1 of 7 DOCUMENTS

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JOSEPH and JEAN KARASH, Plaintiffs, -against- BUKKY M. ADETUNJI, E-J ELECTRIC INSTALLATION COMPANY, and UNITED RENTALS, INC., Defendants.

Index No. 41780-04

SUPREME COURT OF NEW YORK, KINGS COUNTY, CIVIL TERM, PART 6

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April 27, 2009; April 28, 2009; April 29, 2009; April 30, 2009; May 4, 2009; May 5, 2009

Expert Witness Transcript

VIEW OTHER AVAILABLE CONTENT RELATED TO THIS EXPERT: Merola, Andrew Angelo

COUNSEL: [*1] SACKS and SACKS, LLP, Attorneys for Plaintiffs, New York, New York, BY: HOWARD BOROWICK, ESQ.

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HARRIS BEACH, LLP, Attorneys for Defendant, UNITED RENTALS, INC., New York, New York, BY: DAVID H. KOCHMAN, ESQ.

JUDGES: BEFORE HONORABLE JAMES G. STARKEY, Justice, and a jury

EXPERT NAME: Dr. **Andrew** Angelo **Merola**, M.D.

TITLE: TRIAL TRANSCRIPT OF DR. ANDREW ANGELO MEROLA

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TEXT: 116

A N D R E W M E R O L A , M. D., a witness called on behalf of the Plaintiff, after having [*2] been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

COURT CLERK: Thank you. Please be seated.

In a loud and clear voice for the record,

please state your full name.
THE WITNESS: **Andrew Merola**, M-E-R-O-L-A.
COURT CLERK: Please state your full address.
THE WITNESS: 36 Seventh Avenue, Suite 502, New York, New York 10011.
COURT CLERK: Thank you.
MR. BOROWICK: May I proceed, Judge?
THE COURT: Yes.
DIRECT EXAMINATION
BY MR. BOROWICK:
Q Dr. Merola, would you tell the jury what your occupation is.
A. I am an orthopedic reconstructive spinal surgeon.
Q And what background education do you have that allows yourself to call you such?
A. I attended medical school. And after medical school, I did a residency in orthopedic surgery at SUNY Downstate here in Brooklyn. After that, I went to the

117

University of Colorado in Denver, where I did a spinal surgical fellowship. And after that, I came back here to practice as a full-time orthopedic spine surgeon.
Q Are you board [*3] certified?
A. Yes, I am.
Q What does it mean to be board certified; explain that.
A. Board certification is a process whereby we take several examinations to test our competency in our field of specialization. In my case, it's orthopedic surgery. After you finish your residency training, which lasts five years, you take a written examination. And that written examination tests your knowledge. After that, when you're in practice for a minimum of two years and you're actually treating patients and doing surgery, you collect all of those patients that you've treated and all of those surgical procedures, and you bring those to a board of physicians and surgeons, and they test you on your surgical skills.
When you've passed both phases of that exam, the written and the oral, you are certified as being boarded by the Board of Orthopedic Surgery. So it means you're knowledgeable and competent with what you do.
Q What kind of conditions do you treat?
A. I treat all conditions of the neck and back in

118

children and in adults.
Q And what range of patients do [*4] you treat?
A. My range --
Q What I mean is, range from, oh, my back hurts to how significant?
A. Yeah. I see basically all kinds of patients. People who have minor issues with their backs, all the way up to including requiring major reconstructive procedures.
Q Have you ever treated patients with paralysis?

A. Yes.
Q Tell the jury, when you have -- when you analyze your patient -- your patient load, do you have patients who come to you with traumatic injuries, congenital conditions, and I guess what I'm looking at is the range of etiologies.
A. Yes. I treat a wide range of etiologies or reasons for having spinal conditions or problems. They can be birth defects. They can be infections. They can be tumors. They can be fractures. They can be disk herniations. It can be injuries. So there's a wide range of issues that can affect your neck and back or your spine, and I basically see all of those issues.
Q Have you had experience to any degree with construction workers?
A. Yes.

Q And are you on the panel for construction workers [*5] who need spinal surgery?
A. Yes.
Q Tell the jury, when you got a patient who has a traumatic injury, and let's say a construction worker, and that injury leads to a lawsuit, are there occasions when you're called upon to come into court and report to a jury what your treatment and opinions are?
A. Yes.
Q And on those occasions, do you charge a fee?
A. Yes.
Q What is your hourly rate?
A. $ 650 an hour.
Q And would you tell the jury in this case, what is your relationship to Joseph Karash?
A. Joseph Karash is my surgical patient.
Q And when did you first see him?
A. I first saw Mr. Karash about five years ago.
Q And when did you last see him?
A. I last saw him on April 20th of this year.
Q And what surgery did you perform?
A. I performed a cervical diskectomy and fusion, with a cage and a plate.
Q Okay. So before we go any further, I'd like you, with the Court's permission, to explain to us a little bit

about the anatomy, or as much as you need to, about the anatomy of the spine.
MR. [*6] BOROWICK: Can he -- Judge, may he do that?
THE COURT: Yes.
Q Would you come down, please.
(Witness complies.)
A. This is a plastic model of a human spine, and I'm going to turn it so that we're facing its side. It's an easier way to understand what's going on.
Up at the top of this model is the space of your skull. Next is flat bone you see up here. Looks a little

bit like a sausage. And then between the skull and the lower portion of the spine is your pelvis. This is where your hips are. That's the spinal column, and it looks very much like a column does.

And that column is made up of multiple elements. It's made of bones, and the bones appear as these white squares. And they're divided into the neck, which is the upper seven bones. The upper portion of your back, which is the middle 12 bones. And the lower portion of your back, which is the lower five bones. And then they go all the way down to your pelvis and your hips.

In between the bones are these cushions known as disks. And behind the column, in an opening of the column

121

called the spinal [*7] canal, runs the spinal cord and the nerves. And the spinal cord and the nerves that come out of your spinal column are responsible for moving your arms and legs and feet around and maintaining your organs, making sure that they all work neurologically. And the -- the nervous system can be looked at as an electrical system, with the computer as a brain, the spinal cord and the nerves as wires coming out of that brain, and the spinal column protects those wires and those nerves.

Q As a diagnostician or an electrician, as it were, is there a way, if somebody has a symptom in some part of his body or her body, is there a way to diagnose where it's coming from, if it's a spinal problem or a root problem?

A. Yes, there is. So each -- each specific nerve and portion of your spinal cord has a certain anatomical part from where it comes out.

Each one of these nerves has a number associated with it, depending upon the bone that it passes by and the disk that it passes by. And each one of these nerves travels into specific locations in your arms and hands legs and feet, and it does specific [*8] things.

It will feel. It will work reflexes. It will work muscles. And it can feel pain. And the areas in which it does those things are specific to the particular

122

nerve that's involved and the particular portion of the spine that's involved.

Q Doctor, for example, you say you have names. I'm holding one. What would that be, for example? What would the name of that be?

A. So this nerve is in your thoracic spine, and it's underneath the fifth thoracic vertebra, so it would be known as the T-5. That is, thoracic five nerve.

Q Does my T-5 do the same thing as your T-5?

A. Yes. The T-5 nerves innervate the same areas. They work the same muscles, and they're very similar from patient to patient.

Q Okay. So now we have the nomenclature and we have the function. Is there anything else -- well, let me ask you, what is the structure of a disk?

A. The disk, which is the cushion that exists in between the bones, can be thought of in terms of -- an analogy is -- a good analogy is to think of a jelly donut.

There's an outer covering to the disk, a lot like [*9] the pastry on the outside of a jelly donut, and then there's an inner, very gooey jelly-like material that's called the nucleus of the disk. So there are two materials in the disks so that that disk can absorb shock, and basically make the bones that are on top and below it work properly. So the disk is made up of these different components, and a good way of thinking about it in your head is, it's just like a jelly donut.

Q And what happens during trauma? You said you treat traumatic injuries. Do you treat traumatic injuries that involve the disks?

A. Yes.

Q And are there different levels of injuries or levels of severity of injuries with regard to the disks?

A. Yes.

Q And would you explain first, what is a disk bulge?

A. A disk bulge basically refers to an even outpouching of the pastry section of the jelly donut. So if you took a jelly donut in your hand, and you took your other hand and you put pressure on it, the jelly donut will flatten, and the jelly donut should flatten in a very symmetrical way, so it would bulge out around its edges.

[*10] In general, bulges are symmetric. There's an even outpouching of the outer portion of the disk or the annulus.

Q And when a disk bulges like that, how does that affect a person neurologically or orthopedically?

A. Now, if that outpouching of the disk comes into an area where the nerves or the spinal cord are, it can cause irritation to that section of the spinal nerves or of the spinal cord, depending upon the section it's on, and depending upon the amount of -- of pressure that it's putting on that particular portion of nerve.

Q How prevalent are disk bulges in society?

A. Disk bulges can happen in patients. It generally depends on your age. The older you are, the more likely you're to have a disk bulge. So a good rough number is if you are about 40 years old, and you took 100 people who were the age of 40, somewhere in the neighborhood of about 30 of those people would have what you would see as disk bulging on their MRIs.

Q Without even having an accident?

A. Correct.

Q What about 50?

A. The number would go up. It would be somewhere in [*11] the neighborhood of 35 or 40.

Q 60?

A. The number would go up again. It would be

somewhere in the neighborhood of 50 or so.
Q Can a person have a bulging disk and work a whole lifetime?
A. Yes.
Q Without knowing it?
A. Yes.
Q Without being limited?

A. Correct.
Q Without needing treatment?
A. Yes.
Q Without having symptoms?
A. Yes.
Q Without having limitations?
A. Correct.
Q Now, tell us what a -- what is disk desiccation?
A. Disk desiccation -- desiccation is a term that means drying, a drying out of the disk.
Q Actually, while you're discussing it, if you would discuss the degenerative conditions which exist in the spine generally, and please include desiccation, osteophytes, and degenerative disease.
A. Sure. So as we get older, we put wear and tear on our bodies. So all of us have some degree of wear and tear, you know, on our joints, on our elbows or hands or fingers, our spinal canal, right.
With respect to the disks, the bones, and the joints of your back, [*12] that wear and tear can show up in different ways. As you age, there is a normal process whereby your disks lose water content and become less spongy and less fluffy. The way we look at your disks is a test called an MRI. An MRI is very specific for picking up water inside of your body parts. And it does this by

converting the water image, what it sees as water, to what we call a bright signal on the MRI.
So if you're looking at your disks and the disks are not bright but they are dark, they are dark because they have lost water. That process is known as desiccation or drying up.
The bones can also have wear and tear on them. And some of the ways that you can see wear and tear on the bones involve the bones coming closer to each other. So if there is an area that is wearing and tearing more than another, the bones will come closer to each other and collapse down on each other. They may come out of their normal alignment. The joints may form bone spurs. And if you've seen older patients who have bone spurs on their hands, they kind of look knobby and knuckled. Those are little [*13] bone spurs on the joints of your fingers and hands. That can also happen to the joints of your neck and your back, and those are some things that you would see with a degenerative process in your spine.
Q Okay. Doctor, would you -- would you tell the jury, is there a way to quantify what percentage of the

population, just by virtue of age and wear and tear, would likely have degenerative conditions in their spine, separate and apart from the bulging aspect?

A. Sure. And that also depends on -- it depends on

127

your age, once again. So if you take a 20-year-old and you take 100 20-year-olds and look at their spines, maybe five or seven out of 100 are going to have degenerative changes. Whereas if you took 100 60-year-olds, you're going to see a much higher percentage. Like I said, maybe 40 or 50 percent of those 60-year-olds are going to have degenerative changes in their spine.

Q Does a person's occupation necessarily predict what kind of -- what level of degeneration or problems they're going to have in their spine, if any?

In other words, does every construction worker [*14] have to have a damaged spine? Does every ballet dancer, or does every clerk or person who works at a desk, does it guarantee they won't have a problem?

A. It neither guarantees they will have a problem, nor does it guarantee they won't have a problem, because not only is the occupation important, and your age and how much wear and tear you have on your neck and your back, but there's also a certain genetic component to it as well, so there are multi, there are more than one factor that goes into saying how much of a degenerative condition you're going to have. There's a lot of things that go into it.

Q Can a person live -- can a person work their whole lifetime with degenerative disk disease and not know

128

it?

A. Yes.

Q Can they live a whole lifetime with degenerative disk disease and not have any symptoms?

A. Yes.

Q Would you tell the jury, what is a disk herniation?

A. A herniation, as opposed to a bulge, is an asymmetrical outpouching of not only the crust of the jelly donut but also that jelly-like nuclear material, so a herniation now involves [*15] the jelly coming out through cracks and/or crevices in that pastry shell, and it protrudes beyond the limits of where the bones end, and it's not as symmetric as a bulge is.

Q Now, I'm going to ask you with regard to this disk model, down at the bottom, is that a disk herniation?

A. Yes. On this particular plastic model, if you look at the lower portion of the back, there --

Q Show everybody, please.

A. There is a lumbar disk that has what looks like a balloon attached to it. And that balloon attached to the disk is a herniation of the nuclear material or jelly-like substance coming out of that pastry crust outside of the disk, so that's an example of what a herniation looks

like.

Q Now, is it a different situation with regard to a person having a herniated disk? For example, can a person live a whole lifetime with a herniated disk and not know it?

A. Yes. You can also have a disk herniation and not be aware of it if it's not what we call symptomatic or producing symptoms or complaints.

Q And does a herniation produce symptoms and complaints that [*16] tip off a doctor like you that there's probably such a problem?

A. Yes. When the herniation contacts a nerve and causes irritation and pressure on a specific nerve, that's the tip-off that it's a symptomatic herniation. That it's a herniation causing the problems.

Q Now, given that you mentioned a nerve and you said about the electrical system, are there specific tests to diagnose whether or not certain funny pains or tingling are as a result of a herniation or an interruption in the electrical patterns?

A. Yes.

Q And what tests are those?

A. There are -- in addition to what we do as a doctor when you're in an office, which is take a history and a physical, there are diagnostic tests which you can do to test the electrical system itself. That's a test called an electromyogram, nerve conduction study. So it's a study whereby the patient's actually wired to a machine and a computer that tests the electrical conduction of the nerves.

Q Is there a shorthand for that?

A. It's also known as an EMG NCV.

Q Do you do those?

A. I do not.

[*17] Q Is there somebody that you send your patients to that performs those EMG NCVs?

A. Yes.

Q And who is that?

A. It's a neurologist. The name is Dr. Harry Hausknecht.

Q And is that a specialty within the field of medicine, to perform EMG NCVs?

A. Yes.

Q Now, do you do MRIs?

A. I do not do them but I can order them.

Q And is it part of the regular practice of a spine surgeon like yourself to send your patient out for these tests, to receive their reports back, analyze them, and proceed accordingly?

A. Yes.

Q Okay. You can resume your seat. And do you have your file with you? Did you bring your file up there with

you?
A. Yes.
Q Oh, great.
Dr. Merola, you mentioned that -- well, tell us again, when did you meet Joe Karash?
A. My first visit with Mr. Karash was in -- on May 17th of 2004.
Q So that would be four days after his accident. When he came into your office, what was -- what were his -- what was the general history and what was his complaints?
A. Sure. Mr. Karash came into the [*18] office and indicated to me that he was in a motor vehicle accident the Thursday before our visit. He said that the truck that he was driving in was sideswiped at a red light. He was emergently taken to Jacobi Hospital in the Bronx, treated and released, and came in to see me because of persistent pain in his neck and low back.
He also indicated that he had a prior issue with his neck, which had resolved. He didn't have any bowel, bladder or constitutional complaints or symptoms.
Q So he told you on that very first visit four days after the accident that he had a prior problem with his neck?

132

A. Yes.
Q Now, did you ultimately become aware of some chiropractic treatment a year before his accident?
A. Yes.
Q Now, knowing what you know, did you receive portions of the testimony of those chiropractors?
A. Yes.
Q Did you receive -- did you review the records of those chiropractors?
A. Yes.
Q Was there anything in there that would lead you to believe that that treatment a year before the accident was significant past medical history, [*19] as far as you were concerned?
A. No.
Q Why?
A. He'd seen a couple of chiropractors and had a total of, I think, four visits. Never had any diagnosis of cervical radiculopathy, had no testing ordered, and had no treatment beyond the chiropractic work.
Q Based on a review of those records, were there any radicular complaints?
A. No.
Q Now, I'm not sure that we went through radiculopathy or radicular complaints, but if you need to

133

use my friend here, please do. And if you don't, don't bother. But would you tell the jury, what is -- what is unique about radicular complaints and radiculopathy?
A. Sure. So when we say radicular, basically,

that's a fancy word for nerve root. It means involvement of a nerve root, and it means a problem with a nerve root.
What that means is that one of the nerves coming out of your spinal column going into your arms is -- or more than one nerve, is having a problem whereby pain is being transmitted along that nerve, and that nerve is malfunctioning. It's not making the sensory job that it has to do work. It's [*20] not making the reflex job that it has to do work. It's not making the muscle job that it has to do work. And it's in a specific area controlled by a specific nerve root or roots. So radiculopathy basically means a specific problem with the nerve coming out of your neck, going into your arms and hands.
Q And based on your review, there was no such radiculopathy or radicular symptoms with regard to his neck?
A. Correct.
Q Now, when you asked him about prior -- any prior neck issues and he told you that, did you ask him whether or not he'd been limited in his activities or in his job as a result of those problems?

134

A. Yes.
Q And was he?
A. No.
Q At the time of his accident, was he performing his full work duties?
A. Yes.
Q Of what significance is it that a person is performing his full work duties, has some chiropractic examinations a year before, continues work duties, and up until the accident, has work duties, and then comes to you four days later after what's occurred? What significance is that?
A. Sure. That's significant [*21] to me in terms of his history because you want to try to get an idea for what the temporal relationship between his present issue is and what has come before.
Significant treatment would be injections into the neck, a loss of function in nerve roots that inhibit your ability to perform your activities at home, inhibit your ability to return to work and duties, require diagnostic studies like EMGs or MRIs, and in some way, shape or form have altered your life. So those are things that we would consider significant, particularly from a surgical point of view.
Q Now, I want you -- I want to ask you -- well,

135

first, I want you to assume that Mr. Karash, way before this accident, had suffered carpal tunnel syndrome through all of the work, whether it was a landscaper, as a waiter or as a bridge painter, had carpal tunnel syndrome in both hands. Would reporting a year before the accident that his hands were tingling, would that be significant to you with regard to an analysis of his neck?

A. Tingling in the hands with a history of carpal tunnel syndrome would basically bear out [*22] carpal tunnel issues and not significant neck issues.
Q What about if he said he had intermittent tightness and pain off and on when he'd have this tightness in his neck, would that be of any great moment to you?
A. Not intermittent, no.
Q Let's move past that. I want to get to your examination.
Tell me what you did when he came in, gave you the history and reported his symptoms.
A. Sure. So basically what you do is, based on his symptoms and his complaints, you do an examination to try to pinpoint what's going on, and then order appropriate diagnostic testing to back up the diagnosis that we've kind of formulated in our head after we've done our exam.

Q And while you're on that subject, explain to the jury what a clinical exam is and what clinical correlation is.
A. Sure. It's everything that goes into looking at a person's body and the way it functions. So you observe the way a patient walks, the way they hold their body. You feel their muscles. You look at ranges of motion. You test for neurological impairment. And then you put those [*23] things together with the history to come up with a diagnosis.
Q Now, Doctor, Mr. Karash, his record, the -- the ambulance and the emergency room talk about left hip and left lower back. In other words, there were pains going down the left leg. Did he report to you those parts of his body having any issues?
A. Yes, yes.
Q And do they remain -- I don't want to belabor the subject, but do they remain a problem for him, or have they essentially resolved?
A. The neck has remained, I would say, his major problem. His low back has had some good days and some bad days, but I would say for the most part resolved.
Q And the hip, no problem?
A. Yeah, no problems.
Q Now, did he -- is he -- over the last five years,

has he been a patient who you would describe as a complainer or a whiner or a stoic?
A. He's more of a stoic or noncomplainer.
Q And has he been compliant?
A. Yes.
Q And what do you mean by "compliant"?
A. Compliant basically means that he keeps his appointments. He comes to the office. He listens to advice and [*24] he tries to help me help him.
Q And do you know what the term "malingerer is"?

A. Yes.
Q Describe for the jury what a malingerer is, and putting it into perspective with Mr. Karash.
A. Sure. "Malingerer" is a term that's used to describe patients that may have or may come into the office and not be completely and entirely truthful or honest with the physician who's examining them or seeing them, and so there are certain things that malingerers will present with that they're not even aware of the fact that they're bringing into the office with that you can pick up on. So there are inconsistencies in their history or their physical finding or their diagnostic testing and in the way they function, through observation, physical exam, that don't bear out strict anatomical surgical problems.

138

Q And over the course of five years of treating Mr. Karash, have you ever found him to be malingering?
A. No.
Q Has there ever been a complaint he's made that you weren't able to clinically reconcile?
A. No.
Q Okay. Now, I want to take us through a few [*25] things that happened before he saw you and ask you if they're of any significance.
The accident. I want you to assume that Mr. Karash has described it as he's sitting at a light in a truck in the driver's seat, belted. The right -- the left side driver's door area is struck by a steel attenuator on the back of a pickup truck that's going between five and 25 miles an hour. As it passes him, the rear attenuator swings around, and this is the basis of other" witnesses as well, swings around and strikes the left side door against which he's seated inside.
He says the first feeling is a jolt from the left that throws him backwards and toward the left rear post, and then the cab is lifted slightly, and then it's dropped down. He's holding the wheel and holding the brake, and instinctively he releases the brake. And then as the vehicle is pulled, he's jerked back again. He says that he followed the vehicle and they both pulled to a stop,

139

and he felt his neck muscles tightening up and becoming painful.
Thereafter, an ambulance came and he was unable to get out of the vehicle, for two [*26] reasons. The door was jammed and his -- and he was in too much pain to climb over -- over the console.
I want you to assume further that there was damage to the vehicle that included the deformation of a steel bumper, the deformation and ripping of a steel fender, and the compression of the door and fender over the wheel well.
Do you have an opinion with a reasonable degree of medical certainty as to whether that scenario could

generate the kind of force and dynamics to cause a spinal injury?
A. Yes.
Q Would you tell us why.
A. Sure. That type of an injury can occur during that situation, particularly given the fact that it's an impact you're not prepared for, number one.
Number two, something that's going to be forceful enough to lift up a truck, bring it back down --
Q No, no, not lift up a truck. It's a cab over -- which is how -- it's a cab over the engine. So when I say lift up, I mean the cab itself, the cab portion comes up

140

so that work could be done on the engine. I don't want you to think it lifted up the truck. It lifted up the cab. [*27]
A. And pardon me for implying that, but if the cab itself came away from the rest of the chassis enough to bring it up and then down again, those forces are going to be transmitted to your head, neck, and body, in addition to the fact that the door underwent mechanical deformation and was jammed shut as well, so there's a significant amount of force transferred there.
The neck is the most flexible portion of your spine, connecting your head to a relatively stiff area of your body or your chest and the rest of your body. And the middle of your spine in your neck is right in the area of the C-5, C-6 disk. That's the area that will take the majority of deformation during an impact such as that.
Q Could you show us on the anatomical model?
A. Sure. So once again, if this is the base of your skull and this is the top of your chest (indicating), there's a chest and your arms that are holding the upper portion of your back stiff and firm.
Q Where are the ribs?
A. The ribs are where my fingers are right now (indicating.) And you've got 12 ribs that come into contact with [*28] the 12 bones of your thoracic spine or upper

141

back. Those ribs come all the way around your body to your sternum or your breastbone, and then they can enclose cage that holds your upper back or thoracic spine in a very stiff fashion.
You've also got your body weight, your arms, your muscles, your abdomen and everything else around this area of your spine all the way down to your pelvis and legs that are essentially fixed to the bottom of the seat. Your head is pretty much floating in space on a tether, which is your cervical spine. And the bones of the cervical spine, as you can see from the model, as are the disks, much smaller than the other bones in your back. So this area is particularly prone to an injury whereby the head and spine are whipped about on a relatively fixed portion.
Q Is that where they get the term "whiplash"?

A. Yes.
Q Now, I want you to assume that after that lifting, Mr. Karash felt there was a pulling such that a steel bumper was -- was distorted about 45 degrees, according to a witness. And then with that kind of pulling, Mr. Karash let go [*29] of his -- let go of the brake and was thrown back again.
Is there a different whipping by that motion than with the oblique contact from the side originally?

142

A. Yeah. That particular motion where you are -- these are what are called acceleration, deceleration issues. So your body is accelerating in one way, and then decelerate -- it accelerates another way, it decelerates, and your head and neck are caught in between that accelerate, deceleration.
Depending upon the motion your neck and head are undergoing, what's called flexion, so you're hyperflexing your neck and you're extending your neck, so you're opening and closing the disk spaces in your neck, like -- like you're opening and closing the hinges on a door.
Q Dr. Merola, do you have an opinion with a reasonable degree of medical certainty given his -- his past medical, history, which you've determined is not significant, the accident details, do you have an opinion as to whether or not the accident was the cause of his cervical issue?
A. Yes.
Q Cervical injury?
A. Yes.
Q Tell the [*30] jury if there is any significance to these items, and I'm reading now from Exhibit -- Exhibit 13, which is the ambulance call report from the fire department:
He was taken from the driver's seat. He had pain

143

in his left neck, left hip, left leg pain. Feels like his muscles are tightening up. Wearing a seatbelt. Describes impact from driver's -- driver's door was hit. And he's removed on long board with a "C" collar and a head immobilizer.
How can you -- can you reconcile that with what you observed when you met him?
A. Yes.
Q Of what significance, is any, of that?
A. It pretty much describes what he told me and what the symptomatic portions of his body were during the exam.
Q Now, with regard to a herniated disk, other than just intermittent tightness, would the onset of radicular pain, as you've described him having, would that onset being immediate after an accident be of any significance as a clinician/diagnostician?
A. Yes.
Q Why?
A. It gives you something to hang your hat on, if

you will, from a surgical point of view and from [*31] a diagnostic and therapeutic point of view, that being an acute injury causing acute or sudden onset pain.
Q Now, in the hospital record which is Exhibit 14, it mentions that he was given Percocet. What is Percocet?
A. Percocet is a narcotic medicine combined with

144

Tylenol.
Q They note that there is sensation -- complaints of sensation issues traveling down his leg.
A. That's a description of a sciatic symptom.
Q Okay. And that he's got a paracervical spine pain and tenderness.
A. That is pain -- paracervical means adjacent to the neck. So there's pain in the neck area and the muscles right adjacent to your neck. And tenderness means that when you touch that area, it hurts.
Q Now, he's got no fractures. According to X-rays, he's got no fractures. Is that any surprise to you?
A. No.
Q Could -- you've determined -- you've given an opinion that the accident caused his neurological problems and his spinal problems. Could -- does it require an accident to cause that kind of damage? I mean an accident meaning a motor vehicle accident.
[*32] A. Does it require a motor vehicular accident to cause this kind of damage?
Q Yes.
A. No, not necessarily.
Q Do you have patients who have herniated disks with far less forces?
A. You can have less force and incur a disk

145

herniation, yes.
Q Isn't it true you could sneeze and herniate a disk?
A. You can sneeze and squeeze out some disk material, yes.
Q Now, after you examined him, did you consider a course of action?
A. Yes.
Q And is there a difference between a course -- an invasive course of action and a conservative course?
A. Yes.
Q Explain to the jury what the differences are, and why you chose one over the other.
A. Sure. So when -- when you're treating a patient, particularly from a spine point of view, there are certain considerations you need to think about, and that means that there are certain things that we do as doctors that carry with them risks and benefits, and that includes everything from physical therapy to surgery.
We try to do the least risky stuff first in the hopes that it is going [*33] to ameliorate or relieve the patient's symptoms and complaints. So we try to get the

most out of the least we can do, because we know full well that sometimes the more we do, the more problems you can cause as well.

So my first course of treatment is to institute what we call "nonsurgical care," and that starts with activity modifications, rest, and antiinflammatories, and ordering some diagnostic studies.

Q And the diagnostic studies that you ordered, I think you mentioned there's an EMG and an MRI?

A. Yes.

Q Did you order them?

A. Yes.

Q And did you get them?

A. Yes.

Q And while the Court is setting up a shadowbox, I'm going to ask you to describe the EMG, which we're not going to see.

Describe the EMG, how it's done -- well, you described how -- strike that.

Can you tell the jury what the EMG showed?

A. Sure. There was an EMG done of Mr. Karash's upper extremities or arms and hands, and that EMG was significant for what's known as a C-5 and C-6 radiculopathy or problem with the nerve root going past the C-5 and [*34] C-6 level in the neck.

Q Is an EMG pretty specific?

A. An EMG gives you what we call dynamic or realtime electrical evidence of nerve function, and it is specific insomuch as it can tell you those nerves that are involved with the problem.

Q Is it reliable?

A. Yes.

MR. BOROWICK: Now, we seem to be having a problem with the --

(Pause in proceedings.)

Q Doctor, with the Court's permission, would you step down and help us out here with a -- you have that?

(Pause in proceedings.)

Q Show us what the MRIs show, please. Hold it as you do that because, you know --

A. Sure. So this is -- this is an MRI. And what happens with an MRI is, you see on this one sheet of film, you see many images, and these are all side views of the neck.

At the top of these images is the bottom of your brain. And at the bottom of these images is the top part of your upper back. To the right of the images are this -- this black area. That's your windpipe. It's full of air so it's black so there's no signal from the MRI. And on the back side, you see [*35] this area where there's this little indentation. That's the nape of your neck. Those are the muscles in the back of your neck.

Each image is a slice through the head and neck,

148
and it's like you're put in a baloney slicer. And each one of those little slices shows you a different section of the head and neck so you can get different views of the bones, disks, and spinal cord.
The bones appear as squares. In between the squares are the disks or the cushions. Behind the bones and the disks is the canal. This contains the spinal cord.
And if we look on the MRI and we go between the fifth and sixth bones, and we're specifically looking at the disk and spinal cord, we can see that the spinal cord is being indented by disk material, so it almost looks like somebody's taking their finger and they're kind of sticking it in the spinal cord. That's disk material that is protruding or herniated beyond the borders of the vertebral bodies going into the area where the spinal cord is. And if we count those actual bones, it's right between the fifth and the sixth bones in the neck.
[*36] Q So how would you refer to that nerve root that's -- or that area that's being impacted upon?
A. It's -- it's the C-5, C-6 level, because that's the level that it is in the -- in the spine. That's the bones that are -- that are on top of and below that particular disk.
Q Now, is the radiculopathy, the nerve roots going
149
out on either side, is it one side or both sides?
A. This -- this particular cut, so if you look at this particular cut, this shows the disk material just about the center of the -- of the spine. So you're getting impingement on both sides of the roots, so you're having involvement of the spinal cord in the middle of the canal, with the roots that exit to both the right and left sides.
Q So let's understand: Does that MRI reconcile with your finding on examination?
A. Yes.
Q And does that MRI reconcile with the EMG that was done at your request by Dr. Hausknecht?
A. Yes.
Q So now your examination, the EMG, the MRI, do those all reconcile with Mr. Karash's symptoms?
A. Yes.
Q And is there any history of any of [*37] the symptoms being present before that are germane to a radiculopathy?
A. No.
Q Now, does that MRI tell you anything else about the level of degeneration, other areas that would tell you whether or not his age and activity level were wearing away his spine?
A. It does.
150
Q What does it tell you?
A. So if we look at -- if we look at this MRI and we

look at it specifically with respect to degenerative changes and other issues that can occur to the neck, what we notice is that the neck itself has pretty good alignment. There is a preservation of the alignment of the bones. We don't see one bone slipped off of another bone. We don't see collapse of one bone on any of the other bones. So the disk spaces are preserved. There's no collapse. We don't see any bone spurs off of the joints that are in this spine. And we don't see a different color in the disks in the spine itself. So all of these disks appear to be a rather uniform color or a shade of gray. So we don't see here anything that leads us to believe that this is a degenerative cervical spine.

Q And [*38] what's the date of that MRI?

A. This MRI is on May 26th of 2004.

Q So that would be two weeks after the accident, there's nothing to indicate that he's got a degenerating spine?

A. Correct.

Q And the only thing it indicates is that C-5, 6 has a bilateral herniation, or is it a herniation or protrusion?

A. This is -- well, a protrusion is a herniation, so

151

a protrusion means something sticking out beyond the confines of the bone.

Q Creating a bilateral radiculopathy?

A. Correct.

Q Now, is there another MRI there?

A. Yes. There's also this MRI. This is -- this is also May 26th of 2004. It's a different -- it's a different, what we call, spin sequence. It's -- when you do an MRI, there are different ways to look at different tissues in the spine, and so it's done under what are called multiple spin sequences. And this MRI also shows the C-5, C-6 herniation, whereby it's impinging the spinal cord. Shows good alignment. Does not show any disk space collapse. Does not show any fractures. Does not show any malalignment.

Q Doctor, [*39] based on these MRIs and the EMG and your clinical exam and his symptoms, as he reported it, and the history of the accident, the ambulance call report and the hospital record, do you have an opinion as to whether or not there is any cause for his pain or injury or condition beyond this accident?

A. None beyond this accident.

Q You can resume your seat, please.

(Witness complies.)

Q Doctor, after you got your tests back and after

152

you reconciled all the evidence, did you set about a course of treatment for him?

A. Yes.

Q And what did you do?

A. My initial course of care and treatment for

Mr. Karash was nonsurgical. As we said, activity modifications, physical therapy, antiinflammatory medicines, so basically, everything that we can do from a nonsurgical point of view to give this a chance to cool off, heal, and get better.
Q Okay. I want you to assume that he tried deep massage. He tried yoga, acupuncture, herbal remedies. He went through the physical therapy. He used all the medications. He even had injections by Dr. Hausknecht. Did all [*40] of this or any of this eliminate his symptoms?
A. No.
Q And I want you to assume that he went back to work at some point. He was permitted by an employer to do very, very light duty. And at different times, he was taken on and let go. Taken on, let go. At some point, did you decide to do surgery?
A. Yes.
Q Why? What had occurred that led you to go invasive?
A. Ultimately, persistent complaints and symptoms

153

interfering with your activities of daily living and your abilities to do what you normally do or what you want to do despite everything, including the ultimate step before doing something surgical, which is injecting medicine into your neck, if all those things fail and your physical findings and your symptoms are consistent with what we call the surgical pathology, which the MRI demonstrates, that's an indication for surgery, and that's why the decision to undergo surgery was ultimately undertaken.
Q Now, can you tell the jury, did he want to have surgery?
A. Ultimately, it had gotten to the point where he could no longer tolerate it, and [*41] yes.
Q Did he want to work?
A. Yes.
Q Based on your familiarity with him as a patient, did he have an active personal life?
A. Yes.
Q Did he want to return to that?
A. Yes.
Q And he was willing to do surgery?
A. Yes.
Q Actually, you were willing to do surgery, and he was willing to go along with it.
I'm going to ask you to step down. I have an

154

easel for you.
MR. BOROWICK: With the Court's permission -- your Honor, may he step down and show us the condition of the surgery?
THE COURT: Yes.
Q If you can -- I'm going to move this up, but I'm going to ask you to try not to block any of the jurors, which is tough. And would you try -- just take us through

what was -- what you did.
A. Sure. So this is a schematic and diagrammatic representation of what's known as an anterior, which is through the front, cervical, the neck, diskectomy, removal of a disk, and fusion, which means stabilizing the bones so they do not collapse or move, procedure. So it's an anterior cervical diskectomy and fusion, August [*42] 22nd of 2006.
And the way that's done is that the patient is placed under a general anesthetic in the operating room. An incision is made along the front part of the neck area through the skin, and then the bones and the disks of the cervical spine are exposed so that you can see the area that you're operating on.
And then using some special tools, the disk itself is removed all the way down to the level of the spinal cord, so that the pressure is now taken off of the

spinal cord and the nerve roots. So you can -- you can see that area, and you can remove disk material all the way down to the cord and the roots.
After you've done that, you take a high-speed bur, and you prepare the bones to accept or accommodate a device known as a "cage." It's a device that is made out of carbon fiber generally. It's filled with what we call bone graph. That bone graph is taken from the bones that we've shaved down. That device is placed in between the bones of C-5 and C-6 so that it acts as a shim, and it jacks up those levels. It prevents them from collapsing them on each other, and [*43] it stabilizes that section so that section no longer causes any nerve root damage or spinal cord damage. And then ultimately to hold everything in place so that it doesn't pop out and give it a chance to heal, you put a titanium plate onto the bones that you then fix into the bones with some screws. That holds the whole process together. So it's a cervical diskectomy and a fusion.
Q And did you accomplish what you wanted in your surgery?
A. Yes.
Q Was surgery successful?
A. Yes.
Q So you made him all better?

A. We -- we didn't do anything bad, number one. So surgery is when you do that, you want to make sure you don't do anything to hurt the patient, and that's part of your surgical success. So it was a successful surgery. He wasn't hurt. We decompressed the spinal cord and the nerve roots appropriately, and we've prevented neurological deterioration and further neurological damage at that area, so those are the, what we call the realistic goals of surgery, and that ultimately determines whether or not that surgery was successful.
Q And I [*44] asked another question. I asked whether or

not, so he's all better?
A. Well, completely better, no. But better than he would have been had he not had the surgery, yes.
Q Okay. How did he do after the surgery?
A. He did pretty well after the surgery.
Q Okay. And did he -- did he continue to progress or did he plateau?
A. He progressed in terms of his healing and his improvement postsurgically and, in fact, was actually able to go back to some duties and work.
Q And did he have good days, bad days, or both?
A. Yes. He was prone to good days and bad days and combinations therein.
Q What kinds of modalities of treatment did you

157

attempt beyond surgery?
A. We used soft collars. We used something called a TENS unit, which is an electrical device that stimulates the muscles in the back of the neck. We used medicines postoperatively, physical therapy, activity modifications, and pain management with injections as well.
Q Okay. Now, you mentioned injections. I'm asking you to explain or describe what those are. Is 21 -- Exhibit 21 for identification, [*45] is that a fair and accurate depiction of the way in which injections would be given to him?
A. Yes.
Q And describe what occurred.
A. So --
Q By the way, who did these?
A. These are done by pain management physicians. Dr. Perpa and Dr. Hausknecht also gave some injections.
Q Okay. And what do the injections do?
A. Injections are medicines that are antiinflammatories, so steroids are used in the injection and local anesthetics are used in the injection. The needles for the injections go into the area that are known as the facet joints. The facet joints are on the back side of your neck. So the front side is on the bottom portion of this diagram. This opening is your windpipe.

158

Your esophagus, the food tube. Right behind the windpipe, the spine. Behind that where the muscles are are the joints of your neck. These are known as the facet joints. And the injection's placed, the antiinflammatory and the anesthetic medication, into the facet joints of your cervical spine.
Q Doctor, when you do -- you can resume your seat now.
When you [*46] do the kind of surgery that you do or that you did with Mr. Karash, are there -- I mean, you told us all the good stuff. Tell us, is there anything -- any consequences of that surgery as a person goes forward in the future?
A. Yes.

Q Tell us.
A. These surgeries do have future implications and future issues that arise.
The fusion is very good at stabilizing that area and preventing it from collapsing. Now, in doing that, what it does is, it -- it sets up an area of abnormal stiffness in your spine, because your body is used to being flesh and blood. So the stiffness of your disks and your bones and your joints is one thing without implants, and it's stiffer -- it's stiffer with implants.
And so what that means is that the joints and the

159

bones that are adjacent or next to the segment that is fused can have extra stress. That extra stress can cause extra pressure on the joints, and that can lead to something we call adjacent segment problem, with some premature degeneration of those areas that can lead to what we call axial pain. When we say axial pain, we mean [*47] pain in the neck or the axis of the neck.
Q When these injections -- you said that the surgery was done in '06, right?
A. Yes.
Q Surgery was done in August of '06, but these injections were done the year after. If he was doing better, why would he need injections in '07?
A. Yes. So those injections are actually a response, to symptoms in the neck secondary to those adjacent segment issues that I just described. So those injections are going into the joints in the back of the neck in the areas of the spine that are seeing extra stress and pressure.
Q Well, is the adjacent segment issue, is that something that occurs mechanically because of the fixation?
A. It's -- it is -- yeah, it's a mechanical process because of the increased stiffness from the fixation and stabilization.

160

Q Is there any way to prevent that once you've done that surgery?
A. Any time you put a mechanical implant or a device into the spine, you're going to increase stress and load in the segments that are adjacent to that area.
Q What is Percocet?
A. Percocet [*48] is a narcotic medication combined with Tylenol.
Q What is Vicodin?
A. Vicodin is also a narcotic medication combined with Tylenol.
Q What is Oxycodone?
A. Oxycodone is a long-acting narcotic medication.
Q Lyrica?
A. Lyrica is a neurological medication that is given for chronic pain and chronic nerve pain.
Q Celebrex?

A. Celebrex is what's known as a nonsteroidal antiinflammatory medicine.
Q Was -- based upon your being his doctor for five years and your review of records, had he ever been on any of these medications before this accident?
A. No.
Q As a result of this accident and his injuries, has he -- have these medications been required?

161

A. Yes.
Q And would it be reasonable and necessary for him to have taken them over the last five years?
A. Yes.
Q Sir, would you tell the jury, as he continued to have axial pain after your surgery, were you the one that referred him for the injections?
A. Yes.
Q And those having been done, let me ask you to step down just for the final [*49] time, and take us through the consequences visually of the segmental issue, and show us what we're looking at.
A. Sure. This is a diagram with an MRI.
Q You know what, I'm going to hold it; otherwise, juror number one aren't -- and alternate number one aren't going to see it.
A. There are two side views of the neck. This is a postoperative MRI. This is from September 27th of 2007. And we're also -- this is known as an axial picture. It means we're looking down from the head, head down.
So we're looking at the spine after the diskectomy and fusion. So if you look at the C-5, C-6 level, we no longer see disk herniation in the spinal canal because I removed the disk herniation from the spinal canal. We see that there are implants fixing C-5

162

to C-6. The cage device is in between those implants.
What we do see is evidence of increased stress adjacent to the fusion. So below the area of fusion, we see a disk that is sticking out, protruding or herniating. And up above the area of the fusion, between C-3 and C-4, we also see a disk that's sticking out, so that's evidence [*50] of what we call adjacent segment or increased stress and pressure above and below the area where the fusion was.
Q Thank you.
Doctor, what is arthritis?
A. Arthritis is a term that refers to inflammation. "Itis" means inflammation, "arth" means joint, so it's a term that refers to inflammation of a joint.
Q Now, have you monitored him for arthritic changes?
A. Yes.
Q And can you tell us what you've noticed? You know what, before you do, I'm going to ask you -- no more easel, but I do need you to do the shadowbox one more time. If you would come down.

And tell us what we're looking at. What exhibit number it is, what we're looking at, and the significance of it.
A. This is Exhibit Number 15, and this is an X-ray of the cervical spine from March 31st of 2008. So this is

163

after the surgery. And so we're looking at a side-view X-ray of Mr. Karash's neck, and we can see the plate and the screws. In between the plate and screws, you see these little dots, those little ball bearings or dots that are inside the carbon fiber cage. The cage doesn't show [*51] up on X-rays because it's carbon fiber. The little ball bearings do, so you can tell where the cage is. You want to make sure the cage doesn't go into the spinal canal or move someplace where it shouldn't be.
So the cage is in place. The plate and screws are in place. C-5, C-6 is well fixed. Hasn't moved around. We look at the bones adjacent to C-5 and C-6, and we look at the joints behind the bones, and what we can see is that those joints start to get a little whiter. Whiteness in a joint area is a joint reaction to extra stress and strain. And that's generally what we call an arthritic condition of the facet joints. Those are the joints behind the neck where the bones actually slide around.
Q And what about the next X-ray, what number is it?
A. This is Exhibit 16. Also March 31st of 2008. It's a front-to-back view of the neck. Shows you the plate and the cage holding the bones together. This X-ray basically shows you that his cervical alignment, front, is basically, he's straight. He's straight up and down and

164

his neck, which is where you want it to be. The bones haven't [*52] slipped off of each other, from side to side.
Q Okay, thank you. Now I'm really done with that. And just take the whole thing down. Thank you.
Doctor, I'm going to refer to your medical chart. Do you have it here with you?
A. Yes.
Q Okay. And is that a chart that you're required by state law to keep?
A. Yes.
Q And do you try to be as complete and accurate as possible?
A. Yes.
Q Do you put every word that's exchanged between you and the patient? Do you include every word in there?
A. No.
Q Is that chart prepared for a lawsuit?
A. No.
Q So, in whatever manner you prepare that and keep that, can you tell us, since surgery in '06, what types of things -- well, has he been symptomatic at all?
A. Yes.
Q And are there -- is there something you could

tell us in a general way that brings on the symptoms?
A. Sure. His symptoms with respect to his neck are

in general what we call mechanical axial pain. That means that mechanical things to the neck reproduce axial pain. And so basically, maintaining the [*53] head and neck in a fixed position for an excessive length of time, putting pressure on your joints, your neck joints, by looking up; putting pressure on the muscles of your neck; waking up in the morning to do certain activities, these kinds of mechanical irritations produce axial pain in the neck area.

Q Now, how about brushing your teeth; would that produce axial pain?

A. So, yeah, for example, something like brushing your teeth, when you wake up in the morning, you're going to -- you have stiffness from the joints. Putting the pressure on your, you know, head and neck in the form of doing a brushing action compounds those mechanical symptoms and produces axial pain.

Q Now, what other types of activities -- I mean, are you suggesting, or have you suggested to Mr. Karash that he do nothing?

A. No.

Q Why?

A. No. Well -- well --

Q If mechanical things are going to increase his axial pain, why wouldn't you have him refrain from any

activities?

A. Right. That's -- you're not having a patient refrain from any activities, but you're having [*54] him modify their activities to basically work around those activities that reproduce significant pain, and to avoid repetitive stress or motion that can cause excessive wear and tear to the cervical spine, so that falls under the general category of what we call activity modifications and restrictions. So basically, I mean, if something hurts, it means avoid doing it. It doesn't mean don't do it or don't ever do it because you're going to -- unfortunately, you have to do certain things. I mean, it's just the way we're put together, and sometimes you even forget you had surgery to your neck. So things are going to happen and that's okay. That's why there's a plate and screws in there, but you want to avoid those activities on a repetitive basis that reproduce pain, and modify your activities in order to be able to deal with it. There's a lot of life modification.

Q Well, how do you adjust to life -- in your adjustments to life and the things that you want to do or try to do, how do you adjust to that with medication?

A. So, for example, the medications themselves are something that you [*55] need to take based on what your symptoms are. These types of issues can be particularly

bothersome during periods of time where the weather is particularly bad, either cold or damp, so those types of things may require more medications than days that are warm and not as irritating.

If you've been doing a lot of repetitive motion to your neck, that might be a day whereby you need to take more pain medicine than a day that you don't. If you're in a position where you've found yourself having to use your head and neck and perhaps maintain it in a given position for a long period of time and that produces stiffness, that's a day that may require more antiinflammatory than another.

Q I mean, he's not -- he's not crippled, is he?

A. Correct, he's not crippled.

Q And there are lots of things he can do?

A. Yes.

Q As long as he doesn't do them all day long?

A. Correct. Yes.

Q Can he lift a jug of water?

A. Yes.

Q Can he -- can he work on his garden?

A. Yes.

Q Can he work on his pool?

A. Sure.

Q Can he -- if [*56] he has pain doing any of those

168

things, if he does it for too long, what's his -- what's the answer?

A. The answer is, stop doing it when it hurts, and take some medications to control the pain that you do have.

Q Has he ever come into your office and told you that he had no symptoms anymore, or on a particular day?

A. Yeah, there have been periods of time where he's done pretty well and he's been relatively asymptomatic.

Q Has -- would you recommend based upon -- by the way, do you know what a bridge painter does?

A. Yes.

Q Do you have an opinion as to whether or not he could ever be a bridge painter again?

A. Yes.

Q What's your opinion?

A. I would not recommend that he return to the duties of a bridge painter. I don't think that that would be an appropriate job for him.

Q How about any manual labor job?

A. Manual repetitive heavy labor, no.

Q Do you have an opinion with a reasonable degree of medical certainty as to whether or not he should return to his activity life-style, to wit, wrestling, instructional coaching, [*57] where his daughters are in the

169

league where he's constantly throwing the ball, catching the ball, batting, teaching, skiing, heavy lifting, anything like that? Do you have a recommendation with

regard to that?
A. Yes. And those types of activities specifically, no, I would recommend that he avoid doing those particular types of activities.
Q Now, have you -- have you reviewed the videotape surveillance that the defendants have done?
A. Yes.
Q Is there anything in those -- in those visuals that surprise you, that he's in those positions?
A. No.
Q Is there anything about those positions or visuals that is inconsistent with what he's able to do on occasion?
A. No.
Q Have there been occasions where he's described that he can't do any of his activities of daily living?
A. Yes.
Q And what activities has he told you on occasion he can't do?
A. He's had difficulty, for example, maintaining the head and neck, in fixed positions. He had some days where it's been difficult for him to wear a hard hat. Driving

170

has had [*58] -- he's had some difficulties with driving. He's had some difficulty, for example, with even brushing his teeth in the morning on occasion.
Q Now, I want you to assume that he, subject to connection, will testify that he was trying to help his daughter move some furniture, and that the pain was so bad, it brought him to his knees. Did he ever share that with you?
A. I don't recall.
Q Do you have a note for January 28th?
A. Let's see.
Q Of '08?
A. January 28th of 2008.
Q Yes.
A. Yes.
Q Would you tell us what happened on that date. What were his symptoms, complaints, and your findings?
A. Let's see. He returned to the office. He was symptomatic, with axial neck pain. He reported some dysthesia or radiating pain into the arms.
Q Is that different from carpal tunnel?
A. Yes. He's utilizing Liddderm patches. On Lyrica, on Celebrex, on Vicodin. Difficulty maintaining head and neck in fixed position for anything in excess of 15 minutes. Difficulty with activities around the house.

171

That include bending, lifting, and twisting. [*59] And he indicated that over the weekend, he tried to help his daughter move some furniture around her room. Had severe pain and spasm in his neck, which indeed did bring him to his knees, and required strict rest for the remainder of the day.

Q Now, you mentioned weather, temperature, etcetera. That was on a January day. In the summertime, as is shown in one of the visuals of the surveillance, he's working on his pool. Tell us about that. Tell us what you see as his position in those visuals.
A. Sure. Basically, it's a gentleman who is out and about during the day doing some pool work. It is -- it's a pretty nice day and it is summertime.
Q Anything about his positioning that as a clinician detective you can discern?
A. Basically, if you look at his --
MR. PLATEK: Objection. Did you just call him a "detective"?
MR. BOROWICK: A clinician detective.
MR. PLATEK: I've never heard the terminology, your Honor. Maybe I'm mistaken.
MR. BOROWICK: Please.
MR. PLATEK: Well, I'm objecting.
THE COURT: That was the objection?

172

MR. [*60] PLATEK: Yes.
THE COURT: Sustained.
Q Doctor, as a clinician, when you're looking for signs, have you ever been -- has a surgeon or a medical doctor trying to diagnose a problem or assess a condition, to your knowledge, ever been referred to as a "detective"?
A. As a medical detective, yes.
Q As a medical detective, is there anything significant that you would tell us about the positioning of Mr. Karash in those visuals?
MR. PLATEK: Again, your Honor, I object. I've never heard of someone called a "medical detective" in the context of a civil lawsuit.
THE COURT: That's a commonly-used term or colloquial or what?
THE WITNESS: Colloquial, I would say, your Honor.
THE COURT: Sustained.
Q As his doctor, can you tell us or what significance there is in those visuals as far as his positioning?
A. When you look at the visuals, you basically see that his head is kept in line or in the axis of the rest of his body during his motion.
Q Is there any correlation to the amount of axial

173

pain he'll feel and the amount of exertion he [*61] puts it through?
A. Yes.
Q And what is the correlation?
A. They're pretty much directly correlated, so the more mechanical axial load you generate, the more or the higher incidence of mechanical pain is.
Q And would you tell the jury, do you have an opinion with a reasonable degree of medical certainty if

my client continues to work, he's doing a light-duty safety manager kind of work, no exertion involved, if he continues to do that over time and stays away from heavy labor, what is his prognosis?
A. If he continues to do a light-duty work, basically what he's doing right now, his prognosis is what we would refer to as guarded, which means he continues to require observational care and management from a surgical point of view. It's acceptable in terms of what he's doing, but he needs to be followed.
Q Now, over the course of the three years since the surgery, we saw that he still continues to have axial pain. His MRI in '07 shows arthritic changes and segmental issues, and the X-rays show the same. Based upon the most current evidence and the most current [*62] examination, what is your opinion as to what the future

174

holds for him?
A. I basically reiterate what I just said. He does have evidence of adjacent segment disease, and he is what we would consider a candidate for revision surgery in the future. I think we actually sat down and talked about that with Joe. I spoke to him about that.
Q Have you spoken with Dr. Root, who's the life-care planner, about your opinion as to the needs that he will have in the future medically?
A. Yes.
Q Amounts of medicine, types of medicine?
A. Yes.
Q Amounts of therapy, types of therapy?
A. Yes.
Q Surgery?
A. Yes.
Q Rehab?
A. Correct.
Q Last visit, how's he doing?
A. Last visit, April 20, '09, increasing activities producing increasing pain. Some difficulty sleeping at night, with some headaches reported. Evidence of adjacent segment issues, according to the history and physical findings. And we sat down and we spoke about things such as possible revision surgery in the future, and continue

175

his conservative care and management, [*63] which included his activity modifications and restrictions, medications, and pain management.
MR. BOROWICK: Nothing further. Thank you.
THE COURT: Any cross-examination?
MR. PLATEK: Can we have a sidebar?
(Sidebar discussion held off the record.)
THE COURT: There'll be a short recess. Please keep in mind -- please remember the rules governing your conduct as jurors. Please adhere to those rules. We'll recall you shortly.
(Recess taken.)

MR. PLATEK: Your Honor, I need to make a phone call because there's a record of a physical therapy treatment. Plaintiff's objecting to me bringing the record in. It's in evidence. It's done at the same time. As a matter of fact --
MR. BOROWICK: You know what, stop. Do it.
MR. PLATEK: Okay, thank you. So can I take it out of this record?
MR. BOROWICK: And I know you're going to do your very best to get him out today.
MR. PLATEK: I'll do my very best.
MR. BOROWICK: Only so much you can yell.
MR. PLATEK: I can yell. You should hear me at home.
COURT OFFICER: Bring in [*64] the jury?
THE COURT: Yes.
COURT OFFICER: Jury entering.
(Whereupon, the jury entered the courtroom.)
COURT CLERK: Case on trial continued. All parties are present, including the seven sworn jurors. Thank you. Please be seated.
THE COURT: You may proceed.
MR. PLATEK: Thank you, your Honor.
CROSS-EXAMINATION
BY MR. PLATEK:
Q Good afternoon, Dr. Merola. We've never met, correct?
A. Correct.
Q Let me ask you something. I'll tell you, something I've been very curious about for a while.
Can we agree that the term "asymptomatic" means no symptoms, right?
A. Asymptomatic means without symptoms.
Q Okay. By the way, in your medical school and residency and internships, did you do an OB-GYN rotation?
A. Yes.
Q So is there any such thing as being really pretty much not pregnant? I mean, you're either pregnant or not pregnant, right, Doctor?
A. Are we talking about OB-GYN?
Q I'm talking about a person who's pregnant, really pretty much not pregnant. Can you be really pretty much not pregnant? [*65]
MR. BOROWICK: Judge, only if he's an obstetrical detective.
THE COURT: Reread the question, please.
(Whereupon, the requested portion was read back.)
THE COURT: Sustained.
Q You're either pregnant or not pregnant, right, Doctor?
A. You're either pregnant or not pregnant.
Q So you're either symptomatic or not symptomatic,

right, Doctor?
A. Pregnancy is not a symptom; it's a condition.
Q Doctor, please, you can answer my questions.
A. I just did.
Q I'm going to try and get you out of here by 5 o'clock if you cooperate.
A. I appreciate it.
Q If not, I can't guarantee you anything.
A. I'm trying to be cooperative.
Q Okay. So you're either symptomatic or you're not symptomatic, right, Doctor?
A. You can either have a symptom or not have a symptom.
Q All right. So when you say someone is really pretty much asymptomatic, that means the person has some symptoms, right?
A. Actually, it means they're pretty much asymptomatic.
Q But they have some symptoms, right?
[*66] A. They may have some symptoms.
Q Okay, thank you. I thought we'd be able to agree on that much.
You talked a lot about degeneration and bulges and herniations, and I'm not going to cover the same ground with you again, Doctor.
But isn't it true, Doctor, that the most two common levels in the neck where you see herniations are at the C-5, C-6, and C-6, C-7 levels?
A. Actually C-4, C-5, and C-5, C-6.
Q Okay. So the C-5, C-6, which is the level we're talking about here today, correct?
A. Yes.
Q Okay. And you said that you could have a bulge without trauma, correct?
A. Yes.
Q And can you also get a herniation without trauma?
A. Yes.
Q Okay. Because as the disks start to squeeze down more and more from degeneration and the water coming out of it, dehydration, right, you could eventually get that jelly from the donut seeping through cracks, right?
A. Yes.
Q No trauma?
A. Correct.
Q No motor vehicle accidents?
A. Yes.
Q Not even a fender bender?
A. Correct.
Q Okay. And [*67] let me ask you this. You said before, and I wrote it down, that a person's occupation does not necessarily predict them having a herniation; is that correct?
A. Yes.

Q All right. Now, you've also told Mr. Borowick that you treat a lot of people in the construction trade, correct?
A. Yes.
Q Can we agree, Doctor, that people who perform heavy manual labor, that they're more likely to have herniations than someone who's done a desk job, like a

180

lawyer?
A. They can have a higher incidence of herniations, yes.
Q And you also said, Doctor, that you can get a herniation from something as minor as a sneeze.
A. A sneeze can cause disk material to protrude past the annulus, yes.
Q A herniation?
A. Correct.
Q Okay. Can you get a herniation from lifting something that's heavy?
A. You can get it from lifting of a very heavy weight, yes.
Q Did you -- did you know that Mr. Karash's job involved the carrying of 80 pounds of cans of paint?
A. Yes.
Q Did you also know that throughout -- at a certain point [*68] in his career as a journeyman bridge painter, he actually would lift 240-pound ladders with someone standing at the top of them? Did he tell you that? Are you aware of that?
A. That is part of duties of a bridge painter, yes.
Q Is it possible that those kinds of activities could cause degenerative changes in the neck?
MR. BOROWICK: Objection. You know what,

181

Judge, withdrawn. It was about "possible." It was about "possible," but I'll withdraw it anyway.
Q In your experience, with those kinds of activities, have you seen people who've undertaken those activities who were not involved in a traumatic car accident have herniations as a result of undertaking those kinds of activities?
A. Yes, those kinds of activities can cause herniations, yes.
Q And what about heavy vibrations? Can that also cause a herniation?
A. Vibrations can cause herniations, yes.
Q Tell me, what activities did Mr. Karash undertake in his career that involved vibrations?
A. Driving would involve vibration. Assembling and disassembling scaffolds may involve some vibration. [*69] Painting with heavy equipment may involve some vibration.
Q Anything else?
A. Those are the ones I can think of offhand.
Q He told you about those, or are those -- that stuff you're just making up now?

A. I'm not making anything up.
Q All right, stuff that you're telling us about from your experience as opposed to personal knowledge with regards to Mr. Karash?

182

A. You -- your question was, are there any things that you may think of that might have involved vibration, so I listed some for you.
Q That wasn't my question. My question is, are you aware of any activities in Mr. Karash's work life that involved vibrations that could have caused herniations?
A. And those are some activities that a bridge painter may involve some vibration.
Q But you're not testifying specifically with regard to Mr. Karash, are you?
A. Correct, I'm not.
Q Are you aware that -- that part of his job encompassed holding an 80-pound vibrator for eight -- eight hours a day?
A. Okay.
Q Are you aware of that? Did he tell you that?
[*70] A. No, we didn't specifically discuss that.
Q All right. Is that the kind of activity that could cause a herniation?
A. That is vibration activity, yes.
Q You talked about radicular complaints, and I think what you said to Mr. Borowick -- correct me if I'm wrong -- is that those radicular complaints were limited to pain; is that what you said?
A. No, I didn't say limited to, but I did say that

183

radicular complaints are pain radiating into a distribution of a nerve root.
Q Is tingling in their hands, would that be considered a radicular complaint?
A. Not if it's isolated to the hands.
Q So how about in your arms, would that be considered radicular?
A. If it's radiating down the arms and a distribution of a nerve, then it would be considered radicular.
Q Now, earlier, you said, Doctor, and you said that -- and as you began to answer questions about the accident, you said that in your opinion, the cause, among other things, the fact that the truck was lifted up, that that could have caused this herniation. Is that something that you were [*71] told by anyone, that the truck was lifted up?
A. No, I actually corrected myself. I misspoke. I meant the cab.
Q Are you aware also, Doctor, that -- well, let me ask you this. Are you aware of the difference between the duties of a journeyman bridge painter as opposed to a journeyman shop steward?
A. Am I aware of the specific differences amongst

those two occupations? I guess it would depend on what the person was a shop steward in.

Q How about a journeyman bridge painter? A journeyman shop steward in bridge painting in the structural steel and bridge painting union, are you aware of what the shop steward, journeyman shop steward's duties are in that capacity?

A. Not specifically, no.

Q Are you aware if they're different from a journeyman bridge painter's job duties?

A. I would say that they're probably different, but I'm not specifically aware of what the absolute differences are.

Q Do you know, yes or no, Doctor?

A. No.

Q Okay. Now, let's talk a little about causation.

In order to determine whether or not something [*72] caused another event medically, are you required, or do you need to know a person's history prior to that event?

A. We need to know -- we take a history from the patient, and we need to know something about their history, yes.

Q And in order to make a -- a medically certain -- have a medically certain opinion with regard to causation, wouldn't you agree, Doctor, that you want to have an accurate history?

A. Accurate history is important, yes.

Q And in determining, you relied on Mr. Karash to provide you an accurate history; is that correct, Doctor?

A. I spoke to Mr. Karash as part of my review of causation, yes.

Q Well, let me ask you something, Doctor.

We'll get to that. Let's talk about your record keeping. You have -- I've looked at your file. You have reports of your -- of Mr. Karash's visits to your office, correct?

A. Yes.

Q And what do you do, do you take handwritten notes while the patient is there? Do you take Dictaphone or something? What do you do?

A. I dictate.

Q So you dictate, and then you give the tape to [*73] -- you send it, outsource it to India, or do you give it to someone in the office, or what?

A. It's transcribed after it's dictated.

Q All right. And I noticed, Doctor, that for some of these reports are signed; some are unsigned. Do you look at the ones that are unsigned?

A. I look at the reports when they're put into my chart. The office staff has to stamp those reports when they're sent out for insurance and billing purposes.

Q Okay. And do you look at them? When you look at

them, do you look at them to determine their accuracy?
A. I refer back to my notes to refresh my memory regarding my treatment of the patient.
Q And do you ever make corrections to the reports based on your notes and discrepancies between your notes and the report?
A. I may in some cases make an addendum or a correction, depending upon the note.
Q It's important to have accurate records, right, Doctor?
A. The records are important, yes.
Q Accurate records are important, aren't they, Doctor?
A. I would say accurate as opposed to inaccurate records, [*74] yes.
Q And in treating your patients, now generally, do you rely on reports from other doctors with regard to treating your patients?
A. Yes.
Q Do you rely on reports from other medical providers with regards to treating the patients?
A. Yes.
Q Do you ever look at physical therapy notes in order to determine how your patient is doing?

187

A. Yes.
Q And I -- Mr. Karash was referred for physical therapy from your office, wasn't he?
A. Yes.
Q Dr. -- I'm sorry if I mispronounce his name, Dr. Touliopolis?
A. Yes.
Q Did I get that right?
A. Yes.
Q He referred Mr. Karash for physical therapy, correct?
A. Yes.
Q Bergenfield Physical Therapy and Pain Management; isn't that correct?
A. Yes.
Q Where in your file are those notes?
A. This is an electronic medical record, and so those notes may not have been transcribed into the EMR.
Q Well, your records were subpoenaed here to court, weren't they, Doctor?
A. Yes.
Q And we asked for all records that you relied [*75] on, billing records, everything that you kept with regard to Mr. Karash; is that correct?
A. Yes.

188

Q Did you send them?
A. As far as I know.
Q Where is the Bergenfield notes?
A. I don't know.

Q You didn't bring them?
A. This is the record that I brought with me today. This -- this record was transcribed by my office staff and printed off of the computer for me this morning so I could bring it here to court.
Q And you didn't bring the Bergenfield Physical Therapy records?
A. If they're not in here, then I didn't bring them.
Q Take a look.
A. I don't think they're in here, because I did look at this before I came into court.
Q I would like to -- if you could look at your May 17, 2004, note, Doctor.
First of all -- I'm sorry.
(Witness reviewing document.)
A. May 17, 2004.
Q First date you saw Mr. Karash, right?
A. Yes.
Q Never saw him before that?
A. Correct.
Q Anyone in your office see him before that?

189

A. Not that I know.
Q Okay. You ever [*76] speak to him before that on a social basis, anything like that?
A. No.
Q Okay. I'm going to refer to Defendant's Exhibit A. Now, you were asked by Mr. Borowick, and I think your testimony earlier was that Mr. Karash had a prior issue with his neck. You remember giving that testimony?
A. Yes.
Q That doesn't say that in this note, does it?
A. It says, having had a neck injury several years ago that --
Q Hold on. Slow up. It says he has a history of having had a neck injury several -- neck injury, right? Correct?
A. Yes.
Q Did you review any records with regard to that neck injury?
A. Well, at the time I took the history, this is what we discussed, and I eventually did review some records regarding that, yes.
Q At the time you didn't, though, correct?
A. Correct.
Q Okay. Do you know how he got that neck injury?

190

A. I think it was a fender bender.
Q Really?
A. Yes.
Q When?
A. I don't know the date of the incident.
Q How severe was it?
A. Insignificant.

[*77] Q Did he treat for it?
A. I think he had eight chiropractic visits.
Q From a motor vehicle accident, he had eight chiropractic visits?
A. I think that's what I said, yes.
Q Is that what he told you, that it was from a motor vehicle accident?
A. He told me exactly what's reflected in the history.
Q That he had a neck injury several years ago.
A. This is what I tran -- well, this was what was transcribed, yes.
Q This is exactly what he told you, neck injury several years ago, right?
A. It's not an exact transcription, because I don't have a transcriber in my office.
Q I thought you did a Dictaphone?
A. I did dictate, yes.

Q So is that what he told you, yes or no, Doctor?
A. That's what I dictated in my report.
Q I didn't ask you that.
Is that what he told you, he had a neck injury several years ago?
A. I don't know how else to answer your question.
Q You don't remember what he said?
A. I transcribed what he told me.
Q How many years ago? How many years before May 17, 2004? [*78]
A. I don't know.
Q Did he mention anything about having that injury at a barbecue?
A. I don't think we talked about a barbecue, no.
Q It was a motor vehicle accident?
A. As far as I know.
Q Okay. And how long did he treat for that neck injury several years ago? You think that was the eight chiropractic visits?
A. As far as I know, yes.
Q Okay. And then it says, "that had resolved," right?
A. Yes.
Q When did it resolve; do you know? Does it say in your note?

A. Prior to me seeing him.
Q Did it resolve completely?
A. As far as I know.
Q How do you know?
A. He didn't require any injections or surgery, nor did he have any diagnostic testing.
Q But he had some symptoms, right, because you said, he was really pretty much asymptomatic until this present accident. So can we agree, Doctor, that he had some symptoms up until the accident, right?

A. No.
Q No? I thought you said pretty much asymptomatic meant he had some symptoms. You agreed with me before, yes or no, Doctor?
[*79] A. Are you telling me what to say?
Q No, I'm asking you if you recall your testimony about seven minutes ago. Pretty much asymptomatic meant he had some symptoms, right?
A. That's why he had some treatment after the incident.
Q Up until this present accident. He was really pretty asymptomatic up until this present accident. You didn't mean by that that he had symptoms up until the accident, Doctor; is that what you're telling this jury?
A. That's exactly what I'm telling this jury,

193

correct.
MR. BOROWICK: Excuse me, Judge, "okay," "good," I think commentary by counsel is inappropriate, Judge.
THE COURT: Yes.
MR. BOROWICK: Yelling at the witness.
THE COURT: Sustained.
Q I apologize.
Do you know when he began working as a journeyman bridge painter as opposed to a journeyman steward -- shop steward? Do you know when that occurred?
A. No.
Q Do you know if it was several years ago after sustaining a neck injury? Is that when that happened?
A. I said I don't know.
Q Do you know if it happened 11 months prior [*80] -- wait a second, I'm sorry, I skipped this.
When were those chiropractic records; when did he treat?
A. We have to check the records. I don't know the dates offhand.
Q If I told you June 2003, would that refresh your recollection?
A. If it was June 2003, then that's when it was.
Q Okay. That's not several years prior to May 17,

194

2004, is it, Doctor?
A. No.
Q So we're talking about two separate incidents now; is that correct, Doctor? He had a neck injury several years ago, and then there's a separate time when he treated with a chiropractor; is that accurate, Doctor?
A. No.
Q "No." Let's talk about what you did.
First of all, you say cervical spine. Significantly diminished cervical spinal range of motion. Did you do -- what's a qualitative study of range of motion, Doctor?
A. Qualitative means there are measurements taken,

and you make a determination based upon the quality of the range of motion, so you make an assessment: mild, moderate, marked, severe, total. That's qualitative assessment.
Q Do you have [*81] any notes with regard to what the qualitative measurements were?
A. Yeah. It's significantly as a qualitative finding.
Q And how about quantitative measures?
A. Quantitative is a number.
Q "A number." Do you have any quantitative measurement in there?

A. No, it's a qualitative measure.
Q You don't have any quantitative measure?
A. No, it's a qualitative measure.
Q So do you know, Doctor, whether or not the symptoms that Mr. Karash was suffering up until the time of the present accident were any different than the qualitative measurement that you referenced in this chart?
A. I don't understand that question.
Q Well, you don't know what symptoms he was suffering immediately prior to the accident; can we agree on that, Doctor?
A. He didn't have any symptoms prior to the accident.
Q He was really pretty much asymptomatic up until this present accident means he didn't have any symptoms?
MR. BOROWICK: Excuse me, Judge, this is the 80th time of this go-round about "pretty much." Doctor says no. He says "pretty much" [*82] --
THE COURT: Overruled.
Q You mean he was really pretty much asymptomatic up until this present accident, you're going to sit here and testify before this jury that that means in your mind and when you wrote it that he didn't have any symptomology up until the accident?
A. Exactly yes, that's exactly what I mean.

Q You did a compression test, cervical spine. Did you say with positive compression, right?
A. Yes.
Q What's a compression test?
A. A compression test is when you push down on the head, so you put pressure on the cervical spine.
Q And you found it to be positive, correct?
A. Correct.
Q If you did a compression test pushing down on someone who suffered a sprain in their neck, would you get a positive finding of pain?
A. No, you would not because the compression test specifically tests for radiculopathy, so it's positive when you have reproduction of an upper extremity radiculopathy with compression, not with mechanical axial pain.

Q So you have someone with a sprained neck and you push down on their head, [*83] their heads are not going to get any symptomology, any complaints of pain from doing that?
A. That's not -- that's not the compression test being positive. That would be the pain in their neck.
Q Now, you put -- I'm not going to put the shadow box up again, Doctor, but the MRI that you looked at with the cervical herniation, can you testify with a reasonable degree of medical certainty simply looking at that MRI,

197

with no other knowledge, when that herniation occurred?
A. To within a reasonable degree of medical certainty, I can give you an idea of whether or not there's significant degenerative changes on that MRI. And based on the history and the physical findings and the MRI, you can put a temporal relationship together. You can't do it based just on the picture.
Q You can't tell me by looking at an MRI that herniation occurred on May 13, 2004, can you?
A. The MRI doesn't give you a date.
Q Okay. And you also, Doctor, ordered MRIs of plaintiff's lumbar, the lower back?
A. Yes.
Q What were your findings with regard to that MRI?
A. The lower [*84] back MRI?
Q I'll ask you this. Did it show degenerative changes?
A. Did the low back MRI show degenerative changes?
I'm just looking for my reading of the MRI for you.
(Witness reviewing documents.)
MR. BOROWICK: Judge, perhaps we can save some time. We're not pressing the low back or the hip. Maybe we could --
MR. PLATEK: That's not the issue.

198

MR. BOROWICK: "That's not the issue."
A. I don't remember -- I don't remember or recall the MRI reading. I think I may have the report in the chart. The low back was not the focus of my treatment.
Q Because the low back resolved?
A. Because the lower back essentially resolved and didn't have any neurologic issues requiring surgery, yes.
Q Oh, let me ask you one other thing, Doctor. When you look at the neck MRI, can you tell if the herniation you're seeing is symptomatic or asymptomatic?
A. The MRI doesn't tell you whether it's symptomatic or not.
Q You're relying on the patient to tell you with regard to his symptoms in an honest and accurate manner, correct?
[*85] A. That's only part of the picture. That, and the EMG, the MRI, and the physical examination are all put together to give you an idea of his symptomatology.
Q When was the next time that you saw Mr. Karash?

A. Next visit was June 14th of 2004.
Q Okay. I'm sorry, just to refer back to the initial May 17th, what medications did you put Mr. Karash on at that time?
A. At that time, I put him on Celebrex, 200 milligrams twice a day.

Q No narcotics?
A. Correct.
Q No Percocet?
A. That's right.
Q No Vicodin?
A. Correct.
Q No OxyContin?
A. Correct.
Q And so you saw him again on June 14th of 2004. And what did you find with regards to his symptomology?
A. June 14, 2004, had complaints and symptoms, neck, low back, and shoulder. Activity related pain, motion related pain.
Q You found -- you found his symptoms to be the same as earlier when you examined him?
A. Examination consistent with prior exam. Decreased spinal range of motion. Decreased lumbar range of motion, and an apprehension and impingement [*86] sign in the shoulder.
Q That's the same findings as 27 days earlier, right?
A. Yes.
Q Okay. And again, you performed range of motion testing again. You just read it, but no quantitative analysis again? You didn't give us the numbers, the

percentage, nothing like that, right?
A. That's right, yes.
Q You don't have that anywhere in your notes, right?
A. Correct.
Q And you told him he should remain off heavy duty?
A. Yes.
Q Does that mean he could do light duty at that point in time?
A. Yes.
Q Okay. And you say, continue physical therapy. That means you referred him to physical therapy in the past?
A. That means he was doing physical therapy, and I suggested that he continue, yes.
Q And that was the physical therapy that was referred by Dr. Touliopoulos of your office?
A. Yes.
Q Okay. And did plaintiff tell you -- did Mr. Karash tell you on June 14, 2004, whether or not the physical therapy had helped?
A. Let's see.

We didn't specifically discuss how much it had or
[*87] had not helped, no.
Q Okay. Is -- is the fact that physical therapy
201
helps, is that at all significant -- help or doesn't help,
is that significant in any way, whether physical therapy
helps or doesn't help?
A. Yeah, it depends on what we're talking about.
Q Okay. But if it helps, it can be significant,
right?
A. Sure.
Q And if it doesn't help, that is also significant,
right?
A. Sure.
Q And by the way, did you ever review Mr. Karash's
deposition transcript?
A. No.
Q Are you aware that he testified that physical
therapy didn't help him at all?
A. Okay.
Q You're aware of that?
A. Well, I am now.
Q You don't have the Bergenfield Physical Therapy
records, so I'd like, with the Court's permission, to hand
you what's been marked as Defendant's Exhibit E.
What's that, Doctor?
A. This is a report from Bergenfield Physical
Therapy and Pain Management dated June 14th of 2004.
Q And that's the same date they examined him, the
202
same date that you examined him and found that he had the
[*88] same symptomology as May 17th, your initial exam, right?
Same day as your second exam, right?
A. Yes.
Q Okay. The first page of that report, Doctor,
does it show that they did range of motion testing on his
spine, on his cervical spine?
A. They -- let's see.
They did manual muscle testing. They did range
of motion cervical spine, yes.
Q Right. And they actually did quantitative; they
put numbers on it, right, Doctor?
A. They do, yes. They gave him a score and they put
numbers in.
Q Okay, let's go through this a little bit.
First of all, I want you to show the jury what a
normal range of motion is with regard to flexion of the
spine. Can you do that? Are you capable of doing that?
A. Yeah. I'm wearing a tie so it's hard to give you
a complete range of motion because my tie blocks it, but a
normal range of motion should be chin to chest.
Q And --
A. For flexion, I'm sorry.
Q And they make reference to a current -- what's a
normal range of motion; what's the number?

203
A. The normal ranges of motion actually depends [*89] on how you measure it. There are two ways, basic ways to measure it. You can use two types of instruments. They're both called goniometers'. And it depends on a couple of different factors.
It depends not only on the actual range of motion in your neck, but it depends on any blocks to motion. So if you have a person with a big fat neck, they're not going to have as much cervical flexion as a person with a long skinny neck. So it's not a true assessment of the amount of motion that's happening in your bones. So when you use a goniometer, you have to --
Q Doctor, let me interrupt you. That's not the question I asked, and I'm going to try to get you out of here at 5 o' clock, okay.
What I asked is, what's the normal number that they put on this chart?
A. The point that I'm getting to --
Q I don't want to know the points. Mr. Borowick can ask you about the points. I want to know what number they have for a normal number for flexion in the neck.
A. They actually don't give you a normal number. They're giving you a previous score, a current score, a percent improvement, [*90] and whether or not there's a deficit. They're not giving you a normal number because there
204
actually isn't a normal number.
Q Wait a minute.
A. It depends on your own individual --
Q Wait a minute, Doctor. You don't see the header at the top of these scores that says previous score, current score, normal improvement, and deficit?
A. Yeah. They do check --
Q Okay, that's very simple.
MR. BOROWICK: Excuse me, Judge, I'm sorry.
Q I asked --
MR. BOROWICK: Counsel's controlling everything like a conductor here. The witness was in the middle of answering that question.
THE COURT: Yes. Sustained.
MR. BOROWICK: Can the witness complete his answer?
THE COURT: Yes.
MR. BOROWICK: Thank you.
A. And I would actually disagree with those numbers, because most accepted for rotation is 90 degrees, not 60 degrees. They've listed it as 60 degrees. So I don't know exactly where they've gotten their normal scores from, and I would argue that there actually isn't a normal value for your cervical spine. It depends on more of what they've given you here, which is a percent improvement or [*91]
205
percent deficit. That's why most of these range of motions actually are qualitative and not quantitative.

Q So you're going to disregard the numbers, but the improvement numbers are what's important to you; is that correct?
A. They're telling you how much these improved with physical therapy. That's their baseline assessment when they've given you their percentage on improvement.
Q Okay. So you're going to disregard the normal numbers. You're going to disregard the current scores, right? So you're going to disregard the previous scores.
By the way, do you know what he had been scored previously at Bergenfield Physical Therapy?
MR. BOROWICK: Excuse me, counsel just made five statements, and then stopped to ask a question.
THE COURT: Objection sustained.
Q Do you know when they made their previous scores on Mr. Karash?
A. It doesn't tell you when they made their previous score, unless there's a notation in here that I'm missing.
Q Do you know if he went to Bergenfield Physical Therapy [*92] before this accident or after the accident?
A. I don't know.
Q All right, so let's get to the deficit numbers. Those are the ones you think are important, correct,

206

Doctor?
A. Yes.
Q All right. So there are six -- six planes of motion of the neck, six ways the neck moves, correct?
A. In general, yes.
Q And under the deficit scores, they show no deficit for four of the six ways that the neck moves; is that correct?
A. That's correct, that's what they have listed.
Q I'm sorry, I didn't catch the end of that.
A. Yes, that's correct, that's what's listed here on the document.
Q Okay. And then with regard to extension, they find how much of a percentage of a deficit?
A. 13 percent.
Q Could you show the jury with regard to extension of the neck the difference between normal motion and a 13-percent deficit? Could you demonstrate first normal, and then 13 percent? Why don't you do normal first.
A. I don't know what they mean by normal. And I'm not sure what they mean by their percentage deficit. As I've said, when [*93] you measure motions, it depends on the specific patient. That's one of the reasons I do qualitative sessions, not quantitative sessions.
MR. PLATEK: Judge, Judge, I'd like to get

207

the witness out of here. I asked him a very simple question.
Q If you can't answer the question, Doctor, tell me you can't answer the question.
A. Fine.

Q But if you can answer the question, I prefer you to just answer the question. And when you want to give a narrative, you can do that with Mr. Borowick, okay.
A. Fine. Sure. So I can't answer that question for you.
Q Thank you.
You can't show this jury what a normal range of motion is with extension?
A. I basically just said that. I can't tell you what their percent deficit was or what they're measuring as a normal range of motion.
Q That's not what I asked you, Doctor. I want -- you can't show this jury what normal range of motion on extension is; you can't do that?
A. I can show you what mine is, but I've also got a shirt and tie, so my range of motion is limited by the fact that I'm wearing [*94] a shirt and tie.
Q So you can't -- would that limitation be more or less than 13 percent?
A. I don't know what they're basing their percentage on.
Q In your evaluations, Doctor, would that limitation, your shirt and tie, does that create a less or more than 13-percent deficit in your ability to do extension?
A. I don't know how to answer that question. I'm sorry, I can't answer that question.
Q Okay, good, we'll move on.
How about left rotation? Can you show the jury what a normal range of motion is with regard to left rotation?
A. Once again, my shirt is pretty stiff right now, and I'm not going to be able to do a normal range of motion for you.
Q And they found the same, 13 percent. That's their findings, right, Doctor?
A. They say 13-percent rotation deficit to the left side.
Q None for the right. Left, 13 percent, correct?
A. Correct.
Q So the shirt-and-tie issue, would that have inhibit you from 13 percent or more or less than 13 percent?
A. It's going to inhibit my range of motion right now. [*95]
Q More or less than 13 percent?
A. I don't know how to answer that question.
Q See page 2.
A. Yes, I'm looking at page 2.
Q And that's another page that -- presumably, did you look at this stuff when you were treating Mr. Karash? Do you recall seeing this stuff?
A. Yes, actually I do, because he did bring in the

Bergenfield Physical Therapy notes. And to be honest with you, they were in the -- in the record. Now, whether or not they were transcribed into the computer is a different story.

Q Did you ever call Bergenfield Physical Therapy to ask them what they meant by these range of motion testing?

A. No.

Q Didn't care?

A. Correct.

Q What does it say, if you could read it to me, below global outcomes of impairment? What does it say next to range of motion?

A. Global outcome impairment.

Q AAOS, cervical spine, what does it say?

A. Initial deficit of 15 percent, final deficit of 4 percent, and improvement of 16 percent.

Q So he had an improvement of 16 percent, according

210

to Bergenfield Physical [*96] Therapy, between the time of their first testing and June 14, 2004, correct, Doctor?

A. Yes.

Q Okay. And that you agreed already, you told me the improvement figures are what are important, correct?

A. As they are reported here, yes.

Q I want you to go to page 3, Doctor. Under anticipated goals, expected outcomes, next to range of motion, AAOS, cervical spine, what does it say there?

A. Under anticipated goals, expected outcome, there's a short term and a long term. Under cervical spine it says, reduced global deficit to 2 percent in two weeks. Current deficit, 4 percent.

Q So they expected him to be at a 2-percent deficit within a two-week time period, correct, Doctor?

A. That's their goal, yes.

Q That would take us to June 28th, correct? They would have expected that he would be at a 2-percent deficit in his neck within two weeks?

A. That's -- that's their goal of treatment, yes.

Q And the long-term goals, Doctor?

A. Long-term?

Q Next to range of motion, AAOS, cervical spine, what does it say there?

A. Long-term range [*97] of motion, cervical spine,

211

reduced global deficit to 1 percent in three weeks.

Q "1 percent."

Let me ask you something, Doctor. A person with a 1-percent deficit in their cervical spine, would you say they were really pretty much asymptomatic?

A. It depends on their entire clinical picture.

Q Let me ask you something, Doctor. When was the next time you saw Mr. Karash?

A. From what date?

Q From the same date that he went to Bergenfield Physical Therapy, and they found that he had a 4-percent

cervical deficit on June 14, 2004?
A. My next visit with Joe was July 26th of 2004.
Q A month and a half later?
A. Correct.
Q Let me ask you something. In that month and a half interim time period, did he see a neurologist?
A. Did he see a neuro in the interim. I'm not sure.
Q You have Dr. Hausknecht's initial report in there, don't you?
A. I have Dr. Hausknecht's EMG, yes.
Q You don't know when he saw Dr. Hausknecht?
A. I have to go back and check the visits for you, but I don't have them listed in the chart, no. [*98]
Q If I told you he first -- when was the EMG study

212

done?
A. The EMG from Dr. Hausknecht was dated October 1st of 2004.
MR. PLATEK: Your Honor, if I may approach the witness? I have --
THE COURT: Yes.
Q I'd like to show you, Doctor, just to refresh your recollection, an initial -- a document from Dr. Hausknecht. That's from Dr. Hausknecht, right?
A. Yes.
Q And when was the initial neurologic office visit?
A. Initial neurologic office visit, it's dated August 3rd of 2004.
Q Well, it says --
A. (Indicating.)
Q I understand that.
Do you have any reason to believe he wasn't examined by Dr. Hausknecht on August 3, 2004?
A. No, it says August 3, 2004.
Q That's when he saw Dr. Hausknecht?
A. Yes. That's that note, yes.
Q So that's after July 26th, can we agree on that, Doctor?
A. Yes.
Q So now we'd agree he didn't see any neurologists

213

between June 14th, when Bergenfield Physical Therapy found him to have a 4-percent deficit, and the next time that you saw him on July 26, 2004? [*99] Can we agree on that?
A. Okay, yes.
Q And did he have any trigger-point injections in that same time period, Doctor?
A. Not as far as I know, no.
Q And he didn't have an EMG NCV study during that time period, Doctor; is that correct?
A. Yes.
Q Did you increase his medications at all during that time period?
A. Let's see, did I give him any increasing meds. Not that I know of, no.

Q Did you finish your answer?
A. Yes, I did.
Q I thought you were checking your records to make sure.
A. No; I'm sure. Sorry.
Q Here's another one I'm curious about, Doctor. "Exacerbate." That means to re-injure something that's already been injured, correct?
A. No.
Q What does exacerbate mean?
A. Exacerbate means make worse, bring about

214

symptoms, cause symptoms.
Q Okay. But -- so to injure something, would you agree to injure something means that the body part wasn't injured, and then you injure it, correct?
A. Yes.
Q So to exacerbate means that there was something wrong with the [*100] body part, whether it was a trauma, traumatic injury, degenerative condition, there was something wrong with the body part first, and then you exacerbate it by doing something, making it worse, correct?
A. Yes.
Q What does re-exacerbate mean?
A. It means there are many things that can cause an exacerbation of pain, and other -- some things may cause a re-exacerbation of pain.
Q So it means you've hurt it again and again, correct?
A. Or you're becoming symptomatic based upon whatever activities you happen to be doing.
Q But it could be you hurt it again and again, right?
A. If you hurt something again and again, you'd -- I would probably use the term "re-injure."
Q I'm going to put up on the board, Doctor, what

215

has been marked as Defendant's Exhibit B, your record note from your July 26, 2004, examination of Mr. Karash. You got it?
A. Yes.
Q And in that note, it says Mr. Karash had a re-exacerbation of his neck pain while picking up a five-gallon water jug the other day and has some significant pain in the neck. You [*101] see that, Doctor?
A. Yes.
Q Okay. Now, you then state that he had a diminished cervical range of motion. Was that more or less range of motion, Doctor, than a 4-percent deficit?
A. I didn't record it in terms of percentage, but I put it down as a diminished cervical spinal range of motion.
Q So when I asked you that, you have no idea, you can't answer that question; is that correct?

A. What's the question?
Q Whether or not your qualitative findings of a diminished cervical range of motion is more or less than the quantitative findings of 4 percent found by Bergenfield Physical Therapy. You can't answer that, right?
A. I can't, no, absolutely not.
Q And at that point in time, you're suggesting that

he do light-duty work, correct?
A. Yes.
Q Let's talk about the chiropractic records a little.
Now, you said, Doctor, and again, I wrote it down. I think I got it correctly. That from your review of those chiropractic records, your belief was -- well, first, withdrawn.
You did see the chiropractic records where [*102] plaintiff was complaining about tingling in his hands, correct?
A. Yes.
Q And it's your opinion, Doctor, that the tingling -- first of all, tingling in his hands can be a sign of a herniation; isn't that correct? Can we agree on that?
A. Actually no, we can't agree on that.
Q And, Doctor, you said that the tingling in his hands and the fact that his hands were falling asleep, you believe that that was consistent with his complaints of carpal tunnel syndrome?
A. Hands falling asleep and tingling of the hands is one of the hallmarks of carpal tunnel.
Q Did you review the confidential patient history that Mr. Karash filled out for Dr. -- for Dr. Schwartz?

A. Is that part of the chiropractic record?
Q Yes.
A. Then I would have seen it, yes.
Q Did you see where Mr. Karash wrote when he was asked, other doctors who treated this condition, where he said not this condition. Had carpal tunnel syndrome five to 10 years ago. Did you see that?
A. I don't have it in front of me, so --
MR. PLATEK: Could I show the witness?
[*103] THE COURT: Yes.
MR. PLATEK: Thank you, your Honor.
(Handing document to witness.)
Q. You want me to point it out to you?
A. I see it.
(Witness reviewing document.)
A. Okay.
Q So Mr. Karash himself was -- was describing the sensations he was feeling in his hands as different than the carpal tunnel that he had experienced five to 10 years prior to seeing the chiropractors; can we agree on that?

A. Actually, that's not the way I read that document, no.
Q By the way, did he receive any treatment for carpal tunnel syndrome in June of 2003?
A. Not that I'm aware of.

Q Did he receive any carpal tunnel syndrome treatment from any doctors that you're aware of after this accident?
A. No.
Q And, Doctor, that's from Dr. Schwartz. You also reviewed the Knickerbocker Chiropractic Center records; isn't that correct, Doctor?
A. Yes.
Q Okay. And I think earlier, you said that he was generally complaining about back pain, was that accurate?
A. I'm sorry?
Q Did you say that, that he was generally
[*104] complaining about back pain?
A. I don't remember that, no.
Q Well, you know what, I may be mistaken. I think that was Mr. Karash who testified this morning.
I want you to assume that Mr. Karash testified earlier that when he went to the Knickerbocker Chiropractic Center, he was just generally complaining about back pain. Your review of the Knickerbocker Chiropractic Center records, Doctor, does that corroborate that testimony?
A. I have to look at that file again for you.
Q You don't remember?
A. I don't remember offhand, no.

Q And yet you were willing to testify as to causation?
A. But we're not talking about his back. We're talking about his neck. I operated on his neck, not his back.
Q Do you remember if he was complaining about neck pain when he went to the Knickerbocker Chiropractic Center 11 months before this motor vehicle accident?
A. I believe he was complaining about tightness in his neck, but not pain per se.
Q And, Doctor, do you remember those records making reference to any, what did you say, motor vehicle [*105] accident that led him to seek that treatment?
Do you have those records referring to any motor vehicle accident?
A. Not that I recall, no.
Q Okay. And do you remember that they referenced any sort of barbecue?
A. I don't remember a barbecue, no.
Q And in fact, Doctor, do you recall if they reference any sort of accident or injury in those records?
A. I don't recall offhand, but if you want me to look at it, I would be happy to look at it again.

Q And that wouldn't be significant to your determination as to whether or not the surgery that you performed was caused by the May 13, 2004, fender bender, whether or not he had a prior accident in June of 2003? Would that be significant?
A. I think we said he had a prior accident, but he had no significant treatment for it.
Q So you don't care if he had a prior accident?
A. Absolutely I care, but whether or not he required surgery or injections or had an MRI or had any EMG or remained symptomatic or couldn't perform his activities or his life work, then that would be significant. But as [*106] far as I know, that's not the case.
MR. PLATEK: Can I approach the witness, your Honor?
THE COURT: Yes.
Q Can we agree, Doctor, that Mr. Karash on June 20, 2003, was complaining about chronic pain?
A. We can agree he had chronic pain in his hands and his low back and in his neck.
Q And his neck?
A. Yes.
Q Pain? Chronic pain, right, Doctor?
A. Chronic pain, yes.
Q On a scale of three to eight, right, Doctor?
A. That's right, yes.
Q And when did he say that his injury occurred?

A. Let's see.
Q "Where did your injury occur?" What does it say there?
A. It says over time, hands -- it says over time.
Q Over time?
A. Yes.
Q Not a motor vehicle accident?
A. The date says 6/1/03.
Q Where did your injury occur? Over time, correct?
A. Actually, it says when did your --
Q No. Where did your injury occur? Over time, correct?
A. Yeah, but that's a location, that's a time, so they don't really go together.
Q Thank you.
Did you ever speak to the [*107] chiropractors at Knickerbocker Chiropractic Center --
A. No.
Q -- to determine what treatment they rendered?
A. Their documents were available for review, and as I said, he never had an EMG, an MRI, injections or surgery.
Q Did you ever speak to them, Doctor, to determine what treatment they rendered?
A. I think I said no.

Q Did you ever speak to them about what complaints of pain Mr. Karash made as of the last date of their treatment, yes or no, Doctor? Yes or no, please.
A. I just told you, no.
Q Doctor, I'm going to ask you a question. I'd like you to pay attention to it. It's a little long, okay.
Doctor, I'd like to know, given what you now know about Mr. Karash's history, that he injured his neck several years prior to the accident, according to your note. That he was undergoing chiropractic treatment less than one year prior to the accident. That he was still pretty much asymptomatic up to the present accident. That there's been testimony that the accident was a minor fender bender, at no more than five miles per hour. That [*108] according to the Bergenfield Physical Therapy records, his symptoms had improved in less than a month after the May 13, 2004, accident. And on June 14, 2004, 31 days after the accident, he was found to have a 4-percent deficit in his neck. That his physical therapist, who had been referred by your office, Doctor, believed that within seven weeks of the accident, that his deficit would be diminished to 1 percent. That on July 21, 2004, nine weeks after the accident, he lifted a five-gallon jug of water and "re-exacerbated his neck."

223

I'm going to ask you, Doctor, are you still going to testify with a reasonable degree of medical certainty that this surgery that you performed over two years after the accident was related to the May 13, 2004, accident? Yes or no, Doctor?
A. Yes.
Q You saw Mr. Karash on May -- May -- in May of 2005, didn't you, Doctor?
A. What's the date we're looking at?
Q I don't have an exact date. When was the nearest date you claim you saw Mr. Karash in May of 2005?
MR. BOROWICK: May 5th.
MR. PLATEK: Thank you, Mr. Borowick.
[*109] Q You saw him May 5th. What physical complaints did he make to you on May 5th?
A. I don't have my May 5th note.
MR. BOROWICK: It's in the subpoena records. I'll hand it to you.
MR. PLATEK: Thank you, Mr. Borowick.
MR. BOROWICK: Happy to help.
THE WITNESS: Thank you.
MR. BOROWICK: These are in order.
A. May 5, 2008.
Q 2005.
A. I'm sorry. This is May 5, 2008.

224

MR. BOROWICK: You said "2008."
MR. PLATEK: Did I? If I did, I apologize.
Q I believe I said the nearest visit to May 19th.

Let's say May 19th. When's the nearest visit you had to that?
A. I have --
Q 2005.
A. I have March 21, 2005, and I have June 20, 2005.
Q All right. What were his complaints, the early one?
A. March 21st of 2005?
Q Sure.
A. Neck pain going to the left upper extremities, C-6. Dermatomal distribution exacerbated with activities of daily living.
Q Those are subjective complaints, aren't they, Doctor?
A. Yes.
Q So when he's telling you that, you're relying on his veracity [*110] to tell you the honest truth, correct?
A. Yes.
Q And the next visit, the June visit, same complaints?
A. June 20th of 2005.
Q Same complaints?

A. Yes.
Q Okay. Are you aware that on May 19, 2005, Mr. Karash stated that he did not have any physical limitations that precluded him from performing work for the Alson Bridge Painting Company? Are you aware of that?
A. I am now.
MR. BOROWICK: Can I see that?
MR. PLATEK: I'll have him read it.
(Handing document to Mr. Borowick.)
Q Do you see this application for employment at the Alson Company?
A. Yes.
Q Do you see a signature at the bottom of the second page?
A. Yes.
Q Whose signature is that?
A. Joseph Karash.
Q And does it appear to you the same handwriting throughout the document?
A. Yes.
Q And when Mr. Karash was asked on May 19, 2005, do you have any physical limitations that preclude you from performing any work for which you're being considered, did he check yes or no?
A. "No."

Q Now, that [*111] wouldn't be consistent with what he told you in your --
MR. BOROWICK: Excuse me, I'm going to object. This is a job for which he's being considered. Counsel has not identified that, and I'd like the document marked.

MR. PLATEK: I would be more than glad to mark this copy.
MR. BOROWICK: Please, so I have an objection to counsel -- I think it's apples and oranges in his question.
THE COURT: Little bit late, counsel. Overruled.
Q Would that be consistent with the complaints he was making to you, yes or no, Doctor? Yes or no?
A. Yes.
Q Simple. It would be, okay.
A. Yes.
MR. PLATEK: Can we mark this after, Mr. Borowick?
MR. BOROWICK: Sure, sure.
Q Let's go to May 21, 2007, Doctor.
THE COURT: Just one second. Step up, please, gentlemen.
(Sidebar discussion held off the record.)

Q May 21, 2007. This is -- this is the one where he tells you he's having difficulty brushing his teeth, right, Doc?
A. Yes.
Q And you actually do a quantitative range of motion, correct?
[*112] A. Yes.
Q Show me what zero extension is.
A. It's no extension.
Q He can't bend his head down at all?
A. No, extension is the opposite.
Q I'm sorry. He can't flex up at all, extend up at all?
A. That's right, correct.
Q Been a long day, Doc; I'm sorry.
Right and left lateral bending are 15. Can you show me what that is?
A. Once again, I'm wearing a collared shirt that's pretty tight on me. Ninety degrees would be turning your head, your nose, pointing to the side.
Q (Indicating.)
A. Yes, that's correct.
Q What's 15?
A. 15 would be -- if you were going to do a goniometer on it, it would be 15 degrees off from the

direction you're looking at me now.
Q So what, around here (indicating)?
A. Around there, yes.
Q And what's left -- what's lateral rotation?
A. Lateral rotation, lateral -- I'm sorry, that was actually lateral rotation. Lateral bending was 15 degrees.
Q What motion is lateral bending?
A. Lateral bending is getting your ear to your head.

Q I mean, when [*113] you see those cervical spinal ranges of motion, you wouldn't typically expect someone who had those findings, those quantitative findings, to look normal, right?
A. Well, they're not normal findings.
Q Well, but I'm talking about now if you watch them in their daily activities, are those ranges of motion the kinds -- it wouldn't look normal, right? You would see someone stiff. They wouldn't be really turning or bending at all much, right?
A. Yes. They would have stiffness. But those ranges of motion are based when you palpate their muscles becoming stiffer. So that range of motion is where the range of motion stops, when you're palpating the muscles.
Q If you were watching them, Doctor, in their daily activities after findings of those kind of ranges of

229

motion, would you expect them to look stiff, yes or no?
A. They would have some stiff appearance to their neck, yes.
Q And you, Doctor, did you -- you did, in fact, watch the videotape of Mr. Karash?
A. I -- I did see the pictures of Mr. Karash, yes.
Q And your review of that tape indicates to you [*114] that -- that Mr. Karash in those videotapes showed cervical spine -- cervical ranges of motion in those quantitative measurements, yes or no? Yes or no?
A. I can't answer that question cause it's more complicated than a yes-or-no answer.
Q Okay. And, Doctor, we're really pressed for time, but I've reviewed your records. Your records repeatedly show decreases -- certainly Mr. Karash's cervical ranges of motion didn't get consistently better; is that correct?
A. No, he remained symptomatic and had significant cervical issues, yes.
Q And how many times did you see him between, let's say, May 2007 and May of 2008?
A. Generally seeing him every six weeks or so.
Q And he wasn't getting any better; is that correct?
A. Correct.

230

Q And May of 2008 --
MR. BOROWICK: Is that the one you didn't have the document?
THE WITNESS: I have May 1, 2008.
Q May 1st or May 5th?
MR. BOROWICK: I have May 5th.
THE WITNESS: I'm sorry, May 5th. I do have May 5th; I'm sorry.
Q That's Defendant's Exhibit D.
MR. BOROWICK: [*115] You have it?
THE WITNESS: I do, yes.
Q And that, again, essentially the same cervical

spinal ranges of motion, correct?
A. Yes.
Q Okay. Would you expect somebody to be able to paint like this (indicating), with a zero extension, zero degrees?
A. Not repetitively, no.
Q At all?
A. You may be able to do some painting, but you're going to have a restriction in that neck.
Q Would you expect him to be able to do it without some pain while they're doing it?
A. No.
Q They have pain?

A. Yes.
MR. PLATEK: Okay. And in the interest of time, your Honor --
THE COURT: Two minutes to go, Mr. Platek.
Q There's nothing in the records about Mr. Karash doing his backyard pool work, is there?
A. No.
Q Okay. And one more thing, Doctor.
The chiropractic records, you didn't review those until September of 2008, correct?
A. Correct.
Q And you did that in connection with this litigation, didn't you?
A. Yes.
MR. PLATEK: Okay, thank you, Doctor. Nothing further.
[*116] MR. BOROWICK: Judge, just before he leaves, could we mark his chart that counsel's been reading from? Can we just mark his chart in evidence? You don't have a problem with that, right?
MR. PLATEK: I do, actually.
MR. BOROWICK: It's been subpoenaed.
MR. PLATEK: All right.
MR. BOROWICK: He's a treating doctor.
MR. PLATEK: Okay, fine.

MR. BOROWICK: Thank you, Judge. We don't need anybody here for that.
THE COURT: All right.
MR. BOROWICK: Thank you.
THE COURT: It'll be marked.
All right, ladies and gentlemen, that concludes proceedings for today. We'll resume again tomorrow morning. Please report to the jury room by 9:30.
Please keep in mind and strictly adhere to the rules governing your conduct as jurors. Have a pleasant evening, and see you tomorrow.
COURT OFFICER: Jury exiting.
(Whereupon, the jury exited the courtroom.)
THE COURT: Thank you, Doctor.

THE WITNESS: Thank you.
(Whereupon, Dr. **Andrew Merola** was excused from the witness stand.)
THE COURT: Gentlemen, the -- for your [*117] information, one of the jurors -- can I have the number?
COURT CLERK: I believe it was juror number four.
THE COURT: Has asked if -- he or she?
COURT CLERK: She.

THE COURT: she could have the witness's card.
MR. PLATEK: I want his card, too.
MR. BOROWICK: It'll be on the stationery in his file.
THE COURT: We've -- the clerk obtained a card from the doctor. I guess if you have no objection, it can be delivered to the juror after the trial is over.
MR. BOROWICK: Yes, yes, that's great.
(Whereupon, the trial was adjourned to April 28, 2009.)

* * * * *