SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS: CIVIL TERM: PART 65

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SERGII PAVLOV,

PLAINTIFF,

-against-

V3 231 LLC, PARK DEVELOPERS & BUILDERS, INC., and 229-231 DUFFIELD LLC

DEFENDANTS.

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INDEX NO. 23023/11

DAMAGES TRIAL

Excerpt

Supreme Courthouse
360 Adams Street
Brooklyn, New York 11201
October 31, 2015

B E F O R E:

HONORABLE LOREN BAILY SCHIFFMAN,
Justice, and a jury.

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

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DOLORES LYNCH, RPR
Senior Court Reporter

(Previous proceedings were not transcribed as requested.)

(Trial matter Sergii Pavlov v. V3 231 LLC, et al.)

THE COURT: Ready for the jury?

MR. MOSES: Yes, Judge.

THE COURT: All rise.

(The jury enters the courtroom.)

THE COURT: Good morning, everyone. You may all be seated.

Plaintiff, call your next witness.

MR. MOSES: Thank you, your Honor.

With the Court's permission, Plaintiff would like to call Dr. Andrew Merola to the stand today.

(The witness takes the stand.)

THE CLERK: Raise your right hand. Do you swear or affirm the testimony you are about to give this Court is the truth and nothing but the truth under penalty of perjury?

THE WITNESS: Yes, I do.

DR. A-N-D-R-E-W M-E-R-O-L-A, after having been called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, testified as follows:

THE CLERK: You may lower your hand. In a loud, clear voice state your name and address for the

record spelling your first and last name.

THE WITNESS: Andrew, A-N-D-R-E-W. Merola, M-E-R-O-L-A.

THE CLERK: Address.

THE WITNESS: 567 First Street, Brooklyn, New York 11215.

THE CLERK: You may be seated.

THE WITNESS: Thank you.

THE CLERK: You're welcome.

THE COURT: You may proceed.

MR. MOSES: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. MOSES:

Q Doctor, good morning.

A Good morning.

Q Doctor, are you a physician duly licensed to practice medicine here in the State of New York?

A Yes, I am.

Q When were you so licensed, Doctor?

A 1992.

Q If you would, would you share with the members of the jury your background in the field of medicine.

A Sure. I went to Howard University College of Medicine in Washington, DC. I graduated in 1990. After that I came here to Brooklyn where I did an internship in general

surgery and then a four-year residency in orthopedic surgery at Kings County Hospital Downstate Medical Center. After I did my basic training in orthopedic surgery I went to the University in Colorado in Denver, Colorado, where I did one year specializing on neck and back surgery in children and adults. Came back to New York City in Brooklyn in 1996 where I've been doing orthopedic reconstructive spinal surgery since that time.

Q Dr. Merola, do you currently maintain a private practice?

A I do.

Q Where is that located?

A I have an office in Park Slope, Brooklyn, as well as one in Manhattan.

Q Are you affiliated with any hospitals?

A Yes, I am.

Q With what hospitals are you affiliated, Doctor?

A Mt. Sinai Hospital. New York Hospital and State University of New York here in Brooklyn.

Q Would you share with the members of the jury what it means when you say you're affiliated with the hospital?

A When you're affiliated with the hospital what that means is the hospital grants you the opportunity to treat and admit patients to the hospital, in my case, admit those patients for surgery so that I can do spinal reconstructive

surgery on them and then treat them within the hospital.

Q Are you Board-certified?

A Yes, I am.

Q In what specialty are you Board-certified?

A Orthopedic surgery.

Q Would you let the members of the jury know what it means to be Board-certified?

A So board certification is a process that begins after you complete your training. You take a written examination in your field of specialty. In my case it's orthopedic surgery. After you pass that written examination you then become eligible for an oral examination. The oral exam is taken two years after you're in practice so that you have an opportunity to collect all of the cases, that is the patients that you had an opportunity to operate on and treat. You then bring all of those cases of all of those patients to a board, which is a group of physicians and surgeons who then ask you questions about your treatment of those patients, and that's the oral portion of the exam. After you pass both parts you're then said to be Board-certified. And then that process repeats itself every ten years. So my first certification was in 1998. I recertified in 2008 and I'm due to recertify again in 2018.

Q Dr. Merola, when was the last time you saw patients?

A This morning, actually, in the hospital.
Q When is the next time you're scheduled to see patients?
A Hospital rounds over the weekend and then office hours on Monday morning.
Q When was the last time you performed surgery?
A Yesterday.
Q When is the next time you're scheduled to perform surgery?
A Tuesday morning.
Q Doctor, the nature of the surgeries you perform, do a vast majority of them involve the spine?
A Yes.
Q Are there certain orthopedic surgeons that have specialties in spinal surgery?
A Yes.
Q Are you one of those surgeons, Doctor?
A Yes.
Q Doctor, do other orthopedic surgeons who may not have a specialty in spinal surgery occasionally refer you their own patients to perform spinal surgery upon?
A Yes.
Q Dr. Merola, to be with us here today you're taking time away from your practice?
A Yes.

Q Are you being compensated to be here today?
A Yes.
Q Will you share with the members of the jury what you are getting compensated in terms of your time to share with the members of the jury this case?
A Sure. So it's $650 an hour away from office practice and hospital practice.
Q Dr. Merola, did there come a point in time that you came to see a patient by the name of Sergii Pavlov?
A Yes.
Q When was the first time you came to see Mr. Pavlov?
A April 9th of 2012.
Q Now I see in front of you, Doctor, you brought your own office records with you?
A Yes.
Q They are in evidence for the jury to review if necessary later, but to the extent you need to refresh your memory by looking at them, please do, as they are in evidence, Doctor?
A Yes.
THE COURT: Do you know what exhibit they are?
THE CLERK: Number 4.
Q Dr. Merola, will you share with the members of the jury the first time you saw Sergii?
A April 9th of 2012.

Q Let the members of the jury know what you did on that day?

A On that day my office visit basically involve meeting with the patient. Finding out what we call the chief complaint is what the major problem is that brings them to your office, and then in taking a little bit of what's know the history to find out what it is that occurred that may be causing them to have their particular problem and something about that problem that then leads a doctor to do an examination to try to better understand what's happening with their body so that you can make a recommendation for treatment. So Mr. Pavlov presented with pain in his back that was radiating, that is traveling down into the legs and feet. So those were his major complaints and symptoms. They had begun after he had sustained a fall which had happened in August of 2011. After that fall, he underwent treatment which we consider what we call as a surgeon we consider that non-surgical treatment, for example, he had physical therapy, medications, and something known as pain management.

Pain management is a process whereby specialize physicians and doctors administer medications directly into the area of the spine with injections. So having not had any benefit from those treatments he was referred to me for a surgical consultation to evaluate his back and make treatment recommendations.

Q Dr. Merola, you mentioned the conservative treatment that Sergii underwent before he came to present to you in your office, one of the remedies he utilized was I believe you said epidural injections?

A Yes.

Q Will you go into a little bit more detail about what epidural injections are and how they're administered to Sergii in this case?

A Sure. So an epidural injection means the injection of medication into an area of the spine known as the epidural space. So in your spinal column there's an area where the nerves are and the area just outside where those nerves are is called the epidural area.

Q Doctor, I'm going to stop you right there. Before you begin to talk about the anatomy and structure of the spine in describing this procedure, I am going to ask will it assist you in explaining the procedure to the jury utilizing the model of the lumbar spine?

A Yes.

MR. MOSES: Your Honor, this was previously shown to Mr. Kaminisky.

THE COURT: Okay.

MR. MOSES: To the extent it will assist the jury --

THE COURT: Did we mark it?

MR. MOSES: We didn't. It's for demonstrative only.

With the Court's permission, your Honor, I like to ask Dr. Merola to step down to show the members of the jury the basic anatomy of the spine.

THE COURT: Okay.

A Thank you. (Witness complies.)

Q Doctor, if you take the opportunity to take a look at that spine and describe to the members of the jury the anatomy that makes up of our lower back.

A So this is a plastic model of the lower back. The top portion of that model are the bones which appear as the squares --

THE COURT: Hang on one second.

Doctor, can you turn slightly this way --

(Pause.)

A The top portion of the model are the bones of the lower back, and in between all of the bones are cartilage structures, which are known as discs, and they sit in between the bones. And the lumbar spine, that is the lower part of your back, sits on the bone of your pelvis which is the area where your hips attach.

On the front side of the spine, as it's sitting inside of you, the major structures are the bones and the discs and the pelvis. On the backside, which is in your

lower back area, you can feel there are certain bones, we call those the spinous processes. They almost look like the bones on the back of a dinosaur. And underneath those spinous processes, there's a bone called a lamina, which basically is the covering of the spinal canal. And the spinal canal is the area where the nerves are. So they exist in a canal in the lower portion of your back. Mostly located farther towards the backside of your back.

Inside that canal those nerves are covered by something called the dura. So anything that is outside of the coverage area is called the epidural space. So when we're talking about an injection, if it's an epidural injection, it's an injection that is placed with a needle into the spinal canal in the area where the nerves are in order to administer an anti-inflammatory medication to the nerves that are being damaged by inflammation.

Inflammation is a process that happens normally to your body after there's been a portion of your body that has had a disruption. For example, if you ever had a cut or a scrape on your skin, you'll notice that, that cut or scrape can turn red and sometimes it can leak, not only blood, but some fluid, right. That's inflammation. When there is a problem with the disc or the nerves, that process happens on the inside as well. And one of the ways to block that process or to prevent it from continuing to happen is to

administer a steroid medicine to decrease that inflammatory process, and that's what an epidural steroid injection does. So it's a way of administering medication directly to the area of the nerves in order to block the inflammatory process to try to decrease pain and prevent pain from getting worse.

Q Doctor, while you're there, will you show the members of the jury where the discs are located in the lower back.

A Sure. So if you look at each bone, when you're looking at the spine from the side the bones appear to be squares. And in between the squares, sitting in between each bone, sandwiched in between each bone, is the cartilage structure which we call the disc. And the disc is essentially made up of two different parts. There's an outside part, which is a fibrous ring. And then there is an inside part, which is more jelly-like. It's kind of like a jelly donut. It's got the outer pastry covering to it that holds the jelly center on the inside. And each disc sits between each of the individual bones of the lower back all the way down to where those bones become part of your pelvis known as the sacral area. So the lumbar bones are labelled L 1 through 5 because there is five of them. L4 lumbar or lower back. They then attach to the pelvis in an area known as the sacrum, which is the large triangular bone you see at the bottom of this model. And the sacrum is referred to the

S area. So for example, the L5-S1 disc is that piece of cartilage disc that sits in between the fifth lumbar bone and the first sacral bone.

Q Dr. Merola, the yellow structures on that model, coming off each level of the lumbar spine, what are they?

A These yellow -- they look like yellow wires coming out of the lumbar spine are what we call the nerves roots. Those are the areas of the spine where the nerves that have now traveled through the spinal column, exit the spine in special little openings in order to form the nerves that then go down into your legs and your feet. At the lowest portion of the spine between L5 and S1 the nerves come together to form the large nerve that travels down the lower part of your back into your buttock area and down the back of your leg into your legs and feet known as the sciatic nerve, and that sciatic nerve is made up of the nerves that exit the lower part of your back.

Q Dr. Merola, at each level of the lumbar spine, specifically with regards to the nerves that are existing each level of the lumbar spine, is there a specific distribution that those nerves are responsible for?

A Yes. So each one of these nerves has an associated name, and the name is actually the number of the nerve depending upon which bone it comes past. So, for example, the nerve coming past the L5 bone is known as the L5 nerve

root. And the L5 nerve root travels in a specific way down your leg. If you think about it as though you were wearing a pair of paints with stripes on the pants, that nerve actually travels down along a specific stripe area of your leg. Likewise, the nerves coming out of the S1 region or the first sacral bone also goes down your leg into a specific striped area. That area of your leg is known as a dermatome. In other words, it is a part of the skin area of the leg that is what we call innervated by the nerve. That means the nerve travels into it. Each nerve is responsible for feeling, sensation, moving a particular reflex in your leg --

MR. KAMINSKY: Judge, I'm sorry. Is it okay if the doctor returns to the witness stand?

MR. MOSES: One more question about the model and then I'll put him back on the stand if there is no objection.

MR. KAMINSKY: Thank you.

MR. MOSES: Sure.

A So each nerve is responsible for feeling a specific portion of your leg, managing a specific reflex in your leg, and moving specific muscles around in your leg following a specific pattern, which we call a dermatome for the skin, or a myotome for the muscle.

Q So Dr. Merola, when Sergii presented to you that first day and made complaints of low back pain that were

radiating into his leg, utilizing that model, was that a significant complaint to you in perhaps addressing a potential nerve root injury?

A Yes.

Q How so?

A When we talk about radiating we mean that the pain travels, and when we're talking about traveling we're trying to figure out where the pain is traveling to and what route it is taking. So if it travels along the distribution of a nerve it helps us to more closely localize the actual nerve or nerves that are involved.

Q Thank you, Doctor. You can return to the stand.

A Thank you. (Witness complies.)

Q Doctor, in response to Sergii's complaints of radiating pain into his legs, stemming from his low back, did you perform any clinical examination in your office that day?

A Yes.

Q What was that exam?

A So that exam involves feeling portions of the body and then testing both the nerves and the spine to try to localize the nerves that are involved. One of the things and the first thing that I did for the lower back was to look at the range of motion of the lower back to see whether or not there were any specific portions of the range of motion of the lower back that re-produced pain. And in this case he

had what's known as a positive final Phalen's maneuver, which is bending the lower back backwards, which we call extension. In other words extending the lower back. And in so doing that process of extension closes the area where the nerves are. So if there is a particular nerve or nerves that are irritated and you close off the exit area you will cause pain in the distribution of that nerve. And in this case that test was positive at what we call 0 degrees of extension. So the patient was actually bent forward, the lumbar spine was bent forward a bit, bending it backwards and compressing the nerves was reproductive of pain.

To further examine those nerves the next test that was done was a test whereby you can actually pull on the sciatic nerve. Since the sciatic nerve travels down your leg, if you extend the knee, that is you stick your leg straight out, and then you take your foot and your ankle and you also extend the foot and the ankle, you'll feel that the back of your leg gets tight. When you make the back of your leg tight, as you raise the leg up off the ground you're actually pulling on the sciatic nerve. It's known as a straight leg raise test. If the sciatic nerve is inflamed and irritated the patient's automatic response is to pull away from you pulling on that nerve. That's known as a straight leg raise test. And his test was positive in two positions. One seated. So while sitting down, extending the

knee and pulling back on the foot and ankle, the test was positive and the other way it was positive was lying down on the table, extending the knee and pulling back on the foot and ankle raising the leg and pulling on the nerve also reproduced pain. So those were two signs of nerve root irritation. So we knew that the sciatic nerve was being irritated and inflamed.

The other thing was to test some of the things that the nerves do and that includes testing the sensation in the nerve and the reflexes that the nerves are responsible for. And in this case he had an alteration in sensation specifically in the L5 root and the S1 root of the leg with a loss of what's known as the achilles tendon reflex, which is a reflex in the back of your ankle, and that's a reflex the sciatic nerve was responsible for. So when you add all of those physical findings together you come up with what we call a diagnosis of a radiculopathy, which means a problem with nerve root. These nerves are known as roots. The Latin term for that is radic and any time you hear the word "apathy" it means a problem with. So we knew there was a problem with the sciatic nerves exiting the lower back.

Q Dr. Merola, were there any diagnostic tests performed upon Mr. Pavlov that were made available to you to assist you in rendering a diagnosis in this case?

A Yes.

Q What did Mr. Pavlov have done before he presented to you in April?

A An MRI film of the lower back.

Q All right. Let the members of the jury know what an MRI is?

A An MRI is an imaging study, it's a way of getting a picture of the inside of your body using a very powerful magnet. Your body basically becomes magnetized when you're placed into the machine and then through the magnetic reaction in your body a computer is able to generate an image of the internal portion of your spine in this instance. And that image or that film looks very much like the anatomy that we looked at here. So you'll be able to see what's normal and what's abnormal on the MRI film.

MR. MOSES: Your Honor, at this time I ask the doctor to step down again to the explain to the jury Mr. Pavlov's MRI that was taken on October 4th of 2011, a blowup of which is going to be used as a demonstrative exhibit. The actual MRI film is in evidence.

THE COURT: What is it in evidence as?

MR. MOSES: I misspoke, your Honor, it will be in evidence as Plaintiff's Exhibit 7.

THE COURT: Okay.

Doctor, you can step down.

THE WITNESS: Okay.

A (Witness complies.)

MR. MOSES: Will you bring the model, please, Doctor.

A (Witness complies.)

THE COURT: Mr. Kaminsky, if you need to move to see this, go right ahead.

MR. KAMINSKY: Thank you, your Honor.

MR. MOSES: Okay.

Q Doctor, if you would -- Doctor, utilizing the model by the film so the jury can get a bearing of what they're looking at, tell us what that photograph depicts.

A So I'm holding up a model so that you see it as a side view. And that corresponds to this MRI image which is a side view image as though we are looking at the patient from the side facing the back wall of the courtroom. So when we look at the MRI, when we see the gray squares, what we're looking at are the bones. In between each bone we see something that looks more like an ellipse or an oval or a circle, those are the cartilaginous discs that are in between each bone. And behind the bones and the discs, or to the left on the MRI, we're looking at the spinal canal. That's the white stripe that's running down the left side of the image. So when we look at this MRI film with specific attention to the discs we see that the disc at the lowest part of the spine, between the L5 bone and the S1 bone, that

is the pelvis, that disc is not the same as the other discs and, in fact, if you look at the disc itself you can see that there is a portion of the disc which is sticking out into the canal so it looks like a little P or a piece of disc material has broken off the backside of the disc and is inside the canal area. You can tell that it's in the canal because all of the other discs stop before they get to the area where that white stripe is. Except in this case where there is a piece of disc material sticking into the canal region. Canal region is the area that contains those nerves. So looking at the MRI we can see that in the area where the sciatic nerve begins there is a portion of disc material that is sticking into the area of the nerves.

Q The location of that disc and the location of the material that you showed the members of the jury, what nerve root distribution will that affect in Mr. Pavlov?

A So this is the L5 bone. This is the S1 bone. This area of the spinal canal contains the L5 nerve roots as they pass across the L5 bone, and the S1 or first sacral nerve root as it goes past the L5-S1 disc to exit after the S1 bone. So this is the area of the L5-S1 nerve roots which are the nerve roots that primarily make up the sciatic nerve that runs down the back of your lower leg.

Q The disc that is affected in this MRI image, Doctor, is that consistent with the clinical symptoms and

testing you performed in your office the first day you saw Mr. Pavlov?

A Yes.

Q Doctor, are you familiar with the term disc herniation?

A Yes.

Q What is a disc herniation?

A So when you look at a disc, discs can do several things. Number 1, a disc can be normal or a disc can be abnormal. If it is abnormal, it can be abnormal in two basic ways.

The first basic way a disc can be abnormal is by a bulge. A bulge means that the disc sticks out around the entire circumference of the bones in a very symmetrical way. For example, if you have a tire and it's becoming flat, the edges of that tire stick out in a very symmetrical way all the way around the tire because its lost air. Very similar to a bulge.

A herniation is a way that now the disc is also abnormal, but unlike a bulge, a herniation involves disc material sticking out more in one area than another area. So it's asymmetrical. It is an asymmetrical protrusion or sticking out or leaking out of that jelly-like material in an abnormal fashion that goes beyond the borders of the bones into the canal where the nerves are.

Q Doctor, what is depicted in that October 4, 2011, MRI?

A So what we see here is disc material that is a portion of the disc that is inside the canal, beyond the confines of the bones, in an asymmetrical fashion which we will consider a herniation.

Q Dr. Merola, is there anything else you can observe from that MRI film with regard to the overall condition of his back, specifically his discs, at any level other than the L5-S1 herniation that you noted?

A So when you look at the MRI film what we would look at is you look at the bones, and we see that the bones all have a very nice square appearance with a very nice gray signal to all bones, which tells us that the bones themselves are essentially normal and they're well aligned. When we look in between each of the bones at all of the discs, except for the L5-S1 disc, we see that all the discs have a preserved height, which means that they're maintaining all of the bones at a normal distance, and that all the discs are well contained within the confines of the vertebral borders and that there are no signs or symptoms -- no signs on the MRI film that there are any significant what we would consider age-related or degenerative conditions of the remaining portions of the lumbar spine.

Q Dr. Merola, does looking at an MRI film such as

this one that shows only one level of herniation and otherwise unremarkable levels of discs help you in assessing what caused the herniation that Mr. Pavlov suffers from?

A Yes.

Q How so?

A When you combine this MRI film with the history and the physical findings, you can come up with an idea that this disc herniation has occurred after the accident --

MR. KAMINSKY: I will object, your Honor.

THE COURT: Outside.

(Discussion was held outside the presence of the jury.)

THE COURT: The objection is sustained.

DIRECT EXAMINATION

BY MR. MOSES: (Con't.)

Q Dr. Merola, you talked about the color of the discs at the levels above the L5-S1 herniation. Are there discs in the human spine below L5-S1?

A No. There are no functional discs below the L5-S1.

THE COURT: Next question.

Q What is depicted in that image below the L5-S1 level?

A The sacrum or the large triangular bone that forms a portion of your pelvis is broken up into a variable number of segments. Generally there are about four or five sacral

segments. They're actually all coalescent to one large bone known as the sacrum, which means there are no joints in between the various portions of the sacrum.

When you're developing as an embryo, your spine is made up and becomes made through a process whereby your discs are formed by a very special portion of your developmental process called a notochord. It's a remnant of a previous reptilian existence. When you're born, that notochordal remnant becomes your discs. When you're an embryo, the notochord exists in the segments of the sacrum. But when you're born the sacrum becomes a solid bone. So the notochordal remnant does not develop into a disc. It develops into a what we call a notochordal remnant or a cartilaginous -- a cartilaginous structure that exists between the segments of the sacrum, but it is not a truly functional disc.

Q So these two discs -- well they're not discs -- these two notochordal remnants, okay, you're the doctor, those two levels are not structurally similar to the discs up above it?

A Correct. They're made -- they're embryologically similar, but they are completely entirely functionally and physiologically dissimilar to the rest of the spine.

Q The reason I'm asking is because the L5-S1 disc that you showed the members of the jury appears darkened

compared to the other levels above it?

A Yes.

Q But if you look below it those two levels also appear darkened?

A Yes.

Q Is that significant in any way in changing your assessment as to the lack of structural changes in the discs of his spine?

A Yes and no.

Q Okay.

A No, because these notochordal remnants don't have the same physiological role that the rest of the discs have so those structures are traditionally and very typically dark. When you're looking at an MRI, when we say light or dark or signal, or we are talking about the different shades of gray and colors that you see here, what it really relates to is the way your water content -- the water content of your tissues responds to the magnet.

The spinal canal contains a lot of water. Cerebrospinal fluid is mostly water and you can see that it's very bright white. Bones don't have so much water in them. They have more blood in them than water so they're not as bright white as the cerebrospinal fluid is so it's a grayer signal.

The discs contain water so they light up a bit more

than let's say the bone does, but there's still a lighter shade of white than the cerebrospinal fluid is.

At L5-S1 the signal here is not as bright as these other signals. What you'll notice, if you compare it, the front of the disc has a very similar signal to all of the other discs. The height between the bones is well maintained as it is in all the other discs. And there is a gray signal when you start to see the middle portion of the disc up to the back portion of the disc there is a preserved gray signal within L5-S1 albeit less than the other discs. And that's associated with the area of the herniation. Because once the herniation happens, the blood supply to the disc, and the nutritional supply to the disc, and the fluid within the disc all change, and they start to decrease. Because that outer fiber ring has little blood vessel in it. In order for a herniation to happen the outer fiber ring of the disc becomes torn. The tearing of that fibrous ring causes two things to happen.

Number 1, it causes the disc to begin degenerating and losing fluid, and it also causes the disc to no longer have a normal or appropriate blood supply, and that's when that inner jelly-like course starts to leak out. So these changes happen to the disc after the annulus, that is that outer ring had been torn, and it starts off this process or this cascade of events that lead to the herniation and then

lead to an abnormal disc picture.

Q Thank you, Doctor. You can return to the stand.

A (The witness complies.)

Q Now, you continued as Mr. Pavlov's treating physician for some time; is that correct, Doctor?

A Yes.

Q Now you brought your records to court. They're here for the jury to review so I'm not going to take you through every visit that you performed on Mr. Pavlov, but I do want to get to the point where you recommended that Mr. Pavlov undergo a surgical procedure.

A Okay.

Q When did that happen, Doctor?

A So, when I first saw Mr. Pavlov -- so when we make a recommendation for surgery we call that an indication for surgery or a reason to have surgery. Now, a reason to have surgery in this case is a patient who has had persistent symptoms with neurological findings, that is abnormal nerve function, that has failed non-surgical treatment. And in this case included epidural steroid injections. So when I first saw him he was a surgical candidate. So he was someone that we had a good reason for doing surgery on. So we actually had that discussion first time I saw him. And we went over the options and the alternatives to surgery as well as what we call the realistic expectations of surgery and

some potential complications that are involved as well.

The primary reason to do an operation is, Number 1, to try to decrease some of these symptoms and, Number 2, to prevent the herniation from continuing to cause damage to those nerves that it is now leaning up against. So those are the major reasons to do the actual operation itself. And when I first saw him he was a candidate based on everything that had come before and that failure of conservative treatment.

Q Dr. Merola, what was the nature of the surgical procedure you recommended to Mr. Pavlov?

A So, the surgery that I recommended was a -- what we call taking the pressure off the nerves through a process called a laminectomy. That is the removal of the canal covering called the lamina. What that does is it takes all of the pressure off those nerves and it gives the nerves more cerebrospinal fluid flow, more blood flow and less pressure.

Number 2, removing the disc itself. The entire disc so that the portion of the disc that's leaning on the nerves can be taken out and removed, and then rebuilding and stabilizing the lower portion of the back so that once that disc has been removed it does not collapse down onto the nerves and then cause a subsequent problem. That's called a fusion. So it is a laminectomy and a spinal fusion to take the pressure off the nerves and then to rebuild the lower

back so that the bottom portion of the spine does not continue to cause anymore nerve damage.

Q Dr. Merola, did I show you at some point an illustration of the cervical procedure you performed?

A Yes.

Q Do you think it would assist you in showing the members of the jury the nature of the surgery?

A Yes.

MR. MOSES: Your Honor, I previously showed this to Mr. Kaminsky, this is a demonstrative exhibit showing illustration of the lumbar decompression fusion.

THE COURT: Any objection?

MR. KAMINSKY: None.

MR. MOSES: I would ask the Doctor, and the Court, please, if you step down one more time.

A (The witness complies.)

Q To the extent that, that illustration assists you, Doctor, will you let the members of the jury know what exactly you did in attempt to help Mr. Pavlov.

A So this is an illustration of exactly what I had just spoken about which is a surgical procedure on the lower back to take the pressure off the nerves, remove the disc, and then rebuild the lower back and stabilize it so that it doesn't continue to cause anymore damage to the nerves.

The surgical procedure begins with an approach to

the lower back which begins with an incision in the lower part of the back where the bones are located so that you can then look at directly and expose the area of the spinal canal.

The removal of the lamina is shown in frame number A. So there are specialized tools that are used to actually remove the lamina portion of the spine so that you can expose the nerves and make more room for the exiting nerves. That also involves visualizing the nerves so that you can then move the nerves out of the way, which frame B is showing, so you can actually identify the disc that's in the canal now putting pressure on those nerves. So you can directly remove that disc herniation and take it away from the nerves.

In the upper right hand portion you see a cutaway view where the disc -- the nerves are moved out of the way and when the actual disc itself is being removed from the canal where the nerve is. Now once that disc has been removed there's no longer, if you will, consider it a shock absorber in between those bones. So in the case where that disc has been entirely removed the bones would, over the course of time, collapse down onto each other and then put more pressure on the bones, so in order to prevent that from happening you insert what we call a biomechanical device which is made out of a specialize piece of plastic. It actually acts as a shim that you stick in between the bones

to recreate normal bone height, keep the bones from collapsing down onto each other, and assists in actually gluing those bones together which we call a fusion process. In other words locking the bones together so that they now grow together as one bone which prevents them from collapsing down onto the nerves. That device is inserted in the area where the disc was removed deep in between the bones so that it's not in the area of the nerves or the spinal canal.

After that is done, in order to make sure that this entire area no longer continues to move in an abnormal fashion, we insert screws called pedicle screws which are bone screws designed to hold the bones together that are attached by rods to complete the fusion process. And the bottom right side is a side view of what it looks like to have the bones inserted into -- those screws inserted into the bones to hold them together to complete that reconstruction process known as a fusion.

Q Dr. Merola, following the surgery, do you take post-op x-rays to show whether or not the fusion and the cage is in proper anatomical position?

A Yes.

MR. MOSES: Your Honor, I like to show the members of the jury a blowup of postoperative x-rays -- the exact hospital record is, I believe, Plaintiff's Exhibit 5 previously shown to Mr. Kaminsky.

THE COURT: So it's in evidence?

MR. MOSES: Yes.

MR. KAMINSKY: No objection.

THE COURT: Okay. Plaintiff's 5 in evidence.

(Plaintiff's Exhibit No. 5, x-rays, were previously marked and received in evidence.)

DIRECT EXAMINATION

BY MR. MOSES: (Con't.)

Q Dr. Merola, will you please explain what those x-rays show.

A So these are x-rays of the lower back. So at the bottom, there are four x-ray films here and they are taken at different angles to the body. In the upper left hand corner of the illustration is the front to back view so you're looking directly at the patient. On the bottom of the x-ray is the pelvis. On the bottom of that are the hips. And on top of that you see the spinal column. You can see the very white bright objects are the screws attached by rods, and then you see these three small bright white signals, those are metal markers that are inside that plastic device that sits in between the L5-S1 segment. And you can see on the x-ray that everything is lined up at L5 and S1 from the front to back view.

The next view to the right of that, and then on the bottom to the left are oblique views so they're not actually

front to back view, they're taken off to the side, so you get an idea from what it looks like from the side and it gives you an idea of each screw and its position to the area where the nerves exit. So you can see the nerve root exits to make sure that none of the screws are touching any of the areas where the nerves are, and you do that on both the right side and the left side. So those screws are in good position.

And in the final x-ray is a straight side view x-ray of the screws and rods and the shim device in between the bones holding the entire lower back portion of the fusion process together.

Q Thank you, Dr. Merola, you can return to the stand please.

A (The witness complies.)

Q Doctor, the surgical procedure you described for us, at what hospital was it performed?

A Methodist hospital.

Q You performed the surgery?

A Yes.

Q Contained in your records, and if you need the hospital records I have them, Doctor, do you have the surgical report?

A I do.

Q The surgical report is something you generate that encompasses the observations you made during the surgery?

A Yes.

Q Doctor, when you went into Mr. Pavlov's lower back, utilizing that surgical report, did you see the herniation that we previously identified on Plaintiff's MRI at the L5-S1 level? Did you see it with your own eyes?

A Yes.

Q What level did the herniation occur at?

A L5-S1.

Q What did you do when you saw that herniation?

A I removed that herniation and sent it for what we call a pathological evaluation.

Q Dr. Merola, how long did this surgical procedure take, if you recall?

A So the actual operation itself, that is what we discussed in the illustration taking the pressure off those nerves and removing the disc and inserting the screws and rods and everything, that takes about an hour and a half to two hours. The anesthesia takes a little longer to getting the patient to sleep part and waking them up part.

Q So Mr. Pavlov, is safe to say, was under the effects of general anesthesia for over two hours?

A Yes.

Q Are there risks with being under anesthesia for that long that was explained to Mr. Pavlov?

A Yes. So there are risks with every anesthetic,

correct.

Q What were the risks that were explained to Mr. Pavlov about this surgery?

MR. KAMINSKY: Objection. Just the relevance, your Honor. It's obvious there were no complications.

THE COURT: No, that's not what he is asking. The question is what were the risks that were explained to the plaintiff. Overruled.

Q Go ahead, Doctor.

A So the risk of surgery are the risks of, Number 1, a general anesthesia. So general anesthesia can have a risk of having a problem with a reaction to the anesthetic. And or a problem with lungs or heart or medical conditions after the surgery or during the surgery itself. So there is an anesthetic component to surgical risks.

The other risks of the surgery itself are any time you're opening the skin and you're making an incision there is a risk of an infection. There is a risk that when you're operating on nerves that have irritation to them with a herniation when you're moving those nerves out of the way, the nerves may not appreciate being moved out of the way and there is a risk of potential more nerve damage. There is also a bleeding risk associated with the surgical procedure. And then there is the healing that needs to take place after the surgery has been completed so that the actual fusion

itself heals. So each one of those steps along the way carries with it certain potential surgical risks.

Q Dr. Merola, was Mr. Pavlov admitted to Methodist hospital for this surgery?

A Yes.

Q How long, to the best of your recollection, if you know, did he remain in Methodist hospital?

A Generally a three-day stay.

Q Dr. Merola, I want you to assume that Mr. Pavlov stayed at New York Methodist hospital from December 13th of 2012 to December 17th of 2012, and he testified to the members of the jury what occurred during that four-day stay. I want you to assume, specifically, that Mr. Pavlov shared with us his frustration in not being able to get out of bed on his own. Needing to be assisted. Needing to be taught how to dress himself in the hospital. Sharing with us his frustration with his inability to climb stairs as he was taking himself down the hallway for a walk with his IV.

Do you have an opinion, Doctor, as to whether or not all those complaints, within a reasonable degree of medical certainty, is consistent with somebody that just underwent the surgical procedure you performed in this case?

A Yes.

Q How so?

A So, that initial hospital stay involves a

postoperative rehabilitative process.

When you remove the muscles and need to move them out of the way to do that approach and the exposure of the lower back and then have to reconstruct and rebuild the lower back, your body now needs to be able to get use to having that procedure performed. And that is very common because those muscles in your lower back and the area of the L5-S1 segment are responsible for basically just about everything you need to do including getting up and out of bed and walking around. So all of those types of what we would call postoperative rehabilitative process are very common after this particular procedure.

Q Doctor, are you familiar with the medication that was administered to Mr. Pavlov when he was in the hospital recuperating from the surgery?

A Yes.

Q What prescription medication was given to Mr. Pavlov and what was the reason for it?

A So right after the operation we generally put patients on an intravenous pain medication. A Morphine derivative in order to decrease the surgical pain from the procedure itself. And then we transition those patients to a by mouth version of a Morphine derivative or a narcotic medication in order to decrease the postoperative symptoms of the surgery.

Q Dr. Merola, when was the last time you saw Mr. Pavlov?

A So my last office visit with the patient was on, in March of 2015.

Q When you is a saw the patient in your office approximately seven months ago, what complaints, if any, was he making to you at that time?

A So let's see. The major symptom was what we call mechanical axial low back pain. What that means is, that's pain in the lower back area that's mechanical. So activity related pain in the lower back and in general activities that require motion to the lumbar spine. So for example, and I listed some things here that he was having difficulty with, bending, lifting, and twisting, which would involve mechanical activities to the lower back. Being able to push or pull or to get down onto knees in order to stoop or crawl. Those were mechanical related with problems. Also had a problem with sitting for long periods of time. Particularly having to alternate sitting and standing because being in any one of those positions for a significant amount of time would reproduce symptoms in the lower back. Let's see what else.

Shooting pain had gotten better but the major symptoms were axial, that is lower back related symptoms.

Q Dr. Merola, would you consider the surgery you performed on Mr. Pavlov to be a successful surgery?

A Yes.

Q Why would he still be having complaints if it was a successful surgery?

A So when we talk about the indication for surgery or the reason to do the surgery, the reasons that we list for doing this operation are, Number 1, to take away the severe pain that shoots down into the legs. Get the pressure off the nerves, and then stabilize the area to prevent the nerves from getting worse. Because the sciatic nerve is one of the major nervous that goes into your leg and feet, when you begin to lose the reflex control and you begin to lose sensory control and the nerve has persistent compression on it for a long course of time, the danger is that, that nerve can continue to deteriorate whereby you now begin to experience weakness and progressive disfunction of the nerve which could lead to severe problem with the ability to walk. So the reason for doing the surgery is to maintain the ability to walk. It cannot reverse the damage that's been done to those nerves because there are nerve fibers inside the nerves themselves that have had a period of time whereby they've been damaged and compressed. So that portion of the nerve damage that's happened is irreversible. The reason to do the procedure is to prevent the damage from continuing to the point where you reach irreversible damage and can no longer walk.

Q Dr. Merola, I want you to assume that Mr. Pavlov testified for the members of the jury on Tuesday of this week. And he testified that on August 12, 2011, he was working as a plumbing assistant on a construction job here in Brooklyn. Mr. Pavlov told us that he stood about 6 feet off a concrete floor on this construction site and was drilling into a ceiling that was approximately 12 feet high.

Mr. Pavlov testified that he was standing on a ladder that was resting against the wall of this structure. He told us that as he was drilling into the ceiling the ladder collapsed, gave way, and he landed on his knees and elbow on the concrete floor and ultimately went flat on top of the ladder, on top of this floor.

Do you have an opinion, within a reasonable degree of medical certainty, as to whether or not that fall in August of 2011 was a substantial factor in bringing about that L5-S1 disc herniation?

MR. KAMINSKY: Objection.

THE COURT: Overrule.

A Yes.

Q What is that opinion and why, Doctor?

A That fall is a substantial factor in producing a herniation at L5-S1 by causing the lower portion of the back to basically snap backwards, pressuring the nuclear portion of the disc and tearing the annulus to produce a herniation.

Q Dr. Merola, I want you to also assume that following that fall Mr. Pavlov presented to Brooklyn hospital immediately after, and he was diagnosed in that hospital with a fractured knee cap on his right knee. I want you to further assume that in that hospital, the hospital records revealed that Mr. Pavlov made complaints of pain to his knee, to his elbow, difficulty breathing, but in the admission report there is no mention specifically of pain to his lower back.

Do you have an opinion, within a reasonable degree of medical certainty, as to whether or not the failure to make a complaint on the admission report changes your opinion at all about the causation of the herniation in his L5-S1 disc?

MR. KAMINSKY: Objection.

THE COURT: Overrule.

A I do.

Q What is that opinion, Doctor?

A That it does not change the opinion as to causation of the actual herniation.

Q Well, Doctor, let me ask you this question. If Mr. Pavlov suffered a herniation at the L5-S1 level when he fell and hit that concrete floor, then how come complaints of low back pains aren't all over the medical records?

MR. KAMINSKY: Objection.

THE COURT: Overrule.

A The amount of pain that the back he is going to experience and the amount of pain that the nerve experience is proportional to the amount of that nuclear or jelly-like substance that comes out of that disc. So the first thing that happens with these types of herniation is a tear or a disruption in that annulus. And if we look back at the mechanism of disc herniation, when the annulus, that is that outer tear happens, it now gives that jelly-like material an opportunity to start coming out of its normal position, and as it gradually comes out of its normal position and begins the inflammatory process on the nerves, you develop a progressive pain over the course of time that slowly happens as that substance is making its way out.

Q The substance that you're describing is the nucleus pulposus; is that correct?

A Yes.

Q The consistency of the inside of that disc, the consistency of nucleus pulposus you described it as jelly?

A Yes.

Q So when the annulus fibrosis tears in our discs that jelly does not immediately come out?

A It doesn't all squirt out at the same time, no.

Q I want you to assume that what Mr. Pavlov told us was when he went home he remained home for approximately five

days before he went to see his first treating physician in this case Dr. Raz Winiarsky. I further want you to assume Mr. Pavlov told us that while he was home after the hospital, approximately two days later he began to feel for the first time this lower back pain that he described radiating into his legs. Is that complaint consistent with a mechanism of a herniation that you just described for us?

A Yes.

Q Did you have an opportunity to take a look at the Brooklyn hospital records?

A Yes.

Q Doctor, is there anything in the Brooklyn hospital records that indicated to you that Mr. Pavlov was in fact, although maybe not complaining about it, beginning to suffer from the effects of a herniation?

A Yes.

Q Where in this hospital record, Doctor?

MR. MOSES: If I may approach, your Honor?

THE COURT: Yes.

MR. MOSES: And the hospital record Plaintiff's Exhibit 1 is in evidence. Brooklyn hospital. (Handing.)

THE COURT: Thank you. It's A actually.

MR. MOSES: Mr. Kaminisky had a portion of that as Defendant's Exhibit A. I entered the entire record as Plaintiff's Exhibit 1.

THE COURT: Okay. Thank you. This is in evidence.

MR. KAMINSKY: I think I did actually offer the entire record but --

THE COURT: We marked it twice. It's fine. It's okay.

A There is an exam section inside.

Q Is there a particular page you can refer to, Doctor?

A Hang on one second. 13 of 22.

Q What specifically on page 13 of 22 are you referencing?

A There is a range of motion limitation where it says "Rotation right side and back ROM limited."

Q What did that indicate to you, Doctor?

A That there was a limited range of motion with rotation in the lower back area that would be consistent with low back pain and a disc problem.

MR. KAMINSKY: Objection. Move to strike.

THE COURT: Approach.

(Discussion was held off the record.)

THE COURT: That objection is sustained and the answer is stricken so not to be considered by the jury for any purpose.

DIRECT EXAMINATION

BY MR. MOSES: (Con't.)

Q Dr. Merola, the indication in the record that there was a limitation in Mr. Pavlov's range of motion in his back consistent with Mr. Pavlov's disc herniation in this case?

A Yes.

Q Dr. Merola, I want you to assume that Sergii told us that even though he underwent the surgery and even though he performed physical therapy he still, till this day, continues to suffer from low back pain. He described for us that the pain occurs in two different ways.

I want you to assume he specifically told us that he gets low back pain localized in his lower back. He also told us that he gets low back pain that radiates into his legs. He further told us that he doesn't always get the same pain at the same time. Sometimes he gets both. Sometimes he gets one. I further want to tell you that Mr. Pavlov told us he gets spasm in his lower back till this day.

Are those physical complaints, Doctor, within a reasonable degree of medical certainty, consistent with an individual that sustained a L5-S1 disc herniation that underwent a surgical fusion?

A Yes.

Q How so, Doctor?

A They speak to the mechanical axial nature of the pain and symptoms which are pretty consistent with my last

visit of the patient. So there is this function that is abnormal function of the lower part of the back in an area where the disc was ruptured and there was nerve root damage so that's all consistent with a postoperative course and a post herniation course.

Q Dr. Merola, what is a lumbar spasm?

A A lumbar spasm -- a spasm refers to an involuntary contraction of a muscle so if you ever had a Charlie horse in your leg you feel that there's pain there and that there's -- if you feel it, it feels very hard and that is an abnormal contraction of your muscle.

A spasm is an abnormal contraction of the muscles whereby the muscles become very hard and painful.

Q Doctor, why is it that till this day Mr. Pavlov is still suffering from a lumbar spasm?

A Because there is a certain amount of irreversible damage that occurs that happens to the lower part of the back. And there is a reconstruction of the lower back as well that changes the overall normal way that you were originally put together.

Q Dr. Merola, I want you to further assume that Mr. Pavlov told us on Tuesday that there are certain activities he used to enjoy that he can no longer enjoy as a result of his neck pain -- excuse me -- his back pain and radiating back pain. Specifically he told us that he can no

longer play the game of billiards because when he bends over the pool table his back tightens up and he feels shooting pain and he has to stop.

He further told us on Tuesday that there was certain activities such as taking long walks. He related a story of taking a walk with his roommate and he was unable to complete the walk because his back tightened up and he had to lay down as a result of it.

He further told us, Doctor, that he went out on occasion with friends and wasn't able to participate in the same activities as his friends were participating in. Such as gathering fire wood. He was relegated to playing with the children at this particular event.

Do you have an opinion as to whether or not these limitations that Mr. Pavlov shared with us are all, within a reasonable degree of medical certainty, related to the L5-S1 damage you shared with us?

A Yes.

Q How so?

A They are related to L5-S1 insomuch as the lower portion of your back and the muscles that attach your back to your pelvis and the L5-S1 junction are responsible for, for example, if you're bending forward the lower portion of your back acts what we call tension band. When you bend forward, the muscles in your lower back and the structures of your

lower back as they attached to your pelvis are responsible for maintaining your spine and your body in that particular position. Not unlike if you've seen those construction cranes they have a big wire along the top of the crane. That big wire is a tension band that prevents the crane from collapsing forward. So the low back, muscles and joints act as a tension band for your lower back so leaning forward would be a problem in this case. Also the walking. Your back muscles need to support your lumbar spine so that you can move forward, that's one thing. The second thing the sciatic nerves are responsible for maintaining your ability to walk. So if they are irritated and inflamed it will decrease your ability to work. So all of those things are consistent with an L5-S1 junctional injury.

Q Dr. Merola, do you have an opinion, within a reasonable degree of medical certainty, as to whether or not the pain that Mr. Pavlov was sharing with us on Tuesday is a permanent condition?

A Yes.

Q What is that opinion?

A That it is permanent.

Q Why is it a permanent condition?

A Because of the amount of time that it has been persistent for, up to this point in time. And when that type of pain remains for any particular length of time you begin

to experience what's called a chronic pain syndrome. So there are two things that happen with that. Number 1, there's an actual mechanical way that your lower back is no longer appropriately functioning and, Number 2, your central nervous symptom, that is your brain and your spinal cord, start to have pain imprinted into it. For example, if you ever had or heard of someone who lost a limb but can still feel pain in that lost limb. Even though they no longer have that limb they still experience and can experience pain, that's phantom pain that's imprinting a chronic pain in the central nervous system. So two mechanisms. One is the actual anatomical mechanism and the second is imprinting chronic pain within the central nervous system.

Q Mr. Pavlov told us, Doctor, that at the time of this accident he was working as a plumbing assistant and he was standing on top of a ladder and he was drilling into a ceiling. He told us also for a period of time he never returned to work. I want you to assume that Mr. Pavlov testified that within the last three months he began to do small jobs and get back to work. He specifically said he is now assisting friends with various other construction jobs in which he hands them tools. Or holds things for them while they're working on a structure.

Doctor, are these limitations in what he is able to do consistent with somebody that sustained a L5-S1 disc

herniation?

A Yes.

Q How so, Doctor?

A They are -- they speak to, once again, when we talk about the mechanical problem in the lower back avoiding activities such as bending, lifting and twisting, mechanical activities that would otherwise reproduce pain. And returning to gradual activities on an as tolerated basis up to certain limits are absolutely reasonable with that.

Q Dr. Merola, as Mr. Pavlov's treating physician, do you have any opinion as to what the future holds for Mr. Pavlov with regard to future medical treatment in this case?

A Yes.

Q Will he need future treatment for his lower back?

A Yes.

Q How so?

A So the spinal fusion process is a mechanical process. It involves inserting screws and rods and fusing the lower portion of the back. If you think about your body as a mechanical structure, it is subject to wear and tear as time goes on. And in cases whereby fusions have been undertaking and there is the living of your life whereby you need to do things on a daily basis things wear out as time goes on. And these are age-related over the course of time.

So when you look at patients who had fusions you can expect those fusions to last in the neighborhood about ten years or so.

Q Doctor, the level of fusion that Mr. Pavlov has today is it at his L5-S1 level; is that correct?

A Yes.

Q Doctor, the fact that he has a fusion at that level, how does that affect the disc space adjacent to that level the way his body functions?

A So what happens is L5-S1 now becomes a portion of your pelvis which means that L4-L5 has to take up the work that L5-S1 has previously done. That means L3-L4 now takes up a piece of L4-L5 and it kind of works its way up into the spine. There is extra stress component or extra wear and tear component or low bearing component on the other sections of your back because they're attached to L5-S1 we call them the adjacent segments.

Q Dr. Merola, within a reasonable degree of medical certainty, can you tell the members of the jury what, if anything, Mr. Pavlov is going to need done to his spine in the future.

A Sure.

Q What is it?

A So if we look at patients who have had spinal fusions, who are of moderate demand, and we can predict that

a fusion lasts for ten years the major limiting factor to that is though is the adjacent segment and adjacent segments breakdowns are generally seen within ten years. And when that occurs you then need to redo your procedure to address the adjacent segment. So that's one of the reasons we continue to follow patients either yearly or every two years over the course of time is to monitor those adjacent segments.

Q Doctor, the procedure that you feel will be needed to be performed to Mr. Pavlov what is the name of that surgical procedure?

A That would be known as a revision laminectomy infusion for the proximal adjacent segment or revision laminectomy infusion which include L4 to S1.

Q Am I correct in stating that the procedure you believe Mr. Pavlov is going to need in the future is essentially the same procedure you performed on L5-S1 but now at the next higher level L4-L5?

A Correct.

Q Do you perform procedures such as that, Doctor?

A Yes.

Q Is that something you regularly do in the course of your experience as a treating spinal surgeon for your patients?

A That is something we regularly do and see with

postoperative spinal surgical patients.

Q Dr. Merola, is it fair to assume that the complaints that Mr. Pavlov made with regard to his rehabilitation following this surgery he will once again need to endure after this next surgery as well?

A That's correct, yes.

Q Doctor, are there any additional risks that Mr. Pavlov faces now that you're performing a second surgery to the same area as oppose to the first surgery?

A He would have all of the same risks involved of the first surgery with the addition of the fact that revision surgery do increase the risk of postoperative infection a bit. So the original risk of postoperative infection is increased in this case of a revision because there is certain amount of scar tissue that he needs to go through which doesn't have the same blood supply as non-operated upon areas.

Q Dr. Merola, can you share with us, within a reasonable degree of medical certainty, the reasonable anticipated cost for the surgical procedure that you described that Mr. Pavlov is going to need in the future?

A So if you look at a revision laminectomy and spinal fusion -- so there's an involved hospital stay. There is an operating team of a surgeon and assistant surgeon and a monitoring team with post-operative rehabilitative process

whereby it's a little bit longer than the original process because post-op rehabilitation may take an extra several days or so. That type of cost is in the neighborhood of $125,000 for a revision.

Q Dr. Merola, the limitations and the complaints that Mr. Pavlov shared with us that you said were permanent as a result of the L5-S1 surgery, Doctor, is any of that going to change after the revision surgery?

A No.

Q Is he always going to have the limitations he shared with us today as a result of the fall from that ladder?

A Yes.

Q Is that ever going to get better, Dr. Merola?

A No. That would pretty much be baseline for him.

MR. MOSES: Nothing further.

THE COURT: We're going to take a ten-minute break at this point and then we will have cross-examination.

All rise. The jury may exit.

(The jury exits the courtroom.)

THE COURT: You may all be seated.

MR. KAMINSKY: Judge, may I see the doctor's files?

THE COURT: Sure.

(Recess.)

THE COURT: All rise.

(The jury enters the courtroom.)

THE COURT: You may all be seated. Now we're ready for cross-examination.

CROSS-EXAMINATION

BY MR. KAMINISKY:

Q Doctor, good afternoon.

A Good afternoon.

Q Doctor, you and I have met on prior occasions, correct?

A Yes.

Q In fact, I had the pleasure of cross-examining you probably upwards of a dozen times or so?

A Perhaps, yes.

Q And in addition to that, we've been involved in cases where -- in addition to the cases where we actually had the opportunity to appear in court together for me to cross-examine you there's been dozens of other cases that you've been involved in that didn't go forward where you would be the doctor for the plaintiff in the case, correct?

A I may very well be, yes.

Q How did Mr. Pavlov come up under your care?

A So he's been treating with a couple of other doctors I know including a pain management physician

Dr. Gladstein.

Q Dr. Gladstein referred him to you?

A I'm not exactly sure how he gotten the referral over to me, but I do know Dr. Gladstein specifically. In fact, I have actually spoken to him about Mr. Pavlov.

Q So if Mr. Pavlov would have said he found you on the internet?

A I wouldn't be surprised because I am listed on the net as well.

Q But you told us he got referred by Dr. --

THE COURT: No he didn't. He didn't say that.

A I know Dr. Gladstein.

Q Okay. Fine.

Now, the type of surgery that you did, you said that he may necessitate a revision surgery ten years from now?

A Yes.

Q I assume you've done a lot of these types of surgeries, correct?

A Yes.

Q Approximately how many?

A So I generally operate about several hundred times per year. About 200 to 225 cases per year. And I've been doing it for about 20 years now.

Q So you've done thousands of these surgeries?

A Yes.

Q Tell me, have all thousands of your patients require a revision surgery?

A Not all. No.

Q Okay. So some do, some don't?

A Correct.

Q So in Mr. Pavlov's case he may or he may not need revision surgery, true? You can't say for certain?

A I can't give you a hundred percent certainty.

Q Okay. I'll accept that.

Now, let's discuss the accident itself. By the way, let's back up.

The thousands of surgeries that you performed were they all as a result of someone suffering a traumatic injury?

A No.

Q Would it be fair for me to say that a percentage of those surgeries were due to other causes?

A Yes.

Q And those other causes could include things such as degenerative problems a person may have, correct?

A Yes.

Q And degenerative is something that occurs over time, correct?

A Yes.

Q Trauma is something that happens right then and

there, correct?

A Yes.

Q All right. So the thousands of surgeries you've done some were due to patients that suffered traumatic injuries, correct?

A Yes.

Q And some were due to patients that had conditions not related to trauma?

A Yes.

Q Wear and tear over extensive periods of time, correct?

A Yes.

Q 'Cause if you have wear and tear over extensive periods of times that could cause a problem to your back, correct?

A Yes.

Q And is it fair for me to say that the level L5-S1 that's generally the most common area where a person will have problems with their back?

A One of the more common areas.

Q That's where the lumbar spine -- that's the lowest level of the lumbar spine -- well you told us where it reaches the sacrum, correct?

A Yes.

Q So we know that the area that Mr. Pavlov has had

his problem is the most common area for a person to have problems with their back?

A One of the more common areas.

Q Okay. And that's one of the more common areas for someone that has degenerative problems, correct?

A It can be, yes.

Q Okay. So we differentiate what's as a result of trauma and what's a result of degeneration. We know that in Mr. Pavlov's case the location of where you performed the surgery is one of the locations most commonly associated with degenerative problems, correct?

A It can be. Yes.

Q And we also know that some of the people require revision surgery and some don't?

A Yes.

Q Okay. Now, in order to make a determination as to whether or not something is due to trauma or something is due to degenerative problems, wouldn't you need to know the extent of the trauma?

A Not necessarily. No.

Q Okay. Can you tell us the manner in which Mr. Pavlov fell?

A According to what we heard here today it was of a consequence of a fall which is consistent with the history that he had given me of a ladder.

Q We know he fell?
A Correct.
Q Did he land on his back?
A He landed forward sustaining a patella fracture and an elbow contusion as well.
Q Okay. All right. And just so we're clear, in the hospital records, he did not make any complaints of pain to his back, correct?
A There was nothing listed as a subjective complaint of pain, correct.
Q There were subjective complaints of pain in numerous parts of his body, correct?
A Yes.
Q His elbow. His chest. His knee. But no complaints of pain to his back, true?
A Yes.
Q Okay. And they did x-rays of the parts of the body as a standard precaution, I use the word "standard" when I was cross-examining Mr. Pavlov. Would you agree with me that when someone makes complaints it's standard hospital procedure to look into them; take precautionary --
A Yes.
Q And that's what the hospital did here?
A Yes.
Q Took an x-ray of chest, of his knee, his elbow, but

they didn't even take an x-ray of his back, correct?

A Correct.

THE COURT: Just a minute.

Ladies and gentlemen, Mr. Kaminsky, questioning Mr. Pavlov, the question and answer were stricken that used the word "standard." So that's not part of our record. Okay.

MR. KAMINSKY: Okay. Thank you for that, your Honor. Let me ask Dr. Merola if I may.

Q Regardless of what I said to Mr. Pavlov, is it standard procedure for a hospital to take x-rays of portions of a patient's body that they complained of pain?

A Yes.

Q And just so we're clear, there were no x-rays taken of the Plaintiff's back in any way, correct?

A Correct.

Q Now, in determining the extent of the fall, was the fall sufficient enough to cause Mr. Pavlov to lose consciousness?

A I do not believe he had a loss of consciousness. No.

Q So whatever the extent of the fall was he didn't lose consciousness, true?

A Correct.

Q And whatever the extent of the fall was, he had

some bleeding from his elbow, but no bleeding from anywhere else, correct?

A Except into the fracture site at the patella. Correct.

Q And you did review the emergency room records, true?

A Yes.

Q Did you review all of the medical records in this case?

A I don't know what the extent of all of the records is but --

Q I'll ask you specifically.

A Okay.

Q Did you have an opportunity to review the report prepared by Dr. Sherry (phonetic.)?

A Not that I recall, no.

Q Did you have the opportunity to review the report prepared by Dr. Rubenstein?

A Igor Rubenstein?

Q Allen Rubenstein?

A Allen Rubenstein, I don't remember. No.

Q So you reviewed, I would imagine you reviewed your file?

A Yes.

Q And you probably reviewed other materials that were

sent to you by Mr. Pavlov's Counsel, true?

A Hospital records. Spoke to the pain management doctor and also reviewed physical therapy records, yes.

Q But for whatever reason you didn't review the reports of Dr. Sherry and Dr. Rubenstein?

A I don't recall those names off the top of my head, no.

Q So those weren't sent to you, correct?

A I don't recall seeing them --

Q That's fine.

A -- I don't remember the names.

Q All right. We'll discuss those reports a little bit later.

So we know the nature of the fall. Do you know if an ambulance was called to the scene?

A I don't know.

Q All right. I want you to assume that an ambulance was not called to the scene. I want you to assume that Mr. Pavlov did not lose consciousness. I want you to assume when he arrived in the hospital he said he wasn't dizzy and he didn't have a headache, okay. And those could be signs of the severity of a fall, how traumatic it was, correct?

A Well, they'll be signs of a head injury.

THE COURT: Wait. Wait.

Q We know he didn't have an injury in that regard.

We know the fall was not sufficient enough to cause him to lose consciousness, true?

A As far as we know, he did not have a head injury, correct.

Q You've written some articles on biomechanics, correct?

A Yes.

Q What is G force?

A That is a force of gravity.

Q Okay. And are you able to make a determination as to the G force of this accident or you don't have sufficient information?

A You need to know the height and weight of the individual and the distance upon which they fell in order to calculate what we would call -- really more than the G force. It's the transfer potential energy -- kinetic energy transfers -- which would be a mathematical calculation based on height and wait, and gravity.

Q You did not do that in this case, correct?

A No.

Q Now, normal day-to-day activities exerts G forces on a person's body, correct?

A Actually they're not so much G forces because a G force is the force of gravity that relates to acceleration.

Q Tell us what G1 is?

A Sure. That's the normal gravity force.

Q Okay. And so normal day-to-day activities causes certain types of forces on a person's body, correct?

A Yes.

Q And just like we need to know the extent of the trauma and the force associated with trauma, would it be helpful for you to know the extent of G forces or the extent of wear and tear Mr. Pavlov may have experienced in his life prior to this accident; yes or no?

A Well, I don't think I can answer that just yes or no.

Q Okay. Then let me ask you a different way.

THE COURT: Hold on. I didn't understand the question. In terms of helpful in what regard?

MR. KAMINSKY: Okay. I withdraw the question. Thank you, Judge.

CROSS-EXAMINATION

BY MR. KAMINSKY: (Con't.)

Q Do you know what Mr. Pavlov's daily activities were like in the Ukraine beginning at age 19 up until the time he left to come to the United States? What did he do on a day-to-day basis?

A I don't know what he did on a daily basis.

Q What type of work did he do?

A I know that he was working as a plumbing assistant

when he was here at the time of the accident.

Q Correct. What was his day-to-day activity in the Ukraine?

A I don't know.

Q Well, when we're trying to draw a distinction between wear and tear that may cause problems with a person's disc, and trauma, you've indicated that it's important to understand the extent of the trauma, but isn't it also important to understand what the person was doing an a day-to-day basis as far as the issue of long-term wear and tear; yes or no?

A I can't answer that just yes or no.

Q Okay. On this blowup of the MRI of Mr. Pavlov's spine we see the bones, we see the discs, correct?

A Yes.

Q And this is the disc, here, (Indicating) at L5-S1 that we're talking about, correct?

A Yes.

Q And this is the disc that's most commonly associated with a person having back problems from wear and tear, correct?

A It's one of the commonly associated discs.

Q Okay. Now, do you know if Mr. Pavlov --

THE COURT: Let me stop you for a minute.

(Pause.)

CROSS-EXAMINATION

BY MR. KAMINSKY: (Con't.)

Q If a person was working in a factory, bending, twisting, turning, lifting things for 15 years, could that cause wear and tear on a person's back?

A It can. Yes.

Q Okay. And do you know if, in fact, Mr. Pavlov was working in a factory for 15 years bending, twisting, lifting, carrying things prior to coming to the United States?

MR. MOSES: Objection.

THE COURT: Sustained.

Q Okay. Do you know what disc desiccation is?

A Yes.

Q Tell the jury?

A Desiccation, when we talk about desiccation we mean drying. When they refer to disc desiccation on an MRI film what they're referring to is the signal of the water content of whatever particular structure they're looking at so if they're saying disc desiccation, they mean the drying up of a disc based on what its color looks like when you're looking at the MRI film.

Q And when we look at this MRI we see a change in color at this location, correct?

A Yes.

Q It's clear, would you agree with me, that there is

disc desiccation at this location?

A Yes.

Q Would you agree with me that for disc desiccation to occur that is a lengthy process that takes years to happen, true?

A Not necessarily. No.

Q Okay. Well, the reverse of that would be it couldn't, true?

A It can, yes.

Q So what we have here is a clear indication of disc desiccation as evidence by the fact that this disc -- the color of the disc on the MRI the fact that it does not light up like the signals to the other discs this shows disc desiccation?

A Yes.

Q And that's a loss of water, correct?

A Yes.

Q Which could take many, many years to occur?

A Which can, yes.

Q Okay. But, now, I know there would be no reason, but just for the record, you never saw, nor do we have any reason to even believe, that there was an MRI taken of the Plaintiff's back before this accident occurred, correct?

A Correct.

Q So we have nothing to compare this to?

A Yes. Correct.
Q So we can just look at what we have here and make our own conclusions, correct?
A Yes.
Q So what was the date this was taken?
A I believe that's October 4th of 2011.
Q Okay. So the accident happened in August of 2011 and within three months of the accident we have a clear indication of disc desiccation?
A Yes.
Q Which you told us could take years and years to develop, true?
A It can. Yes.
Q It is, especially, in an area, most -- one of the areas most commonly associated with back problems due to wear and tear, correct?
A I don't know if I would use the adverb "especially."
Q Okay. Take that out.
A Okay.
Q Now am I correct?
A So let's take that adverb out and talk about it again and ask me the question.
MR. KAMINSKY: Could the question be read back?
THE COURT: Yes, please.

(The Court Reporter read back the requested portion.)

A Without especially. So I still don't necessarily understand the question. I wouldn't use the adverb "especially" because I don't think that it's an appropriate qualifier.

Q We are going to take that out.

A Okay. I would not find it unusual if there would be desiccation in this case at that time period from the accident.

Q I didn't ask you that question. But obviously you want to answer it a certain way.

MR. KAMINSKY: I move to strike the doctor's answer.

THE COURT: No. I'm going to allow the answer.

MR. KAMINSKY: Okay.

CROSS-EXAMINATION

BY MR. KAMINSKY: (Con't.)

Q Let's try and answer my questions, okay?

A Okay.

Q What is lumbar lordosis?

A Lumbar lordosis refers to the normal position of the lumbar spine. When we refer to lordosis, what we mean is the backward curve that your lumbar spine should have so if you feel your lower back it feels like there is a hollow in

the lower portion of your back. That's lordosis. It also refers to bending backwards.

Q Would you agree with me that complaints of pain could be subjective?

A Yes.

Q Would you agree with me that complaints of pain could be objective?

A No. A complaint by definition has to be subjective. In other words it's something that the patient tells you.

Q Okay. And in your experience, you've been involved in probably hundreds of cases where your patients are plaintiff's in a lawsuit, correct?

A I don't know the exact number but --

Q I'm not asking for the exact number.

A But I've been doing this for 20 years so I'm sure I had a fair amount of patients that had been plaintiffs.

Q Hundreds, correct?

A I don't know the number.

Q Okay. A significant number?

A I would say patients.

Q Do you take into consideration when they're complaints of pain being subjective that they are involved in a lawsuit asking for money? Do you take that into consideration when you do your examinations?

A I don't take any litigation into consideration when doing an exam. No.

Q Do you know what the term "secondary gain" mean?

A Yes.

Q What does "secondary gain" mean?

A "Secondary gain" is a term that refers to, in this case, a patient having some alternative benefit from a problem or a condition. We also call it, it's also known as the sick role, and that can happen with patients.

Q So, in other words, in a case where someone is suing for monetary damages and complaining of pain, you are familiar, at least with the concept, that a patient may exaggerate complaints of pain for the secondary gain of recovering money in a lawsuit, true?

A An exaggerated symptom would be known as symptom amplification, which can happen under the circumstance of a secondary gain.

Q And my question to you, you already answered it, you did not take that into consideration in any of your opinions, true?

A No. When examining --

Q Okay.

MR. MOSES: Your Honor, I'm going to ask the witness be allowed to answer the question.

MR. KAMINSKY: I would ask if the witness can

answer it yes or no.

THE COURT: No. Try to answer the question yes or no, if you can. If you can't, let us know.

Objection overruled. You'll deal with it on redirect.

Q Okay. Maybe I misheard you a couple of questions earlier.

Did you consider secondary gain in this case at all; yes or no?

A I can't answer that strictly yes or no.

Q Okay. If you can't, you can't.

The complaints of pain that Mr. Pavlov presented to you when you saw him by their very nature they were subjective, correct?

A Yes.

Q And you accepted them at face value, true?

A Yes.

Q Would you agree with me that the surgery you performed, you told us about the risks that are inherent in that surgery, those risks are inherent in any surgery, correct?

A Some of the risks are inherent in all surgeries and some of the risks are more specific to that particular operation.

Q And the risks you told us about in the surgery you

performed on Mr. Pavlov those are the same risks that are associated with the hundreds of similar surgeries that you've done to the other patients, correct?

A Yes.

Q And while we know there are risks with those surgeries, thank goodness in this case, those risks had -- none of them came to fruition thank goodness, correct?

A Yes.

Q So while there are risks in the surgery, Mr. Pavlov tolerated the surgery very well, true?

A Yes.

Q And didn't experience any of those risks or side complications, correct?

A Correct.

Q Thank goodness. And can we agree, Doctor, to your credit, the surgery was very successful?

A Yes.

Q It had the intended result?

A Yes.

Q Before the surgery Mr. Pavlov was complaining of pain, including pain radiating down to his leg, correct?

A Yes.

Q Subsequent to your surgery, is it fair to say that he had shown significant improvement?

A He has improved, yes.

Q And, in fact, he's told several doctors he's experienced significant improvement, correct?
A Yes.
Q And can we also agree that after the accident he was having physical therapy, true?
A Yes.
Q And can we agree that during the course of his treatment he was telling his doctors his condition was improving?
A Yes.
Q And can we agree that after the surgery he was telling you that his condition was improving?
A Yes.
Q And can we agree that after the accident the physical therapy he was receiving, not only diminished in frequency, but he's not even receiving any physical therapy anymore, true?
A Correct.
Q He told us he does some exercises at home, correct?
A Yes.
Q So the pain has lessened, correct?
A -- (No response.)
Q The --
THE COURT: The pain has lessened?
A Yes -- I thought it was a multi-question.

Q I apologize to you. I'll break it down.

Can we agree that the pain he experienced has lessened, yes?

A Yes.

Q Can we agree that the amount of physical therapy he received not only lessened, but it's over, correct?

A Formal physical therapy, yes.

Q Formal physical therapy. By the way, just so we're clear, the physical therapy, we're talking about massages, we're talking about heat pads, we're talking about tens electrical stimulation, correct?

A Yes.

Q Those are all conservative. And by the term "conservative" I mean they're not invasive, correct?

A Yes.

Q It's very basic, painless, very basic stuff, true?

A Correct.

Q Okay. And when was the last time he even had any physical therapy?

A I couldn't tell you the exact date.

Q Would it be more than six months ago?

A I don't know the exact date.

Q Would it be more than a year ago?

A I, once again, couldn't give you the date on that.

Q Okay. That's fine.

In one of your reports you said one of the problems he's having is the pain makes it difficult for him to sit for periods of time, true?

A Yes.

Q Well, would you agree with me, that except for the break that we took, Mr. Pavlov has been sitting for several hours?

A Including our breaks. Yes.

Q I don't know if you aware of this, but I want you to assume similarly that he was sitting for several hours when he was in court other day, okay.

A Okay.

Q The fact that he, obviously, the jury has seen with their own eyes, the fact that he is able to sit for an extended period of time without, I can't get inside Mr. Pavlov's mind, but without evidencing any notable expressions of pain or getting up or stretching or anything along those lines, those are good things, true?

MR. MOSES: Objection, your Honor.

THE COURT: Sustained.

Q Well, while you've been here observing Mr. Pavlov, have you seen him get up to stretch at all?

MR. MOSES: Objection. My objection is that wasn't Mr. Pavlov's testimony as to why he --

THE COURT: That's not what the doctor is being

asked. The question deals with your observation of Mr. Pavlov.

Can you answer it?

THE WITNESS: I have not seen him get up to stretch this morning, no.

Q And that's a good thing, correct?

A I would assume that it's good based on the fact that he's --

Q Thank you.

A -- that he is able to sit there. Yes.

Q Thank you.

THE COURT: Is this a good time to break?

MR. KAMINSKY: You know what --

THE COURT: Continue.

MR. KAMINSKY: The only reason I would say no is because I would imagine --

Q Correct me if I'm wrong, Doctor, if you have to come back after lunch do you charge more money --

A It's all on time away --

THE COURT: Keep going.

MR. KAMINSKY: He is such a nice guy. We are going to keep going so you don't have to come back after lunch --

MR. MOSES: -- that's -- nice --

I will show the same consideration when your

doctor is here on Monday.

MR. KAMINSKY: I appreciate it. I told you we get along. All good.

CROSS-EXAMINATION

BY MR. KAMINSKY: (Con't.)

Q Now you spoke about the experiences he had while he was in the hospital for three days, okay. We heard it was hard for him to get out of bed, it was hard for him to take care of himself. You would expect to see that, correct?

A Yes.

Q There was nothing unusual about that given the nature of the surgery he underwent, correct?

A Yes.

Q But after he was discharged from the hospital those conditions resolved themselves. In other words, would you agree with me that Mr. Pavlov is self sufficient?

A Yes.

Q He's able to dress himself?

A Yes.

Q He's able to feed himself?

A Yes.

Q He's able to take care of his own personal hygiene?

A Yes.

Q He uses public transportation, does he not?

A Yes.

Q He's not using a cane or a walker or any type of device to help him ambulate, correct?

A Yes.

Q And those are all good things, correct?

A Yes.

Q So when you talk about his prognosis for the future we know that subsequent from his release from the hospital, subsequent to surgery, he has significantly improved over time, true? In large part to the successful surgery that you did, true?

A He has improved, yes.

Q We know that he is able to get around on buses and subways, correct?

A Yes.

Q And we know that he is able to take care of himself, dress himself, feed himself, cook, all those things, true?

A Yes.

Q Now, when you test to see if a person can move their back forward and back, again, that's subjective, correct?

A No.

Q Okay. Well a person says, "Stop. It hurts." Or something like that, if you're examining them, you want to see how far they can move you say, "Tell me when it hurts"?

A No.
Q Okay. Did you do any subjective -- did you do any objective tests to correlate subjective complaints?
A Yes.
Q And you told us by the nature of the complaints of pain are subjective, correct?
A Yes.
Q Now when you look at an MRI -- by the way, are you a radiologist?
A No.
Q A radiologist is someone who is specialized and has training in reading x-rays and MRIs and CAT Scans, correct?
A Yes.
Q And I understand you have training, as a medical doctor you can certainly look at an x-ray and interpret it, but you don't have the specialized training that a radiologist does, correct?
A I have the specialized training that an orthopedic reconstructive spinal surgeon has.
Q Of course. I don't dispute that for a second, but you are not a radiologist, correct?
A Correct.
Q A radiologist might be able to tell us by looking at a film if a problem with a disc is caused by trauma or if a problem with a disc is caused by something else, true?

A Not necessarily, no.
Q Okay. Could be, though?
A Anything could be.
Q Okay. Anything could be.
And here, you acknowledged that you see an absence of water at this level, which is consistent with disc desiccation which could take years to develop, true?
A Yes.
Q And disc desiccation, taking years to develop, could be consistent with working in a factory in the Ukraine lifting, bending, twisting and doing the same types of things over and over again, true?
MR. MOSES: Objection.
THE COURT: Sustained.
Q You're not familiar with what he did in the Ukraine?
A Correct.
Q So you did not take into consideration what he may have done in the Ukraine in looking at the lack of this disc being lit up on the MRI film but recognizing that there is an absence of water and there is clearly disc desiccation, true?
A No.
Q No. All right. I asked the question incorrectly. I'll do it one step at a time. I apologize.
There is disc desiccation?

A Yes.
Q There is an absence of water?
A Yes.
Q This disc does not light up on the film?
A It has a signal within it.
Q It's a weak signal?
A There is a weak signal in the medial and posterior aspect of the disc, yes.
Q Regardless what we see here, it is consistent with an absence of water and disc desiccation and something that could develop over many years, true?
A Yes.
Q And in determining whether or not something could develop over many years it's important to know what that person was or was not doing for those many years, correct?
A Not when we're looking at the MRI, no.
Q Okay. You don't know what he was doing for those --
MR. MOSES: Objection. Asked and answered --
MR. KAMINSKY: Withdrawn. That's fine.
THE COURT: Sustained.
Q What is the significance of a person with such as Mr. Pavlov having undergone the type of surgery that he did, what is the significance of his being able to, as of recently, being able to walk on his heels and his toes? Is

that a good thing?

A Yes.

Q If he's able to walk with a normal gait, that's a good thing, true?

A Yes.

Q If he's able to squat, that's a good thing, correct?

A Yes.

Q And if there is no evidence of paraspinal muscle spasms that's a good thing, correct?

A Yes.

Q And when you're looking at his recovery and his potential for the future, the things I mentioned, those are good findings that a doctor such as yourself would want to see, correct?

A Yes.

Q And are those the types of findings, yes or no, that could make a determination as to whether a person would fall in the category of needing revision surgery or of possibly not needing a revision surgery; are those some of the things you would look at, yes or no?

A That's not a yes or no.

Q Okay. Well, a person --

MR. MOSES: Judge can we -- may we approach, your Honor.

THE COURT: Yes.

(Discussion was held outside the presence of the jury.)

THE COURT: Now you may continue.

CROSS-EXAMINATION

BY MR. KAMINSKY: (Con't.)

Q All right, Doctor, we're going to get you out of here, okay.

Just for the record, the last time you saw the plaintiff was several months ago?

A Yes.

Q And do you have an appointment scheduled to see him in the future?

A Yes. We'll generally at this point in time we're going to see him on a yearly basis.

Q There's no plans to do any surgery as we sit here today, correct?

A Right.

Q Okay. Doctor, always a pleasure.

A Thank you.

Q All the best to you. No further questions. Thank you.

THE COURT: Redirect.

MR. MOSES: Thank you, your Honor.

REDIRECT EXAMINATION

BY Mr. KAMINISKY:

Q Doctor, Mr. Kaminsky was talking to you about the idea of desiccation in a disc; is that correct?

A Yes.

Q And Mr. Kaminsky asked you about this process of desiccation, correct?

A Yes.

Q And desiccation is exactly that. Over a period of time a disc could conceptually lose height, correct?

A Yes.

Q Lose its water content, correct?

A Yes.

Q And that can be conceptually part of the aging process, correct?

A Yes.

Q But the process of desiccation, Doctor, it doesn't affect just one disc --

MR. KAMINSKY: Judge, I'm going to object to leading.

THE COURT: Yes. Form. You're cross-examining him.

Q Doctor, typically, desiccation affects all discs or a single disc?

A Typically desiccation and the normal aging process

affects across the board all of the tissues and portions of your body, and in the case of the lumbar spine it would affect the entire spine.

Q So I want to talk about this particular picture of Mr. Pavlov's spine. Do you see any signs of desiccation in any other level other than the L5-S1 disc in this case?

A No.

Q Doctor, do you see a loss of signal in any other level other than the L5-S1 disc in this case?

A No.

Q Mr. Kaminsky was asking you hypotheticals about whether you knew what Mr. Pavlov was doing in his course of work as a factory worker. Do you remember those questions?

A Yes.

Q Doctor, if ordinary wear and tear were the cause of an L5-S1 desiccation, would it be reasonable to expect to see desiccation at some other level of the spine?

A Yes.

Q Do you see it at any other level?

A No.

Q Doctor, you opened up this man's spine; is that correct?

A Yes.

Q Did you look inside his spine during the course of your surgery?

A Yes.
Q You have an operative report from that surgery here in court, correct?
A Yes.
Q Did you, at all, note desiccation or wear and tear at any other level of this man's spine other than the single level of L5-S1?
A No.
Q Isn't it true, Doctor, that desiccation can also be traumatically caused?
A Yes.
Q And a traumatic cause of desiccation, what does that mean, Doctor?
A That means that an injury to the disc has led to the loss of blood supply, blood flow, and water content within the disc.
Q Because the disc has ripped open?
A Yes.
Q And the contents are coming out; is that right?
A Yes.
Q In this case, Doctor, within a reasonable degree of medical certainty, is it your opinion that the desiccation at the L5-S1 level was caused by trauma in this case?
A Yes.
Q And, Doctor, isn't it consistent with that opinion

that if Mr. Pavlov suffered the trauma on August 11th of 2000 -- excuse me -- August 12th of 2011 that two months later the type of desiccation you saw at L5-S1 was caused by --

MR. KAMINSKY: Objection to leading, Judge.

THE COURT: Sustained. Rephrase.

Q Okay, Doctor. How is it, within a reasonable degree of medical certainty, that this disc desiccated within the two months from the time of the trauma to the time of the study?

A Disc material that has broken off the posterior or backside of the disc with the tear in the annulus and the herniation at L5-S1, no loss of disc space, height, and no other changes to any other portion of the MRI.

Q Dr. Merola, Mr. Kaminsky asked you on cross-examination about this concept of secondary gain. Do you recall that question?

A Yes.

Q And I believe you testified that you did not consider the concept of secondary gain in rendering your opinions today?

A Yes.

Q What was your answer to that question?

A My answer was that we consider what's known as symptom amplification when we're examining patients and we objectively need to examine them to see whether or not

there's an actual anatomical problem based on their subjective symptoms.

Q Let's be frank here. When you say, "symptom amplification" that's a way of saying that the patient is faking or exaggerating complaints because they have a pending lawsuit or another secondary reason for those complaints being amplified or exaggerated, correct?

A Yes.

Q So what you say you try and do is try and find something objective that just justifies the complaints is that correct?

A Yes.

Q Doctor when you look looked into his spine, opened it up, did you see a large exit true Ted disc and herniation found with a large central tear?

A Yes.

Q Did he do that?

A No.

Q Did he exaggerate that?

A No.

Q Did he make that up?

A No.

Q Did he amplify that?

A No.

Q Did he physically somehow subjectively tear his own

annulus?

A No.

Q And then correlate clinical complaints that goes along with that level herniation? Is it your opinion he did that?

A No.

Q Doctor, every complaint that Mr. Pavlov made to you in your office when you first saw him, were they clinically correlated to the L5-S1 disc?

A Yes.

Q When you opened up his spine and saw the disc material was it contacting the surrounding nervous?

A Yes.

Q Was that objective finding correlating with the complaints he was making in your office?

A Yes.

Q When you saw an MRI with no other degeneration other than the one level, L5-S1, that correlated with his clinical complaints, did he somehow subjectively effect this MRI?

A No.

Q Can a patient control an MRI film?

A No.

Q Based on all of these factors, Doctor, is that what causes you to share with us your opinion today that the fall

off a ladder that was severe enough to fracture bone was also severe enough to cause a herniated disc at a single level in an otherwise pristine spine?

A Yes.

MR. MOSES: Nothing further, Judge.

THE COURT: Recross.

RECROSS-EXAMINATION

BY MR. KAMINSKY:

Q Doctor, none of the questions I asked you about objective versus subjective have anything to do with the surgery. No one disputes that. Okay. What I'm questioning you about is complaints of pain today, okay. I'm asking you if his complaints of pain today -- we know that you did the surgery. We know that you did a very good job. I'm not saying any of that's not true. I'm asking you the complaints of pain today, okay.

If a person says to you they're in pain when they sit for a short period of time, but we can see for ourselves that they can sit for longer periods of times, that's the type of thing I'm asking you about, okay. So as far as the objective versus the subjective, forget the operation, did you consider secondary gain in the Plaintiff's present complaints; yes or no?

A As far as my last examination goes, yes. The exam was taken into consideration to look for signs of symptoms

and amplification.

Q In your last report --

THE COURT: Are these reports in evidence?

MR. MOSES: Yes.

THE COURT: His chart?

MR. MOSES: Yes.

Q You said he is 100 percent disabled from all work and all duties, true?

A As of March 30 of 2015 I think the last sentence was advised to avoid bending, lifting, and twisting. Advised to avoid activities that reproduce pain and symptoms and then counseled about adjacent segment problems.

Q Let's look at some of your reports, and I apologize I didn't intend to go into this.

MR. MOSES: I think this is beyond the scope of my redirect, your Honor.

THE COURT: Depends upon what area you're going into.

Q As far as objective versus subjective, you wrote throughout your reports that he was 100 percent totally disabled --

THE COURT: That is beyond the scope.

Q As far as what we saw on that MRI, you told us during the operation, you sent out the material that you removed for a pathology report, correct?

A Yes.
Q Isn't it true that, that pathology report came back and said it is positive for degeneration?
A Yes.
Q And degeneration is just like desiccation, it's something that happens over time, true?
A Yes.
Q So according to the pathology report of the operation that you performed, the pathology said positive for disc degeneration. Something that takes years to develop, true?
A Not in this case.
Q That's your opinion?
A No.
Q Did I properly state what the pathology report found?
A Yes.
Q Okay. The pathology report said positive for degeneration?
A Yes.
Q Okay.
MR. KAMINSKY: Nothing further. Thank you.
MR. MOSES: I have one follow-up on that one report, your Honor.
THE COURT: Okay. One redirect.

RE REDIRECT EXAMINATION

BY MR. MOSES:

Q Doctor, explain to the jury what the finding of degeneration means with regard to pathology in this case?

A So the pathologist looks at the disc and what he is saying is that when he looks at the disc that disc lacks a normal blood supply, it lacks a normal water content.

MR. KAMINSKY: Objection. He can't interpret what somebody else is thinking.

MR. MOSES: Your Honor -- it has --

THE COURT: He is saying what it means medically. He is not interpreting it that way.

MR. MOSES: Thank you.

THE COURT: Overruled.

A Correct. And the medical pathological diagnosis for the herniation is degenerative portions of disc material which by nature it has to be because it has incurred damage which has led it to become degenerative.

MR. MOSES: That was it, Judge.

THE COURT: Cross on that?

MR. KAMINSKY: No. Thank you, Doctor.

THE WITNESS: Thank you guys. Thank you, your Honor.

THE COURT: Thank you.

THE WITNESS: Thank you.

(The witness is excused.)

THE COURT: Plaintiff, call your next witness.

MR. MOSES: Dr. Raz Winiarsky.

THE COURT: Why don't you go get him.

MR. MOSES: I can get him.

THE COURT: My expectation is that we will be finished today by around three, okay. Even after lunch.

(The witness enters the courtroom.)

THE COURT: Doctor, raise your right hand.

Do you swear or affirm under penalty of perjury that the statements you're about to make will be the whole truth?

THE WITNESS: Yes.

DR. R-A-Z W-I-N-I-A-R-S-K-Y, after having been called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, testified as follows:

THE COURT: Have a seat, please. State your name and business address for the record.

THE WITNESS: Raz Winiarsky. Business address is 1414 Newkirk Avenue, Brooklyn, New York 11226.

THE COURT: Spell your first and last name.

THE WITNESS: First name R-A-Z. Last name W-I-N-I-A-R-S-K-Y.

THE COURT: You may proceed.

MR. MOSES: Thank you.

DIRECT EXAMINATION

BY MR. MOSES:

Q Dr. Winiarsky, good afternoon.

A Good afternoon.

Q Dr. Winiarsky, are you a physician duly licensed to practice medicine here in New York?

A Yes.

Q When were you so admitted, Doctor?

A To practice medicine in the State of New York 1999.

Q Would you mind telling us your background, briefly --

A Sure.

Q -- education in medicine?

A I graduated from Albert Einstein College of Medicine in the Bronx, New York. And then I obtained my residency in Orthopedics from the University of Pennsylvania, and then I went to special surgery where I did a year of fellowship in joint reconstruction.

Q Are you Board-certified, Doctor?

A Yes.

Q What field are you Board-certified in?

A Orthopedics.

Q When were you so Board-certified?

A 2002.

Q Do you maintain a private practice?

A I do.
Q Where is that located?
A One of our offices is in Brooklyn.
Q Dr. Winiarsky, are you affiliated with any hospitals?
A Yes.
Q What hospitals?
A I am the Chairman of Orthopedics at Interfaith Medical Center in Brooklyn. I work out of the North Shore system. And I work in New Jersey at Meadowlands hospital and also the Beth Israel system.
Q Dr. Winiarsky, what are your responsibilities as Chairman of Orthopedics at Interfaith?
A To make sure the Orthopedic Department works efficiently. To train staff. Train residents. Train physician assistants.
Q You train other doctors?
A I do.
Q On how to perform surgery?
A Yes.
Q Dr. Winiarsky, when is last time you did perform surgery?
A What day is today? Yesterday. Today is Wednesday--
THE COURT: Today is Friday.

A Yesterday.

Q When is the next time you're scheduled to perform surgery?

A Tuesday.

Q Are you being compensated from your time away from the office today?

A Yes.

Q What are you being compensated?

A $500 an hour.

Q Dr. Winiarsky, did there come a point in time that you met Sergii Pavlov?

A Yes.

Q Did you become his treating orthopedic surgeon early in his treatment in this case?

A Yes.

Q Did you bring with you today your medical records?

A I did.

MR. MOSES: Your Honor, these medical records had been admitted into evidence as Plaintiff's Exhibit Number 3, and to the extent you need to read from them, Doctor, please do.

Q The first time you came to meet Mr. Pavlov was when?

A August 17, 2011.

Q Now on August 17, 2011, Mr. Pavlov gave you a

history; is that correct?

A Correct.

Q Would you tell the members of the jury what he told you?

A That he was working as a plumber's assistant. He he was on a ladder and he fell 10 feet and he was taken to Brooklyn hospital where he had complaints of injury to his knees and to his back.

Q Did you perform a physical examination on Mr. Pavlov?

A Yes.

Q Did you have any of the Brooklyn hospital records available including the diagnostic testing that was performed?

A I don't recall.

Q Okay. Let the members of the jury know what exam you performed on Mr. Pavlov.

A Sure. I examined his back. And I examined his elbow. And I examined his knee.

Q What complaints did he make to you with regard to his back?

A That he had radiating -- he had back pain that radiated down his legs.

Q And that was made to you on August 17, 2011?

A Correct.

Q Approximately five days after his accident?
A Correct.
Q Doctor, what complaints did he make to you about his knee?
A Severe knee pain and swelling. Difficult to sleep at night and pain with all activities.
Q Did you perform any other tests on him during that initial visit?
A I examined his neck. His back. Both elbows. His left knee and his right knee.
Q Okay. Let's stick to just the right knee.
A Sure.
Q And let's stick to the low back.
A Okay.
Q Okay. He made complaints to you about low back pain radiating into his legs, correct?
A Correct.
Q Is that a significant complaint to you as an orthopedic surgeon?
A Yes.
Q Did you refer him to another doctor in your office specifically for lower back pain?
A Yes.
Q Did you eventually refer Mr. Pavlov to have epidurals for his low back pain?

A Well, Steven Horowitz (ph) referred him. That was his treatment, not mine.

Q Okay. Let the jury know who Steven Horowitz is?

A He's a pain management doctor in my office.

Q So when Mr. Pavlov came to you with low back pain radiating into his legs you referred him to the pain management doctor, Dr. Horowitz, in your office?

A Correct.

Q Dr. Horowitz is the one that ultimately referred him for the epidurals?

A Correct.

Q We're not going to get into the back because we had his treating spinal surgeon in here earlier today, okay?

A Okay.

Q Let's just stick to the knee.

A Sure.

Q All right. So with regard to the knee, what was your diagnosis at the end of the first visit with regard to his right knee?

A He had a very large, you know -- when I examined his knee he had very large effusion. He had signs of instability. I couldn't take him through range of motion because it was too painful. So I, I asked him to get an MRI of his knee and then put him in a brace and told him to follow-up with me.

Q Did he in fact follow-up with you?
A Yes.
Q Did you have an opportunity to look at an x-ray of his right knee?
A I had an opportunity to look at an x-ray and an MRI of his right knee.
MR. MOSES: And the x-rays are in evidence, your Honor, and the Brooklyn hospital records.
Q But will you share with the members of the jury what the conclusion was reached by the radiologist that had the x-ray performed on his right knee and your conclusions as an orthopedic surgeon?
A He had a fracture of the knee cap.
Q Was there a specific part of his knee cap that was fractured?
A Yes.
Q What part?
A It's called the inferior pole.
MR. MOSES: Okay. Your Honor, I like to utilized it's a much smaller model of the knee. I showed it to Mr. Kaminsky. Doctor, I don't know if you need to step down. You might have to.
THE COURT: Probably.
A Sure.
Q Let the members of the jury know what that is and

utilizing that model show them specifically what part of the knee was fractured.

A Sure. So this is the thigh bone. This bone right here. This is the shin bone, which is this right here. (Indicating.) And this is the knee cap. And these are the three bones that make up our knee. And the knee cap has three different parts to it. One part here. (Indicating.) Another part here, and then there is the bottom called the inferior pole. So his fracture was at the inferior pole which is the bottom part of the knee cap.

Q Dr. Winiarsky, you can return to the stand, please.

A (The witness complies.)

Q Dr. Winiarsky, is it fair to say sometimes fractures don't need surgery to repair?

A Yes.

Q Is it fair to say sometimes they do?

A Yes. Of course.

Q In this case did Mr. Pavlov, in your opinion, need surgery to his knee to repair the fracture to his patella?

A Yes.

Q Why?

A Because it was not going to heal in the way it was positioned. Also because when it's the inferior pole there's a lot of forces that prevent the two bones from actually healing.

Q All right. When did you perform the surgery on Mr. Pavlov's knee?

A So the surgery was performed on 1/12/2012.

Q Where was it performed?

A In Beth Israel hospital.

Q Were you solely responsible for that surgery?

A Well I had an assistant.

Q Okay. What type of assistant?

A He's a physician assistant.

Q All right. The surgical procedure that was performed, utilizing the model if necessary, will you tell the members of the jury specifically what you noted in the operation and what you did in attempt to fix that knee?

A So that inferior pole could not be fixed so I removed it. And I thought that was the best thing to do for this bone which I was worried that it would not heal so an excision of it is what -- I excised it.

The second thing I did was I looked at the ligament called the anterior cruciate ligament and I found it had 30 percent tear. I thought it was going to be larger, but it wasn't. And so he had 70 percent left of a major ligament and I just debrided it and left it alone.

Q Can you show on that model where the ACL is located?

A Sure. Can I come down?

MR. MOSES: Sure. If that's okay, Judge.

A (The witness complies.)

So you have these two massive bones. Two of the largest bones in your body. Your thigh bone, your shin bone, and they're connecting this very mobile joint. And you only have four ligaments to really connect them. And the ACL is a ligament, it's right here in the front, it's probably one of the strongest ligaments in your body connecting these two bones, and he had a 30 percent tear of that ligament. 70 percent was intact and; therefore, when it's over 50 you don't. You leave it alone.

Q When it's under 50 you leave it alone?

A Yes --

Q Oh --

A -- when it's under 50 --

Q Okay. So in this case you noted a 30 percent tear to his ACL and you left it alone?

A I debrided it, yes.

Q Doctor, did you continue to act as Mr. Pavlov's knee doctor for a period of time following the surgery?

A Yes.

Q And those records are in front of you?

A Yes.

Q When was the last time you saw Mr. Pavlov?

A I saw him last on April -- May 4, 2015.

Q Okay. And when he presented to you on May 4, 2015, was he making any complaints to you about his knee?

A Yes. He said that his knee, he had more pain. Some instability. Yes. He complained of more pain in his knee.

Q Okay. I want you to assume, Doctor, and we'll certainly save some time, that your medical records will reflect that there was a period of time that Mr. Pavlov had no pain in his knee, that in April of, I believe, 2013 he presented to you and he said his pain had more or less subsided, but when he re-presented to you on this last visit he said to you that the pain had been there for some time, is that somewhat accurate based on your medical records?

A Yes. Absolutely.

Q That his pain went away and that it slowly started to come back?

A Correct. Absolutely.

Q Doctor, is that type of complaint something that you see in a patient such as Mr. Pavlov that sustained a 30 percent tear of an ACL?

A It's not just a 30 percent tear, he had other injuries to his knee. And, yes, sometimes after a period of time when the knee is doing fine, it's not a perfectly good knee, and it can break down, as it did in his case.

Q Doctor, will you consider your surgery a successful

surgery?

A I think success is very hard to judge and very hard to -- hard to say something is successful or not. You know, success is a very hard word to use.

Q Okay. Did you accomplish what you had hoped the knee surgery would accomplish?

A Yes.

Q Now when he presented to you back in 2015, did you perform an x-ray on his right knee?

A I did.

Q We have that marked as Plaintiff's Exhibit 8 in evidence. We have a shadow box.

THE WITNESS: Go down, Judge?

THE COURT: I assume so. Yes.

THE WITNESS: Just to save some time.

Q Dr. Winiarsky, I want you to assume that, that is the 2015 x-ray that was taken at Doshi Diagnostic Imaging as a result of your request asking that an x-ray be taken in light of his complaints of pain.

A Correct.

Q Okay. Utilizing that x-ray, would you let the members of the jury know what you found significant in that x-ray that may account for his continued complaints of knee pain?

A Sure. (Indicating.) Thigh bone. Shin bone. Knee

cap, disc orientation. It's a side view so it's an x-ray taken this way. What he has is very large pieces of free moving bone here. (Indicating.) It's about 8 millimeters, maybe a little more and that's about 4 millimeters. So he has loose pieces of bone floating in his knee.

Q Doctor, within a reasonable degree of medical certainty, do you have an opinion as to whether or not the notations you made on this x-ray were caused by the knee fracture and ACL tear that you noted during your surgery?

A I believe that these fragments of bones were due to the accident. I don't know exactly when they occurred. I don't know how much after surgery -- I didn't note them during surgery so it happened after my first surgery of 2012 and 2015.

Q Doctor, do you have an opinion, within a reasonable degree of medical certainty, as to whether the accident in this case, as described to you by Mr. Pavlov, was a substantial factor in causing the inferior patella fracture and the 30 percent tear of the ACL you noted?

A Yes.

Q What is that opinion?

A That it was due to the accident.

Q Why do you say that?

A Because somebody falls 10 feet, which is a very significant fall, and then they're a young, healthy, strong

person with a perfect knee, working, going up and down a ladder, you fall 10 feet, you have 30 percent tear of the ACL, you have a fracture at the nose of the patella, and then you have free floating pieces of bone moving around, this is all due, to me, it was very obvious, to the accident.

Q Doctor, do you have an opinion -- you can return to the stand, Doc.

A (The witness complies.)

Q Doctor, I want you to assume that Mr. Pavlov told us that on the date of the accident he was standing on top a ladder working on August 12, 2011, when he fell and landed on that right knee. I want you to further assume he went to Brooklyn hospital and they performed x-rays of the right knee. Those reports are in evidence. Those x-rays are in evidence. And those x-rays and reports reveal an interior pole fracture of the patella consistent with what you noted. Doctor, would x-rays at a hospital necessarily show the 30 percent ACL tear that you noted during your arthroscopic surgery?

A Not at all.

Q Do x-rays necessarily show ACLs?

A Not at all.

Q What do x-rays show?

A Bones.

Q And during your arthroscopic surgery you noted the

30 percent tear of the ACL?

A Correct.

Q So approximate four months after the accident?

A Correct.

Q Doctor, do you have any doubt in your mind, within a reasonable degree of medical certainty, that, that 30 percent ACL tear was caused by the fall I just described?

A No.

Q Doctor, is it possible or is it another suggested cause that, that ACL may had just torn organically or as a result of wear and tear?

MR. KAMINSKY: Judge, I'm not arguing that.

MR. MOSES: All right. Okay. All right.

Q Doctor, I want you to assume that Mr. Pavlov told us that, till this day, he still feels instability in his knee while walking. He told us that he still feels pain in his knee especially while he's taking stairs.

Doctor, does the instability and the weakness and the pain in his knee he shared with us, within a reasonable degree of medical certainty, are they all complaints that were caused by the patella fracture, the ACL tear, and the loose bodies you noted in his knee?

A I think they were all caused by it.

Q Why is that, Doctor?

A Because of the timing of the events. Because of

the fall. Because I saw him five days after the fall. I've operated on him. I've witnessed him getting better, getting worse again, and everything just makes sense from the time my point of view, clinically and categorically (sic) that it's all related.

Q Doctor, I want you to further assume that Mr. Pavlov within the last few minutes has just started to return to work. He testified that he's doing jobs different than the job he was doing at the time of the accident, but he's assisting colleagues in various construction work.

Do you have an opinion, Doctor, whether or not that activity is consistent with somebody that sustained the injuries you noted in your surgery?

A Sure.

Q He's able to walk; is that correct, Doctor?

A Absolutely.

Q He's able to take stairs; is that correct?

A Yeah, with some difficulty. Yes.

Q Doctor, do you have an opinion, within a reasonable degree of medical certainty, as to whether or not complaints of pain that Mr. Pavlov shared with us in his knee are permanent complaints?

A Yes, they're permanent complaints.

Q They're never going to go away?

A I don't think so.

Q Doctor, do you have an opinion, within a reasonable degree of medical certainty, as to what the future holds for Mr. Pavlov with regard to the right knee?

A One thing is those loose bodies can act like stones in a shoe. I think at some point it should be removed. And, unfortunately, I think more loose bodies can form. I think that an attenuated ACL has a history of rerupture. I think he's going to have traumatic changes to the cartilage in his knee cap. I think that knee is, you have to watch it very carefully so it does not get worse, but I think that the loose bodies are definitely an issue and one that should be attended to.

MR. MOSES: Thank you very much, Doctor. I have nothing further.

MR. KAMINSKY: Judge.

THE COURT: Short?

MR. KAMINSKY: Not only we're going to get the Doctor out before lunch, more importantly, we are going to get the jury out of here before lunch.

THE COURT: You know lunch is in two minutes.

MR. MOSES: Yes. But this was coordinated, your Honor.

CROSS-EXAMINATION

BY MR. KAMINSKY:

Q Doctor, how are you? My name is Alan Kaminisky. I

represent the defendants in this case. We own the location where Mr. Pavlov had his accident, okay.

Now, just for the record, I believe it's acknowledged he fell 6 feet and not ten, but we'll put that aside, okay.

I'm just a little confused by some of your testimony so just bear with me and we'll get you out of here in a couple of minutes.

First of all, let's talk about the type of surgery you did. You did what's called arthroscopic surgery, correct?

A Correct.

Q That's laser surgery, correct?

A No -- people say laser, I don't know why they say laser.

Q All right. Let's use the correct --

A Arthroscopic. It's a scope of a knee.

Q Scope. Arthroscopic.

A Arthroscopy.

Q We hear about athletes having arthroscopic surgery all the time.

A Good.

Q Would you agree with me that as far as knee injuries go, if we put arthroscopic surgery in one end and put a knee replacement at the other end, knee replacement

would be ten and arthroscopic surgery would be more like a one, true?

A No.

Q Arthroscopic surgery, how long did this surgery take?

A 25 minutes. Could be 30 minutes.

Q And it was done on an outpatient basis, correct?

A Correct.

Q In other words he was not admitted into any hospital. He came in -- it was done in your office?

A No. It was done at a hospital.

Q He comes into the hospital. 20 minutes you do the surgery and he's released the same day, correct?

A The surgery itself is 30 minutes, yes. But.

Q 20, 30 minutes?

A He's released the same day.

Q Just so we're clear, he had arthroscopic surgery. Nothing more, nothing less, true?

A True.

Q Okay. And I'm not going to go through all your reports. I only want to go through your most recent report which is May 4, 2015. If you could turn to that for me, okay. And then we'll get you out of here.

Now, you say on "May 4, 2015, history of present illness. The patient is status post right knee arthroscopy

and has some pain and discomfort. He is not back to work. Not because of the knee, but because of his back. But we want to make sure so we got a new MRI to make sure there are no issues with his patella tendon, no meniscus or anything of that sort." Correct?

A Correct.

Q Now, listen to the next line that you wrote. "Basically, the MRI came back completely negative."

A Correct.

Q You wrote that, true?

A Yes.

Q Okay. Now, you did a physical examination the last time you saw him. And the physical examination says "he has a benign knee examination."

A Uh-hum.

Q Benign means, for lack of a better term, there's nothing wrong?

A Right.

Q There's nothing wrong. It's benign. It's harmless. It's good?

A It's good.

Q Okay. So your own words. The MRI comes back completely negative and then you examine his knee, I would imagine -- well it was his right knee -- I would imagine you looked at his knee, right? You did a physical examination.

He has a benign knee examination. Just a very small effusion. Correct?

A Yes.

Q And then you gave an assessment. An assessment is you reviewed everything, you've done your examination, you looked at the films, and now it's time for you to give an opinion, correct?

A Yes.

Q And you write everything is looking really good?

A Yes.

Q Your words; not mine?

A Yes.

Q Your words?

A I agree with you.

Q Okay. Now, the worst case scenario. He needs another arthroscopic surgery to remove a couple of loose bones that you didn't originally see, right?

A Yes.

Q Comparable to the initial surgery that you did?

A Yes.

Q Okay. We're talking about another outpatient, arthroscopic surgery, that if he does have pain to his knee, you would remove those loose pieces of bone and that's that, correct?

A Correct.

Q And that would cost approximately how much?
A 15,000 all together.
Q Okay. 15,000?
A Yes.
Q Okay. And he may or may not need that some day, true?
A I think he will need that.
Q Okay. And if he does, that will rectify any -- the pain he may have, correct?
A It will rectify the loose pieces of bone that he has.
Q Fair enough. Thank you.
And just to conclude, "everything is looking really good," your words?
A Those are my words.
Q Thank you. Nothing further.
MR. MOSES: I have one question.
REDIRECT EXAMINATION
BY MR. MOSES:
Q Doctor, will you explain to the jury how you can say things are looking really good and also say that he's going to have pain in this knee for the of his life?
A You know he has some days -- he had three years where I didn't see him. He was doing really well. And over that time he developed loose pieces of bone which are there.

They're physically there. And if you remove them, they can come back just the way they formed again. He has -- he complained to me of instability. Pain. He has cartilage that's definitely lost and the infra -- (witness repeats) he lost cartilage at the bottom part of his knee cap, which is going to affect him going up and down the stairs. He lost 30 percent of ACL. And he's forming, over time, loose pieces of bone. This is not a benign knee. He can have good days. He can have a benign knee exam that day, but by no means does this mean a normal knee.

MR. MOSES: Nothing further.

MR. KAMINSKY: No. That's it.

THE COURT: You may step down. Counsel -- thank you -- that's it for the day?

MR. MOSES: That's it for the plaintiff, your Honor.

THE COURT: For the day. Do you have -- you don't have a witness this afternoon?

MR. MOSES: When I say that's it for plaintiff, plaintiff rest.

THE COURT: I understood that.

MR. MOSES: Yes.

THE COURT: Okay.

(The witness is excused.)

THE COURT: So ladies and gentlemen, we're

going to break for the day. I will see you Monday morning and defendant will begin his case. Okay.

Have a wonderful weekend.

All rise. The jury may exit.

(The jury exits the courtroom.)

THE COURT: You may be seated. I need charges and verdict sheet proposals.

MR. KAMINSKY: We have them ready, Judge.

THE COURT: Excellent.

MR. MOSES: Can I get you mine by end of the day?

THE COURT: You can get them to me by Monday.

MR. MOSES: We'll put something on the record just briefly, your Honor.

It was part of the stipulation of the high low agreement but just formally speaking there is no loss earnings claim being advanced in this case. Plaintiff has rested in this case and we'll limit to exclusively to the future medical being the only special -- being the only special -- and perhaps past medical if Mr. Kaminsky and I can agree on a number.

MR. KAMINSKY: That's why I have to modify my verdict sheet.

THE COURT: Great. Have a good weekend.

Good travels Mr. Kaminsky.

MR. KAMINSKY: Thank you, Judge, you too.

THE COURT: See you Monday.

(The trial was adjourned till Monday, November 2, 2015.)

* * * * *

CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT
OF THE STENOGRAPHIC MINUTES TAKEN HEREIN:

_____

DOLORES LYNCH, RPR
SENIOR COURT REPORTER