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DR. ANDREW MERCOLA

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF THE BRONX : PART IA-4

LUIS BARROS,

Plaintiff,

TRIAL

-against-

Index No.

CAPPELLI ENTERPRISES, INC. NEW ROC PARCEL 1A, LLC, GEORGE A. FULLER COMPANY, INC. GEORGE A. FULLER CONSTRUCTITON MGMT. INC., AND HRI CONSTRUCTION LLC,

Defendants.

January 13, 2010
Bronx, New York

BEFORE: HON. SHERMAN

Justice.

APPEARANCES:

Attorney for Plaintiff
JACOB ORESKY, Esq.
155 E. 149th Street
Bronx, N.Y. 10451
BY: Howard Borowick, Esq.

Attorney For Defendant
Milber, Makris, Plousadis & Seiden, LLP
3 Barker Avenue
White Plains, N.Y. 10601
BY: Andrew Pisanelli, ESQ.

JACQUELINE GLASS
Senior Court Reporter
Supreme Court

COURT OFFICER: Jury entering.

THE COURT: Your next witness is.

MR. BOROWICK: Doctor Andrew Merola.

THE COURT CLERK: Stand up and place your hand on the Bible.

DOCTOR, ANDREW MEROLA, a witness called by and on behalf of the Plaintiff, was duly sworn and testified as follows:

THE WITNESS: Andrew Merola, 36 7th Avenue, Suite 502, New York, New York, 10011. M-E-R-O-L-A.

DIRECT EXAMINATION

MR. BOROWICK:

THE COURT: Good afternoon. Doctor, please speak up. The acoustics in here are terrible.

THE WITNESS: Okay. Thank you.

Q. Doctor, any relation to Merio Merola former DA?

A. Actually he used to be a cousin of my dad.

Q. Doctor Merola, what is your occupation?

A. I'm a reconstructive orthopedic spinal surgeon.

Q. Are you licensed to practice medicine in the state?

A. Yes, I am.

Q. Tell us your background, education, and

experience that allows you to call yourself, and your mother to call yourself doctor?

A. Sure. After college I went to medical school. I went to Howard University College of Medicine in Washington D.C. Did four years of medical exchange there and came to New York City where I did an orthopedic surgery residency there, but that lasted five years.

After five years of being an ortho surgical resident, I went to the University of Colorado in Denver Colorado where I did one year as a spinal surgical fellow. Came back to Brooklyn and New York City in 1996 where I became an assistant professor of orthopedic surgery at Suny Downstate, and then went into private practice doing orthopedic surgery and spinal surgery.

Q. Are you board certified in your field?

A. Yes, I am.

Q. Tell the jury what it means to be board certified and what's the name of the association?

A. Sure. I am a board certified orthopedic surgeon, so I have my boards in orthopedic surgery and basically what that means is after your education is

finished you take an exam. It's a written examination that tests your knowledge of orthopedic surgery.

After you pass that examination and you've been in practice for a minimum of two years, you collect all of your surgical cases and patients. You

put those together. You go to Chicago and then you sit down and then the board examines you and they ask you questions about your cases and your surgeries. And you show them your X-rays and tell them what you did and why you did it and how you did it. That's the second part of the exam. When you pass both parts you are then qualified to call yourself board certified.

Every ten years we recertify. So I was certified 13 years ago. I just recertified two years ago and that's another examination process. It makes sure that we stay current with techniques and our education.

Q. Now, speaking of education, do you teach orthopedic surgery, spine surgery?

A. Yes, I do.

Q. And where and to whom do you teach?

A. I teach orthopedic spinal surgery to medical students and residents at both Suny Downstate Medical Center in Brooklyn, New York, and New York Medical College which is out of Westchester. So I have

teaching responsibilities, research responsibilities, and I'm an associate professor of orthopedic surgery.

Q. And on occasion when you have a patient in your private practice and that patient has a lawsuit arising out of an accident which made him your patient, do you occasionally come to court and offer your opinions and relate what you've done for that patient?

A. Yes, I do.

Q. And in this case is Luis Barros your patient?
A. Yes.
Q. And have I asked you to come to court?
A. Yes.
Q. And are you being compensated by my office for your time away from your practice?
A. Yes, I am.
Q. Do you maintain a chart reflecting your treatment of the patient?
A. Yes, I do.
Q. And is that required by state law?
A. Yes.
Q. Did you bring it with you today?
A. Yes, I did.

MR. BOROWICK: I'm gonna ask, Judge, when he got here we got it so we didn't premark it.

If we could just premark or can we mark that for identification?

THE COURT: Okay. We are up to. So marked.

(Whereupon, an exhibit is marked as Plaintiff's 17 for identification by the reporter)

Q. Doctor, feel free to refer to that document if you need to during your testimony. I want you to be as complete as you can as you present to the jury. When did you first meet Luis Barros?
A. My first visit with Mr. Barros was on January

14th of 2008.

Q. And when was your last visit with Mr. Barros?

A. My last visit with Mr. Barros was September 28th, of 2009.

Q. Okay. And in between '08 and your last visit, did you perform surgery on him?

A. Yes, I did.

Q. And when you first met Mr. Barros, did you take a history of why he was there?

A. Yes.

Q. What brought him to you?

A. Yes.

Q. First of all who referred him to you?

A. Doctor Arden Kaisman referred him to me for a

consultation.

Q. What type of doctor is Doctor Arden Kaisman?

A. A pain management physician.

Q. When he referred him to you for consultation, what was the nature of the consultation?

A. The reason for the referral was that Mr. Barros had a failure of what we called conservative care in management and Doctor Kaisman sent him to me for a surgical opinion and a consultation regarding his condition.

Q. And in the 17 months -- I'm sorry. In the 19 months that you treated Mr. Barros, how many times would you say that you saw him?

A. In that span of time I saw him at least 15 to

16 times over that course of time.

Q. And during that course of time you -- did you have occasion to obtain an understanding of how he was hurt?

In other words, was it a motor vehicle accident or something else?

A. Yes.

Q. And what was it?

A. This was a fall from a height.

Q. And have you treated patients who have fallen from heights before?

A. Yes.

Q. Have you treated construction workers before?

A. Yes.

Q. Have you been the treating physician for patients who I happen to represent as a lawyer?

A. Yes, I have been.

Q. And accordingly on occasion have you been called in by me to come in and testify before a jury about your patient?

A. Yes.

Q. Can you tell the jury if you've had an opportunity to review the medical records from Sound Shore Medical Center of Westchester Exhibit 1, from Saint Vincent's Catholic Medical Center Exhibit 2, and from Beth Israel Medical Center Exhibit 3?

A. Yes, I have.

Q. And -- are you prepared to discuss the

significant aspects of those records as they relate to Mr. Barros' spine both cervical and lumbar?

A. Yes.

Q. And in addition to that have you reviewed his films, films meaning CAT scans, X-rays, MRI's or whatever relating to his neck and his back?

A. Yes.

Q. Would you tell the jury just so we get a

basic recap of what's gone on for him in the context of conservative treatment versus invasive treatment.

Describe for the jury what each of those is and what his course has been in a big overview before we break it down.

A. Sure. When we say conservative care and management we're basically saying non operative management. Management that doesn't involve opening the skin and that includes activity modifications which include being off duty work, avoiding those activities that reproduce pain, physical therapy, medications including pain medications like narcotics and anti inflammatories. And that's the first level of conservative care.

The next level of conservative care involves pain management. With pain management we get into some more medications that are a little bit stronger than standard medicines and we start to involve procedures. And those procedures can include percutaneous procedures. Procedures that do not involve actually

opening the skin and doing something more invasive that would be considered surgical. Pain management is the next tour of treatment in management.

By the time Mr. Barros had come to me, he had done those two tiers of treatment and had essentially

exhausted them and that's why he came in to me for consideration for an open surgical procedure.

Q. Begging the question, I guess I have to ask it. Were those different levels, those two materials of treatment involving all of those modalities? Were they successful?

A. They were not completely and entirely successful. They were helpful, but not entirely successful and that's why the referral was made to my by Doctor Kaisman.

Q. So that we understand the terminology, I would ask if you would step down with the court's permission and give us a little background anatomy lesson.

Would that be okay, Judge?

THE COURT: Sure.

Q. I ask him to move 15 in evidence which is a spinal model. And if you could do it without blocking anything that would even be better.

Tell us what the spinal column is the cord etcetera and the important structures.

A. Sure. So there is a -- it's a plastic model of the human spine and this is the base of your skull,

the bottom of your skull. And this is your pelvis just about where your hips would connect. And so connecting

your head to your pelvis and your hips and your legs is the spinal column. And the spinal column is basically made up of bones which we call vertebrae.

In between the bones are the shock absorbers or the discs. And in the back of the vertical column there is a canal through which runs the nerves and the spinal cord and those are depicted here as being these yellow -- they almost look like wires coming out of the spine.

A spine has three basic parts, the upper part or your neck is the cervical spine. The middle part or your upper back is your thoracic spine. And the lower part or your lower back is the lumbar spine. And each one of these bones is numbered. There are seven in the neck, twelve in your upper back, and five in your lower back. And those numbers tell us what nerves run next to them and what disc is adjacent to them.

So when we're talking about a bone you may say like C5, so that would mean the fifth cervical bone. We may say the C5 C6 nerve root. That's the nerve root right between the fifth and sixth bones.

Q. How do you refer to a particular disc?

A. The disc is a little bit like it's sandwiched in between the bone so when we talk about the disc it doesn't have one number. It has two numbers assigned

to it and it's the numbers above and below the bone. So the disc in your lower back between L4 and L5 would be the L4, L5 disc. In your neck the disc between the fifth and sixth vertebrae would be the C5 and C6 disc. So the disc has two numbers associated with it.

Q. Doctor we've all heard the term slipped disc or herniated disc. What are the different levels of disease or disability or injury to discs in gradation? Take us from the least problematic to the middle to the worse?

A. Sure. Your disc acting as a shock absorber. In between these bones is made up of two basic pieces. There is a -- it's a lot like a jelly donut. So the outside of that jelly donut the pastry of the outside of the jelly donut holds a jelly like center together. And that's a normal healthy disc. As we age and as we get older our bodies start to undergo a wear and tear process.

The disc is made out of collagen just like your skin and the rest of your body. Connective tissues are made out of collagen. You know when we get older we look in the mirror in the morning and start to develop some wrinkles in the skin and that happens to discs. That's called degenerative disc disease. There is a loss of water, a shrinkage and a normal type of

wear and tear process that happens to discs. When we

look at discs over time they normally degenerate. They lose water and start to shrink a little bit.

Q. Does that require there be an accident?

A. No.

Q. So as they dry out or they lose water, that's degenerative disc disease. What's the next level?

A. The next level when we're looking at a disc and describing what a disc looks like on a tester, a MRI and we're looking at it visually, the next level of disc problem is something we call a disc bulge. A disc bulge is picture that jelly donut. We're talking about if you were to put your hands on the donut and start to press down on it just to start flattening it out not very hard. The donut would start to bulge around its outer edges and that bulge would be nice and even all the way around the outer edges of the donut. And that's a bulge. So the disc is absorbing weight, absorbing shock and it is symmetrically or evenly bulging around its outside. And that's the next level of what we call disc pathology.

Q. Now, this bulging and flattening, can a person have that? I mean do we have it those of us who are say over 30?

A. Yes.

Q. 40?

A. Yes.

Q. 50?

A. Yes, absolutely.

Q. When do we start to bulge?
A. In general bulging is seen usually around 30 is a good number to pick. Around that age we do start to see these disc processes start to happen.
Q. And can a person have bulging disc without any symptoms?
A. Yes.
Q. How about without any complaints or feelings of pain or otherwise?
A. Correct. That's right. You could have bulging disc and it could be what we call asymptomatic without causing symptoms or problems.
Q. Are bulging discs tipically seen in any particular part of the population or is it everybody?
A. Everybody who has a disc can have a bulging disc.
Q. Can people live a life time with bulging disc without even knowing it?
A. Yes.
Q. Can they work a life time with bulging disc without even knowing it?

A. Yes.
Q. How about construction workers? Can they have bulging discs without even knowing it?
A. Yes.
Q. No symptoms?
A. Yes.
Q. No treatment?

A. Yes.
Q. Have you had patients who are construction workers who have asymptomatic bulging discs?
A. Yes.
Q. How do you explain that?
A. Once again when we're looking at the discs and the types of things that can happen to discs that normally process that normal degenerative process that we have does lead to bulging of your discs and that's just the way the disc is taking up weight and strain in the spine. And that doesn't necessarily mean it's going to cause a problem.
Q. Now, if someone has bulging, a bulging disc and there are symptoms, whatever those symptoms might be, are they necessarily permanent symptoms?
A. No.
Q. And would you explain that?
A. Sure. So if you have a patient that has say

a bulging disc and they are what we call symptomatic, they would be complaining of pain and pain aggravated with motions. Motion aggravates the pain. Rest relieves it. Those symptoms can be ameliorated or relieved with physical therapy anti-inflammatory and some mild activity modifications.
Q. Can that be done without any permanent consequence?
A. Yes.
Q. What's the next level of injury or disease to

a disc?

A. We had the normal degenerative process. We have the disc bulge and then the next step above disc bulge is what we would call a herniation. So that same jelly donut again if we're pressing on it harder now, let's press on it even harder than it was to make it bulge. Eventually what's going to happen you'll see the jelly skirts out of that donut. When the jelly skirts out it's not going to go skirt out evenly. It's gonna skirt out in a particular area of that disc. That asymptomatic jelly migrating its way out of the donut or out of the disc is what we call a herniation. So that inner jelly like material is herniating or coming out of where it normally belongs into a more abnormal location. That's not symmetrical and that's

what distinguishes it from a bulge.

Q. Now, is a herniation reversible?

A. A herniation once that herniation occurs in that what we call nuclear material or jelly has migrated. It's way out of that outer ring. That is not a reversable process. There really isn't a process that's going to suck it back in and heal it. You could control the process, but you can't make it go back again to the way it was prior to herniation.

Q. So I really overstepped at one point. I wanted to ask you if you have a bulge and it's symptomatic whether temporary or not and you have a herniation are there necessarily symptoms. And if

there are, what's the mechanism. Why would you feel pain just because it's bulging or herniating.

A. Well, two different ways. With the bulge you feel pain because there is abnormal stress and strain absorption from the area where the bulge is occurring. And that produces inflammation. And inflammation that inflammatory process produces pain and that's where anti inflammatory Moltrin, Advil, Alleve, come in to block that inflammatory process. With a herniation there are actually two things happening. Because that nuclear material is now outside the confines of the disc. It's out of where it normally belongs. That

material can produce pressure, direct pressure to a nerve or to the spinal cord where it's next to and thereby produce direct irritation or trauma to the cord or to the nerve so there is a direct mechanism of pain production.

Q. Is there a portion of the model which shows the herniation?

A. Yes, in fact there is. There is in the lower portion of the spine here if we look at the bottom.

Q. Just show it to everybody.

A. You see this thing that looks kind of like a grape in here where the nerve is. And it's right up where that nerve is. That's a demonstration of what a herniation would look like in the spinal canal.

Q. And whether it touches up against the nerve or the spinal cord, what are the symptoms that might

occur and what are they called?

A. Now, when it touches a nerve or a nerve root, it starts to produce a problem with the nerve roots and that's a fancy term doctors like to use any time you see a problem with a body part. We call it an opathy. A nerve root in medical term is a radic. So a ridiculopathy is a problem with a nerve root. Nerve root irritation and problems with nerve roots are referred to as ridiculopathies.

Q. If you have a bulge that's impacting or impinging upon a nerve root, can that produce ridiculopathy?

A. If it is contacting and compressing the root and irritating it, yes it can produce ridiculopathy.

Q. You mentioned before there is a first year of treatment in physical therapy anti inflammatory that kind of thing that can ameliorate that problem. Does that mean that injury to the nerve is relieved or erased or what?

A. It depends on how badly damaged that nerve is and how much pressure is on the nerve. So you would have to grade the degree of compression and the degree of nerve root damage. And one way to do that is to do an exam and to find out what parts of the nerve are working and what parts aren't. Everything in medical and surgery kind of has a mild, a moderate, and a severe status. So if the damage is mild, you can ameliorate or make the effects of that damage go away.

If it's moderate or severe, it's far less likely it's going to happen particularly with severe nerve damage. It's irreversible.

Q. Now, Doctor, you can resume your seat and I'm gonna ask you when you met Mr. Barros for the first time, did you ask him what had happened? You mentioned

already what he told you. Are the -- strike that.

Did you ask him -- strike that also. Have you had an opportunity to review records relating to motor vehicle accident four years before the accident that we're here for?

A. Yes.

Q. And if you could describe for the jury is there a difference between that automobile accident and its affect on Mr. Barros and this accident and its affect on Mr. Barros from a mechanical stand point?

MR. PISANELLI: Objection, Judge. Foundation.

THE COURT: Sustained.

Q. Sir, having reviewed the records from the previous from four years before when he had a car accident, did you formulate an opinion as to whether or not that was significant in the context of the accident that we're here discussing?

A. Yes.

Q. And what was your opinion?

A. My opinion was that that was not a significant contributing factor to what his problem was

at this time.

Q. Okay. Tell us why.

A. Sure. When we go back four years before this

particular incident and we look at what he had going on and what his course of treatment was and his response to that treatment, it was that first tier of conservative care and management. From which I was able to successfully transition back into full work and full duty without having any further symptoms, or any signs or evidence of we call moderate or severe nerve damage.

MR. PISANELLI: Objection, Judge. Can we approach?

THE COURT: Yes. Let's go inside.

(Whereupon, there is an off the record discussion held at the bench)

THE COURT: I don't know if there was an objection. The objection is sustained if there was an objection hanging out there and go to the next question pursuant to our discussion.

Q. Doctor, I want you to assume in January of 2002, a little more than four years before this accident, my client was in a car accident in which he sustained an injury, that there was some damage to the vehicle and that he had symptoms. That he was taken by ambulance to a hospital, treated and released. Came under the care of a doctor. And over the course of the next two months received conservative care and

transitioned into a return to work. I think he returned to work.

I want you to assume within a month back to full duties and ultimately within a month after that or six weeks after that no more treatment, no more meds, no more anything.

I want you to assume further that from April of '02 to December of '02 worked full time, full duties, no limitations, no symptoms, no treatment. I want you to assume in '03, January to December full time no symptoms, no treatment, no problems, no issues with his neck or back. 04, January to December no treatment, symptoms, limitations or otherwise full duty. '05, January to December no symptoms, no treatment, no limitations, full duty. And then this accident which has been described to you.

Do you have an opinion whether or not that car accident for which he received conservative care bares any significance on his presenting problems or the problems for which you treated him?

A. I do have an opinion.

Q. What is your opinion?

A. That it is not significant with respect to this present injury.

Q. I want you to assume that he was put through

X-rays and MRI's and there was shown to be some bulging in his neck and in his low back and immediately after that '02 accident, and he had associated symptoms, but then the symptoms went away and he went back to work and functioned the way I just described in my last question.

How can you say that it wasn't significant in connection with your analysis and treatment of him beginning in '07 or '08?

A. That history of a return to full work and duties without any symptoms and successful first tier conservative management indicated to me that he had no significant, what we would call a significant prior history of injury that would be contributing to what was happening with him at this time. Because this time after this particular accident his clinical course, that is, how he was doing on a physical basis was a deteriorating clinical course and he failed those stop gaps of first tier and second tier treatment and ultimately ending up with a surgical consultation because they were no longer able to control the symptoms.

Q. So, Doctor, if you were following the clues as a detective, when you look at the first event in '02 and you see event, symptoms, treatment, transition back

to norm, does that suggest to you there is any permanent damage, or other significant impact from that

car accident?

A. Right. That would suggest no permanent damage or significant sequella from that particular incident.

Q. Now, I want you to assume that my client fell from a height of 15 to 20 feet landing on his leg and then onto his back.

That he appeared at the hospital, the Sound Shore Hospital and was diagnosed with -- they did a work up for his leg, his neck, and he was diagnosed with a P long fracture of the leg. Are you familiar with that term?

A. Yes, I am.

Q. And have you ever treated a patient with a P long fracture?

A. Yes, I have.

Q. Have you ever operated on that type of fracture?

A. Yes, I have.

Q. Once, twice, or many many times?

A. Many, many times.

Q. And would you tell the jury is there anything significant or -- there anything unusual or unusual

about a fracture being a P long fracture?

A. That particular kind of fracture which involves the ankle joint, the bottom part of your lower leg bone where it articulates, comes to meet your ankle joint. It basically involves the entire articular

surface of the joint. That is where the joint meets together and it demands a significant what we call an axial load or heavy duty compression to fracture that portion of your lower leg.

Q. Would a fall from a height of 15 to 20 feet generate that type of force to cause such a fracture?

A. Yes.

Q. When you have that kind of mechanical or mechanical event and it's significant enough to cause the kind of multiple fractures that it did in that part of the bone, is there a risk with that axial loaded to the rest of your body?

A. Yes.

Q. Explain that.

A. So when we look at that spine model and we saw that at the bottom of that spine model is the pelvis that connects to your hip joint, the axial load that comes up through your legs is then transmitted through the pelvis into the spine. And not only is there a transmitting of axial load into the spine and

the fractures of the spine, but there is also what we call complex motion that happens in the spine. Because of the articulations in the spine and I mean by that the way these bones come together, and you know by the way move, they don't just involve like a knee joint. It's a hinge. Your knee joint, your elbow, those are hinges. In your spine not only can you flex, but you can rotate. That complex motioning that happens in the

spinal column and the transmission of that axial load force results in what we call a complex mechanism of injury to the spine, and that we consider a significant mechanism of injury for trauma to the spinal column.

Q. Do you have an opinion to a reasonable degree of medical certainty as to whether or not he experienced any injury as a result of the axial loading during the accident of 2006?

A. Yes.

Q. And explain that?

A. So by reason or rationale of the fact that he has this complex loading process from that abrupt axial load to the lower extremities which was bad enough to result in that fracture that he sustained, he also sustained injury to the -- he sustaineed rib fractures to the right side of his chest and in addition to that an injury to the neck, to the lower back, the soft

tissue structures for the disc of the neck and the lower back.

Q. Now, we mentioned before about MRI's to those portions of the body. Have you reviewed MRI's of his neck and his back after the accident that brings us here?

A. Yes.

Q. And did they confirm or belie your motion of injury to the neck and back from this axial loading?

A. They confirmed the injuries from this mechanism.

Q. And did he have as he had after the car accident where he had bulging, did you have bulging or did it elevate to the next level.

A. It went beyond these -- went beyond the bulging level to the actual herniation level whereby there was abnormal migration of that or movement of that inner disc material.

Q. And at how many levels?

A. In the cervical spine he had significant herniation of what we call the C5, C6 level with smaller herniations above that and below that area and in the lower back herniations were most significant at L4, L5 with para adjacent injuries as well. Para adjacent herniations.

Q. When you did your clinical exam two years ago, first explain what clinical exam is. What clinical correlation is and what you did and what your findings were.

A. Sure. So the clinical exam is basically the physical examination so when I meet a patient and the patient comes in you talk to them first and you find out what their problem is, and through the process of touching them and doing some basic testing, physical testing, we could try to determine what the extent of the problem is and whether or not we might be able to do something to help them. And that's the physical examination. So my exam, my first physical exam was on January 18th, 2008.

Q. Before you go on let me just ask you. He already had by the time he saw you according to what you said before the physical therapy, the medication, the anti inflammatory the pain meds, the injections all that conservative care the two tier levels of that conservative levels failed. Why would you then be assessing whether or not you could do more than surgery?

A. I always do as a surgeon just because it's possible that there might be somebody else that can help the patient. And it's also possible that on my

exam my review of the films I might say I don't think surgery is going to be helpful. There have been those circumstances where I feel tier one and tier two, but I don't think surgery would help. Particularly because surgery involves a certain amount of risk. Every surgery has a certain amount of risk versus and a certain amount of benefit. We need to be sure that the benefit outweighs the risks of the surgical procedure.

Q. Doctor, if you would step down. What I would like you to do as you relate your clinical exam, I'd like you to help us out with some anatomical graphics which counsel has agreed to that we leave them for identification and they will be demonstrative only.

THE COURT: Okay.

Q. Okay. Doctor, if you would just step down and we'll just go through these. I ask you to stand on the side where I am so the reporter can see you and

hear you as we post these one at a time.

Let's start with the cervical spine findings with the MRI and also as depicted.

A. Sure. So his complaints and symptoms related to his neck and his low back and radiating pain into the arms. He had bilateral what we call C6 dermatomal distribution which is pain that radiates into your hands particularly between your thumb and your index

finger. And that's an area controlled by the 6th cervical nerve root.

And on exam he had some positive provocative signs. So when you test that root you test the neck to see whether or not you could provoke pain in that distribution by depressing the neck putting more pressure on the nerve distributing the neck to relieve pressure on the nerve and see whether or not you could correlate your physical finding with the imaging studies.

Q. Is that in some way related to the axial loading?

A. Yes.

Q. Explain.

A. Compression is an axial load. So you take the patient's head and you push down on it and produce loads which would produce pressure on the nerves in the event of herniations and that would reproduce pain.

Q. How does that mimic the fall?

A. In the same way you have an axial load due to

fall to compression manueuver reproduces that same type of axial load or force distribution in the neck.

Q. What did you find when you did the compression maneuver?

A. That was positive for reproduction of pain.

That did demonstrate pain in the nerve root distribution.

Q. What about the distribution that you mean?

A. You take the weight off the spine and you're pulling the discs apart and by pulling them apart you are artificially taking pressure off those nerves. So it's the opposite of the compression maneuver and when you extract that's the verification of the compression manuever and if it relieves pain you know that you had a positive compression test.

Q. You know what, Doctor, if you could stand on this side, then the reporter can actually watch you. Why don't you just stand here and that way you will be speaking in her direction.

Doctor, what is palpitation?

A. Palpitation is touching. So when you touch a patient you palpate them.

Q. When you palpate someone that comes to you with the complaints and the history that Mr. Barros did, what are you palpating for?

A. You're palpating to treat muscles and the response of muscles underneath your skin. One of the things we palpate for is spasm. When you're doing an

orthopedic exam you could feel muscle spasm. If you've ever had a Charlie horse and you feel that Charlie

horse, it feels like a rock in your muscles and that's basically what spasms feels like when you're feeling a muscle.

Q. When the spasm is in the base of the spine, or the muscles around the spine, what does that do to the normal curvature of the spine?

A. Those muscles when they pull or when they become spastic, what they have a tendency to do is they have a tendency to flatten out your spine. Your normal spine should be curved. Your neck should be curved backwards so it keeps your head upright.

Q. Is there a description or a terminology for that curvature?

A. That curvature does have a specific term. We call it lordosis. The normal -- the normal curvature should curve backwards so that keep your head up. If the lordosis is lost because of spasm in the neck motion, the lordosis becomes straightened. You lose it and so it's hard for you to look up because your neck flattens out. You try to look up by looking up above the tops of your eyes. So if you ever seen anyone with a stiff neck, that stiff neck is a loss of cervical lordosis.

Q. Any pain associated either head or neck whatever associated with a spasm in the neck?

A. Yeah. In fact that can be caused because when you have spasm in your neck, those muscles attach to the back of your head so they attach to your skull. And your head and the eyes are also strange to look up if your head is stretched forward. So you could have a combination of headaches and head complaints not only because your eyes are not accustomed to being relaxed when they are looking around, also because the muscles directly attached to your head are generating pain.

Q. Other than feeling spasm when you palpate, are there other tests that you do to determine whether or not there is something limiting the motion and normal motion of the spine?

A. Yeah. One of the things, one of the most important things that you can do is what we call inspection or observation, so you could watch a patient. You could watch the patient walk down your hallway. The pattern that they are using to walk will tell you a lot about how their spine is functioning.

If you see a patient walking down the hallway, if they have to come around the corner and they have to turn their shoulder and upper body to look, you know that they are not able to normally turn their head and their neck. If you watch their lower back as they are walking and their pelvis and their

hip, if the low back is in spasm and you lose lordosis,

you see the similar type of affect happening in your lower back area.

Q. Is spasm around the spinal column affect the range of motion that would typically be associated with any given area?

A. Yes.

Q. And why does that happen?

A. It happens because the muscles are now working against motion. They the muscles don't want your neck to move around. When your neck moves around it has a tendency to cause these disc herniations to push up against the nerves and reproduce irritation. So muscle spasm is an attempt that your body makes to reduce inflammation by reducing motion so that you're no longer banging those discs up against those nerves where they are causing irritation.

Q. How do you measure the degree of mobilization by spasm? How do you measure that?

A. Basically we use a special type of -- it's called a gonometer. It's a ruler attached to a 360 degree circle. And it's got two ends on it and that ruler when you bend the ruler it's got little arrows that tell you what degree of bending you're doing. Both ends of the ruler line up. You're at zero degrees

then as you create an angle through the elbow of the ruler. You get degree measurements on how your joints are moving or how your spine is moving.

Q. Tell the jury what is the difference between

objective and subjective complaints, or subjective complaints and objective findings?

A. A subjective finding is someone comes into the office and says doctor my neck hurts. So that's a subjective complaint, that's a complaint that the patient offers. An objective finding is something that as a physician you feel and test for and can measure.

For example, if a patient says my neck hurts, that's subjective. Objective you would measure motion and feel their muscles so that we could objective quantify or measure how bad their neck is.

Q. So if somebody is a faker, has a lawsuit and wants to trump it up, couldn't they just limit the motion of their neck or just create a spasm?

A. You could block motion and try to create spasm, but when we're doing our testing and looking at our testing, one of the things that we're doing when you're doing a range of motion and you're palpating the muscle through that range of motion, there should be symmetrical construction of the muscle. You have a long batch of muscles on the right side, another long

column of muscle on the left side of your spine. Those muscles work together with each other. You could voluntarily control how those muscles are behaving if you're sitting perfectly still and tense yourself up really really strong. If you're walking or palpating those muscles or taking your patient through a range of motion and palpating those muscles. It's virtually

impossible to tell those muscles how to behave. They are either going to contract symmetrically, or they are not going to contract symmetrically.

Q. Does the compression maneuver, the distraction manueuver, the Phalen's manueuver, are those objective testing?

A. Those are what we call objective provocative tests. They are tests to reproduce spinal neck and low back pain. And when you do those tests what you're doing is you're palpating the muscles in the arms and legs and back to see whether or not there is an involuntary response to your provocative test.

Q. What is a Phalen's test?

A. A Phalen's test is basically you're bending the lower back to extension. You're extending the lower back. When you do that, when you do the extension maneuver in your lower back, you close up these little openings where the nerves are that go into

your legs. If the leg nerves are being irritated and there is something in the canal that causes pressure on those nerves, when you bend the lower back and extend it and close these nerve root holes, you reproduce leg pain. You know there is something compressive in the canal. When you straighten out the lower back again and go forward a little bit, that compression goes away, the symptoms and pain.

Q. What about reflexes? Any reflexes you could assess in a clinical exam that could --

A. Yes.
Q. Explain.
A. A reflex if you ever seen the doctor takes out his hammer and taps on your elbow, wrists, or knee or ankle and looks to see if there is an involuntarily contraction of the muscle. Those reflexes are under involuntarily neurological control. Because the reflection what we call a reflex, happens in your spinal cord. So when you tap on a tendon and you cause an abrupt stimulus to that tendon, your muscle will reflectively contract. That's an objective way of determining whether or not a nerve or a muscle or unit are functioning together.
Q. I want to ask you -- I took your chart off the bar. And I want to ask you just to speed things up

a little bit.
I'm looking at your physical examination and I want to ask you why you did something or tell me the significance of your finding. Severely restricted cervical and cervicothoracic range of motion. What significance is that finding?
A. That means that there is palpable finding in the neck, in the area where the neck touches the upper portion of the back.
Q. Positive compression and distraction manuever in the neck with reproduction of bilateral upper extremity C6 dermatomal distribution pain.
A. That's where I'm pushing down on top of the

head and then pulling up on top of the head and it's reproducing pain going into the arms.

Q. Extension is limited to zero degrees?

A. That's neck, so instead of being able to get your neck back to where the back of your head touches the nape of your neck, zero degrees would basically mean your head and neck are in a straight up and down fashion.

Q. Flexion is 30 degrees?

A. Flexion is forward bending, so normally forward bending you should be able to get your chin all the way down to your chest. 30 degrees means when you

measure it with that little thing I was talking about before, you're going to have 30 degrees of forward motion to the neck.

Q. Right and left lateral bending are 20 degrees?

A. Right lateral and left lateral. Those are 20 degrees each. Normal you should be able to get all the way down to just about a finger presented or to your ear and your shoulder both left and right.

Q. Right and left lateral rotation five degrees.

A. Rotation left lateral, rotation right lateral rotation. You should be able to rotate so you could get your nose over your shoulder to see what's coming to your side. Five degrees limits you that move.

Q. Lumbar and lumbosacral range of motion are severely restricted.

A. Measure range of motion by touching the motion to the lower back. Severely restricted means there is a significant amount of pain and spasm you could palpate causing a blocking of motion.

Q. Positive reversal of lumbar lordosis upon ascent. Positive spinal Phalen maneuver and dysesthesia from L4 through S1.

A. What that means is we're observing the lower back and palpating it. The loss of lordosis is usually

what we call an ascent maneuver.

If a patient gets up off a chair and you ask them to bend forward and they straighten out, if they are unable to reproduce the normal sway back of their lower back, that's a loss of lordosis.

If you can't feel the normal curvature of the back and it's flattened, that's a normal loss of lordosis. You bent the lower back backwards, you extend it closing off the nerve roots reproducing pain and spasm into the legs.

Q. And the dermatomal dysesthesias?

A. Abnormal sensory finding when you touch them or when you use pin prick and the L4 through S1 dermatomal are the nerve roots that go five front of your legs, top of your feet, and back of your legs.

Q. Now, Doctor, did anything in your physical examination your clinical examination not correlate with his complaints?

A. No.

Q. There has been a suggestion by doctors who have consulted with the defendant that Mr. Barros is exaggerating in the 15 times that you've had to experience Mr. Barros in your office, and the surgery over the two years that you've treated the limb. Have you assessed anything clinically that wasn't so? Have

you ever listened to any complaint that you weren't able to verify objectively?

A. No.

Q. Have you ever found him to be a malingerer?

A. No.

Q. Has he been an exaggerator, stoic, or anything in between?

A. He's more than not would be more stoic. So he is on the opposite side of complaining. He's an anti complainer if anything.

Q. Now, the films that you reviewed and we're going to go into some of them standing graphics, anything in the films that was not clinically correlative to his complaints?

A. No.

Q. Now, show us on the film what his problem was that lead you to your surgery?

A. Sure.

Q. First show us on the film if it's easier on the diaphragmmatic. You could skip back and forth.

A. Sure. There is on the right side of this illustration is a MRI image.

Q. You mean the left side as you look at it?
A. Yes. Unfortunately doctors always refer to the right as you're looking at something. So I may

refer to it wrong, but on the left side as you're looking at it is a MRI image of the neck or the cervical spine. What you see is the bones that appear to be light gray. In between the bones are the discs. They also have their light gray appearance to them. Behind the bones and the discs is a gray stripe, thick gray line. This thick gray line is the spinal cord which contains the nerve roots and behind that are the muscles and skin and soft tissues of your neck.
Q. Now, show us and for the rest of your testimony if you can, related to the diagrammatic which is alot easier to understand?
A. Sure. On the diaphragm it's easier here because they are illustrated with different colors representing the different shades of gray that you see on a MRI. And these different areas once again are the bones and they are numbered C2, C3, 4, 5, 6, etcetera. The yellow stripe here is the spinal cord and nerves associated with it and in between the bones are the discs. And the MRI tells us that we have some disc sticking out behind the normal borders of the bones at C3, C4. C5 where we have some disc material looking down into the canal area. At C5, C6 where there is a pretty significant amount of discs material reaching into the canal and stretching the cords and roots.

Lesser extent between C6 and C7.

Q. Doctor, do you have an opinion to a reasonable degree of medical certainty whether or not those conditions are injuries caused by this accident?

A. Yes.

Q. What is your opinion?

A. They are injuries resulting from this particular accident.

Q. I want you to assume for the first couple of weeks after the accident in the hospital where he was treated for the PL fracture and after a couple of follow-ups there was no mention of low back complaints although it was in the hospital records initially, the neck.

How do you explain there not being finding by doctors who were examining him in those first several weeks or months that these aren't showing up?

A. Now, when he was treated for his P long fracture of the leg, his weight bearing status was non weight bearing and treated in a way that was not producing axial loads and irritation to the spinal structures.

So it's not unusual if you are modifying your activities which is that first tier of conservative care and management, if you're not doing things that

reproduce the painful portions of your neck and your back, you're going to decrease symptoms in those areas.

Q. Now, the fact that there was a call for a CT of his neck in the hospital, is that of any significance?

A. Yes.

Q. Why is that significance?

A. That tells me at the hospital at the time of trauma when he was initially brought in their concern would be to make sure that he didn't have a fracture of his neck because of a problem with the neck.

Q. Now, would you be surprised that a patient with these many discs in his neck in the first several weeks that he wasn't weight bearing, that he wouldn't complain about it?

A. Not if he wasn't weight bearing, no. You're basically by default doing that first tier of treatment which is activity modification and not axial loading your spine.

Q. Now, did you after your assessment and course of treatment of conservative care, did you operate on him?

A. Yes, I did.

Q. And why the operation on him for his neck before his low back?

A. The neck.

Q. Let's change this. We're now looking at

Exhibit 7 which is the cervical surgery. 7.

A. So the thing about your spinal cord is that your spinal cord starts at where your brain ends and it goes all the way down into your lower back just about where your upper back meets the top of your lower back. Your lower back contains nerve roots and those nerve roots although very important are not as important as the spinal cord itself. The spinal cord in your neck contains all of the wiring that controls your body from the neck down, so it's a very important place in terms of how you're wired because there is cord tissue here. Spinal cord tissue is very very sensitive stuff. When there is excessive pressure on it for a long period of time, the spinal cord itself can start to die and if it starts to die, and it malfunctions, it will produce irreparable damage not only to your arms and hands, but also to your legs. Whereas there is lower back the nerve roots that go into the legs are not as sensitive as this cord is.

So in terms of triaging how you take care of the patient with these injuries, we treat to do the neck first particularly if there is a large enough herniation producing enough pressure, symptomology, and

pathology, so that we could protect the cervical spine and then worry about the rest of the body later.

Q. Tell the jury what you did.

A. Okay. So what I did was it's called an anterior which means through the front cervical, neck,

discectomy. Remove the disc and fusion which means locking the bones together so they no longer move. And that's done through open surgical procedure through the neck.

So basically what I do is I make an opening in the neck area in the skin of the neck and then through that opening, I guess the voice box and the esophagus and the trachea, move them out of the way. Carotid artery, jugular vein and external and mastoid muscle in the opposite direction to expose the cervical spine. So I'm actually looking at the bones of the cervical spine. Once I see these bones, I could now start to do my discectomy. And the way I do that is I take some special tools. As you could see there is on a cross section. The upper corner of this illustration shows us a cross section of a special tool called a Rongeur, through which I could now start to remove disc material all the way back into the spinal canal and eventually down onto the nerves and nerve roots.

So I'm directly looking at the spinal cord

and nerves of the neck. After I take this disc material out, and I take the disc material out of the spinal canal where it has otherwise been placed abnormally, so now after the pressure is off of the cords and the roots I need to stablize these bones now because the disc is missing.

If I don't stablize those bones, they are just going to collapse and the neck is going to come

off. To stablize those bones I take another piece of bone which I then through some carpentry fashion to fit in between the C5 and C6 vertebrae and then I lock that together with a titanium plate and screws to stablize that cervical site and area so that it no longer does any damage to the nerves and spinal cord.

Q. And what happens to that hardware eventually?

A. That hardware stays there. We leave it in there. We don't take it out.

Q. Doctor, is that hardware harmful to him or let me ask you this. Does the fact that there is now a fusion affect his pain level?

A. The fusion in terms of overall pain level, the operation itself is an operation we do to prevent a we call further neurological deterioration. If the pressure and the irritation remains on those nerves and you don't take it off and it hasn't gotten better with

anything else, it will cause permanent damage to the arms and legs and can even result in paralysis. So the operation is done to prevent that from happening. The pain, the neck pain that comes from that herniational damage and the ridicular or nerve root pain that comes from that herniation or damage to a certain extent are irreversible.

Q. I'm posting Exhibit 14 which is a series of X-rays of Mr. Barros's neck and I know there is something similar on the graphic, but can you explain what we're seeing here and what it does to the pain or

function of that portion of the spine?

A. So these are side view X-rays post operatively. So after the surgical procedure of the plates and you could see the screws. And you could see these little dots. These little dots are actually titanium ball barings that are inside of a special plastic cage that I've packed with bone graft to do the reconstruction. You can't see the plastic cage. We put these ball barings in there so I could see where we put the cage. This is the fuse process between the fifth and sixth vertebrae of the neck. What this basically does is turns those two bones into one bone.

Now, that has a mechanicl affect on the neck because what it does is you're no longer absorbing

stress and motion through that segment because now that segment no longer exists. It's one bone out of two. You increase of stress and strain on the adjacent segment, so you're always concerned, always looking how below the area of the fusion and above the area of the fusion are doing because you could speed up some of those degenerative processes we spoke about after the fusion.

Q. What is the exertion on that process of the adjacent segment being affected?

A. Sure. Because the adjacent segment is affected by wear and tear and loading, so the more you do the more wear and tear. When you're loading you place to there, the quicker this can wear out or wear

down.

Q. Okay. Are we done with the cervical?

A. Sure.

Q. Let's take that down and let's just move right into the lumbar. After your surgery did he have additional surgery at the hands of Doctor Kaisman?

A. Yes.

Q. And the surgery, I want you to assume the surgery is reflected in the Beth Israel medical records which is Exhibit 3.

And I'm gonna ask you to take us through

first injuries and the graphic which is Exhibit 8, and then we're going to go through the surgery that was performed.

MR. PISANELLI: I object that this is not the surgeon who performed that procedure and Doctor Kaisman should be here to do that.

THE COURT: Overruled. We'll put more on the record later.

Q. Go ahead, Doctor.

A. Okay. So this -- so before we were looking at the neck now we're looking at the lower back. There is a side view of the lower back MRI and once again we're looking at the bones. They are the gray squares in between the bones and the disc. Gray line behind the bones and the disc. These are the nerves that go down into the legs. This is the fourth vertebrae and the fifth vertebrae and the third and fourth and the

fifth and the first and basically what we're looking at is these black clouds --

Q. You have to step a little further behind so every juror can see.

A. We're looking at these black clouds behind the vertebrae body between behind the L4 and the L5 vertebrae bodies. There is herniated nucleus.

Q. Show us on the graphic as opposed to the

films because it's lighter.

A. The graphical representation of this the bones are labeled for us. In between the bones are the discs and right here between L4 and 5 we're looking at disc material by the spinal bone right up near the nerve root covering between L4 and L5.

Q. What was necessary to relieve that pressure?

A. Now, to get some of this disc pressure off of here, off of these nerves, what was done is a percutaneous lumbar decompression or a percutaneous discectomy. Closed surgical technique done through a special canullar like a big long steel straw.

Q. Does this exhibit which is Exhibit 9 reflect the surgery that was performed and if it does take us through it.

A. So this is a graphical representation of that percutaneous procedure called a posterior or through the back side lumbar low back decompression taking the pressure off the nerves and you could see this device that the surgeon's hand is holding this device is like

a long steel straw. On the inside of that steel straw is a special device that is halfway between a drill and a cork screw. So this device is inserted through the skin, through the muscles of the lower back, in between the bones and down onto the disc. That little cork

screw device then goes into the disc and then starts to remove disc material that is then sucked out the back end of this straw or this cancullar taking disc material and pressure off the nerve roots.

Q. Now, looking at the exhibit and closest to you section B and C, can you show us what you mean by the cork screw and canullar?

A. Sure. So the cork screw is if you see looking at the red arrow. The red arrow is pointing at this device that looks like a cork screw. The cork screw is inside the disc and what happens is the blade of the screw scoop up disc material and then pass it up and out that straw or canullar and you could see that illustrated here as this red disc material coming up and out the canullar.

Q. When you were talking about the cervical spine, you said once you remove the disc material if you didn't do something to maintain the spacing the neck would fall apart.

What is done after this decompression procedure that maintains the low back spacing?

A. Now, there is a percutaneous minimally invasive procedure to take the pressure off that nerve.

It actually limits the amount of disc material that is removed during this procedure with the hope that we're

going to -- we're not going to take out the entire disc, but we're going to take out enough disc material to hopefully get enough pressure off of this nerve to give it a chance to get better. And this would be that intermediate step for you would consider formal surgical decompression and surgical stabilization.

Q. By doing this surgical procedure the hope is that it stablizes it and there is no more symptoms. That's great, but what if the symptoms come back and are worse?

A. In the event that this device was not successful in removing enough herniation or that you had to remove more herniation nuclear material than you're able to do with this type of device, the next step would be to do an open discectomy where you open the entire low back area over L4 L5 and utilizing that same instrument I used in the neck a Rongeur, you would then scoop out larger portions of disc material.

Q. Doctor, to save time would it be a same type of procedure you did in the neck but down there?

A. It would be similarly done through the back side not the front side.

Q. With that understanding I'm just going to ask you before you resume your seat to explain for us in that conservative modality before you got to the

surgery you talked about epidural injections. What are epidural injections and when received those in his neck and back, what were they supposed to do? What did they do?

A. Sure. Epidural steroid injections are putting a needle in what's called the epidural spacing or the space around the nerve root in the spinal cord. The injection or the medication that you inject here a steroid. A steroid is a very potent anti inflammatory drug. Because disc herniations produce pain because of two mechanisms, one compression. We talked about that before direct trauma -- direct inflammation to the nerve.

The second way they produce pain is in inflammation process. The hope is that the steroid will block the inflammatory process to get the pain controllable enough so that the patient can tolerate that pain. And that's what the purpose of an epidural steroid injection is.

Q. The surgery done, yours and Doctor Kaisman's, were they successful?

A. Yes.

Q. What does it mean for a surgeon to say his surgery was successful?

A. It means we did not encounter any post

operative complications that risk you could have in any

type of surgical procedure. Fortunately none of those bad things happened. There was no risk. There was risk, but we didn't encounter any problems from that risk. That's what we mean by surgeons that says the procedure was successful. Basically we didn't hurt the patient which we never want to do. That's one of our good goals of surgery.

Q. You could resume your seat, Doctor. Thank you. You could leave that up.

Doctor, after you performed your surgeries, after the surgeries were done, you performed one of them, did you continue to follow up with Mr. Barros in your office?

A. Yes.

Q. And in the follow up over the last year, would you describe for the jury how he did?

A. Sure. So post operatively after the neck procedure, Mr. Barros did well in so much as we had no complications, we had no issues with the surgical procedure itself. Surgery was successful in preventing further neurological deterioration and decay. From that point of view, we accompliced our primary surgical goal which was to prevent further neurological deterioration.

Q. And over the course of the last year, how has he done?

A. Once again he has removed -- essentially stable with respect to his neck and his back in terms

of not getting clinically worse.

So before surgery if we graph it out, it would look alot like the stock market before the crashing. It was getting progressively clinically worse. We were able to get him at a plateau. So we have been able to prevent that downward spiral that he was undergoing prior to surgery.

Q. And as of your last visit, how was he?

A. So last time I saw him was September 28th and he continued to have the axial complaint and symptoms in his neck with some residual ridicular symptoms in the arms consistent with the nerve root irritation that he had had preoperatively.

As far as the low back went he continued to the axial or low back complaint and symptoms as well.

Q. what's left?

A. Well, what's left is what I'm doing basically for him is surgical observational care. The issues that we spoke about in terms of watching his neck to see whether or not he developes any adjacent segment problems that do require future surgery to prevent and

the low back after the percutaneous compression to see whether or not his clinical course starts to deteriorate again if he falls off that plateau and falls off again then we're looking at doing an open procedure for the lower back.

Q. With regard to that adjacent segment aspect of the spine, do you have an opinion to a reasonable

degree of medical certainty as to what his future looks like?

A. Sure. So if we given his age and wear and tear status, and we talked about wear and tear before, the more wear and tear it is and more loading there is, the more rapid the degenerative process becomes. I believe reasonably we would be looking at a revision cervical status in about 10 to 12 years as a conservative estimate.

Q. And as he ages if he's more active, if he tries to go back to work, or get up every day and work for a 40 hour week or something like that, how is that going to affect his neck and his back?

A. That significantly accelerates the degenerative process. Plus we also know that he has those para adjacent herniations. So there was a big herniation at C5, C6 with a smaller herniation above it and a smaller herniation below it. So stress and

strain on those areas would be significantly accelerated if he were to return to activities that put more stress and strain on his neck. Also with the low back same scenario.

Q. As a matter of your practice and in the course of your practice, are you called upon on a regular basis to assess a person's employability, his physical capacity to be employed?

A. Yes. As an orthopedic surgeon that is something that we do.

Q. In connection with Mr. Barros, do you have an opinion with a reasonable degree of medical certainty as to whether or not he could ever be a construction worker again?

MR. PISANELLI: Objection, Judge.

THE COURT: Approach please.

(Whereupon, there is an off the record discussion held at the bench)

THE COURT: I'll sustain it as to form. We're going to take a break in a couple of minutes. Somebody needs a break. If you could hang on for a few minutes.

Q. Doctor Merola, as part of your assessment of a person's physical capacity, I'm going to ask you specifically based upon your treatments over the last

two years and your review of the medical records, do you have an opinion as to whether or not Mr. Barros could sustain, physically sustain a regular employment situation?

A. Yes, I do.

MR. PISANELLI: Objection.

THE COURT: I'm gonna sustain it as you said regular employment.

Q. 40 hours a week, Monday through Friday, going somewhere to do work, could he do that?

A. No.

Q. Why not?

A. Being able to do that on a continuous basis

or a daily basis given the cervical herniations and lumbar herniations and the cervical ridiculopathies, his aching pain, and his ridicular or nerve root problems, that would be an unsustainable type of activity for him to undergo.

Q. And I want you to assume that he was an active sportsman. He has a son now who is probably 14 or 15. He used to play ball with him, played soccer with his friends, fishing in the ocean or in rivers. Could he sustain comfortably any of those activities any more?

A. No. Not on a regular basis, no.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not any of the injuries you've now described in the neck or the back, any of those injuries preexisted this accident?

A. Correct, they did not.

Q. And I want to ask you whether or not the changes in his disc in the lumbar or cervical spines are those changes permanent?

A. Yes.

Q. And are they ever going to get better?

A. No.

Q. Or they could, they remain the same -- strike that.

In your opinion, what is the likelihood with regard to his spinal condition, cervical and lumbar as he ages?

A. As he undergoes that normal aging process and those discs continue to dry up and in the driving process also become brittle because of the herniations he will sustain more herniations and degenerative changes to a more rapid extent to both the neck and the lower back.

Q. Sir, do you have an opinion to a reasonable degree of medical certainty as to what categories of treatment he will need in the future medical attention

within your specialty having nothing to do with his legs and his legs leave that for Doctor Dassa?

A. Sure. My recommendations for care would be that he would maintain at the minimum what we calling maintenance physical therapy. So patient maintains physical therapies to the neck and back, medication to control his pain from a pain management point of view, injections including future epidural steriods and trigger points. To decreased periods where he may have exacerbations in his pain. Those would all be reasonable. He should also have because of the fusion and because we're interested in the degenerative process, X-rays, MRI's and nerve conduction studies to monitor this process over time.

Q. And will he need services of an orthopedic surgeon or orthopedist or neurologist periodically as well?

A. Yes.

Q. What about medications?

A. Medications to control and ameliorate his axial pain, yes.

Q. With regard to the medications that he's taking, I want you to assume he's taking a form of narcotic painkiller. A form of an anti inflammatory, a form of an anti anxiety medication, a sleep medication

and an anti depressant.

Do you have an opinion within a reasonable degree of medical certainty as to someone who is taking that number of medications should ever be around machinery?

A. They should not be around heavy machinery, no.

Q. I want you to assume that counsel has retained a vocational person to say that he could be a factory worker or an assembly line worker, or a locker room person, do you have an opinion if he could do any of those things?

A. No, he could not.

Q. Did you ever since in the 15 times you met with Mr. Barros notice that he didn't want to work?

A. No, I did not.

Q. That he was happy hanging out at home?

A. No.

Q. Did you review Doctor {Roots'} life care plan?

A. Yes, I did.

Q. Do you have an opinion with a reasonable

degree of medical certainty as regards your specialty and the treatment you would offer as to whether or not it's reasonable or necessary subject to connection?

MR. PISANELLI: Objection.

THE COURT: Sustained.

MR. BOROWICK: Judge, I think I'm done. If you would give me one second. One second I will be sure of it.

Q. I want you to assume, and this relates not necessarily to the leg, but it relates to how it interacts with the back.

I want you to assume that that P long fracture occurred to the degree that you've read and seen in the records and the films. How does that affect his low back, his upper back, and his overall spinal health?

A. The extremities injury particularly what we call the intra articular injury that he suffered make the low back worse over time because your gait pattern is abnormal. So the way your hips and your pelvis moves and the stress imparted on your lower back and your spine are highly abnormal. It does impact and impacts the spine in a negative way.

Q. And the more he walks or tries to walk, or the more he sits and stays in a static position, if he does that is that gonna accelerate or have no effect or diminish the symptoms that he has from his low back?

A. The more walking he does, the more it

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accelerates the back symptoms and the less he does the better.

MR. BOROWICK: Nothing further.

THE COURT: Okay. We'll take a ten minute break before we begin cross examination. Please do not discuss the case.

COURT OFFICER: All rise. Jurors exiting.

(Whereupon, a brief recess is taken)

THE COURT: Welcome back. Have a seat. A couple of hours with the window closed, I see you all have your clothes off. We did open the windows. Just as well you did bring your coats. You all will be leaving from here fairly soon.

CROSS EXAMINATION

BY MR. PISANELLI:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. You're compensated for your time in court, Doctor?

A. Yes.

Q. How much is it?

A. Six hundred and fifty dollars an hour. So I will submit a bill when we're all done.

Q. 650 dollars an hour?

A. Yes.
Q. And that's pretty typical, correct?
A. Yes.
Q. Any professional that were to come in to give an opinion, it would be fair for them to be compensated for their time away from their office, correct?
A. Yes.
Q. You wouldn't expect any professional in any way the fact he was being paid to mean anything about whether or not his opinion is accurate, or truthful, or bias in any way?
A. Correct.
Q. You seem to have some familiarity with plaintiff's counsel?
A. Yes.
Q. You've worked with him before?
A. Yes, I have.
Q. How many cases have you worked together before?
A. I've been in practice since 1996 when I came back and I would say that since that time perhaps 15 or 20 cases.
Q. That you've testified in court?
A. Yes, correct.
Q. And it seems like you work together pretty

well. Did you rehearse your testimony today with Mr. Borowick?

A. No, I did not.

Q. You testify on plaintiff's side, defendant's side, both sides. What's your typical pattern?

A. I have testified on both sides for both plaintiff and defendant.

Q. How many times have you testified per year?

A. On average I would say about four times per year.

Q. And are you involved in other cases that do not go to trial?

A. I don't always know whether a case -- whether or not there is a litigation pending on a particular patient. So I'm sure I've had patients with litigation going on and I've never going to trial.

Q. You've been retained on cases to testify that have not gone to trial?

A. When you say retained.

Q. You're contacted by a lawyer to come to court. For whatever reason you're not actually called into court in that case.

A. I do get contacted by attorneys to ask me whether or not I might come to court on a particular patient, yes.

Q. You never knew Mr. Barros before you saw him in 2006, correct?

A. Correct.

Q. First time you saw him was on that February 14th, visit?

A. Yes.

Q. And between the time of his accident in February of 2006, until that first visit, you didn't have any direct contact with him or any of his doctors about his care during that period of time, correct?

A. Correct.

Q. So when he got to you in February of 2008, all the information you got back came from either him or other doctors, correct?

A. Yes.

Q. And you asked him about his medical history when you first saw him?

A. Yes.

Q. And you asked him specifically about injuries to his neck or his back?

A. Yes.

Q. And it's fair to say that he denied having any injuries to his neck or his back prior to the accident of February, 2006, correct?

A. Any significant injuries, yes.

Q. What do you mean by significant? Did he tell you about other injuries that he had?

A. Significantly exactly what we were speaking about before which would mean surgical procedures minimally invasive procedures, pain management procedure, that type of thing.

Q. He never told you he had an injury connected with his back back in 2002; did he?

A. At my first visit, we did not review the 2002 accident, no.

Q. If you had known about the 2002 accident and the subsequent treatment to his cervical spine, his lumbar spine, you would have noted it in your records, would you?

A. If it had been significant I would have noted it, yes.

Q. If you knew that he had received, undergone testing by a physician for injuries to his cervical spine, his lumbar spine, would you have considered that significant?

A. Depends on what the outcome of the testing was and what types of procedure he had done.

Q. If he had an MRI performed, the MRI showed bulging disc for cervical spine bulging disc with the lumbar spine, would that have been significant?

A. Not the bulges, not at all, no.

Q. Even -- well, we'll get to that, Doctor. Now, the history that you took from Mr. Barros, is that what you would call prior medical history?

A. I'm sorry. Which history?

Q. The history you took from him in February of 2008?

A. First visit.

Q. February 14th, correct?

A. January 14th, 2008.

Q. I'm sorry. I'm sorry January 14th, 2008,

correct. Let's go right to your report.

A. Sure.

Q. Now, did you receive any information about the accident that he had in February of 2006 prior to Mr. Barros coming to your office in January?

A. Doctor Kaisman had sent me some information regarding Mr. Barros, yes.

Q. The information contained in your report, is that solely from your discussions with Mr. Barros or your combination of that, or your discussion and review of records with Doctor Kaisman?

A. The report is an initial evaluation and conversation that I had with Mr. Barros when he initially presented to me to get his spin on the

incident and his complaints and symptoms.

Q. Now, you wrote that he injured himself in the February 21, 2006 sustaining a fall from approximately 15 feet from the scaffold. Is that something that he told you?

A. Yes.

Q. And then you wrote he had direct trauma to the neck and back?

A. Yes.

Q. Did he tell you that?

A. Yes.

Q. Okay. And what did he tell you about having direct trauma to his neck and back?

A. Precisely that. That he had sustained an

injury to his neck and back as a result of that fall.
Q. Did he tell you that he actually struck his back when he fell?
A. I don't know how to answer it other than that because I don't have a transcription of what he said but the essence of what he said is transcribed in the notes.
Q. Did you review the hospital records for the day of the accident, Doctor?
A. Yes, I did review the hospital record.
Q. Is there anything in that hospital record

reflecting your direct trauma to his neck and his back?
A. The CAT scan they did of his neck. They also scanned his abdomen and pelvis which also scanned his lower back. There is evidence of the --
Q. Isn't it true that the a CAT scan taken at the hospital was negative?
A. Yes.
Q. The Sound Shore records. Anyplace where it talks having a direct blow to his neck or his back?
A. I don't believe that it has those words within it, no.
MR. PISANELLI: May I approach, your Honor.
Q. Thank you, Doctor. Is there any other source that you're aware of that speaks to a direct blow to Mr. Barros neck or his back at the time he fell?
A. Not that I'm aware of, no.

Q. And it's your understanding that when he fell he landed on his feet, or at least on the foot that was fractured?

A. That there was an axial hold as we've described a complex mechanism of injury to the spine.

Q. Now, you wrote that he was treated at the hospital of New Rochelle you're referring to Sound Shore Medical Center?

A. Yes.

Q. You also wrote that he was under the care of Doctor Allmed. There is no doctor Allmed, correct?

A. Right.

Q. You're talking about the facility who he was treating with?

A. Right.

Q. Now, when did specifically Mr. Barros have his first complaint of back pain? Do you know that?

A. When did he first make a complaint about back pain?

Q. Yes.

A. On my initial visit?

Q. No, following the accident of 2006?

A. I don't know.

Q. Did you review any records with regard to his care immediately after his discharge from Sound Shore Medical Center?

A. Yes, I did, but I couldn't pick out of there verbatim time frame regarding the complaints that he

offered. No.

MR. PISANELLI: Okay. May I approach, your Honor?

THE COURT: Yes.

Q. Doctor, I've given you portions of the

records from the Allmed facility. Do you know what Allmed is by the way?

A. This is a it says Allmed Medical and Rehabilitative Center, I think.

Q. And what is that?

A. It would be a group of physicians that do orthopedic surgery and rehabilitation and that type of thing.

Q. And was the patient referred to you from the Allmed group?

A. No, he was not.

Q. Do you know any of the physicians at the Allmed group?

A. Let's see. I've heard of Doctor Mitchell Kaplan. And these appear to be notes from Doctor Kaplan. And also I've heard of Doctor Gabriel Dassa, and I have some notes from there as well.

Q. Do you know Doctor Kaplan?

A. I've heard of them. I don't know of them personally.

Q. I refer you to the first note July 3rd of 2006.

MR. BOROWICK: Note my objection. May

we approach?

THE COURT: Yes.

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(Whereupon, there is an off the record discussion held at the bench)

Q. Doctor, I want you to assume that on that first visit March 3, 2006 -- I'll take that from you. That there were no complaints of pain relating to the lower back?

A. Yes.

Q. And at that time I want you to assume that on the straight leg raise test there elicited no symptoms whatsoever.

A. Okay.

Q. And, Doctor, what is a straight leg raise test?

A. Straight leg raise test is a test whereby you extend the leg of a patient to see whether or not there is nerve root irritation.

Q. And if a patient is able to straight leg raise without pain in his back, what is that significant of?

A. That tells you that the S1 nerve root is not significantly irritated, so it's a test for a specific nerve root, that is the S1 nerve root.

Q. Doctor, I want you to assume for this section too as of April 17th, 2006, that was the first time that you made any complaints to Doctor Dassa, history

and physician of any back pain and reporting that he had been experiencing pain since the time of the accident.

Now, you said that there was no evidence that-- I'm sorry. Withdraw the question. You talked about the fact that because he was non weight bearing he would not feel any pain at all?

A. No. Actually I said if he is non weight bearing he is by default undergoing that first tier of conservative management for neck or back injury which would be avoiding things that would produce neck or back pain.

Q. So the fact he didn't report any pain between his accident in February and until April of 2006 in your mind has no meaning at all?

A. Actually, to me it confirms the fact that avoiding activities such as weight bearing were good for him in terms of him not having any pain and it sounds like in April when he should have started to weight bear on his P long, that he became symptomatic. So it underscores the fact that there were neck and back injuries.

Q. But he's reporting that he had pain throughout that period of time. How do you reconcile that?

A. Okay. I don't have a problem with that

because it depends what his degree of pain was during that time. So if he brouoght it up in April and I wasn't there for that visit, so I can't recall exactly what happens, but it sounds to me when he became weight bearing he became more symptomatic and that's why they noted it in the chart at that time.

Q. Doctor, can you describe briefly the difference between subjective and objective complaints?

A. Yes.

Q. Now, the objective complaints, are those which the patient presents to you. You can't otherwise confirm or disprove, correct?

A. The subjective complaint is what the patient tells you about what their problem is. Whether or not you could objective confirm, that is separate and apart from the actual complaint itself.

Q. Do you have any information about the patient's level of pain between the car accident of 2002 and 2006?

A. Yeah. He was working full time as a carpenter without any treatment records at all. So I would say that at that point in time he was what we would consider asymptomatic, without complaints or symptoms.

Q. You never saw the patient during that period of time, correct?

A. I haven't seen any treatment records during that period of time.

Q. And his reporting to you or anybody else that he was asymptomatic during that period of time that would be a subjective reporting, correct?

A. Subjective description of his history of that period of time, yes.

Q. So that in that reporting that would be just as accurate as him reporting that he had no prior injury to his neck or his back?

A. Not at all. We would look for objective evidence whether or not he had treatment during that period of time in the absence of that and a work record indicating he was working full time full duty we can objectively confirm his subjective history which was that he didn't have any problems at that time.

Q. Doctor, you don't have any testing done during that period of time, correct?

A. As far as I know, correct.

Q. So from 2002 when he was in a car accident until 2006 when the first tests were performed by his treating physicians, there were no MRI's done?

A. Correct, as far as I know.

Q. There was no range of motion tests performed by any doctors?

A. That's right, yes.

Q. There were no X-rays done?

A. Correct.

Q. There were no EMG's done?

A. Yes.

Q. What's an EMG?
A. EMG is an electromyographic study. It's a study whereby a physician take usually a needle electrode, places it into a muscle, stimulates a nerve and then looks to see how that nerve responds to stimulation.
Q. Were there EMG's performed on Mr. Barros in 2006?
A. Between 2002 and 2006.
Q. No, in 2006 following his fall from the scaffold?
A. I believe he did have a subsequent EMG performed, yes.
Q. Were those positive for certain findings, yes?
A. Yes.
Q. Would it surprise you to know he had positive EMG's following his 2002 accident?

A. No.
Q. He had range of motion -- would it surprise you to know that he had range of motion limitations following the 2002 motor vehicle accident which were very similar to those noted following his fall in 2006?
A. No, I would not be surprised to know that.
Q. And it wouldn't surprise you to know that his MRI findings in 2002 were strikingly similar to those in 2006?

MR. BOROWICK: Objection.

THE COURT: Overruled. Would that surprise you?

THE WITNESS: Would that surprise me? It would surprise me if they were similar, but they were not.

Q. Have you seen the results of the MRI's that were done in 2002?

A. Yes.

Q. What did you actually see?

A. I saw the report that indicated he had a bulge.

Q. A bulge in what way?

A. C5, C6.

Q. And that is different from the 2006 MRI in

what fashion?

A. Some of the 2006 MRI indicates an exclusion of nuclear material or herniation.

Q. In 2002 let's be clear he had a bulging disc in his neck, correct?

A. Yes.

Q. And that bulging disc in his neck, was discovered immediately after a motor vehicle accident, correct?

A. Yes.

Q. And he had symptoms in his neck immediately after the motor vehicle accident, correct?

A. Yes.

Q. And those included pain?
A. Yes.
Q. Limited range of motion. That is, he couldn't bend his head forward as he he normally could?
A. Yes.
Q. He couldn't bend it back as he normally could?
A. Correct.
Q. He couldn't move from side to side as he normally would, correct?
A. Yes.
Q. Those were -- withdrawn. You talked about

degenerative changes in the neck and spine. Based upon your age things happen?
A. Yes.
Q. Were those changes that were discovered in 2002 on that MRI that was result of a trauma from a motor vehicle accident, or age or combination of both?
A. That was a result of the normal degenerative process of the discs of the neck.
Q. Okay. And what role did the motor vehicle accident play?
A. The motor vehicle accident based upon the history that we know about from 2002 and his diagnostic findings caused some soft tissue aggravation from his underlying condition then responding quite well to conservative care.
Q. Any degenerative changes that he had in 2002,

they would remain in his body from 2002, 2004, up until the present day, correct?

A. Yes.

Q. The degenerative changes don't go away?

A. No.

Q. And in addition to the MRI that was done on his cervical spine in 2002, after the motor vehicle accident the MRI in his lumbar spine also?

A. Yes.

Q. You read the MRI from that too?

A. Yes.

Q. That also showed pathology in his low back in 2002, correct?

A. I believe those were bulges as well, yes.

Q. How are bulges in the low back significant as of 2002?

A. Once again it goes back to what we talked about with discs, the degenerative discs, the bulging discs versus the herniation.

Q. And in 2002 following the motor vehicle accident, the plaintiff had symptoms in his low back, correct?

A. Yes.

Q. And those symptoms included pain?

A. Yes.

Q. Inability to move forward and backwards, side to side?

A. Yes.

Q. Pain running down into his legs?
A. Yes.
Q. And correct me if I'm wrong Doctor, but those are all symptoms like the one he had in cervical spine which were very similar to the pain that he had in 2006 following his fall from the scaffold?

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A. The symptoms were similar at their onset, yes.
Q. Now, in 2002, what type of treatment did Mr. Barros have? Are you familiar with that?
A. Yes.
Q. And what did he do?
A. There was pretty much that first tier conservative care management, physical therapy medications. He had some nerve root procedures performed as well, as far as I know and I believe his treatment lasted for approximately a month. Maybe six to eight weeks worth of treatment after which he then returned to work.
Q. Well, what if I suggested to you it went from the date of the accident in January of 2002 through April of 2002. Does that seem right to you?
A. January, February, March, April, so about three months or so, okay.
Q. Okay, give or take. What about if I suggest to you he had 44 chiropractic visits during that period of time and he received adjustment to his cervical spine and lumbar spine, would that seem right to you?

A. That would also seem appropriate.
Q. And that's the same level of care that you're talking about that is less than surgery, correct?

A. Tier one the entry level conservative care in management.
Q. That's what's done for mild symptoms or to see if you could treat the patient without going to a more serious follow up, correct?
A. Correct, yes.
Q. Now, would it surprise you to learn that the chiropractor and the physicians that were treating him in 2002 described --
MR. BOROWICK: Objection. Objection.
THE COURT: Sustained.
Q. Doctor, do you know what Mr. Barros's prognosis was following his treatment in April of 2002?
A. Objection.
MR. PISANELLI: Objection.
(Whereupon, there is an off the record discussion held at the bench)
THE COURT: We'll take a one minute break.
(Jurors exit)
THE COURT: Welcome back. Have a seat. Go ahead.
MR. PASANELLI: My question is withdrawn, Judge.
THE COURT: Okay.

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Q. Okay. Okay. Doctor, as of April of 2002, would it surprise you to learn that Mr. Barros was still complaining of radiating pain to his right and left upper extremity?

A. No.

Q. Or that he was still complaining of lower back pain and stiffness?

A. No.

Q. And that he was still complaining of radiating pain down his right and left legs?

A. No.

Q. Does that sound like something that had resolved as of April of 2002?

A. He still offered those complaints so they were still something that was an issue for him.

Q. So after that three and a half, four months of treatment, he's still complaining of pain and limiting range of motion in his neck and spine?

MR. BOROWICK: I don't know how 10 weeks became three or four months.

THE COURT: Why don't we just say mid April of 2002 he was still complaining without characterizing unless we want to figure exactly how long.

Q. He was in the car accident January 6th of

2002 and he last treated for the condition April 6th of 2002.

THE COURT: For the record, that would be slightly in excess of three months.

Would it surprise you after that period of time whatever it is. Go ahead.

Q. That he was still complaining of pain at the 8 dash 9 level?

A. No. He's still at about twelve weeks post injury which is a very early acute stage for healing, particularly for soft tissue trauma. So no I'm not surprised.

Q. What would it mean to have pain 8 over 9 or 8 slash 9?

A. You can't take that number of hits, context. You have to know whether or not it's 8 out off 9 depending on activity. Is it on a daily basis? Is it constant so? That pain scale is an important measure of pain, but the pain scale is only part of the picture. You need the pain scale and then you also need to know what it is that's reproducing that pain and how often it happens. So in and of itself that number doesn't mean much. But at least according to Mr. Barros as of April of 2002 on a scale of zero to 10 he was still feeling pain in the 8 to 9 level, correct.

A. I don't know what they are giving. There is no denominator to that equation. There is no 8 to 9

over the course of a day, at the end of the day, at the beginning of the day, aggravated with motion, aggravated with less, relieved with medication, constant, unremitting. So I have the number which is the top half of the fraction, but I don't have the bottom half of the fraction. So I can't give you the answer.

Q. Fair to say that 8 is more painful than 1 or 2?

A. Once again it's confusing to me because the pain scale is important, but it's important in terms of aggravating and relieving factors during and temporal relationship to the pain.

Q. So the fact that doctor he had to treatment after April of 2002 doesn't mean he didn't have any pain following that day, correct?

A. It's interesting the way you worded that, but I would say because he did not have any treatment after April of 2002, it is significant because if you are experiencing significant pain and your clinical course is deteriorating, none of us would sit around and let it go. You would treat it. So that to me is a very important finding. I think that's the most important

finding that you brought up so far.

Q. You reviewed the Sound Shore Medical records, Doctor?

A. Yes, I did.

Q. Was there any complaint in there after the

admission following the fall from the scaffold that showed he had any pain in his neck or back?

A. No significant subjective complaints that I could recall, no.

Q. In the 15 or 16 visits you saw the plaintiff over the time you were treating him, did he ever tell you about the motor vehicle accident of 2002 himself and the injuries he sustained in that accident?

A. We didn't discuss 2002, because we were up in 2008 and I was worrying about preventing spinal cord damage in his neck. So to be honest with you, we never sat down and discussed that because it was pertinent what I was going to do in 2008.

Q. That's a no?

A. Correct, that was a no.

Q. You said you sat down and spoke to him about his treatment, correct, during the time you were caring for Mr. Barros?

A. And with specific respect to what.

Q. Well, you spoke to him in English?

A. I also speak Spanish, and I also have a translator in my office. I'm also bilingual. Actually, I'm trilingual. I speak Italian as well.

Q. Did you speak to Mr. Barros in Spanish?

A. Yes. Did I speak to him in Spanish?

Q. Did you speak to him in Portuguese?

A. Portuguese, Spanish, and Italian are quite similar. I actually have Portuguese cousins that live

in Brazil. I don't speak it fluently, but I am able to communicate, yes.

Q. There is no question that you and Mr. Barros never had any problems communicating your thoughts to one another, correct?

A. I did not have a problem treating him or communicating with him for his surgical reconstruction. No, I did not.

Q. Doctor, you spoke during the direct examination about the future care that Mr. Barros may or may not require, correct?

A. Yes.

Q. And it's fair to say that right now he doesn't need any further surgery at the present time?

A. Right now I have not indicated to him that he requires surgery as of now, no.

Q. And we talked about the things that he can do

with his body. Is he able to use his hands now?

A. He could use his hands, yes. His hands are functional in terms of he can use them, yes.

Q. He can lift things. He could work a computer. He could use a telephone. He could turn on water, turn it off. He could do the things around the house?

A. As a tolerated basis.

Q. As tolerating them as he can?

A. Yes.

Q. He could sit and stand as he needs to?

A. Yes.
Q. He's able to walk?
A. As he needs to, yes.
Q. And is it fair to say that if there were a job position that could accommodate his special needs that he could do that job?
A. If there were a job that let him that, didn't require a daily day in and day out pattern of actually-- yeah if there was a job that you didn't have to go to, yes.
Q. That you didn't have to go to?
A. Yes, that he didn't have to perform at as a continuous or repetitive basis, at a particular time schedule. If he could make his own schedule and

accommodate his needs based on an as tolerated basis, provided he was off the narcotics medication and the other meds, yeah. I would say that he would be able to hold that type of work, if there were any.
Q. Now, you haven't given Mr. Barros any treatment for his leg fractures, correct?
A. I have not treated the leg, no.
Q. He hasn't had -- are you aware of the treatment that he has received?
A. I know he's had closed treatment for the P long fracture, yes.
Q. You're aware that he hadn't had any real treatment for his leg since early 2007, correct?
A. He hasn't had any surgery for the leg or any

open treatment for it, no.

Q. Now, going forward, how often -- let me withdraw the question. You don't have any schedule procedures for Mr. Barros. Currently there is nothing currently to take place?

A. I haven't scheduled any surgery for him, no.

Q. You talked about the monitoring that you would do for him as you go forward?

A. Yes.

Q. How often?

A. Minimum of every three months to do a basic

neurological exam and a spine exam, basically quarterly on a yearly basis depending on his clinical situation.

Q. If he doesn't have any symptoms, does he need to come see you?

A. If he's asymtomatic I would still want him to come back every three or four months just for the neuro exam.

Q. Does he need to see you or someone else?

A. He could also see a neurologist provided we're in communication.

Q. The person managing his pain, is that somebody that can manage his neurological exam?

A. The pain management physician could do a basic neuro exam, but I don't know that they would be looking at neurological deterioration in the same way as a neurologist would or I would.

MR. PISANELLI: Nothing further.

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q. Doctor, let me just go back in reverse order about this job. In this world is there a job that you know of for a man with a fourth grade education and no tranferrable skills, having done heavy manual labor all his life, is there a job 40 hours a week Monday through Friday that somebody was going to give him that he

didn't have to go to, he could do it on his own schedule and when he's not on his medication? Do you know any job like that?

MR. PISANELLI: Objection.

THE COURT: I'll sustain the objection. We're now getting into education etcetera. We're going beyond cross.

Q. Based upon your treatment of him is there any job that you think he could do on a full time basis, any job?

A. No.

Q. Any job he could do when his back and his neck and his leg are acting up so that he's gotta take his narcotics, pain medication, his anti inflammatory medication -- strike that.

Do those medications affect your ability to focus?

A. Yes.

Q. His expert says he should be near machines-- strike that. Strike that. Done.

Counsel just brought up that in Sound Shore he wasn't complaining about his neck and his back even though they did a series on his neck, but he wasn't complaining about his neck and back what was going on in Sound Shore?

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A. He was on morphine at the time because of the leg fractures with the PL fracture. He was medicated with morphine sulfate.

Q. Not weight bearing?

A. Correct.

Q. Okay. Now, there was that sequence that counsel just did where he said well when I had symptoms he went for treatment back in '02. Let's talk about the old car accident again. He had symptoms. He went for treatment, right?

A. Yes.

Q. 44 chiropractic visits to get adjustments so that he could work, right?

A. Yes.

Q. In fact, after a month he went back to work, right?

A. Correct, yes.

Q. Continued to go for treatment as he needed it, obviously unabashed, not ashamed to go for if he needed it?

A. Yes.

Q. So after this April date --

THE COURT: Sustained, only in terms of

the narrative.

Q. After the April date that counsel kept

bringing up as the date the last date that he had any recorded complaints, is there any reason to believe based on any hard evidence that he continued over the rest of '02 to have any symptoms?

A. No.

Q. Over '03 is there any evidence that he had any symptoms?

A. No, none.

Q. '04?

A. No.

Q. '05?

A. No.

Q. Somebody who after a car accident went for treatment from whoever gave him treatment, would you expect that if he had symptoms he'd go for treatment?

A. Yes.

Q. You were talking about you answered counsel's questions about the treatment in '02 that it was tier 1 and it worked, it got him better, correct?

A. Yes.

Q. Okay. Isn't that tier 1? Isn't that what's supposed to happen with tier 1?

A. Precisely.

Q. And when counsel said well there is something strikingly similar on the MRI, is it strikingly similar

the MRI's from the bulges in '02 to the herniations in '06?

A. No.

Q. Is there anything similar neurologically to a traumatic herniation or degenerative bulge?

A. No.

Q. And I'm talking clinically significant in a neurological orthopedic spine, orthopedic realm. Is there anything strikingly similar when you're trying to compare a motor vehicle accident with resolved symptoms to a herniated disc from a traumatic fall with symptoms that went through tier 1, tier 2, tier 3, and still exists?

A. No, they are completely and entirely separate.

Q. Counsel said how do we know if there was no testing in those four years. Can you imagine why anybody would do testing in any of the four years while he's working without symptoms and limitations? Why would anybody go for testing during those four years?

A. No indication for testing at all.

Q. Did anybody ever say there was a direct blow to his neck and his back other than maybe when he fell onto his back?

A. No.

Q. Is there any suggestion that the injuries

that you diagnosed in his low back and in his neck, is there any indication they came in other way than from the obvious modem, than from the impact to his leg?

A. No, not at all.

MR. BOROWICK: Nothing further.

MR. PISANELLI: Nothing, Judge.

THE COURT: Thank you, Doctor. You could step down. And with that that concludes todays proceedings. We will adjourn. We'll start a little bit later. I ask you to be here at 10:15 tomorrow. I have another matter that will just take a few minutes. Be here at 10:15 and we'll start with the next witness at 10:15. Have a good night and please do not discuss the case.

COURT OFFICER: All rise. Jurors exiting.

(Whereupon, the case is adjourned to January 14, 2010)

Certified to be a true and accurate transcript of the original stenographic notes.

JACQUELINE GLASS
SENIOR COURT REPORTER

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