Sehgal versus www.nyairports.com continued. You may be seated. Come to order.

COURT OFFICER: Jury entering.

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

THE CLERK: Please be seated. Let the record reflect six jurors and one alternate are seated in the jury box.

THE COURT: Welcome back. Call your next witness.

MR. MURPHY: Yes, your Honor. Thank you.

Plaintiff calls Dr. Ali Guy.

A L I G U Y, M.D., called as a witness on behalf of the Plaintiff, having been first duly sworn by the Clerk of the Court, was examined and proceeded to testify as follows:

THE CLERK: For the record, say your name and address and spell your name.

THE WITNESS: My name is Dr. Ali Guy. First name A-L-I. Last name is G-U-Y. Office address is 15 Jericho Turnpike, Jericho, New York 11753.

THE CLERK: Thank you.

THE WITNESS: Your welcome.

MR. MURPHY: May I inquire?

DIRECT EXAMINATION

BY MR. MURPHY:

Q. Good afternoon, Dr. Guy.

A. Good afternoon.

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

A. Yes, I am.

Q. When did you become licensed?

A. 1985.

Q. I would like to go over your background and training a bit.

A. Yes, sir.

Q. Start with undergraduate college and go from there.

A. Yes. Undergraduate, Queens College, Flushing, New York. Medical school, I graduated from University of Northeast in Dominican Republic June of 1981.

Thereafter, I did three separate residencies. I did my first residency in the field of internal medicine at Mt. Sinai School of Medicine, Mt. Sinai Medical Center for a period of 18 months, then one year of surgery at Cabrini General, New York City. I then completed a three-year training program in physical medicine and rehabilitation at Mt. Sinai School of Medicine.

I'm board certified in the field of medicine and rehabilitation. I have a subspeciality in pain management.

I was the chief of the department of rehab medicine at Maimonides Medical Center in Brooklyn from 1997 until 2002. That's five years where my duties were to be in charge of all

the inpatient/outpatient rehab services, provide teaching to the house staff, that's the internal medicine residents, general surgical residents or surgical residents, other doctors in my department of speech therapists, the physical therapists and the occupational therapists in my department.

I was in charge of NYU's Hospital For Joint Diseases neuromuscular * equipment clinic from 1990 until December of 2005 -- that's roughly 15 years -- where my duties were to be in charge of the clinic, take care of the patients assigned to the clinic, Visa patients that are born with birth defects, spinal cord injury and all kinds of other deficits and also to teach the residence from NYU.

And from January 1st of 2006 until the present I'm a clinical instructor at NYU School of Medicine NYU Medical Center where my duties are to see patients and to teach the residents, prepare them for the boards, part 1 and part 2.

Q. Doctor, do you have any hospital affiliations currently?

A. NYU.

Q. And you talked -- told us you were board certified. Remind us what that is.

A. Board certification is the highest degree you can obtain in your level of specialty. It's the equivalent of a Ph.D. to a nonmedical person.

In order to be board certified in any specialty, you

have to have training in a field other than physical medicine and rehabilitation, preferably one to two years of internal medicine or one to two years of general surgery. Both was met.

Then you have to take and pass a three-year residency training program, pass the monthly evaluations given by your teachers, pass the annual examinations given by the department.

And once you finish your training, you take and sit for the boards. Part 1, which is an eight- to a nine-hour examination written, covers everything you learned from beginning until the end. You get tested in principles of orthopedic surgery, neurosurgery, muscle nerve physiology, interpretations of X-rays, CAT scans, MRIs, EMGs, disability impairment evaluation, cardiac, pulmonary, rehabilitation, neurology and other principals of physical medicine and rehabilitation.

Once you pass that, you have to be in private practice for at least 18 months, accumulate additional knowledge and experience, be sponsored by two other doctors that are already board certified. You have to be in good medical standing.

You then fly to the Mayo Clinic in Minnesota where all the top doctors that do research and write textbooks test you orally for half a day, again, on same topics; neurology, neurosurgery, orthopedics, muscle nerve physiology, interpretations of X-rays, CAT scans, MRIs, EMGs, disability impairment evaluations and other principles of physical medicine

and rehabilitation. Also pain management.

Once you pass this examination, all of your credentials from college, medical school, residency is sent to the American Board of Physical Medicine and Rehabilitation. They review everything.

If everything is up to par, they give you a title of a diplomate of the American Board of Physical Medicine and Rehabilitation. That was obtained in May of 1989 and it has remained in good standing since then.

Q. Very good. Do you have experience treating patients with traumatic injuries?

A. Extensive. Yes.

Q. How much?

A. Wow. A lot of my patients that come to see me have been injured in some capacity where it's from a sports injury, whether it's from a car accident work related accident or overuse syndromes. I treat many types of patients with traumatic injuries. I've treated tens of thousands of such patients.

Q. Do you have experience treating patients with problems to the spinal column and spinal cord?

A. Yes, I do.

Q. What percentage of your practice deals with patients with those types of injuries?

A. I can't give you an exact number. My practice is very

very mixed. I would say about 30 percent.

Q. Okay. What about injuries to the extremities; shoulders, knees, things of that nature?

A. Again, I can't give you an exact number, but I would say maybe another 15, 20 percent.

Q. Okay. And currently in private practice?

A. Yes, sir.

Q. Where is your practice?

A. I have a practice in Gramercy Park, Manhattan and Long Island, where I saw Mr. Sehgal, and also at NYU Hospital for Joint Diseases. I'm also in charge of the interventional pain management services at Medical Alliance in the Bronx.

Q. The practices you have, they are of physical medicine and rehabilitation practices?

A. Yes, sir.

MR. MURPHY: At this time I would like to offer Dr. Ali Guy an expert in physical medicine and rehabilitation.

MR. SOBEL: No objection.

THE COURT: All right. So moved.

Q. Dr. Guy, before moving forward, are you being paid to be here today?

A. I'm compensated for scheduling no patients for the entire afternoon and evening, yes.

Q. How much are you being paid?

A. 4,000 for half a day.
Q. Doctor, you testified before, correct?
A. I have, yes.
Q. And approximately how many times do you testify a year?
A. On the average, eight to ten times per year. Some years less, some years more, but on the average eight to ten. And that's that constitutes less than one percent of all the patients that I treat.
Q. Did there come a time when you came to see my client, Anil Sehgal?
A. Yes.
Q. And the first time that you saw him, when was that?
A. June 21, 2011.
Q. And for what purpose did you initially see him?
A. For the purposes of a disability impairment and a life care plan.
Q. Can you tell me, tell us, what that is?
A. Yes. A disability impairment life care plan is a special report that's generally, performed, by a physiatrist like myself or vocational rehab expert. You take a history, review all the pertinent medical records and you arrive at a diagnosis, a prognosis, which means you look into the future and evaluate to see if that patient is totally disabled or partially disabled and what the future medical needs and expenses for that patient will be based upon medical indications, not what a

patient does or doesn't do. Simply what is medically indicated for that patient and their expenses, costs.

Q. Do you have experience preparing these types of reports?

A. Yes, sir.

Q. How much experience?

A. Oh, my gosh. Over 20 years.

Q. And do you prepare these reports for patients?

A. For patients, yes.

Q. And do you use them to treat your patients?

A. I do.

MR. MURPHY: I would like to offer Dr. Guy as an expert in life care planning.

MR. SOBEL: No objection.

THE COURT: All right.

Q. Now, you performed this analysis of Mr. Sehgal, correct?

A. Yes, sir.

Q. And in doing so -- let me ask you this, doctor: Later on after performing this analysis, did Mr. Sehgal eventually become a patient of yours?

A. Yes, sir, he did.

Q. He treated with you for a period?

A. Yes. He had many visits, many diagnostic studies and over 40 physical therapy sessions.

Q. Do you have a chart for Mr. Sehgal?
A. Yes, I do.
Q. Was that prepared in the regular course of business?
A. Yes, sir.
Q. Was it prepared by somebody whose job it was?
A. Yes, sir.
Q. Was the contents prepared at or near the time of treatments?
A. Yes.
MR. MURPHY: I would like to submit it into evidence as a business record.
MR. SOBEL: No objection.
THE COURT: So marked.
(Whereupon, the Dr. Guy's chart was marked in evidence as Plaintiff's Exhibit 26 by the Reporter.)
Q. Dr. Guy, we'll get into your treatment in a little bit. I would like to go over the life care plan first, since that's the first time you saw Mr. Sehgal.
A. Okay.
Q. Do you have that life care plan in front of you?
A. I do.
Q. How many pages is the document?
A. One, two, three, four pages.
Q. Okay. Now, you said that you take a history, correct?
A. Yes, sir.

Q. And you also look at medical records?

A. Yes, sir.

Q. And did you do so for this evaluation?

A. Yes, sir, I did.

Q. Can you tell us what you reviewed and what the history you took was?

A. Yes. I reviewed records from orthopedic surgeon Dr. Barry Katzman. I reviewed the operative report of the right shoulder taken on October 20, 2010. Reviewed the surgical records of Dr. Berkowitz's operative report of 3/4/11 from the NYU Hospital for Joint Disease. The cervical surgical procedure performed by Dr. DeMoura. MRI reports of the lumbar spine taken on 8/30/2010. MRI reports of a cervical spine taken on 8/30/2010. MRIs of the right shoulder. Prior EMGs. Records from Dr. Gregorace. Records from Dr. Fyman from Comprehensive Pain Management Services. And I took my own history.

Q. So you took a history, correct?

A. I did.

Q. What was the history at that time?

A. The patient was 59 years of age, right-handed. He was driving his car, became involved in a car accident. He was hit with a severe impact. He was hit from the rear. He sustained injuries to his neck, back, right shoulder. At first he went to Dr. Gregorace. X-rays were taken. Revealed no fractures. He treated with Dr. Gregorace for some time and then Dr. Fyman. He

had epidural injections. He had shoulder surgery, cervical neck surgery. And when he came to see me, he complained of right shoulder pain, neck pain shooting down both arms, lower back pain shooting into the bilateral buttocks areas.

Q. In addition to the history, did you also perform an examination of him?

A. I did.

Q. Can you tell us what the examination was and the results?

A. Yes. The right shoulder was diffusely tender there. Were three well healed surgical scars. A positive Hawkins, positive O'Brien's tests. These two tests are indicative of damage to internal structures of the shoulder. I examined the neck, showed diffuse tenderness, showed moderate spasm, showed multiple trigger points. Lateral flexion bending from side to side was 30 degrees out of 45. Lateral rotation was 60 out of 80. The back shows diffused tenderness. Moderate spasm, multiple trigger points. Backward extension was 15 degrees out of 30. That's about half. Bilateral flexion, lateral rotation was 15 degrees out of 30. That's also half. Straight leg raising was abnormal, 75 degrees out of 90. That's indicative of anything damaging the disks in the lower back or the nerve roots or both. Active range of motion was normal for all four extremities. Muscle testing was normal except for right shoulder, 4 plus over 5. Sensation was diminished to pinprick,

and touch right biceps reflexes were normal. Gait was normal.

Q. Okay. I'm going to ask you to explain what tenderness is and spasm. And we have your report broken up so you can explain it to the jury.

Before we do that, I would like to go over what your diagnosis was and what your recommendations were.

A. Yes. Diagnostic was a C-5/C-6 disk herniation bilateral, C-6 cervical radiculopathy.

Status post anterior C-5/C-6 cervical diskectomy with a C-6 corpectomy, C-5 partial corpectomy, fusion at C-5/C-6 with anterior cervical instrumentation and structural graft L-3 through S-1. Disk bulges L-1/L-2, L-2, 3. Disk herniations C-5 -- sorry. C-2, 3 to C-5 disk bulges with bony ridging. C-5, 6, 7 disk bulge with bony ridging.

Right shoulder, orthopedic surgery with a partial rotator cuff repair, scarring to the right shoulder and anterior cervical spine and traumatic myofacial pain syndrome.

Q. And at that time did you have a plan for the patient and did you come to an opinion as to his condition?

A. Yes. The plan was continued physical therapy and periodic diagnostic studies.

Q. Do you have an opinion as to his condition at the time and as to what he would need for medical treatment in the future?

A. Yes. Based -- after I reviewed all the medical

records, the history I obtained, the physical exam findings, I felt he had a partial, 90 percent partial disability as a result of the accident of August 7 2010. And since these injuries were permanent and progressive, he would need the future medical care and the cost based on medical indications. That means what is medically indicated, not what a patient does or doesn't do. So I felt that at the minimum -- this is a very low conservative number -- he should be seen by a physiatrist, like myself, or doctors, at a minimum five times a year. The cost for each visit is 150 a session. And seen by a spinal surgeon, like Dr. DeMoura, two to three times a year. The cost is $150 per session. He should be seen by an orthopedic surgeon four to six times per year. The cost is $150 per session. He should have, at the least, 50 physical therapy sessions at a year at a cost of 150 a session. That's like once a week. And periodic MRIs of the cervical spine, neck, back, right shoulder every two to three years. And the approximate cost is $2,000 for each study. He should have EMGs of his neck and back every two years. The cost is $2,000 per each study. And with time the back would worsen and he will need surgical intervention. The cost will be anywhere from 35,000 to $55,000, depending on what exactly is done. And then he would need physical therapy after the surgery three times a week for four to six times a month. And also at the level of the neck he would have future surgery because that area will become weekend, pressure on the areas above and below.

Another 50 to 60,000, including expenses. And after physical therapy three times a week four to six months, repeat. Right shoulder, orthopedic surgery another two to three years cost is about 8,000. Afterwards he will need physical therapy four to six months. And he would also need periodic epidural injections to his neck and back at three to four per year to the neck and three to four per year to the lower back. Each epidural is 1,500. If it is done in an outpatient surgical facility, it's extra, $3,000 per each injection.

Q. Okay, doctor. Did you -- did I prepare an enlargement of that plan?

A. Yes, sir.

Q. Is it the same as what you read to us?

A. Essentially the same, yes.

Q. And will it help explain to the jury your findings and what this all means?

A. Yes.

MR. MURPHY: May I set up an easel.

Q. Will it help you to step down?

A. It will help me if I have a few minutes explaining why a shoulder needs surgery and why a disk herniation is permanent and progressive.

Q. Okay. Let's talk about the shoulder first.

MR. SOBEL: Note my objection. They are having a dialogue here, Judge. I didn't hear any question.

THE COURT: Pardon?

MR. SOBEL: I didn't hear any question, just a dialogue of the witness and his counsel without there being any questions.

THE COURT: All right. I didn't hear it. Ask a question.

MR. MURPHY: Sure.

Q. Doctor, we talked about three areas of injury for this particular patient, right; the shoulder, neck and lower back?

A. Yes, sir, that's correct.

Q. I want to talk about the shoulder. You reviewed the medical records pertaining to Mr. Sehgal right shoulder?

A. I did, correct. Yes, sir.

Q. And you read the operative report?

A. Yes, sir.

Q. And you examined Mr. Sehgal's right shoulder?

A. Correct.

Q. Can you tell us a little bit about the condition of his right shoulder and how it factors into your life care plan?

A. Yes. May I step down and use those models?

MR. MURPHY: May he, Judge?

THE COURT: That's fine with me. Yes.

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

A. May I again?

Q. Please.

A. The shoulder is one of the most complicated joints in the body. The reason being is because you have three complex articulations at one joint. You have the head of the humerus gliding with the scapula. That's the shoulder blade. And the clavicle. There is three articulations.

The shoulder has six ranges of motion. We have shoulder flexion extension, external rotation, internal rotation, abduction, conduction. These for a normal person looks very simple and easy.

When a patient has a rotator cuff tear, the muscles that hold the shoulder in place, there are four muscles that holds the shoulder in place; supraspinatus muscle, the infraspinatus muscle, which is down here. We have subscapularis and teres major. These four muscles hold the shoulder in place. So, if you have a tear -- and that's called a rotator cuff.

If you have a tear and a surgeon places a probe inside a sterile joint which has not been opened up and submitted to trauma, you are putting an orthopedist's scope inside with a blade and you start to dig up around the shoulder joint, muscles and bone, you have invaded the normal integrity of this shoulder joint.

So what happens as a result down in the future, many years down the road, you will have scar tissue beginning to form inside here. And that scar tissue forms adhesive capsulitis

which is frozen shoulder.

Now, when you have just a shoulder injury, it's not as bad, but when you have a shoulder injury and mechanic injury, that's very bad, because each one of the -- because of its close proximity of the neck to the shoulder and they both share many similar muscles the shoulder -- I'm sorry. The neck and the shoulder, the shoulder aggravates the neck. We have what's called a vicious cycle of dysfunction. Each one aggravates each other.

So that's why a shoulder injury that requires surgery is going to be permanent and progressive and eventually traumatic arthritis and scar tissue and adhesive capsulitis will form as a future sequela.

Now, may I talk about the disks?

Q. Sure. Well, doctor, let me ask you one questions. You talked about you reviewing medical records and operative report. Based upon your clinical findings and the records, do you have an opinion based on a reasonable degree of medical certainty whether Mr. Sehgal's shoulder injury was related to the collision of August 7, 2009?

A. The answer is yes.

Q. What's the basis of the opinion?

A. Patient had no prior problems whatsoever. So his right shoulder, the MRI showed a rotator cuff tear. It required surgical intervention. Also, he had disk herniations to his

neck which required surgical intervention. They both required surgical intervention.

Nobody has a condition to the neck with a disk herniation and a rotator cuff walking around that's asymptomatic and not know about it. These things typically coming from trauma, major trauma. It can be a mild trauma also but in this case it was a major impact. It was not a light impact. There was a lot of damage to his spine, multiple body areas.

Q. Now, in addition to the right shoulder you talked to us about reviewing medical records of Mr. Sehgal's --

A. Yes.

Q. -- cervical spine. Can you explain to us a little bit about disk herniation and what the symptoms are?

A. Yes. Can I have that chart.

Q. Sure.

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

A. Inside a human spine we have three segments. We have three segments in the spine. The neck, known as the cervical spine, seven vertebrae. The middle back is known as the thoracic spine, and there are 12 vertebrae in your lower back. We have the lumbar spine which has five vertebrae. Each area is labeled according to its anatomic location.

You are going to hear terminology such as C-5, C-6. C means cervical. Five means the 5th vertebra and 6th means the 6th vertebra. We have L-1, the first level vertebra, L-2, L-3,

L-4, L-5, okay. The vertebrae in the low back are larger than the neck, because they have to hold up a lot more weight than the neck.

Then, abnormal conditions to a disk in the mildest form is a bulge, which, in layman's term, means a partial tear of the disk. The severest form, a herniation, which means a complete tear of the disk, the disk material leaks out and passes the disk margin.

I will show you an example of each one. Before I do that, a disk is like a jelly donut. Outside we have 100 rings of a fibrocartilage material called the annulus fibrosis. Inside we have a gelatinous material, analogous to the jelly portion of a jelly donut. This is this gelatinous material that gives us our ability to bend forwards and backwards, bending forwards, backwards, rotating to the sides. When you jump up and down, if we didn't have this disk, bone would hit bone and would break. So it's this disk that serves as a cushion or like a shock absorber.

The problem with the fibrocartilage is once it tears it does not have the ability to repair itself. It's permanent and progressive. Bone -- when bone breaks, all you have to do is put the two pieces together. As long as you unite the two pieces of bone together, they will heal with cement protection known as bone cement or callous formation. And, in fact, that becomes the strongest part of the body. Fibrocartilage does not

have that ability. That's why it's permanent and progressive.

This is a normal disk. It's filled with water. This is a bulge, a partial tear. Normal disk, partial tear or bulge (indicating).

Now, herniation. This is a normal disk. This is a herniation. Disk material passes the disk margin. May or may not hit a nerve, which is behind it (indicating). Normal disk herniation, okay.

Now, what happens at a microscopic level, once a disk -- you can look at a person with a disk herniation, look normal. But when you look inside on an anatomic level, microscopic level, you see a lot of changes going on.

To give you proper orientation, what we are looking at here, that's the disk. This is the spinal process, which is what you touch when you touch the back of your neck or the back of your back. That's the spinal process. This is the transverse process. That's the disk. This is the spinal cord, okay.

So we are looking at this. This is the axle view, and this is the side view like so. So, a disk bulge, layman's term, is a partial tear of the disk. Partial tear of the disk. Herniation is a complete tear.

What happens at a microscopic level, you get a microscopic leak where the tear is. The outer one-third of the fibers have nerve fibers called nociceptors which comes off the

synovial nerve which comes off the actual nerve root.

Once you have this tear, you have a release of over 500 chemicals. These chemicals will constantly irritate the surrounding structures. That's the muscles, tendons, ligaments and the nerve roots. You could have nerve root damage by direct compression of a disk, like here, or you can have damage to a nerve root by this chemical release or you can have damage to a nerve root by bone osteophytes like these or by the rotational forces that work on the spine which causes a forceful pull of the nerve.

Once you have a forceful pull of a nerve, the nerve becomes red and becomes damaged. These are usually permanent. These chemicals are constantly irritating the surrounding structures.

Once a disk herniates, the body try to stabilize the injured area by forming bony spikes called osteophytes. These osteophytes will crowd the joint space, and eventually the disk will be completely worn down like so.

This is an end stage disk where the disk material is completely replaced by bone. And neural foramen, where the nerve roots exits, is almost compressed by bone. That's why the condition is permanent and progressive. This condition has no cure, okay.

There is many conditions in the medical field that have no cure; arthritis, diabetes. Only treatment is physical

therapy, medications, epidurals. Surgery does not profess to cure the problem. All surgery does is remove the part of the disk material that's leaking out, compressing the nerve root. It takes the pressure off, allows the nerve to function better.

And when you do fusion, which this patient had, you automatically lose 20 to 30 percent range of motion. Once you lose range of motion, the neck is always stiff. When the neck becomes always stiff, it doesn't have its normal flexibility.

So the laws of physics, heat expands, cold contracts. In the winter, cold months, the metal makes the muscles contract, become tight. When that happens, the muscle fibers shorten and you lose more range of motion. You get more stiffness. That happens also in rainy weather, snowy weather and humid. When it's very humid, this will worsen over time and this is, again, permanent and progressive. So -- because of these conditions, my life care plan, why he needs continued medical treatment, he needs to be seen on a regular basis to make sure there is no significant change in his condition, to make sure these nerve roots are not being compressed badly because you want to catch it early. So early intervention is the key.

Q. Doctor, I want you to assume that during this trial there has been testimony that X-rays and MRIs of Mr. Sehgal showed some degenerative conditions. Is that unusual?

A. Not at all. To have normal degeneration of a disk is

normal. Natural aging process. Is normal. We all have it in this room. The aging process in females starts between 24 and 28. In a male starts between ages of 38 and 40.

Different hormones protect different sexes from different conditions. Women don't get heart attacks until after menopause. Men as early as 30. Men don't get arthritis as early as woman do. Different hormones protect different sexes from different conditions.

Normal aging process in a male, 38 to 40. So when Mr. Sehgal was around 58, of course, you are going to have some natural degeneration of a disk. It's perfectly normal for that age condition.

Q. Further assume Mr. Sehgal before these collisions he experienced no musculoskeletal pain whatsoever in his neck, lower back and his right shoulder. Is that unusual for somebody with a degenerative condition?

A. No. People have degenerate disk condition or degenerative disk conditions have no pain, no symptoms. Absolutely none. Perfectly normal range of motion. No loss of sensation. No radiculopathy. They have no herniations, et cetera.

Q. And I want you to further assume a while later MRI. There was an interpretation there was no cervical herniations. Dr. DeMoura, who is Mr. Sehgal's spine surgeon, from the Hospital For Joint Diseases testified that upon entering the

spine anteriorly visualized a herniated disk, is that consistent with your clinical analysis of Mr. Sehgal?

A. It is, for a variety of reasons.

Q. Tell us why.

A. Yes. Yes. An MRI, it stands for magnetic resonance imaging. It's only an image of what you are looking at. It's not the whole picture. It's an image. So it is not the most accurate way to diagnose a disk herniation. The best way to diagnose a disk herniation is with your eyes on your direct visualization during surgery. That's the best way. Undisputed in the whole entire medical field. Nobody will dispute this fact. That's the right way to diagnose a full disk herniation.

Many times MRI may show something and intraoperative findings are completely contradictory. What you go by is intraoperative findings, what you find at the time of surgery.

Q. Further assume Dr. DeMoura testified last week that herniated disk he saw in Mr. Sehgal's neck was directly related to the collisions of August 7, 2010 and caused Mr. Sehgal to undergo the cervical fusion, is that consistent with your analysis and findings?

A. Yes. He failed conservative treatments, failed physical therapy, epidural injections. And the pain was intractable. And pain was radiating. Any time you have pain that radiates from the neck to the arms, it means the origin is in the neck usually caused by something compressing on a nerve

root, in this case disk herniation, that had to be surgically corrected.

Q. Doctor, do you have an opinion, based on all of your clinical findings and your review of medical records, whether Mr. Sehgal's treatment to his cervical spine, surgery to cervical spine, whether all of that relates back to the accident of 2010?

A. The answer is yes.

Q. Can you tell us why that is?

A. Yes. He had all of his symptoms beginning after this accident. He had no symptoms before. And the full impact of an injury does not really begin to fully manifest itself until three to four weeks later. In the beginning, normal neurological examination based on Dr. Gregorace's reports and findings. And after several weeks, neurological deficits began to manifest. He had an EMG performed by Dr. Gregorace which showed nerve root damage to C-6. He performed an EMG which confirmed there was damage to the C-5, C-6. When you put all of these small pieces of a crossword puzzle together, you arrive at the full picture.

Q. And that is your opinion with a reasonable degree of medical certainty, correct?

A. Yes, sir.

Q. Doctor, further assume that plaintiff's primary care physician, Dr. Banik, testified here that Mr. Sehgal had no

prior musculoskeletal complaints for years before the accident, is this consist with your analysis and review of the medical records and your conclusion to a degree of medical certainty?

A. Yes, that confirms my assessment.

Q. And your assessment being?

A. That all these injuries are causally related to the August 7, 2010 accident.

Q. Thank you, doctor.

Doctor, at this time you told us about your life care plan. I would like to go over with the jury a little more detail and describe the tests you are talking about.

A. Sure.

Q. If you want to flip back and forth between pages --

A. Okay. What I find or findings?

Q. Just what where your findings are.

A. Exam or diagnose?

Q. Physical exam first, please.

A. Okay. This is my second page of my report. The first page indicates all the medical records. I reviewed voluminous records. This is more what the patient went through and what he is complaining about. So patient complains of radicular neck pain and lower back pain and right shoulder pain and his blood pressure was a little bit elevated. He has what is known as white coat syndrome. Wearing a white lab coat, patients get nervous. Take white coat off, it goes back to normal. The

right shoulder showed defused tender --

Q. Tell us --

A. Defused means whole entire area.

There were three well-healed orthopedic surgical scars present, one in the front, one in the middle, and one in the back, so that through the scope a doctor can have a good visualization of the entire shoulder joint.

There was a positive Hawkins. Positive Hawkins, when you bring your arm all the way, after 150 it starts to hurt indicates something is caught inside the shoulder joint such as impingement syndrome. Positive Brian's sign is a test of, again, something that is damaging inside the shoulder joint. It could be a torn labrum ring around the shoulder, or it could be anything else as part of the rotator cuff muscles.

Q. Just diffusely tender, can you explain what that means?

A. Tender means painful to touch to the entire shoulder area.

Q. And does that indicate anything to you?

A. There is trauma. Trauma is involved. And also three surgical scars, those are permanent. And these two tests indicate something is going on inside the structures of the shoulder still, despite the surgery.

Q. Okay.

A. Next page. The neck showed defused tenderness. Defused means whole entire area. Tenderness, was painful to

touch. Moderate spasm. Spasm is defined as a prolonged involuntary contraction of a muscle fiber.

Normally when you touch your muscles, it's soft to touch. Once it gets injured, you have a protective mechanism. It's called a reflex mechanism. The body tries to provide and protect itself from getting reinjured. The fibers shorten, the area becomes as strong as possible. That's what spasm is. It's involuntary. You have no control over it. It's an involuntary prolonged contraction of a muscle fiber.

Q. Does it indicate anything to you?

A. Trauma. There was trauma involved.

Trigger points usually come from trauma, muscle scarring muscle. There is a little pinpoint tenderness with a palpable nodule inside a muscle fiber. Once you have injury to the neck and back, you have a microscopic tear that then heals with permanent scarring, that permanent scarring results to trigger points.

It indicates and confirms there was trauma to the area. So that's why I said gotta put all the pieces together, history, physical exam, findings, one by one. So tenderness goes with trauma. Spasm goes with trauma. Trigger points going with trauma.

And then the range of motion. Lateral flexion normally is zero to 45. Here it's zero to 30. 30 percent. Loss of range of motion.

Lateral rotation is bending, turning your neck left to right. Normally it's 80. In this case it's 60 degrees. It's about 25 degrees loss.

The back. Again, defused tenderness, moderate spasm, multiple trigger points. Backward extension, normally 30 degrees. It was one half normal.

Bending and flexing with lateral rotation this way, this way, this way and this way (indicating) is one half normal.

Straight leg raising, which is a test to check to see if there is any problem with the nerve roots in the back or disk is abnormal. Usually 90 or greater.

Muscle testing was normal for all extremities except right shoulder. Normally 5 over 5. Neck, 5 over 5. Neck is 4 plus over 5. That's abnormal.

Sensation to pinprick and touch. That's where you ask the patient to close his eyes. You test both sides with a paper clip to see if they feel the touch, the same exact area on the right as left. You ask which is less. If they tell you -- this case it was the right biceps -- that's a pure nerve root that comes off from the neck from C-5, C-6. So it correlates to the MRIs findings, correlates to the EMG findings and correlates to the neurological dermatomes.

It's all beginning to fit, all beginning to make sense and all coming together. As I said, put all the pieces together.

Then I came to formulate my diagnoses which is a C-5, C-6 disk herniation neck bilateral, C-6 cervical radiculopathy, damage to the nerve root in the neck. Status post anterior C-5, 6 diskectomy with partial corpectomy means you break part of the bone to get access to a disk herniation. C-5, partial corpectomy. Arthrodesis means fusion. You fuse the two bones to make the area stronger. And you do that by instrumentation and bone graft, which usually comes from the hip, the iliac crest.

We have L-3 through L-1 disk bulges. We have L-1, L-2, L-2, L-3 disk herniation which consists of the first two disks in the lower back, both herniated. And then multiple bulges in the neck from C-3 to C-5, C-5 and 7.

Status post right shoulder arthroscopic with right rotator cuff repair and permanent scar right shoulder and front of his neck. And traumatic myofacial pain syndrome, which is usually caused by trauma as it indicates. The hallmark is two trigger points affecting two body parts or more. In this case, the neck, upper back and lower back. That confirms the traumatic myofacial pain syndrome.

And plan, continued physical therapy and periodic medical supervision and periodic diagnostic studies. And then my opinion and life care plan.

Opinions, since this condition is permanent and progressive and has no cure, this is a basic requirement. This

is an absolute minimum, not a maximum, of what he needs. This is a minimum. Needs to be seen by a physiatrist, like myself or Dr. Gregorace, once per month. And sometimes more than once per month. And each visit has a price of $150.

Spinal surgery, two to three times a year with spinal surgeon to make sure surgical site is correct, the bone does not become loose. There is no nothing forming around the surgical site abnormal, because you want to catch it early. You don't want to see a surgeon once a year or every two years, too late. So, see the surgeon at least two to three times a year.

And orthopedic surgery for the right shoulder, at least four to six times per year. Cost $150 per session.

Physical therapy, on the average 50 per year. Some years more, some years less. That averages to once per week, which is very, very minimum.

One is check the MRIs of the neck, the back, the right shoulder every two to three years to make sure there's no new pathology going on so you can catch it early. The cost is about 2,000. You want to check the nerves to the neck and the back every two years. Cost is about 2,000. I checked them in about -- I think it was 2012. And low -- if low back pain persists, patients needs surgery stabilization procedure, $20,000 more.

Basic microdiskectomy. Only 35,000. Afterwards the patient needs therapy three times a week for four to six months.

Periodic cervical and lumbar epidural sessions, six a year to each area. I didn't put down the outpatient surgical surgery, but should be performed in an accredited New York State Health Department approved outpatient surgical facility in case something goes wrong. Heart stops, you have the appropriate equipment to give resuscitation. That is an extra $3,000 for each injection. And he will need periodic medications for pain, spasm and inflammation. And the approximate annual cost is 5,000.

And repeat right shoulder orthoscopic surgery another two to three years. And that's about $8,000. Afterwards he will need physical therapy three times a week for four to six months.

Q. I see you say overall prognosis remains guarded. Tell us what that means.

A. Guarded means in no shape or form has his condition healed. It continues. Permanent progressive conditions don't heel. They continue. So guarded, not completely healed and continuous and progressive.

Q. Before we sit down, a couple of important points. The neurological examination you mentioned before, I want you to assume that Dr. Gregorace testified that initially Mr. Sehgal had no neurological complaints on his first visit two days after the accident but later developed neurological symptoms, is that unusual? Can you tell us what that indicates?

A. In fact, I mentioned that and it is not unusual because the full-blown symptoms of a traumatic event shows its colors typically a few weeks after. Sometimes, at the minimum, three to four weeks, sometimes longer. Nerve injuries typically take three weeks to manifest. If you do a test to check nerves sooner than three weeks, might get a false normal study. That will be misleading. So full neurological deficits take three to four weeks, sometimes longer, to manifest itself.

Q. If on that initial exam there were neurological findings, what does that indicate?

A. No pre-existing injuries to neurological system. If there was neurological deficits such as muscle weakness, loss of sensation, et cetera. None was present two days after his initial evaluation.

Q. Okay. And lastly, assume Mr. Sehgal testified he didn't feel initial pain. It got worse the night of the collisions then worse the next day. And is that unusual, like a delayed onset of symptoms?

A. No, that is not unusual. Because the symptoms of a traumatic event usually begins two to three days later. That's why when boxers are fighting you don't see the massive swelling and hematomas to the face and kidneys until three to four days later. All go in hibernation, hide from the public. That's when you really see the massive swelling, not in the beginning. Two to three days to fully show. And nerve injuries take

longer, if a nerve injury.

Q. Thank you, doctor. I would like to talk about your further treatment of Mr. Sehgal, if you would.

(Whereupon, the witness resumed the stand.)

Q. Doctor, after preparing this life care plan, Mr. Sehgal came to treat at your facility, correct?

A. Yes, sir.

Q. And can you tell us when the first time you saw him was after you prepared this life care plan?

A. Um, I saw him a month later, July 26th, 2011.

Q. And at that time did he make any complaints?

A. Radicular neck pain, right shoulder pain, radicular lower back pain, and he was getting physical therapy approximately two times per week.

Q. Was he doing physical therapy at your facility?

A. Yes, sir.

Q. And at that time what was your plan for him?

A. Continue physical therapy, re-examine him in two months.

Q. And did you re-examine him in two months?

A. I did. I saw him again on 9/27/11. He continued to have radiating neck pain down both sides, lower back pain radiating down both lower extremities and right shoulder pain. And he was working at the time light duty. And he was getting his physical therapy approximately two times per week. And it

was helping slightly while he was getting it.

Q. And how many times have you seen him up until the present day?

A. Approximately a dozen times.

Q. And when was the most recent time you saw him?

A. June 4th, 2013. Approximately two weeks ago.

Q. And before that was there a gap from when he saw you before that?

A. Yes, there was a gab.

Q. What was the gap?

A. I stopped seeing him as of June 26, 2012. I felt at that time he reached a temporary plateau. I put him on home exercise program and I told him to come back and see me periodically.

Q. What is a "temporary plateau"?

A. It means he benefitted as much as he could from the physical therapy, he benefited as much as he could from the surgery and now the rest is you have to wait it out and re-evaluate him periodically see what his condition is going to be.

Q. That last time you saw him, June 2012, what were his physical complaints? What was his condition?

A. Complained of right shoulder pain, neck pain radiating down the right arm, lower back pain radiating down both lower extremities.

Q. And now you saw him recently, right?

A. Yes.

Q. Two weeks ago. At that time did you perform an examination, and did he make any complaints to you?

A. Yes, I did an examination.

Q. Can you tell us what the results were?

A. Yes. He had neck pain radiating down the right upper extremity, right trapezius area. That's the shoulder girdle area. Lower back pain shooting to the bilateral buttocks area. Right shoulder pain was getting better with the home exercises and the stretches.

On physical exam the neck showed moderate tenderness, moderate spasm, multiple trigger points. Lateral flexion was 30degrees out of 45. Lateral rotation was 50 degrees out of 80. Forward flexion backwards extension was 45 degrees out of 60. The back showed moderate tenderness, spasm, trigger points. Backward extension was 15 out of 30. Forward flexion was 60 degrees out of 90. Straight leg raising remained the same, 75 degrees. Range of motion to all four extremities was normal.

Q. Okay. Now, your last exam of him, did you come to a prognosis or conclusions about his condition?

A. Yes. He is left with a permanent partial disability. He needs to continue with the life care plan that I gave an opinion on. And some patients stick to that plan fully. Some patients deviate for financial reasons or other reasons, but

essentially that is the basic plan that's required for him to manage his condition, based upon medical indications, for the rest of his life.

Q. A couple of years before that you put guarded as prognosis. What was your prognosis a few weeks ago?

A. Same. Guarded.

Q. What does that mean?

A. His condition is still permanent and progressive and requires continued medical care and attention.

Q. Doctor, I want you to assume Mr. Sehgal testified here this morning that he has good days and bad days and that the bad days can be very bad. Is it unusual for somebody to have good days where there is no pain when they have these types of conditions?

A. That's exactly how it behaves. One example is law of physics. If the weather is cold, rainy or humid, it will be worse. If the weather is nice, warm, sunny, dry, very little humidity, it will be better. If he is doing the home exercises, taking physical therapy, anti-inflammatory medications, pain medications, it will be better. Without these, it will be worse. So it goes up and down, but the condition is progressive for the reasons I've shown on the model on the table over there.

Q. I want you to further assume he did testify he has -- as a permanent loss, he can't move his neck certain ways; for example, he can't look up or to the side. Is that consistent

with this condition?

A. This is consistent with this condition and the type of surgery which he had which is the fusion to the C-5/C-6. As I indicated you, automatically lose between 20 to 30 percent range of motion and this condition is permanent.

Q. And you told us before he has a permanent partial disability. Is that based on a reasonable degree of medical certainty?

A. Yes, sir.

Q. Can you tell us what that means, what that --

A. Well, we have two types of disabilities. We have no disability and we have some disability. A patient that's disabled, either totally disabled, cannot do any work, or partially disabled, can do some work and some function with certain preparations and restrictions. He can work but with certain restrictions. He can't do heavy lifting, pulling or pushing. He can't do any type of activity which will stress his neck or back.

Q. You mentioned in life care plan epidural injections?

A. Yes.

Q. I want you to assume Mr. Sehgal had three epidural injections. Are you familiar with that?

A. Yes. I performed them myself.

Q. Can you tell us what that is?

A. Yes. May I use the models to explain?

Q. Sure?

MR. MURPHY: Your Honor, may the doctor step down?

THE COURT: Yes.

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

A. When we do epidural injections, delivering medication exactly to where the problem is, when you give cortisone by way of the epidural route, the improvement is much better and ratio of dosage.

For example, 100 milligrams of morphine by mouth and one milligram through the epidural, they are equal. One milligram through the epidural space equals 100 milligrams by mouth. You can deliver doses of medication with much higher efficacy with much less side effects.

What we are doing is delivering cortisone, Kenalog, which is a long-lasting cortisone derivative, and putting it next to the structures damaged, into the nerve root or the space around it.

If we do the neck, there is only one place you can do it safely. That's the interlaminar space directly into the spine, into the epidural space. You have a machine, a fluoroscope, which is like an X-ray. It guides the needle exactly where it's supposed to go. Then, you have a loss of resistance, you have a needle and are pushing the needle in. Once you lose resistance, you are in the right space. Confirm

it to confirm you are in the right space and deliver 40 milligrams of Kenalog where it has to go. It has a special protein, sticks to a nerve root, two to three months relieves pain and swelling to the nerve.

When you do the lower back, two places. Directly to the interlaminar space or transforaminal space outside the spine right below the transverse process. Put the needle here and squirt the medication and by gravity it false and sticks to the nerve root, gives you, again, the same.

In the lower spine, the transforaminal is safe. When you go to the spine, in the lumbar region, the pressure is high, leakage of the spinal fluid and have pounding headaches for a few days to a few weeks later.

So that's what an epidural is. And it does not cure the problem. Just gives you a long lasting relief, several weeks of duration. And have to be done -- do a second one usually two to three weeks later -- second one six to eight weeks later. And next one two to three months after that. No more than six per year to each area.

Q. Thank you.

(Whereupon, the witness resumed the stand.)

Q. Doctor, I want you to assume Mr. Sehgal testified that the three epidurals to his neck provided no relief. Does that indicate anything to you?

A. Yes. It means that the disk herniation was severe. It

was compressing on a nerve root. Gives no relief. The next step would be surgery.

Q. Now, in addition to the treatment you told us about, did you perform any testing on Mr. Sehgal?

A. Yes, I did. I performed EMG testing of his neck, upper extremities, back and lower extremities.

Q. Are you aware he had a prior EMG with Dr. Gregorace?

A. I am aware of it, yes.

Q. The EMG of the cervical spine, tell us what the results were?

A. I did the EMG on the upper extremity February 28, 2012, found right sided C-5/C-6 cervical radiculopathy. And I did the back and the lower extremities on 3/6/12, and I found left sided L-4, L-5 lumbar radiculopathy.

Q. Those are performed almost two years post collisions, correct?

A. That's correct, yes.

Q. And the results of those EMGs to the neck and lower back, what do they indicate to you?

A. They confirm there is still pathology going on at the neck and lower back.

Q. What do you mean by that, "pathology"?

A. Damage to the nerve roots.

Q. Doctor, based on your examination and your looking at all the medical records of Mr. Sehgal, do you have an opinion as

to a reasonable degree of medical certainty whether this condition in Mr. Sehgal's cervical spine, including all the treatment, the epidurals, the cervical fusion and pain and limitation of movement he experiences today, whether it all relates back to the August 7, 2010 collisions?

A. The answer is yes, for the reasons I gave earlier.

Q. And do you have an opinion as to whether the conditions to his cervical spine, including the results of the surgery are permanent?

A. Yes, these are all permanent.

Q. And --

A. For the reasons I gave earlier.

Q. And do you have an opinion as to whether the condition of Mr. Sehgal's cervical spine, including the surgery, the epidurals, all the treatment and his current pain and limitations, whether all of that has resulted in a significant limitation to Mr. Sehgal's cervical spine?

A. Yes. He still has loss of range of motion to his neck and to his back as of my last examination of 6/4/13. That's more than three years later. In the medical field anything that lasts more than one year or is expected to last more than two years is permanent. Three years is above and beyond permanent.

Q. I want you to assume Mr. Sehgal testified he still has pain to his lower back, still has trouble bending and lifting certain things and he has trouble with movement. Do you have an

opinion as to whether the current condition of Mr. Sehgal's lumbar spine relates directly back to the August 7, 2010 collisions?

A. Yes, my opinion, it does.

Q. What is your opinion?

A. The answer is yes, for the reasons I gave earlier.

Q. To a reasonable degree of medical certainty, correct?

A. Yes, sir.

Q. Do you have an opinion to a reasonable degree of medical certainty whether the condition to Mr. Sehgal's lumbar spine is permanent?

A. Yes, it is permanent.

Q. Can you tell me why?

A. Disk herniation is permanent for the reasons I have given. Range of motion deficits were examined as of 6/4/13. They are permanent. EMGs were done in 2012. More than two years later it still shows radiculopathy. Confirms permanency.

Q. Do you have an opinion as to whether the condition of the lumbar spine represents significant limitation to the lumbar spine?

A. The answer is yes. Based on the MRI, EMGs and range of motion deficits I found on 6/4/13.

Q. Now, lastly, the right shoulder. Do you have an opinion as to whether --

MR. MURPHY: Withdrawn.

Q. I want you to assume Mr. Sehgal testified he has trouble fully extending or using the right arm, he has trouble lifting thing and experiences occasional pain in his right shoulder.

A. Right.

Q. Do you have an opinion to a reasonable degree of medical certainty the condition of his right shoulder relates directly back to the collision of August 7, 2010?

A. The answer is yes, and it does.

Q. Okay. And can you tell us briefly why?

A. Yes. There was no prior problems to his neck, back or right shoulder. That was confirmed by his own history and the primary doctor's evaluation records. And the MRI showed the rotator cuff, which required surgery. And when you put all the pieces together, then you can see the answers. Crystal clear.

Q. And do you have an opinion to a reasonable degree of medical certainty whether the condition to the right shoulder is permanent?

A. It is permanent for the reasons I've given earlier, and it's progressive for the reasons I gave earlier.

Q. Do you have an opinion as to whether the condition to the right shoulder represents a significant limitation?

A. Yes, because it's permanent and progressive and it will worsen over time.

MR. MURPHY: I have no further questions at this

time. Thank you.

THE WITNESS: Your welcome.

CROSS-EXAMINATION

BY MR. SOBEL:

Q. Good afternoon, doctor.

A. Good afternoon, sir.

Q. So, page 1 of your report you list the records you reviewed?

A. Yes, sir.

Q. And these were all the records you reviewed?

A. Yes, sir.

Q. There were no other records you reviewed?

A. Whatever is in my report, page 1 and page 2. Page 2 I -- I believe, I mentioned are the records from Dr. Fyman from Comprehensive Pain Management.

Q. Okay. And all the records that you have relative to Mr. Sehgal are provided to you?

A. Yes.

Q. There are no other records?

A. That's all I have, correct.

Q. Doctor, you've been testified for how long?

A. Since approximately 1990 or 1989. I'm not 100 percent sure.

Q. Doctor, would it be fair to say you testified over 200 times since 1997?

A. Yes. Exactly what I said, eight to ten times a year, when you do the math, more than 20 years, about 200. That's about correct.

Q. Now, in reaching your opinion that you shared with us today, you took your time, gave a thorough exam of the plaintiff on this first occasion in June of 2011?

A. Pertinent. As what is pertinent, yes.

Q. You said pertinent. I asked you if you did a thorough --

A. I said, okay, pertinent thorough exam, yes, which means focus to the area of injury.

Q. Okay. So it was a meaningful examination?

A. I would say so.

Q. Okay. An exam that you believe to be fair based on what this patient was telling you true?

A. Based on what the patient is telling me, based on the medical records and my own findings.

Q. Certainly one that was thorough and complete?

A. In my opinion, yes.

Q. And in order to be complete and thorough you needed to see all of his records, right?

A. Whatever is pertinent. Not every record is pertinent. Pertinent means it may be important or not important but not necessarily important.

Q. And that will be keeping with your standards that you

set for yourself when you see patients?

A. Pertinent records, yes.

Q. Doctor, you gave us your background. Did you teach? Have you taught?

A. Yes. I still teach.

Q. Where are you teaching now?

A. NYU.

Q. And you would agree that if you didn't take your time to do a thorough exam it wouldn't really be a fair indicator of your opinion, it wouldn't help you to come to a good opinion?

A. Not necessarily. You could be a very experienced clinician and do -- be able to do a good, thorough exam that short time and be a novice and take a long, long time and still be incomplete. It depends.

Q. If you didn't take the time to review appropriate records, the foundation for your opinion could be less than adequate, correct?

A. May or may not. Depends on what it is that you reviewed or did not review.

Q. Okay. So --

MR. SOBEL: Withdrawn.

Q. You wouldn't come to court and give an opinion to this jury without insuring that your opinion was based on the all the relevant facts?

A. Based on my report says based on the history obtained,

clinical exam, review of the medical records that is my opinion.

Q. Doctor, did anybody prevent you from reviewing the MRI of the plaintiff's cervical spine from January of 2011?

A. Prevent me, no. Nobody prevented me from anything. But the intraoperative findings are much more accurate. When I have the intraoperative findings, I don't need any MRI reports.

Q. Well, you have the report in your file?

A. I do. I do.

Q. Okay. But you didn't see fit to list it here in the body of your report?

A. The reason is because the intraoperative findings --

Q. Well, do you list report in here? Did you list the report in your report, the existence of the report even?

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

A. Yes, I did. Right there on page 1 it says I reviewed the cervical spine MRI which showed mild degenerative changes from C-5 through C-7. Right there on page 1 you see it.

Q. No --

A. Would you like me to step down and show it to you?

Q. Yeah.

THE WITNESS: Judge, may I?

THE COURT: Sure.

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

A. Cervical spine showed some mild degenerative changes

C-5 through C-7. If you look, you will find it.

Q. Where is there a report dated --

A. The date of report is not mentioned, but I did review it. It's right here.

Q. Okay. Doctor, tell us, what is uncovertebral joint --

A. Bony ridging.

Q. And where is the uncovertebral joint? Can you show us?

A. The joint space. That's the disk space.

Q. And, doctor, in that MRI report from January of 2011 it specifically says there is no herniations, correct?

A. That is correct.

Q. So when you said before that herniations never heal, they never get better, only get progressively worse, can't they get better?

A. Disk herniation can temporarily feel better, not that it's cured, no. The symptoms go up and down. You can have periods of little or no symptoms, but the condition is a permanent condition.

I also mentioned that MRI is not the best way to diagnose a herniation. The intraoperative findings are the best way. I also explained why.

Q. Okay. Now, when are you told us earlier you do the injections --

A. Epidurals.

Q. Okay. And after you do an epidural and administrator

an epidural injection, what do you tell your patient after you are done?

A. Come back and see me the next day so I can make sure there is no side effects, no dangers, no complications.

Q. Basically send them home after the procedure?

A. After the procedure I re-evaluate them to make sure neurologically stable.

Q. Well, my question was: Do you send them home?

A. Yes, I do.

Q. Okay. Now, doctor, I want you to assume that after Mr. Sehgal had these procedures he went for physical therapy. Wouldn't that be adverse to the good that would come from the injection?

A. That's not what you asked me. That is not what you asked me. I said after the procedure I send them home. They follow to continue with physical therapy. I see them the next day. You did not ask me about physical therapy. That should be continued after an epidural because the area where the needle was placed will be sore. They'll need some therapy to get rid of the soreness and continue the physical therapy. So you have a synergistic effect, the epidural and physical therapy combined together.

Q. So the same day you do an injection you have the patient go to physical therapy?

A. Could be the same day or the next day.

Q. I didn't ask you about the next day. I asked you about the same day.

A. Me, per se, I let them go because I give the epidurals with anesthesia. Some doctors do not give the epidurals with anesthesia. When you get with anesthesia, you want to go home and sleep it off.

Q. Now, you discharged or you felt that Mr. Sehgal hit a temporary plateau in 2012, correct?

A. From the --

Q. You testified earlier, I believe, that you found that the patient had -- had hit a temporary plateau in June of 2012?

A. From the physical therapy, yes.

Q. Doesn't that go against your whole life care plan where somebody has to see, go to physical therapy once a week on average? Those were minimums you said?

A. Yes.

Q. That you said he hit a temporary plateau, isn't that contradicting?

A. No. I said on the average. 50 per year on the average. Some years will be more, some years will be less. There will be one or two years that he'll have minimum treatments. I also indicated that is what is medically indicated, not what a patient chooses to do or not to do, okay. Ideally.

Q. When you --

A. I'm not finished. Not finished. That temporary maximum medical improvement was not supposed to have been for one year. It was supposed to be for maybe a couple of months, come back and see me as needed. So he chose not to come back and see me for whatever reasons he had in his mind, financial reasons, whatever reasons he had in his mind.

MR. SOBEL: Move to strike the nonresponsive portion of the answer.

Q. Doctor, he didn't come back and see you until this month, the month of his trial?

A. That's correct.

Q. He didn't feel it was important enough that he see you for the one year?

MR. MURPHY: Objection, what another witness feels, Judge.

THE COURT: Sustained.

Q. Can you have a bulging disk without symptoms?

A. Yes.

Q. Have a herniation without symptoms?

A. Extremely rare but it's possible.

Q. Earlier you told us how the neurological symptoms of somebody with a herniation manifest themselves within three to four weeks; is that right?

A. That's not what I said.

Q. What did you say? Neurological symptoms --

A. Now you change your question. Now it's different.

Q. I am changing the question. You said it's not what you said. I'm trying to help you explain to us.

A. Okay. Fair enough. Typical -- nerve injuries typically take three weeks or more to fully manifest themselves. If you do a test like an EMG to check a nerve problem sooner than three weeks, it usually is normal. It's a false normal. That's why you have to wait at least three weeks or more to do an EMG for this very same reason.

Q. Well, how much longer after the three-week period does it take in your experience for these neurological symptoms to manifest themselves?

A. It's different in every single patient. No two patients present exactly the same. That's why we have different patients with different presentations. So you have to follow the patient once per month to see what the subjective and objective findings are.

Q. Can you give me a range, doctor? Give us a range of three weeks?

A. To maybe three months.

Q. Doctor, I would like you to assume that Mr. Sehgal saw Dr. DeMoura, the spinal surgeon, on October 11th, 2010.

A. Okay.

Q. So over two months post accident and across the board, motor sensory reflexes all normal, upper and lower extremities

unremarkable neurologically?

A. Okay.

Q. Doctor, isn't that an unusually long period of time to go without any neurological symptoms? Were those very significant injuries you are telling us about?

A. No. Dr. Gregorace found neurological deficits sooner. In fact, he did an EMG that confirmed neurological damage by his first EMG. And let's see when that first EMG was done. I will tell you in a second.

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

A. On September 29th, 2010. That's less than two months. From August to September 29th, talking about six or seven weeks. As early as six to seven weeks he found neurological deficits and he confirmed it with an EMG.

Q. Now, your life care plan that you presented, those are all minimums?

A. Yes. Very conservative number.

Q. And you said approximately 15 times per year at $150 a visit he needs to see a physiatrist such as yourself?

A. Yes. For intermediate evaluation, yes.

Q. Then 50 times a year he will need physical therapy sessions at $150 a session which your facility also provides, right?

A. That is correct, yes.

Q. And then you also do the EMGs, correct?

A. Yes, which I did.

Q. And you propose that it should be done every two years of both upper and lower extremities?

A. Which was done.

Q. And all these other -- and these things alone add up to somewhere in the $10,000 a year range for you to earn as you continue to treat this gentleman for the rest of his life?

A. Absolutely not. Correct, he can go to anybody he wants. He can go to Dr. Gregorace. Dr. Fyman, he does therapy. Also, he can go to Dr. Smith, Dr. Y, Dr. Z. Go any place. And I don't do any MRIs. He can go for the MRIs any place he wants.

Q. Now, of all the times that you told us you testified in the past, what percentage do you testify for plaintiffs and what percentage do you testify for defendants?

A. The vast is for my patients. I've testified for the defendants probably maybe less than one to two percent. I treat patients. You call them plaintiffs. So that's why it's mostly plaintiffs. I call them patients.

Q. Doctor, after the cervical surgery I want you to assume that Mr. Sehgal continued to see Dr. DeMoura and that on his visit in April, May and July of 2011 the doctor found that his neurological and upper extremity and cervical symptoms were benign. Benign meaning what?

A. Benign means normal.

Q. And doesn't that indicate that he's fine at that point?

A. Maybe at that point.

Q. And you started to see him when?

A. June 21, '11.

Q. So there was an overlap of one month where you examined him and found findings and Dr. DeMoura found that the findings were benign?

A. It depends on who examines the patient and when he is examined. And the findings may vary from doctor to doctor and from patient. Same day I've examined a patient on numerous occasions and his findings were a little bit different on each of those evaluations.

Q. Do you know what Mr. Sehgal does for his past history? Did he play sports? Is he athletic, like to sail or anything like that?

A. I know he is a bookkeeper/accountant. In terms of sports, that was not discussed.

Q. Did you know that he played tennis for 20 years right-handed?

A. Irrelevant. I did not know.

Q. Okay. Would playing tennis for 20 years put wear or cause wear and fatigue to the right shoulder, right, if you are right-handed?

A. If anything, it will cause impingement syndrome, not a rotator cuff tear.

Q. Well -- well, you reviewed the MRI report of the right

shoulder, correct?

A. I did.

Q. Okay. There was no indication of a tear on the right rotator cuff, was there?

A. One second.

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

A. No. Again, the intraoperative findings are much more accurate than the MRI findings, because an MRI is basically an image of what you are looking at. It's not a full visibility of the actual pathology.

Q. So with respect to both the MRI of the right shoulder and the January 2011 MRI of the cervical spine, which both showed in the cervical spine no herniations and in the shoulder MRI no tear --

A. Correct.

Q. -- those were both negative but when both physicians went in then they found things?

A. For very good reason. As I explained to you earlier, there is nothing unusual about this. This is the norm, not the abnormal.

Q. So it's normal to have a negative MRI and then operate and find something torn?

A. There you go again taking words out of context. No. What I said clearly, crystal clear, was that MRI is only an image. If you want to see the full pathology, it is found at

the time of intraoperative findings. Undisputed. Go to any medical school, go to any hospital, they will tell you the same thing.

Q. When Mr. Sehgal came to you initially, was he coming to you because he was claiming to be disabled and unable to work?

A. No. No. Initially he came to you for disability and impatient evaluation? He was working.

Q. Well, what do you mean by disability evaluation?

A. I explained that earlier. I will be happy to explain it to you again, if you would like.

Q. I would be delighted.

A. Okay. I will repeat myself again. A disability impairment evaluation is when you examine a patient, take a history, review pertinent medical records, arrive at a conclusion whether or not that patient is disabled, if that disability is partial or total and what the future medical needs of that patient will be, including its expenses.

Q. So disability evaluation you are doing for purposes of creating this life plan?

A. That is what a life care plan is, yes.

Q. Okay. It's not to apply for Social Security disability?

A. No.

Q. Or another form of disability?

A. No.

Q. Because you know he continued to work after this accident up until the time of the shoulder surgery, right?

A. And he still continues to work.

Q. Right.

Now, doctor, if a patient were to come to you complaining about neck, back, right shoulder and you found some positive findings relevant to all three areas I just mentioned, would you commence a period of physical therapy as to those parts of the body?

A. First thing I would do I will give the patient informed consent. That means explain to him thoroughly what is wrong with him, make sure he understands what is wrong with him, explain to him all the different treatment options. It's the patient that decides, not I, as to what he is going to get. You can't force a patient to get treatment.

Q. Okay. But you would go through the consent, you would explain to him what you believe the treatment should be; is that fair?

A. Yes, that is correct.

Q. All right. And then how long do you allow for -- and I will call physical therapy conservative treatment, if that's all right by you. How long would you go for, have the patient come for conservative treatment before you would start considering other options?

A. Every case is different. And it's also based on the

clinical presentation and what the patient wants or does not want. You can't tell a patient, okay, you need surgery. He'll tell you go do something else to yourself, okay. You explain to him what his options are. He decides, not you.

Q. Okay. Well, if you have a patient that's treating with you for a couple of months with a shoulder and nothing seems to be getting any better, at some point -- at that time do you start talking to him well, you know, maybe you should start thinking about surgery on that or go for a consult even?

A. Me, I would. Other doctors may do things differently, but I would.

Q. Okay. And you wouldn't -- for instance, you wouldn't have a patient come in your door on day one and say okay, you are going to have to go for a surgical consult with this guy and this guy and this guy on day one, unless it's something very dramatic?

A. Right. Unless you have sufficient diagnostic studies to confirm exactly what is wrong with him and you give informed consent and he wishes to go through the surgical route and initial surgical, second consultation. It's his choice, his option after informed consent has been given.

Q. And do you feel it's prudent medical practice to have a second opinion when you are considering surgery?

A. Every patient is entitled to his or her choice. It's their choice. Initially when he came to see me he didn't come

to me for treatments. He liked my explanations. He liked the way I explained things to him, decided to come to me for continued treatments. So some patients may go to a doctor, have very good confidence with the doctor. They may feel very good and comfortable with the way he is explaining things. Some patients may not. Second, third, fourth, fifth opinions. Every case is different.

MR. SOBEL: Thank you.

THE WITNESS: You're welcome.

THE COURT: Any questions on redirect, counsel?

MR. MURPHY: Just a moment, your Honor. Thank you.

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

MR. MURPHY: I have no redirect, Judge. Thank you.

THE COURT: All right. Thank you. You may step down.

THE WITNESS: Judge, does this stay here?

COURT OFFICER: I take it. Thank you.

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

THE COURT: Counsel it's 3:54. About 35 minutes. What do you want to do?

MR. MURPHY: Can we 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.)

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

THE COURT: All right. We're done for the day. You never tell me you need a break. We'll continue tomorrow at -- well, be here 9:45 like today. Be prompt. It really is appreciated. I know all of you are thinking I'm preaching to the choir, as they say, but see you tomorrow and have a wonderful evening.

Don't talk about the case yet. We still have a while to go, okay. Have a wonderful evening.

(Whereupon, the jury exited the courtroom.)

(Whereupon, the matter was adjourned to June 25, 2013.)