SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS : CIVIL TERM : PART 33

- -X

JUAN CARLOS RIVERO VIVANCO : INDEX NO.: 517138/2017

PLAINTIFF :

- against - :

ZNKO CONSTRUCTION, INC., G & C CRANE SERVICE, LLC., and SULLIVAN HEIGHTS, LLC :

DEFENDANTS : TRIAL

- -X

360 ADAMS STREET
BROOKLYN, NEW YORK 11201
MAY 2, 2025

BEFORE: HONORABLE DESMOND GREEN,
JUSTICE, AND A JURY

APPEARANCES:

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JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

THE COURT: Case on trial. Appearances remain the same.

We will deal with the plaintiff's motion in limine, okay. Mr. Morgenstern, I will hear you, sir.

MR. MORGENSTERN: Good morning, your Honor. As you know, we argued yesterday on our motion in limine. I don't need to go into all of the cases I cited to you yesterday during our brief, but there is one thing I would like to mention to be more clear on based on the opposition filed by the defendant.

Our motion is not strictly just to not bring up the Rico actions against Dr. Merola. In the opposition, there is mention to Dr. Katzman being in there, the medical facilities. Some of them the plaintiff treated at. And some of the treating physicians, Dr. DeMarco, and maybe some others.

Our request to relief is to not have the action mentioned at all. Not just the cross-examination against Dr. Merola. It is the cross-examination against any witness. It is the cross examination against the plaintiff. Openings already happened, but it is also to include summations. It is not to be referenced at all based on the prejudicial effect compared to no probative value as mentioned in my argument yesterday and that is

why I will keep this brief.

This also includes Dr. Katzman, who we do intend to call. That is why I am trying to be more clear here, because Dr. Katzman, DeMarco, medical facilities, were all mentioned in our request for the motion in limine, that they all be precluded against any evidence including summations, including cross against the plaintiff.

THE COURT: Let me ask you this. Let's say the defendant were to ask a question, "Isn't it a fact, Dr. Merola, that you perform surgeries for the sake of billing? Objection. Objection sustained".

What about a question like that? One of the things I strive to do is to keep questions like that out -- and I will hear from you in a minute. The reason being the jury will hear the question even though there is an objection and it was sustained. Why is the attorney objecting to it? And it plants a seed in the back of the jurors' minds that there is something improper going on. And jurors don't forget.

No matter how many times I say it is questions coupled with answers the minute they hear that question from an officer of the Court, okay, and Mr. Farrell is an officer of the Court, if he asks a question like that it is going to be in the back of their minds. What

about questions like that?

MR. MORGENSTERN: Questions like that, I believe it would be very similar to the reaction that Judge Rivera had in one of cases I cited to you yesterday. I believe the quote was to the defense counsel, "do not touch it".

THE COURT: I think, in fact, thank you, I have that decision. But wasn't it, "don't go near the Rico case"? But what about the underlying fact without mentioning the case, such as a question I just posed?

MR. MORGENSTERN: That also goes to the 2023 Geico action, the New Jersey case. I think it is Robinson that is in here too about how there was actually a mistrial after when there was just subtle questioning into allegations such as that. We believe that would be extremely prejudicial. Similar to what your Honor just mentioned.

Here, if an officer of the court asked a question like that and hearing an objection sustained would be a clear prejudicial effect to the jury in this action.

THE COURT: Okay, let's see if Mr. Farrell agrees with your assessment.

MR. FARRELL: Your Honor, no, I don't. The defense definitely believes that the questioning should

be allowed of Dr. Merola and Katzman regarding the pending federal Rico actions against them as set forth in detail in our opposition and we rely on our opposition brief and the cases cited therein.

But this case tends to fit that pattern of Rico lawsuits. A lot of the similar conduct, similar facilities, similar doctors. And the claims set out against these doctors in many of the Rico suits are not just bald allegations. They are definitely supported by detailed affirmations of other well credentialed physicians who describe the fraudulent suits in detail.

So I do believe that provides a good faith basis to inquire about the prior acts and allegations as this case goes forward.

Again, as set forth in our brief, the defendant should be allowed to inquire the Rico allegations to impeach the physicians' credibility and discuss their motive and intent.

Also, as the physicians are interested witnesses and particularly in a case that is damages only at trial, physicians' credibility is arguably the central issue in this case. And therefore, we believe that the probative value of the questioning far outweighs any protection prejudice.

THE COURT: All right, I respectfully disagree

with you, sir. And my concern, as I mentioned yesterday and I mention it again, because I am mindful of the fact whatever I do is going to be appealed and I think the Appellate Division, I think, needs to know that.

As I mentioned yesterday, this is my third Labor Law case, construction site case. Every single one the plaintiff was compelled to file this type of motion, motion in limine, because after the notice goes out as to who the doctors are going to be, then all of a sudden the insurance companies then state that they want to -- well, when you get that, the insurance company wants them impeached.

And I as I stated before and I have stated this on other cases, this is not just this case, I have a problem with that. It is a chilling effect.

Now, only certain doctors do these cases for plaintiffs or even defendants. You know, you will always have a treating physician, he or she will probably be different, but the experts for the most part are going to be the same. And my view is that this is a chilling effect and basically what the insurance carriers want to do is to prevent doctors, experts, men and women experts in their field, from testifying on behalf of plaintiffs.

And I just want to put this on the record

because as I stated, I expect there to be an appeal no matter who wins.

Okay and your exception, sir, obviously is noted for the record.

MR. FARRELL: Understood. Thank you, your Honor.

THE COURT: All right, you're welcome.

MR. ROSE: Your Honor, we haven't marked the films yet.

THE COURT: Yes, let's do that now and we will bring the jury in.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom and is seated in the jury box.)

THE COURT: Everyone, please be seated. Thank you. Both sides stipulate that all jurors are present and properly seated?

MR. ROSE: Yes, your Honor.

MR. FARRELL: Yes, your Honor.

THE COURT: Okay. The answer to your question jurors is, no, we are not going to watch the replay of the Knicks victory. But we will be using the television monitor. I apologize, there is a juror there I cannot see.

Remember at the very beginning I mentioned

that there are times when we are dealing with experts that we have to take other of witnesses out of turn. The plaintiff, who is here, he has not completed his testimony and he has not yet been cross-examined.

However, the plaintiff does have an expert witness present, so we will go out of turn. And the witness will testify and then we will go back to the plaintiff to complete his testimony.

This is Dr. Merola?

MR. ROSE: Yes, your Honor. The plaintiff calls Dr. Andrew Merola.

THE COURT: Okay.

D R. A N D R E W M E R O L A, having been called as a witness by and on behalf of the Plaintiff, having first been duly sworn, was examined and testified as follows:

COURT CLERK: State your name and address for the record. Andrew Merola M-E-R-O-L-A. 567 1st Street, Brooklyn, New York 11215.

COURT CLERK: Thank you.

DIRECT EXAMINATION

BY MR. ROSE:

Q. Good morning, Doctor.

A. Good morning.

Q. Let's first talk about your qualifications.

A. Yes.

Q. Okay, could you first discuss your educational background?

A. Sure. I went to NYU undergraduate. After I graduated college I went to Howard University College of Medicine. I graduated from medical school and went to the State University of New York here in Brooklyn, Health Science Center in Brooklyn, where I did a year internship in general surgery. I then did a four-year residency in orthopedic surgery.

Q. Explain to the jury what that means. Thank you.

A. Sure. I am an orthopedic surgeon, which means that I am a surgeon that specifically deals with problems involving the musculoskeletal system and everything that you need to be up and walking around. That is muscles, tendons joints, bones, nerves.

And so my training is in musculoskeletal surgery or orthopedic surgery with a sub-specialty in what is known as spinal surgery, which is specific to neck and back. And I did that in a one-year fellowship at the University of Colorado between the years 1995 through 1996.

Q. Have you also held any academic positions?

A. Yes, I continue to teach at SUNY Downstate where I teach medical students and residents. And I am also privileged and credentialed at university hospitals as well.

THE COURT: Doctor, one question, SUNY

Downstate is the same as the Health Science Center of Brooklyn?

THE WITNESS: That is correct, your Honor.

Q. Please let's talk about hospital positions that you held.

A. Yes. So as I said, I teach at the Health Science Center here in Brooklyn, New York. I am associate professor and adjunct professor at New York Presbyterian where I also teach residents and medial students.

Q. Do you uphold any licenses?

A. I am licensed here in New York City. I was first licensed in 1992.

Q. Do you hold any board certifications?

A. I am board certified in orthopedic surgery. I was certified after I completed my training and I continued to be certified today.

Q. Do you have any professional memberships, Doctor?

A. I am a fellow of the American Academy of Orthopaedic Surgeons and I am also a fellow of what is known as a Scoliosis Research Society.

THE COURT: Doctor, what does the term "fellow" mean.

THE WITNESS: Fellow means that you are accepted as a member of that particular society which includes your standing in terms of your practice as well

as board certification. And then that particular society, essentially as a fellow, means you are an accepted member into that society.

THE COURT: Thank you.

Q. Have you received any honors and awards?

A. Yes, I have.

Q. Please tell the jury.

A. When I was in medical school I actually got the Charles Epps award for orthopedic surgery. Subsequent to that I received the Russell Hibbs Award from the Scoliosis Research Society for my research in scoliosis work.

Q. Have you published any works, Doctor?

A. Yes, I have.

Q. What are those?

A. I have done research predominately in spinal surgery and mostly in the area of biomechanics for spinal surgery where we study how implants behave in the spine. Those are when we need to do a reconstructive procedure, meaning we need to insert utility rods or screws or plates into a person's spine. The research that we have done details how those objects interact with the human body.

I was also integral in being able to do research regarding pediatric or child deformity surgery and scoliosis surgery as well. And I have edited several textbooks in spinal surgery.

Q. I was getting to that next, but you have covered it. Please tell the jury that. You have published certain works, correct?

A. Yes.

Q. Can you me a little bit about that please?

A. A couple of those works on biomechanics, which is the study of how implants work in the human body. And I have also published and edited articles and books on the actual techniques of spinal surgery that are involved in how to operate and treat spinal conditions on spinal disorders in humans.

Q. Okay it looks like you have done quite of bit of publishing of your work. Could you give the jury a sense of how many works that you have published?

A. So, I probably published at least 25 to 30 articles on the topic of spinal surgery in orthopedics and I have edited, I want to say, about four or five books.

Q. Okay, great. Thank you.

Now, are you being paid for your time here today, Doctor?

A. Yes.

Q. Okay and the custom and practice for doctors is when they came into Court to be paid for their time to be away from there practice?

A. Yes, it is.

Q. Do you maintain a private practice?

A. Yes.

Q. Okay, what does that consist of?

A. That is, essentially, myself and consists of being able to treat patients who have spinal issues regarding the neck and back of pediatrics and adult.

Q. Do you ever testify or have you ever testified on behalf of people who developed lawsuits?

A. Yes.

Q. Okay, now, what I would like to do before we start talking about Mr. Vivanco and Mr. Vivanco is your patient, correct, Doctor?

A. Yes.

MR. ROSE: Before we start talking, just for the record, your Honor, Plaintiff's Exhibit 7 which is the MRI film taken of Mr. Vivanco on September 5th of 2017. That is already in evidence.

We are going to use this right now so with the Court's permission, Dr. Merola, if you could step down or if you could do it from there, Doctor, whatever you are more comfortable with as far as explaining the anatomy of the lumbar spine to the jury.

THE COURT: He is a doctor, he is accustom to standing and pointing at a screen.

But counselor, are you asking that he be

deemed an expert?

MR. ROSE: Yes, of course, your Honor. Yes I would ask the Court to recognize Dr. Merola as an expert in spinal surgery.

THE COURT: Okay, Mr. Farrell?

MR. FARRELL: No objection, your Honor.

THE COURT: Without objection, Dr. Merola is deemed to be an expert.

Here's the distinction between an expert and let's say someone like me testifying. He can give his opinion, okay? Other witnesses can't. An attorney could give a fact pattern and ask what his conclusion would be based on that fact pattern. Bear in mind at the very end of the case it is up to you as to whether or not you accept the doctor's findings based upon what you hear and based upon all the other factors in the case, okay? Because if the fact patterns are not what they come out to be, then obviously the doctor's conclusions would be inaccurate.

Okay, so that is why you pay close attention not only to what the experts say, but also the facts as they come out. And, again, at the very end of the case I will give you a specific charge with regards to experts, okay. Thank you.

MR. ROSE: Thank you, your Honor. I

appreciate that.

Q. Okay, Dr. Merola, could you explain to the jury the anatomy of the lumbar spine?

A. Sure.

Q. Please do.

THE COURT: You can step down, Doctor.

A. So these images, these images are an MRI film of our particular patient, Mr. Juan Rivera.

An MRI is a magnetic way of taking an image of the internal anatomy of your body, where these images are generated based on the water content of your various structures. And in this image we are basically seeing the bones and the cartilage that is in your lower back. Specifically the discs that are in between the bones and made out of cartilage.

And we are also looking at nerves which are contained within a special canal that exists within the bones of your lower back.

THE COURT: Doctor, one second.

(Whereupon, an off-the-record discussion was held.)

THE COURT: Please continue. Thank you.

A. If we are looking at images, what we will notice is that in the MRI there are different images in front of us. Those different images are based on the way that it picks up

the water content in your body so that we are looking at shades of gray. The brighter the colors are that we see the more water content there is. The darker the colors are the less water content there is.

If we look at the center of the images we will see an area that contains what looks like gray squares. The gray squares are the bones of the lower back. And they are all lined up on top of each other. They are stacked on each other.

In between the gray squares we see these ovoid structures and these are the discs that exist in between each of the gray squares. And these discs are made up of cartilage. There are two parts to the disc, there is a inner jelly-like core that absorbs shock and is very squishy. And there is also an outer ring, not unlike a tire, that encompasses that jelly-like core that keeps that jelly inside the disc. And the discs act to glue the bones together to prevent them from moving around abnormally. They absorb shock and they take away the stress that is involved when you are up and about and moving.

To the right of the bones and the discs there is a bright area that you see. Inside that bright area you will see some very wispy gray lines. That is the is spinal canal. It is very bright because it contains spinal fluid that is really water. 99.9 percent of that fluid is water,

which is why it appears to be so bright on the MRIs.

The gray lines being nerves don't contain as much water. That is why you can see them in that area. You will notice looking at this MRI, we can see there are a number of bones that then sit on a bone that is just almost triangular shaped and that bone is contained inside your pelvis, which attaches to your hips and legs. And that bone is called the sacrum.

And because it starts with an S, the designation on the MRI is the S level. And typically it is a S1 level because it is a first level of the sacrum.

We then see there are five bones stacked on top of the sacrum and they are your low back bones or your lumbar spine. And therefore, they contain the designation L for lumbar. In between each, as we said it sits on a disc, so the disc is sandwiched in between those bones.

So the name of the disc takes its name from the bones below and the bone above. So, for example, the disc all the way on the bottom is the L5-S1 disc because it sits between 5 and 1. Above is the L4-L5 disc because it sits between L4 and L5. Using that nomenclature, you can also name the nerves because all of those nerves are now named based on where they exist in the lower back.

For example, between L5 and S1 you might imagine that the L5 nerve root is traveling past that bone around

the disc and the S1 nerve root is traveling past that bone and disc because they are in that neighborhood.

Q. So if you could explain to the jury the terms bulging disc and herniated disc and the definitions of those terms, please.

A. So when we are talking about the discs, we want to know whether or not they are protruding in some way or not. Protrusion is a general term that just means sticking out. Bulge and herniation provides a little more specificity to the general term protrusion.

So a bulge, if you might imagine, is a symmetrical protrusion. That means when you look at multiple different slices and multiple different areas it protrudes symmetrically. So bulging is a chemical protrusion. Not unlike if your belly was bulging over your belt you would have kind of a symmetrical protrusion around your abdomen and waist.

Herniation on the other hand is asymmetrical. So it is protruding in one area more than another. You might imagine if you have a hernia it is sticking out in one area more so than the other. And therefore, it is a herniation or a hernia.

So those terms really describe the way the disc itself looks as it, quote, unquote, "protrudes" or sticks out beyond the area where the bones border it.

Q. How are those terms and definitions significant as they relate to the nerves in the spine as you described?

A. So because the nerves are traveling behind the area where the bones and the discs are, and because the nerves are adjacent to the bones and the discs, you might imagine that something is causing an irritation to a nerve that it would be meaningful and you would want to know kind of anatomically where that irritation is coming from.

Q. Okay, great, thank you, Doctor.

So now, do you have your chart here today, Doctor?

A. Yes.

Q. Great. Would that be helpful in refreshing your recollection of the treatment of Mr. Rivera?

A. Yes.

Q. Okay, great. So please, if you could, refer to that as we are speaking.

When did Mr. Rivera first come to see you?

A. August 5th of 2019.

Q. And before he came to you-- I am sorry, let's start with talking about your initial evaluation, okay?

A. Yes.

Q. Could you please tell us what your initial evaluation was of Mr. Rivera?

A. Sure. So I initially saw him on August 5th of 2019 and the evaluation essentially starts with a conversation

with the patient regarding why he is coming to see you so that you can get an idea for what his major issue is. And it then gives you an idea how to come up with some options and how to treat the major problem that he is facing.

In this case he had come to me after he had been doing some conservative treatment.

Q. Can we just explain to the jury what that means, "conservative treatment"?

A. Sure. In terms of orthopedic care, there is what is called conservative or non-surgical management and then there is surgical management. Any time you are thinking about a procedure you are talking about doing something surgical.

Any time you are talking about giving a medication, or performing some type of physical therapy or advising some way of modifying your ergonomic behavior you are doing something conservative or non-surgical.

Basically, any time you are doing something active and mechanical to change a person's physiology, that is a surgical issue. If you are doing something in a non-mechanical or non-interventional way that is a conservative type of care for treatment.

For typical cervical care for orthopedics is activity modifications, physical therapy, medications chiro, acupuncture. Those kinds of things.

Q. Could you please continue with your history.

A. Sure. So he had come in and he had given a history of having had conservative treatment. That is non-surgical treatment after an accident that occurred in August of 2017.

In addition to conservative treatment that he was getting, he was also seeing a pain management physician where he was having some pain management procedures done. Which is just the next level up from conservative care.

Q. What do pain management treatments and procedures consist of?

A. Sure. So pain management is the next level of care for a musculoskeletal problem that is not responding to physical therapy or medications. It typically involves placing medications through needles and injections into areas that are causing symptoms in order to diminish those symptoms by using specific medications which can be a combination of a local anesthetic and a steroid medication which is designed to decrease a process known as inflammation.

Q. Could you continue, please.

A. Sure. So what is known as the chief complaint or his major symptoms were that he had pain, which was rated in the back and to some extent in the neck as well. With some associated, what we call, radiating symptoms, which is to say that there were symptoms of pain traveling into the arms

and legs and hands and feet.

Q. Okay and did you speak to the patient regarding whether or not he was taking medications at that time?

A. Yes.

Q. What did he tell you?

A. So there were three medications that I had listed that he was taking when he came to see me. That included Meloxicam, which is a non-steroidal anti-inflammatory medication. And Sertraline and Trazodone, which are neurological medications designed to decrease symptoms as well.

Q. Did you perform a physical examination?

A. I did.

Q. What did that consist of?

A. So physical exam typically involves observation of the patient so you can see when the musculoskeletal system is doing and in this case it starts with an observation of the way they are walking. And his initial gait pattern was that he was utilizing a cane to ambulate. And he had what we call a kyphotic and antalgic gait, which translates to a slight limp with a pitched forward low back posture.

So the gait pattern can tell you a little bit about how his lower back and lower extremities are working. So it is a bit of an abnormal gait pattern. That is based on observation.

The next part of the physical examination involves touching the patient or palpating them to feel areas that are abnormal. For example, within the muscles themselves you can feel areas that are in spasm or become spastic through a range of motion. And you can also test --

Q. I am sorry, spasm, what does that mean?

A. Spasm is an abnormal contraction of a muscle. So if you have ever had a Charley horse or you have had muscular pain in a portion of your body, you feel that area where those muscles are, they feel tighter and they feel much more tender than other areas that are not experiencing pain. So that is spasm.

So it is the body's response to a blocking motion in an area where motion would otherwise cause pain.

Q. Okay. I wanted to ask you, Doctor, before we continue with this visit. Subjective and objective, those words, could you explain the definitions of those words, please?

A. So subjective is what the patient tells you. So if a patient says, "I have pain in my back and it travels into my legs" that is subjective because the subject, the patient, is giving you that information. Objective is something that is not under the patient's control. So if you are doing an examination and you feel their lower back and there is spasm, you can objectively correlate the low

back examination with their subjective symptoms.

Q. Spasm would be objective?

A. Correct. Other things that are objective are, for example, an MRI film. And although a film is subject to the interpretation of the viewer, the MRI is generated by a computer that is taking images of the internal structures of the body. So if there is someone subjectivity involved in the interpretation of the film, but it is an objective test.

Q. Meaning what you see may be different than what someone else thinks they see, for example?

A. Correct.

Q. Great. Okay, thank you.

Could you please continue with your explaining to the jury your examination?

A. Sure. So because he had symptoms in the neck and back, the examination consisted of examining, touching and testing the neck and back areas. And there was palpable spasm in both his neck and in his lower back.

For example, in his neck area he had a finding called a Spurling's Test which is a test where you literally push down on a patient's head. You rotate their head a bit and move it into a position where you are increasing pressure on the nerves that come out of the neck.

In so doing, you reproduce pain, but you also cause a reflexive spasm in the muscles of the neck which are then

considered to be positive. It is a sign of what we call nerve root irritation also known as radiculopathy.

Q. Could you just real quickly, if you could, just explain the term "radiculopathy" and what this means?

A. So a radiculopathy is -- any time you hear the word opathy it means a problem with. And in this case a radiculopathy is a problem with a nerve root. Radic is the Latin term for the root. We are talking about nerve roots.

So radiculopathy means a problem with a nerve root. And so in this sense there were problems with the nerve roots in both the arms and hands and the legs and feet.

Q. Okay and what is that indicative of?

A. It is indicative of irritation of nerve fibers that are traveling into the arms and hands and the legs and feet.

Q. Could you continue, please.

A. Sure. In the lower back there was also palpable spasm with something known as a Straight Leg Raise, which was positive on his right side. And a Straight Leg Raise Test is a test where you are, essentially, extending the leg. That is your -- flexed is when your joints come together. Extended is when your joints go apart.

So you are extending the knee and you are extending the foot and ankle as you, essentially, pull up on their leg while they are either in a sitting position or on a lying down position. And that test is what is known as the

sciatic nerve, which is the nerve that comes out of your lower back and travels down into your leg. So if that nerve is irritated or has a problem, the reflexive response is to withdraw from that painful stimulus and that would be recorded as a positive Straight Leg Raise.

Q. Okay. Please continue.

A. And in addition to that, he also had difficulty with his ability to heel-toe raise, which is a sign that there was some difficulty with the motor or muscular function of lower extremities involved in the sciatic nerve distribution. As there were some altered sensations in the sciatic nerves which are the L4, the L5 and the S1 nerves.

Q. Okay now, I know you reviewed the films, but before we get to that, what films did you review at your first visit?

A. At the first visit I looked at an MRI of the cervical spine and an MRI of the lumbar spine and a CT scan of the lumbar spine with an ancillary test called a Discogram.

Q. Okay, great. Now, could we now turn to the --

THE COURT: Why don't we ask our doctor here to describe the difference between a CT scan and an MRI.

A. Sure. So the MRI, as I indicated before, is a magnetic way of looking at your internal anatomy based on water content. So you might imagine that the MRI is very

good at looking at the internal structures of the things that have a lot of water in them.

For example, tendons, joints nerves, the spinal canal area, disc. Things like that. A CAT scan is an x-ray taken many thousands of times, over the course of time, which is very good at looking at hard tissue structures such as bones and things that are more dense than the tissue that contain water. So there are different ways of looking at the internal structure based on the hardness of your internal structures and the amount of water.

So if you are looking at water related issues and soft tissues, MRIs are very good at that. If you are looking at hard structures and non-water related issues, CT scans are a bit better at looking at that.

Q. Now, while we have the 2017 film before the jury, Doctor, could you explain the significant MRI film findings in regard to the 2017 MRI?

A. Sure.

Q. Please do.

THE WITNESS: May I go down?

THE COURT: Absolutely.

A. All right, so while we are looking at these images one of the things we want to look for is whether or not things are symmetrical or asymmetrical.

So the first thing that we can look at are the

bones. We see that they are all lined up symmetrically. Nothing is out of place or dislocated. They are all squares, so there are no fractures. So because everything is lined up, you don't see any fractures. You don't see any dislocation. You don't see any tumors or infections in any of the bones because they all have a nice homogenous gray signal pattern.

Now, then we look at the discs. We can see all of the discs, essentially, have the same signal pattern as well. So they all have relatively good water content within them with the exception of the lowest disc, that is L5-S1, where there is a line that lacks water with respect to the rest of the disc.

And that line, you can see it very good on this image, all the way to the right is a line that you don't see in any of the other discs and it is associated with a protrusion. That is a bump or a sticking out of some disc material behind the confines of the vertebral bodies.

One easy way of looking at that when you are looking at that is to put a piece of paper up against the vertebral body. If you put a piece of paper against L4 and L5, I don't see any real bumps behind L4 and L5. But if I do that right behind L5 and S1, there is a little dark shadow there. And that little dark shadow, that little dark shadow that you see, comes right behind the bones and that

is associated with this little line. So that is an area where the discs are sticking out a bit.

If you look at all of the images on the MRI, it is not quite completely and entirely symmetrical. It is a little more in the center. So in that sense that could be considered herniated in a central portion of the disc area. And that dark line that you see right in there is an area where the outer ring is not receiving its normal blood supply and is missing some fluid because that fluid is kind of leaking out of the disc in that area.

Q. Okay, great. While you are up there, I would like to show you the 2019 lumbar MRI film. So that I think it will help the jury.

MR. ROSE: Your Honor, for the record, this is Plaintiff's Exhibit 8.

THE COURT: Thank you.

Q. Okay, so what date was that study done, Doctor?

A. So this is Elmhurst, September 13, 2019.

Q. And what do you see here?

A. So if you notice, I was playing with the mouse pad and images were changing. That is because there are different slices to the MRI. And in those different slices you can see a couple of different things. In the image all the way to the right, this is the side view. So this is the side view image similar to the images we were previously

seeing.

So we can see the gray squares are all lined up on top of each other. We see the discs in between each of the gray squares. And we see the spinal canal containing these wispy gray lines or the nerves.

And in between L5 and S1, once again, if we put our piece of paper up against the back of the bones we can see a bump behind L5 and S1. So there is protruding disc. And there is a little bit, just a wisp of some protrusion in L4-5, but not quite as much as you see at L5-S1.

To get a better idea what that looks like there is another image here adjacent to this side view image and there is this yellow line will tell you where that image is.

So the yellow line here is between L5 and S1. So this image is us looking down the spinal canal where the bottom of the image is the spinal canal. The top of the image is the area where the disc is. And the sides of the areas where the nerves exit. And if we look at where that nerve exits and what this image looks like we can see that there's kind of a dark shadow coming up and touching what are called at facet joints or the joints of the lumbar spine. And that dark area there is the area where this disc is sticking out into the canal.

To give you an idea of an area that is normal, if we go up to this section which is between L3 and L4, you

will see there this looks like it is almost, for lack of a better term, a upside down U. There is no dark shadow in the spinal canal there because there is no disc abnormality at L3-L4.

There is a little bit of abnormality at 4-5, so that I didn't bring that level up. But hopefully 4 is entirely normal and you can get a sense for that on this image.

So you can see this nice white stuff here, this is nerves. This is spinal canal. Completely entirely open. No pressure on either the canal or the joints. And that is different than all the way down here between L5 and S1 where you can see the disc literally touching the area where the joints are. You can see this dark shadow here inside of the canal area.

So, clearly not like the normal area at L3-L4. And once again, it is mostly localized down here at L5-S1, which is also the area that correlates with his physical exam, right. This is just an image and all by itself doesn't really mean much. You have to correlate it or add it up to what is happening to the actual patient, which is why you want to examine him.

Q. That is what you call a clinical correlation, correct?

A. Correct.

Q. Could you explain that?

A. Sure. So if you are just looking at an image it doesn't tell you anything because lots of things can be happening to this patient. And in the absence of the physical exam, this person may be completely entirely asymptomatic running around doing normal things or they may have a problem. Do they have a problem? Depends on what they are telling you subjectively. And is that problem really a problem? Depends on what your physical exam shows. So it is kind of like you want to add one plus one and then see what it adds up to.

So you are looking at all of these things all of the parts of the puzzle to try to figure out what is happening to a patient to then be able to make a recommendation about how to take care of them.

Q. All right, so we are talking about combining the subjective complaints, correct?

A. Yes.

Q. In conjunction with your objective testing; is that correct?

A. Yes.

Q. Okay, and how would the MRI -- what is the significance of the 2019 MRI film, the lumbar 2019 film?

A. So, it shows there is a persistent or continued issue or problem with that L5-S1 disc. And it correlates

with or adds up with what the patient is actually telling you and it correlates with what their physical exam is.

And it also goes along with the treatment that they received up until when they came into the office, which is why they were sent to you in the first place.

Q. Okay. Now, there was also a CAT scan reviewed here; is that correct?

A. Yes.

Q. What were the findings there?

A. Now, a CAT scan, so here's the interesting thing about the CAT scan. It wasn't just a clean CAT scan by itself. It was a CAT scan with what is known as a Discogram. So nothing to do with the dancing, but the term disco has to do with the disc. Any time you hear the word gram, it comes from the word graph, which means to write.

So Discogram or discography is disc writing. How would you write a disc? The way you write a disc or the way the disc tells you something is you inject the disc with contrast. Contrast is a material, the fluid or liquid, that shows up on the CT scan. So when you inject that contrast it pops up as something that is opaque on the CT scan so you can see where it is. In this case --

Q. Can I stop you for one second, Doctor?

A. Yes.

Q. Would an illustration be helpful in explaining what

the Discogram is to the jury?

A. Sure.

Q. Okay. Great.

MR. ROSE: Counsel has seen it, your Honor. For the record this is Plaintiff's Exhibit 12 for identification.

THE COURT: We do have an easel.

COURT CLERK: Marked for identification.

THE COURT: If it is only for identification the jury can't see it.

MR. ROSE: On consent it is stipulated into evidence.

THE COURT: Okay, that will be plaintiff's?

MR. ROSE: 12.

COURT CLERK: Plaintiff's 12 into evidence.

Q. Doctor, if you could explain the procedure, please?

A. Sure. So it's a procedure where you take a needle and you inject the disc with this contrast material. That is material that you can see on an x-ray or CAT scan in order to look at how the disc is behaving, right? Because you can't ask an MRI how the disc is behaving, but you can do an injection, typically done with the patient awake so you can talk to the patient while you are injecting the disc.

And while injecting the disc, you are, as you might

imagine, you are causing an increase in pressure inside the disc. And you are also looking to see where the contrast is. If contrast is completely entirely inside the disc and it doesn't go anywhere else, that is normal. If the patient says they don't really feel any increase in pain while you are injecting them and you can feel pressure, that is a normal disc.

If you, on the other hand, inject the disc and while you are causing pressure inside the disc the patient goes, "that hurts." Then you ask them, "what is your pain level? Is that the typical pain that you feel? Describe the pain for me".

Although those are subjective issues only the examiner knows that he is or is not doing an injection. And that is how you can figure out whether the disc is causing a problem or not.

Additionally, you can see whether or not there is a tear or a leakage that is occurring because there is damage to the annulus. That contrast material will show up in the area that is torn.

So the Discogram is a way of internally testing the disc itself to give you more information about what that disc is particularly doing to a patient.

Q. And what were the findings in regard to this test?

A. So when this test was done and the CAT scan was

done after the test in order to look at where the material was, the test itself was read as normal as L3-L4.

Essentially, normal at L4-5. That is to say no leakage, no increase in pain or symptoms in either L3-L4 or L4-L5. L5-S1 produced pain in the patient and, additionally, there was an area where the contrast material was seen to go into a tear that was rated grade two tear, which is a significant tear. It is a tear of multiple layers of that annulus or outer ring, which was pretty consistent with the MRI that showed that linear signal area.

Q. Okay, so can we just explain to the jury, real quickly, what an annular tear is? What the annulus is and what the annular tear is?

A. Sure.

Q. Thank you?

A. On this diagram, to the right of the diagram, this is a -- we are looking down into the spinal canal. The disc is on top. The gray outer covering of the disc is the annulus, which are these interwoven fibers that hold the inner like jelly core in place.

You might imagine that because those fibers are interwoven, right, there may be defects in those fibers that would then be considered a tear. And if there is a tear in any portion of the annulus, you have that squishy jelly-like stuff on the inside, you might imagine that when the disc

gets loaded or squeezed or starts to move around, that jelly-like stuff can make its way into the annulus or leak out of the annulus into the canal.

Q. Are those findings consistent with the 2017 lumbar MRI?

A. Yes.

Q. Okay, and of course, consistent with the 2019 MRI as well?

A. Yes.

Q. Okay, thank you, great. Anything else we need to talk about in this regard?

A. I don't think so.

Q. Okay, great. Okay, so I would like to get you off your feet in a minute. If we can do the cervical MRI before you sit down, this way you don't have to get up again.

MR. ROSE: Can we have the 2017 cervical MRI, please.

THE COURT: And that is?

MR. MORGENSTERN: Plaintiff's Exhibit 10.

THE COURT: Mr. Farrell?

MR. FARRELL: It is in evidence. Thank you.

Q. While he is doing that, Doctor, we can talk about something else for a minute.

Your medical record review also indicates that Mr. Vivanco had had a lumbar transforaminal epidural steroid

injection prior to coming to see you?

A. Yes.

Q. Okay, could you explain to the jury what those are?

A. So that is the next step up in conservative care when physical therapy hasn't helped. So it is the injection, not unlike the Discogram, although you are not injecting the disc, you are going into the epidural space which is the space that contains the nerves. And you are specifically injecting a steroid, which is a medication designed to reduce inflammation and swelling in the area where the nerve is.

Ultimately you feel pain, for example, if you have a cut on your skin it turns red. It gets a little weepy and it hurts. That's the process of inflammation. So there are chemicals that are causing that redness and that weepiness and that pain to occur. And that is an inflammatory process. The steroid blocks those chemicals from causing inflammation.

So an epidoral steroid injection is to decide to basically block inflammation in an area that is producing pain with the hope that your body can recover if it is a condition that is recoverable.

Q. Thank you. Okay, now before we get to the finding, can we do a quick anatomy lesson in regard to the cervical spine. As far as just not to repeat anything, but as far as

any significant difference that the jury should know before we speak about Mr. Vivanco specifically?

A. So cervical, same basic principles. We are looking at the gray squares which are the vertebral bodies. They are much smaller in the cervical spine as you might imagine because your neck is not as big as your waist. These bones are somewhere in the neighborhood of about the size of the tip of your pinky or your ring finger.

Head and brain up top, face to the right on this image. Bones, once again, lined up on top of each other with the discs in between the bones and the spinal canal to the right of that. Major difference here is that you see a big thick gray line. That big thick gray line that you are looking at is the spinal cord. There is no spinal cord in your lower back. There is a spinal cord any in your cervical spine and neck.

Q. All right, now can we now discuss these significant findings in regard to Mr. Vivanco?

A. Sure. So once again we see that all bones are lined up. There are all of the same height and signal. So there are no fractures, dislocations, tumors or infections.

The discs all have essentially the same kinds of signal to them with the exception of the lowest disc here that has lost a little bit of its signal. So we know that it's got a little decrease in fluid.

And then we look at the contour of the back of the areas here. We see there is a bit of a bump here, which is between C5 and C6. And the little bit of a bump here on the bottom between C6 and C7.

Once again, these bones are named C for cervical for your neck. They take the number of the position that they exist in your neck. There are seven bones in the neck and each disc, once again, takes the name of the bones in between the discs that it sits in.

Q. Okay. Anything else?

A. That is pretty much it for the neck.

THE COURT: Doctor, you mentioned decrease in fluid. As we get older, isn't that a natural process?

THE WITNESS: Yes.

THE COURT: We get shorter as we get older, could you explain how that works?

THE WITNESS: Sure.

A. So, if you think about babies and children, they are very flexible. And if you drop them they bounce like a ball, right? They contain a lot of fluid, a lot of water. They are very rubbery and very flexible. They have a lot of resilience to them and they are also growing. So those are all generative processes.

As you get older you become more brittle. Your body dries out a bit. That is why we develop wrinkles,

because the collagen in your face and in your tissues loses water. It becomes more brittle. It cracks much more easily. And we are not resilient.

So a typical normal finding for humans as we -- all animals -- as we age is for these typical quote, unquote what we call "degenerative conditions" to occur. Most prominent of which is a loss of fluid hydration or water in those soft tissues that contain water.

THE COURT: I think this is a perfect time for us to take a break. Now that we have talked about bouncing babies.

Please bear in mind our reporter here, she has been doing this today for an hour. Not that I keep track, but I need to make sure her fingers, you know, don't fall off. So we will take a brief 10 minute recess. The usual admonitions, even if I don't say it, please continue to keep an open mind. Please do not talk about this case amongst yourselves or with anyone else. And we will be back at 11:15.

All right, thank you.

COURT OFFICER: All rise. Jury exiting.

(RECESS TAKEN.)

THE COURT: Let's get the jury back.

(Whereupon, the jury enters the courtroom and is seated in the jury box.)

THE COURT Everyone can be seated. Do both sides stipulate that all the jurors are properly seated?

MR. ROSE: Yes, your Honor.

MR. FARRELL: Yes, your Honor.

Q. Doctor, can you tell the jury how the objective findings correlated to your clinical exam?

A. So, he had a positive Straight Leg Raise, which is irritation in the sciatic nerve distribution which is the collection of nerves that travel directly adjacent to the L5 S1 area. And on the MRI films and the Discogram and CT we saw that the L5 S1 disc was responsible for producing the patient's symptoms.

Q. Okay, now, did you then order anything, any additional testing?

A. After I initially seen him in August of 2019, I did order that updated MRI, which we looked at and I had an opportunity to look at all our diagnostics that we just discussed as well. Because the patient was symptomatic and unresolved with conservative treatment we did recommend surgery for the lower back.

Q. And Mr. Vivanco came back to you on October 21st of 2019; is that correct?

A. Yes.

Q. Okay and is there anything notable about that visit that we should discuss, Doctor?

A. Essentially he continued to remain symptomatic and his examination was consistent with his previous exam.

Q. And do you typically have discussions with your patient regarding surgery?

A. Yes.

Q. Did you do that here?

A. Yes.

Q. Could you tell the jury about that conversation?

A. Sure. So typically that involves reviewing with the patient their condition and going over options for treatment. And in this sense if we are making a recommendation for surgery, we typically discuss the benefit and the risk of having the surgery done here. The benefit being to try to decrease the radiating symptoms that are going down into the legs and feet.

The realistic expectation of surgical intervention which are that surgery can be helpful, but would not necessarily make all of the symptoms go away. Particularly if they had been persistent for quite some time.

Additionally, there are potential risks to the actual procedure itself. And those risks can include the risk of a general anesthetic, which is required to do the surgery. The risk of infection any time you make an incision. The risk of bleeding any time you do a surgical procedure. The risk of irritating the nerves that have been

already irritated because they are in an area that you need to operate on to take a pressure off of them. And the overall healing process that is required after the surgical procedure itself.

So those are some of what we call the realistic goals and expectations of surgery and some of the potential complications and risks involved.

Q. Thank you. Do you see that note, the October 21st where you talk about the counselling session?

A. Yes.

Q. Who was present there?

A. Both the patient and his wife.

Q. Thank you. You saw him -- I am not going ask you to talk about every note. Just so the jury has an understanding of the amount of times that you saw Mr. Vivanco.

You saw him again on December 16th of 2019?

A. Yes.

Q. Okay, all right, so at some point, Doctor, did Mr. Vivanco end up having the surgery?

A. Yes.

Q. Okay, when was that?

A. January 22nd of 2020.

Q. Now, I am going to want to have you discuss the surgery and explain the surgery to the jury. So I have two

things, I will ask you what would be most helpful to you.

We have your operative report, would that be one thing that would be helpful?

A. Yes.

Q. The second would be a medical illustration of the surgery; would that be helpful?

A. Yes.

Q. Okay. Great.

MR. ROSE: This is in evidence, your Honor.

THE COURT: That is?

MR. ROSE: That is Plaintiff's Exhibit 13. This is also in evidence by stipulation.

COURT CLERK: All agreed?

MR. FARRELL: Yes.

Q. What I would also like to do, Doctor, just tell me if you disagree with me, if we put the operative report up on the screen so the jury can see that; would that be helpful?

A. Sure.

THE COURT: Has it been moved into evidence?

MR. ROSE: It has not. Do we have it here? We can do without it. Judge.

THE COURT: Counsel. Come up for a second.

(Whereupon an off-the-record discussion was held.)

MR. ROSE: Could I have Dr. Merola's chart, please.

THE COURT: What happens now that it is being stipulated into evidence, the doctor can read from it. Anyone can read from it now that it is in evidence.

Also since it is in evidence, when you are deliberating, if you want it, it will be given to you.

Now there will probably be certain redactions, such as a person's phone number, social Security number. There is certain information that has nothing to do with the doctor's treatment that is personal to the patient that will be redacted. So if you see something blacked out, that is the reason for it, okay.

MR. ROSE: For the record, by stipulation, we have admitted Dr. Merola's chart as Plaintiff's Exhibit 15.

THE COURT: Mr. Farrell, accurate?

MR. FARRELL: Yes.

THE COURT: It is in evidence.

Q. Doctor, could you please explain the surgery that you performed?

A. Sure. So the essence of that procedure is to, essentially, open up the area where the nerves are in order to make sure that there is no significant pressure on the nerves. And to additionally remove any pieces of disc

material that are up and touching or coming into contact with any of the nerves.

The purpose being, basically, to preserve neurological function and to decrease radiating, that is the radiculopathy symptoms that the patient has. In order to do that, the procedure is done under a general anesthetic whereby the patient is asleep and you are approaching the lower portion of the back by making an incision over the area between the L5 and S1 bones.

After You have made that incision, you then need to localize that area by taking an x-ray in the operating room. Once you are sure you are where you are supposed to be, you can then proceed to, essentially, remove the covering of the spinal canal which is made up of what we call at the lamina.

If you think about shingles on a roof, the lamina are shingles on your lower back that are above the level of your attic, if you will. And your attic would be where your spinal canal is.

So we are, essentially, opening that area by shaving a way and removing shingles or lamina to expose or open the spinal area. Once that area is open, you can see the area that covers the nerves. So there is a covering to those nerves. They are contained within a sac called a dural sac. That is a sac that is filled with that water fluid that you saw in the MRI.

More specifically, you can see these little things that look like yellow pieces of spaghetti. Those are the nerves as they exit the lower back area. And in this case, we are specifically looking at the L5 nerve and the S1 nerve.

So we gently move those nerves away from the disc and then we can see the disc so that we can see if there are any pieces of disc that are up in contact with those nerves. And in so doing, we can remove those pieces of disc material.

And in this case in the operative report, because I don't have every procedure that I have ever done memorized, but I will dictate what it is that I saw the day that I saw it, so that if I ever need to go back and reference it I get an idea of what I did and how I did it.

There is a section called intraoperative findings. And in this case there was disc material which was appreciated to touch some of the nerves and I removed that material. And I also noted that there was the visible tear in that annulus, which is that area that that disc material had leaked out, if you will, on the nerves.

Q. This is what we saw in the film, correct?

A. Yes. On the film and intraoperatively when that procedure was done in an area of L5 and S1.

Q. With your own eyes?

A. Yes.

THE COURT: One second. Mr. Farrell there is a chair if you would like to move over.

MR. FARRELL: I am good right here for now, unless something changes. I appreciate it.

A. After that decompression is done, we basically take a little -- it is a small metallic tool that is very blunt and soft. As soft as metal can be. And pass it is up along the area where the nerves are to make sure there is room for those nerves without any other pieces of disc material or anything touching them. And then once we have ascertained that everything is free and open and clear, we basically sew the entire area back together again and that completes the procedure. The patient is then awakened and then they start their post-operative healing course.

Q. Anything else we should discuss with the surgery, Doctor?

A. No, that is pretty much the whole thing.

Q. Okay, thank you.

And if we can discuss the first post-operative visit on January 24th of 2020, please?

A. Yes.

Q. What did that visit consist of?

A. The first post-operative visit is, essentially, a brief visit to check on the incision to make sure that it is

healing properly and to check on the patient to make sure that they haven't had any issues with either the anesthetic or the incision or any of the potential complications that can occur after a surgery is done.

Q. Okay. And did you form an impression and plan at that point in time?

A. Yes.

Q. What was that?

A. That everything appeared to be healing appropriately and correctly. And that I had suggested that physical therapy could be started on what is known as an as tolerated basis. Which means after surgery there is some soreness and stiffness.

The patient may have difficulty getting to physical therapy, so I say, you can get started as soon as you like, as soon as you feel comfortable. So I recommend physical therapy to start on as tolerated basis. Avoid what we call BLT or bending, lifting and twisting. Those are activities in your lower back that would aggravate the area where the incisions is. They would be painful.

You are probably going to avoid that normally, but I would like to reinforce it and then advise to return in a about eight to twelve weeks, depending upon how the patient was feeling and doing. Certainly sooner if they felt as though they need to come in sooner or later if they felt as

though everything was going well.

Q. Okay, great. Thank you. And in this case how much time went by before Mr. Vivanco came to you next?

A. About a month or so. I then saw him back in February of 2020.

Q. What did he report at this time?

A. So on this visit he did indicate that the surgery decreased some of those radiating or shooting symptoms down to the legs. As you might think that it would after I took pressure off of those nerves.

The majority of those symptoms, what we call axial. Axial is just a fancy way of saying pain localized had to the, in this case neck and back. So that is pain and stiffness in the neck and back, which is mechanical. You might consider that obvious if you think about the spine as a mechanical member that is maintaining your head over your pelvis. So its got a mechanical aspect to it. And so a mechanical pain is pain that is aggravated when it is in motion and when it is active.

So in his postoperative course, at that point in time, had what we call mechanical pain in his neck and back which is a normal finding post surgically.

Q. Okay. Great. Let's just talk about a concept for a moment. We talked about when we were discussing the MRI findings, for example, we were talking about terms such as

disc protrusion and annular tears, which are deformities in the spine, okay?

A. Yes.

Q. In a general sense, are these things that can be caused by a trauma?

A. Sure.

Q. Okay and in other circumstances not caused by a trauma, correct?

A. Yes.

Q. Okay and how do you make a determination as far as whether or not these findings that you discussed today are caused by a traumatic event?

A. So in several ways.

Q. Okay.

A. The first of which is, of course, you know, a history. And in terms of history, there are several things that we can consider. First, we consider the version that you had with the patient and what they tell you about when their problem began and what their problem is. And you also have a medical record where you can see who they have seen before they have seen you to see what kind of symptoms and treatment they have had prior to coming to see you.

And then you can also do a physical examination in order to, once again, correlate what it is that they are telling you with what is actually happening to their body.

And then you can further correlate that with the diagnostic studies. In this case the Discogram, the CT and the MRI.

And then ultimately you also have an opportunity to see them after, in this case the treatment which was surgery, to notice that their clinical course, although not perfect, has improved over time.

You can take all of these things, if you will, all these parts of the puzzle to put them together to formulate an opinion.

Q. Great. Thank you. Okay, now, I would like to direct your attention -- I am sorry. We were on February 17, 202; is that correct?

A. Yes.

Q. Okay and did you perform an examination at that time?

A. Yes.

Q. Okay and what did that consist of? What were your findings?

A. On this exam, once again, we were looking at how the patient is walking and doing a physical examination of their neck and back. And in this case his walking status demonstrated that he was not actually using the cane on this visit, but he did have a persistent limp, also known as antalgia.

He did have some loss of his low back normal

lordosis, which is known a kyphosis, which is a little bit of pitched forward posture.

Q. Can we talk about those two terms, please. Thank you.

A. The antalgia and kyphosis?

Q. Yes, that.

A. Antalgia basically means a limp. It means when you are walking you are spending less time on one leg than on your other. You notice that your gait is not fluid, right? Kyphosis basically means that your lower back should have --

Q. Before you get to that, the antalgia gait, why is that significant for someone with a back injury?

A. It comes into play with both a back and lower extremity injury. It tells you a little bit about how the nerves and the muscles, bones and joints and lower extremities are working. And whether or not there is persistent, you know, symptoms or pain in the lower extremities.

Q. Okay. Thank you. Kyphosis?

A. So kyphosis, your lower back, if you feel your lower back, right, you should have a little bit of a C shape to it. A certain amount of C shape to that lower back. That is called lordosis. If you look at that C shape to your lower back or this swoopiness to your lower back and it flattens out or it pitches forward, it is known as kyphosis.

Conditions that involve nerve-root irritation or spinal issues typically have a loss of lordosis or a development of kyphosis. It is also why you see some folks as they get older have a tendency to pitch forward a bit because as their spines have and develop issues as they get older, the typical effect of gravity is to pull you forward. So that is one of the things you can observe and feel in a patient's lower back as well.

Q. Did you make a recommendation as far as treatment is concerned at this point in time?

A. Yes. So treatment at this point in time continued to remain one whereby he was healing from surgery. So I had recommended that he remain off of his duties, which were heavy labor. I also recommended that he continue --

Q. That would be your comment regarding disability?

A. That is correct.

Q. Could you explain that part of it? What your comment regarding disability was and what it means, basically?

A. Sure. So this is a patient that was involved in what we consider a heavy labor activity. So you might imagine that involves a significant amount of bending, lifting, twisting and repetitive motion. Also exposure to hazardous environments and conditions.

And in a patient with an active radiculopathy, that

would be something that it is wise to avoid, a patient not return to not only for the benefit of the patient, but for anyone else who might be involved with him they might need to rely upon him in that work environment.

Q. Now, did you recommend treatment?

A. Yes.

Q. What was that?

A. Continuing his pain management and continuing post-operative care to include physical therapy and avoiding, once again, bending, lifting and twisting. With other activities that could be on as a tolerated basis or essentially advising the patient that pain should be his guide in terms of what he felt comfortable doing.

THE COURT: Doctor, could you explain, you know, we have heard that term pain management, how does someone manage pain? You are either in pain or not; how do you manage that?

THE WITNESS: That is a great question. So if you think about a disease like hypertension or high blood pressure or a disease like diabetes, those are managed by a primary care doctor. They manage your diabetes or your hypertension by measuring your blood pressure, measuring blood sugar and doing blood tests and administering medications in order to keep your blood pressure controlled and in order to be able to

keep your blood sugar controlled.

Patients that have chronic pain -- so there are two kinds of pain typically. Acute pain, "I sprained my knee, it really hurts". You treat it, the knee pain goes away over six to eight weeks. You go back to normal activities. You don't have any more problems with your knee. That was acute knee pain that was treated successfully conservatively.

Chronic pain is pain that lasts for more than several months. That continues to interfere with activities of daily living. Which requires underlying management. And that management typically includes, unless there is deterioration, typically includes a combination of medications and therapy. And in some cases injections which can be done again as well.

So chronic pain is not unlike hypertension or diabetes or any other disease that can be managed based on the application of medications and therapies. Plus or minus injections.

Q. Okay. You saw Mr. Vivanco again on April 16th of 2020; is that correct?

A. Yes.

Q. You saw him again on April 23rd of 2020; is that correct?

A. Yes.

Q. Then the next visit was on July 6th of 2020; is that correct?

A. Yes.

Q. Okay, let's talk about that visit. What did he tell you when he came to the office?

A. So continuing to experience primarily back and neck symptoms. He was utilizing a left knee brace at that time as well as a cane. So he had some increase in his knee pain. But the primary complaints in symptoms were both neck and back pain related.

Q. Did you perform a physical examination?

A. Yes.

Q. Could you explain those findings, please?

A. Sure. He did continue to demonstrate the limp and that kyphotic gait pattern. He had spasm in his lower back with difficulty heal toe raising in his right and left lower extremities. No progress and neurological deficits were otherwise appreciated.

Q. Okay, and did you suggest any testing at that point in time?

A. I suggested a post-operative MRI at that time.

Q. What is the purpose of doing that?

A. A couple of things in this case. Number one, you know this was July of 2020, so we were in Covid related issues going on at this time. And persistent pain in his

neck and back regions in a post-surgical patient, one of the things that would be helpful here is to make sure there were no hidden infections or issues happening with his lower back. So a post-op MRI was helpful to see that.

It was also helpful in at least determining what his condition was and whether or not he had something called a recurrent disc herniation which can occur in patients who already had herniations.

Q. Okay and did you recommend further treatment?

A. Continued physical therapy and once again the no BLT, bending, lifting and twisting.

Q. Also the same comment regarding the disability from work, correct?

A. Yes.

Q. Now let's look at, if you could, the July 27th 2020 visit?

A. Yes.

Q. Let's talk about what he told you first when he came into the office?

A. So, neck and back symptoms which were painful and significant to him in terms of decreasing his ability to bend, lift and twist. Also using a left knee brace and he was using a cane at this time as well.

Q. Okay, did you perform a physical examination?

A. Yes.

Q. What were your findings?

A. That he was neurologically essentially stable. Which is to say he did have some persistent sensory loss in that sciatic nerve distribution, the L4-L5 and S1 root distributions. Some reflexive loss in his quadriceps and achilles tendons.

Q. What does that tell you?

A. That is the distribution of the sciatic which is consistent with a preoperative status.

Q. Meaning symptoms of radiculopathy?

A. Meaning some persistent neurological deficits based on the chronicity of his condition. Over the long-standing nature of his condition prior to his surgical intervention.

Q. Got it. Thank you.

A. And no other progressive neurological deficits or other neurological findings.

Q. Did you receive that -- was that follow up MRI done?

A. Yes.

Q. Could you explain to the jury what the findings were in regard to that follow up MRI?

A. Sure. So as we had seen on previous MRIs, L5-S1 had an annular tear that was also confirmed operatively. L4 and L5, we had noticed on previous MRIs, although not producing significant compression, also had a disc

protrusion at L4-5. And the updated MRI showed that there was progressive loss of fluid in both the L4-5 and L5-S1 disc, which you anticipate in a patient that had herniations and annular tears.

Q. And then you used the term post-traumatic disc space collapse at both L4 and L5 five and L5 S1, correct?

A. Yes.

Q. Could you explain to the jury what that means?

A. The patient had presented to me and had a medical record consistent with trauma that had resulted in disc protrusions or herniations at L4-L5 and L5-S1 with an L5-S1 disc that was producing primary symptoms. So that is what he was being treated for. And the post-operative MRI was consistent with what he was being treated for. So it essentially continued to show us the picture of his clinical condition.

Q. Thank you.

THE COURT: Doctor, I was looking through my notes, I don't recall whether or not this question was asked. What is a disc made of, is it cartilage or is it bone?

THE WITNESS: So the disc is made up of cartilage, which is made of collagen. And there are two different types of collagen and cartilage. We touched about this earlier, the internal portion of the disc is

made of this collagen that is essentially jelly like and very liquidy and the outside portion of collagen or the ring or the rim of the disc is much denser and more fibrous. The overall structure of the disc is collagenous in nature and not bony.

THE COURT: Thank you.

Q. Okay, you make a note under what you call "MRI update", where you said "the patient underwent", okay. Do you see what I am referring to?

A. Yes.

Q. Could you read that portion of the report in your note to the jury and then it is just those two sentences and then we are going to explain that; if we could?

A. Sure.

Q. Thank you.

A. So I what I wrote was, "the patient underwent a decompressive procedure". That is the surgery that I had described. And then I said, "and is quite young ." So he was, of course, young and still is. "The major issue is to try to avoid fusion surgery and as such, a consideration at this juncture would be for a possible spinal cord stimulator".

So that is a lot of things that I just said there. Typically, we should try to avoid -- we should try to do the least amount of surgery for the most potential benefit with

trying to avoid potential complications, right? So a fusion surgery is a surgery where you are mechanically altering the lower back by inserting screws and rods into it to hold things together. Which is quite a big procedure for a young person to have unless you have a good reason to do that, right?

There may be a dislocation or a fracture or there may be an area that you need to like really take a lot of pressure off a nerve and thereby you would remove so much bone that you would have to hold it together with rods and screws.

But in younger patients our concern as surgeons is to really do as little surgery as possible without having to do that. And in this case in the absence of any significant instability that would require rods and screws in a patient that has persistent axial pain, one of the ways to manage that chronic pain is through pain management. And not only through medications and therapy an injections, but perhaps even this particular thing called a spinal cord stimulator which is an electronic device, not unlike a pace maker, that stimulates the nerves in order to decrease the brain's ability to sense the chronic pain that the patient has.

Q. Okay. Thank you. Also, Doctor, are you familiar with the term adjacent segment disease?

A. Sure.

Q. Explain what that is to the jury?

A. You know, if you think about all these bones that are stacked up on each other they are all connected like a chain, right? So each bone and disc affects the other bones and discs. So if you have a problem in one area, eventually that one area can lead to problems in the other areas because there is an abnormal interaction between all of those bones and discs.

Q. Thank you.

THE COURT: Doctor, one quick question. When you decrease pain with the stimulator, doesn't that endanger the patient if there is, if there is, in fact, something going on there he or she will not know because the pain is a message to the patient?

THE WITNESS: So the stimulator actually specifically works on the -- let's call it the neurogenic component of the pain. So the neurogenic component of the pain is the chronic component of pain that is related to the long-standing nerve issue that they had had prior to, in this case a decompression, and it does not block normal sensory nerves.

So your normal sensory nerves and the nerves that are responsible for the way your legs and your feet work are still in tact and working, but your brain's perception of the chronic pain that you've had

essentially turned off by this electrical impulse that is produced by the stimulator.

THE COURT: Thank you.

Q. Doctor, you made the same comment at the end of that visit regarding Mr. Vivanco being disabled, correct?

A. Yes.

Q. Okay, you saw him next on September 28, 2020, correct?

A. Yes.

Q. That was your next visit. And what were his physical complains at that time?

A. The mechanical axial pain in low back and neck area with difficulty performing activities requiring bending, lifting and twisting.

Q. And still the same comment regarding disability, correct?

A. Yes.

Q. Back to see you December 14th of 2020, correct?

A. Yes.

Q. Okay and at that point in time I notice he was using a back brace; is that correct?

A. Yes.

Q. Utilizing a cane at this time as well?

A. Yes.

Q. Let's just talk about the counseling session that

you had with him there, please?

A. Yes.

Q. Okay. Thank you.

A. So we were talking about the chronic pain that he was having and the statement that I had made regarding trying to avoid having to do a fusion surgery. So suggesting continued conservative treatments up to and including a possible spinal cord stimulator to try to avoid having to do anything further, surgically, particularly a fusion.

Q. Same comment regarding disability at that point in time, Doctor?

A. Yes.

Q. Did you make medical recommendations at that point in time?

A. Yes.

Q. Okay, what were those?

A. Once again, pain management, low back brace, physical therapy. And as discussed, that spinal cord stimulator.

Q. Back to see you again in February of 2021; is that correct?

A. Yes.

Q. Then next he was there to see you on May 3rd of 2021. I would like to direct your attention to that note,

please.

A. Yes.

Q. Okay, what was reported to you at this point in time?

A. Neck and back symptoms.

Q. Before we get to that, it says that he was utilizing a TENS. Tell the jury what that is, please?

A. It is an external device that applies a bit of electrical current to your muscles and it kind of stimulates the muscle area where you are feeling symptoms in order to decrease symptoms and spasm.

Q. Please continue.

A. So primarily on, once again, neck and back symptoms with an aggravation of neck and back symptoms with activities requiring bending, lifting and twisting and the such.

Q. Okay and did he speak about activities that were causing him issues at that point in time?

A. Yes. So, for example, maintaining head and neck in a fixed position, like watching TV, was difficult. Putting on shoes and socks. Even in some cases, and I discussed his personal care and hygiene, getting dressed and undressed, things like that, were painful at this juncture.

Q. Did you make any medical suggestions to him at this point in time?

A. I did think that the bracing and the TENS unit were helpful and advised that those could be utilized and for him to continue conservative care and remain off work.

Q. Did you discuss a brace for the neck at this point in time?

A. Yes.

Q. What was that?

A. That a brace would be helpful to decrease his neck symptoms.

Q. He saw you next in June of 2021; is that correct?

A. Yes.

Q. Still disabled; is that correct?

A. Yes.

Q. Now, I would like to direct your attention to October 4th of 2021, please?

A. Yes.

Q. Could you please discuss that visit?

A. So he was using his TENS unit. That is the electrical stimulation unit, as well as a low back brace and a cervical collar. Soft brace. Pain and symptoms in both his neck and back regions which were consistent with his previous symptoms as well.

Q. Okay now, what were your physical findings at that point in time?

A. He did have a kyphotic gait pattern. He was using

his brace at that time. As well as a cane and a knee brace as well. Spasm was palpable in the neck and in the low back areas. He did have a positive Spurling's Test in his neck.

Q. What does that mean?

A. That he did have nerve root irritation in the neck. And in the lower back he did have some difficult heel-toe raising. A little bit worse on his left side than right side with persistent sensory loss in the sciatic nerve distribution.

Q. How is that significant?

A. That shows the chronic nature of his nerve condition.

Q. Okay and did you make medical treatment representations at that point in time?

A. Yes.

Q. What were those?

A. To continue his therapy and pain management. As well as bracing, which was helpful, and to continue to avoid bending, lifting and twisting and to remain off of heavy labor.

Q. Okay. Thank you. Next he saw you in November of 2021; is that correct?

A. Yes.

Q. Still remained disabled at that point in time, correct?

A. Yes.

Q. Let's now go to the visit of December of 2021, please.

A. Yes.

Q. What was discussed at that visit?

A. So continued to remain symptomatic with respect to his neck and back. And we had had a discussion about continued treatment including continued physical therapy, pain management and bracing. And that we also discussed a possible spinal cord stimulator as well.

Q. At that point in time did you perform a physical examination?

A. Yes.

Q. What did that consist of? What did that consist of, what were your findings?

A. Very similar to our previous examinations with spasms in his neck and back area. He did continue to show a Spurling's Test in his neck and in his lower back. He did continue to show some sensory and reflex deficits in the sciatic nerve distribution.

Q. Did you test range of motion at this point in time?

A. Yes.

Q. What were your findings there?

A. That he did have decreases in his range of motion.

Q. And I see that you found quadriceps and achilles

tendon reflexive loss, could you explain the significance of that to the jury?

A. That is evidence of his persistent nerve loss in the lower extremities.

Q. Okay, now, the same treatment recommendations I see, they continued?

A. Yes.

Q. Same disability comment as well?

A. Yes.

Q. Okay. Now Doctor, I would like you to assume the following okay: On August 9th of 2017 Mr. Vivanco was working on a construction site standing on a ladder. There was a beam that was being hoisted that weighed 4,000 pounds. Approximately 4,000 pounds. That beam fell striking Mr. Vivanco in his left leg causing him to fall, violently fall, from the ladder onto the ground below.

Do you have an opinion, Doctor, to a reasonable degree of medical certainty as to whether the injuries that you've described were caused by this accident?

A. Yes.

Q. What is that opinion?

A. That the injuries described were caused by the accident.

Q. Okay, why is that?

A. That history of the fall is consistent with my care

and treatment of the patient and my review of his records as well.

Q. Are Mr. Vivanco's injuries permanent?

A. Yes.

Q. Why?

A. He has evidence of some permanent neurologic deficits. Particularly involving the lower extremities with MRI evidence of what we call post-traumatic disc changes at L5 and L5-S1 that.

Q. How about the neck?

A. The neck had remained symptomatic and did show consistent C6 and C7 nerve root deficits, which were also consistent with his MRI findings.

Q. Now, Doctor, you saw Mr. Vivanco recently; is that correct?

A. Yes.

Q. What was the date of that visit?

A. April 21 of this year.

Q. April 21, 2025?

A. Yes.

Q. Okay, now, let's talk about that visit. At the beginning of the report you did you make a comment regarding disability; is that correct?

A. Yes.

Q. What is your comment there?

A. "50 percent disabled from heavy labor".

Q. And that was a change from your prior reports, correct?

A. Yes.

Q. Could you explain that, please?

A. Yes. Eventually the patient did return to work in an alternative occupation. An occupation that did not require heavy labor. I had recorded him as working as a parts inspector.

Q. Was anyone with him at that visit?

A. Yes, his wife.

Q. Did he speak to you about what his symptoms were at that point in time?

A. Yes.

Q. What did that consist of?

A. They consisted of mechanical pain, once again, in his neck and back areas. Whereby he was continuing to use anti-inflammatories and modifying his activities to decrease symptoms. Although he had reported that the pains did cause some requirement for him to visit emergency departments at various times because of the symptoms.

Q. Did he perform a physical examination?

A. Yes.

Q. And could you discuss the physical examination with the jury, please?

A. Sure. So his gait pattern remained consistent with his previous patterns which was kyphosis in the lower back area. With antalgia or a limp. In this case on this exam using a left knee brace. His neck and back region did demonstrate persistent spasm in the neck. He had a Spurling's Test, which reproduces spasm in his neck area and in his lower back and lower extremities. He did show pretty much a persistent, in this case L5 and S1, sensory loss with somewhat worse left graded and right lower extremity achilles tendon reflex loss.

Q. What does that mean?

A. Those are some signs of his long-standing nerve root deficits.

Q. Please continue.

A. Sure. So mostly neck and back mechanical pain with L5 and S1 left grade and right-sided nerve deficits.

Q. Did you make any medical recommendations at that point in time?

A. Yes. I had indicated that working in light duty capacity was completely entirely reasonable. And I told him that it is a condition that we call guarded, which means that he should have continued follow up and care as necessary over time.

Q. I believe you told him that physical therapy would be helpful; is that correct?

A. Yes. If available on a maintenance basis, correct.
Q. Pain management as well?
A. Yes.
Q. I know you said the injuries were permanent, would the injuries be a competent producing cause of pain for Mr. Vivanco?
A. Yes.
Q. Why is that?
A. Because they are intermittently involved with the way that the entire spine works.
Q. So would that mean for the rest of his life?
A. Sure.
Q. Doctor, are you familiar with the term life care plan?
A. Yes.
Q. Did I ask you to review the life care plan in this case?
A. Yes.
Q. Okay, did you agree with the life care plan in this case?
A. Yes.
Q. Okay, Doctor, would all of the opinions that you have given today be to a reasonable degree of medical certainty?
A. Yes.

MR. ROSE: Thank you four your time. Thank you.

THE WITNESS: Thank you.

THE COURT: Cross examination?

MR. FARRELL: Yes.

CROSS EXAMINATION

BY MR. FARRELL:

Q. Good afternoon, Dr. Merola. I apologize in advance, I am going to try to certainly not go over too much of what has already been covered, but this is pretty dense, there is a lot to it. So I may cover some grounds that have already been covered.

So first of all, can a person have a bulging disc in their back and not give any symptoms or not have any symptoms?

A. Yes.

Q. And the same question, can a person have a herniated disc in their back and not have any symptoms from that?

A. Yes.

Q. Okay, is it fair to say that those symptoms would usually come when there's some type of impingement on a nerve, as you have explained?

A. Yes.

Q. And are symptoms such as radiculopathy and pain

down someone's leg, I believe you testified earlier that that would be something that, at least one way of finding that out would be, it being reported to you by the patient themselves, correct?

A. Yes.

Q. And that would be a subjective symptom we discussed before, correct?

A. Yes.

Q. So to some degree, at least with regard to the symptoms being told to you by a patient, you had to take to leap of faith with what they are telling you is true; is that correct?

A. Yes.

Q. And you see patients who are both involved in litigation and/or who are not involved in litigation?

A. Yes.

Q. Is there any way you can approximate the percentage of how many of your patients are in litigation as opposed to not litigation?

A. It is hard to know. If you think about orthopedics and the things that we do in the absence of either congenital problems and pediatric deformities and adult degenerative deformities, everything else is about 60 percent, so of trauma.

So often times in trauma, as you know, there may be

litigation involved. Sometimes there isn't enough to tell overall.

Q. And I believe you've testified in lawsuits numerous times before in cases like this?

A. Yes.

Q. Can you estimate, approximately, how many times you testified in Court?

A. So I graduated medical school 30 years ago. I have been testifying for about 25 years or so. So five or six times per year on average.

Q. Okay, I know plaintiff's counsel asked at one point whether you have ever testified on behalf of defendants and I believe you said yes, correct?

A. Yes.

Q. Can you estimate, approximately, what percentage of the cases you have testified are for plaintiffs as opposed to defendants?

A. I would say -- I can't give you a number, but I would say a majority have been for plaintiffs versus defendants.

Q. Any way you can put a percentage on that or no?

A. Maybe 90/10.

Q. And with regard to patients in general, would it be fair to say that the different patients that you see have different motivations when you are treating them?

A. In terms of? I am not sure I understand that question.

Q. Okay, would different patients have different motivations in different settings, potentially, whether they are involved in litigation or not?

A. I am not -- I don't understand. When you are saying motivation, do you mean like they have different goals regarding what their expectations are for their treatment or?

Q. Well, let me ask it this way. Would it be possible that a patient who is involved in litigation might report subjective complaints differently than a patient who is not involved in litigation?

A. Patients in general can report subjective complaints in symptoms that vary depending upon their circumstances whether or not they are involved or not involved in litigation. Yes, I will say that patients can report what they are reporting to you based on their constitution.

Q. Okay. Now, with regard to Mr. Vivanco, we have established his accident occurred August 9th, 2017 and you first saw him August 5th, 2019, correct?

A. Yes.

Q. That is, approximately, two years later?

A. Yes.

Q. Okay and you have issued a report in this case. I am going to go through portions of it. Certainly not in as much detail as we have already gone through.

You issued a report on June 4th, 2021, correct?

A. I am going to pull it up here for you.

Q. Sure, feel free to reference it.

A. I have June 21, '21.

Q. When you first saw Mr. Vivanco in August of 2019, can you indicate -- well, I believe it's been established one of your recommendation the first time you saw him was to do another lumbar MRI, correct?

A. Yes.

Q. Okay, before that lumbar MRI was recommended, had you reviewed any other lumbar MRIs of his?

A. So he had had a lumbar MRI done in 2017.

Q. Right, when you saw him in 2019, had you reviewed that 2017 lumbar MRI at that time?

A. When I first saw him I didn't record the date of the MRI that I had reviewed, but I had reviewed the MRIs that he had brought into the office when I initially saw him. They were done at, I believe, one of the imaging networks that was accessible online. So I would be on their line main server and I would be able to see all their MRIs.

Q. Do you have any report in your file or anything in your file that indicates that you reviewed the August -- I

am sorry, the September 5th, 2017 MRI when you first saw him in 2019?

A. I do not have a copy of that report, no.

Q. Okay. So do you know for sure whether when you first saw him you had reviewed this September 5th, 2017 MRI?

A. Yes, I can't tell you with certainty if I did or didn't.

Q. After you saw him that first time, you referred him for an MRI which was therein conducted September 13, 2019, correct?

A. That is correct.

Q. And we have gone over the findings of that MRI in detail and had it up on the screen, but just so I am clear, essentially, what were the findings -- at the L4-L5 level, essentially, what were the findings of September 13, 2019 MRI?

A. So there was a disc protrusion appreciated at L4-L5 and also at L5-S1.

Q. At that time when you reviewed that 2019 MRI film, you don't know whether those disc protrusions existed at the time of the 2017 MRI because you had -- you are not sure that you reviewed them, correct?

A. Well, yes, I couldn't tell you with certainty if at that time I was making a comparison between '19 and '17.

Q. Okay, when making a determination on whether a

certain accident caused a certain injury, is it fair to say that it would be most important to see the MRI that took place closest in time to the accident?

A. It is helpful, but not necessarily mandatory.

Q. Okay. If an accident occurs in 2017, wouldn't an MRI taken, approximately, three weeks after that accident be more informative than an MRI taken two years after the accident?

A. Not necessarily, no.

Q. Why would that be?

A. Several reasons. The MRI that is taken immediately after the accident in the absence of a fracture or a dislocation may or may not show exactly what is happening to the patient. Plus the MRI film itself still needs to be correlated with what is happening to the patient clinically. Plus, any subsequent MRIs will also show you what the progression of any of those previous findings were.

So, when you do an MRI, the MRI is a little bit like a -- although there is no time stamp on the MRI, the MRI is a little bit like a time capsule because it tells you everything that has been happening to that patient up to that point in time when the MRI was taken.

So if you have degenerative changes on it you know that those degenerative changes had happened up until that point in time.

If you have a herniation and you have a patient with symptoms, you know that that herniation remains at the very least persistent and/or worse and/or progressive from whatever the previous one was.

Q. Right, but to establish an opinion on medical causation whether something is caused traumatically from an accident wouldn't it be crucial to see the MRI and review the MRI that occurred three weeks after the accident?

MR. ROSE: Objection.

THE COURT: Overruled. You can answer that, Doctor.

A. Sure. You know in this case there are several issues.

Q. I am asking in general.

A. In general, I would answer that question as not necessarily, no.

THE COURT: Why don't we talk about this case. You are not talking about general.

MR. FARRELL: That is going to be the next question.

Q. So before I get to that next question let me ask you, in this case, is there a reason why reviewing that 2017 MRI taken three weeks after the accident would not be as important or I don't mean misstate the words that you used, but why in this case would that not be essential?

A. Sure. Great question. Because he was coming to me from treating physicians who had been treating him for the accident over that preceding two years who had already made a recommendation for referral based on radiculopathy. So those previous treating physicians had been treating him for an underlying problem that he presented to me with that was consistent with their medical records.

Q. Understandable, but wouldn't it be best practice to look at that MRI yourself?

A. I did see the MRI here today. So I want to be clear that if I am going to opine, particularly in this setting in court on the record, that's why we reviewed that MRI to see whether or not it was consistent with all the other MRIs just to make one hundred percent certain that it was.

Q. Understandable, but --

THE COURT: One second. Go ahead.

Q. You have issued an opinion long before being here today that the accident is causally related -- I am sorry, that the injuries are causally related to the accident, correct?

A. That was -- well, let me put it to you this way, those opinions were based on the treatment that he was receiving from all of his treating physicians, including myself.

Q. Right. I understand.

A. So that was based on the underlying understanding that his injuries were causally related to that accident.

Q. Right, so just back to my question though, long before today you had made an opinion that his injury was causally related to this accident, correct?

A. I treated him based on injuries that were causally related to the accident, yes.

Q. You have indicated in your reports, as plaintiff's counsel has discussed with you, that prior to today that it was causally related to the accident, correct?

A. Within a reasonable degree of medical certainty based on everything that I was aware of, yes.

Q. Right. But I don't mean to misstate you, was today the first time you actually reviewed that September of 2017 lumbar MRI film?

A. Today is the first time that I can tell you I can swear to it with one hundred percent certainty because when I first saw him I did not indicate the dates of the MRIs that I looked at.

Q. Okay. Are you a licensed radiologist?

A. I don't have a -- radiology is not my primary specialty.

Q. Okay. Is it fair to say that the surgery that you recommended, which was performed in January of 2020, was

based upon the September 13, 2019 MRI in those findings?

A. In part.

Q. Is it possible for a patient to have an MRI at one point at and then an MRI two years later with different results?

A. Sure. MRIs can change, yes.

Q. And could potentially there be some type of intervening cause, something that happens in the time in between that turns into a different result in the second MRI?

A. Sure.

Q. Doctor, it seems obviously self explanatory, but the surgery that you performed was a partial discectomy, correct?

A. Yes.

Q. Explain what the difference is between a partial discectomy opposed to a full discectomy?

A. Sure. A partial discectomy only involves removing those portions of the disc that are touching or coming into contact with the nerves and not the entire disc.

Q. And I don't know if your operative reports indicate it, but is there any way to tell what percentage of the disc is removed in this particular case?

A. No.

Q. But in Mr. Vivanco's case the full disc was not

removed since it was a partial discectomy?

A. Correct.

Q. Is it correct that the procedure that was performed on Mr. Vivanco did not involve the installation of any plates or screws or any type of hardware?

A. Correct.

Q. Getting back to the records that you reviewed, at the time that you first saw Mr. Vivanco in 2019, do you know whether you reviewed any records in your file telling you whether you reviewed any records at any time in 2018?

A. No. I just indicated the doctors who had been treating him, their records and the physical therapy records, but I did not know of their dates.

Q. The same question with regard to 2017. Do you know, in your file, if you can confirm whether you reviewed any records from 2017?

A. Correct. I just reviewed the physicians and the treatings, but I did not record all the dates.

Q. I believe, if I understood the time line correctly, that the last time that you -- well, withdrawn.

You did see Mr. Vivanco in April of 2025, correct?

A. Yes.

Q. If I understood correctly, the last time you saw him before that was December of 2021; is that correct?

A. I am going to check for you.

Q. Absolutely.

A. That's correct, December 20th of 2021.

Q. Okay, and then your recent visit was on April 21st of 2025, correct, just a few weeks ago?

A. Yes.

Q. Is there any particular reason why you haven't seen him in that time period in between?

A. My understanding is either he has been stable and hasn't had any significant deterioration.

Q. And I assume that is a positive thing from a surgeon's standpoint?

A. Yes.

Q. Now, referring to your follow-up visit report from April 21st of 2025, I believe we covered this ground, but there seams to be -- can you tell me what the indication was with regard to his radiating symptoms in his lower extremities at this point?

A. Surgery had been helpful, yes.

Q. So at least for that particular aspect the surgery was considered a success?

A. Yes.

Q. And, your findings with regard to his ability to work when you had seen him last in 2021 was that he was 100 percent disabled, correct?

A. In 2021, yes. His previous occupation, correct.

Q. Correct. And now when you saw him in April of 2025, you placed him at a 50 percent disability, correct.

A. Yes.

Q. But it is your opinion light duty work he could do, would that be full time?

A. Sure.

Q. And it is your understanding that is what he is actually doing now, correct?

A. Yes.

Q. Do you have an understanding of when it was that he went back to work?

A. No, I don't have the date.

Q. When you had your visit with him in April of 2025, did he discuss with you or was there any discussion of whether he has any types of accommodations at work, special accommodations or anything like that?

A. No.

Q. Did he ask you for any type of note or anything for his employer to determine whether or not to ask for any types of accommodations or anything like that?

A. No.

Q. Are you currently recommending any cervical surgery for the plaintiff?

A. No.

Q. Are you currently recommending any lumbar surgery

for the plaintiff?

A. No.

Q. When plaintiff's counsel was questioning you there was some testimony about -- at one point you had, back in 2021 under "Future Care and Management" had stated that or did you make any recommendation then back in 2021 about whether he would need additional lumbar surgery?

A. We discussed trying to avoid any additional surgery.

Q. Right, but did you issue any reports or were in any of your notes where you indicate that he will need any future lumbar surgery and what the cost would be?

A. No.

Q. None of your notes in your file indicate from 2021 that he would require surgical intervention in the future in the form of a revision lumbar surgery at a cost of $125,000?

A. I think that we were trying to avoid that at all cost.

Q. Well, can you go to the last visit date from 2021 in your file?

A. Yes.

Q. And is there a paragraph that says, "Future Care and Management"?

A. No, I don't have that on this particular note. That may have been a supplemental note.

Q. Can you do me a favor? Take your time, look in your file and see if you have any supplemental note with "Future Care and Management" where you state that he will need surgical intervention in the future in the form of a revision lumbar surgery at a cost of $125,000?

A. I do not have that, but I am not recommending that at this time.

Q. That was going to be my next question.

Plaintiff's counsel asked you about the Life Care Plan and if you reviewed that?

A. Yes.

Q. If future lumbar surgery and treatment subsequent to that is included in the Life Care Plan, would that be necessary?

A. I just want to check the Life Care Plan for you and I did review it. I don't see future lumbar surgery in the Life Care Plan.

Q. Okay. But you are in agreement that, at least as things stand today, there is no recommendation for a future lumbar surgery, correct?

A. Correct.

MR. FARRELL: I don't have anything further, Doctor. Thank you.

THE WITNESS: Thank you.

MR. ROSE: Very fast.

THE COURT: Very fast?

MR. ROSE: Before lunch very fast.

REDIRECT EXAMINATION

BY MR. ROSE:

Q. Let's just back up about reading films, okay?

As a spinal surgeon do you have a custom and practice in regard to reading MRI films?

A. Yes.

Q. What is that?

A. To look at an MRI film for every patient that I am going to make a recommendation for.

Q. Why do you do that?

A. MRI films are subject to interpretation, so a radiologist will give you their interpretation or spin on the film. As a treating spinal surgeon, I had an opportunity not only to look at the film myself, but also to correlate it with the actual physical findings of the patient.

Q. Okay and this, I believe, is what we discussed at the beginning of your testimony when we were talking about reading films, correct?

A. Yes.

Q. And what we meant by that is that the image itself is objective, correct?

A. Yes.

Q. But someone's read on that film is something that is subjective, correct?

A. Yes.

Q. Meaning that you could have a different opinion than a radiologist, for example?

A. Yes.

Q. Have you ever met a spinal surgeon that didn't read their own films?

A. No.

Q. Neither have I. And let's just talk about 2017 and 2019 lumbar MRI films specifically.

Did you see any differences between those two films?

A. They were pretty consistent with each other. There was a herniation at L5-S1 with a defect or tear in the annulus at L5-S1. The only major difference was that L4-5 was in the subsequent MRI maybe sticking out a touch more than the previous MRI, but L5-S1 was pretty consistent.

MR. ROSE: Okay, Doctor. Thank you for your time here today.

THE WITNESS: Thank you.

MR. FARRELL: Nothing else. Thank you.

THE COURT: Okay, thank you very much, Doctor.

A couple of things, the four young ladies that you saw that got up and left, they are interns from the

interpreters' office, okay?

And at this point in time we are going to take our lunch recess. Please continue to keep an open mind. Do not talk about this case amongst yourselves or with anyone else.

Inside this courtroom we can't get to see outside. It cuts down the noise, but I am assuming it is a beautiful day, okay. Have a wonderful lunch. Please be back in the jury room at 2 p.m. and we will pick it up shortly thereafter. Thank you so much.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Okay, we are in recess until two o'clock. All right. Thank you.

* * * *

(At this time, a luncheon recess was taken, and the trial adjourned to 2:00 p.m.)

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

COURT CLERK: Raise your right hand. Do you swear or affirm that the testimony you about to interpret from English to Spanish and Spanish to English will be to the best of your ability?

THE INTERPRETER: Yes.

COURT CLERK: State your name and title for the record, please. And spell it.

THE INTERPRETER: My name is Efigenia Placeres E-F-I-G-E-N-I-A. Last name P-L-A-C-E-R-E-S. Spanish interpreter.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom and is seated in the jury box.)

THE COURT: Everyone, please be seated. Do both sides stipulate that all the jurors are present and properly seated?

MR. ROSE: Yes, Judge.

MR. FARRELL: Yes, your Honor.

THE COURT: Good. We are continuing with the plaintiff.

MR. ROSE: Yes, your Honor.

THE COURT: Okay, sir.

MR. ROSE: Mr. Vivanco will re-take the stand.

THE COURT: Sir, you are reminded you are still under oath.

THE WITNESS: Okay.

THE COURT: Please be seated.

MR. ROSE: Thank you, your Honor.

THE COURT: Do you remember where we left off?

MR. ROSE: I think I do.

THE COURT: Psychological treatment.

DIRECT EXAMINATION

BY MR. ROSE:

Q. Good afternoon.

A. Good afternoon. Good afternoon to everyone.

Q. So I would like to show you what we have marked as Plaintiff's Exhibit 16 in evidence.

Do you recognize what is shown in that photograph?

A. Yes.

Q. When was that photograph taken?

A. August 9th, 2017.

Q. What does that photograph show?

A. That was the day that I was in the emergency room at the hospital after the accident.

MR. ROSE: Your Honor, may we publish this photograph to the jury, please.

THE COURT: Yes.

(Whereupon, the exhibit is published to the jury.)

MR. ROSE: Thank you.

Q. Mr. Vivanco, how were you feeling at that point in time?

A. I was disconcerted because of everything that had happened and I had a lot of pain in various parts of my body.

Q. Now, we are going to fast forward to where we left off yesterday.

A. All right.

Q. To remind you we were discussing your psychological treatment?

A. Okay.

Q. Can you give the jury a sense of how much psychological treatment that you have had as a result of this accident?

A. I requested and solicited psychological treatment because after assessing the extent of the physical damages.

Q. How many different medical providers have you seen for psychological treatment as a result of this accident?

A. Two doctors.

Q. Okay, who was the first one?

A. Doctor, female doctor, Miller.

Q. Now, approximately, how many times would you say that you saw Dr. Miller?

A. Approximately four months, but it wasn't with seeing her directly, but with the other persons in her personnel.

Q. Okay, how many times would you say that you were treated at that office?

A. I would make an estimate of about around 30 times.

Q. Were you prescribed any medications for the issues, the psychological issues, that you were suffering from as a result of this accident?

A. Yes. Yes, I did receive medications.
Q. What types of medications did you receive?
A. I don't remember the name of the medication, but it was to control anxiety, insomnia, depression.
MR. ROSE: And so I am sorry, could I have the answer read back.
(Whereupon, the previous question was read back.)
Q. So insomnia, fair to say you were having trouble sleeping?
A. Yes.
Q. What was that like for you?
A. Because of the matter of what could have happened. Because if that thing that fell on me had fallen on my body it could have killed me instantly.
Q. Now, who was the other psychiatric professional or practice that you saw as a result of this accident?
A. I remember the name, it was Dr. Nuttman.
Q. And again, what were you seeing Dr. Nuttman for?
A. For the same symptoms.
Q. And describe those?
A. I had panic attacks all the time and anxiety. I was unable to fall asleep. Great deal of headaches. For the same reason.
Q. And how long were you treating with that office?

A. Honestly, I don't remember how long exactly, but, approximately, six months.

Q. Was that treatment helpful for you? And what I mean by that, collectively, the psychiatric treatment that you had following this accident, is that something that helped you?

A. Up to this date, even through now, I am taking medication to be able to help me to sleep and for the anxiety.

Q. Okay. And so, let's talk a little bit about the anxiety. Can you describe for the jury what that feels like for you?

A. I think of a lot of things and I am thinking them over in my mind. First of all, it is the trauma that the accident has caused. And the second is the issue of how much am I going to be able to continue providing for my home and my family. We live in a situation now where if we cannot work we cannot survive.

Q. Okay, now, let's now turn back to your medical treatment for your physical injuries?

A. Okay.

Q. Now, I believe we discussed a Dr. Ratzker; is that correct?

A. Correct.

Q. And Dr. Ratzker was also a spinal surgeon just like

Dr. Merola; is that correct?

THE INTERPRETER: I am sorry. The other doctor's name?

MR. ROSE: Merola.

A. Yes, that is correct.

Q. Did Dr. Ratzker make recommendations to you regarding whether or not you needed surgery on your lower back?

A. Yes, that's correct.

Q. What were those recommendations?

A. He told me that I have a lesion to my lower back and he recommended fusion.

THE COURT REPORTER: I am sorry, I didn't hear the beginning of that.

THE INTERPRETER: He told me I have a lesion in my lower back --

MR. ROSE: Lesion was the word he used?

THE WITNESS: Yes, he saw an injury in my lower back.

MR. ROSE: I just didn't hear what you said.

THE COURT: There was more to it.

He saw an injury to your lower back.

A. The doctor reviewed the medical records and he had noted that there was a lesion to the lower back and he recommended surgery.

THE COURT: What type of surgery?

THE WITNESS: He recommended fusion.

Q. Then you saw Dr. Merola after that; is that correct?

A. Correct. That's correct.

Q. Thank you. Now, let's turn our attention to --

MR. ROSE: I am sorry, one second, please.

THE COURT: Counsels, can I see you for a second.

(Whereupon, an off-the-record discussion was held.)

THE INTERPRETER: In the best interest of getting verification as to the word I am not exactly sure about, I would like to have access to my cell phone for verification. Would that be possible?

THE COURT: Yes, please.

MR. ROSE: Could this be done --

THE COURT: No, let's do it right now. Do you need to speak to someone? You can go in the hallway.

MR. ROSE: May we approach?

THE COURT: Yes.

(Whereupon, an off-the-record discussion was held out of the presence of the jury in the hallway).

THE COURT: Okay, the reason why we are having this meeting outside of the presence of the jury is

because there seems to be a question with regards to the translation of a word "lesion".

THE INTERPRETER: Yes.

THE COURT: Okay, now, I heard two things come out. I heard lesion and I also heard injury.

THE INTERPRETER: Correct.

THE COURT: Now, our interpreter would like to confer with a colleague to get it right and I think that is absolutely appropriate. Because, again, I don't know, he is from Ecuador and I do know there are differences with regard to the Spanish language, like there is with English.

THE INTERPRETER: Yes, your Honor, I believe that is true. But it also is an issue of both translations would be correct. Perhaps some fine tuning done by the questioning of the attorney could also remedy the issue.

In other words, a follow-up question.

THE COURT: Yes.

MR. ROSE: That was going through my head as well as you were speaking.

THE COURT: I will permit you to do that. It is up to you, I think you should do it right now because this is the issue we are dealing with. And since we are dealing with an interpreter here, I will permit you to

lead for this purpose only.

MR. ROSE: Okay, thank you, your Honor.

THE COURT: Okay, thank you.

MR. FARRELL: Fair enough.

(Back in open court in the presence of the jury).

Q. We are going to go back to Dr. Ratzker questions for a moment.

You discussed your injuries with Dr. Ratzker, correct?

A. Yes.

Q. Did you discuss with Dr. Ratzker whether or not your injury to your back was caused by this accident?

A. Yes.

Q. And what did he tell you?

A. That it was a severe injury and that I would have to do repairs through a surgery.

Q. Did he tell you -- so injury, so does that mean to you that it was caused by the accident?

A. Yes.

Q. Okay.

THE COURT: Well.

MR. ROSE: If you would like to clarify, your Honor, please.

THE COURT: Yes, I think I should. The word

lesion was used. The question is, the way you are using it, does it mean injury or does it mean a disease that was there from before?

THE WITNESS: The injury as a result of the accident.

THE COURT: Okay.

MR. ROSE: Thank you for asking that question, your Honor.

Q. Okay, now, we are going to turn our attention back to your knee. We were talking about it yesterday.

A. Okay.

Q. Right, so just to give time frame, knee surgery was the end of November, 2017, correct?

A. That's correct.

Q. What was the condition of your knee leading up to the time of the surgery?

So let's go, how you felt right before your knee was operated on. I would like the jury to understand that.

A. I was unable to move my leg nor to set my foot down on the floor.

Q. Then did you ultimately end up having surgery for -- well, which knee was it? Just to remind everyone.

A. The left knee.

Q. Same leg that was struck by the beam?

A. Yes.

Q. Who performed the surgery?
A. Dr. Michael Seidenstein.
Q. After you had the surgery, did you have to use crutches for a certain period of time?
A. Yes.
Q. Now, you were still having problems with your back and your neck at that time; is that correct?
A. That's correct.
Q. How was it for you to use crutches when you still had the other difficulties?
A. Recommendations that were made by pain management was to do only one at a time.
Q. Did you have difficulties using the crutches?
A. Yes.
Q. Physical therapy, did you do physical therapy following the knee surgery?
A. Yes.
Q. And still going to pain management during that period of time as well?
A. Correct.
Q. Okay, now let's turn your attention to your shoulder.

To give the jury a time frame, your shoulder surgery was in April of 2018; is that correct?
A. That's correct.

Q. Okay, so same questions that I just asked about the knee.

Let's take, for example, the week before your shoulder surgery, how was your shoulder doing during that period of time?

A. I remember that the shoulder took longer to heal.

Q. Okay, so let me just be clear about my question. Right before your shoulder surgery, how did your shoulder feel?

A. I always felt as if it was torn. I would also have a great deal of difficulty lifting the shoulder.

Q. Okay. You have the shoulder surgery in April of 2018, correct?

A. Correct.

Q. Who performed the shoulder surgery?

A. The same orthopedic surgeon, Michael Seidenstein.

Q. Following the shoulder surgery, did you undergo physical therapy?

A. Yes.

Q. Were you still undergoing pain management?

A. Yes.

Q. Now, you began seeing Dr. Merola; is that correct?

A. Correct.

Q. Okay, and now we are talking about your neck and your back to give you perspective?

A. Neck and back, correct.

Q. What were your physical complaints at that point in time when you started seeing Dr. Merola?

A. It was a lot of pain. A lot of pain in my back and I was having spasms in my neck.

Q. Leading up to that period of time, what type of medical treatment were you having for your neck and your back?

THE INTERPRETER: Repeat the question.

(Whereupon, the previous question was read back.)

A. Only physical therapy before the surgery.

Q. Any injections?

A. Yes.

Q. Could you speak about that, please?

A. Pain management recommended injections to deal with that problem.

Q. Did you have those injections?

A. Yes.

Q. What body parts did you have those injections to?

A. All the injuries, my neck, the shoulder, the back and the knee.

Q. Would the injections help you when you had them?

A. During some days after the injection, yes, they would lessen and it would help.

Q. Then what would happen after that?

A. The problems would revert to like before with regards to the pain.

Q. Do you recognize the name Dr. Edwin Perez?

A. Yes.

Q. Who is Dr. Perez?

A. He is the doctor from pain management also. And I saw him after having seen Dr. Colon.

Q. During this time period, from the time of the accident up until -- now we are right around 2019, 2020?

MR. ROSE: I am trying to break it up so that you can translate.

THE INTERPRETER: Please repeat the question.

MR. ROSE: Okay, I am going to withdraw the question and reask it if it is okay. I am not sure if it is clear.

Q. From the time the accident happened up until 2020, were you taking medications?

A. Yes.

Q. What types of medications were you taking during this time period?

A. A number of them. Many. Usually they were for pain, to reduce pain and for the problems that I had with pinched nerves.

Q. Were the medications helpful for you?

A. Temporary. A matter of hours.

Q. You began seeing a doctor named Dr. Katzman; is that correct?

A. Correct.

Q. What were you seeing Dr. Katzman for?

A. He is an orthopedic, that type of doctor. And it was for the shoulder and for the knee.

Q. Okay, were you seeing Dr. Katzman for the same reasons that you had been seeing Dr. Seidenstein?

A. Yes.

Q. When you began seeing Dr. Katzman, did you stop seeing Dr. Seidenstein?

A. Yes.

Q. Okay, what type of medical treatment did you receive from Dr. Katzman?

A. It was for pain medication and he made a recommendation for physical therapy.

Q. Did you do additional physical therapy?

A. Yes.

Q. So, there was a point in time where you ended up going forward with your back surgery; is that correct?

A. Correct.

Q. And that was in January of 2020; is that correct?

A. Correct.

Q. That was with Dr. Merola, correct?

A. Correct.

Q. Okay, so same thing, let's talk about how your back felt that week right before you had the surgery.

So I want the jury to understand how your back felt right before the back surgery.

A. I was unable to -- I could not bend. I could not squat and I had a great deal of pain in my lower back.

THE INTERPRETER: Your Honor, I would request that he would respond one more time for me, please.

THE COURT: Okay, can you answer again?

A. I cannot bend and I could not also bend forward, squat. And pain to my lower back was very intense. It was a great deal of pain to my lower back.

Q. Why did you decide to have the back surgery?

A. Two doctors had already told me and had both diagnosed that I had to do the same thing.

Q. After the back surgery, did you resume physical therapy?

THE INTERPRETER: Repeat that, please.

MR. ROSE: Yes, sure. Read it back, please.

(Whereupon, the previous question was read back.)

A. Yes about two months after the surgery.

Q. Did you resume pain management?

A. Yes.

Q. So, now let's just talk in general terms.

Following the back surgery --

MR. ROSE: I am sorry. May I withdraw that, your Honor?

THE COURT: Yes.

MR. ROSE: Can we take a break at any point?

THE COURT: I am just waiting for the right time.

Do you need a break now?

MR. ROSE: That would great.

THE COURT: Okay.

Jurors, we will take a recess right now for ten minutes. It is three o'clock, so we will be back in the courtroom at 3:10. Please continue to keep an open mind. Do not talk about this case amongst yourselves or with anyone else. Thank you.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and a recess is taken.)

THE COURT: Let's get the jury back.

COURT OFFICER: All rise. Jury entering.

THE COURT: Welcome back. Everyone, please be seated.

Do both sides stipulate that all jurors are present and properly seated?

MR. ROSE: Yes.

MR. FARRELL: Yes, your Honor.

THE COURT: And jurors, before you leave here today I am going to tell you what the schedule is.

Okay, you may proceed.

MR. ROSE: Thank you, your Honor.

Q. In 2021, 2022, You are still seeing pain management doctors, correct?

A. Yes.

Q. Still having physical therapy?

A. Yes.

Q. Still having seeing orthopedists, correct?

A. Yes.

Q. So then it is Katzman during this time period, correct?

A. Yes.

Q. Okay, now, what were your physical complaints during that time period? Let's start with your neck.

A. With regards to my neck and the injury to my neck, the pain would get continuously worse as the days went on. And I started to feel like pin pricks in my elbow because my nerves were pinched.

My spasms to my neck were more frequent. The shoulder felt weaker as if it was more sensation of being torn. And my lower back, the pain to that area stayed the

same as from the very beginning. The thigh in my left leg, I started to have more problems to that area.

With regards to my knee after the surgery, the knee was weakening and it was also less able to bear the weights.

Q. Were you still having issues or difficulties sleeping?

A. Yes.

Q. Okay, still having issues with anxiety?

A. Yes.

Q. Now, there came a point in time in around 2023 where your medical treatment slowed down?

A. Yes.

Q. Can you tell the jury why that happened?

A. Throughout the process there had been difficulties or problems with Workman's Compensation with regards to payments made for therapy or surgery, the treatments for that purpose. And also medication.

Q. Now, at some point in time did you make a decision that you were going to try to go back to work?

A. Yes.

Q. Okay and what steps did you take in order to get yourself back to work?

A. It was my obligation to take that determination or decision. The pain and the injuries were still there and we had many difficulties in my home because of the economic

issues. I had no other option. I had no other choice.

Q. When was that time frame, was that 2024?

A. Yes.

Q. Did you do any course work or take any additional education in order to get yourself to a point where you could do a new job?

A. Because of my injuries I was forced to look into and consider another work environment. And I made the decision to take a course in manufacturing.

Q. Could you tell the jury about that course?

A. It has to do with manufacture and the computers that work doing that. Small parts and measuring small parts.

Q. How long did this course work take you?

A. The October semester was in 2023.

Q. Now, how did you find this course?

A. Not all universities or colleges provide these types of courses so I had to look into it on the Internet.

Q. And why did you choose this type of course work?

A. I saw that I would -- I considered that I would be drawn to it since I had throughout my whole life been drawn to technical things.

Q. How do you feel about no longer being able to work in the construction field?

A. First of all, it is the economic impact. Because

where I am working right now I have had to start from the zero, from the lowest possible point.

Q. What else?

A. It is also with regards to my ability and my abilities that I used to have before. For example, with regards to picking up things that are heavy.

Q. How does it make you feel that you can no longer do construction work?

A. I feel frustrated because before I was able to do the type of job that resulted in making more money. Now what I am trying to do is continue with my life and go forward, not withstanding what happened to me.

Q. When did you go back to work?

A. March 2024.

Q. Are you still working in the same job?

A. Yes.

Q. So one job since you have been back to work?

A. Yes.

Q. What is the name of the company?

A. Magellan Outer Space.

Q. Could you tell the jury a little bit about what you are doing now?

A. It is a machine that is computer -- the use of the computer is what makes it work. And the way it is is that I control it through the computer and I inspect the parts that

are made by it.

Q. Do you lift anything heavy?

A. Honestly, that job is not very requiring me to pick up something very heavy.

Q. How does it make you feel to be working again?

A. I feel that I am reintegrating into real life because I have been out of it as a result of the injury for so long.

Q. Now, let's talk about your current complaints of pain.

What are your current complaints of pain?

A. I feel like what I would characterize as a hole in the my back of my neck, close to the back of my head and this results in my having muscular spasm at least two times per month. And this affects me when I want to drive, when I want to speak to somebody. And when they present themselves at night when I am in bed someone has to assist me to move, otherwise I am unable to do that.

With regards to the shoulder I still feel that tear there. The orthopedist recommended a new surgery and I asked him what guarantee of this is there. And he explained that could not give me a guarantee. And therefore, I decided not to continue doing that.

With regards to my lower back, the pain still remains there. That discomfort remains there. And the

thigh, the left thigh where the beam fell on, there has been a surge of new injuries that have presented themselves that are now permanent. And it makes it impossible for me to lean forward to try to pick something up. And if my left knee, when I am standing for let's say a period of two hours, the knee bends forward, it bends backward. And when I am walking down the street the knee is out of joint. Seems to be out the joint.

I have since then used, all of the days of my life, a brace for me knee. And I have also used a brace for my neck and the stimulator for my neck.

Q. Okay, how do your injuries now impact your ability to enjoy the activities that you enjoyed before this accident happened?

A. It has been a drastic change that has occurred in my life. Before, as I explained yesterday, I was a sports man. I was a family man. I was a worker and I spent time and enjoyed it with my family. After the accident I haven't been able to do anymore of those activities. It has impacted me socially, economically and with my family. And emotionally.

Q. Is there anything else you think this jury should know?

A. I would simply like to say that I have been traumatized because of this incident. They could have

killed me. I think that it is a miracle that God gave me another opportunity, another chance. I have been trying, but now that I am reinvolved with the society, to present the best version of me and everything that I do in everything.

There has been eight years of suffering since the accident until now. I lost my daughter's childhood all together. And I lost my son's youth. And there is no price that could be affixed to that.

Tomorrow or the next day I will have to have operations to my neck and I am worried about the money to be able to have this operation. And I am worried that once again I will be disabled. And I am worried that I might lose this job. And I don't have much hope for the future.

And if I am sitting here today, I would like to say to the jury and to your Honor, we are only here to get justice. What could have happened if I had lost -- died, because of that accident? What would have happened to my family and my children?

And that is all. Thank you.

MR. ROSE: Thank you.

THE COURT: Okay, cross-examination?

MR. FARRELL: Thank you, your Honor.

CROSS EXAMINATION

BY MR. FARRELL

Q. Good afternoon, Mr. Vivanco.
A. Good afternoon.
Q. As a result of this accident, did you break any bones in your body?
A. No.
Q. As a result of this accident and the surgeries that we have heard about, have there been any plates or screws or anything like that put in your body?
A. No, but the doctors did attempt to do that.
Q. Which doctor attempted to do that?
A. Dr. Ratzker.
Q. Do you mean he made a recommendation about that?
A. Yes.
Q. Okay, when you say he attempted to do that, you don't mean he actually tried a surgery?
A. The doctor recommended fusion.
Q. Okay. That was not done, correct?
A. No, because I went to get another opinion with Dr. Merola.
Q. And did you just see Dr. Merola in April of 2025?
A. That's correct.
Q. And did Dr. Merola tell you that you do not need surgery on your neck of any kind?
A. In April of this year he did not recommend operation.

Q. And did he, in April of this year, recommend any operation to your back?

A. No.

Q. I am going to try not to cover any ground too much that we have covered before.

Going back to your time in Ecuador, did you work for a company there by the name of Indurama?

A. Yes, that's correct.

Q. How many years did you work for Indurama?

A. Eleven years. A little over.

Q. Okay, and what type of work did you do for Indurama?

A. We would construct matrixes and --

THE INTERPRETER: I am sorry, your Honor, I need a clarification.

A. Molds so that we can construct stoves and refrigerators.

THE INTERPRETER: Sorry, I needed a clarification.

Q. If I understand correctly, you were involved in constructing molds for machine parts?

A. Not directly. We would make molds --

THE INTERPRETER: I am sorry, your Honor. I need a clarification from the witness, please. May I have it?

THE COURT: Okay.

THE INTERPRETER: Your Honor, he is indicating that the translation for molds M-O-L-D-S in Spanish would be molds and dies.

Q. Was that involved in the process of making parts for, I think you said, refrigerators?

A. Yes.

Q. And stoves did I hear?

A. Yes, that is correct.

Q. Would any part of your job in doing that involve computer work?

A. Very little.

Q. While you were working at Indurama, did you have any other benefits other than getting paid?

A. No, it was only the salary.

Q. No health benefits or anything like that?

A. Social Security.

Q. Okay, while you were there, did you work with blueprints at all?

A. We did have some contact with blueprints.

THE COURT: Why don't we clarify something. You mentioned Social Security, is the Social Security in Ecuador, is it medical insurance while someone is working?

THE WITNESS: They provide access to doctors

and medication.

THE COURT: Okay. Thank you.

MR. FARRELL: Thank you, your Honor.

Q. While you were at Indurama, did you work with any particular types of computer software?

A. No. I don't remember that.

Q. Okay, did you obtain any other types of certificates while you were in Ecuador?

A. Yes, many.

Q. Did you obtain a certificate in electrical installations?

A. For machinery. Not for buildings or homes.

Q. Did you obtain a certificate in repairing motors?

A. Yes.

Q. And did you obtain a certificate in something called Autodesk?

A. That's correct.

Q. What is Autodesk?

A. It is computer generated drawings.

Q. You had that certificate at the time you left Ecuador to come to the United States?

A. Correct.

Q. Were you also a licensed welder in Ecuador?

A. I had taken courses for welding, but I did not receive the certification or certificate.

Q. Okay. When you started to work at Steelfab, were you paid in cash, checks something else?

MR. ROSE: Objection. May we approach, Judge?

THE COURT: Yes.

(Whereupon, an off-the-record discussion was held.)

MR. ROSE: Your Honor, I withdraw the objection.

THE COURT: Okay. Could you read back that last question?

(Whereupon, the previous question was read back.)

MR. ROSE: Objection to the extent as to how he was paid.

THE COURT: Okay, overruled.

MR. ROSE: You understand what I am saying?

THE COURT: Yes. Overruled. You can answer that question?

A. In cash.

Q. And would you be paid hourly or something else?

A. It was salary and hourly basis.

Q. And Steelfab was steel erection work, correct, essentially?

A. That's correct.

Q. If there were in New York a snow storm or bad

weather or things like that, was there days where there was no work?

A. There would be no work when it would rain or snow.

Q. He when there were days that you wouldn't work, would you get paid for those days?

A. I would like to bring up something and make clear. They had a number of buildings, when it would rain or it would snow we did not install the outer, the outside beams. But we would go and we relocate to another building to do interior work.

Q. In all the time that you worked for Steelfab, were there ever times where there was no work to be done on a certain day?

A. Yes.

Q. If there was a day that you had no work to do, would you get paid for that day?

A. No.

Q. You would only get paid for the days that you would work?

A. That's correct.

Q. It was hourly, correct?

A. That's correct.

Q. Okay, you currently work at a place called Magellan Outer Space you said, correct?

A. That's correct.

Q. And do you work there five days a week?
A. Yes.
Q. Do you get paid for holidays?
A. Yes.
Q. How are you paid at Magellan?
A. Direct deposit.
Q. Do you get paid, at Magellan, a salary or do you get paid hourly?
A. Per hour.
Q. How much per hour are you paid?
A. Right now I am getting paid $26.00.
Q. And what were you getting paid per hour at Steelfab?
A. $23.00, but you must remember that that was in 2017.
Q. Right. And there were certain days where you wouldn't work and wouldn't get paid, correct?
A. Yes.
Q. Where is Magellan Out of Space located? Where you work?
A. They have a number of locations.
Q. Do you work in one specific location or do you go to different locations?
A. Only one location.
Q. Where is that you go to?

A. In Queens.

Q. And you go there five days a week?

A. That's correct.

Q. How do you get there each day?

A. On three days my wife drops me off and picks me up. But sometimes the whole week. And one or two days I go on my own.

Q. When you go on your own how do you get there?

A. Driving.

Q. Can you describe for me on a normal day of Magellan what you do?

A. My schedule work day starts at 6 a.m. And I use a computer to control the machine and I verify that everything is in order. Some parts take two hours to be fabricated, some take three hours. When the part comes out I have a desk where I work to confirm the measurement of the parts. And that is the whole job.

Q. Okay, I am sorry if you answered this, but what other parts, parts of what? With is it again that you are manufacturing?

A. These are parts for airplanes, basically.

Q. Do you have a title, a job title there?

A. It is something that I am not aware of what it is.

Q. Okay, do you have a supervisor there?

A. Yes.

Q. And in the office that you or the location that you work at, can you estimate, approximately, how many employees work there?

A. There are about 50 people in the plant.

Q. And other than your salary, do you receive any other benefits there like health benefits?

A. No, no. Not that.

Q. Is your wife employed?

A. Yes.

Q. Does she have health benefits through her employer?

A. No. No.

Q. Does Magellan offer health benefits?

A. I remember that when I went into start working with them they offered them to me, but I did not accept them because I have my own health insurance.

Q. You have your own health insurance currently?

A. Yes, I do have medical insurance.

Q. That is not provided through your employer, is it?

A. No.

Q. Are you referring to Workers' Compensation benefits?

A. No.

Q. Okay, are you just paying out of pocket for health insurance benefits?

A. No.

Q. If you can explain to me how it is that you have health insurance benefits?

MR. ROSE: May we approach? Objection, your Honor.

THE COURT: Yes.

(Whereupon, an off-the-record discussion was held out of the presence of the jury.)

THE COURT: I have gotten a lot of surprises before in a trial. This one came from -- not even left field. This came from out of the ball park.

MR. ROSE: The only thing I would remotely suspect is maybe that there is a government benefit here.

THE COURT: We can't suspect. I take it you did not know?

MR. ROSE: That's correct.

THE COURT: Okay, so.

MR. ROSE: I also question that maybe --

THE COURT: There is nothing for any of us to do. You can continue with your cross-examination.

MR. ROSE: My only concern is that there is something here that could be said that could prejudice the jury that wouldn't be admissible. I would suggest an offer of proof outside of the presence of the jury, your Honor.

THE COURT: Offer of proof as to what?

MR. ROSE: As to what let's find out what it is.

THE COURT: That is what cross-examination is for.

MR. ROSE: I am just making a suggestion. It is not my courtroom.

THE COURT: It is not mine either. It is the taxpayers. I just work here.

So you can ask your questions, okay? Ask him where this insurance is from.

MR. ROSE: Yes.

MR. FARRELL: I think I did. He says he doesn't really know. I will reask to try to clarify. I am very confused.

THE COURT: That is the only way to do it is on cross.

MR. FARRELL: That is fine. I have no problem doing that.

THE COURT: Okay, let's go back.

(Whereupon, back in open court in the presence of the jury).

THE COURT: Okay, JeanMarie, when you are ready can we have the last question and answer read back, please.

(Whereupon, the previous question and answer was read back.)

A. It is an ordinary type of health insurance like Medicaid. It is similar.

Q. Is it through a particular company?

A. I don't know exactly how insurances operate, but it is Health First.

Q. Health First?

A. Health First.

THE COURT: Is that a government assisted program?

THE WITNESS: Sincerely I can't tell you because I am unsure. My wife is the one who helps me with these things.

THE COURT: Okay.

Q. And if you have a medical appointment now is it covered, at least in part, by Health First?

A. With regards to the accident, no. But usually with any other kind of medical needs, yes.

Q. So currently if you go for a procedure, or not a procedure, or check up for your back, who, if anyone, pays for the care?

A. The doctor that where I am going to and be seen knows about the accident and if it has to do with something regarding the accident, he would request that I bring in

documents or proof of documentation about it because they want payment for what they do. And my insurance does not cover anything that is related to the accident. Anything that is not regarding the accident they do cover.

THE COURT: Let's say you have come down with the flu, would they cover that?

THE WITNESS: Yes. Definitely they would.

Q. Did you say that Magellan has or when you first started working at Magellan, they have healthcare coverage that they offer to you?

A. Yes.

Q. And you turned it down?

A. That's correct.

Q. Do you know if their healthcare coverage would cover you for a back appointment or neck appointment?

A. I couldn't tell you.

Q. Okay. Since you have returned to work at Magellan, have you had to take any medical leave of absence or missed time for work because of your medical conditions?

A. I have gone to the doctor on a couple of occasions and I do remember that they gave me sick leave for three days. But I did not use them and I kept on working.

Q. So is it fair to say you have been able to work steadily at Magellan since you started working there?

A. Yes.

Q. Is it your hope to stay working there?
A. Yes.
Q. Is there any chance for promotion and different levels that you could move up at Magellan?
A. I wouldn't be able to tell you that since I don't know. It is has been too little time. I'm new.
THE INTERPRETER: Your Honor, would now be a good opportunity time for us to switch out the interpreters?
THE COURT: Yes.
(Whereupon, Jacob Lipshitz took over translating English to Spanish for the plaintiff.)
THE INTERPRETER: Jacob Lipshitz, Spanish interpreter.
Q. For your work at Magellan, did they provide you with any special accommodations at work?
A. What do you refer to?
Q. Do you have any special accommodations due to your medical conditions that they accommodate you for?
A. When the person that I started interviewing from the beginning I told him something about the accident, but not in detail because I was afraid of not getting a contract. And whatever I do there it is quite light.
Q. So you don't get any particular accommodations that other workers don't get?

A. They don't do it, but I know if I request it that the company would provide it.

Q. I believe you said you started you start 6:30 in the morning; is that correct?

A. Six o'clock sharp.

Q. And what time do you end your work day there?

A. At 2:30.

Q. That is five days a week?

A. Correct.

Q. While plaintiffs counsel, your attorney, was questioning you, you had talked about after your accident having insomnia, some anxiety and depression; do you recall that?

A. Yes.

Q. And was a significant portion of that because fear for family and making sure that were provided for?

A. That's correct.

Q. Isn't it true at Magellan you are now earning more money than you were making when you were at Steelfab?

A. I would like to explain something.

Q. Sure.

A. In 2017 I was earning $23.00 an hour. Right now if I wouldn't have gotten -- if the accident wouldn't have happened, I would be easily making $40.00 or more. If we make comparison now today I am earning $26.00 an hour.

Q. But you said you are new at the company. Correct?
A. Yes.
Q. And you said you don't know whether they -- they do have managers and supervisors there?
A. Yes.
Q. They provide health insurance?
A. I don't know.
Q. They provide light duty work for persons like yourself?
A. Yes.
Q. Paid holidays?
A. Yes.
Q. And you said you don't know whether there is room for advancement, but you would you hope to be able to move up the chain in the company at some point?
A. I hope, but I don't know it.
Q. I believe you used the phrase that when you were asked about how you feel about working that it feels good to be back integrated into real life; is that what you said?
A. Yes.
Q. Explain that to me a little bit about what you meant by that?
A. When the accident happened I spent six-and-a-half years with the crutches, with a cane, braces in my neck. Up to today I still have braces on my legs. I missed a lot of

family moments, invitations. I had a lot of problems due to that. I was in bed or I couldn't go out for long periods of time. There was a certain point where I decided by myself to try to do things by myself. I saw my children and I wanted to do as much as possible for them.

Q. The question though is now that you are back working at -- let me finish the question.

Now that you are back working, do you feel that you are back integrating into life?

A. Yes.

Q. And is the fact that you are back working, at least to some degree, eased the anxiety of the financial burdens?

A. No.

Q. So the fact that you are back working hasn't changed the anxiety of the financial burden at all?

A. Nope.

Q. At the time of your accident, did you have a primary care physician?

A. I don't recall that year.

Q. Do you currently have a primary care physician?

A. Yes.

Q. Did I hear you correctly yesterday when you were asked about how you knew what doctors to go to after Kings County Hospital; what was your answer?

A. Can you repeat it, please.

Q. Sure. It was a bad question.

After your accident you went to Kings County Hospital, correct?

A. Yes, correct.

Q. And then you have had a significant amount of treatment since then?

A. Yes.

Q. How did you know what doctor to go to after Kings County Hospital?

A. After that I received a large bill at home. I was worried and they told me from the hospital to look for -- to get a lawyer so he could help me to cover those bills. In the emergency -- at emergency they told me to look for specialist and as I didn't know anyone or nothing I asked the lawyer to recommend me a specialist so they should review me.

Q. So the first doctor you went to after King County Hospital was recommended by your lawyer?

A. That's correct.

Q. And which doctor was that?

A. Charles DeMarco.

Q. Did your lawyer recommend to you any other doctors other than Dr. DeMarco?

A. Majority of the doctors were recommended by the lawyer.

Q. The majority of the doctors; is that what you said?
A. Yes.
Q. Does it make you feel proud and happy, the fact that you have gone back to work?
A. Hundred percent.
Q. With regard to your left knee, can you tell me when was the last time it was that you had an MRI on your left knee?
A. I think it was last year.
Q. And have you had any injections in your left knee?
A. Before.
Q. Before what?
A. Before the last MRI.
Q. Okay, in total, from the date of your accident until present, how many injections have you had in your left knee?
A. Only the left knee?
Q. Yes.
A. Three.
Q. Have you had any injections, at all, to your right shoulder?
A. Yes.
Q. How many, since the date of your accident, how many injections have you had in your right shoulder?
A. Three.

Q. And with regard to your left knee, do you know what year that last injection was?

A. No.

Q. The same question then on your right shoulder. Do you know what year the last injection was?

A. No, not exactly. Not.

Q. For your lower back, I know you have had injections, how many injections have you had in your lower back since the accident?

A. I receive packages of -- two packages of three and three.

Q. So six total since the accident?

A. Yes.

Q. Do you know when the last one was?

A. No.

Q. For your cervical spine, how many injections have you had since the date of the accident?

A. Three.

Q. Do you know when the last one was?

A. No.

Q. I want to go through some information about the accident itself.

At the time of the accident, you were standing on a ladder, correct?

A. Correct.

Q. Were the feet of the ladder on the ground?
A. The ladder was on the floor and against the wall.
Q. Okay, were the feet placed on the ground?
A. Yes, on the ground.
Q. And was it a frame ladder or extension ladder?
A. A-type ladder.
Q. Do you know how tall of an A-type ladder it was?
A. I don't recall exactly, but it was close to ten feet.
Q. When your accident occurred do you know what rung of the ladder you were on?
A. I was on the second rung from top to bottom.
Q. Okay and was that where your feet were or your hands?
A. My feet.
Q. Your feet were on the second from the top rung?
A. Yes.
Q. If I understood your testimony correctly, the beam was being placed and I believe you said that the holes on the other side of the beam wouldn't line up correctly?
MR. ROSE: Objection.
THE COURT: Overruled.
THE INTERPRETER: Can I have that question read back, please.
THE COURT: We are not relitigating liability.

This is simply going to establish the accident, the force of the accident, how far he fell. It is not relitigating liability.

MR. ROSE: Holes in the beam?

THE COURT: Okay, could you ask the question again?

MR. FARRELL: Yes. I will rephrase the question.

Q. As the beam was being placed, was there an issue or problem at the other end of the beam?

THE COURT: That is irrelevant.

MR. ROSE: Thank you.

THE COURT: That is irrelevant.

MR. FARRELL: That was the testimony yesterday.

A. Yes.

THE COURT: Sustained. Disregard it. It is irrelevant.

If you want to get into the height, the distance of the fall.

Q. What is your understanding of what caused the beam to move?

MR. ROSE: Objection. May we approach, Judge?

THE COURT: Yes.

(Whereupon, an off-the-record discussion was

held.)

THE COURT: Continue.

Q. At some point you saw the beam coming at you, correct?

A. Correct.

Q. And did you move in an attempt to try to get out of the way of it?

A. Yes.

Q. And the beam struck you, correct?

A. Anyway, it hit me.

Q. The beam hit you, correct?

A. Yes.

Q. Hit your left leg, correct?

A. Correct.

Q. Can you tell me what direction the beam was coming when it hit you?

A. I could not tell you that because I didn't see it directly. I only saw with the corner of my eye that the black mass was moving.

Q. Do you know whether it was moving from above or down or from the side toward you?

A. Yes, I only saw it coming down.

Q. Okay. Did the beam strike your neck at all?

A. My neck?

Q. Yes.

A. No.
Q. Did the beam strike your right shoulder?
A. No.
Q. Did the beam strike your lower back at all?
A. No.
Q. The beam did strike you on the left leg, correct?
A. Correct.
Q. You testified yesterday that your foreman was in a hurry right before the accident happened, right?
MR. ROSE: Objection.
THE COURT: Sustained.
Q. After the beam struck you in the left leg, you fell to the ground, correct, off the ladder?
A. Yes.
Q. Do you know what happened to the beam after you fell to the ground?
A. It was on the floor.
Q. Okay. So the beam also fell to the ground?
A. Yes.
Q. Okay, when you landed on the ground, did the beam land on top of it you?
A. No.
MR. FARRELL: Thank you, sir. I have nothing further.
THE WITNESS: Thank you.

THE COURT: Any redirect?

MR. ROSE: Yes, your Honor.

REDIRECT EXAMINATION

BY MR. ROSE:

Q. You have three children?

A. Yes.

Q. They live with you?

A. Yes.

Q. You pay rent?

A. Yes, correct.

Q. Do you feed your family?

A. Yes.

Q. Two of your children go to school, correct?

A. Yes.

Q. You do you send your children to school in clothes?

A. Yes.

Q. Do you care about how your children appear in school?

A. Correct.

Q. You have a car?

A. Yes.

Q. Pay for gas?

A. Correct.

Q. You have other expenses as well, correct?

A. That's correct.

Q. You make $23.00 an hour; is that correct?

A. $26.00.

Q. I am sorry, 26. You do still have financial pressures or -- withdrawn.

MR. ROSE: Excuse me, I withdraw the question.

Q. Do you have financial pressures?

A. Yes.

Q. Tell the jury, please, how your body feels during the course of a work day?

A. Sometimes I feel like glass that receives an impact of a stone and it is all shattered because everything hurts.

Q. How do you feel at the end of the work day?

A. I do a daily effort because I have to do things. But what I want most is to get home and rest.

Q. Tell the jury why you don't ask for a accommodations at work?

A. As I said before, if I present myself with a lot of aches and pains I would think that no company would like to hire me. I have to do an effort even though I have pain. I have to do what I need to do it.

Q. Tell the jury why you don't take sick days?

A. Since I started working at 19 I have always been very responsible. And I feel like I am new here and I don't want to cause any problems and cause any problems so they

should fire me.

MR. ROSE: Thank you.

THE COURT: Okay, thank you, sir.

MR. FARRELL: One question, your Honor.

RECROSS EXAMINATION

BY MR. FARRELL:

Q. At the time that you worked at Steelfab for $22.00 an hour, did you feel financial pressures at that point as well?

A. Not on the whole.

MR. FARRELL: Okay, thank you.

THE COURT: All right. Thank you.

MR. ROSE: Nothing further, your Honor.

THE COURT: Okay, thank you very much.

(Whereupon, an off-the-record discussion was held.)

THE COURT: We are back on the record.

So jurors, we will recess now for the week. Safe home. Do not think about this case. Think about what we hope Boston will not do to the Knicks. And again, thank you so very much.

I think I can tell from the work of the attorneys how much effort they have put into this. It is important to both sides, so please continue to keep an open mind. There is still a lot more to be done in

this case, okay, a lot more. I don't think we are halfway through.

So safe home, enjoy this beautiful weather and we will see you Monday morning at 9:30. Thank you.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and the trial adjourned for the day.)

M