SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK:TRIAL TERM PART 12

JOHN MESCALL and ELIZABETH MESCALL,

Plaintiffs, Index:109157-04

-against-

STRUCTURE TONE, INC.,

Defendants.

STRUCTURE TONE, INC.,

Third-Party Plaintiff.

-against-

EMPIRE ARCHITECTURAL METAL CORP.,

Third-Party Defendant.

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60 Centre Street
New York New York
September 27, 2010

B E F O R E :
THE HON. PAUL G. FEINMAN, JSC

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

For the Plaintiff:
SACKS AND SACKS
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For the Defendant:
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By: Andrea Camacho, Esq.

Joyce Fisher, CSR and Sara C. Stanley CSR

Dr. Merola - Plaintiff - Direct

MR. BOROWICK: we are marking into evidence Exhibit 39, Dr. Radna.

(Whereupon Plaintiff's Exhibit 39, was marked for identification.)

MR. BOROWICK: And Exhibit 40, Dr. Palmieri.

(Whereupon Plaintiff's Exhibit 40 was marked for identification.)

MR. BOROWICK: And Exhibit 41 is the model.

(Whereupon Plaintiff's Exhibit 41 was marked for identification.)

THE COURT: What is 40?

MR. BOROWICK: Forty is Dr. Palmieri.

THE COURT: I'm assuming you mean their record?

MR. BOROWICK: Yes.

THE COURT: The doctors themselves are not exhibits.

No objection to 39 and 41, 39 and 40 and 41 Miss Camacho.

MS. CAMACHO: No.

(Whereupon the Plaintiff's exhibits marked in evidence 39, 40, 41.)

THE COURT OFFICER: Okay.

Jurors entering.

(Jurors returned at 10:05 a.m.)

THE COURT: Everybody have a seat.

Jurors, we really are doing our best to try to get this trial done by Friday.

I have my own self-interest in making sure that I keep my word to you, which is that I'm scheduled to leave for a conference on Monday out-of-state, so if I don't get this trial done by Friday, you know it's interferes with my ability to care out that obligation.

But, and I'm also trying to keep my word to you, which was that originally we are not going to be in session on Wednesday, and I now one of you has a problem with that and so as of now, we are not going to be in session on Wednesday.

We have been able to rearrange some of the witnesses, but it means that tomorrow morning and perhaps on Thursday we are going to have to start at 9:00 o'clock, so slightly longer days on Tuesday and Thursday.

And still, as it stands today, no session on Wednesday.

If for any reason that changes, then we will have to talk about it substituting that juror who can't make it on Wednesday, and just, you know, constantly evolving in things trials are dynamic, let's do our best to get it all done.

Whenever you are ready, call your next witness.

MR. BOROWICK: Plaintiff calls Dr. Merola.

THE COURT OFFICER: Watch your step.

Remain standing.

THE COURT CLERK: Raise your right hand.

Do you solemnly swear or affirm that the testimony you are give in this case shall be the truth, nothing but the truth so help you God?

THE WITNESS: Yes, I do.

THE COURT CLERK: Have a seat.

State your full name and business address for the record.

THE WITNESS: Andrew A Merola, M.D.

36 Seventh Avenue, Suite is 502, New York, New York, 10011.

THE COURT: So you are going to be hearing a series of questions posed to you.

If you hear the word, "Objection," please don't answer until I rule on the objection.

If I say "overruled," go ahead and answer it.

If I say "sustained," means you don't answer it.

If the question calls for a "Yes," or "No" please just answer "Yes," or "No."

If you feel that you cannot fairly answer the question "Yes," or "No" just say that, and whoever is asking the question at that point will decide whether they want to go beyond "Yes," or "No."

If at any point you don't understand the question, just tell the questioner, and they will rephrase it.

Please keep your voice loud and clear, so everyone can hear you all right.

THE WITNESS: Yes.

THE COURT: Very good.

Your witness.

DIRECT EXAMINATION

BY MR. BOROWICK:

Q. Dr. Merola, would you tell the jury what your occupation is?

A. I am an orthopedic reconstructive spinal surgeon.

Q. And what background and education do you have that allows you to call yourself a spinal reconstructive orthopedic surgeon?

A. I went to medical school, and after I graduated from medical school, I did an orthopedic surgical residency training program.

After that residency training program, I went to do a spinal surgical fellowship, where I was trained specifically in spine.

And after that, I came back into the active practice of spinal surgery.

Q. And for how long have you focused your expertise on

spinal surgery?

A. Since 1996.

Q. And how long, how often do you operate on spines?

A. Three days a week.

Q. And for the last 14 years, three days a week, other than vacations, only spinal surgeries?

A. For the most part spinal surgeries, yes.

Q. What are the range of surgeries that you do, the least complex the most complex?

A. Least complex type of surgery would be something in the way of what we call a micro-decompression, whereby you use a microscope to make a very small opening in the spine to release some pressure on a nerve root.

The most complex type of surgery would be what we call a major adult or pediatric reconstruction, whereby you would have to actually cut the spine at multiple vertebral places and reconstruct it with screws and rods to put it back into a more normal orientation.

That can be done from what we call a combined approach, both through the front of the body and the back of the body.

Q. Sir, are you Board certified?

A. Yes, I am.

Q. For how long have you been Board certified?

A. I have been Board certified since I finished my

complete training boards.

My initial Board certification took place in 1998.

Q. Do you operate on people with congenital problems?

A. Yes.

Q. And how about people who have been subjected to trauma?

A. Yes.

Q. Now, with regard to either/or, do you have patients who are, after your surgeries, able to recover to the extent that they can resume their career?

A. Yes.

Q. Even industrial careers labor, heavy labor careers?

A. Yes.

Q. Do you have some that can't?

A. Yes.

Q. Do you have some that can return to -- can't return to their job but can return to other jobs?

A. Yes.

Q. Do you have other patients who can't return to their own job or any other job?

A. Yes.

Q. And are your surgeries guaranteed to succeed every time?

A. No.

Q. What is the goal? When you do a spinal surgery what

is the goal?

A. The goal of the spinal surgery is, number one, to do a safe surgery and not harm the patient.

Number two, is to try to prevent further neurological deterioration.

Q. Do you know who John Mescall is?

A. Yes.

Q. And when did you first see John Mescall?

By the way, you have in front of you a folder.

Is that your medical chart relating to your treatment of John Mescall?

A. Yes, it is.

Q. And if you need to refer to it for any reason please feel free.

Have you made it available to counsel for the defense?

A. Yes.

Q. Would you tell the jury when was the very first time you first saw him?

A. I first saw Mr. Mescall in May of 2004.

Q. I want you to assume his accident was May 4th of 2004.

How soon after that accident did he come under your care?

A. May 10th of 2004.

Q. With a patient like John Mescall, who has been involved in an extent, and has spinal issues that your

expertise falls within, are there occasions where sometimes you have to go to court if there is a lawsuit that ensues?

A. Yes.

Q. And on those occasions, do you charge a fee for your time?

A. Yes.

Q. And on many of those occasions have I, in fact, called you as a witness when my client is actually a patient of yours?

A. Yes.

Q. So you know this?

A. Yes.

Q. Tell the jury when you met Mr. Mescall, did you come to learn of what his accident was?

A. Yes.

Q. And did you come to learn about the multiplicity of injuries that he had?

A. Yes.

Q. What did you focus your attention on, what injuries did you focus your attention on in connection with his treatment?

A. My treatment was focused on his spinal injuries.

Q. And what levels of his spine?

A. The neck, the cervical spine, and the lower back.

Q. And I'm going to ask you, we have marked in evidence this guy, and I'm going to ask you, Exhibit 41, the diagram,

would you give the jury a brief anatomy lesson on the spine.

And with the Court's permission can he step down so he is equidistant?

The boney structures, the soft tissue, the neurological tissue.

You can take it off the hook.

(Whereupon the witness stepped down.)

A. So, this is a plastic model of the human spine, and it goes from the bottom of the head, all the way down into the pelvis.

And there are essentially three parts to the spine, there is the neck, or the cervical spine; there is the thoracic spine or the upper back; and then there is the lower spine or the lumbar spine where it attaches to your pelvis through a structure called the sacrum.

The spine is made up of a number of bones.

And these bones all have numbers associated with them, depending upon what portion of the spine they are in.

In the neck, there are seven bones, so they are numbered one through seven.

In the upper back there are 12 bones, they are numbered One through 12.

And in the lower back there are five, numbered one through five.

Q. Are there letter designations for those vertebrae?

A. Yes.

The letter designations that go along with the number depend on what portion of the spine you are talking about.

So for example, if you were to say C3, you would be talking about Cervical Three.

T4, Thoracic Four, and so on.

L for lumbar.

Q. Now, there is material between the vertebra what is that?

A. So in addition to each bone that is within the spinal column, in between the bones are structures that are known as the disks.

The disks are made up of cartilage.

And that cartilage of the disk serves the purpose of holding the bones together, absorbing shock and stress and strain, and controlling normal motion in between each one of these specific bones throughout your entire spinal column.

Q. When you say, "Holding the bones together," do the bones actually touch each other or are they separated by the disks?

A. The bones are actually separated by the disks.

So the disk is, sits in between the vertebral bodies, it holds the vertebral bodies apart, and it prevents the vertebral bodies from collapsing from each other and touching each other.

Q. What is it that you don't see on that model, as far as holding the spinal column together?

A. Some of the things that are not on this model are the muscles and the ligaments and the tendons that are around all of this that make up the rest of the body.

Where the spinal column is involved, these are the most important structures that you have maintaining what we call spinal stability.

The muscles that are here, around the spinal column are found, these are the muscles that you can feel when you are touching your neck, when you are touching your back, and they surround and encompass the spine and they are called the paravertebral muscles.

Q. And what are those things you feel on the back of your spine?

A. If you feel your back, you run your finger up along your back and you feel these hard boney prominences, what you are feeling are known as the spinous processes.

So when you look at the spine the spinous processes are those things that stick out the back of the spine.

They are very reminiscent, if you thought of a dinosaur, those are the things that are sticking out of a Dinosaur's back, these spinous processes are these hard boney things you feel if you put your finger up against your back.

Q. Before we get away from the disks, are they

designated? You mentioned about the designations and the nomenclature for the vertebra, how about for the discs?

A. Since everything in the spine is already numbered, the bones have specific numbers, attached to them the disks in between each of those bones also have some specific numbers, and they actually carry two numbers associated with them, it's the number of the bone above it and the number of the bone below it, because of the sandwich in between those bones.

For example, the disk that's in between the fourth and fifth cervical vertebra would be the C-4,5 disk.

So that disk actually carries with it the bone that is on top and the name of the bone that's on the bottom.

Q. Now, I also see there is yellow tails coming out of each side what those are?

A. The yellow structures that you see coming out of and off of the spinal column are the various nerve roots that proceed into your arms and legs.

One of the major purposes of the spinal column is to contain and to protect the spinal cord and the nerves that go into your arms, hands, legs and feet.

And all of those nerves come off at specific sections of your spinal column, so that they can go to their specific areas.

So in the neck, the nerves that come off of the neck area are those nerves that go into your arms and hands.

In the upper back, they are the nerves that come around your chest wall, and in the lower back these are the nerves that go down into your legs and feet and each one of these nerves also has a number associated with it, depending upon what bone it comes off of, and in which portion of the spine it comes out of.

Q. How does it get from the spinal cord out to the nerve that we see?

A. So, when the nerve comes off of the spinal cord, and it's a little difficult to see because the cord is contained within the spinal canal.

And the spinal canal is covered up by the roof of the spinal canal which we call lamina.

If you were to look inside the spinal canal, you would see that a nerve root is actually exiting the cord, just like a wire would exit cable, and it proceeds out of the spine through an opening or hole.

That hole or opening is called the foramen, specifically a neuro foramen, that is a hole for a nerve.

Q. We have heard a number of terms through Dr. Hausknecht, and I guess just in the ether, we have heard about bulging disks, herniated disk, pinched nerves, would you explain to the jury the, how they are distinguished and how they occur?

A. Sure.

Q. And I'm not talking about congenitally, I'm talking about in a trauma?

A. Sure.

Specifically, when we are talking about a disk and a nerve, when you look at the spinal model, you can see that each one of these nerves as it exits the spinal canal comes through its little opening and its little hole and it lies right next to the area where the disk is.

So the disk itself is in very close proximity to each one of these nerve roots.

And when we talk about a disk, and we say that a disk is bulging versus a disk that's herniated, in essence what we are saying is it's a visual description of what the disk looks like on a MRI, or, if you would open a patient up and actually look at the disc, what the disk would appear to look like to you.

And the simplest way I can explain this is if you were to take a jelly doughnut.

And a jelly doughnut is very much like a disk because a disk, actually has two components to it, there is an inner jelly-like center that gives the disks a lot of flexibility.

And there is an outer covering to the disk that holds that jelly-like center in place.

If you were to take that jelly doughnut and take your hand and put it on top of the doughnut, press down very gently,

you would see the doughnut bulge; the doughnut would flatten out; and it would bulge very symmetrically throughout it's entire border. It would look like it flattened out a circle or a ball or balloon.

The bulging is important in its symmetry, which means that it's equal on all sides, and you see a bulge.

A bulge is that symmetrical or very even out-pouching of disk and disk material.

Q. Let me ask you this, the bulging, is that a function of trauma, congenital origin or each?

A. Bulging can be a function of the all of those things and bulging can also be a function of just weight on the disk, depending on how you take the picture of the disk.

Q. Now, aging, let's talk about that.

When do the disks begin to bulge, if it's just about aging?

A. Sure.

In general, as you go through the normal aging process, all of our body parts begin to age.

Because the disk, its made out of collagen, in many ways it changes just like the rest of the collagen changes, and the best example I can give you of that is your skin.

So as one gets older, and the way your skin changes is also the way your disks change, and that bulging that you see, that normal symmetrical out-pouching of disk is a response to

the collagen of fibers in that disk over time losing their normal elasticity, their normal liquid content and their normal flexibility.

When I say "normal" I mean their younger state.

We generally start to see those changes happen somewhere in the area of about 30, 35.

Q. So, if for example me as opposed to you, all other things being equal, would I have bulging disks that are more bulging than yours?

A. Very likely, that if we did some studies to look at your disks you would have bulging disks.

Q. Can a person have a bulging disk and not have any symptoms?

A. Yes.

Q. Can a person have a bulging disk and have plenty of symptoms?

A. Yes.

Q. How do the bulging disks, and we are just talking about bulging, how do they result in symptoms?

A. So if you look at a bulging disk, and we think about what the disk does for the spine, it keeps the bones apart from each other, and it maintains normal motion between those bones.

If that disk is acting up, the symptoms that it can cause would be symptoms of abnormal motion in your back.

And the most common response to abnormal motion in

your back is a muscular spasm and strain, and that would, you would feel that as a muscular pain and muscular spasm, cramping in or around your neck, back, or lower back or lower back, and that depending upon how bad that muscular spasm is, it can also travel to the other muscles that are wrapped around your spinal column because all of these muscles are connected in some way.

Q. Is there any effect on the nerve, sensation or motor function?

A. Now, there can also be an effect on the nerves that are traveling past the disk, because if the bones are not engaging properly, not moving around properly, or not properly spaced, the nerves there in your neck area can also become irritated because of that abnormal motion that exists in the area where you have a bulge for example.

Q. How would that manifest itself if that opening, for example, were not as large as it would be if the disk wasn't bulging?

A. So what we see in that instances, an irritation of the nerves that could be picked up as a sensation of numbness or tingling going into your arms or legs or pain or spasm waiving into your arms or legs.

Q. And now tell us about a herniation?

A. Sure.

Now, so we talked about a bulge, the symmetry of a bulge.

When you have a herniation, the herniation is different from the bulge because there is an asymmetrical protrusion of disk material.

Most commonly, the jelly-like material that is in the center, the best way I can describe that to you now, take your hand that is sitting on that jelly doughnut and keep squishing it; you keep putting pressure on it.

What's going to happen?

You are going to see jelly squirt out of the doughnut.

But the jelly isn't going to squirt out of the doughnut in a big symmetrical circle, it's going to come out of the doughnut in a specific area, in the area where that pastry contracts or breaks or tears.

And that jelly is going to squirt out a specific area of that doughnut, and it's that asymmetrical squirting out of jelly-like material.

That is a herniation. That jelly has now herniated its way through that outer shell, that outer pastry covering.

Q. And what are the variety of symptoms that can appear with a herniation?

A. Now, with a herniation when you have this jelly-like material that is asymmetrically sticking its way out into the spinal canal down onto the nerve root area, and in the area of the spinal cord, the symptoms are more constant, severe, and more long-standing and progressive as time goes on because you

have two things happening.

Number one, you have chemical irritation from that jelly-like material. That jelly-like material contains specific chemicals within that are not supposed to be up against the nerve, so those new chemicals that are leaking out with that jelly-like material produce an inflammatory action in the nerve, that produces pain and nerve root irritation.

That's one thing.

The other thing is that jelly-like material produces compression, it squeezes the nerve or it pinches the nerve as it makes its way out of the spinal column.

So by inflammation and irritation, through the chemicals that it's leaking as well as direct pressure, you start to develop a problem we call a radiculopathy.

Any time you hear the word 'opathy," in medicine it means a problem with, and "radic, is a root.

So a radiculopathy is a problem with the root.

And when we mean problem, from an orthopedic-spine point of view, we mean that the nerve root fibers are misbehaving and they are not doing what they are supposed to be doing.

Q. What kinds of forces cause a herniation?

A. Now, when you talk about force on a spine, and the way bones move on each other, there are different types of forces that can produce herniations.

You can have, for example, an axial load that comes down and crushes your spinal column, that gives a lot of pressure at an instant in time, that produces a disk herniation just like if you took that jelly doughnut and squeeze it real quick, that would be an axial load.

You can have proportional force which means a tearing that can produce a tear or a rip in that outer covering of the disk that can produce herniation.

You can have a bending moment, and a bending moment is something that produces tension in the spine or the spinal canal.

For example, if you took a stick of chalk, and you bent that stick of chalk on both ends, eventually that stick of chalk would contract in the middle, that is a bending moment, that's a example of a bending moment.

And the spinal column, in that sense, is no different than that stick of chalk, you would see failure happening in the disk, the disk would be ripped apart.

Q. You can resume your seat again.

(Whereupon Sara Stanley was relieved by, Joyce Fisher, as Official Court Reporter.)

MR. BOROWICK: Officer, can I have the tripod, please.

Q Dr. Merola, have you had a chance this morning to review the illustrations in evidence and specifically Exhibit Two, the mechanics of the accident?

A Yes.

Q And, in addition to that, have you had an opportunity to review the mechanics of the injury which is marked Exhibit 23 in evidence?

A Yes.

Q I want you to assume that Mr. Mescall, the evidence in the case so far has been that Mr. Mescall was a construction worker on a job site, that he was working under what is approximately a 1,500-pound steel, stainless steel screen, which came -- it was dropped and came unfurled in a downward and arking motion striking him on the head, the screen striking him on the head and the hard hat laterally, and the bar striking him in a way that severely comminutedly fractured his clavicle, three ribs and a couple of transverse processes in an axial fashion.

Can you tell the jury what is the significance of the mechanics of the accident and his injuries to an orthopedic spine surgeon.

A Well, to an orthopedic spine surgeon that looks at the mechanism of injury and the mechanics of the injury, we

see a combination of forces that produce significant injuries which we call para-adjacent to the spine. That means above and below the spine. With the cervical spine really behaving like that stick of chalk that we're talking about and the bending moment around that stick of chalk.

So, with these types of injuries where you have a comminuted, that means broken in many places, clavicle with rib fractures and a head injury of significant amount of force and trauma enough to break bones, that would cause injury to the neck at that the spinal structures as well.

Q In Exhibit 24 in evidence -- and, if you would step down just for a moment and, using the model and Exhibit 24, can you describe what you mean by para-adjacent.

A Sure.

Q As it relates -- let's first talk about the neck.

A Sure. So, the shoulder, the shoulder is connected to your upper thoracic spine through your rib cage. So, in the upper area of the thoracic spine, right where your neck meets the thoracic spine, is your shoulder joint. And this represents the lower portion of what we would call a bending moment in the lower portion of your cervical spine.

The head represents the uppermost portion of the bending moment with the cervical spine in between these two force anchors, if you will, these two areas that are held more or less rigidly.

So, when you have a mechanism of injury that comes in and forces these two portions, both above and below, para-adjacent to the cervical spine apart causing enough trauma to cause fractures and broken bones, what lies in the middle by definition is also imparting a force load or a force distribution. Because the force isn't isolated to the areas of impact. Because of the bending moment that happens to the neck, there has to be a force distribution along the cervical spine itself.

Q And of what significance is it that the forces acting are acting at the same time in those two different places?

A That is extremely significant in terms of producing an injury to the structures of the cervical spine because you're dealing with multiple forces in more than one area on both sides of the cervical spine.

Q I want you to assume -- okay. You can resume your seat.

Doctor, I want you to assume that as a result of the impact, the witness who was there said that Mr. Mescall dropped like, I think he said, a rag doll, down onto this canopy on which he was working.

I want you to assume that he was knocked out, but I'm not going to ask you about his head injury. But, when he went on the ambulance, and he went into the emergency

room, there were reports, primary complaints of his neck, shoulder. There were indications in the triage notes neck pain, back, the para-spinals, shoulder. They diagnosed or preliminary diagnosed a brachial plexus. There were all these fractures, paraesthesia, severe pain.

Are those complaints, those symptoms, those -- the presentation of those symptoms significant to you as an orthopedic spine surgeon?

A Yes.

Q And why?

A They're significant because you have a mechanism of injury and trauma producing significant and severe musculoskeletal injuries along with complaints that correlate with the body parts that are injured. So, you have correlative complaints and symptoms that go along with a severe mechanism of injury and trauma.

Q Now, I want you to assume that prior to this accident, four years prior to this accident, Mr. Mescall had had an accident where he was in an aerial man lift and, at the base, a vehicle collided with it and he got thrown about.

That he had a cervical complaints, he had lumbar complaints, he had shoulder complaints referable to the cervical complaints and he sought treatment. He missed seven weeks of work as an iron worker and then returned full

duty.

During those seven weeks, I want you to assume that he sought treatment by a Dr. Holt, a chiropractor, and was able to get back to work.

He, at the six-month mark of approximately January, he said he felt fine. And the next month he was back in the office of a Dr. Rizzo making complaints of his neck and back.

I want you to assume that he saw Dr. Rizzo for a period of months and, ultimately, he was treating with Dr. Holt until the beginning of '03. For the year of '03 through the end of Thanksgiving, he was symptom free and he was working full time, full duty.

And then he came into the office of a Dr. Radna while he was between jobs, a neurosurgeon.

Have I asked you to review the records of Dr. Radna?

A Yes.

MS. CAMACHO: Objection.

THE COURT: Step up.

(Discussion at the bench off the record.)

Q Doctor, I want you to assume the facts I've given you, but I have a different question for you.

Given those facts, do you have an opinion with a reasonable degree of medical certainty as to whether or not

you can tell, just from those facts, whether or not he had a disk injury as a result of that accident, whether it's a disk, a bulge, pinched nerve, disk herniation, just from those facts?

A Yes.

Q Okay. Now, I want to add some facts, and then I'm going to ask you what your opinion is.

I want to add that in 2001, his work history demonstrates that he had a jump in his work hours. In 2000, he had worked -- actually in 1999, he had worked 1,300 hours; in 2000, the year of the accident, where he had missed seven weeks, he worked 1,763 hours; in 2001, he worked 1,975 hours; and, in 2002, he worked 1,951 hours. In '01, he submitted to an MRI where the diagnosis by the radiologist was bulging disks.

Do you have an opinion with a reasonable degree of medical certainty as to what type of injury, if any, he sustained in his cervical spine as a result of the 2000 accident?

A Yes.

Q And would you explain to the jury.

A Sure. This is a -- what you've given us is what we call a clinical description of a person or a patient that is suffering from a cervical sprain/strain syndrome.

Q Now, what about his work record, if anything would

be significant in that reference?

A The work history is significant in so much as he was back to work and duties as an iron worker with a significant amount of hours worked.

Q And the -- let's just go to the MRI in 2001.

MR. BOROWICK: If we could pull up the shadowbox.

May I approach, Judge.

THE COURT: Sure.

Q Dr. Merola, the MRI taken on June 1 '01, is Exhibit 29-A.

If you don't mind, would you come down and would you evaluate it for the jury with regard to, particularly, the C-5/6 level, and use the model if you need to because the MRI is pretty small.

A Sure. So, what we're looking at on the MRI, I'm going to put the -- I would put the model next to the MRI and we're going to be looking at it as a side view.

So, what we're seeing here on the MRI is we're seeing a side view of the cervical spine of John Mescall that was done on June 1 of 2001.

Now, when you do an MRI scan, the scan takes what are called slices through the neck. So, picture this spinal model being put into a baloney slicer, and every slice is one of the images that we see on this film.

So, this film contains multiple images. Those images start from one side of the spine and they go all the way to the other side of the spine. The impulses that are in the middle are slices that are taken directly through the middle of the spine.

So, let's look at some of these slices and look at what we see. First thing we see are the bones, and the bones appear as gray squares. So, each one of the gray squares is a bone in the neck.

In between the bones of the neck, as we see from the model, are the disks. So, there's a disk in between each bone of the neck.

Behind the bones and disks that is to the right of this film that is behind on the back side of the neck, we see a gray line surrounded by two white lines. The gray line that you see is the spinal cord, and the two white lines are the normal spinal fluid that that cord is floating around in.

So, let's count the bones. And we're going to look at C-5/C-6. So, the top bone is the first vetebral body and the first vetebral body is a very, very small bone.

So, C-1 is the small bone all the way up at the top. C-2 is this very long bone. And then we count down three, four, five, six and seven. And, if we look at the disks between five and six, what we see is that the disk

between C-5 and C-6 is bulging out, that is, it is sticking out of it.

And how do we know it's a bulge? Well, what we do is we look at the other slices. And, in each of the other slices, we go to the C-5/C-6 area, and we look to see is it sticking out more on one side than the other side, or is it sticking out on all sides symmetrically.

So, if we count at C-5/C-6 where we can see bones and where we can see disks, we look to see if there is a mechanical protrusion or an asymmetrical protrusion.

And what we see on multiple slices is that we see disk material sticking out behind C-5/C-6 in a symmetrical fashion which gives the diagnosis of a C-5/C-6 disk bulge.

Q Now, the radiologist who read this in 2001, a year after his accident, would you take us through this radiological report which is Exhibit 31 in evidence.

A So, this is a report regarding the MRI film of Mr. John Mescall. That MRI was done on June 1, 2001. So, it corresponds to the film we just saw. And the report here is a verbal description of what's on the film as read by the radiologist, Dr. Ossip.

And, when we go to the section here "Conclusion", conclusion is his summary of his visual description of the MRI, he indicates that the -- at the C-5/C-6 level, there are mild disco-vetebral degenerative changes seen in the

absence of posterior disk herniation and spinal canal stenosis.

What does he mean by that? In the body of the report, he says at the C-5/C-6 level, there is mild intervertebral disk space narrowing, and there is a mild posterior disk bulge.

So, what he's telling us is at C-5/C-6, there is a disk bulge with some mild degenerative changes in between the fifth and sixth vetebral bodies.

Q Now, is there any reference to any other level of the cervical spine having any pathology?

A No, there is not, no.

Q Is that of any significance?

A Yes. It tells us that the other levels as we saw on the film are essentially within, what we would say, within normal limits. They're not visually, or by MRI appearance, or by pathology causing any issue or problem.

Q Now, can you tell, with that description and your own reading of the film, can you tell whether or not that defect, that bulge, was traumatic in origin or was it related to the aging process, normal degeneration?

A This --

Q If you could tell with a reasonable medical certainty.

A Given the MRI findings and the fact that we have a

symmetrical disk bulge at one level with mild degenerative changes at that level as well, we would reasonably make the medical argument that these are due to what's known as the normal aging process or normal senescence process.

Q Would you resume your seat, please. I am going to use that again. You could put it down there.

Dr. Merola, I'm going to show you what have been marked in evidence as Exhibit 39, Dr. Radna's report, and also Dr. Palmieri's report, Exhibit 40.

Have you had an opportunity review those?

A Yes.

Q And I want you to assume that after a ten-month or eleven-month period where Mr. Mescall received no treatment at all, that he appeared at Dr. Radna's office as he was having some neck, and back and shoulder problems after working the job for whatever, seven, eight months.

Can you tell the jury is there any significance to Dr. Radna's findings as reflected in his report as to the reports of cervical pain, constant cervical pain, persistent lumbosacral pain, severe bilateral spasm? What is there reference to with regard to his spine, lumbar and cervical?

A The reports from Dr. Radna essentially give us the picture of someone who has a cervical sprain and strain syndrome with significant neck pain and spasm.

Q Now, he put him on -- this is in December,

December 23, 2003, and he put him on Vioox and Skelaxin and talked about further management.

Would that be the appropriate response to a cervical and lumbar strain generating those symptoms?

A Yes.

Q And what is Vioox, and how does it work and what's its purpose? And also Skelaxin.

A Vioox is what's known as a nonsteroidal antiinflammatory medication.

The purpose of that medicine is to decrease the imflammatory response or that chemical irritation that we were talking about that can happen with a bulge and inflammation which is the response to irritation.

Q I'm sorry.

A I was going to say Skelaxin is a muscle relaxant that's prescribed for muscular strain and spasm.

Q Now, if he had a sprain from a bulge, would you expect those medications to make a difference?

A Yes.

Q And I want to direct your attention to his last and final report of January 13, 2004 where he notes -- where he had noted severe bilateral spasm. He now notes moderate bilateral para-vetebral spasm, moderate diminished range of motion and, again, recognizes the need for further management.

Do you have an opinion based upon the progress from one visit to the next, two weeks apart, as to what is happening with regard to Mr. Mescall's spine?

A Sure. So, he was placed on medications, antiinflammatories and muscle relaxants, and went from severe pain and spasm to a moderate level of pain and spasm eventually responding to the medications that he was given.

Q Now, at the end of his last report, the last time Dr. Radna saw him, he said that as a future option, he might recommend decompressive surgical micro-laminectomy and medial facetectomy. He was -- can you tell me the significance of that, if any?

A The significance of that is, this is a small or what we would call minimally invasive surgical procedure to relieve some nerve root compression that a neurosurgeon and/or a spinal reconstructive surgeon would inform a patient is a possibility in the future depending upon what his response to treatment is.

Q Now, the management of a lumbar and cervical sprain from a bulging disk, what would that include? Obviously, you referred to the Skelaxin and the Vioox. What other measures would be involved before you resort to even minimal surgery?

A Sure. The things that you would do to treat these problems are what we call conservative care and management

that is non-cervical care and management, and that would include simple things like activity modifications and restrictions, rest, the antiinflammatories that he was placed on, muscle relaxants to relieve pain, spasm, physical therapy to try to relieve some of the pain and spasm and discomfort.

The next level of care beyond conservative care would involve what we call pain management, which would be the direct injection of medications into the neck where you would directly inject antiinflammatory medications into the area of nerve roots and/or disk.

Q Now, at the same time -- incidentally, with these visits, Mr. Mescall was -- began physical therapy through a chiropractor. I think it was actually Dr. Kostreich. And at the same time that he began physical therapy with Dr. Kostreich, the chiropractor, he saw a Dr. Palmieri.

Have you had an opportunity to review his record?

A Yes.

Q Now, Dr. Palmieri reviewed the same MRI that you did and indicated -- this is Exhibit -- I think it's 40.

He indicated that a review of the MRI examination of the cervical spine revealed evidence of multi-level disk bulging.

Now, again, the bulging, Dr. Radna in his record said he believed it was a herniation.

When you look at the same MRI that the radiologist who took it and Dr. Palmieri who reviewed it as well, when you look at it, do you find yourself consistent with those two doctors or with Dr. Radna?

A I find myself more consistent with the radiologist and Dr. Palmieri.

Q So, whatever it was, Dr. Palmieri was seeing him for a few visits, coincidentally with the physical therapist. How was he doing beyond the improvement with Dr. Radna, how was he doing during the treatment of Dr. Palmieri?

A Dr. Palmieri's notes are pretty much also consistent with improvement overall and a response to conservative care.

Q Now, this is about five months before he begin his treatment after the accident of May 4. Do you -- do you -- well, withdrawn. Strike that.

Obviously, at the time of his accident, he was working. It happened while he was working.

I want you to assume that according to his work records, which is Exhibit 22 in evidence, and the particular records, you know, outlining his specific weeks of employment, I want you to assume that he modified his activities by not working during December and part of January, December and the first half of January, but he

returned to work around the 18 of January and then continued to work straight through to the time of the accident.

Is there any indication -- is there any indication that Dr. Palmieri who saw him through March of '04, was recommending any surgery?

A No.

Q Was he calling for any epidural or nonsteroidal injections?

A No.

Q Was he directing Mr. Mescall not to work?

A No.

Q I want to read from his last report, March 24 of '04, his impression.

"My impression is that Mr. Mescall suffers from a continued cervical and lumbar strain with radiculopathy after a work-related accident."

Do you agree with that?

A Yes.

Q "I request authorization for an EMG and NCV study. He should remain working in his current capacity and should continue chiropractic care."

Now, as of March 24, he had been working about nine weeks. If he were able to tolerate full duty while he was getting chiropractic care, would you have him change that?

A No.

Q If Dr. Palmieri was recommending that he continue working and continue chiropractic care, would that have been the effective approach for a cervical and lumbar strain?

A Yes.

Q Now, when he came to you -- then he has this accident that we've all heard enough about.

When he comes to you, do you notice any atrophy or reflex deficits that would indicate that he had a long-standing problem before this accident?

A No.

Q Of what significance is his initial presentation to you as regards whether or not his problem is from the dropping of this screen or from the four-year old jostling in the man lift?

A If he had had what we call a long-standing radiculopathy, that is, a problem with the nerves secondary to neurological damage from a herniation, over the course of time, the nerve malfunctions. And, when the nerve malfunctions, it can't supply its normal stimulation to the muscles that it innervates.

And, when that happens, over time what you see is, you see a loss of reflexes, you see a loss of muscle tone and bulk, and you see weakness.

So, in long-standing nerve root damage, you would

expect to see, on your clinical exam, a loss of reflexes. Muscle atrophy, that is a shrinking of the muscles that those nerves control and a loss of tone and bulk.

Q And, in fact, were there any indications of those in either Dr. Radna or Dr. Palmieri's records?

A No.

Q When he came to you on the first occasion, did you give us the date?

A Yes.

Q Was that -- tell us again. I'm sorry.

A That was May 10 of 2004.

Q And when was the last time that you treated Mr. Mescall?

A September 10 of this year, 2010.

Q So, for the six and-a-half years that you've been one of his treating doctors, can you tell us first has he been a compliant patient?

A Yes.

Q Has he been a cooperative patient?

A Yes.

Q Has he done whatever you've asked him to do?

A Yes.

Q When you first saw him back in May of '04, was he in need of surgery?

A Not to his neck or his back, no.

Q Okay. Forget -- we're not talking about the shoulder or the head with you, or the ankles or any of that. We're just talking about the neck and low back.

Doctor, when he came to you, what were his complaints that you focused on?

A Sure.

Q I want to just handle -- just deal with your focus.

A Sure. It was neck pain, with low back pain as well, with radiating pain into the upper and lower extremities.

Q Now, he had had that at times with Dr. Radna, Dr. Palmieri and Dr. Kostreich, the chiropractor.

Were these new injuries or were these just more of the same?

A These were new and different from what they had previously been.

Q Explain that to the jury.

A Sure.

Q Just hold that thought for a second.

(Continued on the following page.)

BY MR. BOROWICK:

Q. Would you explain how it was different what he had before the accident with the screen and after?

A. Sure.

Beforehand he was working full duty and under chiropractic care and management and well controlled and what we would call clinically doing well.

We then have him present to my office.

He came into the office with a history of a significant trauma, with multiple fractures, with severe pain in the neck and back area.

So there was a night-and-day difference before and after the traumatic incident.

Q. Did the bulge at C-5,6 which existed, according to you the radiologist and Dr. Palmieri, did that bulge pre-exist, did it make that level of the spine susceptible to injury?

A. Yes.

Q. More susceptible than four, five or six, seven? Did it?

A. Yes.

Q. Why?

A. When we go back and look at the MRI that we had an opportunity to view in 2001, and we looked at all of the disks, that area where there is bulging, that C-5,6 segment was different than the other segments, and there were clearly

changes at that C-5,6 segment.

So given that information, when you incur a significant trauma, that is an area of the neck that has, is already predisposed to further and more significant injury because it is, if you think about it a weaker link than the other areas are.

Q. Now, in connection with this accident, did he suffer a new injury to C-5,6, or simply an exacerbation of C-5,6?

A. I would say --

Q. Hold it?

A. I would say that he certainly made the C-5,6 segment worse with a frank herniation, that is we have gone from bulge to herniation, with neuclear material and disk material now sticking out asymmetrically, that wasn't there before.

Q. Now, were there any other new injuries to his cervical spine as a result of this accident?

A. Yes.

Q. How do you know?

A. Well, we have MRI's after the accident, and we have a clinical course after the accident, that also tells us there are also what we call para-adjacent problems.

Q. Now, in your initial exam after taking a history of his objective complaints, did you do an examination?

A. Yes.

Q. Tell the jury what your examination consisted of and

what significant findings you had if any?

A. Sure.

So the exam on May 10th of 2004, was significant for a patient that was in a moderate amount of distress.

So as part of the physical examination we observe our patients.

And he was in moderate amount of distress which meant he was in pain.

His left shoulder was contained within a sling, so it was held by a sling.

He required some minimal assistance to get on and off of the examination table.

Inspection of his body demonstrated that he had multiple abrasions, that is cuts and bruises to the head and neck area, and left side of his neck, shoulder, clavicle, back, chest and lower back.

So there was multiple abrasions, swelling ecchymosis, ecchymosis means black and blues.

When I did a range of motion exam, he had what I indicated as significantly diminished cervical spinal range of motion.

He manifested a positive compression maneuver and positive Spurlings reproducing bilateral or both sides upper extremity pain with radiation of pain into the C-6 dermatome.

Q. Did -- had Dr. Radna performed a compression or

Spurling maneuver?

A. Yes.

Q. And were those positive?

A. Dr. Radna had a positive Spurlings maneuver for reproduction of pain at the base of the neck.

This Spurlings maneuver reproduced a dermatomal distribution, that is a C-6 dermatomal production of pain.

Q. Is that of any significance?

A. It is different than the findings of Dr. Radna. It is different, specifically with respect to the nerve root involved.

Q. Now, with regard to your course, the course of treatment that you outlined for him, did you get another MRI?

A. Yes.

Q. And did you -- were there MRI's, were there EMGs and NCD's done?

A. Yes.

Q. And have you reviewed them?

A. Yes.

Q. Was there anything about the MRI that indicated a new or amplified injuries?

A. The MRI's, subsequent to this time, demonstrated asymmetrical disk material at the C-5,6 segment, that is herniation at C-5,6.

Q. Would you step down, sir?

And would you take us through your findings in the cervical spine on MRI.

(Whereupon the witness stepped down into the well of the courtroom.)

Q. Try not to block any of the jurors.

A. So what we are looking at here is a picture of the MRI.

The mid sagittal, that is the slice that is in the middle of the cervical spine of the neck of John Mescall.

This is dated June 4th of 2004.

Once again, we are looking at the same basic architecture that is the squares or the bones, and they have been labeled for us, C2, C3, C4, Five, Six and Seven.

We are looking at the grey line behind those bones, that is to the right of this film bordered by two white lines, that is the normal spinal fluid encompassing the spinal cord.

And if we look at this, what we see here is that C-5,6, we can see disk protrusion into the spinal canal area, touching the covering of the spinal canal deforming the flow of spinal fluid at C-5,6.

We can see a smaller deformation of fluid at C4 C-5.

And we see a smaller deformation of fluid at C6, C7.

Q. Based on the complete MRI scan which obviously has more slices than this did, you come to a conclusion as to whether or not there were symmetric bulging or whether or not

there were herniations at any levels.

A. Right.

So when you look at the MRI scan, and you put the slices together, and come up with the description of what these look like, they are asymmetrical, and it's the asymmetry of that neuclear material that is sticking out into the canal that gives you the definition of a herniation.

Q. And where were there herniations now where there had been a single bulge at C-5,6 where are there now herniations?

A. At 5, 6.

Q. Any others?

A. A smaller one at 6, 7.

Q. Would you tell the jury what are those axial views on the right side, it says, "Normal axial view," and his axial view?

A. Sure.

An axial view, so up to now we have been used to look at the side view, the sagittal view or the side view of the spine.

An axial view means you are looking from the top of the head down.

So you are kind of standing on the top of the patient's head, and you are looking down their spinal canal, so what you see is in the front, in the front area, it's a slice or a picture of the actual disk itself.

Behind the disk you are looking down the spinal canal which is the area where the spinal cord is.

And then behind it, this thing that looks like a Y, that is the spinal lamina, and the spinous process.

That's what you can feel in the back of your neck with your finger.

So the normal disk is really well contained within the architecture of the bone, and none of it sticked out into the spinal canal.

And the abnormal disk with the herniation or jelly-like substance, that is sticking into the canal, you can see it coming into the canal here, and touching the covering of the spinal cord called the dura.

Q. What would that jelly-like substance have to have penetrated to get to a place where it was deforming the dura?

A. It has to go through the outer covering of the disk that's known as the annulus.

That is analogous to the pastry crust of the jelly doughnut.

Q. Are there any ligaments that it would penetrate to get to that position?

A. There is also something that is known as the posterior longitudinal ligament, which is a ligament behind the vertebral bodies that pushes up against the disk and that posterior longitudinal ligament is also something that would contain

disk material.

Q. Now, in addition to the MRI you talked about the EMGs.

What about the EMGs which were done? There were four of them?

A. Yes.

Q. What about them did you find significant?

First, as far as the pathology, and second as far as the etiology or the source of the problem?

A. Sure.

The EMGs, an EMG is a nerve test; it's a way of testing the electrical circuit of your nerves.

If your nerves are cables, and they work pretty much on the same principle as an electrical circuit does, the EMG is testing the function of individual nerves.

And the EMGs were abnormal insomuch as they showed a problem with two specific nerves here, and that is the C-5 nerve root, and the C-6 nerve root.

Now, when you look at nerve roots coming out of the spinal canal, those nerve roots come out in the area of the disk.

The fifth nerve root comes out above the body of C-5 and C4, 5, section and the sixth nerve root comes out between the fifth and sixth vertebral bodies.

So you are seeing a change in two levels, that is C-4,5 and C-5,6, to produce a C-5 root and C-6 root abnormality

on the electrical conduction test.

Q. And over the course of the six-and-a-half years, the other EMG, NCDs of what significance were they?

A. Over the course of time, those nerve tests continued to show a problem in the conduction system of those specific nerve roots.

Q. Now, when did you eventually do surgery on Mr. Mescall's neck?

A. I believe it was in 2009.

Q. Over the course of the five-and-a-half years before you resorted to surgery, what other modes of treatment short of surgery did you attempt?

And you can resume your seat.

Strike the question.

Just come back for a second and I want you to explain to the jury, did you have a lumbar MRI done?

A. Yes.

Q. Would you take us through the lumbar injuries as well?

A. So this is a representation of the lower back MRI.

The lumbar MRI of John Mescall.

The date of this MRI is June fifth of 2004.

The MRI image we are looking at is, once again, this is a side view of the lower back.

And the same rules apply to the lower back as they do to the cervical spine.

So the bones are the squares, and they are numbered one, two, three, four and five.

The disks are in between the bones.

And when we look at the lumbar spine MRI here, we see that there is an out-pouching of disk material between L3 and L4 as well as L4, L5 and a smaller one at L5 and S1.

Q. Do you see that on the axial view as well?

A. Indeed, on the axial view, in the upper right hand corner of this board, is an axial view.

When we are looking down the patient's spine, what we see here is the front or the circle is the disk.

The Y, is the back of the spine.

And in between the disk and the back of the spine is this bright area that looks somewhat like a triangle.

This is the area where the nerve roots are that go into your legs.

And what you can see here is one of the angles on the triangle has a, is grey, in other words, we are missing one of the angles of the triangle.

If you looked at this, and it was a triangle, the upper right hand corner of this triangle, you can't see it there is a grey shadow here. This grey shadow is a herniation.

We know it's a herniation, once again, because it's asymmetrical.

If it were a bulge we would see both angles of the

triangle disappear, but because we only see one angle of the triangle disappear, we know it's asymmetrical, we know it's a herniation.

Q. On the left side, on the sagittal cut, there are yellow lines indicating a straightening of the lordosis.

What is the significance of that?

A. Lordosis is the normal curvature that your lower back should have.

So if you put your hand in the lower back there is a hollow to your lower back, that's the normal curve that your lower back should have, and that's called lordosis.

When you see a straightening of the lordosis, what you see is a flattening out of your lower back.

And the significance of a flattening out of the lower back is that there is muscular spasm that is preventing your lower back from having its normal alignment.

Q. Is spasm voluntary or involuntary?

A. Spasm is an involuntary muscle contraction.

Q. And when you examined him, did you palpate or feel that spasm?

A. Yes.

Q. By the way, with regard to the six-and-a-half years of treatment that you offered him, including surgery and whatever else we will go through, did you ever find him to be exaggerating in his complaints?

A. No.

Q. Was it ever a time that you couldn't clinically correlate his complaints to your findings?

A. No.

Q. And why is that significant?

A. Well, it's significant because the clinical picture that we see has to correlate with the anatomy that exists.

And that correlation has to come in not only what the patient is complaining about, but how much pain they are complaining about; what specific problems they voiced to you; what your physical findings are like; and then what your imaging studies show.

And you want all of those things to line up so that when you come up with a treatment plan, you give yourself the best opportunity to fix the problem at hand.

Q. What was your treatment plan?

Now you can resume your seat.

(Whereupon the witness returned to the witness seat.)

Q. What was your treatment plan?

A. Sure.

So my treatment plan for Mr. Mescall is what it is for patients that present with an acute radiculopathy, and it starts with conservative care and management.

So the same things that we would do non-operatively, need to be done here, and that is, activity modifications and

restrictions, antiinflammatory medications; muscle relax amounts and pain medications as you need them, physical therapy, and pain management.

Pain management being the referral to a physician who specializes in injections and treatments of putting medications into the areas that are injured, in the hopes of decreasing pain and inflammation.

Q. And how does that work?

A. I'm sorry, how does --

Q. How do the injections work.

A. Sure.

The injections put a antiinflammatory medication, in most cases it's a steroid.

A steroid is a very powerful antiinflammatory agent.

It directly places that steroid medication into the area of the nerve and the disk.

The steroid blocks the inflammatory chemical irritative process from the disk herniation, and it gives the body a chance to have pain relief, and decrease symptoms by blocking inflammation, by blocking irritation.

Q. And how did that, how did that work over the years?

A. So over the years, with respect to the neck and back, his, he was able to respond to conservative care up to a certain point.

Q. And when you say, "respond," were you able to, with

medication or injections were you able to correct the problem?

A. Medications and injections were able to ameliorate, that is decrease, his complaints and symptoms; make them more bearable for him, particularly with respect to the neck, up until we start to see clinical deterioration.

Q. And with regard to the back, have you been able to control the symptoms in the low back?

A. Yes.

Q. And what measures have you employed in controlling the low back?

A. The same measures that we used for the neck, and that is conservative care, activity modifications and restrictions, medications, physical therapy, pain management.

Q. Now, is disability from work or his not working for the last six-and-a-half years part of the activity modification?

A. Yes.

Q. The medication that has been prescribed, whether by you or by any of the other doctors, the pain management doctors, in what way has that helped?

A. The medications are able to control a lot of the spasm and pain and some of the irritation from which he suffers.

Q. And are there any side effects to the medication?

A. The medications themselves can have side effects, yes.

Q. What medications have what side effects?

A. Well antiinflammatory medications have the side effect of stomach upset and/or possibly also ulcers in your stomach, that would be a non-steroidal antiinflammatory.

The pain medications often times contain narcotics in them, and those can have the effect of making one sleepy and/or drowsy; difficulty with concentration, sometimes constipation.

The neurological agents like Lyrica, which are designed to decrease nerve symptoms, can also produce some drowsiness and difficulty concentrating and things like Lidoderm patches, that is a medication that you apply directly to the skin, it's an anesthetic medication applied to the skin can have the problem of skin irritation in the area where the patch is applied.

Q. Now, what led ultimately to the surgery in '09?

A. So, what you have is when you have the opportunity of to follow a patient over time, you follow what's called their clinical course.

So we see what their complaints and symptoms are; we do examinations over time; and we follow their physical findings and their symptoms.

And if they are stable, if they are plateaued and stable, there is no reason to change what you are doing because what you are doing is keeping them at essentially an even keel or an even state.

If the physical examination and findings over time

start to show that there are what we call progressive neurological problems, or progressive pain, then that steady state that plateau that they are on they are actually starting to fall off of that plateau.

Over time, one of the things that John manifested with respect to the neck and with respect to the nerve function was that he began to the demonstrate a loss of reflexes and some pathological reflexes that were persistent and getting worse.

So at that point in time, the decision is made to do something surgical in order to prevent further deterioration of those nerve roots.

Q. So when you say, "At some point in time," did he have a loss of reflexes or atrophy or any of that stuff when you first saw him?

A. No.

Q. '05?

A. No.

Q. '06?

A. No.

Q. '07?

A. No.

Q. '08?

A. No.

Q. Okay.

So in sometime in '09 he developed these symptoms,

Dr. Merola - Plaintiff - Direct

they gave you concern what did you do?

A. So with a progressively deteriorating clinical course in other words, he was getting worse over time with nerve root symptoms demonstrable of damage.

I performed what's known as an anterior, that is through the front, cervical, neck, discectomy, removal of the disk and fusion, that means stabilization of the bones.

Q. Now, is this remotely like the procedure that Dr. Radna said might be an option in the future?

A. No, this is a different procedure.

(Whereupon Plaintiff's Exhibit 42was marked for identification.)

Q. I'm going to show you Exhibit 42, and I'm going to ask you whether or not this is a fair and accurate depiction of the way in which you performed the surgery on Mr. Mescall in August of '09?

A. Yes, it is.

Q. And would it be helpful for you to explain for the jury to understand that surgery that you did on Mr. Mescall's neck in '09?

A. Yes.

MR. BOROWICK: I would offer it in evidence.

MS. CAMACHO: Objection.

THE COURT: Overruled.

(Whereupon, Exhibit 42, a diagram, was received

Dr. Merola - Plaintiff - Direct

in evidence.)

MR. BOROWICK: Please, if you would step down and take us through the surgery.

(Whereupon the witness stepped into the well of the courtroom.)

THE WITNESS: So what we have is a graphical representation of a surgery that I performed on August 25th of 2009 on Mr. Mescall.

And the name of that surgery is an anterior cervical discectomy and fusion.

BY MR. BOROWICK:

Q. Dr. Merola, I'm following along in Exhibit 11 in evidence.

Saint Vincent Catholic Medical Center, in your operative report of August 25th, '09.

I may just stop you periodically and ask you what things mean.

"Anesthesia, general endotracheal."

A. Anesthesia, general endotracheal, means that the patient is put to sleep. There is a tube inserted into their trachea, into their lungs so that a machine can breathe for them while the procedure is being done.

Q. Pre-and post-op diagnoses, herniated nucleus pulposus with severe radiculopathy recalcitrant to conservative care and management?"

A. So that's essentially a description of what I had explained in terms of his clinical picture, that is a disk herniation, at C-5,6, that was unable to be made better by any other treatments and therapies, including injections, with a deteriorating clinical course.

Q. Just before we leave the injection, injections into his neck, how long would you expect the relief to last with the injections into the neck?

A. Injections can provide short-term relief or intermediate relief, and it really depends on, depends on the patient, and it depends on the factors that are involved in the inflammatory process.

So patients can get three to six months' worth of relief with injections, sometimes they can even have more relief with those injections.

Q. And that wasn't satisfying to you, to the level that you could avoid surgery even further?

A. That is correct, yes.

Q. Okay.

Take us through the surgery.

A. So this surgery is done by, after the patient is asleep, and they are positioned on an operating room table, we need to make a skin incision over the neck, and we need to do what's called an exposure or a dissection of the cervical spine.

And in order to do that we use some special tools and retractors.

In the upper-right-hand corner of the illustration you can see the trachea and the esophagus, that is the top part of this illustration would be your front side.

The bottom of the illustration would be your back side.

What we do is we make an incision; we open the muscles of the neck; we remove the vital structures away from the cervical spine, the trachea and the esophagus, the jugular vein and the carotid artery, we retract them.

There is a special retractor which holds everything apart so we can work on the disk and on the bones, so exposure is the first part.

After we have an exposure and we have identified the disk, we then set about removing that disk with some special tools, and these tools are called Rongeures.

(Whereupon Sara Stanley was relieved by, Joyce Fisher, as Official Court Reporter.)

A (Continuing.) And they are tools that are designed to remove this material up until we get to that portion of the material that has herniated its way into the spinal canal.

When we're in the neighborhood of the spinal canal, we then need to use some smaller instruments so we make sure we don't damage the spinal cord and nerve roots, and we visually inspect this area. So, we're looking directly at it. And we start to remove this material from within the spinal canal to take pressure off of the spinal cord and the nerve roots.

Q Now that you have the disk completely out, how do you -- by the way, while you're getting the disk completely out, how do you keep the vertebra from collapsing on themselves?

A What we do is we insert two pins, they're basically screws, into the C-5 vetebral body and into the C-6 vetebral body. We attach those screws to a distracter. That is a retractor that pulls the screws apart while they're holding onto the vetebral bodies.

So, they're like -- if the vetebral bodies were popsicles, the screws are like popsicle sticks. And you pull the popsicle sticks apart to pull the bones apart so that while you're working on everything, it doesn't collapse into your field of view.

We then take a drill with a burr attached it to. A burr is a round metallic cutting device that then removes portions of the vetebral bodies, a portion of the vetebral body at C-5 and a portion of the vetebral body at C-6 to accommodate a shim or a cage.

This cage is a device that will physically hold the bones apart so that they don't collapse on each other after I remove the distraction screws. That cage is packed with bone graft. And the reason we pack bone graft in there is we wants the fifth and sixth vetebral bodies to heal together as one vetebral body.

That is the fusion process, and that's the process that ultimately stabilizes this segment and prevents those two bones from moving around.

Q Would you -- could you -- just one second while the stenographer sits down.

And, also, if you could just move away so you don't block anybody as you're explaining the fixation.

A After the cage device inserted in between the bones, the final step in the reconstruction process is to lock that device in place and to lock those bones in place with a metal plate and screws. So that now the entire area that you've operated on is securely held together so that it won't fall apart during the healing process.

Q Has that fused?

A Yes. The C-5/6 segment is stabilized and fixed.

Q And what effect does the fusion of two levels of or two vertebra, what effect does that fusion have on the rest of the spine?

A So, C-5 and C-6 being fixed to each other now in a rigid fashion with a fusion, what that does is it produces an alteration in the way your neck now moves and an alteration in the way normal loads are transferred across the neck.

Q Okay. If you would resume your seat. And, if you need to use the model, please do in your discussion of the changes in the mechanics.

A Sure. The best way to picture this is if you were to take a garden hose, and you were to take one section of that garden hose and hold it with your fist so you would have the hose coming through your fist and you would be holding the bottom part of that hose. And the top part of the hose would flop around right the junction where you're holding it.

So, the plate and the cage act like your hand holding the garden hose. And now what happens is when your neck bends and, when your neck moves, it moves right adjacent to or next to the area where it's held fixed. So that it actually gets an increase in the bending and flexibility above the area that you've fused.

So, there's increased amount of bending and an increased amount of stress and strain in the area above the section that's being held rigidly with your plate.

Q What about below the section?

A The same holds true for below the section.

Q And what effect does that increased activity or stress have on those levels?

A So, this is something that, when we speak about a fusion of a particular segment of your spine, we call an adjacent segment. We call these adjacent segment stresses. And those adjacent segment stresses are increased both above and below the areas where the fusion takes place and that makes those segments more susceptible to wear and tear over time.

Q Now, you had told us in the MRI, and before in your testimony, you had mentioned that in the cervical spine, not only had 5/6 been herniated where it had been bulging and exacerbated with a new injury and an amplification of the old, but you said something about C-4/5 and C-6/7. If those are the levels above and below, the fact that they were herniated, is that of any significance to the progress and the adjacent segment stress?

A Yes.

Q Explain that.

A So, we're fixed at C-5/C-6. We know we have a

disk herniation at 4/5 and a smaller herniation at C-6/C-7. So, those two segments need to be very closely watched as time goes on. And, if those segments start to cause nerve problems, we need to address them and stabilize those areas as well. And that's with a revision or another cervical fusion of those segments.

Q And my client is visit years old now. He's one year postop, post your op, your operation. How is he doing? In other words, was your surgery successful?

A Yes. Surgery for his problem at C-5/C-6, with progressive neurological loss, that progressive loss has been stabilized. So, surgery was effective in preventing further neurologic loss. The concern at this time is the C-4/C-5 segment with C-5 nerve root irritation.

Q How is he -- I'm sorry. Go ahead.

A That's the clinical follow-up since the time of surgery that is most concerning to me at this point in time.

Q Would you describe to the jury how he's done in the last year since surgery, 13 months.

A He's done well. He's healed at the surgical site. He had no postoperative surgical complications. C-5/C-6 are stabilized. He hasn't had any progressive neurologic deficits.

Clinically, he has been having trouble with what we call mechanical axial neck pain. That is, pain in the

neck with neck range of motion. And he has had some symptoms and signs of more C-5 nerve root irritation.

Q But I thought you eliminated the disk at C-5/6, and, therefore, that space that it would go through is forever open?

A C-5/C-6 is, yes, but C-4/C-5 remains as does C-6/C-7.

Q And where is it that the nerve root comes out?

A The nerve roots come -- the fifth nerve root comes out between four and five. So, that root is actually above the area of the fusion at the other disk level.

Q And what are the signs that you're seeing that's in trouble?

A Progressive pain in the neck area with more recent EMG findings that show a C-5 nerve root irritation.

Q What is a bone growth stimulator?

A A bone growth stimulator is an electrical device that's worn outside of the body that stimulates the growth of bone. Ultimately, the procedure that we've done, the fusion portion of the procedure, is to get the body to grow bone in between the fifth and sixth vertebrae.

One of the problems that you can have with any type of fusion surgery is that you might not fuse. And then if you don't fuse, you would have a bigger problem at hand because you have to go back in and re-fuse the lack of a

fusion.

Q But, Dr. Merola, he fused fine; right?

A Yes.

Q So, let's move away from that. This past year, 2010, how many times have you seen him this year?

A Let's see. I've seen him about four times this year.

Q At the six-year mark, say in May, did you see him in May at all of the six-year mark from the accident?

A I did, yes.

Q Tell us how is he doing at six years post accident and eight months post surgery?

A So, in May of 2010, he had some difficulties with his activities of daily living with pain and spasm in the neck and low back, difficulty with repetitive motion, some difficulty with keeping the head and neck in a fixed position for anything in excess of about 15 to 20 minutes, difficulty with bending, lifting, twisting, pushing, pulling, stooping, crawling, sitting or standing for prolonged periods of time.

He was at that point in time teaching four and-a-half hours per week and continued to require activity modifications and restrictions.

Q Now, when you say modification of activities with restrictions, is he able to drive?

A Yes.

Q Is he able to walk?

A Yes.

Q Able to bend down, get dressed?

A Yes.

Q Is he able to do any strenuous demonstrations at the school?

A In terms of strenuous demonstrations, no.

Q Okay. Let's just jump ahead.

And when was your last visit?

A Last visit was on September 10.

Q And would you read us -- read your last note from September 10.

A Sure. September 10 of 2010.

Q Yes.

A "John Mescall returns today, continues to have chronic, severe and unremitting pain. He had neurologic deterioration into the upper extremities since his work injury and required cervical intervention to the neck.

"He manifests signs and symptoms of adjacent segment pain at C-4, C-5 and C-6, C-7 with proximal and distal radiculopathic patterns.

"Surgery was undertaken to prevent further neurological deterioration at the most symptomatic segment."

And John and I at that time, September 10, 2010,

had discussion regarding adjacent segment complaints, and an EMG was done with Dr. Hausknecht and I recommended that he continue pain care with Dr. Perper.

Q The EMG, how did that turn out or did he have it yet?

A He had an EMG -- well, he had had an EMG in May of 2010, which I did have an opportunity to take a look at.

Q And what did it show?

A That particular EMG which was done May 19 of 2010 showed that there was a C-5, that is, the nerve root above, and C-6 radiculopathy.

Q Would you tell the jury the changes in his spine, the cervical spine, do you have an opinion as to whether or not they're permanent?

A Yes.

Q And what is your opinion?

A That those are permanent changes.

Q And what about his prognosis.

With a reasonable degree of medical certainty, he's 50-years old, he's got a life expectancy of another 27 years, what's it going to be like -- what's his neck going to look like over the next 27 years with reasonable medical certainty?

A Reasonably over the next number of years, the neck will continue to have problems at that C-4, C-5 and C-6, C-7

segment. So, over time that neck is going to get worse.

Q Do you have an opinion as to whether or not he will need revision surgery or additional fusions at those levels?

A Yes.

Q And what is your opinion?

A That he will require additional surgery in those adjacent segments.

Q Now, have you conferred with Dr. Root with regard to future medical care that he'll need?

A Yes.

Q And have you -- was that in one conversation or more than one conversation?

A More than one conversation.

Q Now, is he getting -- how about his back?

Is his back getting better, getting worse or static?

A The low back has essentially been static.

Q Do you know whether or not he is continuing to teach at the apprentice school?

A He is no longer teaching.

MS. CAMACHO: Objection, objection.

THE COURT: Sustained.

Q I want you to assume that John Mescall in April -- in May of '04 was a ornamental iron worker working full time

out of Local 580. I want you to assume that his job was strenuous with heavy lifting, carrying, climbing, required standing, squatting and all the exertional movements, and that he was doing it full time, full duties.

Now, he was doing it five to six days a week and seven hours a day.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not over the last six and-a-half years that you've been treating him, he's ever been able to do that kind of work?

A I do have an opinion.

Q What's your opinion?

A That he's unable to do that work.

Q Can he do it now?

A No.

Q Do you have an opinion as to whether or not he could ever resume that kind of work?

A I do have an opinion.

Q What is your opinion?

A That he would not be able to resume that kind of work.

Q And what is your opinion with a reasonable degree of medical certainty as to whether or not he can do any manual labor full-time job?

A He would not be able to perform manual labor on a

full-time basis.

Q Let me ask you about sedentary work.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not, given his condition, his prognosis, his medication, his physical therapy regimen, as to whether or not he could retrain and ultimately sustain a full-time sedentary job which would involve sitting, standing, maybe filing, below or above his head; could he do that on a full-time basis?

A Not on a full-time basis.

Q I want you to assume that he, at the time of his accident, had a four-year old and a 14-year old with whom he had been an active dad. He was a home owner and he did modifications of his home and maintenance chores around the home including climbing ladders to do the gutters, and raking and doing landscaping in the back.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not he could ever resume those homeowner type activities?

A He would not be able to resume those types of maintenance activities to the home, no.

Q Okay. Can he drive his kid to school?

A Yes.

Q Can he go to the beach and sit on a chair?

A Sure.

Q Can he walk on the beach for some period of time?

A Yes.

Q Could you tell us with regard to his pain levels, even giving him the medication that he's on, is that a cure for the pain or does it provide temporary relief?

A The medications are symptomatic treatment or temporary relief for the pain.

Q And, with regard to the injections, is that going to do any structural change, or remediation of the structural damage or is that a temporary fix?

A Yes. The injections are not going to change the structure, and they're also something that provides a temporary decrease or amelioration of complaints and symptoms.

MR. BOROWICK: I have nothing further.

THE COURT: All right.

Jurors, why don't you take five minutes to stretch, use the restroom.

Make your file available to Ms. Camacho.

Try to get back as quickly as possible, jurors.

THE COURT OFFICER: All rise. Jury exiting.

(Recess.)

THE COURT OFFICER: All rise. Jury entering.

(The jury entered the courtroom.)

THE COURT: Okay. Everybody, have a seat. Go ahead.

CROSS-EXAMINATION

BY MS. CAMACHO:

Q Good afternoon, Dr. Merola.

A Good afternoon.

Q My name is Andrea Camacho. I represent Structure Tone.

I'm going to ask you a couple question this afternoon.

You indicated that your first exam of Mr. Mescall was on May 10, 2004; correct?

A Yes.

Q And at that point, you did a physical exam as part of the whole exam?

A Yes.

Q And did you examine his gait at that time?

A Yes.

Q And tell the jury how did you examine his gait?

A Observational.

Q And what does that mean?

A It means you watch the patient walking in and out of the examination room or up and down your hallway.

Q And you did that in this case on May 10?

A Yes.

Q And what were your observations?

A That he had what's known as bilateral heel-toe reciprocal gait.

Q What does that mean?

A That means he was walking with -- that's essentially a normal gait pattern. That's heel strike to toe off with both legs.

Q Any abnormality at that time?

A Only some assistance required to get him on and off the examination table.

Q And was that because his arm was in a sling and he had a fractured collarbone?

A In addition to the back pain and spasm.

Q But nothing to do with his feet?

A I'm sorry.

Q Nothing to do with his feet?

A Correct.

Q And then you did an inspection, and I believe you told the jury on direct examination that you found multiple abrasions, and swelling and bruising?

A Yes.

Q Correct?

A Yes.

Q And I believe you told them you found it about the head, the neck, the shoulder. Can you show me where on your

report it indicates you saw abrasions about his head.

A Sure. Let's see. The inspection section demonstrates multiple abrasions, swelling and ecchymosis over the left-sided portion of the neck, shoulder, clavicle, back, chest and lower back.

Q Right. Can you show me where it says head.

A I'm sorry. It does not.

Q It does not. So, you made a mistake earlier when you told the jury there was bruising, and swelling and abrasions on his head?

A Correct.

Q If you had found any bruising, or swelling or abrasions on his head, you would have indicated in your report at that time; correct?

A Yes.

Q And you didn't find any five days after the accident; correct?

A Not that I noted, no, correct.

Q Now, you're an orthopedic surgeon; correct?

A Yes.

Q What's the difference between orthopedics and neurology?

A Orthopedics and neurology?

Q An orthopedic surgeon versus a neurological surgeon, a neurosurgeon.

A Yes.

Q What's the difference?

A The major difference is that a neurological surgeon's training is essentially with the brain and brain surgery, and an orthopedic surgeon's training is with the musculoskeletal system.

Q Meaning the bones?

A The bones, joints, ligaments, tendons.

Q A neurosurgeon deals with the brain and the spine and the nerves coming out of the spine; correct?

A Yes. They deal with the central nervous system.

Q What does the central nervous system consist of?

A Central nervous system is the brain and the spinal cord.

Q So, when you indicated before a neurosurgeon deals with surgery to the brain, it also includes surgery to the spine. That's the whole central nervous system; correct?

A It does, but there are training centers around brain pathology, that is, brain surgery intervention.

Q What does neuro mean?

A Neuro means neurologic, that is, nervous system.

Q And the spine is part of the nervous system; correct?

A The spine is actually part of the musculoskeletal system when we look at the bones, and the ligaments, and the

tendons, and the joints, and the disks and the nerves, because you have nerves in your extremities as well. So, orthopedic surgery --

Q The spinal cord, the spinal cord.

A The spinal cord is a portion of the central nervous system.

Q Now, you indicated that you treated his spine fractures, Mr. Mescall's spine fractures; is that correct?

A I treated his neck and back injuries, correct.

Q Did you treat the left transverse T-1 and T-2 fractures?

A Those were treated basically non-operatively with observational care.

Q Can you indicate to me what treatment, if any, that you provided Mr. Mescall for the T-1 and T-2 fractures.

A Well, observational care means there is no active treatment other than the active modifications and restrictions we placed him on and the physical therapy.

Q Okay. And what treatment did he receive for those fractures in the hospital?

A For these --

Q T-1 and T-2 left transverse process fractures.

A The medications that he received, the sling that he was in on his arm, and his activity modifications and restrictions.

BY MS. CAMACHO:

Q. Those fractures ultimately healed?

A. Yes.

Q. And approximately, when, based upon your observations had they healed?

A. In general, those fractures were healed somewhere in the neighborhood of about six to 12 weeks, so the fractures themselves would be mended.

Q. Is there any indication in your report, sir, in all the treatment that you provided, that those fractures did not heal in six to 12 weeks?

A. No.

Q. Any complications as a result of those fractures?

A. No.

Q. Now, when you first saw Mr. Mescall on May 10th, did you take a history regarding prior neck and back injuries?

A. No.

Q. Is that something you normally do with your patients?

A. If I saw a patient in the absence of the significant trauma that he sustained, I would take a preexisting back and neck history but given the trauma he sustained, I was quite concerned with treating his present injuries.

Q. Well, when did you become aware that he had prior neck and back problems?

A. Upon reviewing medical records.

Q. And when was that?

A. I can't tell you the exact date, but I know that I did review them quite sometime ago, but I don't remember the exact date that I saw them.

Q. Who provided those to you?

A. Those were provided to me by the attorney.

Q. I'm sorry. Could you push the mike away from you?

A. Sure.

The attorney's office.

Q. Mr. Mescall's attorney's office?

A. Yes.

Q. I believe Mr. Borowick said you had testified many, many, times before on behalf of their clients?

A. I have testified previously on behalf of their clients, yes.

Q. When he said, many, many, times you agreed with that?

A. Well, I've been doing this for 13 to 15 years.

So over the course of those years, I would say it's more than four or five times, yes.

Q. I believe what Mr. Borowick asked you was, you responded to affirmatively to, was many, many, times.

Are you changing your testimony now?

Is it not many, many times had?

A. I don't know what number, "many, many," would be.

I would not disagree with the fact I testified

previously.

Q. When Mr. Borowick asked you if you had testified many, many times, here you said you had testified four or five times, you just answered in the affirmative. Correct?

A. Yes.

Q. Now, you've treated a lot of ironworkers?

A. I have, yes.

Q. Worked on a lot of cases with Dr. Hausknecht?

A. I have worked with Dr. Hausknecht, yes.

Q. Testified in cases where Dr. Missun, the economist has testified?

A. Yes.

Q. And that was also cases that ironworkers that were represented by Sacks and Sacks?

A. Yes.

Q. Now, after May 10th 2004, when was the next time that you saw Mr. Mescall?

A. Next saw him on October 11th of 2004.

Q. Now, when you first saw Mr. Mescall, he was, it was five days post injury. Correct?

A. Yes.

Q. He had a clavicle fracture that was causing him pain?

A. Yes.

Q. And rib fractures that were causing him pain?

A. Yes.

Q. When you saw him in October, had those bone injuries healed at that time?

A. I wasn't really paying attention to those boney injuries since they were under the auspices of my associate, Dr. Touliopoulos, basically following him for his neck and his back.

Q. So you don't know?

A. I don't know whether or not those fractures had healed at that time, no.

Q. Okay.

When you next saw him on October 11th, did you do a physical exam?

A. Yes.

Q. And what was, what did your physical exam consist of?

A. It consisted of once again the basic physical exam, which is inspection and then physical examination of his body.

Q. And I missed the first part?

A. Inspection, an inspection of the patient, the initial inspection, inspection.

Q. What did that initial inspection consist of in October of 2004?

A. Well, it was, he was well dressed, well nourished, and in a minimal amount of distress.

Q. Did you watch him walk?

A. Yes.

Q. And what were your observations at that time?

A. There were no significant observations with respect to gait.

Q. Which means he was walking normally in October?

A. Yes, and without a change from his prior exam.

Q. And what other observations did you make of him during that physical exam in October of 2004?

A. That he was alert and oriented times three; and that his mentation and affect were appropriate.

Q. And did he make some complaints to you regarding -- withdrawn.

Did you ask him how he was doing?

A. Yes.

Q. And at that time in October of 2004, what did he tell you?

A. At that time he was pending treatment of the left shoulder.

Q. My question to you was, what complaints did he make to you at that time?

A. I'm just giving you the history that he gave to me at that time.

Q. I want to know what physical complaints, Do you have?

A. Headaches, severe neck pain, low back pain, left upper extremity and left shoulder area pain with difficulty of activities of daily living.

Q. Okay.

Now you weren't treating him for headaches, were you?

A. No.

Q. But when you asked him how he was, he told you he had headaches. Correct?

A. Yes.

Q. So you wrote it down. Correct?

A. Yes.

Q. You weren't treating him for his shoulder pain. Correct?

A. Correct.

Q. But when you asked him how he was, he told you he was having some left shoulder pain. Correct?

A. Yes.

Q. So you wrote it in your report?

A. Yes.

Q. Did he indicate to you at that time he was having any problems with his ankles?

A. No.

Q. Because if he had, you would have written it down correct?

A. Yes.

Q. So in October, some five months after the accident when you asked him how he was, he didn't indicate to you that he was having any problems with ankle pain.

Correct?

A. None that I know of noted, no.

Q. And you made an observation of him walking. Correct?

A. Yes.

Q. And he was able to heel-toe walk up and down the hallway in and out of your office without any problems. Correct?

A. Yes.

Q. Normal gait. Correct?

A. Yes.

Q. Now, what -- the complaints that he made to you of neck pain and low back pain those were subjective complaints. Correct?

A. Yes.

Q. What objective observations did you make with regard to his neck and back in October of 2004?

A. Range of motion examination.

Q. Okay. And with regard to his neck, what objective tests did you do to determine that there was a limited range of motion?

I assume you found a limited range of motion. Correct?

A. Yes.

Q. And you did some type of test?

A. Yes.

Q. And what kind of test did you do?

A. It's a range of motion test whereby you have the patient perform a range of motion, and you palpate the muscles that are adjacent to the spine during range of motion.

Q. Is there some subjective aspect to that as well?

A. When you do the test in combination of palpation, you remove the subjective aspect of the range of motions.

Q. What did you find with regard to the cervical range of motion in October of 2004?

A. Significantly diminished cervical spinal range of motion; most notably with right-lateral rotation and left lateral bending.

Q. What is significantly diminished?

Withdrawn.

There are ways to actually measure how much loss of motions there is. Correct?

A. Yes.

Q. And how do you do that?

A. There are. You can determine an absolute range of motion based upon degrees, or you can qualitatively examine the range of motion whereby you would assign it a qualitative function such as the term, "significant."

Q. How would you do it with regard to degrees? Is there some kind of apparatus you have in your office that allows you to do that?

A. Yes.

Q. What's that called?

A. A goniometer, g-o-n-i-o-m-e-t-e-r.

Q. Tell the jury what that is?

A. Goniometer is basically a protractor whereby there are angular measurements on the circle, and any body part that you take through range of motion, you can compare that body part on the goniometer to tell you what the range of motions degree is.

Q. You have one of those in your office?

A. Yes.

Q. And you use it sometimes?

A. Yes.

Q. But you didn't use it in October when you were measuring Mr. Mescall's cervical range of motion. Correct?

A. Correct.

Q. You just determined that it was significant?

A. Yes.

Q. Correct?

A. Correct.

Q. Do you have in your mind a number of degrees that is significant versus moderate or mild?

A. Well, having done this for 15 years in examining probably about 100,000 patients, I have a clinical sense of what I would consider significant, yes.

Q. And what is that?

A. "Significant," would be that range of motion which is below the functional limit for the cervical spine.

And so I could take you through the different ranges of motion to let you know how we can clarify that.

The functional range of motion for the cervical spine would be something you would require in order to turn to the side or look around you, or to look up or down.

In the event you would not be able to do that, that would, would be qualitatively defined as a significant restriction in range of motion.

Q. Now, what other objective findings were there other than that the limited range of motion was found in October of 2004?

A. There was a sensory and motor examination of the upper extremities that was conducted.

Q. And what objective findings were there that were abnormal at that time?

A. There was a positive compression maneuver, and what's known as a positive Spurling sign.

Q. Anything else?

A. With respect to the neck?

Q. Yes?

A. There was tenderness to palpation in both the cervical, upper and lower cervical upper thoracic region.

Q. That is a subjective response with the plaintiff

telling you it hurts when you touch it. Correct?

A. No, that's actually a palpation of spasm and correlating it with that tenderness.

Q. Not only did the patient tell you it hurt, but you felt some spasm at that time?

A. Correct.

Q. You have plaintiff telling you his neck hurts. Correct?

A. Yes.

Q. You've got your testing range of motion and finding a limited range of motion in the neck. Correct?

A. Yes.

Q. With you finding a positive compression, positive Spurling sign?

A. Correct.

Q. You have some muscle spasm. Correct?

A. Yes.

Q. That's something you felt?

A. Yes.

Q. Anything else?

A. With respect to the neck, that essentially summarizes the neck findings.

Q. So those are the objective findings with regard to the neck.

What about with regard to the lumbar spine?

A. The lumbar spine demonstrated a decreased lumbar and lumbosacral range of motion.

Q. What was the decrease? Withdrawn.

Did you test the lumbar spine with the goniometer? What did you call it?

A. Goniometer.

Q. Goniometer, did you test it with that or did you just do a kind of eyeball?

A. Qualitative assessment of range of motion.

Q. That was based on your observations?

A. Correct.

Q. And you have, I think in your report, a decreased range of motion. Correct?

A. With reversal of lumbar lordosis upon ascent.

Q. How much loss of range of motion do you have?

A. A decreased range of motion.

Q. What does that mean?

A. Abnormal motion.

Q. Is it mild?

A. Doesn't matter.

Q. Well, I'm asking, was it mild?

A. Well, I have it listed as a decreased range of motion.

I didn't give it a, mild, moderate, or severe.

I can tell you it was accompanied by something called as a loss of lumbar lordosis, with a reversal of lordosis upon

ascent, that is an objective finding demonstrative of lumbar dysfunction.

Q. Well, we will get back to the disk issue in a minute.

Right now, what I'm trying to determine is based upon your notes and your examination, can you tell this jury within a reasonable degree of medical certainty what Mr. Mescall's limited range of motion was on his lumbar spine in October of 2004?

A. I can tell you that he had a decreased lumbar range of motion.

Q. But as you sit here today, can you tell them whether it was mild or moderate, or what was the cervical significant?

A. No, I cannot give you that determination.

Q. It was just abnormal. Correct?

A. Yes.

Q. Now, do you know whether or not Mr. Mescall ever injured his lumbar spine prior to this accident?

A. Yes. There are some records that indicate he has had some low back problems in the past.

Q. And, did you ever view any MRI's of his lumbar spine that were taken prior to this accident?

A. There were no films available, but I think that in some reports there was something about some degenerative or mild degenerative changes to the lumbar spine.

Q. That's all you recall?

A. Yes.

Q. Were you ever given records of Mr. Mescall's treatment by his attorney following his 1989 accident?

A. Yes.

Q. And what records were you given?

A. I don't have them here off hand.

Q. Do you have them in your file?

A. No, they are not in my file.

Q. You brought files -- I thought you indicated earlier that you brought Mr. Mescall's file with you to court. Correct?

A. This is Mr. Mescall's treatment file, correct.

Q. But there were other things that you looked at that you didn't include in this file?

A. Well, this is a treatment file. This is the file that I use in order to treat the patient in my office.

Q. Do you keep a list of what Mr. Mescall's attorneys provide you prior to giving your expert opinion to this jury?

A. I have provided my expert opinion based upon my review of all of his medical record as provided to me.

Q. Okay. Well, I'm asking you now to tell this jury what medical records you reviewed following his 1989 accident?

A. I don't have the list of medical records with me, but I can tell you that I did review his medical records. I would not be up here giving you causation.

Q. Do you know whether or not you reviewed the record filed with the '89 accident?

A. I believe I reviewed the complete medical record of Mr. Mescall in order for me to give you an opinion regarding causation.

Q. That would solely depend upon what you were given from his attorney. Correct?

A. I was provided with his medical record.

Q. Now, did you see an MRI film taken of Mr. Mescall following the 1989 accident?

A. Not that I recall, no.

Q. Did you see -- let's go through this.

Did you see records from Intercontinental Medical Care and Diagnostics?

A. From what year, please.

Q. That would have been from 1995?

A. Can I take a look at the document and refresh my memory?

THE COURT OFFICER: (Handing.)

THE WITNESS: (Reviewing the records.)

Yes, I'm sorry.

Q. Does that refresh your recollection as to whether or not you reviewed records from Intercontinental Care and Diagnostics?

A. Yes, as they relate to prior injuries. I do recall

reviewing records regarding his prior injuries, yes.

Q. And they indicated a prior -- withdrawn.

Did you review records from an orthopedic surgeon Dr. McMahon?

A. As far as I can recall, yes.

Q. And a neurologist and pain specialist Dr. Beasley?

A. As far as I can recall, yes.

Q. And based upon your review of those records, they had suggested that Mr. Mescall undergo injections to his lumbar spine.

Correct?

A. In 1995, yes.

Q. That was following the injury to his lumbar spine?

A. Yes.

Q. And it also indicated that he had an MRI of his lumbar spine back in 1994. Correct?

A. Yes.

Q. Now, you indicated that there was another objective finding with regard to his lumbar spine. Correct, that you had testified about before?

A. Yes.

Q. What was that objective finding?

A. It's called a reversal of lumbar lordosis upon ascent?

Q. What does that mean?

A. It means a loss of the normal lumbar curvature in the

lower back, particularly when arising from a seated position.

Q. So straightening up the normal lumbar lordosis?

A. Correct.

Q. When you reviewed the records of Intercontinental Care and Diagnostics, you noted then that when they did the MRI in 1994, they found a straightening of the normal lumbar lordosis. Correct?

A. Yes.

Q. They found disk degeneration at L4/L5, L5/S1, L5, S1?

A. Correct.

Q. They also found a herniation at L5, S1. Correct?

A. Yes.

Q. Did you ask to review the film that showed these findings?

A. Yes. As far as I know, that film is not available and/or has been lost since 1994.

Q. You asked to see it, and you weren't provided with it?

A. Yes, I believe there is no film from 1994. I don't think that film is available.

Q. But there was a finding back in 1994 of normal straightening of the normal lumbar lordosis in the lumbar spine. Collect?

A. Yes.

Q. That's the objective finding you found in October of 2004. Correct?

A. Actually, they are different. That's an MRI finding and this is a clinical examination finding.

Q. Then your clinical findings would correlate to the MRI done in 1994. Correct?

A. The clinical finding would, is actually a little bit different because it is a reversal of lumbar lordosis, it's a motion examination whereas the MRI is not a motion examination.

Q. And I believe you said you also saw that there was a herniation at L5, S1 -- remind me where did you find the herniation when you did the film in 2004?

A. There were herniations at three, four, four, five and five, one.

Q. Now, you also saw the records of a Dr. Sarala Devi, from January of 2006.

A. Yes.

Q. Did you review that?

A. Yes.

Q. And it was her impression that he had a disk herniations at L4, L5 and L5, S1. Correct?

A. Yes.

Q. And she found lumbosacral, radiculopathy what is that?

A. That's a nerve problem with the roots going into your lower legs.

Q. And I think you testified on direct examination that once you have nerve damage it's permanent. Isn't it correct?

A. Once you have a verifiable nerve damage, that nerve damage is unlikely to get any better, yes.

Q. And she also found cervical and lumbosacral paraspinal muscle strain. Correct?

A. Yes.

Q. Now, other than the straightening of the lumbar spine and the limited range of motion that we are not sure what it is, what other objective findings did you report -- withdrawn.

What other objective findings did you discover in October of 2004 with regard to the lumbar spine, Mr. Mescall's lumbar spine?

A. That was it, with respect to the lumbar spine.

Q. Okay.

So with respect to the lumbar spine, he made some complaints of low back pain.

Correct?

A. Yes.

Q. And you found when you palpated his back that there was some straightening of his spine.

Correct?

A. Yes.

Q. And you found some limited range of motion.

Correct?

A. Yes.

Q. And that was it?

A. Yes.

Q. And when was the next time you saw him?

A. November 29th of 2004.

Q. And when you saw him on November 29th, 2004, did you do a physical exam.

A. Yes.

Q. Did you make some physical observations of Mr. Mescall?

A. Yes.

Q. And what were your physical observations of Mr. Mescall in November of 2004?

A. At that time his physical examination was essentially unchanged from the prior exam, and I indicated that he had no pathological reflexes.

Q. So let's go to, "No changes." That meant you observed his gait?

A. Yes.

Q. You watched him walk?

A. Correct.

Q. And he walked the same way, heel-tow, heel-toe heel-toe, in and out of the examination room, up and down the hallway?

A. Yes.

Q. Any abnormality?

A. None that I've noted, no.

Q. Any limping?

A. Not that I've noted, no.

Q. If you saw any abnormality, would you have included it in your report?

A. If I had seen some significant abnormalities, I would have, yes.

Q. It would have to be significant for you to put it down?

A. That's what we would call a significant pertinent finding, yes.

Q. It would have to be something abnormal. Correct?

A. It would have to be something that would make me want to investigate something neurologically, yes.

Q. If he had been limping, would you have put it down?

A. If he had a severe limp, I would have put it down.

Q. If he had a moderate limp, would you have put it down?

A. If he had a moderate limp, most likely yes.

Q. If you noticed him limping in any manner that was abnormal, you would have put it in your reported, that would have been a positive finding that you would have put it in your report?

A. Yes.

Q. And it's not there. Correct?

A. Yes.

Q. Now, "No pathological reflexes are appreciated." What

does that mean?

A. That's when you do your neurological examination, a pathological reflex, something indicates a deteriorating neurological course, so he had no deterioration in his neurological course.

Q. His reflexes were working at that time. Correct?

A. Yes.

Q. No atrophy?

A. Correct.

Q. No problem with reflexes at that time, no atrophy at that time?

A. Yes.

Q. He made some complaints to you about pain?

A. Yes.

Q. What complaints did he make?

A. Let's see.

Continued to remain symptomatic with respect to the neck and the back, as well as his left shoulder.

Q. Okay. So you asked him how he was doing, which is what you generally do when you are about to start an exam normally with patients. Correct?

A. Yes.

Q. And whatever the patient tells you with regard to complaints, you include in your report. Correct?

A. Yes.

Q. And on November 29th 2004, when you asked Mr. Mescall how he was doing he indicated that he had some pain somewhere?

A. Yes.

Q. And that was in his neck. Correct?

A. Correct.

Q. Did he indicate at that time that he was having any lower back pain?

A. There was no change in the low back pain.

Q. Where does it say that?

A. Okay. He has herniated disks in the neck and continues to remain symptomatic with respect to the neck as well as the other injuries he suffered.

Q. Okay. Did he make any complaints to you at that time about his ankle?

A. No.

Q. What, if any, objective findings did you see at that time with regard to his lumbar spine?

A. No changes with respect to the lumbar spine from my last visit.

Q. Where does it say that?

A. "With respect to today's visit, the left shoulder remains unstable, he continues to manifest signs and symptoms of left shoulder radiculopathy, left upper extremity radiculopathy, no pathological reflexes are appreciated."

So there were no other changes in the exam with

respect to his neck or back.

Q. You looked -- the first thing you said with respect to the left shoulder, "The left shoulder remains unstable." Correct?

A. Yes.

Q. You looked at his left shoulder, and it was not stable?

A. Correct.

Q. Then you said, "He continues to manifest the signs and symptoms of an upper -- left upper extremity radiculopathy. Correct?

A. Correct.

Q. You somehow tested -- withdrawn.

Radiculopathy, with regard to the upper extremities comes from the neck. Correct?

A. Yes.

Q. You did some testing with regard to numbness or tingling or pain that was radiating from the neck down into his arms and hands. Correct?

A. Yes.

Q. And what signs and symptoms did he manifest at that time?

A. The same signs and symptoms that he manifested prior to that, which were compression maneuver, and Spurling sign.

Q. You didn't include that in his report?

A. No, because the follow-up report would note any significant changes from previous.

He was essentially status quo with respect to the neck and back.

Q. You said you've been doing this a long time. Correct?

A. Yes.

Q. Thousands of patients; testified many, many times for Sacks and Sacks.

They are not the only patients you testified for?

A. I have testified on behalf of my patients, yes.

Q. You had to come to court many times?

A. I've been to court before, yes.

Q. Many, many, times that's? What you testified to on direct examination?

A. Yes.

Q. Okay. So you know that your reports go to defense attorneys when there is litigation. Correct?

A. Yes.

Q. And you are asked about what you did at the time. Correct?

A. Yes.

Q. And these reports, you -- obviously you don't have an independent recollection of examining Mr. Mescall, correct, on November 29th 2004. Correct?

A. No, but I have my office note.

Q. Right. And there is nothing in this office note to indicate that you did the Spurling test. Correct?

A. It's my usual custom and practice, when treating patients from an orthopedic reconstructive spinal point of view, that we compare our exam on any given date to the exams that have gone before, so what we do is we put down pertinent changes and findings.

During any given day I'm seeing a number of patients, and my job is to point out in my notes for treatment purposes what those changes are, and what our treatment plan is.

Q. Okay. Now this just says, "He continues to manifest the same signs." Correct?

A. That is correct, yes.

Q. There is no indication that's just the same signs and symptoms with regard to a radiculopathy. That's what you wrote. Correct?

A. Yes.

Q. There is nothing in there with regard to range of motion. Correct?

A. That's correct.

Q. Muscle spasms?

A. That's correct. That is not in the note.

Q. Okay. And then the next thing that you say is, "There is no pathological reflexes are appreciated." Correct?

A. Yes.

Q. Which again means his reflexes were fine at that point?

A. Which basically means I don't have to operate on him, and we should continue present care and management.

Q. Anything in here with regard to the signs and symptoms of a radiculopathy with regard to the lumbar spine at all, anything?

A. "There are no changes with respect to the lower back."

Q. Does it say that?

A. That's I'm here for, I'm here to testify as to what these notes mean, to interpret them for you.

There are different levels of examination and different levels of note taking.

This happens to be a brief encounter and a brief visit to make sure that Mr. Mescall has not progressed, a neurological deficit.

Q. My question is, however, is there anything in this note to indicate that he stayed the same?

(Whereupon Sara Stanley was relieved by, Joyce Fisher as Official Court Reporter.)

Q His shoulder remained the same; correct? It didn't change?

A The shoulder wasn't stable, yes.

Q And that was consistent with how it would have been in the prior visit; correct?

A Yes.

Q And you wrote that down in your note, correct, with respect to the left shoulder?

With regard to the left shoulder, it remained unstable. It didn't change from the prior visit; correct?

A Correct.

Q And that's what you wrote in your note. That with respect to today's visit, the left shoulder remained the same, unstable, remained unstable; correct?

A Yes.

Q No change; correct?

A Correct.

Q He continues to manifest the signs and symptoms of a left upper extremity radiculopathy; correct?

A Yes.

Q Nothing had changed; correct?

A Correct.

Q And that's what you put in your note; correct?

A Yes.

Q And there was no pathological reflexes

appreciated. Again, that's the same as the visit before; correct?

A Yes.

Q And that didn't change there; correct?

A Correct.

Q Okay. Now, after November 29, 2004, when is the next time you see him?

A February 7 of 2005.

Q Okay. When you see him on February 7 of 2005, do you do a physical exam?

A Yes.

Q And do you make observations with regard to his gait?

A Yes. There were no changes in his gait pattern.

Q Which means he's still heel-toe walking normally in and out of your examination room, up and down the hallway with no complaints; correct?

A With nothing that I need to note in terms of a change. That is correct, yes.

Q Did you ask him how he was doing at that point in February of 2005?

A He was getting over reconstructive surgery of the left shoulder, yes.

Q My question was did you ask him how he was doing?

A Yes.

Q And did he tell you how he was doing?

A Yes.

Q And, when he told you how he was doing, did he make any complaints to you with regard to his ankles?

A No.

Q Did he make any complaints to you with regard to his lumbar spine?

A No new complaints, no.

Q No new complaints.

He had just had an arthroscopic procedure on his left shoulder?

A Yes.

Q And he was recovering at that time from that procedure; correct?

A Yes.

Q And he was having neck pain?

A Yes.

Q What objective findings did you perceive at that time with regard to Mr. Mescall's cervical spine?

A He had a neurologic examination.

Q And what objective findings were there with regard to his cervical spine in February of 2005?

A His neurologic status remained stable.

Q Which meant his -- no evidence of nerve damage?

A No evidence of any progressive nerve damage,

correct.

Q No atrophy?

A That's correct.

Q What objective evidence was there at that time? What objective findings when you examined him on February of 2005 were there? Any muscle spasms, any limited range of motion, anything like that?

A He continues to manifest difficulties with the neck and back, and he continued to have his physical findings that were consistent with injuries to the neck and back, including cervical radiculopathy.

Q What was the -- what limited range of motion did he have with regard to his neck at that time?

A It was eventually unchanged from prior exams.

Q Was it moderate at this point?

A Unchanged.

Q So, you're telling the jury in February of 2005, it was -- he had a significant loss of range of motion of the cervical spine?

A Yes, particularly after the shoulder surgery, yes.

Q And did you include that in this note?

A No. Once again, this is a brief encounter note with a neurological follow-up to determine whether or not he required emergent surgery. And he did not. He remained neurologically intact and stable.

Q Did you palpate the muscle spasms?

A Once again, yes, without any changes noted from any prior visits.

Q Now, your next visit in March of 2005, does he make any complaints to you with regard to his lumbar spine?

A No basic changes in his clinical situation with respect to the neck and back.

Q My question is, did he make any complaints to you with regard to his lumbar spine on March 21, 2005?

A Once again, he made no significant complaints with respect to the back that hadn't been made before. So, there were no changes in his findings.

Q Well, I think the first sentence is he continues to remain symptomatic with respect to his neck and shoulder.

Were there any changes with regard to the complaints he was making regarding his neck and shoulder?

A The neck and shoulder were the most predominant problem. And his neck was far more of an issue than the lower back was. So, if there had been any significant changes with respect to the lower back, I would have noted them, but there weren't.

Q Were there any changes in his complaints with regard to his neck from February of 2005 until March of 2005?

A He continued to have persistent neck pain.

Q Okay. Did he continue -- withdrawn.

He also told you that he continued to have persistent shoulder pain; correct?

A Yes.

Q And you wrote down that he complained of persistent neck and shoulder pain; correct?

A Yes.

Q But you didn't include anywhere that he complained of lumbar back pain at that point, did you?

A No, not on that note.

Q No. Okay. And, if he had complained about lumbar -- persistent lumbar pain at that point in March of 2005, you would have included that in your note; correct?

A If there was a significant change in the lumbar condition, I would have put that in my note, yes.

Q Well, if there was a complaint of persistent pain, you would have included that; correct?

A The notes once again reflect my treatment. And my primary treatment at this time was with respect to his neck and to make sure that his neurologic status was not progressive. His neurologic status was not progressive. He essentially remained the same. From a surgical point of view, we continued observational care and management.

Q Would you just do me a favor and push the mike. Thank you.

You asked him how he was doing like you had every other time when he came in for the exam?

A Yes.

Q And, if he had indicated to you that he was having persistent pain in his lumbar spine, you would have included that in your note; correct?

A If there were significant changes, yes.

Q If he had made that complaint, you would have put that in your note; correct?

A Yes.

Q Thank you.

And you continued seeing him through 2005. And he continued to complain of neck pain; correct?

A Yes.

Q And let's go to November of 2005. Because I think that's the next significant report that you have in your file; correct?

Those are just follow-up notes?

A November 14, 2005?

Q Yes.

A Yes.

Q And what complaints did he make to you at that time?

A Severe unremitting cervical pain with pain going into both upper extremities, left side worse than right.

Q So, he was having some radiculopathy issues at that point; correct?

A He was having progressive radiculopathic issues at that point in time.

Q He was having pain that traveled from his neck down through his arms; correct?

A Yes.

Q And what complaints did he make to you at that time regarding his lumbar spine?

A No changes with respect to the lower back.

Q There's no indication in this note that he made any complaints to you regarding his lumbar spine; correct?

A That's right, yes.

Q And you did a physical examination; correct?

A Correct.

Q You watched him walk?

A Yes.

Q And, again, he was able to heel-toe walk with no difficulty; correct?

A Yes.

Q At this time, you again noted a diminished cervical range of motion; correct?

A Yes.

Q That hasn't changed. But you include it in your note; correct?

A Yes.

Q And there was a positive compression maneuver?

A Yes.

Q Correct? And that had stayed the same the whole time?

A Yes.

Q But on this day, you decided to include it in your note?

A Yes.

Q Any complaints with regard to his ankles?

A None that I've noted, no.

Q Any objective findings that you included in this note with regard to his lumbar spine?

A No.

Q Now, let's go to January of 2006.

January of 2006, what -- now, we're a year and-a-half after the accident about?

A Yes.

Q What complaints did he make to you in January of 2006?

A Let's see. Bilateral ankle pain, shoulder pain, severe and unremitting neck pain.

Q Anything about any lumbar pain?

A No.

Q But he told you he was having some problems in his

ankle, correct, ankles bilateral, both ankles?

A Yes.

Q And, when he told you that in January 16, 2006, you again did a physical examination; correct?

A Yes.

Q And this time you had a positive finding a year and-a-half after the accident; right?

A I'm sorry. A positive finding?

Q Yes.

A With respect to?

Q His ankles.

A He had somewhat of an antalgic gait pattern, yes.

Q So, he started to limp in January of 2006; correct?

A His gait is bilateral heel to toe reciprocal, although antalgic, yes.

Q That means he's limping; right? That's what antalgic means?

A Antalgic means diminished stance phase into the legs, yes.

Q Can you, in lay terms, explain that to the jury.

A It means you spend less time on one leg than the other.

Q If you're watching somebody spend less time on one leg than the other, it kind of looks like a limp, right, an

abnormal walking?

A Yes. It looks like they're favoring one leg over the other or, in this case, if it's bilateral, it almost may look as though they're trying to hurry their gait.

Q And you had never seen that before; correct?

A Not noted, correct, yes.

Q Just if you could let us know how many times you examined -- did a physical examination between May 10, 2004 and January 16, 2006.

How many times did you do a physical exam on Mr. Mescall during those two time periods?

A Would you like me to count them?

Q Yes.

A Looks like about seven times.

Q So, you examined him and observed his gait seven times between May of '04 and January of '06 and, on none of those prior occasions, did you ever see any indication of an abnormal walking, an abnormal gait; correct?

A Yes.

Q And you actually looked for that; correct?

A Yes.

Q Now, you saw him -- that was, let's see, that was January of '06.

Now, you saw him again in March of '06; correct?

A Yes.

Q What observations did you make with regard to his gait in March of '06?

A No changes.

Q When you say "no changes", what does that mean?

A His physical findings are consistent and concordant with my prior visits.

Q Well, we have eight prior visits, seven with a normal gait, one with an abnormal gait. Which is it consistent with?

A The most recent last visit of abnormal gait pattern.

Q So, when you said "visits", you didn't really mean visits. You wrote plural there, "my prior visits".

A Right. It would be January 16 of 2006.

Q Okay. And, to finish that sentence, it says: "His physical findings are consistent and concordant with my prior visits, including significantly restricted cervical range of motion with positive compression and distraction maneuvers"; correct?

A Yes.

Q So, you talked about the cervical spine being consistent with your prior visits.

You don't mention anywhere in there that there is an abnormal gait; correct? You're only referring to the neck; correct?

A Well, I put -- I said including significantly restricted cervical and cervical thoracic range of motion.

Q But you don't mention it specifically in March of 2006; correct?

A I don't specifically mention what? I'm sorry.

Q You don't specifically mention that he had an abnormal gait or anything with regard to his ankles; correct?

A No, correct.

Q What about his lumbar spine?

A Nothing specific, no.

Q Now, you talked about his -- that you saw him recently. I think you saw him on September 10, and you saw him in September and July, correct, of this year?

A Yes.

Q And tell the jury, in July, with regard to his lumbar spine, what were his complaints?

And that's July 12; correct?

A That's right.

Q And what are the complaints then?

A Mechanical axial low back pain.

Q I'm sorry. I couldn't hear you.

A Mechanical axial low back pain.

Q And was that a subjective complaint made by Mr. Mescall?

A Yes. That's a complaint of low back pain.

Q Okay. So, he was complaining of low back pain at that time?

A Yes.

Q And were there any objective findings to support his complaints of lumbar back pain in July of 2010?

A Palpable spasm in the lower back with asymmetrical contraction of the para-lumbar vetebral muscles.

Q Did he have a limited range of motion as a result of it?

A Let's see. I didn't give any range of motion assessment for the lower back at that time.

Q Based upon your practice and procedure, and reviewing your notes, and your note taking and any independent recollection you have, because it was only a couple months ago, did he have a limited range of motion in his lumbar spine on July 12, 2010?

A Yes. Based upon the fact that he had palpable spasm in the lower back, with asymmetrical contraction in the lumbar para-vetebral muscle -- pain, spasm and tenderness in the lower back with asymmetrical contraction of the para-lumbar vetebral muscles during both gait and range of motions, yes, he had a restricted range of motion.

Q And how would you characterize that limited range of motion in July?

A Limited.

Q Was it severe?

A It was limited.

Q Was it moderate?

A It was limited.

Q Can you tell the jury what it was.

A Limited.

Q Give them some idea.

A Abnormal.

Q What does that mean?

A Not normal.

Q Could he bend?

A He was able to bend, but with palpable spasm and asymmetrical contraction of the para-vetebral lumbar muscles.

Q Would that mean that he would be in pain when he bends?

A Spasm certainly produces pain, yes.

Q Would he have difficulty turning?

A Yes. That would mean he would have difficulty turning.

Q Would that cause pain?

A Spasm, once again, does produce pain, yes.

Q Would he have difficulty bending over?

A Yes.

Q And would that cause pain?

A Once again, spasm would produce pain, yes.

Q And did he -- did you see evidence that Mr. Mescall was in pain when he bent or turned in your office in July of 2010?

A Yes.

Q Can you tell the jury what you saw with regard to Mr. Mescall that would indicate to you that he was in pain in July of 2010.

A He had palpable spasm and palpable asymmetrical contraction of the muscles around his spine.

Q Did he grimace?

A Well, he had palpable spasm, which is an objective assessment of abnormal motion.

Q My question to you is, what evidence was there when he tried to turn or bend in your office in July of 2010 to indicate to you that he was in pain?

A I think I answered that by telling you that he had palpable spasm with asymmetrical contraction of the muscles.

Q Did he tell you it hurt when he bent or turned?

A Well, he came in with complaints of pain, yes.

Q Did he, when you were going through your range of motion testing, did he tell you as he turned when it started to hurt?

A Once again, he had objective findings of painful

range of motion which were palpable and spasming.

Q Did you see him grimace?

A I don't recall.

Q Now, let's talk about his cervical spine.

Well, stop. Let's go back to you saw him in July and then you saw him again in September with regard to his lumbar spine. Any changes?

A In September?

Q Between July and September.

A No, no significant changes.

Q So, he still had painful limited range of motion?

A With respect to the lumbar spine.

Q His lumbar spine?

A Yes.

Q You palpated and found muscle spasms at that time?

A There were absolutely no significant changes between July and September of 2010.

Q So, he would still have pain when he turned or he bent; correct?

A Yes.

Q And that was obvious to you during your examination; correct?

A Yes.

Q Okay. Now, let's talk about his cervical spine.

What were his complaints with regard to his

cervical spine in July of 2010?

A Progressive difficulty with maintaining head and neck in any given position for anything in excess of approximately 15 to 20 minutes.

Q What is that, 15 to 20 seconds or minutes?

A Minutes.

Q Okay. So, what does that mean?

A That means it's difficult for you to hold your neck in a specific position for any significant amount of time in excess of 15 to 20 minutes.

Q And what made it difficult for him to hold his head in one position for that long?

A Pain.

Q Pain. And is that something he told you or something you saw?

A That is something that he told me, confirmed by a physical exam.

Q Okay. And what objective findings -- withdrawn.

Did he have any other complaints other than he couldn't hold his head in one place for more than 15 or 20 minutes?

A Progressive complaints and symptoms with respect to his neck and his upper extremities, particularly his shoulders. He had just had some more injections with Dr. Perper. And mechanical axial low back pain.

Q So, he was still having problems with his shoulders even after he had the injections?

A Yes.

Q And tell the jury what complaints did he have with regard to his shoulders, even after he had the injections into his shoulders?

A He was saying that he had problems with his shoulders.

Q Did he give you any specifics?

A No.

Q Well, what did that indicate to you? What kind of problems was he having?

A That he continued to have bilateral shoulder pain.

Q Shoulder pain?

A Yes.

Q Fair to say that that pain would be made worse by lifting or moving your arms?

A It could be, yes.

Q What else would cause him to have pain in his shoulders?

A I wouldn't -- you know, the shoulders were really not the focus of my treatment. So, I didn't go into any specifics with respect to the shoulders.

Q Okay. But he indicated to you at that point that he was having pain in his shoulders; correct?

A Yes.

Q And how did he describe it?

A Let's see. He said he was having shoulder problems, and he had just recently received more injections from Dr. Perper.

Q So, he was having continued pain problems despite those injections; correct?

A Yes.

Q Now, what about his ankles, did he make any complaints about his ankles in July or September?

A Not that I know of, no.

Q Okay. Did you ask him how he was doing?

A Yes.

Q But no complaints about ankles?

A No significant complaints that I noted, no.

Q Well, what about his cervical spine?

A Once again, we just talked about his cervical spine. He continued to have neck pain.

Q Okay. I think -- and I interrupted you, and I apologize -- he indicated to you in July, that he couldn't hold it in one place for more than 15 or 20 minutes?

A Yes.

Q What other complaints did he have with regard to his cervical spine?

A That was the major complaint offered on that day.

Q And what about in September?

A In September, essentially the same complaints with pain radiating into the upper extremities.

Q Tell the jury what it means when pain is radiating to the upper extremity.

A Radiation basically means the pain starts in one area and then travels to another area.

So, radiating pain into your upper extremities means that you have pain that you can feel going down into your arms and hands.

Q And that would affect the way somebody used their arms and hands?

A Yes.

Q And he was having that problem in September?

A Yes.

Q And he had that problem in July as well?

A Yes.

Q And he had that problem despite the injections that he was given?

A He was having persistent pain, yes.

Q I think you describe it as chronic, severe and unremitting?

A Yes.

Q Severe is what? Tell us, on a scale of one to ten, what is severe?

A Severe is between seven and-a-half, to eight to ten.

Q Okay. So, between seven and-a-half and ten is severe pain?

A Yes.

Q And he had severe pain in his neck radiating down to his arms regularly; correct?

A Yes.

Q And that was based on what he told you; correct?

A That is -- those were his complaints at that time, yes.

Q And that was despite any injection he had gotten in his shoulder or his neck; correct?

A He was continuing to have persistent pain, yes.

Q What is unremitting?

A It means persistent.

Q Persistent.

Does it mean anything else, unremitting, despite medication, despite injections?

A Persistent.

Q Just persistent or persistent despite medication? I don't want to put words in your mouth. Is it persistent despite all that was being done medically to try and stop the pain?

THE WITNESS: Do I have to answer every

question several times or can I keep going?

THE COURT: Actually, that's a good time to break, and we'll come back at 2:15.

Jurors, it's already 1:15.

Do not discuss the case, form no opinion, conduct no investigation.

But, no, the witness cannot make an objection of asked and answered. But the question really was a simple one, which is she's trying to get you to define unremitting as whether or not it means despite pain medication.

That's the question, but we'll come back to it after lunch.

MR. BOROWICK: We're going to leave an open question on the lunch break?

THE COURT: You'll ask it again. Maybe he'll figure it out over lunch.

MS. CAMACHO: Okay.

THE COURT OFFICER: All rise. Jury exiting.

(Luncheon recess.)

* * *

THE COURT OFFICER: Remain seated.

Come to order.

Jury entering.

(Jurors returned at 2:35 p.m.)

THE COURT OFFICER: All rise. Injury entering.

THE COURT: All right jurors.

Have a seat.

Welcome back. I do want to thank you. I know you were all here on time this afternoon.

Unfortunately, we had a snafu, having nothing to do with this case but having to do with another matter which is actually being handled in the courtroom next door, so I had to resolve that issue before I can get back to you.

Now, you once again have my undivided attention.

I do believe we have an open question.

Why don't you re-put the question and get an answer.

CROSS EXAMINATION

BY MS. CAMACHO:

Q. Dr. Merola, do you remember the question that was posed to you prior to lunch break?

A. I do, but if you could restate it I would appreciate it.

Q. My question was, with regard to your description of

his pain in September of 2010, this month, the last time you saw him, could you tell me what your description was again?

A. The description was chronic severe and unremitting pain.

Q. With regard to "unremitting," my question to you is, when you say "unremitting," does that mean he had chronic and severe pain despite the medication that you provided or was provided by other doctors and the therapies?

A. Unremitting, essentially in this sense, means that it's long-standing pain that keeps reoccurring, even with treatments.

So he has got good days, bad days, but recurring pain that persists over time.

Q. What was the first word in that one?

A. "Recurring."

Q. No, in your description of September 10th, what is the first --

A. Chronic, severe, chronic.

Q. Chronic? Doesn't chronic mean long standing?

A. Yes, it does.

Q. So you've got chronic and you have unremitting?

A. Yes.

Q. Now, on direct examination, you talked about the kinds of forces that can cause herniation.

Do you recall that?

A. Yes.

Q. And you testified that in addition to an axial load, which is being hit on the head, a herniation could be caused by a bending movement or a twisting movement correct?

A. Moment, yes.

Q. Moment?

A. Bending moment or twisting moment.

Q. Moment, yes.

And that just means that you have patients and other treating doctors who have patients who were fine up until the moment that they bent and then all of a sudden they had herniation of the disk. Correct?

A. Yes, bending over can cause a disk problem.

Q. And lifting or pulling a heavy object can cause a herniation?

A. Sure, certainly.

Q. And twisting could cause a herniation. Correct?

A. Yes.

Q. And are you aware -- withdrawn.

You indicated that you reviewed his prior medical records prior to this incident. Correct?

A. Yes.

Q. And that included records of Dr. Holt and Dr. Rizzo?

A. Yes.

Q. And that included a November 9th, 2001, incident where

plaintiff injured his low back and neck pushing steel beams. Correct?

A. Yes.

Q. And he had pain as a result of that. Correct?

A. Yes.

Q. And I believe you testified pushing or pulling steel beams can cause a herniation. Correct?

A. In general, yes it can.

Q. And are you aware of an incident in November of 2002, where Mr. Mescall was lifting heavy objects, and had another work-related incident. Correct?

A. Yes.

Q. And that caused pain in his neck and back. Correct?

A. Yes.

Q. And those two incidents were subsequent to the 2000 incident?

A. Yes.

Q. I believe you also testified that plaintiff was symptom free for 2003. Is that correct?

A. That he was working full-time, full duty, yes.

Q. My question to you is, Mr. Borowick asked you a question, and the question was, had to do with him being symptom free for the year of 2003.

Do you agree or disagree that plaintiff was symptom free, no pain in his neck or back through the year 2003?

Dr. Merola - Plaintiff - Cross

MR. BOROWICK: Objection.

THE COURT: Rephrase it.

Q. To your knowledge, based upon your review of the record, was Mr. Mescall symptom free in 2003?

MR. BOROWICK: Judge, I think I had said through Thanksgiving.

MS. CAMACHO: Through Thanksgiving. That's fine.

THE COURT: Because I believed your objection was how she worded the question, that's why I had her rephrase it.

She didn't ask the question as rephrased referencing -- she has asked a separate question which is a proper question.

So the objection is overruled.

Disregard the comments both of counsel and the Court.

BY MS. CAMACHO:

Q. Based upon your review of the records, was Mr. Mescall symptom free during the year 2003?

A. Based upon the review of the record, he did have some complaints of neck and back pain.

Q. In 2003?

So he wasn't symptom free in the year 2003. Correct?

A. Correct.

Q. And I believe you testified that during the

six-and-a-half years that you treated plaintiff, your never believed he was exaggerating. Correct?

A. That's correct.

Q. You never had any reason to question his complaints. Correct?

A. Yes.

Q. Any reason to suspect he has exaggerated prior to your treatment based upon your review of the record?

A. No.

Q. Any reason to believe he wasn't an accurate historian with regard to his complaints prior to your treatment of him?

MR. BOROWICK: Objection.

THE COURT: Overruled.

THE WITNESS: No.

Q. Okay. Now, do you -- you indicated to this jury that you reviewed Dr. Palmieri and Dr. Radna's medical records?

A. Yes.

Q. Okay.

And it's fair to say that in December of 2003 when plaintiff went to see Dr. Radna, he indicated that his cervical pain had been constant from the time of his accident up until 2003. Isn't that fair to say?

A. According to Dr. Radna's note, yes.

Q. What does "constant" mean to you in medical terms, based upon your medical opinion, what does "constant" mean?

A. That he had pain there continuously, from the time of the accident through when he saw Dr. Radna in December, 2003.

Q. According to that at the same time.

A. Yes.

Q. I believe Dr. Radna's record, you reviewed those. Correct?

A. Yes.

Q. Do you have those up there?

A. I have Dr. Radna and Palmieri, yes.

Q. The second paragraph of Dr. Radna's report, would you read that?

A. Cephalgia persists to the current time, and has been emanating from posterior impact after which he was dazed with the onset of cephalgia, constant, with exacerbations lasting as long as all day, and associated with post-concussional symptoms.

Q. What does that mean?

A. That means he had headaches.

Q. Cephalgia means headaches?

A. Cephalgia, "ceph," is the Greek term for head, and "algia" is complaints of symptoms there in cephalgia, is basically head pain or headaches.

Q. So Mr. Mescall reported to Dr. Radna in December of 2003 that he was having, he had been having headaches from the time of the accident up until December, 2003?

A. With exacerbations, yes.

Q. I think it says constant with exacerbations lasting as long as all day. Is that correct?

A. Yes.

Q. That was associated with a post-concussion symptoms?

A. Yes.

Q. Suggesting that he had some type of concussion in 2000?

A. Or post-concussive symptoms, yes.

Q. And that was something Mr. Mescall reported to Dr. Radna. Correct?

MR. BOROWICK: Objection, objection.

Q. Based upon your review of this record?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q. Well, Mr. Borowick asked you to give this jury opinions with regard to your review of this record, did he not?

A. Yes.

Q. Can you give this jury an opinion based upon your review and your experience as to whether or not that's what Mr. Mescall told Dr. Radna at that time?

MR. BOROWICK: Objection.

THE COURT: Why don't you rephrase that to whether the record reflects in a note?

I mean this particular reference in the record,

you can ask him about that.

BY MS. CAMACHO:

Q. Does this record reflect that that's what Mr. Mescall told Dr. Radna?

MR. BOROWICK: Objection.

THE COURT: Overruled.

THE WITNESS: It is interesting.

THE COURT: That's what you are talking about, that's in evidence --

MS. CAMACHO: Yes.

THE COURT: -- as 39, correct.

MS. CAMACHO: Yes, your Honor.

THE WITNESS: It reports this head pain that Dr. Radna then talks about in the second paragraph.

BY MS. CAMACHO:

Q. My question, Dr. Merola, does this report indicate to you that Mr. Mescall provided this information to Dr. Radna back in December 23rd 2003?

A. Yes.

Q. And with regard to the cervical pain, did it indicate -- withdrawn.

Was there an indication in this record as to whether that pain radiated down his arms?

A. The record does indicate radiating pain, yes.

Q. And with regard to cervical and lumbar pain, is that

with regard to cervical and lumbar pain?

A. Yes.

Q. And fair to say that this report indicates that that information came from Mr. Mescall?

A. Yes.

Q. And based upon this record, did Dr. Radna do a physical examination?

A. Yes.

Q. And did he have any objective findings with regard to Mr. Mescall's cervical spine?

A. He has palpable spasm in the neck and lower back with severely diminished range of motion.

Q. Is that pretty much the same findings you found with regard to Mr. Mescall's cervical spine in September of 2004?

A. Palpable spasm with diminished ranges of motion, yes.

Q. And what about, did he find anything else, any other objective findings?

A. He has a Spurlings maneuver, eliciting discomfort at the base of the neck.

Q. That's an objective finding as well?

A. It is objective, but inconsistent with radiculopathy.

Q. The spasms reported by Mr. Mescall are consistent with radiculopathy. Correct?

A. They are consistent with a strain or sprain.

Q. Okay. With regard to the lumbar spine what objective

findings were there?

A. The lumbar spine exam also indicates para-vertebral spasm.

Q. So he had some objective spasms back in December '03 when he was examined by a neurosurgeon, correct?

A. Yes.

Q. Did he look at Mr. Mescall gait, Mr. Mescall's gait in December of 2003?

A. Yes.

Q. And what were his objective findings with regard to Mr. Mescall's objective gait in December of 2003?

A. He indicates an antalgic gait.

Q. He was limping at that time?

A. Well, he called it antalgic gait, then he says he has attenuated dorsi and plantar flexion of both feet.

Q. What does that suggest to you?

A. That actually suggests a slow gait pattern, because an attenuated dorsi and plantar flexion means that when you are walking in normal ways, your ankle in order to clear the ground when you are walking, it's a very rapid response, so you can get your toes away from the street or sidewalk before you trip on them, and his indication of an attenuated dorsi plantar flexion of both feet indicates a slower gait pattern.

Q. But a limping gait nonetheless?

A. Actually --

Q. Abnormal?

A. An abnormal gait pattern.

Q. Abnormal?

A. Yes.

Q. Something that would be obvious to a doctor watching him walk?

A. Yes.

Q. Okay.

Now, he concluded after his physical examination and his clinical examination and listening to Mr. Mescall's as an historian of his symptoms, that he had a causally related cerebral concussion.

What's causally related?

A. Causally related means that he has a cerebral concussion related to, let's see, according to the his story of present illness an injury on July 24th of 2000.

Q. And then he had post concussional syndrome. What is that?

A. A post-confusional syndrome would be consistent with the cephalgia that Dr. Radna described.

Q. The headaches Mr. Mescall claimed he was having from 2000 through December of 2003?

A. Yes.

Q. Daily?

A. Yes.

Q. And he also found radicular pain syndrome, what is radicular pain syndrome?

A. Let's see. Cervical and lumbosacral musculoskeletal and radiculopathy radicular pain syndrome.

Radicular pain syndrome means nerve pain?

Q. So he found cervical and lumbar nerve pain syndrome. Correct?

A. Yes.

Q. And he said, "Based upon the chronicity" the chronic nature of that pain, the patient's symptoms have permanency. What ask that mean?

A. It means that in Dr. Radna's opinion at this time those are permanent symptoms.

Q. Okay. Now, in your opinion, chronic basically means long lasting. Correct?

A. Yes.

Q. So if something has been around for longer than six, eight or one weeks, it would be considered, in your opinion, chronic. Correct?

A. Chronic really means to be in the neighborhood of about six months or so.

Q. Well, do you remember giving this, being asked this question and giving this answer?

"QUESTION: Can you explain to the jury -- and this is in March of this year when you were called on

behalf of a plaintiff.

"QUESTION: Can you explain to the jury what chronic radiculopathy and chronic pain is?

"ANSWER: Chronic means basically it's long standing, so it's been around for a long time, longer than six, eight or one weeks."

Q. Do you remember being asked that question and giving that answer?

A. Yes, for radiculopathy, absolutely correct.

Q. So the question was, can you explain to the jury what chronic radiculopathy and chronic pain is?

A. Yes.

Q. So fair to say, if somebody has chronic pain for longer than six, eight, one weeks in your opinion, it's chronic?

A. Yes, or long-lasting.

Q. Okay. Now, radiculopathy means that the nerve root is just not working well.

Correct?

A. Yes.

Q. That there is some kind of problem with the nerve root?

A. Yes.

Q. And radicular pain is evidence of a nerve root pressure or nerve root irritation. Correct?

A. Yes, radicular pain is evidence of nerve root irritation, yes.

Q. And if somebody has chronic radiculopathy, that is an indication that the nerve is affected and causing pain. Correct?

A. Yes.

Q. And if someone is complaining of chronic radiculopathy with pain and numbness and tingling that is consistent with a herniated disk that is pressing on the nerve. Correct?

A. With all of those factors involved, yes.

Q. Okay. And once somebody has chronicity or long-term pain, it's less likely that all that pain will go away. Correct?

A. Depends upon the amount of nerve root damage that there is, sure, and the amount of time that it's been around, yes.

Q. Well, four years is a long time isn't it?

A. If it's been persistent or for that long, four years is certainly a long time, yes.

Q. Now, you have indicated that you performed fusions pretty regularly in your specialty.

Correct?

A. Yes.

Q. And the purpose of a fusion is to decrease pain and block abnormal motion in the spine. Correct?

A. Yes.

Q. Now, once you have damaged, damage to the neck, it's not going to get better. Correct?

A. Once the nerve root is damaged, depending upon the amount of damage that's had and the amount of time that it's been there, it may not get any better, yes, that's correct.

Q. I believe you indicated that following the 2004 accident changes in the plaintiff's spine were permanent.

Yes?

A. Yes.

Q. Dr. Radna opined that the changes to the plaintiff's spine after 2000 were permanent. Correct?

A. With respect to the muscular pain, yes.

Q. And you indicated because of the condition of Mr. Mescall's spine, he will continue to get worse. Correct?

A. Yes.

Q. And he will continue to have problems. Correct?

A. Yes.

Q. And that's what Dr. Radna opined on in December of 2003. Correct?

MR. BOROWICK: Objection.

THE COURT: Overruled.

THE WITNESS: He actually said that he had a partial disability, but did have permanency based on his symptoms.

Q. "Permanent and chronic." Correct?

A. Yes.

Q. Okay. Now, you indicated that Mr. Mescall could not go back to work as a manual, in manual labor. Correct?

A. Yes.

Q. But, I believe you opened your testimony by saying that you have patients who go back to manual labor jobs following spinal fusion. Is that correct?

A. I do have some patients that can return to manual labor following fusion, yes.

Q. And actually have gone back to manual labor. Correct?

A. Yes.

Q. So there is nothing about the fact that somebody who has a herniated disk that says they can't go back to manual labor. Correct?

A. In general, no.

Q. There is nothing about the fact that somebody has had a fusion, which means they cannot go back to manual labor. Correct?

A. All by itself and taken alone, correct, no.

Q. Okay. But you have also indicated that he can't return to any type of work on a full-time basis. Correct?

A. In Mr. Mescall's case, yes, that is correct.

Q. And just so the jury is clear, there is nothing about the fact that somebody has a herniation that keeps them from

working. Correct?

A. Are we talking about somebody in general?

Q. In general?

A. In general, if a herniation is symptomatic and requires treatment, it depends on the circumstances in the clinical situation, so --

Q. My question to you is, there is nothing about the fact that somebody has a herniation that means they can't work. Correct?

A. No, in general that statement holds true.

Q. And there is nothing about the fact that somebody has had a fusion, which means they can't work, every person who has had a fusion doesn't stay home as a result of having a fusion. Correct?

A. No, not all patients with fusions stay home, that is correct.

Q. Now, in your opinion, having examined and treated Mr. Mescall for the last six-and-a-half years, is there any point in time during that six-and-a-half years where he could have attempted training?

A. Over that -- over the course of those six years he has had some good days and some bad days, and he did try to get back into work and that's one of the reasons I believe he was teaching.

Q. Based upon your are review of the record, when is it

that he tried to get back into work?

A. Well, let's see.

I do recall us discussing his teaching job where he was working four-and-a-half hours per day it was July 12th 2010 and we discussed that.

Q. Do you know how long he had been working, teaching that four-and-a-half hours during the six-and-a-half years that you have seen him?

A. The entire length of time, no, I don't have that. I don't know off the top of my head, no.

Q. Was he able to do that in 2005?

A. Was he able to do any work and/or duties in 2005? I don't know. I would have to go through all of the notes here.

Q. Well, it's fair to say you reviewed his records with Mr. Borowick prior to testifying?

A. Reviewed, but not memorized yes.

Q. I understand that. And you treated him for six-and-a-half years, so you are familiar with his situation. Correct?

A. Yes.

Q. Based upon your treatment of Mr. Mescall in 2005, was he able to work?

A. Not on a sustained basis, no.

Q. What about 2006.

A. Once again, not on a sustained daily basis, no.

Q. 2007?

A. Also correct, not a sustained, fully working, no.

Q. What about part-time work?

A. Well, once again, we have his teaching duties and he did try to get back into the work force, so he was trying to do the best that he could with the situation he had.

Q. What did he do to try to get back into work?

A. He was taking that teaching job.

Q. Other than that?

A. I think that's a pretty significant step, particularly given his injuries.

Q. My question, Dr. Merola, is, what, if anything, else he did that you're aware of?

A. Nothing I'm aware of other than that very significant step.

Q. You indicated you performed surgery -- withdrawn.

When did you perform this fusion?

A. August 3rd 2009.

Q. Okay. And let's talk about what is the recovery from that surgery like?

A. In terms of recovery, do you mean short-term recovery or long-term recovery.

Q. Both?

A. Short term recoveries, most patients are generally in the hospital about a day.

Q. Do they stay overnight?

A. Yes.

Q. Overnight procedure?

A. For the most part, yes.

We would like to make sure their airway stays open, and they don't have any significant post-operative swelling. And then there is a course of rest while the incisional site heals.

Q. How long a period of time is that?

A. Generally that's in the neighborhood of four to six weeks, depending upon the patient.

Q. You would recommend four to six weeks of rest following the surgery?

A. In general I like to hold off, for the most part, physical therapy or other activities that can exacerbate post-operative pain, somewhere in the neighborhood of four weeks or so.

Q. In September of 2009 to -- after the surgery, when was the first time that you examined Mr. Mescall?

A. Let's see. August 31 of 2009.

Q. What were his complaints in August of 2009?

A. That was his first post-operative visit.

Q. Which is how long after the surgery?

A. Let's see. The date of operation, the date of surgery was August 25th.

Q. So about one week?

A. About a week or so.

Q. What was the complaint at that time?

A. He had no significant post-operative complaints at that time.

(Whereupon Sara Stanley was relieved by, Joyce Fisher, as Official Court Reporter.)

Q And when was the next time you saw him?

A November 9 of 2009.

Q And what were his complaints at that time?

A He was starting a formal post operative physical therapy program for his neck, and he remained neurologically stable offering no new complaints of symptoms.

Q So, based upon your reading of your notes, what, if any, complaints did he have at that time with regard to his cervical spine?

A No new complaints with regard to his cervical spine, no complaints of anything that I should be concerned about post operatively.

Q Did he have any old complaints?

A None of that is listed because we're in the postoperative period now. So, we're looking for new problems and new changes that would herald a redo or a take back to the operating room.

Q What I'm trying to find out is what, if any, complaints did he have, old or new, in November of 2009?

A Nothing old or new in November of 2009.

Q He was pain free at that time?

A No, just nothing old or new that would impact upon my treatment of him.

Q Okay. What did he have, old or new, that would impact upon your treatment?

A I'm sorry. I don't know how else to answer that question for you.

Q Okay. So, he wasn't pain free. He had some pain. He had some complaints. We just don't know what they were.

A He was post op.

Q I understand that.

A He had no complications.

Q I understand that.

A And, from a surgical point of view, there was no indication that he had had any issues or concerns to take him back to the operating room for.

Q You indicated earlier that Mr. Mescall has a problem sitting for any length of period of time; correct?

A Yes.

Q Currently, how long a period of time is he able to sit based upon your experience?

A How long can he sit for any length of time?

Q Yes?

A I guess it would depend upon the day and about whether or not he was having a good day, a bad day, whether or not he was on medicine or off medicine.

So, sitting tolerance, and a lot of the tolerances that he would experience depend upon any particular day. That's one of the things about subjective complaints that are unique to the patient depending upon the clinical

situation.

Q My question to you, doctor, is can you give this jury an opinion within a reasonable degree of medical certainty based upon your six and-a-half years of treating Mr. Mescall how long a period of time that -- what his sitting tolerance was -- what his sitting tolerance currently is?

A I can tell you what I would recommend in terms of sitting restrictions, but I couldn't hazard a guess as to what his sitting tolerance was because I didn't really do a sitting tolerance examination of him.

Q You can do a sitting tolerance exam?

A We can do something called a functional capacity examination which is not something that I did.

Q What is a functional -- what is that, a functional tolerance exam?

MR. BOROWICK: Capacity.

A A functional capacity examination.

Q And what is that?

A It's an examination to determine a patient's functional capacity or residual functional capacity.

Q And you've done that before?

A It's outside my area of expertise, but I have interpreted functional capacity examinations, and I do discuss them with patients, yes.

Q What do you mean it's outside of your expertise?

A I'm a surgeon. So, my job is diagnosing and treating those issues with respect to the neck and back that have surgical solutions.

Q Okay. Who performs a functional capacity test?

A A functional capacity evaluation can be performed by any variety of physician. Most commonly it's a physiatrist.

Q What is a vocational rehabilitation doctor?

A A vocational rehabilitation specialist is a person who specializes in assessing and making recommendations regarding work for a particular individual. So, vocation would be work and a vocational rehabilitation specialist would be someone who looks at a person's ability to work.

Q And is it based on the functional capacity test, much of their --

A It's really based on many things, including their level of education, their mental function, their physical capacities. So, it's based on a variety of things.

Q Certain things that vocational rehabilitation people take into account is somebody's sitting tolerance; correct?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q Based upon the vocational -- the functional

capacity test that you reviewed in your capacity, I believe you indicated that you've interpreted functional capacity tests, one of things they rely on is sitting tolerance; correct?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q You're not a vocational rehabilitation specialist; correct?

A That is correct.

Q I'm sorry. Where did you indicate that you have surgical privileges?

A I have surgical privileges at State University of New York, Downstate Medical Center, New York Methodist Hospital, Mount Sinai Hospital here in Manhattan. Where else? Long Island College Hospital. I'm trying to think of all the places I have privileges. Those are the major institutions at which I operate.

Q And some, if not all, of those institutions have vocational specialists?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q Do you know whether those facilities have vocational experts?

MR. BOROWICK: Objection.

THE COURT: Sustained. I'm not sure this is

within the scope of the cross of this witness.

Q Well, let me ask you this question:

You were able to communicate with Mr. Mescall during the six and-a-half years that you treated him?

A Yes.

Q He has no problem with his communication skills; correct?

A I was able to speak with him, and talk to him and treat him, yes.

Q Ever speak to him on the phone?

A Not that I can recall, no.

Q Any reason to believe he couldn't use the phone?

MR. BOROWICK: Objection, Judge.

THE COURT: Sustained.

Q Do you know whether or not he knows how to use a computer?

MR. BOROWICK: Objection.

THE COURT: I'll sustain the objection, although I understand what you're trying to do.

Let's move it along.

Q I believe you testified on direct examination that Mr. Mescall cannot work -- return to any type of work on a full-time basis; correct?

A That is correct, right.

Q And that at this time, he cannot be retrained;

correct?

A I don't recall specifically talking about retraining.

Q Well, tell the jury, can he be retrained?

A I don't know. I haven't made an assessment of whether or not he can be retrained.

Q So, you don't have an opinion with regard to whether or not he could be retrained?

A You know, once again, if we're talking about retraining, I can tell you what I would or would not recommend in terms of his musculoskeletal system, but I wouldn't -- I couldn't give you an overall retraining assessment.

Q Now, just so we're clear, you're not telling this jury that he couldn't go back to work in some type of part-time capacity; correct?

A As long as there were some type of part-time capacity which would accommodate his neck and back function, his musculoskeletal function, that would ultimately be the hope that he could do something like that, yes.

Q Okay. Just going back to his pre-injury, pre-2004 injury complaint for a moment.

You talked about the complaints he had in December of 2003 to Dr. Radna. He made the similar complaints of chronic and persistent cervical pain to Dr. Radna in 2004,

correct, January 2004?

A Yes.

Q And Dr. Radna who's a neurosurgeon, found the same objective findings with regard to his cervical spine, limited range of motion, spasms, some positive tests, in January 2004 during his clinical evaluation; correct?

A Yes.

Q And he also found that he had hyper-reflective clawing in both hands. What is that?

A That means that there was spasm in his upper extremities and hands.

Q Indicating some kind of nerve root problem; correct?

A Hard to really say whether or not it was specifically nerve root related or carpal tunnel related because it involved the entire -- both entire hands with bilateral clawing.

Q And, with regard to his disability at that time in January 13, 2004, 5 months before this accident, what was Dr. Radna's opinion with regard to plaintiff's condition?

MR. BOROWICK: Objection.

THE COURT: Rephrase that.

Q Does the report indicate to you what Dr. Radna's opinion was with regard to plaintiff's disability?

MR. BOROWICK: Objection.

THE COURT: Overruled.

MR. BOROWICK: Judge, may we approach.

THE COURT: Sure.

(Discussion at the bench off the record.)

Q Can you tell the jury based upon your review of the January 132,004 report what Dr. Radna's opinion was with regard to Mr. Mescall's disability at that time.

A On January 13 of 2004, Dr. Radna relates a total disability.

Q What does that mean?

A That means that he said that he should not work at that time.

Q And, again, he -- withdrawn.

And did he believe that Mr. Mescall's symptoms were permanent?

A He did not offer any information regarding permanency at that time.

Q Let me ask you if you could read right below the level of causally-related disability is total.

What's the next line?

A In light of it, yes. I'm sorry. In light of the chronicity of the patient's symptoms, they have permanency.

Q Meaning they're permanent; correct?

A Yes.

Q And, not to go through them, but Mr. Mescall made

the same complaints about chronic pain and chronic radiculopathy to Dr. Palmieri in December of 2003; correct?

A In December of 2003 with Dr. Palmieri, complaints on that visit for Palmieri are bilateral hand numbness.

Q Since the time of the accident?

A Complained of bilateral hand numbness since he was taken to an emergency room in Manhattan where he was treated and released.

Q And that was following the boom accident that Mr. Borowick was referring to earlier?

A In July 24, 2000.

Q And, in March 2004, based upon what Mr. Mescall reported to Dr. Palmieri, did he continue having pain radiating down his arms and his legs in March of 2004?

A Yes.

Q And did Dr. Palmieri note that he had an antalgic gait at that time?

A Yes.

Q So, in March 24, 2004, about 6 weeks before the accident which is the subject of this litigation, Dr. Palmieri made an objective finding of an antalgic or abnormal gait?

A Yes.

Q He also, in March of 2004, found a limited range of motion, correct, in the cervical spine?

A I'm just checking. Hang on. A moderate restriction of range of motion.

Q So, that's an objective finding of a limited range of motion?

A Yes.

Q And he had spinal tenderness?

A Mild spinal tenderness.

Q That's an objective finding?

A Yes.

Q And pain with lateral bending and turning.

And a positive spurling sign, what is that?

A The spurling sign is a rotation of the neck reproducing pain. But Dr. Palmieri doesn't tell us if it's radicular or not.

Q You did a spurling test; correct?

A Yes.

Q And it was positive when you did it; correct?

A But I also indicated that it would produce C-6 dermatonal distribution of pain, neither of which Dr. Palmieri or Dr. Radna record.

Q They both indicated that they found a positive spurling test; correct?

A Although their definition of the spurling maneuver is inconsistent with a true spurling sign because there's no dermatonal distribution of pain noted.

Q Well, they both concluded based on their objective exams he had continued to suffer from cervical and lumbar radiculopathy; correct?

A Actually, Dr. Palmieri says cervical lumbar strain with radiculopathy.

Q He found objective evidence of radiculopathy; correct?

A Actually, there isn't objective evidence of radiculopathy when you examine the note. It's more musculoskeletal strain than radiculopathy.

Q Plaintiff certainly gave a history, right, in March of 2004 of continued pain with radiation down his arms and legs; correct?

A That was the history, correct, yes.

Q And you have no reason to doubt that Mr. Mescall gave that history to Dr. Palmieri six weeks before this accident, do you?

A No, that's the history that's in the record.

Q Okay.

MS. CAMACHO: I have nothing further.

THE COURT: Mr. Borowick.

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q Counsel, just suggested to you that the complaints in Dr. Radna's reports from December when they were severe

were the same in January. In fact, Dr. --

MS. CAMACHO: Objection, Judge.

Q In fact, Dr. Merola, they weren't the same. They went from severe to moderate; isn't that true?

MS. CAMACHO: Objection, Judge.

THE COURT: Sustained as to the form.

Q So, when counsel read to you and said isn't it true that they were the same complaints of spasm and --

MS. CAMACHO: Objection, Judge.

Q -- and tenderness, that's not true at all?

THE COURT: Sustained as to the form.

Q In the two times, two times -- by the way, how many times have you treated this patient?

A I've treated him for six years.

Q Six years. And how many times would you say you've seen him?

A Probably 10, 12, 13 times at least.

Q And you've operated on him and you've made recommendations for his care; correct?

A Yes.

Q And you plotted out a conservative course of treatment and monitored him; right?

A Yes.

Q So, counsel is relying upon Dr. Radna, saw him twice and not for seven, almost seven years, and reads that

even within the two times, he was getting better.

Does it mean when he goes from severe to moderate, is that a good thing?

A Yes.

Q And then Dr. Radna says he's totally disabled January 13, and January 17 he goes back to work full time. Does that sound like a total disability?

A That is not a total disability.

Q How do you explain Dr. Radna's record?

A It's hard to explain all of the findings that are in the record other than to say that a sprain/strain syndrome can have good days and bad days, and this appears to have been a particularly bad day.

Q And, when he came back, and he was now moderate in his limitation and he's seen Palmieri, they put him in chiropractic care.

Did the chiropractic care seem to work?

A Yes.

Q Now, counsel went into great detail about the 2000 accident in the aerial lift, and I want to talk to you about that because in the context of the Radna report, counsel said oh, he's had headaches consistently, persistently, continuously, had you define those terms.

I want to connect this to his life and his work record. You've reviewed his work record, have you not?

A Yes, I have.

Q In 2000, he had this accident in July, out seven weeks. Worked the rest of 2000. Had pretty good hours in 2000. 2001, he had the best hours of his life. 2002, he had the second best hours of his life, way above average of the iron workers in his field.

Does that sound like somebody who's got a herniation, which is what Radna said, that he's got a herniation going back from 2000 to 2003 and '4; does that sound like it?

A No, not with those hours.

Q So, if somebody has a herniated disk in C-5, C-6, is it conceivable that he could work as an iron worker doing manual labor, heavy lifting, bending, drilling, clipping, hanging, could he do that for four years without significant symptoms?

A That would be impossible for him to do.

Q And the fact that he has periodic exacerbations which bring him to Dr. Radna and Dr. Palmieri, does that mean he's destined to have a bad back and disability?

A No.

Q The fact that Dr. Radna says totally disabled, Dr. Palmieri at the same time says stay out a few weeks, go to chiropractic -- and let me just be clear that that's exactly what was said.

In December, he says the MRI shows bulging and then he says at the end of his report he suffers from a cervical and lumbar strain with radiculopathy. He should remain out of work and follow-up in the next two or three weeks for a repeat evaluation. And that's what he did, from December until the middle of January stayed out for two or three weeks and followed up for another evaluation.

Is that a reasonable course?

A Yes.

Q Is it a different opinion than Dr. Radna?

A Yes.

Q Does Palmieri, does Kostreich, did you find any clawing of the hands?

A No.

Q Did anybody send him for an injection, did anybody send him for surgery, Radna, Palmieri, Kostreich, anybody?

A No.

Q And then right after that, when he sees him in February, he's already working, and he says he should remain working.

Does that sound like somebody who's got a severe herniation, severe concussion, severe anything?

A No.

Q The fact that he's going to work and telling his doctors he's going to work, does that sound like a

malingerer or an exaggerator?

A No.

Q And, in the last report, Dr. Palmieri says he continues with a cervical lumbar strain with radiculopathy, he should remain working, should continue chiropractic care, and he did.

MS. CAMACHO: Objection to form.

Q I want you to assume that's what it says. It's in evidence.

The fact that he continued chiropractic care, is that what you do for somebody with bulging disks?

A Yes.

Q And, when you have chiropractic care for someone who, if it's good care, for someone with bulging disks and a lumbar strain or sprain, is it unusual for that person to progress to the point where he can work effectively?

A No. With good care and good symptomatic treatment, he could return to his work and duties.

Q And, if counsel brings up a back sprain 15 years ago in '94, where somebody may have said there's a herniation in his low back, have you ever seen a film or a film report that said herniation in low back?

A No, I have not.

Q Dr. Radna said herniation in his neck. And you don't see a herniation in his neck; right?

A Correct.

Q People say lots of things. The radiologist didn't see a herniation in his neck, did he?

A No, he did not.

Q Retraining. You mentioned in a very general way that in order to assess whether a person can work, you need to know his education, his mental function and you said physical capacity.

Would you defer to a vocational counselor when considering John Mescall's physical capacity to perform work?

A Yes.

Q And when -- the physical capacity of a person, does that include his ability to be -- to sustain employment?

A Yes.

Q And does it include a person's medical, when he's on medicine, the ability to concentrate and actually do the job?

A Yes.

Q Would you allow a vocational counselor to determine his mental function while he's on medication?

A No.

Q If you believe that based upon his need for physical therapy, his degenerating cervical situation, his

consistent and persistent radiculopathy from L-5 -- I mean from C-5 --

MS. CAMACHO: Objection, Judge.

Q If you believe that, would you let a vocational counselor say send him to work?

A No.

Q Why not?

A Because we would be going counter what his clinical findings and symptoms are. We couldn't allow them to do that.

Q And who judges his clinical symptoms, you or some vocational counselor?

A I do.

Q And, in judging his clinical symptoms and his physical capacity to sustain a full-time or part-time job, to sustain full-time retraining, is that something in your opinion with a reasonable degree of medical certainty after six and-a-half years of treating him, operating on him, supervising his spinal care, do you believe he can do either of those things, retrain full time, work full time?

A Not based on his clinical symptoms and findings, no.

Q And, whatever a vocational counselor hired by the defendant says, do you defer to that vocational counselor with regard to his physical capacity to do a job?

A No.

Q Sitting tolerance.

Mr. Mescall's been sitting here sometimes consistently, sometimes walking out. Does a sitting capacity reflect the patient's own pain tolerance?

A It can, yes.

Q His medication, what he's got in his system?

A Yes.

Q Do you know what he's got in his system right now?

A He's been prescribed --

MS. CAMACHO: Objection.

THE COURT: Sustained.

Q Do you know what medication he's been prescribed at the current time?

A Yes.

Q And what is that?

A He's on pain medications, antiinflammatories, analgesic patches and neurologic medication.

Q In your experience with Mr. Mescall over the last six and-a-half years, would you say on a scale of one to ten, one being a whiner and a complainer and ten being a stoic, where does he fit in on that scale?

A A stoic.

(Continued on the following page.)

Dr. Merola - Plaintiff - Redirect

BY MR. BOROWICK:

Q. And counsel asked if he was grimacing or if he was making faces when you, when he is in pain.

When he walks into your office, even when he is in pain, was he wincing, making the whole big show of "Oh, I'm in pain, Whoa is me?"

A. No.

Q. Is he a doom-and-gloom guy?

A. No.

Q. What about when you examined and palpated his spasm, when you were touching his para-spinal muscles and determining they were in spasm, how did he react?

A. When you touched him and you could feel the spasm, he does react to the spasm, because he feels pain; he has a withdrawal response and pull away from that pain and spasm.

Q. Does he verbally report to you the symptom?

A. Yes.

Q. When you touch his spasm, what is his reaction besides the pull away and the withdrawal?

A. Yes, that it hurts.

Q. Does everybody who is in pain grimace or lean over and grab themselves.

A. No.

Q. You said that tolerances are patient specific. What do you mean?

Dr. Merola - Plaintiff - Redirect

A. Everybody is different. Every patient is different in so much as we are all different, so we do have different tolerances and all of our clinical findings are somewhat different.

Q. You said that his going back, at least when he went back to teach part-time at the apprentice school was a significant step.

What did you mean?

A. I meant that given all of the injuries that he has had, and specifically with respect to the neck and his lower back, that trying on get back into that work to do something to get more functional, to do something to try to move forward is very significant.

Q. Is he lazy?

A. No, absolutely not.

Q. Is he shiftless?

A. No.

Q. Is he a malingerer?

A. No.

Q. When he went back after the boom accident, after seven weeks and had his best years as an ironworker, does that show someone who is motivated or somebody who is lazy?

A. That shows motivation.

Q. Well, then, why can't he go back after this accident?

What's different about this accident than what

Dr. Merola - Plaintiff - Redirect

happened to him in '00?

A. This accident produced significant clinical deterioration, neurologically, none of which was previously documented.

No previous documentation of any significant nerve root problems, no atrophy, no motor loss, no weakness.

Whereas this accident, over the course of time that I've been able to treat him, clearly demonstrated a loss of reflexes and progressive neurological deficits.

In fact that was the indication for surgery.

Q. Was there ever any documented herniations in his neck before this accident?

A. No.

Q. Was there ever any documented concussions or loss of consciousness or -- I'm talking about documented, not something Dr. Radna put in his record, I'm talking about a hospital record from 2,000, anything about unconsciousness or concussion anything?

A. No, not in the record.

Q. When Dr. Radna made his note in 2003, in December, right after this man had two-and-a-half great years at work, and he said, "Radiating pain, spasm," is that what chiropractic care is supposed to manage?

A. Yes.

Q. And is that what medicines like Vioxx or Skelaxin is

Dr. Merola - Plaintiff - Redirect

supposed to address?

A. Yes.

Q. And did it?

A. Yes.

Q. Successfully?

A. Yes.

Q. Your file, I'm going to ask that, by the way is that a complete and accurate file that you maintained in connection with your treatment?

A. Yes.

Q. And is it, it have a sticker on the top?

A. Yes.

Q. And what does it say?

A. It says Plaintiff's Exhibit 45.

MR. BOROWICK: I'm going to offer it in evidence as Plaintiff's Exhibit 45.

MS. CAMACHO: Your Honor, subject to redaction and exclusion of documents that are not Dr. Merola's work product, I have no objection.

MR. BOROWICK: I agree to that.

THE COURT: Okay.

(Whereupon the Plaintiff's exhibit was marked in evidence 45.)

Q. With your file, now, with regard to your file, counsel asked maybe a million questions, maybe it was only seven but it

had to do with, "Well, did you write that in your report?" And sometimes you said, "I did, yes I wrote it in my report." Sometimes you said, "No, I didn't write it in my report."

Six-and-a-half years, were you writing a book there?

A. No.

Q. Were you treating the patient or treating the record?

A. Treating the patient.

Q. As long as you made notes for yourself and documented your file, did you satisfy yourself with the continuity of your record.

A. Yes.

Q. Did you ever think you were going to have to come to court and satisfy someone that you wrote every word down? Instead of treating him you were treating that record?

A. No.

Q. 10/4 counsel read the record, and she quoted, "Minimal distress."

Is that -- is that the presentation of someone who is trying to capitalize on misfortune in a lawsuit that he comes in and he reports minimal or presents minimal distress?

A. No.

Q. Explain that.

MS. CAMACHO: Objection, Judge. I move to strike.

THE COURT: Overruled.

Q. Explain that?

A. Sure.

This speaks to the stoic nature of Mr. Mescall. This is kind of goes along with his desire to get back into the work force, and to improve himself, try to get better.

You know we deal, and we can deal with patients that are known symptom amplifiers.

MS. CAMACHO: Objection. Move to strike.

MR. BOROWICK: Please.

THE WITNESS: So they can take symptoms, either back pain, neck pain, or radiating pain; take those symptoms out of context and actually amplify them beyond what they actually are.

You can determine that on physical exam.

Then, there are patients that are stoic, the other end of the spectrum. They try not to demonstrate the amount of pain they have.

Those are also verifiable on physical exam.

John falls on the latter side of that spectrum.

Q. Now, when a person, one of these symptom amplifiers, are they the folks that will go back to work and put their elbow to the grindstone or whatever the expression is, or are those the people, those amplifiers, are those the people that are going to stay out?

MS. CAMACHO: Objection, Judge.

Dr. Merola - Plaintiff - Redirect

THE COURT: Sustained as to form.

Q. How do those patients, the symptom amplifiers versus the stoics, how do they function as far as work is concerned?

MS. CAMACHO: Objection, Judge.

BY MR. BOROWICK:

Q. Based on your experience?

THE COURT: Do you understand the question, and the wording?

THE WITNESS: Yes.

THE COURT: You can answer it.

THE WITNESS: A symptom amplifier will basically do everything they can to not try to get back to work, whereas a stoic would rather just hold on to their pain, not show it and try to get back into work.

BY MR. BOROWICK:

Q. Dr. Merola, counsel asked you about this goniometer, this protractor-type device.

After your experience as an orthopedic spine reconstruction surgeon, do you need a goniometer to measure whether someone's range of motion is mildly restricted, moderately restricted, or severely restricted?

A. No.

Q. When was the last time you used the goniometer?

A. I've used them from time to time, depending on the patient but it's not something that is required, particularly

Dr. Merola - Plaintiff - Redirect

given my experience.

Q. Now, given the context of his injuries, I mean not just, I think the words you used were, if you just take that alone, counsel had asked you about, can't someone go back to work even if they had a herniation?

And you said, "Are you talking about Mr. Mescall or are you talking about in general that alone?"

Explain your qualifying of the answer.

A. In general, a herniation can just be a finding on an MRI film, but that finding needs to correlate with the patient's history and their physical findings and your experience of treating them over time.

So if you just see herniation on an MRI, and a patient has no complaints, no symptoms, no physical findings, then there is no reason why that patient with herniation that appears on a MRI can't go back to work.

The difference is that when you correlate film findings with complaints, symptoms, physical exam findings, a treatment record, that makes the whole difference.

Now we're talking about a patient we're not just talking about an MRI, we're talking about the whole patient and that's the difference.

Q. And when you take this patient not in the context of whether he has a bulge or herniation you say bulge, fine. Palmieri says, "bulge," not just because he has a bulge, but

Dr. Merola - Plaintiff - Redirect

now you have an accident which causes three herniations, you have fractures to the clavicle, the ribs, the transverse processes of the vertebrae, you have shoulder problems, ligaments chondral injuries tendons injuries, you have a low back, you have the ankle that needs to be reconstructed, you are a concussion, when you take this whole patient, this patient, not Mr. General with a bulge or a herniation, you take this whole patient, do you have an opinion, is there any doubt about your opinion that he cannot go back to his job, or any job that requires consistent attendance, focus and effort?

MS. CAMACHO: Object to the form.

THE COURT: Sustained as to form.

BY MR. BOROWICK:

Q. Given this patient with his injuries from this accident, is there any doubt in your mind about his disability total disability from his job, or any job that requires full-time effort, concentration, and focus?

A. No.

Q. Finally, counsel asked you about two of your notes, one from July 12th, and I want you to go to that note on July 12th.

And in the context of this patient that you have known for six-and-a-half years, tell the jury what was going on in July of this year?

A. So in the beginning of July, July 12th, 2010, he was

having persistent pain in the neck, with difficulty maintaining his head and neck position.

He was trying to get back to work.

He was having difficulty tolerating the teaching job, and he continued to remain under pain management with Dr. Perper.

Q. Now, with those kinds of symptoms, and that kind of report, what kind of management now that you've already tried surgery, what kind of management do you as his treating doctor put him as your patient, that you care about what kind of treatment do you send him for?

A. Pain management.

Q. And did he have pain management after that date?

A. Yes.

Q. And what's the goal and purpose of pain management for a patient who presented like that in July, in the middle or the beginning of July of this year?

A. The goal is to try to decrease those severe symptoms that he is suffering from.

Q. Now, I'm going to read to you from Exhibit 19 in evidence, which is the record of Dr. Perper.

MS. CAMACHO: Objection, beyond the scope.

THE COURT: Doctor who?

MR. BOROWICK: Dr. Perper, counsel was talking about July, and I'm putting it in context.

Dr. Merola - Plaintiff - Redirect

THE COURT: Hold on a minute.

Step up.

(Whereupon an off the record discussion was held.)

(Proceedings continued on the record as follows:) (

BY MR. BOROWICK:

Q. Let me rephrase.

Dr. Merola, counsel asked you about that picture that you paint in that report, in that note from July.

Now, having said that you would refer him or referred him for pain management, I'm going to read to you from ten days later on July 22nd, 2010, from Dr. Perper's record.

"Neck and shoulder pain, reports pain is worse with humidity and weather."

Obviously this summer.

"Increase with a change in pain.

Complaint of morning stiffness.

Reports unable to do work.

Will go with -- "

Can't really read it.

Maybe you could read it.

You guys with your handwriting.

Tell us what treatment -- let's just do it this way, tell us what treatment he provided in July of this year, after

Dr. Merola - Plaintiff - Redirect

your note?

A. He gave him injections.

Q. Where?

A. Into the neck and shoulder area.

Q. How long did those injections provide relief for, based on your experience with this patient and injections into his neck and shoulder, how long could he have been provided relief, in your opinion, with a reasonable degree of medical certainty from those symptoms that you are reported ten days before?

MS. CAMACHO: Objection to, "Could have."

THE COURT: Overruled.

THE WITNESS: These --

THE COURT: Well, hold on a second.

I want you to rephrase that, when you state as to what the common understanding of the doctors is.

BY MR. BOROWICK:

Q. Okay. Dr. Merola, when you reported and painted that picture of your patient on July 12th, 2010, and indicated that he was in need of pain management, and now I show you the record from ten days later, where he gets the pain management in the form of shoulder and neck injections, do you have an opinion with a reasonable degree of medical certainty as to whether or not that pain medication, that injection into his neck and into his shoulder would provide him any relief, and if

Dr. Merola - Plaintiff - Redirect

so, what measure of relief could he expect to have for how long?

MS. CAMACHO: Objection to form.

THE COURT: Do you understand the question asked?

THE WITNESS: Yes.

THE COURT: Okay. Go ahead.

THE WITNESS: So these injections would provide him with relief of his pain, it would take his pain symptoms which were getting worse in both my notes and Dr. Perper's notes would decrease these pain symptoms down to a more tolerable level, and that would be expected to last for a temporary amount of time, a number of weeks.

BY MR. BOROWICK:

Q. And with that reduction of symptoms, would he be able to do more?

A. Yes.

Q. With less pain?

A. Correct, yes.

Q. Have some modicum of normalcy in his activity?

A. That's the entire point of giving those shots.

Q. You used the phrase, "In connection with," in many of your answers to Miss Camacho's questions; good days bad days.

Let me ask you this, with a patient who is taking the medications he's taking including Ambient, pain relievers, narcotic medications, antiinflammatory analgesics, what does

the effect of sleeplessness or an inability to get a good night's rest have on a person's physical condition?

A. It makes that condition worse.

Q. And the -- when you use the term, "Good days and bad days," following the injections, would you describe if the weather is right, and the wind is at his back, and the meds are working, and everything kicks in, and the stars line up, what's a good day for him?

A. A good day would be able to perform activities of daily living and getting to a more normal routine to do those things that he was used to doing.

Q. Could he drive?

A. Yes.

Q. Could he sit longer?

A. Sure.

Q. Walk longer?

A. Yes.

Q. Find joy in a walk on the beach?

A. Why not.

Q. Carry a beach chair and sit in a beach chair?

A. Sure.

Q. Tell the jury what a bad day, when the meds wear off, when the injections wear off?

THE COURT: Sustained as to the form.

Q. Tell the jury what a bad day for Mr. Mescall looks

like?

MS. CAMACHO: Objection.

THE COURT: That one I'll allow.

Q. He said you can answer.

THE COURT: Of a bad day.

A. A bad day with these problems would be someone who really isn't able to get out of the house or do much of anything.

MR. BOROWICK: Nothing further.

RECROSS EXAMINATION

BY MS. CAMACHO:

Q. Now, I believe you indicated you need not only an MRI film, but you need clinical symptoms or complaints in order to diagnose a herniation. Correct?

A. You need -- the MRI is the testing.

Q. Right?

A. That is then put into context with the history or the complaints, their symptoms, and then the physical findings.

Q. And you indicated that there are people who actually have herniations with no symptoms. Correct?

A. You can have asymptomatic herniations. Yes.

Q. They go about their daily living, lifting objects, doing their jobs, and they can have herniations without symptoms?

A. Yes.

Q. Could basically do manual labor with a herniation with no symptoms. Correct?

A. Yes.

Q. And in 2004, when you first saw Mr. Mescall, did he need surgery?

A. With respect to the neck?

Q. With respect to his neck?

A. No.

Q. And when you first saw him -- withdrawn.

That is not any different than what Dr. Radna said in 2004, correct?

He didn't need surgery prior to, in March of 2004 and he didn't need it in May of 2004.

Correct?

A. When I initially saw him, I did not indicate surgery and I didn't say that he needed surgery.

Q. And he didn't need it in September 2004. Correct?

A. That's correct.

Q. Didn't need it in 2005?

A. That's right.

Q. Didn't need it in 2006?

A. That's right.

Q. Didn't need it in 2007?

A. We continued to manage him conservatively, yes.

Q. Symptoms, you talked about symptoms having to do with

Mr. Mescall and his ability to work. That's the symptoms are what he tells you. Correct?

A. The symptoms are, yes, the symptoms are what the patient tells you they are feeling.

Q. Hmm-mm. And what they can and can't do?

A. And, that, yes.

Q. And you indicated that you had a different opinion from Dr. Radna with regard to the 2001 film. Correct?

A. Yes.

Q. You personally reviewed that radiological film?

A. Yes.

Q. And you do that in your practice every day?

A. Yes.

Q. Would you ever do surgery without looking at a film?

A. No.

Q. Would you ever do surgery without relying -- withdrawn -- by relying on what a radiologist wrote?

A. By solely relying on the radiologist's report, no.

Q. Now, you indicated that a lack of sleep could make a condition worse. Correct?

A. Yes.

Q. And I believe Mr. Mescall has been described Ambient to help him sleep?

A. Yes.

Q. He was prescribed Ambient prior to 2004. Correct.

A. Yes.

Q. And he was complaining of problems with sleep as a result of neck and back pain prior to May of 2004. Correct?

A. Yes.

Q. Now you indicated the goal of pain management is to alleviate pain. Correct?

A. Diminish, ameliorate pain.

Q. I believe you indicated on cross examination, and in your note of September that despite the pain management that he received, the shots and the medication, he was still having chronic, severe, and unremitting pain. Correct?

A. Over the long-term, yes.

Q. That was his complaints to you in September after he had those shots?

A. That's right, several months after, yes.

Q. Also, you indicated that he couldn't work on a full-time basis to Mr. Borowick you are not precluding any type of part-time employment. Correct?

A. Based upon being able to accommodate his current symptoms and complaints and based upon trying to get him off the medicines and right now I actually have him 100 percent disabled.

Q. And that's based upon his current symptoms and complaints. Correct?

A. His current symptoms, complaints and adjacent segment

problems.

MS. CAMACHO: I have nothing further.

THE COURT: Anything further, Mr. Borowick?

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q. Just explain that last comment, one hundred percent disable disabled and adjacent segment problems.

A. Sure. That relates to that herniation at C4 C-5 producing a C-5 radiculopathy that we have on EMG, and his symptoms of progressive neck pain for which he required the injections which were done at the end of July.

MR. BOROWICK: Nothing further.

THE COURT: All right. Doctor you may step down.

THE WITNESS: Thank you.

THE COURT: Jurors, step out for about five minutes and then we will resume. All right.

Do not discuss the case, give your opinion, no investigations. Refrain from any opportunity to speak about the case.

THE COURT OFFICER: All rise. Jurors exiting.

(Trial recessed.)

(Whereupon Sara Stanley was relieved by, Joyce Fisher, as Official Court Reporter.)