SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM : PART 21

MANUEL CABRERA AND NUBE GALLEGOS CABRERA,

Plaintiffs,

- against -

THE CITY OF NEW YORK, THE NEW YORK SCHOOL CONSTRUCTION AUTHORITY, and MORRIS PARK CONTRACTING CORPORATION a/k/a MORRIS PARK CONTRACTING CORP., a/k/a MORRIS PARK CONTRACTING,

Defendants.

Index Number
12766-00
Civil Jury Trial

Kings Supreme Court
360 Adams Street
Brooklyn, New York 11201
November 16 & 17, 2006

B E F O R E :

HONORABLE LAURA L. JACOBSON,

Justice, and a Jury of 6 plus 3

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(Appearances continued next page.)

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* * *

COURT OFFICER: Jury entering.

THE COURT: All right, the courtroom may be seated.

Mr. Block, are you ready?

MR. BLOCK: I am, your Honor. If it please the Court, I call Dr. Ali Guy to the stand.

THE COURT: Jurors, everybody is comfortable? Got your notebooks? Got your pens?

JURORS: Yes.

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

COURT CLERK: You may have a seat.

I need for you to state your name and your professional address for the record.

THE WITNESS: My name is Dr. Ali Guy. A-L-I. Last name is G-U-Y. My office address is 7 Gramercy Park West, New York, New York 10003.

THE COURT: You may inquire, Mr. Block.

MR. BLOCK: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. BLOCK:

Q Good afternoon, Dr. Guy.

A Good afternoon, Sir.

Q I'm just going to ask you to keep your voice up and direct it toward the jurors so they could hear your testimony.

A Yes, Sir.

Q Doctor, briefly tell us your educational background and qualifications.

A Yes. I am a physician licensed to practice in the State of New York since 1985.

My undergraduate. I went to Queens College, Flushing, New York.

Medical School. I graduated from the University of Northeast Dominican Republic in June of 1981. I then did three separate residencies.

My first residency was in the field of internal medicine for a period of 18 months at Mount Sinai School of Medicine, Mount Sinai Medical Center.

Then I did one year of general surgery at Cabrini Medical Center.

Then I completed a three-year residency training program in the field of physical medicine at Mount Sinai school of Medicine at Mount Sinai Medical Center.

I was the director of the Department of Rehab Medicine at Maimonides Medical Center from 1997 to July of 2002, approximately five years.

My duties were to be in charge of all the

inpatients' and all the outpatients' rehab services; provide teaching to all the therapists. In my department there were approximately 50. Provide teaching to the other attending doctors in my department. There were about ten. Provide teaching to the surgical residents in internal medicine residents and orthopedic residents. I had to do consultation to other doctors in my hospital, and teach the house staff.

Also I was a director of NYU Hospital for Joint Diseases, Department of Neuromuscular Equipment Clinic from 1990 until December of 2005. That's about 15 years.

My duties were to treat the patients that were assigned to the clinic. These are people that are born with birth defects, with spinal cord injuries, with equipment needs.

My job was also to teach the residents assigned to me from NYU, and as of January 2006 I'm a clinical instructor at NYU School of medicine. I teach the residents from NYU. I help them pass the board part one and part two by teaching them.

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

A Yes.

Q Are you board certified?

A Yes. I forgot to mention that; yes.

Q In what field?

A Physical medicine and rehabilitation.

Q First tell us what the field of physical medicine and rehabilitation is, and then tell us what is board certified.

A Yes. The field of physical medicine and rehabilitation is a medical specialty that was founded shortly after World War Two by Dr. Howard Russ. It deals with traumatic injuries to the whole body covering the whole body from head to toe.

Deals with neurological problems, orthopedic problems, neurosurgical problems. Deals with muscle and nerve physiology. Deals with cardiac and pulmonary rehabilitation. Deals with electrodiagnostics. Diagnoses muscle and nerve problems. It deals with the disability and impairment evaluation which means we evaluate the patient and see if that patient is totally or partially disabled; if it's mild, moderate, or severe.

And also we have training in life care planning. In life care plan our job is to evaluate a patient, review pertinent records, and come to an opinion as to whether that patient needs future medical care and attention, how often, and what those costs are. We have training, and we're familiar with the costs of those services in the metropolitan area.

Q When were you board certified, Sir?

A 1989.

Q And how did you get board certified? What does it mean, board certified?

A First of all, board certification is the highest degree which you can obtain in your level of specialty. In order for you to become board certified in my speciality you have to have training in the following areas.

You have to have training in internal medicine, and/or general surgery, at least one year of each. You then have to have sat naturally and -- complete a three-year accredited residency training program in the field -- pass the annual examination given by the Department. You must pass the evaluation given by your teachers.

Once you finish all that, you sit and you take your boards, part one which is an eight-hour written examination which covers everything you learned from the beginning to the current time.

You get tested on principles of neurology, muscle and nerve physiology, orthopedics, neurosurgery, muscle and nerve pathologies, electrodiagnostic interpretations of X-rays, CAT scans and MRIs.

Once you pass that, you then have to be in private practice at least 18 months to be sponsored two other doctors that know your work closely.

You then fly to the Mayo clinic in Minnesota where the textbooks and all the research is done. You then get tested orally by the elite top doctors in the field. They test you orally for about half a day.

They test you on orthopedics, neurology, muscle and nerve physiology, electrodiagnostics also known as EMGs, and interpretations of X-rays and other radiological studies. If you prove to these doctors that your knowledge is up to par, they pass you and they review all your credentials from the beginning to the current time, and they give you a title of Diplomate of the American Board of Physical Medicine and Rehabilitation. That was obtained in May of 1989.

Q Now, Doctor, in everything you have told us, do you also -- have you also maintained a private practice for seeing patients?

A Yes, Sir.

Q Now, Doctor, let's just describe a couple of terms if we may --

MR. BLOCK: And I don't know if the Court. I actually apologize to the Court. I would like at this time your Honor to move Dr. Guy as an expert in the field of physical and rehabilitation medicine in life care planning.

THE COURT: Any objections?

MR. WILLIAMSON: Just to the last part, Judge.

THE COURT: Yes. What's the life care planning? He didn't give any testimony on that.

MR. BLOCK: I believe he did, your Honor, but I'll ask him to.

Q Can you please tell us, Doctor, what a physiatrist does in the life care planning field?

THE COURT: I didn't hear the doctor describe himself as a physiatrist. He just said he was board certified in physical medicine.

MR. BLOCK: I apologize.

Q Doctor, what is the field that you hold as a doctor of physical medicine and rehabilitation?

A It is also known as physiatry: Not psychiatry, not podiatry, but physiatry. Physiatry doctors and doctors of physical medical and rehabilitation are synonymous.

Q As a board certified physiatrist, given all that you have had and told us about, can you repeat that part of your testimony about your knowledge and familiarity with life care planning?

A Yes. As a physiatrist we evaluate patients and we have training on rendering opinions on life care plan which is to evaluate a patient and see if that patient is disabled.

Life care plans are typically for patients that are disabled; either totally disabled, or permanently or partially disabled. It indicates what the level of disability is, and indicates what is their prognosis, what the future holds for them.

It indicates what types of treatments they need, how frequently, and what the cost of those services are. It includes the expense, the certain medication that they might be taking; MRI studies, EMG studies, X-rays, and so on and so forth.

Q And, Doctor, for how long have you been a physiatrist?

A Since 1988.

Q And since 1988 have you been qualified as an expert in the area of physical and rehabilitative medicine in the courts of the State of New York in the past?

A Several courts that I have testified; yes.

Q Have you ever been qualified in the courts of State of New York to give an opinion with regard to life care planning as a physiatrist?

A Yes, Sir.

Q On how many occasions?

A Just about every single time I have testified.

MR. BLOCK: I move this doctor at this time as an expert in both areas, your Honor.

MR. HARRINGTON: Your Honor, I register an objection as far as the life care planning is concerned. I don't really think that it's relevant that he has been admitted in all of these courts. "Just about every one" is what he said which leads me to believe that he --

THE COURT: Did you said serve a 3101 notice about the doctor? How did you qualify him as an expert in that notice?

MR. BLOCK: The answer is yes, your Honor, and including the life care plan.

THE COURT: Jim, would you get that for me please?

Counsel, you all received Mr. Block's 3101 notice?

I need to see counsel outside.

(Off-the-record discussion.)

Okay, we're going to qualify the doctor as an expert in physical medicine and rehabilitation.

DIRECT EXAMINATION

BY MR. BLOCK: (Cont'd)

Q And, Doctor, that does include being able to prognosticate about future medical needs and future costs of same; is that correct?

A Yes, Sir.

Q Now, Doctor, tell us basically a couple of terms. What does the word trauma mean?

A Trauma is defined as anything that interrupts normal body functioning or integrity.

Q What type of patients do you treat in your practice?

A I treat patients from all walks of life. I treat pediatrics. I treat adults. I treat the senior citizens with arthritic problems, joint replacements. I treat people injured on the job, people injured in sports injuries, people injured in industrial accidents, car accidents, sports injuries, slips and falls, head trauma, nerve problems; all types of problems.

Q Doctor, did there come a time that you began to treat Manuel Cabrera?

A Yes, Sir.

Q When was that?

A September 2, 1999.

Q And are you still treating Manuel Cabrera?

A Yes, Sir.

Q During the course of your treatments of Mr. Cabrera, did you procure and review various medical records?

A Many, many records; yes.

Q Just tell us the records that you procured and

reviewed?

A I reviewed records from the Kings County Hospital. I reviewed records from Dr. Facini; records from Dr. Peter Gotsic, Dr. Richard Radna, Dr. Daniel Klein; many X-rays, MRI results; records of Dr. Steven Sclafoni, Dr. Sharma, Dr. Sundaresan; many CAT scan studies from the hospital, many X-ray studies, many MRI studies, studies performed by myself of the cervical lumbar spine, lower extremities, venous Doppler studies.

Q How about hospital records? Did you review the hospital records for this surgical procedure?

A Yes. I reviewed the hospital records for surgical procedure performed at St. Joseph Hospital. I reviewed the Fire Department of New York EMS evaluation; the records from Elmhurst Hospital, the emergency room visit of 3/25/03; Lenox Hill Hospital records of the surgery of 7/18/05.

Q Okay. Now, doctor, when Mr. Cabrera first came to you on September 2, 1999, did you take a history?

A Yes, Sir, I did.

Q Just briefly tell the jury what a history is, and tell the jury what the history that he gave you was.

A The history is what a patient complains to a physician, and we refer to as the area of chief complaint. Based on the areas of chief complaint then a physician extracts additional history and important stuff from the

patient.

For example, if a patient comes and says, I have neck pain, we then ask does the pain shoot down the arm. That's a very important piece of history, because if it does shoot down the arm it means the origin is in the neck from the nerve roots right behind the disc.

We then ask if there is any numbness and/or tingling in your arm. If it does, it indicates there is a nerve damage.

We then ask if there is any history of any trauma; any history of any prior significant injuries, these are some of the important points.

It appears that 70 percent of a doctor's working diagnosis comes from the history, ten percent comes from the physical exam, the remaining 20 percent is confirmed by other diagnostic stuff such as CAT scans, MRIs, EMGs, X-rays, operative reports; so and so forth. The history is very important.

Q What history did Mr. Cabrera give to you?

A That he had no prior problems with his head, neck and back; that on August 31, 1999 when he was working on a job -- it was on a scaffold -- he fell from a height of approximately 15 to 20 feet. He lost consciousness for a few minutes, and he injured his head, right shoulder, right hip.

Initially he had several sutures to his scalp, and when he came to me which was two days after the accident, he complained to me of headaches, dizziness, trouble concentrating, memory problems, neck pain shooting down the arm; complained of lower back pain shooting down the right leg with numbness in his right foot; and those were the areas of chief complaint.

Q Okay, just stop right there. At some point in time after the first visit did you review -- I think you already told us the Kings County Hospital record and the fire ambulance call report?

A Yes, Sir.

Q Now, they're in evidence as Exhibit 1.

MR. BLOCK: If I may hand this up to the witness, your Honor?

THE COURT: Just for the record, Exhibit 1 is?

MR. BLOCK: For the record, Exhibit 1 is the Kings County Hospital emergency room and hospitalization for the period August 31, '99 through September 1, '99 as well as the ambulance call report.

Q Now, Doctor, you review those records prior to coming to court; correct?

A Yes, Sir.

Q And do they correlate with what the plaintiff told

you, that he fell 15, 20 feet off a scaffold and lost consciousness?

A Yes, sir. That's correct.

Q Let look at the ambulance call report first of all if you can.

A Okay.

Q It's in evidence. You see where it says, "Unconscious upon arrival"?

A Yes, Sir.

Q Tell us what that means.

A It means that he was completely out of it, unresponsive.

Q And then it says permissive -- I'm sorry, "Responsive to painful stimuli", what does that mean?

A When you have loss of consciousness there is a level consciousness. If you do not respond to shaking or to constant stimulation and you only respond to painful stimulation, that means you have a deep state of loss of consciousness or coma; and in the case of severity, of head trauma.

Q Now, let's look at -- if we may, let's look at the emergency room records.

A Okay.

Q What was significant with regard to his head? You see this, "Several centimeter laceration which required

suturing"?

A Yes, Sir.

Q Let's talk specifically about his lower back. That's what I'm really interested in. Did Mr. Cabrera make complaints of his lower back pain at the emergency room immediately upon arrival by the ambulance -- "Yes" or "No"?

A No. He was unresponsive. He had lost consciousness. How could he complain of lower back pain.

Q My question is -- that's in the ambulance. Upon arriving -- I'm going to read something you. It says, "Cervical spine pain, lumbar pain, abdominal pain, and chest pain." What does lumbar pain mean?

A Lumbar is lower back. Cervical is neck.

Q So if it says lumbar pain, is it fair to say that he made complaints of lower back pain or lumbar pain in the emergency room?

A Yes; and also chest pain.

Q Right, Sir. There was a physical examination, if you could pull up that sheet in emergency room. It looks like this.

A Yes. Okay, I have it.

Q Can you read us under physical examination what it says please?

A Yes. "First of all, his blood pressure was elevated. He was in mild distress. There was a

three-centimeter laceration over his scalp. His cervical spine was tender. He had lumbar pain".

Q Stop. Sorry. If someone was up here telling the jury that he didn't have any lumbar pain in the emergency room, would that be true or false based on the record that you just read?

A I would say the person did not read the record properly and carefully.

Q Okay. Now, at some point of time -- by the way, what language does Mr. Cabrera speak?

A Spanish.

Q Who translated for you during the visit with Mr. Cabrera?

A Myself. I speak fluent Spanish.

Q Now, Sir, at some point in time after he was released from the emergency room, he went to your office and you started telling us about the history. Can you tell us what your physical -- what did you do? Did you review -- did you examine him? What did you do?

A After I took the history, I examined him. He came accompanied by his wife who was present throughout the entire evaluation.

In my physical examination he appeared to be in moderate distress secondary to pain. On top of his head he still had five sutures in place that were not removed. The

area had swelling over it from a hematoma. A hematoma is a collection of blood under the tissue, under the scalp.

His neck was tender. There was spasm. Spasm is defined as a prolonged involuntary contraction of muscle fiber which means the patient has no control over it. The neuromuscle when you touch it is soft to touch. Once a muscle gets injured the fibers shorten, and the muscle goes into spasm. It's a reflex posture so that the body protects itself from the recurrent injury, and as a result the range of motion becomes diminished.

The range of motion for extension which is backward bending of the neck was one-half. I'm sorry, lateral flexion was one-half. The back extension was one-half. Extension is bending your back backward.

In the back there was tenderness. There was spasm. There was trigger point present both in the neck and in the back.

Q Stop right there for a moment. September 2, the day after he got out of the hospital he has spasm and trigger points, and one-half normal extension. Tell us what the significance of that is for a man who just fell 15 or 20 feet off a scaffold onto the floor.

A It confirms what the history indicated, namely he has neck pain shooting down the right arm. On physical exam the neck shows tenderness, spasm, and the range of motion

for bending from side to side is one-half normal. And there is trigger point. Trigger point most commonly comes from trauma.

Definition of trigger point is area of muscle fibrosis or muscle scarring. Once a muscle gets injured, you get a microscopic bleed inside the muscle fibers. It then heals with permanent scarring. That is what a trigger point is. On physical exam you palpate and pinpoint an area of tenderness with a nodule like a little marble inside the area, and that's very painful to touch.

So when you put the history together; when you put the physical examination findings together, it indicates something is going on with this man's neck, his back, and the nerves from his neck down to the arm, and the nerves from the lower back down to the legs, and also the discs because nerve roots end right behind the disc.

Q You were able to make that determination on your very first visit with Mr. Cabrera?

A Yes, Sir.

Q Did you report that in your very first written report which is in evidence as Plaintiff's Exhibit 8; part of the packet which is Plaintiff's Exhibit 8 in evidence, your records? Did you report that in your report dated September 10, 1999?

A Yes.

Q And can you tell us, what was your initial assessment or plan?

A My initial assessment means your diagnosis.

His status post, multiple trauma. Status post, skull laceration, rule out.

Rule out means to prove he has, or he doesn't have.

Rule out intracranial bleed versus subdural hematoma.

Subdural hematoma is a collection of blood inside the brain.

Rule out cervical and/or lumbar disc bulge versus herniation means to prove that he either has or didn't have a ruptured disc in his neck and/or lower back.

Rule out cervical and/or lumbar radiculopathy means to prove that he has nerve damage to his neck and/or lower back.

And the last diagnosis was traumatic myofascial pain symptom which is when you have two trigger points in two or more parts of the body. That was found in his neck: Upper neck, lower neck, upper back, lower back. That's more than four areas.

Q I'm going to jump way ahead and come back. Please forgive me.

At some point in time did you send him out for

MRIs of his lower back?

A Yes, Sir.

Q Did you, Doctor, yourself perform an electromyography study of his lower back?

A Yes.

Q When did you send him for the MRI?

A The MRI of the lower back was done on January 19, 2000.

Q And the EMG?

A EMG of lower back was done on 3/29/2000.

Q Just let's just take a jump ahead. We're now going to the results of the MRI and the EMG. Can you tell us what the results of those were, and then contrast them to what you thought that he had on the very first time you saw him?

A The MRI of January 19, 2000 showed a disc herniation at L5-S1 which contacts the right L5 nerve root, and also a bulge at L4-L5 with some normal natural aging degenerative changes which is normal for a 33-year-old spine?

And the EMG of the lower back performed on 3/29/2000 revealed a right-sided L5-S1 radiculopathy, the same level as the disc herniation. In my very first report, I indicated that we have to rule out lumbar disc bulge versus herniation. He happened to have both; one of each.

I also put down to rule out lumbar radiculopathy. That was confirmed by way of EMG.

Q So now we know that by taking these diagnostic studies in January and March of 2000, that what you saw on your very first visit was exactly what you thought it was; correct?

A Yes, Sir.

Q Okay. Now let's go back. What did you prescribe for Mr. Cabrera at the very beginning? Did you start treating him?

A I started him on a course of physical therapy. I tried to get approval for an urgent emergency MRI of the brain.

According to the Workmen's Comp rule you just can't send in a patient for testing. You have to obtain permission first. That took awhile until I got the approval; and you have to also get approval for physical therapy. I tried to wait, but he was in so much agony I started the therapy without the approval, and so he was given physical therapy, and then on a subsequent visit I gave him medications for pain and inflammation as well.

Q How frequently did you prescribe him to have therapy in the beginning?

A Two to three times per week.

Q For what purpose did you do the therapy?

A Physical therapy is designed to decrease pain, decrease spasm, improve range of motion, break up trigger points, improve flexibility and conditioning, and to prevent further deterioration.

Q Sir, did he follow your regiment?

A Yes, Sir, he did.

Q Was he going for physical therapy two to three times a week?

A He had a total of 460 physical therapy sessions to date.

Q 460.

A Yes, Sir.

Q How many times have you personally seen him yourself as a physician?

A Over 80 times.

Q To date?

A To date, yes, Sir.

Q Now, Sir, as he is being treated is that physical therapy being done in your office or somewhere else?

A In my office.

Q Under your supervision?

A Yes, Sir.

Q Are there notes that accompany the physical therapy?

A Yes. I have them.

Q Sir, I'd like you to take out those physical therapy notes. They are in evidence also as part of Exhibit 8. You could use yours if it's easier. Let's just flip to the date of September 7, a couple of days after the accident?

A Okay.

Q You see it. Physical therapy are physician's notes.

A The first physical therapy note is September 9 and I believe --

Q Maybe it's a physician's note then; is that a handwritten note?

A That's my chicken handwriting, yes.

Q I'm sorry. That's your note?

A That's my note.

Q Can you go to the September 7, '99 note?

A It's September 8. That's an 8.

Q Nope.

MR. BLOCK: Your Honor, may I please show the witness?

I just want to show him this page.

Q Is that a record from your office?

A Yes, that is. That's the physical therapy note.

Q Yes. I was correct.

A I'm sorry.

Q Tell us the diagnosis in the physical therapy note only one week after the accident?

A "Multiple trauma. Rule out cervical and lumbar radiculopathy, and traumatic brain injury".

Q Radiculopathy. What does it mean?

A The word radic means nerve root. The word opathy means damage to nerve roots. Cervical radiculopathy means damage to the nerve roots in the neck. That's what the cervical region is. Lumbar, lower back. So lumbar radiculopathy is damage to the nerve roots in the lower back.

Q Now, Doctor, as Mr. Cabrera is coming to your office and going to physical therapy and treating with you during the first couple of weeks, can you tell us what his complaints of pain were relative to his lower back and any radicular component? I'm really inquiring about the history of the back and radiculopathy.

A Yes. He continued to experience radiating neck pain and lower back pain. He continued to experience right wrist pain, right shoulder pain, and headaches and dizziness.

Q As you were treating him in the first couple of weeks, was he getting better, worse, or something else?

A He was not getting better.

Q Now, Doctor, at some point in time you said you

sent him out for an MRI. Tell the jury why you waited until January of 2000 to send him for the MRI.

A As I explained, according to the Workmen's Comp rules and regulations you have to obtain permission first to send a patient. You can't just send him out, and I was waiting for that approval to come, and in the beginning, nobody was approving anything until finally the approval came and I sent him out.

MR. WILLIAMSON: Can we approach?

THE COURT: Okay.

(Off-the-record bench conference.)

Members of the jury, you heard the witness testify several times about having to get approval for MRI. That's from Workmen's Comp. That is an outside interest. That is not an entity who is represented at the defendant's table. They had nothing to do with that, and that's an outside entity that has to pay for these medical tests, and the MRI was requested as the doctor testified, and it took awhile to get that payment request approved so that test has nothing to do with the defendants. That's just an explanation being offered by the doctor why it took so long to get an MRI.

MR. BLOCK: Thank you, your Honor. May I?

Q Doctor, as you were treating Mr. Cabrera up to the

time of MRI -- withdrawn.

After the MRI, I'm association I strike that withdrawn.

Prior to the MRI, did you ever recommend that he treat with any other doctors?

A Yes.

Q Whom?

A Dr. Richard Radna and Dr. Ficini.

Q What is Richard Radna?

A He is a neurosurgeon.

Q Why did you recommend that he see the neurosurgeon before the MRI?

A I was concerned about his head. I was concerned about his neck and his back. I wanted a second look. I wanted a second opinion.

Q Now, at some point in time when that MRI was ordered, did it come back to you with the film and the report?

A Yes, Sir.

Q Did you reviewed the film and report?

A Yes.

MR. BLOCK: They're in evidence as Exhibit 10.

Q Question to you, Doctor. The MRI report in its body itself reads as follows.

"At L5-S1 there is diffused degenerative disc bulge as well as a right-sided extra-foraminal disc herniation".

Is that what it says?

A I have four models that could best explain my answer.

MR. BLOCK: With the Court's permission could the doctor step off the stand to demonstrate the models to the jury?

THE COURT: First of all, show the models to counsel.

Do you have any objections to the doctor using some of those models; and let's just mark them for ID.

MR. BLOCK: Absolutely, your Honor.

THE COURT: And have the doctor identify them first before we use them.

MR. BLOCK: Sure.

THE COURT: What is it that you are holding in your hand?

MR. BLOCK: I'm holding a lumbosacral --

THE COURT: I'm sorry. I wasn't asking you.

MR. BLOCK: Sorry.

THE COURT: That's why we brought the doctor. Plaintiff's 11 for identification, Doctor; what is

that?

THE WITNESS: This is a depiction of the human spine indicating the areas that we're going to be talking about; the cervical area, the lumbar spine area, nerve roots, and surrounding structures.

COURT OFFICER: Eleven for ID?

THE COURT: 11 for ID.

And that we're going to mark Plaintiff's 12 for ID; and what is the second item, Doctor?

THE WITNESS: This is a model of the spine indicating the vertebra, the discs, the surrounding structures, the nerve roots.

THE COURT: And we'll mark that Plaintiff's 13 for identification.

And, Doctor, what is that?

THE WITNESS: That's an additional model of the spine indicating what are normal discs; what a bulge is; that a protrusion is; what a herniation is.

THE COURT: Show those to the defendants please.

Any objection to those charts?

MR. WILLIAMSON: No.

THE COURT: For demonstrative purposes only; for ID.

As to the first one, Plaintiff's 14 for

identification, Doctor, what is the heading on that?

THE WITNESS: The role of inflammation in the lumbar spine.

THE COURT: The second one which we will mark Plaintiff's 15 for identification, what is the heading on that?

THE WITNESS: Intervertebral disc.

MR. BLOCK: With the Court's permission may I just have the doctor step off the stand and demonstrate the anatomy by use of a model to the jury so we can get them to understand what the lumbar spine is made of; what the bony part and the disc is made of, your Honor?

THE COURT: Okay, counsel, if you have to reposition yourselves around, that's fine. Feel free to move around.

A What we are looking at is a model of the human spine. This is the back portion of the spine. This is called the spinous processes.

Take your finger and touch the back of your neck. You're touching this structure called the spinous processes. This is the back. This is the front. This is the side.

In the neck, the cervical area, we have seven vertebra. Each vertebra is numbered and labeled according to its anatomic location. If I use the word C5-C6 this means the fifth and sixth vertebra. And if I say C5-C6

nerve root, it means the nerve root behind the fifth and sixth vertebra.

Then we go to the midback which is the thoracic spine. There are 12 vertebrae in the thoracic spine. The lower back is the lumbar spine. It ends with our tailbone, the coccyx; what we are all sitting on. The coccyx and the sacrum are the lower back, the last five vertebrae.

Between each vertebrae we have a disc which functions as a shock absorber; right. I'm going to use the other models.

Right behind --

MR. BLOCK: For the record, the doctor is looking at Exhibit 13 for identification.

A This is a model of the disc. This is the spinous processes. This is the spinal canal, and this yellow structure is the spinal cord. It runs from the neck all the way down to the lower back. It indicates between the first and second lumbar vertebra, and then it continues with branches of other nerves called the cauda equina.

THE COURT: And that's Exhibit 12 for identification.

MR. BLOCK: Actually, no, your Honor. That's 13. 12 is this one.

THE COURT: What is that?

MR. BLOCK: The doctor --

THE COURT: Oh, he took it off of Exhibit 13.

A So this spinal cord gives rise to nerve roots on the right and left sides. All the nerves that go down your arm, they come off the nerve roots in the neck. From an anatomy position, those muscles are supplied by its nerve roots.

For example, the biceps is supplied by the nerve root between the fifth and sixth vertebrae in your neck.

The muscle in your calf called the gastrocnemius muscle is supplied by the nerve root from the fourth, fifth, and some of the S1 nerve root which is the last. After the last lumbar vertebra we have the sacrum. So S1 means the sacrum, and we have --

Q Excuse me, Doctor. Before you get any further, what are these pieces made of in between? These are bones?

A These are bone, yes, Sir.

Q And what is the disc made of?

A The disc has two structures. It's like a jelly donut. The outer perimeter is made of a fibril cartilage material called the anulus fibrosus. There are approximately 100 rings of this fibril cartilage material.

Inside we have a gelatinous structure filled with water. It is this gelatinous structure that allows us to bend our necks forward, backward, left, and right as with our lower backs.

And to continue, there are three abnormal conditions to a disc, and I'm going to show them to you. A normal disc is filled with water. It's referred to as turgid.

THE COURT: That's Exhibit 13 that you're showing the jury?

THE WITNESS: Yes, your Honor. That's correct.

A The next abnormal condition to a disc is called the disc bulge.

May I use those charts simultaneously?

THE COURT: Yes.

A What I'm referring to on the chart and the model, what you're looking at here is, this is a model of a disc. This is the spinous process right here which is this; the spinous process.

This is a transverse process here and here which is this in this structure, and this is the disc I was telling you about.

The disc has approximately 100 rings of this fibril cartilage material in the periphery, and inside is this gelatinous material. Any time we have a partial tear of a disc, the disc begins to bulge out. So a bulge in layman's term is partial tear of a disc.

Herniation in layman's terms is a complete tear of

the disc when the disc material not only tears, but passes the border, the margin of a disc. I'll give you an example.

This is a normal disc. This is a partial tear. That's a bulge, normal partial tear. Normal disc, partial tear. Partial tear, normal disc.

Next is a disc protrusion and herniation disc.

Disc protrusion, a complete tear of disc, but the material stopped at the border of the disc. If it passes beyond that border of the disc it's referred to as herniation?

Mr. Block asked me to define foramina. Foramen is the space here. The neuroforamen is when the nerve root exits when you have a disc herniation.

This is intraforamen, inside the space. Extra means outside. Extraforaminal disc herniation means it is outside this space.

Q In that MRI, is what we are seeing a right-sided extraforaminal disc herniation? Tell us what that is.

A This is the intraforaminal herniation. Intraforaminal herniation means the material is here in the disc. The extraforminal herniated disc is probably back here.

Q Doctor, this model 11 for identification, does this show disc herniation as well?

A Yes. This is showing disc herniation.

Q Would you show it to the jury please?

A There red objects right here show disc herniation.

Q Doctor, just stay with us for a moment.

MR. BLOCK: What is in evidence is 10. I'm going -- this blowup is 10A of one of the reports. It is blown up so the jury can see it.

THE COURT: Did counsel see it?

Any objections?

Okay, so we'll mark that 10A.

MR. BLOCK: Thank you, your Honor.

THE COURT: Blowup of Plaintiff's 10.

Q Doctor, I'm going to hand you Exhibit 10A in evidence. Can you put that up for the jury, and then I'm going to ask you to demonstrate please.

First all, what are we looking at, Doctor?

A We are looking at the MRI of Mr. Cabrera's lower back, the lumbar spine. How do we know that? On top of it is the patient's name. It has the date it was done, January 19, 2000; and what we are looking at is, this is the sacrum which is this bone right here. This is L5-S1. So the last -- this is the L5-S1 disc.

And when we're looking at an MRI here, we're looking at the side view. To orient you properly, this is the back. This is the front. This is the back. This is the front.

So this is the first sacral, S1. At L5-S1 we see a disc herniation. We see this ruptured disc material sticking being out and indented on the nerve root. This is the L5-S1 nerve root. Right before it you see a bulge.

So at L5-S1, herniation here. At L4-5 above it you see it again here. This is the disc. This is the vertebra. This is the nerve root. This is the L4-5 disc bulge right here, and that's it essentially.

Also, at the lower back we have what's called the lordotic curve which is like a C.

Here it's completely straight, indicating severe muscle spasm which is what I picked up on my physical exam findings. MRI confirms it. That's basically what the MRI shows.

MR. BLOCK: We're looking at 14 for identification, your Honor.

A The outer one-third of a disc has nerve fibers. They're called the nociceptors. They are a bundle of nerve roots, and any time you have a tear in the vicinity of the outer one-third, these nerve bundles become irritated and cause pain.

Also, when a disc ruptures or completely tears, you have the release of certain chemicals which causes inflammation to nerve roots, the surrounding muscles, tendons, ligaments.

Some of those chemicals are phopholipase A2, prostaglandins, nitric oxide, metalloproteinases, and so on and so forth.

Anytime you have a tear any of this disc material this is permanent irreversible injury. The body cannot repair a torn fibrocartilage. However, a body can repair a broken bone by callous formation which is bone cement. This condition cannot be repaired. Even with surgery you cannot glue this back together. You cannot suture this back together.

So then you ask then why do surgery to remove this disc material that's putting compression on the nerves that's causing the pain.

It's like you're putting your hand on a fire, and that is how painful it becomes, depending on the level of compression and/or irritation. If you don't remove this compression the pain becomes unrelenting; will not stop.

Q Thank you, Doctor.

Doctor, MRI indicates a diffuse degenerative disc bulge at L4-L5. What does it mean to have a diffuse degenerative disc bulge in a person whose 32 years old, who has been a farm worker and a laborer?

A First of all, once a disc herniates, the water contents leaks out and the thickness of a disc begins to shrivel up or narrow. That's desiccation or degenerative

disc.

Look. This MRI was taken in January 2000 which is approximately three and a half months from the time of the injury. So once you have a disc bulge, the water content leaks out. Same with herniation. The disc as you could see in front of you, begins to shrivel up. That's one process.

Also, a 33-year-old spine begins to have some normal wear and tear to the disc as part of the normal natural aging process. In the female it starts much earlier, at the age of 23 to 25. In the male it starts a little bit later. Different hormones protect us from difference diseases. So it is not unusual to have some degeneration at those levels.

Q Is some degeneration at those levels normal or abnormal absent trauma?

A They're normal in a 33-year-old person.

Q Something that we would expect to see?

A Yes.

Q Let's jump ahead a little bit and talk about the EMG you performed of the lower extremities?

A Okay.

Q Tell the jury when that was.

A March 29, 2000.

Q Can we separately mark that EMG as part of your chart in evidence as Exhibit 8?

MR. BLOCK: Can we mark that as a separate item Exhibit 16, your Honor?

THE COURT: Any objection?

MR. HARRINGTON: No, your Honor.

THE COURT: Okay, Exhibit 16 in evidence of the doctor's?

MR. BLOCK: EMG dated March 29, 2000.

COURT CLERK: What page, Judge?

THE COURT: You want the doctor's record?

MR. BLOCK: Actually I'd like to do that one please.

THE COURT: Counsel, do you want to see it?

MR. LOMBARDO: I know what it is, Judge.

THE COURT: It's okay then?

MR. LOMBARDO: Yes.

THE COURT: Exhibit 16. Okay go ahead.

Q Doctor, pull out Exhibit 16 and let's talk about what an EMG first of all.

A An EMG stands for electromyography. It is the study that is done by a physician, either a neurologist or a physiatrist like myself. It is done to see if there is any muscle or nerve damage. The study has three components: The motor study, the sensory study, and thirdly, the actual needle EMG.

Q Is this something that is objective or a

subjective test?

A This is an objective test.

Q What does that mean?

A That means the patient has absolutely no control over it.

Q Is it something that's done with the use of a computer or something else?

A It's done with the use of the computer, and has a printout as well.

Q Please tell the jury how you administer this EMG and whether it's painful.

A It is painful. The first two points, the motor and sensory involve placing electrodes over different muscles in the foot and the ankle with a simulator. In layman's terms it's called a prong.

You stimulate different parts of the foot and the ankle, and you increase the electrical intensity until you get the right response. So the patient gets zapped.

So you test the distal portion which means the portion further away from the body, and the proximal portion closer to the body; and you check them to see the conduction process by the speed which it travels from two points; the actual site of the responses.

In a radiculopathy which means damage to a nerve root, the rate of intensity is almost always normal aspects

as was here. It's the needle EMG that checks the actual nerve root. The way that is done is you insert a sterile needle usually about this long into various muscles in the legs, various muscles in the lower back. That is a painful test.

Once you insert the needle into the muscle, you have a computer with an oscilloscope. You flick on the oscilloscope to see what is happening. When you insert the needle into the muscle, normally it's quiet, at rest. You don't see a lot of activity. When you see a lot of activity, that is called increased insertional activity.

The next abnormal finding you're going to see is called positive sharp waive. It's a downward deflection that looks like a V. I have the tracings if I may be allowed to show them.

MR. BLOCK: That was Exhibit 16 in evidence. You can show them to the jury.

A This is the EMG that was done on Mr. Cabrera on March 29, 2000. At the right L5-S1, that's the muscle in the lower back. We see increased activity, and we see one, two, three, four, five, six, seven downward deflections, seven positive sharp waives. If you have more than one positive sharp waive, it is confirmatory of a radiculopathy. Here we see seven. Also a of note of interest is the positive sharp waive if they have more than three dips.

They're called polyphasics.

So an EMG not only gives you a diagnosis, it also tells you how old this nerve injury is. If you see multiple phases on each spike, three or more, it's called a polyphasic; and if you have a lot of polyphasics indicated, this nerve injury is more than one year old.

Q What was your finding with regard to Mr. Cabrera from the March of 2000 examination?

A There are no polyphasic potentials here.

Q What does that mean?

A That means that these nerve injuries are recent. They are less than one year, and that was done about five months after.

Q Does that comport with the fact that Mr. Cabrera fell 15 to 20 feet off of a scaffold?

A It confirms the history. The physical exam is that; the pieces of crossword puzzle. You now begin to fill in the pieces of crossword puzzle. If it were a crossword puzzle and you say is it possible, anything is possible, but once you complete the picture, then it either becomes possible or not possible. The EMG starts to begin to fill in those little pieces of crossword puzzle.

Q At some point in time as you're treating Mr. Cabrera -- first of all, is he in pain?

A Yes, he's in pain.

Q How do you know?

A Well, one, he has muscle spasm; and two, trigger points. They both cause pain. Third, we know he has a disc herniation.

I've shown you different diagrams of a disc. Anytime you have a tear of the outer one-third -- there are nerve fibers. Anytime you have the destruction and irritation to those nerve fibers, that causes pain.

I showed you on the same chart. You have release of certain chemicals. If one of those chemicals leak, they cause surrounding pain and inflammation to the nerve root muscle tendons, ligaments. That causes pain.

We have an EMG that confirms nerve root damage in the lower back at the right L5-S1. That confirms nerve damage. Nerve damage causes pain.

Q How do the EMG findings and the MRI correlate to Mr. Cabrera's complaints when he came to your office the day after the accident?

A He complained of lower back pain shooting down the right let, with numbness in the foot.

The foot is covered and controlled by the nerve root in the lower back at L5-S1. So that nerve distribution correlates to that particular disc level of herniation.

Then the clinical findings, the physical exam findings, the EMG findings, and the MRI findings all began

to correlate completing the picture.

Q And, Doctor, between the present time of now and March of 2000, did you start prescribing injection to his lumbar spine -- "Yes" or "No"?

A Yes, Sir.

Q What was the purpose of those injections?

A To give him some relieve of pain, and to reduce the inflammation caused by disc herniation and the release of those chemicals and the nerve root damage; to give him some relief of pain, and the injections have three different medications inside of it.

One was Lidocaine which is a local anesthetic and numbs the area for six hours.

The second medication is Methylprednisolone. That begins to work after 24 four hours and lasts for 72 hours.

The third medication is Dexamethasone. It's a powerful cortisone medication which works shortly. Begins to work after four to six hours and only lasts for 24 hours.

So by giving him three medication he gets continuous sustained relief, and injections are given right at the level where the disc herniation was and where the nerve root was damaged along the paraspinal muscles.

Q Why are you giving Mr. Cabrera injections into his back? For what purpose?

A To relieve the inflammation caused by the disc

herniation and nerve root damage and radiculopathy.

Q As he was treating, did you make recommendations regarding him seeing a neurosurgeon?

A Yes, I did.

Q And did you discuss with Mr. Cabrera what type of surgery he might have to undergo?

A Yes. As of 2/14/2000 when I reviewed all the MRI findings with him when I did the EMG of his neck, I told him that he has a permanent injury. He has problems that have not been working well with the physical therapy and the pain medications. It's time for him to get a second opinion from a neurosurgeon. I referred him to Dr. Radna. He was -- it took him months until he got himself to go.

Q Now, in fact he saw Dr. Radna for the very first time in October of 2001. Are you aware of that?

A Yes. That is correct.

Q So that's more than a year. Almost a year and half after you recommended him to go; is that correct?

A Yes.

Q Now, just tell us why did you continue doing physical therapy to the man if he wasn't responding to physical therapy?

A Well, let's not say he wasn't responding. It was helping him slightly. Physical therapy is not designed to cure his problem. There is to cure for disc herniation as

there is no cure for arthritis and diabetes. There is only treatment.

If you treat the patient, the patient feels better, and they don't get progressively worse. If you don't treat a patient with advanced arthritis they become crippled up; and if you don't treat a patient with diabetes with Insulin, they go into Insulin shock and die. So the physical therapy was not designed to cure his problems, it was designed to decrease some of his pain, decrease some of his spasm, improve his range of motion, and more importantly, to prevent him from getting worse. When the physical therapy was stopped he got progressively worse, so the physical therapy was doing some good.

Q At some point in time did he actually to your knowledge go to Dr. Radna?

A Yes, Sir, he did on 10/15/01.

Q Now, were you provided with those records and reports?

A Yes, Sir.

Q That's evidence. Dr. Radna's entire chart is Exhibit 9.

Doctor, I want to jump ahead a little bit. Do you remember knowledge Dr. Radna sent him out for tests?

A Yes.

Q What he send limb out for?

A A CT scan.

Q And ultimately did he perform surgery?

A Yes, Sir, he did. He had a total of five surgeries.

Q Okay. Let's talk about the first surgery. In evidence is Plaintiff's Exhibit number 2. What I have right here is the St. Joseph Medical Center record for the period of February 1, 2002 to February 4, 2002. Do you have that op report with you?

A Yes, I do.

Q Could you look at that op report for a moment please?

A Yes.

Q And just read the preoperative diagnoses and then read the postoperative diagnosis to the jury.

A Preoperative diagnosis which means the diagnosis before the surgeon went in to do the surgery. Postoperative diagnosis means what his diagnoses was after he performed the surgery which included what he saw with his naked eyes at the time of surgery.

Preoperative diagnosis was posttraumatic lumbosacral radiculopathy with herniated discs L4-L5 at L5-S1 level in the presence of a spondylolysis.

Lysis means a defect in one of the vertebra, and postoperative diagnosis was the same.

Q Now, tell the jury, what does posttraumatic lumbosacral radiculopathy with herniated discs mean?

A The condition which occurs after trauma, after an accident. In this case it was the accident of August 31, 1999, because prior to that he had no other accidents.

Q So now, Doctor, if someone got up in front of this jury and told the jury no records exists that would show that the surgery performed in February of '02 was at all related to the trauma, is that borne out by the record that you just read -- "Yes" or "No"?

A Crystal clear. Yes.

THE COURT: I didn't understand your answer. Is that borne out by the record -- "Yes" or "No"?

THE WITNESS: Yes, it is.

Q The record shows what?

A Shows posttraumatic lumbosacral radiculopathy with herniated disc at the L4-L5 and L5-S1 levels.

Q How long have you been a doctor?

A Since 1985.

Q Is there any question that the posttraumatic as referenced in that report is referencing a posttraumatic fall from the scaffold?

A No doubt in my mind.

Q Is that what you sent Dr. Radna?

A Yes.

Q Let's look at the second operative report in evidence as Exhibit 3 for the March 5, '03 -- I'm sorry, through March 15, three hospitalizations.

A Okay.

Q Do you have that one, Sir?

A I do.

Q Can you look at the preoperative diagnosis and tell us what it said?

A The preoperative diagnosis is posttraumatic lumbosacral musculoskeletal and radicular pain syndrome with herniated discs at L4-L5 and L5-S1. The postop diagnosis is the same.

Q I'm looking at 3-5. You might be looking at a different - the next one after that?

A 3/5/03.

Q Okay, fine, the op report?

A Yes, Sir.

Q Sir, where it says posttraumatic and it's lumbosacral radiculopathy with herniated disc, what does that mean in medical terms?

A Again, post means the condition after trauma which is what I explained earlier; and posttraumatic lumbosacral radiculopathy means the damage to the nerve root is resulting from disc trauma and herniated disc.

Posttraumatic means the disc herniation that came as a result of this trauma.

Q Doctor, if someone got in front of this jury and said that the first surgery was not caused by the fall off the scaffold, does that record say otherwise?

A Most definitely.

Q If someone up they said the second surgery was not caused by that trauma, does that record say otherwise?

A Yes.

Q Let's look at the third one, Doctor. Let's look at the operative report dated May 16, 2003. It's in evidence as part of Plaintiff's Exhibit 4. You see that one?

A Yes.

Q Can you please read to the jury the pre and postoperative diagnosis on that one?

A It states, posttraumatic lumbosacral radiculopathy with posttraumatic microinstability and musculoskeletal pain syndrome.

Q Now, Doctor, again, does that operative report, op report number three relate to the trauma of the fall off the scaffold?

A Yes.

Q How do you know?

A It states right there.

Q Is there any question that those documents are in existence and easy to read in black and white?

A Yes.

Q If someone got up here said, ladies and gentlemen, the three surgeries, one, two, and three were not traumatically induced, do those records clearly state they were traumatically induced?

A Yes.

Q Doctor, they say traumatically induced with herniations? Do those records state that or not?

A Yes, Sir.

Q Doctor, if someone got up in front of this jury and said the herniations were not caused or traumatically induced by the trauma from the fall off the scaffold, would they be being forthright to the jury? Are those records something that discredits that person?

MR. HARRINGTON: Objection.

THE COURT: Sustained.

Q Do those records clear as day show that Mr. Cabrera sustained disc herniations as a result of falling off the scaffold?

A Yes.

MR. HARRINGTON: Objection.

THE COURT: You've asked and had that answered several times.

Q Let's jump ahead to the fifth surgery, not the fourth. Let's to go the fifth one. It's in evidence as plaintiff's Exhibit 6. Let's look at the operative report there, Doctor.

A Okay.

Q Please read the pre and postoperative diagnoses again for the jury.

A It states posttraumatic lumbosacral musculoskeletal and radicular pain syndrome.

Q Tell us again begin in English what that means, Doctor.

A The posttraumatic radiculopathy is the damage to the nerve root as a result of this trauma; and the musculoskeletal traumatic is what I call traumatic myofascial pain symptoms; damage to the muscle trigger points and spasm in the surrounding area. So there is damage to the nerve roots, the discs, and the muscles.

Q Doctor, at some point in time as you have been treating Mr. Cabrera, can you tell us, over time before he had his first back surgery up until this point of time, was his condition getting better or worse from the time you first started seeing him?

A His condition was beginning to get progressively worse and not better.

Q As a result of the -- first of all, Mr. Cabrera

went for that first surgery; is that correct?

A Yes, Sir.

Q Do you have an opinion within a reasonable degree of medical certainty as to whether his going for that surgery was reasonable or unreasonable?

A It was most definitely reasonable.

MR. HARRINGTON: Objection.

THE COURT: One second. May I see counsel up here?

(Off-the-record bench conference.)

The objection is stained. We need a little more background before that question can be asked.

Q Doctor, leading up to this first surgery what were Mr. Cabrera's complaint of pain, his medical condition; and what did you think as a medical doctor would be changed by that surgery?

THE COURT: That's a question with 16 parts. Let's just do it one by one.

Q What were his complaints and conditions?

A Persistent progressive worsening of severe neck and back pain. The fact that he was very upset being unable to work not being able to earn a living for his family.

Medications I placed him on; the injections I gave him did not give him adequate relief. He was placed on Ultram which is in strength similar to Tylenol with Codeine?

I had given him Vioxx until it was taken off the market. For an antiiflammatory he had the paraspinal injection; again, with Lidocaine and cortisone. And all the physical therapy he was still not improving, and finally, he succumbed to a referral for surgical evaluation.

Q Why did you send him for a surgical evaluation referral?

A Because nothing else was working.

Q Was it reasonable for him to follow your medical advice?

A I would say so.

THE COURT: I'll allow it, but I don't know that what he thinks is reasonable is reasonable.

Q Did the patient report back to you that he felt better or worse after the first surgery?

A I will tell you in a second.

Initially he got some partial relief, and then progressively -- got progressively worse over time.

Q In the field of medicine, is it a course of treatment to treat someone conservatively or aggressively?

A Yes, Sir, that's all the way.

Q Does physical therapy come before a surgery?

A Yes, Sir, unless surgery becomes an emergency as a cauda equina system where there is loss of bowel and bladder and immediate paralysis.

Q Is surgery an accepted form of treatment for people suffering traumatically induced disc herniation and radicular pain syndrome?

A Yes.

Q Doctor, we're going to have you come back. I just want to bring the jury up to one area please. So forgive me if I'm jumping ahead.

At some point -- I'm talking about the first surgery -- were you able to formulate an opinion within a reasonable degree of medical certainty as to a diagnosis?

A Yes, Sir.

Q What was your diagnosis up until that point of time?

A L4-L5 and L5-S1 disc herniations. C5-C6 disc complication. Right C5-C6 cervical radiculopathy. Right L5-S1 lumbar radiculopathy. Status post lumbar laminectomy and laminotomy and facetectomy surgeries. Traumatic myofascial pain syndrome.

Q Did you form an opinion with a reasonable degree a of medical certainty as to everything, what was the cause of all of those diagnoses you have just told the jury?

A Yes. It was all caused as a result of the accident of August 31, 1999.

Q And, Doctor, within a reasonable degree of medical certainty, when a man falls 20 feet -- 15, 20 feet off a

scaffold and lands on the floor, does he get hurt?

A Most definitely.

MR. LOMBARDO: Objection.

MR. HARRINGTON: Objection.

MR. WILLIAMSON: Objection.

THE COURT: Sustained.

Q Doctor, Mr. Cabrera, when he fell 15, 20 feet off the scaffold, in your opinion, was that the competent producing cause of his injuries?

A Yes.

MR. BLOCK: I think it's a good time to break, your Honor.

THE COURT: Okay, members of the jury. We're finish with our testimony for today. We have more testimony scheduled for tomorrow. I'll ask the jurors to be here at a quarter to 10 so we can start our testimony at 10:00.

Just don't discuss this case amongst yourselves or with anyone else, and remember; we can't start until all the jurors are here. So please be on time jurors.

Leave your notebooks on your chairs. We lock them up and hand them out again tomorrow.

All rise and let the jurors exit the courtroom.

(Jury exits courtroom.)

All right, Doctor, you may step down.

MR. BLOCK: Your Honor, I spoke with the doctor earlier. Is it okay if we put him on Monday morning as he can't make it here tomorrow. I have another doctor, a neurosurgeon tomorrow.

MR. LOMBARDO: I object, your Honor. I'd like the opportunity to cross-examine the doctor while he's here.

THE COURT: He will be here on Monday.

Mr. Williamson, did you say your doctor is coming in Wednesday morning?

MR. LOMBARDO: I haven't cancelled my witness. I forgot all about it. I will have to do that tomorrow.

THE COURT: This is off the record.

(The case was adjourned to November 17, 2006.)

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