

**A 172**

**Direct [A172]**

Dr. DeMoura - Plaintiff - Direct

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1 THE WITNESS: Good afternoon, your Honor.

2 THE COURT: Good afternoon.

3 THE CLERK: For the record, say your name and  
4 county where your office, medical office, is at.

5 THE WITNESS: Thank you. Alexandre,  
6 A-L-E-X-A-N-D-R-E, last name D-E-M-O-U-R-A. My office is in  
7 Manhattan. My office is 761 Merrick Avenue, Westbury, New  
8 York 11590.

9 THE COURT: You may inquire.

10 MR. MURPHY: Thank you. Understood.

11 DIRECT EXAMINATION

12 BY MR. MURPHY:

13 Q. Good afternoon, doctor.

14 A. Good afternoon, sir.

15 Q. Are you duly licensed to practice medicine in the State  
16 of New York?

17 A. Yes, I am.

18 Q. When did you become licensed?

19 A. 1996.

20 Q. I would like to go in to your background and training a  
21 bit.

22 A. Sure.

23 Q. What -- where did you start? Where did you go for your  
24 undergraduate?

25 A. Gorge Washington University in Washington D.C.

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1 Subsequent to that, Chicago Medical School in Chicago. Then  
2 decided to become an orthopedic surgeon, and I did one year of  
3 general surgery internship in Philadelphia at Temple University  
4 Hospital and another four years of orthopedic residency training  
5 at the same facility and then I did one added year  
6 specialization in spinal -- neurological spine orthopedic  
7 surgery at NYU Medical Center.

8 Q. Just to go back over that a little bit, at some point  
9 you graduated medical school and after that was your internship?

10 A. Yes, sir.

11 Q. Was is an internship?

12 A. Internship is basically you finish medical school,  
13 you've had a broad, basic training of general medicine. Now you  
14 are starting to get focalized as to what you want to do with  
15 your medical career. So internship, you basically get aspect  
16 training of all types of surgery from general surgery, cardiac  
17 surgery, orthopedic surgery, neurosurgery, and spend one year  
18 having exposure to all types of surgery.

19 Q. And then after that you mentioned a residency?

20 A. Correct.

21 Q. Can you tell us what that is?

22 A. So after you do the one year of generalized surgical  
23 training, you then spend another four years where you train to  
24 become an orthopedic surgeon and that's what I did.

25 Q. And where was your residency?

1 A. Temple University in Philadelphia.

2 Q. Did you mention fellowship?

3 A. Yes.

4 Q. What is a fellowship?

5 A. After you become specialized as an orthopedic surgeon,  
6 a lot of surgeons want to focus in on even a much tighter aspect  
7 of the their surgery and I did one more year of just  
8 specifically spine surgery at NYU.

9 Q. Now, there came a time when you completed your  
10 residency training and your fellowship?

11 A. Yes.

12 Q. At that time did you become what's known as board  
13 certified?

14 A. Yes. So you go to medical school. You have to take  
15 multiple tests in medical school. You become -- you take your  
16 boards to graduate from medical school. Those are three type  
17 exams. And then after you trained to become a surgeon you then  
18 become board eligible and then board certified. So to become  
19 certified you take a written test. After you finished your  
20 residency and after you pass that test, then you have to be in  
21 practice for a couple of years more. And then when you are in  
22 practice for a couple of years, you then have to take a  
23 written -- actually, oral test where you go to Chicago, present  
24 cases to other surgeons specialized as you are and they grill  
25 you on 10 cases you present them that you have been in practice

1 for the past couple of years.

2 Q. What are you board certified in?

3 A. Board certified in orthopedic surgery.

4 Q. Now, do you have experience now in treating patients  
5 with injuries to the spinal cord and spinal column?

6 A. Yes, I do.

7 Q. What percentage of your practice now deals with  
8 patients with these types of injuries?

9 A. Approximately ten years ago I formed New York Spine  
10 Institute. We have one of the largest facilities in Long Island  
11 where we treat specifically spinal disorders, injuries, and my  
12 practice is 100 percent dedicated to the spine.

13 Q. Do you currently hold any teaching positions?

14 A. Yes, I do.

15 Q. Where is that?

16 A. Assistant clinical professor of orthopedic surgery at  
17 NYU School of Medicine. I perform all of my surgeries at  
18 Hospital For Joint Diseases at NYU. And part of my distinction  
19 of practicing there and bringing my cases there is I also  
20 treated -- I also teach the residents and fellows to become  
21 orthopedic and spine surgeons.

22 Q. Are you a member of any professional organizations?

23 A. Yes, I am.

24 Q. Which organizations?

25 A. I'm a member of the American Academy of Orthopedic

1 Surgery and North American Spine Society.

2 Q. Okay. And your hospital affiliation now is at NYU --

3 A. Yes, it is.

4 Q. -- Hospital For Joint Diseases?

5 A. Correct.

6 Q. And are you also in private practice?

7 A. Yes, I am.

8 Q. Is that what you told us about on Long Island --

9 A. Yes.

10 Q. -- now in treating your patients you have when you told  
11 us it's 100 percent spinal patients?

12 A. Yes.

13 Q. When treating your patients, do you have to know how to  
14 read MRIs and X-rays?

15 A. Of course, yes.

16 Q. What do you use those for?

17 A. Well, as we know, you can't look inside a human body  
18 unless you actually do the surgery. But short of doing surgery,  
19 we want to diagnose a patient and find out what's going on with  
20 them. One of the easiest ways is to get X-rays. X-rays and CAT  
21 scans use radiation energy which shows bone -- I'm sure you have  
22 seen X-rays in the past. You know what broken bones looks like.  
23 If it's broken, it looks cracked.

24 If we want to see soft tissues as well as muscles,  
25 nerves, disks, it's hard to see with an X-ray because the X-rays

1 penetrates through it so we use something called MRI, magnetic  
2 resonance imaging, and that's a magnetic machine. You go inside  
3 a tube and it gives you a clear picture of what you see inside  
4 the human body regarding the soft structures.

5 Q. And do you have experience reading them yourself?

6 A. Yes, I do.

7 Q. Do you read them in conjunction with treating your  
8 patients?

9 A. I always do.

10 MR. MURPHY: Your Honor, I would like to offer  
11 Dr. DeMoura as an expert in orthopedic surgery and reading  
12 radiographic films.

13 MR. SOBEL: No objection.

14 THE COURT: All right. So moved. You may  
15 continue.

16 MR. MURPHY: Thank you, your Honor.

17 Q. Are you familiar with the term "clinical correlation"?

18 A. Yes, I am.

19 Q. Can you tell us what that is?

20 A. Clinical correlation means it's relevant to what's  
21 going on clinically. How the patient feels, for example.

22 Q. So how -- can you tell us a bit more about that?

23 A. For example, if a patient has, let's say, an MRI that's  
24 important to this case. If they have an MRI taken of, let's

25 say, the neck and that shows a disk herniation -- and we'll talk

1 about what a disk herniation is but image a jelly donut. You  
2 squash the jelly donut and jelly squirts out. That's what a  
3 herniation is. If a herniation squirts out, it pinches a  
4 certain nerve or causes pain in an area. You want to see how  
5 that's related clinically to the patient.

6 So, for example, in this instance the patient damaged  
7 his neck --

8 MR. SOBEL: Objection.

9 Q. We'll, get to that, doctor.

10 A. Okay.

11 Q. Did there come a time when you came to treat  
12 Mr. Anil Sehgal?

13 A. Yes, I did.

14 Q. Can you tell when that first was?

15 A. So, Mr. Sehgal was initially seen in any office on  
16 October 11th, 2010.

17 Q. And did you bring your chart regarding Mr. Sehgal's  
18 treatment?

19 A. Yes, I did.

20 Q. Is that chart prepared in the regular course of  
21 business?

22 A. Yes, it is.

23 Q. Was it prepared and kept by somebody whose job it was  
24 to keep in the course of regular business?

25 A. We have electronic medical records. It's computerized

1 and remains in the computers.

2 Q. Were the relevant records prepared near or at the time  
3 of the treatments?

4 A. Yes, sir.

5 MR. MURPHY: I would like to offer the chart into  
6 evidence as a business record.

7 MR. SOBEL: No objection.

8 MR. MURPHY: I offer the chart into evidence as a  
9 business record, Judge.

10 THE COURT: All right. No objection. Great.  
11 It's hard to hear so if you can just keep it up.

12 MR. MURPHY: Sure.

13 (Whereupon, Dr. DeMoura's Chart was marked in  
14 evidence as Plaintiff's Exhibit 19 by the Reporter.)

15 (Whereupon, the item was given to the witness.)

16 Q. Doctor, you can refer to your chart for these  
17 questions.

18 Before we proceed, doctor, are you being paid to be  
19 here today?

20 A. Yes, I am.

21 Q. How much are you being paid to be here today?

22 A. My fee to show up in court is \$10,000 for the day.

23 Q. How do you come to that amount?

24 A. Well, I'm not seeing patients in the office, not doing  
25 any surgery, and I have a 10,000 square foot facility to keep

1 going, operating expenses, and that's my fee to show up in  
2 court.

3 Q. Now, I want to talk about treatment of Mr. Sehgal.  
4 Now, the first time you treated him, you stated, was, I believe,  
5 October of 2010?

6 A. Yes, sir.

7 Q. When you first treated him, I want you to assume he was  
8 involved in a motor vehicle accident in August of 2010, an  
9 impact to the rear resulting in a frontal impact which totaled  
10 his vehicle did you become familiar with that set of facts?

11 A. Yes, sir.

12 Q. And did you become familiar with that set of facts when  
13 you first saw Mr. Sehgal?

14 A. Yes, sir.

15 Q. When you first saw him, did you examine him?

16 A. Yes, I did.

17 Q. Can you tell us what the results of your examination  
18 were?

19 A. Examination of the cervical spine, which is the neck,  
20 showed that there was tenderness to palpation which means it was  
21 tender to the touch. His range of motion was decreased. His  
22 range of motion was also painful regarding the thoracic spine,  
23 which is the middle spine where your are rib cage is. There was  
24 also tenderness in that area. And then examination of the  
25 lumbar spine proved positive also for pain, decreased range of

1 motion and range of motion was painful.

2 Q. Can you tell us a little bit more? How did you measure  
3 the range of motion? How is that done?

4 A. I measure it by vision. I have the patient -- I put  
5 him through a range of motion. Tell them to flex their head  
6 forward, flex it backwards, to turn to both sides and then to  
7 rotate also. So various means of what you, you know normal is,  
8 you can look at yourself, you know what normal is, and determine  
9 if the patient can do what normal is. If not, then you evaluate  
10 that.

11 Q. And the other results, tenderness to palpation, the  
12 other things you mentioned, tell us a little more detail what  
13 those test results mean?

14 A. So when patients have muscle spasms and they have pain  
15 going on in the neck, if you squeeze certain parts of the muscle  
16 it elicits pain and I documented that's what I saw.

17 Q. And at that time after the first visit did you have a  
18 prognosis or did you come to any conclusion regarding  
19 Mr. Sehgal's condition?

20 A. Well, I reviewed the MRI. And once again that MRI is a  
21 study that shows the soft tissue nicely. And as I'm sure you  
22 know, the spine are various little blocks of bone. In between  
23 that are little shock absorbers.

24 Like I said earlier, a disk is a little jelly donut.  
25 If you squash it hard enough, the gel squirts out. That jelly

1 squirts out. It's not supposed to be out, stay inside the  
2 donut. If it comes out, it will cause pain and irritation to  
3 the area, inflammation.

4           And just image having a tiny pebble in your shoe, you  
5 know immediately when the pebble is in your shoes. Your spine  
6 is infinitely more sensitive to that.

7           So when you have a herniation in your neck right next  
8 to the spinal cord and where the nerves exit that, go down your  
9 arms, you get severe neck pain, have difficulty moving your  
10 neck, and these are symptoms that occur in that instance.

11           So I had an MRI to look at and the MRI, which is a  
12 soft-tissue study, clearly showed that the patient had a disk  
13 herniation at the C5/C6 level. There are certain vertebrae in  
14 the neck. And this occurred between the 5th and 6th level.

15           Also, neurological studies to review. And one thing  
16 important is something called an EMG. EMG is nerve conduction  
17 tests. Let us know nerves that exit the spine going down the  
18 arm are working normally or whether there is inflammation or  
19 irritation of these nerves.

20           And the nerve tests he had done also showed that the  
21 specific nerve that comes out between the 5th and 6th level was  
22 also being irritated.

23           Q. Doctor, I have a model here I would like to show you to  
24 see if it helps in explaining this to the jury, okay. First I  
25 would like to show you what's previously marked Plaintiff's

1 Exhibit 13 for identification?

2 MR. MURPHY: Your Honor, may I give it to the  
3 court officer.

4 THE COURT: Yes.

5 (Whereupon, the item was given to the witness.)

6 Q. Dr. DeMoura, is that an accurate model of a human  
7 spine?

8 A. Yes, it is.

9 Q. Will that model help you explain to the jury what you  
10 were talking about regarding Mr. Sehgal's condition?

11 A. So as we can see here, this is a model of the human  
12 spine. It's a pretty long structure. And it's basically  
13 divided up into three main parts. Actually four, but let's go  
14 for three right now.

15 The upper portion where your neck is, that's called the  
16 cervical. This middle portion here is called the thoracic where  
17 you are rib cage attaches onto. And then lumbar, the set of  
18 vertebrae, five of them in the lower back.

19 Mr. Sehgal injured himself up here in the neck region  
20 between the 5th and 6th vertebrae. This is number 2, 3, 4, 5 6.  
21 So this disk right here, that little structure between the two  
22 vertebrae is the one that got damaged.

23 And you can also see where the nerves come out on the  
24 side and that's all associated. So what was happening with this  
25 patient --

1 Q. Doctor, I have other models here marked as Plaintiff's  
2 Exhibit 14 and 15 for identification?

3 MR. MURPHY: May I give it this to the court  
4 officer, your Honor?

5 THE COURT: Yes.

6 (Whereupon, the item was given to the witness.)

7 Q. Dr. DeMoura, the models you have, are they accurate  
8 representations of the human spine?

9 A. Yes, they are.

10 Q. Will those help you explain Mr. Sehgal's condition to  
11 the jury?

12 A. Yes, sir.

13 Q. What I see, they are smaller. Would it help you  
14 doctor, if you came down.

15 A. Yes.

16 MR. MURPHY: Your Honor, may Dr. DeMoura step down  
17 from the stand?

18 THE COURT: Yes, he may.

19 MR. MURPHY: Thank you.

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

22 A. What we have here is a model of one segment of the  
23 spine. We can see there are two bones. Those are the  
24 vertebrae. One is clear so I can show you what the inside looks  
25 like, okay.

1           And, of course, between the vertebrae we have the disk  
2 which allows the spine to move. Both directions. If it didn't,  
3 you would have a solid one bone in your back and wouldn't be  
4 able to move at all. This allows us to have motion.

5           One of the major importance of the spine is to protect  
6 the spinal cord. You have your brain up here which attaches to  
7 the spinal cord. Spinal cord goes down this long tube which is  
8 the spine itself. And at each level there are branches that  
9 shoot off which are nerves and the nerves have specific  
10 functions.

11           So it's almost like having Cable Vision which sends  
12 fiber optic signals from the major center until it hits your  
13 house and you are able to see the TV picture. That information  
14 has to get somewhere.

15           So here we have the brain which sends signals, signal  
16 travels down the spinal cord. The spinal cord then branches off  
17 at certain areas where nerves go and each one of these nerves  
18 has a specific function.

19           Take, for instance, the 6th nerve, but this is the 5th  
20 and 6th vertebrae. That's where this patient got injured. So  
21 that nerve that gets injured, it travels down the arm. If you  
22 make a number 6 on your hand, that's the distribution where the  
23 6th nerve goes. So if you damage that nerve or irritate it,  
24 maybe have some pins and needles, you know, numbness in the  
25 hand. And that's the sensation part of these nerves.

1           Now, the nerves, also when your brain tells your hand  
2 to move, any little thing you do, that's your brain telling you  
3 to do something. That message has to get to the muscles so  
4 that's a motor function.

5           So when you raise this part of your wrist (indicating)  
6 that's a 6, C6 function, brachioradialis muscle. When that is  
7 innervated, when your are brain tells you raise this up, that's  
8 the 6th arm firing. That's the function of the nerves and the  
9 spinal cord, to get the information to you.

10           Even more important in this case, I show you how this  
11 patient's anatomy was damaged, if you look inside here.

12           MR. SOBEL: Judge, I object. This is a longwinded  
13 narrative. At this point he is not asking any questions.

14           MR. MURPHY: Asked him to explain how Mr. Sehgal's  
15 condition is represented in this model. He said it would  
16 help and is explaining it to the jury.

17           THE COURT: Continue. Overruled.

18           A. So inside here we see something I explained earlier is  
19 like a jelly donut. So you see that white portion, the outer  
20 portion of the donut, and inside a gelatinous material  
21 buoyancies and shock absorber. In real life it looks like crab  
22 meat, not gel.

23           What's important to say is the outer portion of the  
24 donut has nerve fibers in there. So when you start squashing  
25 the jelly donut, that gel starts going through the donut, starts

1 to pierce the outside of the donut which has nerve fibers.

2           You know how painful it is when you have a tooth  
3 cavity. Those nerve fibers, when that protrudes through the  
4 outer portion of the donut, you start to get pain. And  
5 ultimately when that disk ruptures, which is like a blowout on a  
6 tire, then you can have the nerves affecting spinal cord  
7 affected such that you have decreased conduction. Things we see  
8 on the nerve test, the EMG.

9           If you look inside here, I will show each one of you.  
10 As you see, when I squeeze in here the jelly comes out. See  
11 that (indicating).

12           So that that little gel you saw oozing out, that's what  
13 happened to this patient. He damaged that disk. That material  
14 oozed out. It damaged the area between the 5th and 6th  
15 vertebrae and, as a result, he was impaired by that.

16           Q. Thank you, doctor.

17                           (Whereupon, the witness resumed the stand.)

18           Q. Doctor; on that initial examination -- and you  
19 explained this condition to us. Did you have any treatment  
20 recommendations at that time after that initial examination?

21           A. Well, this patient came to see me a couple of months  
22 after this type of injury. Usually I tell all of my patients  
23 surgery should be the last resort and indeed I wanted him to try  
24 some other conservative steps; injections in the spine with  
25 cortisone-type material to see if maybe that would help his

1 symptoms, even though in the back of the mind I was confident he  
2 would require surgery. But, nevertheless, I can -- I like to  
3 give another opportunity to get better on their own.

4 After the first visit I recommended patient continue  
5 physical therapy. And I think I -- let me check my record here.

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

7 A. I also recommended that he get an injection in the  
8 spinal -- in the neck region to see if that medicine would help  
9 soothe his symptoms.

10 Q. Did you ever become aware Mr. Sehgal did have epidural  
11 injections into his cervical spine?

12 A. Yes.

13 Q. And did you become aware he had three injections into  
14 his cervical spine?

15 A. Yes.

16 Q. Can you tell us what an epidural injection is?

17 A. So you probably heard of epidurals. A lot of women  
18 nowadays when they have babies ask for epidural. Well, the  
19 epidural is space, is just a space above the dura. The dura is  
20 the lining of the spinal cord and lining of the nerves. So when  
21 we refer to epidural, we're referring to putting a needle into  
22 the spine right into that little space and injecting some  
23 cortisone in that. That cortisone seeps throughout, bathes the  
24 nerves in cortisone and then hopefully that will diminish some  
25 of the inflammation and they will feel better and hopefully get

1 better.

2 Q. Did you ever become aware in this situation, doctor,  
3 that Mr. Sehgal did not experience relief from these epidurals?

4 A. Yes.

5 Q. And does that indicate anything to you?

6 A. That indicates to me that the herniated disk was enough  
7 to continue to irritate that area. Just image, once again, you  
8 have that little pebble in your shoe. I can give you medicine  
9 to soothe or maybe you forget about that pebble. But if that  
10 pebble doesn't go to the arch of the foot and stays in the ball,  
11 what do you have to do? You have to get the pebble out.

12 That's what happened here. Mr. Sehgal continued to  
13 have incapacitating pain. At that point I felt surgery was  
14 warranted.

15 Q. So did Mr. Sehgal come back to you after trying these  
16 epidural injections?

17 A. Yes, sir.

18 Q. When was the next time you saw him?

19 A. I saw him back on December 6th, 2010.

20 Q. And at that time did he make complaints to you?

21 A. Yes. He continued to have neck pain. His symptoms had  
22 worsened. He had tried the epidural injection, and at this  
23 point I told him that I thought surgery was the option for him.

24 Q. At some point did Mr. Sehgal elect to proceed with that  
25 surgery?

1 A. Yes, sir.

2 Q. And can you tell us when that was performed?

3 A. The surgery was ultimately performed in the spring of  
4 2011.

5 Q. Tell us what type of surgery that was.

6 A. Let me give you the date.

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

8 A. On March 4th, 2011, the patient had an anterior  
9 cervical diskectomy and fusion. Now, what that means is  
10 anterior means through the front. So I make a little incision  
11 on the neck horizontally at the level where the 5th and 6th  
12 vertebrae is. Diskectomy means I'm going to remove a disk. And  
13 then fusion means I'm going to make these two bones grow  
14 together.

15 Once you take that disk out, there is no shock absorber  
16 left. Imagine if you leave it that way. The bones grind  
17 against one another and that will continue to cause pain.

18 So with this surgery, a very delicate surgery, I use a  
19 microscope when I operate. We go in through the neck. A lot of  
20 land mines. You got the jugular vein, Cortaid artery,  
21 esophagus, food pipe, trachea, wind pipe. Have to get through  
22 those structures now down to the spine.

23 Once down to the spine, now I can see the disk just  
24 like I showed you on the model between the two vertebrae. I now  
25 scoop out the jelly and the donut and once I have everything

1 cleaned out nicely I put a little spacer in there to keep that  
2 space out. Remember the disk acts like a shock absorber. And  
3 also a spacer.

4           If that space collapses, then it can pinch the nerve.  
5 So we keep that space open with a bony spacer. Looks like a  
6 sugar cube. Comes out of a bone of somebody who died. Pure  
7 calcium. We insert that sugar cube type of graft. That keeps  
8 the space open. And then eventually the two bones will grow  
9 together.

10           Now, to create the fusion, just as what you have heard,  
11 when you break your arm we put plates and screws on your arm to  
12 help it heal quicker. By holding the bone still and putting  
13 that plate in there, that allows the fusion to take place  
14 between the 5th and 6th bone.

15           Once it's fused, a good three to six months, the  
16 patient has had a solid bone, like any other bone in the body,  
17 the 5th and 6th vertebrae have now become one.

18           Q. Doctor, I have a chart here and I would like to ask the  
19 court officer to show it to you.

20           A. Okay.

21           MR. MURPHY: Your Honor, may I give this to the  
22 court officer?

23           THE COURT: Sure.

24           (Whereupon, the item was given to the witness.)

25           MR. MURPHY: Marked as Plaintiff's Exhibit --

1 COURT OFFICER: Plaintiff's Exhibit 16 for ID.

2 MR. MURPHY: 16 for identification.

3 Q. Doctor, is this chart or is this board an accurate  
4 depiction of the surgery that we're talking about?

5 A. Yes, it is.

6 Q. Would it help you to explain that surgery to the jury?

7 A. Yes.

8 MR. MURPHY: Your Honor, may the doctor step down  
9 and show the board to the jury?

10 THE COURT: Yes.

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

13 Q. Doctor, if you would explain to us from top to bottom  
14 what this chart depicts and how it relates to Mr. Sehgal's  
15 condition.

16 A. So here, seeing the patient lying face up on the  
17 operating room table put to sleep by anesthesia. We make that  
18 incision, as I told you, horizontal incision on the neck. I go  
19 down to the spine.

20 Once we are down to the spine, put retractors in to  
21 keep everything open. You can see the vertebrae. This is the  
22 5th one. That is the 6th one. And decide where that disk  
23 material will be. Then, as I said, we clear out that entire  
24 space. We take out that jelly material that has oozed out.

25 In this case, I clearly saw where that jelly had come

1 out, oozed through the fibers, ligaments that holds the spine  
2 together that was causing all the pain. So we took that out.  
3 And once I've taken the jelly out, I prepare the boney surfaces,  
4 nice little bleeding surfaces. We want fresh bone to grow  
5 together.

6 Here you see a picture of what that little sugar cube  
7 looks like, a graft of bone. We slide that in and then put a  
8 plate on here and the plate acts like -- it's called internal  
9 fixation. It holds that area still.

10 Imagine building a model airplane, move the piece,  
11 don't glue together. If you hold it together with a vice clamp,  
12 it glues together quicker. That's what the vice grip does. If  
13 you look at this, it shows you what it looks like. This is a  
14 two level plate. Mr. Sehgal only had a one level surgery. So  
15 that's put in there.

16 And remember all the surgery is next to the spinal  
17 cord. One wrong move, the patient wakes up paralyzed. It's a  
18 delicate surgery, and it's done as a last resort.

19 Q. Thank you, doctor.

20 (Whereupon, the witness resumed the stand.)

21 Q. Doctor, did Mr. Sehgal have to be hospitalized for any  
22 period of time after the surgery?

23 A. Yes.

24 Q. And this was at Hospital for Joint Diseases?

25 A. Yes.

1 Q. For how long did he have to remain in the hospital?

2 A. I don't recall. Usually patients stay 24 hours.

3 Q. After that time in the hospital, what is the recovery  
4 period?

5 A. So for the first week the patient will have a sore  
6 throat. We move the food and wind pipe out of the way. They go  
7 home the following day. Usually I see them back periodically.  
8 In the office the first couple of weeks. Usually takes about a  
9 good three months for the bones to get sticky and start growing  
10 together. By six months, bones usually have fused. Around  
11 two -- 8 to 10 weeks after surgery, start physical therapy to  
12 help give them some increased range of motion back and  
13 strengthening their neck. That's what is entailed with this  
14 type of procedure.

15 Q. Did you see Mr. Sehgal after this procedure was  
16 performed?

17 A. I have seen him on numerous occasions.

18 Q. Can you tell us the first time you saw him after this  
19 surgery?

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

21 Q. You know what, doctor? Refer for a second to the  
22 surgical report. Is that in your records?

23 A. Yes, it is.

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

25 Q. Doctor, you mentioned before MRIs, CAT scans were a

1 good way to visualize --

2 A. Yes.

3 Q. -- the soft tissue disk in the spine?

4 A. Yes.

5 Q. And is there a better way to visualize that area?

6 A. The best way to visualize is to actually look at it  
7 with a microscope. See clearly when operated under high  
8 magnification and illumination. You can see exactly what the  
9 pathology -- which is what the problem is. And in this case I  
10 clearly saw that disk herniation was traversing, meaning going  
11 through, the PLL which is the longitudinal ligament in the back  
12 of the spine next to the spinal canal.

13 MR. SOBEL: Sorry?

14 (Whereupon, the requested portion of the record  
15 was read back.)

16 A. So to answer your question, again I saw him on  
17 3/14/2011.

18 Q. When you saw him on 3/14, did you perform an  
19 examination?

20 A. Yes.

21 Q. At that time did he have any assistive devices, a  
22 collar or something like that?

23 A. I put him in a collar. For a couple of months after  
24 surgery he was wearing a collar.

25 Q. For what reason did you see him on that date?

1           A.   Well, just did surgery on the patient.  You want to see  
2 how well they are doing after surgery and periodic follow-up  
3 X-rays to see -- once, again, remember the X-rays show how bone  
4 is healing and since this is a fusion I want to see how well  
5 those two bones are going together.  So every two months get an  
6 X-ray to observe the bony healing.

7           Q.   At some point did you have a post-surgical X-ray or  
8 order one for Mr. Sehgal?

9           A.   Yes.

10          Q.   Can you tell us when that was?

11          A.   That day.

12          Q.   Are they included in your chart?

13          A.   Yes.

14          Q.   Did you bring them with you today?

15          A.   Yes.

16          Q.   Would it help you to show them to the jury to help  
17 explain Mr. Sehgal's condition?

18          A.   Sure.

19                   MR. MURPHY:  Mr. Court Officer -- may I plug in  
20 the shadow box, your Honor?  May I --

21                   THE COURT:  Yes.

22                   MR. MURPHY:  Thank you.

23                   May the witness step down to use the shadow box,  
24 your Honor?

25                   THE COURT:  Yes.

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

3 A. So once again this is a side view of an actual X-ray of  
4 Mr. Sehgal. You can see head up here and his jaw. These are  
5 the vertebrae in the neck. This is number 2, 3, 4 so 5 and 6.  
6 You can see the plate here which we put in. Also see the graft  
7 put in. This little -- the little cube of bone to allow it to  
8 grow together. A side view. Eventually this all becomes one  
9 fuzzy blur which means the bones have grown together. So that's  
10 a side view. And this is a frontal view. You can see the plate  
11 on there from the front.

12 (Whereupon, the witness resumed the stand.)

13 Q. Now, you mention the first time you saw him. How many  
14 times after the surgery have you seen Mr. Sehgal for followups?

15 A. Usually every couple of months.

16 Q. When was the last time you saw him?

17 A. So he was seen in my office most recently on the last  
18 visit I have here was July of 2012.

19 Q. So between March of 2011 and 2012 he saw you every  
20 couple of months?

21 A. Yes.

22 Q. Now, referring to that last examination, if you would,  
23 the July 2012 examination, at that time did you perform and  
24 examine Mr. Sehgal?

25 A. Yes.

1 Q. Can you tell us the results of that exam?

2 A. So examination that day proved he now has a scar on the  
3 front of the neck, still some tenderness to palpation, to touch.  
4 There was some muscle spasm present which is involuntary so  
5 still some irritation.

6 Range of motion, I saw some pain in decreased range of  
7 motion which is expected.

8 Q. Doctor, I would like to give you some hypotheticals,  
9 okay. I want you to assume that after -- following the  
10 collision to the front and back, automobile collision that we  
11 spoke about, following that Mr. Sehgal did not immediately feel  
12 pain to the neck, only later that night and the next day; is  
13 delay onset of pain unusual?

14 A. No. That's actually usual.

15 Q. Can you tell us why?

16 A. Well, remember the scenario I gave, jelly donut and the  
17 outer portions of that donut have little nerve fibers. So once  
18 you get the trauma -- remember the body is 60 percent water. So  
19 mostly water, a bag of water. Now what's important to  
20 understand also is when you are prepared for a traumatic event  
21 you are tensed up and ready to go like a linebacker running down  
22 the field, knows he is getting tackled. When you are in an  
23 automobile accident and when the car is totaled, all of that  
24 kinetic energy, which is energy in motion, is transported from  
25 one vehicle --

1 MR. SOBEL: Objection.

2 A. -- striking the other vehicle.

3 MR. SOBEL: Objection.

4 THE COURT: Sustained.

5 MR. MURPHY: I'm sorry, Judge. What's the basis  
6 of the -- I'm sorry. I'm curious. What's the basis of the  
7 objection?

8 THE COURT: State your basis.

9 MR. SOBEL: Testifying about kinetic energy. I  
10 didn't hear this witness is qualified to testify about  
11 kinetic energy.

12 THE COURT: Rephrase your question and go on.

13 Q. Doctor, what is kinetic energy?

14 A. Energy in motion. Physics. We train in college and  
15 orthopedic surgery and so forth. Let's not talk about kinetic  
16 energy, just energy.

17 When that one car hit his car, energy was transmitted  
18 through that car into the patient's body which damaged the  
19 patient's cervical spine and that's what happened.

20 Q. Okay. And I believe that we were referring to the  
21 delayed onset of pain?

22 A. Right. So when you have the jelly donut scenario, that  
23 disk gets traumatized. That gel can continue to ooze. And as  
24 it continues to ooze through those fibers of the outer portion  
25 of the donut, then you start getting more and more pain until

1 ultimately it courses through there and that causes even more  
2 pain.

3 Q. Now, doctor, just to further the hypothetical, later  
4 that day and the next day when Mr. Sehgal began to feel pain in  
5 the neck, in other areas of the body, do you have an opinion to  
6 a reasonable degree of medical certainty whether that onset of  
7 pain was related to the automobile sent?

8 A. So this patient had no history of spinal problems  
9 before and I would say within a reasonable degree of medical  
10 certainty, which means more probably than not, we have a  
11 traumatic history, the patient then develops pain so the pain  
12 comes from the traumatic history. He didn't have the problems  
13 before.

14 Q. Now, I want you to assume further Mr. Sehgal had  
15 increased pain, as we discussed, at some point had three  
16 epidural injections to his cervical spine, do you have an  
17 opinion to a reasonable degree of medical certainty whether  
18 those epidural injection were related to this accident, the need  
19 for the epidural injections were related to the accident?

20 A. Exactly. The need for the injections were related to  
21 the accident. The accident caused the patient to be damaged and  
22 the injections were trying to make him get better.

23 Q. Now, assume further that the injections did not provide  
24 any relief and in the spring of 2011 Mr. Sehgal underwent the  
25 surgery that we talked about and do you have an opinion to a

1 reasonable degree of medical certainty whether this surgery or  
2 the need for this surgery was related to the accident of August  
3 7, 2010?

4 A. Without a doubt, within a reasonable degree of medical  
5 certainty the accident this patient was involved in caused him  
6 to damage that disk which ultimately led him to have to have  
7 surgery.

8 Q. Now, I want you to assume further that following  
9 surgery, following recovery, assume Mr. Sehgal has improvement?

10 A. Yes.

11 Q. Okay. But that he occasionally experiences pain and  
12 discomfort?

13 A. Correct.

14 Q. And limitation?

15 A. Yes.

16 Q. Do you have an opinion to a reasonable degree of  
17 medical certainty whether those current symptoms are related, go  
18 back to the accident of August 7, 2010 and result of trauma?

19 A. I believe so.

20 Q. Can you tell us the basis of your opinion?

21 A. Well, we know the patient damaged C5/C6 level. That  
22 level that is fused is taken care of but the patient has lost  
23 some range of motion. You know, when you take out one segment  
24 of motion, you lose one-seventh of 50 percent of your motion.  
25 So with time the levels above and below are being stressed.

1           Now, it might be in a couple of years, it might take  
2 another ten years, eventually those levels will wear out to the  
3 point he develops even more pain and ultimately require further  
4 surgery.

5           Q.    Now, do you have an opinion within a reasonable degree  
6 of medical certainty whether Mr. Sehgal's condition of the  
7 cervical spine is permanent?

8           A.    It's permanent, yes.

9           Q.    Can you tell us why?

10          A.    Well, it's been damaged.  It's been fixed I'm not God.  
11 I didn't make it the way it was before it got hurt, you know.  I  
12 did the best I could to try to fuse that level and take care of  
13 the problem right then and there.  So the best we as humans can  
14 do.  The patient does not have a completely normal neck anymore.

15          Q.    I want you to assume, doctor, there is an opinion out  
16 there that treatment of the injury, the surgery, are not related  
17 to the accident of August 7, 2010.  Do you agree with that  
18 opinion?

19          A.    No.

20          Q.    Can you tell us why?

21          A.    Why?  Because I believe in my patient.  My patient had  
22 no history of this problem before.  And we know there was a  
23 traumatic incident.  Tried to get better without surgery,  
24 didn't.  Multiple injections, physical therapy.  I tried to  
25 delay it for him.  He ultimately told me doc, I can't put up

1 with this. When you tell me doc, I can't put up with this,  
2 surgery is needed and required because he injured it during that  
3 accident.

4 Q. Did you have an opinion based on a reasonable degree of  
5 medical certainty whether the condition of Mr. Sehgal's cervical  
6 spine represents a significant limitation of the cervical spine?

7 A. Well, I feel it limits his cervical spine. As far as  
8 being significant, significant enough he had to go through  
9 spinal surgery, which is not a walk in the park. And, as I  
10 said, um, his treatments of his neck are not through. For now.  
11 Sometime in his future life, he will require further treatment.  
12 That's pretty significant.

13 Q. Do you have an opinion within a reasonable degree  
14 medical certainty whether he will require further treatment?

15 A. Yes, I do.

16 Q. Can you tell us what that is?

17 A. He will require further treatment in the future.

18 Q. What does that require?

19 A. In the meantime, conservative-type treatment and  
20 physical therapy to keep muscles relaxed, medications as needed,  
21 as well as above and below the fusion start to wear out. Within  
22 a reasonable degree of medical certainty, which means more  
23 probably than not, he will require another fusion at those  
24 levels or artificial disk replacement.

25 Q. Doctor, can you tell us the approximate cost of a disk

1 replacement or fusion?

2 A. With hospital anesthesia cost, it's in the range of  
3 \$100,000.

4 Q. I believe you said Mr. Sehgal should do physical  
5 therapy?

6 A. Yes.

7 Q. Do you have an opinion as to how long or how often he  
8 should do it?

9 A. He should do it at least once or twice a week, pretty  
10 much ongoing for the rest of his life. This will give him, you  
11 know, more freedom, range of motion, diminish some of the muscle  
12 spasms he has, to endure things of that nature.

13 Q. Can you tell us what the approximate cost of a session  
14 would be?

15 A. Anywhere from 50 to 100 bucks.

16 Q. You mentioned medications. What types of medications?

17 A. Anti-inflammatory medications like Motrin, Advil,  
18 Tylenol. If it gets real bad maybe some mild pain medication,  
19 you know. Acupuncture. Things of that nature. Yoga. Physical  
20 therapy. All of these things to keep him mobile in dealing with  
21 his symptoms.

22 MR. MURPHY: No further questions at this time.

23 Thank you, doctor.

24 THE WITNESS: Thank you.

25 THE COURT: Mr. Sobel.

1 MR. SOBEL: Your Honor, may we approach?

2 (Whereupon, an off-the-record conference was held  
3 between all counsel and the Court at the sidebar, out of the  
4 hearing of the jury.)

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

7 THE COURT: We'll take a 10-minute break.

8 COURT OFFICER: Ten minutes?

9 THE COURT: Yes. I'm sorry.

10 COURT OFFICER: Jury follow me, please.

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 (Whereupon, the witness resumed the stand.)

17 COURT OFFICER: Jury entering.

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

20 THE CLERK: Please be seated.

21 THE COURT: You may inquire, Mr. Sobel.

22 MR. SOBEL: Thank you, Judge.

23 CROSS-EXAMINATION

24 BY MR. SOBEL:

25 Q. Good afternoon, doctor.

1 A. How are you, sir?

2 Q. Okay.

3 Doctor, you have your chart in front of you and one of  
4 the first things you told us today was that the plaintiff,  
5 Mr. Sehgal, told you how the accident happened. Can you show us  
6 in your chart where you made note of that?

7 A. No.

8 Q. You told us before that you were aware of -- of the  
9 accident; is that correct?

10 A. Yes, sir.

11 Q. Okay. And you have an independent recollection of the  
12 first meeting with Mr. Sehgal with respect to how this accident  
13 occurred?

14 A. No.

15 Q. In -- the first time you met with Mr. Sehgal was about  
16 two months, two and a half months post accident; is that fair?

17 A. Yes, sir.

18 Q. And -- so that's in 2010 and we're in 2013 and you  
19 recall at this point as you sit here today how this accident  
20 occurred?

21 A. You just asked me that, sir, and I said I don't have an  
22 independent recollection.

23 Q. Okay. How did you learn how the accident occurred?

24 A. I have discussed it with counsel. They have shown me  
25 pictures and I know that the cars were totaled.

1 Q. So depending on what counsel told you is what your  
2 knowledge and understanding is of this accident; is that right?

3 A. As of today, yes.

4 Q. Okay. What else did counsel tell you about today?

5 MR. MURPHY: Objection.

6 MR. SOBEL: It's not attorney/client.

7 THE COURT: Sustained.

8 MR. SOBEL: Note my exception.

9 Q. Your practice is 100 percent dedicated to the spine?

10 A. Yes, sir.

11 Q. And you read X-rays and MRIs?

12 A. Yes. I own my own MRI.

13 Q. Okay. And are you aware of any X-rays being performed  
14 prior to your first visit with Mr. Sehgal?

15 A. Not that I recall.

16 Q. Okay. Doctor, with respect to the EMG you mentioned to  
17 us earlier before, the nerve test where you told us about the  
18 needles?

19 A. Yes, sir.

20 Q. Did you perform that test?

21 A. No, sir.

22 Q. Who performed that test?

23 A. I have to check the chart. Usually a neurologist does  
24 it.

25 Q. Okay. Feel free.

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

2 A. The EMG test was performed by Dr. Joseph Gregorace.

3 Q. Have you talked -- worked with Dr. Gregorace before?

4 A. I -- I don't work with him, no. I know of him but I  
5 don't work with him.

6 Q. Do you have any knowledge of the circumstances under  
7 which the EMG were performed; in other words, the room  
8 temperature, the machine, the calibration?

9 A. No. No.

10 Q. So you don't know, as you sit here today, whether the  
11 EMG was properly performed; is that fair?

12 A. Well, I have no reason not to believe why it would not  
13 be performed correctly.

14 Q. But on the other, you don't know if it was performed  
15 properly because you didn't perform it, you weren't there?

16 MR. MURPHY: Objection.

17 A. I have a medical report.

18 THE COURT: Overruled.

19 A. From a colleague that states an EMG was performed.

20 Q. Okay. And part of what you told us this afternoon was  
21 that the last thing you wanted to do was surgery. You were  
22 trying conservative modalities beforehand; is that fair?

23 A. Yes. I tell all of my patients what I stated prior,  
24 until they tell me they can't live with what they are dealing  
25 with.

1 Q. I would like to talk to you about the first visit. It  
2 was October 11th. Were there any neurological symptoms on that  
3 occasion when you examined Mr. Sehgal?

4 A. No. His main complaint as stated was severe neck pain.

5 Q. So there was none of the numbness and tingling you told  
6 us about when you made the 6 with your fingers?

7 A. Yes. Yes.

8 Q. Okay. There was no radiation down the arms?

9 A. That's correct.

10 Q. There was no radiation of pain into his lower  
11 extremities either, was there?

12 A. Well, the neck doesn't -- the neck has nothing to do  
13 with the lower back and legs.

14 Q. Is that correct? Well, he made complaints of lumbar  
15 pain to you sir; is that correct?

16 A. Yes.

17 Q. And, again, he didn't make any complaints of a  
18 radiating pain down his lower extremities?

19 A. Yes.

20 Q. Is that fair?

21 A. Yes.

22 Q. And he didn't complain about tingling or numbness into  
23 his lower extremities; is that correct?

24 A. That's correct.

25 Q. The rest of the neurological exam was normal; in other

1 words, the motor, the sensation and the deep tendon reflexes  
2 were all normal on that first visit on October 20 -- I'm  
3 sorry -- October 11th, 2010; is that correct, doctor?

4 A. Absolutely.

5 Q. There was no abnormal spinal cord findings during that  
6 visit either, was there?

7 A. I just stated what you asked me.

8 Q. Well, I'm reading from your neurological examination,  
9 doctor. You tell me if I misread it.

10 A. As I stated, counsel, they were normal. Main chief  
11 complaint was severe neck pain.

12 Q. And your recommendations as to procedures were  
13 cervical, epidural, steroid injection?

14 A. Yes, sir.

15 Q. And at this very first visit, the very first time you  
16 saw him, recommendation as to surgery, spine surgery, is a  
17 potential future option or cervical deep compression fusion. So  
18 after the very first time you saw him you already had it in your  
19 mind this might be a candidate for surgery; is that fair?

20 A. Exactly. That's why patients come to me, for surgical  
21 consultation.

22 Q. Now, in terms of any X-rays did you review any X-rays  
23 regarding Mr. Sehgal?

24 A. I don't recall.

25 Q. Well, doctor, I would like you to assume that X-rays

1 were performed two days after the accident at All County Open  
2 MRI and I would like you to further assume that the lumbar spine  
3 showed minimal degenerative changes. Is that a significant  
4 finding?

5 A. Lumbar spine you said?

6 Q. Yes, degenerative changes in the lumbar spine.

7 A. No.

8 Q. And how about degenerative changes most remarkable at  
9 C-5, 6 and C-6, 7; is that a significant finding?

10 A. Not on a person that's 60 years of age, no.

11 Q. Because those types of findings, degenerative findings,  
12 those are things that happen over the course of time; is that  
13 correct?

14 A. Exactly.

15 Q. Doesn't happen within a matter of days?

16 A. No.

17 Q. How long does it take for -- based on your medical  
18 understanding, how long does it take for degenerative findings  
19 to show up?

20 A. Months to years.

21 Q. And these findings existed, as I said to you, two days  
22 after this accident. In terms of MRIs, what MRIs, if any, did  
23 you review personally?

24 A. The MRI that the patient brought.

25 Q. What MRI was that?

1 A. I think you just stated that, right? It was All  
2 County, counsel? Can you just state where it was done?

3 Q. No. The MRIs were done at Hempstead Open MRI, a  
4 different facility.

5 A. Okay. So I have reports here from Hempstead Open MRI  
6 on September 2nd, 2010, and they were performed on the neck and  
7 back.

8 Q. Okay. And the MRI as to the neck, cervical spine has  
9 findings loss of lordosis; is that correct?

10 A. If that's what the report says, I guess that's what the  
11 radiologist interpreted, yes.

12 Q. Did you personally review those films, doctor?

13 A. Yes.

14 Q. And did your review of those films concur with or  
15 differ from the radiologist from Hempstead Open MRI?

16 A. As a matter of fact, counsel, my personal reading of  
17 them the films coincided exactly with what the radiologist read.  
18 For example, the radiologist reads there is a posterior to left  
19 posterior disk herniation with posterior to left posterior  
20 lateral disk herniation with an associated bony ridging at the  
21 C5, C6 level.

22 Q. And when you reviewed those films, your findings  
23 concurred with that, correct?

24 A. Yes, sir.

25 Q. Okay. And the bony ridging, is that a traumatically

1 induced finding?

2 A. No. We already stated that. We said they were  
3 degenerative changes which had to -- if the X-ray was done two  
4 days after the accident and you see some degeneration there, the  
5 patient had some pre-existing arthritis which is normal for a 60  
6 year old.

7 Q. So he had pre-existing arthritic changes in his  
8 cervical spine in the C-3, 4 level C-4, 5 level as well as the  
9 C-5, 6 level; is that correct?

10 A. That's correct.

11 Q. It was also in the C-6, 7 level; is that correct?

12 A. Yes.

13 Q. So throughout Mr. Sehgal's cervical spine in his neck,  
14 he had all these bony ridges?

15 A. Yes.

16 Q. Can you tell the jury a little bit about bony ridges?

17 A. What would you like to know, counsel?

18 Q. I want you to tell them about it. I'm not a doctor. I  
19 would like you to tell the jurors.

20 A. I don't understand the question. What specifically?  
21 How they are formed?

22 Q. What causes it?

23 THE COURT: Would you hold it. Let me set some  
24 ground rules. You have to ask a question and wait for that  
25 question and you answer it. You can't both talk at the same

1 time.

2 Ask the question, counselor.

3 Q. Doctor, can you tell what the cause of the bony ridges  
4 are in Mr. Sehgal's neck as they appeared in the MRI that was  
5 performed on August 30th, 2010 as reflected in the reports  
6 September 2nd, 2010?

7 A. Bony ridges can occur at any joint surface in your body  
8 after a certain period of time.

9 Q. And those bony ridges, they form as a result of uneven  
10 wear and tear on different joints of the body; is that fair?

11 A. As a result of degeneration of a joint, bony spurs can  
12 form.

13 Q. And the bone is formed because of the uneven wear and  
14 tear on the joint?

15 A. I wouldn't say uneven. I would say because of wear and  
16 tear on the joint.

17 Q. Earlier you told us that the diskectomy you performed  
18 was done between the 5 and 6 level; is that correct?

19 A. Yes, sir.

20 Q. Okay. And that was because there was an impairment on  
21 the 6th nerve root or something else?

22 A. No, I never said that.

23 Q. What was the reason for the surgery at that level?

24 A. Because as per my interpretation in reading the MRI  
25 that's where the patient had the disk herniation which I felt

1 needed to be operated on. And, number 2, he also had nerve  
2 conduction studies which showed slowing conductions of the 6th  
3 nerve root and the 6th nerve root exits between the 5th and 6th  
4 level.

5 Q. And earlier when you were talking about the nerve  
6 conduction studies and the 6th nerve level, I believe you stood  
7 in front of the jury and made a number 6 talking about how it's  
8 reflected with numbness and tingling?

9 A. It can be, yes.

10 Q. But it wasn't in this case, was it?

11 A. No. No.

12 Q. And then ultimately another MRI of the cervical spine  
13 was performed at your place, New York Spine Institute, in  
14 January of 2011, doctor, correct?

15 A. I don't recall, but I will take your word for it.

16 Q. Okay. Well, do you have a copy of that report?

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

18 A. Yes. I have one from January 18th.

19 Q. Okay. Did you review those films, doctor?

20 A. I don't recall, sir. I would think so.

21 Q. And those were taken at your facility and they were  
22 interpreted by a fellow doctor there, Dr. Ortiz?

23 A. Yes.

24 Q. And, doctor, the impression that Dr. Ortiz has is  
25 degenerative disk in uncovertebral joint diseases 4-5, 5-6, and

1 C-6, 7 as described with no associated disk herniation?

2 A. Yes.

3 Q. Do you agree with your colleagues interpretation of  
4 that film?

5 A. No.

6 Q. Can you tell us what the -- I can't even say it. Can  
7 you pronounce that?

8 A. Uncovertebral.

9 Q. Can you explain to us what that means?

10 A. That's a joint in the spine between the two vertebrae.

11 Q. And what's hypertrophy mean?

12 A. Bigger. They get bigger.

13 Q. So is the joint essentially overgrown in that area?

14 A. Yes.

15 Q. And that's not a traumatically induced symptom or  
16 condition, is it?

17 A. No.

18 Q. It's something that happens over time?

19 A. Correct. Exactly.

20 Q. And Mr. Sehgal had that in the right exit foramen at  
21 C-4, 5, 6 -- C-5, 6 and C-6, 7; is that correct?

22 A. Yes.

23 Q. So that's an enlargement that happens over time of a  
24 joint area in the cervical spine?

25 A. Yes.

1 Q. And that's the condition that existed in January about  
2 a month and a half before you performed surgery?

3 A. Yes.

4 Q. Doctor, you still work with Dr. Ortiz?

5 A. Yes.

6 Q. You rely on him to properly and accurately review  
7 radiological studies?

8 A. I don't rely on anybody. The buck stops with me when I  
9 make a cervical decision. That's why I read all of my films  
10 before I do a surgery.

11 Q. The bucks stops with you because you are the surgeon?

12 A. Yeah. It's my patient. I have a rapport. I can talk  
13 to the patient. I know what they are feeling. A radiologist is  
14 looking at a screen, looking at the film. He doesn't have the  
15 benefit of having any interaction with the patient there in  
16 front of you which I do.

17 Q. Well, doctor, didn't you tell us earlier that the MRI  
18 gives a clear picture of what's inside the human body?

19 A. Yes.

20 Q. And you are saying in this case though the MRI at your  
21 facility did not do that?

22 A. No, on the contrary. You are saying that I'm saying  
23 what I just told you, counsel, was I didn't agree with  
24 Dr. Ortiz's interpretation based on clinical correlation, which  
25 was a term we brought up right when we started this entire jury

1 trial. So based on the fact that the patient had severe neck  
2 pain, had a nerve conduction study, which is completely  
3 independent, showing the nerves between the 5th and 6th left are  
4 irritated, based on my readings I saw of the disk herniation on  
5 the MRI and also based on the fact I actually saw that piece of  
6 disk protruding, the fibers, under microscopic examination  
7 during the operation. So put all of that together shows you  
8 where my aspect of this case comes from.

9 Q. The second time you saw Mr. Sehgal was about two months  
10 later in December 2010?

11 A. Yes, sir.

12 Q. And then you saw him again in January, was it?

13 A. I believe so.

14 Q. Then you operated in early March -- March 4th?

15 A. Yes, sir.

16 Q. The first time you saw Mr. Sehgal postoperatively after  
17 the operation was ten days later on March 14; is that fair?

18 A. I believe so.

19 Q. Okay. And at that point in time his present cervical  
20 symptoms were benign and not of concern to the patient?

21 A. Yes, sir.

22 Q. What does "benign" mean?

23 A. That his symptoms improved. Benign means not bad.

24 Q. You saw him approximately a month later again in April  
25 and again he told you that the cervical symptoms were once again

1 benign and not of concern to Mr. Sehgal?

2 A. Yes. Don't forget he is taking pain pills, too.

3 Q. Do you know if he was on pain kills the day you saw  
4 him?

5 A. Well, he was prescribed pain pills so I would assume he  
6 was still taking them.

7 Q. But you don't know?

8 A. I don't recall.

9 THE COURT: Counsel, can you approach please, both  
10 of you.

11 (Whereupon, an off-the-record conference was held  
12 between all counsel and the Court at the sidebar, out of the  
13 hearing of the jury.)

14 (Whereupon, the following took place in open  
15 court:)

16 Q. You then saw Mr. Sehgal in May of 2011 and once again  
17 he told you that his cervical symptoms were benign and not of  
18 concern?

19 A. Yes. Yes.

20 Q. And he also said there was no upper extremity complaint  
21 of pain relative to the spine?

22 A. Yes.

23 Q. Is that correct?

24 A. Correct.

25 Q. Doctor, was the bony ridging that you saw when you were

1 in operating on the cervical spine significant or not?

2 A. I don't recall, sir, but I wasn't operating on the  
3 patient for bony ridging. I was operating on the patient for a  
4 disk herniation. The bony ridging, as we know, was there before  
5 the accident.

6 Q. But while you were in there you removed the posterior  
7 osteophyte; is that correct?

8 A. I usually burr them down, yes.

9 Q. You went so far as to perform complete removal of all  
10 the posterior osteophyte as you were operating that day in March  
11 of 2011; is that correct?

12 A. If that's what my op report says, yes.

13 Q. And that would mean that it would be significant, bony  
14 ridging, for you to do something like that?

15 A. It's not that it's significant. I just do it. I mean,  
16 that's part of the operation. You are in there, you want to  
17 clean the thing out, clean the disk space out, make a nice  
18 preparation for your graft, want a nice fusion to take place,  
19 make sure nothing is left over to pinch the spine. So, yes, if  
20 my op report says I took care of it then I took care of it.

21 Q. And you did an -- aside from the disectomy you also  
22 did is a partial corpectomy at C6 and C5, correct?

23 A. Correct.

24 Q. Can you tell the jury what a corpectomy is?

25 A. We have vertebral bodies. Each one of those cubes is a  
cbb

1 body. Corp is a Latin term for body. So, as I told you, when  
2 I'm preparing the fusion, I take off part of the body above and  
3 below where the disk space is to freshen up that area so it  
4 takes the little bone graft I put in there. So I call that a  
5 posterior corpectomy.

6 Q. And corpectomy is done because the spinal stannosis  
7 caused by bone spurs, correct, doctor?

8 A. No.

9 Q. At any time during the course of time that you have  
10 treated Mr. Sehgal, have you examined his right shoulder?

11 A. Not that I recall, no.

12 Q. Doctor, earlier you said that when you do a fusion  
13 typically there is a problem down the road with the patient's  
14 upper or level above and below that level; is that correct?

15 A. I said more probably than not, yes.

16 Q. So it could happen or it could not happen?

17 A. Exactly.

18 Q. It's speculative on your part?

19 A. Yes.

20 MR. MURPHY: Objection. Argumentative.

21 THE COURT: Sustained.

22 Q. Do you know that, a reasonable degree of medical  
23 certainty, whether Mr. Sehgal is going to require fusion at the  
24 level above the fusion that you performed?

25 A. I stated that prior and I said more probably than not

1 he will require future surgery. Yes, more probably than not.

2 Q. And the same would go for, of course, the level below  
3 where you operated?

4 A. Yes.

5 Q. And that's a result of the way his spine moves now?

6 A. Yes.

7 Q. It has nothing to do with the pre-existing arthritic  
8 condition he had in his neck?

9 A. No. That adds to it.

10 Q. That adds to it?

11 A. Sure.

12 Q. And is the bony ridging the arthritic condition or is  
13 that something else aside from the arthritic condition?

14 A. Repeat the question.

15 Q. Sure. Can you repeat the question.

16 (Whereupon, the requested portion of the record  
17 was read back.)

18 A. The question doesn't make sense.

19 THE COURT: Rephrase your question.

20 Q. We've been talking about bony ridging. Is that the  
21 arthritic condition you referred to earlier?

22 A. Yes.

23 Q. It wasn't something separate, that was my question.

24 A. Yeah. That was there before the accident. We know  
25 that.

1 Q. Okay. Since you last saw Mr. Sehgal in July of 2012,  
2 do you know if he has gone for any physical therapy?

3 A. Um, I don't know, sir.

4 Q. Do you know when it was, the last time Mr. Sehgal had  
5 physical therapy?

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

7 A. I don't think the physical therapy records are part of  
8 this chart. This is my chart. Physical therapy is a separate  
9 department in my center so...

10 Q. Doctor, do you know if Mr. Sehgal did physical therapy  
11 after the surgery in March of 2011?

12 A. Do I know if I underwent physical therapy?

13 Q. Yes, sir.

14 A. Yes. I have seen him there many times after surgery.

15 Q. When was the physical therapy performed that you saw?

16 A. At our facility.

17 Q. And that -- those records are not part of the chart  
18 that you brought today?

19 A. That's correct.

20 MR. SOBEL: No further questions. Thank you.

21 THE COURT: Any redirect?

22 MR. MURPHY: Just briefly, Judge.

23 THE COURT: Briefly.

24 MR. MURPHY: A couple of questions. I promise.

25 Understood.

1 REDIRECT EXAMINATION

2 BY MR. MURPHY:

3 Q. Doctor, we talked a little bit -- a lot about bony  
4 ridging. Was it -- when you actually visualized the spine, what  
5 was the most significant finding?

6 A. The disk herniation.

7 Q. Was it the bony ridging or the disk herniation that  
8 required Mr. Sehgal to undergo the surgery?

9 A. The disk herniation.

10 Q. Did -- was it the bony ridging or disk herniation that  
11 caused Mr. Sehgal's pain after this accident?

12 A. I believe it was the disk herniation.

13 Q. The bony ridging or the disk herniation that will  
14 require Mr. Sehgal to undergo the further treatment we discussed  
15 earlier?

16 A. We know there was bony ridging there before the  
17 surgery. You had -- he had no pain before the surgery -- I  
18 mean, before the accident. So it's not the bony ridging that  
19 caused the problems before. He didn't have problems before.  
20 Once he damaged the disks and the jelly protruded out, the disk  
21 that caused him to have to ultimately undergo surgery and  
22 because he had surgery most probably than not the levels above  
23 and below will degenerate further in the future requiring more  
24 surgery.

25 MR. MURPHY: No further questions. Thank you.

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MR. SOBEL: Nothing further, Judge.

THE COURT: Thank you. You may step down.

THE WITNESS: Thank you, your Honor.

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

THE COURT: We have about ten minutes? No.

MR. MURPHY: I don't think so, Judge. May we --

THE COURT: Yeah. Come up.

(Whereupon, an off-the-record conference was held between all counsel and the Court at the sidebar, out of the hearing of the jury.)

THE COURT: Because of the budget cuts we try to squeeze everything in but sometimes we decide not to. All right. We wanted to know what time we'll start tomorrow I have other matters. Well, another matter first in the morning. So you don't sit around waiting, I'm going to ask you to come in -- be here no later than 10:30, right? Is that okay? And then we'll go on from there.

Remember, don't talk about this case -- first of all, let me apologize for my eyes. I have an issue with one eye and the light bothers me so I do apologize, okay. Secondly, don't talk to anyone else, even amongst yourselves about what you've heard so far. You still have several witnesses to listen to. You haven't gotten the whole picture so don't talk about it. Go home. Enjoy your

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evening. I will see you tomorrow 10:30 sharp, all right.  
Have a wonderful evening.

THE CLERK: Will the last juror please close the door behind you. Thank you.

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

THE COURT: Anything else for today counsel?

MR. MURPHY: No.

MR. SOBEL: Nothing.

THE COURT: You are okay. All right, put your exhibits wherever they are, out of the way. Have a wonderful evening. 10:30.

MR. MURPHY: Yes.

MR. SOBEL: Yes, Judge.

THE COURT: Okay.

(Whereupon, the matter was adjourned to June 19, 2013.)

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THE COURT: You may.

DIRECT EXAMINATION

BY MR. MURPHY:

Q. Good morning, Dr. DeMoura.

A. Good morning.

Q. You were here two weeks ago. You were Mr. Sehgal's spine surgeon; is that correct?

A. Yes, sir.

Q. Yesterday Dr. Gregory Montalbano, an orthopedic surgeon for the defendant, testified here. I have his transcript here of his testimony and I'm going to ask you some questions, okay?

A. Yes, sir.

Q. Okay. Now I want you to assume the following, that these were the questions and answers of Dr. Montalbano yesterday and I will ask you questions. Page 29 of the transcript, line 19?

"QUESTION: Doctor, in terms of the cervical spine, you had an opportunity to review the operative report by Dr. DeMoura regarding his surgery, correct?

"ANSWER: I did.

"QUESTION: Okay. And he does a discectomy and fusion at that area, doctor, you know, with respect to the operative report, does it or does it not indicate herniated disk at C-5, 6 level?

"ANSWER: Um, well, it's mixed.

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"QUESTION: How is that?

"ANSWER: The -- in the operative report there is one sentence that reports findings and in that sentence which is the beginning of the report before he describes the surgery he says that he saw the disk herniation and he saw the disk herniating posterior to the posterior longitudinal ligament. In other words, into the spinal canal. So says I saw is the disk herniation and saw it from the spinal canal the disk herniating in, okay. That's what he describes. One sentence.

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

The surgery he does is not surgery from the back of the neck. He does it from the front of the neck, okay. So to do it from the front of the neck you are going into the front of the spine. You are looking at the front of the disk on your initial exposure. There is no way when you are looking in that hole you are looking at the front of the disk. There is no way to see from the other side, you know what I mean? The whole body is around it so you are looking through a small window so there will be no way for him from that exposure to actually see from the spinal canal, which is 180 degrees polar opposite, to see it was herniating into that spinal canal.

1           He describes opening up the disk space, tearing  
2 out the disk, removing it with his" -- and this is  
3 phonetic -- "putary grandure (phonetic) which is typical,  
4 standard protocol for taking out the disk. After the disk  
5 is removed he says the longitudinal ligament is intact.  
6 Described it as being intact. And describes himself  
7 removing the poor longitudinal ligament.

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

15           He does describe taking out part the vertebrae  
16 above and below. He describes opening up the foremen of the  
17 vertebrae where the nerves exit. And, again, that's  
18 consistent with what we see in the MRI's record by the  
19 radiologist that the right, there is bony hypertrophy, bony  
20 ridging. And, again, that's degenerative, not caused by the  
21 accident. And, in fact, that's in the report. He does  
22 address that in the surgery. So -- also, it's on the EMG.  
23 The EMG describes nerve compression of C6 bilateral, not on  
24 one side, bilaterally.

25           I think that's also significant because when you

1 herniate" --

2 MR. SOBEL: Judge, he is going on and on.

3 MR. MURPHY: It's one answer.

4 MR. SOBEL: Dr. Montalbano testimony now.

5 MR. MURPHY: I have to complete the answer, Judge.  
6 I'm assuming. I'm almost finished.

7 THE COURT: Overruled.

8 Q. "Typically the disk herniates to a path of  
9 least resistance which is one side the other. To go  
10 directly out the back you have to go through the ligament.  
11 And the ligament, as he describes, is intact. He has to  
12 take it out so the disk would have to go to one side or the  
13 other side and that causes a radiculopathy on either the  
14 right or left side, not both sides. But we know it's on  
15 both sides from the EMG and that is consistent with a  
16 diagnosis of arthritis. Stannosis at that level which is  
17 circumferential causing nerve compression on both sides.

18 So when I look at the documents and look at the tests  
19 that are done, it all is very consistent with a theory that  
20 does not support a causally related injury from the  
21 accident."

22 Now, doctor, two questions for you. First question,  
23 Dr. Montalbano in his testimony that I just read states  
24 impossible to see a posterior herniated disk from an anterior  
25 approach, as you did in Mr. Sehgal's surgery. Is that a correct

1 statement?

2 A. No, it's not.

3 Q. Okay. Do you agree with the accuracy of that  
4 statement?

5 A. Absolutely not.

6 Q. Okay. And I have one more question and I want you to  
7 explain to the jury. The other part of it, Dr. Montalbano  
8 states that you describe the PLL the posterior longitudinal  
9 ligament as intact; is that correct?

10 A. No.

11 Q. Okay. And he further states or he testified later on  
12 cross-examination that you describe it as being breached and  
13 then you describe it as intact and it would be impossible to  
14 remove a breached PLL; is that correct?

15 A. No.

16 Q. Okay. Is that accurate?

17 A. No, none of that is accurate.

18 Q. Okay. I would like you to explain your answers to the  
19 jury, okay?

20 A. Okay.

21 Q. Would it be helpful to step down from the stand?

22 A. Yes.

23 MR. MURPHY: Okay, your Honor, may he step down?

24 THE COURT: Yes. Step down.

25 MR. SOBEL: Judge, I object. He already answered

1 the questions.

2 MR. MURPHY: He is explaining his answers, Judge.

3 MR. SOBEL: He answered the questions, that we  
4 agreed to.

5 THE COURT: All right. Sustained.

6 MR. MURPHY: Judge, how -- he has to explain his  
7 answers to the jury. How, if it's yes or no, he has to  
8 explain it.

9 THE COURT: He can explain it.

10 MR. SOBEL: Judge, he answered the questions that  
11 we agreed to.

12 MR. MURPHY: That's --

13 MR. SOBEL: That's it. That's what we agreed to.

14 MR. MURPHY: It's not --

15 MR. SOBEL: We open up the door.

16 THE COURT: Stop.

17 MR. MURPHY: It's not what we agreed to.

18 THE COURT: All right. Sit down, please.

19 (Whereupon, the witness resumed the stand.)

20 MR. MURPHY: Can I ask him why?

21 THE COURT: Any other questions?

22 MR. MURPHY: Just ask him to explain his answer.

23 MR. SOBEL: Objection. He answered the question.

24 MR. MURPHY: Doesn't want the doctor to explain

25 why.

Dr. DeMoura - Plaintiff - Direct (Rebuttal) 712

1 MR. SOBEL: Objection. Now we are grandstanding.

2 THE COURT: Okay. I'm going to allow it, very  
3 briefly.

4 MR. MURPHY: Sure.

5 Q. I will combine the two into one question. Can you --

6 MR. SOBEL: Objection.

7 Q. Can you explain why those statements regarding the  
8 herniated disk and PLL are incorrect?

9 MR. SOBEL: Objection. Asked and answered.

10 MR. MURPHY: Explain why?

11 MR. SOBEL: Judge, the questions were agreed to.  
12 He is going beyond that. I knew this was going to happen.

13 THE COURT: Counsel, come up for a second.

14 (Whereupon, an off-the-record conference was held  
15 between all counsel and the Court at the sidebar, out of the  
16 hearing of the jury.)

17 (Whereupon, the following took place in open  
18 court:)

19 Q. Doctor, can you explain your answers, please?

20 A. Yes, sir. First of all -- so first of all --

21 Q. As brief as you can.

22 A. So, ladies and gentlemen of the jury, first of all, one  
23 of the major points of this whole testimony of the prior surgeon  
24 yesterday was that I could see not see what I was doing through  
25 a small, hole. I do this with a microscope which greatly

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1 magnifies everything I do.

2 He also said you cannot see a posterior disk herniation  
3 from an anterior approach which means if I go through the front  
4 he is saying I can't see what I saw because the disk is in the  
5 back of the spine. That's completely false.

6 As I told you before, there is nothing complicated  
7 here. If you think of the jelly donut scenario, if you have the  
8 front part of the donut and the back part of the donut is the  
9 little hole where they inject the jelly, if you squash that  
10 jelly donut the jelly is it going to squirt out the back. If  
11 you bite off the front of the donut, keep chewing and eating it,  
12 you are eventually going to see where the jelly you ate squished  
13 out the back.

14 That's what I saw. That's what I stand by. And that's  
15 what happened during the surgery. And you really need to be a  
16 spine surgeon to know what takes place in the surgeries, which  
17 the doctor who testified yesterday is not a spine surgeon.

18 Q. And the PLL?

19 A. Regarding the PLL, the PLL is the ligament which  
20 attaches the two bones together. I'm sure you have been to car  
21 washes. In the wintertime they have those curtains that allow  
22 the people in the car wash to stay warm. Well, image that  
23 curtain being the ligament and the ligament is made up of fibers  
24 as such if you poke your head through that curtain you can see  
25 the outside of the car wash. Same thing with the jelly. When

1 the jelly protrudes through that ligament, it rips part of that  
2 ligament and squirts through.

3 So I, as the surgeon, when I'm going in, I see where  
4 the jelly donut has squished through that ligament and gone out.  
5 So, if this is the fibers, the jelly has gone through I go in  
6 microscopically and I see where the jelly had squirted through,  
7 with microscopic instruments grab that piece of disk material  
8 and pull it out.

9 After I take the disk out which was causing all the  
10 pain, I then go in further and take more of the ligament out.  
11 So, this whole testimony about ligament and what I can and can't  
12 see, I know what I saw. I do it as a daily living and I stand  
13 by what I saw.

14 MR. MURPHY: I have no further questions. Thank  
15 you.

16 THE WITNESS: Thank you.

17 CROSS-EXAMINATION

18 BY MR. SOBEL:

19 Q. So, doctor, you come here after getting a call from  
20 Mr. Murphy regarding Dr. Montalbano's testimony, correct?

21 MR. MURPHY: Objection.

22 A. Yes, sir.

23 Q. He discussed what Dr. Montalbano testified to, came  
24 back on behalf of Mr. Murphy's client today to support  
25 Mr. Murphy's client, correct?

1           A.    I came back to sport my patient and to state the record  
2 correctly.

3           Q.    Same person; your patient, his client, correct?

4           A.    Exactly.

5           Q.    And nowhere in your report, other than in your findings  
6 do you mention the disk herniation, you went in through the  
7 front and you chewed it away, okay, and then when you got to the  
8 back then you say you saw the gel but it's not indicated  
9 anywhere in your report, is it?

10          A.    On the contrary, if you read the report it's the first  
11 line in my report.

12          Q.    Right, findings?

13          A.    Yes, findings.

14          Q.    But nowhere else during the course of the procedure as  
15 you describe your procedure do you mention that?

16          A.    I described it in the findings.

17          Q.    Yes, sir.

18                   MR. SOBEL: Thank you. No further questions.

19                   THE COURT: Thank you, doctor.

20                   THE WITNESS: Thank you, your Honor.

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

23                   THE COURT: Okay. No more rebuttal, witnesses,  
24 correct?

25                   MR. MURPHY: That's all.