

1 SUPREME COURT OF THE STATE OF NEW YORK
2 COUNTY OF WESTCHESTER

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3 EDDY ARMIJOS AVILA,

4 Plaintiff,

Index #
58754/22

5 -against-

JURY TRIAL

6 MIRIAM OSBORN MEMORIAL HOME ASSOCIATION,

7 Defendant.

-----x

8 111 Dr. MLK Jr. Blvd
9 White Plains, New York 10601
April 21, 2026

10 B E F O R E:

11 HONORABLE DAVID EVERETT,
12 Supreme Court Justice

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

14 WILLIAM SCHWITZER & ASSOCIATES, P.C.
15 Attorneys for Plaintiff
16 820 Second Avenue
17 New York, New York 10017
BY: KARDON A. STOLZMAN, ESQ.
Of Counsel

18 PILLINGER MILLER TARALLO
19 Attorneys for Defendant
20 555 Taxter Road, 5th Floor
Elmsford, New York 10523
21 BY: RICHARD J. FREIRE, ESQ.
& GABRIELLE L. SCIBETTA, ESQ.

22
23
24 ERICA ANDREWS, Senior Court Reporter

25

1 (Whereupon, the following occurred on the record in
2 the courtroom.)

3 (Whereupon, an item is received and marked in
4 Evidence as Plaintiff's Exhibit 2, by the Court Reporter.)

5 THE CLERK: This is Index number 58754 of 2022,
6 Eddy Armilos Avila versus Miriam Osborn Home Association.

7 Appearances.

8 MR. STOLZMAN: Kardon Stolzman of counsel to William
9 Schwitzer & Associates, for the Plaintiff.

10 MR. FREIRE: Richard Freire, Pillinger, Miller
11 Tarallo.

12 MS. SCIBETTA: Garielle Scibetta, Pillinger Miller
13 Tarallo for the Defendant.

14 (Whereupon, items are marked Plaintiff's Exhibits 3
15 & 4, for Identification, as of this date by the Court
16 Reporter.)

17 THE COURT: Doctor, why don't you come on up.

18 (Whereupon, the witness takes the witness stand.).

19 COURT OFFICER: All rise, jurors entering.

20 (Whereupon, the sworn jury panel enters the
21 courtroom.)

22 THE COURT: Okay. Please be seated everyone.

23 Let the record reflect that all jurors and
24 alternates are present and in their assigned seats. Good
25 morning everybody.

1 We had some matters to take care of. I apologize
2 for the delay but we're going to get right into the
3 testimony. I'm just going to say and we haven't had this
4 issue come up before but before we leave the jury room, just
5 check that your cellphones are off. I just checked mine if
6 mine was off and this is a true story. When I was in
7 private practice I had to make an appearance in bankruptcy
8 court on behalf of a client. I always make sure I say that
9 it was on behalf of a client. So I had to make an
10 appearance on behalf of a client and the Judge who was kind
11 of a stocky guy said if anybody's phone goes off, I'm going
12 to have the marshals confiscate it, this and that. Guess
13 whose phone went off? Not mine, the Judge's. Very
14 embarrassing.

15 So we're going to get right into it.

16 Counsel, please call your next witness.

17 MR. STOLZMAN: Thank you, Judge.

18 Mr. Avila calls Dr. Ari Lerner.

19 THE COURT: Dr. Lerner, would you stand up.

20 Do you solemnly swear or affirm that the testimony
21 you're about to give will be the truth, the whole truth and
22 nothing but truth?

23 THE WITNESS: I do.

24 THE COURT: Please have a seat. State your full
25 name for the record.

1 THE WITNESS: My name is Ari Benjamin Lerner.

2 THE COURT: If you want to move closer, it's
3 usually easier.

4 You may inquire, counsel.

5 DIRECT EXAMINATION

6 BY MR. STOLZMAN:

7 Q Good morning, doctor.

8 A Good morning.

9 Q You might need to move the microphone, so the jury can
10 hear you.

11 Doctor, can you please tell the jury what you do for a
12 living?

13 A I'm a physician. I do interventional pain management
14 which is focused on treating patients for pain, including
15 injection procedures, medication management, referring them for
16 physical therapy, ordering diagnostic tests and managing their
17 treatment plan. I focus mainly on the neck and back.

18 Q And doctor, are you licensed in the State of New York?

19 A Yes, I am.

20 Q Are you licensed in any other states?

21 A Also licensed in New Jersey.

22 Q Can you please tell the Court your education and
23 training to become for your practice?

24 A Okay. So I went to SUNY Stony Brook, I majored in
25 psychology. I graduated and did my postbaccalaureate in my

1 sciences at Queens College and I took all my premed courses
2 including some extra courses in biology and chemistry and then I
3 got into SUNY Downstate Medical School. I went there for four
4 years, I graduated in 2001.

5 I went to Staten Island University Hospital for one
6 year for my medicine internship and then from 2002 to 2005 I was
7 a resident of anesthesiology at SUNY Downstate Medical School in
8 Brooklyn. And then I did a fellowship year in interventional
9 pain management at St. Luke's Roosevelt Hospital in Manhattan.

10 Q And after you finished your fellowship, doctor, what
11 year was that?

12 A 2006 and-a-half.

13 Q And so for the last, after 2006 tell us about your
14 practice?

15 A I worked for almost two years at Mt. Sinai Hospital in
16 Queens as an attending anesthesiologist and I also ran a pain
17 clinic there.

18 After that I did anesthesiology for several years for
19 outpatient treatment. A lot of colonoscopies, urology
20 treatments and then I started my practice in pain management in
21 about 2010, 2011 and I opened my office in Queens in 2013. And
22 I have been working there and some other part-time offices ever
23 since.

24 Q And doctor -- may I approach?

25 THE COURT: Sure.

1 Q I'm handing you what's been marked as Plaintiff's
2 Exhibit 3, for Identification.

3 Doctor, just the during the course of your practice,
4 have you created a CV or Curriculum Vitae?

5 A Yes.

6 Q Does that Curriculum Vitae accurately reflect your
7 professional experiences as a practicing doctor? It's a
8 two-page document?

9 A Yes.

10 MR. STOLZMAN: At this time I would like to move
11 Plaintiff's Exhibit 3, into evidence.

12 MR. FREIRE: Objection, your Honor.

13 THE COURT: Just have him go through it.

14 MR. STOLZMAN: Okay.

15 Q I'll just refer to a couple of other things, doctor.
16 Can you tell us about your experience at Mt. Sinai
17 Hospital of Queens as a professor?

18 A I provided anesthesia services for a myriad of
19 different cases. I also did a pain clinic approximately one
20 day a week. I rounded on patients for pain management. There
21 was a nearby outpatient clinic where I saw patients for pain
22 management. Mostly I was doing anesthesiology.

23 Q And do you have any certifications, doctor, board
24 certifications?

25 A I'm board certified in anesthesiology and also in pain

1 management.

2 Q And what about hospital affiliations today?

3 A Presently I'm affiliated with New York Presbyterian
4 Queens Hospital.

5 Q Do you have any patients there, doctor?

6 A No.

7 Q Okay. And I understand, doctor, you have done some
8 lectures throughout the course of your career?

9 A Yes.

10 Q Can you tell the Court about those please?

11 A I gave some when I was at Mt. Sinai Queens I gave a
12 lecture on lower back pain. I also gave some lectures for the
13 New York State Fund. I was doing a lot of independent medical
14 exams and peer reviews at that time and they asked me to come
15 and give a talk about patients' pain, which I did. I did that
16 at a couple of different locations.

17 Q Can you explain for the jury what peer reviews are,
18 doctor?

19 A If a patient, let's say they have a procedure by
20 another physician, they'll ask me to review the medical records
21 and procedure report and give an opinion whether the procedure
22 was medically necessary and required for the patient.

23 Q And what about professional memberships, doctor. Can
24 you please tell the Court about professional memberships which
25 you're a member?

1 A Medical Society of the State of New York, American
2 Medical Association, American Society of Anesthesiologists and
3 New York State Society of Anesthesiologists.

4 Q And doctor, have you appeared in court, doctor, to
5 testify as an expert?

6 A Yes.

7 Q And during the course of your testimonies, have you
8 been qualified as an expert before?

9 A Yes.

10 Q Has there ever come a time -- strike that.

11 Do you know how many times you have been qualified as
12 an expert?

13 A Probably six, less than six times, maybe six.

14 Q To your knowledge, doctor, has there ever come a time
15 when you were deemed not qualified to testify as an expert?

16 A No.

17 THE COURT: All right, so let me just give you an
18 instruction.

19 Sometimes during the course of the trial I'll give
20 you an instruction but typically you'll hear it again at
21 the end of the case.

22 So different judges when it comes to witnesses have
23 different practices. A number of my colleagues will be
24 asked by the attorney for one side or the other to deem the
25 expert or deem the witness to be an expert. I don't do it

1 that way. I put some of that determination into your
2 hands. Let me just give you a little bit of an
3 explanation.

4 So when a case involves a matter of science or art
5 or requires special knowledge or skill that most people do
6 not have, a qualified witness is permitted to state his or
7 opinion for the information of the Court and the jury. The
8 opinion by such a witness which is frequently referred to as
9 an expert witness must be based on particular facts as that
10 witness obtained knowledge of them and testified about them
11 or as the attorney who questioned that witness asked them to
12 assume, for example, a hypothetical question.

13 You may reject any opinion, if you find the facts
14 to be different from the facts that form the basis for the
15 opinion.

16 You may also reject an opinion if after careful
17 consideration of all of the evidence in the case, including
18 the cross-examination of that witness, you decide that an
19 opinion is not convincing.

20 In other words, you are not required to accept any
21 opinion to the exclusion of the facts and circumstances
22 disclosed by the evidence.

23 Opinion testimony should be evaluated in the same
24 way as the testimony of any other witness. It is given to
25 assist you in reaching a proper conclusion. It is entitled

1 to such weight as you find the witness's qualifications in
2 the field warrant and must be considered by you but is not
3 controlling upon your judgment.

4 So based on the foundation that's been laid,
5 counsel's asking what the doctor's qualifications were, I am
6 going to allow him to testify and to give his opinions, okay
7 but what weight is given to those opinions, that's up to
8 you.

9 Okay. Go ahead, counsel.

10 MR. STOLZMAN: Thank you, your Honor.

11 Q With that in mind, doctor, I'm going to ask you, I
12 would like to proceed with some questions about your treatment
13 of the Plaintiff, Mr. Eddy Avila.

14 Before I do, doctor, I want to focus, for today's
15 testimony we're just going to focus on the treatment that you
16 gave Mr. Avila as it relates to his neck and back.

17 And doctor, you have you brought with you your file,
18 your chart?

19 A Yes.

20 Q And that's the same records that have been marked into
21 evidence as Plaintiff's Exhibit 2. The records marked into
22 evidence as Plaintiff's Exhibit 2 are up until November 2025.

23 Doctor, can you tell the Court when did you first start
24 treating Mr. Eddy Avila?

25 A He was first seen in my office on February 9, 2022.

1 Q And why did he come see you, doctor, what treatment was
2 he looking for?

3 A He had been in an accident, a work-related accident and
4 he was seeking treatment for his -- he was complaining of pain
5 in the neck, back, shoulders, wrists, left hip and his knees.

6 Q Before actually, doctor, before we go to talk about
7 your treatment of, your hand's on treatment with Mr. Avila,
8 you're testifying today at the request of Mr. Avila's attorneys,
9 correct?

10 A Correct.

11 Q And because you're not treating your patients today,
12 you work at a clinic, correct, doctor?

13 A Correct.

14 Q And that's where you treat your patients, that's your
15 daily business?

16 MR. FREIRE: Objection.

17 A Yes.

18 THE COURT: Overruled.

19 MR. FREIRE: I apologize, object to the form.

20 Q Okay.

21 Doctor, instead of being with your patients today at
22 the clinic are you being provided with compensation for coming
23 to the court today?

24 A Yes.

25 Q And can you tell the jury what your compensation is?

1 A Today it's \$15,000.00.

2 Q And why did you need that compensation to come to court
3 today?

4 A I had about 40 patients scheduled today, I had to
5 cancel them on short notice last week. I also did preparation
6 for this appearance. Not seeing the patients created a
7 significant burden on the practice. It will be hard to
8 reschedule them in a timely manner. We also use this time to
9 schedule procedures. There will be a fair amount of a loss of
10 procedures that I would do.

11 The patients, some of them scheduled to be seen today
12 won't be able to come for a good period of time. I also have
13 to pay my staff, regardless.

14 Q And doctor, you mentioned before that you've testified
15 in court. Have you ever testified with me questioning you
16 before, doctor?

17 A No.

18 Q And have you ever testified for William Schwitzer &
19 Associates law firm, if you know?

20 A I think once before.

21 Q And have you -- The times that you've testified in
22 court, doctor, as an expert, were those for patients or for
23 somebody else?

24 A For a patient.

25 Q Okay, forgive me. Let's go back to your first

1 examination of Mr. Avila.

2 With that in mind, when you saw him that was on
3 February 9th was it?

4 A February 9, 2022.

5 Q And that was at your clinic?

6 A Yes.

7 Q And can you tell the Court --

8 A That was at one of the clinics that I rotate through.

9 Q Okay. Where was that?

10 A It was in the Bronx, Third Avenue.

11 Q And what happened at that first examination, that first
12 visit to your office?

13 A I took a history of the injury. I checked his past
14 medical history, past surgical history, medications. I
15 evaluated his complaints, I did an exam. I did a treatment
16 plan. I discussed treatment options with him. I did
17 referrals, prescribed medication. I referred him for diagnostic
18 testing.

19 Q Let's break those down, doctor.

20 First of all you said that you took a history. What
21 does that mean and why is it important?

22 A I want to know what the patient's prior medical history
23 is, whether he has any medical problems, whether he had any
24 surgical history. As I mentioned I want to find out whether he
25 had any prior injuries, prior complaints, anything that would

1 have impacted his current complaints. I wanted to determine
2 what the mechanism of injury was. I wanted to correlate, to
3 the degree possible, his complaints with the mechanism of injury
4 and determine causality, what caused the injury. And then
5 based on the information that I received from him I could do a
6 focused physical examination and with all that information I
7 could devise a diagnosis and treatment plan.

8 Q And what was your understanding of Mr. Avila's history
9 when he came to see you on February 9, 2022?

10 A He was working in construction, he was on a ladder and
11 he fell from the ladder.

12 Q Besides that fall from a ladder, was there any other
13 history to his medical history, medical treatment of any kind,
14 doctor?

15 A He had no prior surgical history, no prior medical
16 history. He reported no prior accidents or injuries or pain
17 prior to this injury.

18 Q And what complaints did he have when he came to see you
19 that first time?

20 A He reported pain in the neck, lower back, shoulders,
21 wrists, left hip and his knees.

22 Q And you did an exam?

23 A Yes.

24 Q Can you tell the Court what your exam was for Mr. Avila
25 when you first saw him?

1 A He had tenderness on palpation of the cervical
2 paraspinal musculature on left. He had a positive Spurling
3 Test on the left and negative on the right. There was
4 tenderness of the thoracic paraspinal musculature on the left.
5 There was moderate tenderness on palpation of the lumbar
6 bilateral musculature with muscle spasm. The straight leg raise
7 test was positive 40 degrees on the left and negative on the
8 right.

9 Just to be clear, a person can complain of pain and
10 that's a subjective finding. That's what they feel.
11 Tenderness is a clinical finding, where when you actually touch
12 the area, it elicits pain. So the patient after touching it
13 they will say that hurts and typically I would ask him, I
14 understand that that's the area where it hurts, but does it hurt
15 more when I touch the area. Okay, so that's a distinction.

16 Spurling Test is an exam that we do where we bend the
17 head to the side and back and we apply light pressure to the
18 head and if it's positive the patient would complain of pain and
19 radiation, things like numbness and a tingling sensation which
20 would signify a compression of a nerve or inflammation of a
21 nerve in that area.

22 With regard to muscle spasm that's also a clinical
23 finding, where you would actually palpate or feel a tender area,
24 which when compressed it would give rise to radiation or pain.
25 Typically you can feel kind of like a knot where that muscle has

1 tightened.

2 Straight leg raise test was positive 40 degrees on the
3 left and negative on the right. Straight leg raise test is
4 another clinical test we do, where the patient is lying down.
5 We raise the leg up without the patient applying any pressure
6 and the patient would complain of pain from the back radiating
7 down the extremity, which would signify a nerve compression or
8 inflammation in the area because you're essentially stretching
9 the nerve.

10 In the sacrum there was a positive Patrick's, also
11 known as the FABER Test. Where we would where, we would rotate
12 and bend the leg over the other leg and press down and see if
13 the patient complains of pain, either in the sacrum or in the
14 hip. It's another clinical test that we use. He complained
15 at that time of pain in the left hip.

16 The shoulders were examined. He had reduced range of
17 motion of the left shoulder with tenderness. He was unable to
18 hold the left shoulder at or above shoulder level and there was
19 tenderness on palpation with range of motion of the left knee.

20 Heel and toe walk is a test we use to check for the L5
21 and S1 -- L4 and L5 nerves, where they would stand on the toes
22 and then on the heels. He complained of difficulty with that
23 maneuver.

24 Then I did a range of motion exam, which we do with a
25 handheld goniometer. He had reduced range of motion of the

1 cervical and lumbar spine. During range of motion testing, he
2 complained of pain.

3 Neurologic exam, I checked for muscle strength of the
4 upper and lower extremities. During this exam they were
5 normal.

6 Sensory exam of the upper extremities was normal.
7 Sensory exam of the lower extremities showed decreased sensation
8 in the L5 distribution on the left and normal on the right.
9 Deep tendon reflexes were symmetric bilaterally.

10 Q Doctor, you mentioned before -- first of all, let me
11 see if we can just do some vocabulary for the jury.

12 Tell the jury what cervical means.

13 A Cervical refers to the neck, thoracic is the midback
14 and lumbar is the lower back.

15 Q And you also made reference, doctor, to the term
16 subjective versus objective. Can you explain to the jury the
17 distinctions between the two please?

18 A Subjective is what the patient has control over, what
19 the patient complains of personally. It's what they are
20 feeling, it's what they're expressing. Objective are things
21 that myself as a clinician or other people would be able to see
22 or test for independent of their control.

23 Q And doctor, can you explain to the jury the
24 relationship that subjective and objective findings go into
25 making your diagnosis?

1 A I utilize both the subjective and the objective
2 findings. The subjective elements are if anybody had an
3 accident or complains of pain, you would go to the doctor and
4 complain of pain in those areas. Those would be your
5 subjective complaints. That's part of the initial part of the
6 exam.

7 The objective portion is the portion where we're
8 testing things that are not necessarily under the patient's
9 control. And that would include diagnostic tests, MRI exams,
10 EMG exams and to a certain extent a portion of the physical
11 exam.

12 Q And for the physical exam, can you just tell us,
13 provide a list of what objective testing you did during the
14 physical exam?

15 A Well, I will say most of this, most of the exam there
16 is a degree of subjective element to it. Testing for the
17 tenderness, the patient could complain of pain when I touch it
18 but I don't have any measure to say whether the patient truly is
19 complaining of pain.

20 The specialty of pain management is unique in that
21 regard because we're relying to a large degree on the patient's
22 subjective complaints both during the exam as well as the
23 patient's reports of pain, itself.

24 Similarly, with the Spurling Test I'm relying upon the
25 patient's report of their subjective sensations when I do the

1 test. Same thing with the straight leg raise test. Same thing
2 with the range of motion. There's a subjective component to
3 it.

4 When I'm testing for muscle strength, that's under the
5 patient's control. Sensation, I do a pinprick in multiple
6 areas that correspond to the -- I will tell you now, in terms of
7 sensation, I'm checking the patient's dermatomes. A dermatome
8 is a physical representation over the skin for sensation that
9 would originate in a particular nerve coming from the neck with
10 regard to the arms and in the lower extremities, the legs with
11 regard to the back, the nerves and vertebral levels. And the
12 vertebrae are the different levels of the spine.

13 The reflexes I test with a reflex hammer and that has
14 an objective element to it but also could be under the patient's
15 control, as well.

16 Q And doctor, as a result of your exam that you did, just
17 on that first visit, what treatment did you recommend going
18 forward for Mr. Avila?

19 A Well, I referred the patient for orthopedic evaluation
20 for his left shoulder, hip and knee. I referred the patient
21 for physical therapy for the same areas. We went over a home
22 emphasized program, which typically includes range of motion and
23 stretching and then the patient is also typically given a home
24 exercise regiment by the physical therapist.

25 I went over some physical restrictions, things such as

1 avoid any excessive bending, twisting, jerking maneuvers that
2 could potentially exacerbate the patient's pain or reduce his
3 recovery. Avoid lifting anything heavy, avoid strenuous
4 activity.

5 I prescribed him two medications. One is a muscle
6 relaxant, cyclobenzaprine. The other is Naproxen, which is an
7 antiinflammatory analgesic, both to be taken as needed. I
8 ordered the patient to go for an MRI of the cervical, thoracic
9 and lumbar spine. I ordered him to undergo an MRI of the left
10 shoulder and left hip.

11 On that date for his muscle spasm in the lower back I
12 did do a trigger-point injection, which is an injection into the
13 area where the spasm is felt and injected some medication. I
14 did some gentle needling to help reduce the muscle spasm and
15 reduce the pain.

16 Q And when you did the trigger-point injection, was there
17 a diagnosis that was included for that?

18 A Yes. That would be an objective finding in that the
19 patient did have muscle spasm that was present when I examined
20 them and touched the area, which again would be an area which
21 you would feel kind of a knotty muscular region, which when
22 pressed you would feel some radiation of the pain.

23 Q And you said you also referred or ordered MRIs, is that
24 right?

25 A Yes.

1 Q And can you explain to the jury what the purpose of
2 MRIs are?

3 A So the MRI is a test that we do that helps to give us
4 further clarity into the patient's underlying problem, in light
5 of the patient's complaints and exam findings. It helps to
6 give us information about the soft tissues of the spine, about
7 the bony structures, whether there is any problems with the
8 patient's discs which are in between the vertebrae and are in
9 close proximity to the nerves. So that would help to tell us
10 whether there's any encroachment upon those nerves, whether
11 there's any stenosis, which is compression of those nerves, any
12 pressure on the spinal column or the areas that encapsulates the
13 spinal column, itself.

14 Q Doctor --

15 MR. FREIRE: Your Honor, may we approach.

16 THE COURT: Yes.

17 (Whereupon, an off the record discussion was held
18 at sidebar. The Court and Counsel are present.)

19 THE COURT: Do you want to withdraw the question
20 and ask a new question?

21 MR. STOLZMAN: I'll ask a new.

22 THE COURT: Okay. Go ahead.

23 THE WITNESS: Can I just grab a cough drop?

24 THE COURT: Yes.

25 All right, counsel go ahead.

1 MR. STOLZMAN: Thank you.

2 Q In that first exam, doctor, going back to February 9,
3 2022, did you provide a prognosis or indicate a prognosis?

4 A Yes.

5 Q And what was that prognosis?

6 A Guarded.

7 Q Can you explain that? Explain for the jury what that
8 means?

9 A So the prognosis is what we expect the patient's
10 clinical course to be like in terms of his injury. It goes,
11 some of the words we use are good, poor and guarded.

12 At this point I had just seen him, the accident was
13 pretty recent. Guarded means we'll have to see how he does and
14 essentially hold off on making any determinations regarding
15 whether I think it will be a good progression or a poor
16 progression. So just guarded, we're just keeping an eye on him
17 to see how he does.

18 Q Just so we're clear, doctor, when you say the accident,
19 what are you referring to?

20 A I'm referring to the accident which occurred on
21 January 24, 2022.

22 Q Okay.

23 And doctor, you also provided an attestation of --
24 Strike that.

25 Doctor, during the February 9, 2022 exam, did you

1 indicate a cause of the symptoms that Mr. Avila had presented
2 with?

3 A So within a reasonable degree of medical certainty my
4 opinion was that the patient's complaints were due to the
5 accident which occurred on January 24, 2022.

6 Q And doctor, you just said the opinion you gave at that
7 time. Can I ask that all of the opinions that you give today
8 for this Court are to a reasonable degree of medical certainty.

9 A Yes.

10 Q Okay.

11 And with respect to the trigger-point injection that
12 you gave, that you administered to Mr. Avila to his lumbar
13 spine, can you explain for the jury what the effectiveness or
14 the expected effectiveness of the trigger-point injection will
15 be for someone's lower back pain, like Mr. Avila?

16 A Pain relief. A muscle spasm is, it's when the muscles
17 cramp up and do not relax and that can cause pain in a number of
18 ways by compressing, like any other muscles in the body, when
19 you are using that muscle it creates byproducts of metabolism
20 and those byproducts typically get mobilized away from the area
21 within the blood stream. When there's spasm because it's
22 compressing, those byproducts are not mobilized away from the
23 area and they can further cause pain and increase the spasm.

24 So we do this trigger-point injection and we use
25 needling and inject some pain medication, which is essentially a

1 local anesthetic to help relax the muscle, help to calm the
2 muscle and mobilize away those metabolites to decrease the pain.

3 This injection can last anywhere from hours to weeks.
4 It depends on the patient and it's really, independent of
5 anything objective it's hard to say how long it will last for.
6 I've had reports where patients say it lasts several hours and
7 some that say it lasts several weeks but it's something I can do
8 in the moment for the patient.

9 Q And after that first visit on February 9th, did you see
10 Mr. Avila again?

11 A Yes.

12 Q And was that on March 23, 2022, doctor?

13 A On that date he was seen by the physician assistant in
14 my office.

15 Q And can you explain to the jury why a patient would see
16 your physician assistant as opposed to you and what difference,
17 if any, they would have?

18 A Yes. The physician assistant works in my practice as
19 -- he will see patients typically for followups. It helps to
20 manage the number of patients, they help to insure that the
21 treatment plan is being followed. They'll do an exam like I do
22 an exam. They'll assess the patient's response to treatment,
23 make any changes. If anything stands out, we would discuss it
24 at length. We typically have discussions about the patients
25 and any issues that come up during the day. If anything is out

1 of the ordinary, I would be there to evaluate the patient as
2 well with the PA.

3 Q And at the time of the March 23rd exam, doctor, what
4 were the findings or based on that exam, how did Mr. Avila
5 respond to that first injection?

6 A He reported a decrease in the pain. He was able to do
7 housework and sleep better. He denied any side effects.
8 However, the patient's pain had returned. He complained of
9 pain of eight out of ten on his followup visit.

10 Q And was he prescribed any additional medication at that
11 time?

12 A Yes, his medication for the muscle relaxant
13 cyclobenzaprine was refilled. He was also prescribed a
14 Lidocaine patch. He was also given a cervical trigger-point
15 injection on this date.

16 Q And can you explain for the jury the cervical
17 trigger-point injection and any distinctions between that and
18 the lumbar one that he had received earlier?

19 A What I described about the lumbar trigger-point would
20 be same injection, same reason, different area.

21 Q And why was it decided to give him the injection for
22 his neck at that time?

23 A He was found to have spasm on exam. He was
24 complaining of pain in the neck. That was one of his major
25 complaints on this visit.

1 Q And at that exam, was there an assessment made in terms
2 of his percentage or disability at that time?

3 A Yes. He was again listed that he should not return to
4 work due to his injury.

5 Q And after the March visit, what happened next with
6 respect to his treatment?

7 A So he was recommended to continue with physical
8 therapy. He had brought his cervical MRI. We decided not to
9 do anything more invasive and to continue with physical therapy.

10 On June 1, 2022, I saw the patient. He was
11 complaining of pain again eight out of ten, complaining of neck,
12 lower back, pain in the legs and arms. He reported a reduction
13 of pain in the neck on this visit of 80 percent, which lasted
14 for eight weeks. He was able to cook and sleep better. No
15 side effects. Pain had returned.

16 Q And at that time, the testing that you had talked about
17 before, the Spurling, the left Spurling Test, leg raise range of
18 motion, were those tests done at that time?

19 A Yes.

20 Q And what were the results?

21 A Spurling Test was again positive on the left, straight
22 leg raise test was again positive on the left and negative on
23 right.

24 Q And what about with respect to the neurological exam,
25 were there any deficiencies found there, doctor?

1 A He had decreased sensation in the L5 cervical
2 distribution on the left and normal on the right.

3 Q And at some point was he recommended to have an EMG?

4 A Yes. He was recommended for EMG of the upper and
5 lower extremities. So whereas the MRI can take a picture of
6 the neck and back, the EMG is like an extension of the physical
7 exam. It will give us information that we may not be able to
8 get on the physical exam, itself. It helps to tell us whether
9 there is any consequences, let's say, of the findings on the MRI
10 and on the exam. It will determine whether there was any nerve
11 wave slowing or any abnormal nerve patterns and that's done by a
12 separate physician.

13 And we order that when the patient has complaints of
14 things like radiating pain or nerve-related symptoms, like
15 numbness or tingling or when an MRI shows multiple levels, it
16 helps to delineate the particular level involved.

17 Q When you talk, doctor, about radiating pain, can you
18 just explain for the jury what you mean by that, from where to
19 where?

20 A A patient may have pain, let's say in the neck and what
21 we say it radiates or travels from the neck down the arm or it
22 can radiate down the back and these are subjective components,
23 again this is what the patient is telling us. And for the
24 lower back, you would feel the pain radiate from the lower back
25 down the leg.

1 Q And when you talk about numbness and tingling, where
2 would that or where was Mr. Avila having that numbness and
3 tingling and what would be causing it?

4 A So a word we use for this numbness and tingling are
5 paraesthesias and he was complaining of these in the neck, lower
6 back and both arms. And so that would be things like numbness,
7 tingling, burning, electric shock type sensations, things that
8 signify nerve-related pain.

9 He was complaining of radiation and radiation can go
10 along with the paraesthesias and those symptoms. He was
11 complaining of radiation of pain to the bilateral arms. So the
12 sensations were radiation from the neck to the arms with these
13 paraesthesias.

14 Q So just so I'm clear, doctor, if he's having a
15 sensation or feeling in his arms or shoulders, does that mean
16 that that's the place that was injured or something else?

17 A No, you can have an injury to the neck, an injury to
18 nerves and even though you might not have injured the arm, you
19 can feel the pain radiating because that's where the nerves from
20 the spinal column exit into the arms. So if you have a damaged
21 disc, it could irritate the nerve while it's exiting the spinal
22 cord and as it goes down the arms. So you wouldn't just feel
23 it in the neck, you would feel it going down the arm.

24 And he also was complaining of lower back pain with
25 radiation down the legs, worse with walking with complaints of

1 numbness.

2 Q And you mentioned the results, how many EMGs did he
3 have?

4 A One for the upper extremities and one for the lower
5 extremities.

6 Q Can you tell us about the results for the upper
7 extremity?

8 A So for the upper extremity he had this done in June of
9 2022 and the impression --

10 MR. FREIRE: Objection, your Honor. May we
11 approach?

12 THE COURT: Come on up.

13 (Whereupon an off the record discussion was held at
14 sidebar. The Court and Counsel are present.)

15 MR. FREIRE: Withdrawn, your Honor.

16 THE COURT: You can continue your answer.

17 (Whereupon, the last question was read back by the
18 Court Reporter.)

19 A The impression revealed evidence of left -- wait,
20 that's the lower. Evidence of a bilateral C5 C6 radiculitis.

21 Q Can you explain to the jury what that means in lay
22 person's terms?

23 A That showed that at the C5 C6 level, there was
24 radiculitis and radiculitis is an extrapolation of the word
25 radiation and it's basically suggesting that this inflammation

1 of the nerve at that level is causing radiation.

2 Q And can you explain to the jury what C5 C6 means,
3 doctor?

4 A Each of the vertebral levels are numbered. So in the
5 neck it goes from one to seven and then thoracic it goes up
6 until twelve, from one to twelve and in the lower back it goes
7 from one to five.

8 We name the levels of the disc space in between the
9 levels. So C5 C6 is the disc space between the C5 and C6
10 vertebral body vertebrae.

11 Q When you say disc space, that means the space where the
12 disc is?

13 A Yes. So the spine is not a rod. It's made up of
14 different bony structures that connect to each other. In
15 between them, in each vertebral body there's an intervertebral
16 disc, which is considered soft tissue. It has a fibrous outer
17 coating and an interior gelatinous matrix. And when you're
18 very young, it will be very well hydrated and then as you get
19 older it might dry out and that's why people shrink when they're
20 older.

21 And then you have on the sides of the vertebrae what
22 are called facets or zygapophyseal joints, which are like other
23 joints in the body. They have a synovial capsule and they
24 connect to each other one on top of the other. For our purposes
25 here I don't think that's important.

1 More important are the discs. So typically these
2 discs have an ovoid roundish shape. However, they could become
3 deranged due to things like as you get older, they can be
4 degenerated and they could also become damaged due to things
5 like trauma.

6 Q And doctor, I didn't ask you this but when Mr. Avila
7 first presented to you, how old was he at the time?

8 A I think he was 25. He was 25 years old.

9 Q And just so we're clear, you had mentioned young, old.
10 How would you describe Mr. Avila's age at that time in the
11 context of what you were just discussing?

12 A Young.

13 Q And for all of these visits, doctor, you include that
14 or can you tell us -- strike that.

15 For the visit in June and the visit in March as well,
16 doctor, did you have the same or was it different with respect
17 to the cause of Mr. Avila's symptoms at that time?

18 A I asked the patient whether in between each visit there
19 had been any interim accidents and he has consistently reported
20 no interval accidents. So I attributed his current complaints
21 to the initial injury.

22 Q And had his disability or his level of disability
23 changed at any time from that first visit until June?

24 A No.

25 Q And moving on, doctor, you then saw him again a month

1 later, is that right?

2 A He was seen 7/19 2022.

3 Q And anything different about that day's examination
4 from the ones you've told us about so far?

5 A His pain level was seven out of ten. He was
6 complaining of pain in his neck and back. Pain continued to
7 radiate to his arms and legs with paraesthesias. He continued
8 followup with his orthopedist Dr. Dassa.

9 Q And at that time, I just want to focus again on the
10 neck and the back, doctor. What was the plan for him on
11 July 19, 2022?

12 A Yes. So we had reviewed his MRI and EMG. He was
13 recommended for injections, epidural injections to his neck and
14 back.

15 Q What's the difference between an epidural injection and
16 trigger-point injection?

17 A So as we discussed the trigger-point injection is an
18 injection into the muscle where a spasm is present, something we
19 can do in the office on the same day.

20 An epidural injection is something that we schedule the
21 patient for because it needs to be done in either an
22 office-based surgery center or in a hospital or in an ambulatory
23 surgery service. The reason being is that the patient is
24 offered to be given intervenous anesthesia.

25 The patient also requires for this procedure we need to

1 use a C-arm, which is essentially an x-ray machine on wheels,
2 which has a C-shape, so it can go around the bed.

3 This is to insure proper placement of the injection.
4 And I am very often asked when recommending this injection if
5 it's anything like a labor epidural.

6 So to draw a distinction between the two, a labor
7 epidural is very different from an epidural for pain.

8 The reason is that and I'll tell you the main
9 similarity between them comes from the word epidural. And the
10 word epidural refers to an anatomic space in the spine. So
11 whereas a labor epidural is being done with landmarks at the
12 bedside without x-ray and you're injecting different medications
13 and you're hooking up a line that has a constant infusion, with
14 a pain epidural the patient is placed flat on the table.
15 They're allowed to get anesthesia, interavenous anesthesia if
16 they need it. The area is specific, rather than typically with
17 a labor epidural we'll put it in the place that you could find,
18 usually the L-4 5 vertebral space. With a pain epidural
19 we're going to do it at the level where the most pain is and
20 which correlates with the EMG and MRI findings. So the C-arm
21 helps to give us a more specific spot for where we place the
22 medication.

23 And for the epidural we're using a number of different
24 techniques to insure proper placement. Aside from using x-ray
25 guidance, which we rotate around the bed to get both the

1 direction and the depth of needle placement, we're also
2 injecting some contrast dye to insure proper spread and I'm
3 using a particular technique called, what I use is called a loss
4 of resistance technique. So when we get the needle at the
5 right spot, there's a typical giveaway to the needle. So I'm
6 tapping on the syringe and we get to the right spot, there's a
7 giveaway, which is pretty consistent in human anatomy but not
8 100 percent. So we also use the contrast and we use the x-ray.

9 Then I'm injecting the medication, which is typically a
10 medication like you would call Cortisone but I would call it
11 Dexamethasone for the neck and methylprednisolone for the lower
12 back along with some local anesthetic and water to help it
13 spread. And that helps to reduce the pain, reduce the
14 inflammation and stop this cycle of pain from the disc because
15 part of the pain that's coming from the disc, if it's not
16 necessarily -- it doesn't have to necessarily press against the
17 nerve, itself or press anatomically against the spinal column,
18 although in many cases it does. Just by virtue of there being
19 a traumatic bulge from the disc, it can leak contents from the
20 disc and if you recall earlier, I mentioned that the disc is
21 made up of a gelatinous matrix that makes it kind of squishy.
22 And the analogy we use is it's like a jelly donut with the jelly
23 on the inside and if you press the jelly donut, the jelly will
24 shoot out. Similarly with the disc the contents can leak out
25 pretty consistently and irritate the surrounding nerves and

1 sensitize the nerves and those chemicals from the disc causes an
2 inflammatory reaction and those mediators of inflammation can
3 cause pain in themselves.

4 So the medication is meant to be a pain reliever, to be
5 an antiinflammatory and to decrease this feedback loop.

6 With regard to the needle, itself, it's a particular
7 type of needle and the needle I don't have with me today. But
8 if you can visualize a needle approximately this long, with a
9 slightly curved tip and the reason why we have the slightly
10 curved tip is so that it would kind of bounce off of the dura.
11 Because we don't want to go past the dura in the spinal column,
12 otherwise we'll have what's called wet tap and cerebral spinal
13 fluid will leak out and cause all types of problems including a
14 very severe headache.

15 So this is why -- this is all my training for this and
16 in part you want to make sure that you're having this injection
17 done in the right hand, so that you put it in the right place.
18 I do it, it's a pretty quick procedure.

19 But the needle, itself, like I said it's about this
20 long with a curved tip on the end and we'll numb the area in the
21 back. We'll place the needle, we use the x-ray like I
22 mentioned and advance the needle into the correct spot.

23 Q So in July, the July of 2022 exam you recommended for
24 both the cervical and the lumbar that epidural injection?

25 A Yes.

1 Q And do you know if Mr. Avila had the cervical injection
2 done?

3 A I don't believe he had that injection done.

4 Q And what, if any additional treatment, after the
5 July 2022 exam did Mr. Avila have next for his neck?

6 A Yeah, he underwent cervical spine surgery on
7 September 9, 2022.

8 Q And just so we're clear, that was not done by you or
9 anybody at your office, right, doctor?

10 A Correct.

11 Q Okay. So your next visit with him or his next visit
12 with you was in November of 2022, right, doctor?

13 A Yes.

14 Q And what complaints did he have then or how, if at all,
15 did his complaints change?

16 A His pain level was again an eight out of ten. He was
17 status post surgery for his neck. He complained of neck pain
18 with occasional radiation into his arms with tingling. He also
19 reported lower back pain that radiated to his legs.

20 Q And had his restrictions or limitations or his level of
21 disability changed in any way from the prior visits?

22 A No, it did not.

23 Q And on that day November 3, 2022, he received a
24 trigger-point injection to his spine, is that right, to his back
25 lumbar?

1 A To his lumbar, yeah.

2 Q Doctor, do you need to take a break?

3 A No, no, I'm fine. I just I'm getting over a cold.

4 THE COURT: Actually, when you're at a good point
5 we'll take our morning break. You tell me when you're
6 ready.

7 MR. STOLZMAN: This is fine, Judge.

8 THE COURT: All right, we'll take our morning
9 break. Please don't discuss the case. Follow the officer.

10 COURT OFFICER: All rise, jurors exiting.

11 (Whereupon, the sworn jury panel exits the
12 courtroom.)

13 THE COURT: The jury has left the room. Please
14 take ten minutes.

15 (Whereupon, a recess was taken by all parties.)

16 (Whereupon, the witness retakes the witness stand.)

17 COURT OFFICER: All rise, jurors entering.

18 (Whereupon, the sworn jury panel enters the
19 courtroom.)

20 THE COURT: Okay, please be seated everyone.

21 Let the record reflect that all jurors and
22 alternates are present and in their assigned seats.

23 Doctor, you're reminded that you are still under
24 oath.

25 You may inquire, counsel.

1 MR. STOLZMAN: Thank you, your Honor.

2 DIRECT EXAMINATION (CONT'D)

3 BY MR. STOLZMAN:

4 Q So doctor, we were just discussing the lumbar
5 trigger-point injection that Mr. Avila received in November of
6 2022.

7 After that, he came to your office in January of the
8 following year, two months later, is that right, doctor?

9 A Yes, January.

10 Q Now doctor, can you explain to the jury why it was
11 recommended or why this patient, Mr. Avila, came to your office
12 every couple of months or so, so far?

13 A Yes. I'm doing pain management, I'm managing his
14 pain. Again I mentioned the role of pain management, we are
15 assessing the patient, checking his pain, making referrals,
16 giving treatment plans, kind of overseeing their care.

17 So I like to see patients on a regular basis either
18 every month, every two months or every three months, depending
19 upon where they are in their injury and how their body has been
20 responding to the treatments that we're giving the patient.

21 Q Now on that January 23 exam, was the topic of
22 additional pain injections discussed?

23 Just so it's clear, the January 3, 2023, examination.

24 A Yes, his pain level was seven out of ten.

25 Q I'm sorry, January 31st.

1 THE COURT: 2023, correct?

2 MR. STOLZMAN: Yes.

3 A We're up to January 31st?

4 Q Yes.

5 A January 31st, so on this date another trigger-point
6 injection for his lower back, that seemed to have helped his
7 pain in between visits. I prescribed him pain medication and I
8 gave him -- I started him on a medication called Gabapentin,
9 which is a neuropathic pain medication used for treating nerve
10 related type pain.

11 He was also refilled with the muscle relaxant, the
12 Lidocaine patch and Naproxen. He was recommended to continue
13 with physical therapy. On the previous visit it looks like we
14 had recommended or discussed further injections and he wanted to
15 hold off at least for that visit. But we did do the
16 trigger-point injection on the 31st.

17 Q Thank you, doctor. And I think we got a little bit
18 confused about dates. So let me just clarify.

19 There was, in fact, a January 3, 2023, examination,
20 correct?

21 A Yes.

22 Q And it was at that point where you had a discussion
23 with Mr. Avila regarding additional injections, correct?

24 A Yes.

25 Q Okay. And you just testified he said he didn't want

1 anymore injections.

2 In your experience as a pain management physician,
3 doctor, is that something you encounter from time to time?

4 A Yes.

5 Q And what is your experience as to why a patient would
6 decline additional injections?

7 MR. FREIRE: Objection.

8 THE COURT: I'll allow it. Overruled.

9 A A patient may decline injections because they don't
10 like the idea of having a needle stuck in their spine or their
11 neck for that matter. A patient may decline --

12 MR. FREIRE: Your Honor, may we approach, your
13 Honor?

14 THE COURT: All right, come on up.

15 (Whereupon, an off the record discussion was held
16 at sidebar. The Court and Counsel are present.)

17 THE COURT: The objection is overruled.

18 Q You can continue your response, doctor.

19 THE COURT: Doctor, in your general experience
20 we're talking about.

21 A Yes. So a patient may also decline because they're
22 looking for definitive care, they typically would ask me will
23 this help to cure my pain? I tell them that I'm not a magic
24 wand. My speciality is pain management, not necessarily pain
25 curing. I'm here to reduce the severity of your pain and assist

1 with the other treatments that you're receiving to help move you
2 towards recovery.

3 Some patients would say to me, I just want definitive
4 treatment for my pain. I don't want to do these injections, I
5 just want to fix the underlying problem.

6 Those are some of the reasons why a patient may defer
7 certain types of injections.

8 Q Thank you, doctor.

9 And going forward, you recommended that he come back in
10 four weeks which he did on January 31, 2023, you told us about
11 that and you made a reference doctor to Gabapentin.

12 Can you explain to us what that medication is and why
13 you recommended it and prescribed it to Mr. Avila at that time?

14 A He was continuing to complain of these paraesthesias,
15 numbness and tingling, which again as I mentioned they're
16 typically associated with nerve related pain in conjunction with
17 his regular pain.

18 The medication Gabapentin was initially developed to
19 treat seizure disorders and it found widespread use for things
20 like postherpetic neuralgia and spinal cord type injuries or
21 peripheral diabetic neuropathy and it started to be prescribed
22 in a widespread manner for all different types of neuropathic
23 pain. It also tends to reduce, as an aside it reduces the
24 reliance upon controlled substances, as an adjunct. Things like
25 opioids, which I try to avoid as much as possible.

1 So I thought it would be a good medication to start him
2 on to see, particularly since he didn't want to do the
3 injections, which are good for the nerve-related pain for the
4 reasons that I mentioned before. But patients that don't want
5 to have injections I may prescribe this medication as an option.

6 It's not always my first choice because I have a couple
7 of issues with it. One is that in order to reach an effective
8 dose in certain patients you need to titrate or increase the
9 amount up higher and higher over a period of time and a lot of
10 times the patients complain of side effects before they get to
11 that effective dose and the other thing is it requires patients
12 to be taking it on a consistent basis to reach that dose and I
13 found that there have been difficulties with compliance with
14 this medication.

15 But even if you're taking it on an as needed basis,
16 which I prefer they don't, they do tend to find some benefit and
17 some patients have good benefit even with one pill a day. And
18 I thought a good dose for this patient was twice a day, which he
19 was started on.

20 Q And to clarify, doctor, was that for back pain or neck
21 pain or both?

22 A Both.

23 Q You indicated or it was indicated in that visit he had
24 constant back pain, is that right, doctor?

25 A Yes.

1 Q And then again you saw him February 28, 2023.
2 Anything about that exam -- strike that.

3 As a result of that exam, doctor, was there any change
4 in Mr. Avila's symptoms or limitations or pain?

5 A This patient was seen by my PA and he was continuing
6 to complain of centralized lower back pain as well as neck pain,
7 left leg pain. And previously he had, we did a trigger-point
8 injection and on this visit he again deferred recommendation for
9 an epidural for his neck and wanted to continue with more
10 physical therapy. And we again prescribed him Gabapentin as it
11 looks like he did not receive his prior prescription because it
12 needed authorization.

13 Q And has his level of disability stayed the same at that
14 time?

15 A Yes.

16 Q And then you saw him again in May or he came back to
17 your office in May and was again recommended for the epidural
18 injection, is that right?

19 A An epidural for the lower back this time.

20 Q And did he receive that epidural for the lower back?

21 A I believe he did. Yes, we did that injection on
22 June 8, 2023.

23 Q And then you saw him a month later and what were his
24 symptoms then, doctor?

25 A So he was seen on July 6, 2023. He was seen at that

1 time by my PA.

2 He had a moderate reduction in his lower back pain but
3 it returned to baseline by the time he was seen on July 6th.

4 Q And in your experience, doctor, as a pain management
5 physician, is that normal to have that sort of response to the
6 epidural spine injection?

7 A I'll say that we consider a patient that obtains two
8 weeks of relief, 50 percent relief of pain as a good result.
9 Patients usually have a longer duration of relief and sometimes
10 they have a shorter duration of relief. But if they have at
11 least two weeks or at least a couple of weeks, I consider that a
12 good outcome in the overall picture of a patient's pain.

13 Q And then you continued to see him, doctor, throughout
14 2023 on November 7th and as well then into February of 2024,
15 right, doctor?

16 A February 2024, February 13, 2024 I saw this patient.

17 Q Okay. And doctor, I don't know if the jury needs to
18 understand about each and every visit. But is it fair to say
19 that you continued to see or treat Mr. Avila on a regular basis,
20 in fact, up until the present time, isn't that right?

21 A Correct.

22 Q And he received an additional lumbar trigger-point
23 injection in May of 2024, correct?

24 A Yes.

25 Q And based off of the examination that you had with him

1 or he had with your office on July 23, 2024, what were the
2 effects of that lumbar trigger-point injection, the smaller one?

3 A July 22, 2024, he was taking less as needed medication.
4 So we talked about subjective versus objective. So pain in
5 itself is subjective. So we use different, we have different
6 ways to see whether or to determine the degree of pain. One of
7 them is are they taking their medication, how often are they
8 taking the medication.

9 So for this followup, he reported as a result of the
10 injection he was taking less of the as-needed medication. So
11 the difference between as-needed and the standing dose is that
12 as-needed you just take it when you feel pain and the standing
13 dose would be, I want you to take it twice a day every day, for
14 example, you need to take it this amount of time, as opposed to
15 just when you feel pain.

16 Anyway he was taking less needed medication as a result
17 of the injection, which is a good sign.

18 He said that he was able to sit better but again the
19 pain had returned and he was asking about what the next steps
20 are.

21 Q Forgive me, doctor. I wanted to go back for a second.

22 In October of 2023, are you aware of an additional
23 procedure that Mr. Avila had on his spine with a different
24 doctor?

25 A Yes. He had a lumbar spine surgeon. He had a

1 laminectomy surgery done on October 13, 2023.

2 Q But yet he still needed the trigger-point injection in
3 May of '24 after that laminectomy, right?

4 A Yes.

5 Q And why was it that he still needed the trigger-point
6 injection after he had a surgical procedure just a few months
7 before?

8 A He was still recovering from the surgery. He had
9 spasm on exam. The trigger-point had helped him in the past
10 and they were recommended. His pain level was elevated, so it
11 was performed.

12 Q And when you say his pain level was elevated, was that
13 just because of the surgery that he had six months earlier?

14 A I wouldn't say that. His pain level has been pretty
15 consistent between a seven and an eight throughout the course of
16 time that he was seeing him.

17 Q And was that continued and when you say throughout the
18 course of time, you mean throughout the course of the period
19 that you've been treating him that's up until this month,
20 correct, doctor?

21 A Up until the last time he was seen it was six to seven
22 out of ten.

23 Q Can you explain to the jury what this number means? I
24 mean, how you use that number to treat your patients?

25 A Yeah, the bane of my existence, this number.

1 So we use, I'm sure you've seen it, the pain scale on a
2 scale from zero to ten with zero being no pain and ten being
3 what I like to say burned alive, how would you rate your pain,
4 in that spectrum. And there's a little picture with different
5 faces, that's called a visual analog scale going from zero, no
6 pain, happy and smiling to ten, essentially crying. I show
7 them the picture. First we ask them to report their number.
8 Then when I see them I generally challenge their number. I
9 say, I usually threaten them that if it's a nine or a ten I'm
10 going to send them to the hospital, that's considered a medical
11 emergency to try to get for them to understand the pain scale.
12 Because that's what we have as pain doctors.

13 I show them the pictures and a six to seven would be
14 considered severe. Ten would be worst pain imaginable and I
15 do tell them burned alive and I say it without even thinking
16 about it now. And what else can I tell you about that.

17 Q Why do you give such a severe explanation or
18 description to your patients? What's the point of that?

19 A In my experience most patients tend to overreport their
20 pain level, so I want to be clear about what this pain level
21 means. So if I see a patient coming in skipping into the room
22 and they say it's like a ten out of ten or a nine out of ten, I
23 personally get a little, you know, frustrated about that. And
24 I will try to talk them down with using the different scenarios
25 that I mentioned, burnt alive, you know, we're going to call the

1 ambulance. And then I ask them, then I ask them are you taking
2 your pain medication, how often are you taking it and that will
3 give me a better idea. And then I say, if you're not taking
4 your pain medication, is your pain really to the point where
5 we're going to call ambulance? And then they usually will walk
6 it down a little bit.

7 Q Is there any indication in your chart, doctor, that
8 Mr. Avila needed to be walked down or that he wasn't taking his
9 medication or any of the things you just referred to that, that
10 would lead to an inaccurate assessment?

11 A I would say no, because I typically, what I just
12 described to you is what I go through with most of the patients
13 if they report a high level of pain. And if they attest to it
14 and they stand by it, then I will, you know, I will accept it
15 and base my recommendations in part around that.

16 Q I should point out, doctor, Mr. Avila testified in this
17 courtroom with the use of a translator?

18 A Yes.

19 Q How do you communicate with him and he communicate with
20 your office for the exam when he comes to see you?

21 A With the use of a translator.

22 Q Is that someone he brings or is that someone that the
23 office has?

24 A No, my offices are all bilingual.

25 Q Okay, doctor. I'm going to try to pick up on timeline

1 without having to go through each and every examination.

2 In March of 2025 about 13 months ago, he also presented
3 to your office, right?

4 A March 24, 2025, yes.

5 Q And at that time he reported that he still had pain to
6 his back, right?

7 A Yes.

8 Q And how, if at all, had that pain been effecting his
9 ability to walk?

10 A He was able to walk one to two blocks and he had to
11 stop.

12 Q And was that an improvement or exacerbation or did that
13 mean it had gotten worse from the history of his treatment with
14 you?

15 A Well, on a lot of visits we ask in a general manner
16 what his limitations were as a result of the pain. On this
17 visit we more specifically asked him how far he can walk and
18 since then that's been pretty consistent. Also asked him how
19 he got there, you know, how was this effecting his activities of
20 daily living.

21 Q Okay. Let's talk about activities of daily living.
22 Because in fact, you noted in August of 2025, the August 11th
23 visit or your office had noted that he was able to do his ADLs,
24 activities of daily living, right?

25 A Yes.

1 Q Now, can you explain to the jury what that means if
2 someone is able to do an activity of daily life?

3 A Yes, I consider the activities of daily living to be
4 are you able to bathe yourself, brush your teeth, comb your
5 hair, dress. These are things that you might do throughout the
6 day. I would not include things like clean the house, going
7 for your groceries, cooking. I would put it in the realm of
8 being able to feed yourself and just take care of your bodily
9 needs.

10 Q And does being able to do these bodily needs mean that
11 the pain is gone?

12 A No, no. No, that's I would say -- I mean, that's a
13 person that is like an invalid or someone that's like a
14 quadriplegic that would not be able to perform, that's an
15 extreme example but they may not be able to perform all of their
16 activities of daily living and need complete assistance and
17 again there's like a spectrum of different activities that you
18 may or may not be able do beyond that.

19 Q And again on that August 11, 2025 visit, there was
20 range of motion testing done with a goniometer again, is that
21 right, doctor?

22 A Yes.

23 Q And what were the results of that testing?

24 A Well again I'll point out this was by the physician
25 assistant. So for the cervical spine, range of motion of the

1 neck was 45 degrees with 50 being normal. Flexion, extension
2 50 degrees with 60 being normal. Right rotation 60 with
3 80 degrees being normal. Left rotation 50 with 80 degrees
4 being normal. Right lateral flexion 25 with 45 degrees being
5 normal and left lateral was 20 degrees with 45 degrees being
6 normal. For lumbar flexion was 60, 90 degrees being normal.
7 Extension was 20 with 25 degrees being normal. Right rotation
8 25 degrees with 30 degrees being normal. Left rotation
9 25 degrees with 30 degrees being normal. Right lateral flexion
10 20 degrees with 25 degrees being normal. Left lateral flexion
11 with 20 degrees, 25 degrees being normal.

12 Q As a pain management physician doctor, these
13 limitations, are these the limitations you would expect to see
14 after someone has had the injury that he's had and the treatment
15 that he's had?

16 A After looking over his history, his accident as well as
17 the interventions including surgery, this is not unexpected.

18 Q And again he continued to have radiating back pain at
19 that time in August of '25, right, doctor?

20 A Yes.

21 Q And then he saw you in just December of 2025. And it
22 was at that time, doctor, in addition, some of the limitation
23 that he indicated was sitting?

24 A Yes.

25 Q Can you explain to the jury why someone with his

1 incident and his treatment experience, why sitting is a problem?

2 A Well, when you're sitting you have your knees flexed,
3 you could be leaning forward, there's a lot of pressure on the
4 back. If you don't have proper support, it can cause pain in
5 the buttocks. You can develop some the paraesthesias I
6 mentioned and it can be uncomfortable and patients that have had
7 these injuries and surgeries would shift in their seat and may
8 need to change positions, get up and sit down or lean to one
9 side.

10 Q And doctor, I would like you to look at the February 9,
11 '26 visit and Mr. Avila again complained about his experiences
12 from prolonged sitting. Can you explain to the jury what he
13 complained of at that time?

14 A He was complaining of midback and left knee pain. He
15 reported radiation of pain to the back, there was numbness in
16 the lower back. He had difficulties with bending. He
17 reported occasional electric shock sensation in the midback with
18 prolonged sitting and occasional low back pain without radiation
19 or associated paraesthesias. He was able to sit for about an
20 hour without pain. He was able to walk for two hours without
21 pain, but reported significant pain in the left knee and midback
22 with climbing a flight of stairs.

23 Q And doctor, based on the examinations, by this time you
24 had been treating him for about four years and you had reviewed
25 the diagnostic studies that we talked about and continued to

1 treat him as well as the treatment you were aware of from his
2 other doctor. These limitations that you just reported that he
3 had, that he reported having, are they consistent with someone
4 who had, someone who reported having a fall from a height?

5 A Well, he had a significant amount of treatments. He
6 had surgery and as you can see in this report, he had some
7 improvement in his functionality. So yes, I would say, yes,
8 that is consistent.

9 Q And when you say improvement, does that mean he's cured
10 or something else?

11 A No, no, I wouldn't say he's cured. And looking over
12 his records, there are periods of time where he does have
13 significant limitations with regard to sitting and walking and
14 other times where he reports significantly decreased
15 functionality.

16 So typical of these types of injuries, the condition
17 can wax and wane over time with periods of exacerbation and then
18 periods improvement.

19 Q Just so we're clear, when you say exacerbation, you
20 don't mean from some other of other event, you just mean it gets
21 worse or not?

22 A Just without doing anything or let's say like if you
23 inadvertently twist or bend the wrong way or get out of bed the
24 wrong way, even a cough or a sneeze can increase intrathoracic
25 pressure, put some pressure on a disc and cause that leakage of

1 those elements inside of the disc to leak out and exacerbate the
2 pain and typically you would have a spike in the pain and then a
3 slow progression towards baseline.

4 Q And doctor, you recently saw him on April 7, 2026,
5 right?

6 A Yes.

7 Q And that was again from one of his two month followups,
8 doctor?

9 A Yes.

10 Q And during this whole time, from February 9th of 2022
11 until April 7th of this year, is it your understanding that
12 Mr. Avila was still going to physical therapy, as well?

13 A Yes.

14 Q And again and you did a range of motion. You have that
15 record in front of you right now doctor?

16 A Yes.

17 Q And is that, that you have which is separate from
18 Plaintiff's Exhibit 2, that was kept in the normal course of
19 business at your office?

20 A Yes.

21 Q And that's a record that you made as a result of your
22 examination with Mr. Avila?

23 A Yes.

24 MR. STOLZMAN: I would like to move that now into
25 evidence. Do we have that marked? I'm sorry, we'll mark

1 that as 5, Plaintiff's 5, for Identification.

2 MR. FREIRE: No objection.

3 THE COURT: No objection to it going into evidence?

4 MR. FREIRE: No objection. I thought it was in.

5 MR. STOLZMAN: We'll mark that now as Plaintiff's
6 Exhibit 5.

7 (Whereupon, the item marked for Identification as
8 Plaintiff's Exhibit 5, is received and marked in evidence by
9 the Court Reporter.)

10 MR. STOLZMAN: For timing, Judge, we'll finish this
11 day's exam and then we can take a break.

12 THE COURT: Okay.

13 Q So again doctor, when you saw him just a couple of
14 weeks ago, what was his pain scale at that time?

15 A Six to seven out of ten.

16 Q And you also did range of motion testing?

17 A Yes.

18 Q And I want to focus for a moment, doctor, on the lumbar
19 spine range of motion testing. That was done with a
20 goniometer?

21 A Yes.

22 Q Can tell the jury what a goniometer is and why it is
23 important for your examination?

24 A It's a measuring device with -- it's like this
25 (indicating). You'd have it move in this direction here and it

1 has degrees. So if they bend forward, I can bend it at the
2 side and get the degree of his flexion similar with him being
3 backwards and I'll check the degrees there.

4 Q So tell us the results of the range of motion testing
5 for the lumbar spine, again on April 7, 2026?

6 A Range of motion flexion was 30 degrees with 90 degrees
7 being normal. Extension 10, 25 degrees being normal. Right
8 and left rotation 15 with 30 degrees being normal. Right and
9 left lateral flexion 10 degrees with 25 degrees being normal.

10 Q So let's go one at a time.

11 Can you describe for the jury what flexion means on a
12 person's body?

13 A This is flexion (indicating), this is extension
14 (indicating). Okay, this is rotation (indicating) and this is
15 lateral flexion (indicating).

16 Q So the first motion flexion is essentially what we
17 would consider bending, right?

18 A Yes.

19 Q And you had mentioned your exam with a goniometer said
20 30 over 90, right?

21 A Yes.

22 Q So does that mean, was that normal, doctor?

23 A No.

24 Q And can you explain to the jury what his limitation
25 would be, that's 30 over 90. That means he's got a two-thirds

1 reduction in his ability to bend forward, is that what that
2 means, doctor?

3 A Yes. I'll point out this is active range of motion
4 versus passive.

5 Q And what does that mean?

6 A It was under the patient's control.

7 Q Sure, okay.

8 Which means it's subjective, okay. And the same thing
9 you also did testing, doctor, with respect to his neck at the
10 time, right?

11 A Correct.

12 Q And that testing also showed limitations, correct?

13 A Correct.

14 Q With respect to the subjectivity versus objectivity,
15 that test you mentioned to us before you testified about in
16 August of 2025 the numbers were different, correct?

17 A Correct.

18 Q And it was a subjective test then too, right?

19 A Yes. And I'll also point out, I tell the patient to
20 stop when they feel pain. So it's not necessarily they can't
21 mechanically go any further. It's when they state that this is
22 where it starts to hurt.

23 Q And you also did -- Forgive me.

24 And at that time, doctor, what medications was he
25 taking or were prescribed by you as of that time?

1 A He was prescribed Naproxen and Lidocaine patch.

2 Q And what is Naproxen?

3 A Naproxen is an antiinflammatory analgesic. It's a pain
4 medication essentially.

5 Q So no more Gabapentin?

6 A No more Gabapentin.

7 Q And what was your determination based on your exam at
8 that time about Mr. Avila's disability, had it changed in any
9 way?

10 A No, I still did not find him capable of returning to
11 his work.

12 Q Just so the jury is clear, when you say to his work,
13 what do you mean by that?

14 A He shouldn't do his construction work.

15 MR. STOLZMAN: Your Honor, if I may, I think this is
16 good time to break.

17 THE COURT: All right, great.

18 Doctor, you can step down.

19 (Whereupon, the witness steps down from the witness
20 stand.)

21 THE COURT: All right, members of the jury, we're
22 going to break for lunch until 2:00 p.m..

23 Do not discuss this case with each other or anyone
24 else, including family or friends. Do not speak to anyone
25 or permit anyone else to speak with you regarding this case.

1 If anyone approaches you or tries to speak with you
2 concerning this case, do not discuss this with your fellow
3 jurors and report it to the Court through the officer.

4 Do not use the internet websites or any other
5 source to research this case. Do not visit any of the
6 locations pertaining to this case. When you return to
7 court, report to the location which you have been instructed
8 to report by the officer.

9 Do not speak to any of the parties in this case,
10 they have been directed not to speak with you. Do not form
11 or express an opinion or come to any conclusion as to the
12 facts of this case during the trial. Wait until the entire
13 case has been submitted to you by the Court. Enjoy your
14 lunch. See you back here at 2:00 p.m. Thank you.

15 COURT OFFICER: All rise, jurors exiting.

16 (Whereupon, the sworn jury panel exits the
17 courtroom.)

18 (Whereupon, a luncheon recess was taken by all
19 parties.)

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

21 (Whereupon, the following occurred on the record in
22 the courtroom.)

23 THE COURT: Doctor, why don't you come on up.

24 (Whereupon, the witness retakes the witness stand.)

25 COURT OFFICER: All rise, jury entering.

1 (Whereupon, the sworn jury panel enters the
2 courtroom.)

3 THE COURT: Okay. Please be seated everyone.

4 Let the record reflect that all jurors and
5 alternates are present and in their assigned seats.

6 Doctor, you're reminded you are still under oath.

7 You may inquire.

8 MR. STOLZMAN: Thank you. May it please the Court.

9 DIRECT EXAMINATION (CONT'D)

10 BY MR. STOLZMAN:

11 Q Good afternoon, doctor.

12 A Good afternoon.

13 Q I would like to pick up where we last left off. We
14 were talking about the course of your treatment with Mr. Avila.

15 By the way, do you expect to see him again after the
16 April 7th visit?

17 A Yes, he's actually scheduled for an injection for his
18 lower back on I think May 7th.

19 Q What type of injection is that?

20 A Another epidural for his back pain, for his lower back.

21 Q And when we talk about epidurals, doctor, you spoke
22 before about for the cervical spine, the injection -- Strike
23 that.

24 Is there a level that he should be, for where the
25 epidural injection that he's going to have is going to be for

1 his lumbar?

2 A This one I believe is going to be at the L5 S1 level.

3 Q Given your four years of treatment that you've given
4 and provided to Mr. Avila and your experience as a pain
5 management physician that you told the jury about, what is your
6 prognosis again to a reasonable degree of medical certainty for
7 Mr. Avila?

8 A I think that his course following, he'll have periods
9 of exacerbation and periods where the pain will be present and
10 limit his activities but may not be so severe as to necessitate
11 an injection at that particular moment, but it will cause him
12 great difficulty in his ongoing lifestyle.

13 Q And doctor, I want to with respect to hypothetically if
14 the jury were to hear evidence of degeneration in the levels
15 that we've talked about on Mr. Avila's spine, to what extent, if
16 any, would the fall that he reported to you have effected his
17 spine if, in fact, there was degeneration and he was
18 asymptomatic up until date of the fall?

19 A Being that he was asymptomatic, I would say that the
20 fall created the problems that he has had going forward
21 regardless of whether there was something present prior to the
22 accident, it was not causing him any pain or disability and was
23 unnoticed. He was able to work at full capacity as a
24 construction worker, heavy lifting, fast paced environment.
25 Afterwards he has not returned to that work. He's required

1 surgery. So if it was -- if anything was there prior, it
2 became symptomatic after the fall.

3 Q Was it one surgery or two surgeries?

4 A He's had one for the neck and one for the lower back.

5 Q Now doctor, fair to say after this treatment that he
6 receives from you in I guess one month or next month he can
7 expect to have additional treatment with you?

8 A Yes, we'll continue to follow him. We'll continue to
9 monitor his progress, recommend treatments as needed, things
10 like physical therapy, further injections if there are pain
11 exacerbations, modify his medications, refer him if necessary to
12 further diagnostic testing, if necessary.

13 Q And doctor, what is your overall prognosis for
14 Mr. Avila as you sit here today?

15 A I would say it's still guarded to poor. I haven't
16 seen him make -- he's had some improvement. His condition has
17 gotten better at certain points, which is reflected in his exam
18 and there have been periods and exams where his condition has
19 shown significant limitations.

20 Q And when you talk about significant limitations, is
21 that regarding his neck, his back or both?

22 A Yes, both his neck and his lower back.

23 Q Doctor, I would now like to show you what has been
24 marked for Identification as Plaintiff's Exhibit 4.

25 (The Exhibit is handed to the witness.)

1 Q Now doctor, at some point you provided a report with
2 respect to Mr. Avila's future care, is that right?

3 A That's correct.

4 Q And based on your examination and your review of
5 Mr. Avila's records and the file that you've talked about here
6 today, is he going to incur future medical costs for his optimal
7 treatment?

8 A Yes.

9 Q And did you do a report of what those future treatments
10 for optimal treatment would be there and the costs?

11 A Yes.

12 Q And is that what's in your hand as Plaintiff's
13 Exhibit 4, for Identification, without referring to what it
14 actually says?

15 A Yes.

16 MR. STOLZMAN: I would like to move that into
17 evidence as Plaintiff's Exhibit 4.

18 MR. FREIRE: Objection.

19 THE COURT: There's an objection. Just have him
20 testify about it.

21 Doctor, you can refresh your recollection, so just
22 look down. If you don't know off the top of your head, just
23 look down.

24 Q Doctor, at this time can you tell us what future care
25 you're expecting that the Plaintiff will need for his optimal

1 care?

2 A I recommended that he should have the opportunity to
3 have injections one to his neck, one to his lower back, the
4 epidural injections up to two per year for a period of ten
5 years. I recommended for him to continue with his current
6 medication, again for a period of ten years. He would need
7 updated MRIs of his neck and lower back to assess progression of
8 his condition and for any changes in his condition as well as
9 physical therapy.

10 These are recommendations based upon the need at the
11 time. So I'm recommending these so that he has the option to
12 use them, should that be the case during periods of
13 exacerbation.

14 Q And doctor, can you please tell the jury what each of
15 those procedures would cost based on your experience as a pain
16 management physician and again, this is to a reasonable degree
17 of medical certainty, right, doctor?

18 A To a reasonable degree of medical certainty and these
19 costs are if you were paying out-of-pocket.

20 Q Rack rate?

21 A Excuse me?

22 Q This is the basic price for these treatments?

23 A Yes, this is what -- these are the costs if you weren't
24 using any health insurance. I guess the retail cost.

25 The medications, cyclobenzaprine, the Lidocaine patches

1 and Naproxen, approximately \$80.00 per month.

2 Q \$80.00 per month. For how long for his optimal
3 treatment do you recommend?

4 A I put this down for a ten-year duration.

5 Q So each of these you're providing is for a ten-year
6 period, okay. So \$80.00 per month for those medications.

7 What's next, doctor?

8 A Pain management office visits approximately four to six
9 per year for a ten-year duration at \$250.00 per followup visit.

10 Cervical epidural steroid injection with fluoroscopic
11 guidance, anesthesia and facility support, up to two per year as
12 needed for \$2,000.00 for the procedure, \$1,200.00 for anesthesia
13 and \$1,000.00 for the facility.

14 Similarly with the lower back lumbar epidural steroid
15 injections with fluoroscopic guidance anesthesia and facility
16 support approximately two per year as needed. \$2,000.00 for
17 the procedure, \$1,200.00 for the anesthesia and \$1,000.00 for a
18 facility fee.

19 Trigger-point injections under ultrasound guidance, for
20 the neck and the lower back, \$500.00 per procedure, once every
21 eight to 12 weeks, as needed, for ten years.

22 MRI of the cervical spine, approximately \$1,300.00 per
23 procedure every three years for ten years.

24 Lumbar MRI of the lumbar spine, \$1,300.00 per
25 procedure per study every three years for a ten-year duration,

1 also as needed.

2 Physical therapy \$120.00 per session twice a week for
3 six months followed by four times a month for 12 months. Then
4 once a month for muscle strengthening and improvement of
5 functionality, range of motion, prevent deconditioning and for
6 enhancement during the injections that I mentioned earlier, also
7 for a ten-year duration.

8 Q Thank you, doctor.

9 We talked also about work. You told us before that at
10 this time you do not recommend that he continue any construction
11 work, is that right?

12 A Correct.

13 Q Are there other types of work that you do think he
14 would be able to do?

15 MR. FREIRE: Objection, your Honor. Can we
16 approach?

17 THE COURT: Come on up.

18 (Whereupon, an off the record discussion was held
19 at sidebar. The Court and Counsel are present.)

20 MR. STOLZMAN: I'll withdraw, your Honor. I can
21 rephrase.

22 THE COURT: Okay.

23 Q Dr. Lerner, we've heard testimony from Mr. Avila and
24 you've also indicated from your examinations, that Mr. Avila has
25 trouble standing for prolonged periods of time. Do you recall

1 that testimony?

2 A Yes.

3 Q Fair to say then that jobs that require him to stand
4 for long periods of time would also be difficult for him?

5 A Yes.

6 Q And we've also heard testimony both from Mr. Avila and
7 from your examinations throughout the four years that you have
8 been seeing him that he has trouble sitting for prolonged
9 periods of time.

10 Fair to say that jobs that require that type of work or
11 that type of activity or inactivity would also provide pain and
12 be difficult for him?

13 A Yes.

14 Q And what about with respect to lifting objects. Based
15 on the testimony -- strike that.

16 You've testified that he has limitations with his
17 ability to lift things, I believe you said up to ten pounds?

18 A Yes.

19 Q Fair to say then that, that would then limit him from
20 being able to take any job that would require him to lift more
21 than ten pounds?

22 A Yes.

23 Q And what about with respect to bending. Would there
24 be any jobs that you would recommend he take or he do that would
25 require bending in any way?

1 MR. FREIRE: Objection. Objection, your Honor.

2 THE COURT: Read it back.

3 (Whereupon, the last question was read back by the
4 Court Reporter.)

5 THE COURT: Can you rephrase the question? Just
6 rephrase it.

7 Q No problem. How, if at all -- what, if at all would
8 you advise to Mr. Avila, given the fact of the limitations that
9 your understanding is with respect to bending as it relates to
10 work?

11 A He should avoid excessive bending. It should be done
12 infrequently, not as a matter of part of his regular job duties.

13 Q And would you say the same thing about lifting?

14 A Yes. He could lift up to ten pounds I would say on an
15 infrequent basis, not frequently. Not like a conveyer belt
16 type of a job, where he's constantly moving with ten pounds.

17 Q So by -- strike that.

18 What would happen if Mr. Avila were to stop his
19 physical therapy treatment and his treatment with you?

20 A Well, if he stopped -- if he observed physical
21 restrictions and avoided any excessive bending or lifting
22 maneuvers, he may be able to continue living his life.
23 However, his condition may deteriorate without physical therapy
24 and without proper, without him being directed for treatments.
25 There may be periods as I mentioned where his pain exacerbates

1 without any treatment, then he could be in severe pain. He
2 could have more significant limitations and his condition can
3 potentially get worse and the pain that he experiences could go
4 from being intermittent to more chronic.

5 Q Doctor, can you say whether or not that prognosis is
6 more likely than not?

7 A I would say without proper direction and oversight of
8 his condition it's more likely than not that his condition would
9 deteriorate.

10 Q Is there any scenario, doctor, that you provided today
11 that would cure Mr. Avila of the pain that he has now?

12 A I can't think of any cure that would help him at this
13 point. Again I do pain management, so I'm trying to manage his
14 symptoms. I wish there was something that could magically cure
15 his condition.

16 MR. STOLZMAN: Thank you, doctor.

17 THE COURT: Cross-examination.

18 MR. FREIRE: Thank you, your Honor.

19 CROSS-EXAMINATION

20 BY MR. FREIRE:

21 Q Good afternoon, doctor.

22 A Good afternoon.

23 Q Doctor, I would like to start with something you said
24 during your direct examination. And correct me if I'm wrong,
25 if I'm paraphrasing you incorrectly but you testified you told

1 this jury that your speciality in pain management is unique in a
2 sense because it relies in large part on a patient's reported
3 symptoms and complaints, is that fair?

4 A That's fair.

5 Q And in fact, on direct examination you ran through
6 several of the tests that you perform or would throughout the
7 course of your treatment of the patient that were subjective in
8 nature, correct?

9 A Correct.

10 Q And just to remind the jury, the basic difference
11 between subjective versus objective is that subjective is
12 essentially what the patient is reporting to you, correct?

13 A What the patient is reporting as well as what the
14 patient has control over themselves.

15 Q Versus objective in the most pure form would be
16 something like an MRI or x-ray, correct?

17 A Yes.

18 Q Something that is completely outside the control of the
19 patient, correct?

20 A Correct.

21 Q And so as a corollary to that, let me remind the jury,
22 remind the jury of the difference between active and passive
23 range of motion, if we could.

24 You agree with me, doctor, that active range of motion
25 is when the patient on their own moves their, whatever part of

1 their body you asked them to move, up to the point that they say
2 they can without any pain, is that fair?

3 A Yes.

4 Q And I think you mentioned on direct that, in fact, you
5 will often tell the patients to stop when they are feeling pain
6 or when they report some pain, correct?

7 A That's correct.

8 Q And that is to be contrasted with passive range of
9 motion, which is where the external force, usually the physician
10 is the one that's actually moving the body part for the patient,
11 correct?

12 A Correct.

13 Q And even in that situation when there's a passive range
14 of motion test, the doctor would move that body part up to the
15 point where generally speaking the patient would report some
16 pain, correct?

17 A Up to when the patient would report pain or you can
18 move to the point where it's no longer moveable.

19 Q It can't be moved anymore?

20 A Can't be moved any further.

21 Q So an example of that would be if your elbow, for
22 instance, if you're able to move it straight and then you can't
23 go any further, that would be an example of that, is that fair?

24 A Yes.

25 Q So with that in mind, you testified on direct that in

1 your first instance when you first saw this Plaintiff back in
2 February of 2022, you were seeking to and correct me again if
3 I'm wrong, you were seeking to correlate the Plaintiff's
4 complaints, your patient's complaints with the mechanism of
5 injury to then make a determination as to causation, which would
6 then allow you to develop a treatment plan, is that a fair
7 paraphrasing?

8 A Yes.

9 Q So let's break that down.

10 First of all, is that what is commonly known as a SOAP
11 method, S-O-A-P?

12 A Yes.

13 Q In fact, your records often use that terminology at the
14 top of the form where it says note type, some of them will say a
15 SOAP note, is that correct?

16 A Yes, that's for subjective, objective, assessment and
17 plan.

18 Q Right. And those are the components, subjective,
19 objective, then an assessment and then a plan, correct?

20 A Correct.

21 Q And so let's break that down a little bit.

22 When you say you were correlating the complaints with a
23 mechanism of injury, the complaints we can agree are subjective,
24 correct?

25 A Correct.

1 Q And many of the testing that you were talking about in
2 the direct examination, the Spurling Test, the Patrick Test, the
3 straight leg raising test, they all have some element of
4 subjective, most if not completely subjective, correct?

5 A Yes.

6 Q The clinical part is your observation, of course, in
7 what they tell you, correct?

8 A Well, the clinical part would be taking everything
9 overall into consideration, all of the tests, in conjunction
10 with the objective diagnostic tests and the mechanism of injury
11 and the patient's subjective complaints.

12 Q So let's get to that. Let's get to the objective part
13 because when you first saw the Plaintiff on February 9th, we can
14 agree that although your aim was to combine both subjective and
15 objective to come to an assessment you didn't have any objective
16 testing at that point, is that fair?

17 A I had no MRIs, no diagnostic testing at that point.

18 Q So the answer is no, you did not have any objective
19 testing at that point, is that fair?

20 A That's correct.

21 Q Okay.

22 So that objective part wasn't quite there yet on
23 February 9, 2022, can we agree on that?

24 A When you say I didn't have any testing that was imaging
25 or the EMG, no, I didn't have any of those at that time.

1 Q Right. So you didn't have any of the objective
2 components that we were talking about in the SOAP formula,
3 subjective, objective, right, before we get to your assessment
4 and plan, that objective piece you didn't have yet, is that
5 fair?

6 A That's fair.

7 Q And actually let's actually turn to, so if the
8 complaints we've established is objective, the mechanism of
9 injury that you testified to the jury about, that you were
10 trying to combine to determine causation, the mechanism of
11 injury was also as reported by Mr. Avila, can we agree on that?

12 A Yes.

13 Q You didn't have at that time any independent records
14 other than what he told you regarding the mechanism of the
15 injury, can we agree on that?

16 A Yes.

17 Q In fact, to this day, your chart doesn't have any
18 records of anything regarding how his incident occurred,
19 correct?

20 A I have his reports and I have the records that I
21 reviewed.

22 Q Right. The records that you reviewed are in your file,
23 right, that's what you brought with you?

24 A Yes.

25 Q So the records you reviewed, you're referring to your

1 own office records, correct?

2 A Yes.

3 Q And what you just said about what he told you again, it
4 goes back to what he told you about how the incident occurred?

5 A Yes. I have also reviewed other doctor's records,
6 hospital records, that mention the accident as well.

7 Q So let's just stick with the information you had at the
8 time of your very first examination of him on February 9, 2022.
9 Can we do that, doctor?

10 A Yes.

11 Q Can you pull that up in your file.

12 Can we agree that, that first visit was on February 9,
13 2022?

14 A Yes.

15 Q And you saw him that day, was that at the Bronx
16 location?

17 A Yes.

18 Q Doctor, you're aware that the Plaintiff lives in Port
19 Chester, right?

20 A Yes.

21 Q You would agree with me that, that Bronx location on
22 Third Avenue in the Bronx would be about say 30, 40 minutes away
23 from Port Chester, would you say?

24 A I'm not sure of the exact distance.

25 Q And do I understand correctly that, that same day you

1 also performed a trigger-point injection in his lumbar spine?

2 A Yes.

3 Q Can you look at that record from that injection.

4 Doesn't that say that, that location was performed at your
5 Queens location?

6 A Yes.

7 Q He went to both your Bronx location and the Queens
8 location in the same day?

9 A No, that's a typo.

10 Q Okay. All right, so let's go back to your note of
11 that first visit on February 9, 2022, okay? Is that okay?

12 A Yes.

13 Q So Plaintiff's counsel was questioning you early on in
14 your direct examination about the history you obtained from the
15 patient at that time in the first visit, correct?

16 A Yes.

17 Q And we would agree that the history is essentially what
18 the patient is relating to you in terms of his past medical
19 history, how the incident happened, what his complaints are and
20 things of that nature, is that fair?

21 A Yes.

22 Q And at that time, he reported to you that he had been
23 involved in a work-based accident where he fell from a ladder,
24 is that fair?

25 A That's correct.

1 Q We agree that at that time when you were examining him
2 for the first time and you came to a conclusion regarding
3 causation, you did not have the benefit of any records regarding
4 his accident and how it occurred, can we agree on that?

5 A Yes.

6 Q If you had, that would be within your records, correct?

7 A Yes.

8 Q And along with the history, we would agree that the
9 Plaintiff denied any past relevant medical history or any past
10 surgical history, correct?

11 A Correct.

12 Q But again you didn't have any records or absence of
13 records to verify that, can we agree on that?

14 A I had the absence of records.

15 Q The absence of records?

16 A Yes.

17 Q Meaning that you didn't have any records?

18 A Correct.

19 Q But in fact, you're aware of course that the Plaintiff
20 arrived in this country just about a year before the incident,
21 correct?

22 MR. STOLZMAN: Objection.

23 Q Are you aware of that?

24 THE COURT: I'll allow it.

25 Q Are you aware of that?

1 A No.

2 Q You're not aware of that.

3 And does your chart reflect any efforts to have
4 obtained any prior medical history records, if there were any?

5 A No.

6 Q So we'll go back to the fact that the only reason you
7 document that the Plaintiff had no relevant past medical history
8 or past surgical history is because that's what he told you?

9 A Yes.

10 Q We don't have -- are you aware of any way that we would
11 verify right now what his past medical history was from back in
12 Ecuador?

13 A No.

14 Q Are you aware of whether or not there were any records
15 from the year that he was here in the United States before the
16 incident that would tell us anything about his past medical
17 history?

18 A No, I have no records.

19 Q So when you earlier told this jury that the Plaintiff
20 was asymptomatic before the accident, that's based entirely on
21 his telling you that he was asymptomatic before the accident,
22 can we agree on that?

23 A Yes.

24 Q And in terms of the actual tests that were performed
25 that day, actually before I even get there. We agree that on

1 that day the first time you saw him, he described his pain on a
2 zero to ten scale as a seven?

3 A Yes.

4 Q The various tests that are noted within your records of
5 that first visit that Plaintiff had with you on February 9,
6 2022, we agree that the Patrick's/FABER test that you found was
7 positive, that's a subjective test, correct?

8 A Yes.

9 Q The straight leg raising test, subjective at least in
10 part?

11 A In part, yes.

12 Q Tenderness, so when you feel something and someone says
13 it hurts, subjective, yes?

14 A Yes.

15 Q The spasm that you note that was, I believe you
16 testified on direct, spasm is objective, it's something you
17 feel, right?

18 A Yes.

19 Q We can agree that that's as you described like a knot?

20 A It's like a muscular knot that when compressed you
21 would feel pain radiate, also subjective in terms of the
22 radiation.

23 Q But in terms of the actual knot is something you're
24 feeling, like an actual knot?

25 A Yes.

1 Q You agree that there are various reasons why someone
2 could have a knot in their neck, for instance or in their back,
3 that you can have a knot?

4 A It's something that's pretty typical of spasm, that you
5 feel as opposed to a lipoma or like a mass.

6 Q I'm saying a knot, you can sleep and get a knot in your
7 neck, can we agree?

8 A There's multiple reasons why you can develop a spasm,
9 yes.

10 Q That was my point.

11 Now I want to take you to some of what you have in your
12 initial subjective section of your record of February 9, 2022.
13 And directing your attention to the part where it says,
14 following the accident patient was seen at Greenwich Hospital
15 the same day where he was evaluated and treated, do you see
16 that?

17 A Yes.

18 Q Did you know at the time that he actually went to -- he
19 was taken to a different facility where he left before he was
20 treated and then went to Greenwich? Did you know that at the
21 time?

22 A I don't have it documented here.

23 Q And you would normally document if you had known it, is
24 that fair?

25 A Yes.

1 Q And in terms of Greenwich Hospital records, you didn't
2 have the benefit of those records at the time of this first
3 assessment?

4 A Not at the time of this first assessment.

5 Q And continuing, it says since the accident the patient
6 has been treated with physical therapy. Do you see that?

7 A Yes.

8 Q Can we agree though that when it says since the
9 accident, it actually wasn't right after the accident, do you
10 agree with me on that?

11 A You mean the same day?

12 Q Yeah. Well, let me be more precise. Isn't it true
13 that Plaintiff did not actually go get any further treatment and
14 certainly didn't start any physical therapy until about a week
15 and-a-half after the accident, isn't that true?

16 A Okay.

17 Q Do you know that?

18 A I have his records. I don't remember exactly the time
19 period afterwards.

20 Q So when it says since the accident though, that would
21 only be precise or fair or accurate if, in fact, it meant that
22 the patient had gone immediately after being released from
23 Greenwich Hospital and then was on his way to physical therapy,
24 not a week and-a-half later, can we agree on that?

25 A No, I think the word --

1 Q So since the accident just basically means after the
2 accident?

3 A Since the accident, yes, after the accident.

4 Q Okay, okay.

5 So the range of motion testing that you note in your
6 first report of February 9, 2022, you mentioned to the jury
7 that, that was done with and I always mess up this phrasing,
8 goniometer or goniometer?

9 A Goniometer.

10 Q And that is a tool that shows the range of motion,
11 correct?

12 A Yes.

13 Q But we would agree again that, that is subject to how
14 far the Plaintiff moves that body part, correct, so it's
15 subjective?

16 A Yes.

17 Q So when you note some range of motion deficits in your
18 report, that's based on what the Plaintiff did when you told him
19 to move his body in certain planes, correct?

20 A Yes.

21 Q Doctor, to fast forward a little bit. By the end of
22 that first visit, you note in your report that, to paraphrase
23 again, that you believe that the accident as the Plaintiff
24 related to you, combined with the complaints as Plaintiff
25 relayed to you were related, meaning that the complaints he had

1 were caused by the accident in the way he says it happened? Can
2 we agree on that?

3 A Yes.

4 Q And you made that assessment on February 9, 2022, first
5 time you saw him, without the benefit of any MRIs at that point
6 or any other testing that had been done yet, is that correct?

7 A Yes.

8 Q And without the benefit of any other records that would
9 have shown you or confirmed the mechanism of the accident, such
10 as some incident report about the incident, a hospital record or
11 something else at that point, correct?

12 A Yes.

13 Q Doctor, we've all had the experience where we go to a
14 doctor's office and the first thing we have to do is fill out a
15 bunch of paperwork.

16 Do patients fill out any such paperwork when they first
17 get to your office, a questionnaire, the usual forms that
18 everybody has to fill out 18 times when they go to the dentist
19 and things like that?

20 A Yes.

21 Q They do?

22 A Yes.

23 Q That's not located anywhere in your chart?

24 A Not here, no.

25 Q No. Well, it's also not in your subpoenaed records.

1 So we subpoenaed your entire medical chart on the Plaintiff and
2 would it surprise you to learn that it's not there either?

3 A Whatever he filled out would be in the patient
4 demographics as well as integrated into his note.

5 Q I'm actually talking about the forms he filled out.
6 Those are not located within your subpoenaed records or in the
7 file that you have with you, are they?

8 A No.

9 Q But they do exist, right? Your patients do fill out
10 those type of forms, right?

11 A Yes.

12 MR. FREIRE: I would like to have this marked as
13 Defense Exhibit C.

14 (Whereupon, an item was marked Defendant's Exhibit
15 C, for Identification, as of this date by the Court
16 Reporter.)

17 (The Exhibit is handed to the witness.)

18 COURT OFFICER: Defense Exhibit C to the witness for
19 ID.

20 Q Thank you.

21 Doctor, showing you now what has been marked as Defense
22 Exhibit C, for Identification, would you agree with me that
23 those are the forms that your practice uses for patients to fill
24 out when they first come for treatment at your clinic, correct?

25 A Yes.

1 Q Any idea why the ones that Mr. Avila filled out did not
2 make its way into the subpoenaed records?

3 A No. I think my staff just sent the medical records
4 from the EMR. These are not in the EMR.

5 Q I'm sorry, the EMR? What is the EMR?

6 A Electronic medical record.

7 Q But they would be part of the patient's file, correct?

8 A We have it in a separate file.

9 Q For the patient?

10 A For the patient, yeah.

11 Q So when we subpoenaed records of your office for all of
12 the patient's records, did it occur to anyone to send us not
13 just the electronic file but what is actually in the patient's
14 file, all parts of the patient's file?

15 A When we're asked for medical records, we typically just
16 send them the records that are in the EMR.

17 Q But we would agree those are the forms that your office
18 uses, yes?

19 A These are the forms, yes.

20 MR. FREIRE: I would like to move these into
21 evidence.

22 THE COURT: Any objection?

23 MR. STOLZMAN: Yes Judge.

24 THE COURT: At the sidebar please.

25 (Whereupon, an off the record discussion was held

1 at sidebar. The Court and Counsel are present.)

2 THE COURT: All right, C will go into evidence.

3 (Whereupon, the item previously marked for
4 Identification as Defendant's Exhibit C, is received and
5 marked in evidence by the Court Reporter.)

6 Q So doctor, we established that this is the form, these
7 are the forms that the Plaintiff would have filled out for your
8 clinic but we don't have the filled out version?

9 THE COURT: That's two questions.

10 Q I'm sorry, your Honor.

11 Sir, we agree that on that first page of the forms that
12 you're looking at, there is a space for how the patient was
13 referred to your office, isn't that true?

14 A Yes.

15 Q And on the second page, the questionnaire, it also has
16 a space for the patient to state how he was referred to your
17 office, correct?

18 A Yes.

19 Q We don't have that information, correct?

20 A Correct.

21 Q Sir, you mentioned and I want to segway a little bit
22 into something you mentioned during direct examination. And
23 that is, did you say that your compensation for the day for your
24 time for today is \$15,000.00 for today?

25 A Yes.

1 Q And that's in part because you would have to otherwise
2 be at your office and you have to pay your staff, doing
3 procedures, things of that sort, yes?

4 A Yes.

5 Q We'd agree that in addition to the time that you're
6 being compensated, I'm sorry, the \$15,000.00 that you're being
7 compensated for today, have you been compensated in any way for
8 any of your other work in connection to this case?

9 A Other than the visits and the treatments I have been
10 given but not by the law firm, if that's what you're referring
11 to.

12 Q Okay. No, let's go into what you just said.

13 You are compensated and you've been compensated for all
14 of the treatment that you've provided to the Plaintiff during
15 these four plus years, correct?

16 A I would hope so, yes.

17 Q For the physical therapy?

18 A Not for the physical therapy.

19 Q That's at a different facility, right?

20 A I believe so, yes.

21 Q But for the injections?

22 A I would hope so, yes.

23 Q Every injection, yes?

24 A I don't know exactly if we got paid for all of them. I
25 assume so.

1 Q You have a charge for every injection, yes?

2 A Yes.

3 Q Epidural to the extent that I believe there was one
4 epidural, steroid injection since you first started seeing the
5 patient, that's a separate charge as well, correct?

6 A That's a charge, yes.

7 Q And that includes a charge for anesthesia and things of
8 that nature, correct?

9 A Yes.

10 Q Speaking of anesthesia, that's where you're board
11 certified?

12 A That is one of my board certifications.

13 Q Anesthesia as well as pain medicine?

14 A Yes.

15 Q You are admittedly not an orthopedist, correct?

16 A Correct.

17 Q You're not a neurologist?

18 A Correct.

19 Q You're not an orthopedic spine surgeon?

20 A Correct.

21 Q And you're not a vocational rehabilitation expert
22 certainly?

23 A Correct.

24 Q You're not a radiologist either?

25 A Correct.

1 Q You're not board certified in any other specialty
2 besides pain medicine and anesthesia, can we agree on that?

3 A Yes.

4 Q So when your records note a neurological exam, to be
5 clear you're not holding yourself out to be a neurologist,
6 correct?

7 A Correct.

8 Q And to the extent that you alluded to reviewing MRI
9 films or some of the diagnostic films during the course of your
10 direct examination, we'd also agree that you're not a
11 radiologist, correct?

12 A Correct.

13 Q And in so far as you also testified about various
14 surgeries that the patient, that you're aware the patient
15 underwent, Mr. Avila, we would also agree that you weren't the
16 surgeon on any of those surgeries, correct?

17 A I did not perform those surgeries.

18 Q And you're not an orthopedic spine surgeon, correct?

19 A Correct.

20 Q Or an orthopedic surgeon?

21 A Correct.

22 Q Did I hear you correctly that you don't have any
23 patients at Mt. Sinai, is that correct?

24 A I'm not affiliated with Mt. Sinai.

25 Q I'm sorry, which is the hospital you're affiliated

1 with?

2 A New York Presbyterian Queens.

3 Q Got it. You don't have any patients at that hospital,
4 correct?

5 A Correct.

6 Q And in fact, I'm looking at your CV now. Apologies,
7 I'm looking at it on my phone. I took a picture of it. You
8 have been in forensic practice essentially since 2007?

9 A What was the word you used?

10 Q Forensic, legal related, is that fair or no?

11 A No, I'm a physician. I'm not like -- I treat
12 patients at --

13 Q Private practice?

14 A Private practice.

15 Q But you have testified in court before yes?

16 A Yes.

17 Q And you mentioned that to your recollection you've only
18 testified on one case where the counsel of record in this case
19 William Schwitzer's office was your patient's counsel in an on
20 going litigation, is that fair?

21 A Yes.

22 Q Can we agree though that you've had more than one
23 patient who has been represented by William Schwitzer's office
24 just not someone that ended up having to testify for in court,
25 is that fair?

1 A Yes.

2 Q When I say more than one, many more than one, can we
3 agree on that?

4 A Yes, I've had several.

5 Q Another test that Plaintiff's counsel talked about
6 during direct and elicited from you was EMG Electro --
7 EMG/NCB(sic). Can you tell the jury what that stands for?

8 A Nerve conduction study and electromyography.

9 Q Can we agree that even those tests are subject to, to
10 some extent interpretation and the performance of the test by
11 the person that's administering it?

12 A Yes.

13 Q And can we also agree that you weren't actually the
14 person that administered either of this Plaintiff's EMG/NCB(sic)
15 studies?

16 A I was not.

17 Q And in fact, although we went through a lot of your
18 office visits with Mr. Avila, you were not admittedly the person
19 who saw Mr. Avila on all of those visits, correct?

20 A Correct.

21 Q You mentioned there were times that you would have a PA
22 that was actually the person that saw him, correct?

23 A Correct.

24 Q In fact, I think you misspoke earlier. Because you
25 testified that and you may not have done this on purpose but on

1 January 3, 2022, you saw him on January 3, 2023, I apologize.

2 On January 3, 2023, you saw him but in fact, it was someone else
3 from your office who saw him that day, correct?

4 A January 3, 2023.

5 Q Yes, I believe so or maybe I'm mixing up my dates.
6 January 3, 2023, who saw him, if anyone?

7 A He was seen by the PA.

8 Q Right. And on January 31, 2023 also by the PA,
9 correct?

10 A Yes. Yes.

11 Q And so in addition to the fact that it's not always you
12 that would see the Plaintiff, there were times that some of
13 these trigger-point injections you were talking about, they were
14 administered by other people as well within your practice,
15 correct?

16 A Yes.

17 Q I want to talk a little bit about this testimony about
18 prolonged sitting.

19 Doctor, you're familiar with the concept of axial
20 force, correct?

21 A Yes.

22 Q Axial load as it's sometimes called. It's the
23 vertebral pressure on a spine, correct?

24 A Yes.

25 Q It's the force vertically on the spine that has a

1 potential to compress and put pressure on the spine, correct?

2 A Yes.

3 Q That's specifically why sitting can aggravate or just
4 generally speaking just not be good if you have lower back pain,
5 is that correct?

6 THE COURT: Just repeat the question.

7 Q Doctor, can we agree that it's the axial force on the
8 spine that makes prolonged sitting something that's harmful, if
9 you have lower back pain?

10 A I'd say in part.

11 Q Let's just be clear on why.

12 Sitting tilts the pelvis forward, correct?

13 A Yes.

14 Q And that straightens what would ordinarily be the
15 normal curve in the spine when someone's standing, correct?

16 A Yes.

17 Q That is what presents and creates that axial force on
18 the spine, correct?

19 A Yes.

20 Q And in fact, the axial force on the spine, that
21 increased pressure on the spine is actually greater when you're
22 sitting versus when you're standing, correct?

23 A Yes.

24 Q By a significant amount, anywhere from 40 to 80,
25 90 percent, can we agree on that?

1 A I don't know about the exact percentages but yes.

2 Q So all this to say, doctor, is that you mentioned on
3 direct that prolonged sitting is not recommended, can we agree?

4 A Yes.

5 Q And in fact, prolonged sitting, the ability to sit for
6 a prolonged period of time would be inconsistent with someone
7 who's claiming significant lower back pain, can we agree on
8 that?

9 A Can you rephrase the question?

10 Q I'll make it even simpler.

11 Please tell this jury how long would you define as a
12 prolonged period of time to sit without experiencing lower back
13 pain, if you had that issue?

14 A You know, it's different for each person. I wouldn't
15 be able to tell you a person that has back pain how long they
16 would be able to sit for because some patients who have back
17 pain, sitting is actually relieving for the patient.

18 Q Now it's relieving for the patient. Sometimes it
19 could be relieving for the patient?

20 A Yes.

21 Q Got it.

22 So I want you to assume for a moment that the Plaintiff
23 is able to sit for an hour and-a-half, 45 minutes, another hour
24 and-a-half, another 30 minutes, that this might be one of those
25 instances where it's actually helping him?

1 A I wouldn't say helping him, but I would say that they
2 would likely need to change position if they have significant
3 back pain and they were sitting. Plus by sitting for that
4 prolonged period of time, that could increase the pain in their
5 back.

6 Q So maybe they need to stand?

7 A They would shift positions, stand up, walk around, sit
8 back down or lie down or recline.

9 Q How about stand for about three minutes until the Judge
10 tells them it's okay to sit down. What would that be
11 compatible with?

12 A If the Judge told him to stand for three minutes?

13 Q No. If he asked to stand up and after about three
14 minutes the Judge said it's okay to sit, then he immediately
15 sat. What would that tell you about what would be better for
16 him, sitting or standing?

17 A It would depend upon what the patient reports and as
18 far as the amount of pain that they have, if they have chronic
19 back pain, they should shift positions.

20 Q And if you did not observe a patient shift position for
21 like an hour and-a-half, what would that tell you?

22 A They could have -- I think it would depend on the
23 patient and it would depend on the instance. It could also be
24 that the patient, they might have taken pain medication that day
25 or they might have had some recent intervention or therapy.

1 Q At this point you're not sure, can we agree on that?

2 A Yes.

3 Q Okay, so let's move on.

4 You mentioned earlier that patients can often overstate
5 the level of pain on that scale of zero to ten, is that fair?

6 A Yes.

7 Q That's known as the VAS scale, correct?

8 A Yes.

9 Q I think you explained it earlier. It's that scale I
10 think we've probably all seen at some point where there are
11 little faces under the numbers and it goes from the very sad
12 face to sort of a stoic face to a very happy face, right, to try
13 to help people note where they think their pain is, correct?

14 A Correct.

15 Q And you said sometimes they overstate it to the point
16 where you have to bring them down, correct?

17 A I have to explain to them the pain scale, so that they
18 have a better understanding of the pain scale.

19 Q Can we agree that the Plaintiff in this case by and
20 large, I think you testified on direct, his reports on the pain
21 scale has stayed basically the same from the time you first saw
22 him in February 2022 until a couple of weeks ago, April 2026, is
23 that fair?

24 A They've fluctuated very minimally.

25 Q So for the most part they've stayed around the same?

1 A Not the same but yeah, within between six and eight.

2 Q Six and eight, right?

3 A Yes.

4 Q So, despite the surgeries that he's undergone with the
5 exception of an occasional trigger-point injection and one
6 epidural steroid injection, you would agree with me that the
7 Plaintiff still reports generally the same amount of pain?

8 A Yes.

9 Q Is it customary to continue to have a patient on the
10 same modalities and treatment for over four years where there
11 appears to be no tangible benefit to the patient?

12 A That's why we try different modalities and try to
13 modify the treatment plan and offer other options to them.

14 Q How about the fact that your prognosis on February 9,
15 2022 is guarded and you just told this jury that in April 2026
16 your prognosis is guarded to poor. So your prognosis hasn't
17 gotten any better, despite the four plus years of treatment that
18 you've given him, is that fair?

19 A Yes.

20 Q And yet you still continue to plan another injection
21 next month?

22 A Yes.

23 Q And in fact, your prognosis is guarded to poor, so
24 you're telling this jury that he's gotten worse?

25 A I'd say as far as his prognosis is concerned, being

1 that we've had several years of treatment, I don't see
2 significant improvement in the short term.

3 Q So when you said on direct that you would be monitoring
4 his progress, that's the words you used, future treatments in
5 order to monitor his progress, we can agree that he's had no
6 progress according to your testimony?

7 A Yes.

8 Q You mentioned his ongoing lifestyle during direct
9 examination.

10 A Let me just go back a second. I would say that his,
11 in reviewing his records there have been periods where the pain
12 has -- where his exams have not been as bad as other times. So
13 I would say there has been improvements. Like I said his
14 condition has kind of gone up and down over time. There have
15 been periods where his condition has improved.

16 Q But we've wound up at the same spot?

17 A Yes.

18 Q His ongoing lifestyle that you referenced during the
19 direct examination, what is his lifestyle as you understood it?

20 A When I speak of lifestyle I'm talking about his
21 activities of daily living.

22 Q So let me stop you there. Activities of daily living,
23 you noted that in your most recent record that, your office's
24 most recent record that he's independent in his activities of
25 daily living, correct?

1 A With regard to his ability to feed himself, to brush
2 his teeth, to get dressed.

3 Q To shower?

4 A To shower, yes.

5 Q I want you to assume that yesterday -- not yesterday,
6 these are long days. I want you to assume that Friday,
7 Mr. Avila testified that when he showers he can't even bend down
8 to shower. Would you consider that independent in his
9 activities of daily living?

10 A When I spoke with him I don't believe he mentioned that
11 as far as having difficulty with showering.

12 Q Let's fast forward a little bit to your most recent
13 records. May I have that Exhibit. I believe it's Plaintiff's
14 Exhibit 5 that's in Evidence.

15 (The Exhibit is handed to counsel.)

16 Q So there's context for this. We can agree that since
17 February 9, 2022, Mr. Avila has gone to your clinic and been
18 seen by either you or one of your PAs every few months since
19 then, right, until now?

20 A Yes.

21 Q And we can also agree that there have been five
22 occasions on which he's gone, undergone trigger-point injections
23 to his either his back or his neck, is that fair?

24 A Yes.

25 Q And up until today, over four years since you first

1 started seeing him, he's had exactly one epidural injection to
2 his back, correct?

3 A Correct.

4 Q So a lot of the testimony you gave earlier about
5 everything that goes into an epidural exam, epidural injection,
6 apologies, there's actually only been one injection, correct?

7 A Yes.

8 Q The next one will allegedly be next month, correct?

9 A Yes.

10 Q I'm sorry, I'm actually looking for the record, not
11 this latest one. No, it is this one.

12 I want you to take a look at your record of April 7th
13 and this is when you saw him last, right, April 7th. Do you
14 have a copy of that?

15 A You have my copy.

16 Q Okay.

17 (The Exhibit is handed to the witness.)

18 Q Am I correct that this states that he is not driving
19 because he doesn't have a car?

20 A I think --

21 Q No, no, my question is very simple. Does it say that
22 he's not driving because he has no car?

23 A Yes.

24 Q Now in terms of the future treatment that you testified
25 on direct that Mr. Avila would need, I want to just touch on

1 those very briefly.

2 You testified that one of those things that you are
3 telling this jury that Mr. Avila will need going forward are
4 cervical epidural steroid injections two times a year, correct?

5 A Yes.

6 Q For ten years, correct?

7 A Yes.

8 Q We can agree he's never had a single cervical epidural
9 injection since this incident?

10 A Correct.

11 Q You also testified that you believe the Plaintiff
12 should receive two lumbar epidural steroid injections a year,
13 correct?

14 A Yes, as needed.

15 Q For ten years?

16 A Yes.

17 Q We can agree that in over four years he's had exactly
18 one?

19 A Yes.

20 Q You also testified that he would need trigger-point
21 injections every eight to 12 weeks as needed, correct?

22 A Yes.

23 Q For ten years?

24 A Yes.

25 Q And that he would need steroid injections for his knee

1 and both shoulders up to two times a year, correct?

2 A For those I would -- when I saw him he did have
3 significant pain in those areas. He hasn't complained of
4 significant pain since then, so --

5 Q So you would not recommend those now?

6 A Correct.

7 Q And how about steroid injections to the left hip, which
8 I believe you opined that he would need twice a year also for
9 ten years. Do you still stand by that?

10 A No. At the time that I did this I thought it would be
11 necessary. Since then his condition hasn't or he hasn't
12 complained of those areas.

13 Q Okay. So we can agree he doesn't need those?

14 A Yes.

15 Q And in terms of MRIs, you also recommend MRIs of the
16 neck and MRIs of the back both, once every three years for ten
17 years?

18 A Yes.

19 Q When was the last time he had any sort of MRI to his
20 neck or back?

21 A Earlier in April.

22 Q April of this year?

23 A Yes.

24 Q How about before then?

25 A Since he was first seen.

1 Q So back in 2022?

2 A Yes.

3 Q So he had MRIs in 2022 at other facilities, by the way,
4 right?

5 A Yes.

6 Q And then he had an MRI this month you said?

7 A Early April.

8 Q So if we put aside February, March of 2022, he's had
9 one set of MRIs in the approximately four years since, can we
10 agree on that?

11 A Yes.

12 Q But you're recommending one every three years for ten
13 years on both his neck and his back?

14 A Let me be clear about these recommendations. These
15 are for when he would potentially need it.

16 Q So these are not set in stone, these are just as
17 needed?

18 A These are -- these would be like in my opinion if his
19 condition continued or worsened, which is possible, this should
20 be available to him including the MRIs.

21 Q So let's get this last piece. I didn't mean to talk
22 over you. What did you say?

23 A Including the MRIs, including the therapy. I'm not
24 saying that he has to have it twice a year regardless. I'm
25 saying that his condition would go through or is likely to go

1 through periods of exacerbation and periods where he could
2 potentially be symptom free. He hasn't had any symptom free
3 period of time when I've seen him but he's had periods where his
4 condition appeared to improve on exam. But there may be
5 periods which is the natural course of these disc problems,
6 where the condition could exacerbate and during those periods
7 it's recommended an injection, an injection with therapy. If
8 there are new symptoms that could occur, an MRI may be
9 indicated. If he's recommended for other types of surgeries by
10 another physician perhaps then he could potentially need another
11 MRI.

12 THE COURT: Counsel, let me know when you're in a
13 good spot to stop.

14 MR. FREIRE: I'm almost done, Judge.

15 Q So doctor, if I could put a bow on that then. All of
16 the recommended treatment that you're saying is based on what
17 you see as potential likelihood and then potential need and
18 therefore, what it would cost, if, in fact, he does need that,
19 so that he could avail himself of those treatments, is that
20 fair?

21 A Yes.

22 Q So let's get into that last piece and this whole idea
23 of how likely it is or is not that he's going to get better.

24 I believe you testified on direct that his condition
25 may deteriorate without further treatment, is that fair, you

1 said that?

2 A Yes.

3 Q That he could be in significant pain going forward,
4 correct?

5 A Correct.

6 Q That he could get worse if he doesn't continue
7 treatment, correct?

8 A Correct.

9 Q And then I think you lastly said it's more likely than
10 not in your opinion?

11 A Yes.

12 Q But we can agree that you don't know that, correct?

13 A Correct.

14 Q In fact he's never stopped seeing your clinic since he
15 started treating four years ago, correct?

16 A Correct.

17 Q So we don't know whether or not the day he stops he
18 never has to return, do we?

19 A How do you mean? The day that he stops whether he
20 would ever need to return?

21 Q Yeah, the day he stops treatment. Let's say right
22 after this lawsuit ends, if he never shows up again at your
23 office, that could happen?

24 MR. STOLZMAN: Objection.

25 THE COURT: Rephrase the question.

1 MR. FREIRE: Withdrawn.

2 Nothing further.

3 THE COURT: All right, we're going to take ten
4 minutes. Please don't discuss the case. Follow the
5 officer.

6 COURT OFFICER: All rise, jurors exiting.

7 (Whereupon, the sworn jury panel exits the
8 courtroom.)

9 THE COURT: Can I see counsel at the bench.

10 (Whereupon, an sidebar discussion was held off the
11 record.)

12 (Whereupon, a recess was taken by all parties.)

13 THE COURT: Doctor, come on back up.

14 (Whereupon, the witness retakes the witness stand.)

15 COURT OFFICER: All rise, jury entering.

16 (Whereupon, the sworn jury panel enters the
17 courtroom.)

18 THE COURT: Please be seated everyone.

19 Let the record reflect that all jurors and
20 alternates are present and in their assigned seats.

21 Doctor, you're reminded you are still under oath.

22 REDIRECT-EXAMINATION

23 BY MR. STOLZMAN:

24 Q Doctor, let me maybe start where we finished. You
25 were just asked several questions by defense counsel regarding

1 sitting and whether or not somebody would be able to -- strike
2 that.

3 Regarding sitting, doctor or any of the activities that
4 we talked about, can you describe the distinction as a medical
5 doctor between being able to do something and doing something
6 pain free?

7 A I think it's self-explanatory. There are certain
8 things that we as pain free adults take for granted. Something
9 as simple as getting out of bed, bending down, putting your
10 shoes on, we do those things without difficulty.

11 As we get older, maybe some of the older people would
12 agree to this, that it gets a little bit harder, a little bit of
13 discomfort starts to set in and it becomes more difficult.

14 So if you could just think about those things in your
15 own life or a period of time when you might have had pain and
16 consider that he is having pain even with basic activities, with
17 walking short distances, with sitting for short periods of time.
18 He's able to do basic activities on his own. He's able to,
19 like I mentioned, care for himself, feed himself, go to the
20 bathroom on his own but he does have difficulties with other
21 activities. And I would expect that this would continue to a
22 certain degree and as far as sitting is concerned, there may be
23 periods where he would be able to sit longer and as I mentioned
24 several times, there may be periods where his pain exacerbates
25 beyond the baseline level, where it would be more difficult for

1 him to sit or stand for prolonged periods of time.

2 Q And doctor, you were asked questions by the Osborn's
3 attorney regarding certain information or records that you
4 didn't have at your initial exam, such as an incident report or
5 an ambulance report.

6 What, if any, is your experience with treating patients
7 with pain with those types of documents?

8 A If they had those types of documents?

9 Q Or if they don't. Could you explain to the jury what
10 importance, if any, they have?

11 A When I see a patient that's been involved in an
12 accident, they're coming to me for treatment. I mean I'm a
13 physician and I do want to address as much as possible the
14 medical legal elements for which we're here for today. But my
15 primary concern is treating the patient medically and making
16 sure he's getting the care he receives and to formulate his
17 treatment plan going forward.

18 We don't always have the medical records. Sometimes
19 we have discharge papers from the hospital but it takes time to
20 obtain those medical records afterwards and we review them in
21 due course when they are received.

22 As far as the information that I had, I do rely on a
23 patient's history. In other words, I do rely upon what the
24 patient is telling me, at least initially, when I'm determining
25 whether or not the accident is the causative factor in his

1 injury.

2 Q And bluntly, doctor, does a patient who sees you for
3 the first time need to have a police report or an incident
4 report in order for them to get treatment from you for pain?

5 A No.

6 Q And why is that?

7 A They don't always have it available. I can't turn a
8 patient away because they don't have ceratin documentation that
9 the accident took place.

10 Q And if at some point, let's say, a document did come or
11 would be available, would you ever need that document in order
12 to treat a patient for pain?

13 A The documentation that I receive would help me, if the
14 documentation had something in there that countered what the
15 patient reported to me, I would take that into due
16 consideration. But I'm not going to rely upon the records for
17 me to go forward with treating his degree of pain.

18 Q Let's talk about the records that you have relied upon
19 for your testimony today here, doctor.

20 A I'll just go back to the last question you mentioned.
21 I mean if a person was in an accident or any of us were in an
22 accident and you go to a hospital, they're not going to say,
23 well, where's the documentation that you, you know, hit your
24 finger with the hammer, I'm not going to treat you.

25 I'm going to treat them, I'm a physician and I'll

1 review whatever records I receive later on to incorporate into
2 his plan and into any legal elements of it.

3 Q And in preparation for your testimony today, you
4 reviewed not just -- I should say during the course of this,
5 your treatment for Mr. Avila there came a time when you reviewed
6 other documents outside of what's in your chart, correct?

7 A Yes.

8 Q And those included the hospital records that counsel
9 made reference to?

10 A Yes.

11 Q And they included the MRI reports, correct?

12 A Yes.

13 Q And also the records from the other treaters that
14 Mr. Avila has had since for this incident, correct?

15 A Yes.

16 Q In any of those documents, any of those records, was
17 there any reference, at all, to any prior injuries or incidents
18 for Mr. Avila prior to this incident?

19 A Not that I saw or recall.

20 Q Does the fact that Mr. Avila was in, prior to being in
21 the United States was in Ecuador in any way factor into your
22 treatment for his pain?

23 A No, he deserves proper treatment just like any other
24 person that comes into my office.

25 Q And the Osborn's attorney also asked you about passive

1 versus active and made a distinction that passive sometimes can
2 be more indicative of a patient's pain, correct?

3 A If passive can be more indicative of --

4 Q I should say that passive, the patient himself has less
5 activity within a passive exam, the doctor is the one who does
6 the manipulation, right?

7 A Yes. I really, for the neck and back as a spine and
8 an interventional pain management spine specialist I would only
9 do the active, because for the neck and back for passive it
10 really doesn't, it really doesn't work.

11 Q And why is that?

12 A Well, you know, I can't bend the trunk forward or
13 backwards and as far as the neck is concerned it's also limited
14 by the amount of voluntary movement or if I move his head a
15 certain way, he would stop it if it was voluntary. So I don't
16 think it really holds with those two areas.

17 Q And the Osborn's attorney also asked you questions
18 about SOAP as referenced in your records. That's not something
19 that's unique to your office, right?

20 A That's standard.

21 Q Standard.

22 And the goniometer that we talked about, why is it
23 doing a range -- strike that.

24 Doing range of motion testing that Osborn's counsel
25 asked you, why is that useful for your exam for when you treat

1 somebody with pain?

2 A It helps to guide the progression of the illness, gives
3 us a percentage off of normal of how badly he is restricted.

4 Q And you would agree it's not perfect, right?

5 A Correct.

6 Q But you do it anyway?

7 A Yes.

8 Q And why is that even though it's not perfect?

9 A First off, I don't do it on every exam, use a
10 goniometer. Many times I'll have the patient in front of me
11 and I'll ask them to do the same movements but I don't document
12 the degrees. I'll put mild, moderate or severely restricted.
13 And it's part of the exam that I do at each visit along with the
14 neuro exam and the straight leg raise and the Spurling. These
15 are the things that we do in pain management to see whether the
16 condition is worse, changing, when any other areas are involved
17 and again to see whether the range of motion is reduced or
18 improved.

19 Q And when you say we, doctor, do you mean specific to
20 the practitioners in your office or something else?

21 A I would say in reviewing other doctors' records that
22 are in pain management or other doctors in other specialties,
23 they typically do similar exams specific for their specialty
24 within the musculoskeletal.

25 Q That would include range of motion testing and the

1 active testing that you talked about?

2 A Yes.

3 Q Even though they are considered subjective?

4 A Yes.

5 Q Doctor, from time to time in the course of your
6 practice, have you had patients who you would, who you've
7 observed or you came to believe did not have the pain that they
8 said they have or were reporting, that did not line up with the
9 diagnostic testing or the other testing that you were able to
10 do?

11 A Yes.

12 Q And how would you characterize Mr. Avila compared to
13 one of those patients?

14 MR. FREIRE: Objection.

15 THE COURT: Sustained.

16 Q When that happens, doctor, when you find a patient who,
17 the complaints don't match up to all of the testing that you do,
18 objective, subjective, clinical, diagnostic, what do you do
19 next?

20 MR. FREIRE: Objection.

21 THE COURT: Sustained.

22 Q Doctor, based off of all of the records you reviewed
23 and your own chart, was there anything to indicate that
24 Mr. Avila's, the complaints that Mr. Avila was having in some
25 way were insincere or fake?

1 A I don't have anything that would suggest that.

2 Q And if you did, would you provide him with the
3 treatment and the medications that you have been giving him and
4 that you continue to give him?

5 A No.

6 Q And why is that?

7 A It wouldn't be indicated. I wouldn't feel comfortable
8 providing certain invasive treatments to a person that didn't
9 have a condition that required it.

10 Q The Osborn's counsel also asked you about the fact that
11 over the four years of treatment, that in many ways Mr. Avila
12 has not, his prognosis is the same or hasn't changed.

13 Why is that in your opinion, doctor?

14 A Well, he's been getting as much treatment within the
15 scope of my specialty that I'm comfortable providing and his
16 condition just hasn't responded to it. I will say that he
17 hasn't -- it doesn't appear as though he has deteriorated
18 further. So he does say that the injections have helped.

19 If any of you, if anybody has been in severe pain if
20 only to get a respite of pain even for a short period of time
21 could be very significant. So we do these injections, we do
22 these procedures, some patients don't like to take medication
23 but they do because they are in a lot of pain and -- I think I
24 got off track.

25 Q That's okay. Let me ask you another question.

1 Mr. Avila testified and I believe you testified about
2 Lidocaine patches. What's the importance of those for someone
3 with his -- why did you describe those to Mr. Avila?

4 MR. FREIRE: Objection. Outside the scope of my
5 cross.

6 THE COURT: I don't think it was brought up.

7 MR. STOLZMAN: Okay.

8 Q Going back the treatment that you have been providing,
9 what would happen based on your opinion, doctor, if Mr. Avila
10 didn't have that treatment that you have been providing?

11 A His pain level could go from a seven eight up to a
12 nine. It could become worse, his limitations could worsen. He
13 may potentially require more invasive treatments, more
14 surgeries.

15 Q And would you say that is more likely than not, doctor?

16 A I wouldn't -- it would be hard to say because again
17 he's had periods where he has done -- he appears to have
18 improved to a significant degree but then he kind of back
19 slides.

20 Q And just so I'm clear, the periods where he's improved
21 and/or back slides, that's throughout the treatment you've been
22 giving him, the injections, the medication and the physical
23 therapy, he's improved and then sometimes not, right?

24 A Yes, yes but there have been some prolonged periods
25 where his exam showed some significant improvement. And I will

1 also say that he's young and younger patients have more reserve.
2 So there moves a little bit of the percentage towards some
3 degree of improvement. So it would be hard to say how his
4 condition would change significantly without treatment but I
5 will hedge on the side of saying that without further treatment
6 like I'm recommending, without being available to him, he could
7 be, he could have some significant pain episodes that are not,
8 that if not treated they could become quite painful and really
9 significantly impact his life.

10 Q Just to be clear, that's why you have made those
11 recommendations that you provided to the court before?

12 A Yes, as if I was going to continue treating him, these
13 are the things that I would like for him to have available to
14 him as I mentioned before if it does exacerbate. Even though,
15 it's true, he hasn't had -- he's had one epidural, he's had a
16 bunch of trigger-point injections but within the scope of what
17 he could, what could occur, he may, in fact, need to have these
18 injections more frequently both with the epidurals and the
19 trigger-points should his condition worsen. I won't say that he
20 would need it more than that but that would probably be within
21 certain parameters. I mean, hopefully it will stay on the lower
22 end but if it does get worse potentially within that perimeter
23 these are what would be available to him.

24 Q Again that's to a reasonable degree of medical
25 certainty, right, doctor?

1 A To a reasonable degree of medical certainty.

2 MR. STOLZMAN: Thank you, very much.

3 THE COURT: Okay, doctor.

4 MR. FREIRE: Very briefly, Judge.

5 THE COURT: Only on what he's gone into.

6 MR. FREIRE: Yes.

7 RECROSS-EXAMINATION

8 BY MR. FREIRE:

9 Q Doctor, you mentioned goniometer testing. And you
10 mentioned that it's not done on every visit, correct?

11 A Correct.

12 Q And in fact, that's true if you look at your chart, we
13 would note that there are occasions in which there is no
14 goniometer test results, correct?

15 A Correct.

16 Q And you testified on redirect right now that you would
17 in those instances where you do not perform the testing with the
18 goniometer, that you would note whether or not the restriction,
19 if there was a restriction, as either mild, moderate or severe,
20 correct?

21 A Correct.

22 Q But you would agree with me that in your chart there
23 are several instances in which the range of motion does not have
24 those indicators, it doesn't say mild, moderate or severe, it
25 just says restriction?

1 A Yes.

2 Q So even though you testified that those adjectives
3 should be there, there are occasions which they're not?

4 A There are periods where I would just put the range of
5 motion was restricted and left it at that.

6 Q Also mentioned on redirect that there is not to your
7 understanding and recollection any mention of any prior
8 incidents that Mr. Avila was involved in, in any of the records
9 that you reviewed in connection with this case including your
10 own records, correct?

11 A As far as him having prior accidents or injuries?

12 Q Yes.

13 A Yes.

14 Q By the way, have you ever prepared a detailed a
15 narrative report what we refer to as narrative report, a report
16 on your treatment of Mr. Avila?

17 A Yes.

18 Q Did that narrative report include mention of all of the
19 records that you reviewed in connection with this case?

20 A I believe so, yes.

21 Q And so of those records, you didn't see any prior
22 incidents, can we also agree that all those records, all the
23 records that you reviewed in connection with this case, in fact,
24 all of the records in this case, the only source of any
25 information regarding Plaintiff's prior medical history would

1 have come from Plaintiff, can we agree on that?

2 MR. STOLZMAN: Objection.

3 THE COURT: I'll allow it.

4 Q Can we agree on that?

5 A Yes.

6 Q Also I just want to make sure that I heard your
7 phrasing correctly just now.

8 That you would hedge on the side of your opinion that
9 without the treatment you recommend, Plaintiff could have some
10 episodes of increased symptoms such that he may need those
11 treatments within the range that you have recommended, is that
12 all fair?

13 A Yes.

14 Q Lastly Plaintiff's counsel started your redirect with
15 questioning about whether or not the absence of documentation
16 regarding his accident or his status in the United States or the
17 fact that he came from Ecuador would impede you or inhibit you
18 or prevent you from treating him as a patient. And we can
19 agree that of course that wouldn't prevent you from treating
20 him, correct?

21 A Yes.

22 Q Of course you would treat him if he came to you as a
23 patient, correct?

24 A Yes, correct.

25 Q As a physician, you're there to treat whatever he says

1 is wrong with him, correct?

2 A Yeah, I didn't think that you were implying or anybody
3 was implying that based upon his nationality that I wouldn't
4 treat him.

5 Q Correct, exactly because I'm not.

6 A Yeah, I know.

7 Q What I am getting to though is that and the purpose of
8 my cross-examination earlier which was now the subject of the
9 redirect, is that the lack of documentation of his accident or
10 the lack of documentation regarding any prior medical history,
11 that does, however, inform you when you're making a
12 determination on causation, can we agree on that?

13 A Yes.

14 Q Meaning that when you made that determination that his
15 symptoms as reported by him, his complaints were caused by the
16 accident that he reported to you, you did not have at that time
17 documentation regarding the actual happening of the accident,
18 correct?

19 A That's correct.

20 Q That's fine, you answered the question.

21 You also did not have any records regarding any past
22 medical history to the extent that could have been relevant, is
23 that fair?

24 A Yes.

25 Q And you didn't have at that time any objective

1 diagnostic evidence such as MRIs or x-rays at that time when you
2 first saw him on February 9, 2022, is that fair?

3 A Yes.

4 Q So assume for a moment that on the first visit that you
5 saw the Plaintiff, he told you, he reported to you that he
6 tripped and fell on a broken sidewalk and that his knee hurt and
7 that you did your examination and he reported pain when you did
8 tests for his knee that were subjective in nature.

9 You didn't have the benefit of any x-rays or MRIs on
10 his knee at the time. You didn't have any evidence regarding
11 how his alleged trip and fall occurred or if it occurred, at
12 all.

13 Under those circumstances you'd agree with me that with
14 that limited information, just what he told you and with nothing
15 else, in that circumstance you would come to the conclusion that
16 his claimed manner of accident, the mechanism of the accident,
17 the trip and fall on a sidewalk was the cause of his symptoms of
18 his knee pain, would you agree with that?

19 A Yes.

20 MR. FREIRE: Nothing further.

21 THE COURT: Okay. Doctor, you can step down.

22 (Whereupon, The witness steps down from the witness
23 stand.)

24 THE COURT: Okay. So I have some good news and
25 some that's however you want to take it, news.

1 The trial is going on course and I expected that it
2 will end, subject to the earth being struck by a meteorite
3 by the time that the lawyers said it would end. But for
4 various reasons that are beyond our control, you're going to
5 be here tomorrow, okay. As I said, this is not going to
6 effect the time that it takes to try the case. We had to
7 move certain things around because of like I said
8 circumstances beyond our control. You're going to be here
9 tomorrow, so tomorrow the 22nd and you'll be here at 9:30,
10 okay. When we finish because of what I was saying things
11 beyond our control, you will not have to be back here until
12 Tuesday the 28th. So you'll have Thursday, Friday,
13 Saturday, Sunday, Monday. So like I said it all depends on
14 how you take that. But some of you may prefer to be here,
15 nice people and everything, but some of you have may prefer
16 to have the day off. Like I said, it's not going to effect
17 the length of the trial, it's just something that happened.
18 So see you back here tomorrow morning at 9:30 and then when
19 we finish, we'll see you Tuesday morning at 9:30.

20 So let me just give you the instructions.

21 Do not discuss this case with each other or anyone
22 else, including family or friends. Do not speak to anyone
23 or permit anyone else to speak with you regarding this case.
24 If anyone approaches you or tries to talk to you concerning
25 this case, do not discuss this with your fellow jurors and

1 report to the court through the officer.

2 Do not use the internet websites or any other
3 source to research this case. Do not visit any of the
4 locations pertaining to this case. When you return to
5 court report to the location to which you have been
6 instructed to report by the officer.

7 Do not speak with any of the parties in this case.
8 They have been directed not to speak with you. Do not form
9 or express an opinion or come to conclusion as to the facts
10 of this case during the trial. Wait until the entire case
11 has been submitted to you by the Court.

12 So again remember the admonition, do not look up
13 any of this stuff that I've referred to as expert testimony
14 that we've had. Pretty much the balance of the case we
15 have will be under the heading of expert testimony from
16 various people.

17 So there's going to be that tremendous urge to do
18 independent research. Please don't do that. It will
19 really mess things up if you do so.

20 With that in mind have a great evening. See you
21 back here tomorrow morning at 9:30. Follow the officer
22 please.

23 COURT OFFICER: All rise, jurors exiting.

24 (Whereupon, the sworn jury panel exits the
25 courtroom.)

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THE COURT: All right, be seated. Anything else we need to put on the record?

MR. FREIRE: No, your Honor.

MR. STOLZMAN: No.

(Whereupon, the proceedings are adjourned to Wednesday, April 22, 2026 at 9:30 a.m.)

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