is that it's constructed like layers of an onion. So it has several different layers as we go from inside of the disk to outside where the nerves leave the spinal canal. The spinal cord runs up and down. The spinal canal is

buffered in front by vertebral bodies and disks and behind is the facet joints and spinous processes.

Q Just to give another view, this perhaps is Number 6 that's been marked for identification, if you can just identify the parts of the spine there?

A This is the jello part, the nucleus pulposus, and the annulus fibrosus, which is layers. It's very tightly wound layers.

Q And that outside of the disk is that hard, that annulus fibrosus?

A Yes. It's much more -- it's much less compressible than the disk itself. And I usually -- it's the consistency of your jeans as compared to the consistency of jello, which is what the disk is.

Q On the inside what the disk is?

A Yes. And when you have a herniated disk, the jello part breaks through all the layers of the lining. And this is looking straight on, this is front to back. This is the vertebral body with the disk. This is the spinous process, facet joints and these are called lamina. This is the spinal cord going up and down. This is the nerve root. So as this material comes out here, it can compress the nerve root and cause pain radiating down the leg.

In the instance of a bulging disk, when only some of the layers are disrupted, the body releases chemicals in its

attempt to seal the tear off and choke the extruding part of the disk. And those chemicals can seep from that level to other levels as well as at that level and that can cause what's described as a chemical radiculitis. So chemicals can cause the tingling down the leg as well as a mechanical irritation where the actual disk hits the nerve.

Q Doctor, we heard you use two different terms. And just to be clear, you used the term herniated disk where there is an actual tear in this outside -- where the material inside comes through?

A Right. It's broken through all the layers in the lining of the disk. That is a herniation. Whereas a bulge, it has only broken through some of the inner layers. You can think of a bulge as sort of a contained herniation where it's broken through some of the layers but has not violated all the layers.

Q What is the effect on the patient when there is a contained herniation like a bulge versus a herniation where it has actually broken through? Is there any difference in the manifestation?

A There is usually no difference in the clinical symptoms. They have pain radiating down the leg. This is where the MRI will aid in deciding or determining whether it's a bulge or herniation.

Q You talked about the nerve roots before. What are the

roles that the nerve roots play in relation to bulging or herniated disk?

A Well, the nerve roots sit in a canal, the intervertebral canal. And that canal, when it's normal, allows those nerve roots to move. That's why you can -- that's why -- so this is the intervertebral canal between the vertebral bodies. This is the intervertebral canal.

It's a very confined space and that means that it has very little give. So any excess material there will impinge on the nerve as it leaves the canal and goes down, in this case to the leg and in this case to the arm. And what that will do is, when you move the leg or move the arm or when you compress the disk, you can reproduce the irritation on the nerve and reproduce the radicular pain. That's what a straight leg raising does. The patient is either sitting or laying flat and the leg is raised up and that stretches the nerve. And if there is any impingement or material within this foramen here, then it will reproduce the patient's pain and that will help you decide or identify your pain generator.

Q Now, with use of the MRIs -- we can hang this guy up over here.

With the use of the MRIs, can you explain to the jury, with the use of the shadow box and the films themselves, what you see when you look at the MRI that was taken. First, if you can just identify for us what part of the spine that MRI film

shows.

A This is the MRI of the lower back, lumbar-sacral spine. This is a transverse cut. That's going up and down this way.

Q And this was taken on June 27th?

A June 27th, 2008.

Q Can you just then put that up and --

A Okay. As you can see, these lines tell you where you are with respect to the spine. So as you go across, it has -- and these images go down. You're taking cuts going down this way here. And one of the better cuts is this level.

Q Can you identify for us what cut that is, Doctor?

A This is 7 of 14. So you know you're looking at the spine from the side. If you look here, you can see a white shadow and a nice spacing here.

Q What does it mean to have a nice spacing?

A It means -- this is called the spinal canal which runs up and down. It means that there is no violation of that canal. There is something pressing on the canal or pressing on the spinal cord. If you go up here, you'll see that there is an indentation here. That's quite obvious when compared to here, here or above it.

Q Now, I'm going to ask you, just so we can more properly understand the levels that you're referring to, are each of the lumbar vertebra numbered?

A Yes.

Q So the large bones that we see here of the vertebra, they're numbered?

A Yes.

Q And what is the way that the lumbar vertebra are numbered?

A Right. The way to determine what level you are, especially in MRIs, the sacrum does not have any disks. This is the sacrum, right, so this is S1.

Q And if we look at our model over here, we see that in the middle column over here, Plaintiff's 6 for identification, we see clearly for the jury where the lumbar vertebral bodies begin.

A Yes. This is L5, L4 and L3. And this is the sacrum here. If you look at L3-L4, you see an obvious indentation here which is described by the radiologist as a bulge. And that is subjective. I could easily call that a moderate herniation.

Q Now, sir, in looking at our diagram over here, where you're referring to is down in this area here, the L3-L4 area?

A Yes.

Q That would be in the area of the lower back?

A Yes.

Q And the radiologists, when they look at these and interpret these, they don't get the benefit of examining the

patient, correct?

A Correct.

Q Now, having found the L3-L4 indentation as you put it, that indentation is, if you can use the model again, Number 5, can you show the jury, what it would be like if there's an indentation at that level?

A Well, what it would mean is that you see how you can see through these openings? The pins, they're not being pressed upon. There's nothing in there. When you have an indentation, it obviously will press on the nerve. Or depending on where it is, it can also press on the spinal cord. Depending on how severe it is, it will produce varying types of symptoms, pain, tingling, loss of bowel or bladder function.

Q Thank you, Doctor. So you see clearly the indentation that the radiologist having determined it's a bulge or what could be described as a herniation there.

Doctor, I'm going to ask you, if you can, take a look at another film. Thank you.

A This is an MRI with cervical spine.

Q Cervical spine, that's the neck region?

A The neck. And using the same terminology, you can see here that clearly there are several levels where you have that same indentation. This one more so than the others.

Q And, sir, would you, again, just so we understand this better, can you tell us the numbering system for the cervical?

A Yes. The first cervical vertebral body does not have a disk, so it's C2, 3, 4, 5, 6, 7. So if you look here, there is, I think this is a herniation at C3-4, C4-5 and maybe a bulge at C5-6.

Q Doctor, can you give us the particular number, the one you told us before is 7 out of 14?

A This is 6 out of 12, cut 6 out of 12.

Q Let me just take this down. And if you don't mind, why don't we just have you, with your notes, and you can stay down here because I'm going to ask you questions with regard to the model. But if you need your notes, you can refer to them with regard to your initial examination.

You told us you did an initial examination of Ronald Weathers.

A Yes.

Q Can you tell us what you found in your initial examination of him?

A Yes. Significant findings were positive straight leg raises on both sides, that is extension, flexion of the --

THE COURT: Are you done with it?

MR. AVANZINO: I'm going to ask him a couple of questions, Judge, just from the exam that he did.

THE COURT: I want him to sit down when he's testifying and take that down so the jurors can see him.

MR. AVANZINO: Yes, Judge.

Q I think, Doctor, you were telling us about the straight leg raising tests and results of that for Mr. Weathers.

A Yes, they were positive. As I stated earlier, it involves raising the leg and moving the nerve roots along the intervertebral foramen that I showed you. And when there is encroachment on the nerve root in that canal from a bulge or herniated disk or tumor or infection, the patient will report tingling down the leg.

And normally the patient should be able to raise his leg when laying flat to about 90 degrees without any irritation, and when sitting, to about 30 degrees. So you note the degree where the patient experiences tingling and it's called a positive straight leg raising.

Q As well in your physical exam you noted that his gait was markedly antalgic. What does that mean?

A Yes, he walked with a limp.

Q And when you asked him to flex and to extend his lower back and his neck, what were the results of that?

A He had increased pain.

Q What's a Spurling's sign?

A A Spurling's sign involves eliciting the same tingling except this is done in the neck. It basically increases pressure on the disk. And if the disk in the neck is contained, if the annulus is not violated, the patient will not

have any tingling.

The actual test involves extending the patient's head and bending it to one side and then putting pressure on the top of the head. And what that does, it increases the intra-discal pressure. And if there is violation of the lining of the disk, the patient will have tingling down the side to which the head is being bent. So the left side has tingling to the left. That is how a Spurling's sign is carried out and it allows you to determine whether the patient has radicular symptoms in the neck.

Q Sir, after obtaining the history and, by the way, in the history, did you come to learn that Mr. Weathers had arthritis?

A Yes. In his past medical history he reported a history of rheumatoid arthritis.

Q Doctor, can you explain to the members of the jury what effect rheumatoid arthritis generally has on a patient?

A Rheumatoid arthritis is an autoimmune disease where the body attacks the synovial joints. Synovial joints are usually joints that have a high degree of movement, fingers, the knees, the shoulders. It rarely attacks the spine. A synovial joint has a lining with fluid and the spine just does not have that type of material. So rheumatid arthritis usually affects small joints, fingers, knees, toes.

Q Doctor, I ask you to assume that Mr. Weathers

testified in here in court that although he's been treated for arthritis for a few years before this automobile accident, that the treatment for the rheumatoid arthritis was limited to his hands and his knee. Would that be consistent with what you know about rheumatid arthritis and what you found in this patient?

A Yes, it would.

Q Sir, did you make an initial diagnosis after having reviewed the MRI films, the history and taking an examination of Mr. Weathers?

A Yes. My diagnosis was lumbar and cervical post-traumatic disk pathology, myofascial trigger points. I couldn't rule out facet syndrome.

Q And did you find radiculopathy in the lumbar and cervical low back and neck regions?

A Yes, I did.

Q Sir, did you set forth a plan for this patient?

A Yes. The plan was to institute lumbar and cervical epidural steroid injections, diagnostic facet nerve injections.

Q Let me just stop you at that point. Can you explain to the jury about what an epidural steroid injection is and what the purpose or what the use is for somebody with Mr. Weathers' symptoms and problems?

A Right. The epidural space is the space where the spinal cord and nerves live and where the disk can herniate

into. An epidural steroid injection involves delivering an anti-inflammatory steroid into that area and the steroid works two-fold. It's a particulate steroid, so it has particles and that can help shrink the bulge or herniated disk. The steroid also can go inside of inflammatory cells and shut down their ability to produce a substance called Phospholipase A, which is one of main mediators of pain and inflammation and what causes the chemical radiculopathy and tingling down the leg.

So it works both ways, to help decrease the mechanical pressure on the nerve that can cause abnormal sensation such as tingling, as well as the chemical irritation by blocking the production of that substance, Phospholipase A.

Q And the goal in providing epidural steroid injections is also to relieve the pain, the symptoms that the patient is having?

A Yes.

Q And, sir, are those usually conducted in a series of threes?

A Yes.

Q Can you explain to the jury why that is?

A The reason we give a pulse steroid, because the steroid takes about seven to ten days to work, each injection involves giving a certain, a reduced amount of steroid to affect the relief in the pain. So the patient is either given a week to two weeks apart and each time they receive a smaller

amount of steroid to help decrease the pain, irritation and swelling.

Q Was Mr. Weathers given a series of three epidural steroid injections?

A Yes.

Q Can you just, perhaps with your hands, however you choose to do it, can you explain to the jury what that needle is like that goes into the area of the spine when you inject the epidural?

A I have one here.

Q You have it with you?

A This is a -- can I?

MR. AVANZINO: Would that be okay, your Honor, just for the doctor to --

THE COURT: You can hold it up.

A This is an epidural needle. And we advance this -- this is about a three-and-a-half inch needle, and we advance this about two inches into the tissue, about a few millimeters, actually goes into the epidural space. And we then inject a contrast material to confirm that you are in the epidural space and then we administer the medicine. Of course, we numb up the skin before.

So the needle passes through skin, soft tissue and a ligament and then it gets into the epidural space. Although this much is in the body, only about this much is in the

epidural space.

Q And he had a series of three. And were those successful, sir?

A No.

Q What was the next course of action for Mr. Weathers when the epidural steroid injections were not successful?

A Because he had pain on extension and reported pain on movement, I then performed a diagnostic procedure. So now I'm trying to find out or pinpoint the pain generator. And my first --

Q Let me interrupt.

THE COURT: You got to let him answer, counsel.

A And my first diagnostic procedure was a diagnostic facet nerve injection.

Q And I want you to explain to us what a facet nerve injection is.

A If you recall, I described the facet joints, those two joints that are behind the intervertebral joint behind the spinal cord, behind the disk. Because of the rigid construct on each of those levels, when you have a bulging disk or herniating disk, the spacing between the vertebral body is lost. Those vertebral bodies move and the joints, facet joints can rupture and those joints can become arthritic and cause pain.

So the diagnostic facet nerve injections numbs up the

nerve. It's called medial marginal branch nerve and all it serves is to transmit pain from those joints. So a small amount of local anesthetic or Novocaine is injected in or around the nerve. The patient then waits in the office for about ten, fifteen minutes. Then they try to twist and turn. If the pain that was produced with twisting and turning is reduced by fifty percent or more, then we have a positive diagnostic facet nerve injection and the patient is a candidate for a more permanent treatment of that nerve to help alleviate the pain.

Q Can you tell us what the result was when you gave Mr. Weathers the facet block injections?

A They did not change his pain.

Q So what was the next step along your course of the treatment for him?

A The next step was to identify which of the disks, if any, was actually causing his pain to see if he would be a candidate for percutaneous discectomy. That is done by doing a diagnostic discogram.

The diagnostic discogram is akin to actually going in to each disk and actually squeezing the disks to see which causes the patient pain. It's a blinded test. It's an objective test. The patient does not know which disk I'm irritating. I put a needle in all five disks and then I inject the dye. The dye increases pressure in the disk akin to when he sits for a long time or coughs or sneezes and that pressure, if

there's violation around the lining of the disk, will reproduce the patient's pain down the leg.

Q And did you, in fact, do a discogram on this patient, Mr. Weathers?

A Yes, I did.

Q And, sir, can you tell us about the results of the discogram?

A The discogram, we have a special monitor that measures the pressure and volume injected into the disk and we record the patient's pain. And if he has any when we're injecting the dye, the pain is then -- the patient is then asked to correlate that pain that he has with the same pain that we're trying to treat. And if he says it's the same pain going down the same leg, it's described as concordant pain.

When the patient has concordant pain, that disk is then identified as a painful disk. We also inject -- when we inject the dye, we use a live x-ray, fluoroscopy, so we can watch the dye spread and we keep pictures of the dye spread. If you imagine the disk and the annulus, the lining around the disk, if that lining is intact and you inject material in the center of the disk, it will stay in the center of the disk. If there are rips or tears in the lining, the dye, the contrast will leak out.

And depending how rapid the dye leaks out, how much of it leaks out, you can then determine that that disk has tears

around the lining of it and is a painful disk.

And during the discogram you can have an abnormal disk that has tears in it, but it just doesn't cause the patient pain. So that's the beauty of the discogram, it allows you to ascertain which disk is causing the pain and what the extent of that pathology of the disk is so you can target treatment.

Q And what were the results of the discogram you performed on Mr. Weathers?

A Ronald had concordant pain at three levels, L3-4, L2-3 and L4-5.

Q And that concordant pain means pain that is consistent with the clinical findings of your exam?

A Yes.

Q Were any pictures produced that are part of your record from that discogram?

A Yes, I have pictures here.

MR. AVANZINO: Your Honor, can the doctor display those so the doctor can just explain what they are?

THE COURT: Have you seen these?

MR. GORKIN: No, I haven't.

THE COURT: Are these part of his medical records?

MR. AVANZINO: Yes.

Q Would it help for you to show the jury?

A Yes.

MR. AVANZINO: With the Court's permission.

A This is the cross table. This is the back, the front. This is the L5, S1 disk. This, if you look at this dark shadow here, it looks sort of like a cotton ball and that means that the dye is staying in the center of the disk.

If you look here, above here, this sort of looks like it's going outside of the lining of the disk. There's defect here, this is 4-5. And above that is 3-4. You can also see that there is some narrowing here of the dye. It's not staying in the center. It's sort of seeping out here at L3-4. This indicates that the lining is violated and it's consistent with a bulging disk.

Q Or contained herniation as you were talking about?

A Or herniation, yes.

Q Thank you, Doctor.

Sir, after getting the results of the discogram, with the concordant findings of the discogram results consistent with your clinical exam and the patient's complaints, did you discuss them with Mr. Weathers and the prospect of doing the discectomy?

A Yes.

Q And can you explain to the jury what the purpose is of a discectomy?

A It has many descriptions and one of the best descriptions, it is also described as a disk decompression. If you envision a contained herniated disk, its propensity wants to move back in the space it came from. But because of the

abnormal changes from the trauma, it has difficulty doing so. And sometimes it will, but then it will move back along the path of least resistence.

The discectomy allows the disk, because it is contained and under pressure to move back, it allows that disk material to move off the nerve back into the center of the disk. And what it does, it is simply going in with a special probe and taking out two to three millimeters of disk, very small amount, and that creates a space. And the patient is then told to avoid any pressure this way on the spine. So no excessive sitting or standing, lifting, pushing for two weeks. And over that two-week period, the material moves off the nerve and back into that space.

Q So that's the objective. That's the hope from the surgery?

A That's the theory behind this percutaneous discectomy, yes.

Q Sir, in describing to the patient about the discectomy, what the goal is, what the purpose is, do you also go over the potential risks with the patient?

A Yes.

Q Can you explain what the risks are?

A The risks are, the main risk is, although very small, is infection. The disk has very little blood supply. So if you have infection in the disk, you get a diskitis, one of the

only ways to treat it is to open the back and clean out the disk, a major surgical procedure. Other complications are procedure dependent. You can inadvertently sever a nerve root. You can impale a spinal cord. But that usually doesn't happen with experienced surgeons.

Q And, sir, we have in evidence the actual Brooklyn Hospital record where the surgery was performed. I want to ask you to comment on that in a moment.

Doctor, I'm going to show you what has been marked as Defendant's C in evidence. This is the Brooklyn Hospital record. Do you see that, sir?

A Yes.

Q And that has your operative record in there?

A Yes, it does.

Q Can you tell us what date the operation was performed?

A February 19, 2009.

Q Can you describe for the jury what you did during the operation, what the operation consisted of?

A Right. I spoke to Ronald before and on the morning of the procedure and ascertained exactly where most of this radiating pain was, which was around the knee and the upper thigh. And so the decision was made to just decompress two disks, the L3-4, which was the disk that had the bulge on MRI, in addition to the L4-5 disk, which was not described as abnormal on the MRI, but on the discogram reproduced his pain

and showed leakage or tears in the annulus fibrosus.

Q And did you then set about removing that disk material from the L3-4 and 4-5 levels?

A Yes.

Q Was he under anesthesia when you did this?

A Yes.

Q Doctor, can you tell us, we know what the goal is the benefit of the removal of the disk material, but I've heard it described essentially as borrowing from tomorrow to help today. What is the long term effect when you remove disk material from the patient?

A Any time you go into the body like that, it responds with an inflammatory response. You also lose disk material. So you can have loss of his height. You can have arthritic changes in the disks. But because the probe is so small and we remove such a small amount, a normal disk is about 69 cc's of material. We don't remove more than two or three cc's at a time. And so the long-term effects are minimal when it is done this way.

Q Sir, can you tell us what the results were from the surgery you performed on Ronald?

A Ronald had excellent relief of his radicular pain. He did quite well with the procedure, but he continued to have axial back pain in the back.

Q When you say axial back pain, can you tell us what

that means?

A Meaning the pain that stays in the back and is not radiating down the legs.

Q So nothing from the injections or the surgery were able to assist or alleviate that axial or localized back pain?

A Correct.

Q Sir, did you continue to have the opportunity to treat Ronald Weathers after the surgery?

A Yes. And we tried several different medications to try to alleviate the axial back pain including Tylenol, Motrin and long-acting and short-acting opiates.

Q And over what period of time did you continue to see Mr. Weathers as a patient?

A I saw him about every four weeks and I last saw him in the summer of 2011.

Q And, sir, did you come to an ultimate diagnosis based on your examinations of him and your treatment of him over the course of that period of time?

A Yes. It was my opinion that, especially in the lower back, he continued to have pain. And because he had back surgery, his diagnosis changed to something called post-back surgery symptom or chronic intractable pain. And I proposed to him a very beneficial treatment called a spinal cord stimulator for his continued lower back pain.

Q And can you explain to the jury what is involved with

a spinal cord stimulator?

A Right. It is a therapeutic intervention that it's not a cure. It basically blocks the pain. It does so by taking advantage of the gate control theory of pain.

The gate control theory of pain emphasizes that -- the central nervous system, the brain has different gates. And when one set of nerves are working, the gate shuts off other sets of nerves. That's why you can focus on different things. And so with pain, when sharp burning pain is being processed in the central nervous system, other gates are closed. When vibratory pain is being processed, the gate to the sharp burning pain is shut off.

The best example of that is if you ever stubbed your toe or hit your elbow or your finger and you give it a deep rub, it makes the pain better. Basically what you're doing when you're rubbing it, you're stimulating one set of fibers, beta fibers, that require a smaller current. And when you stimulate those, they shut off the gate, they close the gate on the sharp burning pain, A delta and C fibers. So the spinal cord stimulator uses gentle electrical stimulation on the spinal cord to modulate those painful signals.

This is delivered by using specialized electrodes that is implanted into the epidural space. It requires a trial period where the temporary electrodes are implanted through epidural needles, similar to this one, and the patient keeps it

in temporarily. The patient is taught how to turn the stimulator on and off. And after five to seven days they're removed and the patient is assessed for pain removal, they're ability to tolerate the tingling and their use of pain medicines. And if there's a fifty percent reduction in the pain medicine score and if the patient is able to tolerate the tingling and if they use less pain medication and able to sleep better, that is deemed as a successful trial.

The temporary leads, electrical, is removed and a more permanent system is implanted which requires a mild -- the only minimal surgery that you'd ever have, it's a surgical procedure where two incisions are made, one incision in the back, two to three new electrodes are implanted. They're secured to the ligaments above the spine. The leads are then tunneled into one of the butt cheeks where a battery pack is implanted and everything is on the skin and the patient can control the permanent system by remote.

Q Doctor, if you could go over with us, please, what the cost would be for Ronald, if he chose to undergo that spinal cord stimulator, first the trial and then the actual implantation of the stimulator.

A The trial, if it's done in the office, which would not require anesthesia or hospital bill is about $15,000. Each lead is about $7,000. But usually if it's done in the office, I can get it discounted. In the hospital that cost increases

because there's the cost of anesthesia and cost of the facility. So in the hospital, the trial is about $25,000.

And then the implant is the same $25,000 in addition to the battery pack, which is about $30,000. So the permanent is about 50 to $60,000.

Q And as far as the permanent stimulator, what type of maintenance or upkeep is necessary with the permanent stimulator?

A Well, if everything goes well and the patient uses their stimulator moderately, the battery lasts between seven to nine years. They have a rechargeable battery that the patient can recharge through the skin through telemetry remote control. When it gets depleted, it needs to be replaced. So that would require another $30,000 plus the physician, hospital fee and anesthesia fees.

Q Doctor, I'm going to ask you a hypothetical now. I'm going to ask you to assume the following information: I'm going to ask you to assume that Ronald Weathers, at 56 years of age on June 23 of 2008 was involved in a motor vehicle accident;

That he was the driver of a car wearing a seat belt traveling on Shell Road when another car coming the opposite direction made a sudden left turn in front of him causing Mr. Weathers' car to strike the passenger side of this other vehicle, this SUV that had made the turn in front of him;

And that Mr. Weathers, as a result of the impact, seated in the car, was caused to go forward in the car and be restrained or stopped by his seat belt;

That in the course of being stopped by his seat belt, he was then snapped back toward his seat;

And that as a result of this impact, his glasses and hat flew off his head;

And as a result of the impact, the fastener by the seat belt actually snapped;

That Mr. Weathers is approximately six feet, two inches tall and at the time of the accident weighed approximately 250 pounds;

That Mr. Weathers had previously been diagnosed with rheumatoid arthritis which he testified affected his knee and his hands;

That he had also been working throughout his adult life, primarily as an automobile mechanic;

And that he had last worked in December 2007 when the dealership where he was working as an auto mechanic was caused to close down;

That over the next six months leading up to this motor vehicle accident he was being treated for prostate cancer, even had surgery in April and undergoing radiation treatments at the time this accident actually took place, this auto accident;

That following the auto accident, Mr. Weathers had

complained about his neck and his back, but not severe enough for him to go in an ambulance from the scene to a local emergency;

And it wasn't until the next afternoon that he went to Coney Island Hospital emergency room where he had complaints again about his neck and his back. And he was treated, x-rayed, and given pain medication and released, being told to follow up with his doctor;

That the next day he went to a doctor, Dr. David Delman for treatment. Dr. Delman examined him, ordered MRIs for him and set him out on a course of physical therapy;

That the MRIs were taken at Stand-Up MRI on June 27 and those MRIs consisted of MRIs of his cervical, neck region and his lower back; that those MRIs revealed herniations in his neck as well as a bulge or contained herniation in his lumbar spine.

MR. GORKIN: Objection.

THE COURT: Sustained.

Q That he was sent for MRIs of his neck and his back and that he was then given physical therapy with -- he was given physical therapy with Dr. Delman's office and was sent to you on August 20th of 2008;

That you reviewed the MRIs and found there to be herniation in the cervical region as well as contained herniation or bulge in the lumbar region in L3, L4;

That you set Mr. Weathers out on a course of epidural steroid injections. He had three of them, followed by a month later, facet block injections. Neither set of injections were successful in alleviating his pain;

That you had him undergo a discogram which required dye being injected into his spinal column to determine the actual level where the pain source was coming from;

That you made a determination that he had concordant pain at the levels in his lumbar including L3-4 and L4-5;

That Mr. Weathers then underwent a discectomy or decompression at the L3-4 and 4-5 levels at Brooklyn Hospital;

That he continued to treat with you over the course of the next two-and-a-half years. And that although the surgery relieved the radicular pain that he had been experiencing, he still had the axial pain or lower back pain as well as discomfort and pain in his neck;

That Mr. Weathers was then advised by you of the prospect of having a spinal cord stimulator implanted on your last visit in July 2011.

Sir, I'm going to ask you now, based on those details, if you have an opinion with a reasonable degree of medical certainty, sir, as to whether Mr. Ronald Weathers' condition, the condition producing a pain in his neck and lower back, the herniations in his neck, the contained herniation in or bulge in his lower back, if those were causally related -- and the one

other detail I'll add is that he had no prior complaints of neck or back pain prior to the motor vehicle accident, nor had he treated for neck or back pain prior to the motor vehicle.

Now, sir, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Ronald Weathers' pain in his lower back and his neck, the herniations and bulging disk, whether those were causally related by the motor vehicle accident of June 23, 2008?

A Yes, I do believe that all his pain and subsequent inability to work were a result of the motor vehicle accident.

Q Now, sir, I'm also going to ask you, based on that same hypothetical, do you have an opinion with a reasonable degree of medical certainty as to whether these injuries that Mr. Weathers sustained, the herniated disk as well as the bulging disk, whether those injuries were or are permanent in nature?

A Yes.

Q And can you amplify that or expound on that?

A Yes. He clearly has had some benefit from the treatments that I've administered to him, but he continues to have pain primarily in his lower back. And it tends to be in the moderate to severe region and limits his ability to work and, therefore, would require additional treatments if we were to plan to decrease the pain and improve his function. So there is permanency. The treatment offered is not a cure. It

is sort of a symptomatic treatment to block the pain.

Q And, sir, do you have an explanation for us with regard to the term exacerbation and remission? Are those conditions, the herniations in his neck, the contained herniation problems with his lower back, are those conditions that can be subject to exacerbations or remissions and can you explain what that means?

A Yes. The nature of the disk as I described it, it being movable and not rigid, there can be instances where Mr. Weathers might cough, perform sudden movement and this can certainly increase his pain. Because of the defect of the lining around the disk, he's at increased risk for worsening of the herniation, extruding the disk into the spinal canal. That could cause severe neurologic deficits that would require immediate surgery.

Q So the disks, as you've examined, based on your examination and your review of the MRIs, discogram and surgery, you're telling us Mr. Weathers' disks that have been injured as a result of this motor vehicle accident are now more -- make him more vulnerable and susceptible to injury going forward?

A Yes.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty whether the injury, first I'm going to deal with the cervical region, with regard to Mr. Weathers' cervical region, is that a significant limitation of his

ability to use his cervical region or his neck region?

MR. GORKIN: Objection.

THE COURT: Sustained.

Q Doctor, do you have on opinion with a reasonable degree of medical certainty whether the injury, as you've diagnosed it with regard to Mr. Weathers' neck, is a significant limitation for him?

MR. GORKIN: I don't know that he ever diagnosed his neck of any injury. I don't think we've had any testimony about his neck.

THE COURT: Do a little back-up before you ask that. Sustained.

Q Sir, you reviewed the MRI films for us of Mr. Weathers' cervical region?

A Yes.

Q And you found in those MRIs that there were three levels of herniated disks?

A Yes.

Q Sir, you also performed a number of examinations on Mr. Weathers. You told us in that initial diagnosis that you had found there to be a positive Spurling's sign, positive tenderness throughout the facet joints, range of motion decreases in his neck.

A Yes.

Q And that you had made an initial diagnosis of the

cervical post-traumatic disk pathology, cervical radiculopathy?

A Yes.

Q And you continued to examine Mr. Weathers over the course, that was August of 2008 you continued to see him basically for the next three years and continued to treat him through last summer.

A Yes.

Q And, sir, did you reach a conclusion about the herniated disks that you had seen on the MRI films and were those consistent with your findings, your clinical findings?

A Yes, they were.

Q And is it your opinion, with a reasonable degree of medical certainty, that those herniated disks that you saw on the MRI films and consistent with your clinical examinations, that those were injuries related to the motor vehicle accident of June 23rd, 2008?

A Yes.

Q And subject to the exacerbations and remissions, is this a permanent condition, the injury to his cervical region?

A Yes.

Q And do you have an opinion, with a reasonable degree of medical certainty, whether that produces a significant limitation of his ability to use his neck?

A Yes.

Q Do you have an opinion -- and what is that opinion,

sir?

A That it significantly limits his ability to use his neck and upper extremities.

Q Sir, with regard to the lower back now, his lumbar region, with the same basis, the MRI that you reviewed as well as all your clinical examinations of him, do you have an opinion, and the treatment you rendered, do you have an opinion with regard to the lumbar, lower back region, does the injury to his lower back as you've diagnosed related to this motor vehicle accident, does that produce a significant limitation of Mr. Weathers' ability to use his lower back?

A Yes.

Q What is that limitation?

A It produces a significant limitation in his ability to use his back and his legs.

Q Now, I know that he has been your patient for a number of years and you've seen him on many, many occasions. And we didn't go through each and every one of the visits, but were your findings on your visits with him consistent with these conclusions that you've reached?

A Yes, they have been.

Q And is it your opinion, sir, that the spinal cord stimulator that you spoke to Mr. Weathers about, if a trial is done and successful and a permanent spinal cord stimulator is inserted for Mr. Weathers, might that help to alleviate some of

the problems that he has with his spinal column?

A Yes.

MR. AVANZINO: Thank you, sir.

THE COURT: We're going to take a break so you can look at the records. And you've been going for an hour-and-a-half, so we'll take a fifteen minute break.

(Whereupon the jury exits and a recess was taken)

(Whereupon the jury enters)

THE COURT: Ladies and gentlemen of the jury, we're now going to have cross-examination.

CROSS EXAMINATION

BY MR. GORKIN:

Q Good morning, Doctor.

A Good morning.

Q Can you tell us, sir, you testified that you did some work for plaintiffs, testified for plaintiffs?

A Yes.

Q Have you ever testified on behalf of any of Mr. Resnick's clients?

A No.

Q Have you ever testified on behalf of any of Mr. Avanzino's clients?

A No.

Q Approximately how many cases have you testified for for plaintiffs?

A Maybe this is my fifth one.

Q Have all those cases involved automobile accidents?

A I don't remember.

Q Have all those cases involved injuries, claimed injuries to a person's neck or a person's low back?

A Yes.

Q You have the Coney Island Hospital record as part of your records that you just looked at?

A Yes.

Q Before we get to that, when you first saw Mr. Weathers, you took that history you told us about, correct?

A Yes.

Q And you told us that he told you that he was involved in a motor vehicle accident on June 23rd?

A Yes.

Q And did you ask him other than where the two cars happened to hit, did you ask him any other questions about the accident such as were you moving? Were you standing still? Were you going fast? Were you going slow?

A Yes. Yes, I did.

Q And what did he tell you with respect to how fast he was going?

A I did not ask him that or did not document that. I documented that his car was moving and it was hit in the front.

Q Did you indicate or did he indicate to you whether it

was the right front of his car that was hit or the driver's side of the car?

A No.

Q He didn't. Did you ask him that?

A I don't think so.

Q Did you ask him about whether the impact was light, medium, heavy, any questions along those lines?

A No.

Q You didn't think that was important to know?

A No.

Q As to whether or not those injuries that you told us about were caused by the impact or not, maybe not caused by the impact?

A I really don't dwell on the specific mechanics or, you know. I focus on the patient's pain.

Q I understand that. But did you think it was important to know the force of the impact with respect to what developed after the impact?

A No.

Q When you saw him for the first time, that was after he had been seen by Dr. Delman, correct?

A Yes.

Q And after he had been to Coney Island Hospital, correct?

A Yes.

Q Did you have the Coney Island Hospital record when you first saw him in August of 2008? Did you have it in your possession?

A No.

Q So at that time in August of 2008 when you first saw him, you didn't know what they did or didn't do for him at Coney Island Hospital?

A Correct.

Q When did you find out what they did or didn't do for him at Coney Island Hospital?

A A few weeks ago when I obtained the records.

Q You got the Coney Island Hospital records a few weeks ago?

A Yes.

Q You never had them at any time while you treated Mr. Weathers?

A No.

Q Any particular reason why you decided to get them three weeks ago?

A Just to be thorough in preparing for today. They're not necessary. As is the mechanism of the accident wasn't necessary because he had no pre-existing --

Q Doctor, if you would, if you could just answer the question I'm asking you.

A Sure.

Q You didn't feel that the Coney Island Hospital records were necessary to care or treat Mr. Weathers, correct?

A Absolutely not.

Q When you got those records, did you review them?

A Yes, I did.

Q And I think you told us that the records, which are in evidence, indicate that Mr. Weathers came into the hospital on June 24th, correct?

A Correct.

Q And he came in -- the doctor who took the initial history took the history of the accident on the day before, correct?

A Yes.

Q And he took the history with respect to complaints that were made by Mr. Weathers at that time?

A Yes.

Q And you reviewed those complaints?

A Yes.

Q Is there anywhere in the Coney Island Hospital record that you reviewed of Mr. Weathers making a complaint of radiating pain from his low back into any of his legs?

A No.

Q There was an examination done at Coney Island Hospital, a neurological examination?

A Yes.

Q What does a neurological examination consist of, Doctor? Can you tell us?

A Yes. Basically sensory, motor testing, the dermatomes and myotomes, patient's bulk or tone of the muscles. You can also test cranial nerves, vision cells.

Q What is the doctor doing that neurological exam, what is he looking for?

A He's looking for sensory motor deficits that would require immediate either diagnostic or therapeutic intervention.

Q And you reviewed that examination?

A Yes.

Q The doctor performed a motor examination. What does that motor examination consist of?

A It basically consists of the patient's ability to move their extremities, to generate pressure either by grasping. Also standing on their toes or heels.

Q And that motor examination, that was done with both arms and both legs, correct?

A You're talking about the Coney Island exam, correct?

Q Right, the neurological exam dated June 24th, 2008. Do you have it?

A I have.

Q My question is, was the motor examination done of both arms and both legs?

A Yes.

Q And what did they test with respect to power?

A Right. The power is graded zero to five, five out of five is normal.

Q And they test the nerves?

A Yes, the power tests the nerves.

Q So they tested both arms and both legs, correct?

A Correct.

Q I think you said it ranges from zero, zero being what?

A No movement.

Q No movement. And one next up from zero, what would that indicate?

A It says here muscle fasciculation.

Q What is that?

A Twitching movements of muscles.

Q And up from there, number three would be what?

A Movement that's not against gravity.

Q Are you familiar with any of these tests, Doctor? I get the impression you're not familiar with these types of neurological tests.

A Not in that detail.

Q You're not a neurologist, correct?

A Correct.

Q You don't do neurologic testing?

A I do.

Q You do, but you're not familiar with that?
A Not in that minute detail.
Q And then number four, there's a number four that the doctor could use?
A Yes.
Q What does that indicate?
A That is movement without resistence.
Q And then there's number five and number five means that everything would be considered to be normal?
A Yes.
Q Isn't that what the doctor who examined him on June 24 found on the motor examination, his arms and legs, everything was normal?
A Correct.
Q And then the doctor also does another examination, correct?
A Correct.
Q Of his deep tendon reflexes, correct?
A Correct.
Q What are deep tendon reflexes?
A Deep tendon reflex is the response to a stimulus and it examines an arcing in the nervous system, a sensory and motor response.
Q Does it indicate in the report whether the findings were normal or abnormal?

A Normal.

Q So both his motor examination and his tendon reflexes were normal, correct?

A Yes.

Q On June 24th?

A Yes.

Q Now, did the doctor also, according to the record, examine Mr. Weathers' neck?

A Yes.

Q And what did he check off with respect to the examination of Mr. Weathers' neck on June 24th?

A Supple.

Q What does supple mean?

A It means that he could move his neck in all range of motion.

Q Freely?

A Yes.

Q Without pain?

A Yes.

Q And after that examination, did the doctor, the neurologist, the doctor who examined him, what was his impression as recorded in the record?

A I can't make this out.

Q Would it be neural, NL, neurological normal exam?

A Okay, normal. Okay. Okay. Yes, yes.

Q Now, did they also do some x-rays, you told us, at the hospital?

A Correct.

Q And the radiologist gave his findings on x-ray, correct?

A Correct.

Q On the front page. He took x-rays of the neck, correct, cervical spine?

A Yes.

Q The lumbosacral spine?

A Yes.

Q And the left knee, correct?

A Correct.

Q And what were his findings with respect to the x-rays that he took?

A They were normal.

Q Did he find any degenerative changes on those x-rays?

A Not that he indicated.

Q Are you familiar with that term, Doctor, degenerative?

A Yes, I am.

Q Could you give us a definition of that term?

A It's a deviation from normalcy that usually occurs over time.

Q And not caused by any trauma, correct?

A I disagree. A trauma can result in degeneration of an

area over time.

Q Over time?

A Yeah. Trauma can initiate the degeneration.

Q How much time would it take for a trauma to initiate a degenerative change?

A About six weeks to several months.

Q Now, you treat a lot of patients you say with back problems?

A Yes, I do.

Q Do all those patients who come to you with back problems, they come as a result of some trauma to their back?

A Most of them, yes.

Q Do others come for other reasons beside trauma?

A Yes. There are patients who have cancer pain causing back pain.

Q Other than trauma or cancer, any other reason why someone would come to you with a complaint of low back pain?

A Yes, from just sudden --

Q Normal wear and tear?

A -- sudden onset or gradual onset from normal wear and tear.

Q Over time?

A Yes.

Q Now, basically when it comes to herniated disks there's two causes. There's either a traumatic cause, correct?

A Correct.
Q As you say in this case, correct?
A Correct.
Q Or some other cause such as degenerative changes, correct?
A Yes.
Q Not instituted by trauma, just degenerative changes?
A Correct.
Q So it could be either traumatically caused or degeneratively caused?
A Yes.
Q Would that also be the case with bulges?
A Yes.
Q You can get a bulge from trauma?
A Yes.
Q You're sure about that?
A Yes.
Q When you first saw Mr. Weathers, you got the information that he had been referred by Dr. Delman?
A Yes.
Q And when you got that information from the patient, did you contact Dr. Delman to find out what had gone on with respect to Dr. Delman's either diagnosis or Dr. Delman's care and treatment? Did you contact him when you first came to see Mr. Weathers?

A No. I don't usually do that.

Q It's not important to know what another treating doctor found?

A No. That actually is not good because it will then create a bias in your determination and your approach to the patient's complaints.

Q Let me just go back to the Coney Island Hospital record for a second. You told us that the diagnosis there was neck and low back musculoskeletal pain.

A Yes.

Q And left knee sprain.

A Yes.

Q And according to the hospital record, his discharge condition was listed as what?

A Good.

Q Now, with respect to herniated disks, would you agree with me that if there was no history of radiating back pain, that would kind of lead you away from the diagnosis of a herniated disk, if there was no indication of radiating pain?

A Yes, it would.

Q When you first saw Mr. Weathers in August of 2008, did you ask him whether or not this pain that he was telling you about, this low back pain, did you ask him whether it radiated?

A Yes, I did.

Q What did he tell you?

A He said no.
Q He said no?
A Correct.
Q If I tell you that Mr. Weathers testified yesterday that, in fact, he did tell you that he had radiating pain, is that something you would have written down?
A I would have written it down.
Q So as far as you know, based on your records, Mr. Weathers, when he first came to you, never complained to you about any radiating pain from his back to his legs?
A That's correct, according to my notes, yes.
Q And you, when you first saw him, never did any testing of your own to confirm this diagnosis other than the straight leg raising you told us about; is that correct?
A That's correct.
Q And that straight leg raise test, that's a little different than an MRI, isn't it?
A Yes, it is. Wait, I did do diagnostic tests afterwards.
Q We're talking about the first visit. That's all we're talking about, the first visit.
The only diagnostic test you did is a straight leg raise test, according to your records?
A Yes.
Q You never did any range of motion, having him turn his

neck from side to side or his back?

A I'm sure I did. He had pain -- yes, I did do those.

Q What did you do?

A I had him bend forward. I had him bend backwards. I noted that he had pain on those maneuvers.

Q Did you make any notation as to the degree of forward flexion or back?

A No, I did not.

Q You also asked him whether he had any numbness, tingling or spasms, correct?

A Correct.

Q Would it indicate if he said yes?

A It would indicate severe neurological deficits.

Q And his answer to those questions were no?

A No, consistent with the emergency room doctor's findings.

Q Now, did he tell you, sir, that he hasn't been able to work since the time of the accident because of the pain, is that what he told you?

A Yes.

Q He didn't tell you that he had been out of work since six months before the accident because his place of business went out of business? He didn't tell you that?

A No.

Q Now, when you saw him on the 8th, did you have the MRI

films?

MR. AVANZINO: 8th of what?

Q I'm sorry, August, not 8th, August 20. When you saw him in August of '08, did you have the MRI films at that time?

A I think so, yes.

Q You think so?

A Yes.

Q Did he bring them?

A Yes, I think, yes.

Q Did you examine the films at that time?

A Yes.

Q And did the films also contain in the folder a radiologist report?

A Yes, I had the radiologist report.

Q And did you read that report before you looked at films or after you looked at films?

A Probably before.

Q And with respect to the low back, your opinion after reading the MRIs is not consistent with the board certified radiologist who read the MRIs; is that correct?

A Well, I said I wouldn't have called that a bulge.

Q Just --

MR. AVANZINO: Can he answer the question?

THE COURT: Sustained. Let him answer the question.

A I said I would not have called that a bulge.

Q And could you tell us then, Doctor, when you became board certified in radiology?

MR. AVANZINO: Objection, Judge.

THE COURT: Sustained.

Q Did you ever become board certified in radiology?

A No, and that's why I incorporated his report in my report.

Q Well, his report differs from your report?

A Correct.

Q So he's the one who made the mistake; you're the one who read it correctly?

A No, no, you're fragmenting the case. You're fragmenting the neuro exam and radiology. You have to put everything together. I'm not a neurologist. I'm a pain specialist. So neurologic deficits doesn't rule out pain. One can have a normal neurological exam and be in severe pain and that needs to be emphasized. So the fact that this neurologic exam was normal does not in any way, shape or form rule out the fact that he had pain from the accident and from the physical findings which was corroborated with the MRI findings.

Q Doctor, just so I'm clear, your opinion is that all of those findings on those MRIs that you read to the jury, all of those findings resulted from trauma of the accident of June 23, 2008; is that correct? Is that correct? Yes or no.

MR. AVANZINO: Or if the doctor can't answer it.

THE COURT: Let's see what his answer is.

A Not all of them.

Q Not all of them?

A Some of them.

Q So which were the result -- let's do it this way. Which weren't as a result of the accident? Which findings were not as a result of the accident?

A I don't know.

Q Which findings were the result of the accident?

A The bulging disk, the herniated disk. It's difficult to -- you know, we're focusing a lot of attention on a diagnostic test that is very overly sensitive and will show abnormal findings even when the patient has no clinical finding and symptoms. I understand your job and what you need to do, but that's not how I treat patients by fragmenting and focusing on one thing.

So with all due respect, to answer the question, yes, obviously Mr. Weathers is a 56 year old gentleman who did a lot of heavy work. So some of the findings were probably present before his accident. But none of the findings caused any pain or disability or his inability to work.

Q Well, I need to know, Doctor --

A And that was my focus.

Q You told us that on direct examination with a reasonable degree of medical certainty, that all of those

injuries that Mr. Weathers sustained came as a result of the accident, but now you're telling us some of them predated the accident?

A Let's define injuries. Are you saying MRI findings? That's not my definition of injuries. Injuries to me means that he has pain. He has, after the history of an inciting event, he has clinical findings on exam which is consistent with his complaints and the MRIs corroborate that.

Q In fact, Doctor, if he took the MRI the day before the accident, you'd have the same findings the day before the accident that you had three days after the accident; isn't that true?

A That is not true. I don't know the answer to that.

Q Well, if you don't know that, you don't know if it's true or not?

THE COURT: He just said that, Counsel.

MR. GORKIN: Okay.

Q Would you agree, Doctor, that a board certified radiologist is in a better position than you or more qualified than you to read and interpret MRIs?

A Absolutely not. He does not have the clinical input that I have. And if you look at most radiology reports, you will see that they request clinical correlation. So I strongly disagree.

MR. GORKIN: I move to strike everything after the

first two words out of his mouth.

MR. AVANZINO: He answered the question.

THE COURT: Overruled. Counsel, sometimes you get an answer you're not planning for.

Q Would you agree with me, Doctor, that you, as an anesthesiologist, is better qualified to administer anesthesia than a radiologist?

A Yes.

Q No ifs, ands or buts?

A Correct.

Q And a radiologist is not better qualified than you, who is board certified or specialized in radiology, that radiologist is not better qualified to interpret an MRI; that's what you're telling us?

A That's not what I'm saying. All I'm saying is --

MR. GORKIN: Judge, he answered the question "that's not what I'm saying."

THE COURT: Okay, next question.

Q You saw him that first visit and let's take your office records for that first visit, okay. You have them in front of you?

A Yes.

Q Now, at the bottom of the record, your initial -- where it says physical exam findings?

A Yes.

Q What did you put in your physical exam findings?

A That he's alert, oriented to person, time and place, afebrile. Vital signs are stable. I noted his height and weight. His gait was markedly antalgic bilaterally. He had pain on flexion, increased pain on extension. Lumbosacral spine, positive straight leg raises to 30 degrees both sitting and supine. His neck was notable for positive Spurling's sign bilaterally. Tenderness throughout the facet joints and multiple myofascial trigger points throughout.

Q Now, the straight leg raising, you said that was a subjective test?

A Yes, it is.

Q That means that as you raise the patient's leg, it is up to the patient to tell you when it hurts?

A Correct.

Q So they can tell you anything?

A Oh, yes.

Q And that doesn't necessarily mean that you accept that finding, or do you?

A I do.

Q You do?

A I do. As a pain specialist, I do. I have to believe my patient that they hurt at least at the onset.

Q Now, you continue to see him over the course of time, correct?

A Yes, I did.

Q Did you ever, at any time, did you contact Dr. Delman to find out what was going on with respect to the therapy Mr. Weathers was getting?

A No, I did not.

Q Were you aware that initially Dr. Delman diagnosed him with cervical and lumbar strain/sprain? Were you aware of that?

A Yes, I was.

Q How did you become aware of that?

A I saw his notes, Dr. Delman's notes.

Q When? The same time you saw the Coney Island Hospital record?

A Recently, yes.

Q Tell the jury what is a cervical lumbar sprain or strain?

A It's just a soft tissue injury.

Q Minor injury?

A If it's not your injury, yes. And I'm not being facetious. Pain is a very subjective entity. So it's very difficult for me to sit here and trivialize someone's complaints of pain, even if it's from a strain, that it's minor.

Q Certainly not permanent, correct?

A Well, a sprain or strain certainly isn't a

radiculopathy.

Q Usually they go away over a period of time?

A Eventually.

Q Maybe six months or so of treatment, they go away?

A Yes.

Q So those are not "significant" injuries?

A Again, it's difficult because it's not my -- it's difficult to say that because pain, being subjective, it might be significant to the person with the sprain or strain.

Q Well, as to a physician, you wouldn't consider it to be significant?

A As a pain specialist, I cannot answer in that line, sir. I cannot. Unless it's my sprain or strain.

Q When you continued to see Mr. Weathers, did you make some notes in the chart over a period of time?

A Yes, I did.

Q On any of the occasions that you saw Mr. Weathers, did you ever make a notation with respect to the range of motion or lack of range of motion of his neck or his back?

A Occasionally I did.

Q Occasionally? Did you put down the degree of loss of motion?

A No, I just put decreased range of motion or reduced range of motion. I did not measure the degrees.

Q Did you ever -- are you familiar with a test called an

EMG?

A Yes, I am.

Q Could you tell the jury what that is, an EMG test?

A EMG is electromyography. It measures the nerve conduction from one end of the nerve to the other. A signal is sent from one end of the nerve and then captured at the other end. And they have normal times and velocities that they chart. And based on the normal values, it could be abnormal or normal.

Q And, for instance, if there was an abnormal finding, what could that be indicative of?

A It certainly indicates that there is something wrong with the nerve conduction, i.e. there might be some radiculitis of the nerve. There might be some impingement of the nerve.

Q Did you, before you did your surgery, ever request that that test be done for Mr. Weathers?

A No, I did not.

Q Isn't there a notation, sir, in your record that asks Dr. Delman to do an EMG?

A Well, yes, I said to check. I assumed he had done one so I wanted to check it.

Q And he didn't do one?

A I have not seen one.

Q Did he?

A I haven't seen one.

Q Why would you ask him -- why would you want to know if he did one or not?

A Just to correlate my other findings to bolster up my diagnosis.

Q So you asked Dr. Delman to check to see if it was done and he told you he didn't do it?

A No. I actually never asked him. I indicated -- what I did, I assumed it was done and in my note I wrote to check the EMG, that I would check it. But obviously it wasn't done, so.

Q Did you call Dr. Delman's office to see if it was done?

A My staff probably did. I don't remember. I didn't actually call.

Q When you saw -- let me ask you this: The MRI that you read to the jury with respect to the lumbar area, you said there was some problem that's indicated there at L3, L4.

A Correct.

Q And what was that problem?

A A bulge.

Q A bulge. Was there any evidence that that bulge was causing some neural impairment on the MRI?

A You mean neural impingement?

Q Yes, sorry, impingement.

A No, there was none.

Q So that bulge that you told us about wasn't pressing on any nerve?

A No, it was not. At the time the MRI picture was taken?

Q Yes.

Would that indicate, sir, that there was no indication to do any further epidural injections since there was no neural impingement?

A No, it does not mean that. And I emphasize that at the time that that picture was taken, there was no impingement. Remember, the disk is fluid and it can move. And I don't treat neural impingement, I treat pain. And the patient had pain.

Q Were you aware that none of Dr. Delman's neurological testing that he did on any of the visits Mr. Weathers made to his facility were all within normal limits?

A I disagree. I see where Dr. Delman found positive straight leg raises on the left side on one visit, on both sides on one visit.

Q I'm talking about deep tendon reflexes and motor strengths, the same ones they did at Coney Island Hospital?

A Doesn't really mean much.

Q Doesn't mean much? So why bother doing it then?

A It shows whether the patient has severe neurologic deficits which is different from pain. You know, you do not have to have neurologic deficits to have pain and that's what

I'm trying to emphasize.

Q So without any neurological deficits being caused by this accident, you're saying Mr. Weathers' pain is caused by this accident?

A Absolutely.

Q Are you familiar, Doctor, with the term osteophyte formation?

A Yes.

Q Would you tell the jury what an osteophyte is?

A Osteo is the prefix that describes bone. Osteophyte is an abnormal growth of bone or arthritis in the bone.

Q It's not caused by trauma, correct?

A Again, trauma can precipitate -- its formation is from remodeling of the bone in response to an insult. So yes, trauma definitely can cause it.

Q And it can also be caused naturally, correct?

A Well, when you say naturally --

Q Yes or no, can it be caused naturally? It's a simple question.

A I don't like your terms. Aging can cause it. It's not natural.

Q So it comes from aging?

A It can come from aging.

Q It's more likely to come from aging than from trauma, is it not?

A Guess what? Aging causes micro-trauma. Just your lifestyle can cause it. You cannot sit there in a vacuum and get it.

Q So then basically anything that's wrong with anybody's back, at some point in time, be it trauma from an accident, micro-trauma, someone's going to have a bad back no matter what, just from getting older?

A With all due respect, the minute we stood up on all fours we created that problem. The answer is yes. The spine is not meant to be standing against gravity. Animals don't get osteophytes.

Q Do you have a degree in veterinary medicine doctor?

MR. AVANZINO: Objection, Judge.

THE COURT: Sustained.

Why don't we break here at this point in time. We'll continue in the afternoon. The court rules, I'm not allowed to pay overtime, they're trying to reduce overtime.

So, again, we're going to break until 2 o'clock. Do not talk amongst yourselves. Do not talk to your friends, wives, relatives, et cetera. Do not Twitter, blog. Do not do Internet research regarding any of the terms you've heard about, et cetera. Do not talk to the lawyers or anyone you've seen in this courtroom at this point in time. Keep an open mind until you heard all the evidence and final charge to you on the law which you will not get until

next week.

See you. Come directly to the jury room as I've said in the past. See you at 2 o'clock. Thank you.

(Whereupon the jury exits)

THE COURT: Doctor, don't talk to the lawyer about your.

(Whereupon a luncheon recess was taken)

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

(Whereupon the jury enters)

THE COURT: Sit down. Thank you for being prompt, ladies and gentlemen. Thank you, attorneys, for being prompt.

MR. GORKIN: May I?

CROSS EXAMINATION

BY MR. GORKIN:

Q Doctor, I think when we left off at lunch we were discussing osteophytes.

A Yes.

Q Now, osteophytes, would you say that's a fairly common finding on an MRI of a person of Mr. Weathers' age?

A Yes.

Q And those osteophytes, generally speaking, are not caused by trauma like from an automobile accident?

A Yes.

Q Yes, they're not?

A Some are, yes.
Q Some are, yes, and some are not?
A Yes.
Q And would you agree that an osteophyte can cause pain?
A Yes.
Q And it can cause, if it's in the lumbar area, it can cause low back pain?
A Yes.
Q And if it's in the cervical area, it could cause neck pain?
A Yes.
Q When you examined the MRI films in August of 2008, did you find any evidence of any osteophyte formations?
A No.
Q At any point in time that you saw Mr. Weathers in your office, on any of those office notes that you wrote, did you ever write that he complained of radiating pain from his lower back into any of his legs? Did he ever make that complaint to you at any time you treated him?
A I don't -- I'd have to look through the notes.
Q Take a look. Be my guest. That's what we're here for.
A You want specifically in the complaint?
Q Yeah, did he ever complain to you -- I'll withdraw the question for a second.

You generated several reports concerning your care and treatment of Mr. Weathers, correct?

A Yes.

Q In any of those reports that you generated, do you ever make mention that Mr. Weathers complained of radiating pain from his lower back into his legs?

A No.

Q If, in fact, he made that complaint at any time he saw you, you certainly would have noted that, correct?

A Yes.

Q So we can safely assume then since there's no mention of it in your records, he never mentioned it to you?

A Not as a complaint, correct.

Q Now, you told us, Doctor, one of the elements of the vertebra is the annulus, correct?

A Yes.

Q That's the outermost layer?

A Yes.

Q When you reviewed the MRIs, let's take the neck first, on any of those neck herniations that you reviewed, was there any evidence that you found a tear in any of the annulus on any of those levels where he had herniated disks? It's a yes or no?

A No, I didn't specifically look.

Q You didn't specifically look for it?

A Tears, no. But you're asking --

Q Doctor, please, you answered my question.

In your report, in your report, your initial report that you sent to Dr. Delman that was generated when you first saw Mr. Weathers, you make reference to the MRI findings, correct?

A I dictated the report word-for-word. I did not --

Q It makes reference to certain findings on the MRI, did it not?

A I describe the MRI finding that the radiologist described. I did not include my findings.

Q Did the radiologist make any reference to any annular tear?

A No.

Q So whatever herniations there were, that outermost level of the disk didn't get torn, correct? Didn't herniate through that entire disk, correct?

A No, that's not correct. I proved that with the discogram. You're asking me --

Q Doctor, if you could just answer the question.

A No, the answer is no.

Q The answer is no. Okay.

So your findings on the MRI, you didn't note, when you made your report, you didn't make note of any annular tear, correct?

A In the initial, yes.

Q And I think you told us that you differ in opinion from the board certified radiologist who read the films. You say that the bulge that he found in L3-L4, that's not really a bulge, that's a contained herniation. Is that what you told us?

A Yes.

Q Can you show us in your report where you mention that, use that term "contained herniation."

A I didn't mention it in the report.

Q Because you just made it up today?

A That's not correct.

Q You had an opinion when you first read those films that there was a contained herniation, but you didn't see fit to report that to Dr. Delman?

A No.

Q It didn't matter to you? You didn't think that was important?

A No.

Q You didn't think he would think it would be important?

A No.

Q Are you telling us, Doctor, that when you read the films initially, you initially came to a diagnosis of a contained herniation at that time; is that what you're telling us?

A No, that's not what I'm saying.
Q You came to that conclusion at some other time?
A Correct.
Q When did you come to that conclusion?
A After the discogram.
Q After the discogram. You wrote a report in, I think it was September of 2011, correct? You wrote a second report in December of 2011, correct?
A Correct.
Q And would you show me where in that report you mention that, in your opinion, Mr. Weathers had a contained herniated disk in his lower back? Show me where that is in your report. That report was after the discogram, correct, and it was after the surgery, correct?
THE COURT: Counsel, you just asked him three questions. Let's go back to the first question when you asked him to show you where it is in the report.
Q Can you find that report?
A It's not in the report.
Q You don't mention that in your report?
A Correct.
Q So even though you say you diagnosed it from the discogram, it's not anywhere in the report of December 2011, correct?
A Correct.

Q Are you sure you didn't diagnose it like last week when you were preparing to testify in this case?

MR. AVANZINO: Objection.

THE COURT: Sustained.

Q Now, was there any evidence in the MRI, Doctor, that you read of the low back of any age-related findings?

A No.

Q No, none?

A No.

Q Are you familiar with the term desiccation?

A Yes.

Q Would you tell the jury what that term means?

A It means arthritic, sort of dried disk. The disk is, as I said, like jello. That means it has a lot of fluid in it. So a dessicated disk means it's not as fluid. There's less liquid in it.

Q That condition, disk desiccation, that's not caused by trauma, is it? That's caused by the aging process, is it not?

A No, absolutely not. They both can cause it, sir.

Q Are you telling us, Doctor, that the trauma from the accident of June 23rd caused disk dessication on June 27th when the MRI was done?

A How can I see that? I said I didn't see any disk desiccation.

Q If, in fact, there is any disk desiccation, whether

you saw it or not, are you saying it was caused by the accident as opposed to the aging process?

A Well, based on the time frame of the MRI, no.

Q No, it wouldn't be caused by the accident?

A No.

Q Now, you performed some surgery, you told us, on Mr. Weathers, correct?

A Yes.

Q And in that surgery you removed some tissue from certain levels of his spine?

A Correct.

Q And what did you do with that tissue that you removed?

A Sent it to the pathologist.

Q And why do you send it to the pathologist?

A To confirm that it is, indeed, the tissue I intended to remove.

Q Does the pathologist examine the tissue?

A Yes.

Q And after he examines it under the microscope, he makes a diagnosis?

A No, no, he generates a report. It's hard to make a diagnosis with just that information. I send the diagnosis with the request.

Q You say he doesn't make a diagnosis?

A No.

Q Doctor, do you have the Brooklyn Hospital report there?

A Yes.

Q Would you turn to the page that's entitled Surgical Pathology Report?

A Yes.

Q Do you have that page?

A Yes.

Q The pathologist received two specimens labeled L3-L4 disk material and L4-L5 disk material.

A Yes.

Q And he examined that tissue?

A Yes.

Q And, in fact, Doctor, he issued a diagnosis, did he not?

A No, he issued a pathologic diagnosis. There's a big difference.

Q He issued a pathological --

A He just described the tissue.

Q Doctor, please.

THE COURT: Let him ask you the question.

Q So his final pathological diagnosis was what?

A Fibrocartilaginous tissue showing degenerative changes.

Q For all the specimens, correct?

A Correct.

Q And degenerative changes as far as you're concerned means what?

A An old process that's been around for more than six months.

Q At least six months, correct, if not longer, correct?

A Correct, correct.

Q So that could be there for years?

A Could be, yes.

Q Minimum time it's there for is six months is your opinion?

A About six weeks is when the tissues start to regenerate and can create changes that might resemble degeneration of tissue. It starts to heal itself. It's not normal, so six weeks.

Q Did you just tell me six months? Did you mean six weeks? Did I hear you wrong?

A I said it's been around at six months, but starts at six weeks. The degree is hard to tell, sir.

Q All I'm asking, sir, the minimum amount of time it would take for degenerative tissue to develop is six months, at least six months prior to the time you took it out?

A To develop meaning to start to show degeneration or to set in as a distinct degenerative finding? Six weeks is when it starts. It can be present six weeks after insult.

Q Are you telling us, Doctor, that the pathologist would classify this degenerative if it was there for six weeks; is that what you're telling us?

A Yes. If these findings that he saw were there, he would describe it as degenerative even if it had occurred six weeks before.

Q You didn't describe it as degenerative, did you? You never diagnosed degenerative disk disease, did you?

A That's correct.

Q At any time?

A That's correct.

Q Can we agree, Doctor, that a man of his age, 57 years old, I think, or 56 at the time of the accident would certainly be within the realm of possibility to have degenerative disk disease in spine?

A Yes.

Q It's common in people that age?

A Yes.

Q Especially with the work he did, the bending, lifting of tires, things like that?

A Yes.

Q None of those conditions would be traumatic in origin, correct?

A Not as you described.

Q Doctor, you said in addition to testifying on behalf

of plaintiffs, you also do some work as an independent medical examiner on behalf of defendants.

A Yes.

Q And you do a lot of that work?

A No.

Q How often would you say you do it?

A Once every two years.

Q Okay. When you do it, I assume you do it with the same degree -- you treat the person who comes to see you in that capacity, as a claimed injury party, you treat that person with the same manner of treatment that you would your own patient?

A No, you cannot because there's no physician/patient relationship. It's usually an isolated visit.

Q When they give you a history, do you write it down?

A Yes.

Q Do you accept it?

A Yes.

Q When you examine them, you examine them carefully?

A Yes.

Q As carefully as you would examine a patient of your own?

A Yes.

Q And when you do that, you know that there's a possibility that you may come to court to testify, correct?

MR. AVANZINO: Objection.

THE COURT: Overruled.

MR. GORKIN: I'll withdraw the question.

Q You bill for that examination? You send a bill?

A I'm paid for it, yes.

Q And you generate a report?

A Yes.

Q Now, do you -- withdrawn.

Let me ask you this, Doctor, because I'm not sure we were clear on this this morning. I'm going to ask you if -- all of these questions I'm going to ask you now, if you have an opinion with a reasonable degree of medical certainty and if you can answer it yes or no or I can't answer it, if you can do that, okay? I just want to make sure we're clear, okay?

In your opinion, with a reasonable degree of medical certainty, was the accident of June 23, 2008 the competent producing cause of Mr. Weathers' herniated disks at C4-C5?

A Yes.

Q Was the accident the competent producing cause of the herniation at C5-C6?

A Yes.

Q Was the accident the competent producing cause of the herniation at C7-T1?

A Yes.

Q And was the accident the competent producing cause of

bulges in his L2-L3 -- I'm sorry -- yes, L2-L3 -- I'm sorry, withdrawn.

Was it the competent producing cause of the bulging disk at C2-C3?

A Yes.

Q And at C3-C4?

A Yes.

Q Was it also the competent producing cause of the bulging disk at L3-L4?

A Yes.

Q So that means then, Doctor, none of those conditions that you just testified were caused by the accident occurred prior to the accident?

A Yes.

Q They all resulted directly from the accident. And the MRIs, if they were taken the day before, you wouldn't see any of those findings there?

A Yes.

MR. AVANZINO: Objection. It's a multi-layered question.

THE COURT: Well, overruled. I don't think --

Q Just so we're clear, if you took the MRIs the day before the accident, if Mr. Weathers went for an MRI the day before the accident, none of those herniations and none of those bulges would have been present?

MR. AVANZINO: Objection.

Q They all resulted from the accident?

MR. AVANZINO: Objection.

THE COURT: Sustained. Calls for speculation.

Q Can you answer that with a reasonable degree of medical certainty?

THE COURT: I sustained it.

MR. GORKIN: That's not speculation.

THE COURT: I sustained the objection, counsel.

Q Would you agree, Doctor, that the dessication, if there was any, that would have pre-existed the accident?

MR. AVANZINO: Objection. Are we talking about referable to the MRI?

Q Yes, as seen on the MRI.

A Repeat the question.

Q Are you saying that also, assuming there was desiccation on the MRI, that you didn't find, but assuming it's there, would that have been something that was caused by the accident or something that pre-existed the accident?

A Probably preexisted.

MR. GORKIN: Thank you.

THE COURT: Any redirect?

REDIRECT EXAMINATION

BY MR. AVANZINO:

Q Dr. Davy, you were telling us about the pathological

diagnosis, the pathologist diagnosed, and how that differs -- you were trying to explain how that differs from, let's say, your diagnosis. What's the role of the pathologist after the surgery?

A The pathologist's role is to examine the tissue center and to describe it in scientific terms and then to make a conclusion in terms of whether this is, indeed, disk material.

Q And was that, in fact, found to be the case? Was it found to be disk material?

A Yes.

Q In addition to disk material, the finding about there being degenerative changes, would that be consistent seven months after or eight months after a traumatic event for there to be that finding?

A Yes, absolutely.

Q Doctor, the emergency room record from Coney Island Hospital, you were asked a great many questions about the neurological exam that was done by one of the doctors in the emergency room the day that Mr. Weathers went in. And you were asked about the findings on the page that says Consultation Notes Neurological Examination 4DDR. You were asked up to the midpoint of that page by my colleague.

What about the bottom half of that page, can you tell the jury about what was written by the doctor there?

A Stark contrast. I was queried on the normal part of

the exam, but not the abnormal part of the exam.

Q Would you explain to the jury what the abnormal part of the exam was?

A Lumbar spine spasm, tenderness to palpation, straight leg with pain bilaterally, sensory intact, left knee tender, full range of motion of the knee with pain.

Q All abnormal findings, Doctor?

A Yes.

Q And all findings consistent with what your ultimate diagnosis was?

A Yes.

Q Doctor, you also were asked great many questions about the MRI. The MRI is a tool that you use in helping put together the entire picture?

MR. GORKIN: Objection to the form, leading.

THE COURT: Sustained.

Q Doctor, can you explain, you were asked great many questions about the MRI. Can you explain the role the MRI plays?

A As I stated earlier, the MRI is used help to confirm or refute my clinical diagnosis and also to aid me in pinpointing the pain generator or the area that is causing the pain. It also aids me in assessing a patient's poor response to treatments. And there is a legal term that says --

MR. GORKIN: Objection as to any legal term, Judge.

THE COURT: I haven't heard it, so.

MR. GORKIN: Before we hear it, that's why I'm objecting.

THE COURT: Give us a medical term.

A Well, the medical term is that a patient may have pre-existing conditions but it no way, shape or form can affect their clinical presentation.

And that is what I would like to emphasize with Mr. Weathers. Even if he did have these findings in his neck and lower back, he was working full-time, full duty without any complaints of neck or low back pain, any treatments to these areas. After the accident, he started to complain of pain and required advanced interventional treatment to help decrease his pain.

And so, regardless of what was present on the MRI finding before the accident, it was not manifesting itself clinically. And that is why I can assuredly tell you that I think the accident, within a certain -- within a reasonable degree of medical certainty, in my experience, was the antecedent cause of Mr. Weathers' pain, inability to work and suffering.

Q Sir, you were asked questions about bulging disk versus a contained herniation. Can you explain about how those terms are similar, in fact?

A Right. As I stated earlier, there is a chemical

response that the body initiates to any type of injury. You have redness, swelling, pain. And that is how the body heals itself. The body doesn't recognize whether it's a bulge or herniation.

Once you have a violation of those annular fibers, the body sends out chemicals that can cause radiating pain and the end result is drying of the disk, degeneration of the disk and chronic changes. The body cannot differentiate between a herniation and bulges in that respect. The main difference between the two is that one is mechanically more significant and presses more on the nerve. It violates the spinal canal more. That would be a herniation. Whereas the bulge might not present as much mechanical stresses on the canal.

Q Would the contained herniation be more akin to the bulge as opposed to the tear in the outer layer of the annular?

MR. GORKIN: Objection.

THE COURT: Overruled.

A Yes. A bulge is a contained disk herniation. It rests in the inner layers of the annulus fibrosus and the protrusion of the nucleus pulposus towards that tear. Because it hasn't gone through or torn through all the layers, it's a bulge or contained disk herniation. That is the diagnosis. And the -- I'm trying to find the word -- that is the specific cause for which a percutaneous diskectomy is beneficial, contained disk herniation.

Q Sir, with the discogram that you did prior to the surgery, did that confirm your findings about the extent of the injuries sustained by Mr. Weathers?

MR. GORKIN: This is improper redirect, Judge. We had this all on direct.

MR. AVANZINO: You brought up all the issues.

THE COURT: Overruled. You asked about the discogram.

A I just want to emphasize that the discogram is to identify disks that are causing concordant pain. It is not to differentiate between contained versus bulge. It is to identify the disk that is causing the patient's pain and then to see the dye spread.

And the dye spread clearly shows that there were tears in the annulus and that these disks would benefit from the procedure, and he did.

MR. AVANZINO: Thank you, Doctor. Nothing further.

THE COURT: Anything else on recross?

RECROSS EXAMINATION

BY MR. GORKIN:

Q Doctor, just so I'm clear, you just told me a few minutes ago that the accident was the competent producing cause of the herniations and the bulges, correct?

A Correct.

Q But now you're saying that's not the competent producing cause of the herniations and the bulges. The

accident is the competent producing cause of pain that Mr. Weathers experiences in his back?

MR. AVANZINO: Objection. I don't understand what that question means.

A My specialty tells you that I'm a pain specialist, not a bulge or herniating disk specialist. I treat patients' pain.

Q Doctor, the plaintiff is claiming in this case that this accident of June 23, 2008 was the competent producing cause of all those herniations and all those bulges that I discussed with you. That's the claim in this case. That's why we're here. They're claiming the accident caused all of those conditions.

MR. AVANZINO: Objection.

THE COURT: Sustained.

Q The claims that are being made in this case have to do, among other things, with herniations and bulges, okay? And they're saying the accident caused that.

MR. AVANZINO: Again, objection.

MR. GORKIN: That's the element of the case. That's why we're here.

MR. AVANZINO: Objection to the form of the question.

THE COURT: Sustained.

Q Can you tell us, Doctor, with a reasonable degree of medical certainty, in your opinion whether the accident was the competent producing cause of all of those conditions or were

they caused by something else?

A Let me start off to answer your question by emphasizing that I treat Mr. Weathers and most patients for pain, pain that results in inability to sleep, to work or engage in recreational activities. I do not treat MRI findings, isolated EMGs, isolated clinical findings. I treat the whole patient. And it's my opinion that Mr. Weathers' pain, suffering and disability is a result of his accident on the date in question.

Q Caused by what? The disability and pain caused by what?

A Caused by herniation and bulging disks in his back.

Q That didn't pre-exist the accident.

A I'm not aware that they -- I don't think that pre-existed the accident.

Q That's all I'm trying to find out.

THE COURT: Let's not make this an argument.

Q So then would it be fair to say that you're saying that the accident was the competent producing cause of all of the herniations and all the bulges?

A At least the ones that resulted in pain.

THE COURT: That's the answer.

Q Are there some findings that you found that were not caused by the accident? Whether they caused pain or didn't cause pain, were there some findings on the MRI that you didn't

believe were caused by the accident?

A I don't approach it that way. I didn't look for those.

MR. GORKIN: Thank you.

THE COURT: Thank you. You may step down.

Okay, ladies and gentlemen of the jury, as I said, we have a chopped up schedule. We have another doctor coming in tomorrow morning. You should be aware of the fact that we prefer to hear from doctors in the morning. Because of the budget cuts that occurred last year, we're not allowed to go past 4:30 anymore. We get reprimanded for overtime.

So, again, I remind you not to talk among yourselves. Do not talk to friends, wives, lovers. Do not Twitter. Do not blog. Do not go on any search engines, whether it be Bing, Safari, Internet Explorer, et cetera, to look up any of the terms that were talked about. Do not do any research on any individuals in this courtroom. Do not talk to any of the attorneys you've seen in the courtroom or anyone else that you've seen in this courtroom. And certainly, do not contact anyone who's been a witness at this point in time.

Thank you. We'll see you tomorrow.

What time is Dr. Delman coming in?

MR. AVANZINO: I told him 9:30, Judge.

THE COURT: Why don't you try and be in the jury room