2004 WL 5757021 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Mai Linh DEVIRGILIO, Plaintiff,
v.
FELLER PRECISION STAGE LIFTS, Littlestar Services Broadway, Inc., Mamma Mia Broadway, Limited, Mamma Mia Broadway Ltd Partner, Shubert Organization, Inc., Defendants;
Littlestar Services Broadway, Inc., & Mamma Mia Broadway Limited Partners, Third-Party Plaintiffs,
v.
Shubert Organization, Inc., Third-Party Defendant.

Nos. 2001-122252, 03L04434.
November 3, 2004.

Testimony of Plaintiff's Expert Witness, Andrew Merola, M.D.

Name of Expert: Andrew A. **Merola**, M.D.
Area of Expertise: Medical & Surgical >> Orthopedics
Area of Expertise: Medical & Surgical >> Surgery -- General
Representing: Plaintiff
Jurisdiction: New York County, New York

For the Plaintiff: Gross, Schwartz, Goldstone & Campisi, LLP., By: Bruce H. Goldstone, Of counsel, 90 Broad Street, Ste. 403, New York, NY 10004.

For the Defendants: Hoey, King, Toker & Epstein, By: Leonard Toker, Of Counsel, 55 Water Street, New York, NY 10041.

Before: Honorable Marcy S. Friedman.

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

ANDREW MEROLA, 36 Seventh Avenue, Suite 502, New York, New York 10011, called as a witness by and on behalf of Plaintiff herein, having been first duly sworn, was examined and testified as follows:

THE CLERK: Please be seated.

In a loud and clear voice, state your name and address, spelling your first and last name for the Court.

THE WITNESS: Andrew Merola, A-N-D-R-E-W, M-E-R-O-L-A, 36 Seventh Avenue, Suite 502, New York, New York, zip 10011.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Good afternoon.

THE COURT: You may inquire.

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DIRECT EXAMINATION

BY MR. GOLDSTONE:

Q. Good afternoon, Doctor.

When you say "doctor," is that a medical doctor?

A. Yes.

Q. Do you have any particular specialty?

A. Orthopedic surgery.

Q. What is orthopedic surgery?

A. Orthopedic surgery is surgery of the musculoskeletal system, bones and joints, tendons and ligaments, muscles and arms, legs, neck and back.

Q. Doctor, could you tell the jury something about your background, educational, professional background.

A. Sure.

I did my undergraduate medical training at Howard University in Washington, D.C. I did my orthopedic surgical residency and general surgical residency at the State University of New York in Brooklyn.

After that, I did a spinal surgery reconstructive fellowship at the University of Colorado in Denver, Colorado.

I returned to SUNY Downstate in Brooklyn at the request of the chairman to head up their spinal surgery division and to head up the research efforts of the department of orthopedics is at SUNY Downstate.

I'm currently an assistant professor of orthopedic surgery as well as the chief of the section of spinal surgery for the orthopedics department at SUNY Downstate in Brooklyn.

THE COURT: Doctor, if you sit closer to the microphone, it will help. As you can see, the ceilings are high. So if you try to reach for the last juror, that would be very helpful.

Q. You are licensed in New York State?

A. Yes, I am.

Q. Anywhere else?

A. New Jersey and Colorado.

Q. Are you board certified?

A. Yes, I am.

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Q. In what specialty?

A. Orthopedic surgery.

Q. Would you explain what board certified means.

A. Sure.

Board certification is a process whereby, after we have completed an accredited residency training program in orthopedic surgery, we take several examinations.

The first one is a written examination which is given to all orthopedic surgeons in Chicago, administered once a year, and after we have successfully completed that, and we proceed into private practice, after two years of private practice, we're examined on our cases and on our surgeries by an oral examiner. That's part two of the exam.

After passing that, as well as a moral and ethical component of the practice of orthopedics, whereby the orthopedic board inquires of my peers and my colleagues to evaluate me, we're granted what called board certification in orthopedics.

That's also accredited by the American College of Graduate Medical Education to certify that we have now passed and met all of the requirements of the orthopedic board.

Q. Are all surgeons board certified?

A. No.

Q. So, a doctor can perform surgeries every day and still not be board certified, is that correct?

A. Yes, that is correct.

Q. Do you have any affiliation -- medical affiliations?

A. Yes, I do.

Q. Would you tell us what they are, please.

A. Sure.

I'm affiliated with the State University of New York in Brooklyn Downstate. I'm also affiliated with the St. Vincent's Hospital here in downtown Manhattan.

Q. Have you ever lectured?

A. Yes.

Q. Where? Under what circumstances would that be?

A. Part of my responsibilities through the State University are to lecture and teach medical students as well as residents, so I lecture at the State University, and I also lecture at St. Vincent's Hospital in Manhattan to the residency program there.

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Q. Do you belong to any professional organizations or societies?

A. Yes, I do.

Q. And what are they, please?

A. I am a fellow of the American Academy of Orthopedic Surgeons. I am also --

Q. Let me stop you a moment.

What does that mean, a fellow?

A. A fellow means that I am basically a member of the American Academy of Orthopedic Surgeons. That is that I have met and fulfilled all the requirements of their board, which includes the active practice of orthopedic surgery, as well as boa ?? certification.

Q. Would you continue, please.

A. Sure.

I'm also a member of the Scoliosis Research Society, which is an orthopedic spinal reconstructive society. It's an international membership. I'm one of the American members.

Q. Do you do any consulting?

A. Yes, I do.

Q. Tell us about that, please.

A. I do consulting for the hospitals which I work at, as well as for the boards that I'm a member of.

I've also been asked to consult by various industries to speak about orthopedic implants and the testing of various orthopedic devices.

Q. You mentioned before some of the lecturing that you were doing. Have you ever been a guest lecturer?

A. Yes, I have.

Q. Under what circumstances was that and where?

A. I've been a guest lecturer at some colleges and universities, including the Cooper Union here in New York City, as well as for my professional societies and other meetings, including my teaching responsibilities at SUNY Downstate and St. Vincent's and New York Medical College.

Q. You mentioned teaching. Are you a member of any faculties?

A. I am on the faculty at SUNY Downstate, yes.

Q. Have you ever received any awards?

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A. Yes, I have. C. What were they?

A. I have received the Hibbs award for spinal reconstructive surgery. I received the Charles Epps award for orthopedics when I was in medical school.

I have received the Mercer Rang paper competition award from the Brooklyn Orthopedic Society.

I've also received the American Orthopedic Association award for best presentation at several of their meetings.

Q. Have you ever written anything that's been published?

A. Yes, I have.

Q. Tell us what they were.

A. I've written several articles published in the Journal of Bone and Joint Surgery, which is the journal of orthopedic literature here in the United States.

I have also published in spinal, which is a particular publication with respect to spinal surgery. I have just recently authored and edited a textbook on spinal reconstructive techniques that was published last fall.

Q. About how many times would you say you have been published?

A. Over the last five years, I would estimates that I've been published somewhere between 75 to 80 times.

Q. Have you written any books?

A. Yes.

Q. About how many?

A. Edited three books and written chapters in approximately four or five.

Q. When did you write the most recent book?

A. Most recent one was published last fall.

Q. We won't go through all the publications, but would you say it was about 75, 80?

A. Yes.

Q. Have you ever done research work?

A. Yes.

Q. Could you tell us about that, please.

A. Sure.

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I do both basic science and biomechanical research in orthopedics as well as spinal reconstructive surgery.

So, that involves looking at, for example, the genetic basis for a disease known as adolescent idiopathic scoliosis.

I've done work with biomechanical testing of spinal implant devices as well as devices that test lower extremities, ankle and knee problems, to mention a few.

Q. And you've already told us about all of the medical associations you belong to, or were there any others?

A. There are always a few extra that you forget about, but those were the most important societies that I belong to.

Q. Are you associated with any hospitals?

A. Yes. SUNY Downstate in Brooklyn and St. Vincent's here in Manhattan.

Q. Let's talk about St. Vincent's. What was your connection with St. Vincent's?

A. I'm an attending surgeon.

Q. What does that mean?

A. At St. Vincent's Hospital, an attending surgeon is a physician and surgeon who has privileges to admit and treat patient at that hospital.

Q. What does it mean when you say you have privileges?

A. Privileges means that the hospital has accredited me to treat patient at that institution. That accreditation process is similar to a board certification process, so I need to submit all of my academic credentials.

Then the hospital reviews those, speaks to my associates, and then the hospital grants me privileges in order to be able to practice at that institution.

Q. So you can bring your patient into that hospital, correct?

A. Yes.

Q. Have you ever been called in by the hospital for your services with reference to somebody who has been admitted to the hospital who you had never met before?

A. Yes.

Q. Would you tell us if you've ever met Mai-Linh DeVirgilio?

A. Yes, I have.

Q. Before today, did you ever meet me?

A. No.

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Q. Did you ever testify for me or my firm?

A. No.

Q. Do you get involved in litigation matters?

A. Very infrequently. Only if I have a patient that happens to have a case pending or that has some type of litigation pending.

Q. Now, would you tell us the circumstances under which you first met Mal-Linh DeVirgilio?

A. I met Ms. DeVirgilio in September of 2001. I was the orthopedic surgeon on call when she presented to the emergency room of St. Vincent's Hospital.

Q. Did you go see her?

A. Yes.

Q. And did you physically examine her?

A. Yes.

Q. Did you obtain a history from her?

A. Yes.

Q. Has she remained your patient until the present time?

A. Yes.

Q. Would you tell us the history that you obtained from her over that time and any history you obtained from any other records, plus your findings -- let me rephrase that.

Did you obtain a history from her and from other medical records?

A. Yes.

Q. Did you also conduct a physical examination of Mai-Linh?

A. Yes.

Q. Did you also examine x-rays, x-ray reports, MRI reports, CAT scans and CAT scan reports?

A. Yes.

Q. Or the basis of all of that, had you reached a diagnosis in her case?

A. Yes.

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Q. Would you tell us in detail what that was and how you arrived at it?

A. Yes.

MR. TOKER: Objection.

THE COURT: I'm sorry. Is this an objection to form?

MR. TOKER: The things he incorporated into the question. I guess it's to form.

THE COURT: Can you break it down, please, counsel.

Q. Did you reach a diagnosis?

A. Yes.

Q. Will you explain what that diagnosis was and how you reached it.

A. Yes. The diagnosis for Ms. Mai-Linh DeVirgilio, upon presentation to the hospital, was one of, number 1, polytraumatic injuries.

Number 2 --

Q. Okay. Let's take it one at a time. When you say polytraumatic, what does that mean?

A. Polytrauma refers to multiple traumatic injuries to the same person in a small frame of time.

Q. Trauma means what?

A. Trauma would refer to any type of unexpected or untoward contact with the human body.

Q. I'm sorry. Continue, please.

A. Yes. So polytrauma, number 1.

Number 2, she had sustained right hemothorax rib fractures.

Number 3 --

Q. I get lost on these things, so can you explain them as you give them.

A. Sure.

She basically had rib fractures on the right side of her chest which resulted in some pleural effusion, which are fluid within the lung areas and the chest. That was her second diagnosis.

Q. Is that a painful type injury?

A. Yes.

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Q. How does a broken rib and fluid that you told us about induce pain?

A. There are several things involved here. Number 1 is the mechanism of injury.

The mechanism of injury for Ms. DeVirgilio was a crush injury that involved her chest and her pelvis and her leg.

Specifically with regard to the chest and the ribs, the ribs themselves are like bony branches, if you will, that encase your lungs. The ribs are responsible for protecting your lungs in your chest.

When the ribs themselves are broken, what happens is the bones fracture, and then that fracture moves out of place.

It rips and tears the covering around those ribs and, in so doing, creates an inflammatory process around that fracture area.

The lungs that are underneath the fractured ribs are then prone to the crush injury itself, and then those lungs respond to the trauma and the crush by leaking and sweating on the inside of your chest, which then produce fluid into the chest area.

In and around the ribs and all of the soft tissues that encompass them, as well as on the inside of your chest are nerve endings.

Those nerve endings are there to let your body know how these little portions of your body are behaving and performing.

If everything is fine, you feel no pain. If something is broken or out of place or damaged, those nerve endings fire and then send signals back to your brain to tell you that there is something wrong, and that's the pain response.

Your body uses that to key you in on a particular portion of your anatomy that may not be functioning properly.

So, after those ribs fracture and break, and there's bleeding and leakage of fluid and damage to the lungs that are underneath them, all those little pain fibers and signals start being generated up into your brain area so that it makes you say, hey, my chest hurts. Let's take a look at it. There is something wrong there.

That's the first way the pain mechanism is generated.

The second thing that happens is the inflammatory response or the response that your body now uses to try to heal that injury.

What happens there is you leak -- leak certain chemicals. Those chemicals then call other special cells into that area where the injury is to try to set off a reparative process.

That inflammatory process is painful in and of itself. So your body is now trying to bring cells into where the fractured ribs are, the torn tissue and the leaky lungs are to try to get something in there to try to start to heal things and to make those fractures heal and to repair the broken tissues and the leaky lungs.

So, the inflammatory process is also painful.

So, there are basically two pain mechanisms that are at work. The first is the direct trauma that lights up those nerve endings that say there is something wrong.

And the second one is a chemical leakage that then brings your body's own cellular mechanisms into play to set off a reparative process.

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The third thing that happens is, after all that is over with and said and done, those nerve endings that have fired and lit themselves up to tell you that there was something wrong are now also a little more vigilant.

They're also a little bit more hypersensitive to that area because they know it's been injured in the past and there is a potential for more injury because it's not the same as it was.

So, there is also a little bit of extra hypervigilance in those nerve areas that have been injured.

So there are three basic mechanisms for pain generation.

Q. Would you continue, please. Number 3?

A. Sure. Number 3, she sustained a complex pelvic fracture, secondary to the crush injury which involved fractures of both the front part of her pelvis and the back part of her pelvis, the so-called pubic rami, or the rings of her pelvis, as well as sacrum and sacroiliac area, or the back part of her pelvis, secondary to the crush injury.

Q. Perhaps you could either if you have a diagram or just show us on yourself what area of the body that would be.

A. Sure.

MR. GOLDSTONE: If the Court permits.

THE WITNESS: May I?

THE COURT: Yes.

THE WITNESS: Thank you.

A. Your pelvis is that area of your body that acts as a basin or a bucket on the bottom part of your abdomen and your chest, so all of your organs, including your chest, sit inside this part of your body or the pelvis.

So, it's really kind of like a bucket, and it's circular, so it has a front part to the circle and a back part to the circle.

In Mrs. DeVirgilio's case, what happened is the front part of the pelvis was crushed in two places and broken and the back area of her pelvis was also crushed and broken in several places.

So, she had a break in both the front half of her pelvis and the back half of her pelvis.

So, it's what we call a complex pelvic injury, because it's not an injury that's only confined to one specific area, but it involves multiple areas.

The significance of that is when you're dealing with the pelvis, it requires the integrity of the entire ring of that pelvis to be able to maintain stability for your legs to make you walk and to transmit your what we call center of gravity over the earth.

So, your pelvis is responsible for maintaining a normal center of gravity and acting as a connection between all these organs that we have up here and our legs and feet and the ground.

That's the way we bipedal animals or human beings are able to actually walk.

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In dogs and cats and animals that walk on all fours, the pelvis is not that important. If you look at pelvises in cats and animals and dogs, they're a lot more shaped a lot more like ?? triangle than a circle.

So, this pelvis is a very import ?? part of human anatomy in the way we actually walk ?? maintain our normal safe center of gravity.

When it's broken in two separate places, that ability to maintain normal center of gravity and normal ambulation is lost.

Q. As I understand it, Doctor, there were fractures in the pelvic area. Yet there was no surgery. Was there a reason for that?

A. Yes.

Q. Would you explain it, please.

A. Certainly.

The type of pelvic injury that she sustained was a crushing injury. It's not a clean break fracture.

One way of thinking about this is if you were to take a potato and slice that potato with a knife, you'd have a clean break with two halves of the potato that you could put right back together again and make it look a lot like the potato that wasn't cut.

A crush injury is like take a potato with a hammer and beating it with the hammer, now you've got mashed potato and it's hard to make it look like a potato again.

It's also very difficult to get it anatomically aligned surgically because those bones that are now crushed don't have clean edges to just pop back in together.

They are kind of floating around in a little bit of a soup or an other meal, mashed potato kind of millieu.

What needs to happen in that case is you need to just set up this circumstance for healing so that the body can come in and heal that broken area as best it can.

So it's very difficult to actually operatively fix with screws and rods and plates and hooks and things a crush injury to the pelvis.

That's the most difficult type of pelvic fracture to put back together again.

Q. Is that pain induced?

A. Yes, it is.

Q. How would that come about?

A. It's pain inducing for the same mechanisms that we talked about with the rib fracture.

Additionally, we need to understand that this particular portion of the pelvis -- in fact, the pelvis itself is a transition zone between your spine and your abdomen and your legs.

There are muscles that pass through the pelvis and then descend into your legs and they actually move your legs around.

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The muscles that make it possible for you to bring your knees up to your chest actually originate inside your abdomen and pass through the pelvis.

So, now we have an area that's injured and fractured and traumatized that connects the top half of our body to the bottom half of our body, and, row that all those injuries have bleeding and swelling and inflammation and hyperactive nerves in them, we now get pain generated from both the top part of your body and the bottom part of your body.

So, a pelvic fracture, particularly a crushing pelvic fracture, can be an exceptionally painful injury.

Q. Continue with your findings, please.

A. Sure. Then the third diagnosis that we have was a crush injury to the right lower extremity was a fibular fracture.

As her crush continued, it involved her leg. She had a laceration that was near the knee joint and, in addition to that laceration or cut near the knee joint, she also had a crushing of the lower leg.

That crushing of the lower leg resulted in a fracture of one of the bones of her lower leg called the fibula.

Additionally --

Q. Excuse me. Could you show us which bone that would be, the fibula.

A. Sure.

THE WITNESS: If I can stand up for a minute?

THE COURT: Yes.

THE WITNESS: Thank you.

A. So, in your lower leg there are two big bones. The one you can feel in the front part of your leg when you run your finger along your shin, that big one is called the tibia. That tibia takes up most of the stress of when you're walking.

Then on the outside, which you can't really feel unless you get down to your ankle joint, is the fibula.

Your lower leg looks a lot like a chicken wing. It's got two bones in it and a lot of muscles and tendons in between those two bones encased in skin.

The small bone on the outside of the lower leg, the fibula, was cracked up in the upper half of it and the muscles, the tendons, the ligaments.

Everything between those two bones were crushed and subsequently the covering of those muscles were torn, and those muscles herniated through the tearing in that covering.

So, a crush injury to the lower extremity as well.

Q. I think that was 4. That was number 4, I believe.

Was there any other finding?

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A. She also had a small amount of free air in her abdomen, which was noted on some of the diagnostic studies.

That was one of the reasons that she had been admitted to the intensive care unit for several days.

Q. What does that mean? What the significance of that?

A. Your abdomen is an area, the belly section of your body should not contain any air except inside your stomach and your intestines.

If there is any air outside of your stomach and your intestines, there's got to be a reason it got there, and it's abnormal.

It can signify the rupture of an internal organ or it can signify the tearing of the tissues that overlie the abdominal area with subsequent leakage of air into the abdomen.

That is something that if an internal organ were ruptured, it would need to have something immediately done for it, and you also need to see that air resorb over time.

So that the best place to watch a person who has something like that is in the intensive care unlit.

Q. Did you observe any unusual or at any time in the treatment herniation on the leg of Ms. DeVirgilio?

A. She has on her right leg where that crush to the right leg happened and she got her fibula fracture, that muscle that's in between those two bones has herniated beyond its covering.

So, there is a herniation of the muscles of the right leg in between the two bones, one of which was fractured.

Q. What does herniation mean?

A. Herniation means a poking of the muscle through its normal covering.

Q. Is that something that could be removed cosmetically, for cosmetic purposes?

A. It's very difficult to treat that type of issue, particularly for cosmetic reasons, because the muscles of your lower legs have a covering around them that we call fascia.

That fascia is -- it's a lot like a leather sac that holds your muscles in place.

If you close that leather sac back up together again, the muscles that are underneath it are prone to experiencing excessive pressure, and you can develop what called a compartment syndrome or an exertional compartment syndrome.

You can experience pain or even muscular death or injury in that leg if you go back and tightly close that fascial layer back together again.

So that's not something that you would want to do for cosmetic reasons or really any reason.

That muscle blew through that fascia for a reason, and you don't want to go back and close that over again because, if you do, you can be causing more problems.

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Q. Did you examine the sacrum area?

A. Yes.

Q. What were your findings there?

A. She has a, what known as a diastasis, or a widening, of the left sacroiliac area with what called pelvic obliquity, or a malalignment, of the pelvis.

So if the pelvis needs to line up in a perfect circle like this, if you have a break in the front and the back, the pelvis itself, half a portion of that pelvis can now rotate away from the rest of the pelvis and cause what we call an obliquity, or an abnormal alignment.

She does have that abnormal alignment of her pelvis.

Q. And the sacrum is where?

A. The sacrum is in the back portion of the pelvis, closer to your buttock area.

Q. Did you take any x-rays of any of these areas?

A. Yes.

Q. Do you have them with you? A, Yes, I do.

Q. Would you be able to show us some of the areas that you've indicated in your x-rays?

A. Yes.

MR. GOLDSTONE: With the Court's permission.

THE COURT: Have these x-rays been marked?

MR. GOLDSTONE: They just came in. No, your Honor.

THE COURT: Yes, Mr. Toker?

MR. TOKER: Could we have them marked collectively?

THE COURT: Excuse me. Mr. Toker.

MR. TOKER: I do have an objection under 4532. I haven't been provided these.

MR. GOLDSTONE: He was given authorizations for all.

THE COURT: Excuse me. We'll have a sidebar on this issue. Let's bring the x-rays with us.

(In chambers, the following was recorded:)

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THE COURT: Have you seen them, Mr. Toker?

(Handing.)

MR. GOLDSTONE: I don't know if those other x-rays have come up yet from the clerk's office, part of St. Vincent's.

THE COURT: I don't see my court officer back, so I'm assuming they haven't come up yet.

MR. TOKER: May I go off the record for a moment?

THE COURT: Off the record.

(Discussion off the record.)

THE COURT: Let's go back on the record.

Mr. Toker, you're producing the authorizations at this time, is that correct?

MR. TOKER: Yes. These are authorizations all given in 2002.

THE COURT: May I see it, please.

MR. TOKER: This is the one for Dr. Merola.

(Handing.)

THE COURT: We'll have to get a copy of this at some point and we'll mark it as a Court exhibit.

It provides for the doctor to furnish medical records pertaining to Mai-Linh DeVirgilio on or about 9/5/01 and thereafter. It is dated August 16, 2002.

Now, your position, Mr. Toker, is?

You had asked to go off the record, so let's have you put your objection on the record at this time.

MR. TOKER: four Honor, I maintain that in any case such as this, if a plaintiff provides authorizations, their process, the doctor sends the records, that thereafter, and in this particular case, two years after, apparently, if further x-rays or diagnostic tests are performed, particularly x-rays, that the plaintiff's counsel is under an obligation, in order to authenticate these records and to put the defense on notice, to give the defense an opportunity at least ten days before trial to have these records reviewed by its own physician and to notify defense counsel that these records are going to be used.

I respectfully submit there is no continuing obligation of the defense in a case to constantly request that any further diagnostic tests be -- that they be notified of these diagnostic tests.

It is the obligation of counsel in this case, if he intended to produce into evidence x-rays taken, I believe the x-rays taken -- and I'm not sure about all of them, as I haven't seen the shadow box, but, clearly, there are x-rays -- and we can establish this with the doctor -- that they are dated April of '04, that this is just being produced in court now, I would submit, without proper notice to the defense to have them reviewed and looked at.

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MR. GOLDSTONE: There is nothing in any statute that says we're under a continuing obligation.

In fact, authorizations were given. The authorizations are not steel.

When a patient continues going to a doctor for treatment, counsel for the defendant is not entitled to a report every time the patient goes to the doctor.

The only time that they would be entitled to a new report would be if there is, say, all of a sudden we said now she has brain damage, and the doctor found that out. Then we would have to send them a new report.

But the normal progress of the injury that they're aware of and its sequelae is not something that we have to keep reporting on and the x-ray is nothing more than that.

It is not a new finding.

MR. TOKER: I don't disagree that, if I may, your Honor, that Dr. Merola was required or counsel is required to give me new reports every time the plaintiff went to see the doctor for treatment.

My point is that with regard to x-ray films under 4532-A, there should have been some notice to the defense so that the defense would have had the opportunity, within en days prior to trial, to have these records reviewed.

I think the statute is very clear that whenever such diagnostic tools are going to be used, there is an obligation to notify the other side.

MR. GOLDSTONE: I don't think the statute says that. It says we have to supply authorizations, and then it's up to the defense counsel to use those authorizations appropriately.

MR. TOKER: I don't see how the defense counsel could be aware these x-rays even exist unless plaintiff's counsel notifies him.

THE COURT: The statute provides -- this is 1532-A, subdivision 2, quote, “In the event said exhibit has not previously been examined by the party or parties against whom it is offered, that at least ten days before the date of trial of the action, the attorney for the party intending the offer such graphic, numeric or symbolic or pictorial representation as a proposed exhibit serves upon the attorney or attorneys for the party or parties against whom said proposed exhibit is to be offered a notice of his or her intention to offer such proposed exhibit in evidence during the trial and that the same is available for inspection at his or her office,” close quote.

This was not proffered, is that correct?

MR. GOLDSTONE: Correct.

THE COURT: The objection is sustained. We will mark these so that you have a record, and we can mark them, I think, collectively.

What exhibit will this be, Mr. Goldstone?

MR. GOLDSTONE: I don't know.

THE COURT: You need to make a list of your exhibits. Do you have it out there?

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MR. GOLDSTONE: No.

THE COURT: Ask the court reporter.

(Whereupon, the trial resumed in the courtroom.)

(Plaintiff's Exhibit 7 was marked for identification.)

Q. Doctor, in your examinations of Ms. DeVirgilio, did you conduct any tests?

A. Yes.

Q. Would you tell us what they were and what the findings were?

A. Sure.

During my examinations of Ms. DeVirgilio, there are several different types of tests. There are physical exam findings, and there are also diagnostic studies.

The diagnostic studies include x-rays and x-ray studies.

The physical findings include things such as inspection, basically meaning observation of her gait, how she walks, and any abnormalities that we see, testing what we call palpation, where we feel various portions of the body to see how they are functioning or behaving or how they are standing or sitting, that type of thing.

So, the tests and findings can be both diagnostic as well as physical.

Q. And when you gave those tests, would you tell us what your findings were.

A. Sure.

Ms. DeVirgilio is a young lady who now has what we call pelvic obliquity with an altered gait pattern, as well as persistent pain.

Q. Let's take it one at a time.

MR. TOKER: I'm going to object to anything other than his testimony of physical examination at this point. The diagnostic testing, I think we have other matters to consider.

THE COURT: We're going to have to have a sidebar on this issue. I will give the jury a break at this time, since the last sidebar turned out to be a longish one.

(The jury left the courtroom.)

MR. TOKER: Yes, your Honor. The question that was asked of this doctor was twofold.

One, to talk about the physical examination portion of his and the findings upon physical examination.

The second part, which I object to, is not as yet having proper foundation. It's for the doctor to comment on c??tain diagnostic tests that perhaps he did or perhaps he did not do.

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The Court has written extensively on this, and what he can and what he cannot testify to as a treating physician with regard to certain diagnostic tests and what, if any, foundations should first be provided before he can discuss that.

So, the nature of my objection at this point is to limit the doctor's testimony, at least at this stage, upon physical findings -- upon physical examination.

THE COURT: Mr. Toker, do I understand, perhaps reading somewhat between the lines, that you're seeking to preclude any testimony as to what the April 2004 x-rays, to which I just sustained an objection, showed?

MR. TOKER: Yes, as well as an other diagnostic tests which we don't know what he's talking about.

The doctor hasn't -- it hasn't been brought out what diagnostic tests were done, when they were done and whether this physician is ??lidly testifying about this material.

This has not been fleshed out yet. So, the question incorporated both.

THE COURT: Mr. Goldstone.

MR. GOLDSTONE: Well, first, in the doctor's reports, all of which counsel has, and his office records, which he has pursuant to the authorization which we gave him, and, in fact, in the April 12, 2004 report he was given notice about the x-rays.

If I may read, “radiographs, x-rays are taken in the office today.”

So, he did have notice of those x-rays. In the reports it mentions the tests that were given and their findings.

THE COURT: Weren't you suppcsed to provide copies of the x-rays if you were going to offer them as an exhibit?

MR. GOLDSTONE: I think they were requested. We make them available for inspection.

MR. TOKER: No, they were never made available. At no time did I get notice.

THE COURT: All right. Was notice given?

Let's just stick with the statute for a moment. That's a narrower point.

You're essentially attempting to reargue my ruling at the last sidebar. You're saying notice was given, that x-rays were taken.

4532-A, subdivision 2, provides for a notice of the party's intention to offer the proposed exhibit in evidence during the trial and that the same is available for inspection at his or her office.

Let's focus on that for a moment, Mr. Goldstone.

Are you saying that you served such a notice, that this exhibit was available for inspection?

MR. GOLDSTONE: In effect, yes, your Honor, because when we give an authorization, we're saying it is available. It can be turned over for inspection.

THE COURT: Excuse me. You gave an authorization in 2001. Did you give a new authorization?

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MR. GOLDSTONE: There was no need to. That's not stale. It's still good.

THE COURT: Very well. My ruling on that issue is going to stand.

To hold otherwise would be to eviscerate the meaning of 4532-A, and this problem could have been avoided by the simple expedience of compliance with the statute.

Now, turning to the next issue, which is Mr. Toker's attempt, I will put this in poetic terms, to essentially nuzzle the doctor's trial testimony.

There are certain procedures here. I think that if Mr. Goldstone is going to ask Dr. Merola to testify about the contents of x-rays that are not in evidence, that is going to be a problem under the governing evidentiary precepts, but I do not think that a treating doctor is precluded from giving his diagnosis or stating what his conclusions were based on both diagnostic studies, which may or may not have been in evidence, and physical findings.

It is only if specific testimony is elicited about x-rays or other reports that are not in evidence, then we have a problem under the evidentiary rules.

So, let's try to get as many documents in evidence as can be got in evidence.

I know, Mr. Goldstone, you're waiting for some x-rays from St. Vincent's. I think they're fortuitously arriving at this very moment, and, hopefully, that will eliminate a lot of the evidentiary disputes that would otherwise arise.

Let me just ask you to take a few minutes during this break to review these documents that have just arrived with a view to either having them marked for identification or, if there is agreement, to their admission to having them marked into evidence.

Is there anything else you wanted to say?

MR. GOLDSTONE: Yes, your Honor. They're part of the St. Vincent's Hospital record which is already in evidence, so I don't think we have to do that, but what I'm asking is that we be given some time so the doctor can take a look at them.

THE COURT: Well, we have x-rays here, correct?

MR. GOLDSTONE: Yes.

THE COURT: These weren't previously marked, were they?

MR. GOLDSTONE: Well, they're part of the St. Vincent's record, which they should have been included when the St. Vincent's Hospital's record came over. They weren't.

THE COURT: So they can have the same number, but if there are specific films that you are going to review now with the doctor, you should have then separately marked as 1-A or B or whatever, so that we don't lose track of them.

MR. GOLDSTONE: Can he view them so we see which ones we want to offer?

THE COURT: Yes, we'll take another ten minutes.

MR. GOLDSTONE: Could he use the shadow box?

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THE COURT: Yes.

MR. GOLDSTONE: Thank you.

(Plaintiff's Exhibits 3-A thru 3-C were marked in evidence.)

(Short recess taken.)

THE COURT: Counsel, we have 3-A through C for the x-rays.

(The jury entered the courtroom.)

THE COURT: Please be seated, members of the jury.

Doctor, if when you're testifying about an x-ray, you're more comfortable stepping down, feel free to do that.

Mr. Goldstone.

MR. GOLDSTONE: Thank you.

DIRECT EXAMINATION BY

MR. GOLDSTONE (Cont'd.:)

Q. Doctor, I think you indicated that tests had been given to Ms. DeVirgilio, is that correct?

A. Yes.

Q. And, in fact, x-rays were taken at St. Vincent's?

A. Yes.

Q. I think you have some of those in front of you now. At this time they have been marked in evidence.

So, if you could illustrate any of the things that you've been telling us with those x-rays, would you please do it, and use that shadow box.

A. Yes.

MR. TOKER: Is that a question, Judge?

THE COURT: All right, counsel. These are x-rays that were taken at the time of the 2001 hospitalization right after the accident, is that correct?

MR. GOLDSTONE: Yes.

MR. TOKER: Judge, I'm just objecting to the form of the question calling for a narrative illustration.

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THE COURT: Let's have a question about the x-ray that's up on the screen.

Q. Will you tell us what those x-rays illustrate, please.

A. These are x-rays that demonstrate the original injuries in September of 2001.

Q. Could you point out what your findings were.

MR. GOLDSTONE: Could the jurors in the back perhaps move up.

THE COURT: If anybody needs to move up in order to see better, you may feel free to do so.

A. This first x-ray is an x-ray of the pelvis, and you can see how it is very much like a bucket. This is the spine or the lower portion of the back on top. These gray areas that you see in here, these are loops of intestine that are inside the pelvis.

These are the hip joints on both sides of the pelvis and the legs as they go down into your feet.

This is the pelvis itself.

Now, on this x-ray -- this is a front-to-back view of the x-ray, and what it shows us is, it shows us -- this is the front part; this is the back part.

Along the front part of the pelvis we can see that there is a break, with a chunk of bone missing and in a poor position right here.

So, if you look at this circle, this circle is missing its bottom portion, and there is a chunk of this bone that's broken off.

On this side we see that there is a portion of bone up on this area that's been indented. These represent what we call the pubic rami fractures in the front part of the pelvis.

The back part of the pelvis is a little bit more difficult to see on this x-ray, so I'm going to show you on CAT scan. That shows the fracture better.

But, just briefly on this x-ray, if we look here, this is the area of the sacrum. There are these little wispy lines.

On this side, on the left side, these lines are broken. They represent crush fracture of the left side of the pelvis.

Q. What kind of fracture?

A. A crush. I will show you that a little bit better on this CAT scan.

THE COURT: Doctor, can you just give us the letter from the back, from the orange tab.

THE WITNESS: Sure. The first one was 3-B, and the second one I'm going to show is 3-C.

THE COURT: Thank you.

Q. Would you tell us what a CAT scan is first?

A. Sure.

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A CAT scan is an x-ray examination, is made whereby the patient is placed in a special machine that takes, literally, hundreds and thousands of very rapid x-rays of the particular body part in question.

That information goes into a computer. Then the computer spits out what we call the slices. So it's like taking your body and putting it into a salami slicer without having to actually put you into the slicer.

Then it gives you pictures of your body in different cuts. They're actually called slices or cuts. That's why we see all these multiple views on this one piece of film.

The pelvis we're looking at here, we're not looking at a front-to-back view of the pelvis, but we're looking at a top-to-bottom view.

If I were put in the salami slicer and you were taking slices of me off like this, that's the slices we're looking at here. So there are slices coming along this way.

I would look inside. It's very good for showing us areas that don't pop up on that front-to-back view.

Now, this is the spine, this thing that kind of looks like a hat back here, maybe a little bit like Napoleon's hat or Napoleonic sailor hat, that's the lumbar spine, the bones of the lumbar spine. They're in the middle.

The intestines and the bowels and all that stuff are floating around up here in the abdomen. This is the front side, this indentation is where the belly button is. This is the backside.

As we take a look at these cuts, these things that look like bat wings are the pelvis itself.

All the way back here in the back part of the pelvis is this thing that starts to look a little bit more like a butterfly or a bat. That's the sacrum. It's a little difficult to see on this because they're such small films, but if you compare this side, the right side of the sacrum, to the left side, you can see that on the left side there is this gray line that goes all the way through the entire length of the sacrum.

That's an area where the sacrum was crushed and disrupted or mashed. So that's the crush or the mashing portion of the left sacral area.

Then if you look at the joint on that side, which is this area where this piece of bone meets this piece of bone on the left side, that joint is a little bit wider than it is on the right side.

Once again, that's telling us that this area of the sacrum has been crushed and moved out of place.

So, these two pieces of tests, the x-ray of the pelvis, is showing us the injury up in the front very nicely, and the CAT scan of the pelvic, which isshowing us the injury in the back in the area of the sacrum.

So, this tells us exactly where those breaks were in the front and in the back of the pelvic area.

This other x-ray -- this is 3-A -- is the lower leg. This is a side view of the lower leg. Your knee is up top. Your ankle is on the bottom.

These are the two chicken wing bones of your lower leg. You can see there's a big bone here that's called the tibia. There *is* a smaller bone here. That's called the fibula.

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If you look up in the upper portion of the fibula, you can see that there are no longer incontinuities with each other.

There is a break here. That break shows us that one portion of that bone has been pushed in front of the other portion of that bone, and there is an oblique fracture or an oblong or obtuse fracture in that area.

This shows us the crush injury and the fracture of the fibula in her right lower leg. These are the films that really best show the injuries most clearly (indicating).

Q. Are you through with the shadow box?

A. Yes.

Q. Now, aside from x-rays, MRIs or CAT scans, did you administer any other tests?

A. Yes.

Q. Could you tell us what they were and what the findings were?

A. Sure.

Q. Take them one at a time.

A. These are our -- basically part of what we do when the patient comes into the office to see us or in the hospital.

We take a history. We get an idea of how they are how they're feeling. What's bothering them. That's called a history portion of our examination.

A. ?? historically Ms. DeVirgilio has had long-standing or chronic pain. She's had difficulty with her activities of daily living, difficulty with walking, and she has also been experiencing anxiety and depression.

So, those are the significant findings of the history or what the patient tells me about how they're doing or how they're feeling.

Her physical findings are those findings that I then try to elicit from her body by looking at it or touching it or doing some tests.

What we see from examining Ms. DeVirgilio over time that I've known her, over the last several years that I've known her, are, she has what we call a gait disturbance or abnormality in the way she walks, with an obliquity of her pelvis or a displacement in her pelvis, with a leg length discrepancy, one leg shorter than the other because of the pelvic obliquity or displacement, with a disturbance in the way her lower back performs when compared to her pelvis and her lower extremities that also demonstrate dysfunction in the lower portion of her back.

Q. Would this abnormality in the leg that you told us about, at the time, have any effect on the other leg?

A. Yes, because of the relationship of the pelvis and the legs to gait --

MR. TOKER: Your Honor, I object to this portion.

THE COURT: What is the basis?

MR. TOKER: It was beyond the scope of the bill of particulars and not disclosed to the defense in any reports prior to trial.

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MR. GOLDSTONE: Fart of the sequelae of the injuries that have all been disclosed.

THE COURT: Counsel will approach, please.

(Out of the presence of the jury, the following was recorded:)

THE COURT: Is there any notification in any of the reports that were exchanged of an effect on the other leg?

MR. GOLDSTONE: That's sequelae. That's in the bill of particulars.

MR. TOKER: No, it's not.

THE COURT: So it's not in the reports?

MR. GOLDSTONE: No.

THE COURT: Let's look at the bill of particulars.

MR. GOLDSTONE: It says sequelae, or words to that effect.

THE COURT: I'm looking at item 10. Can you show me anything in there or any other item which refers to this physical condition?

MR. GOLDSTONE: I don't think it has to specifically say it. I think sequelae are always included whenever you have the injuries listed, and we do have the injury listed here about the leg. That's one of the sequelae of that injury.

THE COURT: The objection is sustained.

Q. Doctor, when you said “an abnormal gait,” would you explain what you mean by that, please.

A. Sure.

A normal gait pattern is what we call bilateral, which means side to side, heel to toe and reciprocal, which means one leg moves in front of the other. That's essentially a normal gait pattern.

If there is any deviation in that type of gait, then we say there is a gait abnormality.

They can come in different flavors. Those gait abnormalities can happen because of muscular weakness or because of leg length discrepancy or because of pain or from a condition such as a pelvic obliquity.

In Ms. DeVirgilio's case, she has what we call a Trendelenburg type of case which means if a portion of her pelvis, if you put your hands on it while she's walking and you feel the pelvis move, the portion of that pelvis dips as she moves, that's known as a Trendelenburg gait.

That happens because of the pelvic obliquity as well as difficulty with the muscles that hold the pelvis stable during the gait.

Q. Would you continue with any other tests or findings that you may have done.

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A. Sure.

Additionally, she has difficulty with her lumbar spine. One of the things that we noticed are that her lower back does not function normally.

MR. TOKER: Objection. Same objection.

THE COURT: Overruled.

You may continue.

A. That her lumbar spine does not function normally when, for example, arising from a seated position or from a forward bending maneuver, she experiences what we call reversal of lumbar lordosis upon ascent.

Most people, when you have a normal lumbar spine which functions normally, the muscles in your back curl your lower back into its normal swayback configuration, and you're able to arise from a seated position.

If there is an abnormality in the way the lower back is functioning because of muscle imbalance or imbalance in your pelvic musculature, you have a tendency to lift up your lower back more like a train, in a flatter way. You don't get that normal swayback thing you normally see with an uninjured back.

So, she exhibits that in the lumbar portions of the back as well.

Q. What result does that have for Ms. DeVirgilio?

A. That has several things.

Number 1, it tells us that the muscles in the lower part of her back that attach to her pelvis and her legs are prone to easy fatiguability and are not functioning properly, and they have decreased endurance.

Number 2, that tells us that the joints of her lower back are in a position to prematurely break down, wear and tear and age.

Q. What would the result of that be?

MR. TOKER: Objection.

THE COURT: We'll have to have a sidebar.

(In chambers, the fallowing was recorded:)

THE COURT: I'm at a bit of a loss here because all I have is the bill of particular , and I was not provided with the narrative reports. Where are we going here, Mr. Goldstone?

MR. GOLDSTONE: Just the sequelae of what has been indicated. This report it says left sacroiliac injury. It's right in the report.

There are other mentions of the area in the reports. This is what happens when you have such an injury.

MR. TOKER: It's my position, your Honor, that he's going far beyond anything contained in the bill of particulars, and there is nothing mentioned in the reports he gave about a lower lumbar spine injury.

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THE COURT: The reports do not mention problems with her lower back? There is nothing?

MR. GOLDSTONE: They do.

THE COURT: Show me what is in there.

MR. GOLDSTONE: I have the lines marked.

THE COURT: March 8, 2004.

MR. GOLDSTONE: Which they got a copy of.

THE COURT: Sacroiliac joints, is that what you are referring to?

MR. GOLDSTONE: Yes, that's part of it.

THE COURT: Sacroiliac joint, joint in the lower back, is there any agreement with that?

MR. TOKER: That's a joint in the lower back, but he's talking about the lumbar spine.

MR. GOLDSTONE: Which is the lower back.

MR. TONER: The lumbar back is not the lower sacroiliac joints. It's a different part of the body.

MR. GOLDSTONE: It is not a different part of the body. It's the lower back.

THE COURT: You can lay a foundation for this, then. If the doctor says it's the same thing or the same part of the body, then I will allow it.

MR. TOKER: It's the same general area of the body, but it's different. If they're claiming a lumbar spine injury, they should have told me about it.

MR. GOLDSTONE: You were told.

THE COURT: Here's another one. Lumbar spinal examination, December 22, 2003: “Consistent with lumbosacral strain.”

I am showing this to Mr. Toker.

(Handing.)

MR. TOKER: Well, here again, none of this was provided prior to trial.

MR. GOLDSTONE: It was so. That's a report.

MR. TOKER: This is a report that wasn't provided to me prior to trial.

THE COURT: I'm sorry. Excuse me. This was not provided to you?

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MR. TOKER: Correct.

THE COURT: We're looking at something here from December 22, 2003. Can you give me something to show that this was part of what was served on counsel.

MR. GOLDSTONE: For one, you saw the authorizations that they were given. That's the doctor's office record, and they have the authorizations, and they got those records.

MR. TOKER: No, we were not given those records. We were given authorizations.

THE COURT: Counsel, does this feel like a legal argument to either of you, where there is all this back and forth, and one of you says “is so,” and the other says “is not”

Mr. Goldstone, you are representing that this document that I have in my hand, December 22, 2003, is one of the doctor's records?

MR. GOLDSTONE: Yes.

THE COURT: And you did have an authorization for this, Mr. Toker, did you not?

MR. TOKER: No, I had an authorization to get records given a year before, and the doctor sent those records.

There was never any authorizations for any further records or treatment records past that, so the doctor didn't send me any.

THE COURT: Excuse me. But you did have an authorization that gave you access to ongoing medical treatment, did you not?

MR. TOKER: No, I had an authorization to get her records from treatment up until the time of the process.

THE COURT: And hereafter. Did it not say hereafter?

MR. TOKER: I have to take a look.

THE COURT: I prefer to have all of us go in and use the courtroom at the same time, so we will go out together while you get that.

(Pause in the proceedings.)

MR. GOLDSTONE: Your Honor, this is from 2002, where I have the lines, which they definitely got (handing)

THE COURT: I don't know what you're handing me.

MR. GOLDSTONE: Right here (indicating).

THE COURT: All right. Maybe this obviates the problem.

Mr. Goldstone has just handed me something from May 7, 2002 referring to the lumbosacral spine.

This is a report of Dr. Merola, correct?

MR. GOLDSTONE: Yes, your Honor.

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MR. TOKER: Your Honor, the doctor did not -- I have never seen this before.

THE COURT: Let me see your authorization.

As I indicated earlier, we'll have to have a copy of this so we can have it marked as a court exhibit.

All right. It does say that Hoey, King is authorized to obtain records pertaining to the plaintiff on or about 9/5/01 and thereafter.

I am going to allow this testimony.

In the interest of trying to avoid further sidebars, can you tell me where else you're going in terms of conditions, so we'll see if there are any similar objections to notice?

MR. GOLDSTONE: The limp, the pain, the C-section which we spoke of. Basically that's it. I mean, your Honor, the doctor is going to expand on it, but that's basically it.

THE COURT: All right. On the C-section --

MR. GOLDSTONE: He will not testify in a gynecological fashion.

THE COURT: What will be the testimony?

MR. GOLDSTONE: That, based on the tilt of the pelvis, which she's already testified to, in his diagnosis she will need a C-section. That's based on a bone.

I mean first I maintain that even if it wasn't, as a doctor, he is qualified to give such testimony. But we don't even have to get to that point because he is not going to base it on a gynecological finding.

THE COURT: Are you going to be able to elicit testimony from this doctor that he considers himself competent, based on his training and experience, to give an opinion to a reasonable degree of medical certainty as to whether a C-section will be required?

MR. GOLDSTONE: Yes.

THE COURT: I will expect you to elicit a proper foundation, and then if there is still an objection, I will hear from counsel.

(Whereupon, the trial resumed in the courtroom.)

THE COURT: Mr. Goldstone.

MR. GOLDSTONE: Could we have the last question read back.

THE COURT: Yes.

(Question read.)

A. The result of those problems is an increased incidence of degenerative disk disease in the lumbar spine ,with the possibility for future surgery.

MR. TOKER: I object again and move to strike.

THE COURT: Will counsel approach, please.

(At sidebar, the following was recorded:)

THE COURT: I don't recall having heard anything about degenerative changes or future surgery.

MR. GOLDSTONE: Degenerative change are in the reports.

MR. TOKER: I specifically asked where we're going with this.

THE COURT: This happens in the press of the trial.

I suppose one way to approach this might be to say this is what makes it interesting. There might be some other different approaches that might also be taken.

Now, the degenerative changes are mentioned in the report?

MR. GOLDSTONE: Yes.

MR. TOKER: No.

THE COURT: No? There is a dispute about that?

Let's take a look at the rep-rts.

(Pause in the proceedings.)

THE COURT: The record will reflect that I have an April 12, 2004 report.

This is -- you're representing that this is a medical report?

MR. GOLDSTONE: Yes; Dr. Merola's.

THE COURT: A medical report of Dr. Merola's.

MR. TOKER: Not exchanged.

THE COURT: Just a moment. This refers to degenerative changes. The same ruling, then, based on the fact that the authorization did cover future treatment.

Is there anything with respect to surgery?

MR. GOLDSTONE: No, that's just the sequelae, but here' more on that.

THE COURT This is also the same May 7, 2002 report?

MR. GOLDSTONE: That we referred to earlier.

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THE COURT: ??is is the ??rt, Mr. Toker, that you ??s ??i you did ??reviously receive?

MR. TOKER: hat's corr

THE COURT: Let's make ??ental note that we reed to get these document marked so that they're exhibits on this. We'll do that at the end of the day.

All right, I am going the adhere to my ruling on that. I am going to allow --

MR. TOKER: About future surgery as well?

THE COURT: Nothing in the report, in any of se reports refers to surgery?

MR. GOLDSTONE: No, the sequelae.

MR. TOKER: Nothing in the bill of particu??rs or the supplemental bill of particulars about surgery, needed in the future, nothing in the medical reports about surgery in the future and the report he gave me for April 2004, which he never exchanged with me.

MR. GOLDSTONE: He got all of these reports in the authorization.

THE COURT: There is that “did so.”

I am going to ask one last time: Is there anything anywhere that refers to surgery? I know it's not in the bill of particulars. Is there anything in any of the doctor's reports?

MR. GOLDSTONE: No, that, I didn't say. I said that sequelae was not specifically mentioned.

THE COURT: I just wanted to be sure about that.

I am going to sustain the objection to testimony about the future surgery.

MR. GOLDSTONE: But the degenerative, he can testify about.

THE COURT: Yes.

(Whereupon, the trial resumed in open court.)

THE COURT: Members of the jury, the testimony about future surgery is struck and is to be disregarded by you.

You may continue, counsel.

Q. Doctor, what do you mean by degenerative changes?

A. Degenerative changes means an increase in the wear and tear on the joints of the lumbar spine, as well as the disks.

Those changes can happen normally throughout the course of your life, but they can happen sooner than later if you have an abnormal anatomical situation and a muscular imbalance situation.

So, premature degeneration and aging of the disks and joints of the lumbar spine, with resultant arthritis.

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MR. TOKER: Objection. Move to strike the last part as well, Judge.

THE COURT: Overruled.

Q. And in Ms. DeVirgilio's case, especially considering her age, still being in her 20s when this accident happened, how would you characterize this; as normal or related to the trauma?

A. Related to the trauma.

Q. What is arthritis?

MR. TOKER: Objection. Beyond the scope. There is no claim for this, Judge.

THE COURT: Overruled.

You may answer.

A. Arthritis is a condition which refers to inflammation of a joint, in this case in, particularly, the joint of the lumbar spine and the lower extremities. That inflammation happens when those joints are abnormally loaded.

Those joints are built to slide along each other the way God put you together, and if there is an alteration in that way, for example, through trauma, those joints now no longer load normally. So, your body needs to do something to accommodate for that abnormal load.

What your body tries to do is it tries to put extra bone into the area of that joint to make it stiffer and stronger, but in so doing, it sets up an inflammatory process that can result in pain and the joint surfaces themselves prematurely wear down.

So, the cartilage that covers them, the thing that keeps those joints gliding along each other breaks down and eventually you get bone on bone rubbing, and that is an arthritic change in a joint.

Q. Is that a painful situation?

A. Yes.

Q. What causes the pain?

A. Several things cause the pain. The inflammatory response causes pain, but the leakage of those inflammatory chemicals that your body is using the try to repair that area.

And the second thing is the nerve endings adjacent to the joint are now becoming stimulated by the abnormal joint load.

So, those two things result in pain.

Q. Did you have any other tests or findings?

A. I'm reviewing in my mind the things I already talked about.

Q. Let me ask you this, Doctor: In medical school, did you ever take any courses in obstetrics?

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A. Yes.

Q. For how long was that?

A. The last -- well, your entire medical school course covers surgery and obstetrics, part of your entire medical curriculum.

The last two years specifically we do a rotation in obstetrics and gynecology.

Q. What does rotation mean?

A. A rotation is a period of time whereby the medical student is exposed to the practice of ob/gyn.

As medical students, we are sort of like apprentice physicians to the ob/gyn practice.

Q. Have you ever delivered a baby?

A. Yes.

Q. About how many?

A. 30 or 40.

Q. Now, would the condition of Ms. DeVirgilio with reference to her pelvic bone have any bearing on childbirth?

A. Yes.

MR. TOKER: Objection.

THE COURT: Overruled. The answer will stand.

Q. Can you state to a reasonable degree of medical certainty what that would be, and why?

MR. TOKER: Objection.

THE COURT: Let's have two separate questions.

Q. What would that be?

THE COURT: Let's start with the first part first and see if there is still an objection, the reasonable degree part.

Q. Can you state to a reasonable degree of medical certainty if this would have an effect on chilldbearing?

MR. TOKER: Objection.

A. Yes.

THE COURT: The objection is overruled. The answer will stand.

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Q. Could you tell us what it would be?

MR. TOKER: Objection.

THE COURT: Overruled. You may answer.

A. The pelvis is the bottom part of your pelvis. The hole in the bottom of the bucket of your pelvis is the area through which the child passes during birth, so it's the opening to the birth canal. It's a bony enclosure.

Under normal circumstances, as you go through the pregnancy process, the ligaments and the joint of your pelvis become more lax. They get looser over time.

That allows your pelvis to expand and open to conveniently accommodate childbirth.

During the birthing process itself, the pubic symphysis, which is the joint in front of the pelvis that connects both sides of the pelvis, opens, and in back of your pelvis, both sacroiliac joints which are connected.

Now, the back part of your pelvis, those joints also open, so that the pelvis, a tight circle that's held very tightly together under normal circumstances, during birth now expands and opens so that it can accommodate the head and body of a child as it's born.

What happens when you have a pelvic fracture such as this, with a crush injury, the pubic symphysis and the sacroiliac joint can now no longer accommodate that normal opening mechanism, so those joints become locked in place, and the pelvis can now not open to the extent that it needs to in order to accommodate what we call a normal spontaneous delivery.

Q. And what kind of delivery would be required?

A. A cesarean type delivery.

Q. Which is what?

A. It's an operative surgical procedure whereby the ob/gyn makes an incision in the lower part of the abdomen, goes into the uterus, opens the uterus and removes the baby without the baby having to pass through the birth canal or pelvis.

Q. Now, Doctor, did you examine the report of a Dr. Crane, who examined Ms. DeVirgilio in behalf of defendant?

A. Yes.

Q. Did you agree with everything in there?

MR. TOKER: Objection.

A. No.

Q. Could you tell us which portions of that --

MR. TOKER: I have an objection.

THE COURT: Just a moment, please. There is an objection to whether the doctor agreed with the defendants' examining doctor's report?

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MR. TOKER: Yes.

THE COURT: I'll allow that answer to stand, but let's see where we go from there.

MR. GOLDSTONE: May I hand this to the doctor?

THE COURT: Let's have it marked, please.

MR. GOLDSTONE: It's the report. Sure.

(Plaintiff's Exhibit 8 was marked for identification.)

THE COURT: Doctor, you will not be permitted to read from that document because it is not in evidence.

Mr. Goldstone.

Q. If you want to refresh your memory, you can look at it, but don't read.

Would you tell us what in that finding of Dr. Crane's you disagree with and why?

MR. TOKER: Objection.

THE COURT: I don't think we can do this this way. If you want to point to specific conditions and ask questions that give Mr. Toker an opportunity to object, you can do that, but I can't just have narrative testimony.

MR. GOLDSTONE: All right. Could I have it back, please.

(Handing.)

MR. TOKER: Your Honor, can we approach, please.

THE COURT: I think what I'll do at this point is give the jury a five-minute leg stretching break. We ourselves will not take one, because, as you can see, we have many legal issues to discuss this afternoon.

Members of the jury, I would like, if possible, to finish the doctor's testimony this afternoon. That means that the defendant has to have a fair opportunity for cross-examination.

So, I would like you during the break to send me a note -- each of you to send me a separate note saying how late is the latest you can stay. I'm not talking about 8 o'clock ac night or something of that sort.

I'm not quite sure how long we're going to need, but I'm curious to know or interested to know if you could stay somewhere in the 6 to 6:30 range or the 5:30 to 6:30 range.

But the best way for me to do this is for you just give me what your outside time is.

As I said earlier, I know people have commitments and child care obligations and the like, so if something like that requires you to leave by a certain time, of course, you should feel free to say so.

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(The jury left the courtroom.)

THE COURT: Counsel.

MR. TOKER: Yes, your Honor.

I object to the procedure in question. The report by Dr. Crane is not even arguably something that Dr. Merola used for purposes of treatment or relied upon for purposes of treatment for his patient.

It is pure hearsay, and at this time Dr. Crane is going to testify, and what counsel is trying to do is get in rebuttal evidence before the evidence is even presented in the case.

THE COURT: I think there are ways that can be used to do this that are proper, and it is not uncommon in trials for a party to anticipate its adversary's evidence, but it will have to be done without calling for a reading from the report.

MR. GOLDSTONE: I will do it a different way.

THE COURT: And without calling for narrative testimony.

MR. TOKER: I would assume it means that he can't stand in front of this jury reading a portion of the report and saying, do you agree with this.

THE COURT: That is correct. You will have to focus the witness on particular areas and perhaps ask him his opinion about that area, but let's try to do this in a way that conforms with good and usual trial procedures.

If you need to take five minutes, please do so.

Off the record.

(Short recess taken.)

THE COURT: Counsel, I have one juror who cannot stay past 5 pm. Everybody else is flexible. That was Juror Number 1 who cannot stay past 5 p.m.

Do you have any suggestions about how to deal with this?

MR. TOKER: Judge, I can only tell you I can't finish before 5 p.m.

THE COURT: I understand that.

MR. TOKER: And I don't know what we can do about asking her to stay after 5 p.m., but I would not agree to let her off the jury for that reason.

THE COURT: Anything on this subject?

MR. GOLDSTONE: Does the note indicate why?

THE COURT: No, I just asked people to let me know how late they could stay, and it just says, “Judge, I cannot go past 5 p.m.”

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I will hand these notes up so that counsel can look at them.

MR. GOLDSTONE: Then I'd ask that an alternate replace her.

MR. TOKER: Judge, I have to say that I feel a bit inhibited at this point. Regardless of the fact that some *of* these jurors can stay a little late, I feel that providing a reasonable cross-examination, I'm under the gun here in terms of their minds and being rushed through it.

I didn't anticipate that Mr. Goldstone would be going this long.

MR. GOLDSTONE: I didn't anticipate so many object ions and conferences that were caused by papers that were received and that were claimed weren't.

THE COURT: Fair enough. I've heard what I need to hear.

Unfortunately, we cannot stay past 5, so we will break at the usual court time, and I will not replace Juror Number 1.

I don't think that this would be an appropriate reason for doing that, particularly given that at least one of the other jurors said they could not stay past 5:30, and, with less than an hour, I can't say that Mr. Toker would have a reasonable opportunity for cross-examination.

We will now bring the jury back out.

Counsel, would you kindly hand back the jury note

MR. TOKER: Are we breaking now?

THE COURT: No, we'll go for another few minutes until 5 o'clock.

Can we have the notes marked.

(Court's Exhibit V marked.)

(The jury entered the courtroom.)

THE COURT: Members of the jury, please be seated.

Thank you for your generosity in agreeing to serve late.

You do, however, have one or more jurors who are unable to stay late, so we are going to break at the usual time.

Now, you have completed your questioning, Mr. Goldstone?

MR. GOLDSTONE: No.

THE COURT: All right. Please continue.

BY MR. GOLDSTONE:

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Q. Doctor, did you indicate earlier that you had tested the way that Ms. DeVirgilio walked?

A. Yes.

Q. And in what way should that be tested to see if there was a limp?

A. You put your hands on top of her pelvis and then you feel the way her muscles in her pelvis are moving through the gait cycle.

Q. Is there anything else that you would examine not on her body?

A. Her shoe wear can also tell you something about how her gait is behaving.

Q. What do you mean it will tell you something? How is that?

A. Your shoes are a rather accurate representation of how your foot reacts with the ground.

If you look at the bottom of your feet, you'll notice that there is a wear pattern on your heels and on the soles of your feet, and that tells us the type of what we call ground reaction force or ground accommodation force that your body experiences ??ring gait.

Q. And, Doctor, what is palpation of the body or the sacrum?

A. Palpation means touching and feeling the various anatomical part, such as the sacrum.

Q. And how should that be conducted?

A. There are several ways to do it. You can actually feel that body part in question and then, after feeling it, to tell whether or not there is a problem with a particular joint, you can stress the joint.

For example, the sacral and iliac joint can be stressed with a hip maneuver called a Faber test.

Q. What is that?

A. That's a maneuver where you basically put the patient's leg into a crossed leg position and then you exert external or outward pressure on the hip joint to see if you can pull the sacroiliac joint apart.

If that elicits pain, you know there is a problem with the SI, or sacroiliac, joint.

Q. Is that something you do in addition to the palpation?

A. Yes.

Q. You showed us x-rays taken at St. Vincent's of the left hip -- I'm sorry -- of the sacrum.

Did you find them positive, meaning something is wrong, or negative, that nothing was wrong?

A. Positive.

Q. What did you base that on?

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A. The x-ray findings that demonstrate the fracture line through the sacrum.

Q. Would you consider the muscle hernia on Ms. DeVirgilio's leg incidental?

A. No.

Q. Why not?

A. It did not exist prior to the trauma, and at this point in time contributes to her gait abnormality and pain.

Q. How does it contribute to pain?

A. That muscle itself and the nerves that enter that area are sensitive. As we spoke about before, when nerves are hypersensitized during a traumatic injury like a crush injury, as well as the fact that the protrusion of that muscle in that the lower leg compartments or the fascia container of that leg can cause what's called an exertional compartment syndrome or pain in the lower leg after you've walked for a period of time.

Q. And let's say it was a slight bump against that muscle herniation. What would be the result of that?

A. Bumping into that muscle herniation or rubbing up against it or traumatizing it fires those hypersensitive nerves and results in pain.

Q. Now, as far as Ms. DeVirgilio's job, did you obtain a history of that?

A. Yes.

Q. And she's presently working lifting, say, up to 20 or so pounds, I believe, which is done, according to her testimony, approximately 12 times per performance.

What effect, if any, would that have on Ms. DeVirgilio?

A. Repeated lifting of weights, as she needs to do and during her job produce easy fatiguability of muscles in her lower back and her pelvis and her legs.

So, we have a fatiguability issue, as well as the decreased endurance and decreased tolerance over time.

Q. At the end of the day, when she's through with the work and returned home, would that have any effect?

A. Yes.

Q. What?

A. Effectively, that renders you pretty incapacitated for the remainder portion of the day. That can require bed rest, pain medication and may in some circumstances make you even miss work.

Q. Would all of this be true even with the taking of a narcotic drug?

A. Yes.

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Q. Now, in your opinion, would she be able to lift 50, 60 pounds to handle a job where she's lifting 50, 60 pounds by herself?

A. No.

Q. Why is that?

A. Those increased weight requirements put further stress and strain on her musculoskeletal system.

Q. As far as the future, would you say that her condition will stay the same, get worse or get better?

A. Get worse.

MR. TOKER: Objection to the form of the question.

Which condition are you talking about?

Q. Let's take them one by one. The condition of her leg with the muscle herniation and the problem with the limping, is that going to get better, stay the same or get worse?

A. Get worse.

Q. Why would that be?

A. It is a wear-and-tear phenomenon as well, and over time the more wear and tear that's there, the more work the muscles and tendons and ligaments and joints need to do. They're going to prematurely wear.

Q. The arthritic condition that you mentioned earlier, is that going the stay the same, get better or get worse as she gets older?

MR. TOKER: I'm going to object.

THE COURT: Overruled.

A. Likewise, for the same reasons, that condition will also get worse over time.

Q. The area of her pelvis which is presently causing pain, will that get better, stay the same or worsen?

A. Also for the reasons that I mentioned before, that is going to get worse as well.

Q. Can she expect improvement in her ability to bear children or would it -- in other words, will that condition that would require a C-section remain permanent?

A. That will remain as it is, permanent, yes.

Q. Would all of her injuries be permanent?

A. Yes.

Q. Now, in the future, is Ms. DeVirgilio, as a result of these injuries, going to receive or need any further medical treatment?

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A. Yes.

Q. Would she need physical therapy?

A. Yes.

Q. And for how long?

A. Lifetime.

Q. How frequently?

A. Three times per month.

Q. Are you familiar with the charge, the billing for physical therapy?

A. Yes.

Q. And what would that be?

A. It's in the neighborhood of between 75 and a hundred dollars per visit, depending upon how many different kinds of modalities or treatments they administer per particular visit.

Q. And would there be office visits to a doctor that would be necessary?

A. Yes.

Q. About how frequent would that be?

A. At least quarterly.

Q. What would the charge for such visits be, doctor?

A. The office visit itself would be in the 150 to $175 neighborhood, depending upon how much time is spent with the patient, and then whether or not x-rays were required during that visit.

Q. X-rays would be additional?

A. Yes.

Q. What about the medication? Is that going to be a situation that would be with her for the balance of her life?

A. Yes.

Q. And what would the charge for that be?

MR. TOKER: Objection.

THE COURT: Can you elicit more details about this, please.

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MR. GOLDSTONE: Surely.

Q. What kind of medication do you feel would be necessary for her to take and with what frequ??cy?

A. She requires at this time Vicodin extra strength, which is a narcotic pain medication, as well as over-the-counter and prescription anti-inflammatory.

Q. How much would that cost?

A. In the neighborhood of about a hundred dollars or so per month.

Q. If she net led future surgery, could you tell us what that would cost?

MR. TOKER: Objection.

THE COURT: Sustained.

Q. In the past ten years, have the prices of medical services increased?

A. Yes.

Q. And at approximately what rate?

MR. TOKER: Objection, your Honor.

THE COURT: If I am surmising correctly, you're going to be asking this doctor to give an opinion as to future increases in medical services, office visits and the like?

MR. GOLDSTONE: Not necessarily the amount of. That, I hadn't even come to yet.

I was going to ask does he anticipate that the price of medication, the charge for office visits, the charge for physical therapy will increase at the same rate as it has in the past ten years.

THE COURT: Well, we'll have the foundation for this testimony on the next court date.

In view of the lateness of the hour, we will break for the day.

Members of the jury, you remember that I am unavailable for jury trials on Thursday, unless you have reached a point of deliberations, so we will not be working tomorrow.

We will resume at 9:30 on Friday morning. I expect to have a very full day for you.

Let me remind you not to discuss the case among yourselves or with no one else and to keep an open mind.

We will see you on Friday. Thank you.

(The jury left the courtroom.)

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THE COURT: Doctor, you may step down.

We will go off the record for a moment to give Mr. Goldstone the opportunity to confer with the doctor about his schedule.

(End of proceedings.)

(Trial adjourned to November 5, 2004)

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