SUPREME COURT OF THE STATE OF NEW YORK
BRONX COUNTY : CIVIL TERM : PART IA-10
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WILLIAM BURNS and KAREN BURNS,

Plaintiff(s), INDEX NO. 305430-2008

-against-

1 BRYANT PARK, LLC, DURST DEVELOPMENT LLC, TISHMAN CONSTRUCTION CORPORATION and REGIONAL SCAFFOLDING & HOISTING CO, INC.,

Defendant(s). Trial
----------X

June 3, 2016

851 Grand Concourse
Bronx, New York 10451

B E F O R E:

THE HONORABLE LIZBETH GONZALEZ,

JUSTICE.

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THE COURT OFFICER: All rise. Jurors entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Jurors, good morning. How are you today?

Everyone can be seated.

It's kinds of muggy in here, so we have the windows open in the robing room to see if we can get some circulation. We'll see how it goes. But if you wish to take off your shirts or your jackets, as always, please feel free to do so.

Jurors, we have a change in schedule for next week. It turns out that one of the witnesses who was scheduled to come on Tuesday, he has had a medical emergency, so there is going to be a substitute doctor for him and that person is not available on Tuesday no matter what.

So, we are going to be down Monday, Tuesday, Wednesday next week. Okay. I don't know if that makes you happy or that makes you sad, but we will be down three days, and then we will be up on Thursday and Friday, which would be the 9th and the 10th.

Like I said, the schedule is something that we can envision, but human reality is what it is.

THE JUROR: Are we going to add on another day?

THE COURT: So, trials are a dynamic. You don't

know how long a witness is going to take. You could theorize as to how long that person is going to take, but you really don't know, because nothing is written in stone. So for right now, the week of the 13th still remains as is. It would be Wednesday, Thursday -- Wednesday and Thursday, that's it. I can't do Wednesdays because I'm not here. I'm doing mental hygiene cases. We will give you the week of the 13th next week. Otherwise, I'm going to get schizophrenic. We'll do it that way. But for next week, we have two days of testimony, Thursday and Friday. It's just the way it is.

Having said that, Mr. McCrorie, are you ready to call the plaintiffs' next witness?

MR. McCRORIE: Yes, your Honor. The plaintiff calls Andrew Merola, M.D.

THE COURT OFFICER: Remain standing. Place your left hand on the Bible, raise your right hand.

Do you swear or affirm under penalties of perjury that the testimony you shall give is the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE COURT OFFICER: Please have a seat, sir.

Sir, please state your name and business address for the record.

THE WITNESS: Andrew Merola, M-E-R-O-L-A, 567 1st

Street, Brooklyn, New York.

THE COURT: Doctor, what is your area of specialty?

THE WITNESS: Orthopedic reconstructive spinal surgery.

THE COURT: Are you board certified?

THE WITNESS: Yes.

THE COURT: Thank you.

Counsel, you may inquire.

MR. McCRORIE: Thank you.

A N D R E W M E R O L A, M.D., having first been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. McCRORIE:

Q I told you beforehand, but I'll tell you again. I can hear you from back here, but, if you could, just speak a little louder than you normally do.

Good morning.

A Good morning.

Q Are you licensed to practice medicine?

A Yes.

Q You're the first doctor to testify. So the other doctors don't have to do it, could you just define any terms as you come across them? That would be terms like "fellowship," things like that.

A Yes.

Q Or any medical terms that you state.

How long have you been licensed to practice medicine in the State of New York?

A Since 1992.

Q As succinctly as you can, without leaving out any of your accolades or fellowships, can you please tell the jury your education and work history?

A Sure. So, I went to medical school in Washington D.C., Howard University College of Medicine. After I graduated medical school, I went to Kings County Hospital, Downstate Medical Center, where I did what's known as a year internship in general surgery. I then did four years of residency, that is training, in orthopedic surgery.

After I completed my training in general surgery and orthopedic surgery, I then went for an additional year, which is known as a fellowship, where I did spinal reconstructive surgery only. That is spine surgery, neck and back surgery. And I trained in childhood disorders, pediatric problems and adult problems.

I then came back to New York City in 1996, where I went to Downstate as full-time academic faculty doing research and teaching spinal surgery and seeing and treating patients. At that time I also established a private practice, whereby I also had my own patients, and that was at the St. Vincent's Hospital

in Manhattan.

I am presently an Associate Professor of Orthopedic Surgery at Downstate. I also hold clinical teaching appointments at Mount Sinai Hospital and New York Hospital, and I operate at both the Mount Sinai Hospital system and in the New York Hospital system as well.

I continue to teach and do research, so I train medical students, residents, fellows. Fellows are doctors that are doing additional training in a specific field. And I also train allied health professionals, such as nurses, nursing students, physician's assistants, physician's assistant students in orthopedic spine surgery.

Q Doctor, even if the jury can hear you, we need the judge to hear you back there. The acoustics loses it at 22 feet of ceiling.

The judge asked you before if you were board certified.

Can you tell the jury what the significance of board certification is, ending in what field you're certified in?

A So, board certification is an academic process. When you finish your training, you take a written examination in your specialty, orthopedic surgery. After you pass that written examination and you've been in practice for two years, that is treating patients and doing surgeries, you collect the surgeries that you've done in that two-year period, and then you present those patients that you've treated to a Board of Examiners.

And it's an oral exam where you -- in my case I went to Chicago, sat down in front of a Board of Examiners, and we discussed those surgical cases. They ask you questions about those cases.

When you pass that second part of the exam, so you pass two parts, a written and an oral, you're then board certified.

Now, that process repeats itself every ten years. So my first certification was in 1998. That's two years after I finished my training. I then recertified in 2008, which was ten years later. And my next recertification will be in 2018, ten years from 2008.

So, it's an academic process where we stay current with all those things that we need to be current with in order to treat patients.

Q Although you said it in the beginning, can you tell the jury what your specialty is within orthopedics?

A So, orthopedic surgery is surgery that focuses on the musculoskeletal system. That's everything that's required for your body to get up and move around: Bones, joints, ligaments, tendons, muscles, nerves.

Orthopedic spinal surgery focuses on your spine; that is, your neck and your back and the nerves and the structures that are attached to that.

So, general orthopedics is the entire musculoskeletal system. In my case, dealing with orthopedic spine surgery, it

specifically focuses on neck and back issues.

Q Do you, as a board certified orthopedic spinal surgeon, treat the extremities or do shoulder, knee surgeries, things like that?

A I do not do extremity surgery, but of course when I'm examining a patient and I'm examining their spine, the arms and the legs are attached to your spine, so of course I'm examining those parts of the body as well. But I limit my surgeries to the neck and back.

Q How many spine surgeries do you perform on an annual basis, approximately?

A So, in any given year, both myself and the other folks that I work with, I have two associates that I work with who are also spine surgeons, we do about 200 to 225 spinal surgeries a year, and that's a combination of neck and back surgeries, childhood deformity, and all of those issues that require surgical intervention to either the neck or the back.

Q And you said that you had hospital privileges at Mount Sinai and other hospitals.

Where do you perform these surgeries?

A So, I admit patients and operate upon them at Mount Sinai Hospital and New York Hospital, and that's in both Manhattan and Brooklyn. New York Methodist Hospital in Brooklyn and Mount Sinai and New York Hospital in Manhattan.

Q And during those surgeries you performed here, you

talked about St. Vincent's Hospital.

What occurred with St. Vincent's Hospital?

A Sure. So, St. Vincent's Hospital was one of the Catholic Medical Center hospitals in Greenwich Village, Manhattan. That was one of the first hospitals that I came back to when I was an attending surgeon. And for a number of various reasons, at a certain point in time that hospital actually closed. It shut down. The entire Catholic Medical Center system shut down, and St. Vincent's being part of that, so that hospital no longer exists.

When that hospital closed -- I also had offices at that hospital in lower Manhattan -- when that hospital closed, that's when myself and my associates moved to the other Manhattan hospitals, that's Mount Sinai and New York Hospital.

Q And can you tell the jury where your current practice, where the offices are?

A Sure. So, I have two offices. I have one office in Manhattan on 28th Street, and then I have another office in Brooklyn, in Park Slope, Brooklyn.

Q Does that practice have a name?

A It's my name, so it's Andrew Merola, M.D., orthopedic spinal surgery.

Q Just because your records have been stipulated into evidence, in the beginning, or for a part or a portion of a period of time, there is a name of a practice.

Can you explain what that name is and what your affiliation was or is with them?

A Sure. So, when I first came back to practice, one of the things was that I got together with some of the other residents that I had trained with, who are also orthopedic surgeons, and the name of that practice is University Orthopedics. So, I was the spinal consultant for University Orthopedics when I first came back to practice, and I stayed with University Orthopedics up until when St. Vincent's closed, because we were all together at that hospital.

And then after St. Vincent's closed, I stopped formally going to University Orthopedics as their spine consultant. I still see their spinal surgical consultations, but I don't go to that office anymore.

Q And that would be the point where the letterhead changes, not the letterhead, the top of the office note?

A Yes.

Q Does your practice, and did your practice back in 2008, accept work accident benefits and all of the rules, procedures and authorizations associated with accepting such cases?

A Yes.

Q Does your practice also accept motor vehicle accident benefits and those cases?

A Yes.

Q By doing so, do you have an occasion, if either a

worker or someone in a motor vehicle accident is injured, do you have an occasion to come in to court on behalf of your patients to talk to juries about procedures you've done?

A Yes.

Q Other than coming on behalf of your patients, do you ever come in as an expert witness for someone that is not your patient?

A Only very rarely, when I first started my practice in 1996, 1997, and I'd actually done some work for the United States government at that time reviewing some cases, but otherwise I've strictly restricted myself to coming in only for patients.

Q And you've testified in court before, correct?

A Yes.

Q Have you testified in court before for construction workers that the firm of Sacks and Sacks has represented?

A Yes.

Q And, in fact, have you testified in cases, construction cases, where Mr. Kaminsky has been the defense attorney?

A Yes.

Q Are you on the plan of any construction unions?

A Yes.

Q Can you explain to the jury what plan or what unions you are on the union plan for?

A Sure.

So, the trades, many of the trades have unions associated with them, and those locals run health care plans. And so a lot of, for example, orthopedic surgeons that deal with patients who are in the trades become members of those plans so that there is a generalized referral list for doctors that are familiar in treating those types of patients.

Q The jurors will hear from each of the witnesses, a doctor or a professional witness.

Are you being paid for the time away from your practice and the followups for the surgeries and moving the surgeries?

A Yes.

Q What rate are you being compensated, not just for today, for any other preparation you did beforehand?

A $650 per hour.

Q Did we, in fact, meet to prepare for the testimony, go over your notes and the exhibits?

A Yes.

Q Did you, in fact, when we met, select certain views of MRI films that would aid you in discussing Mr. Burns' surgeries and injuries?

A Yes.

Q I'm just going to hand up, with the Court's permission, stipulated into evidence, just so they're up by you, Plaintiffs' 5, the Medcor reports of Mr. Burns; Plaintiffs' 6 would be an identical copy of your office chart; Plaintiffs' 7 is Dr.

Hausknecht's office chart and Plaintiffs' 24, all in evidence, is the St. Vincent's Hospital record containing both admissions and surgeries. So, they'll just be up there, and if you have to refer to them, you can.

Okay?

A Yes.

Q Can you tell the jury when it was that Mr. Burns, William Burns, became a patient of yours?

A So, I first saw Mr. Burns in June, on June 9 of 2008.

Q When a doctor, since you're the first doctor, takes a history, what does that mean medically, a history?

A So, when you first see a patient, the history is -- well, patients come to you, they come to you with what we call a chief complaint. They walk in and say my X, Y, Z hurts, my neck hurts, my back hurts. So that's their chief complaint. That's their major problem.

The history is when did this happen, how did it happen, what aggravates it, what makes it better, something about that chief complaint to give you kind of a character for what it is specifically about that complaint that you can then focus your examination on to try to find out whether or not there is a physical issue related to that complaint that, in my case, can or cannot be treated with surgery or some other means.

Q And what was the history as relayed to you?

A So, he came in with a history indicating a hoist

accident that had occurred on May 20 of 2008. Symptoms, in other words, the complaints were neck pain and low back pain, as well as headaches.

Additionally, there were described as pins, needles, numbness and tingling radiating, which means traveling down, into the legs, as I indicated lower extremities. A prior problem with the lower back.

Q Let me just ask you this, too, and we'll get into the details of that later on, but if in your notes on the first date it indicates the prior problem is 1998, several notes later it indicates '89, and Dr. Hausknecht days later indicates '89, can you explain why it says '98?

A It's a typographical error where the "9" and the "8" were transposed.

Q Just because it does say '98, I wanted to get that clear.

The prior accident that is referred to in the notes on two or three occasions is 1989, correct?

A Yes.

Q You just told the jury a hoist accident, but what was your understanding of how the accident, not liability-wise, but how did it happen?

A So, Mr. Burns was in an elevator that sustained an abrupt drop and deceleration.

Q Did he tell you that he hit the bottom springs?

A Yes.

MR. KAMINSKY: Objection.

THE COURT: Sustained. Sustained.

Jurors, disregard, please.

Q When you described the hoist accident, that he came in and described a hoist accident, did you ask what type of hoist accident?

A Yes.

Q Did he give you the full details of it?

A Yes.

Q And, briefly, what was your knowledge of it? It's in evidence; I don't want to read it. But, did you know about his prior accident and whether or not he returned to work?

A Yes.

Q All that is indicated in your notes, correct?

A Yes.

Q So what, if anything, did he tell you about what he was feeling or what he was limited with doing before coming to you on June 9?

A So, symptoms, his complaints and symptoms were in the neck area and in the back area with radiating symptoms into what we call the extremities.

Aggravating factors, that is, what made them worse, were what we would call mechanical things, and I listed them, such as bending, lifting and twisting, that is, motion of the

neck and back, aggravating or making the symptoms worse; maintaining his head and neck in a fixed position for what I indicated was about 20 minutes or so; and headaches with difficulty with his ability to sleep.

THE COURT: Difficulty with his?

THE WITNESS: Ability to sleep.

THE COURT: Thank you.

Q Did you do a physical examination?

A I did.

Q Of what body parts?

A So I examined the musculoskeletal system, the spine, the neck and the back, and the musculoskeletal system.

Q And can you please tell the jury -- let's define this for your examination and any other doctor -- when someone asks for you to describe positive findings and negative findings, what does that mean medically?

A Sure. So, when we're doing an exam and then we're talking about the examination that we've done, we're looking for -- positive basically means a visualized or a felt response when you're testing a body part that tells you something about that body part tested. So if, for example, you feel a muscle and you can feel that that muscle is rock hard, there's spasm there. That would be positive spasm. I found a spasm in a muscle.

Q And I know it sounds positive but it means negative, correct? It means it's not a good thing?

A Yes. So, in general, if you're thinking about is a finding a good thing or a bad thing for the patient's musculoskeletal system, a spasm is not a good thing, it's a bad thing, but it's a positive finding because you found it on an examination.

Q Can you tell the jury, right from there, what objective and subjective findings are?

A Sure. So, subjective is what the patient tells you. I have neck pain. That is subjective. It's based on what the patient tells you. It is a complaint or a symptom.

Objective is a test that is not under the patient's control that you either observe, test, or feel, for example, a spasm or a reflex or a loss of neurological function.

Objective findings are those findings that are within the body itself that are not based on what the patient is telling you, but it's based on what the body is actually doing.

Q So, can you please, when you go through the physical examination, could you please just tell us anything that you found that was medically significant or any positive findings and objective findings, defining them, just for the first visit?

A Sure. So, there was spasm, which means I felt muscles that were tight and hard in the neck and in the back areas that were associated with a loss of range of motion.

A range of motion means you have a body part, for example, your wrist or your neck or your back, and you move that

body part into the various positions that it should be able to move into. If it is unable to get into those positions and you can feel that the muscle is preventing it from doing so because it's spastic, you can then say that there is a restricted range of motion based on the spasm that you're feeling.

Q What is spasm?

A Spasm is an involuntary contraction. In other words, it is an automatic contraction of a muscle that's attached to a specific part of your body, and it occurs when that body part does not want to be put into a position that causes more pain.

So, if you have an injury to your neck and putting your neck into an extended position increases the pain level, you will feel spasm in the muscles of your neck because you're body is trying to prevent it from continuing to cause pain.

Q Objective or subjective, spasm?

A So, spasm would be objective.

Q So, before you continue with the examination, can you describe -- can you define for the jury, medically, what symptomatic means, what asymptomatic means?

A So, a symptom is a problem that a patient tells you about associated with an anatomical problem. So if something is symptomatic, it means that it is causing a problem in that patient.

If something is asymptomatic, it means that it is not causing a problem in that patient. It is not producing a

complaint or a symptom in the patient.

So, symptomatic means it is a problem for that patient. Asymptomatic means it is not a problem for that patient.

Q Two more definitions, radiculopathy and dermatomal.

A Any time you see the word "opathy" in medicine or surgery, it means "a problem with." So, radiculopathy is a problem with a radic. A radic is a nerve. So, radiculopathy means a problem with a nerve.

Dermatomal, "derm" means skin. "Tomal" means geographical location. So, when you talk about something that's dermatomal, you're talking about a specific geographical anatomical location of a particular portion of skin.

Specifically, when you talk about a nerve, nerves, very interestingly, run into your arms and hands and legs and feet in very specific ways, and they distribute themselves in what we call dermatomes, not unlike the stripes, perhaps, on a striped suit, and they do that in your arms and in your legs.

So, when testing the nerve, you can actually figure out which nerve it is, depending upon what part of the arm and hand or leg and foot is involved. So, radiculopathy means problem with nerves. Dermatomal means the way that nerve distributes itself in the arms and hands or the legs and feet.

Q Continue with the physical examination, giving me definitions discussing the positive findings.

A Sure. So, we just talked about spasm and restrictions

in neck and back motion. There's a test whereby you actually try to reproduce pain. It sounds strange, but if you have an idea that pain is coming from a particular body part, you try to put that body part into a position that reproduces pain, because if you do that, you can check to see whether or not that part is involved.

And in this case I did something called a compression and a distraction maneuver. That's where you push down on the head and neck in order to try to narrow the area where the nerves are. You palpate for spasm, and then you try to figure out where the pain is going.

And in this case it traveled down into what I recorded as two specific nerve roots: The C5 nerve root and the C6 nerve root. Those roots take their names from the bones beyond which they exit in your neck, and they're numbered. So, there's a letter in front of the nerve root name and then there's a number. So, if you know the letter and the number, you know which nerve root it is.

So, I did that in the neck, and then I also did it in the lower back.

Q In the neck what did it reproduce, if anything?

A It reproduced symptoms, that is, radiating pain down into the fifth root and sixth root distributions.

Q In your notes you used the word "radicular," but when you write "pain was shooting into both the lower extremities and

the hands," what does that indicate, "pain shooting," when you write that?

A So that means the same thing as radiating or traveling. So, those nerves are like, they're like electrical wires that go down into your arms and your hands or your legs and your feet, so if that pain shoots down those wires, it is radiating, or distributed, in the area of those nerves.

Q I'd like you to assume, it's in evidence, that when Mr. -- it's in evidence as Number 5 up there -- that when Mr. Burns, after the accident went to Medcor, he complained of back pain and headache on the three occasions, just as he did when he came to you.

Could you tell the jury if lower back pain causes headache?

A So, lower back pain is not associated with headaches.

Q What is?

A Upper back pain and neck pain are associated with headaches.

Q Can you tell the jury when you write in your notes "impression" and "plan" at the end of each note, define "diagnosis" or "impression" and then discuss not what your plan is in this case, but what that means on your notes, the "plan"?

A Sure. So, at the end of examining and speaking with the patient, in your mind you come up with what could be causing these problems, and that's, in general, known as a diagnosis.

So, what's the diagnosis that we suspect? What do I think is happening? It also means what's the impression, in other words, what did I think of when I saw that patient.

An impression and diagnosis is pretty much the same thing, like what did you think about that patient. I thought they had a radiculopathy. What's the diagnosis? The diagnosis is a radiculopathy.

A plan is what do you suggest. So, okay, you think they have this particular problem, what's your recommendation, what would you think might be able to help them. And then that would be the plan. I think they should do X, Y, Z or what have you.

So, an impression and a plan, when I write it in the notes section, means what do I think is going on and what do I recommend for them to try to make this condition better.

Q Can you please tell the jury your initial impression and plan? And if you mention another doctor's name, explain who that is, please.

A Sure. So, I had a patient who came in with headaches, neck problem, back problem, with physical findings telling me that there was evidence of what we know as a radiculopathy in the neck and in the lower back. So, the plan is what are we going to do about it.

And what I had suggested, number one is I suggested a neurological, that is a doctor that specializes in nerves and

brains, take a look at the headaches for an opinion. That doctor's name is Hausknecht.

And the other thing that I suggested was imaging studies, that is, diagnostic images of the neck and back, to confirm the diagnosis that I suspected on exam.

I also recommended what we would call the beginning of conservative treatment. Conservative treatment is nonsurgical treatment, and that included off-duty work, which really means activity modifications and restrictions. In other words, if something hurts, don't do it, because if it hurts, it probably means that it's continuing to cause irritation and/or damage.

So, that's the mainstay of a treatment for this problem is when you start with these issues, modify the activities that are reproducing the problem.

Anti-inflammatories, so an anti-inflammatory medication, for example, Motrin, Advil, Aleve, those medications decrease what's known as inflammation. Inflammation is the body's response to irritation in some way. For example, if you've ever cut your skin, you'll notice that that area that gets cut turns red and sometimes it can be a bit weepy. That is the process of inflammation. So, that area hurts. Maybe it's a little itchy, it's red and it's a bit weepy. That's inflammation.

So, an anti-inflammatory blocks that process, and it can, therefore, decrease pain and help with the healing process.

And then I had advised a return visit and --

Q When did you tell him to come back?

A Four weeks.

Q And by stating "off-duty work," were you telling him not to work?

A Yes.

Q When did Mr. Burns next see you after June 9 of 2008?

A I saw him back in February of 2009.

Q At that time and during that time, did you have knowledge that he was seeing Dr. Hausknecht?

A Yes.

Q You had not seen the MRI you sent him out for?

A Not at that visit, no.

Q And, in fact, when he came back in February of 2009, what was the history you took?

A So, when I saw him at that follow-up, that next visit with him, let's see, he was following up with Dr. Hausknecht. He had been working. He said that he was having some progressive symptoms, that is, going into the arms and hands and down into the legs and feet, and also had some complaints of right knee pain.

Q You don't treat for right knee pain, you're just noting it?

A Yes.

Q What does that word "progressive" mean medically?

THE COURT: Counselors, can you step up, please?

Jurors, stand and stretch.

Doctor, you may stand and stretch.

THE WITNESS: Thanks.

(Discussion off the record.)

THE COURT: Okay, everybody. Let's resume.

Q Dr. Merola, in speeding it up, everything is in evidence, and although we're not going to be calling all of the doctors, I'd like you to assume, as you note in your records, that he had seen Dr. Hausknecht over that period of time, tried chiropractic, had EMGs that indicated positive radiculopathy in the lumbar spine, and had been trying epidurals as of January 2009. Okay?

A Yes.

Q Can you tell the jury, when you note in February of 2009 weakness into the arms and later on atrophy, what that indicates to you?

THE COURT: Sorry. Weakness into the arms and what's the other thing?

MR. McCRORIE: Atrophy.

A So, weakness, so the nerves do several things. The nerves are responsible for feeling things. Nerves will distribute pain in your arms and your hands. They are responsible for reflexes, and they're responsible for the muscles.

Now, weakness means that a portion of the nerve that's responsible for making the muscle move is malfunctioning, not working well.

Atrophy means that because the nerve is not appropriately stimulating the muscle, a muscle will contract a bit, so atrophy means a shrinkage of a muscle. And usually you can tell that. You can look side to side. Sometimes you might not tell that there's atrophy because you'll have equal involvement in both arms, but if you have perhaps more involvement in one than another, you can see that there's a difference in the girth or the bulk of a particular muscle.

Q So, when you began seeing Mr. Burns again, going to May 18, 2009, okay, you noted weakness, and now, for the first time, you note atrophy in the mid arm, left side, compared to the right, 1.5 to 2 centimeters.

Was that atrophy present on the first visit in June of 2008?

A No.

Q What, if anything, was medically significant about the progressive weakness that you noted that he had and now the atrophy of 1.5 to 2 centimeters on one arm compared to the other?

A So, the significance of that, it tells me that the nerves that are responsible for that portion of the arm are not functioning well. So, conservative treatment, giving the body a

chance to heal, had not been successful in healing or preventing those nerves from getting worse, so a worsening of the nerve situation resulting in weakness and a shrinkage of those muscles.

Q And in the complaints of shooting pain into the biceps and the progressive weakness, what, if anything, did that tell you?

A So, the biceps is the muscle that flexes your arm. The biceps is controlled by the C5 nerve root, that's the fifth nerve root. Pain going into that fifth nerve root area tells you that it is a cervical fifth nerve root problem, and you then take that finding and then you correlate it with an imaging study, for example, an MRI, to confirm that there is pressure in that area. And if that pressure is causing a nerve problem, that's when we consider patients to be what we call a surgical candidate.

So, at that point in time when you see neurological problems with anatomical, that is, actual physical compression, you then can tell these patients that surgery is an option to prevent that condition from continuing to get worse.

Q In just a moment I'm going to have you step down, with the Court's permission, and go over the anatomy and the findings, but did you review both the cervical and lumbar MRIs that were taken in August and September of 2009?

A Yes.

Q Can you tell the jury what you found on them? You'll show them in just a moment. Just in general, you can do the detail in a moment, what is your finding when you looked -- do you look at the MRIs yourself?

A Yes.

Q As a board certified spinal surgeon, do you have any radiologist employed by you or do you look at all the films yourself?

A I review all the films from the patients that I'm treating myself.

Q How many films do you review in a given year, MRI films?

A I probably review and see about maybe 75 a week. So, in a given year it's a lot of films. I mean, it's on every patient, so.

Q First, Doctor, just tell the jury the difference between x-ray, CT, MRI, CAT scan?

A Sure. X-ray is a way of imaging your body parts through x-radiation. It's like a very -- think about it like as a really bright flashlight. It shoots through your body, and the density of your tissues, your muscles, your tendons, your bones then block that radiation and show up on a film.

X-rays, for example, are really good at looking at dense tissues, like bones. That's why if you look at an x-ray and you see a bone, the bone shows up as a white object on the

x-ray because it's really dense, it's made out of calcium and phosphate and minerals. So it's dense. It pops up on an x-ray.

CAT scan is lots of x-rays taken over a rapid period of time in multiple, different directions that a computer then assembles to give you a very detailed image of the body. So a CAT scan is a really specialized x-ray that involves some computer technology to give you even more detailed images, mostly, once again, dense tissues, like bones.

An MRI is a way of imaging the body that uses a magnet. Your body is magnetized, and, based upon the magnetic field that your body is put into, an image is generated that a computer program then assembles into a picture.

So x-ray and CT are x-rays of looking at the inside of the body, and an MRI is a magnetic field way of looking at the inside of the body.

Q After seeing what you saw on the films, after examining Mr. Burns again in February 16, 2009, did you request permission from another entity to do surgery upon Mr. Burns?

A Yes.

Q To what part of the body did you first request permission to do surgery?

A The cervical spine, or the neck.

(Continued on the next page.)

Q. And what was your -- why were you requesting authorization to do such a surgery under the work accident?

MR. KAMINSKY: Objection.

THE COURT: Sustained. If you want to ask what medical basis, that's different, counsel.

MR. McCRORIE: Sure.

Q. Why don't we do this, with the Court's permission I'm going to ask you come down first, describe the anatomy, then we will go to the films and what you saw. Is that --

THE COURT: Yes. Could you set up the easel please, Kenny?

COURT OFFICER: Sure.

THE COURT: Let's move the podium back.

The attorneys can all move.

So, jurors, we are going to view illustrations now and it's keenly important that you be able to see. If you can't see, you have to tell me, then we will reposition the easel so that you can see.

All right. So let's just -- which one are you going to start with, exhibit what?

MR. McCRORIE: These are all for I.D., the illustrations. Twenty-five for I.D. is the spine.

THE COURT: Well, let's just begin with the first ones. I want to see how it shows up on the easel relative to the jury.

MR. McCRORIE: I should put it up, your Honor?

THE COURT: Yes, please. And you take Mr. Bones away? Thank you.

MR. McCRORIE: I was going to have 28 to be used --

THE COURT: Okay. All right. So the first question is, jurors, can you see this exhibit clearly? Yes? All of you? Not you? Okay. All right.

What do you need? Do you need an angle this way or that way?

SWORN JUROR: I'm able to see the structure, the wording I can't see.

THE COURT: Say it again.

SWORN JUROR: The wording I wouldn't be able to see.

THE COURT: The wording is too far away? You need it closer?

SWORN JUROR: Yes, please.

THE COURT: Okay. Let's move it closer.

SWORN JUROR: No good.

THE COURT: Yeah. Okay.

SWORN JUROR: Exactly. If the wording is not necessary, then I could see the structure, like I said.

THE COURT: The words -- well, they need to see the words, counsel?

MR. McCRORIE: No, your Honor. They are going to describe the image.

SWORN JUROR: Very top line of the wording is okay with me.

THE COURT: Just the little words?

SWORN JUROR: Right.

THE COURT: Okay. We will leave it there.

Counselors, you can reposition yourselves so that you can see the exhibit and, Kenny, if you could just set up a chair for me down there?

Doctor, you may step down from the stand.

You have to wait until everybody is set up.

MR. McCRORIE: Yes, your Honor.

THE COURT: All right. Now, jurors at the end, it's angled this way. Can you see? Can you see? You're good? Everybody else is good?

Remember, if you need to stand, it's okay for the back row. The front row, if you need to bend over the rail it's fine, not a problem. The important thing is that you be able to see and, of course, that you be able to hear.

Okay. Let's begin.

Q. Utilizing the illustration and the model, can you describe the anatomy of the spine for the jury, the normal anatomy and just sagittal and axial views?

A. So this illustration and this model tells you that the

spine is a column. It is a column that supports the head over the pelvis and it's necessary for you to be able to walk in an upright fashion and to be able to look forward and around and it is made of several structures.

Now when we talk about the way you are looking at a person, you look at them usually from front to back. When we are looking at the spine from front to back, it's straight up and down and that is this image here. This is -- actually, we are looking it from the back side, but, nevertheless, it's straight up and down from front to back, that's what we would call the front to back view or anterior posterior view.

When you look at the spine from a side perspective, it doesn't look completely entirely straight. It's sort of an S, more like that.

THE COURT: Doctor, you're saying that this model does not look straight or you are saying that the spine in the body doesn't look straight?

THE WITNESS: The spine in the body when looking at it from the side is no longer a straight line up and down, it takes on an S shape to it.

A. And we could see that on the side-view illustration of this spine. The reason that that happens is in your lower back there is a reverse curvature. That accommodates the way your hips connect to your pelvis and because there's reverse curvature there in order to balance this curve that you get an

upper back curve that comes forward so that now if you have a forward curve here and a back curve here, they're balanced, and then on top in order to balance out your head, there is another reverse curve.

So on the side-view this is called a sagittal view or a side-view, the spine appears to be more S shaped. So it's a column when you look at from front to back or back to front straight up and down when you look at the spine from the side, it's got this S shape to it.

The spine is made of three basic parts. The first are the bones of the spine and the bones of the spine are called the vertebrae and they start up at the top and those are the cervical vertebrae. There are seven of them. So any time you see a bone with a C in front of it, the C stands for cervical and that means the neck.

The upper back, these are called the thoracic vertebrae, so any bone that you see with a T in front of it means thoracic. And in the lower back are the lumbar or the lower back vertebrae and they have an L in front of them.

At the very bottom of the spine sitting inside of the pelvis is something called the sacrum and the sacrum when you are looking at from front to back appears to be kind of like a wedge or perhaps it's heart shaped. You could describe it as either wedge or heart shape. When you are looking at it from the side it appears to be almost triangular shaped with a little

tail at its end. This is known as the sacrum. Any time you see an S, it refers to the sacrum.

In between the bones are pieces of cartilage that we call the discs, and the disc is made up of cartridge, not only like the cartilage at the tip of your nose or in your ear or in other parts of your body. It's softer than bones and it's more elastic than the bones are and those discs are important in terms of gluing these bones together because they hold the bones together. They absorb shock when you are up and walking around and they provide for normal motion within the spine as you do your normal activities that require your spinal motion. So we have bones and discs.

Now at the top of this model and at the top illustration is the head. The head contains a brain. The terminal or the end portion of your brain is your spinal cord. Your spinal cord is actually brain matter that travels into the spinal canal. Spinal canal is on the back side of your spinal column and that spinal cord contains that portion of your brain that is specific for telling the rest of your body what to do and how to do it and the spinal cord itself continues throughout the entire spinal column up until just about the top of the lower back vertebrae. It ends right around there and then it continues as something we call the cauda equina which are a collection of nerve roots coming out of the lower portion of your spinal cord, and those roots then descend and travel down

into your legs and feet.

Q. What is that Latin term for?

A. So the Latin tern for that is the horse's tail or the cauda equina, equina being horse, cauda being tail.

If you look at the nerve roots, it looks just like horses tail, that's why they named it the horse's tail and it's the terminal portion after the spinal cord itself has ended and spinal cord itself ends in the upper portion of the lower back bones.

There is an important implication to that because the cord because, it's a part, a direct part of your brain, is very sensitive to pressure and damage. The nerve roots are a little more resilient because they are nerve roots, so they are a little tougher than the spinal cord, so we could do different things with nerve roots that we can't do to spinal cords.

So the three basics parts are the bones, the discs and the nerves and the nerves are in spinal cord, then the actually nerves themselves, and every name of this column depends on where it is. Cervical spine, C-1 through 7; Thoracic T-1 through 12; Lumbar, L-1 through 5 and then Sacrum, S-1 through 5.

All the nerves are numbered based on where they exit, som fortunately, they don't all have different names, they all have numbers and letters.

Q. Such as what?

A. For example, when talking about the fifth nerve root that goes into your bicep, we know that comes out of the area between the fourth bone and the fifth bone, so the C-5 nerve root is adjacent to the fourth cervical bone and the fifth cervical bone and sitting between the fourth cervical bone and the fifth cervical bone is what we call the C-4, C-5 disc.

Q. Utilizing the illustration, can you describe what an axial view is? Give the jury anatomy of the disc.

A. So we looked at the front to back view, the back to front view. We looked at the side view and then there is a top down view or a bottom up view depending upon how you want to look at it.

So if you were standing on top of the cervical canal looking down into the canal as though you were peering over into elevator shaft, you are now looking at the illustrations that are on the right part of this diagram, and when you do that, so you are looking down the spinal canal, the top in this oval area is the disc.

Behind the disc sitting in this area that is a Y where the spinal cord is in your neck and where the cauda equina is in your lower back.

The canal, the back side that you see here, this structure that looks like a Y is what we call the lamina. So when you are looking down the canal, the lamina appears to be like a Y and sitting inside of that Y is where the cord is or

where the collection of nerve roots that we call the cauda equina sit. You could see sitting on top of that or in front of is the area where that cartilaginous disc is.

Q. Doctor, just a moment. When we go over the actual MRI, does the MRI image take both sagittal and axial views of each level of the disc?

A. So the MRI images take multiple views from front to back, from side-to-side and up and down. Those multiple views we call them slices, so as though you took this spine and you put it on a bologna slicer and cut it across, cut it front to back and cut it up to down.

Because when you are looking at an image, for example, an MRI or a CAT Scan, that is a two-dimensional picture, but to get an idea of what the entire structure looks like, you need to take multiple different views otherwise you could have an area of the spine that is may be in one position that you didn't see at a particular slice.

So those images in the MRI are multiple images of side-view images, front to back images, and top down images.

Q. Can you tell the jury what degenerative means, specifically, degenerative disc disease?

A. So when you are born up until when you attain your skeletal maturity, your musculoskeletal system is in the process of generation. You are getting taller, your shoe sizes change, your clothing size changes because your body is putting on new

tissue. You are making muscle. You are making bone. Your bones are getting longer. This is the process of generation.

When you reach skeletal maturity and it's different for boys and girls -- boys somewhere around 17, girls 13, 14. At that point in time, that process of growth is now replaced by a process whereby your body is repairing these tissues but to a certain extent the wear and tear of life causes degeneration.

So as you're up and walking around, there is wear and tear on your body parts and so those body parts over time after skeletal maturity begin to degenerate.

Best example is the collagen or the cartilage that is in your facial structures. So if you look in the mirror, you see a picture of yourself when you are 15. It doesn't look quite the same when you are 25 or 30 or 40 or 50 because the collagen that exists in our skin has degenerative changes within it that cause it to crease or sag or move or change in some way.

So those degenerative changes are part of what happens to our body in a normal way as we age in your skeletal maturity.

Q. Assuming everyone in this room is above the age of 18, who in this room has degeneration of the spine?

THE COURT: No. No. No. This is not a question for the jury.

Q. For you, doctor, only to you.

A. So if we're examining a tissue in the body and we are above that skeletal maturity age, there will be some form of

degeneration within it as part of what we call the normal senescence or aging process.

Q. What does desiccation mean?

A. Now, desiccation is a descriptive term that refers to the appearance of a structure on an MRI. An MRI looks at the way the water in your body is magnetized, so it's a water signal.

So when you are describing water, you can talk about a lot of water or a little bit of water. A desert is a very desiccated place, it is very dry. An ocean is completely and entirely the opposite, it's very wet.

The term desiccated means dry, so if you look at an MRI and you see an object on the MRI that looks as though it has lost water content, it would be described as desiccated. It's a term most often used when talking about the discs.

MR. KAMINSKY: Judge, can the doctor return to the witness stand?

THE COURT: Yes. Counsel, if you are not going to use the exhibits, then there is no reason for the doctor to be here away from the witness stand. Your adversary is correct, that's why I'm sitting here. I don't have to be sitting here.

MR. McCRORIE: I'm going to use each exhibit, your Honor.

THE COURT: Okay, then let's return to the witness

stand until we are done. I spoke to you about this before. Please, let's use the exhibits.

Q. Okay. Using the first two exhibits sagittal and axial views, 13A and 13B, can you please put up the exhibits.

Just tell the jury to speed it up, the date of the MRI. And just for the record, an MRI takes many, many images, correct?

A. Yes.

Q. I am holding up 13 right here. That is just one slice or two slices?

A. Yes.

Q. Okay. Could you please put that up for the jury. I'm going to have you go through all of the exhibits, then we can explain why you did certain procedures.

Please tell the jury what you see on there of significance.

A. Sure. This is an MRI.

THE COURT: Exhibit?

MR. McCRORIE: 13A.

A. This is an MRI side view image of the lower back or lumbar spine of Mr. William Burns and it is dated August 17th of 2008.

Q. I'm going to leave a red pen Sharpie pen if you do mark the exhibit, just tell the record what you are marking.

A. So we are looking at the side view of the lower back to

the left of the MRI. The squares that we are looking at are the vertebral bodies and they are numbered 5, 4, 3, 2, and 1. These are all lumbar vertebral bodies.

In between each of the vertebral bodies is a disc. Between the last vertebral body is what is known as the sacrum. The sacrum has an S-1 to it. It's also a disc that is the L-5, S-1 area.

To the right of the image there is an area of the spinal canal that appears to be bright white. The reason it is bright white is that the fluid inside the canal being made up mostly of water appears to be very white on the MRI and this is the area that contains the nerves that go into the legs and feet and you could actually see some of those nerves because they have these gray stripes. They are the gray stripes inside the canal.

If we look at, for example, the area between L-4 and L-5, we see that there is some bulging or protrusion of disc and if we see the area between L-1 and S-1, we see that there is some desiccation of disc, that is, some darkness within the disc and we also see that there is some protrusion or herniation of disc into the canal region as well.

Q. Can you please define herniation for the jury?

A. So when talking about the disc, the disc is made of a central jelly like component we call the nucleus pulposus. There is an outer ring known as the annulus. The annulus has

interwoven tough fibers that hold the jelly on the inside. It's like a jelly donut, dry on the outside jelly inside.

Herniation refers to the abnormal protrusion or sticking out of that jelly like material in a specific portion of the disc. So if you squeeze the jelly donut and the jelly comes out and drips on to the table, that jelly has herniated out of the donut.

Q. Can herniation be caused by trauma?

A. Yes.

Q. Can herniation be caused by normal and wear and tear?

A. Yes.

Q. Can herniation be asymptomatic?

A. Yes.

Q. Does desiccation mean there is herniation?

A. No.

Q. Okay. Please describe anything else on that film of significance and then you could show the axial view, 13B.

A. These are the major findings on the side view or sagittal view of the MRI.

Q. Okay. Did you indicate where the herniation was?

A. Yes.

Q. Okay. Just describe the axial view, then we will go to the cervical things. I will just take that from you.

A. So this image, this collection of images is what is known as the axial. It is that top down view. This is 13B and

we are looking at the lower portion of the lumbar spine. We could tell where we are because there is a small diagram in the lower right-hand corner with some lines and numbers through it.

So it tells you what part of the spine you are looking at and on the bottom of these, of this image, and we look at the top down view, we are looking through the disc we could see that the disc itself is encroaching upon the area where the canal is or the nerve roots are. That's the dark shadow in the area of L-5 and S-1.

So there is some darkness. That darkness is that disc area and that disc area is coming into the canal area as we look top down.

Q. I'm going to have you put 13A up again, and can you -- you've seen what is in evidence as Plaintiff's 21, Mr. Burns' prior MRI studies at least in the record, correct?

A. Yes.

Q. Okay. I would like you to assume it has been stipulated the physical films from 1991 and 2003 no longer exist, just what is on that paper?

A. Yes.

Q. Can you please tell the jury using, first using Plaintiff's 26 for I.D. because we don't have the nerves extending on the model how what causes radiculopathy regarding a disc problem?

A. So the discs because they are adjacent to the area

where the nerves are that go into your legs and feet, the nerve becomes irritated when the disc produces inflammation on the nerve.

This is an illustration of the nerves in your leg as they travel into the muscles and down into your foot and leg region and you could see that these cables, the yellow which are actual nerve cables themselves come out of the spinal canal in specific areas where the nerve roots are that are adjacent to the areas where the disc are.

Q. I would like you to assume that in 2003 the MRI reads, as you know, L-5, S-1 there's a posterior disc herniation resulting in obliteration of the vertebral epidural adipose tissue.

Can you please tell the jury utilizing Plaintiff's 27 in conservative treatment what an epidural injection is intended to do for herniation or inflamed epidural tissue?

A. This is an illustration of an injection of medication into the spinal canal which is called an epidural steroid injection.

The steroid is a medication that is a very strong, anti-inflammatory medicine that is designed to block that swelling process, that inflammation process, the inflammatory process and to shrink the area where that inflammation is within the disc. It is the next step in conservative treatment when looking at disc herniations that are producing radiating pain

and symptoms as a way to more aggressively or, specifically, blocking the inflammatory process.

Q. Okay. If you could take that down. Looking at -- and take the next one down. I will put them away.

Looking at Plaintiff's 13A, I would like you to assume Mr. Burns said that he previously had epidural injections in 2003 and that the radiating pain was done up until this accident of 2008.

Looking at what it was called before, an obliteration of the tissue and the disc, does that bump that you see there, is that an obliteration?

THE COURT: Counsel, when you refer to obliteration, what were you referring to?

MR. McCRORIE: On the L-5 --

THE COURT: No. No. Are you referring to 2008 or are you referring to prior accidents?

MR. McCRORIE: In 2003, not an accident, after being hit by a football during a practice, he had an MRI that showed the obliteration of that disc.

Q. Does that disc that you saw in 2008 look like it's obliterated?

A. No.

Q. If the epidural did, in fact, work, what does the epidural due to a disc that is protruding when it works?

A. When it works, it's decreasing the swelling and the

protrusion of the disc and blocks the inflammatory --

Q. If a new trauma occurs, can it cause an asymptomatic disc to become symptomatic?

MR. KAMINSKY: Objection.

THE COURT: Can you repeat the question for me, please?

(Whereupon, the court reporter read back the above-requested testimony.)

THE COURT: I don't know the basis for your objection.

MR. KAMINSKY: Speculation, Judge.

THE COURT: I will allow you to cross examine in this regard, counsel.

So, doctor, you may answer the question. Counsel will cross examine you as to your opinion here.

So, you may answer.

THE WITNESS: Okay.

Q. Previously symptomatic, epidural is done. Now there are no symptoms in the new trauma.

A. So in the absence of symptoms with a new trauma that disc can be rendered symptomatic.

Q. Okay. If we could just go to -- while you are here, you said you first requested a neck surgery. I'm going to put up Plaintiff's 14B. Can you do the same thing with 14B and then we will utilize 14C, and 14A.

Just tell the jury what they are seeing here and any positive findings.

A. This is MRI of William Burns' cervical spine, neck, September 12, 2008. These are side-view images. So we are looking at the cervical spine and I'm putting the numbering in 2, 3, 4, 5.

THE COURT: Tell me the number of the exhibit, again, if you don't mind.

THE WITNESS: This says 14B.

THE COURT: This will be for identification, right?

MR. McCRORIE: These are in evidence, Judge.

THE COURT: These are?

MR. McCRORIE: Yes.

THE COURT: The MRIs?

MR. McCRORIE: The MRIs, the films are in and these are the larger images.

THE COURT: Okay. So it's not in evidence, just the illustration?

MR. McCRORIE: Just the illustration. Yes.

A. We are looking at the base of the brain at the top of the image. You are looking at this gray structure which is the spinal cord in the spinal canal. We are looking at the bones that I have numbered 2 through 7. In between each of the bones we are looking at discs and at C-4, between C-4 and C-5, we see

what I'm going to circle as disc material in the spinal canal.

Q. Okay. Is there, in fact, disc material in the spinal canal on the other areas as well?

A. Yes.

Q. Does -- well, just tell the jury what levels have herniations or protrusions of disc material?

A. So when you are looking at this side view of the cervical spine, the way to tell whether or not there is any disc material in the canal is to see if you see any disc outside of the confines or the vertebral body margins.

So, for example, between C-5 and C-6, there is some protrusion of material. I put a line on it, so there is by definition a herniation at C-5, C-6 as there is at C-3, C-4 to a certain extent, but there is, there is a larger one here at C-4, C-5 that is actually coming into the contact with the cord itself.

Q. Can you explain to the jury why with so many views how you could see a protrusion on one view, but not the other using like a telephone pole hiding behind it or something?

A. So because it's asymmetrical that means the disc is not sticking out this direction. Just like you squash down on to that jelly donut, if you are looking at it from the front, but the disc is squashed out behind it. You can't see the behind section. You won't see the jelly outside the donut. You have to come around the donut to look at the back side to be able to

see where the herniation is.

That is why multiple images are taken on the MRI films, same reason you want to look all around the disc here and the canal region to see where and if there is a herniation.

Q. I would like you to assume in 1991 in evidence there was an MRI showing bulges at C-3, C-4, a mild central posterior disc herniation at C-4, C-5, mild posterior disc herniation at C-5, C-6, those exist on that film as well, correct?

A. Yes.

Q. In the 1991 film is there any cord involved in that?

A. No.

Q. I'm just going to hold up or put up Plaintiff's 14A and please tell the jury if there is any disc touching the spinal cord in this view?

A. So on this image, the gray line is the cord, so we are looking at the cord and we can see there is an area that I'm highlighting between C-4 and C-5 that is in direct contact with the cord.

Q. Before when you told the jury over the -- I think it's from June of 2008 the progressive symptoms and then atrophy appearing with progressive weakness, what does a disc touching the cord cause, what type of symptoms and what types of physical manifestations?

A. So because this is between C-4 and C-5, we are looking at the area of the nerve that would be the fifth nerve and the

descending sixth nerves going into the arms and the hands, bicep muscle and the arm and we see neurological lost in terms of sensation, reflex, and muscle.

What that means is that this zone is becoming progressively more damaged because of the pressure effect of this disc on the cord and the nerve roots.

Q. If the disc had been on the cord from say 1991 or sometime thereafter, would you have expected to see atrophy to any part of his body when he first saw you in June of 2008?

A. Yes.

Q. Just 14C and then we will move to what you did for the 14C.

Can you tell the jury what that is and how you know which level is the one that you circled on the prior view?

A. So these are the top down views in the cervical spine and we know where we are based on the lines and if we go between 4 and 5, it's 8, 9 and 10. So we are looking for the 8th, 9th and 10th cuts which are here, here, and here. That is towards the bottom of this area and we are looking top down.

I'm highlighting the disc region and you could see the gray center portion is the cord. You could see that above the area in question and below the area in question to some extent the cord is rounder than it is in the top down view because there's a certain amount of squashing front to back pressure coming from the C-4, C-5 disc.

Q. And what about the full, almost looks like an egg yolk, a full white circle around the disc that are, in fact, labeled as herniated?

A. This tells you that there is a good signal of cerebral spinal fluid around the cord in the upper areas here which this is at C-2, C-3, so you see nice full cord, full spinal signal, C-3, C-4 full spinal signal. It tells you that these areas are not so much of a concern as the area where the cord starts to become more flattened out.

Q. Okay. So, doctor, if even though on such a view where there are herniations, does the herniation mean there is going to be symptoms?

A. No.

THE COURT: We are going to take a break. Take five.

COURT OFFICER: All rise. Jurors exiting.

(Jurors leave the courtroom.)

THE COURT: Counsels, let me speak to you in the back.

(Whereupon, there is a discussion held off the record, in the robing room, among the Court and counsel.)

THE COURT: Let's resume our places and let's bring in the jury.

COURT OFFICER: All rise. Jurors entering.

(Jurors enter the courtroom.)

THE COURT: Thank you, everyone. Please be seated.

Jurors, just a reminder. You're free to stand, all right. You're free to lean, whatever is helpful. That is fine. You don't have to be rigid.

Q. Doctor, you previously --

MR. McCRORIE: Sorry. Your Honor, may I continue?

THE COURT: Please.

CONTINUED DIRECT EXAMINATION

MR. McCRORIE:

Q. You previously testified that you received authorization to do a cervical surgery first. I'm going to go to that in just one minute because those are both the same date, one view of the disc looks dark, in another they look like --

Can you explain the difference between T-1 and T-2 images on an MRI?

A. This particular MRI image looks at water signal where water signal is very, very bright. So cervical spinal fluid appears to be very bright because it's specifically designed to look at water and these particular images on 14B are a bit different.

This is a lower water signal, more of a fat signal, so you could see fat in tissues more clearly. Here the cerebral spinal fluid appears to be darker or gray.

Q. Okay. You've already noted the symptoms that caused

you to request the surgery. Can you please put up for identification Plaintiff's 18 and your operative report is behind you here.

Could you tell us the date of the surgery and what is the surgery performed. Could you go through this as succinctly as possible telling us what you did for him and at what level?

A. So this illustration of the surgical procedure done to the neck, it's called anterior which means through the front. C-4, C-5 which is the area where the four compression or herniation is.

Decompression which means taking pressure off of and fusion which means looking or fusing the bones together with a stabilization, and this is an operation that's done through the front side of the neck because the spinal cord in the cervical spine is being compressed directly from the front and we don't want to move that cord because if we put in extra pressure on that cord, it would result in paralysis. You need to come in through the front side to be able to safely take the pressure off. That is why it's done through the front.

The first portion of the operation is what is known an exposure and it involves making a small skin incision in the neck in order to move the neck structures that are in front of the spine out of the way to expose the C-4 and the C-5 bones.

Once this is confirmed that the exposure is correct, that is done with an x-ray in the operation, we then begin to

remove disc material until we reach the back of the bones because it is the back of the bones and the back portion of the disc that are in the canal.

By using very specialized magnification devices on our eyes called loupes, we could see very tiny structures, the disc, and we follow the herniation into the canal and then remove it from the spinal canal.

You know that you've removed the herniation because once you've taken out that material that is in the canal, you could then directly look at the spinal cord. So when you're directly looking at the cord and the nerves that exit that region, you know that the pressure has been taken off of the cord and the nerve.

There is also a little tool, it is a little metal tool that you actually pass along the nerve root to make sure that there is no disc hiding in any other little areas and that is the decompression portion of the operation.

Q. Okay. It's called an anterior cervical discectomy with decompression of the spinal cord and nerve roots, just so we are clear.

THE COURT: Counsel. You can't testify. Please.

MR. McCRORIE: Okay.

Q. Which level in this view, 14A, did you decompress the spinal cord at?

A. C-4, C-5.

Q. Without me testifying, which one is it?

A. It's the area that I marked where the disc herniations is in contact with the cord.

Q. Okay. And just because this is in evidence when it says in utilizing loupe magnification, disc material was removed from the spinal cord which was noted to have been herniated into the canal through a posterior longitudinal rent. What does that mean?

A. So the disc, the annulus has fibers to it. The back side of the annulus is the posterior aspect of the annulus. Annulus has a tear in it and you follow the fibers of that tear in order to find the disc material inside the canal so that you can then remove it.

The loupe magnification is the magnification on your eyes so you could see the structures.

Q. I'm going to show you, put up Plaintiff's 17A. Could you tell the jury what they are looking at? It's taken May, 2016, May 13?

A. It's a post-operative x-ray.

THE COURT: Like a few weeks ago?

MR. McCRORIE: Yes.

Q. X-rays are taken post-operatively, correct?

A. Yes.

Q. We will get to it later. Do you take post-operative x-rays at intervals?

A. Yes.

Q. Are the hardware implanted in Mr. Mr. Burns' body permanent?

A. Yes.

Q. Whenever you take the x-rays, it's going to be there?

A. Yes.

Q. Okay. All right. Just utilizing, again, you talked about MRI to see which is tissue and some bone. Can you see disc in an x-ray?

A. The disc spaces on x-ray appear to be clear spaces because you can't visualize the actual disc itself because it's soft cartilage.

Q. Okay. Were post-operative MRIs done, several of them actually?

A. Yes.

Q. We are just going to take one view, 15A from the March 6, 2014 MRI. They are also done in 10, 13 and 16, but we are just going to do this:

Can you tell the jury if there are still herniations and whether or not they are causing Mr. Burns any issues?

A. So there are herniations in the other areas that we looked at previously which are at C-3, C-4 and C-5, C-6 and at C-6, C-7, but we see that the canal and the cord itself are well decompressed and there is no herniation at C-4, C-5 which is the area of the actual surgery.

Q. Okay. And are any of the discs that are protruding touching the spinal cord?

A. No. They are not putting compressive pressure on the cord.

Q. You already said what the T-2 and T-3 image, the same date, which image is up at 15A? What is that?

A. This is a -- this is where fat is bright. This is T-1.

Q. Okay. So looking at the T-2 image, where it would be easier to see because we have the light now all those are herniations. Are any of them touching the cord?

A. You could see that the cord has signal that is white cerebral spinal fluid around it.

THE COURT: So, excuse me, these are 2016 MRIs?

MR. McCRORIE: Fourteen, your Honor. After the surgery.

Q. Did you remove the disc that is touching the spinal cord?

A. Yes.

Q. Okay. All right. Do you operate on the word herniated disc or the effect of herniated disc or something else?

A. You don't operate on the MRI. You operate on the patient based on what we would consider their clinical findings and the neurology of the patient when you examine them. You're operating on the patient. You're operating on the nerve that is involved depending upon the severity of nerve involvement.

Q. Okay. I will try to finish with the exhibits, then have you sit down.

You've already showed the jury the lumbar MRIs. And we are speeding through it, but after the cervical surgery was done and Mr. Burns testified he went through some physical therapy, did you put in for authorization for a surgery to his lumbar spine?

A. Yes.

(Continued on the next page.)

Q And if you could utilize both Plaintiffs' 19 and 19A. You'll take down what's here.

Your operative report from St. Vincent's is also here?

A This is an illustration of low back surgery.

THE COURT: Doctor, are we speaking of a second, different surgery?

THE WITNESS: Correct, yes.

THE COURT: What's the date?

THE WITNESS: This operation was done after the cervical spine surgery, and this is the lower back surgery.

Q And so when I said he testified he was going to physical therapy and then you put in for authorization, did you get authorization to do surgery for this work-related accident to his back?

A Yes.

Q And it's up there, the date, and your report is here, but just take the jury through the surgery as succinctly as you can, telling them what you did and what you showed them on the MRI?

A So, this surgery is done through the back side instead of the front side, because it's an area where the spinal cord is not down in this area so we can actually manipulate the nerves in the lower portion of the lumbar spine. So we can avoid having to come through the front side, and we can do it all through the back side.

And it's done by making an incision in the lower back, and then doing an exposure of the bones by moving the muscles out of the way to determine the L5-S1 region. That area is then opened, that is to say that the canal is opened in order to decompress, or take pressure off, of the nerves between L5 and S1.

And removal of the disc is done through that opening in the spinal canal that you create. So you actually look at the nerves, you move them out of the way, you then find the herniation by looking at it and then pulling it and dissecting it, pulling it out of that spinal canal.

And then what we do is we stabilize L5 and S1 in order to hold that area together so it does not continue to move or cause any more irritation or damage to those nerves.

That's a process of a fusion, similar to what was done in the neck.

Q When you say you moved the nerves away, utilizing the cervical, 14A, it's a solid spinal cord, you talked about the cauda equina.

Going back to the presurgical MRI, 13A, these lines --

MR. KAMINSKY: Judge, I have to object.

THE COURT: Sustained.

Don't testify, please.

Q There's a cord here, but what are these lines?

A The lines are nerve roots in the lower portion of the

lumbar spine.

Q When you just said you moved nerves, what do you mean?

A You're moving the cauda equina out of the way of the herniation so that the herniation can be removed.

Q Utilizing just the second part of the surgery, if you're done with the first part.

A After the decompression, or taking the pressure off, a portion of the operation is done. The stabilization portion, or the fusion part, is done by connecting the screws that you placed into the bones to rods in order to maintain the bones together and hold them together and then gluing the actual bones themselves together with bone graft that we take from the area where the decompression was done. That completes the fusion process.

Q Just looking at the final version, although it's been there since 2010, I'm going to put up Plaintiffs 17B, the most recent x-rays.

What is that you're looking at?

A It's a side view image of the lower back of Mr. Burns showing the L5-S1 fusion.

Q Just like was done in the cervical, is there something in between the bones where the disc used to be?

A There's a spacer placed in between the bones, which we call a biomechanical device, or a cage, and that acts to maintain the height of the bones and to also fuse or glue the

bones together.

Q Here's one of the four postoperative MRIs, March 6, 2014.

Do you see the spacer in that image?

A The spacer is the black rectangle that you see sitting between L5 and S1. That's the spacer that sits in between L5 and S1 that I inserted into the region where the disc was.

Q And only because -- is the metal hardware, is that still in these images?

A Yes.

Q Where is it?

A These are MRIs. The metal is titanium, it's not magnetic, and when you take the MRI images, on most of the images, the metal actually disappears.

The spacer is made out of a special type of plastic, and that actually does show up here as a black area, because it also does not generate any magnetic signal, so it shows up as no signal, which is black.

Q I'm going to have you sit down in just a moment.

Did Mr. Burns undergo something recently that there's another device in his body?

I'm just going to hold up Plaintiffs' 17D in evidence?

A Yes.

Q What are we looking at here, and what is that device?

A This device that looks like a calculator or a computer

is what's known as a spinal cord stimulator. It's very similar to a pacemaker, but instead of it being wired to the heart, which a pacemaker would be, it is wired to the spinal cord through these wires that you can see traveling into the spinal canal.

Q Are the wires also viewed in 17C?

A Yes.

MR. McCRORIE: Doctor, I'm going to have you step back up onto the stand.

THE COURT: Jurors, you may stand and stretch.

(Brief pause in the proceedings.)

MR. McCRORIE: May I continue, your Honor?

THE COURT: Please.

Q So we sort of went over everything. I just want to go back to some of the notes.

Did Mr. Burns indicate to you in May of 2009 that he had stopped working due to inability to tolerate the duties?

MR. KAMINSKY: Judge, again, there's testimony in every question.

THE COURT: Sustained.

Q Go to May 16, 2009, please.

A Yes.

Q What, if anything, did Mr. Burns indicate to you regarding work?

A He indicated that he was no longer able to tolerate

work duties.

Q Did he indicate whether or not he wanted to be at work?

THE COURT: If you remember, Doctor.

A I don't remember.

Q The second line under "Physical Examination" in evidence.

A Correct. Yes. I wrote that he is depressed because of his present condition and would like to return to work.

Q One and a half to two centimeters of atrophy in the arm that wasn't there ten months before, what does that equate to? Can you do the math for us?

A Well, that is indicative of nerve root muscular dysfunction.

Q What does one-and-a-half to two centimeters equal?

A It would be what we would consider a significant side-to-side difference finding.

Q How many centimeters in an inch?

A What is it, it's one point something centimeters per inch. Correct. Yeah.

Q So almost an inch of atrophy?

A That's right.

MR. KAMINSKY: Judge, that's way off.

THE COURT: Yes. We can look it up.

Q 2.2 I think.

A 2.2 inches per centimeter -- no, 2.2 centimeters per

inch.

THE COURT: You can pull out your iPhone if you want and look it up.

Q Is it less than an inch but more than half an inch?

A I would say yes, yes.

Q Is that medically significant?

A Yes. I mean, it's an appreciable side-to-side difference in the upper extremity in terms of muscle surface area loss.

Q In July of 2009, prior to the surgery, you speak again about the 1989 fall. You use the words that he was asymptomatic with respect to the neck and back for at least five years before the acute onset of neck and back --

MR. McCRORIE: I'm reading what's in evidence.

MR. KAMINSKY: Objection.

THE COURT: Sustained.

Q Can you tell the jury what you noted about how long he had been asymptomatic -- you already defined that word -- to the neck and back?

A I put down that he had been asymptomatic at least since what I recorded as 2003.

Q After the cervical surgery, was it reported to you that it helped him?

A Yes.

Q In what way?

A It was able to decrease the severe shooting pains into the arms and hands.

Q Did it take away Mr. Burns' pain in total?

A Not in toto, no.

Q Was that something you told him it would do?

A No.

Q What do you tell a patient about the risks of surgery and what you expect from a cervical surgery such as the one you did?

A So, when we're talking about a surgery, we talk about the reason to do the surgery, which is to take pressure off the nerves in order to prevent the nerves from continuing to deteriorate. We also talk about what's known as the realistic expectation of surgery, what is it that surgery is expected to accomplish.

It's expected to decrease some of the severe symptoms. It's expected to prevent the nerves from getting worse.

It is not expected to make all pain go away in the neck or back areas, because pain is what we would consider multifactorial. There are many reasons for developing pain.

Surgery is a structural process specifically designed to operate upon those nerves traveling into the arms and hands, but does not address all of the contributing factors to overall pain. So those are the realistic expectations of any surgery and what it can and cannot accomplish.

And we also discuss what are known as the risks of surgeries. So the advantage is to prevent nerves from getting worse. The disadvantage is it is an operation that requires a general anesthesia; it requires an incision; and it requires the manipulation of the tissues that overlie the area of the operation; a manipulation, in some cases, of the nerves and the spinal cord; and a healing process for the fusion.

So all steps along the way of that procedure can have what we call potential complications or unintended effects. We do things to minimize those potential effects, but they're not zero, and they could potentially have some problems along the way.

So it's part of the discussion we have with the patient, and we offer them the option for or against an operation.

Q Can you tell the jury the purpose of postoperative physical therapy, and, in certain cases with people whose pain is not relieved, in continuing with both the neck back fusion, what the purpose of physical therapy on a maintenance basis is?

THE COURT: Counsel, can we focus on this particular plaintiff, please, and would you please ask the questions within that context?

MR. McCRORIE: Yes.

Q Did you prescribe physical therapy to Mr. Burns after each of his surgeries?

A Yes.

Q For what reason?

A In the short-term phase after surgery, it helps with the healing process, and it decreases postsurgical stiffness and provides some strength and some flexibility to the areas that you've operated on.

In the longer term, it helps with maintaining the patient's overall condition.

Q I'm just going to skip over many notes, but in your notes on several occasions you order new MRIs of either the neck or the back after having done surgery.

Can you tell the jury the purpose for monitoring or ordering the MRIs in this particular patient?

A So, the purpose of postoperative MRIs in this particular case are to look at the areas that you've operated upon to make sure that it continues to remain stable and that the cord remains well decompressed without any changes to it. And then you're also monitoring the other aspects of the spine to see whether or not any of those other areas where the discs are located are now protruding, sticking out, herniating or causing any other problems.

Q Can you turn to the October 4, 2010, note, please.

You've answered the question about the cervical. Can you please tell the jury whether or not the lumber surgery alleviated Mr. Burns' pain or symptoms in any way. If so, what?

A So, let's see. In terms of the lumbar surgery, some benefit in terms of decreasing some of the severe shooting pains well and maintaining him neurologically stable.

Q In October of 2004 were you aware of Dr. Hausknecht prescribing other forms of pain management after having been seeing him for the two years?

A Yes.

Q Did you concur with that pain management recommendation given what you've known to that date?

A Yes.

Q It says, "Undertaken with Dr. Thomas Mandelbaum." Is that two different people?

A Dr. Thomas and Dr. Mandelbaum are partners in the pain management practice.

Q What was being considered at that point?

A Two things: One was a pain pump versus a spinal cord stimulator.

Q What's the pain pump and the purpose of it?

A A pain pump is a, it's a reservoir that contains medication that is slowly delivered into the spinal canal to deliver medication over a persistent and continued course of time.

Q As succinctly as you can, can you tell us what the purpose of a spinal cord stimulator is intended to do?

THE COURT: Step up, please.

MR. McCRORIE: I could withdraw it.

(Discussion off the record.)

Q Mr. Reiff told me I might have said October 2004. October 4, 2010 is the note we were referring to?

A Yes, that's the note.

Q You never saw him before 2008, correct?

A Correct.

Q Is the spinal cord stimulator in his body permanently in?

A Yes.

Q Can Mr. Burns get MRIs in the future now that the spinal cord stimulator is in his body?

A No.

Q And with regard to the other metal that's in his back, the metal that you put in, why can you get MRIs with that? What type of metal is that?

A It's titanium.

Q The other doctors will talk about the effect of the spinal cord stimulator.

What does axial neck pain or back pain mean?

A When I refer to the term "axial neck pain" or "axial back pain," I mean pain that is localizing itself to the neck and back that is nonradiating pain. Not pain traveling, but pain in the area of the neck or back.

Q And what does -- it's in your notes -- chronic pain

syndrome mean?

A Chronic pain, a chronic pain syndrome is whereby a patient has pain which is localized, which is coming from imprinting of pain in the central nervous system, not unlike what you might see in a patient that has a painful part of their body that's been amputated but nevertheless can still feel pain in that amputated part.

It happens because the central nervous system, that is, your brain and your spinal cord, are projecting. They have pain imprinted within the central nervous system that is perceived as pain in a body part.

THE COURT: Counsel, can we connect this testimony to this plaintiff, please?

Q Go to the note of February 13, 2012. I won't say it. I'll have you read it. What did you state -- we'll just pick that note in general.

What was Mr. Burns continuing to complain of, and what did you label it as?

A So he had persistent symptoms which were consistent with what I indicated in the impression section as a chronic pain syndrome.

Q In that note did you indicate whether or not the surgery had been successful to any degree?

A Yes.

Q Surgeries?

A Yes.

Q Can you just explain that, and we'll move on.

A So, the stabilization process and the decompression process was able to maintain the anatomy of that C4-C5 segment and the anatomy of the L5-S1 segment in a stable fashion, in other words, no more collapse, compression, or irritation specifically in those areas. But, you still had a patient that did have what we would consider long-standing or long-term pain in a chronic pain fashion.

Q Did you consider your surgeries to be successful, each of them?

A Yes.

Q Can you explain to the jury if he still had pain and he went to a chronic pain syndrome why you consider your surgeries to be a success on each of those, the back and neck?

A The surgeries are done primarily to prevent the nerves from getting worse, that is, maintaining the nerve function in your muscles so that you are able to use your arms and your hands and your legs and feet, structurally stabilizing the spine. So from a structural perspective, a rebuilt perspective, those areas stayed stable.

From a neurological perspective, he did not have any further progressive nerve damage.

Once again, the situation itself had otherwise stabilized from an anatomical perspective, which is the goal of

surgery.

Q On that visit, February 13, 2012, the record will indicate how regularly you saw him before, but did you indicate to him on what basis you'd see him going forward into the future?

A Sure. So, at that point in time when you're monitoring patients that have had fusions, that have had those fusions remain essentially otherwise stable, in general, every year to two years would be the kind of period of time whereby you would want to see those patients back again to look at their necks and backs to see if there were any other issues.

Q Were you aware that he was in and had been in active pain management on a monthly basis at that time?

A Yes.

Q What was your understanding as to whether or not he would continue seeing Dr. Thomas and Dr. Mandelbaum?

A That he would continue.

Q Were you aware of the injection therapy they were doing to him?

A Yes.

Q As indicated in your notes?

A Correct, yes.

Q What was your understanding as to what, if any, medications he was on?

THE COURT: Counsel, step up, please.

(Discussion off the record.)

THE COURT: Let's continue.

Q Doctor, let me put it this way: All of the records in evidence, Dr. Hausknecht's full record, the entire pain management record of Dr. Thomas and Dr. Mandelbaum, mostly Dr. Thomas, have you reviewed everything that they have prescribed, medications, injections, etcetera?

A Yes.

Q In that note, that last note we were talking about, did you concur with their treatment?

A Yes.

Q We'll have you them tell the reasons why, or one of them actually. Okay.

Before, I'd like to hand you up, it's in evidence, it's the prior record of Mr. Burns, it's the complete prior record. Okay?

In either of these, the cervical or the lumbar, did you see any cord involvement?

A No.

Q And I understand it was clarified, but you just have the reports, correct?

A Yes.

Q Did you review that entire -- it's in your notes, but did you have all of this information prior to rendering your final treatment to Mr. Burns?

A Yes.

THE COURT: Counsel, I need a clarification. Your question to the doctor was in light of the medical records that he's reviewed, was there any cord involvement prior to the accident or prior to the surgery or prior to what?

MR. McCRORIE: As indicated, we're dealing with the prior record only, Plaintiffs' 21.

THE COURT: I need a context as to prior to what. Prior to the surgery or prior to the accident?

Q I'll do it this way: I'm going to ask your opinions about what you believe caused what you showed the jury was touching the spinal cord, but, for now, in 1991 does that report indicate any involvement with the spinal cord?

A No.

Q And in 1989, April 20, when Dr. Scrimenti, a neurologist, states that EMG and nerve conduction testing --

THE COURT: Counsel, let's be concise. Just go through the different time periods. Your question had to do with prior, so let's just have a clarification as to what prior means.

MR. McCRORIE: Okay.

Q All of the questions I'm going to ask you deal with all of the prior medical records, prior to the accident of May 20, 2008. Okay?

A Yes.

Q By the way, have you also reviewed the four reports from the two examining physicians, the board certified neurologist and board certified orthopedist, Dr. April and Dr. Sherry, that the defendants had examine Mr. Burns in 2010 and 2016?

A Yes.

Q Because I need your opinions later as to what caused, what was going on with his symptoms here, in April 20 of 1989, a neurologist writes, Dr. Scrimenti, that "An EMG and nerve conduction testing was performed. A thorough examination of both lower extremities and the lumbar paraspinal muscles did not reveal any abnormality."

Did you see that?

A Yes.

Q Did you know that after Dr. Hausknecht did his EMG in September of 2008, that there was abnormality on EMG?

A Yes.

Q What, if anything, did that indicate to you?

A That there wasn't, by a review of those prior records, we don't see that there were any significant neurological cord or nerve root manifestations.

Q What does the term --

THE COURT: Or what?

THE WITNESS: Nerve root.

THE COURT: Nerve root?

THE WITNESS: Yes, nerve root or spinal cord neurological deficits.

Q What does the term "waxes and wanes" mean in medical?

A Comes and goes.

Q What does "intermittent" mean when Dr. Scrimenti or any doctor writes some numbness or any pain or anything would be intermittent, to a doctor, not a lay person?

A Comes and goes.

Q Prior to your testimony here today and throughout your treatment, did you review all of the medical records connected to Mr. Burns' case, including the defendants' doctors' examinations in this case?

A Yes.

MR. McCRORIE: Your Honor, I could probably just do the opinion questions after the hypothetical since it's five to.

THE COURT: We're going to break then.

Jurors, here's how it goes. I would like to resume at 2:00 o'clock so that we can get in as much testimony as possible today. So, can we eat quickly and we'll start at 2:00?

Thank you very much.

THE COURT OFFICER: All rise. Jurors exiting.

(Whereupon, the jury exits the courtroom.)

MR. KAMINSKY: To save time, can I see the

doctor's file during the lunch break?

THE COURT: Yes, absolutely you can do that.

(Whereupon a lunch until recess was taken.)

(Continued on the next page.)

A F T E R N O O N S E S S I O N

COURT OFFICER: All rise.

THE COURT: Thank you. Doctor, return to the stand, please.

(Witness takes the stand.)

COURT OFFICER: All rise. Jurors entering.

(Jurors enter the courtroom.)

Thank you, everyone. Please be seated.

Mr. McCrorie, you may continue your direct examination of Dr. Merola.

MR. McCRORIE: Thank you, your Honor.

CONTINUED DIRECT EXAMINATION BY
MR. McCRORIE:

Q. Dr. Merola, in addition to testifying already that you know and knew the complete contents of Plaintiff's 21, the prior medical records, did you also know that in March of 2006 he was hospitalized for reactive airway disease and through one note in the hospital chart after seeing a gastrointestinal person, one of the complaints was backache from coughing and headache?

MR. KAMINSKY: Again, this is such leading.

THE COURT: Well, I'm going to allow it because it's going to focus the questioning.

Are you aware of this, doctor?

THE WITNESS: Yes.

Q. Okay. So, if we could do this, doctor, I'm going to

ask you about the most recent exam, the symptoms, then I'm going to ask you the hypothetical question that is required and I'm asking you your opinions based on the causation. Okay?

A. Yes.

Q. And right before we do that, I don't know if it was clear looking at Plaintiff's 14A, you pointed out what you said was a disc touching the cord. When you were using the loupe magnification during that surgery, did you actually see the disc on the cord before taking it off?

A. Yes.

Q. At the 4, 5 level?

A. Yes.

Q. So go to your last note of the physical, not telephone conversation, physical visit, March 21, 2016. Okay?

A. Yes.

Q. The rest of your notes are in evidence. Could you tell the jury briefly what Bill's symptoms were or what during the history portion --

THE COURT: Sorry. I'm confused.

Your question is about a March 2016 examination by this doctor?

MR. McCRORIE: Yes, the last examination before this trial.

THE COURT: Before the trial. Okay.

A. So his symptoms when he came into the office on that

day were what I listed as mechanical axial symptoms.

Q. Just a little higher.

THE COURT: Doctor, yes. I can't hear you.

A. Mechanical axial symptoms. Mechanical being motion or activity related, axial being neck and back symptoms, with respect to his both his neck and his back.

THE COURT: Doctor, I can't hear you, so you are talking down to the pages that you have in your hand, and as a result, your voice is going right down to the floor instead of across to the jury.

A. So the majority of the symptoms were mechanical axial, neck and back symptoms.

Q. It's noted in your record, but was he having difficulty doing activities?

A. Yes.

Q. All right. Can you please tell the jury what your -- you did a physical examination?

A. Yes.

Q. In the impression and plan because the records are in evidence, can you tell the jury what, in the last visit what you found or what you, what was your impression?

A. So impression and plan on that last visit was that he was continuing to suffer from a chronic pain syndrome with some residual lost in the neck and back areas and the plan at that point in time was that he was going to proceed forward with

spinal cord stimulator placement under Dr. Thomas.

Q. What is the new word used, myelopathy. What is cervical myelopathy?

A. It refers to weakness coming from the cervical spinal area, cervical spinal cord.

Q. What, if any, restrictions did you note and find on that exam?

A. So the findings on the physical exam were restricted ranges of motion in the neck and back and persistent neurological deficits to the arms and hands and legs and feet.

Q. Can you just quantify in any way the lost range of motion that -- withdrawn. The restricted range of motion with the neck and the back?

A. So I actually used an adjective to describe the restrictions in his ranges of motion and I indicated that they were severe losses of range of motion.

Q. Doctor, with the mechanism of an injury of being an elevator that hits the bottom steel floor hitting something else steel underneath it, could you describe what axial load is?

A. An axial load would be a load that comes down on to the column, in this case, on to the column of the spine or load if you are transferring it from the bottom up, up into the column of the spine.

Q. And what was -- when you are treating a patient, is it important for you to know the mechanism of injury?

A. It's helpful to know what kind of an injury occurred and some of the circumstances under which that injury did occur, yes.

Q. What was your understanding of the mechanism of Mr. Burns' injury?

A. So the type of injury that would be sustained is one where there is a rapid deceleration and transfer of force to the spinal column in an axial loading type of a mechanism.

Q. Okay. I would like you to assume that both he and other witnesses testified, but he testified they were packed in like sardines, so there was not room to go left or right.

What, if any, effect would that have on what you are calling axial load when the elevator struck the bottom?

MR. KAMINSKY: Objection.

THE COURT: Step up.

(Whereupon, there is a discussion held off the record, at the bench, among the Court and defense counsel.)

THE COURT: Rephrase.

Q. In this particular case, why was it important to you to know that it was an axial loading mechanism of injury?

A. So in this particular case it gives us an idea of how an impact on the spinal column can cause an increase in pressure within the disc that could then lead to the mechanism of disc compression on to the cord and on to the nerves.

Q. And what I meant before on the mechanism, if someone

can't go to the ground because there is --

MR. KAMINSKY: Again, objection, Judge.

THE COURT: Sustained.

Q. I would like you to assume that both Mr. Burns and another witness testified that there were so many people on the elevator that when it hit, their bodies went down, but the people on the left and right, they did not go to the floor, but it caused bending involuntary of their knees?

MR. KAMINSKY: Objection.

THE COURT: What's the question, counsel?

Q. What effect would someone standing up and being forced to stay up when the elevator hit the bottom have upon their spine?

MR. KAMINSKY: Objection.

THE COURT: Sustained.

Q. All right. Doctor, for the purposes of the questions I'm going to give to you, I'm going to do what is called a hypothetical question and ask you the standard that is required by the law. I would ask that you--

THE COURT: Counsel, he can't give you the standards by law. I give the standards of law to the jury.

MR. McCRORIE: Yes, your Honor.

THE COURT: Yes.

MR. McCRORIE: Yes.

Q. Each of the questions I ask you, I'm going to ask that

you state your opinions within a reasonable degree of medical certainty. Okay?

A. Yes.

Q. Whether I ask that each time to avoid having to repeat those words, I would ask that all of the opinions you give would be within a reasonable degree of medical certainty. Okay?

A. Yes.

Q. For whatever they cannot be within a reasonable degree of medical certainty, you will tell the record. Okay?

A. Yes.

Q. I still may say the word, but -- okay.

First, I would like you to assume -- I would like you to assume that in evidence in Plaintiff's 21 -- so I don't have to read all of it but Mr. Kaminsky read a lot of the portions into the record during questioning of Mr. Burns and they're in the record -- that the MRI findings are what they were in 1991 -- just taking them in order -- that there is a letter by a Dr. Sylvester that Mr. Burns has not been seen in over 21 years, right, and that in 1986 with no injury, Mr. Burns treated for low back pain with a chiropractor for seven visits in 1987, he treated with 12 visits and then he testified that he was asymptomatic thereafter.

I would like you to assume this is true until 1989 when he fell, had a work accident falling off a ladder and a scaffolding. Okay?

A. Yes.

Q. I would like you to assume that after that 1989 accident in February 23rd of 1989 he began treating in February of 1989 and he treated until March 17, 1989. In that time he had both low back and now neck pain. Okay?

A. Yes.

Q. I would like you to assume that in 1991 Mr. Burns testified that his pain had been on and off and he was sent for an MRI to the neck which are those findings of the herniations at three levels. Okay?

A. Yes.

Q. I would like you to assume that you've testified there is no court involvement and that Mr. Burns testified that thereafter he remained asymptomatic through 2002 when there was a football accident while coaching, standing on a sled, someone hitting the tackle sled transferring that force?

A. Yes.

Q. I would like you to assume everything in these records that you already testified about the negative E.M.G.s and the fact that no prescription medication both by Mr. Burns' testimony and the records had been ever prescribed for him for either neck or back pain in his life. Okay?

A. Yes.

Q. I would like you to assume that in 2003 he had after treating with chiropractor for several months, he did not take

narcotic pain medication, but went that other level of epidural injection to the lower back, only was treating for low back. Okay?

A. Yes.

Q. I would like you to assume that he had three epidural injections in 2003 and that it's, it was his testimony that he was asymptomatic with regard to any radiating pain whatsoever in the back, was no neck issue back in 2003 his testimony was and that during that, up until the date of this accident. Okay?

A. Yes.

Q. And other than a reference in having been treated during a hospitalization for something with his airway, there is no way -- doesn't state radiating or not -- but that Mr. Burns' testimony was he was asymptomatic with regard to radiating pain after those epidurals. Okay?

A. Yes.

Q. In 2003. Without having to read it with stipulation that Mr. Kaminsky read the records, the hours that I've -- withdrawn.

Did I tell you all of Mr. Burns' hours from the beginning of his career all the way up until the date of the accident and thereafter?

A. Yes.

Q. And show you the chart of the number of hours?

A. Yes.

Q. And were you aware of what Mr. Burns' physical activities required of--

THE COURT: Counsel, this is a hypothetical?

MR. McCRORIE: Yes. I need all of--yes, your Honor.

Q. I would like you to assume that during, from 1989 having worked 2282 hours and only missing two days of work from that fall on the ladder and from 2002 all the way up until the date of the accident, all of the hours in excess of 3,000, 2500, all the hours he worked up until the date of the accident. Okay?

A. Yes.

Q. I would like to you assume that Mr. Burns' testimony was that he was pain free and had no restrictions to the neck or the back while he worked those hours from 2003 through 2008 up until the date of the accident.

I would like you to additionally assume his partner testified that he was his partner for four or five years and he exhibited no restrictions prior to the date of the accident. Okay?

A. Yes.

Q. I would like you to assume that Mr. Burns testified that he was involved in the elevator accident of the hoist where the hoist dropped 15 to 20 feet as determined and is a fact in the case, dropped to the, passed the ground level hitting the

springs and that both Mr. Burns and a man named Luis Palacios testified it was an abrupt stop upon the steel bottom hitting the steel springs. Okay?

A. Yes.

Q. I would like you to assume that as indicated in Defendant's A in evidence that they put into evidence, 19 people showed up with neck or back issues within the hour to Medcor?

MR. KAMINSKY: No. No.

THE COURT: Sustained. Sustained.

Q. I would like you to assume that Mr. Burns within the hour showed up complaining of what is in evidence in Medcor with headache and back pain. Okay?

A. Yes.

Q. I would like you to assume that Mr. Burns testified that from, in the days following the accident he felt what he had never felt before, an electric like sensation that did not stop going down his arms, mostly in his biceps from his neck and the same feeling from his back going down into his legs. Okay? The same electric like feeling.

A. Yes.

Q. I would like you to assume that Mr. Burns testified from the date of the accident forward he had restrictions in the ability to do his job as a steam fitter and that his partner testified to the same for at least a two-week period after. Okay?

A. Yes.

Q. And, finally, I would like you to assume that Mr. Burns did all of the treatment that you've testified to that's in your notes and in the notes of all the doctors that's the records entered into evidence, Dr. Hausknecht, that he tried what he had worked in the past, conservative treatment in the form of chiropractic in the ten months between seeing you, getting the MRI and coming back to you, that he had tried chiropractic narcotic pain medication and epidural to the lower back and the neck at this time all to no relief. Okay?

A. Yes.

Q. I would like you to assume that on your first visit there was no atrophy to either arm and no weakness and that ten months later your notes indicate there was progressive weakness and as noted by Mr. Burns and physical objective atrophy in the left arm to the degree you said it was. Okay?

A. Yes.

Q. I would like you to assume that the E.M.G.s that were previously negative in 1989 were positive by the time he came back to you and that after having reviewed the MRIs and you did the surgeries that you told the jury that you did?

A. Yes.

Q. Okay. The first question I have for you is do you have an opinion within a reasonable degree of medical certainty as to the cause of the symptoms of the radiating electric like pain

and causing the restrictions that Mr. Burns testified to and the pain? Do you have an opinion as to what caused those symptoms to both the neck--

MR. KAMINSKY: Objection.

THE COURT: Sustained.

Q. -- and the back?

MR. McCRORIE: May we approach, judge?

THE COURT: We may go into the robing room.

MR. McCRORIE: Yes. Thank you.

THE COURT: Jurors, you may stand and stretch.

(Whereupon, there is a discussion held off the record, in the robing room, among the Court and counsel.)

THE COURT: Jurors, take five.

COURT OFFICER: All rise. Jurors exiting.

(Jurors leave the courtroom.)

(A recess is taken.)

COURT OFFICER: All rise. Jurors entering.

(Jurors enter the courtroom.)

THE COURT: Thank you, everyone. Please be seated.

MR. McCRORIE: May I continue, your Honor?

THE COURT: Yes, counsel. Let's rephrase.

Q. Okay. Dr. Merola, set aside the question that I asked you before. Without having to read everything that is in the record, did you review the entire contents of the medical

records from all of the doctors in this, case, Dr. Hausknecht, Dr. Thomas, Mandelbaum, your own surgical records, the MRI, Medcor, every single record that is in evidence here to --

A. Yes.

Q. Did you also review prior to rendering your final opinions your -- did you also review Plaintiff's 21, all of the records of Mr. Burns past and whatever in those records from all of the various chiropractors and MRIs from the past?

A. Yes.

Q. As well as anything else that was done that you may know from prior epidurals from testimony and from him?

A. Yes.

Q. And relying on what Mr. Burns told you about how the accident happened. Okay?

A. Yes.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not prior to the date of this accident from 2003 until 2008 he was asymptomatic to both his neck and his back?

A. Yes.

Q. What is your opinion and what do you base it on?

MR. KAMINSKY: Objection.

THE COURT: I'm allow it.

A. My opinion is that he was asymptomatic and able to work up until the day of the accident and that's based on my review

of the medical records and, of course, my treatment of the patient as well.

Q. Only because we did the new hypothetical, I just wanted to add to the old one that all of the hours that are in his union --

THE COURT: Counsel, make it a separate question, please.

MR. McCRORIE: Okay.

Q. Separate question. Do you have an opinion within a reasonable degree of medical certainty after reviewing all of the records that you just testified you reviewed in addition to his work records from 1983 through 2009, okay, the work hours, do you have an opinion within a reasonable degree of medical certainty as to the cause of the symptoms that he testified, that he told you he was feeling after the 2008 accident to both the neck and the back?

MR. KAMINSKY: Objection.

THE COURT: Sustained. Rephrase, please.

Q. First question was that he was asymptomatic. You said in your opinion he was. Do you have an opinion as to whether or not he became symptomatic after the elevator accident of May 20, 2008?

A. Yes.

Q. To what parts of his body?

A. To the neck and back.

Q. And what do you base that opinion on?
MR. KAMINSKY: Objection.
THE COURT: Yes. He said he could answer the question, but he didn't give an opinion.
Q. What is your opinion?
MR. KAMINSKY: Objection.
THE COURT: I will allow it.
A. That Mr. Burns became symptomatic.
MR. KAMINSKY: Can I voir dire on this?
(Whereupon, there is a discussion held off the record, at the bench, among the Court and counsel.)
THE COURT: The objection is overruled.
Doctor, do you remember the question so that you could answer it?
THE WITNESS: So-so.
THE COURT: Okay. Let's read back last question, please.
(Whereupon, the court reporter read back the above-requested testimony.)
THE WITNESS: I think I have it.
THE COURT: Yes. Have it?
THE WITNESS: Yes.
A. That opinion is based on the review of the medical records and my treatment of the patient.
THE COURT: And your what?

THE WITNESS: Treatment of the patient.

THE COURT: Thank you.

Q. Well, because it was a break in between the first long question, have each of these past two opinions been within a reasonable degree of medical certainty?

A. Yes.

Q. The same thing in the future, all of your opinions will be under that degree of medical certainty unless I state so. Okay?

A. Yes.

Q. Why is it your opinion that this accident caused him to become symptomatic to both the neck and the back as you just --

MR. KAMINSKY: Objection.

THE COURT: Sustained. That is asked and answered.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not this accident aggravated a pre-existing asymptomatic degenerative condition in either his neck or his back?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. Yes.

Q. Please tell us what the opinion is and if the Court will allow the basis thereafter, right after you give the opinion.

MR. KAMINSKY: Objection.

THE COURT: We need two questions.

Q. The opinion first, please.

A. My opinion is this accident can aggravate a pre-existing degenerative condition in Mr. Burns neck and back.

Q. What do you base that opinion upon?

A. That opinion is based upon my review of the medical records that I've he seen and, of course, my treatment of the patient.

Q. Do you have an opinion within a reasonable degree of medical certainty whether or not this accident caused any new additional injury to Mr. Burns' neck and back?

MR. KAMINSKY: Objection.

THE COURT: I'll allow it.

A. Yes, I do.

Q. What is that opinion?

MR. KAMINSKY: Objection.

THE COURT: Say it again.

MR. KAMINSKY: Just objecting for the record, Judge.

THE COURT: Okay. Thank you. Overruled. Please.

A. That my opinion is that it did cause a new injury to the neck in the form of a herniation with cord compression and nerve root compression and cervical spine.

Q. Do you have an opinion within a reasonable degree

of--withdrawn.

Within a reasonable degree of medical certainty can a herniation get larger through trauma?

A. Yes.

Q. Did that happen here?

A. Yes.

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

Q. If Mr. Burns had a pre-existing herniation on his spinal cord at C-4, C-5, even from 2003 to 2008, would you have expected there to be weakness, atrophy to either arm on the first visit?

MR. KAMINSKY: Objection.

THE COURT: Sustained. Rephrase.

Q. What, if any, significance of the fact that on your first visit with Mr. Burns, June 9th of 2008 the first examination that he did not have atrophy and the fact that he did have it 11 months later with progressive weakness?

MR. KAMINSKY: Objection. Asked and answered several times.

THE COURT: I don't understand your question, so I can't really rule on an objection.

Q. If Mr. Burns had a pre-existing herniation on his cord, spinal cord at C-4, C-5 existing from 2003 to 2008, what would you expect when you saw -- what would you expect to see

physically when you examined him in January of 2,008?

MR. KAMINSKY: Objection.

THE COURT: Sustained.

Q. Why do you believe he did not have the herniation on his cord as you just testified at the C-4, C-5 level prior to the date of this accident?

MR. KAMINSKY: Objection.

THE COURT: Sustained. Asked and answered.

Q. Do you have an opinion within a reasonable degree of medical certainty as to the cause of the need for the surgery you performed to Mr. Burns' cervical spine in February of 2009?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. Yes.

Q. What is that opinion?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. The opinion is the need for the surgery to the cervical spine.

THE COURT: Okay. I just want to -- you're saying need?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Requirement.

THE COURT: That's not K-N-E-E. Need, like

N-E-E-D?

THE WITNESS: Like necessary.

THE COURT: Okay. So may be it's me. I thought you were talking about knee originally, but, no, now we are good. Need?

THE WITNESS: Yes.

A. That the requirement for the surgery was a consequence of the accident.

Q. That is the neck surgery, yes?

A. Yes.

Q. What do you base that opinion on?

A. My opinion is based on the review of the medical records and my treatment of the patient.

Q. Do you have an opinion within a reasonable degree of medical certainty as to the cause of the need for the lumbar surgery you performed on the L-4, L-5 level?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. I do, yes.

Q. Please tell the jury what your opinion is.

A. My opinion is that the requirement for the surgery in the lumbar spine at L-5, S-1 is a consequence of the elevator accident.

Q. Have each of the last opinions you've given, have they all included your review of all of the records we discussed in

the first hypothetical?

A. Yes.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not in the absence of this accident Mr. Burns would have required surgery to either his neck or his back?

A. Yes.

MR. KAMINSKY: Objection.

THE COURT: I didn't hear the last part of the question.

Q. In the absence of this accident, do you have an opinion whether he would require surgery to the neck or the back?

THE COURT: Wait. Wait. Wait. Read that back, please.

(Whereupon, the court reporter read back the above-requested testimony.)

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. Yes.

Q. What is that opinion?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

A. That in the absence of this accident Mr. Burns would not have required surgery to the neck or to the back.

Q. What do you base that opinion on?

A. My --
Q. What is the basis?
A. My review of the medical records and my treatment of the patient.
Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Burns will require any future surgeries?
MR. KAMINSKY: Objection.
MR. McCRORIE: It's in the BP and notes, Judge.
THE COURT: That is what I wanted to know. Yes. Overruled.
A. Yes.
Q. Can you please tell the jury--withdrawn.
Is that indicated in your notes? Have you discussed these with Mr. Burns?
THE COURT: No. The answer is that he has an opinion.
MR. McCRORIE: Okay.
Q. Okay. Tell us your opinion, please.
A. My opinion is that the patient having had mechanical reconstructions of the neck and back will in the future require revisions of those reconstructions as they wear out.
Q. Is that, in fact, reflected in your notes?
A. Yes.
Q. Okay. Could you tell the jury what adjacent level

breakdown is?

THE COURT: Sorry?

MR. McCRORIE: Adjacent level breakdown.

Q. Adjacent segment.

THE COURT: Do you understand the question, doctor?

THE WITNESS: Yes.

THE COURT: Could you answer it, please?

THE WITNESS: Yes.

A. An adjacent segment is the area of the spine that is next to or adjacent to the area that has been reconstructed and those areas are subject to wear and tear as time goes on and that is the purpose of the monitoring of the neck and back surgeries into the future to monitor those adjacent segments, the segments that are attached to the reconstructed segments.

Q. In stating your opinions because we are going to go through this rather quickly and I said all of the records in this case, they are also records stipulated into, MRIs seen from 2016, you are speaking about all the records in this case, correct?

A. Yes.

Q. Do you have an opinion -- have you treated -- other than Mr. Burns, have you treated steam fitters in your career as an orthopedic physician?

MR. KAMINSKY: Objection.

THE COURT: Say it again?

MR. McCRORIE: Excuse me?

THE COURT: Could you repeat the question?

MR. McCRORIE: Sure.

Q. Have you treated other steam fitters over the course of your career? I know you said you treated construction workers, but other steam fitters.

MR. KAMINSKY: Objection.

THE COURT: Objection sustained.

Q. Are you familiar with the duties of a union steam fitter on the construction sites of New York City?

MR. KAMINSKY: Objection.

THE COURT: Objection sustained.

Q. What, if any, recommendation -- withdrawn.

Can Mr. -- in your opinion, can Mr. Burns continue working as a union steam fitter after the surgeries that you've performed?

MR. KAMINSKY: Objection.

THE COURT: I will allow it.

Q. In his current condition?

A. No.

Q. Can you please tell the jury within a reasonable degree of medical certainty why or what the basis is?

A. So the basis of that opinion is, of course, my treatment of the patient, his restrictions in ranges of motion,

his neurological findings and his chronic pain syndrome with having a reconstruction of both the neck and the back.

Q. Understanding what you just called it, just for the record, do you have an opinion within a reasonable degree of medical certainty as to whether or not into the future beyond the date of your testimony here whether or not Mr. Burns will continue to have pain to either his neck or his back?

A. Yes.

Q. What is your opinion?

A. My opinion is that the patient will continue to manifest chronic pain syndrome and continue to require treatment because of that.

THE COURT: Excuse me. One second.

(Pause in the proceedings.)

THE COURT: Thank you. Please, continue, Mr. McCrorie.

MR. McCRORIE: Yes, your Honor.

THE COURT: You may continue.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Burns will continue to have the restrictions to his neck and his back in the motion that you've noted in your most recent note and the notes before?

A. Yes.

Q. Are those restrictions permanent?

A. Yes.

Q. Can you please tell the jury the basis of your opinion as to why he will continue to have restrictions in his neck and his back?

A. So he has residual deficits in his ranges of motion with neurological neck and low back injuries and has had reconstruction surgery of both the neck and the low back areas and so his within a reasonable degree of medical certainty that given those conditions that he presently has, he will continue to have those restrictions into the future.

Q. Do you have an opinion within a reasonable degree of medical certainty as to what the competent producing cause of his pain from May 28, 2008 until today has been?

A. Yes.

Q. What is that opinion?

A. That --

MR. KAMINSKY: Objection.

THE COURT: Isn't this asked and answered, counsel?

MR. McCRORIE: Not with the word pain and the injuries, Judge.

THE COURT: Okay. I will allow it with respect to pain.

A. That the pain from which the patient is presently suffering from are a consequence of that accident based on the review of the records and my treatment of the patient.

Q. Just for the record, when you state permanent for both the pain and the restrictions into the future, what does that mean? Do you mean lifetime?

A. Yes.

Q. His lifetime?

A. Correct.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not past the date of this testimony you will require follow-up treatment with an orthopedic surgeon such as yourself or another surgeon?

A. Yes.

Q. What is that opinion?

A. That he will continue to require orthopedic follow up to monitor the neck and the back.

Q. With what frequency would you suggest -- other doctors will talk about their specialty -- but with what frequency could you suggest within a reasonable degree of medical certainty that he continue to see a doctor such as yourself for follow up?

MR. KAMINSKY: Objection. It has been asked and answered.

THE COURT: Not the frequency.

MR. KAMINSKY: I already know the answer, so it has already been asked and answered.

THE COURT: I'm glad. May be you will win the Lotto, too.

Doctor, how frequent, please.

A. At least every year and then going forward depending upon what symptoms might arise thereafter.

Q. Okay. Can you please tell the jury --

THE COURT: Sorry. At least a year and what?

THE WITNESS: Then going forward depending upon symptoms more frequently, if necessary.

THE COURT: Oh, I see. Thank you.

Q. Can you please tell the jury the current cost to the patient, the full cost, what it would be for a follow-up visit with an orthopedic surgeon such as yourself?

A. So depending upon what we would consider the complexity of the office visit, it can vary anywhere between 150 to about $275 for follow-up visits. Depending upon how many body parts examined and, of course, how much time is spent with the patient and how complicated the decision making was based on their presentation at that office visit.

Q. Do you have an opinion within a reasonable degree of medical certainty whether or not into the future Mr. Burns would require diagnostic testing at those yearly visits to monitor the conditions of his neck and his back?

A. Yes.

Q. Could you please tell the jury within a reasonable degree of medical certainty your opinion as to what types of medical diagnostic testing?

A. So, in this case, monitoring the neck and the back and also taking into consideration the cord stimulator you would be looking at C. T. Scans or CAT Scans of the neck and back regions at least every year to two years, of course, depending upon symptoms.

Q. What is the current cost of a C.T. or CAT Scan?

A. So the average cost of a C. T. Scan for a cervical spine, a portion of the spine that is either cervical or lumbar is about roughly about a thousand dollars.

Q. And, just for the record, what parts of the body would that be to --

A. So, in Mr. Burns' case, it would be cervical and it would be lumbar.

Q. Okay. Do you have an opinion with a reasonable degree of medical certainty in addition to the C. T. Scan whether or not x-rays would be done to either the neck or the back?

A. X-rays would be done in the intervening years based upon symptoms.

Q. What does that mean intervening years?

A. So, if you did a C.T. Scan -- let's say you did a C.T. Scan every two years. You would anticipate that may be one year instead of doing a C.T. Scan you could do an x-ray, then the following year would you do a C.T., then you could alternate x-ray and C. T. Depending upon symptoms.

(Continued on the next page.)

Q Would you recommend that with a reasonable degree of medical certainty?

A Yes.

Q Could you just tell the jury the cost of either the neck or the back x-ray, and if there's a difference?

A A series of x-rays for either the neck or back averages about $250 or so.

Q Can you please tell the jury, we'll just do current cost, it's in the notes, when you say for the future cervical fusion -- withdrawn.

What was the type of surgery you were talking about in the future for the neck?

A So, it would be a revision, that is, a redoing of an anterior cervical discectomy and spinal fusion at an adjacent segment.

Q And with a reasonable degree of medical certainty, can you please tell the jury the cost, if you could include the facility, the surgeon, radiology, anesthesia, what is the current cost for this cervical surgery?

A So the average cost for that, including the implants and the hospital and all the care required for that procedure is on average of $100,000.

Q That would be full cost, assuming no benefits or anything?

A Correct.

Q How about you've talked to the jury about the lumbar surgery. Can you please tell the jury --

THE COURT: Excuse me. The revision surgery that you just testified to is with respect to the cervical spine?

THE WITNESS: Correct.

THE COURT: Only?

THE WITNESS: Yes.

THE COURT: Thank you.

Q With a reasonable degree of medical certainty can you please tell the jury the cost of current, although the notes say, the cost of a current lumbar -- what type of fusion -- withdrawn.

What type of surgery would be the lumbar and cost of it?

A So, the lumbar surgery would be similar for an adjacent segment, and it would be a revision as well. And for the lumbar surgery, the cost for an average lumbar revision with a hospital stay and all of those costs involved is about on average of $125,000.

MR. McCRORIE: Your Honor, could we just approach one second?

THE COURT: Yes.

(Discussion off the record.)

THE COURT: Counsel, do you have any more

questions?

MR. McCRORIE: No.

Thank you for your time. I'll speak to you again on redirect next week.

THE COURT: Mr. Kaminsky, you may commence your redirect.

CROSS-EXAMINATION

BY MR. KAMINSKY:

Q Hello. How are you?

A Good. Thank you.

Q We've had a chance --

THE COURT: Did I say commence your redirect. I meant commence your cross.

MR. KAMINSKY: The jury knew.

THE COURT: Thanks.

Q We've had the chance to meet many times, true?

A We've met before, yes.

Q In fact, I've had the chance to cross-examine you on numerous occasions, correct?

A You have cross-examined me before, yes.

Q In fact, just this year, 2016, this is the third time I am cross-examining you?

A Yes.

Q And in all three of these cases, Mr. McCrorie has been the attorney for the plaintiff, correct?

A He may. Perhaps. Yes. We have been together with Mr. McCrorie, yes.

Q And I've cross-examined you on many other cases involving Mr. McCrorie and the firm that he is affiliated with?

MR. McCRORIE: Objection to "many" with me.

THE COURT: Yes.

Q At least a dozen?

THE COURT: Sustained.

MR. McCRORIE: It has not been a dozen or even --

THE COURT: Sustained.

MR. KAMINSKY: Regardless.

Q In those other cases, the issue is often whether or not something is caused by trauma or something is degenerative, true?

MR. McCRORIE: Objection.

MR. KAMINSKY: Very important, Judge.

Q In those other cases --

THE COURT: I'll allow this subject to connection, but this will be a very short leash, Counsel.

MR. KAMINSKY: Yes, it will.

Q We've often battled over whether something is caused by trauma or something is caused by degeneration, true?

MR. McCRORIE: Objection.

THE COURT: I'll allow it.

A Yes.

Q And in those other cases have you testified under oath that the single most important factor in a doctor such as yourself determining whether something is caused by trauma or something is caused by degeneration is whether or not that person has ever had problems with that portion of their body before the trauma? Yes or no?

THE COURT: Or you may say I cannot answer with a yes or no.

A I cannot answer completely with a yes or a no.

Q Have you testified that your opinion that an incident is caused by trauma is because of the absence of prior complaints by a person to that part of their body? Yes or no?

MR. McCRORIE: Objection. Incident caused by trauma.

THE COURT: Read back the question.

(Whereupon, the requested portion was read by the reporter.)

THE COURT: I will allow it.

A That can be one of the factors, yes.

Q Is the answer to my question yes, you have?

A I have testified in the past --

Q Thank you. That answers my question.

THE COURT: No. Counsel, I will allow him to answer the question that way. It's a qualified answer.

Q In this case can we agree that there is an extensive

past medical history of Mr. Burns having complaints to his neck and his back?

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

Q Okay. In this case you said you reviewed all of the records before testifying.

A Yes.

Q You were kind enough to give me your file during the lunch break?

A Yes.

Q Is it fair of me to say that the prior records concerning Mr. Burns' complaints of pain to his neck, his back, his headaches are not in this file?

A Yes.

Q So, you were provided with certain information before testifying, correct?

A Yes.

Q And you put that information in your file.

I'm going to hand the file back to you in a minute.

Would you agree with me that the materials provided to you by Mr. Burns' attorneys do not include the records from the 1980s?

A I did see the records from the 1980s.

Q I'm asking you if they were provided to you and if they are in your file?

A They're not a part of the file --

Q Thank you.
A -- but I reviewed those prior to coming here.
Q Yes, we'll get to that.
A Okay.
Q They were not provided to you and they are not part of your file, correct?
A They were provided to me, but they are not part of that file that you have.
Q You have another file?
A No. That's my treatment file for the patient.
Q Okay. So, in this file, you have some documents and some you don't, correct?
A Yes.
Q You don't have the Medcor records, correct?
A Not in that file, no.
Q And you don't have the records from Hackensack Hospital in this file, correct?
A Correct.
Q Now, also, in determining -- and I apologize to you because I'm only going to touch on, I'm going to jump around a little bit, because I only have ten minutes to get into details, and that's fine -- but in determining if something, an incident caused an injury, you need to know the nature of that incident, correct?
A It's helpful, yes.

Q For instance, did you do any sort of biomechanical analysis of the force --

MR. McCRORIE: Objection.

Q -- that was --

THE COURT: Sustained.

Q In the notes from Dr. Hausknecht, which you gave to me during the lunch break, on June 19, 2008, this is from Dr. Hausknecht to you, Dr. Hausknecht took a history from Mr. Burns and it says, "Mr. Burns is a 50-year old, right-handed man who was involved in a work-related injury on May 20, 2008. On this date he was riding a lift that fell approximately 15 feet. He was knocked up against the rear gate."

THE COURT: I'm sorry. I can't hear you.

Q "He was knocked up against the rear gate. He denies any head trauma or loss of consciousness."

Are you aware that Mr. Burns made that statement to Dr. Hausknecht?

A Yes.

Q And do you place any significance --

MR. KAMINSKY: Judge, may I give the witness back his file?

THE COURT: Please.

Q Is it of any significance to you, just tell me yes or no, is it of any significance to you that Mr. Burns denied any head trauma?

A Yes. It tells us he didn't have a loss of consciousness or specific head trauma, yes.

Q So the fact that he did not complain of injuring his head, that's something you'd want to know, correct?

A Yes, it's helpful.

Q And in dealing with his neck injury, in this incident, did he --

THE COURT: Counsel, you have about two or three minutes. I'm sorry.

MR. KAMINSKY: I understand.

Q Let's start with the neck. We know that CAT scans were taken of his neck, correct, before the accident?

MR. McCRORIE: CAT scan?

Q MRIs were taken of his neck before the accident and we know MRIs were taken of his back before the accident, correct?

A Yes.

Q And we know that those films showed herniations, correct?

A Yes.

Q And we also know that it is at those very locations where the herniations were shown before the incident that you ultimately performed your surgeries, true?

A Yes.

Q Just yes, no, or I can't answer that yes or no. Is it a coincidence that the very locations shown on prior films where

the plaintiff already had a herniated desk, is it a coincidence -- yes, no or you can't answer yes or no -- that that's the exact location that you, 10 or 20 years later, ended up performing surgery?

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

Q Okay. Now, you said --

THE COURT: Counsel, we need to stop. I'm very sorry. It's 3:30. I have to leave. I'm sorry.

I'm sorry, Doctor.

MR. KAMINSKY: It's okay. I understand.

THE COURT: You wanted to squeeze in a little bit, so I let you squeeze in a little bit, but the squeeze is over.

MR. KAMINSKY: I appreciate it. Thank you, Judge.

Have a seat one second, Counsel.

Doctor, the attorneys will speak to you about your return date so that you can work out the time with them. Okay?

THE WITNESS: Yes.

THE COURT: I understand that you're not available on Tuesday. Is that so?

THE WITNESS: I have surgery.

THE COURT: You have surgery?

THE WITNESS: Yes.

THE COURT: You can't reschedule?

THE WITNESS: No.

THE COURT: Not a problem.

MR. McCRORIE: He told us. We'll speak to his office.

THE COURT: You can come Friday morning?

THE WITNESS: Yes.

THE COURT: Thank you. We'll see you then.

Jurors, I have an appointment at 4:30 is what's going on, and I have to leave. I can't change that. We will see each other on Thursday. Thursday, that's a long time away from now, right? So, here's the drill. You're going to hear this for the 50th time. I don't care what temptation befalls you. I don't care what temptation comes across your path. Do not discuss this case. Do not discuss this case no matter what temptation comes to you.

You can see that there is so much information that is unique to us. Everything that happens here has to happen within our universe, and that information is varied. Okay. You have to hear everything, and the last thing we want is somebody interfering with your perceptions and your thoughts. All right? So, don't discuss it on the phone, on the computer, over dinner, at the breakfast table. You can't fill in all the gaps. No discussions. All right?

So, we will pick this up again on Thursday, and the reality is that at the end of the case, when the

attorneys do their summations, they will bring everything together in their closing arguments, and they will remind you of the different testimonies that you have heard. Okay? They will present their perspective as to how you should analyze and how you should decide at the end so you can come to your verdict. So don't go nuts.

We will resume on Thursday. Is everybody good? Anybody need anything signed that we can help you with?

THE JUROR: Yes. I need a letter again.

THE COURT: If you need a letter, please speak with Kenny or speak with Ellie, and we'll get that done. Okay. Thank you very much. Have a wonderful, wonderful weekend.

THE COURT OFFICER: All rise. Jurors exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Counsel, do you wish to say something for the record?

MR. McCRORIE: Yes, Judge.

During the examination, the hypothetical was objected to. I still stick to the fact that it was a proper hypothetical. In this case defense is claiming the pre-existing herniations from '89, '91, and 2003 in their reports are, in fact, the reason for these surgeries and that the surgeries were unnecessary.

The doctor needed to know -- and I believe my

position is proper -- the entire history and, in addition, what was testified to here in court was needed to make his opinions complete, and that's my position.

When we came back from the break, I shortened the hypothetical, based on the discussions we all had. He was still objecting. I just wanted it on the record that I didn't really want to end the examination before making the record and potentially having the weekend to research, because we're ordering dailies, the hypothetical and the reasons why I thought it was proper to begin with.

But, I just wanted to place that on the record that that's what went on both up at the bench and in the back.

MR. KAMINSKY: I think that's a one-sided version, actually, of what transpired in the back, Mr. McCrorie. So I won't say anything else other than I disagree with your assessment of what transpired.

I stand by my objection to that hypothetical. I don't think the Court needs me to stand by its ruling, but I think the objection to the hypothetical is appropriate. I think it contained not only convoluted information, unnecessary information, but it also contained information that was beyond the province of this particular witness to testify to. You were asking a lot of biomechanical-related stuff. So, you stand by your question; I stand by my

objection.

It's irrelevant because you got the questions you ultimately needed anyway, so I don't know why you're making the record.

MR. McCRORIE: I do want to state the hypothetical contained no biomedical or biomechanical. That was all before the hypothetical.

MR. KAMINSKY: The hypothetical speaks for itself.

MR. McCRORIE: I know. We have the record.

THE COURT: Counsels, here's the bottom line, and I want to say this very briefly, I have repeatedly directed counsel not to testify. You may not testify, and at every point where you testify in lieu of asking proper questions, the objection will be sustained. All right?

With that said, I look forward to seeing you on Thursday. I hope you have a wonderful weekend. Be well. May the sun shine tomorrow because I understand that it's going to pour.

(Whereupon, the matter is adjourned to June 9, 2016.)

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