SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY - CIVIL TERM - PART 5

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CHRISTOPHER MILLER,

PLAINTIFF ,

-against-

JETBLUE AIRWAYS and TURNER CONSTRUCTION,

DEFENDANTS

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Index No. 111750/06
TRIAL

80 Centre Street
New York, New York
September 24, 2008

B E F O R E:

HONORABLE EILEEN RAKOWER, Justice, and a jury

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

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Don't talk about the case with anybody or anybody else, we have another witness this afternoon.

Enjoy your lunch.

THE COURT OFFICER: All rise.

(Whereupon, the jurors are exiting the Courtroom.)

* * *.

(P. M. S E S S I O N).

THE COURT: Are we ready, now.

MR. BOROWICK: Ready.

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jurors are entering the Courtroom.)

THE COURT: Welcome back, please come in and sit down.

THE COURT: Mr. Borowick call your next witness.

MR.BOROWICK: The plaintiff calls Dr. Andrew Merola.

D O C T O R A N D R E W M E R O L A, Witness, called on behalf of Plaintiff, having first been duly sworn, took the witness stand and testified as follows:

THE COURT CLERK: Please state your name and address for the record.

THE WITNESS: Andrew Merola, 36 Seventh Avenue, suite 502, New York, New York, M-E-R-O-L-A.

THE COURT: Use the microphone. Just sit close enough to it, that would be great.

MR.BOROWICK: May I, Judge?

THE COURT: Yes.

DIRECT EXAMINATION

MR. BOROWICK:

Q Dr. Merola I want you to keep your voice up, we have a hard time with the air-conditioning going up, so please project, if you can.

What is your occupation?

A Orthopedic reconstructive spinal surgeon.

Q And what background education do you have that allows you to call yourself one of those?

A I went to medical school, and then after I finished medical school, I did a residency in orthopedic surgery. Subsequent to that, I did a spinal surgery fellowship to train in spinal surgery for one year and I have been in practice here in New York City since 1996.

Q And are you licensed?

A Yes, I am.

Q Are you board certified?

A Yes, I am.

Q And in your particular field of spinal reconstructive surgery, what does it mean to be board certified?

A Board certification is a process that you undergo after you finish your training. It's an-- actually a three step process.

The first step is after you finish your residency you take a written examination in order to determine your competence and knowledge in the field of orthopedic surgery.

After you're in practice for two years your cases are directed, reviewed, they go to a board of orthopedic surgeons who then give you an oral examination and ask you questions about your cases.

After you pass those two exams, you become board certified.

And then, every ten years we re-certify, so that's the third step. So there's initial board certification and then there's re-certification every ten years to make sure that you stay current with your education, and your training.

Q Dr. Merola, are you affiliated with any

medical institutions?

A Yes, I am.

Q And which?

A I am affiliated with New York Medical College, in Val halle, New York, through St. Vincent's Manhattan, New York City and State University of New York, Health Science Center in Brooklyn.

Q Do you maintain membership in any professional associations?

A Yes, I do.

Q What are those?

A I'm a fellow of the American Academy of Orthopedic Surgeons. I am also a fellow of the Scoliosis Research Society, member of the New York State Medical Society and New York State Society of Orthopedic Surgeons.

Q Have you operated and lectured around the world.

A Yes.

Q Tell the jury about your private practice at this point. What does it consist of, who are your patients, just give us a background of what you're doing.

A So, what I do is I basically take care of people who have problems with their necks and their

backs and those problems range from children who have difficulties or issues with scoliosis, or kyphosis, or birth defects, all the way up to and including older folks, or adults who have problems with degenerative spine.

I deal with fractures, disc herniations tumors, infections, trauma and just about everything that affects the neck and back in both children and adults.

Q Is there a different approach that you might take whether a condition is traumatic, degenerative or congenital?

A Yes.

Q And in Chris MIller's case and I want to ask you about his, was his traumatic, congenital or degenerative?

A Traumatic.

Q Was there any components of Chris MIller's condition or injuries that was degenerative?

A There was. There was some degenerative changes on some of his films but they did not significantly or substantially contribute to his overall condition or problem.

Q Did anything about his body contribute to either his problem, the need for surgery or any of the

treatments?

A No.

Q Tell the jury, if you would, when the first time you met Mr. Miller, and I'm going to give you your chart that you brought that we've marked as Exhibit 3 in evidence.

Use it if you need to, to refresh your recollection about any of the events in the last two years.

A Sure.

Q Tell us when you saw him for the first time?

(Witness looking at exhibit.)

A This is my office chart. I actually first saw Mr. Miller when he was admitted to St. Vincent's Hospital, in Manhattan.

Q Do you share that chart with any other doctors in your practice or is it exclusively yours?

A It's actually shared with my associates.

Q And who of your associates have participated in the treatment and care of Mr. Miller?

A Dr. Steven Touliopoulos, Dr. Eric Popathomas and Dr. Yakoff Perper.

Q Dr. Merola, when you first saw him in -- was it in the hospital?

A Yes.

Q And who referred -- who brought you in to become part of the treatment team?

A Dr. Touliopoulos.

Q And when you met Chris Miller, what was his condition?

A Chris was admitted to the hospital and had-- my consultation was for injuries which he sustained to his back. He had a lumbar compression fracture and amongst some other appendicular or arm and leg injuries.

So when I saw him he was in bed admitted to the hospital on the general trauma service.

Q Now, I'm going to ask, before we get into the nuts and bolts, literally nuts and bolts, I'm going to ask you to step down, with the Court's permission and give us a little spinal anatomy lesson.

MR.BOROWICK: Would that be okay, Judge?

THE COURT: Yes.

Q Just give us the terminology, functions and this way we'll be able to understand what you did and why.

(Witness complies.)

A Sure, this is a --

Q Just stand back as much as you can so

you're not blocking anybody.

A This is a model of a spine, it's a plastic model of the spine of the up at the top of the spine is the base of your head, that's the bottom, the back of your head. This is the front; front is facing towards your left, back is facing towards me.

The spine is broken up into different sections, the top section is called your cervical spine or your neck. The middle section is called your thoracic spine, or your upper back. The lower portion is called your lumbar spine, or your lower back, and ultimately that all attaches to your pelvis.

At the bottom of your spine is a triangular piece of bone that's call the sacrum and that sits right in between your pelvis, and then your hips are all the way down at the bottom part of this. They're not shown, here, but you can picture your hips hanging off of this thing going down towards the floor.

The spine has the major purpose of maintaining your head over your pelvis when you're up and walking around. It also protects the spinal cord, and the nerves that lie within it. And the spinal cord and the nerves that are within the spine are responsible for controlling various parts of your

body.

The nerves that come out of your neck are responsible for controlling your arms and hands, the nerves that come out of your lower back are responsible for controlling your legs.

Q Is that true in every human, the same nerves control the same thing?

A Yes.

And those nerves and spinal cord, all run through the back side of your spine which contains a canal or an opening that's much like the drain pipe in a sink, and you can picture the spinal cord and the nerves running through that canal or opening in your back.

To exit the spine, those little nerves come out of the small little openings or holes and there's a fancy name for those foramina, that basically just means openings or holes, and that is what your nerves come out of before they go into your arms and legs.

The spine itself is made of bones and they appear as these white block like things and in between the bones are smaller thinner jelly -like shock absorbers called discs and those discs are there to curb the effect of the bones and how they work and

interact with each other.

So, over all, the spine is made of bones, discs, and it contains the spinal cord and the nerves that go into your arms and legs.

Q Now, as a clinician, is there something that --

MR.BOROWICK: Strike that.

Q When a patient comes into your office and says, you know, I have a pain in thus and such, whether it's a right leg, left arm or whatever, and you suspect that it may not be an orthopedic injury but more like neurological injury, how is it that you can trace back to the spine some kind of symptom like that?

A So, what we do is we try to break up things into what we call axial which means in the spinal column itself, or dermatoma radicular, which means root.

Each one of these nerves has a name and a number associated with it and it's responsible for specific things in either your arms, hands or legs. Those specific things that it's responsible for, can trace it back to portion of the spine where it lives.

And nerves do various things. They feel, so you can feel stuff, that's called sensibility, so

you feel things with your nerves. You move your muscles around, nerves control your reflexes, they feel pain, and all those things that they do, go along with certain specific nerves, sometimes combinations of nerves, but generally, the specific nerves that come out of each specific little portion of the spine.

Q Would you tell the jury when Chris Miller came in, you said he had an L-1 compression fracture. What is an L-1 compression fracture?

A In your lower back, or in your lumbar spine there are five basic bones and they're numbered one through five, L-1, L-2, L-3, et cetera, all the way down until you hit the sacrum.

L-1 is the first bone, so we count up, go five, four, three, two, one, it's the first bone in your lumbar spine and it's attached to the last bone in your thoracic spine.

So, when we say an L-1 compression fracture, what we mean is that the L-1 vertical body or bone was crushed and that describes its anatomical location and the injury.

Q I want you to assume for a moment that there's been testimony that my client fell from a height of either 20 or 30 feet, landed on his feet first and there was an axial force that was exerted

beginning with his heels through his legs and up.

How can you mechanically account, with a reasonable degree of medical certainty for the compression fracture at L-1?

A So, axial force is a fancy way of saying that when he fell, all the force got transmitted directly up his feet and legs and spinal column.

So, when it went up -- so his body weight accelerated by gravity because of the fall was transferred up the spinal column. The L-1 vertical segments because it's at the junction, which is a very important thing, at the junction of his upper back which is connected to the chest and rib cage and the lower back which isn't connected to anything but the pelvis that segment undergoes the most force transfer when the trauma happens.

So, that mechanism of injury is very consistent with an L-1 compression fracture. That's the area of your spine that you most commonly fracture, when that type of low transmission happens from an accident.

Q What were his clinical symptoms?

A That symptom, when that happens, it presents with significant, what we call axial back pain.

So there's pain in the spinal area adjacent to the segments that were fractured because of bleedingswelling, inflammation and the fracture, itself, in the upper portion of your lumbar spine.

That pain, because there are muscles that go all the way from the bottom of your butt and top of your legs all the way up to your head can be referred along the whole aspect of your back.

Q Is that a painful injury?

A Yes.

Q Now, separate and apart from the compression fracture of L-1, what is radiculopathy and how does it relate to the anatomy of the spine insofar as discs and vertebrae are concerned?

A A radiculopathy is a term that refers to a problem with a radicula or a nerve root.

So root is radicula opothy means problem with and a radiculathopy means that there's inflammation, swelling and irritation of a nerve root that then presents with either pain or dysfunction or both in the distribution of that nerve root.

Q You can resume your seat.

Just take the skeleton with you, in case you need to use it.

(Witness complies.)

Q Doctor, I want you to assume that Mr. Miller was a healthy 29-year old sheet metal worker, who before this accident had worked, the year before he worked 2,000 hours, the year of the accident, he worked 1,733 hours, that he was an active father and an active caretaker of his home, had no physical injuries, no complaints of pain from any part of his body, was not under the care of any orthopedists, spine surgeon, spine doctor, chiropractor, et cetera, et cetera. He was taking no medication for any condition whatsoever and then this accident happens and he has the injuries that you have observed.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not the accident was the sole competent producing cause of that injury?

A Yes.

Q My client has been your patient since the original hospitalization at St. Vincent's until when?

A Until now, he's still my patient.

Q So, for two and some part of a third year, he has been your patient.

Have you had occasion to operate on him?

A Yes.

Q To chart his course as far as medication, and therapy is concerned?

A Yes.

Q Have you monitored him on a periodic basis?

A Yes.

Q How often do you see him?

A About four to six weeks.

Q And over the course of the say twenty-eight months since this accident, have you been able to assess whether or not he's a cooperative patient?

A Yes.

Q Compliant?

A Yes.

Q Has he been motivated to get better?

A Yes.

Q Have there ever been times when his motivation waxes and wanes given his circumstances?

A Yes.

Q Describe that?

A Christopher has done his best to try to get better and comply with all of our treatments. It's been a lengthy process, his initial hospitalization was quite lengthy, he required another

hospitalization for other surgeries, which he's had. I had to hospitalize him, as well, and he's undergone a lengthy postoperative rehab course.

So in some ways, Christopher has felt a bit, I would say dejected regarding his own body, and his clinical course and everything that has taken a little bit of a toll on him, so he's not always the most upbeat person when I see him in the office.

Q Have you ever assessed him to be a malingerer?

A No.

Q Or exaggerator?

A No.

Q Have you ever -- well, here you are today, in a Courtroom, in the middle of a lawsuit that Christopher has brought against a construction company and an airline.

Has he -- so you've known about this lawsuit; correct?

A Yes.

Q Is there anything about the way in which he has been a patient for you that suggests that he is motivated in any way in regard to his complaints, treatment or otherwise, by this lawsuit?

A No.

Q Question; are you familiar with the hospital record from Jamaica?

A Yes.

Q And what about from the initial hospitalization, three and a half weeks at St. Vincent's?

A Yes.

Q I want you to --I am going to ask you to assume without going through the record, et cetera, there's some notation that he smokes, he's a smoker, one pack a day. He consists confirmed that today.

Is that at all in any way contributing to his condition or his rate of recovery or failure to recover?

A No.

Q Women, smoking is not a good thing, is it?

A No.

Q Can you tell us whether or not -- I want you to assume further, that there's a notation that when he was a teen, he had some pancreatitis, some inflammation of the pancreas.

Are you aware of that?

A Yes.

Q Have you spoken to Chris about it?

A Yes.

Q Is there anything about that reflection in the record of that inflammation, anything that affects his injuries, his recovery, or lack of recovery from them?

A No.

Q Is there any diagnosis, at all, in any hospital record from the time of this accident onward, that he suffers any level, or degree of pancreatitis?

A No, none.

Q When you were treating him or operating on him, did you see a scintilla of evidence that would cause a workup or medication or treatment, any scintilla of evidence of pancreatitis?

A No, none.

Q Did Mr. Miller suffer from anything when you've treated him, that would decrease or cut into his life expectancy?

A No.

Q Does smoking a pack a day necessarily decrease a person's life expectancy knowing that it's not a good thing?

A Smoking is not a good thing and you shouldn't smoke, but, it may or may not decrease one's life span.

Q Would the fact that he had an inflammation when he was 18 that was that he was released from the hospital and with no treatment, no medication or anything, would that in any way influence or affect his life expectancy?

A No.

Q Tell us how you treated his L-1 compression fracture at the very outset of your relationship?

A Treatment for his L-1 compression fracture was by orthotic containment or bracing, TLSO brace which is a big plastic brace which goes from the upper back to the pelvis to immobilize his spine and hold it in place in order to give the bones themselves a chance to heal.

Q And at some point, did you treat him at all after that?

A Yes.

Q Now, besides the L-1 fracture in this brace, was there any other treatment that you could offer for the L-1 fracture?

A The L-1 fracture itself, initial treatment is closed with the brace and then subsequent to that it's symptomatic treatment based upon how much axial pain he's having or how much pain he's having in

his back and then the treatments for that depends upon pain, pain level and that range from anti-inflammatories, pain medications injections and physical therapy all the way up to and including stabilization if he has progressive pain and/or deformity.

Q Were you able to coordinate his care with Dr. Perper and Dr. Touliopoulos and Dr. Papathomas?

A Yes.

Q And which of the four of you were medicating him.

A Dr. Perper.

Q And was he on narcotic medication?

A Yes.

Q Was he, over the course of the first couple of months, was he complaining to you of the L-1 compression fracture?

A Yes.

Q How long did those complaints last?

A They have persisted throughout his treatment.

Q Do they continue, now?

A Yes.

Q How can you localize, how could you identify and connect a complaint of pain --

MR.BOROWICK: Strike that.

Q Does he identify his pain as L-1 compression fracture pain?

A He identifies it as back pain.

Q And how do you distinguish between back pain from L-1 compression to lumbar pain down at the bottom of the base of the spine, or cervical pain?

A It's anatomical in terms of where it pops up the most, so, L-1 compression fracture pain and mechanical axial pain is basically in the upper portion of the lumbar spine, lower portion of the upper thoracic spine or mid to lower back pain, whereas lumbar or lumbosacral pain is lower and cervical pain is higher.

The cervical and lumbar pain are associated with dermatomal distribution or radiculopathic pain so that's a further distinguishing factor.

Q Does he still --

MR.BOROWICK: Strike that.

Q Did the L-1 compression fracture knit together?

A Yes.

Q And did it knit together in original anatomic geomotry?

A No.

Q Tell us about how it healed and if there are any consequences, physically, as a result of that?

A So, compression fracture is very much like crushed cups, so I took this cup and kind of crushed it a little bit. I compressed the cup. And when the bones heal back together again unless you physically go in there and put rods and screws and everything to straighten it out, it will heal in that position, in a compressed state.

That area at the thoro lumbar junction can, over time, cause what we call progressive deformity or imbalance because it throws off the normal spinal curvature and that's one of the things we watch over time in serial x-rays.

If the lumbar thoracic and cervical suffer of curvature, become altered because of that fracture, then you may have to make a surgical adjustment to contain it.

When the fracture itself heals what the body does is as soon as the fracture happens, it bleeds. Bleeding starts up an inflammatory process which is not unlike the process if you cut yourself and you see it get red and swollen.

That redness and swelling is the body

sending blood cells in to heal the body if it's fractured. And fractures heal with bone production the body puts down callus or extra bone and then the areas adjacent to the fracture heal with fibrous tissue or scar tissue in the areas adjacent to where the fracture happens and that's what your body does to knit the fracture back together again.

Q Now, after the -- are you treating him, doing anything for him other than medicating him for the pain associated with his L-1 compression fracture at the present time?

A Right now, it's observational care, taking x-rays at serial x-rays to watch his overall alignment and make sure he doesn't develop any neurological issues related to the fracture.

Pain medication, pain management are with Dr. Perper. Occasionally when he has particularly bad days, I'll ask him to go back into his brace, so that the brace takes the pressure off his back, to decrease some of the symptoms that he has.

So, right now, we're basically treating that fracture on a symptomatic basis depending on how he feels and what his clinical status is.

Q Dr. Merola, the serial x-rays that you say he requires, how long will he require that kind of

monitoring?

A Those serial x-rays should be carried out basically for his life time.

Q This exhibit, 15, is the brace that you have on his body, is that the brace that you gave him in the hospital or is that the brace that you gave him after his back surgery?

A That's the -- that is the TLSO brace, that's the brace that he was administered after I saw him in the hospital.

Q Okay. And is that comfortable?

A It's restrictive, it's constrictive and patients do complain about pain with the brace.

Q Doctor, after -- let's get past the L-1 compression fracture and let's talk about any other complaints that he made to you.

During the hospitalization at St. Vincent's in '06 did he register any complaints of symptoms that gave you concern about any other parts of his body?

A Yes. He had other issues with respect to what we call the appendicular skeleton; that means the arms and legs. So he had some fractures and trauma to both his upper and lower extremities and those were particularly concerning to him.

Q Did he refer to any radicular complaints if not by that term, did he describe any pain or other sensation that you took to be radicula?

A Not specifically, at that time, no.

Q Tell us what happened after his release and discharge from St. Vincent's as far as your treatment is concerned and bear in mind, as far as Dr. Touliopoulos, been there, done that. We heard from him on Monday.

So, try to keep your discussion to the spine, low back, mid -back, cervical.

A So, with respect to the spine and back, some of my job was made easier by the fact that he was not ambulatory or not weight bearing for a prolonged period of time and that was helpful to me in terms of his fractures, because it gave them a little extra chance to kind of settle down and give the TLSO a chance to heal those fractures.

What I began to see with Christopher is that as he became more ambulatory, as his extremety fractures started to heal and he was weight bearing process started to progress he started to experience what we term radicular symptoms or complaints and those complaints are referable to the nerves that go into his arms and hands as well as the nerves that

proceed down into his legs.

Q Now, let me ask you to explain a term and I'm going to apply it to your treatment with Chris.

What does it mean to clinically correlate.

A Clinical correlation basically means that if you -- for example, let's say a radiologist who reads x-rays and sits in a little dark room and sees film up on a board and he may see something on a film, he may write on his report clinically correlate.

What that means the clinician or somebody who has direct patient contact then looks at the film and says, is that little thing that we see on that film causing a problem in the patient.

So, you touch the patient, you feel the patient, you talk to the patient and you examine the patient to see whether or not there's a an actual physical issue with respect to what pops up on a lab test, or an x-ray, or an MRI.

Q Can you clinically correlate the other way, somebody gives you a symptom and then you go out and look for objective testing whether it's as a clinical exam or radiographic study?

A Yes, and that is what we do in the office when a patient comes in. We listen to the patient and

take what they call their chief complaint.

So they make a complaint and they say my leg hurts. I say where does it hurt. What I'm trying to do is localize it to something I can put my finger up to fix or ameliorate and that's what we do when we take a history.

So we see a patient, they say something or voice a concern. We take a history to try to correlate it with something anatomical and do an examination to further back up that correlation and then order a test to check ourselves to see if we were correct with the diagnosis that we suspected.

Q And tell us now, with regard to Chris, when did he start making radicular complaints?

A Chris, I have to look at my notes to tell you exactly when he started making those complaints, but they did happen in the office, after he became weight bearing.

(Pause.)

Q Doctor, I have an idea let's just do it generally.

At some point, did he begin to make radicular complaints?

A Yes.

Q And you said it was after he became

weight bearing.

Assume he had an injury to his low back, what would weight bearing do mechanically that might trigger the onset of those complaints?

A So, what weight bearing does is when you start to get up and walk around, those forces that you transfer from your legs and your feet and your hips go up into your spine, because your spine as we saw on the model previously, is connected to your pelvis and your sacrum, so as you're up and walking around and the discs and bones start to move and vibrate and flex and extend, they start to rub up against the nerves that are in the lower back area, as they exit those little holes and they can start to trigger nerve pain or radiculitum.

Q If you can just grab that model and show us which nerves we're talking about as they relate to Chris Miller?

(Witness complies.)

A So, in Chris's case, basically what we're talking about are the nerves in the lower part of the back, in the L-5 and S-1 area, which is all the way down where the lower portion of the lumbar spine meets the sacrum and the pelvis.

Those nerves form part of what's called

your sciatic never. Your sciatic nerve is a big nerve that runs all the way down the back of your leg past your hamstrings and foot and ankle. And you may have heard the term sciatica, that's another way of saying radiculopathy or inflammation of the sciatic nerve of which those L-1.

Q So, once he started to register those complaints, became weight bearing he started to feel those -- I mean how did he identify the complaints you found to be radicular?

A Pain radiating or going down the leg, below the knee, down into the foot and ankle area.

Q Now, was it just pain or was there some sensory change?

A When a person complains about that type of pain, the clinical correlation comes in, where you do an exam and through that exam, you look for reflexes, you look for the way the muscles are working, you look for sensation along those specific nerve roots to confirm that it is those roots that are involved.

So, in Chris's case, he had reflex changes and sensory changes along with his complaints and symptoms that pointed to those nerve roots.

Q Now, there are people that come in your

office, I'm sure, that they have got a lawsuit or looking for attention and say, oh, doc, my back, my back, I must have a disc.

On those patients, if they don't have it, are you able to clinically correlate it or clinically dismiss it?

A Yes.

Q How?

A Well, first of all the complaint itself is very important, because most folks haven't read the anatomy book and are not familiar with where these nerves travel.

So if they come in and complain about basically pain in the low back or pain that just localizes to a portion of the buttock but is not radiating it's highly unlikely that they have a sciatica or a disc herniation resulting in a significant radiculopathy, so the distribution of their pain is one thing.

The other thing that you look for is sensory loss along a dermatone. And a dermatone is that portion of the nerve which controls a particular portion of skin in your leg.

There, again the dermatone runs down your legs in certain specific stripes so there are portions

of your leg that are going to have a sensory change, while other portions of your leg will remain unchanged.

Also reflexes, and you test the reflexes in the lower extremety, to correlate all of those other findings.

Q Was there anything about your clinical correlation of the symptoms that he presented with, that led you to believe that he was just trying to, you know, up the anti, make his lawsuit better, anything like that?

A No.

Q Have you ever seen Chris do any of that?

A No.

Q Now, he comes in, he complains. You do a clinical exam, and you are able to correlate his complaints to your reality in the clinic.

What about taking photographs, or radiographic studies, did you do that?

A Yes.

Q And what did you find?

A Well, we did an MRI of his lower back to see if I was right on with the diagnosis of nerve root irritation and disc herniation.

And the MRI confirmed nerve root

compression, so, it told me that we had compression of the roots in his lower legs, that went along with his symptoms.

Q Now, let's -- let me ask you if the problem you found on his low back, that you confirmed with the MRI, and by exam was that one side or both sides of that level of his spine?

A The majority of his radiculopathy, before the operation was actually more localized to one leg than the other.

Q What level of pain that led you to go further into the surgical field?

A His pain level had to be what we call recalcitrant to confer to pain management and interfere with his ability to ambulate or walk. So that type of pain, when you're talking on a pain scale is generally something on a seven, if ten is the worst possible, zero is none, five is about average, seven is beyond average by at least two points and that pain can vary anywhere between seven and ten.

Q So, at some point in January of '08, what did you do?

A We did a -- I did a decompress laminectomy with microneural foramina to take the pressure off the nerves in the lower back.

Q Did you have any choice; were there conservative methods, physical therapy, medication anything else that you didn't try that you could have?

A He failed conservative care and that's what makes you go do and operate.

Q Had you put him through physical therapy?

A First of all, his physical therapy was complicated by the fact that he had those appendicular or arm and leg injuries and in fact I think it's in my office notes about the fact that the pain was interfering with some of the therapy that he was doing for his arms and his legs. So, that significantly contributed to his low back problem.

And in Chris's case, when you have a patient that has multiple injuries, it's very difficult to be able to give them a specific program for their low back without affecting everything else, as well.

So that's one of the things that help me make a decision about doing a decompression on him, rather than having to torture him any further by waiting.

Q Doctor, I'm going to ask you to step down and describe for the jury the surgery that you did, you know, if you wouldn't mind stepping down and that

easel is just no good. And I'm just going to hold it up and ask you to from that side, if you can, without --

(Witness complies.)

Q Okay.

A Okay, so this is an illustration.

Q Try not to block anyone.

A Of Mr. Miller's surgery and what it shows you is the lower portion of the back. It's a back view of the lower portion of your back because the surgical approach is through the back, it's through the muscles of your lower back.

And what it shows is in the first illustration, A, it demonstrates an exposure of the bones of the lower back, between the L-4 and the L-5 segment which are all the way down in the lower portion of your back. S-1 is at the bottom, L-4 is at the top. And it describes removal of the lamina, or of bones covering the spinal canal.

Q Could you show us on the model what the lamina are?

A So, on the spinal model, the lamina are these pieces of bone on the back side, they're covering up the spinal canal so you can't see the nerves actually inside the canal themselves, because

there's a roof of bone overlying the canal and that roof of bone is called the lamina. So.

A laminectomy is a removal of the lamina to unroof the spinal canal.

And when you're unroofing the canal, you then unroof the sac that contains those nerves so it increases blood flow into the nerves through the sac and additionally, on B, what you see is what's called a neuro foraminotomy and this is a process whereby a special tool is inserted into the hole through which the nerve exit to unroof and open or enlarge that hole in order to give the never itself more room to exit, which also increases blood flow to the nerve itself. And that increased blood flow helps that nerve decrease inflammation from pressure that's being exerted on it.

So it's basically a process of opening of the nerve root holes and the spinal canal, to increase or improve nerve root blood flow.

Q What was the goal of this surgery?

A The goal, the underlying goal of the surgery is to decrease leg pain, decrease leg pain not eliminate it, improve blood flow into the nerves and to prevent those nerves from further damage or deterioration.

Q Now, was there a goal of removing the lamina?

A Yes.

Q Is that accomplished?

A Yes.

Q Was there a goal of opening up the foramina?

A Yes.

Q Was that accomplished?

A Yes.

Q Overall, was your surgery successful?

A Yes.

Q You accomplished what you intended to accomplish?

A Yes.

Q So, does that mean he was cured?

A No.

Q Well, we'll go into that in a second but let's finish the procedure.

A Sure. These other two sections are sections that are cross sections looking down the spinal canal, and it shows you, this purple sack containing your nerves that's moved out of the way as you remove the lamina and this other section shows you the dural sack or the container for all those nerves

being moved out of the way as the opening for the nerve itself is opened up and bone is removed thereto make more room for the nerve root.

Q Now, does the lamina, and the design of the natural design of the foramina, are those mechanically and geometrically important.

A Yes.

Q And did your surgery necessitated by this injury, did it forever change that anatomy and geometry?

A Yes, because I'm actually removing that bony anatomy so I'm changing it, I'm changing the way he's put together.

Q Now, is there anything else about the surgery that you think would be helpful to the jury, to understand?

A No.

Q Okay. You can resume your seat.

(Witness complies.)

Q Following the surgery that you did in January of this year, did you continue to follow up with Chris Miller?

A Yes.

Q And -- with regard to his low back, before we get to the cervical spine, with regard to

his low back, how did he do?

A With regard to his low back, he had decrease in those leg complaints and symptoms early on, after surgery so it was helpful in ameliorating those radicular complaints.

Q That's a good thing, right?

A Yes.

Q Improvement, right?

A Yes.

Q Progress?

A Yes,.

Q Okay.

A So that was helpful, he continued to experience mechanical axial which is pain in the low back and it's mechanical because it's aggravated with things like ambulation, or bending or lifting or twisting the lower back.

So, he had mechanical axial low back pain, unrelieved with surgery but that wasn't the major goal of surgery.

So --

Q Wait a second, so that progress we just talked about, what you just talked about, axial pain aggregated by ambulation, et cetera, that's not a good thing?

A Correct.

Q So, that wouldn't be progress, would it?

A That would not be considered progress, correct.

Q Please continue?

A Though those complaints and symptoms persisted and he began to have some recurrent radicular pain on the contralateral or other side as time went on, so that's something that he began to experience, as well.

Q So, now he's having some radicular pain. I thought you relieved or got rid of the radicular pain?

A I did, I was able to help with some of the radicular pain and one of the things I had gone over with Chris before the operation was that this procedure is a symptomatic treatment for the leg pain but not treatment for the low back pain, and that at some point in time, he might require what we call an instrumented fusion, which is something that you want to avoid in a younger patient.

Q So, if -- so that I'm clear, you got rid of some of the pain; that was progress. And then he had axial low back pain which is bad and a recurrent radicular pain, which is bad; right?

A Yes.

Q Okay. So, at this point in time, has the axial pain, or the radicular pain from the low back that you tried to address, is it gone, is it better, is it worse, is it the same, is he getting better, getting worse or the same?

A That pain is essentially about the same as it has been.

Q And what's the diagnosis or condition -- is his low back heading for future surgery?

A Yes.

Q When do you think he's going to need that future surgery?

A Given Chris's age and his progress thus far, I would anticipate he will need it within five years.

Q Is that major surgery?

A Yes.

Q And I'm going to show you an exhibit and ask you if this is the instrumentation surgery that you've just described and if you could just, with the Court's permission, just hold it up there, if you can and give us a little sense without hitting the Reporter, tell us what you're going to have to do?

A Yes, this is an illustration of a

revision or full line bilateral laminotomy.

Q I have to interrupt you because you really can't see it from over there.

Would you step down.

(Witness complies.)

Q We'll try it on here.

A I don't think that's going to work, either.

Q I got it, okay, I got it.

A So, this is a representation of a complete laminotomy, which involves a removal of the entire lamina itself on both sides and a clear out of the nerves. That's what described on this illustration.

So this is a full complete bi-lateral total laminotomy.

Q And once you've cleared it out, removed the bone?

A And then so when you do that, you take off the entire lamina.

Sometimes you also remove a significant portion of the joints that hold the bones together and what we do, then, is we put what are called screws and rods into those bones in order to replace the bone that we've removed to stabilize the bones of the lower

back and basically fuse them together or glue them together so that they no longer move and decreasing that motion between those bones stabilizes the lower portion of the lower back, and in that way, treats that mechanical component of their low back pain.

Q What is this going to eliminate for Chris?

First, how is it going to relate or affect his pain level?

A This, the purpose of this operation is to decrease the axial pain that he's having in his lower back.

Q How is it going to affect his functional level?

A This will block motion from L-4, through S-1 in the lower back so his activities will be restricted in terms of his ability to bend, lift and twist.

Q Okay. Please resume your seat.

(Witness complies.)

Q Dr. Merola, after you do the fusion on his low back, are there any consequences besides the fact that he's going to lose motion in his low back, whether it's twisting and all different movemetns but other than that, is there any consequence of doing an

instrumental fusion that relates to any other components of the spine?

A Yes.

Q Explain that to the jury with the model, if you could?

A So, once you fuse the lower portion of the back, what you're essentially doing is making this lower back area, which at one point in time was able to kind of move around and flex as you walked and did your activities, you're making it a solid piece of your pelvis.

And what happens there, is that the segments that are adjacent to that area or next to that area, then take up increased stress and load. And what we see is that the adjacent segments can deteriorate over time, become dysfunctional and eventually you need to incorporate those segments into the fusion when they start to cause problems with the nerves and the joints.

Q Now, you said that having done the laminotomy and foraminotomy, his symptoms returned as he became more active, ambulating; correct?

A Yes.

Q Now you're telling us that you're going to fuse him, you're going to fuse his low back and

you're going to limit his motion even more and that the adjacent segments are going to deteriorate if he gets up and walks around and does stuff?

A That's correct, yes.

Q So, do you recommend that he not do anything?

A Well, what I recommend is, and what my recommendation was before the first surgery is for us to try to avoid doing fusion for as long as we can, number one.

And number two, absolutely limiting his activities so we decrease stress and strain on the lower back and hopefully, if we can maintain his pain level at something that's manageable with medicines, try to avoid a fusion for as long as possible.

Q Let's talk -- let's turn our attention to his cervical spine.

Give us a little bit of anatomy of the cervical spine and radicular mapping or dermatomal mapping?

A Sure, the cervical spine is all the way up at the top. It's the bones of your neck, and those nerves, those nerves that are up in your neck area, are the nerves that go up into your arms and hands.

And they basically, it functions in very

much the same way as your lower back functions. There are bones and discs and nerves, and they basically do the same thing but only not in your arms and legs. Only not in your legs, in your arms and hands.

Q Did he register any complaints referable to his cervical spine?

A Yes.

Q And what were those?

A He was having axial neck pain with radicular pain, radiating into the arms and hands.

Q And what did those complaints spell out to you as a spinal surgeon?

A Those complaints added up to what we call a cervical radiculopathy or inflammation of the nerves coming out of the neck.

Q And did you do anything -- did you examine him?

A Yes.

Q By the way, when was the first time those complaints arose?

A Those I would say those popped up probably about six to eight months ago.

Q And when they came about, did you examine him?

A Yes.

Q Were you able to form any impression or clinically correlate those symptoms to anything?

A Yes.

Q What?

A What we call a C-6 radiculopathy.

Q Now, after you had that impression, did you cause to be performed any radiographic studies to confirm or rule out that diagnosis?

A Yes.

Q And what did you have performed?

A An MRI of the neck.

Q Now, I have Exhibit 34 and I'm going to ask you if you would, I don't know if it's going to reach.

If you could, describe what an MRI is, and take us through what this one is and what this one shows?

A Sure. An MRI is a test whereby you go into a big machine and it's a magnetic test.

The magnet causes the tissues of your body, your bones and your discs and nerves and the water that's in those tissue to give off a signal and that signal is translated via computer to an image and that's the image that you see on an MRI.

In this case, those images are the images

of the neck, of Christopher Miller, and what we're looking at are multiple side views of his neck going from one side of his neck, all the way across the other.

Because the film is, it's a two dimensional representation of a three dimensional object, of the body they use multiple different slices so that you can get a sense for where things are, in that third dimension when you're looking at them.

Q And tell us, with regard to Chris, how did that correlate to the symptoms he complained about?

A What this MRI shows is when we count the bones in the neck, so we count from the top, the first bone is just an arch so it doesn't pop up like a bone, doesn't look like a little bone, it looks like a thumb in the bone. So one is at the top and we count down from two, we see two, three, four, five and six.

And between the fifth and sixth bones of the neck we see what looks almost like a little thumbprint reaching into the spinal canal which is this area that lights up very brightly, it looks white.

And if you look at that, it looks like there's a little fingerprint or thumbprint reaching

into the canal. That is a disc herniation which is in the spinal canal, between the fifth and sixth bones of the neck, touching the nerves that then proceed down into your hands.

Q Now, doctor, herniated discs, people have them for lots of reasons other than accidents, don't they?

A Yes.

Q And let's talk about a 29-year old who was working consistently, without complaints, without symptoms, without medicine, without doctors, no problem, no limitations.

Do you have an opinion with that history, do you have an opinion with a reasonable degree of medical certainty as to whether or not the cervical herniation was caused by this accident?

A Yes.

Q What is your opinion?

A That it is caused by the accident.

Q What about the -- what about the radicular problems in his low back?

Do you have an opinion with a reasonable degree of medical certainty as to whether or not those were brought about by the accident and his injuries?

A Yes.

Q And what is your opinion?

A That they have been caused by the accident.

Q How have you treated, over the last six or eight months, how have you approached his cervical injuries?

A The cervical spine was approached basically conservatively which is observant. We give it a little time to see if he gets better. He's already on medications. We try to decrease activities that may cause increase in pain and also seeing our pain management associate.

Q How has his neck been? Is it progressing, is it digressing or is it just stable?

A His neck, along with the rest of his back is unfortunately been digressing or getting worse.

Q And do you have an opinion with a reasonable degree of medical certainty as to whether medication will control the pain from his neck?

A Generally, if pain, particularly radicular pain persists for greater than six weeks it's unlikely that medication is going to make a difference at that point in time.

Q What is the radicular pain in his case, where does it go?

A It goes into the hands.

Q And do you have an opinion with a reasonable degree of medical certainty as to whether or not physical therapy or injection therapy will control and stabilize his neck?

A Injections can act to temporize the pain. They are a little more difficult to do in the cervical spine because there's less wiggle room because there's a big spinal cord in there. You don't really have a spinal cord in the lower back.

So injections are at best temporizing for the radicular pain, and at worse, they can actually cause a little bit more of a problem.

Q So, if surgery is your last resort, and you're up to the last resort, what kind of surgery do you anticipate?

A The surgery for this particular problem is similar to the low back, but a little bit different because it's the neck.

So, anatomically, it's different. It basically involves a removal of the entire disc, and then a stabilization of the two bones so that there's no more motion in that segment to protect the nerve.

It also protects the spinal cord and that is part of what makes it different is that there is a

spinal cord involved in your neck, whereas there isn't one in your lower back.

Q No spinal cord in your low back?

A It contains the termination of your cord or just nerve roots. Your spinal cord, the actual substance of your cord which is really technically part of your brain, actually ends right around T-12, L-1 so the actual substance, the cord stops at that point in your back.

The canal below that area contains the nerves only, and those nerves are called the cortagana or horse's tail because when you look at them they look like the horse's tail.

So you can go into a lumbar canal and move them out of the way because you don't have any spinal cord to injure. In the neck if you touch the spinal cord you can cause paralysis because it's concentrated, we like to say it's concentrated evil. It's the subject of your central nervous system, any pressure on it will basically kill it.

So that's why in the cervical spine you can't afford to touch the cord, in the lumbar spine you can take the nerve roots and move them out of the way and pull them around and do whatever you have to do.

Q When do you expect that this surgery will take place?

A I actually anticipate that would happen rather soon.

Q Meaning weeks, months, years?

A Within the next several months.

Q Now, once you do that, that disc -- is it discectomy?

A It's a discectomy and fusion.

Q Once you do that fusion, would you need instrumentation with that?

A Yes.

Q Would it be a cage or would it be rods and screws?

A It's a combination of a cage and a plate.

Q When you would do that, does that, and assuming the fusion takes, does that involve the same consequences with the adjacent segment above and below?

A Yes.

Q How do you avoid that?

A It's difficult if not impossible to avoid because of gravity and everything else that your body body goes through, but it's a consequence of what we have to do to reconstruct the spine.

Q What types of --

MR.BOROWICK: Strike that.

Q Is there any correlation between the level of activity of the cervical spine, I mean looking up, looking down, twisting your head, is there any correlation between level of activity and the speed at which the degeneration would take place?

A Yes.

Q Explain that and explain that for both the cervical and lumbar spine?

A Sure-. So, basically, if you want to think about it in terms of cycles, and if a cycle is the normal motion that your neck and back go through while you're let's say just doing something like walking, those cycles produce wear and tear on every portion of your spine.

If you increase those cycles, there's a linear increase in the amount of wear and tear that happens.

So if you do anything to augment those cycles and you add things like bending, lifting, any kinds of weights twisting motion exposure to vibrations, for example truck drivers, taxi drivers, being in automobiles for prolonged periods of time, all these increase the cyclical loading of the spine

and increase the wear and tear phenomenon in your joint and bones.

Q I want you to assume that Chris Miller was a sheet metal worker. I want you to assume that's a very heavy duty, heavy labor intensive occupation.

Do you have an opinion with a reasonable degree of medical certainty as to whether in the past two years at the present time, or into the future, he would be a candidate to return to that career?

A He would not be a candidate to return to that type of career, no.

Q I want you to expand that, and let it cover any career that involves manual labor.

A No.

Q I want to ask you first of all, are you familiar with, from your coordination of his care with the other doctors, are you familiar with the type and extent of the injuries to his feet, his knee, his wrist?

A Yes.

Q Are you familiar with the way in which he's medicated with the various medications?

A Yes.

Q The fact that he's on Percocet and all the other drugs and also the psychotropic drugs from

Dr. Spitz?

A Yes.

Q Given his condition, the various injuries that he has had, the medications that he's under, and the fact that he doesn't sleep well, he's always tired, can you tell us, with a reasonable degree of medical certainty in your field, whether or not you would clear him to retain with the New York State educational retraining service if that training required medical clearance, the ability to appear and train for four or five days a week, and ultimately, the ability to entertain and occupy a job for five days a week?

Would you clear him for that?

A No.

Q Why not?

A We've just listed a host of different problems including his arms and legs, neck and back, radicular problems, and medications as well as psychotropics ,in addition to the fact that he requires physical therapy and activity modifications and restrictions.

So combining all that together makes it impossible for him to be able to restrain or perform any kind of repetitive or enumerative labor on a

weekly basis.

Q Isn't it part of a doctor's job to encourage and motivate a patient?

A Absolutely, yes.

Q And do you encourage and motivate your patients?

A Yes.

Q Is there a responsibility on the part of a doctor, in addition to motivating and encouraging a patient, to be realistic, in that motivation?

A Yes.

Q Realistically, could this high school drop out, with the level of injuries and disabilities that he's had, with the medication that he's under that affects his clarity of thought, realistically could he ever competitively engage in job seeking?

A No.

MR.KAMINSKY: Objection.

THE COURT: Overruled.

Q Do you have an opinion as to whether or not he could reliably --

MR.BOROWICK: Strike that.

Q I want you to assume that he and his wife have testified, that he described to the jury how when it rains he doesn't even get out of bed. When there's

snow and ice on the ground, he doesn't go out.

Do you have an opinion with a reasonable degree of medical certainty, given the totality of his reality, whether or not he could ever, in the future, hold a job that requires regular, consistent attendance with attentiveness, focus and ability?

MR.KAMINSKY: Objection.

THE COURT: Overruled.

A No.

Q Why?

A For all those factors that I just mentioned, it's rather impossible for him to do that.

Q Well, you know, let's face it, we're only 28 months out, since the accident and his injuries. He's had surgeries the doctors hope will fix him up, make him better. And you've described at least two additional surgeries within your specialty that he's going to need.

Do you think we've given him enough time for you to prognosticate that he will not realistically be able to work?

A Yes.

Q Why?

A Generally, particularly when one receives these types of traumatic injuries, we can pretty much

tell within about a year or so, what their course is going to be.

And generally, 12 months are set aside as a reasonable amount of time to be able to determine whether or not a patient is going to suffer from chronic pain or psychological sequelae from that chronic pain. The requirement for pain medications and how their body has responded to the actual initial trauma itself.

In general, 12 months is pretty good to give you the type of prognostic information that you need, in terms of what's going to happen in the future and whether or not that patient can get back to work.

In Chris's case we actually have quite a bit more time than the 12 months.

Q I want you to assume that he was an active father, he did a lot of stuff outside the house, inside the house, on weekends, active with his kids, physical guy; I think he's got four boys. At the time of the accident he had three boys and a daughter, would roughhouse with them, and enjoy a physical relationship with his wife.

Are these activities that, from your point of view, singly about the spine and neck and the low back, do those injuries cause any consequences --

MR.BOROWICK: Strike that, that was terrible.

Q I want you to assume that other than at work Chris was an active individual. And the way in which he cared for his home, in the way he acted with his kids and with his wife and lifted weights after work.

Are any of these activities going to be impacted upon by his injuries?

A Yes.

Q And if he were to try to continue or get back to those activities to the same level, would that have consequences for his neck and his spine?

A Yes.

Q Explain?

A Well, for example, lifting weights or engaging in sporting activities would have rather significant consequences because those are high stress issues, particularly weight lifting. Sports involve oftentimes contact, lots of bending, lifting and twisting, also putting him at risk for falls, so all of those things, substantially, affect both the neck and the back.

Q Did you see Chris today, as he was leaving in the car service?

A Yes.

Q And did you notice anything, as his spine doctor, did you notice anything as he was leaving about him?

A Yes.

Q What did you notice?

A One of the things that I noticed that's most striking is the fact that he has significantly abnormal gait pattern and in addition to that, when he's getting in and out of a vehicle such as a car he really can't even move his neck or back and he has to recline as much as he can when he gets into that car.

Q And how does that affect his spine -- I understand his spine is controlling, how he comports himself, but, how does the fact that he walks the way he walks, how does that affect his spine that you're trying to improve?

A Your normal gait pattern so when you walk normally, that is designed to provide as little impact and as little force transfer as possible, on your back.

So, that normal fluid motion of when you're walking, your pelvis actually floats. And if you take a picture of it or a film, the pelvis looks like it's floating on a wave in the ocean.

When you watch Chris walk, he walks pretty much like Frankenstein so he kind of puts one leg down, has a lot of force transfer, his pelvic goes oblique. So his pelvic gets obliquity and that fluid gait is no longer there. It's all force transfer.

So when he's walking, the spine no longer has low impact on it, it has high impact because there's a force transfer in the lower extremities because they're not functioning properly.

Q With regard to his cervical spine and lumbar spine, did he suffer injuries that were neurological in origin?

A Yes.

Q He didn't have a brain injury?

A Correct.

Q He didn't break his pelvis?

A Correct.

Q Shoulders?

A No.

Q His elbow's fine?

A Yes.

MR.BOROWICK: Nothing further.

THE COURT: Let's take five minutes so the Reporter can take a break.

Don't talk about the case among

yourselves or anybody else.

THE COURT OFFICER: All rise.

(Whereupon, the jurors are exiting the Courtroom.)

(Witness excused.)

(Whereupon, a brief recess is taken.)

(Record resumed.)

THE COURT: All right, get the jury, please.

THE COURT OFFICER: Jurors entering, all rise.

(Whereupon, the jurors are entering the Courtroom.)

(Witness resumes the stand).

THE COURT: All right, please sit down.

Cross-examination.

MR.KAMINSKY: Thank you, Judge.

CROSS EXAMINATION

BY MR. KAMINSKY:

Q Doctor, good afternoon.

A Good afternoon.

Q It wasn't very exciting but it was informative.

Anyway, you wouldn't clear him for VESPID?

A Correct.

Q Would you clear him to get a GED?

A No.

Q No, you would not clear him to study?

A I don't think he's able to study in his present condition.

Q Okay, you caught me by surprise, there.

You don't think he's able to study; is that because he's not intelligent or because he physically is unable to study?

A He is on narcotics.

Q Okay.

A And other psychotropic medications.

Q Now, he watches TV several hours a day, is there any reason he can't study?

A Television is a passive exercise.

Q I want you to assume he was in Court this morning and he and I and Mr. Borowick were able to have a fully comprehensive series of questions and answers for several hours, and I want you to assume -- well, I'm not going to ask you to assume.

When you see him, are you able to communicate with him?

A Yes.

Q Okay, you speak to him, you explain the

risks of surgery, do you not?

A Yes.

Q It's complicated stuff?

A Yes.

Q Something that you wouldn't even do, unless a patient was coherent and intelligent enough and not under the influence of narcotics to be able to understand the risks and benefits of the surgery?

A Correct?

Q You make him sign off on things?

A Yes.

Q So, he's certainly coherent and capable enough to consent for you to do surgery on him but he's not coherent enough to study on a computer at home; is that basically what you're stating?

A He's competent.

Q He is competent, okay.

MR.BOROWICK: I'm sorry, Judge he started an answer and then counsel starts cutting him off.

THE COURT: There's an overlap of question and answer. You always repeat the answer, that's your style. But that doesn't help the Reporter get the answer.

MR.BOROWICK: Excuse me, can we have that

question and answer read back so that doctor could finish it?

THE COURT: Did you finish your answer, Doctor?

THE WITNESS: I'm sorry, Your Honor, I did not.

THE COURT: All right, ask your question again.

MR.BOROWICK: Could we have it read back, I'm sorry, Judge.

THE COURT: No, we can't have it read back. I don't know that the Reporter got it.

Let's get question and answer.

Thank you.

MR.KAMINSKY: Judge, candidly, I don't remember the question.

MR.BOROWICK: Can we have whatever she got read back, Judge? I think it was during the answer that he interrupted him.

MR.KAMINSKY: I'll tell you what, I'm going to safe everybody a lot of time, I'm going to start over.

Q If you can, please answer my questions yes or no.

When Mr. Miller comes to your office, is

he coherent?

A Yes.

Q And he can communicate with you?

A Yes.

Q And he understands you?

A Yes.

Q And he understands the nature of his treatment; true?

A Yes.

Q And when he signs off on surgery, you do that to protect yourself; correct?

A I do that to provide informed consent so that he knows what he's getting into in terms of an operation.

Q Yes, and if he was incoherent and not able to understand it, you wouldn't accept that as valid and informed consent; correct?

A Correct.

Q Now, you would not clear him to go to VESPID.

When is the last time you spoke to anybody at VESPID?

A I don't recall that I have spoken to anybody there ever.

Q What are the requirements of VESPID?

A I don't know what they are, offhand.

Q Okay. Just so we're clear, you don't know what they are, but you wouldn't let him do it; correct?

A The --

Q Correct?

A I don't know what the specific requirements are but I do understand that VESPID is vocational rehabilitation.

Q Please remember --

MR.BOROWICK: Judge, he's doing it.

THE COURT: Well, actually, no, counsel, Mr. Kaminsky is correct, when the question calls for a yes or no, please answer yes or no. Mr. Borowick will have another opportunity to ask questions when the cross-examination is finished.

Q Do you know, specifically what VESPID does?

A Not specifically, no.

Q Do you know if VESPID sends people to a person's house who are not able to come to them?

A Yes.

Q Would you sign off, to use your words, to allow somebody from VESPID to come to the Plaintiff's house to retrain; yes or no?

A I don't know that I can answer that completely yes or no.

Q Fine.

I want you to assume, then, that VESPID supplies services where if someone, for whatever reason is unable to come to them, VESPID will come and train them in their own home.

Would you be opposed to someone sitting at Mr. Miller's house, training him; yes or no?

A No.

Q And if that person weren't able to retrain him and find some sort of a job that accommodated his specific physical limitation to your satisfaction, would you allow him to accept that position; yes or no?

A I can't think of a --

Q Sir --

A I cannot answer that yes or no.

Q Fine.

By the way, how many of the surgeries you described and by the way, let's take some of these illustrations, here.

This is from --would you agree with me this is kind of bloody and graphic?

A Is it bloody or graphic?

Q Is it graphic?

A It is a graphic description of a procedure, yes.

Q Did you ever hear of Med Visuals? Do you have any idea how much they charge for illustrations like this?

A No.

Q Do you know if it's a couple of thousand dollars?

A I don't know.

Q How many of these surgeries have you done?

A Several thousand.

Q Are all several thousand people who underwent this surgery currently in some rehabilitation home?

A No.

Q Are they all under 24-hour home health care?

A No.

Q Have a fair number of these people gone back to work in some capacity?

MR.BOROWICK: Objection.

THE COURT: Overruled.

A Yes.

Q Doing sedentary type work?

A Yes.

Q Any of these people, to your knowledge that had the surgery making six figures?

A I --

MR.BOROWICK: Objection.

A I don't know.

THE COURT: Overruled.

The answer stands.

Q Here is another one. Would you agree with me this is very graphic, as well?

A (No response.)

Q I mean this is not pleasant for a layman to look at but this is what you do; isn't that correct?

A This is what I do in terms of surgery, yes.

Q And if you were to do this surgery to Mr. Miller, it would be no different than the surgery you've done thousands of times?

A Correct.

Q They all look like that?

A They --

Q More or less?

A Yes.

Q Okay. And do any of these people that have had this lumbar decompression and fusion surgery any of them, to your knowledge work?

A I would suspect that some of them work, yes.

Q And the -- by the way, would you consider yourself here in Court, do you consider yourself an advocate for Mr. Miller?

A I'm Mr. Miller's physician.

Q I understand that, but would you also consider yourself his advocate?

A I'm here to answer the facts in the case, so I don't know exactly what you mean by the definition of advocate.

Q Okay. Well, you're here on his behalf?

A I was called in to testify for Mr. Miller, yes.

Q Prior to testifying, did you have occasion to speak with his attorneys?

A Yes.

Q When and how often?

A We spoke today.

Q Okay. When was that?

A This afternoon.

Q Did you have lunch or what did you do?

A No, we just basically met in the park and discussed the case.

Q And are you aware that one of the components of this case is a claim that Mr. Miller cannot return to work?

A Yes.

Q That was explained to you by the attorneys?

A The question was whether or not he could return to work so I know that is a question.

Q That was explained to you by the attorneys?

A I don't remember if they explained that to me but I know that we did discuss a return to work.

Q Okay.

Now, you explained the difference between a trauma and degeneration.

Degenerative diseases are generally something that get worse over time; right?

A Degenerative diseases are something that happen because of the aging process over time, yes.

Q It can be an arthritic condition that sets in, gets worse over time, it could be -- and you would see these degenerative changes on film; is that correct?

A You can, yes.

Q Were there any other films of Mr. Miller that show degenerative changes in the body that are involved in this lawsuit.

A He did have some degenerative changes in the lumbar spine, yes.

Q Do you know if he was previously in a car accident that involves --

A I know that he had a prior injury to his hand and I think he had a prior injury to his head as a child.

Q Okay. And as far as trauma goes, would you agree with me, generally, that a person's injuries are generally at their worst at the time of the trauma.

In other words if you're in a car accident or you have a fall, that's when you're in your worst shape, as a general proposition.

Would you agree with me?

A No.

Q Okay, well, after a person's in a trauma, would you agree with me that the goal is to try and help get that person better over time?

A Yes.

Q And that's in fact, where you come in,

true?

A Yes.

Q You were part of the team that has tried to help the plaintiff in this lawsuit get better over time to the best of your abilities?

A Correct.

Q That's what you -- where did you go to medical school?

A Howard University.

Q That's what you're devoting your career to, helping people get better; right?

A Yes, correct.

Q In this case, I want you to assume that when Mr. Miller fell, he said he thought he was going to die, that he was covered with blood and he was spitting out blood.

You heard from other witnesses he was in real bad shape when he got to the hospital; true?

A Yes.

Q Would you agree with me that from the time he got into the hospital over the next period of months and the next two years, he has shown improvement in different areas?

A (No response.)

Q Yes or no?

A That's not a yes or no answer.

Q Okay. Well, if he was confined to a bed and couldn't walk, and now he can, would you consider that improvement?

A That's just a change in his status, not necessarily improvement.

Q Okay. I'm using the wrong term, then.

If he was unable to walk up a flight of stairs and now he can, would that be a change in his status?

A Correct, that's right.

Q If he was unable to brush his teeth and feed himself and take care of his personal needs such as going to the bathroom and so on, and now he can, would that be a change in his status?

A Yes.

Q And if he couldn't go outside and couldn't walk around the neighborhood but now he can, is that a change in his status?

A Yes.

Q And if he couldn't get down a flight of stairs without people carrying him and now he can, is that a change in his status?

A Yes.

Q And if originally he can only walk a few

feet and now he can walk a couple of blocks, is that a change this his status?

A Correct, yes.

Q And if, at the time of the occurrence, he told a doctor he wanted to kill himself, but he no longer does, and his wife and he have indicated that he has shown some positive changes from a psychological standpoint, is that a change in his status?

A Yes.

Q Now, you're not saying that we should take Mr. Miller today, and lock him up in some home for the rest of his life, are you?

A Correct.

Q In fact, you're still attempting to improve upon the changes of his status that we've already seen; true?

A Yes.

Q So, you say after a year you can generally tell what's going to happen to a person.

After a year of this accident, did you stop treating him and say that's it, I'm done?

A No.

Q Did you continue to treat him?

A Yes.

Q And are you still treating him?

A Yes.

Q Now, his injuries-- and the reason my cross-examination of you is going to be short, okay, I don't dispute his injuries, okay.

What I want to ask you about is what if anything, how he's progressed over time and what may or may not happen in the future, okay.

The injuries are what they are and we don't need to see the x-rays or anything like that.

Today, two years and a couple of months after the occurrence, you're still treating him?

A Yes.

Q And if he does have this neck fusion, the reason you're doing that is to make him even better; correct?

A To prevent further neurological deterioration.

Q And to lessen the pain?

A To try to decrease the pain, yes.

Q So, just --I don't want to get caught up in terminology, but, you wouldn't do such a surgery for no reason. You're doing it with a goal, and the goal would be to improve his physical condition; true, Doctor?

A Correct, yes.

Q And if you do the surgery to his back which you've done how many times?

A Thousands of times.

Q You're good at it?

A Yes.

Q I'll give you some prop, consider yourself a good surgeon?

A Yes.

Q Okay. The people that undergo this surgery, do you generally help them?

A Yes.

Q Okay. If Mr. Miller were to undergo that surgery, is there a likelihood that, I think he used the term you the reason you would do that surgery is to improve his blood flow and to lessen the pain; is that correct?

A Improve blood flow into the bones and ameliorate some of the pain, yes.

Q With your experience and expertise, if you were to perform that surgery, would you expect to achieve those goals?

A Yes.

Q Okay. So, if he undergoes those surgeries, we can expect that his pain will lessen;

yes or no?

A That's a hard question to answer yes or no.

Q Is the goal of that surgery, to lessen his pain?

A Yes.

Q And have you, with your experience enjoyed success in performing those surgeries?

A Yes.

Q I would imagine if you weren't successful you wouldn't have done it a thousand times, people would stop coming to you; correct?

A Correct.

Q So, if Mr. Miller were to undergo that surgery, can we reasonably anticipate that he would experience a lessening of his pain?

A Yes.

Q Okay. Now, if he has a lessening of his pain, would that also, because you're not just treating a leg, or an ankle, you're treating the whole person; correct?

A Yes.

Q So one thing kind of leads into another; right?

A Yes.

Q In your experience, if a person is upset, feels embarrassed, feels like he's a loser, feels like his life sucks, okay, if you can show improvement in one area by lessening the pain, would you expect that might also have a positive impact on a person, emotionally?

A It can.

Q Okay. So if you can lessen the pain, you can also improve someone's outlook on life?

A Yes, it can.

Q And if you lessen the pain and improve someone's outlook on life, would you be more or less inclined to want that plaintiff, want that person to try and get back in the work force so he or she could even feel better about themselves?

Do you follow what I'm saying?

A Yes, I think I do.

Q Would you agree with me, that part of Mr. Miller's --I'll call it his overall physical status is he wants to return to work; isn't that correct?

A Yes.

Q But, as another witness has pointed out, as wonderful a doctor as you are, even you can't return him to be a sheet metal worker; agreed?

A Correct.

Q But, if you could return him, because of lessening his pain and improving his emotional status and weaning him off the psychotropic medications and possibly lessening the other medications that he takes, and he were able to do some kind of job, do you think that would be -- what was the term you used a positive change of status, if those things could happen?

A That's a big if, yes.

Q It's a big if, yes, I agree, you've got your work cut out for you.

But, if that could happen, would that be a positive change of status?

A That would be a very hopeful thing to positively change his status, if that could happen.

Q Agree.

Now here is the thing, okay. He's still treating; correct?

A Yes.

Q So, since he's still under your care and we've established that even though his treatment is not finished yet by a longshot, he's already had numerous positive changes in in status; correct?

A He's had some positive changes in his

status, yes.

Q And if you continue to treat him, and obtain the results that you hope to obtain and have obtained on numerous, hundreds of other patients, we can expect we can expect to see additional improvement change in his status; correct.

A Realistically, with Mr. Miller --

Q My questions are designed for you to answer them yes or no.

Is your purpose -- if there was nothing you can do for him, you wouldn't be treating him; true?

A Correct.

Q So obviously there are things you can do; true?

A Yes.

Q And there are things you can do before you get to the surgery; right?

A Yes.

Q You're monitoring his condition?

A Yes.

Q You call that -- what, just clinical observation?

A Observational, yes.

Q So, we're still a way, counsel called it

a last resort, okay, if you want to call surgery a last resort, we'll call it a last resort.

We're still a bit away from that last resort; true?

A Yes.

Q There are other things that can be done in the interim?

A Yes.

Q Are there doctors in your office that specialize in -- what are they called, they're called pharmacologists, that specialize in pain medicine?

Do you know what a pharmacologist is?

A It's someone who is specialized in medicines, they usually have a degree in Pharmacology, yes.

Q And a degree in Pharmacology they study all the various different pain medications contraindications, how they react, the person's physical and emotional state and psychological condition and then they prescribe some type of medicine to try to address as much they can; true?

A Not the the Pharmacologist.

Q Not the Pharmacologist?

A No.

Q Is there one in your officer?

A No.

Q Have you ever recommended that he see a pharmacologist?

A No.

Q Do you prescribe the pain medication or does that come from somebody else.

A That comes from the pain management specialist.

Q Who is affiliated with you?

A That's correct.

Q Now, you guys are where, in Queens?

A There's a Manhattan and Queens office, yes.

Q Where does he see you; in Manhattan or Queens?

A Queens.

Q And here is your chart.

First time you saw him was February -- this is your writing. Are these dates that you saw him?

A That's the secretary's writings and those are the dates he came into the office.

Q Okay. So, the -- so you saw him last couple of times you saw him were on July 28th of this year, September 2nd, of this year and September 5th,

of this year; is that correct?

A In the office, yes.

Q When is your next appointment to see him?

A My appointments with Chris are scheduled every four to six weeks.

Q And that will be an observational care and management review?

A Yes, in addition to an examination and diagnostic testing as indicated, sure.

Q Now, are you by any chance being compensated by Mr. Borowick for appearing in Court today?

A Yes.

Q How much?

A Five hundred dollars per hour.

Q And is there a minimum, or what do you expect your total compensation will be for your involvement in this lawsuit?

A I don't know, it depends on how late I'm going to be here today.

Q You were asked about smoking, whether or not that had anything to do with this accident; correct?

A Correct.

Q You were asked if smoking decreases a

person's life span and you said we don't know?

A It can. Smoking is not a good thing for you to do, it may or may not decrease one person's life span, yes.

Q Is there a correlation between the longer you smoke and how long you smoke to the shortening of a person's life expectancy?

A That's interesting. There's a correlation between smoking and some diseases particularly some lung diseases.

Q Would you consider smoking one pack of cigarettes a day for ten years to the present, and still continuing to do it, is that something you would advise your patients to do or to quit?

A To quit.

Q Now, I don't want to go over this pancreatitis stuff anymore because I'm more sick of it than the jury is. But I'm just going to ask you one question about it.

You said he had an episode of pancreatitis ten years ago and therefore you weren't concerned about it; correct.

A I think I answered a question about pancreatitis.

Q Could you speak up a little?

A I think --I don't know if this is on but I think he had an issue of whether or not he had pancreatitis when he was younger. I believe about ten years ago.

Q Right, and because it was so long ago it's not really relevant to his current condition?

A That's correct.

Q If it was more recent it might be relevant?

A It might be, yes.

Q What if I told you he felt an onset of pancreatitis appearing before this accident happened; is that something that you were aware of?

A No, I can't answer that yes or no.

Q Well, this, you can. Were you aware of that, yes or no?

A Not in that specific form, no.

Q Can you get pancreatitis from drinking one beer?

A No.

Q You would have to consume a considerable amount of alcohol over a considerable period of time; correct?

A To -- well, there are many possible reasons for you to have pancreatitis.

Q Sure, alcohol being one of them?

A Alcohol can be a reason for pancreatitis.

Q Is it the most common cause?

A Actually, no, the most common cause for pancreatitis is usually a problem with your biliary system or gallbladder or gallstones.

Q Then I'll rephrase the question.

Would alcohol be the most common cause of pancreatitis for a person who admittedly "drank a lot" for several year period of time?

A Depends on their age.

Q Okay. I said I was only going to ask one question about it and I asked six, I'm sorry.

All right, doctor, thank you very much.

A Thank you.

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q Dr. Merola, maybe we can resolve this once and for all.

You treated him in the hospital after this accident. Did he have pancreatitis?

A No.

Q Other than a mention about it ten years before, is there any indication that he had pancreatitis anytime after that, anytime?

A No.

Q The fact that he felt pain in his side and thought it might be a recurrence, does that make it a recurrence?

A No.

Q It had nothing to do with the accident -- did it have anything to do with your treatment of him?

A No.

Q His success or failure of any of the treatments of him?

A Nothing to do whatsoever.

Q Does it have anything to do with his life expectancy?

A No.

Q The fact that -- you said, counsel was asking you about this sequence of-- his logical sequence of improvement, the fact that if you do the cervical surgery and if he does well with it, and if it limits the pain and if that makes him feel good, and if he feels good, maybe he's happier, and if he's happier, maybe he can go back to work.

Does that logical sequence apply to Chris Miller?

A No.

Q Let me ask you this; there might be some

circumstances where Chris can go back to some job if his limbs and all the fractures in his limbs heal back to normal; right?

A (No response.)

Q Wait one second. And if his spinal injuries and the surgeries that you do all work like a dream and if his depression goes away, notwithstanding his depletion, if no more chronic pain, even though it's lasted through all the medication and if the adjacent segment issues miraculously don't affect his spine and if the arthritis, for which there's no cure stops in his foot, in his hand, and in his spine, and if the grinding in his knee and hand and foot cease to happen and if his RSD fades --

MR.KAMINSKY: Is there a question?

MR.BOROWICK: Yes, here it comes.

Q --and if his sleep becomes sound and if his ankle stops turning with it's laxity, if all of those things happen, might he train for some other job?

A Yes.

Q And this VESPID, counsel has indicated that there's sometimes VESPID will come, I think he said that sometimes VESPID will actually make house calls to a person they're hoping to train that can't

even come to training for a job in the competetive labor market.

Doctor, I want you to assume, I want you to assume that a prerequisite for a person to be accepted into a VESPID program is that he's medically cleared to work and that he can work for full-time job and show up reliably, consistently, and with the type of clarity of thought that he can work full days.

Would you clear him for such a job?

A No.

Q Would he be able to do such a job?

A No.

Q And if that's a criteria for VESPID to train him, would you recommend that he see a VESPID person?

A No.

Q Counsel asked you if you have lots of surgical patients very into deference; if you're a great doctor?

MR.KAMINSKY: Is there a question, Judge?

MR.BOROWICK: There is, it's coming, a little patience.

Q Do they all do well?

A No.

Q Even though you're a good doctor?

A Yes.

MR.KAMINSKY: Objection.

Q Mr. -- Dr. Kaminsky said some go back to work.

Do all of your patients go back to work?

MR.KAMINSKY: I love when he calls me Dr. Kaminsky.

MR.BOROWICK: Professor.

MR.KAMINSKY: I'll take that, too.

Q Do all of your patients go back to work?

A No, not at all, not all.

Q Do all of your surgeries result in positive outcomes?

A Not all of them, no.

Q Do all of your patients, some patients even make six figure salaries. Is each case case specific?

A Yes.

Q Do these people who go back to work, any of them, do any of them to your knowledge have fractured heels on both sides, a fractured knee with ACL problems and meniscal problem with a fractured hand, discs in his law back, discs in his neck, are those the patients that you have that go back to work?

A No.

Q So, whether counsel loads up a question with --

MR.KAMINSKY: Objection.

Q With some, some, some -- I'm going to ask you just about my client, just about Chris Miller and just so that we put it to rest.

As much as you might hope that he would be well enough to get a job and sustain a job, is his reality going to include employment?

A No.

MR.BOROWICK: I have nothing further, Your Honor.

RECROSS EXAMINATION

BY MR. KAMINSKY:

Q So you wouldn't clear him for VESPID even though you don't know what VESPID requires; is that correct?

A (No response.)

Q Yes or no?

A I don't know that I can answer that because we found out a little bit more about it right now.

Q So, basically, anyone who is depressed can never go back to work?

A Not depression alone, no.

Q Anyone who has an inability to stand for long periods of time, anyone is who bound to a wheelchair can never work; correct?

A No.

Q Anyone who suffers from any sort of -- is on any type of medication can't go back to work?

A Depends on the medicine.

MR. KAMINSKY: Nothing further, thank you.

THE COURT: Anything, counsel?

MR.BOROWICK: Nothing, thank you.

THE COURT: Thank you, doctor, you can step down.

(Witness excused.)

MR.BOROWICK: Judge, the Plaintiff rests.

THE COURT: Thank you.

All right, ladies we're going to call it a day.

Mr. Kaminsky what do you say, ten o'clock tomorrow?

MR.KAMINSKY: Sounds good.

THE COURT: Come in at 10 o'clock tomorrow morning. Somebody had asked about the schedule and I do -- is that better? Somebody had asked about the schedule and I do want to let you know, we are on schedule. And one of the big --the

difficult problems with this case are the number of days that we're going to be taking off and I told you at the beginning that we were going to be taking off on Friday, the 26th, we were going to be taking off on Tuesday, the 30th, and Wednesday the 1st. We are also going to be taking off on September 29th because of a conflict in one someone's schedule and so we're going to have a full day tomorrow and then there's going to be this hiatus until the following Thursday when you'll be here at 9:30 in the morning again on the following Thursday, and I expect that we will complete the case and give you the case for your deliberations that Friday.

So while it's taking two weeks, we're really only working seven of those days. So bear with me, and we need you to be on time. I appreciate that today you were on time and we'll see you tomorrow morning at 10 o'clock.

Don't talk about the case among yourselves or anybody else. Don't do any independent research, on any topic that you may have heard testimony about and see you tomorrow.

THE COURT OFFICER: All rise.

(Whereupon, the jurors are exiting the

Courtroom.)

THE COURT: For the record, I do have a motion in limine that was given to me this morning, this morning, actually late yesterday and served upon defense counsel late yesterday, a motion to preclude Dr. Goldman.

I am to understand that defense will have a response to these papers tomorrow morning. Please have that to me by 9:15 tomorrow morning so that I can render a decision on it.

* * *.

(Whereupon, the matter was adjourned to 9-25-08.)

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