SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX : CIVIL TERM : IA-6

----------x

GEORGE BAZARNICK, Index No. 23134-12E

Plaintiff(s)

-against-

EXTELL WEST 57th STREET, LLC AND LEND LEASE (US) CONSTRUCTION, INC.,

Defendant(s)

----------x

851 Grand Concourse
Bronx, New York 10451
March 16, 2018

B E F O R E:

HONORABLE JAMES W. HUBERT,
Presiding Justice.

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

SACKS & SACKS, LLP
Attorneys for the Plaintiff
150 Broadway, 4th floor
New York, New York 10038
BY: JAMES J. McCRORIE, ESQ.

CERUSSI & SPRING, P.C.
Attorneys for the Defendants
One North Broadway
White Plains, New York 10601
BY: THOMAS F. CERUSSI, ESQ.

SHONELL N. MABRY
Senior Court Reporter

THE COURT: All right, case on trial.

The doctor is not here yet, correct? Or he's here?

MR. MCCRORIE: He said he's in the building. I assume that he's in the building or outside.

THE COURT: You know what, we'll take him at the next break. We are going to bring the jury down and call the plaintiff and we'll resume testimony then.

MR. MCCRORIE: Emm --

THE COURT: Yes? What?

MR. MCCRORIE: Can I just give him one more call, Judge?

THE COURT: No, don't give him any more calls. This is what I'm going to tell you now.

MR. MCCRORIE: I understand.

THE COURT: I'm telling you on the record, for everybody.

MR. MCCRORIE: I'm sorry about it.

THE COURT: No, no I don't want to hear sorry. I don't want to hear anything. I don't want to hear apologies or none of that stuff. I'm telling you guys what is going to happen. I'm not asking you, I'm not begging for apologies or anything like that.

I get paid to be here because this is my job, right?

MR. MCCRORIE: Yes, your Honor.

THE COURT: Is his job to testify or his job to take care of patients and do surgery? His job is to take care of patients and do surgeries. He doesn't come here because he has to be here. He comes here because you want him here and you're willing to pay him to come here. That's not his job.

As far as I'm concerned, when doctors and experts get called, I don't want to hear about all the other things that are important to them that they have to do. When you tell me this witness is coming to court, he's not on his time any more. He's on my time. He's on the jury's time. He's on the court's time. So if you can't get your witness here, you can't get your doctors here, fine. We'll go on without them.

It's not my problem. It's not the jury's problem. It's not my job to accommodate them. You asked me for 10:30, we're almost at eleven o'clock. We could have done testimony from the other witness.

So, you know --

MR. MCCRORIE: I understand, Judge. The --

THE COURT: I don't want to hear anything. I don't want to hear anything about it. I want you to listen to what I'm saying to you. Incorporate that into your judgements and considerations and decision making. There's nothing to

discuss here. That's what it is.

Bring down the jury, please.

(Pause.)

COURT OFFICER: Ready, Judge?

THE COURT: Yes, bring them in.

COURT OFFICER: Jury entering, all rise.

(Whereupon, the sworn jury panel is escorted into the courtroom and take their respective seats.)

THE COURT: Please be seated.

All right, ladies and gentlemen, we're going to resume the presentation of evidence. Do you have your witness?

MR. MCCRORIE: Yes, we do, your Honor.

THE COURT: All right, call him.

MR. MCCRORIE: Plaintiff calls Andrew Merolo, M.D.

THE COURT: All right.

Once again, ladies and gentlemen, we are going to take the witness out of turn. Remember my prior instructions to you. We'll resume testimony of the witness, the plaintiff who has already given some testimony, as soon as we are done, I guess, with this witness. We'll see.

In any event, Doctor, give your attention to the court officer.

COURT OFFICER: Remain standing and raise your right hand.

Do you solemnly swear the testimony that you are about to give in this case will be the truth, the whole truth and nothing but the truth so help you God?

THE WITNESS: Yes, I do.

COURT OFFICER: Please be seated.

In a loud and clear voice, state your name for the record.

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

THE COURT: All right, Dr. Merola, during your testimony you are going to have to keep your voice up. And that's because we don't have any audio assistance here. It's a big courtroom and your voice will get lost unless you project. So keep your voice up.

Also, speak slowly enough so that the Reporter seated in front of you can accurately record your testimony. And if at any time you don't understand a question, please indicate that and we'll have it rephrased.

And, finally, please wait until the question is fully asked before you give your response so that both the question and the answer could be accurately recorded and comprehended by the jury. Okay?

THE WITNESS: Yes.

THE COURT: All right, counsel, you may inquire.

MR. MCCRORIE: Thank you, your Honor.

DR. ANDREW MEROLA, having been called as a witness

by and on behalf of the Plaintiff, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Dr. Merola, thank you. Good news is we premarked all of the evidence.

So, can you please tell the jury -- first, I called you doctor. Are you a medical doctor?

A. Yes, I am.

Q. Can you tell the jury for how long you've been licensed to practice medicine in the State of New York?

A. I've been licensed since 1992.

Q. As the first medical doctor, I may ask you to define medical terms. If I do, please do so. If there are any medical terms that come out of your mouth that you think the layperson would not know, if you could please define it -- if you're speaking in your own vernacular -- as succinctly as you can without leaving out any accolades or educational teaching positions out.

Could you please tell the jury your educational background, just leading up to your employment but don't go through your full --

A. I did my undergraduate studies at New York University. After I graduated from NYU and I went to Howard University where I did my medical studies for four years in Washington, D.C.

I then went to the State University of New York, Kings County Health Science Center, in Brooklyn where I did a one year internship in general surgery. I then did four years of orthopedic surgery, as a resident.

After I completed all of that training, I went to the University of Colorado, in Denver. I did another year in spinal reconstructive surgery, which is surgery on children and adults for their necks and their backs. After I completed that training, I came back to the State University where I took a teaching position as a Professor of Orthopedic Surgery, doing primarily spinal reconstructive surgery on both children and adults.

Q. First, can you define this for the jury; what does board certification mean in the medical field?

A. So, board certification is an academic process. It begins after you complete your training, that is after you finish all of your experience in orthopedic surgery. You take a written examination, it tests your knowledge of the subject of orthopedic surgery. So that comes after you finish your training program.

You're then in practice for two years, taking care of patients. You collect all of your x-rays and all of the patients that you've had an opportunity to operate upon and you then bring all of that information to a board of examiners. Literally, it's a table with other orthopedic surgeons who then ask you questions about your treatment of those patients and the surgeries that you've done. And they examine you and question you on your care.

When you've passed both parts of that examination, you're then board certified. I was originally board certified in 1998, which was two years after I was in private practice. I recertified again in 2008 and then I just recently recertified. That recertification process takes place every ten years, so that we maintain current knowledge and practice in our fields.

Q. And I asked for the definition but what is the area you are board certified in?

A. So I'm a board certified orthopedic surgeon, which is surgery and the treatment of problems with your musculoskeletal system. That's your bones and your joints and your nerves. I have a subspecialty, which means I specifically focus on the spine, that's the neck and the back.

So I'm an orthopedic surgeon, board certified in orthopedics with what's known as a subspecialty in spinal reconstruction surgery.

Q. Can you tell the jury what it means to have hospital privileges?

A. Hospital privileges are the opportunity that the hospital grants you, based upon your academic education and practice, to admit patients to the hospital and to treat them within the hospital.

So as a surgeon, I need to when I do my surgeries, do them in a hospital. And I need to have privileges from the hospital in order to be able to do that.

Q. And can you tell the jury where you are -- do you have hospital privileges?

A. Yes.

Q. Where do you currently have them?

A. Mount Sinai Hospital and New York Hospital.

Q. And can you tell the jury what is your current practice? What is the name of it or who do you work for?

A. So, I work for myself. My current practice is me. And I practice at both New York Hospital and Mount Sinai. I see patients and I treat them in private practice.

And then I also have an academic practice which is teaching residents and medical students, which I do through -- at SUNY Downstate Program, in Brooklyn. I don't operate through there but I teach residents, medical students and actually even run programs for college students and high school students interested in medicine and surgery.

Q. And does your practice have more than one office, other than the hospitals?

A. So I have two basic offices. I have one office in Manhattan and I have one office in Brooklyn.

Q. And when did you start your private practice?

A. So I started private practice after I finished my fellowship in reconstructive surgery, that was 1996.

Q. And can you tell the jury within your private practice, other than what's called private pay or private medical benefits,

do you accept work related accidents and the work related accident benefits rules, authorizations?

A. Yes.

MR. CERUSSI: Just note my objection to form, your Honor.

THE COURT: Can you read that question back, please?

(Whereupon, the referred to portion was read back by the Reporter.)

THE COURT: Overruled.

Q. Okay.

And is the practice limited to that or do you also accept motor vehicle accidents and things like that, other --

THE COURT: Can I just say the compound question thing is -- you know, I understand. You know, it's often times is the way questions are asked but the problem is if you're going to ask him a compound question and what's the answer. Is he answering the first part of the question? The second part of the question?

MR. MCCRORIE: Understood, your Honor.

THE COURT: So break it down.

MR. MCCRORIE: Yes.

THE COURT: Make it simple.

Q. Can you describe the types of patients you see in your practice, including what you saw back in 2012 through today?

A. So I basically see all types of patients. I see pediatrics or children, I see adults, I see patients who have issues regarding their necks and their backs that range from birth defects, infections, degenerative conditions. I see trauma, that is accidents and injuries.

So I see the full gamut or spectrum of patients with spinal problems.

Q. In your practice, are you on the plan of any -- outside the work accident system, are you on the plan of any unions?

A. Yes.

Q. Which unions?

A. Generally, I work with all of the major labor unions that are here in the City of New York.

Q. Okay.

Can you tell the jury practically how many spine surgeries you do on average per year?

A. So because my practice is essentially limited to spinal reconstructive surgery, I spend my time seeing patients both pre-operatively and post-operatively and then doing reconstructive procedures. So I do about a couple hundred procedures per year.

Q. And for instance, where were you this morning?

A. I was in --

THE COURT: Sustained. Sustained.

MR. CERUSSI: Objection.

THE COURT: Sustained.

MR. MCCRORIE: Okay.

Q. Are you being paid for your time away from your practice, your follow-up for surgeries and things like that?

A. Yes.

Q. At what rate are you being paid for that time?

A. $650.00 per hour for time away from the practice.

Q. Does that -- withdrawn.

Prior to you testifying here today, did we have a phone conversation and at least one meeting?

A. Yes.

Q. Is that the same rate -- for all of your preparation outside of even today -- to review the file and records, things like that?

A. Yes.

Q. Okay.

I'm going to have you do some definitions, if you can, because you are the first doctor. Could you please tell the jury, in medicine, what the words objective and subjective mean in terms of medical findings?

A. Objective is when you're dealing with or examining a patient, an objective finding is a finding on the physical examination of the patient that is independent of patient input. For example, if you test a reflex from a nerve the reflex depends on how the nerve works, it doesn't depend on the patient telling

you the nerve is or is not working. It's based on a test, so it's objective.

An image, like an x-ray or a scan is also objective because it's based on what's actually in the patient.

Subjective is what the patient tells you. For example, my leg hurts, my back hurts, my neck hurts, it hurts when I lift, it hurts when I bend. Those are things that are told to you and they are subjective. They're subjective to interpretation, they're subjective to the way the patient describes them to you.

So subjective is something you come to learn simply through discussions with the patient. Objective are those tests that are based upon what actually exists in the patient, irrespective of what the patient says.

Q. Can you please define the words diagnosis and prognosis?

A. A diagnosis is what we think the patient's problem actually is. Appendicitis is a diagnosis. It's an inflammation of your appendix.

Prognosis is what do, what we anticipate for the future. If you have appendicitis and the appendix is removed, the prognosis is good to excellent because you no longer have an appendix to cause a problem. If you have appendicitis and the appendix is not removed and it continues to become infected and cause a problem, the prognosis is poor because the appendix is still causing the problem.

Q. Just to -- in just a moment we're going to speak about your file and your treatment of Mr. Bazarnick. In your notes, when you write impression and plan, you know in your format, what does impression mean? And what does plan mean?

A. Impression refers to diagnosis. In other words, what am I thinking that is going on with the patient that is causing the problem. It's the same thing as a diagnosis.

And then the plan is, what suggestions or treatments can I offer to help with that particular problem.

Q. Can you please, in general terms, explain the differences between x-ray, CT or CAT scan and MRI to the jury?

A. So x-rays, CAT scans and MRIs are ways of imaging or taking pictures of a patient to tell you something about their anatomy or the way they're put together. An x-ray relies on radiation that is shined -- that you shine through the body that produces an image on a film. You can think of it as a very bright flashlight where the light shines through the body. The body casts a shadow on a film and then based on the shadows, you can tell certain things about what's happening on the inside of the body.

A CAT scan is a special kind of x-ray where many thousands of x-rays are taken in rapid succession from many different angles and then we assemble them through the use of a computer to produce a very specific image of the inside of the patient that's taken in slices going from the right side to the

left side of the body and from front to back. So it gives you a better idea of what the three dimensional picture of the internal portions of the body are.

Both x-ray and CAT scan are very helpful in terms of looking at hard structures like bones. To look at softer structures, like tendons or joints or nerves. An MRI is very helpful. An MRI uses a special magnet that magnetizes the water molecules in your body in order to produce an image to give you some idea of what the internal structure of your body looks like.

Q. Can you tell the jury, in medicine, what the word degeneration or degenerative process means?

A. So from birth through when you become mature, your body is in a process of generation. You're getting taller, your shoe size changes, your clothing size changes. You are maturing, you are growing. That is the generation process.

When you reach maturity, the generation process slows down and then wear and tear take over as a part of our normal lives. Wear and tear process is the degenerative process. So it's something that happens to humans and all animals over the course of time, after they have matured and the way the wear and tear process starts to outweigh the generation process. That's the process of degeneration.

MR. MCRORIE: With the Court's permission, we're just going to mark the doctor's file. That is Plaintiff's Exhibit No. 21. We'll give you the whole file

but just your portion of the records will go in.

THE COURT: Are we marking it in evidence?

MR. MCCRORIE: Yes, your Honor, just his portion subject to redaction.

THE COURT: Counsel, any objection?

MR. CERUSSI: No, your Honor.

THE COURT: Okay.

Then it will marked and received in evidence as Plaintiff's?

MR. MCCRORIE: Plaintiff's 21, your Honor.

THE COURT: Plaintiff's 21.

(Whereupon, the item referred to is marked Plaintiff's Exhibit No. 21 in evidence.)

COURT OFFICER: Plaintiff's 21 in evidence so marked.

MR. MCCRORIE: If you can please just show it to the witness.

(Whereupon, the referred to exhibit was handed to the witness.)

Q. Okay.

Dr. Merola, when we say subject to redaction, the only thing I would ask is if you are going to read from anything it be your notes and your notes only. Not the notes of any other doctor or any other diagnostic tests, okay?

A. Yes.

Q. Okay.

So can you please tell the jury, is George Bazarnick a patient of yours?

A. Yes.

Q. When did he become a patient of yours?

A. February 16th -- I'm sorry, February 29th of 2016.

Q. And did I ask you to set some time aside and review your treatment and your file of your treatment of Mr. Bazarnick, including other doctor's notes?

A. Yes.

Q. So in medicine, what is what's called a history?

A. A history is what happens when you first encounter a patient, so that when you begin speaking with the patient you get an idea for what their major symptoms or complaints to you is -- that's known as the chief complaint -- and then a little bit about what that complaint or symptom is doing to the patient.

So that's the history section of when we first encounter or deal with a patient.

Q. And what is a -- what does it mean to take a past medical history of a patient?

A. So when we are examining a patient, we are looking for what's known as pertinent issues regarding our treatment and plan for the patient. So when we look for a past medical history, if a patient comes in with a back problem, a pertinent past medical history would be if there were any other back issues or if there

were any surgeries or if there were any other treatments to the back or might there be any medical conditions that would influence the way we could treat the back, for example heart attack, significant lung disease. Those kinds of things.

Q. Okay.

Can you please go to the initial evaluation, your first note? We won't go through each and every note in detail but just orienting you and the jury can we go over this first note?

What, if anything, was the history or what was told to you? You can go through your notes --

A. Sure.

Q. -- on the first visit?

A. So the patient had come in to me in 2016 after he had been under the care of several other physicians. He was doing pain management. Pain management is a doctor that provides medications and injections for neck and back problems.

He was treating with an orthopedic surgeon who was caring for a problem with the patient's leg. And he was also seeing a rehabilitation doctor, who was coordinating rehabilitation. The issue was an injury that was sustained to the left leg and to the lower back as a consequence of a fall which had happened in December of 2012. He specifically came in to me because of significant pain in his back. And that pain was rated as an eight out of ten on a zero to ten scale. So it was severe enough to interfere with his normal activities. And it was

significant enough to the treating doctors to require a consultation with someone such as myself to evaluate the patient to see whether or not there was a condition that did or did not require further treatment.

Q. Can you tell the jury the names of the doctors that he was seeing?

A. Sure.

Q. With their specialties?

A. So he was seeing a Dr. Schwartz, that's a physical medicine and rehabilitation doctor. Dr. Kaplan, who's an orthopedic surgeon. And a Dr. Liu, L-I-U, who is a pain management physician.

Q. In your practice, and in treating work related injuries, do you know these doctors in your practice?

A. Yes.

Q. Have they referred matters to you in the past?

A. Yes.

Q. What does your practice do if someone has a neck injury but also has what's known as an orthopedic extremity injury to any other part of the body other than the spine?

A. Sure. I would refer that patient out to an orthopedic doctor who manages their arms and their legs.

Q. Okay.

And if you could just continue. What, if anything, did you -- on the first date of treatment, did you have the

benefit of the other notes?

A. Yes.

Q. And what did you write as the -- do you dictate? Do you do your own typing?

A. Well, I in particular -- so when I see the patient, I interview and examine the patient. And then after I'm done with the interview and the exam, I do an electronic dictation of what was just done with the patient. That's then transcribed and placed in my file.

Q. Okay.

What did you have as the accident date on the --

A. The accident date that was transcribed is December 3, 2012.

Q. And what do you believe the accident date to be?

A. December 4, 2012.

Q. Okay.

So just -- is there anything else? Could you go through the initial history and complaints that were relayed and then we'll move on?

A. Sure. So the initial history was severe pain in the back with what we call radiating symptoms, that is symptoms that go down in the foot, legs and the feet, low back symptoms and radiating symptoms were aggravated with activity.

So to then -- with the increase of activity, particularly things like bending, lifting and twisting increased

the symptoms. So it gives us a little bit of an idea about the mechanical nature of the symptoms.

I also did a past medical and surgery history. And he had had ankle and knee surgery on the left side. And he'd also had pain management with things called epidural steroids to the lower back. He was also on a number of medications. He was on a pain medication, Hydrocodone. He was on a nerve medicine called Gabapentin. And he was also on Dilantin for a seizure history.

Q. Okay.

Having nothing to do with this accident, a seizure history?

A. Correct.

Q. Okay.

And did you indicate whether or not you asked about a past medical history?

A. Yes.

Q. Okay, you did?

A. Yes.

Q. What was his occupation, as you knew it to be?

A. He was employed as what's known as an iron worker.

Q. And in your practice prior to December -- February 16th and even after, have you treated iron workers in various unions in New York?

A. Yes.

Q. And have you treated actually iron workers in the

ornamental iron workers, 580?

A. Yes.

Q. Have there been many?

A. Quite a few, yes.

Q. Are you fully familiar with the job duties of an iron worker? You don't have to state them but are you familiar?

A. Yes.

MR. CERUSSI: Objection.

THE COURT: Read back the question, please.

MR. MCCRORIE: If I can maybe withdraw it.

THE COURT: All right, question is withdrawn.

Q. Are you fully familiar with the physical requirements of an iron worker? What they physically have to do, not what their duties are. What they physically have to do.

MR. CERUSSI: Objection.

A. Yes.

THE COURT: All right, I'll let him answer the question.

Q. Okay.

Let's continue with any complaints that were relayed to you, the subjective part that you talked about.

A. So severe pain in the back as an eight out of ten on a zero to ten scale with radiating or traveling symptoms down into the legs and feet. And difficulties with mechanical activities that require bending, lifting and twisting. He was using a brace

for his back and he was also using a cane.

Q. Only because in your notes and they'll be in evidence, what is constitutional complaints and symptoms mean?

A. So constitutional means nausea, vomiting, headaches, how you feel in general. Your constitution, your body's constitution.

So constitutional complaints and symptoms would include things like headaches, nausea, vomiting, abdominal pain, constipation, things like that.

Q. What were the constitutional complaints that he was making to you on that day?

A. Difficulty with his ability to sleep, difficulty with sexual function, appetite loss. And then the mechanical symptoms that I indicated particularly bending, lifting and twisting.

Q. On that date, did you take a history of his weight and his --

A. Yes.

Q. What was the physical examination? Why don't you just go through that.

A. Sure. So the physical examination basically starts with an observation of the way a patient is walking. So by observing a patient's pattern of the way they walk, you can get an idea for how they're musculoskeletal system is working. And in this case, there were two things that were visualized to me.

One, is what is known as an antalgic gait pattern,

that means a limp. So when you limp, you spend more time on one leg than another because one leg has a problem so your body just automatically doesn't want to spend time on that limb. So that's called an antalgic gait pattern.

The other pattern of gait that he had was a -- it's a pitched forward gait. So in general when you're walking, your spine wants to balance your head over your pelvis in an upright posture. If you are pitched forward or backwards, that's an abnormal posture. And in this case, it was pitched forward, which is known as a kyphotic gait. So there was an abnormal bait pattern.

Q. What does lordosis mean?

A. Lordosis is the normal amount of curvature that your low back should have, either when you're sitting upright or when you're standing upright. So if you put your hand in the small portion of your lower back, you can feel there's a curve there. It's not flat but it's curved backwards just slightly. That backwards curvature of the lower back is known as lordosis.

Q. Okay.

Please continue with your physical examination.

A. Sure. So testing the body begins with feeling the body parts. And in this case because the lower back was primarily involved. Examining the lower back, I was able to palpate spasm in the muscles of the lower back.

Spasm is an abnormal contraction of muscles that

occurs because your body does not want to go into a particular position. And in this case, spasm was palpable when I extended the lower back.

Q. Is that objective or subjective?

A. Spasm being an involuntarily contraction of muscle would be an objective finding.

Q. What, if anything, does that indicate to you as an orthopedic surgeon?

A. So medically it tells us that it is a physical deficit that exists within the patient's body that is causing the patient to have a problem. So it's objectively there, it's evidence of a mechanical, anatomical actual problem.

Q. Okay, please continue.

A. And it was noted on a special test called a Phalen's Test. Part of the exam involves testing the body to see whether or not it can normally accommodate certain positions. And a Phalen's Test in the lower back is a test where we extend the lower back, that is we push it backwards because we want to see if the low back is, number one, behaving normally. And number two, if the lower back is putting any pressure underneath the nerves that is in the lower back.

The nerves that are in the lower back have a tendency to get squeezed if you extend the spine, if there are other problems with the low back such as a disc problem. Because of the symptoms, a disk problem was suspected in the history. So the

exam is testing for disk problems. And in this case, extending the lower back to seven degrees, which we can measure with a special instrument called a goniometer, the low back went into spasm which meant that that didn't want -- the lower back did not want to go into that seven degrees of extension because there was nerve impingement in that low back area.

So it's further physical evidence of what we call a radiculopathy or a problem with the nerves.

Q. What does that mean, radiculopathy or radicular?

A. So radic means roots. The nerves exit the spine in small roots. So radic means root. Anytime you hear the word opathy, it means problem with. So if you have a radiculopathy, you have a problem with the nerve roots.

And in this case, that's what that test showed.

Q. Okay.

Is there anything else before we move on about --

A. Sure.

Q. -- physical examination?

A. On the physician section, we are also looking for -- because we now know that there is somewhat of a problem with the nerves in the lower back, we want to test the way the nerves are working. Nerves are responsible for sensation, that is they feel things. They're responsible for reflexes and they're responsible for the way your muscles work.

So we can test those things on the body. And in this

case, when testing the L4, the L5 and the S1 nerve roots, there was an absence of what we call pin prick sensation. So the inability to sense the prick of a pin in those nerve roots.

And there was also an absence of tactile sensation, which is dull sensation. So both sharp and dull sensation were lost in those nerve roots and that's the roots of L4, L5 and S1.

The patient also had what's known as a femoral stretch test. That's a test where the femoral nerve, which is the nerve that goes into the front of your leg, is pulled on. And if you pull on the nerve and it is sensitive from irritation or pressure, the body's response to that is to automatically pull away from you. It's almost like a spasm. It's called an involuntary withdrawal response. And Mr. Bazarnick had positive femoral stretch test, telling me that the femoral nerve was irritated.

And he also had a straight leg raise, which is the pulling on the sciatica nerve which goes down the other side of the leg because that nerve root was irritated. And so those tests and the neurological deficits correlate, that means they add together with a problem in the L4 to S1 nerve roots.

Q. What does -- what does clinical correlation mean of a patient?

A. Correlation is the -- it's the medical mathematics that we do to try to figure out what the problem is. So when you examine the patient, if you have certain findings on your

examination that then add up with findings on an imaging study like an MRI and you add or correlate those findings together to come up with a diagnosis.

So a picture can only tell you part of what's happening to the patient. You have to test the patient to see if what you see on the picture is actually causing or not causing a problem.

Q. Before I move on, anything else pertinent from the physical examination to your treatment?

A. Yeah, there was what I appreciated as atrophy of the right proximal leg. So what that means is -- atrophy is a shrinkage of a muscle group. So if you look at the legs or you feel the legs or you measure them, your muscles should be relatively symmetric in your right and left legs because you're using both of your legs to walk.

If the nerves that are going into your legs are working normally, you should have symmetry to your legs. And you can feel it by palpating your calves or your thigh muscles. If a nerve isn't working properly or a muscle group is not working properly, the muscle has a tendency to shrink a little bit. That's atrophy. Proximal leg means thigh.

And so the right thigh was by what I said was qualitative appreciation, that is gripping both legs with your hands so you could measure side to side, the right thigh was skinnier than the left thigh, which is an abnormal muscular

finding. And that goes together with the nerve findings of the losses of sensation in those nerve groups.

Q. Okay. You've already defined MRI, were the MRI -- withdrawn.

What if any knowledge of any MRI testing prior to Mr. Bazarnick coming to you did you have as noted?

A. So I looked at an MRI film that he had had taken in 2014 that was brought in. So I had an opportunity to look at a film and then correlate or add it together with the physical findings on the exam.

Q. Just for the record, all of the films in this case are entered in, the CDs. Did you select from a later MRI film, views to display for the jury that would aid them in understanding your treatment of Mr. Bazarnick?

A. Yes.

Q. Okay. So we'll get to those in a little bit.

When was the -- what was the year of the MRI that you reviewed?

A. So the initial MRI that I saw was 2014.

THE COURT: 2015?

THE WITNESS: 2014, I'm sorry.

THE COURT: 2014, okay.

MR. MCCRORIE: 7-28-14, your Honor.

Q. So what was your impression? We're not going to do each note but after the examination and the history and the review of

the MRI, what was your impression?

A. So my impression was what is known as a lumbosacral radiculopathy, a problem with the nerves in the lower part of the body, specifically the L4 to S1 nerves. Those are known as the lumbosacral nerves. Radiculopathy meaning a problem with those nerves.

Q. In medicine, is there a scale called mild, moderate, marked or whatever?

A. Yes.

Q. How did you label the radiculopathy?

A. I said that it was severe, which meant that it had neurological deficits and positive provocative symptoms with an MRI that correlated. So it was severe and it was severe enough to interfere with his activities of daily living. And it was severe enough to cause his treating doctors to send him over to me for an evaluation.

Q. What do the words axial range of motion deficits mean, axial?

A. Axial means the spine itself. And range of motion deficits mean that the range of motion was abnormal. And we know specifically that the major abnormality was extension where the spinal Phalen's Test was positive at seven degrees.

Q. What was your plan? What did you do that day?

A. So I saw him in February of 2016, he had neurological problems on the exam, he had neurological complaints by his

history. He had a history of trauma. And the MRI I saw was 2014. So what I wanted to do was update the MRI to get a better look at what the lower back looked like now in 2016, rather than only relying on the '14 exam.

Q. What is the purpose, if any, of an orthopedic physician doing serial diagnostic testing either of x-ray or MRI, doing them over a specific time period?

A. The major reason for doing that is in patients who have a progressive problem. So in a patient that has pain that's been getting worse, that has not gotten better with therapy and epidural steroid injections, who has neurological deficits or deficiencies, the purpose of getting another MRI test is to look at the disks themselves and the bones and the nerves to get an image for what's causing the problem to get worst.

Q. Before we go forward, I didn't ask you this on the background but have you testified in court before?

A. Yes.

Q. In your practice -- withdrawn.

Who do you come on behalf of?

A. My patients.

Q. And have you testified on behalf of work accident patients that have had actual third-party lawsuits in the past?

A. Yes.

Q. And have you come on behalf of patients that have had motor vehicle accidents?

A. Yes.
Q. Okay.
Have you testified in court before on behalf of a patient who was a construction worker, who was a client of Sacks & Sacks with a lawsuit?
MR. CERUSSI: Objection to form, your Honor.
THE COURT: Do you understand the question?
THE WITNESS: Yes.
THE COURT: All right, you can answer it.
Overruled.
A. Yes.
Q. And has that been -- have you testified for other iron workers that were clients of Sacks & Sacks?
A. Yes.
Q. As well as other trades?
A. Correct, yes.
Q. Did Mr. Bazarnick -- withdrawn.
What does it mean in medicine to say someone's a compliant patient or a non-compliant patient?
A. Compliant basically means that the patient is working with you to try to help them help themselves and follows through on your suggestions and treatment plans.
Non-compliant means that those are the patients that do not follow through on treatment plans that you might have laid out for them.

Q. Did Mr. Bazarnick get the MRI that you prescribed or requested?

A. Yes.

Q. Did he get it the very same day?

A. I believe so, yes.

Q. Okay.

That MRI test, can you just -- is that like an x-ray? Does it take a second, a minute, something else?

A. It takes -- so an x-ray is very rapid. A CT scan, almost as quick as an x-ray. An MRI can take half an hour, 40 minutes or so, sometimes 45 minutes because the process of being magnetized and generating those images takes a bit longer than x-ray. So MRIs can take a while.

Q. Does your office take MRIs?

A. I do not, no. I send patients out to get those done.

Q. Okay.

So did there come a time where you communicated to Mr. Bazarnick what the results of his MRI were?

A. Yes.

Q. When you have an MRI ordered, are you sent the -- we call them films but are you sent the CDs by the facilities?

A. So in the old days we used to get sent actual films. They actually mail you the films and then your office would have piles of films all over the place. And then they started mailing us the CDs. And now we can actually get secure access online

directly into the hard drives of the MRI facilities.

So we have in our means right now, CDs which are easier to store than films. And we also have direct access into the actual hard drive of the facility.

Q. Do you have direct access to Stand Up MRI in Bronx and Brooklyn?

A. Yes, correct.

Q. Okay.

Did you review the film yourself? You'll do it in detail later but did you review the film -- the CD, the study yourself before communicating to Mr. Bazarnick?

A. Yes.

Q. And when did you communicate to him? How did you do it?

A. Sure. So I actually had another follow-up with Mr. Bazarnick right after the MRI was done in the following month.

Q. Okay.

And do you have the March 6, 2016, note?

A. Yes, that was the telephone conversation to let him know to come in to do the visit, which was then done on March 14th.

Q. Okay.

So you don't have to go through the history again or even the physical examination. Tell the jury what was found on the MRI.

A. So the MRI film showed that there were what we would consider -- and when I say the word significant, I mean herniations that were compressing or leaning on or pressing on nerves in two areas of the lower back. One at L4-L5, which is between the fourth and fifth bones of the lower back. And another at L5 and S1, which means the first bone -- first bone of the pelvis or sacrum and the last bone of the lower back.

Q. Just for the record, you're speaking about the 2016 MRI now?

A. Correct.

Q. You said you reviewed the 2014 MRI?

A. Yes.

Q. Were they the same findings?

A. '16 MRI actually showed that the disk protrusions or herniations were somewhat worst than the previous MRI in '14.

Q. Were they in the same level or spot?

A. They were in the same anatomical locations, yes.

Q. Okay.

Let's do this before we go further. Can you -- without doing the full anatomy just now, can you just tell the jury in general the word bulge, herniation as they relate to the intervertebral disk?

A. Sure. So your spine is made up of -- it's a stack of bones that are stacked up on each other like a stack of pancakes. But in between the bones are cartilage disks. They're called

disks because they're round they kinda look like a disk and they're made out of a similar type of cartilage that's in the tip of your nose or in your ear. On the outside they have these fibers that are interwoven and those fibers prevent bones from being twisted too much.

Q. Excuse me, Doctor. Just to save repeating it, with the Court's permission -- we've talked about using the ledge behind you but with the Court's permission I'm going to give you -- you can stay right where you are so the Court Reporter can hear you.

I'm going to give you plaintiff's -- this is both for ID, it's a model. You can put it down in front of you. And now, I'm going to put up Plaintiff's 13 for identification and that up. I'll step back there but when I ask you just -- you can just state on the record what you're referring to.

Can you give the jury an anatomy lesson of the spine and then as it relates to the herniated -- as it related to intervertebral disks?

(Whereupon, the referred to exhibits were displayed for the witness and the jury.)

THE COURT: What is the identification number on the actual model spine?

MR. MCRORIE: Right there on the head of the skull.

THE WITNESS: It's 15, your Honor.

THE COURT: So Plaintiff's 15. And 13, being displayed to the witness and the jury.

Any objection, counsel?

MR. CERUSSI: No objection.

THE COURT: Okay, continue.

Q. Continue, Dr. Merola.

A. So the spinal column is a column of bones that are stacked up on each other. And in between all the bones are the cartilage disks. And the disks are essentially holding the bones together, so they act as a glue that holds the bones together. They act as cushions to prevent the bones from coming in too close contact with each other.

And the disks also prevents the spinal column from either rotating too much or bending and twisting too much. The disk that's made up of cartilage is made out of two parts. And on the diagram, there's an outer pink circular area. That's called the annulus or the outer ring. And the outer ring has fibers that are interwoven, that are made to hold the inside core, which is gray on the diagram, inside the disk.

Now, that inner core is jelly like, so the jelly like substance acts as a shock absorber and the outer fibers act as a restraint to twisting and bending too much. So the disk as multiple different functions in the spine.

Right behind the disk is the spinal canal area. And on the model, the spinal canal area is the area where the spinal cord and nerves travel down the spinal column and then eventually exit in these small what appear to be wires, yellow wires. These

yellow wires that exit the spinal column are the nerve roots, hence the term radic or radicular. And then those roots travel down into the legs and feet.

So the spinal column is not only here to make sure that you can walk upright and it's not only there to maintain balance of your head over your legs and your pelvis but it's also there to protect the nerves that control your arms and your legs and your hands and your pelvis and everything else.

Q. Can you -- using the illustration first, on MRIs there are two different types of views. Can you tell the jury in medicine what those views would be on an MRI or looking at that anatomy diagram, Plaintiff's 13?

A. So on the diagram, you look all the way on the left side of the diagram it's a side-view with the head at the top and the spine under it. And you're looking at the spine from the side and the bones appear to be squares and the spinal cord nerves are to the right of the square bones.

On the far right of the diagram is a top/down view, as though you were looking down the spinal column. If the spinal column was a big elevator shaft and you were looking down the shaft at the column of nerves, you'd see the disk in the front and the nerves on the bottom.

So those are the two basic MRI views, side-view and also this top down view. And they give you a little bit of a different perspective on what the nerves look like in the

different areas and what the disks look like in the different areas.

Q. Which view is what's called a sagittal view, in which the view is what is called an axial view?

A. Sagittal is the side view. It's easy to remember because S and S is the same. So sagittal side, the axial view is the top/down view.

Q. And with x-rays, if someone -- if a physician says AP or anterior posterior, what view is the middle view right there?

A. So the middle view on this diagram as you're looking at the spine from the back to the front and that's the way an x-ray would be described as what is known as an AP view, an anterior posterior front, back, view.

Q. Either on the model and/or the diagram, do they show the correct lordosis or curvature of the spine?

A. The diagram and the model show the normal lordosis, yes.

Q. The yellow on the diagram, what is that behind the disks? I think you told them.

A. The yellow stripe that you see behind the disks is the area where the nerves are as they travel through the spinal canal.

Q. Okay.

I meant the middle, what is that?

A. The middle -- the upper middle and top of the spine are

the spinal cord area.

Q. Okay.

And what does it connect to?

A. It connects directly to the brain.

Q. Can you tell the jury and using the difference between here and so -- what happens to the spinal cord at, approximately, L1?

A. So the spinal cord is an extension of your brain and it travels as far as about L1. And then at the end of L,1 the spinal cord itself stops and then you're only left with the nerves themselves that travel down into your legs and feet.

Q. And what is that called?

A. And that, that grouping of nerves is called the cauda, which is the Latin term for tail and equina, which means horse so the horse's tail. Because if you look at those nerves inside the spinal canal, it looks like a horse's tail.

Q. Okay.

And then again, the difference between the lumbar and the cervical and -- let me ask you this, is the cervical a solid spinal cord, the spinal cord that would be up there?

A. Yes, the cervical contains a solid spinal cord.

Q. And what happens -- you just said it -- at, approximately, L1 going down?

A. The spinal cord has stopped at about L1 and only contains the grouping of nerves that go into the nerves and feet

known as the cauda equina.

Q. Okay.

So limiting I guess to the -- unless it's relevant to something else -- limiting it to the anatomy, could you please go through the anatomy of the lower spine, the lumbar spine and what the designations of vertebras are and what -- how we get -- how you get disk designations, you know, with several numbers or letters.

A. So there are five bones in the lower part of the back. And because there are five bones, they're numbered one through five. They're called lumbar or lower back bones, so they're all designated with Ls for the term lumbar. And so there's L1, 2, 3, 4, and 5. (Indicating.)

They attach to this triangular bony structure called the sacrum. So when you see an S, it refers to the sacrum. When you see an L, it refers to lumbar.

In between each of the bones, sandwiched in between each of the bones is the intervertebral disk. And the disks are named based on the bones. So the disks in between L4 and L5 is called the L4-5 disk because it's in between those two bones. The disk between L5 and S1 is called the L5-S1 disk because it's in between those bones.

Each nerve that exits the spinal column also has a designation and the designation of the nerve is based on the bone that it is passing behind. So in between the fourth and fifth

bones is the exit of the fourth nerve. Between 5 and 1 is the fifth nerve and underneath one is the first nerve. So the nerve designations have the letter in front of them as well, L4, L5 or S1 based on the bone that it is passing behind.

Q. What is the neuroforamen?

A. When we say the word foramen, we mean opening. In order for the nerve to exit the spine, it has to go through a passageway or an opening and the opening is known as the neuroforamen.

Q. So utilizing either the model or the illustration, can you please describe a herniated disk, a bulging disk or whatever other determination that may be, protruding disk; what the delineation is?

A. Now, because the disk is made up of the jelly like substance on the inside and the fibers on the outside, if there is a defect in the disk, if there is a problem with the disk, the jelly itself can leak out of the disk. If the disk is symmetrically protruding into the canal area -- and by symmetrical, picture a balloon. If you press down on a balloon, what happens to the balloon? The balloons gets squished but it gets squished equally all around. That's a bulge. Bulges are symmetrical. In other words, they are equal all the way around the disk. So a bulge means that the disk is protruding equally in all directions.

Hernia or herniation is asymmetrical. So now picture

if you're pressing down on a balloon but you're pushing more on one side than the other side, part of that balloon is going to stick out more than the others. That's like a herniation. A herniation is an asymmetrical or a more specific protrusion or sticking out of that inner like jelly like material outside of the borders of the bones.

When you look at the model, you can see that the disks are all contained within the borders of the bones. They're not leaking out of the borders. If you had an ice cream cone and the cone was melting and the ice cream was melting all over the cone, that would be stuff leaking outside the confines of the cone but that's not the way the spinal column looks.

In a normal sense, all those disks need to be well contained and neatly packaged in between the bones. If they're not, they're either bulging, which means they're symmetrically sticking out or they're herniated, which means they're asymmetrically sticking out.

Q. What do the words symptomatic and asymptomatic mean?

A. A symptom is a problem or a complaint. If a patient says I have pain going down my leg, that's a symptom. If a disk is causing a problem, it is symptomatic. If it's leaning or pressing on a nerve, it will cause pain.

Asymptomatic means without symptoms, not causing a problem.

Q. Can a herniation be asymptomatic?

A. Yes.

Q. Can a herniation be degenerative? You told the jury what that was before.

A. Yes.

Q. Can a herniation be caused by trauma?

A. Yes.

Q. What does the word desiccation mean in relation to degeneration?

A. Desiccation is a term that means dried out. When we image the body through an MRI -- because the MRI is looking at the water content, in other words we're mostly made up of water and different parts of your body have different amounts of water inside of them. Bones, not a lot of water. Disks, a little bit more. Nerves can have a lot of water within them.

So, when we look at the MRI, we're looking at the amount of water inside the various tissues that we're looking at. When an MRI is interpreted and a patient -- and a radiologist or a surgeon or a doctor looks at the MRI, looks at the MRI and says oh, that is desiccated, it means that on the MRI it appears to be lacking the normal amount of water. A lack of water or the drying out of your body parts, is part of the aging process.

The most obvious sign of that is wrinkles in your skin. Your skin has a lot of collagen underneath the top layers. And that collagen, when you're young is very hydrated and very full of water and you don't notice a lot of wrinkles. But as you

get older you lose water, it desiccates and then you start to notice more wrinkles.

So desiccation is part of the normal aging process that happens in all body tissues. And it specifically refers to the amount of water within the tissue that you're talking about, skin, bone, cartilage, disk, whatever it may be.

THE COURT: All right, we are going to take a five-minute recess so that the jurors can attend to their own desiccation.

We'll return in five minutes. Do not discuss the case among yourselves or with anyone else. Follow the directions of the court officer and we'll see you back in in about five minutes.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: All right, five minutes.

(Whereupon, a brief recess was taken.)

COURT OFFICER: Come to order.

THE COURT: Okay, back on the record.

Before we resume testimony of the witness, I've been advised that alternate number three has experienced a death in the family. I believe it's a cousin.

In any event, it's going to be necessary for her to travel out of state over the weekend. It won't affect

today's proceedings but it would affect Monday's proceedings because she couldn't be back before Monday. So I've spoken informally to counsel on both sides. It would be -- obviously, it's not a situation where she can't -- doesn't know when she can come back. And technically speaking, if a juror is going to miss a day but can promise to be back in a day and wants to serve and both sides are of the mind to keep that juror, then I would have to obviously not have court session on Monday to accommodate that juror.

However, I would prefer to keep going with the case, which would mean that we'd have to excuse the juror at the end of today. So I'll hear both of you on this issue. I'm not pressuring either side to make that particular decision one way or another but if both of you consent to the excusal of the juror then I would go ahead and do that.

MR. MCCRORIE: Plaintiff consents, your Honor.

MR. CERUSSI: Defendants consent, your Honor.

THE COURT: All right.

Then what I'll do is at the end of the day, after we have finished and we break, I'll have that juror remain behind for a few minutes while we deal with her situation and excuse the juror for the balance of the trial, okay?

MR. MCCRORIE: Yes.

MR. CERUSSI: Yes.

THE COURT: All right, the witness can resume the

stand. And if you would be so kind to bring us the jury.

(Whereupon, the witness resumes the witness stand.)

(Whereupon, a brief pause was held in the proceedings.)

COURT OFFICER: Ready, Judge?

THE COURT: Yes.

COURT OFFICER: All rise, jury entering.

(Whereupon, the sworn jury panel is escorted into the courtroom and take their respective seats.)

THE COURT: All right, please be seated.

COURT OFFICER: Doctor, you're reminded that you're still under oath.

THE COURT: Counsel, you may inquire.

MR. MCCRORIE: Thank you, your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Can trauma cause a desiccated disk to herniate?

A. Yes.

Q. Okay.

And can trauma cause an asymptomatic disk, whether it's herniated or not -- meaning no symptoms -- to move onto a nerve and cause symptoms?

A. Yes.

Q. Is that -- are the symptoms always immediate after the

accident?

A. No.

Q. What does delayed onset with regard to spine injuries or any pain -- in medicine, what is delayed onset?

A. It means it takes some time for your body to manifest the signs and symptoms of a problem.

Q. I'd like you to assume that there was testimony in the court by Mr. Bazarnick that initially his body was sore but that his main complaint was his left ankle. And within days, his left knee.

I'd like you to assume that he had soreness and that it's in early February, the soreness went -- subject to connection of Dr. Kaplan coming in -- but that he was complaining of numbness and pain into the left buttock radiating down his left leg and had weakness that developed.

What does that mean, pain radiating to the left leg with weakness through the buttock? What does that indicate, if anything, to you as a board certified spinal surgeon?

MR. CERUSSI: Objection to form, your Honor.

THE COURT: Do you understand the question?

THE WITNESS: Yes.

THE COURT: All right, I'll allow him to answer. Overruled.

Q. Go ahead, Doctor.

A. It's an indication of what we would consider a

radiculopathy in the lumbosacral roots.

Q. I'm going to just put up Plaintiff's 14 for ID.

(Whereupon, the referred to exhibit was displayed for the jury.)

Q. You said that these yellow nerve roots would extend. Just in terms of lumbar radiculopathy and lumbar nerve roots, can you use Plaintiff's 14 to talk about radiculopathy and dermatomal patterns?

THE COURT: Plaintiff's 14 is being showed to the witness and the jury.

Any objection?

MR. CERUSSI: No, your Honor.

THE COURT: All right, go ahead.

Q. It's here for illustration, so please describe in the lower spine where the nerve roots go to.

A. So on the illustration, at the top of the illustration you see the column of the spine and the bones. And each segment of the bones from L1 all the way down to that triangular sacrum you can see the yellow exiting nerve roots.

But then you'll notice that when those nerve roots descend or go down into the leg, they join up with the other roots. And when they join together, they form nerves that are then in the leg itself and those nerves go into specific portions of the leg. The areas of the leg that they go into that is responsible for sensation or how you feel something is called a

dermatome.

And on the right side of the illustration, you will see there's a blue area and a red area, those are what are known as the dermatomes on the front part of the leg and those are the L4 and the L5 and the S1 areas for sensation.

You'll see that on the right side of the diagram, when the nerves come together they go into specific muscles and the major nerve going into the front part of the thigh is the femoral nerve and that's made up mostly of the L3 and the L4 root, mostly L4. And it goes into the right thigh.

So when the nerves themselves exit the spine, they then coalesce or join up with the other nerves. And then they form specific long nerves that go into the muscles of the leg and the skin of the leg, as well.

Q. You had indicated to the jury the difference between the 2014 MRI and the 2016, in that you said that it had gotten more significant or larger?

A. Yes.

Q. Can you tell the jury by what process does either an asymptomatic disk or a herniated disk that came from trauma, by what process does it move within the body? What would cause it to move or -- from its original position?

A. So when you're weight bearing, that is when you're up and you're walking, the spinal column is supporting your head over your pelvis. The bottom part of the spinal column is

supporting the majority of your body over the pelvis. And compression or the force of gravity on your bones is controlled by that jelly like substance inside the center of the disk.

The jelly like substance is held in the center of the disk by the crisscrossing fibers of the outer ring or the annulus. When the fibers are torn, one of two things can happen. The tear can heal or the tear gets progressively larger. As the tear -- and if the tear gets larger, it allows that jelly like material to make its way out of the ring and then into the spinal canal because it takes time, it's squeezed out of the disk. As you're up and you're walking, little portions of jelly come out slowly over the course of time and eventually when those pieces of jelly like inner material press on a nerve and cause irritation, inflammation and pressure, the nerve starts to feel it as pain.

So, typically, disk herniations that progressively get worst over time start off as soreness or pain in the neck and back and then progress into traveling down into the legs and feet as the nerves become involved.

MR. MCCRORIE: Okay.

If I could just alert the Court that I made a mistake with the Court Reporter. These were marked 7A, B and C and they should be marked 9A, B and C. I marked the wrong study. Could I put them up and deem them 9A, Band C rather than 7A, B and C and we'll correct it at a break?

THE COURT: We'll deem them to be 9 what?

MR. MCCRORIE: A, B and C.

THE COURT: Okay, 9A, B and C. And we'll correct whatever the marking is on it.

At this time, any objection?

MR. CERUSSI: Can I just see them?

MR. MCCRORIE: Yeah.

(Whereupon, the referred to document was handed to counsel.)

MR. CERUSSI: No objection.

THE COURT: Okay.

Q. Okay.

I'm going to hand you a red sharpie marker. If you are going to mark any of the items, just call them 9A, B or C. You can tell the record what you'll be marking. What I'm going to do, Doctor, I'll leave them here so I won't have to walk up again. I'm going to put up 9A and if you could just tell the jury what they're looking at on 9A, how do you know when it was taken and who it was taken up?

A. So this is a side view MRI of patient George Bazarnick. His name is in the upper right-hand corner. It was done at Stand Up MRI and it was done on February 29th of 2016.

Q. Is this the MRI that you ordered on February 29, 2016 that you told him -- you had him in after calling him?

A. Yes.

Q. Okay.

Continue with anything else that is relevant on this for identifying.

A. So it tells us the type of image that we're looking at, which is a sagittal image. And it tells us that it's specifically what is known as a T2 image. That's in the upper left-hand side of the image. That means that we're looking specifically at water content in the bones, nerves, spinal canal and disks.

Q. Can you tell the jury what a T1 image is? So this is a T2, what is a T1?

A. T1 images look more closely at fat. And T2 looks more closely at water.

Q. Okay.

And when we put up a T2 image, you could just for the next two images identify whether they're T1 or T2. So you told -- could you, with the Court's permission, can you step up and could you label the vertebral bodies -- which one is L1, which one is L2 -- with the red marker?

A. Sure.

THE COURT: Why don't you point to it first and then we'll figure out how to mark it, okay.

THE WITNESS: Sure.

(Whereupon, the witness approached the referred to exhibit.)

A. So the last square is L5 and then counting up from the last square we have 4, 3, 2 and 1.

Q. So with the Court's permission, I would ask that you would label L1 through S1 on the vertebral body.

THE COURT: Counsel?

MR. CERUSSI: No objection.

THE COURT: Okay, you may do so.

A. (Witness is complying.)

THE COURT: If it helps you to take it down and lay it flat, you can do that.

Q. So very briefly, you told the jury -- you've given them the anatomy. Where is the vertebral body on this image? Where are the disks and where is the spinal cord and the cauda equina?

A. So the vertebral bodies are the squares. In between each of the squares are the disks. To the right of the vertebral bodies and the disks at the top of this image, there's a triangular solid gray line and that triangular solid gray line is the end of the spinal cord.

Below it you see that there are many wispy lines descending all the way down the column of the spinal canal. You can see actually separate nerves. Separate nerves are the gray wispiness. And that gray wispiness, if you use your imagination looks a bit like a horse's tail. So those are the nerves that are going down into the legs and the feet or the cauda equina nerves.

Q. Okay.

And can you please show the jury here where those -- you know, tell them what the findings are in your words and what if anything is medically significant?

A. So if you look in between the L4 and the L5 bones at the L4-L5 disk, you can see that there is disk material that has made its way -- and I'm highlighting the area of the disk that has made its way into the spinal canal.

MR. MCCRORIE: Just for the record, with a red half circle.

Q. Continue.

A. And you can see that it is -- and I will point to one of the nerves, you can see that there is a gray line that is being displaced by that disk material. And that gray line is that fourth nerve as it makes its way behind the L4 and the L5 roots.

Q. Can you just tell the jury, using that one compared to another disk, what -- withdrawn.

What does it mean if a disk or disk material extends beyond a vertebral body?

A. So when the disk material extends beyond the vertebral body, it means that it's inside the canal. And when it comes into the canal, you need to see whether or not it's pressing on any of the nerves that are in the canal.

Q. What do you call that?

A. So this is known as a herniation. This is an asymmetrical protrusion of disk material in the canal at L4-L5.

Q. Okay.

And what if any other -- is that normal or abnormal?

A. That's abnormal.

Q. In medicine, when doctors say a finding is positive and a finding is negative, can you define that?

A. Positive generally refers to something that is causing a problem in the patient. Negative is a finding that in general is not causing a problem in a patient. So this is a positive finding for a herniation at L4-5 causing a problem with the L4 and the L5 nerve roots that are behind it.

Q. Can you tell the jury what the word listhesis or listhesis -- listhesis, what does that mean? And what is a retrolisthesis system?

A. Listhesis means a slippage of. So if you look at the way the bones are lined up between L1 and L5, they're all very neatly lined up on each other. If you look between L5 and S1, you'll notice that a portion of L5 is actually behind a portion of S1. That's a condition known as a listhesis.

Q. Are there any other abnormal findings related to the disks that you discussed with Mr. Bazarnick in that -- on that March 14, 2016 visit, examination?

A. You can also see that behind L5 and S1, there is -- and I'm also going to highlight it with a semicircle -- disk material

in the canal area, in the area of the nerves between L5 and S1.

Q. And what, if anything, is going on in the disk above the L4-5?

A. The L3-4 disk has a small bulge within it but it's not causing any symptoms to the nerves up at the L3-L4 area. The nerves between L2 and L3 are also free and clear. And further up the spine, you can see that there's no significant nerve compression. It doesn't happen until you get to L4-5 where you see that the nerves are being displaced by the actual disk itself.

Q. You had said that Mr. Bazarnick had had a series of epidural injections.

MR. MCCRORIE: And for the record, the records of Eugene Liu are in as Plaintiff's 20.

Q. But if you could just, please, use Plaintiff's 16, it's for identification only. If you could use this illustration to describe what an epidural is but more importantly what is an epidural intended to do to the conditions that you just showed us there?

(Whereupon, the referred to exhibit was displayed for the jury.)

A. So this is a diagram of the lumbar epidural steroid injections. Epidural means that the injection of medicine through a syringe. A needle is placed into this space around the nerves, that's called the epidural space.

When a nerve is being impinged upon by a disk, the nerve becomes inflamed. Inflammation is a process of irritation in part of your body. The most obvious example of that is if you were to have a scratch or a cut in your skin, you notice that it may be red and maybe a little weepy. That redness is inflammation.

A similar process happens to the nerves because there are chemical within the disk itself that leak down onto the nerve and cause irritation to the nerve. By injecting a steroid medicine into the area where the nerves are, the steroid can block the inflammation. It is as though you were to put ice on the area that was cut. And in so doing, if you can block the inflammation, you can give your body a chance to heal without having the pain.

So in cases where the injuries are amendable to having the body actually heal, an injection can cause a decrease in inflammation, a decrease in pain and hopefully stimulate some of the healing process to occur.

Q. Did there come a time after or at the March 14, 2016 examination that you requested authorization to do any type of surgical procedure?

A. Yes.

Q. Okay.

Can you tell the jury what was the type of -- what was the name of the surgical procedure you requested to do and why?

A. The name of the procedure is a lumbar laminectomy, which means a removal of the bones that are covering the spinal canal, removal so that you can take pressure off the nerves.

When removing the bones themselves in cases where you need to totally free up the nerves, you create a condition that's known as instability, which means the bones would become floppy. And in order to stabilize them, you need to do something they call a fusion which is a welding together or a locking together of the bones.

So the entire process is known as a laminectomy and a spinal fusion.

Q. What does ectomy mean in medicine?

A. Ectomy means the removal of. So any time you see the word ectomy, it's removal of. Appendectomy, removal of the appendix. Laminectomy, removal of the lamin.

Q. Did there come a time -- did you see George again -- withdrawn.

Did there come a time that you did perform a surgery? You got authorization?

A. Yes.

Q. Did you see George again before the surgery?

A. Yes.

Q. We don't have to go over it but when did you see him to inform him that you'd be granted authorization?

A. I'd seen him in September of 2016.

Q. Okay.

When did you do the surgery?

A. December 13th of 2016.

Q. Okay.

And where did you do the surgery?

A. Mount Sinai Hospital.

Q. Do you have your surgical report with you?

A. Yes.

Q. Okay.

We are going to -- before we get to the notes and the opinions, you're going to be shown or you're gonna be given Plaintiff's 17A and 17B.

Before we do that, let's just show the jury -- if you can -- Plaintiff's 7B and C. You don't have to use them both, whichever one you want to use but can you show them the difference between the T1 and the T2, if they look different?

A. This is Exhibit 17B, is that 7B or 9B?

Q. It's 9B, yes.

A. Plaintiff's 9B?

Q. Yes.

(Whereupon, the referred to exhibits were displayed to the jury.)

A. If you look at 9B, this is a T1. So it's a little more sensitive to fat. You see that the spinal canal is a darker gray. On the T2, the spinal canal is bright white, the canal is full of

fluid so the fluid is white on the T2 but that fluid is gray on the T1. So that's the basic difference between T1 and T2.

T1, because you're looking at fat. Sometimes you can see if a bone has a fracture to it. So that's the advantage of a T1 MRI. In this case, none of the bones have any fractures or tumors or any other abnormalities in them.

Q. Could you either with a circle or a half circle, indicate on the T1 image the findings that you indicated on the T2 image on either side?

A. Sure. It's a little more difficult to see because we don't have a contrast of dark versus light because it's T1. It's very subtle shades of gray but you can see that the disk at L4-5, which is a solid gray, has solid gray material which I outlined with a red marker in the canal in between L5 and S1. That solid gray material that's also consistent with disks in L5-S1, I also outlined that in the canal.

But it's a little more difficult to see because the contrast isn't as stark as it is when you have bright white fluid lit up inside the canal.

Q. I'll just take those down. You can keep that -- you can put Plaintiff's 17 there -- for identification -- A and B; and can you describe for the jury with your operative report the surgery you performed?

Using the model, the illustration and the actual MRI, if you need it.

(Whereupon, the referred to exhibits were displayed for the jury.)

A. Sure.

So this is an illustration of the surgery. And the surgery starts up in the upper left-hand corner of the diagram with an incision in the lower back over the area of L4 to S1.

After the incision is made, the muscles that overlie the bones are retracted or moved out of the way in order to expose the actual bones themselves. Once the bones have been exposed and we can clearly visualize each individual bone, we then place special titanium screws into each vertebral body on both the left and the right sides because these screws will be able to hold onto those bones for us after we have removed the lamina.

In the upper right portion of the illustration is the diagram of the removal of the covering of the spinal canal. And in so doing, we can then directly look at all of the nerves. And we can also see that adjacent to the nerves in the lower left-hand corner is the area where the disk is. And by directly visualizing and looking at the disk with a special tool, we can remove the actual herniated piece of material that was leaning on or pressing on that never.

Q. Dr. Merola, your surgical operative report is in evidence but can you tell the jury what -- how you visualize the inside of the body, what -- is that your naked eye or something

else?

A. So when we're doing this procedure, we are -- we have on us a special light that illuminates very brightly the area that we're operating on. And we wear special glasses that magnify everything so that it is as though you're operating essentially under a microscope with a very strong light source so that you can visualize all of the little specific areas of the bones and the nerves and the disks in a magnified, well lit way.

Q. What do you call that?

A. They're called loop magnification. They're not unlike a jeweler's loops, when they are putting watches together they wear the special things on their eyes so they can see that little tiny stuff very up close.

We wear the same thing. It's just that our focus is from here to where we're operating and jewelers have a focus that's a little bit closer to their faces.

Q. Okay.

You can continue unless you're done with this with. Anything else with the surgery?

A. So this is the removal or the exposure, placement of screws, removal of the disk material. And the final portions of the procedure is the actual gluing together of the bones, which is known as the fusion process.

Q. And before you get to that, in your operative report if it says you found an annular tear and a herniation, what does

that mean?

A. So that means that -- so when we removed the disk herniation, so we removed disk herniation that's sitting on the nerve. And when the herniation is removed, you can actually see the whole or the opening in between the fibers of the annulus that the disk had herniated itself through. That's called an annular tear.

Q. Okay.

Continue, please.

A. So now we're going to put everything back together again and fuse it so that these bones don't collapse onto the nerves. Because now that the nerves are free and clear of any pressure and because the herniation has been removed, there's nothing holding those bones together anymore.

So if you have a patient and they stand up and they start walking around and the disk is not really there to hold those bones together, what's going to happen is the bones will collapse down on each other and then the nerves that are in between the bones will get crushed.

So to prevent that from happening, we're now going to connect the screws to rods, which are going to prevent the bones from collapsing. And then we're going to stimulate the bones to grow together, which is called a fusion, we have to scrape the bones down and then we put that lamina that we removed back alongside the bones so that it all grows into one solid piece of

bone.

Q. At that point of the fusion where the -- if it grows to the solid piece of bone, what if any effect does that have on the movement of the spine in that area?

A. So that takes the last three portions of the spine and locks them together, turning them into one piece of spine. So it stiffens and locks together, the last three portions of spine.

Q. And it's written up there but in your -- in evidence actually but what does it mean to utilize biomechanical device in place of the disk?

A. So the biomechanical device is a fancy way of saying a shim. It's a piece of plastic that you insert in between the bones to maintain the bones in their proper alignment and spacing.

So it helps to hold the bones together in addition to the screws and the rods that are placed in the bones themselves.

Q. Okay.

And we'll just place up for you and then we'll have you sit down, Plaintiff's 12A and 12B, just the two x-rays taken at some point after the surgery.

What is the point -- well, withdrawn. What if any purpose is there to take x-rays periodically of someone who has had a fusion?

A. This is a -- so these are the x-rays, this is 12B first and it shows that front to back view of the spine. Because it's

a plain x-ray film. It's a mechanical reconstruction of the spine. So now, the patient is no longer just flesh and bone, the patient is now flesh, bone and titanium.

Now, because this is mechanical, it's subject to the laws of mechanical physics and it changes the way the spine works. So when we take an x-ray, we want to make sure that all of the implants are still in place and intact and that they haven't cracked or moved. And we want to see what the rest of the structure of the spine is doing because over time, because of the wear and tear, other portions of the spine eventually wear out and mechanical reconstruction over the course of time needs to be kept up with. Just like you maintain a car or any other machine or airplane or whatever you put together with screws and rods and metallic or plastic things, you're monitoring the condition of the anatomy of the spine. So that's why we do post-operative x-rays.

So B is the front to back view and it shows that we have alignment here and that the screws and rods are all still in place and in tact.

And then A is the side view of the lumbar spine. And the side view shows us that the mechanical -- the biomechanical device is in place, the bone height between 4 and 5 is well maintained and that the screws and rods are still holding all of the bones together in the lumbar spine.

Q. And in fact, even -- that's looks good?

A. Yes.
Q. Plaintiff's 12C is just taken at a more recent date, within the month. Is everything in -- at least anatomically on x-ray, is it in place still?
A. Yes.
Q. Okay.
THE COURT: We are going to have to break for lunch.
MR. MCCRORIE: Yes, your Honor.
THE COURT: So is this a good spot for us to do that?
MR. MCCRORIE: Maybe I could just do a little bit more, so when he comes back he can just maybe do like the opinions? Like five minutes or two minutes?
THE COURT: Well, I think --
MR. MCCRORIE: I'll end it, Judge, and then we'll get to it quickly.
THE COURT: Okay, we'll get to it when we get there.
MR. MCCRORIE: Yes.
THE COURT: Ladies and gentlemen, we are going to break for lunch now. During this intermission do not discuss anything among yourselves or with anyone else. Keep an open mind.
Follow the direction the court officer. We will

see you back here at two o'clock.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the sworn jurors were escorted out of the courtroom by the court officer.)

THE COURT: Okay, two o'clock.

(Whereupon, the luncheon recess was taken.)

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

COURT OFFICER: Come to order.

THE COURT: Good afternoon.

MR. MCCRORIE: Should the doctor go up?

THE COURT: Yes, the doctor can take the stand and then I'll take the jury.

(Whereupon, the witness resumes the witness stand.)

COURT OFFICER: Ready, your Honor?

THE COURT: Yes.

COURT OFFICER: Jury entering.

(Whereupon, the sworn jury panel is escorted into the courtroom and take their respective seats.)

THE COURT: Please be seated.

COURT OFFICER: Doctor, you're reminded that you're still under oath.

THE COURT: We are going to continue with the testimony of this witness, Dr. Merola.

Counsel, you may inquire.

MR. MCCRORIE: Thank you, your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Dr. Merola, when we left you had already gone over the surgery you performed. Before we go on to even the post-surgical visits, was a hospital stay required in the hospital after the surgery?

A. Yes.

Q. How long does the surgery like that take in general, the one you performed on George Bazarnick?

A. The actual procedure itself?

Q. Yes.

A. Several hours.

Q. And how long is a typical hospital stay for a lumbar decompressive laminectomy, with the number of levels that you did?

A. About three days.

Q. And which hospital was George admitted to?

A. Mount Sinai.

Q. During that time, do you do what's called rounds or do you see the patients?

A. Yes.

Q. Okay.

Any of the -- I'm not going to get to the ultimate opinions yet but just in medicine, in general, if I ask for your

opinions I'd ask that it be stated with a reasonable degree of medical certainty, okay?

A. Yes.

Q. Do herniated disks such as the ones you pointed out to the jury on Plaintiff's Exhibit 9A -- meaning exactly that one would be touching the nerve root -- do herniated disks such as those, are they competent produces causes of pain?

A. Yes.

Q. What's the basis of that?

A. They produce pressure and irritation to the nerves.

Q. And you told the jury before what antalgic gait is, didn't you?

A. Yes.

Q. What affect does walking with an antalgic gait or limp, walking differently on one side than the other, what affect if any does that have on an annular tear or a herniated disk?

A. It increases the amount of abnormal motion that occurs in the spine because the spine is directly connected to the pelvis and the legs.

Q. So let's finish up then with your -- oh, separate and apart from any other body part that Mr. Bazarnick was receiving physical therapy for, were you aware of physical therapy to his lumbar spine before he saw you, as part of the conservative treatment?

A. Yes.

Q. And prior to a surgery or to -- with the conservative treatment, just taking it -- you already told them what epidurals would be meant to do; what is the purpose of physical therapy in conservative treatment for herniated disks that are causing radiculopathy?

A. Conservative or non-operative case for a disk herniation gives the body a chance to heal the area where the herniation is. In some instances, the tear that exists in the annulus, that ring, can heal. Sometimes the actual disk herniation itself can shrink a bit.

So there are some healing mechanisms that your body has that can help. When a disk first herniates, which is why in general if there are no severe neurological problems, you can -- you can give a person a course of treatment for about six weeks or so, sometimes a little more, to give their body an opportunity to heal the area that's herniated.

Q. And what about post-surgical, what if any -- is there any difference in purpose with physical to the lumbar spine for such a surgery?

A. So after surgery, the purpose of physical therapy is to give the muscles that have been moved out of the way an opportunity to heal and to make sure that the patient stays mobile and flexible and strong and for you to decrease the post-surgical pain that's created from the actual procedure itself.

So in that sense, the physical therapy is therapeutic and assists the post-surgical healing process.

Q. He's been your patient, so are you aware of all the interventional injection treatments he's been given by a pain management through Dr. Liu?

A. Yes.

Q. What is the purpose of epidural injections to the lumbar spine once the disk is removed, if any?

A. So post surgically, epidurals are helpful in terms of decreasing inflammation and irritation and swelling in the other areas of the spine that are adjacent to the areas that have been reconstructed. So the fusion area is an area that the epidural wouldn't do anything for because it's been fused and decompressed. It's the other areas of the back and spine that the epidural medication then works on.

Q. Utilizing both 9A and 12A, can you tell the jury what if anything in medicine could happen to the adjacent levels -- withdrawn.

What is an adjacent level breakdown in spine surgery?

(Whereupon, the referred to exhibits were displayed for the jury.)

A. Because the fusion is a mechanical reconstruction like a joint replacement is a mechanical replacement of a joint, this is a mechanical stabilization of the lumbar spine. The spine now becomes different than it was before it was fused. And what

happens is that the forces in the fine, instead of the fourth and fifth and first sacral bones moving in a normal way, they are solid and fused, which means that the stress and strain that was normally transmitted in the lower part of the spine is now transmitted higher up, so the other portions of the spine do a little extra work and they need to take up a different function than they had had previously.

So that's part of the mechanical, what we call mechanical adjacent because they're directly next to the area of the fusion breakdown. Breakdown is just another way of saying degeneration or degenerative process that is sometimes accelerated by having had a surgery that changes the normal human anatomy.

Q. Did your -- withdrawn. Was your surgery in surgical terms a success?

A. Yes.

Q. And why do you say that?

A. The primary reason to do the surgery is to prevent the nerves that were not working properly from getting worse. So that atrophy in that muscle, the sensory loss, those things are problems that if they get worst then the muscles that are in your legs would eventually not work and then you would have difficulty walking.

So the surgery is to stabilize the lower back and protect those nerves to prevent them from getting worse. So it's

a stabilization procedure. And in that sense, the patient is stabilized and they're neurologically not progressively getting worse.

Q. Why don't you go all the way and skip the notes up to July of 2017 -- the notes are in evidence -- just so we can get on to the --

A. Okay.

Q. In July of 2017, however many months passed the surgery and/or a year plus, could you please tell the jury what if anything George was complaining about on July of 2017 or not complaining about?

A. So at that time, Mr. Bazarnick said that surgery was helpful in terms of decreasing the shooting or radiating component of the pain. That means that getting the pressure off the nerve was helpful. He had pain mostly in the back, which was -- which I described as axial. That means pain that's in the back, that's aggravated with activities like bending, lifting and twisting.

So mechanical activities aggravating and causing pain and symptoms in the back area. For example, two things that we talked about just at home bending over to wash dishes at a sink was difficult, bending over to put on shoes and socks was difficult, as examples of what we call activities of daily living that were difficult to do with spinal, low back pain.

Q. And what were the -- what did your physical examination

reveal?

A. So on the exam he had spasm, which was palpable. There was what we call a reversal of lordosis. When getting up -- when you get up from a seated position, normally your lower back extends itself and then you get up in a smooth way. When the low back can't do that, you need to get up in parts, in steps and that's called a reversal of lordosis.

Neurologically, he had L4, L5 and S1 sensory loss that was pretty much stable. There was no progressive sensory loss and there was no progressive motor loss, that is muscular loss to any of those nerves. So he was essentially stable, neurologically, to his previous examinations.

Q. What was your impression and plan on that date, July 10, 2017?

A. So at that time, I recommended that he follow-up with his other physicians, including orthopedics, for his leg injury. And pain management, to manage the back pain component of his symptoms. And that we should continue conservative treatment, which I told him the most important thing was modifying activities.

In many ways, modifying or not doing those activities that reproduce symptoms are very helpful because you decrease stress and strain on the lower back. So the very activities that caused the problem, for example bending, lifting and twisting, avoiding those activities decreases stress in the back and gives

these kinds of reconstructions more longevity.

Q. What is maintenance physical therapy?

A. Maintenance physical therapy is something to maintain strength and flexibility, so it can help. The core supports the spine, so maintaining core strength isometric exercises is helpful. And maintaining flexibility in your arms and legs is helpful as well so you don't have to overstress the spine. For example, if you are going to tie your shoes, get out of bed, maybe pick up some bags of groceries or what have you.

So maintenance physical therapy helps to maintain your muscular function around areas that have had surgeries, like this.

Q. What, if at all, is the purpose of home physical therapy outside of the supervised setting with a licensed physical therapist?

A. So once you're aware of some of the basic things that you can do at home in terms of being able to stretch out the tendons in your legs, do some simple isometric exercises, in order to maintain some of your strength and your flexibility, a lot of those things can be done at home and the patient can do them as long as they know what those activities are and they know the limits of their capacity, based on what hurts.

So when something hurts, you know, you're pushing it beyond its normal limit and you should back off from doing that particular stretch or strengthening exercise.

Q. In the beginning you saw Mr. Bazarnick more. You have only been seeing him since 2016 but with what frequency or regularity, if at all, do you see Mr. Bazarnick these days since the surgery and after the first few follow-ups?

A. So at this point and time when we're -- from a surgical perspective, my treatment now is what we call observational. So I'm observing the fusion and I'm observing the adjacent segments. So it takes time for those adjacent segments to have a problem unless something happens in the interim. If something happens in the interim, of course, the patient will come back earlier. But otherwise in general twice a year is about the right amount of time to see patients that have had this reconstruction.

Q. And when did you last see him? When I say see him, not in the courtroom but when did you last -- when did he last come to you for treatment or observation prior to the date of your testifying today?

A. So I saw him in February, actually. I just saw him in February of this year.

Q. Okay.

What date in February?

A. February 26th.

Q. Okay.

On the note I think we both were just given today when you brought it but the first page says 2017, the second page says 2018; is that 2018?

A. Correct.
Q. Okay.
Could you just correct it on the sheet, please?
A. Sure. (Witness complying.)
Q. If you are doing that in a red pen, I don't know if -- but did you ever correct the date of the -- you don't have to, that's fine.
A. I just signed it and dated it today.
Q. Okay.
So just do this, the final visit -- not the final one but the last one you saw him at, what if any complaints did mister -- subjective complaints did Mr. Bazarnick make to you when he was there in February?
A. Let's see. Mechanical symptoms, which are the bending the lifting and the twisting. Those were the majority of his symptoms. Utilizing a cane and utilizing a brace, when he needs to. And those were the major symptoms on that visit.
Q. Okay.
So just so we are clear, when you write he has mechanical and axial back symptoms, is that pain?
A. Yes.
Q. Okay.
The physical examination, what did it show? You don't have to go through it all, only positive findings or medically significant?

Q. So essentially neurologically, sensory loss in the L4 the L5 and the S1 roots consistent with previous exams. So no progressive neurological deficits in February of this year.

Q. Okay.

And understanding in the work accident system, certain language needs to be used. Forgetting about what MMI means, what if anything did you note of his current medical condition?

A. So I indicated that he was awaiting an epidural steroid injection with Dr. Liu. And I also reviewed an updated post-operative MRI.

Q. Okay.

Just for the record, to what part of his body and when was that?

A. Lumbar spine, lower back, February 7th of 2018.

Q. Okay.

It's in evidence as Plaintiff's Exhibit 10 but did you review the film as well as what they called the report from the radiologist?

A. Yes.

Q. Okay.

So independently, what was your review of the MRI?

A. So the MRI showed the area of the fusion at L4 to S1, that was stable and that's consistent with his physical exam. He had a disk protrusion at L3-L4 and to a little bit of a lesser extent at L2-3 and at L1-L2. But L3-L4 showed somewhat of a disk

protrusion, that is some disk herniation in the canal area.

Q. Just for the record, that would be that disk above the two that had the half circle and the disk above that, correct? (Indicating.)

A. Yes.

Q. Now, can you tell the jury how someone can get an MRI, what you -- with what you called metal in the back since it's a magnet?

A. The implants are titanium. So titanium is not the type of a metal that causes an issue with a magnet. It's an anti-magnetic kind of a metal. So if you have a titanium implant, you can do an MRI.

Q. And what, if anything, did that indicate to you with the findings that you just indicated above the level of the fusion?

A. So two things. One, it's a good indication or reason to have an epidural steroid injection to try to shrink up that area a little bit. So it's a good idea for pain management to inject that area with an epidural.

And the other thing is it's the area that we would be focusing on going forward with observation from a surgical perspective to monitor the mechanical status of the spine, that's the adjacent segment issue.

Q. Okay.

And what was your assessment and plan on that date?

It's in evidence so you can --

A. Sure.

Q. Why don't you do this, why don't you read what your assessment is in your plan.

A. Yeah. At this point and time, it is reasonable for this gentleman to undergo continued care, management and treatment which includes and requires epidural steroid injections. And then I say my opinion is that he's not presently at maximum medical improvement.

And then I did a counseling session with George regarding the adjacent segment and I explained that that area is something that we watch and has a life span of about seven to ten years. So when you do the mechanical reconstruction and you can see that that disk at L3-4 is protruded and swelling to a certain extent, it has about a seven to ten year life span.

So we need to continue closely following him over the next seven to ten years to observe that area.

Q. And did you in fact indicate that in earlier notes, as well?

A. Yes.

Q. Did you indicate any concerns with what you found regarding any -- withdrawn.

Did you discuss any potential future surgeries with George on that occasion and the one before?

A. So the monitoring process means that from a surgical

perspective, that's an area that we would consider doing a revision on when that area ultimately is no longer working properly, yes.

Q. Okay, we'll go back to that note a little later.

Doctor, I would like to give you some assumed facts and then ask you questions based on the assumed facts and your treatment and your opinions, okay?

A. Yes.

Q. I'd ask that all the opinions, whether I ask it or not, be stated with a reasonable degree of medical certainty, okay?

A. Yes.

Q. And if at any time you cannot state an opinion with reasonable medical certainty, tell the record and myself. Okay?

A. Yes.

Q. Okay.

I'd like you to assume that George Bazarnick was a building superintendent doing physical work for, approximately, ten years from 1993 to 2003.

I'd like you to assume that in 2003 through the date of the accident, he averaged 1700 plus hours a year as a union iron worker.

I'd like you to assume that on the date of the accident, he was in the process of doing ornamental iron work at the subject construction site. Okay?

A. Yes.

Q. I'd like you to assume that shortly before the accident, meaning like right before the accident, he had picked up an approximate 40 to 50 pound metal post. Okay?

A. Yes.

Q. And that he described it as being in his arms, walking forward when his left foot twisted and caused him to go forward landing on his left knee still holding the 50 -- 40 to 50 pound item and eventually dropping the 50 pound item into the -- onto the floor before him. Okay?

A. Yes.

Q. I'd like you to assume that he was not expecting the twist and said -- you know, the records indicate he twisted his ankle both in the -- or rolled his ankle as the immediate complaint to both the on site medic and in the records of CitiMed M.D., okay?

A. Yes.

Q. I'd like you to assume that to the on site medic and to CitiMed M.D., his complaints are left ankle only, swelling and pain to the ankle, difficulty ambulating, walking. Okay?

A. Yes.

Q. I'd like you to assume that two days -- and that that occurs on December 4, 2012. Okay?

A. Yes.

Q. I'd like you to assume two days later, he appears in Dr. Jeffrey Kaplan's office that he has it looks like an air cast

on and he's ambulating with crutches.

I'd like you to assume that there is swelling, pain to his left knee and his ankle and that those are the complaints there that day. Okay?

A. Yes.

Q. I'd like you to also assume that he complains of something with his right arm, hitting the ground.

And I'd like you to assume that Mr. Bazarnick has testified that in the days following the accident he was sore all over. Okay?

A. Yes.

Q. I'd like you to assume that Mr. Bazarnick testified that he had soreness in his back. And after the accident in the days after the accident, in the soreness -- subject to connection, did you review Dr. Kaplan's initial notes prior to coming here today?

A. Yes.

Q. And I'd like you to assume that in early February 2013, that Mr. Bazarnick's complaints, in addition to his knee, his ankle continuing to have pain, that he began complaining of numbness and pain into the left buttock radiating down the left leg with weakness. Okay?

A. Yes.

Q. I'd like you to assume that he continues with conservative treatment to the area of the lumbar spine and he

also treats with a physical medicine rehabilitation doctor, Douglas Schwartz. All right?

A. Yes.

Q. I'd like you to assume that after the conservative treatment fails to the back, in addition to whatever he's doing for his knee and his ankle, he gets -- begins treating in August of 2014 with an interventional pain management, Dr. Eugene Liu. Okay?

A. Yes.

Q. Okay.

And I'd like you to assume that Dr. Eugene Liu, Dr. Schwartz orders an MRI -- the first MRI that you discussed from July 28, 2014 -- and it indicates herniations in the two areas the L4-L5 and L5-S1. Okay?

A. Yes.

Q. I'd like you to assume that prior to the date of the accident Mr. Bazarnick's lower spine, he's not having any symptoms, that he has full health coverage with the union for ten years, there is no prior back doctor, MRI, chiropractor or anything. Okay?

A. Yes.

Q. And I'd like you to further assume he's able to do his work duties as a union iron work for the approximate ten years, as well as his duties physically as a superintendent for ten years. All right?

A. Yes.
Q. I'd like you to assume that he then has the MRI -- withdrawn.
That he's never in his life had any type of radiating pain prior to the February date that he complained to Dr. Kaplan in 2013. Okay?
A. Yes.
Q. Is the radiating pain what's known as a symptom?
A. Yes.
Q. Is it a soreness to a back known as a symptom?
A. Yes.
Q. Is the numbness and the weakness in the leg known as a symptom of back pain?
A. Yes.
Q. Okay.
And I'd like you to assume that he then eventually after three epidurals and several trigger point injections and all that other care, is referred to you and that everything you have said and did to him and told this jury occurred, okay?
A. Yes.
Q. Including the new MRI, all right?
A. Yes.
Q. The new two MRIs, both of them.
Do you have an opinion with a reasonable degree of medical certainty as to the cause of the symptoms

George Bazarnick was feeling after the work place accident up until the symptoms of radiating pain?

MR. CERUSSI: Just note my objection, your Honor.

THE COURT: So noted.

Overruled.

Q. You can answer.

A. Yes.

Q. And what is that opinion?

A. My opinion is that he was rendered symptomatic, as a consequence of the work place accident.

Q. And we're only speaking about the lumbar spine?

A. Correct.

Q. Okay.

What do you base your opinion, specifically with regard to the radiating symptoms being rendered symptomatic after the work place accident?

A. My treatment with the patient, my experience in treating patients for all of these years, a review of the records and the other treating physicians and his course of care and treatment since the time of the accident. And the fact that he was asymptomatic prior to the accident.

Q. Do you base it on the objective MRIs?

A. As part of the review, all of his diagnostics and treatment, yes.

Q. Do you have an opinion with a reasonable degree of

medical certainty as to the cause of the soreness that he was feeling in his back, leading up to the radiating pain?

A. Yes.

Q. What is your opinion?

A. That the cause of that soreness is a consequence of the accident.

Q. And what do you base that opinion on?

A. My experience with patients, my treatment of patient, my review of records including the diagnostics and his clinical course after the accident.

Q. We spoke about a herniation before. You said it could be caused by trauma, it could be caused by degeneration.

Regarding the mechanism of Mr. Bazarnick's injury, can you please describe to the jury is the mechanism of his injury consistent with the symptoms that came about after the injury, specifically to the backbone?

MR. CERUSSI: Objection, your Honor.

THE COURT: Overruled. You can answer.

Q. You can answer.

A. Yes, that mechanism of injury is consistent with a low back injury.

Q. With a degree of reasonable certainty, can you tell us why that is the basis of your opinion?

A. Sure. Based on my treatment of the patient, my experience with treating patients, my review of all the records,

my treatment including the surgical findings and the diagnostic testing and the twisting of the lower extremity with an abrupt shift in the pelvis transferring stress and strain to the lumbar spine, it's reasonably medically consistent with a disk injury.

Q. I'd like you to assume -- because right now we are just talking about symptoms -- I'd like you to assume for the purposes of this next question that Mr. Bazarnick, although there's no MRI and no complaints, has a herniation but it's the type of herniation you told the jury wouldn't cause symptoms. It's not touching the nerve root, it's not touching the cord or an exiting nerve root.

I'd like to you assume all of the other facts and the same complaints of soreness leading up to radiating pain, approximately, two months later. Okay?

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty whether under that scenario, that hypothetical, whether this accident aggravated any preexisting asymptomatic degenerative conditions and caused them to become symptomatic?

MR. CERUSSI: Objection, your Honor.

THE COURT: I'm sorry, can you read that back for me, please?

(Whereupon, the referred to portion was read back by the Reporter.)

THE COURT: All right, the objection is overruled.

You can answer that.

A. Yes.

Q. Please state the opinion with a reasonable degree of medical certainty and the basis thereof.

A. My opinion to within a reasonable degree of medical certainty is under those circumstances, they would be an aggravation of a preexisting asymptomatic condition. We know that based on the fact that the patient had been working in a rather heavy labor capacity prior to this accident with no previous treatment history and then a history of records which I've had an opportunity to look at, including diagnostic imaging studies, my operative findings and my own physical findings on the patient that were consistent with asymptomatic radiculopathy.

Q. Do you have an opinion with a reasonable degree of medical certainty that in the absence of this accident, whether or not Mr. Bazarnick would have needed the multiple level decompressive laminectomy and fusion?

MR. CERUSSI: Objection.

THE COURT: No, he can answer that question.

Overruled.

A. Yes.

Q. Please tell the jury the opinion and your basis thereof.

A. In the absence of a traumatic event to within a reasonable degree of medical certainty, the patient would not

have required a laminectomy and spine fusion. And that's based on what we know of the normal aging process and my experience treating many patients over the course of all the years that I have treated patients.

And what we know, specifically, about this case from not only the records themselves but my treatment of the patient, the diagnostic imaging studies and the operative findings.

Q. Sounds like the same question but take the surgery out of it.

Do you have an opinion with a reasonable degree of medical certainty whether or not in the absence of this accident, Mr. Bazarnick would have needed the conservative care in terms of the injections both epidural and trigger point that came about after the complaints of radiating pain?

MR. CERUSSI: Objection, your Honor.

THE COURT: Overruled. He can answer.a.

A. Yes.

Q. Please tell the jury the opinion with a reasonable degree of medical certainty and the basis there.

A. And my opinion would be the same. Based on what we know about the patient's work history and the medical records, my treatment of the patient, the diagnostic imaging studies and his being symptomatic with radiculopathy, he would have required the therapy and the injections.

Q. Now, I'd like you to ask you questions regarding

prognosis, the future, okay?

A. Yes.

Q. With a reasonable degree of medical certainty, do you have an opinion as to whether or not the current state of Mr. Bazarnick's back will continue into the future to any degree to cause him pain in his lumbar spine?

A. Yes.

Q. What is your opinion?

A. My opinion is that it does continue to cause pain going forward into the future in the lumbar spine.

Q. For what period of time with a reasonable degree of medical certainty is your medical opinion that he will continue to have pain in the lumbar spine?

A. This is a lifetime issue for the patient.

Q. What do you base that on?

A. I base that on my treatment of the patient, my review of the records, the objective testing, the surgery. And that he's also continuing care at this point and time, including the epidurals which I recommended and the observational care which I recommended after the surgery.

Q. The fact that he has the titanium at the multiple levels, what if any medical affect does that have on the ability of George to move his spine in the future, in the way he can move it before the accident?

A. The implants remove motion in the L4 through S1

segments of the lumbar spine by turning that portion of the spine into one solid bone.

Q. Do you have an opinion with a reasonable degree of medical certainty, based on what you told the jury, on the January 2018 MRIs and your findings in your last two evaluations of Mr. Bazarnick, do you have an opinion as to whether or not he will require any future surgery to his back, lumbar spine?

A. Yes.

Q. What is your opinion?

A. My opinion is that in the next seven to ten years, it's anticipated that he will require a revision for the adjacent segment problem at L3-4.

Q. And what do you base that on, Doctor, with a reasonable degree of medical certainty?

A. To within a reasonable degree of medical certainly, that's based on of course my treatment of the patient and all the records and operative findings, including the most recently updated MRI of the lumbar spine, showing the protrusion at L3-4 and the requirement now for epidural steroid injections, as well.

Q. Do you have an opinion with a reasonable degree of medical certainty, as to whether or not it has been advisable, medically, for Mr. Bazarnick -- whether or not it's been advisable for him to return to work as a union iron worker from the date of the accident through today, just the past?

A. Yes, I do.

Q. What is your opinion with a reasonable degree of medical certainty as to whether or not it would be medically advisable for him to return to work as an iron worker up until today?

A. It would be not medically visible for him to return as an ornamental iron worker.

Q. What's the basis of that opinion, Doctor?

A. My treatment of the patient, my review of the records, my operative findings and his continued treatment.

Q. Can you tell the jury if you advised him not to return to work up until today?

A. Yes.

MR. CERUSSI: Objection.

Q. Yes, you could tell them or yes --

A. Yes, I did tell him.

THE COURT: Wait, give me a chance to rule on the objection. The objection is overruled, the answer will stand.

Q. Okay.

I was just clarifying, yes, you advised him or yes, you --

A. Yes, I can and I did advise him not to return to work, yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not in the future, beyond the

date of this proceedings, it would be visible for Mr. Bazarnick to return to work as a union iron worker?

A. Yes, I have an opinion.

Q. Please tell the jury your opinion and you can give the basis with a degree of medical certainty.

A. My opinion would be that he should not return to work as an iron worker, primarily for the mechanical aspect of the wear and tear process to the lumbar spine.

To decrease stress and strain in the lumbar spine, that would be the first reason. The second reason would also be the fact that the L4, the L5 and the S1 nerve roots are not working properly so it would be a safety issue, realizing going back to that kind of labor would not be possible.

Q. Just in terms of you're not here as a vocational expert but do you have an opinion with a reasonable degree of medical certainty as to whether -- assuming he's physically able to do a sedentary job or a job at all, whether or not he could return to non-manual labor if he's able to?

MR. CERUSSI: Objection.

Q. Physically.

THE COURT: Well, I think --

MR. MCCRORIE: We can stip --

THE COURT: I am going to sustain the objection on that. The evidence is -- I'm not sure if he understand the question.

MR. MCCRORIE: I understand. I want to ask about work, Judge.

Q. Do you have an opinion with a reasonable degree of medical certainty as to -- well, withdrawn.

With what Mr. Bazarnick has, what affect, if any, would sitting for long periods have on him?

A. So sitting for long periods of time can increase stress on the sciatica nerve and cause pain.

Q. What about standing for long periods of time?

A. Standing for long periods of time causes stress on the lumbar spine, which would increase mechanical low back pain.

Q. What about bending or repetitive bending?

A. Repetitive bending increases mechanical wear and tear on the lower back.

Q. What about the process of lifting or reaching?

A. Lifting and reaching would increase mechanical strain on the lower back.

Q. Okay.

Given your testimony about the future, I'm going to ask you questions about it and then we'll be done, future medical care. Beyond the date of this trial, do you have an opinion with a reasonable degree of medical certainty as to whether or not it would be advisable for Mr. Bazarnick -- just with regard to the lumbar spine -- to continue to see yourself or a doctor like yourself, a board certified spine surgeon?

A. Yes.
Q. And what is your opinion?
A. My opinion is that he should see an orthopedic spinal surgeon at least two times a year.
Q. And what is the current cost in the New York City area here? What do you charge for a follow-up visit, privately paid, outside of any work accident or any other system?
A. So depending upon the amount of time and the complexity of the visit, it can vary to within anywhere between $300.00 to about $400.00 for a follow-up.
Q. $300.00 to $400.00?
A. Yes.
Q. Okay.
And do you have an opinion with a reasonable degree of medical certainty as to whether or not x-rays examinations would be advisable with any frequency going into the future?
A. X-rays are advisable on a yearly basis.
Q. When you say on a yearly basis, for this question and the previous one you previously said he would have pain for life.
Can you qualify when you say on a yearly basis how many years or what period of time in the future for both questions?
A. They would be lifetime requirements in terms of going forward, for care and observation management.
Q. For the back, lumbar spine, what is a private pay

series of x-ray, meaning the full series, the side the back, the whole series that you talked about?

A. An x-ray series for the lumbar spine is about $275.00.

Q. Do you have an opinion with a reasonable degree of medical certainty whether or not into the future Mr. Bazarnick should have any type of MRI testing beyond the three that he's had so far?

A. Yes.

Q. What is your opinion?

A. My opinion is that MRIs would be recommended about every two years or so post-operatively.

Q. And what is the current cost of an MRI? You can go, you know, what would be a deal on it but how much is an MRI outside of any system, private pay?

A. A lumbar MRI average is about $1,000.00 for the MRI.

Q. Now, the surgeries that you talk about in seven to ten years, if you can give -- you do that surgery, correct?

A. Yes.

Q. Can you tell the jury with reasonable medical certainty the current cost, inclusive of the hospital, the anesthesiologist, the medication, the hardware and the hospital stay -- withdrawn.

Would it be a similar hospital stay?

A. Yes. Revision surgeries, they have about -- in general, they are about a day longer for the hospital stay just because

the revision surgery is a little bit more -- it's more involved, so it's a longer procedure. And it's a little bit of a longer in-patient rehab process. So it's usually a day more, so it's about four days.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not in the future -- withdrawn.

What is the current cost of that surgery?

A. So if you consider the hospital cost and the implant cost and the in-patient stay, it's about $125,000.00 for the revision surgery.

Q. Including the surgical costs, too?

A. All costs included, yes.

Q. Okay.

Do you have an opinion with a reasonable degree of medical certainty, as to whether or not an injection therapy with specifically epidurals would be advisable into the future for any period of time?

A. Yes.

Q. To the lumbar spine?

A. Yes.

Q. What is your opinion?

A. My opinion would be that epidurals are helpful in this condition. I wouldn't do more than three times a year. I would say maximum three times a year for epidurals.

Q. And for what period of time into the future? You said the surgery is seven to ten years?

A. Correct. I would put the epidurals and the pain management at least at lifetime, as well.

Q. And what is the current cost of an epidural, including the cost for the pain management or anesthesiologist that performs it, the medication, the needles, if it's a lab and --

A. A facility?

Q. Yes.

A. Yeah, so an epidural for all those inclusive costs, it would average about $2,500.00 per injection.

Q. Okay.

I won't ask you frequency or cost but assuming, assuming that Mr. Bazarnick -- not a separate course but assuming he would be in therapy for other parts of his body in the future, do you have an opinion as to whether or not it's visible for Mr. Bazarnick to not just do home therapy but to get into active supervised physical therapy to the lumbar spine only?

A. Yes, it's helpful.

Q. Okay.

MR. MCCRORIE: I have nothing further. Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: All right. Let's take five minutes and then we'll come back for cross examination.

So ladies and gentlemen, don't discuss anything among yourselves or with anyone else. We'll see you back here in five minutes. Follow the directions of the court officer.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the sworn jurors were escorted out of the courtroom by the court officer.)

THE COURT: All right, five minutes.

(Whereupon, a brief recess was taken.)

COURT OFFICER: Come to order.

THE COURT: Doctor, please take the stand.

(Whereupon, the witness resumes the witness stand.)

THE COURT: Please bring the jury down.

(Pause.)

COURT OFFICER: Ready, Judge?

THE COURT: Yes.

COURT OFFICER: Jury entering.

(Whereupon, the sworn jury panel is escorted into the courtroom and take their respective seats.)

THE COURT: All right, you may be seated.

All right, ladies and gentlemen of the jury, we are going to continue with the cross examination of the witness, Dr. Merola.

Counsel for the defendant, you may inquire.

MR. CERUSSI: Thank you, your Honor.

(Pause.)

MR. CERUSSI: May I proceed, your Honor?

THE COURT: Yes.

MR. CERUSSI: Thank you.

THE COURT: You may proceed.

CROSS EXAMINATION

BY MR. CERUSSI:

Q. Good afternoon, Dr. Merola.

A. Good afternoon.

Q. You and I have never met before, correct?

A. Correct.

Q. Other than this morning?

A. Yes.

Q. Okay.

Doctor, you don't have any specialty in the field of accident reconstruction, correct?

A. Correct.

Q. And you're not a vocational rehabilitational expert?

A. Correct.

Q. And you're not biomechanical engineer, correct?

A. Correct.

Q. Now, Doctor, on direct examination you told us about cases where you've testified before; how many cases have you testified in the past five years on behalf of plaintiffs?

A. I don't know the exact number but I do end up coming to court from time to time throughout the year.

Q. Approximately?

A. I would say somewhere between maybe six or seven times a year, depending upon the year.

Q. Have you ever testified for a plaintiff who was your patient on behalf of the law firm of Sacks & Sacks?

A. Yes.

Q. Okay.

What about for Mr. McCrorie?

A. Yes.

Q. Do you know how many times -- withdrawn.

When was the first -- when did you first begin testifying?

A. I first started practice in 1996, so I would say shortly thereafter.

Q. Let's take from June of 2001 till June of 2017, let's take that 16 year window. Would it surprise you that you've been in court during that time period on, approximately, 106 cases?

A. In 17 years?

Q. Yes.

MR. MCCRORIE: Objection, to the number.

THE COURT: Overruled.

MR. CERUSSI: Approximately.

THE COURT: Overruled.

Q. You can answer, Doctor.

A. I would have to look at whether or not those cases were all in court or not because as you know, sometimes cases settle out of court and a doctor can be listed as an expert but you didn't necessarily go to court.

Q. All right.

I want you to assume that you were retained or testified for a patient, approximately, 106 times during that 16 year window; would it surprise you that you testified or were retained by the law firm of Sacks & Sacks, approximately, 21 times?

A. I would not be surprised that I have taken care of 21 of their injured patients that went to court, no.

Q. And out of that 21, would you be surprised that at least six were for Mr. McCrorie?

A. I would not be surprised since Mr. McCrorie, I believe, does a majority of their trial work.

Q. Okay.

Do you remember Mr. Moyer?

A. I do, yes.

Q. And Mr. Kafora?

A. Yes.

Q. Okay.

A. Yes.

Q. And David Mayer?

A. Yes.
Q. Okay.
Now, in the manner -- in the matters that you have testified, they've been on behalf of the plaintiff, correct?
A. For my patients, yes.
Q. In many of those cases where you testified, you were the treating doctor of the patient, correct?
A. Yes.
Q. And would you agree with me, Doctor, that a number of your patients are plaintiffs who are involved in personal injury litigation?
A. For those patients that are involved in trauma and are injured, I would not be surprised that they have personal injury cases regarding their injuries, no.
Q. Okay.
And in the 21 cases I mentioned where you were retained by Sacks & Sacks, would you be surprised in 18 of those cases you actually performed surgery on the plaintiffs?
A. I would not be surprised, no.
Q. And the remaining three you recommended surgery, would that surprise you?
A. No.
Q. Now, Doctor, do you get referrals of patients from plaintiff's personal injury lawyers?
A. I have been referred patients from lawyers, yes.

Q. What about you, yourself? Do you ever refer patients to plaintiff's personal injury lawyers?

A. No.

Q. The patients where you were sent referrals, would you agree that you have sent referrals to the law firm to Sacks & Sacks?

A. I don't refer patients out to attorneys, no.

Q. I'm sorry, when you've been referred cases, they've come from that firm; you have gotten cases from that firm, correct?

A. I have seen patients that have also been represented by Sacks & Sacks, yes.

Q. Okay.

Now, let's talk about Mr. Bazarnick. You began seeing him in February of 2016, correct?

A. Yes.

Q. And do you know how many times you have seen him from today's -- up to today's date since February 29th of 2016?

A. I've seen him at least eight to 11 times, including the hospitalization in December.

Q. Just office visits, approximately seven?

A. I believe it's eight, if we count the one I just recently saw him on in February of this year.

Q. Including this one, that was seven. There was one that was a telephone conversation, correct?

A. Right. I didn't see him but I actually discussed the findings with him.

Q. Okay.

And the last time that you saw him was on February 26th of this year, correct?

A. Yes.

Q. Do you remember how that appointment was set up?

A. No.

Q. When did you first become aware that this case was going to trial?

A. About a week or so ago.

Q. Okay.

Did they ever check with you to see if you were available when the case was coming up?

A. They generally do that with the office and then make an appointment. And then we get it scheduled through my scheduling secretary.

Q. Okay.

Before that last appointment, you saw him in July of last year, correct, seven months ago?

A. Yes.

Q. I mean, seven months before February 26th, correct?

A. Correct.

Q. Okay.

Now, Doctor, the file you have in front of you, is

that your complete file?

A. Yes.

Q. Okay.

Is there anything -- and when I say your complete file, pertaining to Mr. Bazarnick, correct?

A. Yes.

Q. Okay.

Where are the films that you reviewed?

A. They're online.

Q. You were never provided with any disks?

A. No, I have access to both Lenox Hill Radiology and Stand Up MRI.

Q. And did you review those films in your office?

A. Yes.

Q. Anything missing from your file there other than the films that you reviewed online?

A. Not that I'm aware of, no.

Q. Okay.

How is it that Mr. Bazarnick came under your care and treatment?

A. He was sent in by his treating physicians.

Q. Who is that?

A. Well, he was treating with the physiatrist, the orthopedic surgeon and the pain management doctor, all of whom I work with. So any of those physicians would have sent him over.

Q. Okay.

Do you know that for a fact, that that's who referred him to you?

A. To the best of my knowledge, yes.

Q. Did you have any discussions with him before you first saw him?

A. Prior to that visit, no.

Q. Did you have discussions with him afterwards?

A. I do talk with him on an occasional basis, more so with the physiatrist and the pain management doctor.

Q. Okay.

The first visit you had with him on February 29, 2016, that would be, approximately, three years and three months after this accident, correct?

A. Yes.

Q. How old was Mr. Bazarnick at that time?

A. So let's see, at that time about 55 years old.

Q. In a 55 year old male who performed construction for a number of years as an iron worker and also working as a superintendent, would you expect to find degenerative changes in his spine?

A. Yes.

Q. Now, on your first visit with him, did you take a history from him?

A. Yes.

Q. And how do you do that? How do you take a history?
A. You talk to the patient.
Q. Just have a conversation with them?
A. Yes.
Q. Okay.
And by the way, before that first visit you never met him before, correct?
A. Correct.
Q. And you didn't know him?
A. Correct.
Q. Did you know anything about him before you first saw him?
A. No.
Q. Now, going back to the history. Looking at your records from the first visit of February 29, 2016, you told us before that the date was originally -- on your direct, you told us that the date was originally December 3rd of 2012 and that there was a problem with the dictation?
A. It was transcribed as 2013.
Q. Well, actually you told us that it said 12-3-2012 but it should've been 12-2-2012. But in essence the year was wrong, too, correct?
A. Correct, the year was wrong.
Q. You got that information from Mr. Bazarnick?
A. I got that information from a number of sources,

including actually having to go through the entire approval process for the surgery itself. So the date of the --

Q. I'm not talking about the surgery, I'm talking about the first visit.

A. The first visit I would have spoken to the patient and then transcribed what the patient told me.

Q. Okay.

A. And then it depends on how it's written on paper.

Q. Who provided you with those records?

A. My office has a medical records person that is responsible for retrieving records.

Q. Okay.

Did you get the records before you saw him?

A. Sometimes we have records before we see the patient and sometimes we get the records immediately after we see the patient.

Q. In this case?

A. So in this case, when he came in I had the patient and I had the MRI films that he brought in. And there were medical records from his treatings, as well.

Q. Had you reviewed those before you first saw him?

A. Not before I first saw him, no.

Q. Okay.

So looking at the first page of your report from the first visit, it indicates injury occurred on December 3, 2013 --

which we know is an incorrect date -- secondary to a fall in a hole.

The injury you're referring to there, that's his back injury, correct?

A. This is the date of the -- well, it's referring to he was working and he had --

Q. If you could just answer the question, Doctor. You have been through this process before.

Is the injury you are referring to there, the back injury for what he came to see you for?

A. He came to see me for his back injury, yes.

Q. Okay.

And there's an indication there from the history you got from him that it occurred on the date of the accident, correct?

A. He began to have problems on the date of the accident, yes.

Q. Okay. With his back?

A. No, with injuries to his lower extremity that then developed into pain in his back.

Q. Doctor, he went to see you for back pain, correct?

A. Yes.

Q. Okay.

That's what you've been treating him for for the past couple of years, correct?

A. Yes.
Q. So the injury that you were seeing him for was for severe back pain in the back, correct?
A. Yes.
Q. And he reported to you that it occurred on the date of the accident, correct?
A. No, he reported to me that he fell in December of 2012 and began to have problems thereafter. And then in the body of the report, those problems included injuries to his leg, which he underwent surgical intervention for and a course of treatment to his lower back, which included therapy and epidurals.
Q. Right.
Mr. McCrorie gave you the number, many, many, many assumptions and some questions that he posed to you. So in those assumptions, you were told or were you told it assume that he hadn't sought treatment for his lower back injury for six weeks following the date of the accident, correct?
A. Yes.
Q. Okay.
Can you show me anywhere in your records from your seven visit was Mr. Bazarnick where it says that he did not complain of lower back pain until six weeks after the accident? Is that anywhere in your records?
A. No, it's in Dr. Kaplan's records.
Q. Okay.

Is it in your records?

A. No.

Q. Yes or no?

A. No.

Q. At that time he told you about his injury, he stepped in a hole; did he tell you the manner in which he fell?

A. There was a fall in a hole and he then began to become symptomatic thereafter.

Q. Okay.

Did he tell you the extent of the assumptions given by Mr. McCrorie that he gave you to on direct examination?

MR. MCCRORIE: Objection, it's a hypothetical.

THE COURT: Well, no, I just think the form of it. You might need to reformulate the question. It's not clear.

Q. Did he tell you actually the mechanical and manner in which he fell, other than falling in a hole?

A. No, he came in as any other patient would --

Q. Just yes or no, Doctor.

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

Q. Now, you conducted an examination that day, correct?

A. Yes.

Q. And you did a number of tests, correct?

A. Yes.

Q. And did you ask him at that time what his complaints were?

A. Yes.
Q. And those would be subjective complaints, correct?
A. Yes.
Q. Okay.
Now, as part of your examination, you need cooperation from your patient, correct?
A. Yes.
Q. You rely on the patient to be cooperative, correct?
A. Yes.
Q. Truthful?
A. Yes.
Q. And compliant?
A. Yes.
Q. Okay.
Now, you told us you noted that he had atrophy of his thighs?
A. Right thigh.
Q. Right thigh?
A. Yes.
Q. Did you actually measure his thighs?
A. I did, qualitatively, yes.
Q. What's that?
A. I did, yes.
Q. Where are the measurements on your report?
A. It's a qualitative measurement done by palpation.

Q. Did you actually take a tape measure and measure his atrophy?

A. No, I felt his thighs.

Q. Okay. Were you provided with any medical -- well, withdrawn.

You don't know what happened in this case, whether you got the record -- well, whether you got the records before or after your first appointment, correct?

A. Yes.

Q. But you indicated that you reviewed the records after your first appointment, right?

A. Yes.

Q. Okay.

Did you review any x-rays of the lumbar spine on the first visit?

A. No.

Q. And the MRIs you told us about, you reviewed online, correct?

A. Yes.

Q. And you reviewed the MRI taken, approximately, one year and eight months after this accident, July 28, 2014, correct?

A. Yes.

Q. That was the first MRI taken after this accident, right?

A. Yes.

Q. Did you ever become aware of any MRIs that were taken immediately after the accident of the lumbar spine?

A. I didn't see any MRIs immediately after, no.

Q. Now, looking at your report, again, on the second page of the first visit you referred to the MRI?

A. Yes.

Q. Magnetic resonance imaging scan available to review from 2014 results of which are contained within the chart; that's your chart?

A. Yes.

Q. Where are the results of that MRI in your chart?

A. Right here.

Q. Okay.

Did you read the report before you actually looked at the film?

A. No.

Q. Did you at some point look at the report?

A. Yes.

Q. Did you agree with the findings?

A. Yes.

Q. Now, Mr. McCrorie showed you some blow-ups of the MRI that you sent him for?

A. Yes.

Q. You haven't seen any blow-ups of that particular MRI, correct?

A. I haven't seen any blow-ups of it, no.
Q. And that was taken at Lenox Hill Radiology?
A. Yes.
Q. After your first visit with him, your diagnosis was lumbo sacral radiculopathy with neurological deficits and axial range of motion deficits, correct?
A. Yes.
Q. Now, radiculopathy may be caused by a herniated disk, correct?
A. Yes.
Q. And it also can be caused by degenerative disorders of the spine, correct?
A. Yes.
Q. Now, after that first visit you ordered another MRI, correct?
A. Yes.
Q. Why did you do that?
A. It had been several years since the 2014 MRI and he had neurological deficits and was getting worse, so I wanted to update the film.
Q. Okay.
Did that MRI, the February 29, 2016 MRI show any traumatic injury to the spine?
A. I believe so, yes.
Q. Did it show any fractures?

A. No.
Q. Did it show any ligamous ruptures?
A. No.
Q. That's what I'm referring to as far as an acute traumatic injury; did it show any acute traumatic injury in those records?
A. No.
Q. Okay.
And did you discuss the findings on that MRI with Mr. Bazarnick?
A. Yes.
Q. Okay.
And that was at the next visit, correct?
A. Yes.
Q. Oh, I take that back. That was during the telephone conversation you had with him on March 6th, correct?
A. Yes.
Q. Did you recommend the option of surgery, at that time?
A. Yes.
Q. The second visit that you had in person on March 14th, did you actually recommend surgery at that time, the option of surgery?
A. Yes.
Q. Again, looking at your records, specifically the second visit on March 14th, you reference this gentleman has been having

symptoms since injury occurring on 12-3-2013. Again, we have another dictation error.

Doctor, what you're saying there is Mr. Bazarnick told you that he had been having the symptoms with regard to low back since the injury, correct?

A. No, what I'm saying is that the accident that happened was the reason why he was having symptoms.

Q. Doctor, the statement in your report says, this gentleman has been having symptoms since injury occurring on 12-3-2013, which should be 12-2-2012.

The symptoms that you saw him for were related to the low back, correct?

A. Yes.

Q. You haven't treated Mr. Bazarnick for any left foot injury, correct?

A. Correct.

Q. Left ankle injury?

A. Correct.

Q. Left knee injury?

A. Correct.

Q. Okay.

Is this part of another history that Mr. Bazarnick had been telling you what was going on with him as far as his symptoms?

A. No.

Q. What was it?
A. It was the fact that he had had an accident at work, became symptomatic thereafter and presented to me for a surgical consultation.
Q. Okay.
But he did report having symptoms since the date of the accident, correct?
A. As a consequence of the accident, yes.
Q. You heard today, again on the assumptions during direct examination from Mr. McCrorie, that he did not complained about lower back pain until, approximately, six weeks later in early February; there's no reference to that in that second visit, correct?
A. Correct.
Q. Did you examine him again at that visit?
A. Yes.
Q. Was there any change in his status since the first time you saw him on February 29th, two and a half weeks before?
A. No.
Q. Okay.
Now, at that visit, did you discuss the results of the MRI taken on the 29th?
A. Yes.
Q. And you indicate in your second visit office note at the bottom, the actual results of the MRI, correct?

A. Yes.
Q. Significant herniations at both L4-L5 and L5-S1 segments, right?
A. Yes.
Q. Including some evidence of listhesis, correct?
A. Yes.
Q. Now, Mr. McCrorie asked you on direct examination about what listhesis is; that can be caused by trauma, correct?
A. Yes.
Q. And it can also be caused by degeneration, correct?
A. Yes.
Q. Now, Doctor, would you agree with me that the L4-L5 disk herniation, that's one of the most common locations for a lumbar disk herniation?
A. It can be, yes.
Q. Would the same be said for L5-S1?
A. It can also be one of the more common locations, yes.
Q. All right.
And at that second visit, you discussed the options of surgery with him, correct?
A. Yes.
Q. And he chose to proceed with that surgery, right?
A. Yes.
Q. Okay.
Now, the next time you saw him was, approximately, six

months later, right?
A. Yes.
Q. In September of 2016?
A. Yes.
Q. And at that time, you talked about surgery again, right?
A. Yes.
Q. And he agreed that he wanted to proceed with that option, correct?
A. Yes.
Q. Okay.
Do you know if he saw any other doctors, Dr. Merola, with regard to any opinions on whether to have surgery or not?
A. Well, he was sent to me by his other treatings for a surgical opinion.
Q. Just yes or no, Doctor, do you know if he saw anybody else?
A. As far as I know, just his other treating physicians.
Q. Okay.
And then you told us on direct you performed the surgery on December 13, 2016, correct?
A. Yes.
Q. Okay.
Now, on your operative report for that date, you indicate an intraoperative -- there's an intraoperative findings

section; do you see that?

A. Yes.

Q. It's a portion of the operative report and it indicates some normal age related changes, correct?

A. Yes.

Q. As well as annular tear and nerve root compression at the L4-L5 level?

A. Yes.

Q. Also disk herniation at L5-S1 level, correct?

A. Yes.

Q. Now, Mr. McCrorie discussed with you on direct what an annular tear is; that's a tear of the outer layer of the disk, correct?

A. Yes.

Q. And an annular tear, that can be caused by degeneration of the spine, correct?

A. Yes.

Q. And that could be from the natural aging processes, correct?

A. Yes.

Q. Now, you performed the surgery at Mount Sinai West you told us about. And Mr. Bazarnick he was stable after the surgery, correct?

A. Yes.

Q. And did he tolerate the procedure well?

A. Yes.
Q. Okay.
And then the next time you saw him was on January 2nd, right, of 2017?
A. Yes.
Q. That was another office appointment, right?
A. Yes.
Q. Your fourth visit with him?
A. Yes.
Q. At that time he had no acute complaints, right?
A. Yes.
Q. And your report indicates that from a sensory, motor neurologic function he was found to be stable, correct?
A. Yes.
Q. Did you recommend that he start physical therapy, at that time?
A. I indicated that he could start if he so desired, yes.
Q. Do you know if he actually began?
A. I'm not sure if he did or not, at that time.
Q. Okay.
And then the next time you saw him was on April 3rd of 2017, correct?
A. Yes.
Q. Approximately, three months later?
A. Yes.

Q. And you found him to be stable at that time, correct?
A. Yes.
Q. Do you know if he had been attending physical therapy during the time of January through April of 2014?
A. I left that up to his physical therapy doctor, Dr. Schwartz.
Q. And then your next visit after that was in July, right?
A. Yes.
Q. That was the sixth time you saw him?
A. Yes.
Q. And he indicated to you that the surgery was helpful, right?
A. Yes.
Q. In preventing further significant shooting pain into the extremity, correct?
A. Yes.
Q. Was he attending any physical therapy, at that time?
A. Once again, I left that all up to Dr. Schwartz, his treating psychiatrist.
Q. And then the next time you saw him, which was the final time you saw him, the seventh visit, was this past February, right?
A. Yes.
Q. Okay.
And that's the appointment that we talked about from

the beginning where you had ordered another test at that visit?

A. Yes.

Q. An MRI of the lumbar spine?

A. Yes.

Q. Was that for the purpose of looking at the hardware placed in for the surgery?

A. Yes.

Q. And it was in good placement?

A. Yes.

Q. Now, turning back to the first MRI which Mr. Bazarnick had after his accident in July, the accident, the MRI dated July 28, 2014.

Again, that was the year and eight months after the accident, right?

A. Yes.

Q. And that MRI did not show any evidence of acute injury to the spine, correct?

A. Yes.

Q. And it showed what we talked about earlier L4-L5 and L5-S1 disk herniations, correct?

A. Yes.

Q. Now, there were also findings on that MRI, the first one, that were degenerative, correct?

A. Yes.

Q. Now, forgetting about again Mr. McCrorie's assumptions

that he gave you on direct examination, from reading that particular MRI alone and relying on nothing else, can you tell, Doctor, how long those disk herniations actually were there from reading that film?

A. Just based on the film itself?

Q. Yes?

A. The film is meaningless without a patient and the history.

Q. Okay, so the answer is no?

A. Correct.

Q. Now, putting aside your review of records and any history provided to you by Mr. Bazarnick, Doctor, isn't it possible that that disk -- those disk herniations could have occurred between the date of the accident and the time that Mr. Bazarnick first began to complain of back pain six weeks later? Isn't that possible?

MR. MCCRORIE: Objection, to possibility.

THE COURT: I'm sorry, objection to?

MR. MCCRORIE: Objection, to the possibility.

THE COURT: No, he can answer that.

Overruled.

Q. Isn't that possible?

A. Anything is possible.

Q. So the answer is yes?

A. Yes.

Q. And, again, that July 28, 2014 MRI which was the first one taken since the accident, that was the only MRI that you're aware of that Mr. Bazarnick had before you saw him, correct?

A. Yes.

Q. Did you compare the results, Doctor, of the MRI from July 28, 2014 to the one you took on February 29, 2016?

A. Yes.

Q. And how did they compare?

A. The '16 MRI showed progressive herniation, particularly at L4-L5.

Q. And did it also show progressive degenerative changes?

A. Not so much. So more herniation than degeneration.

Q. Okay.

Well, there was degeneration on the July 28, 2014 MRI, correct?

A. Yes.

Q. Did those remain the same in two years?

A. Yes.

Q. How old was Mr. Bazarnick in 2016?

A. Fifty-five.

MR. CERUSSI: That's all I have, Judge, thank you.

THE WITNESS: Thank you.

THE COURT: Redirect?

MR. MCCRORIE: Yes. Very briefly, your Honor, thank you.

REDIRECT EXAMINATION

BY MR. MCCRORIE:

Q. Doctor, I think you were asked questions about the times you've testified where a patient of yours happened to be a construction worker represented by Sacks & Sacks; whether it was Howard Borowick -- the late Howard Borowick or Mr. Kafora or myself as the attorney, whether it was the neck or the back in each of those occasions, did you show the jury the material you removed from the body?

A. Yes.

Q. You were asked questions about degeneration on the 2014 and the 2016 MRI; you previously testified that we all get degeneration after maturity. Would you expect degeneration in any 55 year old body?

A. Yes.

Q. In the spine?

A. Yes.

Q. Does degeneration or desiccation, those words, equal pain?

A. No.

Q. Or symptoms?

A. No.

Q. With regard to an MRI of any part of the body one year later, two years later or three years later, would you expect to see acute findings from an accident that happened years before on

any MRI?

A. No.

Q. Regarding the age of the herniation, I didn't ask you any questions about the age but you were just asked could you tell how long it is from 2016.

When you said you meet a patient you need a history, does the fact that Mr. Bazarnick -- does the fact that he had no symptoms before the accident and that soreness led into radiating pain in the weeks after the accident, give you any clue medically with reasonable certainty as to what caused the symptoms?

A. Yes.

Q. And what caused the symptoms there? It's not hypothetical, what really happened here?

A. A tear of the anulus that led to a herniation that then led to radiculopathy. It's pretty textbook scenario for lumbar disk herniation.

Q. You said anything is possible; it's possible a herniation developed after the fall, correct?

A. Yes.

Q. Is it possible that the normal desiccation or -- withdrawn.

Is it possible his disk from carrying -- from the accident, had an annular tear and as you said caused the jelly to come out with movement over the weeks such that it eventually touched on one of the nerve roots, the cauda equina one of the

nerves, is that possible?

A. Yes.

Q. Is that what you believe happened here?

A. Yes, it is.

MR. MCCRORIE: Nothing further.

THE COURT: Any recross?

MR. CERUSSI: Nothing further, Judge.

THE COURT: All right, Doctor, you may step down.

THE WITNESS: Thank you, your Honor.

(Whereupon, the witness's testimony was concluded and the witness was escorted out of the courtroom.)

THE COURT: All right, let me see the attorneys for a minute.

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

THE COURT: May call your witness.

MR. MCCRORIE: I call Mr. Bazarnick back to the witness stand, your Honor.

(Whereupon, the witness resumes the witness stand.)

COURT OFFICER: You may be seated.

You are reminded that you are still under oath. You may be seated. And please restate your name for the record.

THE WITNESS: George Bazarnick.

COURT OFFICER: Thank you.

THE COURT: You may inquire, counsel.

MR. MCCRORIE: Thank you.

CONTINUED DIRECT EXAMINATION

BY MR. MCRORIE:

Q. George, thanks for your patience and everyone's patience.

Because we have an outstanding Court Reporter, we have the daily transcript and I know the last question that I asked you.

So when I last was asking you questions, George, you had testified something about what we just heard about but that you had talked to Dr. Kaplan and that you -- that the back had changed from soreness to something else, okay.

So you passed the first visit with Dr. Kaplan. Okay, George? And now it's -- I just want to know and I believe that you have already testified that you went back to CitiMed and now you're back at Dr. Kaplan's after the new year, okay?

A. Yes.

Q. Yes?

A. Yes.

Q. So, George, can you tell the jury what if anything you told Dr. Kaplan about the change in your pain -- not to the knee or your ankle but just the back?

A. I told him my back was still sore, my lower back. And I

said all of a sudden I started to feel a radiating pain, you know, going down my leg.

Q. Had you ever --

A. My left leg.

Q. Had you ever in your life felt a radiating pain going down your left leg, prior to the time in 2013 when you told Dr. Kaplan?

A. No, sir, never.

Q. Okay.

I want to speak generally, Dr. Kaplan will be coming in but what were your complaints to Dr. Kaplan, in general? I know you won't remember them exactly but the first six months of 2013, what body parts and what did you tell him? What did you feel?

A. My left ankle hurt, it would swell and I would get shooting pains through it. My knee would hurt on the outside, it would swell up. And then I started to get that pain in my back and it was like a throbbing. And then it would go down my leg. I had never had that before in my life. It was reoccurring. It would get worse, it would get better.

And, you know, my foot would hurt. One day I could be sitting there, I'd get a shooting pain through my ankle and through my knee, too, you know. And I'd stand up and I'd get that numbness feeling going down my leg, my left leg.

Q. Were you able, physically, to go back to work from the

time the accident happened in December until the end of that year, so you know just 2012?

A. Unfortunately not, no.

Q. You heard when Mr. Bellizzi was cross examined about a lawsuit was started in 2012. At the end, you sought out legal services after your accident at some time?

A. Yes, sir.

MR. CERUSSI: Just note my objection to form.

THE COURT: No, overruled.

Q. In addition to seeking out our firm, did you have to seek out help with the work accident portion of the case?

A. Yes, I did.

Q. Okay.

Did you see any new doctors in the first six months of 2013 -- withdrawn. Did you continue to see Dr. Kaplan?

A. Yes, I did.

Q. Do you see Dr. Kaplan these days, today?

A. Yes, I still see Dr. Kaplan.

Q. I forget if I asked you about you but did you see him with any frequency from the time you first started seeing him until today with any regularity?

A. Absolutely, every eight weeks, six to eight weeks.

Q. Okay.

So forget Dr. Kaplan. Then did you start to see any new doctors in the beginning of 2013?

A. Yes, Dr. Schwartz.

Q. Okay.

Who is Dr. Schwartz or what's your understanding of the type of doctor he is? If Dr. Kaplan is an orthopedic, what is Dr. Schwartz?

A. He sort of makes sure you go see the right doctors, like help you coordinate who you're supposed to see and help you make sure you take care of yourself.

Q. Did you hear Dr. Merola say something about MMR or physical medicine ?

A. Yes, physical medicine and --

Q. Just a little louder, too. It's late in the day for everyone.

A. I'm sorry. I don't remember the -- all of the initials for all of these doctors. I just go to them when I have any doctor appointments.

Q. Okay.

We're going to get into what you recall of your treatment. But from the time you first had the accident, December 4, 2012, through today, have you ever had a day without pain to your left ankle?

A. No.

Q. Has the pain varied? Has it gotten better or worst at times?

A. It's gotten better and worst, yes.

Q. Have you ever had a day without pain to your left knee from the time that you had the accident until today?

A. No.

Q. And from the time your pain in your back began to radiate or shoot down the legs -- what you said to Dr. Kaplan, down the leg -- have you ever had a day without pain to your back regardless of whether or not it got better but has there ever been a day without pain to your back from that time until today?

A. Unfortunately not, no.

Q. Okay.

George, did you have any MRI testing within the first six months?

A. Yes.

Q. Do you remember the order of them or what you had?

A. I don't remember the order of them. I know whenever I got an appointment I went to it.

Q. What body parts did they -- you know, in the beginning, in the six months beginning, what did they do, whoever? What body parts?

A. I know there were tests done on my ankle, my left ankle, my left knee and later on there was a test done --

Q. We're just talking the first six months. It went back and forth?

A. Yeah.

Q. I think I asked you yesterday -- why don't you tell the

jury if you could separate it out, what were you feeling to your knee in the first six months of 2013? What basically were you feeling?

A. It's a shooting pain. The way I describe it to the doctor is if I stood up it felt like my leg was going to fall in, like the top of my leg would sheer off from the bottom part of my leg.

Q. And did you enter any form of physical therapy in the first six months?

A. Yes, I did. Yes.

Q. Okay. And do you know -- what are the names -- withdrawn.

Have you been in physical therapy multiple times over the years?

A. Yes.

Q. Can you tell the jury the names of the physical therapy facilities, if you remember?

A. I don't remember the first one shortly but I went to him for six months and then I had gone to the next one that was called Theramax.

Q. Okay.

And in the beginning, what body parts were they doing the physical therapy to?

A. On my ankle and my knee. Left ankle and left knee.

Q. Did you -- although they were doing physical therapy to

your ankle and your knee, not to them but to Dr. Kaplan, did you continue to complain of any issues with your back beyond the first time you complained?

A. Yes, I told them that the pain was still there, it was getting worse and it seemed like it would come more and more. Instead of like just once, it would just keep coming and it got worst.

Q. Did you complain on each occasion to Dr. Kaplan?

A. Yes.

Q. Okay.

Did there come a time that Dr. Kaplan discussed with you the MRI findings of your left knee?

A. Yes, he did.

Q. What is your understanding? Did you have a surgery to your left knee in the first six months after the accident?

A. Yes, I did.

Q. Okay.

What is your understanding of what the surgery is? It's just a basic understanding, not what anyone said to you.

A. It's called a meniscus, it's on the outside of your knee and it's --

Q. A little louder, if you don't mind.

A. It's called a meniscus and it's sort of like something that helps your knee stay together.

Q. Okay.

Did that -- what were you feeling before the surgery? So one week before the surgery, just try to single it out; just to your knee, what were you feeling?

A. Pain. When I step on the floor with my foot, as soon as I picked it up it hurt. And if I turned, it hurt. It just, you know, it's an -- it's avoidable when you are walking, when you are stepping you would feel it. It would hurt all the time.

Q. What types of activities would cause the knee pain prior to the surgery?

A. Walking.

Q. What about stairs?

A. Stairs, yes, stairs. Walking, stairs, any kind of raise in the floor. Like a -- you know the things in between the rooms, the door saddle? Things like that.

Q. Let me ask you this, George. In the six months after the accident -- withdrawn.

From the age of 16 until the date of this accident, had you ever been off of work for six months?

A. No.

Q. How did it make you feel to not be working in that six month time period?

A. I don't know how to describe it to you. I didn't know what to do. I wanted to go back to work because that's all I know how to do.

Q. And, George, did the -- you had the surgery?

A. Yes.
Q. Okay.
Did that surgery help your knee pain to any degree?
A. Yes. I mean I thought it was going to get better.
Q. Okay. I understand what you thought but what did it -- did it -- so take -- withdrawn.
You had what's known as an arthroscopic surgery?
A. Yes.
Q. After whatever surgical pain anyone could feel from that or would feel, just separate that two weeks later a month later. Was your knee feeling any better than from before the surgery? Did it help?
A. It helped a little bit, yes.
Q. Okay.
In what way? Just -- what way, after the surgery did it help?
A. The pain was not as sharp and as quick. Instead of like something hitting really hard, it was hitting softer. That's it. It wasn't as sharp as it was before the surgery.
Q. At the same time you were feeling pain to your knee in that six month period, were you -- you've already told the jury. Describe the pain you were feeling in your ankle at that -- during that period.
A. My ankle, if I was walking and I would pick my foot up and that point where you're just about to turn your foot down, I

would get shooting pain over the top of my foot through my ankle. It would really -- it would hurt, a lot.

Q. Were you able to take any steps without pain?

A. No.

Q. What if any activities did the pain in your knee and your ankle in the first six months stop you from doing? Tell me the things that you did before that you couldn't do then other than work, obviously.

A. Practically everything. I couldn't do anything I could before. Anything that I did, it would be slower and more cautious and it hurt more.

Q. When you I'll say agreed to or did the knee surgery, what was your intention with regard to getting back to iron work at that time, understanding what you were feeling in your back and your ankle but what was your hope, what was your intention?

A. My intention was to work. I was going to work until I couldn't, probably until I couldn't work anymore.

Q. Well, did you have it in your head an age that you were going to work? When you started the iron working, you were 40 years old it looks like age wise?

A. Yes, yes.

Q. What age were you going to work to a --

A. Sixty-five, of course, like everybody.

Q. And had the accident not occurred, is what the question is.

A. Had the accident not occurred.

Q. So did there come a time -- did you continue to have pain in your knee after the knee surgery?

A. Yes.

Q. Did you do the physical therapy after your knee surgery that was required?

A. Everything that they asked me to do, I did.

Q. Okay.

And you were asked if you were in physical therapy at certain times or you weren't asked yet but the doctor was asked, was and is until the end of this proceeding, authorization required by someone else for you to go to therapy?

A. Yes.

Q. Okay.

After your therapy from your knee surgery, can you tell the jury -- we are going to go to like the next year because the doctor is going to be here.

The next year, okay, the next year after your new surgery can you tell the jury what if any complaints you made to Dr. Kaplan about your left ankle? I know you said it generally but now take it there after the knee surgery in May, 2013?

A. I told Dr. Kaplan that the pain isn't going away. I'm waiting for these things to go away. I'm doing everything that they say and it's not going away.

Q. Did Dr. Kaplan prior to January of 2014, from May,

discuss with you about the need for any other surgeries in his opinion?

A. He said there's a possibility that -- he gave me a chance to try to work on it and do it myself and make it better and he said we may have to do surgery.

Q. In January of 2014, did you undergo another surgery, different than your knee?

A. Yes.

Q. What part of your body in January of 2014 did you undergo surgery?

A. My left ankle.

Q. Prior to -- so in the weeks leading up to the surgery and the months, what was that pain, if any, to your left ankle?

A. How do you describe pain? Put it this way, I work with my hands and I worked with my hands my whole life. And if I tell you it hurts, believe me it hurts. I just -- it's hard to explain. When you work in the elements like we do and you do what we do, you learn how to take a little pain. This stuff was putting me down. I couldn't do anything.

Q. Okay.

Other than you said physical therapy, were you taking any medications that the doctor recommended from the time of the accident up until and through January of 2014 for pain in any part of your body?

A. Yes. It varied, different kinds of medications to try

to work on --

Q. Do you remember the -- do you remember the names of the medications?

A. There's so many I can't remember. I can remember some of them.

THE COURT: You know, we are going to stop.

MR. MCCRORIE: Yeah, of course.

THE COURT: We are going to stop.

Ladies and gentlemen, it's a little earlier than normal but we are going to stop. There are a couple of things that I have to do in the court here. So we are going to break now and we're return tomorrow, Friday, 9:30. We are going to resume the taking of testimony at that time -- is today Friday? I'm sorry. You're going to come back on Saturday -- no I'm just kidding, relax, relax. Boy, you know, I tell you, you should've seen the looks on your faces when I said that. Oh, my goodness.

All right, I'm sorry. We are going to return on Monday, Monday at 9:30. And in the interim period of time, do not discuss anything among yourselves or with anyone else and keep an open mind.

See you back here then. Follow the directions of the court officer.

COURT OFFICER: Jury exiting, all rise.

(Whereupon, the sworn jurors were escorted out of

the courtroom by the court officer.)

THE COURT: All right, you may step down, sir.

THE WITNESS: Thank you, your Honor.

(Whereupon, the witness was escorted off of the witness stand.)

THE COURT: All right, we just want to deal with the issue of Alternate Juror Number 3. We are going to bring her in right now and we are going to discharge her for the balance of the trial.

COURT OFFICER: She just went quick to get her stuff from upstairs.

THE COURT: That's fine. As soon as she comes downstairs bring her in, please.

(Whereupon, a brief pause was held in the proceedings.)

THE COURT: Come to order, please.

COURT OFFICER: Come to order.

THE COURT: Please let her in. Bring her in, please.

(Whereupon, Alternate Juror Number 3 was escorted into the courtroom by the court officer.)

THE COURT: Please let the record reflect that in court with us is Alternate Juror Number 3, Adylia Castro.

Am I pronouncing your name correctly?

ALTERNATE JUROR NUMBER THREE: Yes.

THE COURT: All right, Ms. Castro, I have been informed by the court officer that there's been a death in your family.

ALTERNATE JUROR NUMBER THREE: Emm hmm.

THE COURT: First of all, I'm sorry. And I understand that you will need to travel out of the city in order to attend whatever services or other things that need to be done under the circumstances. And I know that that's going to occupy at a minimum of Monday through next week.

ALTERNATE JUROR NUMBER THREE: Yes.

THE COURT: So I have discussed it with counsel for both sides and rather than put pressure on you to be back here let's say Tuesday and you could get out there and find that there are additional reasons that you need to be there and instead of putting pressure on you to just go and rush back here and then try to readjust all of your focus and thoughts on the trial, we've -- I have gotten the consent of the attorneys. We are going to excuse you for the jury service in this trial, okay?

ALTERNATE JUROR NUMBER THREE: Okay.

THE COURT: Now, before i send you off I do want to thank you though for your service. As I explained in the beginning, I said something may come up with the regular jurors that might require an alternate juror to replace them. Well, I guess it's been the reverse situation,

something has happened in your life and so it's necessary for us to excuse you.

ALTERNATE JUROR NUMBER THREE: Okay.

THE COURT: But please understand that we do thank you for your service and your participation here is important and is valued.

So with the thanks of the Court, thanks. People in the Bronx and thanks of the people of the state. Thank you. Your jury service is ended at this time.

Counsel for the plaintiff anything you wish to add?

MR. MCCRORIE: Oh, no, we would just -- I don't know if we're permitted to speak to the juror but we are collectively very sorry for the loss.

And just a remind her not to speak to other jurors until --

THE COURT: Yeah, yeah, you're right.

Do not discuss anything with any of the other jurors or anyone related to any of the jurors. They still have a job to do. They are instructed not to discuss it with anybody and so you're going to have to follow that same admonition. So please do not engage in any discussion with anybody please.

ALTERNATE JUROR NUMBER THREE: Okay.

THE COURT: Okay.

ALTERNATE JUROR NUMBER THREE: As far as the attendance is concerned --

COURT OFFICER: I'll take it of it outside.

THE COURT: Just follow the court officer and he'll guide you through the next steps.

ALTERNATE JUROR NUMBER THREE: All right, thank you so much.

MR. CERUSSI: Thank you, Ms. Castro.

MR. MCCRORIE: Thank you, Ms. Castro.

THE COURT: All right, we are adjourned until Monday morning at 9:30.

(Whereupon, the trial was adjourned to Monday, March 19, 2018 at 9:30 a.m.)

****

This is certified to be a true and accurate transcript from my stenographic notes.

_____

SHONELL N. MABRY

Senior Court Reporter