

1 SUPREME COURT OF THE STATE OF NEW YORK

2 COUNTY OF KINGS : CIVIL TERM : PART 33

3 - - - - - -X

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

5 PLAINTIFF :

6 - against - :

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

9 DEFENDANTS : TRIAL

10 - - - - - -X

11 360 ADAMS STREET
12 BROOKLYN, NEW YORK 11201
MAY 2, 2025

13
14 BEFORE: HONORABLE DESMOND GREEN,
JUSTICE, AND A JURY

15

16 APPEARANCES:

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25 JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

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

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

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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.

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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.

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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

1 why I will keep this brief.

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

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

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

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

1 about questions like that?

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

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

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

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

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

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

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

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

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

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

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

25 THE COURT: All right, I respectfully disagree

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

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

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

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

25 And I just want to put this on the record

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

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

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

7 THE COURT: All right, you're welcome.

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

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

12 COURT OFFICER: All rise. Jury entering.

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

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

18 MR. ROSE: Yes, your Honor.

19 MR. FARRELL: Yes, your Honor.

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

25 Remember at the very beginning I mentioned

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

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

9 This is Dr. Merola?

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

12 THE COURT: Okay.

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

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

19 COURT CLERK: Thank you.

20 DIRECT EXAMINATION

21 BY MR. ROSE:

22 Q. Good morning, Doctor.

23 A. Good morning.

24 Q. Let's first talk about your qualifications.

25 A. Yes.

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

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

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

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

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

21 Q. Have you also held any academic positions?

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

25 THE COURT: Doctor, one question, SUNY

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

3 THE WITNESS: That is correct, your Honor.

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

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

10 Q. Do you uphold any licenses?

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

13 Q. Do you hold any board certifications?

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

17 Q. Do you have any professional memberships, Doctor?

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

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

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

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

4 THE COURT: Thank you.

5 Q. Have you received any honors and awards?

6 A. Yes, I have.

7 Q. Please tell the jury.

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

12 Q. Have you published any works, Doctor?

13 A. Yes, I have.

14 Q. What are those?

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

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

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

4 A. Yes.

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

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

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

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

18 Q. Okay, great. Thank you.

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

21 A. Yes.

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

25 A. Yes, it is.

1 Q. Do you maintain a private practice?

2 A. Yes.

3 Q. Okay, what does that consist of?

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

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

9 A. Yes.

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

13 A. Yes.

14 MR. ROSE: Before we start talking, just for
15 the record, your Honor, Plaintiff's Exhibit 7 which is
16 the MRI film taken of Mr. Vivanco on September 5th of
17 2017. That is already in evidence.

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

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

25 But counselor, are you asking that he be

1 deemed an expert?

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

5 THE COURT: Okay, Mr. Farrell?

6 MR. FARRELL: No objection, your Honor.

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

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

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

25 MR. ROSE: Thank you, your Honor. I

1 appreciate that.

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

4 A. Sure.

5 Q. Please do.

6 THE COURT: You can step down, Doctor.

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

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

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

19 THE COURT: Doctor, one second.

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

22 THE COURT: Please continue. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 Q. Okay, great, thank you, Doctor.

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

11 A. Yes.

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

14 A. Yes.

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

17 When did Mr. Rivera first come to see you?

18 A. August 5th of 2019.

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

21 A. Yes.

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

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

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

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

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

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

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

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

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

1 Q. Could you please continue with your history.

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

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

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

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

20 Q. Could you continue, please.

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

1 and legs and hands and feet.

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

4 A. Yes.

5 Q. What did he tell you?

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

12 Q. Did you perform a physical examination?

13 A. I did.

14 Q. What did that consist of?

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

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

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

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

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

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

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

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

1 back examination with their subjective symptoms.

2 Q. Spasm would be objective?

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

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

11 A. Correct.

12 Q. Great. Okay, thank you.

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

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

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

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

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

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

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

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

12 Q. Okay and what is that indicative of?

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

15 Q. Could you continue, please.

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

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

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

6 Q. Okay. Please continue.

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

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

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

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

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

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

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

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

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

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

18 A. Sure.

19 Q. Please do.

20 THE WITNESS: May I go down?

21 THE COURT: Absolutely.

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

25 So the first thing that we can look at are the

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

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

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

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

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

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

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

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

16 THE COURT: Thank you.

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

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

19 Q. And what do you see here?

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

1 seeing.

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

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

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

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

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

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

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

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

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

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

25 A. Correct.

1 Q. Could you explain that?

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

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

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

18 A. Yes.

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

21 A. Yes.

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

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

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

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

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

8 A. Yes.

9 Q. What were the findings there?

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

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

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

24 A. Yes.

25 Q. Would an illustration be helpful in explaining what

1 the Discogram is to the jury?

2 A. Sure.

3 Q. Okay. Great.

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

7 THE COURT: We do have an easel.

8 COURT CLERK: Marked for identification.

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

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

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

14 MR. ROSE: 12.

15 COURT CLERK: Plaintiff's 12 into evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

14 A. Sure.

15 Q. Thank you?

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

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

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

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

6 A. Yes.

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

9 A. Yes.

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

12 A. I don't think so.

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

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

18 THE COURT: And that is?

19 MR. MORGENSTERN: Plaintiff's Exhibit 10.

20 THE COURT: Mr. Farrell?

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

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

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

1 injection prior to coming to see you?

2 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

10 Q. Okay. Anything else?

11 A. That is pretty much it for the neck.

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

14 THE WITNESS: Yes.

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

17 THE WITNESS: Sure.

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

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

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

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

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

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

20 All right, thank you.

21 COURT OFFICER: All rise. Jury exiting.

22 (RECESS TAKEN.)

23 THE COURT: Let's get the jury back.

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

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

3 MR. ROSE: Yes, your Honor.

4 MR. FARRELL: Yes, your Honor.

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

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

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

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

21 Q. And Mr. Vivanco came back to you on October 21st of
22 2019; is that correct?

23 A. Yes.

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

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

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

5 A. Yes.

6 Q. Did you do that here?

7 A. Yes.

8 Q. Could you tell the jury about that conversation?

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

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

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

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

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

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

10 A. Yes.

11 Q. Who was present there?

12 A. Both the patient and his wife.

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

17 You saw him again on December 16th of 2019?

18 A. Yes.

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

21 A. Yes.

22 Q. Okay, when was that?

23 A. January 22nd of 2020.

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

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

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

4 A. Yes.

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

7 A. Yes.

8 Q. Okay. Great.

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

10 THE COURT: That is?

11 MR. ROSE: That is Plaintiff's Exhibit 13.

12 This is also in evidence by stipulation.

13 COURT CLERK: All agreed?

14 MR. FARRELL: Yes.

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

19 A. Sure.

20 THE COURT: Has it been moved into evidence?

21 MR. ROSE: It has not. Do we have it here?

22 We can do without it. Judge.

23 THE COURT: Counsel. Come up for a second.

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

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

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

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

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

14 MR. ROSE: For the record, by stipulation, we
15 have admitted Dr. Merola's chart as Plaintiff's Exhibit
16 15.

17 THE COURT: Mr. Farrell, accurate?

18 MR. FARRELL: Yes.

19 THE COURT: It is in evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Q. With your own eyes?

1 A. Yes.

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

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

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

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

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

19 Q. Okay, thank you.

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

22 A. Yes.

23 Q. What did that visit consist of?

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

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

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

7 A. Yes.

8 Q. What was that?

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

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

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

1 though everything was going well.

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

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

6 Q. What did he report at this time?

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

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

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

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

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

3 A. Yes.

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

6 A. Sure.

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

9 A. Yes.

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

13 A. So in several ways.

14 Q. Okay.

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

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

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

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

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

10 Q. Great. Thank you. Okay, now, I would like to
11 direct your attention -- I am sorry. We were on February
12 17, 202; is that correct?

13 A. Yes.

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

16 A. Yes.

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

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

25 He did have some loss of his low back normal

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

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

5 A. The antalgia and kyphosis?

6 Q. Yes, that.

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

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

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

19 Q. Okay. Thank you. Kyphosis?

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

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

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

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

15 Q. That would be your comment regarding disability?

16 A. That is correct.

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

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

25 And in a patient with an active radiculopathy, that

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

5 Q. Now, did you recommend treatment?

6 A. Yes.

7 Q. What was that?

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

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

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

1 keep your blood sugar controlled.

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

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

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

20 Q. Okay. You saw Mr. Vivanco again on April 16th of
21 2020; is that correct?

22 A. Yes.

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

25 A. Yes.

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

3 A. Yes.

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

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

11 Q. Did you perform a physical examination?

12 A. Yes.

13 Q. Could you explain those findings, please?

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

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

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

22 Q. What is the purpose of doing that?

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

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

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

9 Q. Okay and did you recommend further treatment?

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

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

14 A. Yes.

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

17 A. Yes.

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

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

24 Q. Okay, did you perform a physical examination?

25 A. Yes.

1 Q. What were your findings?

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

7 Q. What does that tell you?

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

10 Q. Meaning symptoms of radiculopathy?

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

14 Q. Got it. Thank you.

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

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

19 A. Yes.

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

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

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

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

7 A. Yes.

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

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

17 Q. Thank you.

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

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

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

6 THE COURT: Thank you.

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

10 A. Yes.

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

14 A. Sure.

15 Q. Thank you.

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

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

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

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

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

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

25 A. Sure.

1 Q. Explain what that is to the jury?

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

9 Q. Thank you.

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

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

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

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

3 THE COURT: Thank you.

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

6 A. Yes.

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

9 A. Yes.

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

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

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

17 A. Yes.

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

19 A. Yes.

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

22 A. Yes.

23 Q. Utilizing a cane at this time as well?

24 A. Yes.

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

1 you had with him there, please?

2 A. Yes.

3 Q. Okay. Thank you.

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

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

13 A. Yes.

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

16 A. Yes.

17 Q. Okay, what were those?

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

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

23 A. Yes.

24 Q. Then next he was there to see you on May 3rd of
25 2021. I would like to direct your attention to that note,

1 please.

2 A. Yes.

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

5 A. Neck and back symptoms.

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

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

12 Q. Please continue.

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

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

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

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

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

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

6 A. Yes.

7 Q. What was that?

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

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

11 A. Yes.

12 Q. Still disabled; is that correct?

13 A. Yes.

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

16 A. Yes.

17 Q. Could you please discuss that visit?

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

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

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

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

4 Q. What does that mean?

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

10 Q. How is that significant?

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

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

15 A. Yes.

16 Q. What were those?

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

21 Q. Okay. Thank you. Next he saw you in November of
22 2021; is that correct?

23 A. Yes.

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

1 A. Yes.

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

4 A. Yes.

5 Q. What was discussed at that visit?

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

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

13 A. Yes.

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

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

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

22 A. Yes.

23 Q. What were your findings there?

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

25 Q. And I see that you found quadriceps and achilles

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

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

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

7 A. Yes.

8 Q. Same disability comment as well?

9 A. Yes.

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

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

20 A. Yes.

21 Q. What is that opinion?

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

24 Q. Okay, why is that?

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

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

3 Q. Are Mr. Vivanco's injuries permanent?

4 A. Yes.

5 Q. Why?

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

10 Q. How about the neck?

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

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

16 A. Yes.

17 Q. What was the date of that visit?

18 A. April 21 of this year.

19 Q. April 21, 2025?

20 A. Yes.

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

24 A. Yes.

25 Q. What is your comment there?

1 A. "50 percent disabled from heavy labor".

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

4 A. Yes.

5 Q. Could you explain that, please?

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

10 Q. Was anyone with him at that visit?

11 A. Yes, his wife.

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

14 A. Yes.

15 Q. What did that consist of?

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

22 Q. Did he perform a physical examination?

23 A. Yes.

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

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

11 Q. What does that mean?

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

14 Q. Please continue.

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

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

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

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

1 A. Yes. If available on a maintenance basis, correct.

2 Q. Pain management as well?

3 A. Yes.

4 Q. I know you said the injuries were permanent, would
5 the injuries be a competent producing cause of pain for Mr.
6 Vivanco?

7 A. Yes.

8 Q. Why is that?

9 A. Because they are intermittently involved with the
10 way that the entire spine works.

11 Q. So would that mean for the rest of his life?

12 A. Sure.

13 Q. Doctor, are you familiar with the term life care
14 plan?

15 A. Yes.

16 Q. Did I ask you to review the life care plan in this
17 case?

18 A. Yes.

19 Q. Okay, did you agree with the life care plan in this
20 case?

21 A. Yes.

22 Q. Okay, Doctor, would all of the opinions that you
23 have given today be to a reasonable degree of medical
24 certainty?

25 A. Yes.

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

3 THE WITNESS: Thank you.

4 THE COURT: Cross examination?

5 MR. FARRELL: Yes.

6 CROSS EXAMINATION

7 BY MR. FARRELL:

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

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

16 A. Yes.

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

20 A. Yes.

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

24 A. Yes.

25 Q. And are symptoms such as radiculopathy and pain

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

5 A. Yes.

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

8 A. Yes.

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

13 A. Yes.

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

16 A. Yes.

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

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

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

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

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

5 A. Yes.

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

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

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

14 A. Yes.

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

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

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

22 A. Maybe 90/10.

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

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

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

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

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

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

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

23 A. Yes.

24 Q. That is, approximately, two years later?

25 A. Yes.

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

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

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

6 Q. Sure, feel free to reference it.

7 A. I have June 21, '21.

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

12 A. Yes.

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

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

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

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

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

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

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

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

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

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

11 A. That is correct.

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

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

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

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

25 Q. Okay, when making a determination on whether a

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

4 A. It is helpful, but not necessarily mandatory.

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

9 A. Not necessarily, no.

10 Q. Why would that be?

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

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

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

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

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

9 MR. ROSE: Objection.

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

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

14 Q. I am asking in general.

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

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

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

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

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

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

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

16 Q. Understandable, but --

17 THE COURT: One second. Go ahead.

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

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

1 Q. Right. I understand.

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

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

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

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

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

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

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

21 Q. Okay. Are you a licensed radiologist?

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

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

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

2 A. In part.

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

6 A. Sure. MRIs can change, yes.

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

11 A. Sure.

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

15 A. Yes.

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

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

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

24 A. No.

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

1 removed since it was a partial discectomy?

2 A. Correct.

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

6 A. Correct.

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

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

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

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

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

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

22 A. Yes.

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

25 A. I am going to check for you.

1 Q. Absolutely.

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

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

5 A. Yes.

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

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

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

12 A. Yes.

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

18 A. Surgery had been helpful, yes.

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

21 A. Yes.

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

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

1 Q. Correct. And now when you saw him in April of
2 2025, you placed him at a 50 percent disability, correct.

3 A. Yes.

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

6 A. Sure.

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

9 A. Yes.

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

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

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

17 A. No.

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

21 A. No.

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

24 A. No.

25 Q. Are you currently recommending any lumbar surgery

1 for the plaintiff?

2 A. No.

3 Q. When plaintiff's counsel was questioning you there
4 was some testimony about -- at one point you had, back in
5 2021 under "Future Care and Management" had stated that or
6 did you make any recommendation then back in 2021 about
7 whether he would need additional lumbar surgery?

8 A. We discussed trying to avoid any additional
9 surgery.

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

13 A. No.

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

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

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

21 A. Yes.

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

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

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

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

8 Q. That was going to be my next question.

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

11 A. Yes.

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

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

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

21 A. Correct.

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

24 THE WITNESS: Thank you.

25 MR. ROSE: Very fast.

1 THE COURT: Very fast?

2 MR. ROSE: Before lunch very fast.

3 REDIRECT EXAMINATION

4 BY MR. ROSE:

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

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

8 A. Yes.

9 Q. What is that?

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

12 Q. Why do you do that?

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

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

22 A. Yes.

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

25 A. Yes.

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

3 A. Yes.

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

6 A. Yes.

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

9 A. No.

10 Q. Neither have I. And let's just talk about 2017 and
11 2019 lumbar MRI films specifically.

12 Did you see any differences between those two
13 films?

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

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

21 THE WITNESS: Thank you.

22 MR. FARRELL: Nothing else. Thank you.

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

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

1 interpreters' office, okay?

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

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

11 COURT OFFICER: All rise. Jury exiting.

12 (Whereupon, the jury exits the courtroom.)

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

15 * * * *

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

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

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

23 THE INTERPRETER: Yes.

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

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

4 COURT OFFICER: All rise. Jury entering.

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

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

10 MR. ROSE: Yes, Judge.

11 MR. FARRELL: Yes, your Honor.

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

14 MR. ROSE: Yes, your Honor.

15 THE COURT: Okay, sir.

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

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

19 THE WITNESS: Okay.

20 THE COURT: Please be seated.

21 MR. ROSE: Thank you, your Honor.

22 THE COURT: Do you remember where we left off?

23 MR. ROSE: I think I do.

24 THE COURT: Psychological treatment.

25 DIRECT EXAMINATION

1 BY MR. ROSE:

2 Q. Good afternoon.

3 A. Good afternoon. Good afternoon to everyone.

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

6 Do you recognize what is shown in that photograph?

7 A. Yes.

8 Q. When was that photograph taken?

9 A. August 9th, 2017.

10 Q. What does that photograph show?

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

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

15 THE COURT: Yes.

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

18 MR. ROSE: Thank you.

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

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

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

1 A. All right.

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

4 A. Okay.

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

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

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

12 A. Two doctors.

13 Q. Okay, who was the first one?

14 A. Doctor, female doctor, Miller.

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

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

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

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

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

1 A. Yes. Yes, I did receive medications.

2 Q. What types of medications did you receive?

3 A. I don't remember the name of the medication, but it
4 was to control anxiety, insomnia, depression.

5 MR. ROSE: And so I am sorry, could I have the
6 answer read back.

7 (Whereupon, the previous question was read
8 back.)

9 Q. So insomnia, fair to say you were having trouble
10 sleeping?

11 A. Yes.

12 Q. What was that like for you?

13 A. Because of the matter of what could have happened.
14 Because if that thing that fell on me had fallen on my body
15 it could have killed me instantly.

16 Q. Now, who was the other psychiatric professional or
17 practice that you saw as a result of this accident?

18 A. I remember the name, it was Dr. Nuttman.

19 Q. And again, what were you seeing Dr. Nuttman for?

20 A. For the same symptoms.

21 Q. And describe those?

22 A. I had panic attacks all the time and anxiety. I
23 was unable to fall asleep. Great deal of headaches. For
24 the same reason.

25 Q. And how long were you treating with that office?

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

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

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

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

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

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

21 A. Okay.

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

24 A. Correct.

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

1 Dr. Merola; is that correct?

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

4 MR. ROSE: Merola.

5 A. Yes, that is correct.

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

9 A. Yes, that's correct.

10 Q. What were those recommendations?

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

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

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

17 MR. ROSE: Lesion was the word he used?

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

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

21 THE COURT: There was more to it.

22 He saw an injury to your lower back.

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

1 THE COURT: What type of surgery?

2 THE WITNESS: He recommended fusion.

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

5 A. Correct. That's correct.

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

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

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

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

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

16 THE COURT: Yes, please.

17 MR. ROSE: Could this be done --

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

20 MR. ROSE: May we approach?

21 THE COURT: Yes.

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

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

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

3 THE INTERPRETER: Yes.

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

6 THE INTERPRETER: Correct.

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

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

18 In other words, a follow-up question.

19 THE COURT: Yes.

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

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

1 lead for this purpose only.

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

3 THE COURT: Okay, thank you.

4 MR. FARRELL: Fair enough.

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

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

9 You discussed your injuries with Dr. Ratzker,
10 correct?

11 A. Yes.

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

14 A. Yes.

15 Q. And what did he tell you?

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

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

20 A. Yes.

21 Q. Okay.

22 THE COURT: Well.

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

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

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

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

6 THE COURT: Okay.

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

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

11 A. Okay.

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

14 A. That's correct.

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

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

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

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

23 A. The left knee.

24 Q. Same leg that was struck by the beam?

25 A. Yes.

1 Q. Who performed the surgery?

2 A. Dr. Michael Seidenstein.

3 Q. After you had the surgery, did you have to use
4 crutches for a certain period of time?

5 A. Yes.

6 Q. Now, you were still having problems with your back
7 and your neck at that time; is that correct?

8 A. That's correct.

9 Q. How was it for you to use crutches when you still
10 had the other difficulties?

11 A. Recommendations that were made by pain management
12 was to do only one at a time.

13 Q. Did you have difficulties using the crutches?

14 A. Yes.

15 Q. Physical therapy, did you do physical therapy
16 following the knee surgery?

17 A. Yes.

18 Q. And still going to pain management during that
19 period of time as well?

20 A. Correct.

21 Q. Okay, now let's turn your attention to your
22 shoulder.

23 To give the jury a time frame, your shoulder
24 surgery was in April of 2018; is that correct?

25 A. That's correct.

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

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

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

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

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

12 Q. Okay. You have the shoulder surgery in April of
13 2018, correct?

14 A. Correct.

15 Q. Who performed the shoulder surgery?

16 A. The same orthopedic surgeon, Michael Seidenstein.

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

19 A. Yes.

20 Q. Were you still undergoing pain management?

21 A. Yes.

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

23 A. Correct.

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

1 A. Neck and back, correct.

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

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

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

9 THE INTERPRETER: Repeat the question.

10 (Whereupon, the previous question was read
11 back.)

12 A. Only physical therapy before the surgery.

13 Q. Any injections?

14 A. Yes.

15 Q. Could you speak about that, please?

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

18 Q. Did you have those injections?

19 A. Yes.

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

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

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

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

1 Q. Then what would happen after that?

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

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

5 A. Yes.

6 Q. Who is Dr. Perez?

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

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

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

13 THE INTERPRETER: Please repeat the question.

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

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

19 A. Yes.

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

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

25 Q. Were the medications helpful for you?

1 A. Temporary. A matter of hours.

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

4 A. Correct.

5 Q. What were you seeing Dr. Katzman for?

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

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

10 A. Yes.

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

13 A. Yes.

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

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

18 Q. Did you do additional physical therapy?

19 A. Yes.

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

22 A. Correct.

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

24 A. Correct.

25 Q. That was with Dr. Merola, correct?

1 A. Correct.

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

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

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

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

10 THE COURT: Okay, can you answer again?

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

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

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

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

19 THE INTERPRETER: Repeat that, please.

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

21 (Whereupon, the previous question was read
22 back.)

23 A. Yes about two months after the surgery.

24 Q. Did you resume pain management?

25 A. Yes.

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

2 Following the back surgery --

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

5 THE COURT: Yes.

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

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

9 Do you need a break now?

10 MR. ROSE: That would great.

11 THE COURT: Okay.

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

17 COURT OFFICER: All rise. Jury exiting.

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

20 THE COURT: Let's get the jury back.

21 COURT OFFICER: All rise. Jury entering.

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

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

1 MR. ROSE: Yes.

2 MR. FARRELL: Yes, your Honor.

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

5 Okay, you may proceed.

6 MR. ROSE: Thank you, your Honor.

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

9 A. Yes.

10 Q. Still having physical therapy?

11 A. Yes.

12 Q. Still having seeing orthopedists, correct?

13 A. Yes.

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

16 A. Yes.

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

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

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

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

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

5 Q. Were you still having issues or difficulties
6 sleeping?

7 A. Yes.

8 Q. Okay, still having issues with anxiety?

9 A. Yes.

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

12 A. Yes.

13 Q. Can you tell the jury why that happened?

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

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

20 A. Yes.

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

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

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

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

3 A. Yes.

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

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

10 Q. Could you tell the jury about that course?

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

14 Q. How long did this course work take you?

15 A. The October semester was in 2023.

16 Q. Now, how did you find this course?

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

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

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

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

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

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

3 Q. What else?

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

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

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

13 Q. When did you go back to work?

14 A. March 2024.

15 Q. Are you still working in the same job?

16 A. Yes.

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

18 A. Yes.

19 Q. What is the name of the company?

20 A. Magellan Outer Space.

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

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

1 are made by it.

2 Q. Do you lift anything heavy?

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

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

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

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

11 What are your current complaints of pain?

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

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

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

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

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

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

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

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

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

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

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

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

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

20 And that is all. Thank you.

21 MR. ROSE: Thank you.

22 THE COURT: Okay, cross-examination?

23 MR. FARRELL: Thank you, your Honor.

24 CROSS EXAMINATION

25 BY MR. FARRELL

1 Q. Good afternoon, Mr. Vivanco.

2 A. Good afternoon.

3 Q. As a result of this accident, did you break any
4 bones in your body?

5 A. No.

6 Q. As a result of this accident and the surgeries that
7 we have heard about, have there been any plates or screws or
8 anything like that put in your body?

9 A. No, but the doctors did attempt to do that.

10 Q. Which doctor attempted to do that?

11 A. Dr. Ratzker.

12 Q. Do you mean he made a recommendation about that?

13 A. Yes.

14 Q. Okay, when you say he attempted to do that, you
15 don't mean he actually tried a surgery?

16 A. The doctor recommended fusion.

17 Q. Okay. That was not done, correct?

18 A. No, because I went to get another opinion with Dr.
19 Merola.

20 Q. And did you just see Dr. Merola in April of 2025?

21 A. That's correct.

22 Q. And did Dr. Merola tell you that you do not need
23 surgery on your neck of any kind?

24 A. In April of this year he did not recommend
25 operation.

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

3 A. No.

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

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

8 A. Yes, that's correct.

9 Q. How many years did you work for Indurama?

10 A. Eleven years. A little over.

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

13 A. We would construct matrixes and --

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

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

18 THE INTERPRETER: Sorry, I needed a
19 clarification.

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

22 A. Not directly. We would make molds --

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

1 THE COURT: Okay.

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

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

7 A. Yes.

8 Q. And stoves did I hear?

9 A. Yes, that is correct.

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

12 A. Very little.

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

15 A. No, it was only the salary.

16 Q. No health benefits or anything like that?

17 A. Social Security.

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

20 A. We did have some contact with blueprints.

21 THE COURT: Why don't we clarify something.

22 You mentioned Social Security, is the Social Security in
23 Ecuador, is it medical insurance while someone is
24 working?

25 THE WITNESS: They provide access to doctors

1 and medication.

2 THE COURT: Okay. Thank you.

3 MR. FARRELL: Thank you, your Honor.

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

6 A. No. I don't remember that.

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

9 A. Yes, many.

10 Q. Did you obtain a certificate in electrical
11 installations?

12 A. For machinery. Not for buildings or homes.

13 Q. Did you obtain a certificate in repairing motors?

14 A. Yes.

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

17 A. That's correct.

18 Q. What is Autodesk?

19 A. It is computer generated drawings.

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

22 A. Correct.

23 Q. Were you also a licensed welder in Ecuador?

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

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

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

4 THE COURT: Yes.

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

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

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

11 (Whereupon, the previous question was read
12 back.)

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

15 THE COURT: Okay, overruled.

16 MR. ROSE: You understand what I am saying?

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

19 A. In cash.

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

21 A. It was salary and hourly basis.

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

24 A. That's correct.

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

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

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

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

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

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

14 A. Yes.

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

17 A. No.

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

20 A. That's correct.

21 Q. It was hourly, correct?

22 A. That's correct.

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

25 A. That's correct.

1 Q. And do you work there five days a week?

2 A. Yes.

3 Q. Do you get paid for holidays?

4 A. Yes.

5 Q. How are you paid at Magellan?

6 A. Direct deposit.

7 Q. Do you get paid, at Magellan, a salary or do you
8 get paid hourly?

9 A. Per hour.

10 Q. How much per hour are you paid?

11 A. Right now I am getting paid \$26.00.

12 Q. And what were you getting paid per hour at
13 Steelfab?

14 A. \$23.00, but you must remember that that was in
15 2017.

16 Q. Right. And there were certain days where you
17 wouldn't work and wouldn't get paid, correct?

18 A. Yes.

19 Q. Where is Magellan Out of Space located? Where you
20 work?

21 A. They have a number of locations.

22 Q. Do you work in one specific location or do you go
23 to different locations?

24 A. Only one location.

25 Q. Where is that you go to?

1 A. In Queens.

2 Q. And you go there five days a week?

3 A. That's correct.

4 Q. How do you get there each day?

5 A. On three days my wife drops me off and picks me up.

6 But sometimes the whole week. And one or two days I go on
7 my own.

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

9 A. Driving.

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

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

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

21 A. These are parts for airplanes, basically.

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

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

24 Q. Okay, do you have a supervisor there?

25 A. Yes.

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

4 A. There are about 50 people in the plant.

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

7 A. No, no. Not that.

8 Q. Is your wife employed?

9 A. Yes.

10 Q. Does she have health benefits through her employer?

11 A. No. No.

12 Q. Does Magellan offer health benefits?

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

16 Q. You have your own health insurance currently?

17 A. Yes, I do have medical insurance.

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

19 A. No.

20 Q. Are you referring to Workers' Compensation
21 benefits?

22 A. No.

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

25 A. No.

1 Q. If you can explain to me how it is that you have
2 health insurance benefits?

3 MR. ROSE: May we approach? Objection, your
4 Honor.

5 THE COURT: Yes.

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

8 THE COURT: I have gotten a lot of surprises
9 before in a trial. This one came from -- not even left
10 field. This came from out of the ball park.

11 MR. ROSE: The only thing I would remotely
12 suspect is maybe that there is a government benefit
13 here.

14 THE COURT: We can't suspect. I take it you
15 did not know?

16 MR. ROSE: That's correct.

17 THE COURT: Okay, so.

18 MR. ROSE: I also question that maybe --

19 THE COURT: There is nothing for any of us to
20 do. You can continue with your cross-examination.

21 MR. ROSE: My only concern is that there is
22 something here that could be said that could prejudice
23 the jury that wouldn't be admissible. I would suggest
24 an offer of proof outside of the presence of the jury,
25 your Honor.

1 THE COURT: Offer of proof as to what?

2 MR. ROSE: As to what let's find out what it
3 is.

4 THE COURT: That is what cross-examination is
5 for.

6 MR. ROSE: I am just making a suggestion. It
7 is not my courtroom.

8 THE COURT: It is not mine either. It is the
9 taxpayers. I just work here.

10 So you can ask your questions, okay? Ask him
11 where this insurance is from.

12 MR. ROSE: Yes.

13 MR. FARRELL: I think I did. He says he
14 doesn't really know. I will reask to try to clarify. I
15 am very confused.

16 THE COURT: That is the only way to do it is
17 on cross.

18 MR. FARRELL: That is fine. I have no problem
19 doing that.

20 THE COURT: Okay, let's go back.

21 (Whereupon, back in open court in the presence
22 of the jury).

23 THE COURT: Okay, JeanMarie, when you are
24 ready can we have the last question and answer read
25 back, please.

1 (Whereupon, the previous question and answer
2 was read back.)

3 A. It is an ordinary type of health insurance like
4 Medicaid. It is similar.

5 Q. Is it through a particular company?

6 A. I don't know exactly how insurances operate, but it
7 is Health First.

8 Q. Health First?

9 A. Health First.

10 THE COURT: Is that a government assisted
11 program?

12 THE WITNESS: Sincerely I can't tell you
13 because I am unsure. My wife is the one who helps me
14 with these things.

15 THE COURT: Okay.

16 Q. And if you have a medical appointment now is it
17 covered, at least in part, by Health First?

18 A. With regards to the accident, no. But usually with
19 any other kind of medical needs, yes.

20 Q. So currently if you go for a procedure, or not a
21 procedure, or check up for your back, who, if anyone, pays
22 for the care?

23 A. The doctor that where I am going to and be seen
24 knows about the accident and if it has to do with something
25 regarding the accident, he would request that I bring in

1 documents or proof of documentation about it because they
2 want payment for what they do. And my insurance does not
3 cover anything that is related to the accident. Anything
4 that is not regarding the accident they do cover.

5 THE COURT: Let's say you have come down with
6 the flu, would they cover that?

7 THE WITNESS: Yes. Definitely they would.

8 Q. Did you say that Magellan has or when you first
9 started working at Magellan, they have healthcare coverage
10 that they offer to you?

11 A. Yes.

12 Q. And you turned it down?

13 A. That's correct.

14 Q. Do you know if their healthcare coverage would
15 cover you for a back appointment or neck appointment?

16 A. I couldn't tell you.

17 Q. Okay. Since you have returned to work at Magellan,
18 have you had to take any medical leave of absence or missed
19 time for work because of your medical conditions?

20 A. I have gone to the doctor on a couple of occasions
21 and I do remember that they gave me sick leave for three
22 days. But I did not use them and I kept on working.

23 Q. So is it fair to say you have been able to work
24 steadily at Magellan since you started working there?

25 A. Yes.

1 Q. Is it your hope to stay working there?

2 A. Yes.

3 Q. Is there any chance for promotion and different
4 levels that you could move up at Magellan?

5 A. I wouldn't be able to tell you that since I don't
6 know. It is has been too little time. I'm new.

7 THE INTERPRETER: Your Honor, would now be a
8 good opportunity time for us to switch out the
9 interpreters?

10 THE COURT: Yes.

11 (Whereupon, Jacob Lipshitz took over
12 translating English to Spanish for the plaintiff.)

13 THE INTERPRETER: Jacob Lipshitz, Spanish
14 interpreter.

15 Q. For your work at Magellan, did they provide you
16 with any special accommodations at work?

17 A. What do you refer to?

18 Q. Do you have any special accommodations due to your
19 medical conditions that they accommodate you for?

20 A. When the person that I started interviewing from
21 the beginning I told him something about the accident, but
22 not in detail because I was afraid of not getting a
23 contract. And whatever I do there it is quite light.

24 Q. So you don't get any particular accommodations that
25 other workers don't get?

1 A. They don't do it, but I know if I request it that
2 the company would provide it.

3 Q. I believe you said you started you start 6:30 in
4 the morning; is that correct?

5 A. Six o'clock sharp.

6 Q. And what time do you end your work day there?

7 A. At 2:30.

8 Q. That is five days a week?

9 A. Correct.

10 Q. While plaintiffs counsel, your attorney, was
11 questioning you, you had talked about after your accident
12 having insomnia, some anxiety and depression; do you recall
13 that?

14 A. Yes.

15 Q. And was a significant portion of that because fear
16 for family and making sure that were provided for?

17 A. That's correct.

18 Q. Isn't it true at Magellan you are now earning more
19 money than you were making when you were at Steelfab?

20 A. I would like to explain something.

21 Q. Sure.

22 A. In 2017 I was earning \$23.00 an hour. Right now if
23 I wouldn't have gotten -- if the accident wouldn't have
24 happened, I would be easily making \$40.00 or more. If we
25 make comparison now today I am earning \$26.00 an hour.

1 Q. But you said you are new at the company. Correct?

2 A. Yes.

3 Q. And you said you don't know whether they -- they do
4 have managers and supervisors there?

5 A. Yes.

6 Q. They provide health insurance?

7 A. I don't know.

8 Q. They provide light duty work for persons like
9 yourself?

10 A. Yes.

11 Q. Paid holidays?

12 A. Yes.

13 Q. And you said you don't know whether there is room
14 for advancement, but you would you hope to be able to move
15 up the chain in the company at some point?

16 A. I hope, but I don't know it.

17 Q. I believe you used the phrase that when you were
18 asked about how you feel about working that it feels good to
19 be back integrated into real life; is that what you said?

20 A. Yes.

21 Q. Explain that to me a little bit about what you
22 meant by that?

23 A. When the accident happened I spent six-and-a-half
24 years with the crutches, with a cane, braces in my neck. Up
25 to today I still have braces on my legs. I missed a lot of

1 family moments, invitations. I had a lot of problems due to
2 that. I was in bed or I couldn't go out for long periods of
3 time. There was a certain point where I decided by myself
4 to try to do things by myself. I saw my children and I
5 wanted to do as much as possible for them.

6 Q. The question though is now that you are back
7 working at -- let me finish the question.

8 Now that you are back working, do you feel that you
9 are back integrating into life?

10 A. Yes.

11 Q. And is the fact that you are back working, at least
12 to some degree, eased the anxiety of the financial burdens?

13 A. No.

14 Q. So the fact that you are back working hasn't
15 changed the anxiety of the financial burden at all?

16 A. Nope.

17 Q. At the time of your accident, did you have a
18 primary care physician?

19 A. I don't recall that year.

20 Q. Do you currently have a primary care physician?

21 A. Yes.

22 Q. Did I hear you correctly yesterday when you were
23 asked about how you knew what doctors to go to after Kings
24 County Hospital; what was your answer?

25 A. Can you repeat it, please.

1 Q. Sure. It was a bad question.

2 After your accident you went to Kings County
3 Hospital, correct?

4 A. Yes, correct.

5 Q. And then you have had a significant amount of
6 treatment since then?

7 A. Yes.

8 Q. How did you know what doctor to go to after Kings
9 County Hospital?

10 A. After that I received a large bill at home. I was
11 worried and they told me from the hospital to look for -- to
12 get a lawyer so he could help me to cover those bills. In
13 the emergency -- at emergency they told me to look for
14 specialist and as I didn't know anyone or nothing I asked
15 the lawyer to recommend me a specialist so they should
16 review me.

17 Q. So the first doctor you went to after King County
18 Hospital was recommended by your lawyer?

19 A. That's correct.

20 Q. And which doctor was that?

21 A. Charles DeMarco.

22 Q. Did your lawyer recommend to you any other doctors
23 other than Dr. DeMarco?

24 A. Majority of the doctors were recommended by the
25 lawyer.

1 Q. The majority of the doctors; is that what you said?

2 A. Yes.

3 Q. Does it make you feel proud and happy, the fact
4 that you have gone back to work?

5 A. Hundred percent.

6 Q. With regard to your left knee, can you tell me when
7 was the last time it was that you had an MRI on your left
8 knee?

9 A. I think it was last year.

10 Q. And have you had any injections in your left knee?

11 A. Before.

12 Q. Before what?

13 A. Before the last MRI.

14 Q. Okay, in total, from the date of your accident
15 until present, how many injections have you had in your left
16 knee?

17 A. Only the left knee?

18 Q. Yes.

19 A. Three.

20 Q. Have you had any injections, at all, to your right
21 shoulder?

22 A. Yes.

23 Q. How many, since the date of your accident, how many
24 injections have you had in your right shoulder?

25 A. Three.

1 Q. And with regard to your left knee, do you know what
2 year that last injection was?

3 A. No.

4 Q. The same question then on your right shoulder. Do
5 you know what year the last injection was?

6 A. No, not exactly. Not.

7 Q. For your lower back, I know you have had
8 injections, how many injections have you had in your lower
9 back since the accident?

10 A. I receive packages of -- two packages of three and
11 three.

12 Q. So six total since the accident?

13 A. Yes.

14 Q. Do you know when the last one was?

15 A. No.

16 Q. For your cervical spine, how many injections have
17 you had since the date of the accident?

18 A. Three.

19 Q. Do you know when the last one was?

20 A. No.

21 Q. I want to go through some information about the
22 accident itself.

23 At the time of the accident, you were standing on a
24 ladder, correct?

25 A. Correct.

1 Q. Were the feet of the ladder on the ground?

2 A. The ladder was on the floor and against the wall.

3 Q. Okay, were the feet placed on the ground?

4 A. Yes, on the ground.

5 Q. And was it a frame ladder or extension ladder?

6 A. A-type ladder.

7 Q. Do you know how tall of an A-type ladder it was?

8 A. I don't recall exactly, but it was close to ten
9 feet.

10 Q. When your accident occurred do you know what rung
11 of the ladder you were on?

12 A. I was on the second rung from top to bottom.

13 Q. Okay and was that where your feet were or your
14 hands?

15 A. My feet.

16 Q. Your feet were on the second from the top rung?

17 A. Yes.

18 Q. If I understood your testimony correctly, the beam
19 was being placed and I believe you said that the holes on
20 the other side of the beam wouldn't line up correctly?

21 MR. ROSE: Objection.

22 THE COURT: Overruled.

23 THE INTERPRETER: Can I have that question
24 read back, please.

25 THE COURT: We are not relitigating liability.

1 This is simply going to establish the accident, the
2 force of the accident, how far he fell. It is not
3 relitigating liability.

4 MR. ROSE: Holes in the beam?

5 THE COURT: Okay, could you ask the question
6 again?

7 MR. FARRELL: Yes. I will rephrase the
8 question.

9 Q. As the beam was being placed, was there an issue or
10 problem at the other end of the beam?

11 THE COURT: That is irrelevant.

12 MR. ROSE: Thank you.

13 THE COURT: That is irrelevant.

14 MR. FARRELL: That was the testimony
15 yesterday.

16 A. Yes.

17 THE COURT: Sustained. Disregard it. It is
18 irrelevant.

19 If you want to get into the height, the
20 distance of the fall.

21 Q. What is your understanding of what caused the beam
22 to move?

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

24 THE COURT: Yes.

25 (Whereupon, an off-the-record discussion was

1 held.)

2 THE COURT: Continue.

3 Q. At some point you saw the beam coming at you,
4 correct?

5 A. Correct.

6 Q. And did you move in an attempt to try to get out of
7 the way of it?

8 A. Yes.

9 Q. And the beam struck you, correct?

10 A. Anyway, it hit me.

11 Q. The beam hit you, correct?

12 A. Yes.

13 Q. Hit your left leg, correct?

14 A. Correct.

15 Q. Can you tell me what direction the beam was coming
16 when it hit you?

17 A. I could not tell you that because I didn't see it
18 directly. I only saw with the corner of my eye that the
19 black mass was moving.

20 Q. Do you know whether it was moving from above or
21 down or from the side toward you?

22 A. Yes, I only saw it coming down.

23 Q. Okay. Did the beam strike your neck at all?

24 A. My neck?

25 Q. Yes.

1 A. No.

2 Q. Did the beam strike your right shoulder?

3 A. No.

4 Q. Did the beam strike your lower back at all?

5 A. No.

6 Q. The beam did strike you on the left leg, correct?

7 A. Correct.

8 Q. You testified yesterday that your foreman was in a
9 hurry right before the accident happened, right?

10 MR. ROSE: Objection.

11 THE COURT: Sustained.

12 Q. After the beam struck you in the left leg, you fell
13 to the ground, correct, off the ladder?

14 A. Yes.

15 Q. Do you know what happened to the beam after you
16 fell to the ground?

17 A. It was on the floor.

18 Q. Okay. So the beam also fell to the ground?

19 A. Yes.

20 Q. Okay, when you landed on the ground, did the beam
21 land on top of it you?

22 A. No.

23 MR. FARRELL: Thank you, sir. I have nothing
24 further.

25 THE WITNESS: Thank you.

1 THE COURT: Any redirect?

2 MR. ROSE: Yes, your Honor.

3 REDIRECT EXAMINATION

4 BY MR. ROSE:

5 Q. You have three children?

6 A. Yes.

7 Q. They live with you?

8 A. Yes.

9 Q. You pay rent?

10 A. Yes, correct.

11 Q. Do you feed your family?

12 A. Yes.

13 Q. Two of your children go to school, correct?

14 A. Yes.

15 Q. You do you send your children to school in clothes?

16 A. Yes.

17 Q. Do you care about how your children appear in
18 school?

19 A. Correct.

20 Q. You have a car?

21 A. Yes.

22 Q. Pay for gas?

23 A. Correct.

24 Q. You have other expenses as well, correct?

25 A. That's correct.

1 Q. You make \$23.00 an hour; is that correct?

2 A. \$26.00.

3 Q. I am sorry, 26. You do still have financial
4 pressures or -- withdrawn.

5 MR. ROSE: Excuse me, I withdraw the
6 question.

7 Q. Do you have financial pressures?

8 A. Yes.

9 Q. Tell the jury, please, how your body feels during
10 the course of a work day?

11 A. Sometimes I feel like glass that receives an impact
12 of a stone and it is all shattered because everything hurts.

13 Q. How do you feel at the end of the work day?

14 A. I do a daily effort because I have to do things.
15 But what I want most is to get home and rest.

16 Q. Tell the jury why you don't ask for a
17 accommodations at work?

18 A. As I said before, if I present myself with a lot of
19 aches and pains I would think that no company would like to
20 hire me. I have to do an effort even though I have pain. I
21 have to do what I need to do it.

22 Q. Tell the jury why you don't take sick days?

23 A. Since I started working at 19 I have always been
24 very responsible. And I feel like I am new here and I don't
25 want to cause any problems and cause any problems so they

1 should fire me.

2 MR. ROSE: Thank you.

3 THE COURT: Okay, thank you, sir.

4 MR. FARRELL: One question, your Honor.

5 RE CROSS EXAMINATION

6 BY MR. FARRELL:

7 Q. At the time that you worked at Steelfab for \$22.00
8 an hour, did you feel financial pressures at that point as
9 well?

10 A. Not on the whole.

11 MR. FARRELL: Okay, thank you.

12 THE COURT: All right. Thank you.

13 MR. ROSE: Nothing further, your Honor.

14 THE COURT: Okay, thank you very much.

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

17 THE COURT: We are back on the record.

18 So jurors, we will recess now for the week.

19 Safe home. Do not think about this case. Think about
20 what we hope Boston will not do to the Knicks. And
21 again, thank you so very much.

22 I think I can tell from the work of the
23 attorneys how much effort they have put into this. It
24 is important to both sides, so please continue to keep
25 an open mind. There is still a lot more to be done in

1 this case, okay, a lot more. I don't think we are
2 halfway through.

3 So safe home, enjoy this beautiful weather and
4 we will see you Monday morning at 9:30. Thank you.

5 COURT OFFICER: All rise. Jury exiting.

6 (Whereupon, the jury exits the courtroom and
7 the trial adjourned for the day.)

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