SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: TRIAL TERM PART 13

- X

JOAN JANCZEWSKI,

Plaintiff,

- against -

INDEX NO.
651108/13

AUTOCAR LA CAPITALE INC., GROUPE AUTOCAR JEANNOIS INC., and JEAN MARK BINETTE,

Defendants.

- X

71 Thomas Street
New York, New York
February 1, 2016
TRIAL BY JURY

BEFORE:

HONORABLE MANUEL J. MENDEZ,
Justice

APPEARANCES:

LAW OFFICES OF JAMES J. McCRORIE, P.C.
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Bonnie Piccirillo
Official Court Reporter

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

A N D R E W M E R O L A, M. D.,

called as a witness in behalf of the Plaintiff, having been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

THE CLERK: In a loud and clear voice, state your name, spelling your first and last for the

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

THE CLERK: Business address is?

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

THE COURT: You may inquire.

MR. McCRORIE: Thank you. Your Honor.

DIRECT-EXAMINATION

BY MR. McCRORIE:

Q Good afternoon, Dr. Merola. Thank you for your patience today.

A Good afternoon.

Q A little odd configuration. If you could direct over to the jury, I'd appreciate that.

Can you tell -- you're the first doctor. If you come across any words, fellowship, residency, that have to do with medically, if you could explain it to them even though the word might be obvious. So, fellowship, internship, any words or medical terms that you have.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Can you please tell the jury are you licensed to practice medicine in the State of New York?

A Yes, I am.

Q When did you become licensed?

A 1992.

Q As succinctly as you can, going through your CV or your background, can you please give the jury your educational background and qualifications leading up to the present time?

A Sure.

So, I attended medical school whereby after I graduated medical school, I attained an MD degree.

After that, I began in a training program which specifically was with respect to surgery and orthopaedic surgery. I did a year of internship. That's the first year after you graduate medical school in general surgery; and then four years after that, in orthopaedic surgery, which is specialized for the practice of your bones and your joints and your nerves.

After that five years of training was completed, I did a year of extra training whereby I focused on only spinal surgery, that is surgery to your neck and your back in both children and adults.

And when I finally completed all of those years of training, I came back to practice orthopaedic spinal surgery.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Q And can you please tell the jury what if any teaching positions you hold?

A So, I have a teaching position of associate orthopaedic professor at SUNY Downstate Medical Center in Brooklyn.

I'm also assistant professor of orthopaedic surgery at both New York Hospital and at Mount Sinai Hospital.

Q Can you describe your current practice and whether or not -- you just said two hospitals, but whether or not you have hospital privileges and where?

A So I do have hospital privileges and what that means is that I have an opportunity to bring patients into the hospital where I then can take care of them. Since I'm a surgeon, my job is strictly surgical. I have admitting privileges at Mount Sinai Hospital and New York Hospital as well.

Q Are you board certified in any field?

A Yes, I am.

Q Yes, so before you tell us where, can you first tell the jury the significance of board certification?

A So, board certification is an educational process. It involves two exams. One examination is a written examination after you have completed your basic training; and then after you pass that exam and you've been in

practice for two years at a minimum, you then take an oral examination based upon the patients that you've operated upon and you answer questions in front of a board of examiners.

When you pass both parts, you're then board certified. That particular process recycles itself every ten years. So we recertify every ten years.

Q What field are you board certified in?

A Orthopaedic surgery.

Q And how long have you been so board certified?

A My first certification was in 1998. I recertified in 2008, and my next recertification is due in 2018.

Q Within the field of orthopaedics, do you have a subspecialty?

A Yes.

Q What is that?

A It's spinal surgery.

Q Do you in fact operate on extremities, arms, shoulders, knees and such?

A No.

Q Do you only deal with issues of the spine?

A Yes.

Q Can you tell the jury approximately how many spine surgeries you perform in a given year?

A So, between myself and my two other associates who

I operate with, we perform about 200 surgeries per year.

Q Now, I'd like to you assume that during an opening statement, the defense talked about thousands and thousands of doctors.

Does your practice accept motor vehicle accidents and all of the rules and regulations that you must abide by if you take one?

A Yes.

Q And if you take one, must you take all? You can't turn down?

A Yes.

Q You can't discriminate. If you take one motor vehicle, you need to take them all; right?

A Yes.

Q Is that the same with work-related accidents?

A Yes.

Q Do all doctors in the State of New York, orthopaedic spine surgeons accept work-related accident benefits?

A I don't think so, no.

Q By virtue of accepting motor vehicle accident benefits and work accident benefits, have you had to come to court from time to time for patients that have been involved in motor vehicle accidents and/or work-related accidents?

A Yes.

Q In fact, in the past 20 years has your -- have you

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie testified on behalf of any construction worker that we have represented, my office?

A Yes.

Q How many times has that occurred in twenty years?

A So I found myself in court probably about three or four times per year.

Q How many times for our firm?

A I think a couple of times.

Q Okay, are you being paid for your time away from the surgeries, the postsurgical visits to be here in court today to testify about your treatment of Joan Janzcewski?

A Yes.

Q Did you and I meet prior to you coming here?

A Yes.

Q -- and testifying. Did we meet knowing the trial was coming up on occasion to go over certain films to blow up so it would be faster than putting them up on a light box?

A Yes.

Q And did we also meet for the purpose of an illustration of the surgery to see if it was accurately drawn for demonstrative purposes?

A Yes.

Q Your file is in evidence as Plaintiff's 32.

Dr. Merola, can you tell us if Joan Janzcewski is a patient of yours?

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

A Yes.

Q When did she become a patient of yours?

A Her first visit was on April 29th of 2013.

Q And how is it, if you know, did she become a patient of yours? How was she referred to you?

A She was referred to me by her neurologist, Dr. Eric Hausknect.

Q Is that the first patient Dr. Hausknect -- withdrawn.

Do you know if Dr. Hausknect also accepts motor vehicle accident benefits?

A Yes.

Q And is that the first patient Dr. Hausknect has ever referred to you?

A No.

Q Utilizing your first note, did you -- withdrawn.

Did you review your file prior to testifying here today for the purposes of relaying your treatment of Ms. Janczewski to the jury?

A Yes.

Q And did you review -- did you also review the emergency room and other -- the diagnostic films?

A Yes.

Q And your operative report?

A Yes.

Q Can you please tell the jury, as the first doctor, what

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history means when a doctor takes a history?

A So when a patient comes into the office, they first come in with what we call is a chief complaint, that is a problem that they're having and that is usually a description of pain.

In order to be able to get more information about what that particular problem is, we then take what is known as a history.

So we have a discussion with the patient about when the problem started, what aggravates the problem, what relieves the problem. And so we get a better idea of what it is that is bothering them so that we can focus on our examination, that is our physical examination, a bit more specifically to try to come up with what's known as a diagnosis.

Q Okay, and I'm just going to hand you Plaintiff's 1 in evidence. It's the certified hospital record of New York Cornell-Weill.

I'm just going to hand you Plaintiff's 19. It's the records of Ilyce Maranga. We are going to refer to them.

Can you tell the jury what the history was as relayed by Ms. Janczewski to you as to why she was in your office on April 29, 2013?

A So the patient was sent in by her neurologist. Sent her to me for a surgical consultation regarding pain

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which she was having in her neck and back with what we call radiating symptoms.

Radiating symptoms are symptoms that means the pain is traveling down into her arms and hands and legs and feet.

The history was an accident whereby she was struck by a bus on November 30 of 2012. She had seen a physical medicine and rehabilitation doctor, Dr. Maranga; a neurologist, Dr. Hausknect, and an orthopaedic surgeon as well; and she was coming in for me to evaluate both her neck and her back with a diagnosis of a cervical and lumbar sacral radiculopathy and for me to investigate that a little bit further.

Q And Mr. Maranga is, in fact, a chiropractor that has the physical medicine doctors and the acupuncturists and all of that there; correct?

A Yes.

Q And what were the complaints of pain that were medically significant to you after she relayed what had happened; what were the complaints that were medically significant to you as a spine surgeon?

A So, she had pain in her neck region which, as I say, was radiating into the arms and hands; that is, traveling down into the arms and hands with numbness and tingling going down into the arms and hands.

She also had low back symptoms, that is to stay symptoms of pain in the lower back as well. She also complained of occipital headaches and pain in her neck area that was increased with range of motion, including the radiating symptoms that were increased with increasing activities, particularly activities that required range of motion; that is, anything that involves head and neck motion or low back motion.

Q Can you please define occipital in the region where she was having headaches?

A So, occipital refers to the back portion of your head. That's the back underside portion of your head.

Q And did you take a history as to whether or not she had any pre-existing issues with her spine whatsoever in her life up until 47 years old when she saw you?

A No pre-existing prior problems regarding her neck or her back before the accident had happened.

Q And was that noted?

A Yes.

Q Did you also note the medical conditions that she had, the diabetes, the hypertension?

A Yes.

Q Did you she those noted in the ambulance and emergency room and all the doctors that she saw thereafter?

A Yes.

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Q Past surgical history; until the time she came to see you, had she undergone surgeries?

A Yes.

Q What were they as related to the accident -- you could say if there's another one, that wasn't the accident -- from years before?

A So she had a gall bladder surgery that was not accident related.

Q Years before the accident?

A Correct. She also had a shoulder surgery, a knee surgery and a nasal surgery regarding her septum.

Q Okay, the physical findings -- we're in the going to do this for every examination; but can you please tell the jury, go through the physical exam, tell them any medically significant physical findings as it relates to any spinal conditions for which you were seeing her for?

A Sure. So she had what we called palpable spasm. Spasm is an involuntary contraction of a muscle. So when you are palpating or feeling the muscle or muscle group and that muscle becomes hard and spastic, that's what we would consider palpable spasm.

Q I want to just stop you there and I have to do this as you are the first doctor.

Can you tell the jury the difference between subjective and objective findings in medicine?

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A A subjective issue is a patient's symptoms or their complaints. I have neck pain. I have back pain. That's a subjective -- what we would call symptom.

An objective finding is something that's not under the patient's control that is physically examined. For example, a reflex, an involvement of a nerve root, a range of motion by a palpating spasm. Those types of things are objective. They're physical findings that you test while touching the patient and doing an examination, and they're not under the patient's control.

Q Did you -- in fact, you said you felt spasm. I just want to stay on this for a moment before we go through with the exam. You felt spasm on Ms. Janczewski?

A Yes.

Q On what parts of her body?

A In the neck and in the back.

Q It's in evidence, but have you seen records of other treating physicians that actually felt spasm when they palpated her?

A Yes.

Q How about the defendant's examining physician that felt spasms, Vikas Varma, did you see those? Were you shown all the defendant's exams?

A Yes.

Q Where they actually found spasm?

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A Yes.

Q Can spasm be faked?

A No.

Q Or exaggerated?

A No.

Q In a spine or a spine injury, what causes muscles around the spine to go into spasm?

A So, your spine is a column, and it supports your head over your pelvis.

The muscles that are attached to your spine, though, holds that spine in its normal alignment. Spasm occurs when your body tries to prevent the spine from going into a position that would otherwise cause pain.

So, it's there as a defense mechanism that your body has to prevent the spine from being put into a position that would otherwise be painful.

Q Okay, so you got up to the point of spasm.

Can I just ask you this, too.

In the first examination, did you note anything as to Ms. Janczewski's ability to fluidly speak with you?

A She was able to communicate, but it was -- I would describe it -- I actually described it as with difficulty expressing herself, but it was slow, purposeful speech.

Q Okay. In addition to spasm, can you tell the jury any other objective medically significant findings during your

physical examination on the first day?

A Sure. So she had a restricted cervical range of motion. For example, her cervical extension -- extension is the ability to bend your head backwards. That was at five degrees, and so these motions are taken to the maximum amount of motion that the patient can tolerate before you palpate spasm in the muscle group attached to that part of the body.

So in the cervical spine, it's the muscles that are attached to the neck, and she was able to extend up to five degrees. Beyond that there was spasm palpable. Normal extension is 65 degrees, so that you would be able to look upwards towards the sky.

She was able to flex forward; that is, bend forward to 30 degrees. Right lateral bend; that is, bends towards the shoulder on the right side up to 20. Left lateral bend, also to 20.

Rotate, which means turning your head from side to side over your shoulder was 15 degrees on the right side and 20 degrees on the left side.

Q Okay, and that was both for the neck. Did do you the back, as well?

A Let's see. In the lower back, I did a lumbar extension, which was to get her to zero degrees of extension, that is full upright; and at that point, there

was palpable spasm with a positive -- what we call spinal Phalen's maneuver, which means it reproduced pain radiating down the legs.

Q I want to ask you something initially, and then we're going to do later on in the examination, I'm going to ask you what your opinion is with reasonable certainty as to whether or not there were limitations that were significant.

The -- did you -- you said normal during your answer, but did you compare Ms. Janczewski's range of motion in her neck during the first examination to the normal range of motion?

A Yes.

Q And it's in evidence, your findings -- and we'll come to them again at the end. But did you at that time believe her to have a significant limitation of the use of her neck at that time?

A Yes.

Q And did you believe her to have a consequential limitation of a body member called the neck at that time?

A Yes.

Q If you can -- how was she ambulating, walking?

A So in terms of what we would call her gait, she had what I palpated as asymmetrical contraction of the muscles in her neck and in her lower back; and she was actually utilizing a cane when I first met her, which meant

she had an antalgic gait pattern.

Q Just define antalgic?

A It means a limp, antalgic means a limp.

Q Can you please tell the jury anything else so we could then move off it on your physical examination that would be medically significant to the issues you were seeing her for?

A So in her neck, she had what's known as a positive Spurling sign, which means pushing down on the neck and rotating and moving the neck into a side position, reproduce pain going down into the arms and hands. As well as two pathological reflexes; one known as a Hoffman sign and the other known as an inverted flexor response.

A Hoffman sign is a test whereby you flick the tip of the middle finger, and you look for a contraction, involuntary contraction of the thumb and index finger and inverted flex response is a test where you tap the tendon over the wrist and you look for a flexion of the fingers and hand.

Those are signs of spinal cord irritation that you would look to see in a condition which we call myelopathy.

Q And what does myelopathy mean?

A Myelo is the term for the spinal cord, and opathy means problem with. So when you see a patient who has a myelopathy, it's telling you there's a problem with the

spinal cord. In other words, the spinal cord is not functioning properly.

Q And is there anything else significant about the physical examination before we go to your impression and plan?

A That was the cervical spine. In the lumbar spine, I actually already mentioned that she had what we called a positive spinal Phalen maneuver; that is reproduction of lower extremity, leg and foot symptoms with extension of the lumbar spine.

Q Okay, and at that time did you have the opportunity -- well, withdrawn.

Did you have Dr. Hausknect's notes and any conservative treatment she had had including the physical therapy, chiropractic and acupuncture?

A Yes.

Q Can you tell the jury the purpose of conservative therapy in the initial stages of spinal injury?

A Conservative therapy refers to nonoperative treatment; and it, essentially, starts with modifying activities. That's number one.

Number two, physical therapy and chiropractic treatment and medications.

The purpose of that is to decrease the initial inflammatory response to trauma.

Inflammation is -- if you've ever seen a cut

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on your skin, you notice it turns red and sometimes it can actually weep, some fluid can come out of it.

That process whereby that cut turns red and becomes weepy is a process known as inflammation. It can happen on the inside as well as the outside.

The conservative treatments are designed to give your body a chance to heal and to have that inflammation subside.

So the purpose of therapy and medications, particularly anti-inflammatories, is to decrease the inflammatory process, improve flexibility and improve strength to give that inflammatory process a chance to quiet down.

Q And understanding her accident was November 30, 2012, you were seeing her on April 29, 2013; did you come to a determination as to whether or not she had had ample conservative treatment prior to seeing you for a surgical consultation?

A Yes.

Q What was that determination?

A That she had had sufficient conservative treatment prior to coming in for a surgical consultation.

Q I'd like you to first tell the jury the difference. You can define them and tell them the difference, an X-ray, CT scan and MRI.

A So an X-ray is a way of taking a picture of your body utilizing radiation. So you can picture that radiation as a very powerful flashlight that shines through your body, and what it picks up is it picks up very nicely what the bones in your body look like.

So an X-ray tube is really a very, very, very powerful flashlight that shines through your body and casts images of your bones on film.

A CAT scan is a much more sophisticated X-ray device that takes many hundreds of pictures of the internal portion of the bones of your body. And, once again, those images are then transferred to film to give a picture of the inside of the body. It uses radiation, as well.

An MRI is a way of taking an image of the inside of your body using a very powerful magnet that magnetizes what you're made of; and most of what all of us made of is water, so MRI magnetizes the water molecules and really the electron and water molecules, and then converts what happens to those electrons and water molecules into an image.

So X-rays and CT scans use X-ray, and MRIs use a magnet. Always imaging internal portions of the body.

Q When you're looking at the spine, which is the best way to see the intervertebral disk in their condition?

A So since the spine is made up of not only bones,

but also softer tissues known as the disks and the nerves, the MRI is very sensitive at being able to image not only bone changes, but also soft tissue changes.

So an MRI is generally one of the studies of choice that we use in order to be able to image the bones, the joints, the disks and the nerves of the spine.

Q Okay, in your notes -- might be different in other doctors notes -- when you write "impression and plan," does impression equal diagnosis or initial diagnosis?

A Yes.

Q Can you tell -- and a plan is what?

A A plan is what recommendations you would make based on that diagnosis.

Q Okay, what was your -- withdrawn.

Did Ms. Janczewski have actual MRIs with her, diagnostic tests in addition to records?

A Yes.

Q Did you review the MRIs?

A Yes, I did.

Q Of which body part?

A The cervical and the lumbar spine.

Q What was your initial diagnosis, and what was your plan?

A So, my major concern when I first saw her after looking at the films and then correlating them; that is,

using those films in order to back up the physical findings that I found on the exam, my concern was she had what's known as a cervical radiculopathy -- that's a problem with the nerves coming out of the cervical spine -- as well as a cervical myelopathy, which is problem with the cervical spinal cord as a consequence of two herniations in the spine at the C5-C6 and C6-C7 levels.

Q We'll have you define those in just a moment. What was your -- what did you intend to do for that?

A So, at that point in time when you see neurological problems with the spinal cord and the nerve roots, the job of a surgeon is to get the pressure off of the cord and the roots, to prevent the spinal cord and nerve roots from progressively getting worse.

That's a surgical procedure where the disks are removed and then the spine stabilized in order to prevent further damage. It's a process called a cervical discectomy and a spinal fusion.

Q Did you sit down Ms. Janczewski and explain the risks of such a surgery?

A Yes.

Q And briefly tell the jury the risks that you told her there would be?

A So the basic risks to this surgery involve, number one, a general anesthetic because the patient needs to be

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asleep with the general anesthesia.

It involves an incision. Anytime you make an incision, there's a risk of an infection and/or bleeding.

It involves having to move the vocal cord and the food tube out of the way, as well as the great vessels. That's the carotid and jugular. Anytime you do that, you could have difficulty with your ability to swallow or voice afterwards or a problem with one of the blood vessels; that's the carotid or the internal jugular.

Since we're operating on the spinal cord and the nerves and the nerves and the cord are irritated, the surgery can further irritate the cord and the nerves resulting in some more progressive nerve damage; we're doing a process called a fusion, which means we want to get the bones to grow together and we utilize a mechanical device to do that.

Anytime you do any mechanical reconstruction, you can have a problem with the device, either having the device move or having the device break.

At anytime you need to get two bones to heal together, there's a potential that the bones themselves may not heal together and that's a condition we called pseudoarthrosis.

Those are some of the what we would call more major potential risks of this particular kind of surgery.

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Q And just before -- with the Court's permission, of course -- I'd have you step down, could you just take out the New York Cornell -- the Presbyterian record?

A Yes.

Q I'd like to start -- it's in evidence. I'd like to start with the ambulance call report, which is part of the record.

A Yes.

Q First off, as they typically would do, they asked her what medication she was on and it lists what she was on at the time of the accident; right?

A Yes.

Q Metformin, Enalapril?

A Correct.

Q Can you just tell the jury -- this person's handwriting is like mine. It's not good, but when it says "AO x 3," what does that mean?

A That means alert and/oriented times three.

Q And it says "Patient had pain to --

A Says "left side of face, left shoulder and lower back."

Q And when you go to the emergency room, there's a triage. It's numbered page 1 through 14?

A Yes.

Q Do you see that?

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A Yes.

Q The triage. So just taking the first, going to have you -- on the bottom, there's a numeric pain scale and location of pain on the bottom of page 1?

A Yes.

Q What are the locations and we're not going to go through everything, but what was it?

A Head, neck and left shoulder.

Q What's the pain scale?

A Six.

Q Okay. Just jumping to page 5 of 14.

What does a "hematoma on the left orbit" mean?

A Hematoma is a collection of blood, and that's a collection of blood in the left orbit area which is an area around the left eye.

Q If can you go to page 7 of 14.

If you could, just read the first few lines of the "history of present illness" up to the word "trauma."

A On page?

Q 7 of 14, starts with "Chief Complaint," unless we're --

A I may have a different page.

Q On the bottom. Yours is page 4 of 11. Up to the word "trauma." So it's 4 of 11, same printed out, I guess, differently.

So, "Chief Complaint" it starts with in the

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medical exam.

A Says "This patient is a 47 year old female." And it then goes on to state, "Chief Complaint: Hit by bus." And then "History of present illness: Diabetes, hypertension, on aspirin, was crossing road when a bus was making a low-speed turn and struck her left side of body. Patient reports bus impact was more of a push on her body. Positive facial injury with periorbital bruising. Patient was knocked to ground with head trauma."

Q So now what is periorbital bruising?

A That would be -- well, periorbital bruising refers to an ecchymosis, which is a collection of blood or in colloquial terms, a bruising. Periorbital area is the area around the eye.

Q I'm just going to show you Plaintiff's 2 in evidence, a picture of a bus, a tour bus.

(Shown)

You've seen this picture before?

A Yes.

Q Subject to connection, this is the bus that was involved in the accident along with the number and it's been identified; okay?

A Yes.

Q It's subject to questions I'll be asking.

I just want to show you subject to connection some

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photos of Ms. Janczewski in the emergency room.

So I'm holding up 12.

Can you see that?

A Yes.

Q What region is this called? (Indicating)

A That is the periorbital region.

Q And what is this region called? (Indicating)

A That's the region under what's known as the left zygomatic arch or the cheek bone.

Q I'm holding up 13. What is this area right here? (Indicating)

A That's the nose.

Q Where is the septum?

A The septum is in between the nose -- in between the right and left nostril on the inside of the nose.

Q And have you seen these photographs prior to rendering your final opinion?

A Yes.

Q Can you tell the Court -- not Court -- the jury what the word "degeneration" means when you're looking at spinal X-rays, MRIs or CT scans?

A So the word "degeneration" literally means a wearing out of. From the time you're born up until the time you reach skeletal maturity -- boys and girls it happens within a few years of each other -- you are in a process of

generation. You are getting taller. Your shoe size is changing. Your body is making new body parts.

When you reach skeletal maturity, the process of the wearing out of those body parts then starts to outpace the making new body parts. So we all at some point in time start to wear down.

That happens in all of the tissues and organs of your body; and in the spine, it occurs in the bones and in the joints and in the disks and to some extent even in the nerves.

Q In taking a look around the room, who in this room has degeneration going on in their body?

A We all have degeneration in our bodies.

Q Does degeneration equal pain?

A No.

Q Does it equal dysfunction?

A No.

Q Does it equal limitation?

A No.

Q Does the word "degeneration" equal herniation?

A No.

Q Can someone's -- withdrawn.

Can you tell the jury what symptomatic means and the word asymptomatic?

A Symptomatic means that it is causing a perceptible

problem within your body. Asymptomatic means that it is not causing a perceptible problem in your body.

Q And can an asymptomatic degenerative condition become symptomatic if, for example, someone is hit by a 38,000-pound bus?

A Yes.

Q What if it's a 13,000 pound bus; does it make a difference?

A No.

Q In the hospital record of the CT scan, when the radiologist writes: "Mild degenerative changes of the lower cervical spine."

What does "mild" mean when you're quantifying degenerative changes?

A It would mean very little.

Q And what is "mild to moderate stenosis?" What does that mean?

A Stenosis refers to a narrowing of. By definition, that term means a narrowing of.

MR. McCRORIE: With the Court's permission, I would ask for the doctor to be able to step down and go over to the anatomy of the spine and then the hospital record.

THE COURT: Sure. You may step down, Doctor.

(Steps down)

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MR. McCRORIE: This is being deemed 33.

Q So what I'm going to have you do, Doctor. These are for demonstrative only. They aren't in evidence. It's a model of the spine, 33. I'm also going to put up Plaintiff's 24.

If you could explain the anatomy of the spine, using the words "sagittal" and "axial" because we're going to see MRI films when you get to those views.

A So this is a plastic model of the human adult spine. Top of the model has the base of a skull. Bottom of the model has the pelvis. This is where your hips attach.

We're looking at on the left hand of this illustration, the side view; and on the right half of the illustration, we're looking at a back to front view.

Top right of the illustration is a model of a cervical spine as though you were looking down the spinal canal.

Q What do you call that view?

A Axial, this is known as an axial view. At the top of that view is a disk. At the bottom of that view is the spinal cord. Spinal cord sits in this little area that looks like a Y. That Y area is the spinal canal.

The bottom right of the illustration is a lumbar vertebra. Top of the illustration, the disk. Bottom of the illustration, looks a little more T-like, but that's the spinal canal region.

Sagittal means side view. S for sagittal, side view. The back to front view we call an AP view or PA view or acromial image.

So the spine is a column, and that column supports your head over your pelvis. The column is made of bones and disks. Behind the bones and the disks and the spinal canal are the nerves.

When you look at it from the sides, the bones appear do be squares, and the disks sit in between all of the squares.

Top of the spine is the cervical spine. It's all those bones are labeled with a C. Upper back is a thoracic spine. All those bones are labeled with the letter T. Lower back is the lumbar spine. All those bones are labeled with the letter L.

They're also numbered; 7 cervical, 12 thoracic, 5 lumbar and 1 sacrum. Sacrum, S for sacrum. Each nerve takes the name of the bone past which it passes.

So, for example, between the fifth and sixth bones, you're actually touching the sixth nerve root. Between the sixth and seventh bones, it's the seventh nerve root. The lumbar spine, the nerve that comes underneath the third bone would be the third lumbar nerve and so forth.

So you can tell what level you're at based on the letter and the number and that works for the bones, the

disks and the nerves.

Q Can you just tell the jury quickly the difference between a solid spinal cord stemming from the brain and something called the cauda equina and why it's solid on the cervical and stringy on the lumbar?

A So your brain contains most of all of the actual cells that are responsible for generating nerve signals, that are then transmitted to your arms and your legs.

They travel through what we call the terminal portion of your brain, which is the spinal cord. Your spinal cord is actually brain material, but it's in your spinal canal. That spinal cord travels all the way down the spinal canal up until the upper portion of your lumbar spine where it actually ends; and after it ends, you have what are known as nerve roots only.

These nerve roots are bunched together in what we call a cauda equina or cauda means tail. Equina means horse or horse's tail because if you open this area up and you look at the nerve roots, it actually looks like a horse's tail.

So, spinal cord is the continuation of your brain inside the spinal canal that ends in the upper lumbar portion of your lower back.

Q In discussing the risks of surgery, is one of the risks, especially in the cervical region when it's a full spinal

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cord near the brain paralysis?

MR. KAMINSKY: Objection, Judge.

THE COURT: Sustained. Rephrase it, please.

Q Can you please go through -- what is the most serious risk of -- other than you said anesthesia and things can go wrong when operating on the spinal cord or in the area taking a disk off of it?

A So because the spinal cord is the terminal or end portion of the brain and you're operating on that cord region, the cord is very sensitive to pressure -- that's the reason you're doing the operation in the first place. So any excess pressure on that area from the actual surgery itself can cause spinal cord damage and/or paralysis.

Q Can you please define a herniated disk using the diagrams first in the general terms?

A So, if you look at the disk from top to bottom and as it appears on these illustrations -- one top, top side is cervical, bottom one is lumbar. The disk has an outer ring called the anulus and it has an inner-center called the nucleus.

The outer ring is a ring of connective tissue fibers made out of collagen. The inner-center is much more jellylike. It's also made out of collagen, different kind collagen. It's not unlike a jelly doughnut.

When you're talking about a herniation, you're

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talking about the jellylike material making its way out of the outer ring into the area of the spinal canal.

Q And trauma cause a herniation?

A Yes.

Q Can herniation be asymptomatic and not be caused by trauma?

A Yes.

Q Can trauma cause an asymptomatic herniation to become symptomatic?

A Yes.

Q Can you please describe radiculopathy? You describe it in the lumbar region. I'll put up Plaintiff's 31.

What causes it; what does it mean? You've said it before, but.

A So all the nerve roots that exit the spine -- this is an illustration of the nerve roots coming out of the lower back as they travel down into your leg; all these nerve roots are connected in some way to the spinal column. And a radiculopathy means a root, a problem with a root. Radiculopathies are felt by patients as pain traveling down the arms and hand or the legs and the feet.

Q Was Ms. Janczewski complaining of such things?

A Yes.

Q Prior to the surgery. What did that indicate to you?

A That indicated a radiculopathy.

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Q Understanding the treatment she had been gone through, what was your purpose for recommending a surgery? What was the reason you did so?

A The reason I did so was she had what we call abnormal or pathological reflexes indicative of a problem with the spinal cord known as a myelopathy.

The reason that you need to get the pressure off of the spinal cord is if you don't release that pressure from the spinal cord, then the spinal cord will have a tendency to gradually get worse.

Because the spinal cord controls your arms and your hands and everything below that as well, that could lead to progressive dysfunction or poor functioning of the nerves in your arms and hands and in your legs and feet as well.

Q It's in evidence, it's Plaintiff's 20A. I'm going to put it -- superimpose it on here; and if you could just show the jury, first tell them how -- whose MRI it is, how we know, what date it was taken? And I have a red marker here.

Anytime you're going to mark Plaintiff's 20A, please mark it with this red marker and tell the record what you're marking.

A So, these are two side view or sagittal MRIs of the cervical spine of Joan Janzcewski.

Q We all say it differently.

A We know it's her because her name is on it. They were done on September 12th of 2012. So what we're looking at is the side view MRI where we can see at the top of the MRI the base of the brain. Coming out of the base of the brain we see a long gray line, which is the actual spinal cord itself. And to the left of the spinal cord we see the squares, which are the bones, and in between the bones we see the disks.

And what we see is the two areas --

Q Can I just ask you, one is dark, one is light; can you tell the jury what T1 and T2 means in terms of the images?

A These are different ways in which the magnet magnetizes your body and causes those water signals to be picked up as different shades of gray.

In this one, for example, there's a very bright signal here in the fat regions.

Q On the right side, for the record?

A On the right side. On the left side you see a less, less of a fat signal; and you see more of what we call a CSF or cerebral spinal fluid signal. And what you're doing is you're looking at different ways of imaging the cord and the bones and the disks.

Q Okay, can you please label the cervical disks for the jury?

A (Witness complies) So, what I labeled is up on

top, the tall bone is the number 2 bone. If you work your way all the way down, you can see between the number 5 bone and the number 6 bone, there is what looks like a black P in the spinal canal on top of the spinal cord. That's a disk herniation between C5 and C6 causing cord compression.

Q When you say "on top of the spinal cord," what effect would you, as a board-certified orthopaedic, expect if someone's spinal cord wre4e being touched with disk material, what effect would that have on the patient?

A So that has an effect of causing pain and symptoms with radiating symptoms into the arms and hands; and on the physical exam, it produces the abnormal reflexes that were picked up on my initial examination.

Q Do you see degeneration on that film commensurate with a 47 year-old woman?

A Yes.

Q What about the fact that Ms. Janczewski has had full coverage and has never been to an orthopaedic doctor complaining -- despite having a primary care doctor -- in her life of radiating symptoms of neck pain, of back pain; what if anything did that have to do with in playing in connection with your opinions?

A It reinforces the opinions that her particular problem that we see here and what's happening to her body when I initially saw her is a result of that bus accident.

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Q And if I took a post-it, when you go end plate to end plate of the bone and you put a post-it there and you see the white fluid, when you go end plate to end plate and you see what you call the P, what if any ligament is holding in the disk?

A Well --

Q Along the whole length of the spinal cord?

A There's a ligament back here what's known as the posterior longitudinal ligament. It's a thin ligament that holds the disk on the back side of the disk in the canal.

Q When the disk is actually in the canal and touching the cord, what does that indicate?

A It indicates that that disk has made its way through that ligament and is in the canal on the cord.

Q I'm going to show you 20B. Now instead of sagittal, we're going to be looking at an axial from the same date, two different views.

Can you show the jury first what a good functional disk would look like, and if there's anything you'd have to comment about the one on the left?

A So, these are the top down views. The image on the right shows the Y area. That's the spinal canal area, with the cord in it. The cord is gray. I'm labeling it as C. The spinal cord is gray, and the spinal cord is flowing in a very nice sea of white fluid. That's cerebral spinal fluid with no pressure on it.

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Q Did you, in fact, select those images that's at the top of image 4 on section 5 as opposed to going down to image 10?

A Yes.

Q Can you tell the jury what that one is and what, if anything, is abnormal about it?

A Well, on the image on the left, as you're looking at it, the image to the left, you can see that the spinal cord, gray area has now deformed itself because there's no longer a nice area of whiteness around it. So there's a cerebral spinal fluid cutoff because there's actually disk material in the canal putting pressure on the cord.

Q Did Ms. Janczewski agree with the -- your opinion that -- or did she give you consent to do the surgery?

A Yes.

Q And what was your concern if you left the cord being touched by an extruded disk at two levels it was; correct?

A Yes.

Q What was your concern about what would happen to Ms. Janczewski given her complaints that progressed over the five-month period before she saw you?

A Six months. Well, the symptoms in the physical findings would continue to progress or get worse as time went on and that would cause serious dysfunction of her arms and hands.

Q I'm going to put up Plaintiff's 30 for identification,

and I'm going to tell you for the record in addition to you bringing it, the Mount Sinai Hospital record is here as Plaintiff's 23 with your operative report.

Can you please tell the jury, take them through the operation and what you did to correct the two disks that were touching the spinal cord.

A So from surgical perspective, the way you address this particular problem is you address it through the front side and that's what the term "anterior" means. It means through the front.

Discectomy means a removal of the disks, and fusion means locking the bones together or stabilizing the cervical spine.

Q I don't want to be a wiseguy, but I have to ask it.

Can the MRI findings be exaggerated, faked or anything else; or are they what's known as objective?

A MRI findings are what are known as objective.

Q Okay. Please, continue.

A So the operation starts with an incision that is a cut into the neck area so that we can then move the skin out of the way and expose the underlying structures, which include -- you can see on the middle cutaway here, we're looking at it top down, the trachea and the esophagus are moved over to one side. The carotid and jugular are moved over to the other side so you can actually get to the area

where the disk, itself, is located. So this is known an exposure.

After you have an exposure, you take an X-ray in the operating room to make sure that you're exactly where you think you are, and then you begin the process of removing the disk. In this case, it's the C5-C6 disk and the C6-C7 disk, and they're removed with a special tool so that you remove disk material as you gradually make your way towards what's known as backside of the disk where the herniation is located in the canal.

So you can actually visualize the herniation, and then you gently remove it off the spinal cord so that you're actually looking at the spinal cord to make sure that there's no more pressure on the cord.

You then remove a portion of the actual bones themselves so that you can make little extra room both above and below each disk area.

Q What is that called?

A Those are called partial vertebral corpectomies; and you do that to the point where you can actually take a small little probe and pass it up and down the cord to make sure that there's no more pressure on it, and also makes sure that the nerves, themselves, that are in that area are able to freely pass outside the cervical spinal canal.

Now, once those disks are removed, there's

nothing holding those bones together. So you need to, essentially, jack up the bones with what we call biomechanical device or fusion cage, which is made out of a special type of plastic; and that's done at both the C5-C6 and at the C6-C7 levels. And once that's done, you hold them in place with a special titanium plate so that after surgery is over, the patient can get up and walk around and their neck won't fall apart.

Q In the normal healthy disk, an un-herniated disk, is that what gives a person the ability to move their neck and back?

A So each disk -- each level of the cervical spine contributes to a certain portion of movement within the actual cervical spinal area itself.

Q What effect on someone's range of motion and limitation in motion would the touching of a disk on the spinal cord as exhibited in 20B and 20A of the two levels have?

A Because those disks are producing pressure on both the cords and nerves, the natural body response is to block motion in those areas to prevent further damage to the nerves and to the bones.

So this restricts your range of motion. Your body does that where the herniations are.

Q I'm just going to show you -- these were taken by yourself at Lenox Hill, April of 2015. 26A is the first one,

and then you can put up 26B.

Please tell the jury what they're looking at?

A These are postoperative X-rays. On the left of the board is the front-to-back view of the plate and of the cage that you see at both C5-C6 and at C6-C7.

On the right side is the X-ray of the side view of the plate and the cages; and when you count down, you can see that this is at C5 and C6 and at C6 and C7.

Q Can you just put up 26B.

Can you tell the jury -- it's obvious, but we need to hear it from you, the board certified orthopaedic surgeon -- what effect would the two-level fusion with the cage and screws have on her either consequential or significant limitation of the movement of her neck?

A So before we saw that there was a herniation --

MR. KAMINSKY: Objection to the question, Judge.

THE COURT: Overruled.

Q I'm going to ask you more detail later. I just want to know what effect would be putting the hardware in her neck as you did have on the movement of her neck?

A So the implants lock these bones into place and block motion at those levels.

Q Before I have you sit down, Doctor, I'm going to have you just talk about 20C and D, and did you in fact -- you said

you already looked at the MRIs of her back, as well?

A Yes.

Q Is Ms. Janczewski still your patient?

A Yes.

Q Have you continued to see her after the surgery?

A Yes.

Q And can you -- has she had complaints to her neck since the surgery?

A Yes.

Q Can you tell the jury whether or not you've discussed with her this year -- in your notes -- but can you tell them what adjacent segmental breakdown is?

A So, adjacent segment. So if these are the segments that have been operated upon, the adjacent segments are the segments that are directly touching these areas over here.

So, there's a mechanical reconstruction here. You can see this is a titanium plate. It's not bone, so it's stiffer than normal bone. There's no motion that's happening here, but there's motion up on top and there's motion on the bottom.

Since it's mechanical, we always counsel patients that going forward in the future what we look at is we look to see how the top part and the bottom part behave over time. So we're monitoring the adjacent segments to see whether or not they wear down or cause a problem to the area

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where the surgery was.

Q Did she, in fact, have improvement of the radicular pain when you took the disks off of the spinal cord?

A Yes.

Q Does she still continue to complain of pain?

A Yes.

Q Has that pain progressed and increased?

A Her neck pain, yes.

Q So, if we could just -- I'll take down the neck now, and if you could bring up these two exhibits and explain to the jury what they're seeing on the lumbar films.

Again, red pen is here. If you'd like to -- if you could show them where the cauda equina is? You could actually see it in this image, the horse's tail.

THE COURT: What exhibit is that?

MR. McCRORIE: This is 20C.

Q Is that right, Doctor?

A Yes.

Q 20C and the next one would be D.

A So this is a side view of the lower back. You could see that the bones are squares, and in between the bones are the disks; and behind the bones and the disks is the spinal canal area.

You can see that up at the top of this projection, there's a herniation at the top. You can

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counts, 5, 4, 3, 2, 1, 12. That's right around T11-T12.

We count down, 1, 2, 3 and 4 between L3 and L4, we can see that there's disk material in the spinal canal region.

The gray stripes that you see in the canal, these gray stripes that you see in the spinal canal region are the cauda equina. Spinal cord ends up in this region up here.

(Indicating)

Q Understanding there's not a full spinal cord below the L1; is that correct?

A Yes.

Q Approximately?

A Correct.

Q There are still exiting nerve roots at every level of the lumbar spine as there are in the spine above; correct?

A Yes.

Q What effect would a herniation such as the one you circled in L3 and L4 have on the movement of Ms. Janczewski's spine?

A So this area, just as we saw in the cervical spinal area is an area where you your body does not want to move this disk into a position where it reproduces pain.

So there's a restriction in lumbar range of motion.

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Q And I'm just going to put up 20D. It's, again, that other view, the lighter view of T1, T2. Can you just show the jury where it is in this view?

A So we'll look between L3 and L4, and we can see that right behind that area there is a disk sticking out.

Q And this disk, there's no plan to operate on it; it's being treated conservatively?

A That's right, yes.

Q And it will continue to be treated conservatively?

A Yes.

Q Once the disk herniates, what effect does repetitive movement have on it?

A So repetitive movement can cause the jelly-like material that's on the inside to continually make its way out of the anulus, depending upon how much motion is generated in the -- in that area of the spine.

Q I think that's it. I'm going to have you go back. We'll have you sit down with the Court's permission, and I'll ask you about the rest of your treatment and then ask opinions; okay?

A Yes.

(Returned to the witness stand)

Q Can you please tell the jury the purpose of physical therapy when someone has a herniated disk; presurgical, what's the purpose of that?

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A So presurgical, as we had said before, we're trying to decrease that inflammatory process that's happening that's causing irritation, and you're also trying to increase some flexibility and strength, as well.

Q How about the purpose of postsurgical physical therapy once the hardware is put in?

A After surgery, physical therapy takes several forms. The first physical therapy visits are done immediately afterwards to try to decrease the postoperative symptoms and pain and muscular swelling.

And then as therapy progresses over time, it's there to try to improve range of motion to its maximal potential; and then over a longer course of time, it's what's called maintenance in order to be able to maintain, strength and flexibility as best as possible.

Q Okay, can you- tell the jury the purpose of certain medications, both narcotic, anti-inflammatory as it relates just to this body part, herniations to the neck or the back presurgical?

A So from a presurgical perspective, medications fall under different categories.

An anti-inflammatory medicine is something on the inside actually that decreases inflammation.

Narcotics are medications that decrease pain by acting within the actual brain and spinal cord itself in

order to block the pain response.

And, then, there are certain medications that are taken just for the nerves themselves that act actually within the nerves, as well.

Q How long was the hospitalization after what you call the ACDF, the surgery?

A That's an overnight stay.

Q And what you saw on the -- withdrawn.

Did you see -- is it noted -- did you actually see the herniations in the spinal canal when you were using the microscopes on your eyes during the surgery?

A Yes.

Q And is that noted in your report?

A Yes.

Q Was the mechanism of injury consistent with what you saw a bus, or a mirror of a bus or the left side of the face being hit and immediate neck pain occurring thereafter?

A Yes.

Q And progressive neck pain occurring over that period of time before you saw you in April?

A Yes.

Q What is the purpose of taking X-rays, MRIs, like serial X-rays on a consistent basis for someone you're treating who had hardware surgery and could potentially need surgery to the back? Why as a board-certified orthopaedist would you take X-rays more

than once?

A Those are there to monitor the postoperative conditions.

Q How about MRIs?

A Same thing, monitoring the postoperative condition and those adjacent segments.

Q Can you tell the jury the difference between epidural injections and facet block injections, what they do for someone with conditions like Ms. Janczewski?

A Injections are for what we call axial pain. Axial pain is pain in the neck or back area.

An epidural steroid is an anti-inflammatory medicine that's given through a needle into the epidural space. The epidural space is the space where the nerves are in the spinal canal.

A facet injection is an injection into the joints of the spine. Each spinal level actually has four joints. So the facet joint injections can be given into different joints, either right side, left side or both sides. Top, bottom, depending upon the level.

Q I'm going to have you go to your October 28, 2013, note.

A Yes.

Q Noting she just had a left knee surgery. Can you just tell the jury, how did you quantify her overall spinal range of

motion compared to normal motion tested both accurately and passively? We need it for the record.

A So I did a quantification -- basically, I qualitatively, that is, I assessed her overall global range of motion based on normal range of motion, which I gave her a 30 to 40 percent of normal. So there's a plus or minus 10 percent error anytime you're rating motion quantitatively so that's why it's listed as 30 to 40 percent.

Q Is that neck, back or total?

A That's the total global spinal range of motion.

Q When you said you tested her actively and passively, what does that mean for the record?

A An active range of motion is what the patient can move their spine to on their own. A passive range of motion is what the examiner can move the spine to.

So, when you're testing range of motion, I will first have the patient go to their own maximal range of motion; and then as I palpate their muscles, I will passively take them beyond that to a max up to spasm.

Q Can you tell the jury on that date and then I'm ask you about before that date, what if any restrictions on her work did you place or activity?

A So, I had restricted her from all working activities, particularly activities such as bending, lifting and twisting.

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Q Do you know what she did for a living beforehand?

A Yes.

Q Did you restrict her at that time from continuing to that type of work?

A Yes.

Q And if you wrote, "she remains otherwise 100 percent totally disabled from working duties," on that date did you have same opinion beforehand just for the neck and the back, not the other body parts?

A Yes.

Q February 10, 2014.

Indicating, "Palpable spasm in the neck and the back."

Meaning, again you could still feel it?

A Yes.

Q How does spasm still occur after you take the disks out and you put hardware in the neck? Why would there still be spasm in the neck?

A Because the spine is still trying to splint itself in order to restrict positions that would otherwise be painful.

Q Going to May 19, 2014, because these are in evidence. What does -- it says she has "an antalgic and kyphotic gait pattern requiring mild assistance on and off the exam table."

What does that mean, "antalgic and kyphotic gait

pattern?"

A Antalgic is a limp. Kyphotic means pitched forward, and mild assistance on and off exam table is because of the difficulty with her head and neck range of motion.

Q September 22nd, 2014. What did you write about the medications she was on at that time?

A She was at that point in time Naprosyn, anti-inflammatory; Cymbalta, nerve medication for chronic pain; muscle relaxants for muscle spasm, and Vicodin which is a narcotic for pain medicine.

Q Did you consider those appropriate for at least the neck and the back issues she was having?

A Yes.

Q And were you aware of all the other surgeries she had and issues she was having?

A Yes.

Q When it says it produces -- the medication somnolence an stomach upset. What is somnolence?

A Sleepiness.

Q Another word -- March 16, 2015, just to speed it up in the physical examination it says, "There continued to remain dysthesia."

A Dysthesia, which means abnormal sensation in the lumbar 4 and 5 nerve roots.

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Q And then it says, "Of the lower extremity, the legs and feet."

What does that mean?

A That's a lumbar radiculopathy.

Q Okay, and understanding the cervical radiculopathy had been improved, when you write "she has mechanical, axial neck and back."

What does mechanical and axial pain of the neck mean?

A That means pain that's in the neck that is aggravated with mechanical duties: Bending, lifting, twisting, maintaining your head and neck in a given position for any length of time.

Q And it's in the notes there, but we're going to try to get to the end of opinions.

March 16th, you wrote, "Again continued limitation," and you quantified it compared to normal; correct?

A Yes.

Q August 31st, 2015, you indicated Ms. Janczewski had a cortisone injection to her lower back at another doctor's office.

What does cortisone do for someone with back pain and a herniated disk?

A It decreases inflammation.

Q And when you wrote there that you did your surgery

to prevent further neurological deterioration, please explain that?

A We wanted to prevent further spinal cord injury by stabilizing the neck.

Q It states -- and you're the first doctor in the physical examination. "There is reversal of the lumbar lordosis appreciated."

What does that mean?

A That means when you're getting up from a seated position, instead of the normal pattern of standing upright, you actually stand up with a bent-forward posture because your lower back can't tolerate being fully upright when you're getting up from a seated.

Q In December of 2015, did you write another note? Is that the last time you saw her prior to testifying here today?

A Yes.

Q Do you expect to see her after the date of this trial?

A Yes.

Q How often do you see Ms. Janczewski in followup for both her neck surgery to monitor the adjacent level breakdown and the back condition?

A About every four months or so.

Q When you state "She has neck pain with associated headaches," is that separate and apart from anything else that could be causing her headaches, the neck pain?

A Yes.

Q Again, you note any other body parts that are bothering her, but during the physical examination did you do any final -- not a final -- before the trial an assessment of the lost range of motion so you could quantify it to both the neck, back and total spine?

A Yes.

Q Doctor, I'm going to ask you questions. I'm going to ask that all of your opinions be stated with a reasonable degree of medical certainty.

If at anytime, you can't state it under that standard, you would tell us; okay?

A Yes.

Q I'll try to say it, but if I don't we'll assume that you're stating it with a reasonable degree of medical certainty.

Can you please tell the jury -- you know what, I'm also going to give a hypothetical to you before I give it and I'm going to do it once. It will apply to every question, okay?

A Yes.

Q I'd like you to assume that Ms. Janczewski was 47 years old on November 30, 2012, and had never been to a neck doctor, back doctor, had never had an MRI to the neck or back, had never had complaints to the neck or back and had never been told she

had any condition of the neck or back regardless of whether it was disks or anything else; okay?

A Yes.

Q I'd like you to assume she was walking in a street and a 38,000-pound bus -- and you said it wouldn't make a difference if it was 13,000 -- but either a 38 or 13,000-pound bus hits her and moves her neck against her will. She doesn't expect this to be happening, okay.

I'd like you to assume she goes to the emergency room and immediately complains of neck -- in addition to other issues -- neck and low back. It's noted in both the ambulance and the emergency room; okay?

A Yes.

Q I'd like you to assume that from that point on she has radicular pain in her neck, in her back and continues to see conservative care of chiropractic, physical therapy, medication and progressively has worsening pain down her arms; okay?

A Yes.

Q I'd like you to assume that she gets MRIs in December of 2012 of the neck and back and shows exactly what you told this jury was on the MRI films; okay?

A Yes.

Q Do you have an opinion within a reasonable degree of medical certainty as to the cause of the radicular symptoms to both the neck and the back?

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A Yes.

Q Please tell the jury what your opinion is and state the basis with reasonable medical certainty.

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A So my opinion is that she has herniations in the cervical spine and lumbar spine that produced radiculopathy with myelopathy as a consequence of the bus accident; and I know that based upon my treatment of the patient, my operative findings and, also, my review of her treatment records.

Q Do you have an opinion with a reasonable degree of medical certainty as to the cause of the herniation -- I was asking about the symptoms first -- the cause of the herniations in both the neck and the back?

A Yes.

Q Is it the same opinion --

A Yes.

Q -- with a reasonable certainty. Please tell the jury the opinion and the basis?

A That the opinion is that the herniations were caused by the bus accident for the same reasons stated which is my treatment of the patient and my review of the records.

Q I want to give you a hypothetical. It's purely hypothetical.

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I'd like you to assume that Ms. Janczewski had a herniated disk, there had never been an MRI; but that it was herniated, but asymptomatic.

That can occur; correct?

A Yes.

Q Or it was degenerated, but not herniated; that could occur, correct?

A Yes.

Q And not cause symptoms; right?

A Yes.

Q I'd like you to assume that she's hit by the same bus and that a previously asymptomatic -- not bothering -- herniated disk in the neck now becomes symptomatic immediately after this bus hits her; okay?

A Yes.

Q Under that hypothetical scenario, do you have an opinion as to whether or not the bus accident aggravated or activated a previously asymptomatic disk to become symptomatic in the neck?

A Yes.

Q What's your opinion and the basis thereof?

A In that scenario, the opinion would be that there was an aggravation of a previously asymptomatic disk. Of course, based on my review of the records and my treatment of the patient.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Q Not knowing someone's level of degeneration, degeneration always gets aggravated by trauma; correct?

A Yes.

Q How about -- it would be the same question for the back.

Would it be the same basis -- do you have the same opinion as to the lower back under that hypothetical, asymptomatic was existing herniated disk to the lower back?

A Yes.

Q The same basis?

A Yes, correct.

Q Okay. Reasonable degree of medical certainty. I want to now ask you specific questions about whether or not you have an opinion as to whether or not Ms. Janczewski's neck and back present permanent consequential limitations of the use of a body member called the neck and the back, the spine; okay?

A Yes.

Q Do you have an opinion?

A Yes.

Q As to whether or not Ms. Janczewski suffered a permanent consequential limitation of a -- of the use of her spine, both neck and back?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A Yes.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Q What is your opinion?

A My opinion --

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A My opinion is that she has suffered a consequential loss of the use of her neck and back.

Q A limitation of the use of her body member?

A Yes.

Q Can you please tell the jury -- can you quantify the loss using your last exam comparing it to normal and quantify for the jury the neck, the back and then overall with reasonable medical certainty?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A So I would quantify her cervical spinal range of motion loss as 40 percent and her lumbar spinal range of motion loss at 30 percent.

Q Are those losses permanent in you opinion within a reasonable degree of medical certainty?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A Yes.

Q What is the basis for your opinion? Please list them all. It's important for this specific questions.

MR. KAMINSKY: Objection.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

THE COURT: Overruled.

Q I understand you listed it for the other. Please list the basis?

A So my treatment of the patient, as well as my review of the records and diagnostic imaging studies, as well as the surgery.

Q Can you just put on the record -- it's important -- the objective basis, tell us all of those objective bases is for your opinion that she suffered a consequential limitation permanently of the use of a body member?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A So she has a loss of range of motion with quantifiable spasm in both the neck and in the back.

She has neurological loss to the neck and back with objective findings on the MRIs of both the cervical and the lumbar spines, and the cervical spine having had surgery also had positive operative findings.

Q It sounds similar, but it's slightly different.

Do you have an opinion within a reasonable degree of medical certainty as to whether or not Ms. Janczewski suffered a significant limitation of the use of a body function, the ability to move her neck and back?

A Yes.

Q Well, I stated that. What is the significant

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

limitation of a body function that she suffered from as a result of this bus accident?

A So the function itself would be mobility of the cervical and lumbar spines; and, therefore, that function has been lost as we have been able to quantify through range of motion.

Q So can you please tell the record your basis of your opinion citing all of the objective bases for your opinion for this specific question as to whether or not she has an injury under the law?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A So that would also be based on loss of range of motion with quantifiable spasm in the neck and back with neurological loss to the upper and lower extremities, in addition to the operative findings from the cervical spine, and her physical findings correlated with her MRI films of both the cervical and lumbar spines, as well as her treatment that she's undergone.

Q Within a reasonable degree of medical certainty, I want to ask you prognosis questions, the future.

Do you have an opinion as to whether or not Ms. Janczewski will continue to experience pain to the areas of the neck and the back into the future?

A Yes.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Q What is your opinion and the basis thereof with reasonable medical certainty?

A So the patient experiences at this point in time chronic pain. She remains on medications, and she continues to have symptoms of neck and back pain.

So it is within a reasonable degree of medical certainty that that will continue to be the course.

Q For what period of time into the future?

A Lifetime.

Q Do you have an opinion -- and another doctor, we don't have to be cumulative.

Do you have an opinion with a reasonable degree of medical certainty as to whether or not she should continue -- whether it's you or some other board certified spinal surgeon -- continue to see one into the future after the date of this trial?

A Yes.

Q What is your -- for how long into the future should she continue to be monitored by a board certified spinal surgeon for her conditions?

A Lifetime.

Q When that board certified surgeon monitors her, do you have an opinion as to whether or not he or she should do diagnostic testing in the form of X-ray and MRI periodically?

A Yes.

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

Q What is your opinion? Not the amount, just whether or not it should be done.

A Those diagnostic studies should be done on an ongoing basis into the future for her lifetime.

Q Do you have an opinion with a reasonable degree of medical certainty -- as noted in your last few notes -- as to whether or not Ms. Janczewski with the progressive symptoms that have occurred since your -- and I'm only speaking about the cervical -- that whether or not she will require a further surgery to the neck? Not the back, the neck.

MR. KAMINSKY: Objection.

Q With a reasonable degree of medical certainty?

THE COURT: Overruled.

A Yes.

Q What is your opinion and the basis thereof?

A After a mechanical reconstruction of the cervical spine, we begin to see a breakdown within seven to ten years postsurgical.

Q And have you relayed this to her?

A Yes.

Q And has she had progressive symptoms that have gotten worse since the surgery, mechanically and axial?

A Yes.

Q Do you have an opinion as to whether or not she will need the future cervical surgery?

Dr. Merola-by Plaintiff-Direct/Mr. McCrorie

A Yes.

Q And, yes, she'll need it; or, yes, you have an opinion?

A Yes, I have an opinion; and, yes, she will need it.

Q And you've already stated the basis for it?

A Yes.

Q Lastly, so you know that she was a COO. I just wanted to -- is it advisable for a woman -- no other area -- the neck and the back, at least the sequelae -- what does sequelae mean in medicine? I think it's going to be in other notes.

A Sequelae, basically, means what she's suffering from at this point in time as a consequence of her problem.

Q Required to be on her feet and moving around, could be sitting long, standing long, bending, 12-hour days; do you have an opinion as to whether or not right now if she's required to sit and stand for long periods of time, whether or not she should be doing that just for the spinal conditions?

MR. KAMINSKY: Objection.

THE COURT: Overruled.

A I do have an opinion.

Q And what is your opinion?

A Baed on her spinal conditions alone, she would not be able to do that on a prolonged basis during the day.

MR. McCRORIE: I have no further questions of the doctor. Thank you.

Dr. Merola-by Plaintiff-Cross/Mr. Kaminsky

THE COURT: Can I see the attorneys, please.

(Whereupon, at this time a discussion was held off the record at the bench.)

THE COURT: You only have one minute.

MR. KAMINSKY: One minute.

THE COURT: One minute.

CROSS-EXAMINATION

BY MR. KAMINSKY:

Q Doctor, I apologize, you're going to have to come back, but I just want to get one quick line of questioning out of the way.

You told us about the side effects of potential adverse side effects of the surgery that you did on plaintiff; correct?

A Yes.

Q And, obviously, you explained all that, correct, to her?

A Yes.

Q And she understood it; correct?

A Yes.

Q And she gave you consent to do the surgery?

A Yes.

Q And part of the reason you obtain consent from someone is heaven forbid if something should go wrong, you can say she gave consent; correct?

Dr. Merola-by Plaintiff-Cross/Mr. Kaminsky

A Yes.

Q It's a protective device to you; correct? And to her?

A Informative to the patient, as well.

Q So she knows all the risks and you're protected because she signed an informed consent if something, heaven forbid, should go wrong?

A And she can make an informed decision about the operation.

Q Correct. So tell me, would you accept an informed consent from someone who isn't thinking clearly or someone who has brain damage or someone who doesn't know what they're capable of signing; yes or no? Yes or no?

A No.

MR. KAMINSKY: Thank you. We can continue when you come back.

THE COURT: Okay, we're going to stop it at this point.

We will reconvene tomorrow at 9:30 in the morning when we will continue with the trial.

Remember, do not discuss this case among yourselves or with anyone else. Enjoy the rest of your day, and I'll see you tomorrow at 9:30.

COURT OFFICER: All rise, jury is exiting.

(Whereupon, at this time the jury then left the courtroom.)

Dr. Merola-by Plaintiff-Cross/Mr. Kaminsky

THE COURT: You may step down.

* * * * *

(Whereupon, at this time the trial adjourned and continued on February 2, 2016.)

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