SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX : CIVIL TERM : PART IA-4

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LAZARO JOEL MONTAS, :

Plaintiff, Index No. 305620/2010

:

-against-

:

SALLY H. ABOUEL-ELA

Defendant. :

----------x

Bronx Supreme Court
851 Grand Concourse
Bronx, New York 10451

January 27, 2016

B E F O R E: HONORABLE HOWARD H. SHERMAN,
Supreme Court Justice

A P P E A R A N C E S:

Attorney for Lazaro Joel Montas
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BY: TIMOTHY JONES, ESQ.

THE COURT: Okay, on the record.

There was an issue a couple of days ago I think yesterday or two days ago concerning some knowledge of or lack of knowledge by the defendant, one additional treatment in this case, post note of issue, an injection, some type of injection that Dr. Guy provided plaintiff and there was a question by defendant as to notice of it, receipt of any records concerning it, receipt to his office, receipt by report pursuant to subpoena, pursuant to authorization, et cetera, and knew plaintiff has some more information about that with Dr. Guy about the testimony.

MR. OGEN: Right, so two things, one is a further supplemental bill of particulars was served back on November 9th on defense counsel which did set forth the injection to the knee on November 7, 2015 by Dr. Guy and also provided and additional authorization, actually two authorizations, one for defense counsel to get it to their office and one for defense counsel to be able to subpoena it to the courthouse, if they wish, and that was served no more than two months ago on defense counsel.

And in any case, the injections are sequela of the injury and there is no prejudice, specially since they had notice of it.

Additionally, I -- just so there is no surprise here, I did find out that Mr. Montas received another

injection when Dr. Guy saw him on Monday which he did testify that he saw Dr. Guy on Monday, so I don't believe there's any prejudice, specially given the notice in the supplemental bill of particulars of the continuing treatment and, you know, Dr. Guy's records are here, he's free to look at his chart. And, again, there is no prejudice to defendant here.

MR. JONES: You say there is no prejudice, is quite a statement in itself, Judge. We are completely prejudiced and ambushed by this. I just learned for the first time by counsel's statement that his client had an injection two days ago. His own client didn't say that on the stand on direct examination nor on cross-examination. I thought the only issue was the November of 2015 injection which we did see it in the supplemental bill of particulars, but the authorization was not responded to even with a subpoena from our investigator and it's not even here in the courthouse.

I suspect that Dr. Guy has it in his briefcase but we've had no opportunity to inspect it and it is a complete ambush and it is prejudice and to have two injections and to have no record and now to be presented with an expert witness without having any opportunity to present it to our orthopedist sets us up for ambush on cross-examination of our own expert as well as my own cross-examination of the

expert.

He should be precluded from any testimony with regard to the treatment in 2015 and 2016.

THE COURT: I'm going to talk about it one shot at a time because I don't know, I'm not even sure how to express it, but I'm a little more concerned about the shot two days ago that doesn't come up until now when we've been in court for two days talking about a November injection a couple of times and notice and so on.

MR. OGEN: I just found out this morning.

THE COURT: Right. He testified yesterday and I understand it, the questioning of why didn't he mention it, probably because he wasn't asked about it. And why wasn't he asked about it, because you didn't know about it until today.

But getting to the November injection, I'm not sure. There is a supplemental bill shortly after that that refers to injection with a supplemental authorization for updated records which would presumably include the injection, and those -- that authorization was served and then why didn't the records go or come anywhere near his office. I don't know the answer to that.

MR. OGEN: I mean, I don't know when it was served.

THE COURT: Right.

MR. OGEN: How it was served, to who it was served.

THE COURT: Right, but I also think the fact that there was notice is not in terms of prejudice, is not like out of nowhere and we're finding out today, although the second one when you are finding out today but your answer to that it would be an interest of treatment, blah, blah, blah. But the first one, I'm less concerned about the surprise and the shots and the prejudice because in November nobody has denied that there was a notice of bill of particular and authorization. Why it didn't come anywhere, that's another thing, but if it had to come in the courthouse the last day or so that would lessen the prejudice a bit but it wouldn't change all that much about prejudice to your expert because you would have just spoken to him in the last 24, 48 hours about it and he's not testifying till later today.

MR. OGEN: Tomorrow is his expert.

THE COURT: I'm sorry, tomorrow. So all of which I think lessens the prejudice.

So to the extent you want to preclude any testimony from Dr. Guy about an injection in November, I'm going to deny that application. And like I said, we'll get Dr. Guy's records. Obviously we'll review them before your cross but I will ask him to show you at least a note or

whatever is in there referencing that injection right now so you can even have someone get in touch with your expert, fax him a copy of the note or whatever and they can prepare to deal with it when they testify tomorrow on essentially 24 hour notice instead of 48 or 72 hours notice, the injection yesterday or Monday. I'm going to have Dr. Guy give you that note too and until I know the circumstances surrounding it and so on I got to think about it for a few more minutes. I know I got to decide this in the next few minutes but I'll think about it.

So what I'd like to do is have Dr. Guy, any reference in any chart or anything to the injections, and I'm assuming it's not all of that much other than the note. We'll make a copy of right now, give it to him right now, we can fax it or somehow get it to your office, unless you can use the Court's fax so you can reach your expert to deal with that prejudice.

MR. JONES: Okay.

THE COURT: And then we'll talk for a minute or two more about Monday's injection coming up.

MR. OGEN: And what about tomorrow's injection?

THE COURT: Well, I don't think Dr. Guy is going to still be here tomorrow. If he is, I'm not doing my job.

MR. JONES: Okay, let me make a call, Judge.

THE COURT: Okay.

(Pause in proceedings.)

MR. OGEN: My client advised that he did testify yesterday about the injection.

THE COURT: About Monday?

MR. OGEN: Monday's injection, yeah, that he mentioned it. So I don't know if we can review the record, if necessary.

THE COURT: She's not even here today so that's not going to happen.

MR. JONES: All honestly, I did not hear that.

THE COURT: I don't remember hearing it either.

MR. JONES: I remember him saying he went to see him.

THE COURT: Yeah, yeah, that he talked about a visit Monday.

MR. OGEN: I think it was something -- he was refreshing my recollection, something along the lines like, yeah, I saw him Monday, I got an injection. It was something like just kind of thrown in there in passing but it was mentioned.

THE COURT: All right, just show it to him.

MR. JONES: Yeah, yeah.

(Pause in proceedings.)

THE COURT: Just for the record, defense counsel has been -- I won't say given, but shown and given access

to the -- whatever records, apparently two notes of Dr. Guy concerning the injections. So with that we're ready to start.

I'm going to allow Dr. Guy to talk about the injection in November but based on everything else that's happened -- I understand there are also fine lines if he discusses permanence and future treatment and so on, assuming that's all subject to this case.

I don't even know from -- I haven't reviewed all the bills of particulars et cetera, but I'm not going to allow the testimony about Monday's injection. He could just -- you know, it's on the record already that he did see him Monday, you can question him about the visit but -- and I noticed this is sort of splitting hairs and how far but I'm not going to go into Monday's injection cause I have no recollection of that coming up in his testimony yesterday.

MR. OGEN: Okay. I mean, but if he makes an issue of, well, you're saying he needs injections but he hadn't been getting. You know what I'm saying?

THE COURT: Right. You know, if he says how come only one injection, then that's going to open up that there was more than one injection and there might even be more but we'll see how it goes. I'm not going to let it come up on --

MR. OGEN: -- On direct.

THE COURT: Right.

MR. OGEN: Okay.

THE COURT: But based on the previous supplemental bill, supplemental authorization and the fact that the prejudice is lessen by that although the records -- but the fact also that the real prejudice will be his expert who is not coming in till tomorrow and will now have these records at least 24 hours in advance, I will allow the testimony about the complete November injection.

MR. JONES: Judge, just for the record, there is a 9/8, 2012 report from Dr. Guy where he lists future needs. There is no injections, I mean.

THE COURT: You are cross examining him about what changed or why?

MR. OGEN: Fair enough.

THE COURT: Okay, so ready?

MR. OGEN: Yes.

MR. JONES: I guess so.

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Good morning. You can all have a seat.

Is plaintiff ready with its next witness?

MR. OGEN: Yes, Your Honor. We call Dr. Ali Guy to the stand.

THE COURT: Doctor.

(Whereupon, the witness entered the courtroom and took the witness stand.)

Dr. A L I G U Y, a witness called by and on behalf of the Plaintiff, having been first duly sworn, was examined and testified as follows:

THE WITNESS: I do.

THE CLERK: In a loud clear voice state your name, and physical address.

THE WITNESS: Yes. My name is Dr. Ali Guy. First name is A-L-I, last name G-U-Y. My office's address is 7 Gramercy Park, New York, New York 10003.

THE COURT: Good morning, doctor.

THE WITNESS: Good morning, Your Honor.

THE COURT: And as you can probably tell, the acoustics in here are terrible so please keep your voice up.

THE WITNESS: Yes, Your Honor.

THE COURT: Go ahead.

MR. OGEN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. OGEN:

Q. Good morning, Dr. Guy.

A. Good morning.

Q. Doctor, you are licensed to practice medicine and surgery in the State of New York?

A. Yes, sir, I am.

Q. And when did you receive your license?

A. 1985.

Q. And could you briefly go over your educational background?

A. Yes, my undergraduate, I went to Queens College, Flushing, New York, Medical School. I graduated from the University of North East Dominican Republic June of 1981. Thereafter, I did three separate residencies. I did my first residency in the field of internal medicine for a period of 18 months at Mount Sinai School of Medicine, Mount Sinai Medical Center. I did one year of general surgery at Cabrini Medical Center, Manhattan, New York. I completed a three year residency training program in the field of physical medicine and rehabilitation at Mount Sinai School of Medicine, Mount Sinai Medical Center. I'm board certified in the field of physical medicine and rehabilitation.

I was the director of the Department of Rehab Medicine at Maimonides Medical Center in Brooklyn, New York, from 1997 to 2002, that will be five years where my duties were to be in charge of all the inpatients and outpatients rehab services, provide teaching to the intern medicine residents, general

surgical residents, orthopedic surgical residents, other physical therapist, speech therapist, occupation and other doctors in my department to render consultations to other doctors in my hospital. And from 1990 till 2005 I was in charge of NYU's Hospital for joint diseases, Neuromuscular Equipment Clinic where my duties were to see the patients that were assigned to the clinic. These would be patients that are born with birth defects; polio, spinal cord injuries, multiple car accidents. And I would have residents assigned to me from NYU, my duties were to teach them as I treated the patients.

And from January of 2006 to the present I'm a clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU Medical Center where my duties are to teach the residents for the boards part one, part two and also to see patients of scientific clinics. And I'm also in charge of pain management at Med Alliance in the Bronx at Fordham Road near Fordham University. It's an Article 28 facility which is like a mini hospital. We have many, many different doctors that provide pain management service to the patients.

Q. Doctor, are you board certified?

A. Yes, sir, I am.

Q. What does that mean? What does it mean to be board certified?

A. Board certification is the highest degree you can obtain in your level of specialty. In order to be board

certified on my specialty, you have to have training in a field other than physical medicine and rehabilitation, preferably one year of internal medicine, one year of general surgery or more and you have to satisfactorily complete a three year residency training program. You have to pass them, monthly evaluations given by our preceptors, that would be your teachers. You have to pass the annual examinations given by the department.

Once you've finished the training program, you have to sit and take your board's part one, which is a written examination which is eight hours long. They cover topics in orthopedics, neurology, radiology, interpretations of x-rays, MRIs, cat scans and principles of neurology, muscle, nerve, physiology, electro diagnostics disability, disability impairment evaluation, rehabilitation, internal medicine.

And once you pass your written examination, you have to be in private practice for at least 18 months to provide additional knowledge and you have to prepare for your board's part two which is an oral examination and you fly to the Mayo Clinic in Minnesota where are all the experts that write books and give examinations. You have to pass all the exams again in similar topics.

Once you pass all your medical records from college, from residency, the boards are sent to the American Board of Physical Medicine and Rehabilitation. They review all your credentials from A to Z and if everything is up to par, they

give you a title of American Board of Rehabilitation. That was obtained in May of 1989 and it's still in good standing.

Q. You mentioned that you were a clinical instructor to other doctors, what is the requirement to that?

A. You have to be board certified. You have to pass a rigorous credential committee, they investigate your background, they test to see if you have knowledge and ability to teach and if you have the ethical and a moral background to be classified as a clinical instructor. And once you pass all those things, you have to be board certified. Of course they put you on a trial basis for six months. They watch you very carefully and if your work is good you get good reviews they keep you on and it continues.

Q. Doctor, what is the field of physical medicine and rehabilitation?

A. The field of physical medicine rehabilitation is a medical specialty that was founded shortly afterward by Dr. Rusk. That's why the Rusk Institute at NYU is named after him. This specialty deals with traumatic injury, covering the whole body from head to toe. Deals with a lot of comprehensive areas, that's why you have to have training in so many different fields. Deals with internal medicine, general surgery, orthopedic, urology, neuro surgery, muscle, neuro physiology, sports medicine, orthopedics electro diagnostics disabilities and impairment evaluations, which means we have training to

evaluate a patient and see if that patient is disable, whether it's partial or total, it's partial, mild, moderate, severe. What the future holds for the patients along with the future medical needs and expenses.

And, we do pain management. We do injections, knee injections, shoulder, epidural injections, radio frequency procedure where we burn off the nerves off the spine and other orthopedic and neurological and interventional pain management procedures.

Q. And how does your field differ from let's say neurology and orthopedics?

A. Neurology and our field are called physiatry not psychiatry. It's very, very similar. We both diagnose and treat. Every physiatrist is trained and does EMGs but not every neurologist is trained and does EMGs because I get referrals to doing EMGs -- which stands for electrodiagnostic -- to see if a patient has damage to muscle and nerve. Neurologist concentrates on more than central neurology, neurology of the brain, the brain stems, like Parkinson's disease, Multiple Sclerosis. We do more peripheral neurology, that's the nerve that comes off the spine, the nerves that goes down your arms and legs and we do joint disc problems, damage to the nerve roots from the neck, the back and to the arms and the legs. So it's very similar and we refer patients back and forth to each other.

Q. Have you had formal training in neurology, orthopedics, internal medicine, surgery and interpretation of diagnostic films likes x-rays and MRIs?

A. Yes, sir.

Q. Does your field deal with traumatic injury?

A. Yes, sir.

Q. Are you considered a trauma expert?

A. Yes.

MR. JONES: Objection. Leading.

THE COURT: Sustained.

Q. Do you do disability and impairment of evaluation for other doctors?

A. I do.

Q. In what instances do you do that?

A. Many doctors don't feel comfortable and don't have the proper training.

MR. JONES: Objection. What other doctors' field?

THE COURT: Sustained. Just what it is.

A. I get referrals from many different doctors to make a determination as to whether or not a patient is disabled and if so, the extent of disability.

Q. Okay, being a trauma expert and treating trauma patients do you sometimes get called into, called to testified?

MR. JONES: Objection. Called, qualified are not experts in trauma, Judge, it's physical medicine in

rehabilitation.

THE COURT: Sustained.

Q. Do you sometimes get called into court, doctor?

A. Yes, sir.

Q. Okay, and in what situations do you get called into court?

A. As I indicated, in my field, deals with trauma and rehabilitation. People that require rehabilitation sometimes are injured, whether it's from a car accident, whether it's from a sports injury, and I treat those patients. And from time to time when there is an accident or lawsuit, as a treating physician I'm required to come to court and render my opinion as to a treatment. I render the patient and answer the questions that are posed to me.

Q. What happens if you are called to come and you refuse?

A. The medical board can hold us and punish us for not cooperating because we are required to cooperate.

MR. JONES: Objection, Judge. It's not the strain.

THE COURT: Sustained.

Q. Doctor, do you have an opinion as to why experts should come to court and testify on behalf of their patients?

MR. JONES: Objection. Outside the scope.

THE COURT: Sustained.

Q. Do you have an expert -- do you have an opinion as to

why doctors are called to court to testify?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Have you ever been deemed an expert in your specialty in any Supreme, Federal or any other court?

MR. JONES: Same objection.

THE COURT: Overruled.

A. Yes. I've testified many times. I've always been deemed as an expert in my field of physical medicine rehabilitation. I never been turned down.

MR. OGEN: Your Honor, I'd like to introduce this doctor as an expert witness in the field of physical medicine and rehabilitation.

THE COURT: Any objection?

MR. JONES: No objection.

THE COURT: Okay.

Q. Doctor, in your background, have you treated patients with knee and shoulder injuries?

A. Thousands, yes.

Q. Have you -- are you familiar with surgeries that are done to knees and shoulders?

A. Yes, I've assisted on many of them myself.

Q. And have you reviewed operative reports for knee and shoulder injuries?

A. Yes.

MR. JONES: Leading, Judge.

THE COURT: Sustained.

Q. What types of documents have you reviewed for knee and shoulder injuries?

A. Operative reports, arthroscopic reports.

Q. And are you familiar with those types of reports?

A. I am.

Q. What are your qualifications with regards to reviewing those types of reports and giving an opinion about them?

A. As part of my training in the field of general surgery I wrote to the orthopedics department for three months through the Orthopedic Intensive Care Unit one month and we had combined orthopedic general surgery rounds periodically.

As part of my training in physical medicine with rehabilitation for three years, we had the weekly orthopedic and physiatry clinics together combined, we reviewed files, cases together, diagnostic studies, operative findings. I assisted on many of these procedures myself during my prior training in general surgery.

Q. And have you reviewed such operative records?

A. Yes.

Q. How many?

A. Tens of thousands.

Q. Doctor, do you give lectures to various people?

A. I love to teach. I give lectures to every walk of

life. I give lectures to doctors, medical students, physician assistants, physical therapist, nurses and also attorneys.

In fact, once a year I give lectures at Mount Sinai School of Medicine and the lectures are called medical school for lawyers who teach anatomy, the attorneys that teach the legal stuff to each other, but I myself along with several other professors, we teach whatever we are required to teach. Every year is something different but it's basically anatomy, physiology and medicine.

Q. And when you give those lectures, are you compensated monetarily?

A. No, nobody gets paid and nobody wants to get paid. It's considered a great honor to teach at very prestigious medical school like Mount Sinai School of Medicine, so nobody gets paid.

Q. Now, doctor, when you come to court -- withdrawn. Have you come to court to testify before?

A. Many times.

Q. When you come to court do you usually testify on behalf of the plaintiff side or the defense side?

A. For my patients, the legal side calls them plaintiffs. I call them patients. So mostly for the plaintiff side, patients.

Q. And what percentage of your practice is devoted to treating patients or teaching?

A. The vast majority. I generally work six days a week, sometimes six and a half days a week. And as part of my treating patients sometimes I have doctors, students that rotate through my offices and as I'm treating patients, I'm also teaching as well.

Q. And are you here to render expert testimony regarding the treatment and care given to your patient Lazaro Montas?

MR. JONES: Objection. Leading.

THE COURT: Sustained.

Q. Have you treated a patient by the name of Lazaro Montas?

A. Yes, sir.

Q. Now, how many times a year would you say you come to testify in court?

A. On the average, eight to ten times per year. Sometimes less, sometimes more.

Q. Okay, and how long have you been doing that?

A. 24, 25 years.

Q. So that's quite a bit of time, correct?

A. Yes, sir.

Q. Do you have an opinion as to why you've been called to court that many times?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Do you come to court for most of your patients?

A. No, less than one percent of the patients I treat.

Q. Are you being compensated for your time here in court today?

A. Yes, sir.

Q. And did you have to cancel appointments?

MR. JONES: Objection.

THE COURT: Overruled.

A. Yes, sir, I did.

Q. And what is your compensation for today?

A. It's four thousand for half a day, one thousand for pretrial preparation and discussions of the medical aspects of the case with you.

Q. Okay. And, doctor, has my office ever retained you to come and testify before in court?

A. Yes, sir.

Q. And approximately on how many occasions?

A. I can't give you an exact number, a good estimate of guess would be about a dozen times. It could be less, could be more.

Q. And over what time span is that?

A. My entire 25 year career as a physician.

Q. Okay, 20 years for me so would it be over the course of 20 years?

A. Yes, 20 years.

Q. And, doctor, are there occasions where my patients, my

clients are also your patients?

A. Yes, sir.

Q. All right. Doctor, did you bring a file with you today?

A. Yes, sir, I did.

Q. What is in that file?

A. My medical records pertaining to the treatment of Lazaro Montas.

Q. Okay, and where did you first see Mr. Montas?

A. In my Med Alliance Bronx office as a referral from Dr. Ehrlich.

Q. What is the date that you saw him?

A. 8/19, exactly five months after the accident.

Q. And you mentioned that Med Alliance is Article 28?

A. 28 facility.

Q. What does that mean?

A. Article 28 facility is a facility that is governed by the rules, the rules of hospital. It's controlled by the New York State Health Department and it follows basically the same rules as hospitals and has very strict requirements and there is multiple different doctors there, multiple specialists there and that's basically what an article 28 is.

Q. And who referred the patient to you?

A. Dr. Ehrlich, orthopedic surgeon.

Q. And who is he affiliated with?

A. With Med Alliance.

Q. And do you have the records regarding that initial visit with him?

A. I do.

Q. Okay, and at that time did you take a history?

A. I did.

Q. What's a history, doctor?

A. A history is what a patient tells a doctor as what is wrong with them and how it happened. And from that, doctor extrapolates additional information by way of precise questioning that leads to proper diagnosis and a treatment plan.

Q. Okay, and why is it important?

A. Seventy percent of the hurt man history helps the physician make a diagnosis. Diagnosis means what's wrong with the patient. The other ten percent comes from the physical exam, that would be eighty percent. The other twenty percent comes from other diagnostic studies, other medical records such as x-ray, MRI, operative findings, et cetera.

Q. And, doctor, what was the history that was provided to you on August 19, 2010 when you first saw the patient?

A. Yes, the patient was involved in a car accident on 8/19, 2010. He was hit from the rear. He sustained injuries to his right shoulder and his left knee. He initially did not go to a hospital. He was seen by a local doctor about ten, eleven days ago. He had physical therapy. He did not get better.

When he saw Dr. Ehrlich he had left knee arthroscopic surgery. It made him better but then the pain slowly coming back he still had the right shoulder pain. The right shoulder and the left were bothering him at the time I saw him.

Q. Did you examine him?

A. I did.

Q. And what were your findings with regards to your examination?

A. The right shoulder was tender over the whole entire area. There was a positive impingement arc. Impingement arc means when you lift up your shoulder, shoulder flexion goes usually up to one hundred eighty degrees, once you go above one fifty it starts to hurt. That's called the impingement arc. And I have models that will explain later what that means exactly. And the left knee was tender over the joint line, inner and outer portion. And there was crepitation range of motion, was normal on the left knee. There were three well healed arthroscopic surgical scars from the prior surgery and muscle power testing and the range of motion was normal. His gait at the time was normal.

Q. Okay. The fact that his -- first of all, what's a gait and what's the significance of it being normal?

A. Gait is the way a patient, person walks.

Q. And if someone has a normal gait does that mean they don't have an injury?

A. Absolutely not.

Q. Prior to seeing you on August 19th, you mentioned he had had other treatment?

A. Yes.

Q. And you reviewed that other treatment?

A. I did.

Q. Okay, specifically with the Med Alliance treatment, do you have -- those records are in evidence by the way, so you can refer to them.

A. Yes. I referred him a physical therapist, Dr. Ehrlich, he had approximately 40 physical therapy at our facility at Med Alliance in the Bronx. And he had more treatment by Vista (phonetic) as well.

Q. Now, do you know whether prior to having his knee surgery Mr. Montas had had a knee MRI?

A. He did.

Q. And did you review that MRI?

A. I did.

Q. Now, subsequent to that, he had a knee surgery, correct?

A. That is correct.

Q. And you reviewed the operative report?

A. Yes, sir.

Q. Do you have an opinion as to the accuracy and the importance of operative reports with regards to a knee as

opposed to an MRI?

A. I do.

Q. And what is that opinion?

MR. JONES: Objection.

THE COURT: Overruled.

A. Intraoperative findings are much more accurate and complete as compared to an MRI. MRI stands for Magnetic Resonance Imaging. The inventor in the 1970 found a way with sophisticated magnets to take the body protons and transfer them into real life images to see what's going on with the soft tissues, the cartilage, the discs, the ligaments, et cetera, and it's only an image of the actual pathology that you're trying to study, so it's not one hundred percent. Whereas the intraoperative findings, you are putting a scope and with your own eyes you are looking and directly seeing what is wrong.

So the intraoperative findings is much, much more accurate than the MRI. The arthroscopic procedure is done when the MRI is inconclusive and the patient still has tremendous -- has difficulty and has pain and has clinical findings, that's then when you do the diagnostic arthroscopy. If you see anything wrong, you correct it surgically.

Q. Was that the case here with regards to the MRI?

A. Yes, sir.

MR. JONES: Objection.

THE COURT: Sustained.

Q. What was the case here with regards to the MRI?

A. The MRI of the left knee showed --

Q. -- Without giving the specific findings of it.

A. It did not show the proper findings. The patient continued to have pain and clinical findings of the knee examination and the surgeon felt that he had to do -- a next decision would be a diagnostic arthroscopy. It's done for diagnosis. If you see something, you correct it surgically.

Q. Now, doctor, with regards to joint, is there a difference in reliability of MRIs as far as joints versus let's say discs, spinal discs?

A. Yes, the knee and the shoulder are both complicated joints. The shoulder is probably the most complicated joint in the body. There is a lot of grooves and crevices around to navigate and MRI is not always successful to detect the pathology where the arthroscopy is much, much more accurate in detecting the pathology.

Q. Doctor, did you review the operative report for the left knee for Mr. Montas?

A. Yes, sir, I did.

Q. By the way, before we get to that, do you ever -- do MRI ever give false positive? What is a false positive?

MR. JONES: Objection.

THE COURT: Sustained.

MR. OGEN: Okay.

Q. Doctor, what's a false positive?

A. A false positive means it gives you something abnormal when in fact it's not there. So it's a wrong report. And false negative it's the same thing. It's something that's reported as negative or normal when in fact there is something abnormal. Happens many times.

Q. And, doctor, would -- in giving a diagnosis on a case, what is the importance of an MRI when there is an operative report?

A. The operative report cancels the MRI findings because the operative report supersedes it. It's much more intensive, much, much more accurate. And in the medical field, once there is an operative report everyone goes by the operative report not by the MRI.

Q. Now, doctor, let's call your -- our attention to the left knee operative report of Mr. Montas from June 10th of 2010. Do you have that in your records?

A. I do.

Q. Okay, that is in evidence as well. So you can refer to it freely. And, doctor, I'm going to ask you some questions about it. Do you have any assisted devices with you that would help explain the findings in the operative report?

A. Yes.

MR. OGEN: May I hand these up?

THE COURT: Go head.

(Whereupon, the referred to item was handed to the witness.)

MR. JONES: I make an objection, Judge, it's subject to redaction. These are not the doctor's records so hearsay document with my objection, any testimony in regards to that.

THE COURT: In terms of the operative report?

MR. JONES: Yes.

THE COURT: Okay, overruled.

Q. Doctor, do you have any operative report in front of you?

A. I do.

Q. When did Mr. Montas have his operation?

A. To his left knee on June 10, 2010.

Q. Okay, and who was the surgeon?

A. Dr. Ehrlich.

Q. And where was it done?

A. At the surgery care, Ambulatory Surgery Center of New York in the Bronx.

Q. And did Dr. Ehrlich have an assistant?

A. He did.

Q. And just generally, what type of surgery was this?

A. Diagnostic arthroscopy and operative arthroscopy.

Q. What does that mean?

A. Diagnosis means you put a scope inside a patient's knee

under anesthesia and you look around different portions. You look in the medial. Medial means inner, lateral means outer, from the front, two different views from the back, to see if there is anything torn or damaged inside the knee.

You look at the different structures which I will show it through my models. And if you see anything that is damaged, you surgically correct it to the best as can be corrected.

Q. Right. And prior to the surgery, did Dr. Ehrlich list a preoperative diagnosis?

A. He did.

Q. And what was that?

A. Internal derangement of the left knee.

Q. What does that mean?

A. Internal derangement means -- internal means inside, derangement means something that is off, that is abnormal but it's not exactly sure and the intense to find out what that is by way of diagnostic arthroscopy. And the postoperative is after the procedure is performed.

Q. And was this surgery done under anesthesia?

A. Yes.

Q. What type of anesthesia?

A. General anesthesia.

Q. What does that mean?

A. You put the patient to sleep completely by way of mask intubation and anesthesia, to put the patient completely asleep.

Sometimes we have twilight sedation, the patient is half awake half asleep, but general anesthesia the patient is completely asleep.

Q. Are there risks to this surgery?

A. Yes.

MR. JONES: Objection. He's not an orthopedic surgeon. Outside the scope, hearsay.

MR. OGEN: I'll withdraw it.

THE COURT: Okay.

Q. Are you qualified to testify regarding the risks of this type of surgery?

MR. JONES: Objection. Leading.

THE COURT: Sustained.

Q. What are your qualifications with regards to testifying regarding the risk of this surgery?

MR. JONES: Objection.

THE COURT: Overruled.

A. The risks of the surgery are known to any physician that deals with these type of problems and it's also still right in the report. The risks are -- if you like, I can tell you.

Q. Yes, please.

A. From general anesthesia the risks are death, respiratory suppression, you may not wake up. It happens on a rare occasion. The arthroscopic surgery can cause infection, can cause damage to other structures and it can cause

hypovolemic shock. You can go into shock and you can have asepsis massive infection so these are the basic common side effects dangers from this type of a procedure.

Q. And, doctor, what was done in this surgery?

A. The patient had a left knee arthroscopic surgery, had achondroplastic of the patella, which I will show with the models, and major sign of ectomy. The doctor removed the synovium which is the covering to the joint and there were multiple loose bodies that were removed arthroscopically.

Q. You mentioned a bunch of medical terms. Do you have any models with you to explain what those medical terms are?

A. I do.

MR. OGEN: And with Your Honor's permission, can the doctor illustrate --

THE COURT: -- Okay.

MR. OGEN: -- what the general structure of the knee and what was found in this surgery?

THE WITNESS: May I step down?

THE COURT: Go ahead.

THE WITNESS: Thank you.

A. So just to orient everybody, this is a model of the knee. This is the tendon of the femur, the long bone that goes into your hip socket. This is your tibia all the way down to your foot. This is the shinbone. This is the tiny bone that sticks out on the outer portion of your foot and ankle.

Now, this is the femoral chondral which sits in this glove and this is the lateral femoral Chondral. This is the medial and this is the glove where the articulation occurs. The knee joint extends and flexes at this level.

Now, this is your kneecap, it's called the patella. As you can see, normally it has a very smooth surface. It has to be smooth. It has to sit exactly in the middle so it glides, if the surface is not smooth it will not glide normally.

Make believe you have a patio door and a very, very smooth crease and a glove and someone puts sand, a little pebble inside and trying to open and close that patio door, it will not do so.

Same thing happens if the patella is damaged. Now after if the patella is damaged, which happened here, it will begin to move away from its normal midline location. It usually goes away from the joint line and then you have mal tracking, you have a lot of friction when you open and close your knee.

So then you have the meniscus, meniscus is the cartilage that serves for three purposes, as a shock absorber between the two bones; second, it attaches the two structures to the knee joint; and third and most important is it lubricates the knee joints. You take the liquid we have inside the knee which is called the synovial fluid, it lubricates it, it squeezes it around the knee joint. So if a kneecap is damaged, if there is problem inside we have abdominal pain, each

structure aggravates the other structures and the knee is not able to function properly. So, in this case the synovial is the coverage, it's a membrane that covers the knee joint. That was very, very inflamed. Inflamed becomes red and swollen, it has to be removed so now the knee is exposed to any kind of inflammation and there were loose bodies. The loose bodies came from the patella and the joint line. Look and see how smooth this joint line is. See how smooth this joint line is? Now, this is what happens when you have an injury to that area. The patella begins to have chondral lesions. These are all chondral lesions, instead of dimples, inside the knee.

Okay, now this is not going to glide smoothly here and also you're going to have the sand regions on other portions of the joint. So this is cartilage. Cartilage is soft bone. Once it gets damaged, pieces can break loose and form inside the joint.

If you have a little pebble inside your shoe when your walking, what happens? You feel discomfort, you can't walk properly. Same thing happens with these. So there were multiple loose bodies inside this joint which had to be removed with the arthroscopy by suction and the joint had to be cleaned up. That's basically what the patient had.

MR. OGEN: Thank you.

Q. Now, doctor, what did the surgeon do when he found those loose bodies based on the operative report?

A. The arthroscopy is a long scope, at the end of it you have a handle which suctions out fluids and it has another handle which forces fluid inside the joint and at the end of it you have a little scope, you could look inside, and the scope has the ability to magnify it so you can magnify everything while you are looking inside. It also has a light so you can see exactly what you're doing. So the doctor that identified what was wrong with the knee joint and then he shaved the patella, the under portion of the kneecap, he shaved it and he removed loose bodies by suctioning them out. And he did major synovectomy, he removed that membrane that covers the knee joint because it was inflamed, it was very swollen and red.

Q. Those loose bodies, do you know if they showed up on the MRI?

A. They did not.

Q. How about the synovium inflammation?

A. They did not.

Q. Doctor, do you have an opinion as to whether this surgery was required for the patient?

A. Yes.

Q. And why?

MR. JONES: Objection. He's not a surgeon. He did not participate in the surgery.

THE COURT: Overruled.

A. It was required for a variety of reasons.

Q. And what are those reasons?

A. In the medical field we have first to do an x-ray to make sure nothing is broken. We do an MRI to see if there is anything damaged inside. The MRI may show the problem, it may not. In this case it did not, but there was a lot of complaint, there were a lot of clinical findings.

The next thing is a diagnostic arthroscopy. You put the scope in, if you see nothing wrong you come out. If you see something wrong, you correct it. That's exactly what was done. You go from the least invasive to more -- from the most conservative to more invasive.

Q. Now, doctor, in making a diagnosis here, are you missing anything if you're not incorporating the MRI to the diagnosis?

A. In this case no, because the MRI didn't show very much, just a little infusion. And it may consist where the intraoperative findings did not find a baker's cyst. A baker's cyst is a little cyst in the back of your knee. A cyst is a growth like my fingers. It can come from -- nobody knows exactly where it comes from, food nutrition, other possibilities, but the intraoperative findings completely contradicted the MRI findings.

Q. Now, doctor, if I were to tell you hypothetically that there was testimony that the plaintiff was rear-ended in this case, his vehicle was pushed forward into another vehicle and

that his left knee twisted and hit into the dashboard, do you have an opinion as to whether that is consistent with the injury here?

A. Yes, it is.

MR. JONES: Objection. Not the doctor's area of expertise, Judge.

THE COURT: Overruled.

Q. Have you treated such patients before?

A. Thousands of them, yes.

Q. Have you made diagnoses for such patients before?

A. I have, yes.

Q. Have you made causal relation determination for such patients before?

A. Absolutely.

Q. How many times?

A. Tens of thousands.

Q. Is this within your area of expertise, doctor?

A. Yes, sir, it is.

Q. Doctor, do you have an opinion with a reasonable -- well, with a reasonable degree of medical certainty as to what the diagnosis is with regards to Mr. Montas' left knee?

A. Yes. He has traumatically induced chondromalacia, that is, the under surface of the knee was damaged. He has chondral lesion, as I showed you those little dimples inside the joint that was crossed by that. He had synovitis, which means

inflammation of the membrane that covers the knee joint, had multiple loose bodies.

Q. And do you have an opinion as to whether this injury is causally related to the accident of March 19, 2010?

A. The answer is yes for a variety of good reasons.

Q. And what are those reasons?

A. In the medical field we make diagnosis prognosis and causal relationship based on all the facts. The history, the fact that there was no prior problems to his knee. The fact, that of his age, 23, 24 at the time of the accident. He had never gone to a doctor for any problems, had never had a knee MRI. He had never had surgery to his knee. When you put all these things together and you have a history of a causal relationship of a direct trauma, a hit from the rear where his kneecap hits the part of the car in a twisted fashion that can very easily cause that problem.

Q. Doctor, are you aware of the patient's history of having played baseball over the years?

A. Yes, we've discussed that in great length, yes.

Q. Do you know if prior to this accident he had played baseball?

A. Oh, yes, he was a good baseball player.

Q. Okay. And, doctor, do you have an opinion as to whether his baseball playing caused these injuries?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Do you have an opinion as to whether these injuries are related, causally related to the playing of baseball?

MR. JONES: Judge, no exchange on that at all.

THE COURT: Sustained.

Q. In your opinion is there anything else that caused these injuries other than the car accident on March 19, 2010?

A. In my opinion, no, sir.

Q. Does -- would playing baseball cause these kinds of chondral injuries?

A. No, specially not at the age of 23.

Q. Let's go to the shoulder, okay. Did you have an opportunity to review the shoulder operative report?

A. Yes.

Q. And are you familiar with these types of operations as well?

A. Yes, sir.

Q. And when was that operation done?

A. February 10, 2011 at the same facility in the Bronx.

Q. And who was the surgeon?

A. Dr. Ehrlich.

Q. And did he have an assistant with him?

A. Yes, Adam Barile, physician assistant.

Q. And was he under anesthesia?

A. Yes, again general anesthesia.

Q. Okay, are there types of risks for these surgeries as the other one?

A. Yes, sir.

Q. And generally, what was done in this surgery?

A. He had a diagnostic arthroscopy with arthroscopic debridement. Various different structures, the labrum, that's the link around the shoulder and the capsule around the shoulder joint and the removal of the distal portion of the clavicle, that's the collar bone, and subacromial decompression. I would have to use my model again to explain what all these things are.

Q. So doctor, did you bring a model that will help explain that?

A. Yes.

MR. OGEN: Can I give this to the doctor, please?

THE COURT: Go head.

(Whereupon, the referred to item was handed to the witness.)

THE WITNESS: Thank you.

Q. Doctor, can you explain what was done in this surgery and the general structure of the shoulder?

A. Yes. When you do the -- first may I come down to explain?

MR. OGEN: Your Honor, may he step down?

THE COURT: Yes.

MR. OGEN: Thank you.

THE COURT: You're welcome.

(Whereupon, the witness is illustrating to the jury.)

A. To understand what was done for the shoulder we have to first understand what the shoulder joint is like. It is the most complicated joint in the body because we have three different articulations at one spot. We have the scapula, we have the clavicle and we have the humerus. The shoulder has six range of motions. You have shoulder flexion, zero to one eighty. We have shoulder extension zero to ninety. We have abduction, zero to ninety. We have adduction zero to 75. We have external rotation zero to ninety. We have internal rotation zero to ninety. External rotation could be tested this way and internal rotation can also be tested this way.

So, this is the clavicle, that's the collar bone. This is the head of the humerus and this is the scapula. This is the acromion. It's like a little hook right here now.

MR. JONES: Can I see what you are pointing to the acromion?

A. Okay. Now, in some cases the acromion points downwards, when it points downwards right underneath it there is a structure, a supraspinatus tendon muscle. Look at how tight this space is over here. When it points downward it can catch that muscle. When you go above one hundred fifty degrees, that is the impingement arc. Posterior signs is the signs of

impingement which the patient has.

Now, right in this space here there is a little bursa, which is a sac filled with fluid which is a shock absorber, that was inflamed, that was partially removed. So the clavicle approximately away from the heart. This portion of the clavicle was partially removed and the under surface of the acromion was shaved so it has more space so it doesn't catch the supraspinatus tendon. And the labrum is your rim around the shoulder, that was torn so that was surgically shaved to make it smoother so it doesn't cause disfunction.

So and there was adhesion. Adhesions are scar tissues. That was formed, that was removed by a radial frequency procedure which burns them and freeze up all that scar tissue.

Picture a scar tissue or picture like a spiderweb. A spiderweb inside a joint, so that's basically what was done.

Q. Okay, thank you, doctor.

A. You're welcome.

Q. Doctor, do you have an opinion as to whether this surgery was required?

A. Yes.

MR. JONES: Objection.

THE COURT: Overruled.

Q. And what is that opinion?

A. It was required because the patient had continuous pain, the range of motion for the shoulder flexion and other

range of motion was diminished. The patient had a positive painful impingement arc. These were all abnormal. Again, the MRI did not show very much the surgeon what was causing the patient's problem. The diagnostic arthroscopy found the problem and surgically rectified the problem to the best that could be rectified.

Q. Now, doctor, with regards to going back to the knee surgery a moment, did the surgery fix his knee, did it cure him?

A. No. The kind of problems that are present don't have a cure, they have treatments. In the medical field we have many conditions that have no cure, they have treatments. Diabetes is one, arthritis is another one, asthma is another one. They have treatments, no cures. So once you have a damage to inside a joint like this, the knee and the shoulder with these kinds of problems all you can do is make them better.

The labrum, that rim is cartilage, once cartilage is torn it doesn't have the ability to repair itself, you can't glue it back together, you can't suture it back together. All you do is you shave the jagged edges. Like when your nail that is torn and the nail gets caught on your clothes, what you do you? File it down. You cut it with a scissor short, you file it down so it doesn't continue to get caught. That is something similar to the shoulder as well.

And when a synovium is that swollen and red, doesn't even go down as it did not in this case, you have to remove it.

If you don't remove it it's going to cause constant swelling and pain.

Q. And again, doctor, with regards to the shoulder did you arrive at a diagnosis?

A. I did.

Q. What is your diagnosis?

A. There was subacromial impingement. I showed you in the model what that is. And there was acromioclavicular joint damage, that's the joint where the clavicle meets, the shoulder joint here. And there was capsular contracture from adhesions from the scar tissue, and there was a posterior labral tear.

Q. Doctor, in this situation, are you missing any part of the diagnosis by not incorporating the MRI into the diagnosis?

A. No, the MRI missed the boat.

Q. And do you have an opinion with a reasonable degree of medical certainty as to whether these injuries were caused by the accident on March 19, 2010?

A. Yes, sir, they were.

Q. And what do you base that opinion on?

A. Based on the history, the operative findings and the fact that again the patient had no prior symptoms to the shoulder, never required x-rays, MRIs or treatment to this shoulder until this accident.

Q. Now, doctor, did the -- in the shoulder, did the operative finding find something called arthropathy?

A. Yes.

Q. What does that mean?

A. That means damage to the joint opathy means damage, arthro means the joint.

Q. Does that mean that it's something that pre-existed the accident?

A. No, sir.

Q. Now, did the patient have any kind of anatomical variation prior to this accident on March 19, 2010?

A. Yes, he had a natural low line acromion which I showed you on that model which predisposed him to this type of an injury because the space between the acromion and the joint and the supraspinatus muscle was very small, normally should be this much. In this case it was like so. It's very easily for that muscle which is the supraspinatus tendon to get caught in there when you do shoulder flexion, which he had in this case, but because of the swelling, because of the scar tissue because of the traumatic findings, that made that condition worse but he was predisposed to it.

Q. Is that -- was that his injury here or was it something else?

A. No, no, no, that was not his injury. His injuries were the tear of the rim around the shoulder joint, that's the labrum. He had contracture of the different structures inside the joint, he had joint abnormality, the sub -- the acromion and

the bursa which is underneath it became inflamed, so that had to be removed as well as the distal portion of the clavicle had to be resected, cut, so that it puts less pressure on the joint.

Q. Was there any evidence of preexisting injury to his shoulder prior to this accident or the surgery?

A. No, preexisting would be osteophytes bony projections and there were none present, not to the knee, not to the shoulder.

Q. Now, doctor, you examined him on various occasions?

A. I did.

Q. And did you also review findings of his examinations by Dr. Ehrlich and other doctors?

A. Yes, sir.

Q. Okay. Now, were the findings from visit to visit always consistent?

A. No, in some occasions I found that the range of motion of his shoulder was completely normal and in many occasions I found that it was not normal, it was abnormal.

Q. The fact that on certain visits he had normal range of motion does that mean that he didn't sustain an injury?

A. Absolutely not. That's why you have to examine the patient on multiple occasions not just once because if you examine a patient only once, you will not see the variations from time to time.

Q. All right, now doctor you saw him in 2010?

A. Yes.

Q. Okay, we talked about that. Did you see him following 2010?

A. Yes.

Q. When did you see him?

A. I saw him on 10/20, 2012. I saw him on 2/20, 2013. I saw him on June 22, '15. Saw him on November 7, 2015, at that time his left knee was very painful, had to give him an injection with cortisone. I saw him again recently on January 25, 2016.

Q. Did you also see him on September 8, 2012 when you wrote a report?

A. Yes.

Q. Now, do you have knowledge as to why he didn't come to you more frequently than that?

MR. JONES: Objection.

A. Yes.

MR. JONES: Objection.

THE COURT: Sustained.

Q. Did the patient advise you why he didn't come to you more frequently?

MR. JONES: Still objection.

THE COURT: Sustained.

Q. Do you know if the patient had coverage to see you?

MR. JONES: Objection.

THE COURT: Sustained.

MR. JONES: I'm going to have an application, Judge.

Q. Are there times when patients don't come to see you frequently?

MR. JONES: Objection.

THE COURT: Overruled.

A. Yes.

Q. And what are some of the reasons for that?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Doctor, who is qualified to give a diagnosis of someone's injury?

A. It has to be a physician, a duly licensed physician.

Q. And who is qualified to give causation opinion as to an injury from an accident?

A. A physician who interviews the patient, takes a history, examines the patient and reviews pertinent medical records.

Q. And who would be in a better position to do that, would that be someone who is seeing the patient several times over the years or someone who examined him one time a few years ago?

A. Obviously one who examines the patient several times because as I explained to you, I examined him on some occasions, his range of motion was completely normal but on multiple

occasions it was abnormal. So if I had to examined him on once, let's say the first time I saw him on 8/19/10, on September 8, 2012 the range of motion for the shoulder was normal but all the other dates it was abnormal.

Q. Now, doctor, have you treated patients before that have been involved in car accidents?

A. Yes.

MR. JONES: Asked and answered, Judge.

THE COURT: Sustained.

Q. How many?

A. Tens --

MR. JONES: -- Still objection.

THE COURT: Sustained. He answered you.

MR. OGEN: Okay.

Q. Have there been situations where some of your patients were in car accidents where there was a lot of damage?

MR. JONES: Calls for a hearsay response, Judge.

MR. OGEN: I didn't finish my question. May I finish my question?

THE COURT: Finish the question.

MR. OGEN: Thank you.

Q. Are there situations where patients have been involved in car accidents where there was a lot of damage to the vehicles but they did not suffer significant injuries?

MR. JONES: Objection.

Q. Yes or no?

THE COURT: Sustained.

MR. OGEN: I'm sorry?

THE COURT: Sustained.

MR. OGEN: Okay.

Q. Have you had occasion to treat patients where there wasn't a lot of damage to the vehicle but the patient did sustain significant injury?

MR. JONES: Same objection, Judge.

THE COURT: Sustained.

Q. Doctor, have any of your patients ever told you about how much damage they had to their vehicles?

MR. JONES: Objection.

THE COURT: Sustained.

Q. When you diagnose a patient, do you look at photographs of the damage to the vehicle?

MR. JONES: Objection.

THE COURT: Sustained.

Q. How do you diagnose a patient?

A. Taking a pertinent detailed history, pertinent physical exam and reviewing whatever is pertinent medical records or operative reports.

Q. Okay, are photos of the vehicle pertinent?

MR. JONES: Objection. Same objection, Judge.

THE COURT: Sustained.

Q. Do photos figure into your diagnosis?
A. No.
MR. JONES: Judge.
THE COURT: Sustained.
Doctor is here to testify about medicine, he's treating this patient, his opinion on this patient not on photos of car damages, et cetera.
Q. Have you ever looked at photographs in order to diagnose a patient?
MR. JONES: Judge, this is enough.
THE COURT: I'll let you. Yes or no, you ever looked at photos?
THE WITNESS: No, Your Honor, no.
Q. Why not?
THE COURT: Sustained.
MR. JONES: Thank you.
Q. Is someone who is not a licensed doctor qualified to diagnose a patient?
MR. JONES: Objection.
A. No.
MR. JONES: Irrelevant, Judge.
THE COURT: To medically diagnose him?
MR. OGEN: Yes.
THE COURT: I'll take judicial notice but if you're not licensed to practice medicine you should not be

rendering diagnosis treatment or anything else to human being patients.

Q. If someone who is not a licensed doctor qualified to determine causality of an injury to the --

MR. JONES: -- Judge.

THE COURT: Sustained.

MR. JONES: Move to strike.

THE COURT: Qualified judicial notice. There are other physicians, assistants, et cetera, but on this point sustained. I'm not going to have a doctor comment on who else is qualified to give an opinion on things relevant to this case.

Q. Doctor, in this case did you find any evidence of preexisting injuries or conditions that caused the injuries of March 19, 2010?

MR. JONES: Outside the scope, Judge.

THE COURT: Overruled.

A. Absolutely not, for the reasons I gave. There was no osteophytes, there was no sign of degeneration, no sign of significant arthritic findings to connote the possibility of preexisting condition and also the patient's age at the time, 23, 24.

Q. And, doctor, do you have an opinion as to whether these injuries are significant?

A. These injuries are very significant.

Q. Why?

A. Because you invade the integrity of a normal joint, that would be the left knee and the shoulder. You removed synovium from the knee joint, you took a metal probe inside the knee joint and you manipulated different parts of the joint both to the left knee and to the shoulder and you resected different structures from the shoulder. Resection means you remove. You removed the distal portion of the clavicle, you removed the bursa underneath the acromion and you shaved part of the acromion. That's going to come back, it's all going to come back. You did not cure anything. You made the patient symptomatically better but you are far from curing the patient. That is going to come back again in the very near future.

Q. What is the prognosis for this patient?

A. This is a permanent condition that will slowly and progressively worsen over time as he ages.

Q. Will he need future medical care?

A. Absolutely.

Q. Of what nature?

A. He will need to be seen by an orthopedic surgeon at least six times per year to assess the condition to the knee and to the shoulder to see if and when he needs another surgical procedure. He will need to see a physiatrist like myself at least once a month to assess the need for physical surgery, medication, diagnostic duties, referral to different

specialists. He will need at least thirty physical therapy sessions a year to diminish pain, spasm and prevent further worsening. And he will need medication for pain and inflammation periodically as needed.

Q. What are the costs of those treatments?

A. The visits for the orthopedic surgeon is one hundred fifty, the visit for the physiatrist is the same, physical therapy is approximately one hundred to one hundred fifty, depending on how long the treatment is. He will need periodic MRIs of the right shoulder, left knee every two to three years to reassess inside the areas, the cost would be about $1,000. And he will need future procedures to the shoulder and to the knee if that condition worsens and the cost would be ten thousand for each surgery. And the patient will need physical therapy after, three times a week for four to six months.

Q. And is this permanent?

A. The condition is permanent and progressive, as I explained earlier.

Q. You mentioned repeat MRIs, given that it's a joint, would those still be helpful?

A. Yes, because then you want to make sure the other structures are not getting damaged, such as the rotated cuff, such as the other structures inside. You want to make sure there is no capsular thickening around the area. You want to make sure the labrum -- in this case it was torn from the back,

posterior is the back. Now you want to make sure the labrum doesn't get torn from the front or the side. So all of these things have to be checked periodically.

Q. Doctor, if I were to tell you hypothetically that there was testimony that the plaintiff went back to playing baseball a year ago or two years ago, played part of a season, played different positions, catcher, infield; do you have an opinion whether someone is able to do that when he has those injuries?

A. They can.

MR. JONES: Outside the scope, Judge, no exchange on that.

THE COURT: Overruled.

A. Can they? Yes. Can they do it as good as before? No.

Q. Are there situations where people have surgery and they can go back to playing sports?

A. They can but it will never be -- I shouldn't say never -- they generally will never be as good as they were before the pre-injured state.

Q. And is it a good idea to continue to play?

A. Well, every case is different. Some cases maybe, some cases no.

Q. The fact that he's able to play baseball, does that mean he wasn't injured in this accident?

A. Absolutely not.

Q. Can someone sustain a chondral injury to the knee and continue to play baseball?

A. They can. They won't be able to run as fast. They won't be able to be as flexible as before.

Q. How about a labrum tear and the other injuries in the shoulder, does that mean they can't play after that?

A. They can play again, they won't have as much power, they won't have as much flexibility and as much ease in which to play.

Q. And if someone does continue to play, does it mean they weren't injured?

A. Absolutely not.

MR. JONES: Objection. Leading.

THE COURT: Sustained.

Q. All right, you mentioned that you saw him on November 7 --

A. -- Yes.

Q. -- 2015? What happened at that visit?

A. He had right shoulder pain and left knee pain and the left knee was very painful. And on physical examination there was joint line tenderness and was very tender and I gave him an injection of lidocaine and cortisone and I prescribed Mobic, M-O-B-I-C, a pain killer, anti inflammatory medication for him.

Q. And what is the reason for giving the injection?

A. To diminish the swelling and the pain.

Q. And is that -- withdrawn. Did you see him subsequent to November 7th?

A. I did.

Q. And did you examine him on that date?

A. I did.

Q. And what was the reason that you saw him, if you know?

A. My most recent examination of 1/25/16. Generally if I haven't seen the patient in a while, I'd like to see them again to see what the current condition is. And when I saw him, his left knee was acting up again, it was tender and swollen and I had to do a procedure for the knee.

MR. JONES: Your Honor, may we approach, Judge?

THE COURT: Yes. Actually let's go in the back.

MR. OGEN: I'm not going to ask anything further about that, so.

THE COURT: Okay, for now we'll wait till he's finished.

MR. JONES: Okay.

MR. OGEN: I'm almost done.

THE COURT: Okay.

MR. OGEN: I might be done. Let me just double check.

Q. Oh, doctor, is that your true and accurate file for Mr. Montas?

A. Yes.

MR. OGEN: All right, I ask that the doctor's file be admitted into evidence subject to review and redaction.

MR. JONES: No objection to that.

THE COURT: I'm not sure what number we are up to. And it will be admitted and redacted.

MR. OGEN: Thank you.

THE COURT: Okay, now we'll all take a break before cross-examination. We'll take ten minutes.

Please don't discuss the case.

THE COURT OFFICER: All rise. Jury exiting.

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

THE COURT: You can step down.

THE WITNESS: Thank you.

(Whereupon, the witness exited the stand.)

THE COURT: Back on the record.

MR. JONES: Judge, one, Dr. Guy was present this morning when you made the ruling about precluding testimony as to any procedures done two days ago, meaning Monday the 25th.

THE COURT: Right.

MR. JONES: And he just, nevertheless blatantly just blurted that out in front of the jury knowing the Judge's ruling and, you know, it's a flagrant disregard of this Court's instruction and I think it's a basis for a

mistrial. And that's my first request.

So, that's my application, Judge. I think the doctor should be admonished with respect to his testimony in that regard. He's been over -- in court over 250 times, heard you say what he was not supposed to say and did it anyway.

MR. OGEN: I don't know what he heard or didn't hear, there were no direct instructions to him. And he also -- he didn't say, he didn't go into detail. He said, I saw him, I did a procedure. You know, he didn't like go into detail. I don't think there is anything there and he can cross him on it if he wants.

THE COURT: Well, but even in a position in crossing is putting him in a position of bringing even more out about it. He was here, he did hear it and you probably -- then if I didn't direct it to him, you certainly should have told him not to comment on anything past November or whatever it was, November 9th or whatever the date was.

I'll reserve decision on the mistrial application. I did hear him say the visit, I'll reserve decision.

Now, let me ask you, short of a mistrial if I won't, do you want some curative instruction? You are then in a position. You want to emphasize it more?

MR. JONES: No, I think that would make it worse.

THE COURT: I agree. If I bring it up to the jury again to disregard it I'm bringing it up to the jury again, so.

MR. JONES: Yeah, it's bad enough that he refuses a subpoena to provide us with the records, to give us a chance to review them and makes it worse that he compounds a problem by disregarding the Court's directive when he was right here when the Court was giving those instructions.

THE COURT: Okay, I will reserve decision. I won't say anything to the jury. I'll tell Dr. Guy specifically when he comes back -- he's not here -- to not to -- no matter what the question is, not to bring up Monday's visit. It's not a subject of this trial.

MR. OGEN: I believe Your Honor said we could talk about the visit, just not about the injection. I think that was what Your Honor was saying.

THE COURT: Right, but he didn't just say he saw him, he said I gave him some treatment.

MR. JONES: I understand.

THE COURT: We know what the treatment was, so not talk about that beyond the fact that he saw him. And I'll reserve decision.

Is there anything else?

MR. JONES: Yes, Judge.

MR. OGEN: Judge, I just want to say one thing

regarding that if I may to close that up.

THE COURT: Yeah.

MR. OGEN: There is no evidence that a subpoena was served on Dr. Guy's office or that it was ignored, so I just want to put that out there.

THE COURT: Okay.

MR. JONES: Well, I'll avoid the rules of exchange. We know what they are.

A second matter Judge is the films. Now, we have on the subpoena Dr. Rigney and we'll be bringing our own examining radiologist to review the film, that's Dr. Jeffrey Berkowitz (phonetic). For expediency I'm going to offer those films into evidence without the need of calling Rigney.

THE COURT: Is that Dr. Guy?

MR. JONES: No. For Monday we have to issue a check very soon.

THE COURT: We talked about this yesterday, he was going to think about it and he was going to tell you right about now.

MR. OGEN: And I was just going to tell you I will consent to the films coming into evidence without the need for you to bring that foundational witness.

MR. JONES: Okay, let me -- okay.

THE COURT: Okay, Dr. Guy come back up.

(Whereupon, the witness took the stand.)

THE COURT: And the only thing I'm going to ask is no matter what he ask you about your current future, you saw him, the plaintiff, on Monday, do not discuss anything other than you saw him. And you know he's still in pain, whatever, but not any treatment shots.

THE WITNESS: Yes, Your Honor.

THE COURT: Okay.

Now, the fact of the matter, how long do you think the cross is?

MR. JONES: I'll be here until lunch, beyond lunch.

THE COURT: So we will be here till this afternoon?

MR. JONES: Yes.

THE COURT: And you have your guy coming in the afternoon?

MR. JONES: Yeah, I'm meeting him downstairs.

THE COURT: If you need ten minutes but if it's going to go on extensively after lunch, then we'll just break at one and come back at two.

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Welcome back. Have a seat. Everyone

can have a seat.

Whenever you're ready counsel.

MR. JONES: Thank you, Judge.

CROSS-EXAMINATION

BY MR. JONES:

Q. Good afternoon, doctor.

A. Good afternoon, sir.

Q. We've met before, correct?

A. Yes, we have. Yes.

Q. Are you familiar with the rules of cross-examination having testified about two hundred plus times?

A. I'm familiar with the rules, yes, sir.

Q. If I ask you for an explanation, feel free to do so, otherwise I'm going to ask you on occasion to confine your responses to yes or no. Okay?

A. Okay.

Q. All right. Now, as of today, would it be fair to say you testified on behalf of litigants in lawsuits in excess of two hundred times?

A. Yes, for my patients. Plaintiffs, yes.

Q. You called them patients. We'll get into that in a moment.

Are you saying that Mr. Montas is your patient?

A. Yes, sir.

Q. Okay. That can alter certain treatment on behalf of

the doctor, doesn't it?

A. That could what?

Q. You mean you did certain things for him as his physician, correct?

A. Plus give him medical advice and treatment.

Q. So he's your patient and you are his doctor?

A. I'm one of his doctors, yes.

Q. Well, he didn't come to you independently, right? Wasn't he referred to you by the plaintiff's office?

A. No, he was referred to me by Dr. Ehrlich on Med Alliance on 8/19. As I explained earlier.

Q. Med Alliance; is that correct?

A. That's correct.

Q. I'm going to show you what's previously been marked as Defendant's B for identification, take a look at that.

(Whereupon, the referred to item was handed to the witness.)

Q. Does Med Alliance appear on that document?

A. Yes.

Q. Is it part of the business records maintained by your office with respect to the treatment of Mr. Montas?

A. It's not my office.

Q. Are you Med Alliance?

A. I am an employee of Med Alliance. It's not my office. I work there.

Q. Is it their record, doctor?
A. It is. It appears to be, yes.
Q. Does it pertain to the care and treatment of Mr. Montas' result of the accident on 3/19, 2010?
A. This says orthopedic intake form, that's what it indicates.
Q. You are telling me looking at Med Alliance Mr. Montas, that's not your record?
A. This is not my record. It says orthopedic. I'm not orthopedic. I'm pain management and physical physiatry.
MR. JONES: We'll play this game for a little while, doctor.
MR. OGEN: Objection.
THE COURT: Sustained.
Q. Med Alliance appears in that document, correct?
MR. OGEN: Objection. Asked and answered.
THE COURT: Overruled.
A. Yes.
Q. You are an employee of Med Alliance?
A. I am.
Q. Does the name of Lazaro Montas appear on that document?
A. Yes.
Q. His date of birth, April of 1996?
A. Yes.
Q. And does Dr. Ehrlich's name appear anywhere in that

document?

A. No, just says orthopedic intake form but no Dr. Ehrlich.

Q. Who is the orthopedic surgeon who treated Mr. Montas?

A. Dr. Ehrlich.

Q. Is -- does it say orthopedic intake there?

A. It does.

Q. What's the date on there?

A. The date 4/9/10.

Q. Take a look at your records. When is the first day that Mr. Montas went to Med Alliance?

A. The first time was on 8/19/10.

Q. Not you, when he appeared at Med Alliance for the first time. Look at your own notes.

A. Doesn't say the first time he came to Med Alliance.

Q. 4/9 of 2010, doctor, doesn't it?

A. That's on intake form, not on my records.

Q. Have you any idea when he appeared at Med Alliance?

A. No.

Q. Take a look at your report, doctor?

A. Which report?

Q. 8/19 of 2010.

A. Okay.

Q. You see that?

A. I do.

Q. Look at the second line, see the initial report 4/9, 2010 on your narrative?

A. Right.

Q. So you do see it?

A. The way you phrased the question was when was the first time he came to Med Alliance. That's the first time he saw Dr. Ehrlich. That's a different answer to your question.

Q. Is Dr. Ehrlich affiliated with Med Alliance?

A. There are many doctors at Med Alliance.

Q. That wasn't my question.

A. He is.

Q. So, we're talking about Dr. Ehrlich, yourself and Med Alliance.

Are you telling us, doctor, that this piece of paper right in front of you which indicates that the plaintiff is referred to Med Alliance by a lawyer --

MR. OGEN: -- Objection.

Q. Is it your business record?

THE COURT: Is this paper in evidence?

MR. JONES: I'm going to offer it in evidence.

MR. OGEN: Your Honor, I have to look through all the records to see if that paper is in evidence or not.

MR. JONES: I will do that.

THE COURT: The Med Alliance records are in evidence?

MR. JONES: Generally, yes.

THE COURT: And there is a question of whether this particular sheet is within those records.

MR. OGEN: Well --

MR. JONES: I'll get Dr. Ehrlich's records. Not to waste time, I'll get those and I'll get Med Alliance's, Judge.

THE COURT: Well, let me --

MR. OGEN: -- Judge, I will stipulate --

THE COURT: -- Right.

MR. OGEN: -- that it does say the word lawyer there, if that assists Mr. Jones.

THE COURT: Are you objecting to that sheet going into evidence?

MR. OGEN: I have to look at it and I have to look at what the records are. I don't know that they are part of the records.

MR. JONES: It will take a minute, Judge.

THE COURT: All right, unless someone wants to agree that that's part of the record it's in or going into evidence.

MR. JONES: Right here, in evidence.

MR. OGEN: May I look at it please?

(Whereupon, the referred to item was handed to plaintiff's counsel.)

MR. OGEN: Okay, all right.

THE COURT: Okay, so now just for the record I mentioned to you we took time this morning. We put a bunch of medical records in evidence without you having to sit here to watch it.

So what is that? What number is that?

MR. JONES: This is Plaintiff's 11 in evidence.

THE COURT: Okay, so that's plaintiff's exhibit in evidence, the Med Alliance medical records and this piece of paper is part of it and it's in evidence.

So your next question is?

Q. So, doctor, Mr. Montas was referred to Med Alliance through an attorney, correct, based upon that document?

A. That's what it says here, yes.

Q. And it's not unusual for Mr. Ogen to refer his time to you, is it?

A. No.

Q. You testified for him twelve times, which is a lot; isn't it?

A. In 20 years. I don't think it is.

Q. Well, twelve times in court but now you got to assume, doctor, that he has referred you to more people whose cases did not go to court, correct?

MR. OGEN: Objection. To form.

THE COURT: Sustained as to what we have to

assume. Go ahead.

Q. Well, the twelve cases that came to court referred to you by Mr. Ogen, is that the sum total of all the cases he referred to you?

A. I never said that they are all referred by Mr. Ogen. Many have been referred to me by many physicians.

Q. I'm asking you, doctor, other than the twelve cases that were referred to you by Mr. Ogen --

MR. OGEN: -- Objection. There's no foundation for that.

THE COURT: Maybe I'm confused.

You testified before -- maybe I'm -- did you not testify earlier that you had testified in court for twelve patients that were referred to you by or clients of this attorney?

THE WITNESS: No, Your Honor, I testified, I testified for Mr. Ogen approximately twelve times. I never said they were all referred to me by Mr. Ogen. Again I have no way of knowing 20 years back.

THE COURT: Okay.

Q. Doctor, you're telling us when I asked you before if Mr. Montas was referred to you by a lawyer you said absolutely not?

A. He was not referred to me by a lawyer, he was referred to me by Dr. Ehrlich.

Q. You would agree that would be unholy Alliance if he was referred to you, right?

MR. OGEN: Objection.

THE COURT: Sustained as to unholy Alliance.

Q. Are you business partners?

A. No.

Q. Well, you are an employee of Med Alliance; correct?

A. Yes.

Q. Dr. Ehrlich is an employee of Med Alliance; correct?

A. His current status I don't know.

Q. All right. So we can agree since you're an employee of Med Alliance, doctor, logically Mr. Montas was referred to you by an attorney, correct?

A. No.

MR. OGEN: Objection. Asked and answer.

THE COURT: Overruled.

MR. JONES: I'll move on.

Q. Now, with respect to sports medicine, you mentioned before that you treat your facility. Med Alliance has a sports medicine component to it, correct?

A. We have. We treat patients that have sports injuries, yes.

Q. All right, which means that when the patient comes in for his history interview he volunteers or you ask whether or not he's participating in sports; correct?

A. Every case is different. Depends on how he got injured.

Q. But you do have a component in your practice, correct?

A. Again, it depends on every situation. If he was injured from a sports accident, yes, I would ask him sports injury questions.

Q. All right, now, let's talk about your surgical experience. You mentioned before that you did a rotation in orthopedic surgery for about three months. Did I get it correctly?

A. That is correct.

Q. And you assisted in other surgeries, correct?

A. Yes.

Q. But you never been the league physician in a knee surgery or a shoulder surgery, have you?

A. No.

Q. So you don't determine what the indications are for either a shoulder surgery or a knee surgery, you refer that to somebody else, correct?

A. Yes and no.

Q. So in all the cases where you said you assisted in surgeries, you are the guy standing by while the other surgeon performed the surgery, correct?

A. I assisted.

Q. You are not in charge, correct?

A. No, no.
Q. So board certified -- well, withdrawn. And how many such patients did you assist in?
A. I can't give you an exact number but close to a hundred.
Q. And when is the last time you assisted in a surgery?
A. When I was doing my residency. Goes back to 20 years plus.
Q. And you are testifying here today on a surgical case, correct, and you haven't been in an operating room over 20 years?
A. Hadn't changed. The principal has not changed. The diagnosis indications and the risk has not changed.
Q. That was a yes or no.
A. That's the answer.
Q. All right, how many times have you spoken with Dr. Ehrlich about Mr. Montas?
A. I have not, just reviewing his records.
Q. Never?
A. Never.
Q. Right? Now, you mentioned before on direct examination that you reviewed the MRIs?
A. Right.
Q. Did you bring them with you?
A. MRI, no.

Q. Take a look at your report in September of 2012?
A. Okay.
Q. Look at the last sentence, I reviewed MRI report of left knee taken April 23, 2010. I reviewed MRI report of right shoulder taken on April 18, 2010. Did I read that accurately?
A. That's correct, yes.
Q. Go through all of your reports.
A. Ah hah.
Q. And tell the jury where it says you actually viewed the MRI?
A. Doesn't say that.
Q. Because you didn't, correct?
A. I don't know if I did but now I'm looking at my report it says I reviewed the report, that's correct.
Q. So when you testified this morning in front of this jury for the better part of 45 minutes about how the MRI had false positives --
MR. OGEN: -- Objection.
Q. And how the MRI --
MR. JONES: I'm not finished with my question.
MR. OGEN: He's testifying about how long he testified about something.
THE COURT: Whatever it was, go ahead.
Q. However long you testified about what was shown on those films, doctor, and you went through in quite detail,

that's not based upon your own observation of those films; is it?

A. No, the report.

Q. So when you told the jury you actually reviewed the film --

A. -- I didn't say that. I said the MRI. I never said I personally reviewed it, you can go back on the transcript.

MR. JONES: I will. I am going to order a copy of this.

THE COURT: Go ahead.

Q. So, doctor, if you stated that you reviewed the film to this jury this morning?

MR. OGEN: -- Objection, he just said he didn't.

THE COURT: Overruled.

To the extent the doctor believed he didn't, I'll let counsel ask you questions.

Q. Were you mistaken or were you misleading us?

A. Not misleading you. I said the MRI did not show anything significant. I never said I read it based on the report from a board certified radiologist and based on a board certified orthopedic surgeon, they both said what was in the report.

Q. All right, doctor, I'm going to now ask you to define your answer to yes or no, all right.

Who interpreted the actual films, who signed the

reports?

A. Doctor John Rigney.

Q. How many times do you speak with John Rigney about his interpretation of the films?

A. Of these films?

Q. Yes?

A. Never.

Q. All right, so Mr. Montas is your patient?

A. Right.

Q. Correct?

A. Right.

Q. And you haven't reviewed the films, you haven't consulted with the interpreting radiologist and you haven't spoken with his surgeon; am I accurate so far?

A. Yes, because there was no need.

Q. Just a yes or no. When is the first time you saw Mr. Montas?

A. The first time I saw him, as I explained, August 19, 2010.

Q. Okay, August 19th of 2010. So would it be fair to say doctor you never saw -- withdrawn. It's too obvious.

MR. OGEN: Objection.

THE COURT: I'll strike it's too obvious.

MR. JONES: I'm talking to myself, Judge, I'm speaking to myself. All right, I apologize.

THE COURT: Okay.

Q. So you saw the plaintiff after he had already undergone a knee surgery, correct?

A. Yes.

Q. He already undergone it and you told the jury this morning you had an opinion that the surgery to his left knee was necessary, correct?

A. As of today, yes, after I have all the facts, yes.

Q. Now, so doctor, he wasn't your patient in March of 2010, correct?

A. March of 2010, obviously not.

Q. Obviously, April of 2010 he wasn't your patient, correct?

A. No.

Q. May, June, July, August?

A. That's correct.

Q. Right. So you had absolutely no input with respect to the care, treatment or diagnosis of Mr. Montas from the day of the accident through the knee surgery and beyond for two months past that, correct?

A. Obviously no.

Q. All right. But he's your patient?

A. As of 8/19/10.

Q. He wasn't your patient with respect to the knee surgery, right?

A. Once again prior to 8/19/10 he was not my patient.
Q. Yes or no. Now, doctor, you said that he underwent what's called a diagnostic arthroscopy, correct?
A. And therapeutic surgical arthroscopic surgery, both.
Q. Now, Med Alliance as you said operates under strict rules; correct?
A. Yes.
Q. And a diagnostic surgery has certain CPT codes, doesn't it?
A. It does.
Q. All right, so if the facility wants to get paid for a surgery and they are going to designate it as a diagnostic as opposed to a repair, they got to put in the CPT code that it is a diagnostic surgery, correct?
A. That --
Q. -- Yes or no?
A. It could not be answered with a yes or no, it's a trick question.
Q. No, it's not a trick question.
A. Let me explain it to you.
Q. I don't want an explanation, I want you to go through your records -- you think this is funny?
A. No, you don't want me to explain it.
Q. What is the CPT code for a diagnosis?
A. I don't know the code. There are thousands of CPT

codes. I don't memorize them.

MR. JONES: May I have a moment, Judge?

THE COURT: Yeah.

(Pause in proceedings.)

Q. If I suggest to you, doctor, just tell me if you're familiar with the code 29870, does that mean anything to you?

A. No.

Q. Somebody whose assisted in hundreds and hundreds of knee operations and somebody who has worked on thousands and thousands on knees, are you telling me in your practice and you are telling the jury you are not familiar with that code? Yes or no?

A. No, no, I don't do the billing.

MR. OGEN: Objection.

THE COURT: Overruled.

Q. If I challenge you to find that code for which your facility requested payment, could you find the code for a diagnostic knee installment?

A. Our facility did not do the procedure. It was done at a different facility. I don't know if you were paying attention, it was done at the Ambulatory Surgery Center at New York at 3250 Westchester Avenue in the Bronx. That is not our facility I don't bill for arthroscopy procedures. I am not familiar with the codes, I'm familiar with the procedure not the billing codes.

Q. Okay, doctor.

A. I don't do the billing.

Q. Well, I know you don't do billing, doctor, and I know you like to work our way out of this.

MR. OGEN: Objection.

THE COURT: Sustained. Sorry, for both, just ask questions and doctor just answer his questions.

Q. Where did you get your information in the operative report preoperative diagnosis type of procedure performed that this was a diagnostic procedure?

A. This was a therapeutic procedure. It always starts off as diagnostic as I explained on numerous occasions.

Q. Doctor, simple question.

A. Let me answer.

MR. OGEN: Let him answer.

THE COURT: Overruled.

The question is where did you get the information contained within those records that it was a diagnostic procedure.

Q. Where?

A. It's not in these records that says the word.

Q. Thank you, doctor, that's an answer to my question.

A. Okay.

Q. Now, as a physician and a trauma physician, as you told us, you are familiar with certain signs of trauma, right?

A. Yes.

Q. All right, certain things indicate trauma, like a sudden injury to a body part which results in certain physical changes; correct?

A. Depends on the type of -- type of trauma, location of the trauma and the kind of trauma to the physical exam findings.

Q. You got common sense, doctor?

A. I'm sorry?

Q. You think you have common sense?

A. Many people do, I think. Yes, I think I do also.

Q. Let's talk about the knee. There is a claim here that the knee was injured in this automobile accident. You are aware of that, correct?

A. Yes.

Q. And you signed off of that and you said the knee was injured from an automobile accident, right?

A. That's correct.

Q. Okay, I want you to assume that the plaintiff was seen at the scene, ambulance personnel arrived, he did not report any injuries at the scene of the accident. I want you to further assume, doctor, that the plaintiff followed an ambulance to the hospital because someone else was being attended to and he was in the hospital and he never said a word about his knee.

Is the behavior of the plaintiff at the time of the accident, isn't it inconsistent with having received a trauma to

his knee? Yes or no?

A. The answer is no with an explanation.

Q. All right, no need to explain.

Now, doctor, eventually the plaintiff went to Med Alliance, correct?

A. Yes.

Q. And his first date of treatment was April 15th, correct?

A. As I just said earlier, it was April 9, 2010.

Q. Actual therapy doctor?

A. That's not what you're asking.

Q. First day of treatment, doctor. That was an intake. First day of treatment was the 15th?

A. For physical therapy or treatment evaluation?

MR. JONES: Put on the Elmo please.

Elmo just refers to the name of this thing here.

Q. What's that date, doctor, right there?

A. April 15, 2010. That's a physician therapy note.

Q. Which means he went for physical therapy, right?

A. Yes.

Q. Now, as a trauma physician, you are familiar with pain scale; correct?

A. Yes.

Q. Ten out of ten is usually the worse, it's excruciating, I can't stand it?

A. That's correct, yes.
Q. This person needs help, right?
A. That's correct.
Q. That's severe pain. That's almost break through pain, right?
A. Yes.
Q. Eight is pretty close to that, isn't it?
A. It's pretty severe I would say, yes.
Q. All right. And what was the patient's -- well, plaintiff's pain scale upon initial treatment at 4/15 of '10, how about right here, seven and eight?
A. Seven and eight.
Q. Right. So he's in severe pain, right? Right?
A. That's what it says.
Q. Okay, now, take a look here, what kind of medication was he taking?
A. At that time no medications.
Q. So he's got a pain scale almost breakthrough pain with regard to his shoulder and knee and he's not taking any medication. Do you find that a little inconsistent? Yes or no?
A. I didn't examine him on that date, so the answer is it depends on the full facts.
Q. All right.
A. So.
Q. Hah?

A. It could be inconsistent, it could not be inconsistent. You have to have all the facts to answer your question.

Q. Doctor, the fact that he's not taking any medication, claims to have almost breakthrough pain, medically as a physician would it cause you to think that either (a) the person is not telling the truth or he's got some tolerance for pain, right?

A. Depends on a lot of factors but that question cannot be answered with a yes or no.

Q. How much are you being paid for your testimony?

A. I'm not being paid for my testimony, I'm being compensated for cancelling my patients and for my time being here and I explained that earlier.

Q. Next visit, 2/9 of '11?

MR. OGEN: Objection.

MR. JONES: Excuse me, withdrawn.

MR. OGEN: He keeps saying first visit, next visit, and those are incorrect statements.

THE COURT: I don't know.

MR. JONES: Can I just say the day of the visit without characterizing it?

THE COURT: If there is an issue as to whether or not that is the next visit.

MR. JONES: It's not the next visit.

THE COURT: So let's just refer to it.

MR. JONES: Okay, I have it. No problem.

Q. The next visit I have here would be 4/16 of '10, pain scale eight, right?

A. Correct.

Q. No medication, right?

A. That's what it says, yes.

Q. Again, getting back to the history. Take a look at this on the initial intake, the history given stiffness he sustained from an MVA on 3/19/10 while at -- while in a full stop waiting for the green light he got rear-ended hitting his left knee on the dashboard, right shoulder, blah, blah, blah. Do you know if that history is accurate as you sit here right now?

A. Do I know that history?

Q. Yes?

A. Yes.

Q. Is that accurate?

A. That's the history that was obtained.

Q. Is that the history he gave you?

A. I don't have how he injured it. I just have that he injured his left knee and his right shoulder.

Q. Does it say anything about being pushed forward in your history?

A. No.

Q. Does it say anything about two impacts in your history?

A. No, just that he was hit from the rear hard impact.
Q. Rear-end with a hard impact?
A. Yes, that's what I have.
Q. 4/21 of 2010 pain scale eight. You see that?
A. Yes.
Q. No medication?
A. That's what it says, yes.
Q. Right? Doctor, how many prescriptions for pain did you write?
A. Mobic, once.
Q. Once?
A. Once, yes.
Q. When was that?
A. 11/7/15.
Q. 2015?
A. That's right.
Q. Five years after you saw your patient for the first time you write him a pain prescription five years later?
A. That's correct.
Q. And you are telling the jury that this man suffered a painful knee and a painful shoulder from an automobile accident?
A. That's correct.
Q. 4/22, doctor, pain five, no medication, correct?
A. Five is not really that bad.
Q. No, it's not. Well, it's better than eight, right?

A. Yes.

Q. Okay, now here on 4/29 we are back to eight and nine. No medication. See that?

A. That's correct.

Q. Okay. You heard of the term secondary gain, doctor?

A. Yes.

Q. You are familiar with that?

A. I am.

Q. And secondary gain means somebody may say something or do something to get a reward, correct?

A. That's what it is. That's what it means, yes.

Q. And you knew the plaintiff was involved in a lawsuit based upon -- somebody did, based upon this referral?

A. Just based -- a patient is referred by an attorney doesn't mean that there is a lawsuit. Not every case goes to a lawsuit.

Q. Well, where there is smoke there is fire right? Right, doctor?

A. No, not every case goes to a lawsuit.

Q. Well, you knew Mr. Montas was involved in a lawsuit, didn't you?

A. No, there is a possibility that there might be a lawsuit. I have no interest whether he's involved in the lawsuit or not.

Q. Well, getting back to secondary gain, the fact that you

are saying that his pain is almost breakthrough and he's not on medication; as a man of common sense, would it cause you to maybe doubt whether he's telling the therapist the truth?

A. It needs a lot more information, okay. That's possible. The opposite is also possible. You need more detailed information.

Q. Now, on May 1st there is a -- refers here that he took some pain medication. Did you know that or you're seeing this for the first time?

A. On that date?

Q. Yeah.

A. No.

Q. Have you reviewed these records?

A. Very quickly, yes.

Q. Very quickly?

A. Yes.

Q. Not thoroughly?

A. Well, to the point that I focus on how many sessions of therapy he had, I don't read word, line by line.

Q. Well, you're here to give the jury an opinion on causation, aren't you?

A. Yes, that does not change my opinion on causation.

Q. I didn't ask you that. We'll get to that in a minute. In fact, when your attorney ask you questions you can say what you want but just for now I want you to answer my questions.

You're here to give an opinion on causation.

MR. OGEN: Objection to what he said about me being his attorney.

MR. JONES: The attorney.

THE COURT: The.

MR. OGEN: Thank you.

MR. JONES: My apologies.

A. Right.

Q. All right, so doctor, giving an opinion on causation, that means you need to know the history of your patient; correct?

A. That's correct.

Q. Which means you got to review all the records, correct?

A. Pertinent records. Not every record is pertinent.

Q. Not every record?

A. That's right.

Q. So we established that you haven't spoken with Dr. Ehrlich, I guess you don't think that's pertinent; correct?

A. You don't have to. We review records, we don't speak to each other unless there is a need.

Q. Let's stick to yes or no, okay, just for a few minutes. So I assume you did not think that speaking with the radiologist to review an MRI was pertinent either, didn't you?

A. No, if it was important I would have spoken to him.

MR. OGEN: Objection.

THE COURT: Sustained as to.

Q. All right you reviewed the physical therapy record but very quickly, correct?

A. That's correct, yes.

Q. When was that?

A. Shortly before coming here, maybe a week ago.

Q. All right. And, doctor, you stated that you took a detailed history from Mr. Montas; correct?

A. A pertinent history, yes.

Q. All right. Now, this morning on direct examination from Mr. Ogen you stated you were well aware of his baseball history. You knew he was an athlete?

A. Yes.

Q. All right, show us in your notes as a detailed history and a very careful medical practitioner who takes a good history where it states in your records that you knew he was a baseball player?

A. It's not in my records. I don't write everything in the record. If I felt it was pertinent I would have put it in the records.

Q. So now it's not pertinent as to his physical activity level prior and post accident, would that be fair?

A. I have --

Q. -- Yes or no, doctor?

A. The answer the way you phrased the question cannot be

answered with a yes or no.

Q. Let me try it again. I'll try it again. Are you telling us you knew he was a baseball player and participated in baseball throughout his life but deliberately didn't put it in the notes, is that what you are telling us?

A. That's not something I put in the notes, okay. So I felt that it was required to be put in notes I would have done so.

Q. So you didn't think that it was pertinent that he played baseball?

A. The answer is no.

Q. You didn't think it was pertinent the level to which he played baseball, correct?

A. No.

Q. And you didn't think it was pertinent the level to which he may have trained physically for baseball, correct?

A. That's correct.

Q. Are you a baseball fan?

A. I am.

Q. You watched the game?

A. I was the official doctor for Yankee Stadium in 1986. They were losing.

Q. Right across the street, here we go. Then you, doctor, know the involvement with the training with an athlete; right?

A. Yes.

Q. And you know that it's rigorous?
A. Yes.
Q. And you know that baseball players do sprints?
A. That's correct.
Q. They run a lot, they lift weights?
A. They do.
Q. Correct? And they throw a lot?
A. Yes.
Q. Is he right handed or left handed?
A. Right handed.
Q. All right. You had to fit the change to get --
MR. OGEN: -- Objection.
A. It's in my notes.
Q. Okay, so you know that he throws with his right arm?
A. Right.
Q. Over the course of high school, Washington Irving and beyond high school and playing in the Metropolitan Men's Baseball League and the Men's Adult Baseball League, this man has had repetitive stress on his arms and legs, right?
A. He had stress on them, yes.
Q. Doctor, repetitive stress; right?
A. Yes.
Q. You are a Yankee doctor, right?
A. 1986, yes.
Q. 1986. They didn't win till '94, right?

A. They were losing at that time.
Q. It's not your fault.
A. I used to give away tickets, nobody wanted them back in those days.
Q. Now, doctor, let's not kid ourselves, it's a rigorous sports, right?
A. It is, yes.
Q. And you are familiar with the term known as repetitive stress syndrome?
A. Yes.
Q. Okay, it means that when you continually use a muscle or a joint it can wear down, right?
A. Correct.
Q. And when we talk about the labrum -- I brought my own model, if you don't mind -- even though it's not shown, the labrum is a rim of cartilage between the humeral labral bone and this bone right here?
A. That's correct.
Q. And that rim of cartilage is constantly providing insulation when from the ball and socket joint moves around?
A. That is correct, yes.
Q. So, I mean, that's a lot of stress; right?
A. It can be stressful, yes.
Q. And a labral wear and tear is something one might expect to find somebody who continually uses their dominant arm

to throw, fair enough?

A. Usually it's seen after 35 and 40 years old, not on a 23 year old person.

Q. Well, major league people that play that much are considered old by the time they are thirty, right?

A. No, that would be insulting if you say that.

MR. OGEN: Objection.

THE COURT: Overruled.

Q. Say again?

A. It would be insulting if you make that comment.

Q. By the time you get to 23 they train a lot?

A. Yes, and they are in good shape.

Q. So it's not uncommon for young athletes to wind up with arthroscopic surgeries, correct?

A. Everybody's case is different.

Q. Is it something that's uncommon?

A. No, it's not common. Can it happen? Yes, but not common.

Q. It's something, doctor, that athletes undergo based upon your practice as medicine and --

MR. OGEN: -- Objection.

THE COURT: Overruled.

Q. -- and go back to participating in a sports, correct?

A. For some, yes.

Q. Did you watch the Damma Grapple game last week?

A. I did not.
Q. You are familiar with Peyton Manning?
A. Whose case?
Q. Peyton Manning?
A. Not really.
Q. He got a fuse neck?
MR. OGEN: Objection. He's testifying regarding Peyton Manning now.
THE COURT: Sustained.
Q. So, doctor, the findings on the -- during the operative report that there was a labrum debridement requiring something not uncommon, somebody who use their arms thousands and thousands of times, right?
A. Depends on the person's age.
Q. So, you're saying because he's young this could not have been caused by the shoulder?
A. I'm putting the whole picture to go --
Q. -- Let me finish my question. Are you telling the jury that because of his age --
A. -- Right.
Q. -- that the conditions present in his shoulder such as arthropathy, contracting labrum and bursitis could not have been caused by participation of baseball?
A. I'm saying in this case it could not be caused by baseball. If it was, you would see osteophytes around the joint

line. There was no osteophytes, that's how I know it was not caused by baseball.

Q. I'm going to get in the operative report with respect to the shoulder in a moment. But did you rule out in any of your records repetitive stress syndrome or something called chronic syndrome, chronic stress with respect to the knee or shoulder?

A. Did I rule it out, yes.

Q. Where in your notes did you rule it out?

A. I didn't. I put it in my diagnosis part past medical history. There was no problem, I don't rule out stress and sprain injury. I have my diagnosis and I have my prognosis.

Q. Did you speak with Mr. Ogen this morning?

A. I did.

Q. And isn't it a fact that morning is the first time that you heard about your patient's participation in baseball?

A. No.

Q. Doctor?

A. The answer is no.

Q. All right. Okay, but are you telling us that knowing all this and participation in baseball and the running and the throwing, that you don't see any reason to keep it in your notes, doctor, or put it in your notes?

A. The answer to your question, no. If I felt a need, I would have put it in my notes.

Q. All right. Let's continue. 5/8 of '10, doctor, pain severe?

A. Yes.

Q. No medication. Now, through 2010, doctor, do you know how many visits the plaintiff had?

A. To where?

Q. Med Alliance?

A. I do not know. I know he had approximately 40 physical therapy there.

Q. Total?

A. Total, yes.

Q. In total?

A. Yes.

Q. 2010 approximately 14, would that be fair?

A. I have no idea, I didn't count.

Q. Okay. And now looking at May 10th, no medications doctor, you see that?

A. Yes, that's what it says.

Q. Pain scale nine?

A. That's correct.

Q. Pain scale of nine, doctor, as a trauma physician somebody would be running around like the hairs are on fire, isn't it?

A. You are so funny. Nine is severe, yes.

Q. And he's not taking medication. You think that's a

little inconsistent?

A. Again requires to evaluate all the facts.

Q. Do you agree it's inconsistent, it doesn't make sense?

A. Just the way it shows, yes, you need to investigate that a little bit further.

Q. Like interviewing him?

A. Yes, interviewing and examining him and asking him some questions why are you not taking medications are you not on medications. Some people don't want medications unless they really, really have to.

Q. How many prescriptions in total did you see written for Mr. Montas aside from your own?

A. Okay, let me go back and see. I do see that physical therapy was helping him, that could be a form of medication if it's helping.

Q. No, doctor, prescriptions of medication?

A. I'm answering you your question.

Q. Okay.

A. I'm looking through his notes. I don't see anybody prescribing medication.

Q. Okay, doctor, let's get back to this note here. I'm going to pick 6/3 of 2010. All right, it says rotated cuff tear doesn't it?

A. That's what it says.

Q. That's incorrect is it?

A. That is incorrect.

Q. And that's carried through all the notes. Did you know that before today?

A. No.

Q. So as far as the history provided -- you can shut that off. Thank you -- with respect to the accident being one impact as recorded there and the fact that there is a diagnosis of a rotated cuff tear, the history and the notes are inaccurate as it pertains to --

A. They are not my notes. They are not my history. Physical therapist made a mistake.

Q. You are his treating doctor, you didn't see this?

A. No, it doesn't change my diagnosis nor my opinion. It doesn't change the operative findings.

Q. So were if a diagnosis of a rotated cuff tear there is an indication for surgery is it a different charge by billing as opposed to a labral debridement?

A. That question could not be answered with a yes, you are going to a very difficult territory. That requires long details explanation, the answers which I'm sure you don't want.

Q. So as far as the shoulder diagnosis for 2010 these therapy notes are completely inaccurate with respect to Mr. Montas as it pertains to a diagnosis of a rotating cuff?

A. Obviously so.

Q. Now, let's talk about the shoulder surgery.

A. Okay.

THE COURT: Probably you have about one minute to one if we're going to go into a new topic.

MR. JONES: I am.

THE COURT: Good time to break for lunch. We'll be back at 2:00 please, 2:00 p.m. We'll continue with the doctor's examination. Enjoy your lunch but don't discuss the case.

THE COURT OFFICER: All rise. Jury exiting.

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

THE COURT: Okay, 2:00.

You know better than me how long you might think you be with Dr. Guy. It's up to you but if you're not going to get him -- even if you finish Dr. Guy and call him if he's -- I'm assuming specially him having his own expert for rebuttal, he's got a somewhat extensive cross. If we're not going to get him all in today, might want to think about figuring out another date, but we'll talk more later.

(Whereupon, a luncheon recess was taken.)

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

THE COURT: Doctor, come up.

(Whereupon, the witness took the stand.)

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Have a seat. Whenever you're ready.

MR. JONES: Thank you, Judge.

CROSS EXAMINATION CONTINUED

BY MR. JONES:

Q. Welcome back, doctor.

A. Thank you.

Q. Let's talk about the shoulder.

A. Okay.

Q. You reviewed the MRI reports, correct?

A. The report.

Q. Okay. Now, you agree that an MRI is a very useful tool in diagnosing pathologist with respect to the shoulder MRI?

A. Yes, but it's not one hundred percent. The answer is yes.

Q. In fact you rely upon MRIs on your own practice, don't you?

A. I do.

Q. And you sometimes refer your patients for MRIs, correct?

A. I do.

Q. Cause you realize and recognize it's a useful diagnostic tool, correct?

A. Yes.

Q. So if a patient comes to you and says my shoulder hurts, you are not just going to take his word for it, you're going to check it out diagnostically, correct?

A. First I examine him, if I have some physical clinical findings then I would send him for an MRI, not just like this.

Q. And in this case Mr. Montas did go for shoulder MRI, correct?

A. Yes, sir.

Q. And would you agree doctor that an MRI would also be useful in determining whether one has a chronic condition versus a traumatic condition?

A. That's correct.

Q. Okay, and there are certain terms used in the interpretation of the film which is consistent with trauma and there are certain terms in an MRI report which are consistent with a chronic type injury, correct?

A. Yes.

Q. All right. Now, did you review this in detail, the MRI report?

A. I'm sorry?

Q. Did you review it in detail?

A. I read the report.

Q. All right, would you agree doctor that something called edema would be consistent with trauma to the shoulder?

A. Edema where?

Q. Yes or no?
A. Depends. Edema where, sir? To answer your question is yes.
Q. And would you also agree, doctor, that I high signal intensity would be consistent with trauma to the shoulder?
A. Yes and no.
Q. A high signal meaning a bright light?
A. Yes.
Q. Correct? And, doctor, would you also agree that abnormal bone marrow or edema in the bone marrow would be consistent with the trauma, correct?
A. It can be, yes.
Q. And, doctor, you also recognize that certain conditions take a ling time to develop, right?
A. Yes.
Q. One of them being arthritis, correct?
A. Yes.
Q. Takes years to develop?
A. Correct.
Q. And arthritis can developed as a result of repetitive stress, correct?
A. It can, yes.
Q. Isn't that the most likely cause of it?
A. Depends on the age group.
Q. All right.

A. Depends on the patient population.

Q. And now, doctor, would it be -- arthritis, would that be something more likely to be found in someone who has continual over the shoulder activities such as a baseball player?

A. Not at the age of 23.

Q. Could it be, doctor?

A. Anything is possible. Nothing is impossible.

Q. And there are also certain things, doctor, that are congenitive, right?

A. Yes.

Q. Such as a downward sloping acromion, right?

A. Yes.

Q. Has nothing to do with anything other than you were just born with it?

A. That's correct.

Q. And you read Dr. Ehrlich's report?

A. Yes.

Q. And he diagnoses the plaintiff with a type two acromion?

A. That's correct.

Q. Type one acromion means there is more room in between the acromion?

A. Laymen's term, mild.

Q. Right, and in between the acromion and the four muscles

of the rotated cup is the bursa?

A. Yes.

Q. And that provides the fluid to help that joint operate, correct?

A. It's a shock absorbent, it's a cushion.

Q. It helps the muscle move?

A. Helps the joint to rotate.

Q. And, doctor, if somebody uses a shoulder a lot such as overhead activities, would bursitis be something you might find?

A. Yes, sir.

Q. No matter what the age is, right?

A. That's correct.

Q. And, doctor, the type two acromion means that instead of it being a wide space between the acromion and the four muscles of the rotating cuff is very narrow?

A. As I explained earlier, yes.

Q. So one who uses his shoulder a lot with a type two acromion would be more predisposed to an impingement syndrome than someone who doesn't have those types of findings?

A. That's correct.

Q. We know that the plaintiff has a type two acromion?

A. Yes.

Q. And we know that he plays baseball?

A. Yes.

Q. And you said you knew that years ago?

A. Ah hah.

Q. Right? So doctor, isn't it a fact that the type two acromion and the fact that the plaintiff played baseball that predisposes him to the impingement syndrome and bursitis?

A. I don't know about bursitis impingement. Yes, as I explained earlier, that's correct.

Q. That means less room for the person type two acromion?

A. Be careful, the bursa is underneath.

Q. But it impinges down on the bursa as well, correct?

A. It can but the most common is the impingement syndrome from the supraspinatus fibrose.

Q. Now, this is the MRI report of plaintiff's right shoulder and it was taken on --

MR. OGEN: -- No. Your Honor, can we approach on this? If he can take it off the screen for a moment.

THE COURT: Okay.

(Whereupon, a discussion was held at the bench off the record among the Court and counsel.)

(Whereupon, the following took place in open court, in the presence of the plaintiff, defense counsel, plaintiff's counsel and the jury.)

THE COURT: The objection is overruled.

Q. Now, doctor, let's take a look at the date. This MRI was taken only one month after the accident, correct, the MRI right shoulder?

A. Yes, sir, that's correct.

Q. And let's take a look. First line the examination demonstrates no evidence of marrow edema or a fracture in any location. You see that?

A. I do.

Q. That's inconsistent of trauma; isn't it, the statement?

A. That's absolutely wrong, incorrect.

Q. Yes or no, doctor?

A. No.

Q. Okay, you stated before that the presence of edema is a sign of trauma; correct?

A. Yes, therefore the absence does not rule it out.

Q. Okay, doctor. If one had a traumatic injury to the shoulder, would the presence of edema be something you expect to find?

A. In the shoulder, generally, in eighty percent I do not see edema. Some cases you can, eighty percent I've never seen edema.

Q. Now, doctor, the last sentence states that we have a lateral downsloping with effacement to the acromion of the underlying fat plane. Subacromial impingement may be provoked when a patient abducts; which would be this, correct?

A. A flexion.

Q. So he's predisposed of pain in his shoulder based upon an anatomical and general condition, correct?

A. I don't know about pain, he's predisposed to impingement, not necessarily pain.

Q. Does impingement cause pain?

A. Sometimes it does, sometimes it doesn't.

Q. Now, let's take a look at the last paragraph. Supraspinatus tendon demonstrates mild intrasubstance signal changes consistent with tendinopathy. Doctor, that's tendonitis, right?

A. That's right.

Q. Isn't tendonitis something that would be a common finding in a sports athlete?

A. You said the magic word common, not common. Can it be seen? Yes.

Q. Is it something you would expect to find in someone who throws with his right hand?

A. Yes, someone that sustains trauma, that's positive.

Q. No tear is seen, partial or full thickness in nature. What he is talking about there are the muscles in the rotating cup, either the supra-infraspinatus, teres, T-E-R-E-S, minor and subscapularis?

A. The sits muscles.

Q. Beg your pardon?

A. S-I-T-S, muscles. That's mnemonic to remember.

Q. The biceps tendon and tendon sheath is unremarkable. The glenoid labra arc intact?

A. Agreed.
Q. That's what it says. This is a perfectly normal shoulder based upon this MRI report, isn't it?
A. That's what it says.
Q. The impression; lateral downsloping of the acromion process which may cause impingement when the patient abducts. No evidence of rotator cuff tear, bursal inflammation, or joint effusion?
A. Right.
Q. But you told the jury this morning this was wrong?
A. I said it did not show it. I did not say it was wrong, it did not show it, big difference between the two. That's why we did the arthroscopy.
Q. Doctor, based upon this particular MRI report you would agree there were no indications for shoulder surgery, correct?
A. The way you phrased the question is a yes with an explanation.
Q. That's okay, doctor. So you accredited the operative report of Dr. Ehrlich over the radiology report of Dr. Rigney, correct?
A. Sorry?
Q. You're saying the operative report of Dr. Ehrlich is more believable than the radiology report of Dr. Rigney?
A. That question cannot be answered yes or no, it requires an independent answer because of the way you phrased it.

Q. Doctor, you said this morning the MRIs were wrong?

A. I did not say that.

Q. Doctor, did you say that the MRI didn't pick up what was really there?

A. It did not pick up at pathology, that's right. That's what I said.

Q. Before you came in here to testify you must have called Dr. Ehrlich to make sure of that, right?

A. No, absolutely not. There is no reason for me to call Dr. Rigney. This is done six years ago. I'm going to call him from six years ago and say do you remember? Remember, that's not how it's done in the medical field.

Q. You are here to testify based upon your detail and knowledge of this particular case?

A. Yes.

Q. It's your patient?

A. Yes.

Q. You want to give an honest opinion to the jury?

A. I have.

Q. Doctor, you haven't even called the surgeon, correct?

MR. OGEN: Objection. Asked I think for the fifth or sixth time.

THE COURT: Sustained.

Doctor has said he didn't call the surgeon.

Q. Is the surgeon in the best position as opposed to any

doctors to give the jury an honest opinion as to why he did a surgery with a negative MRI report? Isn't he the best one?

A. He's one of the best people in this position, yes.

Q. More informed than you, more informed than any doctor; correct?

A. I would say so.

Q. And you knew that even before you came to testify, correct?

A. Yes.

Q. Right? But still knowing that you didn't consult with him though?

A. There is no reason, I have his reports.

Q. And do you have any notes going back as far as 2010 that you haven't even consulted with Dr. Ehrlich about your patient?

A. Consult for what reason? There is no reason to consult. I have his notes. That's not how it's done in the medical field.

Q. All right, doctor, in the medical field they don't always testify in court and try to establish causation?

A. Some are asked to testify. If they don't ask, they don't testify.

Q. Do you think it would be more important when you come in to testify in the Supreme Court of the State of New York and give an opinion on causation, do you think it would be incumbent

upon you in that circumstance to contact the surgeon? Yes or no?

A. I've answered that.

Q. Yes or no?

A. The answer is no for the reasons I explained on multiple occasions.

Q. Take a look at the operative report.

A. Shoulder?

Q. Yes.

A. Okay.

Q. Preoperative diagnosis doctor which would mean something that the surgeon says here is what I think I'm going to find before I go for the operation, correct?

A. No, no, and no. Three times no.

Q. Doctor, what's a preoperative diagnoses?

A. Right shoulder traumatic -- by the way, that's causal relationship just to -- let me -- you have traumatic internal derangement with subacromial impingement. Number two, acromioclavicular joint arthropathy.

Q. Doctor, we just agreed that there were no signs of trauma on the MRI report?

A. That's not why it's not conclusive. It's not giving the picture. The answer is correct, you are correct.

Q. All right, the fact the MRIs were negative for trauma there is no hospital visit denoting any trauma, there was no

bump, no bruise, no photograph to any injury to this man's shoulder, correct?

A. That's correct.

Q. Yet we have a gratuity preoperative diagnoses of trauma internal derangement, correct?

MR. OGEN: Objection.

THE COURT: Overruled.

A. You said the word fortuitous?

Q. Gratuity.

A. Okay, based on medical findings that is the correct diagnoses; and, traumatic gives you the causal relationship. Answers the question you asked me earlier. And that's for the record, it speaks for itself.

Q. Other than what he said, as far as I hurt my shoulder in an auto accident, was there any diagnostic test that supported trauma to his right shoulder? Yes or no?

A. Only the operative findings and the clinical findings.

Q. We'll get to the clinical ones in a second, doctor, but the fact that he wasn't on medication, doctor?

A. He was.

Q. All right.

A. He was.

Q. Okay. Oh, you checked that over?

A. Yes, it's right here.

Q. Is that before 4/9, 2010?

A. This is 4/9, 2010.

Q. I want you to assume, doctor, the plaintiff testified that he never filled a prescription in any pharmacy for pain medication. Does that change your opinion as to whether or not --

A. -- No, he's also taken Tylenol over the counter as well so.

Q. Doctor, talking about prescription medication.

A. I understand. That was prescribed. I don't know if he took it or not but there was a prescription given to him in 4/9, 2010.

Q. I'm not here to argue with you doctor. And I'm going to remind you again --

MR. OGEN: -- Objection.

MR. JONES: Hold on. Question.

Q. Yes or no? If you can't answer yes or no --

THE COURT: -- Overruled.

Yes or no, doctor?

A. Fair enough.

Q. So you found 4/9, 2010 ibuprofen?

A. Right.

Q. Script?

A. That's correct.

Q. And I showed you on cross-examination earlier he wasn't taking any medication. You believe the report? Is there any

reason to disbelieve it?

A. I can't answer that question.

Q. Is there anything in the records to suggest that he's taking medication, doctor, other than a prescription?

A. None prescription items, yes. Prescription items, no.

Q. The fact that he said all through 2010 no medication except on one occasion suggesting he wasn't taking any medication doctor, correct?

A. Again on the assistant notes he says he was taking Tylenol over the counter.

Q. What note is that? What's the date on it?

A. March 19, 2010. March 30, 2010 those are the only two notes I have from assistant.

Q. How about 4/15, 2010?

A. Those are the --

Q. -- Patient states no current medication. Did you see that?

A. I do.

Q. Okay, doctor. Let's get back to the operative report. Subacromial impingement, doctor, refers to below the acromion, correct?

A. That is correct.

Q. The acromion is a bone, correct?

A. Yes, I showed the picture earlier.

Q. It's a yes or no, doctor.

A. Yes, yes.

Q. And acromioclavicular joint involvement that's where the acromion meets the clavicle, correct?

A. Yes.

Q. Also two bones, correct?

A. Yes.

Q. The operation performed was a right shoulder arthroscopic subacromial decompression which means that the bone was shaved off, the acromion, correct?

A. Yes, sir.

Q. And that means the bone was shaved because it was too narrow and didn't allow the rotated cuffs to operate without impingement, correct?

A. That is right.

Q. And when something impinges on those muscles it can also cause bursitis?

A. Correct.

Q. And we have a finding of the operative report?

A. We did.

Q. And that acromion causing a narrow space was also congenitive wasn't it?

A. Type two acromion, yes.

Q. So so far this operation performed on a bone was on a congenital pre-existing condition, correct?

A. Cannot answer that question with a yes or no.

Q. How much are you getting paid for your testimony?

THE COURT: The entire day.

A. It's four thousand for half a day.

Q. Now, we're in the part two of the day?

A. That is right.

Q. Plus your review you said costs a thousand?

A. That's right.

Q. Plus preparation of reports, correct?

A. Preparation of report, that's correct, yes.

Q. About $10,000?

A. Not quite.

Q. Give or take you are about $10,000 for today?

A. That's correct.

Q. Is that going to affect your opinion in any way?

A. No.

Q. So the procedure. We'll continue. Was a right shoulder arthroscopic subacromial decompression, distal clavicle resection; those first two items, right, they're operations on a bone, correct?

A. That's correct.

Q. All right, anterior capsular radiofrequency, scar tissue?

A. That's correct.

Q. Scar tissue takes a long time to develop?

A. You said long. What do you mean by long?

Q. Months and years?
A. No, it could happen after weeks or months.
Q. And, doctor, a glenohumeral debridement of the posterior labral flap tear, you see that?
A. I do.
Q. Now, there was no labral flap tear on the MRI, correct?
A. That is correct.
Q. But you are telling the jury based upon your review of the operative report that there was a labral flap tear, right?
A. That's correct.
Q. That's because you worked with Dr. Ehrlich?
A. No, that's what the operative report indicates.
Q. But the MRI, doctor, says the labrals, plural, are intact correct?
A. That's right.
Q. These are inconsistent, aren't they?
A. That's right.
Q. It's a yes or no?
A. The answer is yes.
Q. So knowing that you have two inconsistent findings, one from aboard certified radiologist and the other one from a board certified orthopedic surgeon, you decide to tell the jury you believe the surgeon, correct?
A. No, this is how it's accepted in a medical field.
Q. Yes or no?

A. The answer is yes but the reason I gave.
Q. That's enough for now.
MR. OGEN: Objection.
THE COURT: Sustained.
Q. Now, page two. The articular surface of the rotated cuff was visualized that means you looked at the rotated cuff, right?
A. Correct.
Q. And he never mentions it again in that report does he?
A. That's correct.
Q. That's because it was perfect, wasn't it?
A. That's correct, yes.
Q. How do you swear that of the records of your employer diagnosing a rotated cuff tear doctor?
A. That's not my employer. That's not my employer.
Q. You work for Med Alliance?
A. I am an employee of Med Alliance.
Q. Okay?
A. That was written by a physical therapist.
Q. Of Med Alliance Health Services, correct?
A. That's correct.
Q. That's your employer, isn't it?
A. Med Alliance is my employer, yes.
Q. Okay, so on your Med Alliance records your employer's records say rotated cuff tear. You knew that wasn't true didn't

you?

A. I just said that many times that's correct, it's not correct.

Q. As a detailed physician in you weren't just -- this wasn't just pointed out to you on cross-examination, would you just let that go to the jury without correcting it?

A. That doesn't change my diagnosis nor my opinion.

Q. Sure it does. It says, note rotated cuff tear and you're the only one says there isn't?

A. There is no rotating cuff tear.

Q. Does it affect the clinics billing if they say there is a rotating cuff tear versus a non-rotating cuff tear?

A. I have nothing to do with billing.

Q. Can you explain why it appears in every single record?

A. I did not prepare those reports, I have no answer.

Q. But you rely upon?

MR. OGEN: Objection. He's saying can you explain why it appears in every single record and that's incorrect.

MR. JONES: Many ways.

Q. Doctor, capsular contracture?

A. Yes.

Q. You are referring to the labrum, right?

A. No, the capsule is the joint capsule around it, it's capsule around it.

Q. And when that contracts, doctor, the word contractual

denotes a long time, doesn't it?

A. Absolutely not.

Q. When something contracts, doctor, it's not linear, is it?

A. What do you mean it's not linear?

Q. Linear means a straight line which is suggestive of trauma, correct?

A. There you go, wrong again. No.

Q. Doctor, you want to go on the record saying linear tear are not consistent with traumatic event?

A. You can have linear tear to be consistent with trauma, you can also have non-linear tear consistent with, possible.

Q. Do you see any evidence of a linear tear in the operative report?

A. No.

Q. In the MRI report?

A. No.

Q. Acromioclavicular joint arthropathy. You see that?

A. Correct.

Q. Which means where the acromion meets the clavicle?

A. Correct.

Q. There was a disease of that bone, right?

A. Correct, that area, that area.

Q. A disease, doctor, that took a long time to develop, didn't it?

A. Could be short, it could be long. The operative findings cannot confirm that nor can the MRI findings.

Q. Arthropathy doctor means arthritis?

A. No, arthropathy means damaged pathological condition, arthro means a joint.

Q. Doctor, arthropathy, you want to go on the record saying arthropathy in a surgical report does not mean arthritis?

A. Let's go on the record.

Q. It's a yes or no, doctor?

A. I'm trying to explain your answer. I'm not going to answer that question with a yes or no. That requires an explanation.

Q. Well, doctor, you know that sometimes transcripts -- you've been impeached for transcripts in court before, right?

MR. OGEN: Objection.

THE COURT: Overruled.

A. When you say impeach.

THE COURT: I'm sustaining it as to using the word impeach.

Q. Well, doctor, you had some of your own transcripts for more than 250 times you testified at court presented to you at trial on occasion, correct?

A. That's right.

Q. You want to go on the record -- knowing that sometimes you may hear it again and as a physician in physical medicine

and rehabilitation you want to go on the record and saying arthropathy is not arthritis?

A. That's why I say --

Q. Yes or no?

A. It cannot be answered with a yes or no. It requires an explanation. Sometimes yes, sometimes no, because arthritis is a form of arthropathy. We have many different types of pathological conditions, arthritis one of them, therefore indirectly it is and it can be.

Q. So it can be arthritis?

A. It can be but does it mean that it is? Arthritis means osis, O-S-I-S, osis if you have spondylosis or --

Q. -- Doctor, I'll accept that little concession for now. I'm going to move on.

Let's talk about what was done during the course of this operation. Take a look at page three.

A. Okay.

Q. From the second paragraph through the end this report dedicates itself to the operation performed on the bone, doesn't it?

A. No.

Q. Okay the acromion?

A. Bursectomy, it's not bone.

Q. That's the bursa, correct?

A. Right, so it's not bone.

Q. Doctor, how long did this operation take place?
A. How long?
Q. Yes?
A. Let me see if there is a time here. I don't see where a time is mentioned.
Q. Would 45 to 50 minutes be something you expect?
A. It varies. Usually it's a little bit longer, I'm not sure how long this procedure took.
Q. So you don't know?
A. I do not know. It's not mentioned.
Q. Now, with respect to the bursa, doctor, what was done with that during the course of the operation?
A. That was a bursectomy, the bursa was removed.
Q. When something is removed, doctor, during the course of a surgery, would you want to expect to see a pathology report?
A. Generally there is.
Q. It's good practice to generate a pathology report, isn't it?
A. Generally speaking yes, but it's not an absolute.
Q. I didn't ask you that.
A. Generally yes.
Q. It's a good practice. And it's also proof positive that something was removed during the course of the surgery, correct?
A. Yes.

Q. Look through your notes and find the pathology report which would indicate that part of the bursa was removed and we have bone shavings. Take a look.

A. Find the pathology report? There is no pathology report.

Q. So there was no pathology report?

A. I have no idea.

Q. Did you ever inquire as to where the pathology report may be?

A. No, I'm not a detective and there is no reason for me to pursue that. I have the operative findings.

Q. With respect to the labrum, doctor, it was debrided, correct?

A. That's correct.

Q. It wasn't repaired?

A. Same thing, debridement, repaired is the same thing.

Q. No, it's not.

A. You're telling me it's not.

Q. You're telling me, the jury that the debridement is a form of a report?

A. It's a form of repair. Cartilage cannot be repaired once it is torn and I use my nail on my finger saying it can be shaven to make smooth, they are so it doesn't get caught on other structures.

Q. Doctor, a debridement is just a shaving, correct?

A. That is correct.

Q. And do you see any pathology report reflecting that shavings were removed? Yes or no? It's a yes or no doctor?

A. I see no pathology report of any kind.

Q. Everyone of my question is yes or no. If you want to explain anything you'll have a chance with your attorney. I don't want to argue with you.

A. I'm not arguing with you. There is no pathology report.

Q. You understand the difference between a debridement versus a repair, correct?

A. I do.

Q. Where, doctor, on the MRI does it say there was a torn ligament?

A. It's not said.

Q. Where doctor -- withdrawn. Following the operation on the shoulder, doctor, which comes -- which was in 2011 -- you can turn it off -- plaintiff went on to play baseball, are you aware of that?

A. Yes.

Q. And post operatively. Did you see him?

A. I did not.

Q. When is the first time you saw him after the shoulder operation in 2011?

A. 10/20/12.

Q. And did you ask him about his activity levels then?
A. He was working, he was doing his home exercises, that's what I have in my notes.
Q. When did you see him for the next time?
A. 2/20/13.
Q. And after that?
A. 6/2. 6/22/15.
Q. So once in 2012?
A. Ah hah.
Q. Once in 2013. No visits in 2014?
A. Not to me, no.
Q. And another visit in 2015, correct?
A. That is correct.
Q. When the plaintiff saw you in 2015 that was because this case was coming up for trial, correct?
A. I have no idea.
Q. Well, you called him right?
A. On 6/22/15? I didn't call him.
Q. Well, the plaintiff testified yesterday --
A. -- Ah hah.
Q. -- under oath --
A. -- Okay.
Q. -- that you called him?
A. Me personally called him?
Q. Your office called him to come into the office doctor?

A. I don't call the patient.

MR. OGEN: Your Honor, he's being misleading. He's asking about June, Your Honor, and he's talking about January. There are two different dates.

Q. Did you see --

MR. JONES: I'll correct that question.

A. I saw him in January of 2016.

Q. And the plaintiff stated that you called him or somebody from your office?

A. The office called him, my office.

Q. And that's because the case is on for trial?

A. For that date, yes.

Q. It's not for treatment?

A. It wasn't intended for being for treatment, it winded up for being for treatment.

Q. In other words, your office called him because you knew he was on for trial. He comes to the office not because he had complaints of pain but then you gave him treatment anyway?

A. I gave him the same treatment and I've given him in November of 2015 because he had pain.

Q. In November of 2015 did you know he was playing baseball?

A. Yes, on and off.

Q. Tell them in your notes in 2015 where you recorded that?

A. It's not in my notes.
Q. And you consider yourself a detailed historian?
A. Base --
Q. -- Yes or no? You consider yourself a detailed historian?
A. I do.
Q. You think you ask the right questions of your patients?
A. Yes, I consider, yes.
Q. Let me ask you --
A. -- Yes, I do.
Q. And did your question include asking him what types of activities he may have been engaged in?
A. He was playing baseball on and off. He was doing his home exercises and he was working. That's what I have. I don't have baseball listed.
Q. What do you have? What do you have? Show to me the baseball?
A. I just finished telling you I don't have baseball.
Q. After August --
MR. JONES: One second, Judge.
Q. August 5th of 2010 when is the next time the plaintiff went to Med Alliance for treatment?
A. Well, there are a lot of records here.
Q. How about February of 2011?
A. I have a note here from my orthopedic surgeon,

12/28/11. I have a note here from orthopedic surgeon 2/8/12.

Q. Doctor, do you have any records of treatment between August of 2010 to February 2011?

A. And when in 2011?

Q. February.

A. I do not.

Q. That would be almost seven month period, correct?

A. That's correct.

Q. That he's not treated at all?

A. That's correct.

Q. And were you aware of that until just now?

A. With the exact timeframe, yes. I do know there was a lot of gaps and treatment.

Q. On gaps and treatments. And did you ask him about that?

A. I did. I don't think you want to know.

Q. No. Okay, doctor. Did you take a look at the plaintiff's activity level in that period of time?

A. What type of activity, activity of daily living?

Q. Was he working full-time?

A. Sorry?

Q. Was he working full time?

A. On and off.

Q. Was he in school full-time?

A. That's not discussed.

Q. But you don't?
A. I don't know.
Q. But he's your patient?
A. I don't ask about private life. I'm not a detective, I don't follow him.
Q. Doctor, did you see any notes from Dr. Ehrlich that he was not compliant in his postoperative treatment June 12, 2011?
A. I have the report in front of me. What part of the report are you referring to? I see it, I found it.
Q. Indicates he was not compliant with treatment?
A. That's what it says, yes.
Q. Okay.
A. It says the patient was not compliant with his second postoperative follow-up visit. It doesn't say the word treatment, just says with the second follow-up visit.
Q. What does he go to the doctor for, for treatment or just to visit the doctor?
A. He goes for evaluation.
Q. Okay. Let's talk about the knee MRI -- put that on for me please -- take a look at the report, doctor, second paragraph, this examination demonstrates normal marrow signal of the bone structures without edema or a fracture in any location. Did you read that?
A. I did.
Q. All right, and this film was taken on 4/23, 2010, a

little bit over a month after the accident; correct?

A. That is correct.

Q. And that statement right there is inconsistent with trauma to the knee; isn't it? Yes or no?

A. That question cannot be answered with a yes or no.

Q. There is a slight joint effusion with a very small popliteal cyst posterior to the -- I can't read that word.

A. That, medial compartment.

Q. Medial compartment. Now, doctor, that would be the back of the knee?

A. That's right.

Q. Popliteal cyst you know is a chronic condition?

A. There was no popliteal cyst, that's why there is positive --

Q. -- Doctor, did you review the MRI itself?

A. No, the report.

Q. Okay, so you cannot tell us, you can't tell this jury based upon your own observations what was on that film, can you? Yes or no?

A. On the film, no.

Q. Okay. So, doctor, does this report say slight joint effusion with a very small popliteal cyst?

A. That's what it says, yes.

Q. And a popliteal cyst forms in the back of the knee when the knee compresses, correct?

A. That is correct.
Q. Right, do you know what position he plays?
A. Different positions.
Q. Did he catch?
A. He did.
Q. Could you think of a more stressful position on a knee than being in a catcher?
A. In baseball or in sports general?
Q. In baseball?
A. Okay, that could be stressful.
Q. That's it, right?
A. Yes.
Q. So the popliteal cysts form when the knee compresses and the fluid has to go somewhere, right, and it forms a little cyst in the back of the knee, correct?
A. Not every time. That's one of the ways.
Q. That's one of the causes?
A. Yes.
Q. What I just stated was consistent with the formation of a popliteal cyst, correct?
A. Right.
Q. So, doctor, knowing he's a catcher, knowing he's got a popliteal cyst --
MR. OGEN: -- Your Honor, objection. The testimony was that he was an infielder before the accident

and he was a catcher afterwards.

THE COURT: Overruled.

Q. Knowing all these things, doctor, the popliteal cyst was formed, it could have been formed just by his regular activities as a baseball player, correct?

A. That question cannot be answered with a yes or no because there was no popliteal cyst on the operative findings.

Q. Doctor, but there is on the MRI; right?

A. Because it's a false positive.

Q. Now, I want to go back to this again, did you speak to Dr. Ehrlich now about his operative report regarding the knee? Yes or no?

A. No.

Q. Yes or no?

A. The answer is no.

Q. Just a yes or no. I'll move on. Did you speak to Dr. Rigney about his findings on the MRI? Yes or no?

A. I spoke to no Dr. Rigney, Ehrlich about the findings; just the report.

Q. So your opinion that there was no popliteal cyst is based upon the review of the both MRI report of the knee versus your review of the operative report of the knee, correct? Yes or no?

A. Based on the -- again the way you phrase the question cannot be answered with a yes or no.

Q. Did you compare those two documents I just mentioned, that being the MRI report and the operative report and determined that there was no popliteal cyst?

A. I did.

Q. Show us where you put that in your notes?

A. It's not in my notes, it's not in my findings. The operative findings are right here.

Q. Doctor.

A. If says that there was no popliteal cyst.

Q. Doctor, doctor, show us where it says that?

A. Okay.

Q. Are you finished, doctor?

A. There was no mention of it. It doesn't say the word.

Q. Hah?

A. There is no popliteal cyst but none was mentioned to be found in all of the findings. If there was it would have been mentioned.

MR. JONES: No, I'm going to move to strike as none responsive.

THE COURT: Everything after there was no mention is dismissed.

Q. So you just told the jury that the operative report states that there is no popliteal cyst, you just made that up?

A. No, I go by memory. Wait a second there is a lot of stuff here. If I cross-examine you you're going to make

mistakes too, so when I confirmed it I did not see it but there was no mention of a popliteal cyst.

Q. You got to admit, doctor, you have to admit I know your patients better than you.

A. I'll test you out.

MR. OGEN: Objection.

THE COURT: I'll strike comments about who would cross-examine who.

Q. Chondroplasty of the patella. May I borrow your model?

A. Yes, you may.

Q. Thank you very much. The patella right here. Chondroplasty refers to a shaving behind the patella?

A. That's correct.

Q. Chondromalacia is by definition a chronic condition?

A. No, it could be traumatic and chronic.

Q. By the time bodies are formed?

A. Yes.

Q. That takes a long time to develop, doesn't it?

A. Months or years.

Q. Month or years. When was this operation performed?

A. 6/10/10.

Q. Three months after the accident?

A. Three months. It could happen within three months.

Q. Could it have been well there before this accident, doctor, right?

A. Could it be? Anything is possible. In this case unlikely based on all the other findings.

Q. Show us where you ruled out the chronic condition of the left knee in your report?

A. That's not how I write the report.

Q. It's not. Now, doctor, when if there is a popliteal cyst as demonstrated by this report, that means that all the other structures within the knee have to go somewhere right, it impinges upon the cartilage and soft tissues within the knee compartment?

A. The way you phrase the question can't be answered with a yes or no. It can be answered with an explanation.

Q. I'll try again. If a cyst develops within the knee back here --

A. -- Right.

Q. -- It can cause impingement on other parts of the knee, correct?

A. If it's small, no. If it's large, yes. That's a small one that was mentioned on the MRI.

Q. If the cyst breaks up, doctor, that would be called loose bodies?

A. No, there is fluid.

Q. Yes or no is okay, Doctor, okay. Did you look for a pathology report with respect to the knee?

A. I saw no pathology reports of any kind for any body

parts.

Q. Meaning the knee or the shoulder, correct?

A. That is correct.

Q. Tricompartmental reactive synovitis, it's fluid on the knee in three of the --

A. -- Tri means three, compartments means area, the medical radical.

Q. There are four compartments of the knee?

A. That's correct.

Q. So if one continually uses his or her knee for running a life time of athletic performance, could that cause a cyst?

A. Is it possible? Yes. It's possible.

Q. Could it cause fluid to build up on the knee?

A. Is it possible? Yes. In this case, no.

Q. All right. I didn't ask you about this case, doctor. Is chondro relation equally consistent with trauma as well as a chronic condition?

A. It depends in the age of the person.

Q. Is the presence of a popliteal cyst a chronic condition?

A. A popliteal cyst could be acute and or chronic.

Q. Did you see, doctor, anything on the MRI report consistent with a trauma to the knee?

A. On that report?

Q. Yeah?

A. No.

Q. Did you see anything on the MRI of the shoulder consistent with the trauma to the right shoulder?

A. No.

Q. Did the plaintiff ever tell you that he had either a bump or a bruise either on his shoulder or knee as a result of the accident?

A. A bump or a bruise? No.

Q. So no bump, no bruise, no signs of trauma on the only diagnostic test performed on the plaintiff and you are still telling the jury this is a trauma traumatic caused injury, correct?

A. Yes, due to the reasons I gave.

Q. Just a yes or no, doctor. The meniscus of the knee were fine, weren't they?

A. They were fine.

Q. That's the cartilage between the femur?

A. Yes, that's correct, we have the medial and the lateral.

Q. Are you familiar with a letter of a medical necessity?

A. I am.

Q. And it's something that's generated by your office if you want to get approval for a procedure, correct?

A. That's one of the cases it's required, yes.

Q. Take a look at this, doctor.

MR. OGEN: Let me see it.

(Whereupon, the referred to item was handed to the plaintiff's attorney.)

MR. OGEN: Can we approach, Your Honor?

THE COURT: Okay.

(Whereupon, a discussion was held at the bench off the record among the Court and counsel.)

(Whereupon, the following took place in open court, in the presence of the plaintiff, defense counsel, plaintiff's attorney and the jury.)

THE COURT: All right, we are a few minutes away from the break. We will take it right now, ten minute break. And, we'll come back up and finish up with the doctor.

Don't discuss the case.

THE COURT OFFICER: All rise. Jury exiting.

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

(Whereupon, the witness exited the stand.)

(Recess)

THE COURT: Okay, Doctor.

(Whereupon, the witness took the stand.)

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Welcome back. You can continue.

MR. JONES: I'd like to mark this document for identification.

THE COURT: Defendant's?

MR. JONES: J.

THE COURT: We'll deem it for now.

MR. JONES: Okay, thank you.

Q. Doctor, you just told us you're familiar with a letter of medical necessity, correct?

A. Yes.

Q. So you've seen that type of document before, correct?

A. A medical necessity? Yes.

Q. And whose signature appears on that document?

A. This is Dr. Randall's signature.

Q. And that would be the surgeon, correct?

A. Yes.

Q. With regard to what plaintiff, what patient?

A. Lazaro Montas.

Q. The plaintiff in this case?

A. Yes.

Q. And does it request treatment based upon injuries sustained in this accident?

MR. OGEN: Objection.

THE COURT: Overruled.

If you know.

THE WITNESS: Don't know.

Q. Well, did Dr. Randall treat Mr. Montas for any other injuries that you're aware, of any other injuries?

A. Just what I have in my records.

Q. For any other accidents that you're aware of?

A. No.

Q. So the name of the plaintiff, date of birth, are they accurate?

A. Date of birth, yes.

Q. All right, and part of the record of Dr. Ehrlich as it pertains to this plaintiff?

MR. OGEN: Objection.

THE COURT: Overruled.

A. I'm sorry?

THE COURT: If you know that part of Dr. Ehrlich's records as it pertains to this plaintiff.

THE WITNESS: I do not know.

MR. JONES: Judge, he just established that it's his signature.

MR. OGEN: Objection.

THE COURT: Okay, you are offering it into evidence?

MR. JONES: I offer it into evidence, Judge, yes.

MR. OGEN: Objection.

THE COURT: Sustained.

Q. Doctor, take a look at -- without saying what, can you tell us what the body part is referred to on that document?

A. It's a knee, it doesn't say which knee and it doesn't have the Med Alliance logo on top.

Q. But Dr. Ehrlich is an employee of Med Alliance; isn't he?

A. I don't know. I do not know.

Q. And it requests certain treatment for a knee, correct?

MR. OGEN: Objection.

THE COURT: Sustained as to the forms in terms of.

Q. What's the purpose of a letter of necessity? Is it to request treatment or payment for treatment?

A. To request approval for a diagnostic test or a treatment.

Q. Is there -- without stating what it is, is there a diagnosis on that?

MR. OGEN: Objection.

MR. JONES: I'm not saying what the diagnosis is.

THE COURT: Overruled.

Is there a diagnosis?

THE WITNESS: Yes.

Q. Would it be fair to say that the diagnosis on the sheet is inconsistent with anything claimed in this case?

MR. OGEN: Objection.

THE COURT: Overruled.

A. The answer is yes.

Q. And as a general question, doctor, if a bill were submitted for a diagnosis not sustained in this accident, that would be dishonest; correct?

A. It requires an explanation. It might be an oversight, it might be a mistake. It happens in billing all the time, so it has to be explained.

Q. Who is in the best position to explain it, you or Dr. Ehrlich?

A. Whoever is the author of these documents.

Q. Who signed it?

A. Dr. Ehrlich.

Q. He would be in a best position?

A. Correct.

Q. You can't explain what's on there, that document?

A. I do not.

MR. JONES: I'm going to offer that document into evidence.

MR. OGEN: Objection.

THE COURT: Sustained.

MR. JONES: You can put the document aside.

Q. All right, doctor, let's talk about continuing with the knee. The plaintiff has participated in baseball 2014 and 2015, are you aware of that?

MR. JONES: You can shut that off.

A. I believe he stopped some time in 2014.
Q. And you are aware that he was a catcher, correct?
A. Yes.
Q. Would it be fair to say, doctor, that if one gets a catcher's squat several hundred times in a year that that's a pretty good indication that both knees are functioning normally?
A. Yes.
Q. Okay, and that the knee can take a stress of getting in and out of a catcher's squat?
A. Yes.
Q. Did he make any complaints to you that you recorded saying that he had difficulty getting in and out of a catcher's squat?
A. No.
Q. I want you to assume there's been testimony that the plaintiff actually stole a couple of bases during this 2014 season. As a baseball man you are aware that it takes a certain burst of speed to steal a base, correct?
A. Yes.
Q. That would be inconsistent with any long term permanent injury to either one of his knee, wouldn't it?
A. No.
Q. All right, doctor, the fact that the plaintiff participates in baseball as I just stated --
A. -- Right.

Q. -- and is able to swing a bat presumably, if you look would that change your opinion at all, doctor, as to whether or not he sustained a permanent injury to either his shoulder, right shoulder or left knee?

A. The answer is no. I gave the explanation.

Q. I don't want an explanation. The answer is no?

A. The answer is no.

Q. Now, doctor, let's take a look at your report of September of 2012.

A. Okay.

MR. JONES: Please Spencer, if you don't mind? Thanks.

Q. Now, doctor, first sentence says I had the opportunity to evaluate the above patient for the first time on consultation on September 18, 2012. You see that?

A. Yes, from my Gramercy Park office, yes, that is correct.

Q. Doesn't say Gramercy Park office, does it?

A. It's on the Gramercy Park physical medicine for that office, that is correct; yes.

Q. So, doctor, you recognize that that first statement is completely incorrect?

A. No. By your criteria, not by my criteria.

Q. Doctor, I didn't even have to ask you a question, you were all ready to tell me at the Gramercy Park office.

MR. OGEN: Objection.

THE COURT: Sustained.

Q. Can I see your report from 2010, doctor?

A. Yes.

Q. Where is it?

A. Right here.

Q. Have you had any other reports that you generated, doctor?

A. From Med Alliance?

Q. Yes?

A. Oh, yes, there is a physical therapy prescription for Med Alliance.

Q. Any narrative reports?

A. No, no.

Q. So you are saying, doctor, that that's not a mistake, that you're making a designation between your Gramercy Park office and your Fordham office?

A. That's correct.

Q. It's not just a former report that you litigate for litigants reports?

A. No, absolutely not.

Q. It says you reviewed various medical records?

A. Yes.

Q. Do you list which ones you reviewed?

A. Yes, I reviewed the operative report of Dr. Ehrlich

dated 10/11 where it shows the findings I reviewed the operative report of June 10, 2010.

Q. Did you review -- I'll stop you. Doctor, did you review all the physical therapy records with respect to Med Alliance?

A. On that date, no.

Q. Any time before the date or since that date?

A. Any time before that date or since that date?

Q. Have you reviewed the entire record of your patient?

A. Before I came here, yes.

Q. And when was that?

A. Before I came here today.

Q. Today this morning?

A. No, I reviewed the record sometime before today and a week ago.

Q. And it says you reviewed the MRI reports of the knee, correct?

A. Yes.

Q. All right. In reviewing the MRI reports, doctor, did you make any determination that there was a trauma to either his shoulder or knee, yes or no?

A. The --

Q. -- Yes or no, doctor?

A. That question cannot be answered with a yes or no. It can be answered with an explanation.

Q. Now, you made certain prognostications with respect to Mr. Montas with respect to cost he may incur into the future, correct?

A. Yes, sir.

Q. And now, doctor, would you agree that history is probably the best indicator of future treatment?

A. Absolutely not.

Q. Number one, you forecast patient will need to be seen by an orthopedic surgeon at least six times per year at one hundred fifty per session, correct?

A. That's correct.

Q. What orthopedic surgeon did you consult before you made that forecast?

A. I don't have to consult in any orth --

Q. -- Is the answer yes or no?

A. -- to make that determination.

Q. Doctor, you know it's getting late in the day. I'm going to ask you having testified about 250 times if I asked --

MR. OGEN: -- Objection. To the commentary.

MR. JONES: Just say yes or no.

THE COURT: Sustained.

Q. Can you do that?

A. Only when I can.

Q. Tell me you can't?

A. Some of the questions are tricked questions, I can't

answer with a yes or no.

Q. Did you consult with any orthopedic surgeons, for instance, Dr. Ehrlich, before you made that forecast?

A. No.

Q. When is the last time he saw Dr. Ehrlich?

A. I don't know.

Q. Did he see him in 2016 so far?

A. I don't know.

Q. How about 2015?

A. Don't know.

Q. 2014?

A. I don't know when he saw Dr. Ehrlich last.

Q. 2013?

A. Just told you I don't know when he saw him last.

Q. If I told you he didn't see him at all in those times, would that surprise you?

A. No, a very good reason.

Q. Doctor, the answer is no, correct?

A. The answer is no.

Q. And he should be seen by a physiatrist such as yourself?

A. That's correct.

Q. Is that a self serving forecast?

A. No.

Q. He doesn't have to go see you, right?

A. Any physiatrist he chooses.
Q. Okay, now did he see you in 2014?
A. I don't think so.
Q. Did he explain baseball?
A. He did not see me in 2014.
Q. How many times in 2013?
A. Once.
Q. And 2012?
A. Once.
Q. In your forecast here 12 times per year?
A. That's correct, that's what should be done.
Q. Well, should be done, doctor, if he has complaints of pain, correct? If he needed treatment, correct?
A. Not just complaint of pain; if he has disfunction, range of motion deficits, spasm or pain, any one of these three components. And he's had always one of these three components.
Q. The history tells us, doctor, that he has seen a physiatrist approximately three times in approximately three times in the last five years; is that accurate?
A. Four or five times about right, more or less.
Q. Aside from the time you saw him after making a phone call to him?
A. I did not make a phone call.
Q. Your office?
A. Okay.

Q. Your office?
A. That was two days ago for Monday visit.
Q. You are in charge of the office right, you are not going to do the blame of staff?
A. I'm in charge of my office. I don't run the day-to-day operations.
Q. And you forecasted only thirty physical therapy sessions per year, correct?
A. That's correct.
Q. When was the last time he attended physical therapy?
A. A long time ago.
Q. 2012?
A. That's about right.
Q. Almost four years ago?
A. That's correct.
Q. He needs periodic MRI of the right shoulder and left knee every two to three years?
A. That's correct.
Q. Last two or three years how many MRIs has he had in his left knee?
A. None.
Q. How many MRIs has he had to his right shoulder in the last two or three years?
A. It's just indicated.
Q. Doctor, it's yes or no?

THE COURT: Actually it was a none question. Everything after none is stricken.

Q. Med Alliance is a full service facility?

A. They don't have MRIs there.

Q. Doctor, I didn't ask you.

A. Full service means --

Q. -- Does it have a radiological department?

A. No.

Q. X-rays at all?

A. No.

Q. How many prescriptions have you written for the plaintiff for MRIs or x-rays?

A. None.

Q. As you sit here today not one, right?

A. That is correct.

Q. Okay. And that cost is fifteen hundred dollars?

A. That's correct.

Q. Should the patient's right shoulder and left knee pain persist you forecast another surgery, correct?

A. That's correct.

Q. For each one?

A. That's correct.

Q. Okay, who is going to make that determination?

A. I make the referral, the surgeon makes the final determination.

Q. How many orthopedic surgeons have you referred Mr. Montas to in the last five years?

A. I referred him back to Dr. Ehrlich in 2015.

Q. Did he go?

A. I don't know.

Q. I want you to assume, doctor, there has been no testimony that has any appointments with Dr. Ehrlich?

A. Okay.

Q. So would that change your opinion as to whether or not he needs to see a surgeon?

A. It's still medically indicated.

Q. Who would be the best person to determine whether or not he needs to see a surgeon?

A. Anyone would make a determination that's familiar with the specialty with this field. I can make determination when the patient sees an orthopedic surgeon. He or she will determine what the patient needs orthopedically.

Q. Have you consulted Dr. Ehrlich since you saw the plaintiff last week?

A. Consulted by talking to him?

Q. Yeah?

A. No.

Q. Doctor, there are certain indications for surgery, correct?

A. Yes.

Q. There are indications for surgery?
A. Ah hah.
Q. One of which would be MRI of some type of injury that needs repair, correct?
A. That's one of them.
Q. Is that something you as a careful medical practitioner would do before you indicate where a surgery is present?
A. I would indicate to the patient an orthopedic surgeon, he determines what type of MRI he wants and where he wants that patient sent. Many surgeons have medical requirement.
MR. JONES: Can I have the last question read back?
(Whereupon, the court reporter read the requested portion of the record.)
Q. Doctor, in the absence of any radiographic evidence such as an x-ray or MRI, in the absence of any opinion from an orthopedic surgeon with respect to his shoulder or knee, would it be fair, say right now the patient is not a candidate for anything of surgery?
A. At this point --
Q. -- Yes or no?
A. -- it is unknown.
Q. If you throw in $20,000 in expenses for an unknown speculative damage?
A. Absolutely not true. Read it carefully, says if his

symptoms persist.

Q. If?

A. Should the patient's right shoulder, should, right shoulder and left knee persists the patient will be in need of repeat diagnostic and therapeutic arthroscopic surgery.

Q. Did you read the notes of Dr. Ehrlich presurgery with respect to the shoulder?

A. I did.

Q. Yeah? And you see, doctor, that he had perfect ranges of motion on many of those examinations, correct?

A. On some occasions he did have reduction of motion. Before this surgery is a note that he had decrease range of motion.

Q. Sometimes ten degrees, correct?

A. That's correct.

Q. Take a look at the report of 7/9 of 2010, the surgery was in February of 11th, correct?

A. That's right.

Q. You have that in front of you?

A. I do.

Q. Take a look at it.

A. Okay.

Q. The first line, examination directed to the shoulder reveals no periscapular or deltoid atrophy?

A. Correct.

Q. You didn't mention atrophy on direct examination at all, correct?

A. I did not.

Q. And atrophy is a very important finding, isn't it? It's an objective finding?

A. When you say important finding, if a patient is not exercising they are going to have atrophy. If a patient is exercising they are not going to have atrophy and there was no atrophy because it was.

Q. Atrophy means he's using the limb normally, right?

A. No, that's not what atrophy means.

Q. Atrophy's wearing away muscle tissue from disuse or lack of?

A. That's one of the reasons for muscle atrophy that's one of the causes.

Q. So the absence of atrophy, doctor, means that the muscle gird appears normal when compared with the other shoulder, correct?

A. Absolutely.

Q. That's what it means?

A. Yes.

Q. Which means that the indication is in that one statement means that he's probably using the shoulder and arm as he normally would, correct?

A. Yes.

Q. That's inconsistent with the knee for surgery, isn't it, just that one sentence so far?

A. Absolutely not.

Q. Let's continue. The patient has no deformity with no evidence of generalized ligamentous laxity. Which means the ligaments are structurally sound, correct?

A. Yes.

Q. Next sentence. There is no crepitus through passive shoulder circumduction. Crepitus mean clicking?

A. That's correct.

Q. And clicking would occur when there is an impingement syndrome?

A. That's one of the signs that can cause clicking, yes.

Q. So when a doctor manipulated his shoulder there was no clicking and no atrophy so far, correct?

A. That's correct.

Q. The patient has no tenderness to palpation on the acromial clavicular joint, acromial clavicular joint, the anterolateral acromion, lateral acromial margin, anterior or posterior glenohumeral joint margins, as well as the trapezial and the rhomboid levator area. So far so good?

A. So far so good.

Q. So that means that his surgeon pressed down on every single component of the shoulder to try and elicit pain and there was none, right?

A. That is correct.
Q. So so far no clicking, no atrophy, no pain?
A. That is correct.
Q. Correct? And look at all these ranges of motion doctor, 170 out of 180?
A. Right.
Q. That's within a normal range?
A. Slightly diminished.
Q. External rotation 70 out of 70?
A. Normal.
Q. Internal rotation T10 slash T8?
A. Slightly diminished.
Q. Slightly diminished at abduction as well, correct?
A. Yes.
Q. Passive range of motion 180 out of 180, 70 out of 70. 5 out of 5 motor strength which means the muscles were strong as they were supposed to be. You can't get any better than 5 out of 5?
A. That's correct.
Q. Neer impingement signs are negative?
A. Correct.
Q. Negative supraspinatus drop test, that means that the doctor holds his arm out and let's it go and if that elicits pain that means there is some kind of pathology somewhere in that shoulder?

A. Got it wrong. Would you like me to help you?
Q. I don't. We are short for time.
A. Okay.
Q. It's a test to determine whether or not there is any problem with the rotated cuff?
A. Yes.
Q. The drop test and that was negative?
A. That was negative.
Q. And a negative subscapularis belly press test means he presses his hands on his belly to see if there is any pain on the shoulder?
A. Yes.
Q. Negative external rotation lag test, but he's disabled, that's inconsistent, isn't it? That makes no sense does it?
A. No, it does. He's mentioning surgery on March 19, 2010 that's approximately four months before he still has not recuperated from his left knee arthroscopic surgery.
Q. In July 2010 is with respect to the knee, right?
A. Based on that report it appears that way, yes.
Q. 8/16 of '10, doctor, you have that one?
A. I do.
Q. Again no atrophy?
A. Similar findings.
Q. Similar findings?
A. Yes.

Q. That's August of 2010?
A. Correct.
Q. So far based on these two examinations you could say within a reasonable degree of medical certainty based upon these exams and the MRI findings he's not a candidate for shoulder; isn't he?
A. As of that date, no.
Q. Yet, he deemed to be temporarily totally disabled?
A. He tells you why, he's still recovering from his left knee surgery.
Q. Nothing to do with his shoulder, correct?
A. Correct.
Q. And the next exam, doctor, is 2/2 of '11, only one week before the surgery, right?
A. Yes.
Q. But look, patient is a 23 year old male, six day status post right shoulder surgery hadn't even happened yet; right?
A. Yes, that's correct.
Q. But this note says it did?
A. Obviously it's a mistake, maybe the date of the visit is wrong.
Q. Well, that's a huge mistake; isn't it?
A. Yeah.
Q. That's like --
A. -- It is.

Q. That's a major mistake. Did you see that?
A. I do.
Q. No, did you see it before I just pointed it out to you?
A. I don't remember the exact date but now I see it, yes.
Q. That would require a call to Dr. Ehrlich, wouldn't it?
A. Now it does.
Q. Right?
A. Yes.
Q. But the last physical exam prior to the surgery 8/16 of '10 he's fine, right?
A. That's correct.
Q. All right. Would it be fair to say, doctor, that based upon -- please shut that off -- what you were brought out so far in cross-examination that Dr. Ehrlich would be in the best position to tell this jury the opinions on causations and permanency opposed to you?
A. Both of us can.
Q. Wouldn't Dr. Ehrlich be in a better position?
A. He be in a better position to explain his intraoperative findings but he will go from his report because he has no independent recollection from something that was done four or five years ago.
Q. He's also got to explain why he made notes of his surgery one week before it even supposedly occurred?
A. Obviously that's a typo with the date.

Q. You know that for sure?
A. No.
Q. All right.
A. That's the only possibility that makes sense.
Q. Okay. Doctor, I want you to assume that -- I'm going to ask you a hypothetical -- that Mr. Montas was involved in an automobile accident where in the vehicles involved sustained minimal to no damage.
MR. OGEN: Objection.
MR. JONES: It's an assumption.
MR. OGEN: He objected when I tried to ask a very similar question.
MR. JONES: No.
THE COURT: It wasn't the same to the extent there is testimony from at least one witness that there was minimal or no damage.
I'm going to allow the hypothetical to continue.
Q. Furthermore, doctor, I want you to assume that the plaintiff never went to a hospital for treatment for his shoulder or knee ever, okay doctor, and I want you to further assume that the patient participated in baseball from the age of 13 through 2015 which approximately was 17 years, shoulder and both knees; and, I want you to further assume that there were 26 completely negative motions tests performed by his own operating physician back in August of 2010 and July of 2010. I want you

to further assume doctor that the MRIs with respect to the shoulder were completely negative with respect to any sign of trauma to the shoulder.

Isn't it more likely than not, doctor, with your opinion to a yes or no, that any pathology in the shoulder found in the operative report was caused by the plaintiff's participation in repetitive activities such as baseball that predated the accident of 3/19 of 2010? Just yes or no?

A. I cannot answer that question with a yes or no. I can answer it with an explanation.

Q. No, it's okay Doctor. With respect to the plaintiff's knee, doctor, I want you to assume that he had no complaints at the scene with respect to either a bump or a bruise, that he never went to a hospital for his knee, that he participated in sports such as baseball where he was a catcher getting up and down out of his squats, that he was an infielder in high school, that the MRI evidence with respect to his knee was completely negative with respect to signs of trauma; same question, doctor, do you have an opinion within a reasonable degree of medical certainty as to whether or not any conditions found on his knee intraoperatively were caused by his participation to sports activities as opposed to the accident of 3/19, 2010?

A. Same answer as to your last question.

Q. You can't answer it?

A. I cannot answer it. I can with an explanation not with

a yes or no.

Q. It's okay.

MR. JONES: There is nothing further, Judge. And the MRI were deem marked as Defendant's Exhibit H and I, I think.

THE COURT: Yeah, we'll mark them when we're done.

MR. JONES: Okay.

REDIRECT EXAMINATION

BY MR. OGEN:

Q. Good afternoon, doctor.

A. Good afternoon, sir.

Q. I'm going to ask you some follow-up on some of things that you were cross examined about by Mr. Jones, kind of roughly we work kind of backwards with the topics that were covered.

Going back to those visit dates with Dr. Ehrlich of July 9, 2010 and August 16, 2010, is there any notation there and specifically in the first paragraph about whether the patient was doing therapy for his shoulder at the time?

A. He was doing therapy at the time, yes.

Q. And did -- were there any notes in thereabout whether the therapy was helping him?

A. Yes.

Q. Okay, so would that -- could that be one of the reasons why his range of motion and other symptoms were better at the time?

MR. JONES: Objection. Leading.

THE COURT: Sustained.

Q. Does that give you any information about the findings that Dr. Ehrlich had?

A. Yes, it gives me a lot of information.

Q. And what does it tell you?

A. Physical therapy is designed to reduce pain so if you get any physical therapy, it could be a substitute for pain medications. Exercise causes relief from endorphins from the body, that could be a form of medication. And, physical therapy helps decrease pain spasm, improve range of motion and muscle and prevent atrophy. Obviously, while he was getting it he had much less pain and better findings on physical exam.

Q. And, doctor, if I were to tell you that on July 9, 2010 that was approximately one month after his left knee surgery on June 10, 2010 does that give you any information about why he would be found disabled at that point?

A. Yes, he still is recuperating from his left knee surgery, he still had range of motions deficits to his left knee and tenderness to his left knee.

Q. And the same thing, a month later August 16, 2010 which would have been about two months after his knee surgery, would that give you information about why he would be disabled?

A. Yes, the range of motion was zero to 120 degrees, normally is 125 to 135 and he still had tenderness to the area

and he was still recuperating from his surgery.

Q. Okay. Now, doctor, you were asked earlier about atrophy; correct?

A. Yes.

Q. If one does not have atrophy to a joint does that mean they are not --

MR. JONES: -- Objection. Leading.

THE COURT: Sustained.

Q. If someone doesn't have atrophy to a joint, what does that tell you about the knee for surgery, if anything?

A. No relations. Absolutely no relations.

Q. Why not?

A. That's not the indication or lack of indication for surgery. Lack of atrophy means the person is obviously exercising, the body is moving the muscles are contracting, all you need is four forcible contractions per day to avoid atrophy, that's it, four forcible contractions; one, two, three, four. That prevents atrophy.

Q. And, doctor, if someone does not have atrophy what does that tell you about whether they were or were not injured in an accident?

A. Unrelated.

Q. Now, doctor, you were also asked about periods of time when the patient did not see any doctors or didn't have formal therapy?

MR. JONES: Can we approach, Judge?

THE COURT: Yes.

(Whereupon, a discussion was held at the bench off the record among the Court and counsel.)

(Whereupon, the following took place in open court, in the presence of the plaintiff, defense counsel, plaintiff's attorney and the jury.)

MR. OGEN: I'll withdraw that question, Your Honor.

Q. Looking at the left knee MRI, was there any indication of effusion there?

A. Yes.

Q. Okay, so even the radiologist there had found effusion in the knee?

A. Right.

Q. What is effusion?

A. It's a release of fluid inside which comes from trauma and inflammation.

Q. You were asked a lot of questions about the finding of the cyst?

A. Yes.

Q. In the MRI?

A. Right.

Q. Does the cyst cause loose chondral bodies?

A. No.

Q. Would that be responsible for the multiple loose chondral bodies that were found in the knee?

A. No, it comes from the chondromalacia as I explain earlier.

Q. If there was a cyst?

A. Right.

Q. Let's assume for a moment there was, hypothetically, would that have anything to do with the injuries in this case?

A. Absolutely not. Even that the radiologist findings at the very best it's a very small, they used the exact terminology very small popliteal cyst, unrelated causes no symptoms.

Q. And the fact that even if the plaintiff had a cyst, would that mean that he wasn't injured in this accident?

A. No, that does not rule that out at all.

Q. You were asked a lot of questions about whether Dr. Ehrlich would be the best person to answer questions about certain things. In your experience do surgeons remember specifics and details of surgeries --

MR. JONES: -- Objection.

Q. -- that they performed six years earlier?

THE COURT: Overruled.

A. No, they have many patients just like all of us and even if they have a photographic memory, I strongly doubt that they remember everything on an operative findings; so, the answer is, no, they would have to refer to their own operative

report which anybody can relate to.

Q. And in your experience, let's start with you, do you do your own billing?

A. I do not.

Q. Do you know if the doctors in Med Alliance do their own billings?

A. Nobody does their own billings, no, it's very complicated.

Q. Does Dr. Ehrlich do his own billings to your knowledge?

A. To my knowledge --

MR. JONES: -- Objection.

THE COURT: Sustained.

A. -- No.

Q. Why don't you do your own billing?

A. It's very, very complicated. The billing codes changes. In fact, they just changed not too long ago. You have to have a review of the CPT code book which is for diagnoses and procedures and you have to meet certain requirements for those guidelines and basically you have to be familiar with the right coding. If you code it wrong it could be denied.

Q. Now, you were asked before about the surgery and whether it's a diagnostic procedure. You recall that?

A. Diagnostic arthroscopy.

Q. Diagnostic arthroscopy, excuse me.

A. Yes.

Q. How do you know that it's a diagnostic arthroscopy?

A. If you do an arthroscopy to the shoulder, you find nothing wrong, you have to call it a diagnostic arthroscopy and your preoperative diagnosis would be shoulder pain, that could be your diagnosis. And when you go in there you state a diagnostic arthroscopy was performed for this reason and that reason and nothing was found that was abnormal. That would be a diagnostic arthroscopy, not a therapeutic arthroscopy. That's what I was trying to explain and I wasn't allowed to explain.

Q. Now, doctor, as we discussed, the plaintiff did not go to the hospital from the scene, correct?

A. That is correct.

Q. And he didn't go to any hospital for this accident, correct?

A. That's correct.

Q. Have you had situations where someone is in a car accident and they don't go to a hospital?

MR. JONES: Objection.

A. Many situations.

THE COURT: Overruled.

Q. How do you explain that?

A. In the medical field, the inflammatory response takes approximately 28 to 30 days to fully manifest itself. In fact, this is a broad question in our board exams, how long does it take from the time of trauma for the full inflammatory response.

Answer, 28 days minimum. So he seeked medical attention within 11 days, so you don't see the full effects of trauma right away.

Another example is when boxers fight, you see some of the effects for the trauma, they go in hiding for weeks because that's when all the eyes are shut down, their kidneys are urinating blood, et cetera, so you don't see all the full effect until several days, two weeks later.

Q. Does that -- is that an indication to you as to whether the plaintiff was or was not injured in the accident?

A. No, that's not an indication that the patient was not injured.

Q. Now, you were asked also earlier about Mr. Montas' complaints of pain, some of them were seven out of eight, some of them were five, some of them were nine; do you have an opinion as to why those varied and why those numbers were there?

A. The way the question was asked that date, that date what is your pain level right before physical therapy. Of course the pain may be up, may be down after the physical therapy end. If you ask him after the therapy, it could diminished significantly so that's the condition right before physical therapy. And pain is subjective. Some people call a one a five, some people say five, nine or a ten. Pain is very subjective.

Q. And how about the fact that he -- that some other notes say he wasn't taking prescription pain medication, what does

that tell you, if anything?

A. It doesn't tell me anything. He was taking over the counter stuff. In the records it says he was taking Tylenol over the counter. It says in the visit records.

Q. Now, doctor, you were asked about something called secondary gain?

A. Yes.

Q. And that's where someone has other reasons for taking a position in a lawsuit?

A. Another terminology for secondary gain would be a malingerer, is a person who doesn't really have a bonafide condition, they trying to milk the system. They don't have any real positive findings. Nobody would submit themselves to surgical procedures under general anesthesia, it's dangerous.

MR. JONES: Objection, objection.

THE COURT: Sustained. It's stricken.

Q. Doctor, do you know if there is secondary gains on both sides of the lawsuit?

A. I do.

MR. JONES: Objection.

MR. OGEN: He opened the wound.

THE COURT: Secondary gain?

MR. OGEN: Yeah.

THE COURT: Is this related to any medical issue in this case?

MR. OGEN: Well, I'm going to ask him about --

THE COURT: -- Overruled.

Do you understand if there is secondary gain?

THE WITNESS: Yes, Your Honor.

Q. In what sense, on the defense side?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Okay, is there secondary gain by defense doctors?

A. There is.

MR. JONES: Objection.

THE COURT: Sustained.

If you want to cross-examine any witnesses here on the defense on their opinion you can do that. I'm not going to turn the doctor into an expert on people's motivations.

MR. OGEN: Well, he was asked about it, so.

THE COURT: He asked him the context of his treatment of his patient. That's not the same thing.

Q. Now, doctor, were there any findings in the shoulder surgery that indicated a preexisting degenerative condition?

A. None.

Q. Any findings that of a repetitive stress syndrome?

A. None.

Q. Any osteophytes?

A. None.

Q. How about in the knee, were there any findings of preexisting conditions?

A. No.

Q. And by the way, the knee surgery was a mere three months after the accident; correct?

A. That's correct, yes, sir.

Q. And if there were any preexisting conditions, would they have been found in the surgery?

MR. JONES: Objection.

THE COURT: Any preexisting conditions be found? Overruled.

A. The answer is, yes, after it would have been detected on the intraoperative findings.

Q. Now, you also were asked about certain physical therapy notes, a couple of them I think indicated rotator cuff tear?

A. Yes.

Q. In your experience, do physical therapists sometimes write, kind of catch all terms in their notes?

MR. JONES: Objection.

THE COURT: Sustained.

Q. In your experience, what is the level of accuracy of physical therapists when they do their notes?

MR. JONES: Objection.

THE COURT: Sustained.

Q. Is a physical therapist a doctor?

A. No.

MR. JONES: Objection.

THE COURT: Overruled.

Q. Do the physical therapist diagnose the patient's condition?

A. No.

MR. JONES: Objection.

THE COURT: Overruled.

Q. Doctor, you were asked, a number of times we talked about on direct, you were asked nevertheless on cross about the distinction between the findings on the MRI and the operative report. You recall that?

A. I do.

Q. Okay. Is it unusual for there to be essentially normal findings on an MRI but something different in an operative report?

MR. JONES: Objection. Calls for hearsay response.

THE COURT: Sustained.

You want to ask him about his experience?

Q. Well, what is your experience with regards to findings on MRIs and then what is actually found in the operative report?

MR. JONES: Same objection, Your Honor. Nothing to do with this case.

THE COURT: Actually, I'm going to sustain it. He

doesn't do surgery, so I'm not going to let him talk about it.

Q. Well, have you had patients that have had MRIs to their joints?

A. Yes.

Q. And have you had patients that have had MRIs to their joints and have had operations done?

A. Yes.

Q. And have you reviewed -- have you had patients who you reviewed both the MRI and the operative reports?

A. Yes.

Q. How many?

A. Tens of thousands.

MR. JONES: Objection.

Q. Do you have a lot of experience doing that?

A. Tens of thousands, I would say so.

MR. JONES: Same objection.

THE COURT: Overruled.

Q. So, doctor, in your experience in those tens and thousands of cases, is it unusual for the operative report to show something that was not on the MRI?

A. The answer is no for a variety of good reasons.

Q. Okay, why?

A. Many times I have personally seen an MRI show of torn meniscus, the surgeon goes in he does not see a torn meniscus.

MR. JONES: Objection, Your Honor.

THE COURT: Sustained.

Q. Without referring to specific findings.

MR. JONES: Judge, this whole area is --

THE COURT: -- Sustained.

He says it's not unusual. I'm not going to go into details of one particular case, ten thousand cases.

Q. Do MRIs of joints capture every pathology in the joint?

A. No.

Q. Your diagnosis, what is it based on?

A. Based on his history, physical exam findings and the intraoperative findings.

Q. Did the patient's acromion being the way it is anatomically cause the injuries sustained here?

A. No, it did not cause the injuries, it predisposed them to his injuries. If I may be allowed to use an example of a similar analogy?

Q. Okay.

A. It is like a woman who has brittle bones with osteosclerosis and they fall but if a 15 year gymnast would fall exactly the same it would have no damage. So more predisposed to that type of an injury.

MR. OGEN: Okay, nothing further.

MR. JONES: I have a few.

THE COURT: Go ahead.

RECROSS EXAMINATION

BY MR. JONES:

Q. As a physician, who determines what CPT code goes into a billing?

MR. OGEN: Objection.

THE COURT: Overruled.

A. The biller.

Q. You are the physician who determines what procedure is done?

A. The physician writes the procedure and the biller bills according to the procedure that was done.

Q. It starts with the procedure, correct?

A. Yes.

Q. The bone that was operated on?

A. The shoulder surgery.

Q. That's correct?

A. That was one of the areas.

Q. That was a preexisting condition, wasn't it?

A. The downsloping, yes.

Q. That was shaved, correct?

A. That was shaved.

Q. And you can review a film, correct? You are capable of that?

A. Yes.

Q. And in six years almost five years at this accident,

six years, what efforts did you make to get the films and bring them to the jury?

MR. OGEN: Objection. Beyond the scope of redirect.

MR. JONES: You brought it.

THE COURT: Overruled.

Did you make any effort to get hold of the films?

THE WITNESS: No, because there was nothing to show on the films, essentially normal.

Q. You didn't bring the films because it didn't support your opinion that this was a traumatically caused injury; is that what you're telling us?

A. No.

MR. OGEN: Objection.

THE COURT: He answered it.

MR. JONES: Nothing further.

THE COURT: Any follow-up?

MR. OGEN: Just one question.

REDIRECT EXAMINATION

BY MR. OGEN:

Q. The labral flap tear that was found by the surgeon, was that preexisting?

A. No.

Q. How about the capsular contraction?

A. No.

MR. JONES: This is outside the scope, Judge.

THE COURT: It's not only outside the scope but I was about to point out to the jury when an attorney says just one more question -- this applies to all attorneys, not just plaintiff's -- that usually means somewhere between three and thirty-three more. So to the extent you said one you've also already asked two and a half.

Sustained.

MR. OGEN: Fair enough.

THE COURT: Doctor, you can step down before anybody thinks of another question.

(Whereupon, the witness was excused.)

THE COURT: And that concludes today's proceedings just on time. I think I mentioned to you that we talked about scheduling. In case I didn't, we do have a witness tomorrow but not until 4:00 so you have tomorrow morning off. There is no witness that's going to come in tomorrow morning. We do have another, I believe it's a doctor tomorrow at 2:00 p.m. so please be here at 2:00 sharply.

Anybody think that they want to ask me what I do in the morning? Do I have to go to work, should I go to work? I don't care what you do tomorrow. I will tell you, any day we meet on this trial, even if it's for ten seconds, you're on jury duty officially for the whole day.

So have a good morning and a good night, just be

here at 2:00 and don't discuss the case.

THE COURT OFFICER: All rise. Jury exiting.

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

MR. JONES: I just want it marked, these two documents.

THE COURT: Okay. We had the side bar that was off the record on the issue of the bill, unless you want to hold off till tomorrow, I made notes on what everybody and what my ruling was. So just to memorialize it for the record, you want to do it for a minute or two now or wait till tomorrow?

MR. OGEN: I don't have anything to say about it right now.

THE COURT: Okay, we'll do it tomorrow okay.

(Whereupon, the matter was adjourned to January 28, 2014 at 2:00 p.m.)

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Certified to be a true and accurate transcript of the stenographic minutes taken within.

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