In The Matter Of:

Chica Torres v.

Ryder Construction Inc., et al.

February 17, 2026

Queens Supreme Court, Cvil Division

Original File Transcript 2-17-2026_Chica Torres v Ryder 713854-2022.txt

Min-U-Script® with Word Index

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS: CIVIL TERM: PART 17
----------X

VICENTE F. CHICA TORRES

Plaintiff, INDEX NO. 713854-2022

-against-

RYDER CONSTRUCTION INC. and
39 WEST 23RD STREET, LLC

Defendants. Jury Trial

----------X

H E L D:
88-11 Sutphin Boulevard
Jamaica, New York 11435
February 17, 2026

B E F O R E :

THE HONORABLE JOSEPH J. ESPOSITO

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

PENA & KAHN, PLLC
Attorneys for the Plaintiff
1250 Waters Place, Suite 901
Bronx, New York 10461
BY: STEPHEN B. KAHN, Esq.

PEIRCE & SALVATO PLLC
Attorneys for the Defendant
8 Cottage Place
White Plains, New York 10601
BY: RICHARD A. SALVATO, Esq. and
BREANNA C. KROMER, Esq.

NOAH COLLIN
EILEEN AGNOLETTO

THE CLERK: We're here for a returning case on file. Index No. 713854-2022. Let the record reflect all counsel are present.

You can all have a seat.

There's an application to the Court.

THE COURT: Yes. I understand there's an application. By whom?

MR. KAHN: It is by me, I guess.

THE COURT: Yes.

MR. KAHN: We have a medivisual of the actual surgery that Dr. Merola performed. I'd like to use it to aid him in explaining the surgery to the jury. The defendant has an objection.

THE COURT: And what say you?

MR. SALVATO: Yes, Your Honor. We have no objection to the use of the spine to explain it to the jury or the MRI films of the records. But a demonstrative exhibit not of the plaintiff's actual back, but of the procedure blown up in color this way is just to enflame the passions of the jury. It's more prejudicial than probative as to what occurred when other actual pieces of evidence from the surgery are available to them.

THE COURT: OK. I will permit its use. I don't think it's capable of enflaming the jury. You can explain to them when you cross-examine the witness that it's general

display of evidence and not of this particular plaintiff. It is not evidence as well. Demonstrative only.

Are we ready to go?

MR. KAHN: Yes, Your Honor.

MR. SALVATO: Yes, Your Honor.

THE COURT: Ken, line them up.

THE CLERK: Your Honor, should I bring the witness in?

THE COURT OFFICER: Are we ready, Judge?

THE CLERK: Yes.

THE COURT OFFICER: All rise. Jury entering.

(Whereupon the jury entered the courtroom.)

THE CLERK: Do all parties stipulate to the presence and proper seating of the jury?

MR. KAHN: So stipulated.

MR. SALVATO: So stipulated.

THE CLERK: Thank you. You may be seated.

THE COURT: I'm happy to see that you all came back. Thank you and good morning.

At this time I'll ask Mr. Kahn to call his next witness.

MR. KAHN: Your Honor, the plaintiff calls Dr. Andrew Merola.

THE COURT: Dr. Merola, come on up next to me. Remain standing. The clerk will swear you in before you testify.

We have one witness in the morning, ladies and

gentlemen. We have one in the afternoon. And that's Tuesday.

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

THE CLERK: Have a seat. If you want to get comfortable, you can move the chair up so you're closer to the microphone. We ask that you speak clearly and slowly into the microphone. And then if there's any unique words, just slow for the spelling of those words.

In a loud, clear voice please state and spell your name.

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

THE CLERK: And your business address?

THE WITNESS: 567 1st Street, Brooklyn, New York 11215.

THE CLERK: So last name is Merola, M-E-R-O-L-A. Address is 567 1st Street in Brooklyn, New York 11215. Is there a suite or a floor?

THE WITNESS: No.

THE CLERK: Thank you.

Your Honor, the witness has been sworn.

THE COURT: Thank you. Mr. Kahn.

MR. KAHN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. KAHN:

Q. Good morning, Doctor.

A. Good morning.

Q. Are you licensed to practice medicine in the state of New York?

A. Yes, I am.

Q. And can you please tell the jury when you would be so licensed?

A. 1992.

Q. Are you licensed in any other states?

A. New Jersey, Florida, Colorado. I did my fellowship in Colorado, and Nevada as well.

Q. Could you please give the jury your educational background.

A. Sure. I went to NYU undergraduate. I then went to Howard University College of Medicine. Subsequent to medical school, I did my training in general surgery and orthopedic surgery at Kings County Hospital in Brooklyn. And I did a spine fellowship at the University of Colorado in Denver.

Q. What is your specialty?

A. I'm an orthopedic surgeon that deals with neck and back issues.

Q. OK. A fellowship, explain to the jury what a fellowship is.

A. So a fellowship is training in a subspecialty after you've completed your general training. So orthopedic surgery is a five-year program, and so I spent an additional year doing just spinal work.

Q. Are you in private practice now?

A. Yes, I am.

Q. And is it all spinal surgery?

A. The majority of it is, yes. Of course, I see patients who have orthopedic issues, but spinal surgery is my subspecialty.

Q. Can you explain to the jury the process to become board-certified in orthopedic surgery.

A. So after you completed your education and your training in orthopedic surgery, there's a written examination which you take. After you pass the written examination and you've been in practice for two years, minimum, you gather all of your patients and your surgical cases, and then you essentially present those cases to a board of examiners. And you do an oral examination based on the cases that you've seen and evaluated and treated.

Then when you pass that second part -- so it's two parts -- and when you pass the second part, you become board-certified.

And then the process has to be renewed every 10 years. So I was first board-certified in 1996 -- no, 1998, and then

2008, 2028, next one, et cetera, et cetera, et cetera.

Q. Can you tell the jury your hospital affiliations.

A. Yeah. So I have -- I teach at Downstate, and I also have affiliations with New York Presbyterian.

Q. When you say you teach at Downstate, what are you teaching?

A. So medical students, orthopedic residents, and allied health professionals who are doing any kind of orthopedic rotation or spine rotation. Those folks can rotate with me, and they do, either in the office or in the operating room. And then we also do research at Downstate as well.

Q. Have you published any works?

A. Yes.

Q. Can you tell the jury about that.

A. Yeah. So part of the teaching responsibility is typically when you are looking at either clinical work, which means how patients respond to certain treatments, or you're doing, in orthopedics, what we call biomechanical work, which is where you're testing parts of the body or you're testing implants, you gather data on that. And then you see how that can affect the way populations and the human body behaves.

You then present that material to peer-reviewed journals, and it's part of the academic learning process.

Q. Are you a member of any outside associations?

A. Yes. I'm a member of the American Academy of

Orthopedic Surgeons as well as the Scoliosis Research Society.

Q. Now, the Scoliosis Research Society, that interests me. Could you explain what your work has been and what their mission is.

A. Yeah. So that deals with pretty much children and adults who have what we call spinal deformity, so those are curvatures of the spine. And they can occur for a number of different reasons. You can be born with a curvature, or you can develop a curve or deformity as life progresses.

And the Scoliosis Research Society looks at populations of patients that have those conditions and how best to treat them.

Q. Now, do you do any missions with them?

A. Yeah. So --

Q. Can you explain about that.

A. Yeah. So one of the things is -- particularly over the last 15 to 20 years, we've been doing more outreach into different countries where there could be a lack of care for patients with deformities involving either children or adults. And that takes place pretty much across the globe. We've done, you know, Central/South America, Eastern Europe, Asia Pacific, pretty much the whole world.

Q. And do you operate during those missions?

A. Yes. We operate with local surgeons in order to go over practices with them and ways of treating their patients,

yes.

Q. Is that voluntary, or do you get paid for that?

A. It's part of the thing that we do with the SRS, which is essentially 100 percent voluntary.

Q. OK. Could you explain what orthopedics is.

A. Yeah. Orthopedics and orthopedic surgery deal with whatever it takes to make sure that you can be up and about doing your normal activities of daily living. So it's the musculoskeletal system. It's your bones, your joints, your muscles, your tendons, your nerves.

Whenever your brain sends a signal to a part of your body that wants you to get up and do something and you are able to do that using your body, that's basically what orthopedics deals with.

MR. KAHN: Your Honor, at this time I would offer Dr. Merola as an expert in spinal surgery.

MR. SALVATO: Your Honor, we would object only to the extent that he was designated as a treating physician, not a 3101(d) and reserve our rights to object to questions that go beyond the extent of a treating physician.

THE COURT: That application is granted to that extent.

He's a treating physician; correct?

MR. KAHN: He is.

THE COURT: He's not an expert in his field.

MR. KAHN: He is an expert in his field.

THE COURT: Well, I mean, he's an expert in his field, but he's not an expert to the extent that there's a 3101(d)?

MR. KAHN: No. We didn't serve a 3101(d), but he's still an expert in spinal surgery.

THE COURT: He's a treating. He doesn't have to, right.

MR. KAHN: Right. OK.

Your Honor, with the Court's permission, I have a model of the spine, and I would ask the doctor if he can kind of give us a tutorial on the working of the spine, the interaction between the vertebrae and the disks.

THE COURT: Any objection?

THE COURT OFFICER: Your Honor, it hasn't been marked.

THE COURT: Let me first see if he's objecting to it.

MR. SALVATO: No objection to the extent that it has to do with the treatment rendered by Dr. Merola to the patient to explain it on the spine as a demonstrative exhibit, Your Honor.

THE COURT: Of course. We don't have to mark it.

THE COURT OFFICER: I want to make sure, Judge, that you're good.

THE COURT: Thank you.

THE COURT OFFICER: You're welcome.

THE COURT: It's used to assist the witness in his testimony.

BY MR. KAHN:

Q. So, Doctor, if you can just give us kind of a tutorial about the spine itself, the interaction between the disks and the nerves, how they all play out and work.

A. Sure. So basically in the spine is a column that supports your head over your pelvis. So it attaches your head to your pelvis. The column is made up of a number of bones that are stacked on top of each other. The bones are numbered from top to bottom based upon where they are.

The upper portion of your spine is your neck or your cervical spine. The middle portion of your spine is your midback or your thoracic spine. And the lower portion of your spine is your lower back or your lumbar spine. So every bone is numbered based on where it lies: 7 in the cervical area, 12 in the thoracic area, 5 in the lumbar area.

At the bottom of your spine is a part of your pelvis called the sacrum, and that's essentially one large bone that basically joins each half of your sacrum together. So the stacking of these bones is very specific so that they all line up together where they belong. And each bone is essentially glued to the other bone by a little piece of cartilage in between each bone called a disc. It's called a disc because it kind of looks like a disk. And it's a piece of cartilage that's

job is to maintain the bones in their proper alignment and to glue the bones together so that they're not sliding around abnormally.

Now, in addition to that, because your head is on top and your pelvis is on the bottom, your head needs to send a whole bunch of nerves down into your arms and legs and the rest of your body. And the way that it does that is it takes advantage of the column by sending those nerve fibers through your spinal cord and your spinal canal. So the wiring that it uses in order to move your arms and legs around comes through the spinal column through an opening in the back of the spinal column called the spinal canal.

So not only is it a structure that supports your head over your pelvis, but it's also a conduit that through which your nerves basically travel into your arms and legs and hands and feet.

Q. What is the function of the disc? I know you said to keep the vertebrae together, but does it play more of a function for the body?

A. Yeah. So the disc -- I mean, the disc does a whole bunch of different things; most importantly, maintaining normal alignment of your bones and absorbing the stress and strain that the column of your bones goes through when you're performing your normal activities. So when you're bending or you're lifting or you're twisting or any motions that you do, those

discs are absorbing the stress and strain that's involved in those activities in order to make sure that the bones remain in normal alignment and are not basically damaging any other parts of the spine or damaging any of the nerves.

Q. Now, without the discs, if there was just one bone from the top all the way down to sacrum, would the human body be able to bend and to move or rotate?

A. Yeah. So, you know, there is a disease whereby your spine turns into one big bone. It's called ankylosing spondylitis. And those patients are extremely stiff, and they're very brittle as well.

So you might imagine bone is a very -- it's like -- it's a very dense and, in some respects, a brittle substance. So if you just had one big column that was one solid piece of bone, it would not have the flexibility or resilience that it otherwise has with all of these discs in between each bone.

Q. I neglected to ask you: If you weren't with us here today, what would you be doing?

A. So Tuesday is typically an office based practice day, so I would be typically in the office starting around 8 a.m., and then finishing in the afternoon depending on how many patients I have.

Q. And are you being compensated for your time for being away from your office?

A. Yes, I am.

Q. OK. Can you please tell the jury how much you're being compensated.

A. Sure. It's $750 per hour for time away from the office and time away from the practice.

Q. And how many days a week do you operate on?

A. Two days a week.

Q. And you've doing this, or practicing medicine, I guess it's 30 years now; right?

A. Yes. I'm older. It's been at least 30 years, yes.

Q. And how many spinal surgeries have you done, do you estimate, over the last 30 years?

A. So typically it's a couple of hundred spinal surgeries per year, so times 30 years would put it into the thousands.

Q. OK. Now, did there come a point in time where Vicente Chica Torres came under your care as a patient?

A. Yes.

Q. And your records have been admitted into evidence as Plaintiff's Exhibit 9. I believe you have a copy in front of you. And can you tell us what took place on -- when was the first visit?

A. February 6th of 2023.

Q. OK. And what brought him to your office that day?

A. He had been brought in as a referral for an evaluation regarding pain and symptoms in his neck and back.

Q. OK. What were his complaints?

A. So the complaints that I had listed at that time were both neck and back pain with something called radiating symptoms into his arms and hands and legs and feet.

Radiating symptoms mean pain that travel from either the neck or back area down into your hands and fingers and down into your legs and feet.

Q. What causes the pain to radiate from the neck down the arms to the fingers, from the low back down the legs to the toes?

A. Yeah. So typically different things can cause pain to radiate. The issue for a spinal evaluation is to see whether or not any of those radiating or traveling symptoms are coming from either the neck or the back.

Q. OK. And did he tell you what kind of difficulties he was having at that time with -- because of the pain and the radiating symptoms?

A. Yes.

Q. What was that?

A. So typically, for example, and I had mentioned it before with the spine, where everything in the spine is designed to assist you with your ability to perform your activities, particularly activities that require bending or lifting or twisting, for example, putting on shoes and socks or making the bed or taking out the trash. These kinds of things that require you to bend or lift or twist and manipulate your spine are

activities that reproduced symptoms.

Q. So I want to go back to the radiculopathy. And how does that, if at all, relate to the discs in the person's body?

A. So because the spinal column, as I said, transfers the nerves from your brain down into your arms and hands and legs and feet, those nerves pass through the spinal canal. And the spinal canal is a structure that's formed by the bones and the discs. So the bones and the discs act as, if you would consider it, the floor of the spinal canal. And then there are a layer of bones that act as the roof of the spinal canal called the lamina. So the canal --

THE COURT REPORTER: I'm sorry. What is it called?

THE WITNESS: The roof of the spinal canal are formed by the bones called the lamina.

THE COURT REPORTER: Lamina. Thank you.

THE WITNESS: And they're like shingles on a roof.

So the nerves pass through the canal, and the floor of that canal is formed by discs and bones.

BY MR. KAHN:

Q. What causes the radiculopathy, though?

A. So typically --

Q. How does that happen?

A. So a couple of different things can happen. Since those nerves are exiting the spinal canal and traveling beyond the bones and the discs, any abnormality with a bone or a disc,

for example, if a disc protrudes or herniates into an area where a nerve is, it can cause irritation or pressure on the nerve.

The other way that you can have nerve pain is if the disc is damaged and leaks any kind of an internal fluid down onto the nerve, it can cause pain through a process of inflammation.

And then the other way that pain can occur is if the bones are not behaving properly. In other words, if the bones are no longer aligned properly or moving properly, they can cause irritation to the nerves as well.

So there are multiple ways that the bones and the discs can cause a problem with the nerves because the nerves are intimately involved with where the bones and discs are.

Q. Did Mr. Chica Torres relate to you on that first visit the difficulties in his everyday life that he was having as a result of the pain and the radiculopathy?

A. Yes.

Q. Can you please tell the jury what that is.

A. Sure. And those difficulties were exactly related to activities that required him to either bend, lift, or twist, for example, putting on shoes and socks, making the bed in the morning, those kinds of activities.

Q. Now, you set forth in your record what a pain scale. In other words, what was he complaining of pain, what level?

A. Yeah. So a pain scale is essentially a way of trying

to understand, you know, how a patient perceives their pain, how bad their pain is.

And so what I'll typically tell a patient is 0 is absolutely no pain at all; and 10 is, you know, severe pain that is really interfering with your life and your activities. So a 0 is nothing; 10 is really very, very, very bad pain. And so where do you fall in between there, between the scale of 0 to 10?

And in this case it was, in general, particularly with activities, at an 8 out of 10.

Q. Now, did you perform a physical examination?

A. Yes.

Q. And can you tell the jury what the examination consisted of and what the results were of the examination.

A. Sure. So typically an examination involves a couple of different components. One is observation. So you look to see how a patient is behaving in terms of their ability to walk and how they hold their posture. And then you also essentially touch and/or palpate a body in order to test the nerves and the muscles and the joints.

And that thing where you combine observation and your testing of the patient while you're touching them gives you now an opportunity to understand how their body is working and where some of these symptoms may be coming from.

Q. Now, taking a look at your note, you say, "The patient

has an antalgic and kyphotic gait pattern with spasms."

What does that mean?

A. Yeah. So typically when you walk, it should be very smooth, and your heels and your toes should strike normally, and you really shouldn't notice the body bouncing too much. If you notice that the body is spending a little bit more time on one leg than another, that translates to a limp. A limp in medical terms is antalgia.

The other thing is posture. Normal low back posture should have a reverse -- a reverse bend to it; that's called lordosis. An abnormal lumbar posture has a forward bend to it; that's called kyphosis.

So in this case, if you looked at the low back posture in addition to his walking, the pattern was described, as I described it, as a kyphotic and an antalgic gait pattern.

Q. Did you make any impressions at that time, or did you continue with your exam?

A. Yeah. So typically observationally, from what you can see in a kyphotic lumbar pattern in patients that have limps, you understand that there is a problem with the lower extremities -- that's the legs and the feet -- in addition to the lower back.

Q. Now, you also set forth that he had spasm in the cervical, thoracic, and low back regions of the spine. What is spasms? What causes it?

A. So spasm, if you've ever had a charley horse or a muscle cramp, that's your muscle going into spasm. That's a very severe spasm. You can tell that that muscle is in spasm because, well, you feel it; it's painful, number 1.

And number 2, it's harder, right. It's an area where your muscle, it has a certain hardness to it that muscles that are not in spasm don't have.

So when you're doing your examination of the patient, you can palpate the muscles in the back. Your back muscles go straight up and down your lower back on both the right and left sides, from top to bottom. So you can feel if there are differences in the softness or the hardness of the muscles. And it's the same for your arms and legs and the legs and feet. You can see, by comparing one muscle group to another, whether or not you feel hardness or an abnormal contracture of a muscle.

And those things can tell you about those areas of the body because spasm is -- typically your body doesn't want to be put in a position that causes pain, so your muscle is going to contract to prevent that from happening; and, therefore, you would feel or see or in some way elicit spasm from a patient.

Q. In the simplest term, is spasm the body's reaction to pain to protect it?

A. Yeah, correct.

Q. And you mentioned something about palpate, which means to touch?

A. Yes.

Q. Were you able to actually touch his body and feel the spasms that were going on at that time?

A. Yes.

Q. And would that be an objective test?

A. Yes.

Q. Let me ask you something: The body -- we've heard about degeneration, degenerative conditions. What does that mean?

A. So, you know, when you're born and you're growing and your shoe sizes and your clothing sizes change, you're in a process of rapid generation; right? Your cells and your body is rapidly producing more body as you get bigger and taller and wider.

When you've reached your level of maturity, your skeletal maturity, your body stops rapidly growing; you start to see the effects of wear and tear more than replacement. And when those wear and tear effects start to take over, those wear and tear effects are called degeneration.

So after you've reached skeletal maturity, which is somewhere around 12 or 13 for women, and about somewhere between 14 to 16 for boys, beyond that your wear and tear process takes over a bit more rapidly than your production process.

And that's the process of degeneration.

Q. Is it fair to say it's all part of the natural aging

process?

A. Yes.

Q. Everybody here in the courtroom is going through it --

A. Yes.

Q. -- fair?

A. Yes.

Q. Now, just because there's some degeneration in an area of the body, be it a spine, the knees, the shoulders, does that mean that that part of the body can never be injured by trauma?

MR. SALVATO: Objection.

THE COURT: Overruled.

THE WITNESS: So as I understand your question -- would you repeat that, please.

BY MR. KAHN:

Q. Sure. Just because someone has some evidence of degeneration in a body part, such as the spine, the knees, the shoulders, does that mean that those body parts can never be injured again --

A. No.

Q. -- by trauma?

A. No.

Q. Now, did that complete your examination?

A. So, I mean, in addition to the spasm, some of the things that were found were -- with respect to particularly the lower back, was what's known as a provocative test. A

provocative test is, you actually try to reproduce the symptom.

And in this case it's a test called the straight leg raise, which is a test where you're actually pulling on the large nerve that travels down your leg, and you're seeing whether or not there's a withdrawal response from you placing that nerve into a position that reproduces pain. And in this case it was positive.

And that test also went along with reflex and sensory loss in the large nerves that travel down into the lower legs. So that was also kind of confirmatory for a problem with the nerves traveling into the lower legs.

Q. Now, you also write in your report of February 6, 2023, "There is L4, L5, and S1 dermatome, distribution sensory loss noted." What does that mean in laymen's term?

A. Yeah. So that goes along with what I just said in terms of the large nerve going down into your leg. So that nerve is responsible for what your leg feels and how it feels things. And when your sensation is abnormal, you would have abnormal sensory loss.

Q. And he had that?

A. Yes.

Q. Now, did you have an opportunity during that visit to review his MRI films of his low back from March of 2022?

A. Yes.

Q. And what did they reveal?

A. So that showed that there were what are called herniations or disc protrusions; that is discs that stick out beyond the confines of the normal bony vertebrae, particularly at L4-L5 and at L5-S1.

Q. Was there also a herniation at C5-C6?

A. Yes.

Q. OK. And did your opinion and your evaluation of those MRI films, was that -- did you concur with the evaluation of the radiologist, Kolb Radiology, Thomas Kolb?

A. Yes.

Q. So your diagnosis and Dr. Kolb's diagnosis was in lockstep that the MRIs, March of '22, showed herniations at L4-L5 and L5-S1; is that fair?

A. That's correct. There were herniations at both those levels, yes.

Q. OK. And you talk about also an EMG study. Can you discuss with the jury what an EMG study is and what it showed.

A. Sure. An EMG is an electrical study of the way your nerves behave inside your muscles. So if you think about the "E," it's electrical; the "M" is basically with respect to the muscles; and then the "G" stands for graph, which is a graph of the way your nerves behave inside your muscles.

It's a test that involves placing needless into specific muscles in your body that you can then send electrical current through in order to test how the nerves are functioning

within those muscles.

Q. What was the result of the EMG study, the nerve conduction study?

A. So that -- the basic result there was that it showed that there was a C5-C6 radiculopathy, which is the area where the disc and the neck was. And then L4-L5 radiculopathy, right in the area where the L4-5 disc was.

Q. Now, after taking a history from Mr. Chica Torres, performing an examination, reviewing the lumbar and cervical MRIs and the EMGs, did you reach a diagnosis at that point?

A. Yes.

Q. And what was your diagnosis that you reached?

A. The diagnosis was -- so cervical, neck; lumbar, lower back; radiculopathy, meaning problem with nerves in your neck; and problem with nerves in your lower back at C5-C6 and at L4-L5.

Q. Now, with regards to the radiculopathy in the low back, after reviewing the MRIs, did you reach an opinion as to what exactly was causing that radiculopathy? And if you can use the spine maybe to show the jury.

A. Yeah. So the diagnosis is based on that patient's history, what they tell you, and their complaints and their symptoms, the physical exam findings of some nerve dysfunction in the neck and back, and the MRIs and the nerve testing.

And that all led to a problem with the nerves in the

neck area and the nerves in the lower back area.

Q. What was causing those problems with the nerves?

A. Protrusions of those discs, the herniation at C5-C6 and at L4 through S1 in the lower back.

Q. Is it correct to say that in order to have radiculopathy, the discs have to protrude and compress the nerves at those level, which then produces or results in radiculopathy?

A. Yes.

Q. Is that what he had to a reasonable degree of medical certainty?

A. Yes.

Q. I want you to assume the following: That Mr. Chica has previously testified that on July 6 of 2021, about seven months prior to his accident here, he was working at Lawrence Hospital in the Bronx for painting. He bent down to pick something up. He felt some pain in his low back.

The following day he went to Flushing Hospital with those complaints. They gave him an injection. The pain went away after the injection.

He missed a couple of days of work. For the next seven months he was working full-time as a painter five days a week and sometimes on Saturday and Sunday for overtime.

He was never under the care of a doctor for his low back. He was -- never received any physical therapy or any

treatment for his low back. He never had an MRI prior to the accident that we're here for today; that at no time prior to the accident we're here for today did he ever see a spinal surgeon or receive a recommendation that he needed surgery in his lower back.

And then on February 11, 2022, which is the accident that we're here for today, while on the fifth rung of a ladder, he fell backwards onto cartons of appliances, had immediate pain, was taken by ambulance to Bellevue Hospital where he was seen for -- I don't know -- 10 hours or so. Discharged from the emergency room. Came under the care four days later of CitiMed receiving physical therapy to his neck and back and other body parts as well.

Do you have an opinion with a reasonable degree of medical certainty as to the cause of the herniation at L4-L5?

MR. SALVATO: Objection.

THE COURT: Overruled. What's the objection to? Come up.

MR. SALVATO: Yes.

THE COURT: Come up.

(Whereupon a sidebar was held off the record outside of the presence of the jury).

THE COURT: I'll give you a lot of leeway.

MR. SALVATO: Thank you, Your Honor.

MR. KAHN: I --

THE COURT: Wait a minute. Stop.

Noah, what's the last sentence of Mr. Kahn?

THE COURT REPORTER: It's very long. Do you want me to read the whole thing?

THE COURT: No. The last sentence. What did he say?

MR. KAHN: I withdraw it.

THE COURT: Just put the last question to him again.

THE COURT REPORTER: Do you want me to read it to him?

THE COURT: No, no. Mr. Kahn can do it.

BY MR. KAHN:

Q. Do you have an opinion with a reasonable degree of medical certainty as to what the cause of the herniation that you found on the MRI in Mr. Chica Torres's low back was?

THE COURT: You may answer.

A. Yes.

Q. Can you please tell the jury what the cause of that herniation is.

A. The fall of February 11, 2022.

Q. And can you explain why, how that happens? What are the mechanics of it?

A. Sure. You have a history of what we would consider, based upon that history, a low back strain that had otherwise resolved with a return to work and duties up until a point in time where there was an incident; that subsequent to that incident, there was a lengthy process of care and treatment with

complaints and symptoms specifically indicating radiculopathy.

Q. Same question: Do you have an opinion with a reasonable degree of medical certainty as to the cause of the herniation at L5-S1?

A. Yes.

Q. And can you please tell the jury what that is.

A. Yeah. It would be the same rationale based on a history of previous resolution with a subsequent history of a fall on February 11, 2022, with significant complaints and symptoms requiring long-term care regarding the low back injury.

Q. Could you show the jury, please, on the spine model where L4-L5 is and L5-S1 is and why we call them that.

A. Sure. So in the lower back, the green bones that you see here are the lumbar vertebrae, and they're numbered from 1, which is on top to 5, which is on the bottom.

The orange triangle you see is the sacrum. So L5-S1 is the last bone of the lumbar spine and the first bone of the sacrum. And L4-L5 is the bone that's directly on top of L5.

Q. How about in the neck, C5-C6?

A. So in the neck the first bone directly under your head is the C1. And C5-C6 is found right between the fifth bone down and the sixth bone down, which is essentially in the center portion of your neck.

Q. Now, at that time, after history, examination, review of diagnostic testing, MRI and EMGs, did you reach an opinion

with regards to whether he was disabled at that time?

A. Yes.

Q. And what was your opinion?

A. That he was temporarily totally disabled from his work.

Q. And was that with a reasonable degree of medical certainty?

A. Yes.

Q. What was the plan at that time?

A. So at that time, after I had initially seen him, I wanted to obtain -- I ordered a CAT scan of his lower back to better assess the bones themselves because the MRI is very -- you know, it's good at looking at discs and nerves. And a CAT scan gives you a little bit clearer picture of what the joints and the bones themselves look like. So I had ordered a CT scan of the lower back.

Q. Did he come back three weeks later to your office after having the CAT scan of his lower back?

A. Yes.

Q. And what took place at that visit?

A. So same thing. Discussion with the patient regarding his symptoms, and they were essentially the same. A physical examination, which continued to bear out abnormal findings indicative of nerve problems. And the CT images were available at that time, which I looked at.

And one of the things that was noticed on the CT scan was that in addition to the area where the herniations were, there was a displacement. In other words, there was an abnormal alignment of the bones in the lower part of the back, particularly in between L4 and L5. And that's called the listhesis, a spondylolisthesis, which is just a fancy term for an abnormal displacement of the bony alignment.

Q. Did that have a medical significance to you?

A. Yes.

Q. Can you please tell the jury what that is.

A. Yeah. Because, once again, one of the ways that you can have a problem with the nerves is not only through the disc protruding and touching the nerve, but it can also happen because there is a structural problem with the spine, and a structural problem such as a listhesis or a displacement of the bones would contribute to the radiculopathy.

Q. Do you have an opinion as to what the cause was of the listhesis?

A. So based on the herniation at L4-L5, and since the discs' primary job is to maintain normal alignment, an abnormal alignment was resulting in those bones secondary to the disc problem at L4-L5.

Q. Did you formulate any treatment plan at that point?

A. Sure. Yes, I did.

Q. And can you tell the jurors what the treatment plan

was that you formulated after receiving the CAT scan and evaluating it?

A. Yeah. So at that time, because the patient had had symptoms which had been essentially going on for over a year by the time I had seen him with the subsequent follow-up, and he had done therapy, had been on medications, and then also had some pain management procedures, he was essentially at the end of his treatment protocol.

So you've done conservative treatment, which you've exhausted; and, therefore, there are only surgical options left in order to decrease symptoms that he was having and to prevent any further deterioration.

Q. What is the treatment protocol that you were just talking about?

A. So typically everything -- unless there is a life or limb threatening issue, most treatment protocols, 90 percent of them, if you will, involve nonsurgical care, which is basically starting with rest, modifying your activities, utilizing medications, doing physical therapy.

And then if those do not help, there are subsequent treatments, which can involve injecting medications into the areas that are producing symptoms. Those are typically pain management procedures.

So conservative care essentially involves treatment that does not require an open, structural, surgical procedure.

Q. Now, did you recommend surgery on that second visit?

A. Yes.

Q. And can you tell the jurors the type of surgery that you recommended.

A. So the type of surgery is called the laminectomy, which means taking pressure off the nerves by opening the spinal canal area, and a spinal fusion, which means gluing the bones together where the bony displacement was in order to stabilize the area to prevent it from continuing to displace.

Q. Now, because he was involved in a work accident, did you have to await authorization to do the surgery?

A. Yes.

Q. Now, did he continue to see you over the following months until the surgery actually took place?

A. Yes.

Q. OK. And at a certain point, did you receive the authorization to go forward with the surgery?

A. Yes.

Q. Can you tell the jurors when the surgery actually went forward?

A. The date of surgery is March 13, 2024.

MR. KAHN: Now, with the Court's permission, I would ask that the doctor be allowed to come down. And I have a medivisual illustration of the surgery to help the doctor in explaining the surgery to the jurors.

THE COURT: Officer.
THE COURT OFFICER: Coming, Judge.
THE COURT: If you can set that up for Mr. Kahn.
THE COURT OFFICER: Uh-huh.
MR. KAHN: Thank you, Your Honor.
THE COURT: You have something to put that on?
THE COURT OFFICER: I'll find something.
MR. KAHN: If we could just do the tripod, Your Honor.
THE COURT: Where did she put it?
THE COURT OFFICER: Catherine put it over here; that's why.
Judge, do you want to be able to see this also?
THE COURT: Yes.
THE COURT OFFICER: OK. So, Doctor, if you look this way, tell me which way I can move it to help you see better. Do I got to go closer to the table?
THE WITNESS: I think you're OK.
THE COURT OFFICER: Because I don't want you to be uncomfortable while you're trying to see it.
THE WITNESS: No, no, I'm fine. No problem.
THE COURT OFFICER: And you can see. All right.
THE COURT: If he needs to step down, he can do so.
THE COURT OFFICER: Come down, Doctor, if you want to.
MR. KAHN: You may want to use this (indicating).

BY MR. KAHN:

Q. So, Doctor, we have in front of you Plaintiff's Exhibit 10, which we're using for demonstrative purposes.

THE COURT: That means it's not evidence. It's not evidence. And you're not going to take it with you when you deliberate. It's to help the doctor testify about what he's about to tell us.

BY MR. KAHN:

Q. Doctor, taking a look at Plaintiff's Exhibit 10, is this a fair and accurate representation of the surgery that you performed on Mr. Chica on March 13, 2024?

A. Yes.

Q. And could you please explain the surgery using Plaintiff's Exhibit 10 for the jury?

THE COURT: Doctor, did you create this diagram?

THE WITNESS: I reviewed it, Your Honor.

THE COURT: What's that?

THE WITNESS: I reviewed it, Your Honor.

THE COURT: That's not my question. Did you create it?

THE WITNESS: I didn't. I did not draw it, Your Honor, no.

THE COURT: OK. That's a factor that they can consider. You didn't draw it. Tell us what it is.

THE WITNESS: So this is -- there are multiple images

that describe the operative report regarding the procedure on the lower back that was done in March of 2024.

BY MR. KAHN:

Q. Please continue.

A. So the procedure itself is made on the backside of the lower back. There's an incision that's made in the midline, over the area of L4-L5 and S1 so that you can expose those bones in order to do the procedure, which involves basically two processes.

One is the laminectomy; that is, to take pressure off the nerves. And that involves shaving away these backside coverings of the spinal canal called the lamina. And that's done between L4 and L5, which is seen in the right-hand upper corner here (indicating) and between L5 and S1.

So those laminectomies are designed to basically make more room for the nerves which are being irritated in those areas.

The second part of the procedure involves this area where there was displacement of L4 and L5. And that was an area that required the process of stabilization, also known as fusion. And in order to achieve fusion, you have to basically fix those bones together to get them to glue in place so that they no longer continue to displace.

And that's done by inserting several what we call pedicle screws, which are attached to rods to internally brace

the bones of L4 and L5 because that was an area that additionally had displacement. So in order to address the displacement, that area was stabilized.

(Whereupon, the following was recorded and transcribed by Official Court Reporter EILEEN AGNOLETTO.)

Q The bone graft, could you explain what that is all about?

A So bone graft is the glue that your body uses in order to stabilize the bones together, so if you broke your bone, like your arm or your wrist, that fracture would create an area where your bone cells would go in there and then glue those bones together, that is the way you would heal a fracture.

When you are stabilizing bones that are not fractured, you harvest your own bone from other areas, for example, from the area where the laminectomy was and also from the area where a portion of the pelvis called the iliac crest is, and then you combine that with some donated bone, so you make kind of a bony glue to place in between the area that you want to stabilize.

So bone graft can be considered a way of gluing your bones together so that they heal together for stability purposes.

Q Now, the fusion itself, exactly what is a fusion, what are you fusing?

A So you are stabilizing L4-l5, which are the bones that were previously displaced.

Q Now, the pedicle screws that you had identified, what are those made of?

A Titanium.

Q And what about the rods?

A Titanium.

Q And are they still in his body?
A Yes.
Q Will they be there for a lifetime?
A Yes.
Q Anything else about the surgery that you want to discuss?
A No. It's basically just the -- the basic understanding is removing pressure off the nerves to give the nerves a chance to heal and stabilize the bones so they don't continue to cause any other damage.
Q Now, the lamina that you removed, the bone in the L4 and the bone in L5-S1, will that every grow back?
A I mean, yes, you can have some bone grow back --
Q Okay.
A -- in the area where the fusion is, particularly, but that bone when and if it does grow back you still got extra room for the nerves.
Q Now, is this a permanent alteration of Mr. Chico Torre's spine?
A Yes. It's a structural procedure. It changed the way the lower back is operating in order to best prevent any further damage, yes.
Q Now, the fusion, we have a fusion between L4 and L5, is there a total loss of motion now between those vertebrae?
A Well, L4 and l5 essentially grow into one vertebra.

Q So that there is one bone there now?
A Yes.
Q All right. You can have a seat now, Doctor. Thank you.
Now, doctor, do you recall that long question I gave you earlier?
A Was this the question regarding causation?
Q Correct.
A Yes.
Q And I want you to assume all of that as well, and do you have a opinion within a reasonable degree of medical certainty as to whether or not the accident of February 11, 2022 was the competent producing cause for the need for the surgery that you just discussed with the jurors that took place on March 13, 2024 Joe?
MR. SALVATO: Objection, just preserving my right for the record.
THE COURT: Overruled.
A Yes.
Q And can you tell the jurors what your opinion is?
A My opinion is that the need for the surgery was secondary to the fall of February 11, 2022.
Q Now, did Mr. Chico Torres see you postsurgery?
A Yes.
Q And can you tell us the jurors when he came back for a

postop visit?

A So the operation was on March 13th. The first postoperative visit was March 25th.

Q And what took place on that visit?

A First postoperative visit is essentially a visit to make sure that the patient has not had any problems or complications from surgery, and in this case he was healing appropriately subsequent to the surgery.

Q And what were your recommendations at that time?

A That he was he postsurgically stable and could start physical therapy as long as he felt comfortable enough to do that, and to avoid bending, lifting, and twisting and to avoid repetitive motion to the neck and back.

Q When was the next time you saw him?

A July 1st of 2024.

Q And what took place in July of '24?

A So that was the second followup. At that time he was continuing to recover from surgery, and his physical findings showed that that recovery process was essentially going normally.

Q Now, you say in the physical exam he was still antalgic and still kyphotic, why is that?

A So that means that the lower portion of the back had flattened it out, that kyphotic posture that was there, which was there, which is typical in patients that have had a low-back

issue requiring surgery.

Q You also go on to say that there was spasm in the cervical, in the low-back regions. Why was he still spasming at that time?

A So spasm is apart of the normal process regarding his neck and back in the postoperative intervals, so that is not an unusual finding for that period of time.

Q Fusion surgery in and of themselves, what are they actually designed to do?

A Stabilization, so any time you hear the word fusion, you are talking about stabilizing a condition in order to prevent any further damage.

Q Are they designed to eliminate all pain?

A No. So you can think about a spinal surgery the same way you could think about diabetes medicine or high blood pressure. It's a way to manage the condition, so if you have high blood pressure or diabetes, you are never really curing those conditions, but you are taking medications to manage the condition.

Spinal fusion surgery is a way to manage the problem in order to prevent it from getting worries, the same way you would take medication for high blood pressure or diabetes.

Q Now, is the fusion surgery designed to eliminate any further neurologic damage?

A From the areas that have been operated upon, correct.

So the areas that are causing neurological problems with damage you want to prevent that neurological damage from getting worse and that is the primary goal of the surgical procedure.

Q And when we say neurological damage, can you explain in layman's terms what we are talking about?

A So your nerves do a bunch of different things. Number one is they feel things. They can also cause pain. They move your arms and legs and your bones and joints around and they are responsible for your reflexes.

You might imagine that that if the neurological condition gets worse, each one of those actions that nerves are responsible for can become impaired, right, so you could have, in addition to sensory loss, you can now lose your reflexes or you could lose the ability to move your arms and legs.

Weakness is the primary issue that you want to avoid, so the primary neurological damage that you'd like to avoid is you would like to avoid weakness, you would like to decrease painful symptoms, and you want to avoid any progressive weakness.

Q Whatever nerve damage is already there, is it already there, in other words, do nerve regenerate?

A So nerve behave a little -- they behalf differently depending on what they do. The best chance for a surgery to help is with pain. About 90 percent of the time you can decrease radiating pain and symptoms.

Reflexes only come back about 50 percent of the time, and weakness only comes back about 30 to 40 percent of the time, so those nerve fibers have different sensibilities, depending on what they are responsible for, which is why you want to prevent weakness from happening because it has a lower success rate in terms of regenerating.

Q What would have happened if he had not had the fusion surgery and prevented further neurologic damage?

A So the issue would be weakness in the legs and feet and difficulty with the ability to walk.

Q Now, you further noted in your July 1, 2024 note that there is still residual L4-L5 and S1 distribution sensory loss. What does that mean?

A So sensation and reflexes, as I said, have about a 50 percent chance of getting better, so that's where he is right now, at that 50 percent mark. That means you are, you know, you are on the fence. Is sensation going to completely and entirely return? Well, you have a 50 percent chance of that happening.

Q Do you have an opinion as to whether it is going to come back?

A It really depends on what most recent visit was, and if I may jump up to October.

Q Right. Now, October 7, 2024, that was the last visit?

A Yes.

MR. SALVATO: Objection.

THE COURT: There's an objection.

MR. SALVATO: Yes, to the question, the last visit is in 2025.

MR. KHAN: Oh, I'm sorry.

MR. SALVATO: Just to save time.

MR. KHAN: Thank you.

Q So October 7, 2024, what do you say about the sensory loss?

A That at that point in time it had not returned.

Q And at that point in time did you come to an opinion as to whether or not that would be a permanent condition?

A At that point in time it would more likely than not be permanent because of only a 50 percent chance of getting better.

Q Now, after that you saw him a year later. Let's go to your last note of October 6, 2025, about four months ago.

Can you tell us what was going on on that visit?

A Sure. So that was a follow-up visit from the previous October visit of 2024, and let's see. He had what appeared to be some quadriceps reflex improvement, but some persistent lower extremity, that is L4-L5 and S1 sensory loss.

Q So he still had had the sensory loss about four months ago. Can we agree at this point it is probably a permanent condition?

A Yes.

Q Also you say that he still has mechanical and axial

low-back pain. What is mechanical and axial low-back pain?

A Pain with activities that are mechanical, bending, lifting, twisting.

Q Is that is a permanent condition?

A Sure.

Q In regards to his neck, what were his complaints on October 6, 2025?

A Let's see.

Q First page, third paragraph.

A Occasional neck pain, some radiating symptoms intermittently.

Q Did you perform an examination on that date?

A Yes.

Q And can you tell the jury what the examination consisted of and what your findings were?

A Sure. So he had some mild sensory loss in the sixth nerve root distributions.

Q That's in the neck?

A Correct. There were no muscular problems, no significant weakness, and primarily spasm in the neck.

Q Okay, and let's go to the lower back. What did your exam consist of; what were the results?

A So L4-L5, S1 sensory loss, some return of the quadriceps reflexes, and spasm in the lower back.

Q And how about his range of motion in the low back?

A So his range of motion was in, let's see, in extension it was 40 out of 60, in flexion it was 45 out of 60, bending to the right was 40 out of 45, bending to the left was 40 out of 45, and rotation was 45 out of 80 on both the right and left sides.

Q Okay. So with regards to lumbar extension, that's the ability to bend backwards?

A Correct.

Q And you say that his numbers were 40 out of 60, 60 being normal?

A Yes.

Q And would it be fair to say that he's lost a third of his ability to bend backwards?

A That's right, yes.

Q Is that a permanent condition?

A Yes.

Q Now, with regards to flexion, that is the ability for us to bend forward?

A Yes.

Q And you said he was 45 out of 60, 60 being normal, correct?

A Yes.

Q Would it be fair to say that he lost 25 percent of his ability to bend forward?

A Yes.

Q And is that a permanent condition?
A Yes.
Q And do you have an opinion with a reasonable degree of medical certainty as to whether or not the accident of February 11, 2022 was the cause of the loss of range of motion in Mr. Chico's low back?
A Yes.
Q Can you explain to the jury what your opinion is.
A Yes. So the whole treatment plan here was based on the disc problems stemming from the February 11, 2022 injury that required surgery, and so these are his persistent postoperative findings.
Q Now, did you reach an opinion with a reasonable degree of medical certainty as to his disability status at the time that you last saw him in October of 2025?
A Sure, so let's see. I indicated that he would be at, I determined, the 66-percent disability from the entire labor market.
Q What does that mean, 66 percent disability?
A So, you know, a hundred percent would mean you really can't do anything, zero percent means you could do everything up until heavy, heavy, heavy duty labor. 66 percent would mean something between sedentary to light duty. Light duty capacity is typically somewhere requiring the manipulation of about 25 to 30 pounds of pushing and pulling and lifting, so somewhere in

that neighborhood.

Q Could he go back to being a painter?

A So a painter would be more -- wouldn't be a -- let's see, that would be it's not a heavy duty labor, but it is moderate duty labor so that would be no.

Q Can he go back as a construction worker?

A No, sir.

THE COURT: Can he paint?

THE WITNESS: Occasionally, of course, yes.

Q Could he go back as a laborer on a construction site?

A No.

Q Now, do you know if there are -- withdrawn.

You are not a vocational rehabilitation specialist; is that fair?

A Correct.

Q So you would not have any knowledge or opinion as to what the job market was out there for him, fair?

A Correct.

Q So what what is his prognosis?

A I would say the prognosis -- well, when you talk about prognosis, that means was is your -- what is your best educated medical guess for the future, and it's the same educated medical guess that you would give a patient with diabetes or high blood pressure, which means you need to continue care and treatment. The definition of requiring care and treatment in terms of a

prognosis is guarded, guarded basically means you guarding them, right you're watching them and you are maintaining them over their care of their lifetime, so their prognosis would technically be guarded.

Q Did you make any recommendations to him with regards to future treatment or activity modification?

A Yes, so activity modifications and restrictions, specific avoiding repetitive, consistent repetitive motion, such as bending, lifting, and twisting, and then using your body as your guide to do what you can and cannot do, which basically is to avoid activities that reproduce pain and symptoms, and then would not be unreasonable to use medications, such as anti-inflammatories, to treat periods of exacerbation in pain or symptoms to the neck and back.

Q Why did you advise him to avoid repetitive motion, avoid bending, lifting, and twisting?

A So with the neck and back, as we said, your primary issues for your neck and back are activities that involve bending, lifting, and twisting, those are mechanical.

When you alter a patient's normal anatomy, you are now changing their normal way that the spine works. So constant repetitive bending, lifting, twisting in motion produces extra stress and strain to those parts of the spine that you've modified with your surgery, so it only stands to reason that decreasing those activities prolongs the surgical procedure that

you've done.

Q Now, what if somebody would do that repetitive bending, lifting, and twisting with the type of procedure that Mr. Chico Torres underwent?

A So you are going to first off develop symptoms, right. You'll have symptoms of pain and spasm from the constant repetitive motion, and then you'll also start to develop some wear and tear in the areas where you've done your surgery.

Q And when you say wear and tear in the areas on which you've done the surgery, what type of wear and tear are we referring to?

A So you would be referring to degenerative changes from a breakdown of the tendons, and the joints, and the discs in the area adjacent to the area where the surgery was.

Q Now, would it be fair to say that painting involves repetitive motion, such as bending, lifting, and twisting?

MR. SALVATO: Objection.

THE COURT: Overruled.

MR. KHAN: He's not painting at an easel.

A So, you know, painting on a consistent basis would involve consistent bending, lifting, and twisting.

THE COURT: Painting?

THE WITNESS: On a consistent basis, yes, depending on what kind of painting you are doing and whether or not you had any ergonomic modification.

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

THE COURT: Are you ready to do cross-examination?

MR. SALVATO: So we can go through it fully, if we take a two-minute bathroom break, I can finish before lunch.

THE COURT: Good, that's what. We'll take a five-minute bathroom break. Do don't discuss the case. Don't do any research of your own.

Don't discuss your testimony, Doctor, during the break with your attorney.

Ten minutes.

THE COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

Doctor, you can step down. You can't discuss your testimony. If you need the need the restroom, you go out in the hallway and it's right here. Thank you.

(Whereupon, a short recess was taken.)

THE COURT OFFICER: All rise, jury entering.

THE CLERK: Do all parties stipulate to the presence and proper seating of the jury?

MR. KHAN: So stipulated.

MR. SALVATO: So stipulated.

THE COURT: Welcome back everyone.

Mr. Salvato, he's your witness now.

CROSS-EXAMINATION

BY MR. SALVATO:

Q Good morning, Dr. Merola.

A Good morning.

Q I want to start with if at any point during my questioning my pronunciation is so pour, ask me the word again and I'll spell it out for you. Okay?

A Yes.

Q Now, Doctor, you are a orthopedic spinal surgeon, correct?

A Yes.

Q And you're not a radiologist, correct?

A Correct.

Q And I'd ask, going forward on the record, that you do what you you're already doing. If you able to answer yes or no, please do, and if you can't please let me know.

Did you review the prior findings of the radiologist?

A Yes.

Q And in this case the MRI films that you reviewed were predominantly from Kolb Radiology, correct?

A Yes.

Q And can you recall a time where you ever disagreed with radiological findings of Kolb Radiology?

A Yes.

Q On about how many occasions, if you know?

A I don't know, but I have, I sometimes disagree with radiology findings.

Q And, now, you've testified numerous times on behalf of your patients who are plaintiffs in personal injury litigation, correct?

A Yes.

Q And have you testified over 200 times on behalf of the plaintiff?

A I would say over the course of the last 30 years, yes.

Q And you charge for time away from your office, correct?

A Yes.

Q And if I understood you correctly, $750 per hour?

A Yes.

Q And you are being paid for your testimony at that rate here today?

THE COURT: Not for his testimony, for his time.

Q You are being paid for your time at that rate today, right?

A Yes.

Q And how much have you been paid thus far for your time?

A I don't know. I don't have that information with me.

Q Do you have a general idea?

A No.

THE COURT: You don't know how much you're being paid on this case?

THE WITNESS: I don't know how much I've been paid or I don't know how time I will be here today, so I don't know those specifics numbers, your Honor.

Q And when was the first time you had any discussion with plaintiff's counsel about this claim?

A I believe it was about a week or two ago.

Q Now, Dr. Merola, are you able to quantify for the members of the jury, given the procedure that you performed on Mr. Chico Torres, the multiple visits with him, how much you've actually billed for your services for Mr. Chico Torres?

A I'd have to go back and look at the billing records so I'm not sure exactly.

THE COURT: Did you bring your records with you?

Q There was a my next question. Did you bring your billing records here today?

THE COURT: Don't interrupt me.

MR. KHAN: I apologize.

THE WITNESS: Not billing records, your Honor.

THE COURT: He doesn't have them.

Q You were served a subpoena in this case to produce your records here today, correct, Dr. Merola?

A Yes.

Q And did that include a request for your billing records?

A Yes, and I believe for the billing records they are

outsourced so they go to a separate company.

Q So is it your position that you are not in possession of any of your billing records?

A Yes.

Q And do you have a general idea, even using $25,000 to $50,000 of wiggle room as to how much you billed for the surgeries and treatment in this case?

A So I think the standard fee schedules for an initial visit is $125. I think the followups are anywhere between 75 to a hundred and some odd. Then I think the fusion is, I think that's anywhere between, and I'm guessing, I think that's somewhere between maybe 9 and 12 or 13, so those are guesses.

Q Anywhere between 9 and 12 or 13 is the portion of the bill that you personally would receive, correct?

A Yes.

Q The overall bill of a lumbar fusion, is that in excess of $100,000?

A No.

Q Now, as we sit here today, though --

A When you said overall, I'm sorry to interrupt you, do you mean like the hospital and everything else or you just mean me?

Q Everything involved in the lumbar fusion surgery which would include the hospital.

A So I don't know what those numbers would be.

Q And you don't have anything here that would help you substantiate the actual cost?

A Yes, that's correct.

Q Now, Doctor, would you agree you perform about 250 of these fusion surgeries per year?

A More or less, depending on the year.

Q And would you agree the average spinal surgeon performs approximately 80 to 90 of these spinal fusions?

A Depends on where you are and what your referral sources are, so it can vary, so it's variable. I would say anywhere between that number, or less to my number or more depending on what your practice is like.

Q But would you agree that that is half of the amount of surgeries you perform?

A I'm not specifically aware of those numbers.

THE COURT: Well, would your number be on the high side or the low side, nationally or statewide, if you know?

THE WITNESS: I don't know, your Honor.

Q Thank you, Dr. Merola. Now, when Mr. Chico Torres came to see you for the first time, did he fill out an intake form?

A Yes, some folks do fill it out at intake, that's correct, yes.

Q And in terms of the subpoenaed medical records, is the intake form continued within those records?

A I don't believe so, no.

Q Do you know why it is not contained within those records?

A So for the intake forms, sometimes they get scanned in the chart, sometimes I just transcribe it. It demands on when I do the transcription for the office note.

So I will transcribe whatever is on the intake form into the office note, so if I do it right away and rapidly that may not get into the chart. If I have to do it at a later date, then it would get scanned and then I can go back and reference it and do my dictation.

Q What happens to the intake form if you don't keep it as a record?

A All the medical records that we don't scan into the chart are typically shredded so that we don't have any records laying around.

Q So any intake form he fills out on his first visit you're saying is mostly shredded?

A Yes, if it is not part of the electric medical record.

Q And it is not part of the record subject to subpoena?

A I don't believe so, no.

Q How was Mr. Chico Torres referred to you?

A I didn't know specifically indicate it, but I did receive some records from CitiMed, so I think he had come in from CitiMed because we had gotten even some records for him for his initial visit.

Q The way he was referred to you, would that normally be on the intake sheet?

A Not necessarily, no.

Q Now, before we get into everything, I just want to be clear about something. You said, you indicated the plaintiff can return to light or sedentary work, correct?

A Yes.

Q And if I understood your testimony here today correctly, that means pushing, twisting, and lifting up to 25 to 30 pounds?

A Sure.

Q So while if I understood everything you said already about the bending and twisting each day of a painter, light duty or sedentary work, as you recommended, could be a security guard at the front of a building, a front desk clerk, things of that nature?

A Sure.

Q And you've told him since October of 2025 or even the appointment before that he was capable of performing that work?

A Yes.

Q Now, Dr. Merola, would you agree the majority of individuals who undergo a spinal fusion return to work in some capacity within two years?

A Certainly, sure, patients that have undergone spinal fusion surgery can return to work within two years or so, yes.

Q Would you agree that majority of spinal fusion patients recover well enough that they can perform most, if not all, of the duties of household activities, the day-to-day activities of living?

A Sure.

Q Now I want to move to Mr. Chico Torres specifically.

If I understand correctly, he's a gentleman in his mid-thirties who told you he had a fall in 2022, correct?

A Yes.

Q And your first evaluation of him was on February 6th of 2023, about one year after the alleged incident?

A Yes.

Q And if I understand correctly, by the time you saw him a year later he had already had MRI films of both his cervical spine and lumbar spine from March of the previous year?

A Yes.

Q So those films had occurred about 11 months before?

A Yes.

Q And those MRI films from March of 2022, they showed disc herniations at L4 and L5, S1, correct?

A Yes.

Q And, Doctor, would you agree those MRIs from that same date in May of 2022 showed no lumbar fracture, no listhesis and normal vertebral alignment at the time?

A Yes.

Q And, Doctor, would you also agree that the March 7, 2022 lumbar MRI read by Dr. Kolb showed normal disc, normal marrow, no fractures, no listhesis, and normal vertebral alignment?

A Yes.

Q Now, Doctor, would you agrees those are classic indications of chronic disc disease?

A They can be.

Q Now, turning to your notes from the February 9, 2023 visit, which would be the second visit, correct?

A First visit was February 6th, second visit was February 27th.

Q Okay. So, Doctor, would your notes indicate that the CT of the lumbar spine taken on February 9th showed spondylolisthesis and foraminal narrowing at L4 and L5 and S1?

A Yes.

Q And another lumbar MRI any was taken by Dr. Kolb again on October 6th of 2023, correct?

A Yes.

Q And that MRI noted a posterior disc herniation at a L4-L5, a posterior disc herniation and L5-S1, Grade I retrolisthesis on L4-L5, correct?

A Yes.

Q And those were all described as unchanged compared to the March 22nd report 18 months earlier?

A Yes.
Q Did you agree with Dr. Kolb's findings that those were unchanged during that 18-month period of time?
A No.
Q So now the radiological reports from Dr. Kolb in March of -- I don't want to get the dates wrong -- in March of 2022 and October of 2023 did not show worsening, they showed stable, low grade retrolisthesis; is that correct?
A Yes.
Q Would you agree, Doctor, that a Grade I retrolisthesis is a mild, low-grade backward symptom often seen with a degenerative disc disease?
A Yes, it can be.
Q And it is relatively common in construction workers in their thirties and forties?
A Yes, it can be.
Q And, Doctor, would you agree that the L4 and L5, S1, those areas you showed us on the spine, those are among the most active regions of the spine?
A Yes.
Q And as some of the more active regions of the spine, they would undergo more wear and tear than the thoracic spine discs would, correct?
A Yes.
Q And as you pointed out, L4 and L5, S1, that has to do

with the bending, and getting up, moving around and twisting, correct?

A Yes, sir.

Q And, Doctor, would you agreed if someone is standing up a lot, like a painter, we can expect to see more degeneration in the spine in those areas after a prolonged amount of years of work?

A Sure.

Q Now, Doctor, before today -- well, withdrawn. Before you first spoke to plaintiff's counsel about a week or two ago, were you aware that Mr. Chico Torres had complained of back pain the year before this incident?

A No.

Q Were you aware that he had gone to the hospital and gotten injections in his lower back before you heard it from plaintiff's counsel?

A No.

Q So when you were treating Mr. Chico Torres, do you speak Spanish?

A Yes.

Q Okay. You speak flute Spanish?

A Yes.

Q So you were able to speak with him directly?

A Correct.

Q And he never mentioned to you that prior to

February 11th of 2022 he had bent over and was unable to get up and had to go to the hospital the next day?

A Yes.

Q Would that have been valuable information when you're attempting to make a diagnosis as to the causation of his injuries?

A Not so much if it was only transient.

Q Now, Doctor, someone who can't get up, requires an injection, do you consider that transient?

A If there is no further treatment, yes.

Q But you don know if there was any further treatment because he never told you about it in the first place?

A Not at the time.

Q Well, he never told you, correct?

A Yes.

Q And it's not contained anywhere in your medical records?

A Yes.

Q And so as a result you were unable to inquire as to whether there were medical records from Flushing Hospital that you could look at related to his lower back because he never told you?

A Yes.

Q Now, without the knowledge of the prior lower back injury on February 5th of 2024, you labeled plaintiff's

injuries, in part, as posttraumatic symptomatic spondyloptosis at L4-L5, correct?

A Yes.

Q And you claim there was severe vertebral foramina and spondylolisthesis at L4-L5 as per the MRIs of the spine, correct?

A Yes.

Q Those same imaging records from Dr. Kolb, they simply describe a Grade I retrolisthesis and unchanged disc herniations without any acute fracture, edema, or acute instability, correct?

A Yes.

Q So the posttraumatic characterization within your notes, that is your medical characterization, not the radiologist's objective description, correct?

A Yes.

Q And to be clear, this radiologist's description we are talking about, this wasn't a radiologist hired by defendants, this was the treating radiologist of the plaintiff, correct?

A Yes.

Q Now, at your initial visit in February 6, 2023, if I understood you correctly, at that time you characterized the Mr. Chico Torres as temporarily, a hundred percent disabled, correct?

A Yes.

Q And between the first visit and almost exactly a year, so February 5, 2024, we are one day short, your surgical request note, you noted that he still was a hundred percent temporarily totally disabled as a result of the widespread pain and difficulties with daily activities, correct?

A Yes.

Q And when it come to widespread pain or difficulty with daily activities, you are relying upon the subjective complaints of Mr. Chico Torres, correct?

A In part, yes.

Q Now, your operative report, Doctor, on March 13th of 2024, you state the purpose of the decompression and reconstruction it was posttraumatic low-back pain and radiculopathy, correct?

A Yes.

Q And you wrote that the purpose of this decompression and reconstruction was primarily to prevent the condition from getting worse, correct?

A Yes.

Q And you're not claiming you were preventing paralysis or loss of ambulation at this point, you were just trying to prevent any worsening of the current situation?

A Yes.

Q And you were operating basically because of pain complaints since the imaging hadn't changed in roughly two

years?

A Yes.

Q And those pain complaints are the subjective complaints from Mr. Chico Torres, not from anything you can see on the MRI or CAT scan films?

A The complaints are subjective, yes.

Q Now, the procedure you chose for this 38-year-old man, a fusion of L4-L5 with a Grade I retrolisthesis, that was not a high-grade slip, right?

A Yes.

Q And the radiologist never described any -- withdrawn.

His radiologist, not mine, his. Dr. Kolb never described any dynamic instability on flexion or extension, correct?

A Yes, none were taken.

Q And you already answered my next question, but I'll just get right for the record.

No flexion or extension X-rays showing any gross translation or anything of that matter were even taken before the surgery, correct?

A Yes.

Q Now, would you agree that patients can have disc bulges and even disc herniations without any symptoms?

A Yes.

Q And do you accept that the presence of a disc

herniation on MRI does not by itself mandate surgery?

A Yes.

Q And here the MRIs repeatedly showed no progression of the herniations and no change in the Grade I slip, correct?

A Yes.

Q And just to make sure I have this right, and if I asked it you can object, a Grade I slid is considered a mild condition, correct?

A Yes.

Q Now, without any change in the herniations or the Grade I slip over two years and without the MRI identifying there are no changes, you proceeded to perform a multilevel decompression and instrumented fusion surgery based on subjective pain complaints and the posttraumatic diagnosis you had provided, correct?

A And the treatment I had rendered to the patient, which included his physical exam, yes.

Q And now after his first postoperative visit you described him as postsurgically stable, able to go through the physical therapy process, correct?

A Yes.

Q And at that same postsurgery visit you stated that from a sensory motor and neurological function he was stable, correct?

A Yes.

Q And now by July 1, 2024, which is several months after you performed the surgery, you noted the surgery had been helpful in preventing significant and severe pain shooting in the extremities, correct?

A Yes.

Q But the pain you did still characterize in the notes as occurring, the axial low-back pain. That is something that you get based off of the complaints of Mr. Chico Torres, correct?

A Yes.

Q It's not something you can see?

A Yes.

Q And at that point in time, several months after the surgery, you still had it at a hundred percent temporary total disability?

A Yes.

Q Because a surgery like this it takes time to heal, correct?

A Yes.

Q But by October 7th of 2024 in your permanency report, you said that he had benefitted maximally from the surgery, correct?

A Yes.

Q And most people who benefit maximally, which is a medical term, from a spinal fusion are able to go back to most, if not all, the activities of daily living; is that correct?

A Yes.

Q And most people who benefit maximally from a spinal fusion are able to hold some kind of work, I'm not saying the same as before, but some kind of occupation as a result of the success of the surgery, correct?

A Yes.

Q So even when he has a fusion where he benefitted maximally, are you saying he can't do moderate work jobs, in an abundance of caution, you were recommending sedentary and light work?

A I'm not sure I understand the question.

Q We had discussions about painting early.

A Yes.

Q Given that he benefited maximally from the surgery, I understand you're saying he can't go back to work as a painter full-time, but if he wanted to paint a room in his house, would he most likely be able to do that?

A Yes.

Q And if he wanted to do any job where he continued have to lift push or pull more that 25 pounds, he should be able to do that as well?

A Yes.

Q Doctor, what percentage of your patients, after a surgery where you indicate they benefitted maximally, still indicate the axial low-back pain which is subjective in nature?

A So if I understand your question correctly, what percentage of patients that have spinal fusion surgery still have axial low-back pain?

Q I'm going to withdraw it and phrase it a little clearer because it was a poor question.

What percentage of your patients, in your experience, after having a spinal fusion that you characterize as benefitting maximally from still report some level of axial back pain?

A Sure. I mean a fair amount. I can't give you the exactly number, but a fair amount will still have low-back symptoms.

Q Okay. And in terms of your determining his disability status, does that take into account the subjective complaints of pain?

A Yes.

Q And does it take into account what the patient is telling you they can and can't do?

A Sure.

Q Now, March 2022, the lumbar MRI, which was taken just three weeks after the incident that occurred, there was no L4-L5 herniations in those images, correct, and in March there was no evidence of listhesis?

A Not by reading, correct.

Q And, Doctor, would you agree there is nothing in the

radiological reports describing vertebral body edema, disc space collapse, or endplate fractures that would be the markers of an acute structural failure?

A Yes.

Q Doctor, would you agree edema is a term for swelling, increase of fluid in an area of tissue?

A Yes.

Q And can we agree, Doctor, in looking at the records that you had at your disposal when you first examined Mr. Torres, there was no study, no film, no X-ray, or no MRI exhibiting edema in the lumbar spine, correct?

A Yes.

Q So your testimony is that he had a traumatic injury to his lumbar spine, correct?

A Yes.

Q And you are making that diagnosis despite the fact that all the imaging studies that you reviewed during the pendency of your treatment, not one of those films, not one study showed any swelling, correct, to the lumbar spine?

A Yes.

Q So on the imaging alone, the objective evidence we have in the imaging, you cannot say that the L4-L5 retrospondylolisthesis was caused by that incident rather than representing chronic degenerative changes; is that correct?

A Based on imaging alone, that is correct.

Q Now, in your report you say that all the spinal pathology and the need for fusion surgery are causally related, correct?

A Yes.

Q And that conclusion ignores the chronic degenerative features described not just from the radiologist at this hospital, but his own radiologist, Dr. Kolb, right?

A No, I would disagree.

Q Doctor, would you agree that fusion surgeries are generally reserved for cases with instability, deformity, or intractable symptoms that have failed al conservative measures?

A Yes.

Q And here you did a fusion for a Grade I retrolisthesis, stable retrolisthesis, without any instability documented, correct?

A Well, he had an electrical instability on the EMG as well as the physical findings.

Q And the physical finding would be where you are speaking with him and performing tests where you ask him to move his body?

A That's correct, yes.

Q And even the tests for flexion, extension, or anything else, when you ask him to move his body, it relies on the cooperation of the plaintiff or the patient, excuse me, in terms of how far they bend backward or forwards or anything else,

correct?

A In part.

Q In part. Now, you never offered him, before the surgery, a more limited decompression only procedure, correct?

A No.

Q I'm going to say the question again because it was a double negative and I'm not sure about your no.

Did you ever offer a decompression only procedure before recommending the fusion?

A So part of that counseling process is to offer him like all of the surgical options, which would include nonfusion versus fusion.

Q So is the answer yes, you offered him the decompression only procedure?

A Yes.

Q And is that contained within the medical records?

A Let's see, hang on.

Q I'll speed this up to help you.

A I was going to say if you go to the counseling session, it just, in terms of the counseling session, when we talk about options and alternatives to include nonsurgical and we do review the surgical options.

(Whereupon, the following was recorded by Noah Collin.)

CROSS-EXAMINATION (CONTINUED)

BY MR. SALVATO:

Q. OK. So several surgical options were presented to the plaintiff?

A. Yes. There is always, there's always two basic surgical options, decompression versus decompression and fusion.

Q. OK. Now Doctor, would you agree that you never obtained an independent surgical opinion from a non-treating spinal surgeon before recommending the instrumented fusion?

A. No.

Q. What other spinal surgeon did Mr. Torres see to get a second opinion?

A. So I don't know if it was a spinal surgeon, but it's a medical director. There's -- we talked about the whole approval process which goes through a medical director.

Q. OK. Now Doctor, your opinion that the incident made the fusion necessary rests primarily on your interpretation of both the complaints of Mr. Chica Torres and the examinations you performed on him, not on the imaging; correct?

A. It's a combination of all of those things.

MR. SALVATO: I don't have any further questions. Thank you.

THE COURT: Redirect?

(continued on the next page.)

REDIRECT EXAMINATION

BY MR. KAHN:

Q. Now Doctor, did you only recommend surgery because of Mr. Chica Torres' complaints?

A. No.

Q. Can you explain to the jury why that recommendation was made?

A. Yeah. I mean it's -- so when you are treating a patient, obviously you have their complaints and symptoms which are subjective. What it is that's bothering them, how long it has been bothering them, how it interferes with their life. So there is their own perception of their health and well-being. And then you have to combine that with your physical findings. Then you further combine it with your diagnostic testing. And you put all three of those things together to come up with a treatment plan that you then discuss with the patient to see where it is that they fall in that treatment plan.

Q. Now Doctor, when you performed the surgery, did you see the herniations in L4-L5 and L5-S1 with your own two eyes?

A. I'm just going to refer to the operative report. So in the operative report in the operative findings section, I did indicate that there were disk protrusions with protrusion of annular fibers and herniations at L4-L5 and L5-S1 with stenosis which appeared to be somewhat worse on the left side at L4-L5.

Q. On page 2 of 4 of your operative report, under

operative findings, it says we did find herniation at L4-L5 and L5-S1; correct?

A. Yes.

Q. And you saw those with your own two eyes; correct?

A. Yes.

Q. Do you do these surgeries under magnification?

A. Yes.

Q. Explain to the jury what that is, this magnification?

A. Sure. So if you have ever seen a jeweler working on jewelry or watches, they have these things on their eyes called loops. So they're basically eyeglasses with magnifiers on them. So it is called loop magnification. Sometimes, we use microscopes. But more often, it's just loops and a headlight so that you can illuminate and magnify the area that you're operating on.

Q. You've been performing spinal surgeries for over 30 years; correct?

A. Yes.

Q. Do you review all of your own MRIs?

A. Yes.

Q. OK. Would you rely on what a radiologist tells you without you yourself reviewing the MRI before operating on a patient?

A. No.

Q. OK. Do you know if any spinal surgeon would ever just

operate on a patient just based upon what the radiologist says?

MR. SALVATO: Objection.

THE COURT: Sustained.

BY MR. KAHN:

Q. Do all spinal surgeons review their own films?

MR. SALVATO: Objection.

THE COURT: Sustained.

BY MR. KAHN:

Q. How many MRI films do you review per year?

A. It's got to be over 1,000.

Q. So in your entire medical career, it would it be somewhere over 30,000?

A. Yes.

Q. How long does it take for a fusion to heal?

A. Typically, you want to think over your maximum healing at one year.

Q. Are you aware that the Bellevue emergency room records indicate that Mr. Chica Torres had tenderness down his entire spine, his cervical, his thoracic, and his lumbar spine?

MR. SALVATO: Objection.

THE COURT: Sustained.

BY MR. KAHN:

Q. I want you to assume that the Bellevue Hospital records are in evidence as Plaintiff's Exhibit 8. Tell us what that means, tenderness down the entire spine, cervical, thoracic

and lumbar.

MR. SALVATO: Objection.

THE COURT: Sustained.

BY MR. KAHN:

Q. You told us that you and Dr. Kolb had disagreed on the interpretation of the films, the lumbar of the March '22 and October of '23. Tell us what the difference was.

A. I think the major difference is that when we updated the diagnostic testing, there was also a CT scan which also gave more information about the status of the lower back which was clearer in terms of looking at the spondylolisthesis.

Q. Did any of the questions that you received on cross-examination change your opinion that the accident of February 11, 2022 was the cause of the herniations in Mr. Torres's body at C5-C6, L4-L5, L5-S1 and the need for surgery to the lower back?

THE COURT OFFICER: Objection.

THE COURT: Sustained.

Q. Are you still of the opinion the accident of February 11, 2022 is the competent producing cause of the herniations at L4-L5 and L5-S1?

A. Yes.

Q. And you're still of the opinion that the accident of 2/11/2022 are the competent producing cause of the need for surgery that you performed in March of 2024?

A. Yes.

MR. KAHN: I have nothing further.

THE COURT: Recross.

MR. SALVATO: No, Your Honor?

THE COURT: You may step down.

THE WITNESS: Thank you, Your Honor.

(Whereupon the witness exited the courtroom.)

THE COURT: Do we have anybody else or we have to wait until 2 o'clock? 2 o'clock.

The next witness, ladies and gentlemen, is going to be testifying remotely, not coming to the courtroom to testify. With that in mind, we'll break now until 2 o'clock.

Ken, try to get them back here, even at 5 to 2 if possible. We have a long lunch break. So, I want to get started at 2 o'clock if at all possible.

Keep an open mind. Don't discuss the case. Don't do any research. Don't speak to any of us. We will finish with the second witness in the afternoon. Have a good lunch.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon the jury exited the courtroom and the luncheon recess was held.)

(continued on the next page.)