SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS: CIVIL TERM : PART 4

GUSTAVO TAPIA and AMPARO TAPIA Plaintiff(s) - against - 3096 OWNERS CORP., SUNSHINE DAY CARE, MS SUNSHINE INC., AND MY SUNSHINE II. INC Defendant(s)	: : :IND.# :25724/07 : :

360 Adam Street
Brooklyn, New York, 11201
March 4, 2013

B E F O R E : HONORABLE DAVID B. VAUGHAN,
Justice (and a jury)

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

FOR THE PLAINTIFF:

DINKES & SCHWITZER, P.C.
112 Madison Avenue
New York, New York 10016
BY: WILLIAM SCHWITZER, ESQ.

FOR THE DEFENDANTS:

BRODY, O'CONNOR, O'CONNOR, ESQS.
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By: SCOTT A. BRODY, ESQ.

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Official Court Reporters

MR. BRODY: Your honor, on Thursday, you ruled on a motion in limine. The motion in limine was a written motion with written opposition. And I just want to get on the record that the motion should be marked as a Court Exhibit. And the opposition should be marked as a Court Exhibit since they would be part of the record in this case.

THE COURT: No problem.

MR. BRODY: Judge, counsel filed a motion in limine on the alcohol issue.

THE COURT: I thought I've already made a decision on that.

MR. BRODY: At the time you told me I could not comment any more. He then filed a written motion. I think he wants to strike the testimony. I have opposed it and I have -- I think both the motion and the opposition to that should also be marked as Court exhibits.

THE COURT: Okay. The Plaintiff's.

MR. BRODY: Correct. And then I would want to address at some point in the future. But it doesn't have to be before Dr. Merola. I don't want to slow Your Honor up.

The last thing, Judge, is that just to save time today, in light of your ruling on Thursday, I just want to be clear that I have a running objection to any testimony

that is outside the scope of Dr. Merola's report. And rather that constantly, you know, making lengthy objections, I'm just going to say objection. And Your Honor knows what I am objecting to.

THE COURT: You are objecting to the whole line of testimony.

MR. BRODY: On the L5 - S1 or on any direct on diabetes. It is going to come out on cross any way. It is what it is.

THE COURT: Are we all set?

MR. SCHWITZER: One minute, Judge. Just need one minute.

MR. BRODY: There are tons of exhibits. I don't know the exact number at this point. They are all medical exhibits that we are stipulating into evidence. However, certain of the exhibits are illustrations.

THE COURT: Are what?

MR. BRODY: Illustrations that the doctor are going to used to describe the surgery. I have discussed with counsel for Plaintiff and I think at least for the motion, we have agreed that they are not being offered to show the exact condition of L4/5 and L5 - S1. They are just illustration.

MR. SCHWITZER: Just illustration.

MR. BRODY: This type of illustration, which is

Exhibit 19, for example, we are agreeing that it is coming in for L1. But not as a description of the L4 -- the disc at L4/L5.

MR. SCHWITZER: So stipulated.

THE COURT: Okay.

Now, just so I know, this case is going to be finished on Thursday, correct?

MR. BRODY: We are trying.

THE COURT: Because I had a thing and I had to put it off. You have one doctor today, right?

MR. BRODY: Correct.

THE COURT: You've got two doctors tomorrow?

MR. BRODY: Correct.

THE COURT: You've got one doctor Wednesday afternoon. That is four, right?

MR. BRODY: Right.

THE COURT: And then two on Thursday?

MR. SCHWITZER: That is what we are trying to do.

MR. BRODY: Correct.

THE COURT: And that is it?

MR. SCHWITZER: Assuming that all goes to plan.

THE COURT: There is no reason why it shouldn't.

MR. BRODY: I don't know if we will get done with Dr. Merola today.

THE COURT: What?

MR. SCHWITZER: Counsel thinks he is going to go into the afternoon.

THE COURT: Listen. Obviously, there is a lot involved here. But, you know, obviously I'm not going to allow any repetition and things going over and over again.

MR. SCHWITZER: I am not planning. It is just a lot of --

THE COURT: Let's get started.

COURT OFFICER: All rise. Jury entering.

MR. SCHWITZER: I just want to talk about the ruling.

THE COURT: Okay.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury is entering the courtroom).

THE COURT: All right. Have a seat folks. Welcome back. I hope you had a pleasant weekend, counsel.

MR. SCHWITZER: Thank you, your honor. At this time, the Plaintiff calls Dr. Andrew Merola to the stand. Okay.

THE CLERK: Please remain standing and raise your right hand.

D O C T O R A N D R E W M E R O L A, after having first been duly sworn by the Court Clerk, was examined and testified as follows: .

THE WITNESS: Yes.

THE CLERK: Please be seated. In a loud clear voice, please state and spell your name for the record.

THE WITNESS: Andrew Merola, M-E-R-O-L-A.

THE CLERK: Your address.

THE WITNESS: 567 First Street, Brooklyn, New York 11215.

THE CLERK: Thank you.

MR. SCHWITZER: Your honor, if I may have just one moment with counsel.

DIRECT EXAMINATION

BY MR. SCHWITZER:

MR. SCHWITZER: Your honor, at this time, there were just two more items I forgot to put in. I would like to offer the redacted records of Doctor Arden Kaisman and redacted Dr. Betchen records.

MR. BRODY: The parties have reviewed them and they are acceptable.

THE CLERK: 36 and 37.

(Whereupon, Plaintiff's 36 and 37, was marked for identification and moved into evidence)

MR. DEMERS: I thought we've agreed on those.

MR. SCHWITZER: In the meantime, if you don't mind comparing them and I will get started.

THE COURT: Okay. Come on. Let's get going.

Q Good morning, Dr. Merola?

A Good morning.

Q Dr. Merola, did we meet yesterday prior to you coming to Court today?

A Yes, we did.

Q And where did we meet?

A In my office.

Q And was that for approximately one hour?

A Yes.

Q And Dr. Merola, prior to this trial starting, did I meet with you for approximately half an hour to tell you I would possibly need you to come to court?

A Yes.

Q And Dr. Merola, what I like you to do for us is discuss, starting with college, your medical training. Starting from training forward?

A Okay.

Q Sorry about the word medical. Your educational background from college forward?

A Sure. So, I went to New York University for undergraduate. And after I graduated from NYU, I went to Washington DC. I went to Howard University College of Medicine. So I spent four years there. After that, I was accepted into a residency training program here in Brooklyn, New York, at SUNY DownState Medical Center. So I did a year of general surgery and then four years of orthopedic surgery. After that was completed,

I went to the University of Colorado in Denver where I did a one-year fellowship in spinal reconstructive surgery. And then I came back to New York City in 1996 and started the practice of Orthopedic reconstructive spinal surgery.

Q Okay. And can you tell us what that field is?

A That is the field of surgery that specializes in disorders and treatment of the neck and back. The spine. In both children and adults.

Q Doctor, have you written articles?

A Yes.

Q And how many would you say you have written?

A Probably about 30 or more.

Q Have you authored or co-authored any medical text?

A Yes.

Q And what would that be?

A I have done some surgical atlas. I have also done text on biomechanics. And I have been in other books regarding spinal surgery and biomechanics.

Q What is a surgical atlas?

A A surgical atlas is a book whereby residence and students and other surgeon can make reference to standard surgical procedures. Things like indications or contraindications, surgical techniques. That type of thing.

Q Have anything you've written been published to be used by doctors and surgeon in other countries?

A Yes.

Q What countries was it translated? How is that done?

A So some of the books are translated and some of them go over in English. Most Western countries like European Countries use English version. And then sometimes there are translations made into, for example, Chinese for Asian countries.

Q Doctor, do you hold any teaching positions at this time?

A Yes.

Q And what teaching positions do you hold and where?

A So, I teach medical students and residence at the Mount Sinai Hospital medical center in New York as well as SUNY Downstate Medical Center in Brooklyn.

Q And what do you teach them?

A Orthopedic surgery and spinal surgery.

Q So, as part of your teaching, are they actually in the operating room with you at certain times?

A Yes.

Q Now, do they also go on rounds with you?

A Yes.

Q Doctor, do you hold any board certifications?

A Yes.

Q And can you tell us what they are in general and what you hold?

A Sure. So, board certification is, it's a process after

you finish your training and you have completed your training. There is a two step process. One is a written exam that you take when you graduate your residency. So you take a written exam on basic general knowledge. And then after you pass that, after you have been in practice for two years, you then take an oral examination based on your cases or your treatment of patient. When you pass both of those parts, oral part and the written part, then you are board certified. So it means that you have met the criteria in order to be not only educationally knowledgeable about what your field is, but also practically knowledgeable in your field.

Q And when you say you're board certified in the filed of orthopedic, can you tell us what that board is called. The name of it?

A That is the American Board of Orthopedic Surgery. ABOS for short.

Q And it would be a fair thing to say, doctor, there are other academies and board you can just join by paying a membership dues?

A Well, if you are board certified, you need to take an examination in that discipline. So there is American Board of Family Practice, pediatrics, etc. etc. Etc. So for orthopedic surgery, if you are board certified, you are boarded if you have passed an exam of that particular specialty.

Q Now, doctor, do you recognize Mr. Tapia sitting here?

A Yes, I do.
Q And do you recognize, without me telling you, who is sitting next to him?
A That is his wife.
Q How is it that you happen to know just by looking at her that that's his wife?
A Because Gustavo is my patient and he's always come in with his wife.
Q She's always with him?
A Yes.
Q Now, doctor, at some point did Gustavo Tapia come to treat with you?
A Yes.
Q And do you have your records with you?
A Yes.
Q Can you tell us when he first came under your care?
A Sure. So I actually first saw him in June of 2008.
Q And when had he had his accident?
A The accident had occurred on May 26 of 2007.
Q And do you know how it is he came to see you?
A Yes.
Q And how is that?
A He came in as a referral from a pain management physician.
Q Who is that?

A Dr. Arden Kaisman.

Q Okay. And do you have relationships with various doctors. In other words, referrals back and forth with specialities?

A Yes. The various specialities I have. There is a group of physicians who we know each other and orthopedic surgery and spinal reconstructive surgery overlap with numbers of different doctors. So we have relationships whereby we refer patients with each other, yes.

Q So other orthopedists that don't do surgery and neurologist and other specialty refer people to you?

A Yes.

Q And doctor, do you have any privileges in hospitals?

A Yes.

Q And where is that?

A Mount Sinai Hospital in the city. New York Methodist Hospital in Brooklyn. SUNY Downstate Medical Hospitals.

Q Now, doctor. Just jumping ahead for a moment. You did a surgery on Gustavo Tapia, I believe, in January 12, 2010?

A Yes.

Q What hospital was that?

A St. Vincent Hospital.

Q Is that hospital still open?

A No, it is not.

Q Do you recall, approximately, when it closed?

A Yes.

Q When was that?

A Approximately a couple years. It's been about two, two and a half years now.

Q Now doctor, what I am going to hand up to you with the Court's permission is a copy of the Coney Island Hospital Record.

MR. SCHWITZER: I'm handing one up to the Judge.

(handing)

MR. SCHWITZER: And what I did, your honor, to make things flow faster, is I have paginated the record. So we all agree it would be easier to go through this. So it is paginated on the bottom.

Q Now, Dr. Merola, --

THE CLERK: 38 in evidence.

(Whereupon, Plaintiff's 38, was deemed marked in evidence)

THE COURT: We will deem it as 38.

MR. SCHWITZER: So I am going to deem it so that Mr. Demers can look at it.

THE COURT: It will be deem marked. Whatever the number is.

(handing)

MR. DEMERS: Thank you.

MR. SCHWITZER: You are welcome.

Q Now, doctor, when turning to page seven and I am just

going to move through this a little bit, okay. What I marked as page seven, you see that?

A Yes.

Q What is that page?

A This is the emergency department Coney Island Hospital, it looks like a face sheet.

Q And does it indicate a history in there?

A Yes.

Q And can you tell us what it says?

A It says fall. History of present illness. 48 year old mail. Status post fall from second story while on step ladder. No loss of consciousness no dizziness. Patient complains of pain and lower back.

Q And what about prior medical history?

A Past medical history diabetes mellitus Type two.

Q Okay. And what does it say. There are boxes for admitting condition on the bottom of the page what is checked off as far as his admitting condition?

A Admitting condition. It says poor.

Q Now, doctor, turning to page 48 of that record. I'm sorry, page 12 of that record. Do you have that?

A Yes.

Q And under chief complaint present history. That's a workup in the emergency room; is that correct?

A Yes.

Q What does it indicate?
A It says 48 year old male fell from two flights approximately fifteen feet from ladder hit lower back.
Q And then it parenthesis. What does it say as to how he landed?
A Landed on buttocks.
Q And does it have a past medical history?
A Yes.
Q What does it say?
A Diabetes mellitus.
Q Are there initials for it?
A Yes.
Q So in the record, what does it say?
A Capital D capital M.
Q Now, turning ahead to page 42. Do you have that.
A Yes.
Q Now, that's record is dated 5/27 of '07; is that correct?
A Yes.
Q And what does it have under medication administered?
MR. BRODY: Objection.
THE COURT: This is page 42.
MR. SCHWITZER: 42.
THE COURT: Okay. You are objecting.
MR. BRODY: He has never seen this record before.

All he is doing is reading a record that's already in evidence. He has never seen it.

THE COURT: I assume he is going to get to some kind of point.

Q I will ask that question. Prior to coming here today, have you ever seen that record?

A Yes.

Q Okay. Now --

MR. BRODY: Yesterday.

THE COURT: Counsel, you will get your chance. Go ahead. It's in evidence.

Q Under medication administered. What does it say?

A Medication administered morphine sulfate 4 milligrams.

Q And what is that?

A Morphine sulfate is a pain medication.

Q The dosage, is there any significance to that?

A Four milligrams would be the dosage for pain in a male of Mr. Tapia's size.

Q Okay. Now, doctor turning ahead to page 69.

Do you have that?

A Yes.

Q What is that document?

A That is an inter-hospital transfer record.

Q Okay. What hospital does that indicated that he was being transferred from to?

A From Coney Island Hospital to Maimonides Medical Center.

Q And under past medical history, what does it indicate?

A Capital D Capital M. Diabetes mellitus.

Q And as far as the physical findings, what does it note prior to the transfer?

A It says left lower extremity paresthesia from groin arrow distal foot of left lower extremity. Two plus pulses. Positive full range of motion. No weakness. Positive pins and needles.

Q Can you tell us in English what you just read?

A So it says he is, under physical finding, it says that he has numbness and tingling primarily in his left lower extremity radiating down his leg. No weakness, but sensation of pins and needles.

Q Okay. Does it indicate why he was in that hospital? What the condition was.

A L1 burst fracture.

Q I am going to get to that in a moment.

Now, doctor, what I am going to offer into evidence right now. This is a disc of the Coney Island Films. Okay. And that would be number?

THE CLERK: 39.

MR. SCHWITZER: Can we deem it, Judge?

THE COURT: Excuse me?

MR. SCHWITZER: Deem it as 39 and I'll move it along.

THE COURT: Yes.

(Whereupon, Plaintiff's 39, was moved into evidence)

Q And I would like you to do with the Court's permission is number one the computer you brought with you -- actually, we brought. If you can put it in there and then she us looking through this what the film show?

MR. BRODY: I have that running objection, Judge.

THE COURT: I understand.

Q Doctor, number one. What type of film is that?

A I am still opening it. I think these are multiple images.

THE COURT: How many are these do you have.

MR. SCHWITZER: A number of them. If it opens, they are quick. If it doesn't open.

THE COURT: If it doesn't open, we will be here until next week.

MR. SCHWITZER: That is why we said technology is no so great.

Q Doctor, if we let that sit there, will it open on its on?

A It is starting to open. It is a disc. And the images that are on the disk are popping up. There are number of images

ranging from chest X-ray. Cervical thoracic and lumbar spine X-rays. An X-ray of the pelvis. And a CT Scan of the lumbar spine.

Q Okay. Specifically what I'd like you to direct your attention to is the CT of the lumbar spine. And what I'd like you to do, if you could with the Court's permission is open that. And if there are particular images in there that would help you to illustrate to the jury what was seen on film at Coney Island Hospital prior to transfer to Maimonides?

A Sure.

MR. DEMERS: Objection to the form.

THE COURT: Go ahead. Couldn't he just tell us without having to look at it.

Q Judge, I think we have to go through it.

A It's a CAT Scan. It has to load. There are a lot of images on it. And it takes a while for the images to process through the laptop.

THE COURT: Counsel, don't you have a picture. If you have got several of these things.

MR. SCHWITZER: That's what I am trying to do right now as we speak.

THE COURT: Counsel, why don't you ask him what the CD Scan show while the pictures pop up.

THE WITNESS: I have some of the images available.

A It is not scrolling through all of them. But I have

the lateral image.

Q Does any of that show that burst fracture?

A Yes.

MR. SCHWITZER: With the Court's permission, step down.

Q What I'd like you to do to make sure you center yourself or turn as you are talking so that all of the jurors, if you can move over little more.

A This is a CT Scan, which is really multiple X-rays that are then reassembled by a computer to generate an image of the spine and of the bones. And on the left of the screen as you are looking at it, the left-hand side of the screen is what is known as the side-view of the spine. And what you can see on the side-view of the spine is in the upper third section of the side-view of the spine is an area that appears to be wedged or more triangular in appearance. And this is a compression fracture of the first vertebral body. If you compare it to the vertebral body that are adjacent to it, the other vertebral bodies are generally, they look like squares. And the L1 vertebral body has taken on an appearance of more of a triangular appearance.

And if you look to the right of the vertebral body that is where the spinal canal is and you can see that there are bone protruding into the area of where the spinal canal is where the wedge of the bone is.

Q If you could, doctor, I am going to unplug it. Could you go down. It's a little difficult just on the computer.

A So this is the side image of the spine. Normal vertebral body are squares. The damage vertebral or the compressed fracture of the burst fracture of the vertebral body is a wedge or a triangular. And to the right of that triangular, there are bone in the spinal canal.

Q Okay. Please continue, doctor.

A So that represents what we know as a burst fracture. The reason it is called a burst fracture is, it involves all portions of the vertebral body. Vertebral body and the spine has three parts to it. If you look at it from the side, this is a front third. There is a middle third. And then there is a back third. A burst fracture involves all portions of that vertebral body.

Q What does mean in English that there was a burst fracture. What happened to that area?

A So it means that that bone has basically exploded whereby all portions of that bone, front, middle and back are fractured. So that there is nothing holding the top part of the body to the bottom part of the body because all three portions of that vertebral body have been fractured.

Q Please continue?

A So that is primarily what the CAT Scan is showing. It is showing a fracture and this particular image on the CAT Scan

is also very good at showing you the alignment or the way the body lines up on the side-view.

A spine should have some normal curvature to it when you are looking at it from the side. And in the area where this particular vertebral body is, that segment of the spine should actually be rather straight. There is a lumbar curvature in the lower portion of the spine. And there is a thoracic curvature in the upper portion of the spine. But in the area where this vertebral body is, it should not be any curvature noted because it is wedged and compressed. That section has fallen over. And we call that particular kind of an appearance, we call that a kyphosis K-Y-P-H-O-S-I-S. So that's known as kyphosis. It's a post-traumatic kyphosis because it involves a fracture.

Q Okay. Anything else you want to show us on that film or we will move along?

A No.

Q So he's transferred, doctor, to Maimonides Hospital. And doctor, what I am going to do is hand you up a paginated Maimonides Hospital record.

A Okay.

Q And what I want to do in the meantime while I am talking to you is ask you to pop in the Maimonides' film. That would be deemed 40?

THE CLERK: 40.

(Whereupon, Plaintiff's 40, was moved into

evidence.

Q So just put it in. And while that is opening up, I will ask you some questions.

COURT OFFICER: What is this?

MR. SCHWITZER: That would be Maimonides hospital record.

THE CLERK: That's 40.

MR. SCHWITZER: The CD is 40. The Maimonides Hospital would be deemed 41.

(Whereupon, Plaintiff's 40 and 41, was deemed into evidence)

Q Okay. You ready?

A Yes.

Q All right. Turning to the Maimonides Hospital Record. Number one, just for the record just to move it along. He was admitted on 5/28 and discharged on 6/3 of '07. Turning to page 124 of the record. I am just going to read a couple of things just to speed it along. Pain management. Patient met criteria?

MR. DEMERS: Page.

MR. SCHWITZER: 124.

Q Now, doctor, turning to page 180. You have that?

A Yes.

Q What is that?

A This is still part of the hospital record. This is a dispatch information regarding the patient with a summary.

Q And under comments. What does it indicate?
A Under comments it says given morphine.
Q Okay. And doctor, turning to page 181.
A Yes.
Q Now, that information on there is obtained from the patient?
A Yes.
Q And what is the chief complaint of Mr. Tapia?
A My back hurts.
Q And what does he indicate happen to him on the history?
A Fall two stories off ladder two days ago. Fall on the buttocks.
Q And what is he complaining of?
A Low back pain. Pain in paresthesia to both legs.
Q What does that mean that he is complaining of lower back pain and paresthesia to both legs. What does that paresthesia to both legs?
A Paresthesia indicate nerve pain or radiating nerve pain with sensory abnormalities to both legs.
Q Okay. And turning to page 182 under muscular skeletal. What does it indicate?
A It says complaints of weakness in both legs.
Q And turning to 188. Do you have that?
A Yes.
Q Okay. That would be the initial nursing assessment

when he came first came to Maimonides?

A Yes.

Q And at that time, what does he indicate that is under chief complaint?

MR. BRODY: Objection.

THE COURT: I'll allow it.

A Patient states he fell on ladder on to his back on 5/26 of 2007. Patient complains of mid back pain seven out of the ten.

Q And what does the nurse note in Maimonides as far as past medical history?

A Under past medical history, it says diabetes.

Q How does it indicate it in the medical records?

A Capital D and Capital M.

Q And that would mean diabetes?

A Correct.

Q Has that opened up yet?

A Yes.

Q The disk that you have, what type of test is that?

A I am looking at the MRI of the lumbar spine.

Q Dated?

A The MRI date is May 28, of 2007.

Q And I am going to get it to navigate.

THE COURT: Counsel.

MR. SCHWITZER: I am trying, Judge.

A I have the MRI of the lumbar spine.

Q If you could come down to the jury once again and show them on certain slices what you see and what you observed?

A Sure. Okay.

MR. BRODY: Objection. I have that standing objection.

THE COURT: We've already did that. We all know. We did that already.

MR. SCHWITZER: I will ask you to slide down back and forth so that all of the jurors can see . Because it is hard to see.

A So what we are looking at is a side-view of the spine. So we sort of CAT Scanning before like Coney Island Hospital. CAT Scan is looking at bones. The MRI is a little bit more detailed because the MRI will tell you more about, not only the bones but also the soft tissue. So we can see them clearer on this film. And if we look at the image on your right. The right hand of the screen it is a side-view. And so once again, what we are looking at are. Squares are vertebral bodies. And behind the vertebral bodies or to the right of the vertebral bodies is a white line. That white line is the spinal canal. And it's white because it contains spinal fluid. That is where the nerve and the spinal cord are. And behind that, if you continue further out, that is where the back is. The back part of your back.

So if you look at the bones on the MRI, you will

notice one again that one of the bones is a wedge and not a square. That is the burst fracture.

Q Could you show that?

A So I am turning to it now.

Q If you can show it to the rest of the jury and show exactly what you are referring to?

A Sure. So this is the fracture. And if you look at the fracture, you will notice that there are pieces of bone and also some disc material in the spinal canal. So it makes that spinal canal a wavy line. So it's waviness to that spinal canal. That waviness means that there is bone and disc material inside the canal in the lower portion of the spinal cord and in the area where the nerve roots are which go down into the legs.

The other thing that you see is, you see that there is an angulation. This is bent forward. There is a bending forward where that fracture is because of a wedging of the vertebral body. MRI is actually taken -- this particular MRI is a supine. So you are lying on your back. So when you are lying on your back, some of that is reduced. And by reduced what I mean is the angulation is taken out of it a little bit because you are lying on your back. If you are sitting up or standing up, that angulation would be further increased. So that is a significant amount of angulation to see in a vertebral body given the fact that the MRI is taken with the patient lying down.

Q Okay. Anything else on that?

A The MRI also shows you that there is involvement and that is why it is, by definition, a burst fracture. There is involvement of all three columns of the bone. So the first third of the vertebral body is fractured. The middle portion of the vertebral body is fractured. So the bone in the canal and the back portion of the vertebral body in the area we call the spinal process is also fractured. So it is an unstable fracture because it involves all portions of the vertebral body.

Q Doctor, are there many times if someone sustains trauma at that level that there is only a fracture to one column or two columns?

A There are many different types of fracture patterns that can occur in a bone depending upon the amount of trauma that bone absorbs. And this is the most severe portion of fracture because it involves all three columns of bone. So that is why we call it a burst fracture. You can further identify it as a burst fracture because it has a loss of height. Therefore it is wedge.

Q What do you mean loss of height?

A So if you look at the vertebral bodies that are adjacent to it, there are squares. So they have a certain amount of height or thickness to them. This has lost that height. So there is a loss of height. There is a fracture from all three columns of the bone. And there is an angulation. So all those things define it as an unstable fracture.

Q Can you explain to us medically why there is a loss of

height?

A Sure. So, if your bone is square in the vertebral body -- it is not really a square. When you are looking at it from the side, it looks like a square. So you can think of it as having a roof and a floor. If the roof collapses into this room right now, the height of the ceiling is going to drop down on top of us. And that's what happens. Because the supporting members inside that vertebral body, the supporting portion of bone that is inside that vertebral body can no longer maintain the height of its ceiling above you. So there is a collapse or loss of height because of that.

Q Okay. Anything else?

A I think that is it.

Q Now, did they also perform an MRI to any lower levels of the spine?

A Yes. So the lower levels of the spine are also contained in this film. And they are down. So the bottom portion of this film is where your pelvis and your hips are. The top portion of the film is where your head and your neck is. And down in the area where we see these triangular pieces of bone, this is called the sacrum, which is part of the pelvis. And so the lower vertebral segments are contained on this MRI film as well.

Q Okay. Is there any indications of any type of trauma on those films?

A So when you look at this film, what we need to look at it not only the bones which appear as squares, but we will look at the disc which are in between the bones. And we are looking to see which of these discs don't look like the other discs. And what abnormalities happen to be inside the disc themselves. And what you see is two things. Number one, you see that there is a bright signal in the back portion of the disc between the fourth and the fifth vertebral body. There is a bright signal here that --

Q Could you show that to the other jurors?

A That bright signal right there is what is known as an annular tear. The annulus is the outer rim of disc that holds the inner jelly like core in place. The brightness happens because it is just like anything else you injure. It swells. The body brings water and fluid and cells into the area where the tear is to repair it so it swells. And it appears to be bright on an MRI. So there is a tear at the L4/L5 disc. And in the lower, lower portion of the spine between L5 and S1, there is some evidence of disc material in the spinal canal area which you can see beyond the confines of the actual bones themselves. That's the substance back in here in the area were the spinal canal is. And that is disc material or disc herniation inside the canal..

Q Now, I want you to assume that I believe Mr. Tapia was, I believe, approximately 48 years old at the time he was admitted

into Maimonides Hospital. Do those films show what you would consider the normal age related wear and tear on any human being?

MR. DEMERS: Objection to form.

THE COURT: I'll allow it. Go ahead.

A So, when we talk about normal age related wear and tear, what we mean to say is that as we age, the portions of our body that are made out of cartilage. And that includes collagen and cartilage and the soft tissues of our body age as we age. And they start to break down a bit. So we start to develop wrinkles in places we've never them before. And your appearance starts to change a little bit. That happens to the internal structures of your body as well. The disc is composed of cartilage and soft tissues that are not immune to that process. So as time goes on, there are normal constitutive, in other words, that are part of the wear and tear that happens to discs. And you see that in this film.

One of the things, for example, that we see is that the disc in the lower portion of the spine are darker than the disc in the upper portion of the spine. Which means that those disc are what is termed as desiccated. Which means they are drier. They have less water content than the other disc do. And that is a very typical common normal aging process that disc undergo.

The other thing that you can see is normal with wear and tear is that you can have some loss of disc space height.

And you see some of that here at L5, S1 segment. And that loss of height is also common as disc dry up or age or develop in wear and tear changes. And that is just part of the normal constitutive process as you get older. Particularly, in general, of the age of 30 years old.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the annular tear that you observed at L4, L5 was traumatic in nature?

MR. DEMERS: Objection.

MR. BRODY: Objection.

MR. DEMERS: May we approach.

THE COURT: No.

MR. DEMERS: He's not a radiologist, Judge.

THE COURT: He's a doctor. He can say it. Go ahead.

A Yes, I do have an opinion.

Q What is your opinion and why?

MR. BRODY: Objection.

A That annular tear, which is acute swelling in the annulus is traumatic in nature. Particularly given the fact that you have such a severe burst fracture at the L1 segment.

Q Okay. Now doctor, I want you to assume more for a moment that Mr. Tapia was working in construction prior to this accident. And I want you to assume further that during the course of his life that he was in various types of trades that

require manual labor. Okay. Do you have an opinion with a reasonable degree of medical certainty if Mr. Tapia had had that annular tear before he fell off the ladder of May 26, 2007. Do you have an opinion with a reasonable degree of medical certainty as to how that would have affected his ability to engage in labor such as going up and down a ladder?

MR. DEMERS: Objection. Speculative.

THE COURT: Can you answer the question.

THE WITNESS: Yes, your honor.

MR. DEMERS: May I have a ruling on my objection.

THE COURT: Yes. Overruled.

A Yes, I do.

Q And what is your opinion and why?

A So --

MR. BRODY: Objection.

A The annulus contains nerve fibers. And those nerve fibers produce pain when irritated. So with an annular tear of this type, which is a rather significant bright signal. It involves pretty much that entire portion of the posterior annulus. That type of tear would be very painful to your lower back. And it would preclude you from being able to go up and down ladders or bending at the waist or twist at the waist. Or do any of those activities which would put stress and strain on the disc.

Q Now, doctor, anything else you want to show us or we

are done?

A We are good.

MR. BRODY: Can I just ask that we get an image number for that which he has testified from.

A Okay. So the disc is -- let's see. This is sagittal T2. The sagittal T2 image. Number six image. Number six.

Q Doctor, what I am going to do right now is I will be using -- doctor, at this time, what I am going to do is put up the and ask you to come down once again. The Maimonides Hospital Operative record by Dr. Betchen, which is in evidence as Plaintiff's 10 through 12.

A Okay.

Q What I am going to ask you to do and please feel free to make me feel useful. And also what we have is that surgery some blowups. Let me just pull those out in order.

First of all, doctor, if you would, you told us earlier -- and maybe I will put this up first. Plaintiff's Number 19. Could you explain to us, if you could. And I apologize for the tilting. You told us about the burst fracture. Does Plaintiff's 19 help to explain to the jury the burst fracture?

A Yes.

Q And could you please utilize it and explain to the jury?

A So this is an illustration of the thoracic and lumbar

spine based on the images that we saw on the CAT Scan and the MRI. And if we focus on the bones themselves, specifically, we will see that the bones that are labeled five, L5 L4, L3, L2, T12 and T11 are for the most part square. And we will notice that the bone that's labeled L1 is compressed with a loss of height and a wedging with fracture lines. That is fracture going all the way through from the front of the vertebral body through the back of the vertebral body. Whereby we also have angulation between the upper portion of the spine and the lower portion of the spine.

Q Now, before we go into the surgery. I want to ask you a question. And I am going to paraphrase because I have it written down. I want you to assume that when Mr. Tapia was being crossed examined by Mr. Demers that he was asked whether Dr. Betchen had told him he must have the surgery or whether the surgery was recommended. Do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Tapia could have just said Dr. Betchen I don't want to have the surgery. And gotten up and said I am leaving the hospital?

MR. DEMERS: Objection.

THE COURT: Sustained.

Q Do you have an opinion with a reasonable degree of medical certainty as to whether he could have left the hospital without having the surgery?

MR. DEMERS: Objection.

THE COURT: Sustained as to form.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Tapia had to undergo the surgery that was performed by Dr. Betchen?

A I do.

Q And what is your opinion and why?

A That this surgery that Mr. Tapia had by Dr. Betchen was necessary and required in order to stabilize this area of intense gross instability. So that he could get out of bed and be mobilized without further damaging the neurological elements that are in the canal adjacent to this area. So without that particular kind of surgery, getting up and out of bed or being mobilized or mobilizing him would not have been possible given the severity of this injury.

Q Do you have an opinion with a reasonable degree of medical certainty if he had decided I want to get out of bed and walk. Get up and walk out of the bed before the surgery, could he physically have done that?

MR. DEMERS: Objection.

THE COURT: Can you answer that question? Is he capable of getting up and walking.

Q Before the surgery?

A With this kind of a fracture? No, he would not have been able to do that.

Q Now, doctor, please walk us through the surgery.

A This is an operative report from May 30th of 2007. And the operative report is a description of the operation that Mr. Tapia under went.

Q I am going to hand you some more exhibits. And you hand them to me as you want them on this easel in whatever order you want me to put it up.

A So, the operation itself, the indication here is L1 fracture. And it says both anterior and posterior. Which means the burst fracture. Unstable fracture. Nothing holding the top and the bottom part of the spine together. So we have a clear indication for an operation. The diagnosis is the same both pre and post operative. The procedure that was done is a summary of what is contained in the body of the report. And it's an L1 laminectomy. Which means taking pressure off the nerves in the spinal canal by removing a portion of the vertebral body called the lamina. And that's done because there is bone in the canal producing pressure on the nerves.

Q So what is actually taking place?

A So what is taking place is a removal of the covering of the spinal canal. The spinal canal is covered by something called the lamina and the spinous processes. And by removing that area, which is noted here in this illustration as an opening made by this drill, you can take the pressure off of the nerves inside the spinal canal. And that is a procedure in order to prevent the nerves from continuing to be damage because of

pressure in the canal from the fracture.

Transpedicular decompression of the fracture is a further related decompression of the area by specifically removing a portion of the vertebral body called the pedicle. And the best way to look at that is on the side-view of the fracture. The pedicle is a piece of bone that connects the back portion of the vertebral body to the front portion of the vertebral body. It is kind of this bridge of bone over here. And it is a very safe way of taking pressure off the nerves and off the spinal canal without disturbing the nerves that are in the spinal canal itself. So if you move this bridge of bone and you take it out, you now open the spinal canal from two areas. The back side by removing the lamina. And the side by removing the pedicle. So you are taking a lot of pressure off of that canal.

Q I'm sorry. Doctor, could you do me a favor. Circle a pedicle and then just label it on the right.

A I am going to show it on the L3 vertebral body. And I will label it as P for pedicle. So it is this portion of bone that connects the front portion of the vertebral body to the back portion of the vertebral body.

Q I know it doesn't show it. But where would your spinal canal be on this diagram?

A So the spinal canal is in the area where you are seeing these openings that look like ears. These openings that have the appearance of ears. Those are called the neuro foramen or the

neurological openings for the nerves that go down into your bones. And they are coming out of the spinal canal. The reason they look like ears is there is pedicle on the top and pedicle on the bottom. And those border the spinal canal.

So, after the decompression or the taking the pressure off was completed, they put implants or what is known as instrumentation. And implants are placed from the T11, the 11th thoracic vertebral body to the third lumbar vertebral body. With an arthrodesis. Which means a fusion or a gluing together or a welding together of the bones between T11 and L3. And that is --

Q Doctor, I just want to stop you for one moment. Just jumping ahead. This is a CAT Scan taken of the lumbar spine of 5/28 of '07. CAT Scan report. And this operation was done when?

A 5/30 of 2007.

Q Now in, addition to the L1 burst fracture on the CAT Scan and I don't want to spend voluminous time in front of the jury doing this. Does it indicate fractures in addition to the burst fracture any where else?

MR. DEMERS: Your honor, me we note the exhibit number.

MR. SCHWITZER: 28.

A So, it indicates a T12 spinous fracture. And transverse -- fracture of L2.

Q So where is T12 in relation to L1 and also L2 in

relationship to L1?

A So, T12 is above L1. That's the level above L1. And L2 is the level below L1. So it's the level on top on the back side and L2 on the side.

Q Thank you.

A So these on the right side of the illustration of the surgery are screws that have been placed into the vertebral bodies. That is the instrumentation portion of the procedure. And those screws are then connected. Those screws are then connected by rods so that each vertebral body that contains screws can be locked into the next vertebral body to prevent them from moving. And then the actual arthrodesis or fusion process is then done by scraping down the bones so that you expose the inner portion of the bones. That's where the bones grow from. They grow from the inside, the inner spongy portion of the bone. So you need to expose the inner spongy portion of the bone. And then put bone graft, which is donated bone and locally harvested bone in the area in order to finish that fusion process or glueing together of those bones between T11 and L3.

Q Now -- I'm sorry. Please continue.

A And the you further lock your rods together with this little transverse piece called the transverse connector. So that you make a very stable kind of construction. So that you can now get the patient up and out of bed and walk them around without having to worry about the spine falling apart.

Q Now, doctor, you just mentioned the word fused at these levels. What does that mean.

A So a fusion means locking bones together so they become one piece of bone and no longer move. You can think of it as gluing the bones together. Or you can think of it as welding the bones together. Fusion actually means that they grow together and reestablish bone in between two bones that were otherwise separate.

Q Now, doctor, can you explain to us -- are you done with this?

A Yes.

Q You can put that down. I apologize for blocking the Judge?

MR. SCHWITZER: Sorry, your honor.

Q So, what I would like to ask you is this. Whether you want to leave it on or take it off?

MR. DEMERS: May we have this deem marked.

MR. SCHWITZER: Sure.

THE COURT: I am not going to give it to the jury.

THE CLERK: Defendant's B.

Q I don't know if you want it on or off the stand. Show the jurors the levels of the spine that we are talking about. Starting with the cervical down just so we have a frame work?

A So if you look at the spine, the top portion here. This is the bottom or base of your skull up on top. On the

bottom is your pelvis or your hip. This is the openings to the hips right here. So the basic purpose of your spine is to balance your head over your pelvis so that you can walk down the street.

If you are looking at the spine from front to back. So if you looking at it as you are looking at me right now, in general, the spine is pretty much straight up and down. So your head is balance over your pelvis. If you are looking at the spine from the side, it looks a little bit like an S. Right? And the reason it looks like an S is your pelvis is tilted. And your pelvis has to be tilted so you can walk properly. So to accommodate for the tilting of your pelvic, you have this S shape to your spine. And it starts in your neck. So the neck is known as the cervical spine. Where each of the vertebral body is known as a cervical vertebral body. So they have the C determination to them. And there is seven. So it is C1, to C7. And this curve is a backward curve, if you will. There is a gentle backward slope to your neck that makes it so that your eyes can look forward. And it continues down into your thoracic spine. But now reverses the curve so there is a gentle forward curvature to your thoracic spine. That thoracic spine are labeled with Ts. And there are 12 of them. So there are T1 to T12 with gentle forward slope. And then that goes into and transitions into your lumbar spine. It now has another gentle backward curvature to it. Just like your cervical. So there is a balance that the

spine has. And that balance that the spine has is what is known as sagittal. That means from the side balance. So you can maintain your head over, your pelvis and walk down the street without falling over.

So in the zone where the L1 vertebral body is. So if we count vertebral bodies from the bottom and we go up. You have five, four, three, two, one. And that area where the first vertebral body is, you will actually notice that there is almost a straight line between T12 and L2. But that area is bent back a little bit. Because it's a transition zone between the thoracic region and lumbar region. You are going from an area that bends forward to an area that bends backward. And the alignment in that area should generally be neutral. Which means it really should not be bending forward or backward. So a fracture in this area of L1 produces what is known as post-traumatic kyphosis. So now you have this. That is no longer quite the gentle S that it was before the fracture. So what your body tries to do without you thinking about it is, it tries to automatically rebalance the spine by taking into account that you are bent forward in this segment. And it can do that in different ways. One way is to bring your upper thoracic spine back more because it wants to get this head further back in your pelvis. And the other thing it can try to do is it can try to tilt your pelvis forward and try to pull backwards on your lower back. So, you start to develop compensatory mechanisms to correct for the fracture --

Q What do you mean developing compensatory mechanism?

A Compensatory mechanisms are the process by which your body tries to rebalance itself based on the fact that it's off balance because of the fracture. So other portions of your spine then start to undergo different types of changes. Whereby extra load and pressure is put on other portions of your spine to compensate for the kyphosis or the exaggerated forward bending that occurs at the fracture site.

Q Now, doctor, I am going to put up some blowups of films instead of opening the disc up, we can move this along a little easier.

Now, what I am going to ask you to do and these are all going to be Maimonides -- before I say it. This is Plaintiff's 14 and 15, which are Maimonides films from July 30th of 2007. And I'd you to put them up one at a time and show us what we are looking at.

Just for the record that is Mr. Gustavo Tapia's film, correct.

A Yes. So is a front to back image of the spine of Mr. Tapia from Maimonides Hospital from July 30th of 2007. So what we are looking at here is the instrumentation or the implants that span the fracture.

Q Now, doctor, if you can quantify in some manner. Some people depends on whose body considering an arthroscopic surgery a simple procedure. Can you somehow quantify for us the extent

of the surgery that was involved to stabilize this burst fracture?

A So when we describe this type of a procedure, this would be considered a major spinal procedure that involves a decompression and stabilization of an unstable burst fracture whereby multiple spinal elements are fused with rods and screws.

Q Now, what were the risk to the patient, the real risk with a reasonable degree of medical certainty if you hadn't perform or if someone had not performed the surgery?

MR. BRODY: Objection.

THE COURT: Sustained.

Q Okay. Doctor, are there risk to the person if they were just left in that condition and no surgery was performed?

MR. BRODY: Objection.

THE COURT: Counsel, he said he needed the surgery. He needed the surgery.

MR. SCHWITZER: I will move ahead, Judge.

Q Now, can you explain to us and show us the size of the screws involved or the dimensions of the rods involved in this procedure?

A Sure.

Q Could you do that?

A Absolutely. Yes. We can show them on the x-ray. I think I have some screws with me.

Q Both?

A Okay. I have screws in my bag. Which is in the room.

MR. SCHWITZER: If you can direct me, I will go.

(handing)

A This is what's known as a pedicle screw. It's a screw that goes inside the pedicle. It's that portion of bone that we talked about. It goes from the back of the vertebral body to the front of the vertebral body. So these screws are inserted into the pedicle. There are made out of titanium. And they have this tulip head connection on the top part of the screw that allows you to place a rod into it. So this area, it moves around so that depending upon how you place the screw, you can accommodate putting a rod into it. And then there is generally a little connecting nut that you put in there to lock the rod into the screw. So the screw actually serves as -- you think of it as an anchor. When it is in a piece of bone, it is now anchored in that piece of bone to whatever you connect the rod to.

So you can see that the screws are inserted into the vertebral bodies. And that all of the screws are connected by rod that fits into the screw head. And that locks these vertebrae into place so that the fusion process can occur.

Q Now, doctor, you've explained to us the anatomy before. There is suppose to be motion at those levels; is that a fair statement?

A Yes.

Q What happens to the normal body motion or at those

levels after the surgery was performed. Do you have an opinion with a reasonable degree of medical certainty what happens?

A Yes. So by definition because you are doing an arthrodesis or a fusion, you eliminate motion at those levels that you've fused. So from T11, which is the top part, lower portion of the thoracic spine down to L3, the upper portion of the lumbar spine, you are locking that segment of the spine in place. So you are making it so that that portion of the spine no longer moves. So when we are talking about compensatory mechanism in your spine to balance yourself out, your body has to take that into consideration when it is trying to compensate your balance and your normal motion.

Q Do you have an opinion with a reasonable degree of medical certainty when you perform that surgery what, if any, affect it will have in the future on the levels below the surgery that was performed?

MR. BRODY: Objection.

THE COURT: Go ahead.

A So because of the compensatory mechanism that happens, your spine is trying to accommodate for the post-traumatic deformity and the fusion. This is a side-view that shows the screws and the rods standing the fracture segment. So your compensatory motion for your spine wants to tilt back the lower portion of your spine to give yourself more normal tilt on the bottom so that you have better balance and you can walk. It puts

extra pressure on what we call the sub-adjacent or the disc below the level of the fusion. So there is extra pressure. Pressure by definition is force. Force over area. Force is if you think of it as you are pushing down on something. And it is over the area of the disc. So there is extra force over the area or pressure on the lower disc which causes these disc areas over the course of time to, for lack of a better term, break down. And so there is a break down process below the level of long instrumented fusions that occur over the course of time in cases of post-traumatic deformity.

Q Now, doctor, I'm sure the jurors are familiar with someone who can have a broken arm or a broken leg or broken ankle that requires surgery and you have pins and screws put in it sometime to help with the fracture, correct?

A Yes.

Q And many times those are eventually removed?

A Yes.

Q Can you do that in this case? In other words, can you just take all of this out and say okay it is fused together and leave it?

A There is a couple of problems with that. You can take the implants out and remove the implants. You can do that. If you do that, when you have this type of a posttraumatic deformity. Even if you have a fusion. What happen is, overtime because of the remodeling process within the bones themselves,

this area of kyphosis can go on to have more kyphosis. So in adults, what we did was when we have deformities in adults and we have implants spanning fracture segments like this, we don't want to remove these implants because the compensatory mechanism are so great that it is going to force this area back into kyphosis.

Q Thank you. You can sit down, doctor. And that was for the record Plaintiff's Exhibit 15.

Now, doctor, if you come down just for a moment and we will go to your records.

A Yes.

Q I want to show you Plaintiff's 6 and 7. So these are films -- I believe these are Maimonides for the record. Maimonides Hospital films taken in October of '07. About four months post the surgery.

Can you tell us what, if anything, those films show?

A The best way to look at this film if we can compare to the other film.

Q Which one do you want?

A That one right there.

MR. DEMERS: Can we identify the exhibit.

MR. SCHWITZER: 15 and 16.

A So this film is July.

Q Looking at 15?

A Exhibit Number fifteen is July of 2007. And if you look at the overall alignment in July of 2007, you're almost

neutral here. There is a wedge. There is forward bending. There is forward bending area up above. There is some hyper lordosis just below. The below section is trying to bend backward. The top section is bending forward a little bit. This is the fracture. You can see the fracture here. And if you look at the October 8th of 2007, X-ray, what you see is, you see that there is actually a little extra forward bending up on top. With what looks like a little bit of bone protruding into the canal area. So this film shows that there are is a little bit more kyphosis and bony motion at the area of the fracture site.

Q What is the significance of that?

A That means that there is -- it's technically known as subsidence. Subsidence is a show gradual process of settling overtime. Kind of like how your house settles. Some part of your house and walls develop little cracks. Sometimes the wall may not be completely entirely level with the way it was the previously summer. You think about that happening in the body as well. So there is some subsidence happening in the area of the fracture. Remember the pedicle was removed and the lamina was removed to take pressure off the nerves. And this area wasn't instrumented. There is no screws in that section. So that section depends on the spanning fusion process here in order to really prevent that area from moving around.

Q Now, why is there a gap with no screws in this area?

A So this is the area where the bone was retro pulse into

the canal.

Q What does that mean?

A There is bone inside the canal itself. And that is the area where Dr. Betchen did the laminectomy and the transpedicular decompression. She opened up that canal area to take pressure off of the nerves. So there really isn't a lot of safe area to insert screws into a vertebral body, number one. And number two, the vertebral body itself is so squashed, if you will, that it is not going to safely accept a screw. So that screw would not cut out and then cause damage to those nerves. So that is why that area is not instrumented.

Q Now, when you say the pedicle was removed. What do you mean it was removed?

A So when we looked at the operative report that Dr. Betchen dictated, that is transpedicular decompression. So she drilled off the pedicle to open up the side area of that spinal canal.

Q That's gone forever?

A Correct.

Q Okay. Doctor one last film here. Doctor, looking at another film of 10/8/07 marked as Plaintiff's 17. What does that show?

A This is the lumbosacral junction. This is the lower portion of the lumbar spine and the pelvis, the sacrum and the hips.

Q Does that show anything?

A That's the bottom portion of L4, L5, and the sacrum as they are centered over the hip joint. And one of the things it shows, it shows that the L4 area has a bit of a backward tilt on it. It shows some disc space collapse and degenerative changes as L5, S1.

Q And as far as the person who would have those findings on a film, what would that mean to that patient?

A In terms of -- well, this is the kind of thing that in and of itself or by itself, these kinds of X-ray findings would be what we would call some degenerative spondylosis of the lumbar spine. Anybody above the age of 40, per say, would have these types of findings.

Q Okay. Please sit down, doctor.

THE COURT: All right, folks. We will take a break.

COURT OFFICER: All rise.

(Whereupon, the jury is exiting the courtroom)

THE CLERK: The model is Plaintiff's 42. ID only. Come to order.

COURT OFFICER: Ready.

THE COURT: Yes.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury is entering the courtroom).

THE COURT: Have a seat everyone. Of course, you

are still under oath.

Q Doctor Merola, I believe you told us earlier that the first time you saw Mr. Tapia was June 9th of 2008?

A Yes.

Q And that he was referred to you by a Dr. Kaisman?

A Yes.

Q And the other thing what I like to do is hand up to you a copy of a Dr. Betchen's records. You know who that is, correct?

A Yes.

Q And you have seen those records before?

MR. BRODY: Objection.

(handing)

THE COURT: Has he seen the records before all right. Okay. These records are in evidence.

MR. SCHWITZER: Yes.

THE COURT: Okay. Same objection you mean.

MR. BRODY: Correct.

THE COURT: It's preserved.

MR. BRODY: Yesterday versus whenever.

THE COURT: It's preserved.

Q What I'd like to do, doctor, is turn you forward to Dr. Betchen's record of March 31 of '08.

A Yes.

Q And doctor, at that time under physical examination,

did she indicate whether he walked with a cane?

A Yes.

Q And what was he doing?

A Slightly bent and look somewhat uncomfortable while walking.

Q Was he using a cane at that time?

A Yes.

Q And doctor, did she perform a radiological assessment, an X-ray review?

A Yes.

Q And what did that review reveal?

A Further kyphosis and collapse of L1 with some signs of instability.

Q What does that mean?

A What we were talking about on the X-rays before. So it looks like there is an increase in that angulation of that L1 body. And almost like a total collapse of the L1 body in the area where the fracture is.

Q And what is the significance of that to the person if there is a collapse?

A There is a collapse is significant because it means more pressure on the nerves. It means post-traumatic deformity. All of those things.

Q Was there an assessment by Dr. Betchen?

A Yes.

Q What did that reveal?
A Dr. Betchen says Mr. Tapia has pseudo arthrosis. Has not fused and has increased kyphosis.
Q Stop. What is pseudarthrosis?
A Pseudo arthrosis means that the fusion is not solid. It is not healing solidly.
Q This is March of '08?
A Yes.
Q Surgery was May of '07?
A Correct.
Q We are almost a year in?
A Correct.
Q Is that a significant finding that it hadn't fused?
A It's significant in so much he's got increased angulation. The possibility of a pseudo arthrosis and increased angulation, yes, it is significant.
Q Okay. At that time, did she order a CAT Scan?
A Yes.
Q Why?
A She wanted to look at the area a little bit more closely.
Q And by March of 2008, was she discussing a possibility of a further surgery?
A Yes.
Q And what did she indicate for what purpose?

A To keep him from kyphosis more.

Q Okay. Now, the last time she sees him is May 5th of 2008. Could you turn to that?

A Yes.

Q And at that time was he walking with a cane?

A Yes.

Q And what did her radiological assessment reveal?

A Further kyphosis and collapse of L1 with some signs of instability at L3/L4.

Q Now, she did a surgery that you told us about earlier where L1 had burst fracture. Some fracture T12. Some fracture at L2. And the fusion went from T11 through L what?

A Three.

Q What is the significance medically that in May 5th of 2008 that the L3/L4 which she had not perform surgery on had instability?

MR. BRODY: Objection.

THE COURT: What is the question.

Q The question is. Is there medical significance to the original surgery of L1 which led to instability at L3/L4. Do you have an opinion with a reasonable degree of medical certainty?

MR. BRODY: Judge, my objection here is that he's referring to the May 5th date. If the doctor were to read the record, it refers to the prior film on the prior visit.

MR. SCHWITZER: I am -- I will rephrase the

question?

THE COURT: Okay.

Q On May 5, 2008, when Dr. Betchen saw Mr. Tapia, did she have a discussion with him about her review of film?

A Yes.

Q And what did she indicate that the films revealed?

A Instability at L3/L4.

Q In addition to a further collapse, correct?

A Yes.

Q Now, can you tell us whether you have an opinion with a reasonable degree of medical certainty as to whether that instability that she was now observing at L3/L4 was causally related to the original trauma sustained on May 26, 2007?

MR. BRODY: Objection.

THE COURT: Go ahead.

A Yes.

Q And what is your opinion and why?

A That instability at L3/L4 is a consequence of the fracture because of post-traumatic kyphosis. The instability that she's referring to is what I was speaking about when I refer to breaking down of the sub-adjacent segments. The lower back is compensating for the kyphosis. And those areas of the lower back are now undergoing increase pressure and stress and they are starting to break down. And that's why L3/L4 shows evidence of instability.

Q Okay. Now doctor, in her assessment. Turning to the second page of the May 5, 2008. Six lines from the top. It starts with if this continues?

A Yes.

Q And can you tell us that line when she is saying if this continues, is that the kyphosis?

A Yes.

Q Read the line and then explain what she is saying, if you can?

A If this continues to progress, then I would strongly recommend that he have another operation to extend his instrumentation and assess the fusion.

Q Okay. Now, after that conversation, did he indicate that he did not want to have a surgery at that time? Mr. Tapia?

MR. BRODY: Objection.

THE COURT: Go ahead.

Q Above that he states.

A Let's see. It says he says that he would like me to re-write for a brace, which I did. Both a TLSO and a corset for comfort.

Q I am talking about Dr. Betchen's note of May 5, 2008 in the assessment. Four lines from the top?

A Yes.

MR. BRODY: Objection. He is reading from a document in evidence.

MR. SCHWITZER: Yes.

THE COURT: I know.

MR. BRODY: If he didn't see it before, he should not be looking for it now.

THE COURT: It's in evidence. Anybody can read it. I can look at it, too.

MR. BRODY: The jury can read it.

THE COURT: They can. Go ahead.

A It states he is comfortable enough that he does not wish to pursue any surgical options.

Q Now doctor, after that Mr. Tapia does not return to see Dr. Betchen again.

Now turning to Dr. Kaisman's records. He first saw him June 21, 2007?

A Yes.

Q Now turning to July 23, 2007. That's the next time he sees him.

A Yes.

Q Okay. And by the way, can you explain to this jury -- do you have a practice, assuming when Dr. Kaisman refers you a patient what, if anything, do you receive from Dr. Kaisman before you see the patient?

A He actually sends me the records.

Q And do you know if in this particular case prior to you seeing Mr. Tapia if Dr. Kaisman had sent you the records the

records?

A Yes.

Q So turning to July 23, 2007, what did Dr. Kaisman indicate his findings were? On the top of that page.

A Limited range of motion of the lumbar spine. Pain and spasm bilaterally at T10 through S1 levels with decrease sensation throughout the right lower extremity.

Q All right. Stop. Now, doctor, can you explain to the jury what it means that he had spasm bilaterally T10 through S1? What does that mean?

A That means that there was palpable spasm from the thoracic spine all the way down through the pelvis.

Q What is spasm?

A Spasm is an involuntary contraction of a muscle.

Q If I had it and you touched me, what would you be, depending on the degree of spasm, what would you be feeling.

A You would feel a hard like a rock in your muscle. It is like a Charley Horse. That's a spasm. So if you have ever felt one of those and you go feel your calf to try to rub it out, it feels look a big hard knot or rock in your muscle.

Q And doctor, do you have an opinion with a reasonable degree of medical certainly as to whether when they go into spasm whether that person has pain?

A Yes.

Q And what is your opinion?

A Spasm is painful.

Q Can you fake spasm?

A No.

Q Doctor, on October 25, 2007, can you just read the first line of Dr. Kaisman's note?

A The patient came to the office today with a list of medications. He has diabetes.

Q All right. Stop. And those were records that you had in your possession prior to you seeing him?

A Yes.

Q Now, I want to just skip ahead to March 27, of 2008. Do you have that?

A Yes.

Q Did Dr. Kaisman performed an exam of the spine that day?

A Yes.

Q And at that time, looking at the top of the page, was Mr. Tapia receiving therapy.

A Yes.

Q Can you tell us what exam he did and what was normal and what he found? If you can stand up and show us what he was talking about?

A So he did a lumbar range of motion. And the flexion which is forward bending of the spine was limited to approximately 30 degrees. And you should be able to get to at

least about 90 degrees so you can bend fully over. Extension, which is bending backward. The backward bending of your spine should be about 25 to 30 degrees or so. And he's at zero degrees. Right and left lateral bending are at ten degrees. So bending to your right side and bending to your left side were about ten each. And you should be at least 45 degrees or so for lateral bending. And rotation both right and left side was measured at 20 degrees. And your normal rotation should be able to get your upper torso around to look over your right side over your hips and over to your left side around the other side. So twenty degrees is approximately about that much.

Q And doctor, at that time, did Mr. Tapia still has spasm?

A Let's see, yes.

Q And at what levels.

A Palpation of lumber spine reveals spasm bilaterally T10 to L4. So he's got thoracic spine down to the lumbar spine palpation of spasm.

Q Okay. And doctor, at that time was Mr. Tapia on Oxycodone?

A Yes.

Q What is Oxycodone?

A Oxycodone is a long acting morphine type compound that is used for pain.

Q It appears that he was on Oxycodone 20-milligram?

A Yes.

Q Can you explain to us as far as dosage what that is or the significance, if any, of that?

A 20 milligrams is three times a day. So he was taking 20 milligrams three times per day. That's a pretty significant amount of narcotic medication to be taken on a daily basis.

Q Did the patient or did Dr. Kaisman ask the patient whether the Oxycodone was helping.

A Yes.

Q And what did Mr. Tapia indicate?

A He said that patient notes that the Oxycodone is no longer helping.

Q Now, Doctor, May 5th there is a conversation by Mr. Betchen that Mr. Tapia may need to get more films?

A Yes.

Q And he doesn't return to Dr. Betchen after they had the conversation that you should have more surgery to extend the instrumentation. He says he doesn't want to have it at that time. My question to you is. Looking at Dr. Kaisman's note of May 15th, ten days later. Did Mr. Tapia come to Dr. Kaisman ten days later?

A Yes.

Q And what did Dr. Kaisman do on that day?

A X-rays of the lumbar spine.

Q And Plaintiff's number 18. So that day he just did

X-rays?

A Yes.

Q And at that time did Dr. Kaisman refer Mr. Tapia who he had been seeing since June of '07. So now we are almost a year of treatment with Dr. Kaisman. Did he then for the first time refer him to somebody else?

A Yes.

Q Who did he refer him to?

A Myself.

Q Okay. And could you come down and I have the film Plaintiff's 18 in evidence. And if you could, explain to the jury after that X-ray why he was referred to you?

A So, this is the front to back view and do we have the side-view.

Q Doctor, I have a shadow box here if that will help. I don't know if it will reach. It should. I don't mind holding it. If that helps.

A So this is an X-ray of May 15, 2008. Gustavo Tapia?

MR. SCHWITZER: Your honor, if you can just ask the jurors if they can see it. I am not sure.

A So this is the L1 fracture. And we can see that that fracture has almost a total collapse of the fracture site between T12 and L1. So it's gotten flatter over the course of time.

Q Is that what we wanted to have happen after the surgery by Dr. Betchen?

A No.

Q And what was the significant of that? Almost total collapse to Mr. Tapia?

A So that means, you know, that that fracture site is continuing that process of subsidence with post-traumatic kyphotic deformity at the level of the fracture. Increased angulation also meaning increase pressure. And the other portions of the spine, particularly, the lower back which are the areas whereby that spasm palpated.

Q Okay. And does this help you at all?

A This is the front to back view.

Q Okay. If it doesn't --

A I mean, it doesn't give us more information than what we just had.

MR. SCHWITZER: That's fine. Thank you.

MR. BRODY: Judge, just for the record. The doctor used a film that has not been marked by itself. So if we can get that marked so that it can be referred to.

THE COURT: Deem mark for now.

MR. SCHWITZER: This is an X-ray taken by Dr. Kaisman dated play 15th 2008.

THE CLERK: 43.

(Whereupon, Plaintiff's 43, was moved into evidence)

Q Now Dr. Merola, you are now seeing him. And the first

time you see him is June 9, 2008, correct?

A Yes.

Q When he came in that day, did he come alone or with someone?

A With his wife.

Q And did you note what, if anything, was the wife doing to assist him as far as activities of daily living or anyone where else in the office?

A Gustavo would come to the office with his wife. His wife basically attended to him to help him with his commuting and his home care and his home life. As well as when he came to the office. Being able to help him get in and out of the office, etc.

Q Okay. And did he make any complaints to you on that date?

A Yes.

Q What were they?

A Back pain with pain radiating to the legs.

Q Okay. And did you perform a physical exam on that day?

A Yes.

Q And can you tell us what you did and what it revealed?

A Sure. So, the physical exam starts off with an observation of the way he's walking. And he demonstrated what's known as a kyphotic gait pattern. So that meant that his balance when you are looking at him from the side was tipped forward.

And he also had spasm and tenderness which was palpable over the area of the incision in the area of the back were the surgery had been done. So that is the thoracic and lumbar area was spastic and tender. His lumbar and lumbosacral ranges of motion were significantly restricted with what's known as reversal of lumbar lordosis upon ascent. Which means when you are bending forward and you try to straighten yourself up again, your lower back under normal circumstances should flow into that reverse C. A reversal of lordosis when you are trying to stand up means when you palpate the lower back muscles, they never quite get themselves back into the normal C shape that your lower back should have. It is reversed. It is flatter than your lower back.

He had something that is known as a spinal Phalen's maneuver. Phalens is a test where you try to increase pressure in the spinal canal. And that is usually done by tilting the patient back. You palpate the low back when you do that to feel if there is spasm or not. Involuntarily contraction of the muscle. And whether or not that reproduces any radiating pain. If it does, then the test is positive. It was in this circumstance. And he also had about a grade four over five weakness of the lower extremities. And that's tested by getting him to heel-toe raise. So if he is unable to heel-toe raise without assistance, that's essentially a grade four over five weakness of the lower extremity. What we call ankle and foot

dorsi flexors and plantar flexors.

Q Now, doctor turning to July 14, 2008. Did you take X-rays that day?

A Yes.

Q And without popping them up. I want to move along. What did those X-rays reveal?

A They showed rods, screw implants to be intact and in place spanning the fracture site. With what I appreciate it to be breakdown below the level of the instrumentation. Which would be consistent with low back disc herniations and radiculopathy.

Q Doctor, is there a term called adjacent segment degeneration?

A Yes.

Q Is that different or the same as breakdown?

A It is similar. Degeneration is something that happens more slowly over the course of time as part of the degenerative process because of a segment adjacent to a fusion site.

Q And doctor, when there is a fusion at whatever level, whether there is a level above the fused site or a level below the fused site. Can you tell us why there is this term medically called adjacent segment degeneration?

A The segment is adjacent to the area where the fusion was. So that's where the term adjacent comes in. And then degeneration. Because that area is breaking down or falling apart or being exposed to increased wear and tear because of the

increased pressure and force that has to happen at that area. An increase mobility has to happen in that area to accommodate for the other segment that is fused.

Q Okay. Now, doctor, he comes back in on September 15, 2008. And he's utilizing a cane at that time?

A Yes.

Q What did you notice as far as his ability to get off and on your examining table.

A Required some assistance.

Q Who did he come with?

A His wife.

Q Why would it important for you to know if someone needed assistance getting on and off your table?

A There is step up on the table. And it tells you a bit about how the back itself is functioning. So it tells you about the ability to because you have to look behind you get on the table. You have to step up and then look behind you and then balance to sit yourself down. It gives you an idea of what your dynamic functional capacity is for your spine.

Q Okay. Now, on October 6, 2008, you make findings as far as what's going on with his lower back and his pain?

A Yes.

Q And what did you note?

A So, what we looked at was, we looked at the fact that he started to develop, in addition to a spinal Phalen's Maneuver,

which is putting some pressure on the lower back, he also developed some evidence of straight-leg raising in the lower extremities.

Q What is that?

A Straight leg raising is a test whereby you irritate the nerves going down into your legs.

Q And why do you want to irritate them?

A Well, you want to see -- if a nerve is being irritated or has inflammatory process occurring around it, if you stretch that nerve, you are going to reproduce the pain that you get in that nerve.

Q Now, how do you do that with the patient? What do you do to perform that test?

A So straight leg raising is generally you want to have -- and you can do it two ways. You can do what is called a seated straight leg raise. And then you do a reclining straight leg raise. When the patient is sitting on your exam table, you extent the knee. And then you dorsi flex the foot. You tilt it back. That puts a significant amount of stretch on the nerves that go all will way down to the back of your leg. If you feel it, if you extend your leg and you pull your foot back towards you, you will feel a pulling on the back of your leg. If that reproduces pain, you can't do that. The patient wants to break away from that pain so they can't get to that position. If you do that while they are seated and you do that while they are

reclining. And you do it on the right side and on the left side to see whether or not that nerve root is reproducing pain in that process whereby you are stretching it.

Q Now, as of that date and during your treatment, are you in contact with Dr. Kaisman?

A Yes, we will discuss patients.

Q Did you discuss it orally, e-mail combinations? How do you do that.

A Mostly by oral conversation.

Q You would actually speak to him?

A Yes.

Q And at that time did you have a plan?

A Yes.

Q And what was the plan?

A So the plan was for him to undergo placements of medication into the lower part of the back called epidural steroid injection to decrease the inflammation irritation to the nerve roots.

Q And why did you want to do that as oppose to something else?

A Multiple reasons. My goal basically for taking care of the patient is to manage their condition. And by managing the condition, you have to treat their symptoms and you have to try to prevent further damages as time goes on. And so there are different ways that you can do that. You can do that through

modifying some activities. You can do that with medications. You can do that with administering epidural steroid injections. And the these are ways of non-surgery managing pain and symptoms to try to give patients the better quality of life. And try to improve increase function without having to do something surgical. So, as a surgeon, most of the time, we try to actually avoid it if we can. Because any surgery that you do has benefit. But it also has risk and it has what we call morbidity. It means that after a surgery there are changes that your body undergoes that may not always be physiological or normal. So you want to try to minimize risk in morbidity. But you want to maximize function. It's a balancing act that you have with the patient.

An epidural injection or course of injections is a nice way to manage pain and symptoms. So that you can give patients a better, better function without increasing their morbidity.

Q Okay. Now, doctor, on December 15, 2008, he comes into with his wife. He is still using his cane to ambulate?

A Yes.

Q And you recommend more steroid injection for pain management?

A Yes.

Q Now, jumping ahead now to January 26th 2009. By that time, he had had his third epidural?

A Correct.

Q Is that number three significant? Do you normally recommend a series of three? What's the significance of three epidurals?

A Generally, epidurals in general are given in a series of three. Any one epidural has about a third or a 33 percent chance of helping. So if you had up to three of them over the course of time, you are pretty close to your maximum benefit of any particular given injection.

In general, you would like to try at least a course of about three injections to see whether or not they can achieve the maximum benefit from that series of shots.

THE COURT: All right. Folks we are going to break for lunch. I'm asking you to return no later than two o'clock. At which time, the testimony will continue.

Don't discuss the case. Don't form any opinions. Have a pleasant lunch. See you back here by two.

COURT OFFICER: All rise.

(Whereupon, the jury is exiting the courtroom)

(Whereupon, there was luncheon recess held in the proceedings, at which point, Admelinda Rubio relieves Nadonna V. Ferguson as the official court reporter)