

1 were trying to trick me is what it is. All right. So
2 juror -- alternate number 1, will you please take --

3 COURT OFFICER: Seat number 4, please.

4 THE COURT: Seat number 4. All right. Good
5 morning, by the way. You missed the rain, right?

6 Mr. Sobel, you want to call your next witness.

7 MR. SOBEL: Yes. The defense would like to call
8 Dr. Gregory Montalbano to the stand, please.

9 G R E G O R Y M O N T A L B A N O, M.D., called as a witness
10 on behalf of the Defendant, having been first duly sworn by the
11 Clerk of the Court, was examined and proceeded to testify as
12 follows:

13 THE CLERK: For the record, state your full name,
14 spell it and county of the medical office where you work.

15 THE WITNESS: My name is Gregory Montalbano,
16 M-O-N-T-A-L-B-A-N-O. 67 Irving Place, New York City.

17 THE CLERK: Thank you.

18 THE COURT: Good morning. You may inquire.

19 MR. SOBEL: Thank you, your Honor.

20 DIRECT EXAMINATION

21 BY MR. SOBEL:

22 Q. Sir, can you tell us your present occupation.

23 A. I'm an orthopedic surgeon.

24 Q. Are you licensed to practice medicine in the State of
25 New York?

1 A. Yes, I am.

2 Q. Doctor, can you tell us a little bit of your
3 educational background, please?

4 A. Sure. I graduated from St. Francis College with a
5 bachelor of science. I graduated from SUNY Medical College with
6 my doctorate of medicine. I graduated from New York University
7 where I did a general surgeon internship. I then went on to do
8 an orthopedic surgical residency at the Hospital For Joint
9 Diseases which is also in New York City. I then did a
10 fellowship in sports medicine arthroscopy at Georgetown
11 University. I also did a clerkship in orthopedic trauma at
12 University of Washington.

13 Q. Doctor, just so you know, the acoustics in this room
14 are pretty bad so I ask you keep your voice up, if you would.

15 Q. Doctor, can you tell us a little bit about your
16 practice?

17 A. Can you be more specific about what aspects of my
18 practice you would like me to discuss?

19 Q. Do you have a private practice?

20 A. I do.

21 Q. Okay. Do you have one office, more than one office?

22 A. My entire practice take place in three offices. There
23 is an office -- one office in Manhattan, one office in Staten
24 Island and one office in New Jersey. I have also an academic
25 aspect to my practice. I'm on faculty at New York University

1 School of Medicine. And as part of my -- that part of my
2 practice involves training the residents at NYU Hospital for
3 Joint Disease. I carry out those responsibilities at the
4 hospital, the medical school and also at Bellevue Hospital.

5 Q. Okay. And do you have privileges at any hospitals?

6 A. I do. I have privileges at those hospitals. I'm also
7 on staff at Hospital For Joint Disease, Richmond University
8 Medical Center and Metropolitan Surgical Institute.

9 Q. Now, doctor, you are being compensated for being here
10 today; is that correct?

11 A. That is my understanding.

12 Q. Okay. And do you know what the amount of your
13 compensation is?

14 A. I do not.

15 Q. Okay. Were those arrangements for you appearing made
16 through your office?

17 A. Yes, they are.

18 Q. That's something that's independent of what you do at
19 your various offices?

20 A. Well, at my offices I carry out in addition to seeing
21 patients in consultation and performing treatments in the office
22 and indicating patients for surgery upon -- and subsequently
23 doing those surgeries. Also at those facilities I evaluate
24 people that were involved in accidents and I do an
25 examination -- I do a forensic review of reports, records and

1 create reports as I did in this case regarding my opinions in
2 response to questions that I'm asking.

3 Q. Doctor, are you board certified?

4 A. I am.

5 Q. In what?

6 A. Orthopedic surgery.

7 Q. Okay. Can you tell the jurors what it's like to get
8 board certified? What are the steps?

9 A. Sure. Board certification is an elective process. It
10 occurs after graduating from an accredited residency program.
11 It's a series of two examinations. The first examination is a
12 written examination. The second examination is an oral
13 examination in front of the board. Upon successful completion
14 two parts of the examination, you are deemed board certified.
15 Recertification is required every ten years, and I was recently
16 recertified.

17 Q. And, doctor, as part of your practice do you treat
18 patients with neck injuries?

19 A. I do.

20 Q. Do you treat patients with back injuries?

21 A. Yes, I do.

22 Q. Do you treat people with shoulder injuries?

23 A. Yes, sir.

24 Q. Okay. Now, with respect to your practice, do you also
25 treat people with herniated or bulging disks in the neck or the

1 back?

2 A. I do.

3 Q. Do you treat people with rotator cuff issues in their
4 shoulders?

5 A. Yes, I do.

6 Q. Okay. Do you basically work with the internal aspect
7 of the shoulder other than the rotator cuff?

8 A. Yes.

9 MR. SOBEL: Your Honor, I would move to have
10 Dr. Montalbano recognized as an expert in orthopedics.

11 MR. MURPHY: No objection.

12 THE COURT: All right.

13 Q. Now, Dr. Montalbano, did you have an occasion to
14 examine Mr. Anil Sehgal in your office on May 18, 2012?

15 A. Yes, I did.

16 Q. And did you obtain a history from him?

17 A. I did.

18 Q. What was the history that Mr. Sehgal provided to you?

19 A. Mr. Sehgal told me that he was a restrained driver of a
20 vehicle that was stopped at a red light when his car was rear
21 ended. This caused his car to hit the vehicle in front of him.
22 He told me that both EMS and NYPD responded to the scene. He
23 states that he was asked several questions by both parties and
24 ultimately refused treatment at the scene and also declined to
25 be taken to the hospital. He reported going to a sports

1 medicine physician on August 9th for his first appointment.

2 Q. Did you also obtain an occupation history for
3 Mr. Sehgal?

4 A. Yes, I did.

5 Q. What did he tell you about his occupation history?

6 A. He was an assistant manager and bookkeeper. He carried
7 out these functions in an office setting. He told me that he
8 lost two months of work time as a result of the accident, told
9 me that he was back at his job with limited activities and
10 reported that he was unable to do things like lifting heavy
11 boxes which he was able to do before the accident took place.

12 Q. Doctor, did you review any records with respect to your
13 examination of Mr. Sehgal?

14 A. I did.

15 Q. Can you tell us what those were?

16 A. I reviewed the records from his outpatient visits, the
17 records from Dr. Gregorace, a physiatrist that evaluated him on
18 August 9th. I reviewed clinical records also from
19 Dr. Berkowitz, I believe, who was the treating physician for his
20 shoulder. I reviewed the records of Dr. DeMoura who was the
21 spine surgeon which did the cervical spine surgery. I also
22 reviewed records of pain management physician that he was seen
23 by, physical therapy notes also were included in the chart in
24 addition to two surgical reports. There was one for the right
25 shoulder and one for the cervical spine. In addition to

1 multiple diagnostic imaging reports, X-rays, as well as MRIs
2 for the right shoulder, cervical spine and lumbar spine.

3 Q. Did you actually have an opportunity to review the
4 actual films or radiological studies themselves other than the
5 reports relative to those studies?

6 A. I did.

7 Q. Okay. And can you tell us what studies you reviewed?

8 A. I reviewed the X-rays that were performed on August 9th
9 which was the day of his first outpatient visit. This was
10 X-rays of the cervical spine and of the lumbar spine. Also, I
11 reviewed X-rays of the right shoulder from that day. In
12 addition, I reviewed MRIs for the lumbar spine which were
13 performed on August 30th also for the cervical spine on August
14 30th. In addition, a second MRI of the lumbar spine from March
15 29th, an additional MRI of the cervical spine from January 18th
16 and X-rays of the cervical spine which were subsequent to the
17 surgery; March 22nd, December 22nd, August 15th and March 14th,
18 2011.

19 Q. Now, did you ultimately conduct an orthopedic
20 examination of Mr. Sehgal?

21 A. I did.

22 Q. Can you tell us what your findings were?

23 A. Sure.

24 Q. Tell us about the examination.

25 A. Okay. So the examination was initially an overall --

1 well, a general appearance examination. When he came to the
2 office, he was ambulating independently. He did not require any
3 assistance into the office or in the exam room. He was
4 appropriately dressed. He was not using cane, crutches, a
5 walker or any type of assistive device. He also was not wearing
6 any braces. He wasn't wearing a neck brace, a back brace. He
7 wasn't wearing a shoulder sling, and he appeared to be moving
8 normally. He was not limping and there were no deficits in his
9 ability to be mobile.

10 Examination of his cervical spine. The beginning of
11 the examination was observation and he had a 1.25 inch healed
12 incision over the anterior aspect of his neck will be consistent
13 with the surgery that he had performed. The posture of the neck
14 was normal. His muscles appeared to be normal tone. There was
15 no muscle spasm noted. He did complain of some tenderness in
16 the muscles and these were the muscles close to the spine in the
17 paracervical area and also the muscles around the shoulder
18 blades. So periscapular tenderness.

19 His range of motion was diminished. In flexion he had
20 20 degrees of forward flexion which would be an abnormal
21 finding. Extension also 20 degrees which would be reduced
22 compared to normal. He reported that the reason why he couldn't
23 go any further was because of pain.

24 So this examination is done on a request to display
25 motion. There is no forcing of the head into different

1 position. So simply a request to display and then I document
2 what the motions are. So he told me that pain limited his
3 motion in flexion and extension. His rotation to the right and
4 rotation to the left was normal at 35 degrees. Bending to the
5 right and to the left also was within normal limits.

6 For the lumbar spine exam there was -- the skin was
7 normal. There was no scars from any procedures or any trauma.
8 The alignment of the spine also was normal. There was no muscle
9 spasm apparent during the examination. Also there was no
10 tenderness to the muscles with palpation. His range of motion
11 was somewhat reduced in flexion at 65 degrees rotation, lateral
12 bending were all within normal limits and tests for nerve
13 compression were negative, specifically a straight leg raising
14 test.

15 Examination of the right shoulder showed incisions from
16 his right shoulder surgery which were all healed. There was no
17 other skin abnormalities noted, no redness, no swelling. There
18 was no muscle atrophy of the arm. And I measured the muscles of
19 the right arm and forearm and compared with the left. Those
20 measurements consistently showed the right arm and forearm to be
21 larger than the left which is consistent with his hand dominance
22 which was right-hand dominant and what would be considered a
23 normal use of the extremity.

24 Range of motion of the shoulder was within normal
25 limits and compare right to the left side. His strength in his

1 shoulder was normal, measured 5 out of 5. All other tests were
2 negative including drop arm test, impingement signs. No scapula
3 wing was noted. The only test I could not do, what is -- what's
4 called apprehension relocation test and I could not do that test
5 because of his inability to cooperate with that particular
6 maneuver. So he guarded. He reported that it was painful to
7 put the arm in that position and, therefore, that test was not
8 performed.

9 I did a neurologic examination and the neurologic
10 examination showed that everything was normal. There were no
11 sensory deficits. There was no muscle atrophy or muscle
12 weakness. Reflexes were symmetric and normal. And that was the
13 completion of the physical examination.

14 Q. Okay. Now, doctor, I want to step back a moment.
15 Going through your examination with the jury. When you first
16 observed Mr. Sehgal, you mentioned there is no gait
17 abnormalities. Why, if at all, is that a significant finding?

18 A. Well, it would be significant, potentially significant,
19 if he was limping, if he was having trouble ambulating or being
20 mobile. That may be significant. May be related to an injury
21 that occurred as a result of the accident. So that would be
22 something if it was present I would document that and I would be
23 looking for a cause to ascribe that to.

24 Q. Now, with respect to the lack of any spasm noted in
25 either the cervical or the lumbar/thoracic areas, why is that

1 significant or not?

2 A. Spasm would indicate ongoing injury so it would
3 indicate tissue trauma which had not yet resolved. It would
4 indicate nerve irritation which was ongoing. Those things would
5 cause muscle spasm. And if muscle spasm existed on the
6 examination, again, I would be trying to factor that in to my
7 assessment, my opinions.

8 Q. And can spasm be faked?

9 A. No. No. I don't believe it can be faked.

10 Q. In terms of range of motion testing, you rely on the
11 patient you are examining to tell you when the patient can't go
12 any further or if they are experiencing any pain?

13 A. Yes, sir. It's simply a request. A request to display
14 motion. Generally the way I do the examination is I display the
15 motion myself, what I would like the examinee to do for me and
16 then I ask them to reproduce this and I document what they are
17 able to show me.

18 If it's limited, I may ask them, you know, why they
19 can't go any further and I will document the reason. In this
20 case it seemed that pain was the limiting feature.

21 Q. Now, the straight leg test, raise, straight leg raise
22 test was negative bilaterally. What does that indicate?

23 A. Indicates an absence of nerve compression. So it's
24 called a root tension sign. It looks -- essentially indicates,
25 potentially indicates, nerve compression in the lumbar spine.

1 And this part of the examination was negative in his case
2 indicating that there would not likely be a nerve root
3 compression in the lumbar spine.

4 Q. Now, in terms of the shoulder you indicated that you
5 were unable to do the apprehension and relocation testing upon
6 Mr. Sehgal's right shoulder. First, can you tell us what the
7 apprehension test is?

8 A. Yes. It's a test looking for instability, which I
9 don't suspect in this case based upon the results of the MRI,
10 the description of the surgical findings. In any event, it's
11 part of the examination and the way it's performed is by
12 bringing the arm into a position of abduction external rotation
13 as I'm doing and then bringing it behind the plane of the body
14 (indicating).

15 If there is instability, the typical response would be
16 an apprehensive response. In other words, the person would not
17 allow you to move it further than the plane of the body. That
18 would then be supported by a relocation maneuver which is
19 carried out by stabilizing the front of the shoulder with the
20 examiner's hand and if putting pressure on the front of the
21 shoulder eliminated the apprehension then that would be a test
22 consistent with anterior shoulder instability or a positive
23 apprehension relocation test.

24 Q. And you were unable to do those tests on Mr. Sehgal?

25 A. Yes, I was not able to do those tests.

1 Q. Can you explain why was that; he wouldn't move his arms
2 or something else?

3 A. He would not allow me to put his arm in that position
4 so he guarded the arm. He would not let me move it back into
5 that position to do the test.

6 Q. Now, in terms of the neurologic exam, you took
7 measurements of the right biceps and the left biceps; is that
8 correct?

9 A. That's correct.

10 Q. Okay. Why do you measure the right biceps and the left
11 biceps?

12 A. Well, because they -- they relate to each other. If
13 there is a normal side to compare to, that establishes a
14 standard on which we can then make an assessment about the
15 injured side. So in this case the left biceps measures 12 and a
16 quarter inches which now gives us a standard, because the left
17 arm was not reported to be injured in the accident and he gives
18 no past history of injury to the left arm so I make the
19 presumption that's normal. And then I measure the right and
20 then that now would compare to the left.

21 In this case his right arm is one quarter of an inch
22 bigger than the left so he is 12 and a half right, 12 and a
23 quarter on the left. That would be consistent with the
24 hypertrophy or increased muscle size that goes along with being
25 right-hand dominant so that would be a normal finding in my

1 experience. Also for the forearm that was also consistent.
2 When the left forearm was measured, it was 10 and a quarter
3 inches and when the right forearm was measured which is the
4 injured extremity that was 10 and a half inches. So, again,
5 quarter inch difference throughout the arm, biceps and forearm,
6 and that's consistently present and, again, it does also
7 correlate with his description of being right-hand dominant.

8 Q. Now, doctor, I'm going to ask you a series of questions
9 calling for your opinion based upon a reasonable degree of
10 medical certainty and if you can please do so and if you can't
11 please tell me you cannot do so.

12 So what I would like to do, doctor, is if you have an
13 opinion based upon Mr. Sehgal's -- of what his condition was at
14 the time of your examination based upon your examination, his
15 history, your review of his records and the radiological
16 studies, do you have an opinion?

17 A. An opinion in regard to what particular aspect?

18 Q. What his physical condition was at the time of your
19 examination.

20 A. I'm not sure I understand the question.

21 Q. Okay. With respect to his prognosis at the time of
22 your examination, do you have an opinion as to what it was at
23 that time, that is your prognosis?

24 A. Okay. So I guess I'll break this down. The right
25 shoulder was part of the claim in this case, right shoulder

1 injury that required surgery. Based on my examination of the
2 right shoulder, he appeared to have a reasonably good recovery
3 from the surgery. His range of motion was normal in all planes.
4 There appeared to be no evidence of disuse or alter use of the
5 extremity as again objective measurements of the muscle says
6 were all normal and consistent with still being right-hand
7 dominant, still using the right hand to do more of his
8 activities than his left.

9 Essentially, the examination was normal and would be
10 consistent with recovery from the surgery. On that basis I
11 would not expect there to be any future problems with the
12 shoulder; therefore, I would rate his prognosis as very good.

13 Q. Okay. Do you have an opinion as to whether Mr. Sehgal
14 sustained a substantial or significant permanent injury to his
15 right shoulder as a result of the car accident of August 7th,
16 2010?

17 A. I do.

18 Q. And what is your opinion?

19 A. That the accident did not cause a permanent injury to
20 the right shoulder.

21 Q. And why is that?

22 A. Well, there is a number of reasons that led to my
23 opinion for the right shoulder. The -- well, I mean, going back
24 to the beginning, the things that or the way I go about this
25 task of creating an opinion in these cases is to accept a

1 theory. And in this particular case the theory is that the
2 accident caused an injury to the right shoulder, that injury was
3 permanent, he had surgery as a result and, in fact, the
4 relationship is the reason for any deficits that currently
5 exist.

6 Accepting that theory, going back to the records, some
7 of the first records were his -- well, I didn't have records
8 from the day of the accident. I had his history from the day of
9 the accident. I didn't have the police report or report from
10 the EMS, but one of the things I found a bit unusual was that
11 there was a refusal for any care at the scene of the accident.
12 So EMS was there, NYPD was there. They questioned him about any
13 injuries. They offered transfer to the hospital for evaluation
14 and, in fact, he declined that.

15 So, you know, that is one of the things that -- that --
16 that would not correlate with a theory of the accident causing a
17 tear in the rotator cuff or some permanent structural injury to
18 the shoulder that then required surgery.

19 Going forward he's -- that was, I believe, Saturday
20 night was the accident. On Sunday also there appeared to be --
21 I couldn't find anything in the records that he sought urgent
22 medical treatment on that day and would suspect if there was a
23 structural failure of the shoulder; in other words, the tendon
24 was torn off the bone or something serious that was going to
25 lead to a permanent deficit in that shoulder, that there would

1 be a sense of urgency and either a trip to the emergency room or
2 call to your primary care physician or something would typically
3 be done -- in my experience done. That's typically what I would
4 see. And, in fact, that was absent in this particular case.

5 When he is seen on August 9th by Dr. Gregorace, some of
6 the things that I found, something in that report is that he did
7 have right shoulder pain that was indicated and the examination
8 of the right shoulder was not completely normal and that's
9 indicated; on the other hand, the examination of the right
10 shoulder was very close to normal so there were no significant
11 deficits that I could find on that examination.

12 His range of motion measurements were about 10 degrees
13 off normal which, again, now we are two days after the event, I
14 would not expect that to be the case. If, in fact, the accident
15 caused the rotator cuff to tear and that tear being severe
16 enough that it actually required surgical treatment, those
17 things would not be consistent.

18 Also, the fact that the treatment for that shoulder on
19 that day is -- is the absence of applying a sling so, you know,
20 that would be routine and, in fact, that wasn't done on this
21 day. He was not given narcotic pain medication, you know. I
22 would expect the pain levels an after an injury like that to be
23 relatively high; 7 out of 10, 9 out of 10, 10 out of 10.
24 Typically, that prompts a prescribing of a pain medication, a
25 narcotic, something that would be consistent with the level of

1 injury that is being claimed here. And, in fact, that's not the
2 case. He is given Naprosyn which is Aleve. You can buy it over
3 the counter. And muscle relaxant for the back and neck
4 injuries, not the shoulder.

5 He also is not referred for an urgent or emergent MRI.
6 The MRI is not done until many weeks after the examination.
7 Three weeks, I believe. So, again, that would not be something
8 that I would typically encounter in my experience as a surgeon
9 treating trauma injuries. That goes -- you know. That goes
10 along with the diagnosis of strain or sprain which, in fact, is
11 the diagnosis Dr. Gregorace gave him was a shoulder strain or
12 shoulder sprain and, in fact, the examination was all consistent
13 with that.

14 So -- so -- and all of those things are in
15 contradiction to a theory that the accident caused a permanent
16 structural injury in the shoulder that required surgery.

17 Going a bit further, when we talk about the MRI, the
18 MRI now is done on August 30th. So the MRI is reported by the
19 radiologist and, in fact, the radiologist does not describe
20 anything on the MRI that would indicate some recent traumatic
21 event such as there is no -- there is no bleeding into the
22 shoulder or joint defusion, which, again, is something you would
23 expect to see if something was torn in the shoulder or ripped.

24 And we are not talking about a self-limiting shoulder
25 injury here. We are talking about something that was severe and

1 permanent that required surgery. And if that was the case, I
2 would expect to see bleeding in the joint, joint defusion, bone
3 contusion. In fact, none of that was recorded on the MRI.

4 And what the MRI findings consisted of were essentially
5 degenerative conditions. So a low-lying acromion, which is
6 something you with born with or develop over time, it's not
7 something that an accident causes, and there is bone island,
8 which, again, is something that you are either born with or
9 develops over time, but, again, not something traumatically
10 caused.

11 And tendinopathy or tendinosis of one of the rotator
12 cuff tendons, again, that is something that occurs over time, is
13 consistent with a dominant shoulder in a 60-year-old male. It's
14 consistent with those features, not consistent with an accident
15 having caused that.

16 So when you put all of these points together, when you
17 put all of this documentation together and you try and support a
18 theory that the accident caused this permanent injury that
19 required surgery, I just -- I couldn't find it in the records.

20 On the date of the surgery -- and the surgery is done
21 in, I believe, October of that year, the preoperative diagnosis,
22 the diagnosis the surgeon goes in with, okay, is not a diagnosis
23 of a rotator cuff tear from a car accident or anything of that
24 nature. His diagnosis is impingement syndrome.

25 Now, I think impingement syndrome is what the MRI

1 radiologist described on the MRI, which, again, is that
2 pre-existing condition of not having enough space between the
3 bones for the rotator cuff. A common condition. Something
4 that's a routine indication for surgery, okay, over the age of
5 40, and that's his diagnosis going in, again, consistent with
6 all the other records, consistent with the -- with the
7 prospective anyway that the accident didn't cause this.

8 And when he is in the shoulder, what he does is a
9 subacromial decompression. So he makes more space, which,
10 again, consistent with treating a nontraumatic diagnosis. The
11 one thing he does describe is a slap tear.

12 Now, a slap tear is an injury to the labrum, the
13 superior labrum. There are five different types of slap tears.
14 The most benign is type I which is just some fraying of the edge
15 of the labrum, something we routinely see in a 60-year-old
16 shoulder, consistent with routine use of the joint.

17 And in the absence of a description anyway, my
18 interpretation of the record is that was likely what was
19 encountered because of the treatment. The treatment was a
20 debridement. He shaves the edge of the labrum and, again,
21 that's consistent with the treatment of a type I slap tear.

22 If it was a more substantial tear like a traumatic
23 tear, a type II or a type III, then it would be something very
24 different. The labrum would be stretched back to the bone
25 because those traumatic labrum tears where the labrum gets

1 pulled from the bone from the force of the event, from the
2 separation of the bones, ultimately tears the tissue.

3 So -- so -- and, again, that would go along with the
4 type I slap tear, would go along with all the things we just
5 discussed. Again, a theory that what was found in his shoulder
6 was pre-existing, it was degenerative, it was a 60-year-old
7 shoulder on the dominant side and, in fact, none of those things
8 were a result of the accident.

9 Q. Doctor, moving on to the cervical spine, I would ask
10 you as to whether you have an opinion as to whether Mr. Sehgal
11 sustained a substantial or significant permanent injury to his
12 cervical spine again as a result of the accident of August 7th,
13 2010?

14 A. I do.

15 Q. And what is that opinion, sir?

16 A. My accident or my opinion is that the accident caused a
17 self-limiting injury, a sprain/strain, but did not cause a
18 permanent injury that required surgery.

19 Q. Okay. And what do you base that opinion upon?

20 A. Well, my procedure for making, creating, an opinion
21 regarding the spine is the same. Accepting the hypothesis the
22 accident caused a significant spinal trauma, caused a disk
23 herniation at C5 6 which eventually did not respond to
24 nonsurgical treatment and required surgery.

25 Now, going back and looking at the records and finding

1 support for this theory, again, I had a difficult time and, in
2 fact, was unable to find those things. Again, going back to the
3 day of the accident, EMS comes to the scene. The EMS workers
4 question him. They are trained. They do this all the time, to
5 ask questions and evaluate victims of accidents, to make a
6 determination as to whether or not there is likely a significant
7 spinal injury, okay.

8 So this is -- all right. This is the highest liability
9 part of most injuries, spinal injuries. And this is something
10 there is a protocol for when it is suspected. There is a collar
11 placed in the sitting position at the scene. A back board is
12 brought out, okay. The passenger or the victim of the accident
13 is back boarded. They are brought to a local emergency room and
14 the doctors then run tests to make a determination as to whether
15 or not that spinal injury is unstable or stable, okay. Because
16 unstable spinal injuries can lead to paralysis.

17 When we go back and look at this case, right, that
18 doesn't happen in this case, right, so, in fact, there is no
19 cervical collar, there is no back board, there is no EMS
20 transportation to the hospital. So that is one feature of the
21 record that suggests against a significant injury of the spine,
22 a structural failure of a disk from a single moment, a single
23 event, okay, which is, again, what EMS is trained to diagnosis.
24 Or suspect anyway.

25 When we go forward again, the next day on Sunday. Had
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1 this occurred from the accident, I would have expected that
2 there would have been a visit to a local emergency room, a call
3 to a primary care physician or someone to get treatment, to get
4 help. These injuries generally cause pain levels that are as
5 high as 7, 8, 9, 10, muscle spasm, inability to move your head
6 and would typically prompt a reasonable individual to seek some
7 type of urgent care. In fact, that does not happen.

8 When he sees Dr. Gregorace on August 9th and you look
9 at the examination, again, some of the things in the examination
10 stand out very boldly. There is no question that the
11 examination is abnormal. Range of motion is limited, decreased,
12 but it's not decreased that much.

13 So, again, we are talking about 10, about 10 degrees
14 off normal limits. When he looks at flexion/extension, that is
15 not the kind of motion limitations that in my experience you
16 would see after a cervical disk herniation from a single event.
17 And bear in mind disk herniations can occur from degenerative
18 conditions and they play out over time versus it happening in a
19 single moment, okay, from a single impact.

20 Also, there is no -- there is no report by
21 Dr. Gregorace of muscle spasm. So when he sees him in
22 evaluation, he is examining him, he does not describe two
23 things. He does not describe any tenderness in the neck
24 muscles, spasm in the neck muscles. No tenderness, no spasm.
25 And range of motion, that is almost normal.

1 Following through that record, he does not give him a
2 cervical brace, a cervical collar. He does not prescribe a
3 narcotic pain medicine, does not prescribe a steroid medication,
4 which is the kind of things that a doctor would typically do. A
5 doctor experienced in treating spinal injuries, okay, would
6 typically do, if he felt that there was some significant or some
7 injury that was structural, that was permanent, okay, that had
8 the potential for nerve damage. Those things are not done.

9 So then, you know, all of this is now creating a
10 different picture. And I can't put it -- I can't support the
11 hypothesis with this picture of the accident having caused the
12 disk herniation.

13 He then goes for physical therapy for the neck and the
14 lower back and -- which, again, would be counterintuitive. If
15 I'm a doctor and I suspect a disk is herniated and pushing on
16 the cord spinal cord, I would not want to start manipulating
17 that spine or have anyone else manipulating that spine until I
18 know it's safe to do again and that doesn't happen.

19 It does speak to what's diagnosed. He called this
20 cervical sprain/strain. That's what he diagnosed when he saw
21 them on August 9th. Didn't say I think it's a disk herniation.
22 Didn't say that. I think it's a strain/sprain. If you look at
23 his actions, his actions are consistent with that, with that
24 interpretation of the examination on that day.

25 When the MRI is done, first MRI is done on August 30th

1 and then there are two MRIs done subsequent to that. There is
2 another MRI which is done, I believe, month later in September
3 and then another MRI that's done in January of the following
4 year.

5 Now, when you look at those MRIs and you look at the
6 radiologist reports, what you see is you see a lot of different
7 interpretations. Now, what was significant to me is that the
8 first two, the one in August, the one in October, those were
9 both done at Hempstead Radiology, both read by the same
10 radiologist. So -- and so same machine, same radiologist. And,
11 in fact, he reads the scan completely opposite.

12 On August 30th he interprets a disk herniation at C5 6
13 but then when the scan is repeated the following month and he
14 looks at it again he says the disk is not herniated at C5 C6.
15 Says herniated at C3 4. On both of those examinations he does
16 describe degenerative findings throughout the spine; disk
17 bulging, bony hypertrophy, boning ridging.

18 All these things are things we see in a 60-year-old
19 spine, okay. 60-year-old spines have been around for 60 years
20 and they develop these changes. Bony ridging, bone hypertrophy,
21 those are arthritic changes that occur in the spine, are the
22 common cause for nerve compression, are the common cause for
23 neck surgery.

24 And, in fact, that's what is recorded in the MRI. The
25 same radiologist recants his original opinion in August that the

1 C5 6 disk is herniated when he does the examination in
2 October -- the September -- the following month. There is
3 another MRI done in January 2012 which is done prior to the --
4 or 2011 prior to the March surgery.

5 Now, here is one of the key features here. The MRI
6 that was done at Hempstead Radiology, it's is an open MRI. It's
7 a .3 test, 0.3 Tesla. That refers to the magnet strength. The
8 magnet strength is going to impact the resolution of the images
9 of the pictures. It's like high definition TV versus low
10 definition TV. Similar concept.

11 The MRI that's done in January is done on a 1.5 Tesla
12 magnet. So we are talking about magnitudes greater in terms of
13 field strength. That's an institutional size magnet. What
14 hospitals typically had. Dr. DeMoura had it in his practice,
15 New York Spine Institute, and, in fact, when you look at that
16 scan and there is a different radiologist reading that,
17 radiologist look at C5 6 says no disk herniation.

18 So we have two scans done back to back. One on a low
19 field strength magnet. One on a high field strength magnet.
20 Two different radiologists. Both look at C5 6, says disk isn't
21 herniated. What do they both find? Both find degeneration.
22 Both say disk is degenerated, bone hypertrophy and this a
23 degenerative spine we are looking at.

24 So I thought that was very significant and I think it's
25 especially significant because it relates to the other clinical

1 documents. Remember the August 9th document which is now two
2 days after the accident and, in fact, when Dr. Gregorace sees
3 him he says the neck is sprained, the neck is strained, and all
4 of his actions are consistent with a neck sprain, right, which
5 is the prescriptions for the medications he gave, lack of giving
6 a brace, sending him to see a physical therapist to exercise his
7 neck. All of these things are consistent.

8 So this all, you know, supports a different theory of
9 what was going on with that neck and the reason for the surgery.
10 And if you look -- and if you weigh all of those things and you
11 put them in balance, what it means to me in my experience as a
12 clinician seeing these things commonly is the accident likely
13 did not cause a disk herniation. I don't see it in the clinical
14 record from August 9th of Dr. Gregorace's exam. I don't see it
15 in the MRIs, the ones -- the two that were done prior to the
16 surgery. Two different machines. One a very high field
17 strength magnet. So that's the basis for my conclusion on the
18 cervical spine.

19 Q. Now, let me move on to the lumbar spine. And, again,
20 the same question. Do you have an opinion as to whether
21 Mr. Sehgal sustained a substantial or significant permanent
22 injury to his lumbar spine as a direct result of the accident of
23 August 7th, 2010?

24 A. I do have an opinion.

25 Q. What is that opinion?

1 A. Again, that the injury was self limiting, was
2 nonpermanent. It was a lumbar strain/sprain and, in fact, there
3 was no permanent injury such as a disk herniation from the
4 accident. And the basis for my opinions are all very consistent
5 with what I just described for the cervical spine in that the
6 clinical records, when you look at the clinical records you
7 don't find the things in the clinical records I would expect to
8 see from my experience that would indicate a permanent injury
9 had occurred, a disk herniation had occurred.

10 Also, when you look at the MRI, it described
11 degenerative changes throughout the lumbar spine, does describe
12 disk herniations at L1-2, which is the uppermost portion of the
13 lumbar spine. And, again, keeping in mind disk herniations is
14 part of a continuum of disk occurrence changes that occur over a
15 lifetime.

16 We begin our life with healthy disks, robust, not
17 bulging. As life goes on, you begin to lose hydration, water
18 content. That disk begins to sag, bulge. That leads to disk
19 protrusion. Arthritis also develops in the spine. That's part
20 of the aging process.

21 And I believe, based on my review of the records, in
22 fact, that is the condition of the lumbar spine and the accident
23 caused a self-limited injury but did not cause anything
24 permanent.

25 Q. Doctor, in terms of the cervical spine, you had an

1 opportunity to review the operative report by Dr. DeMoura
2 regarding his surgery, correct?

3 A. I did.

4 Q. Okay. And he does a diskectomy and fusion at that
5 area, doctor, you know, with respect to that operative report.
6 Does it or does it not indicate that there is a herniated disk
7 at C5 6 level?

8 A. Um, well, it's mixed.

9 Q. How is that?

10 A. The -- in the operative report there is one sentence
11 that reports findings. And in that sentence which is the
12 beginning of the report before he describes the surgery he says
13 that he saw the disk herniation and he saw the disk herniating
14 posterior to the posterior longitudinal ligament. In other
15 words, into the spinal canal. So says I saw the disk herniation
16 and saw it from the spinal canal. The disk herniating in, okay,
17 that's what he describes. One sentence.

18 But now if you look at his description of the surgery,
19 right, the description doesn't -- is not consistent with that
20 statement. And I will explain to you what I mean.

21 The surgery he does is not surgery from the back of the
22 neck. He does it from the front of the neck, okay. So to do it
23 from the front of the neck you are going into the front of the
24 spine. You are looking at the front of the disk on your initial
25 exposure. There is no way when you are looking in that hole --

1 you are looking at the front of the disk. There is no way to
2 see from the other side, you know I mean? The whole body is
3 around it so you are looking through a small window so there
4 will be no way for him from that exposure to actually see from
5 the spinal canal, which is 180 degrees polar opposite, to see it
6 was herniating into that spinal canal.

7 He describes opening up the disk space, tearing out the
8 disk, removing it with his -- with his putary grandure
9 (phonetic), which is typical, standard protocol for taking out
10 the disk. After the disk is removed, he says the longitudinal
11 ligament is intact. Described it as being intact. And
12 describes himself removing the posterior longitudinal ligament.

13 So based on that description, there is no way for him
14 to know prior to taking out the disk whether or not the disk was
15 herniated into the spinal canal, because by the time he got to
16 the spinal canal he had already taken the disk out and taken out
17 the ligament and that's the only way you can see the spinal
18 canal or spinal cord.

19 He does describe taking out part of the vertebrae above
20 and below. He describes opening up the foramen of the vertebrae
21 where the nerves exit. And, again, that's consistent with what
22 we see in the MRIs record by the radiologist that the right,
23 there is bony hypertrophy, bony ridging. And, again, that's
24 degenerative, not caused by the accident. And, in fact, that's
25 in the report. He does address that in the surgery. So --

1 also, it's on the EMG. The EMG describes nerve compression of
2 C6 bilaterally, not on one side, bilaterally.

3 And I think that's also significant because when you
4 herniate a disk from a trauma, typically the disk herniates to a
5 path of least resistance which is one side or the other. To go
6 directly out the back you have to go through the ligament. And
7 the ligament, as he describes, is intact. He has to take it out
8 so the disk would have to go to one side or the other side and
9 that would cause a radiculopathy on either the right or left
10 side, not on both sides. But we know it's on both sides from
11 the EMG and that's consistent with a diagnosis of arthritis.
12 Stannosis at that level which is circumferential causing nerve
13 compression on both sides.

14 So when I look at the documents and look at the tests
15 that are done, it all is very consistent with a theory that does
16 not support a causally related injury from the accident. I
17 mean, not a permanent injury. A sprain/strain self limiting,
18 yes, but not a permanent injury.

19 Q. Now, doctor, do you have an opinion with a reasonable
20 degree of medical certainty if Mr. Sehgal could perform his
21 activities of daily living at the time of your exam?

22 A. Yes, I do.

23 Q. What's your opinion?

24 A. That he could.

25 Q. Okay. Now, do you have -- did you have any opinion as

1 to whether or not he was restricted at all at the time of your
2 examination?

3 A. For routine activities, no, I did not believe he was
4 restricted for routine activities.

5 Q. Do you have opinion with a reasonable degree of medical
6 certainty as to whether or not he has any permanent disability
7 as a result of the accident of August 7th, 2010?

8 A. Um, as a result of the accident, no.

9 Q. Do you have an opinion as to whether or not the motor
10 vehicle accident of August 7, 2010 caused Mr. Sehgal to have a
11 significant limitation of use of a body function or system?

12 A. As a result of the accident, no, I do not.

13 Q. Do you have an opinion as to whether or not the motor
14 vehicle accident of August 7th has caused Mr. Sehgal to sustain
15 a permanent consequential limitation in use of a body member,
16 organ or member?

17 A. No, I do not believe that that occurred.

18 Q. Do you have an opinion as to whether or not Mr. Sehgal
19 requires any future medical care or treatment as a result of
20 this accident of August 7th, 2010?

21 A. No, sir, I don't.

22 MR. SOBEL: I have no further questions. Thank
23 you, doctor.

24 MR. MURPHY: Can we briefly approach for a second?

25 THE COURT: I'm sorry?

1 MR. MURPHY: Can we approach for just a second?

2 THE COURT: Sure.

3 MR. MURPHY: Thanks.

4 (Whereupon, an off-the-record discussion was held
5 at the sidebar between all counsel and the Court.)

6 (Whereupon, the following took place in open
7 court:)

8 THE COURT: We are going to take a five-minute
9 break to stretch a little bit.

10 COURT OFFICER: All right. Jurors follow me.

11 (Whereupon, the jury exited the courtroom and the
12 following occurred:)

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

15 (Break.)

16 THE CLERK: Doctor, please come back to the
17 witness stand.

18 (Whereupon, the witness resumed the stand.)

19 COURT OFFICER: Jury entering.

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

22 THE CLERK: Please be seated.

23 MR. MURPHY: May I inquire, Judge.

24 THE COURT: Please.

25 CROSS-EXAMINATION

1 BY MR. MURPHY:

2 Q. Good afternoon, doctor. How are you?

3 A. Good.

4 Q. You testified before, correct?

5 A. Yes, I have.

6 Q. Okay. So you know the rules. Keep your answers to yes
7 or no, if there is an explanation required, I will let you
8 finish as long as it's related to the question. Is that fair?

9 A. Understood.

10 Q. Okay, doctor. You testified before that you operate or
11 you do surgeries at the NYU Hospital for Joint Diseases,
12 correct?

13 A. That is correct.

14 Q. And that is the one of the finest hospitals in the
15 world, would you agree?

16 A. Um, I believe it's a very good hospital, yes.

17 Q. One of only five hospitals in the world to be solely
18 dedicated to orthopedics, correct?

19 A. I'm not aware of the number, but it's an orthopedic.

20 Q. You teach there. You are familiar with it?

21 A. Yes, I am very familiar. I train and teach there.

22 Q. You also are familiar with the fact it was recently
23 named the number 6 hospital in the country for orthopedics; is
24 that correct?

25 A. That is correct.

1 Q. Some of the finest surgeons in the world, would you
2 agree?

3 A. Yes.

4 Q. Some of the finest joint surgeons in the world,
5 shoulder surgeons, knee surgeons?

6 A. Yes.

7 Q. Some of the finest spinal surgeons in the world, would
8 you agree?

9 A. Yes.

10 Q. Now, doctor, if you had a patient at the Hospital For
11 Joint Diseases, if they needed a knee surgery, they might come
12 to you, correct?

13 A. Possibly.

14 Q. Needed ankle surgery they go to you?

15 A. Possibly.

16 Q. Several other doctors that they go to. Again, surgery,
17 they might go to you, correct?

18 A. Shoulder, hip, knee.

19 Q. Shoulder, hip, knee. That's your subspecialty?

20 A. Where I focus most of the surgical interventions.

21 Q. If somebody needed neck surgery, they would not go to
22 you, correct?

23 A. That is correct.

24 Q. One person he might go to is Dr. DeMoura, correct?

25 A. Yes.

1 Q. Dr. DeMoura operates at the NYU Hospital for Joint
2 Diseases, correct?

3 A. Correct.

4 Q. You are aware Dr. DeMoura focuses 100 percent of his
5 practice on treatment of the spine, correct?

6 A. Yes.

7 Q. Now, doctor, you also have a private practice you spoke
8 a little bit about before and you don't protest to be a spine
9 specialist, correct?

10 A. I do not. I'm not a spine surgeon.

11 Q. Not a spine surgeon. And you are familiar with your
12 website I'm sure?

13 A. Yes.

14 Q. For Regional Orthopedic and Staten Island?

15 A. We have three offices.

16 Q. Okay. Well, the website has a picture of you on it.
17 You are familiar with the website?

18 A. I am very familiar with the website.

19 Q. If you go to the services, you see services for
20 shoulder, knee?

21 A. Correct.

22 Q. Wrist and hand?

23 A. Correct.

24 Q. Ankle?

25 A. Correct.

1 Q. There is no services, there is nothing to click on that
2 says neck and back; would that be correct?

3 A. That is correct.

4 Q. Okay. Okay. We established you are an orthopedist,
5 you are not a neurologist, correct?

6 A. I am not a neurologist.

7 Q. Not a pain management doctor, correct?

8 A. That is correct.

9 Q. You are not a physical medicine rehabilitation doctor,
10 correct?

11 A. Correct.

12 Q. You are not a radiologist, correct?

13 A. Correct.

14 Q. Not a psychologist, correct?

15 A. Correct.

16 Q. And you are not a spine specialist, correct?

17 A. That is correct.

18 Q. Okay. Now, I want to talk a little bit about your
19 practice. We talked about it a little bit on direct. I want to
20 go into it a little bit more, okay.

21 Now, you see patients, right?

22 A. Yes, I do.

23 Q. Okay. And I am talking about medical practice.
24 Medical legal practice is a separate thing, correct?

25 A. Yes, it is -- well, depends how you look at it. Those
cbb

1 patients are seen in the mix of my general patients when I
2 examine them but the reports that I do are not the same reports
3 I would do for a patient I see in consultation.

4 Q. Fair enough. So you see your own patients for these
5 various things, shoulder, knee, wrist, hands, things of that
6 nature?

7 A. I see a lot of neck and back. I just don't operate on
8 the neck or back. And those cases I refer out to spine surgeons
9 at the Hospital For Joint Disease.

10 Q. Fair enough. One of those doctors might be
11 Dr. DeMoura, correct?

12 A. I don't refer to Dr. DeMoura but for no particular
13 reason other than other spine surgeons I know better that I
14 refer to.

15 Q. Some of the best spine surgeons in the world are at the
16 Hospital For Joint Diseases, correct?

17 A. Yes. Some very good spine surgeons, yes.

18 Q. So you see your patients and they come in and they
19 might see you for a variety of reasons; a sports injury, a work
20 injury, whatever it is right?

21 A. Correct.

22 Q. Okay. And you see them and you said you see them on
23 initial consultation, right?

24 A. Yes.

25 Q. Okay. How long do you spend with your patients on

1 initial consultation?

2 A. Depends upon the scope of the problem.

3 Q. Give me an average.

4 A. I think it's hard to do.

5 Q. Okay.

6 A. You know, again, depending if it's an isolated
7 complaint, you know, such as, say, an ankle sprain, okay. Then,
8 you know, could be a relatively brief visit. If it's multiple
9 body parts, if it's a consultation for surgery, then, you know,
10 those visits might be substantially longer. So it's hard to
11 really give an average.

12 Q. Fair enough. Let me give you a hypothetical. If you
13 have one of your new patients who comes in with shoulder
14 complaints, neck and back complaints from a motor vehicle
15 accident, okay, how long do you spend with that patient on
16 initial consultation?

17 A. Depends.

18 Q. Depends? Well, give me an average.

19 A. Um, I would say are there studies to review, do you
20 have to review X-rays, MRIs?

21 Q. Assuming you have to review X-rays, okay, the person
22 comes to you right afterwards, has X-rays, neck, back, shoulder,
23 how long do spend with that patient on this consultation?

24 A. So reviewing X-rays of the neck, the back and shoulder.

25 Q. Doctor, give me an average. How do you --

1 A. I'm sorry. I am trying to answer your question but,
2 again, I can't answer the question if I don't have an answer for
3 you. It relates to a variety of factors. So the examination
4 can take a lot longer if -- depending upon the number of
5 studies, depending whether the studies are normal or abnormal,
6 depending clinical findings, neurological deficits versus no
7 abnormal findings, no abnormal deficits. That relates to the
8 amount of time that is spent with the patient because it relates
9 to the necessity of time being spent with the patient. So I
10 think it's very, very hard to answer the question the way you
11 are asking. I just can't give you one number that apply to all
12 of those scenarios.

13 Q. You spend more than four minutes with your patients on
14 initial evaluation?

15 A. I would spend more than four minutes with those
16 patients, yes.

17 Q. Okay. Thank you.

18 So these patients come to you and you talked about
19 before how you do see neck and back, often those types of
20 complaints are related to other types of trauma; is that fair?
21 In other words, somebody comes in with a traumatic event with a
22 knee problem or shoulder problem, often they would have neck and
23 back complaints as well?

24 A. No. Depends upon the nature of the event or the
25 injury, but I see a lot of shoulder complaints which are

1 isolated, a lot of knee complaints that are isolated.

2 Q. Fair enough. Any of these neck and back, if you need
3 physical therapy, you have a facility where you send for
4 physical therapy, correct?

5 A. There is physical therapy in one of the offices, and
6 the other two there is not. Any of those office, the physical
7 therapy can be referred out, depending upon what's convenient
8 for the patient.

9 Q. Okay. On your website there is a place called Peak
10 Performance. Is that one of your facilities?

11 A. Yes. Peak Performance is a facility located in the
12 Staten Island facility.

13 Q. You treat these patients, refer them for physical
14 therapy, maybe refer them or give them medication, correct?

15 A. Correct.

16 Q. Okay. You might refer them for diagnostic films,
17 X-rays, MRIs, things of that nature?

18 A. Yes.

19 Q. And some of these patients you will treat over a period
20 of time, correct?

21 A. Yes.

22 Q. You will be their treating orthopedist, right?

23 A. Yes, I would.

24 Q. Now, have you ever treated somebody for, say, over a
25 year?

1 A. Yes.

2 Q. Okay. And that person would come back to you on and
3 off perhaps over that year span?

4 A. Yes.

5 Q. And you would follow how they were doing, maybe
6 increase or decrease the level of their treatment based on their
7 condition, right?

8 A. Yes.

9 Q. And you, as their treating orthopedist, would be in the
10 best position to a make an opinion based on that person's needs
11 and treatment status, correct?

12 A. I might be.

13 Q. Might be another doctor out there that didn't treat
14 them over a year that would be in a better position?

15 A. Possibly.

16 Q. Well, perhaps one of those doctors might be one of the
17 spinal surgeons you refer your patients to, right?

18 A. It's possible.

19 Q. If somebody needs neck surgery, you refer them to a
20 different doctor at NYU Hospital of Joint Diseases, right?

21 A. Some cases. Not every case.

22 Q. But you don't do the surgeries yourself. Refer them to
23 a surgeon?

24 A. I answered that. I do not do spine surgery. I refer
25 those cases out.

1 Q. Fine. That patient of yours has spine surgery. They
2 would begin to treat with that referring physician for that, for
3 the surgery and post surgical care; is that fair?

4 A. Yes.

5 Q. Okay. And that surgeon would be in the best position
6 to treat that patient and to assess their needs regarding the
7 surgery; is that fair?

8 A. Yes.

9 Q. Okay. Now, I want you to assume that Dr. DeMoura, one
10 of the spinal specialists we talked about from the Hospital For
11 Joint Diseases testified here about a little -- about two weeks
12 ago, okay. Dr. DeMoura testified based on his review of
13 Mr. Sehgal's records, he is Mr. Sehgal's treating surgeon, his
14 examinations over a period of time and addition to his clinical
15 findings and he opined Mr. Sehgal's neck injury was directly
16 related to the collisions of August 7th, 2010, wouldn't you
17 defer to Dr. DeMoura regarding that opinion?

18 A. No, not necessarily.

19 Q. Okay. I want you to further assume that Dr. DeMoura
20 testified -- remember a spine specialist, 100 percent dedicated
21 to spinal care, Joint Diseases -- testified delayed onset of
22 pain here, less than 48 hours, even less than 24 hours is not
23 unusual. It is the usual with neck and back injuries. Wouldn't
24 you defer to Dr. DeMoura regarding that?

25 A. What kind of neck or back injury?

1 Q. The kind we are talking about in this matter.
2 Mr. Sehgal's neck and back injury. He opined that a delayed
3 onset of pain is the usual in all types of injuries of these
4 types of injuries and he said it was normal in this case.
5 Wouldn't you defer to Dr. DeMoura regarding that opinion?

6 A. You would need to be specific about the type of injury.
7 I believe we are in disagreement over the type of injury that
8 was sustained here.

9 MR. MURPHY: Can the court reporter repeat the
10 question.

11 THE COURT: Yes.

12 (Whereupon, the requested portion of the record
13 was read back.)

14 A. No. I do not. Again, I think it's important to speak
15 specifically about the type of injury, because there is all
16 types of injuries. There is sprains and strains which are very
17 different than fractures, dislocations, disk herniations. So I
18 think without being specific in regard to the injury it would
19 not be an accurate statement to make.

20 Q. Okay. But you are familiar with this injury, right?
21 You referred the medical records, correct? You reviewed the
22 medical records -- sorry -- correct?

23 A. I did.

24 Q. Okay. Now, I want to talk about your treatment. Well,
25 not treatment. Your examination of Mr. Sehgal. You did not

1 treat him, correct?

2 A. I did not treat Mr. Sehgal.

3 Q. You examined him, would it be fair, for approximately
4 four minutes, would that be correct?

5 A. No, it would not be a full examination.

6 Q. If I told you it was timed, it was a little over four
7 minutes, would that refresh your recollection?

8 A. Taking the history is more than four minutes.

9 Q. You take the history?

10 A. I do it with my assistants.

11 Q. Your assistants take the history?

12 A. They take the history. I review the history with them.
13 Also look at the record in the room.

14 Q. And you prepare the medical report or a report, not a
15 medical report. A report. Now, I want to transition into
16 talking about your medical legal practice, okay; fair enough?

17 A. Sure.

18 Q. Okay. You told us earlier, one of the things you told
19 us today you have no idea how much you are being paid today,
20 right?

21 A. That is correct.

22 Q. Now, you testified in the past, as recently as 2011,
23 that you receive between 6,500 and \$8,000 per day for testimony
24 for defendants. Does that refresh your recollection?

25 A. There was a time -- there was a time when I was made

1 aware of the compensation for my time away from the office,
2 which is what it represents. Since that time -- it's been about
3 a year and a half now -- I asked the office to institute a
4 policy of nondisclosure which means that they are to compensate
5 for the physician's time from the office but that disclosure is
6 not made to the physician and that's done purposefully and
7 that's done in the interest of not allowing or trying to remove
8 any bias from -- from this exercise of coming, giving testimony.

9 But at that time, yes. That was, at that time, the
10 schedule. May have been -- it's updated every year. Done by
11 staff I have that looks directly over this. I'm not part of
12 those conversations. I'm not aware of how the compensation has
13 changed if, in fact, it has changed.

14 Q. Did you also remove yourself from the conversations as
15 to how much your reports cost?

16 A. Yes, I did.

17 Q. And in September of 2011 you were getting about \$1,100
18 for one of these reports. Is that still accurate?

19 A. That was the number in 2011. I believe the number is
20 probably somewhere still in that range.

21 Q. Okay. And you still you were doing three to five per
22 week for defendants. Is that still accurate?

23 A. Um, I have been doing -- this year it seems like a bit
24 less. Varies from year to year. At that time that was prior
25 valid representation. It may be, I would say, maybe in that

1 range of three a week is probably what it seems to be about for
2 this year so far.

3 Q. So for this year three a week. Then it was three to
4 five, fair?

5 A. Yes.

6 Q. It varies. I understand. Varies year to year or month
7 to month?

8 A. Correct.

9 Q. On average, back in September of 2011 you were making
10 between 140 and \$220,000 a year just writing these reports for
11 defendants. Is that still accurate?

12 A. Well, the practice was collecting that revenue. And,
13 again, that goes into general revenue. It's not money in my
14 pocket by any stretch.

15 Q. Okay. Now, regarding this report you actually prepared
16 two reports, right?

17 A. There is an addendum to the initial report.

18 Q. How much did the addendum cost?

19 A. It's based upon the -- I believe it's based upon the
20 number of studies that are reviewed, because there was a review
21 of images, X-rays and MRIs, but I'm not -- I couldn't really
22 tell you what that would be.

23 Q. Now, when you are preparing these reports for
24 defendants, is it fair to say that it's important to review all
25 of the medical records?

1 A. Yes.

2 Q. Okay. And it's important to review all of the medical
3 records because the accuracy of your report is dependent on
4 that; would that be correct?

5 A. Yes.

6 Q. So if you did not review all the medical records, it
7 would affect the accuracy of your report, correct?

8 A. It's possible.

9 Q. And you said that before in the past?

10 A. Yes.

11 Q. Okay. Doctor, when you preparing your report, you told
12 us before what you reviewed -- and I have it here somewhere but
13 what is in your report, is that an accurate statement of what
14 you reviewed before preparing your report for Mr. Sehgal?

15 A. Yes.

16 Q. Now, before you prepared your report for Mr. Sehgal,
17 you stated that you looked at two epidural records, correct?
18 You looked at 12/13 and 11/22; is that accurate?

19 A. Yes.

20 Q. Okay. You did not look at epidural records. Well, you
21 looked at half the records. Didn't look for 10/8 or 1/10/11; is
22 that correct?

23 A. That's correct.

24 Q. So that would be approximately half of that. Doctor,
25 did you review the entire record from NYU Hospital of Joint

1 Diseases?

2 A. The hospital record?

3 Q. Yes.

4 A. No. I had the surgical report.

5 Q. So that's a hospital record. Did anybody stop you from
6 looking at these records before?

7 A. Anybody stop me?

8 Q. Anybody prevent you.

9 A. Well, the records were not provided for my review.

10 Q. Were you aware Mr. Sehgal got a second opinion
11 regarding his right shoulder from Dr. Barry Katzman? Were you
12 aware of that?

13 A. Yes, I was made aware of that.

14 Q. You did not review Dr. Katzman's report; is that
15 accurate?

16 A. Not at the time I wrote the report.

17 Q. In addition to that, did you ever become aware
18 Mr. Sehgal's treating surgeon from about July 2011 to the
19 present date was a Dr. Ali Guy, did you ever become aware of
20 that?

21 A. No, sir.

22 Q. Is it fair to say that up from June 2011 until your
23 report is dated, March -- your later report is dated February
24 2013, you didn't review a year of treating for the record of
25 Dr. Ali Guy; would that be accurate?

1 A. Yes, it would.

2 Q. I want to talk about finding neck and back. You did
3 flexion/extension, things of that nature, right?

4 A. Yes.

5 Q. Now, you found -- I want to talk about the cervical
6 spine. Turn to flexion and extension. Neck is -- I'm sorry.
7 Like this. And like this, right, flexion, is down, extension is
8 up (indicating)?

9 A. Correct.

10 Q. And you found -- let me see. You found both 20 out of
11 30 or 33 percent restriction; would that be correct?

12 A. That's correct.

13 Q. Okay. And wouldn't you consider that, doctor, a 33
14 percent restrict in flexion and extension to be significant
15 limitations?

16 A. Yes.

17 Q. Now, regarding the lumbar spine you found flexion,
18 flexion is forward, right (indicating)?

19 A. Correct.

20 Q. To be 65 out of 90. That's about 30 percent, correct?

21 A. Correct.

22 Q. Wouldn't you agree that is a significant limitation?

23 A. Yes.

24 Q. Okay. Now, you found no spasm, no tenderness, right?

25 A. That's correct.

1 Q. And you told this jury on direction examination
2 regarding the right shoulder Mr. Sehgal did not present with
3 right shoulder complaints the first time he saw Dr. Gregorace.
4 Do you recall saying that?

5 A. No, I didn't say that.

6 Q. Okay. I may have misheard you. But he did report
7 right shoulder pain on his first visit with Dr. Gregorace,
8 correct?

9 A. I'm aware, yes.

10 Q. And reported right shoulder pain throughout his
11 treatment with Dr. Gregorace, correct?

12 A. Correct.

13 Q. And you also told us, I believe before, there was not
14 spasm upon treatment with Dr. Gregorace. Did you say that?

15 A. I did on August 9th report.

16 Q. On the August 9th which was the first visit?

17 A. Correct.

18 Q. Are you aware that I'm looking at August 9th report
19 Dr. Gregorace opined cervical spine strain/sprain with spasms.
20 With spasms. Did you review that?

21 A. Talking about the diagnosis?

22 Q. Yes.

23 A. I'm aware of that, but it was not corroborated in the
24 examination. The documentation and examination did not list any
25 tenderness or any muscle spasm.

1 Q. But it's in his report and you failed to mention that
2 before, did you not?

3 A. I don't believe I failed to mention it. I reported
4 what's in the report which in the examination is what is
5 documented.

6 Q. Actually, throughout Dr. Gregorace's report through
7 January 2012, spasms are indicated for the cervical and lumbar
8 spine throughout the treatment record; is that accurate?

9 A. No. I don't believe that's an accurate representation
10 of what's there. In the subsequent visit by Dr. Gregorace, he
11 does report spasms of the lumbar spine and he does report that
12 in his examination and that's a change from the August 9th. In
13 the August 9th exam, there is no tenderness, no spasm. And then
14 in the subsequent exam, he does report in the exam that there
15 is -- that there is spasm in the lumbar, in the lumbar spinal
16 area.

17 Q. Doctor, looking at August 27 report it says diagnosed a
18 cervical spine spasms, lumbar spine spasms; is that correct?

19 A. Yeah. In the examination where he describes his
20 examination. You are going all the way down to the diagnosis,
21 okay. The diagnosis are -- you not talking about what I'm
22 talking about -- is different than what you are talking about
23 which is in the exam. When he describes doing the exam and what
24 the findings were in terms of range of motion, in terms of any
25 clinical findings, he does not describe it there and that was

1 what I was representing. You are representing something that's
2 quite different.

3 Q. I'm saying it's in a report and you are saying it's not
4 in that right space in the report?

5 A. I'm not saying where it would be. By standard
6 practice.

7 Q. Not where you would put it?

8 A. No. Standard practice. Standard practice it would in
9 the report of the examination that you were performing. That's
10 where it would be. That's where you would put it. It's a
11 narrative description of what you are finding.

12 Q. Spasm is an involuntary finding. Would that be
13 correct? Can't fake it?

14 A. Spasm would be involuntary finding.

15 Q. Spasm is the body's way of splinting a trouble spot,
16 right, an injury?

17 A. Correct.

18 Q. I know you are not aware of it but I want you to assume
19 Dr. Ali Guy's records, about a year of treatment records, all
20 indicate cervical lumbar spasms throughout the treatment record,
21 okay. You are not familiar with that, correct?

22 A. I did not review those records.

23 Q. Okay. And does that change your opinion at all?

24 A. Regarding what happened on the day of the accident and
25 the examination BY Dr. Gregorace?

1 Q. Let me withdraw the question. Wouldn't you agree,
2 doctor, your report may be less than accurate due to your
3 failure to review all of these medical records. Isn't there a
4 danger it's less than accurate?

5 A. No. I feel comfortable my report is accurate regarding
6 the questions of causal relationship and injuries sustained.

7 Q. And you testified before in one of them, DeLuca case,
8 2011, when you testified, Brooklyn; at that time you said that
9 it was important to review all the medical records. You have
10 the same opinion now?

11 A. I do.

12 Q. I want to talk about the surgical report. You don't do
13 neck surgeries, right?

14 A. I do not.

15 Q. You told this jury before that the PLL, the ligament
16 that's in the back of the disk, that it was intact. Is that
17 what you told the jury?

18 A. That's what Dr. DeMoura reported in his report.

19 Q. In the surgical report it was intact or removed?

20 A. To remove it, it would have to be intact.

21 Q. How do you know that if you are not a spine surgeon?

22 A. I have done spine surgeries. I don't do it in private
23 practice but in my training at one of the best hospitals in the
24 world I spent a lot of time on the spine service and I have done
25 a lot of neck surgery. I'm very familiar with the approach.

1 Very familiar with what can be seen.

2 Q. Not in at least 1999, correct?

3 A. Correct. I don't think it's changed much in terms of
4 the approach but, in fact, I'm reporting what Dr. DeMoura
5 reports so that is the nature of what I said.

6 Q. Okay. So are you opining. I want you to assume
7 Dr. DeMoura testified he looked at his report and he said
8 visualized herniated disk at C5 C6, visualized it. That's the
9 best way, not MRI, X-ray, looking into the spine, right?

10 A. 1.5 Tesla magnet, that gives a very good picture.

11 Q. MRI is better than looking at the spine for diagnosis?

12 A. Sure. You never looked at a spine. You don't know.

13 Q. That's true but you don't do it much more either?

14 A. I have done it much more than you.

15 Q. True. Touche.

16 A. Again 1.5 Tesla magnet, institutional magnet gives a
17 very clear picture of the disk and the anatomy; in other words,
18 to see it surgically in this approach, you have to -- you have
19 to take the disk out in order to get to the spinal canal. On
20 the a MRI, you don't need to do that. You can see the disk, see
21 the spinal canal, the relationship of disk to spinal canal, so
22 it gives a very, very accurate representation of what's there.

23 So, you know, that is the difference between the
24 surgical finding and the MRI finding. And you can make it,
25 which you will, but if you have to take the disk out before you

1 can see the spinal canal then how do you make a determination as
2 to whether or not the disk was in the spinal canal.

3 Q. Let me ask you this: Who is in a better position to
4 determine that; you or Dr. DeMoura?

5 A. Depends on your on your prospective. Again, I look at
6 the stuff all the time and you know I on an MRI 1.5 Tesla magnet
7 interpreted by the radiologist. Looked at by myself, okay. The
8 disk does not appear to be herniated. There is disk changes.
9 There is disk degeneration. No question about that. And every
10 radiologist that has looked at all the MRIs has reported that.
11 And it's not at one level, multiple levels. Most significant at
12 C5 6. Maybe Dr. DeMoura told you that's the most common level
13 to degenerate. It fuses through degeneration.

14 Q. Dr. DeMoura testified here. I will give you one more
15 hypothetical regarding Dr. DeMoura. Dr. DeMoura testified here
16 based on Mr. Sehgal's treatment and he said that based on his
17 clinical findings in addition to actually visualizing the spine,
18 being inside the neck and seeing the herniated disk with his own
19 eyes, okay, based on all of that and based upon Mr. Sehgal's
20 presentation following the collisions he opined the collisions
21 caused him to need to have that surgery, I take it you do not
22 defer to Dr. DeMoura, he is treating doctor from Joint Diseases
23 regarding that opinion?

24 A. I do not agree, no.

25 Q. Okay. Now you said you have seen the stuff many times

1 before. Are you talking about where you testified for
2 defendants?

3 A. No. Clinical practice I look at MRIs all the time of
4 the spine of the neck.

5 Q. You testify and write report fairly often in these
6 cases?

7 A. Um, depends on your definition of fairly often but
8 about three times a week.

9 Q. Three times a week for reports. For example, how many
10 times did you testify this year?

11 A. I think I should have that. I think that was given to
12 me by my office.

13 Q. Sure.

14 (Whereupon, there was a pause in the proceedings.)

15 A. So far -- let's see. From January 1st -- this goes to
16 April 22nd, 2013 -- there has been five defendant testimonies,
17 seven plaintiff testimonies.

18 Q. And I do have -- you testified for plaintiffs before,
19 okay.

20 A. I have.

21 Q. Okay. And these are most often -- well, what I can
22 find, these are your patients, correct?

23 A. Yeah. Most often they are.

24 Q. Now, in 2009, you testified that you said before in
25 prior testimony that in 2009 you testified about 30 times for

1 defendants; is that accurate now?

2 A. For 2009?

3 Q. Yes.

4 A. For the single year of 2009?

5 Q. Yeah. Single year.

6 A. On this record, which, again, prepared by my office,
7 they have listed here 13 defendant testimonies.

8 Q. Okay.

9 A. For that year.

10 Q. So I have prior testimony -- I'm not going to read it
11 to you -- which says 30 may be accurate. Is that more accurate
12 than prior testimony?

13 A. Well, if that was from my recollection, this is an
14 accounting that I presume comes out of the computer, this would
15 probably be more accurate.

16 Q. Fair enough. So we were able to do research on this
17 stuff I'm sure you are aware. Now, starting about 1999 until
18 about 2004 you would be referred injured people by a company,
19 right? They would refer you people to see for defendants?

20 A. You are talking about the requests for examinations?

21 Q. Yeah. It's a company, right? And they refer and send
22 people to different doctors. That's how you examine people for
23 defendants for about five years?

24 A. My understanding was that it was companies that worked
25 for insurance companies and they, I guess, acquired physicians

1 that were willing to perform these types of examinations and
2 write these types of reports. So the request came from these
3 entities.

4 Q. Fair enough. I was simplifying.

5 A. Which I believe still is the case today.

6 Q. 2004 did you start doing it yourself through your own
7 office?

8 A. Um, so the report generation you are talking about?

9 Q. Yes.

10 A. Report generation, yeah. In 2004 at that time early on
11 the reports were being generated by an outside company and then
12 I eliminated that and I began to do it in-house so I had full
13 control over the product.

14 Q. Okay. Now, 2011, between writing your reports and
15 testifying you were making about \$300,000 a year from doing
16 these defendant examinations. That still about right?

17 A. From 2004 going forward, talking about general revenue,
18 yeah, probably somewhere in that range.

19 Q. Approximately a year?

20 A. I would say yeah, that's roughly correct.

21 Q. Now, I was able to find some of these prior reports and
22 testimony you have given. Are you familiar with law firm of
23 Baker McEvoy?

24 A. Yes, I am.

25 Q. They are a defendant law firm that represents a lot of

1 taxis and cabs?

2 A. Yes.

3 Q. You testified for and written reports for them many
4 times in the past?

5 A. That is my understanding, yes.

6 Q. Now, I'm going to ask you about some of those cases,
7 doctor. The first I want to ask you about, this case --
8 actually, a report. The case is Incontessa (phonetic). Do you
9 recall that case?

10 A. No, sir, I don't.

11 Q. Okay. That was a report that you wrote for the law
12 firm of Baker McEvoy. It was a 32-year-old man. Do you recall
13 that?

14 A. I do not.

15 Q. I'm sorry?

16 A. I do not recall that.

17 Q. Okay. Do you recall opining in that report in regards
18 to the back and neck injuries regarding to the injury of the
19 cervical spine and lumbar spine there appears to be a soft
20 tissue sprain/strain, did not complain of neck or back pain on
21 visit to emergency room, examination of neck and lower back are
22 without the normal; findings, there is no permanent residual
23 effects as a result of the injury. Do you recall opining giving
24 that opinion?

25 A. In that particular case?

1 Q. Yes.

2 A. No, I do not.

3 Q. Okay. Do you recall the case of another report you
4 wrote for Baker McEvoy, the Solace in the Bronx? Do you recall
5 that case?

6 A. No, I don't recall that particular case.

7 Q. Do you recall that was also a 32-year-old man. I'm
8 sorry. 32-year-old woman who was in an accident with a taxi.
9 Do you recall that?

10 A. I do not.

11 Q. Okay. And do you recall giving this opinion: It is my
12 opinion that these findings are degenerative in nature, rotator
13 cuff tendinosis is a degenerative condition consistent with the
14 patient's age of 32years old. Also my opinion that all abnormal
15 findings are degenerative and consistent with the patient's age
16 32 years old. It is my opinion that the findings on the MRI are
17 pre-existing and degenerative in nature, not the result of the
18 accident. Do you recall giving that opinion?

19 A. In that particular case?

20 Q. Yes.

21 A. No, I don't recall the case.

22 Q. Another report, I don't have who it was written for but
23 involved a taxi. Carrera (phonetic) case. Do you recall that
24 report?

25 A. No, not that selected case.

1 Q. That was a 31-year-old man. Do you recall that?

2 A. I believe I answered that question. I do not.

3 Q. I'm trying to go refresh your recollection.

4 A. I don't recall the case. I don't recall Solace or
5 Inconvera (phonetic). If you show me the report, it may refresh
6 my memory but not just from the last name.

7 Q. Okay. Does it refresh your recollection, the disk
8 bulging are normal changes that occur over time and not the
9 result of an accident, normal degenerative changes not as a
10 result of the accident. Do you recall giving that opinion
11 regarding a 32-year-old man?

12 A. Disk bulging is a degenerative condition and commonly
13 seen in the third decade of life. It's something that I would
14 say if it was encountered and it was relevant to the case but I
15 don't recall making the statements because I don't recall that
16 particular case.

17 Q. Okay. Do you recall the Carrera case -- Gurrera
18 (phonetic) case. Don't have the name of the firm. Also a taxi.
19 42-year-old man hit by a taxi. Do you recall that case?

20 A. No, I don't.

21 Q. Do you recall opining in that case: Also, in my
22 opinion based upon the review of the records, acute herniation
23 is unlikely, MRI changes, most likely degenerative process not
24 caused by the accident. Do you recall giving that opinion?

25 A. I don't recall the case, sir.

1 Q. Okay. Next case. Do you recall also for the law firm
2 ever Baker McEvoy the Sierra (phonetic) case. You wrote a
3 report. Do you recall that?

4 A. I don't recall the name.

5 Q. Do you recall opining in that case -- this was a
6 60-year-old man: It is my opinion after reviewing the medical
7 records, interview and examination there is no injury sustained
8 to the lumbar spine as a result of the accident. It is evident
9 the claimant suffered from a pre-existing degenerative
10 condition. Do you recall giving that opinion?

11 A. I don't recall the case, sir.

12 Q. Next case. Do you recall the Ortiz case involving a
13 34-year-old woman hit by a taxi? Do you recall that?

14 A. No, I don't recall from the last time.

15 Q. Okay. And do you recall giving the opinion that the
16 changes in the MRI were degenerative changes unrelated to a
17 traumatic event? Recall giving that opinion?

18 A. I don't recall the case, sir. Again, if you show me
19 the report, it might help my recollection but not just from the
20 last name.

21 Q. Do you recall opining in that case that: Any
22 complaints of pain were not related to the accident but a result
23 of a degenerative condition in a 34-year-old woman. Do you
24 recall that?

25 A. I think I've answered that three or four times now. I

1 don't recall that particular case without having --

2 Q. Okay.

3 A. -- the report to look at or the examinee to look at or
4 something.

5 Q. I want to talk about some of your testimony in the
6 past. Do you recall testifying on behalf of the law firm Baker
7 McEvoy in the case of Pebble versus Aserta (phonetic) that in
8 2009 --

9 A. I don't recall the names.

10 Q. Do you recall contending in that case testifying for
11 defendants: Mr. Carbone refused medical care at the scene, did
12 not seek medical care until two days later, as a result he
13 didn't suffer from any injury as a result of the accident. Do
14 you recall giving that opinion?

15 A. The only support for my conclusion was that single
16 piece of documentation?

17 Q. In addition you contended MRI reports did not reveal
18 any impingement of the lumbar spine or any tear the left wrist.
19 Does that refresh your recollection at all?

20 A. No. You know, again, none of these reports are based
21 upon one single piece of information. It's about the bulk of
22 information. And so I don't recall the particular case. But,
23 you know, if the MRI was normal and there was no immediate pain,
24 then that would be a valid conclusion to come to.

25 Q. Do you recall testifying in the case of Bengali where

1 you testified -- another taxi case. Do you recall testifying in
2 that case?

3 A. I don't recall the name, sir.

4 Q. Okay. You were the defendant expert orthopedist and
5 knee injury. A knee injury. You opined: Meniscal tears
6 sustained during a single event would have been immediately
7 painful. Absent any complaints on the night of the accident was
8 significant and that, therefore, it was degenerative and not
9 related to the accident. Do you recall that?

10 A. So my conclusion was based on that single finding?

11 Q. The conclusion, all I have, doctor, the conclusion was
12 based on the finding that if it was teared as a result of the
13 accident it would have been painful immediately. That was your
14 conclusion.

15 A. I doubt my conclusion was based upon one single piece
16 of information.

17 Q. On the all the information.

18 A. Not talking about the entire case. Picking one thing
19 out. That's not how I create an opinion on these cases.

20 Q. Do you recall testifying in the case of Vargas in the
21 Bronx, June 2011? Do you recall that?

22 A. I do not recall the name.

23 Q. You testified for the law firm of Baker McEvoy. Do you
24 recall?

25 A. No, I do not.

1 Q. Do you recall opining regarding knee injury that
2 Mr. Vargas' injury was a result of degenerative changes that
3 predated the accident? Do you recall giving that opinion in
4 that case?

5 A. I don't recall the case.

6 Q. Okay. One more case, doctor. Do you recall testifying
7 in February of 2011 for the firm of Baker McEvoy in the Chacone
8 (phonetic) case?

9 A. I don't recall the name.

10 Q. Mr. Chacone was a 25-year-old man. Do you recall that?

11 A. I don't recall the case.

12 Q. Do you recall Mr. Chacone complained of left shoulder,
13 lower back pain, was diagnosed with tears in his shoulder and
14 herniated disk in his back. Does that refresh your
15 recollection?

16 A. Not without, again, having more information. If I can
17 look at the report or see more information, maybe it would but
18 not based on the description are you giving me.

19 Q. Do you recall testifying 25-year-old man, left shoulder
20 MRI revealed degenerative changes, lumbar spine MRI revealed
21 degenerate changes, none of which were the result of the
22 accident. Do you recall giving that opinion?

23 A. I don't recall the case.

24 MR. MURPHY: Okay. I have no further questions at
25 this time. Thank you.

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THE COURT: Any questions on redirect?

MR. SOBEL: Just a couple, Judge.

REDIRECT EXAMINATION

BY MR. SOBEL:

Q. Doctor, earlier counsel had asked you if you found that the flexion/extension deficits in the range of motion of the cervical spine are significant. You said yes. Are those significant limitations causally related to the accident though of August 7, 2010?

A. No, not in my opinion.

Q. And then, doctor, is it one of the benefits of the use of a MRI -- isn't one of those benefits to avoid having to cut into the body to view the internal structures?

MR. MURPHY: Objection. Leading.

THE COURT: Sustained.

MR. SOBEL: No further questions. Thank you.

MR. MURPHY: Nothing further.

THE COURT: Any other questions?

MR. MURPHY: No further questions, Judge.

THE COURT: You may step down. Thank you.

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

THE COURT: Mr. Sobel, any other witnesses?

MR. SOBEL: No, your Honor. Defendants rest.

THE COURT: You want to take the jury out for a