

SUPREME COURT STATE OF NEW YORK
COUNTY OF WESTCHESTER

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EDDY ARMIJOS AVILA,

Plaintiff,

-against-

Index #
58754/2022

MIRIAM OSBORN MEMORIAL HOME
ASSOCIATION,

Defendant.

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JURY TRIAL:

Westchester County Courthouse
111 Dr. Martin Luther King Jr. Blvd.
White Plains, N.Y. 10601
April 28, 2026

B E F O R E:

HON. DAVID E. EVERETT,
Justice

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SENIOR COURT REPORTER

1 (Whereupon, Plaintiff's Exhibits 8 through 13,
2 previously marked for identification, are received into
3 evidence.)

4 (Whereupon, the witness enters the courtroom.)

5 THE COURT OFFICER: Come to order.

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

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

8 THE COURT: Are we ready, Counsel?

9 MR. FREIRE: Yes, your Honor.

10 MR. STOLZMAN: Yes, Judge.

11 THE COURT: Okay.

12 THE COURT OFFICER: All rise. Jurors entering.

13 (Whereupon, the jury enters the courtroom.)

14 THE COURT: Okay. Please, be seated everyone. And
15 let the record reflect that all the jurors and alternates
16 are present and in their assigned seats, so did you miss us?

17 JURY MEMBER: Yes.

18 THE COURT: All right, so we're proceeding
19 according to plan. We have our next witness ready to
20 testify, so all is well, so do you want to call your next
21 witness?

22 MR. STOLZMAN: May it please the Court, your Honor,
23 Eddy Avila calls, Dr. Merola.

24 THE COURT: Doctor, raise your right hand. Do you
25 solemnly swear or affirm that the testimony you're about to

1 give will be the truth, the whole truth and nothing but the
2 truth?

3 THE WITNESS: Yes, I do.

4 THE COURT: Please, have a seat and get your full
5 name for the record.

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

7 THE COURT: You may inquire, Counsel.

8 W H E R E U P O N, the witness, Dr. Andrew Merola,
9 having been duly sworn, testifies as follows in open Court:

10 DIRECT EXAMINATION

11 BY MR. STOLZMAN:

12 Q Good morning, Doctor. How are you?

13 A Good morning. Thank you.

14 Q Can you please tell the jury what you do for a living.

15 A I'm an orthopedic surgeon, with a subspecialty in
16 spinal surgery.

17 Q Can you explain what an orthopedic surgeon is or does.

18 A So I deal with the musculoskeletal system, so that's
19 your bones, your joints, your nerves, everything that you have
20 that makes it able for you to get up and about and walk around
21 and do your normal activities.

22 Q And are you licensed in any states?

23 A Yes, I am. I'm licensed here in New York State.

24 Q In any others?

25 A New Jersey and in Florida, as well as Nevada.

1 Q And can you tell us your education, please.

2 A Sure. I went to Howard University, College of
3 Medicine. Then I did an internship and a residency at State
4 University of New York in Brooklyn. And I a did subsequent
5 spinal surgery fellowship at the University of Colorado in
6 Denver. And then I returned to New York City to practice.

7 Q And do you have any board certifications?

8 A I am board-certified in orthopedic surgery.

9 Q Can you explain to the jury what, Board-Certified
10 means?

11 A It's an academic process. It starts after you complete
12 all of your training. You take a written examination and that
13 tests your knowledge in your field, in orthopedics. And then,
14 after you've been in practice for a minimum of two years, you
15 collect all of your surgical cases, and then you present those
16 to a -- literally, a board of examiners, whom you sit in front
17 of, who ask you questions about your surgical cases and then you
18 answer those questions.

19 And then they judge whether or not if you meet the
20 requirements of an orthopedic surgeon. And that happens to re
21 -- you recredential every ten years, so you're board-certified
22 for a period of ten years and every ten years you go through the
23 process again.

24 Q Is there any higher certification besides -- after
25 board certifications, Doctor, other higher credential?

1 A Not really, no.

2 Q Okay. And can you tell the jury, please, about your
3 work at hospitals as it relates to teaching.

4 A Yes, so I do some research and teaching for residents,
5 for medical students, allied health professionals, residents and
6 fellows. Typically, I do that at SUNY Downstate, as well as at
7 New York Presbyterian, so those are people that are in their
8 educational process. And we are training them or exposing to
9 orthopedic surgery. They're going into the field or in some way
10 connected to the field.

11 Q Doctor, can you please tell us about your experience
12 publishing in your field.

13 A So I've done a number of articles on orthopedic topics,
14 typically, when they relate to the spine. A lot of those
15 contributions have been for children with pediatric deformities.
16 You may have heard of scoliosis or kyphosis, or congenital birth
17 defects, so I've done a number of studies on that.

18 I've also tested and published studies on the way
19 implants behave when they're placed inside the human body, so
20 those are called, Biomechanical studies.

21 Q And are you a member of any medical associations,
22 Doctor?

23 A So I'm a member of the American Academy of Orthopedic
24 Surgeons and I'm also a fellow, what's known as the Scoliosis
25 Research Society.

1 Q And you mentioned your work with scoliosis. Can you
2 please tell the jury what work you have with not-for-profit
3 work?

4 A Yes, so, you know, typically, scoliosis and spinal
5 deformity-involved children, and we have outreach, essentially,
6 all over the world, where we work with and interface with other
7 surgeons and other treating doctors that take care of kids who
8 have scoliosis. And my particular area of interest was in the
9 Caribbean and Central and South America.

10 Q And in addition, Doctor, you treat patients; is that
11 correct?

12 A Yes.

13 Q And -- and what -- strike that.

14 Do you treat patients who have -- what sorts of -- what
15 specialty do you treat your patients with?

16 A So as an orthopedic surgeon, I see patients who have
17 orthopedic problems. I also see patients who have,
18 specifically, neck and back injuries, or issues relating to the
19 neck and back, relating, not only to trauma, but also,
20 congenital defects, infections, fractures, tumors and
21 degenerative conditions.

22 My subspeciality is the spine, so the bulk of -- the
23 majority that I see are related to the spinal issues.

24 Q And besides examining -- I take it that includes
25 examining your patients clinically; is that right?

1 A Yes.

2 Q And besides doing the examinations, what else do you do
3 with the patients?

4 A So as -- as a -- as a surgeon, I would make
5 recommendations about whether or not a patient may or may not
6 have any benefit from a surgical procedure.

7 Q And once you make that determination, if a patient does
8 have a medical -- would have a medical benefit for a surgical
9 procedure, what do you do?

10 A So I make a recommendation. I sit down, I go over the
11 recommendation with them, and then they make a decision about
12 whether or not they want to proceed with surgery. And if they
13 do, I'm happy to do that surgery.

14 Q And how long have you been practicing medicine?

15 A So I graduated medical school in 1990 -- which makes me
16 kind of old. And I've been -- I finished my fellowship in 1996,
17 so I've been in my own private practice since 1996.

18 MR. STOLZMAN: Your Honor?

19 THE COURT: Well, the same instruction about expert
20 witnesses. I don't think I need to repeat it. I'll say it
21 again after the summations.

22 MR. STOLZMAN: Okay.

23 Q Now, Doctor, I'd like to talk to you a little bit about
24 your treatment of Mr. Eddy Avila, the plaintiff, in this matter.
25 Oh, by the way, do you have your chart -- your records --

1 A Yes.

2 Q -- with you? Were they -- I think they were left up
3 here?

4 A Yes.

5 MR. STOLZMAN: May, I your Honor?

6 THE COURT: Of course. Go ahead.

7 Q And before we get into the treatments that we -- that
8 you provided to the plaintiff, Eddy Avila, can you talk -- can
9 you explain to the jury the importance of your work with the
10 spine, what the discs, the vertebrae and how they interact with
11 respect to the nervous system? And, if you'd like, I have a
12 model here for you to explain to the jury.

13 A Okay. Now, I mean, your spine, as you might imagine,
14 is -- runs along your entire back, from the bottom of your head
15 into the top of your pelvis. And it connects -- it connects
16 your head to your pelvis, essentially. It's responsible for
17 your ability to walk upright on two legs.

18 It's made of three basic components; it's made out of
19 bones, that are stacked up on top of each other, and in between
20 those bones, are pieces of cartilage called, discs, which kind
21 of glue the bones together.

22 And the spine contains the nerves that are responsible
23 for moving your arms and hands around and moving your legs and
24 feet around. And responsible for transmitting any signals that
25 your brain needs to transmit to the rest of your body, so your

1 spine is basically a column that contain bones, discs and
2 nerves.

3 And it's responsible for, basically, the way your body
4 is put together, so you can get up and move around and do your
5 normal activities.

6 Q And specifically, Doctor, can you explain to the jury
7 the function of the disc in that system?

8 A So the discs sit in between the bones as they are
9 stacked up on top of each other. And the primary purpose of the
10 disc is to make sure that the bones are in proper alignment.
11 And that the bones do not excessively move in one direction or
12 another, so the disc -- if you would think of it in this way, it
13 acts to hold the bones together and it acts to cushion and
14 maintain normal, boney alignment and function.

15 Q And there came a time when you treated Eddy Avila;
16 isn't that right?

17 A Yes.

18 Q And can you tell the jury about when that was and what
19 -- the nature of that examination?

20 A Sure. I first saw him on May 23rd of 2022, and he had
21 been referred by one of his treating physicians regarding neck
22 and back symptoms, so he had neck and back complaints and pain,
23 with some radiating symptoms -- when we say, Radiating, we mean
24 travelling into his arms and hands and legs and feet.

25 Q And did you conduct an examination?

1 A Yes.

2 Q And before that, Doctor, did you take a history of Mr.
3 Avila when you met with him?

4 A I did. He had indicated that he had been in a fall
5 which occurred on January 24th of 2022.

6 Q And after taking that history, what did you do next?

7 A So I took the history, found out, essentially, why he
8 was in the office and why he was seeing me. He had indicated
9 that he had been treating for his neck and back symptoms
10 subsequent to the accident that occurred.

11 And then, of course, I looked at a physical exam, so I
12 had an opportunity to examine him, and I also reviewed
13 diagnostics as well.

14 Q And tell us about the examination that you do.

15 A So typically, you know, an examination of your spine or
16 any part of your musculoskeletal system, kind of starts with
17 observations, so you observe the way a patient walks. And you
18 observe whether or not they have any particular abnormality in
19 their neck and back.

20 And in this particular case, some of the things that
21 you might want to do are measure range of motion. On this
22 particular day, it was difficult to measure range of motion
23 because he was in a bit of pain, so it was difficult to measure
24 full-on range of motion, but what I was able to do was I was
25 able to conduct some neurological testing in his neck and arms.

1 And then some neurological testing in his lower back
2 and his legs. And what that showed was that he had had what we
3 call a, Positive compression disc traction maneuver in his neck,
4 which is a test that you do when you push down on the head and
5 neck, specifically, to try to reproduce the symptoms that a
6 patient's having into their arms and hands.

7 The test is positive when you feel rebound spasm and
8 the patient indicates that they have pain radiating down into
9 their arms and hands. That's a -- a test that really tells you
10 something about how their spinal cord is working and how their
11 nerves are working in their neck.

12 Also had what we call, Sensory testing. We do that
13 using a blunt pin, if you will, so it's not a sharp-tip pin.
14 It's a blunt tip pin, and we're looking for tactile and
15 sensation, in what are known as, dermatones, in your arms and
16 hands. And we see whether or not any of those sensations are
17 abnormal.

18 And in this case, they were predominantly abnormal in
19 what we call the, C6 nerve distribution, which is the nerve that
20 travels into your arms and hands from your neck down into the
21 area where your thumb and your index finger are.

22 Q I'm just going to stop you right there, Doctor, because
23 I'd would like to ask you some followup questions about the
24 first two tests that did you.

25 A Yeah.

1 Q With respect -- with respect to the neurological
2 testing, you mentioned spasms to the area and in addition how
3 the patient responded to the pressure that you applied; correct?

4 A Yes.

5 Q Can you explain to the jury, how, if at all, or what
6 you would determine or call objective versus subjective results
7 or testing with that particular maneuver first.

8 A Sure, so -- well, in general, if you think about when
9 you're examining a patient; right, when you -- when you speak to
10 the patient and they're telling you about how they feel, that's
11 subjective; right? It's the patient telling you how they're
12 doing.

13 When you're doing an examination, you're looking for
14 feedback from the body in the way the body is functioning that
15 is not influenced by what a patient tells you, that's objective;
16 right, so if you're looking -- for example, if you test a
17 reflex, that's objective, because it's controlled by a reflex
18 arm in your spinal cord.

19 If you produce pain, your body's reflex to a painful
20 stimulus is to tense up, to avoid having that stimulus applied,
21 and that's spasm, so your muscles tense up in order to avoid
22 being put into a position that reproduces pain. And that's what
23 you rely upon when you do, for example, a compression disc
24 traction test.

25 Compression reproducing the symptoms and disc traction,

1 or pulling the spine apart, decreasing those symptoms.

2 Q Is that to say then, Doctor, the spasm tells you
3 something beyond what the patient would have said?

4 MR. FREIRE: Objection.

5 THE COURT: Overruled. I'll allow that.

6 A The spasm is feedback from the patient's physical
7 response. That gives you an idea of whether or not the test
8 that you're performing is positive or negative.

9 Q And would that -- just that test, that would fall under
10 the -- the end of a provocative test; right?

11 A Yes.

12 Q Okay. And, now, Doctor, can you tell us about when you
13 do the dermatomal distribution that you were talking about, the
14 pinprick, can you also explain to the jury where that would fall
15 within the subjective or objective testing?

16 A So that's a little bit of combination of both; right?
17 Medicine and surgery are a combination of both art and science.
18 And it depends upon how adept you are at doing an examination
19 and how you conduct your exam. Everybody does it a little
20 differently.

21 The thing about dermatomes is that they run along your
22 body in stripes, so, for example, the sixth nerve root, the one
23 nerve root where the abnormality was found in this case, runs
24 from your neck, down your arm, along the outside part of your
25 arm, in between your thumb and index finger.

1 Next to that dermatome, running along the back of your
2 arm, is C7. And then, under your arm, is C8 and T1. The fifth
3 root is in your biceps area. Those stripes are known to
4 examining physicians, but, typically, not to patients. And when
5 you're testing dermatomes, you're looking for a width -- two
6 things; you're looking for patient telling you whether or not
7 they feel something normal or abnormal within the same
8 extremity.

9 You're looking for whether or not they tell you it's
10 normal or abnormal in the opposite extremity. And when you
11 pinprick them, the blunt pin, not with a pin that draws blood,
12 you look to see whether or not they withdraw from that painful
13 stimulus, so you're combining what the patient's telling you
14 with what the body is doing. And that's where the art of the
15 examination comes in.

16 When you're looking for sensory deficits, you can,
17 oftentimes, localize them to specific nerves, as in this case.

18 Q And you also mentioned, Radiating. That the plaintiff
19 was complaining of radiating pain in his neck and his back.

20 A Yes.

21 Q Can you explain to the jury what that means to you?

22 A Yeah, so, you know, typically, if a patient comes in,
23 they're complaining about -- they note -- they have pain in
24 their neck. I will often ask them: Does the pain in your neck
25 travel into any other parts of your body?

1 Because the nerves that emanate from your neck or your
2 lower back travel into your arms and hands and your legs and
3 feet. If those nerves are irritated, patients will oftentimes
4 indicate to you that there are symptoms that radiate or travel
5 into either their arms and hands or legs and feet.

6 Q And did you also observe the plaintiff's -- his gait?

7 A Yes.

8 Q Can you explain to the jury what a gait is?

9 A Yes, so that's part of the observational component of
10 an examination. The way you walk and -- you know, after you
11 hear this, from here-on-in, you might look at the way people
12 walk.

13 Your gait pattern can say a lot about your how
14 musculoskeletal system functions, so your gait pattern should
15 be, normally, very smooth. You should be able to move forward
16 or in any direction in a very smooth manner, where your heels
17 strike first, and then your feet, in an alternating pattern,
18 move your body forward.

19 And that depends upon the normal coordination of all of
20 the nerves going down into your legs and feet. If that pattern
21 is disrupted, and not working normally, it can give you clues as
22 to something being wrong with your musculoskeletal system.

23 And in -- in this case, one of the ways that I observed
24 his gait pattern was antalgic, which meant that there was a
25 limp, so he's spending more time on one leg than another. He's

1 kind of protecting one side versus the other.

2 And the other thing that I noticed was that it was
3 kyphotic -- kyphosis, is a term that, essentially, means pitched
4 forward. When you're walking you should be upright and your
5 neck and your lower back should, actually, be bent backwards a
6 little bit, because your upper back is pitched forward, so to
7 balance yourself out, your neck bends backwards and your lower
8 back bend backwards a little bit. That balance gives you an
9 upright posture.

10 If the upright posture is pitched forward, it's called
11 a kyphotic-gait pattern. If it's pitched backwards, it's called
12 a lordotic-gait pattern. If it's pitched to one side, it's a
13 scoliotic-gait pattern. In this case, it was kyphotic, which
14 means, pitched forward in the low back area.

15 Q And what, if anything, does a kyphotic pattern indicate
16 to you?

17 A So, typically, what that means is that loss of a normal
18 upright posture typically happens because your body is trying
19 to, once again, protect areas that are otherwise causing
20 irritation.

21 The backward bending of your spine has a tendency to
22 put increased pressure on nerves, so irritated nerves have a
23 tendency to feel better when you're pitched forward.

24 It's most obvious in older folks who you might see
25 walking down the street in walkers, than they're pitched quite

1 forward and leaning on the walker because their lower backs are
2 producing pressure on their nerves. That's a very obvious
3 kyphotic gait pattern.

4 Depending upon the amount of nerve root pressure you
5 have, that kyphotic pattern can either be very, very obvious, or
6 flattened, depending upon how severely compressed those nerves
7 are.

8 Q And what would you expect a normal pattern for a
9 26-year old patient?

10 A So normal -- your normal gait pattern, as I said,
11 should be fluid, bilateral, right to left, heel-to-toe,
12 reciprocal, with an upright posture, and neither pitched
13 forward, nor backwards, nor side-to-side.

14 Q And we've talked about some of the testing, but I just
15 want to provide some of the names of the maneuvers that you
16 provided with -- for Mr. Avila. I know you already described
17 them generally: Can you tell us -- you did the phalanx
18 maneuver; correct?

19 A Yes, so there are several different kinds of phalanx
20 testing that you can do. The most obvious type of a phalanx
21 test is in your wrist. If you have carpal tunnel, where you
22 bend the wrist forward to compress the median nerve in your
23 wrist. That phalanx test is to see whether or not that nerve is
24 symptomatic.

25 In your spine, the analogous test is to bend the lower

1 back backwards, which compresses the nerves in your low back.
2 Positive test is the avoidance of that posture from the patient
3 with a reproduction of symptoms down into the legs.

4 Q And then you also did a Hoffman's test; is that right,
5 Doctor?

6 A Yes.

7 Q And was that one of the ones that you've already
8 described?

9 A No.

10 Q Well, can you tell us what you were able to do with the
11 Hoffman's?

12 A Hoffman's test is a -- you're looking at the way the
13 hands behave when you -- you know, relaxed manner. Take one or
14 the other hand. You hold onto the middle digit and then your
15 middle digit, right where your -- the tip of your digit meets
16 the rest of your digit, you just, flick that area.

17 And you look to see whether or not the hand and/or the
18 wrist contract. And that's a -- typically something that you
19 see if there's irritation in and around the nerves and/or spinal
20 cord and the neck.

21 Q And when you took the plaintiff's -- your patient's
22 history, did you ask him about his pain?

23 A Yes.

24 Q And what, if anything, did he tell you?

25 A That he was having a significant amount of pain in his

1 neck and back.

2 Q And the jury's already heard about a pain scale from
3 one of his other doctors. Can you tell us: Did you get a pain
4 scale from Mr. Avila and what did that mean to you when you
5 examined him that first time?

6 A Yes, so pain scales are, to a great extent, a
7 subjective way of talking to a patient about how bad their pain
8 is. Zero is always no pain, ten is severe pain.

9 And so you're trying to get kind of an idea for where
10 that patient is on that scale, so, typically, I'll tell a
11 patient, Five is kind of, like, an annoying, moderate amount of
12 pain, zero is nothing, and ten is really bad. Like, it's really
13 interfering with the way you do your things during your day.

14 Q And what, if anything, did Eddy Avila tell you about
15 his pain that first exam in May of 2022?

16 A I indicated that it was significant enough to interfere
17 with his activities of daily living and he had grades as a ten
18 -- a nine, I'm sorry -- a nine, on a zero-to-ten scale.

19 Q And you also took a history of the -- of your patient
20 at that time; right?

21 A Yes.

22 Q And was there anything -- what did you indicate on your
23 chart in terms of what his history was?

24 A So he had sustained this -- what he had indicated to me
25 was a fall on January 24th of 2022. And that he had been

1 undergoing treatment for the injuries that he sustained, but did
2 continue to have symptoms with respect to his neck and back.

3 Q And in addition, Doctor, at that -- did you review any
4 diagnostic radiology?

5 A Yes, I did. I saw an MRI of his neck, as well as his
6 low back.

7 Q Okay. We'll get to the imaging in a moment, but,
8 Doctor, as a result of this exam, all of the symptoms and the
9 testing that you've just told the jury about, did you render --
10 did you come up with an impression and a plan for your patient
11 at that time?

12 A Sure, so, you know, when you're -- when you come to the
13 end of your interaction with the patient, you come to what's
14 called the, Differential. For one of the potential issues that
15 are causing this patient its problems.

16 And in this case, after his symptoms, which he told me,
17 the examination, which I did, a review of the MRIs, the
18 impression was what's known as, Radiculopathy, which is,
19 basically, just a fancy way of saying a problem with your
20 nerves.

21 Radic, is the Latin term for root. The nerves that
22 exit your spine are nerve roots. And any time you hear the
23 word, Opathy, for anything, if means a problem with, so he
24 presented with the signs and symptoms and fine findings of I
25 person who had radiculopathy in his arms and hands and his legs

1 and feet.

2 Q And what, if any, prognosis did you give him?

3 A At that time, I had indicated his prognosis is guarded,
4 so prognosis is -- it's, like your best-educated guess; right?
5 Like, if -- if you say, Prognosis is good, it's something that
6 you're not really worried about.

7 If you say, Prognosis is poor, that's really bad. If
8 you say, It's fair, you're like, okay, you know, things are
9 being handled well.

10 When you say, It's guarded, it, essentially, means it
11 -- it's something that you need to keep an eye on and you need
12 to continue to treat. And I indicated that it was guarded.

13 Q And did you make a determination as to the level of Mr.
14 Avila's disability?

15 A So I had indicated that he was unable to continue work
16 as a heavy laborer and roofer at that time.

17 Q And did you provide a percent of his disability?

18 A I said that he was a hundred percent unable to do that
19 particular job.

20 Q And, Doctor, did you also provide at that -- as a
21 result of that examination and these findings, determine or
22 credit if his injury from the fall was related to the symptoms
23 that you found?

24 A Yeah. Based on the information that I had, it was
25 reasonable to assume that this condition was secondary to that

1 injury in the absence of any other issues.

2 Q And can you just tell the jury what you mean -- what
3 does, Secondary, mean?

4 A As a consequence of.

5 Q Or, caused by?

6 A Yes.

7 Q Okay. And what, if any other, testing did you suggest
8 or recommend for him to undergo next?

9 A So one of the things that I -- I wanted to do when I
10 reviewed the MRIs of his neck, I did see that there were several
11 areas where the discs were protruding, so there were several
12 areas that were abnormal.

13 My examination predominantly picked up a C6-related
14 issue. One of the things that I recommended was for a --
15 what's known as a -- basically, a nerve test or an EMG NCV,
16 which is, an electrical test, to see whether or not the nerve
17 was behaving either normally or abnormally in the muscles that
18 it innervates. Innervates means, Travels into.

19 Q And did that -- did that EMG happen?

20 A Yes.

21 Q And what were the results of that EMG as it relates to
22 cervical spine?

23 A So the EMG showed electrical abnormalities in the
24 function of the nerves at the C5-C6 cervical level.

25 Q And, again, what was your determination as to the cause

1 of those symptoms and that EMG finding?

2 A As I had said before, based on what I have available to
3 to me, it had been caused from that accident.

4 MR. STOLZMAN: At this time, I would like to show
5 to the jury and to the doctor his MRI. One of the MRIs.

6 MR. FREIRE: His MRI.

7 MR. STOLZMAN: One of the MRIs. If I may approach?

8 THE COURT: Sure. Go ahead.

9 MR. STOLZMAN: It's been marked as evidence. This
10 is Plaintiff's 10. Standup MRI.

11 Q Doctor, can you, please, explain to the jury: What is
12 an MRI?

13 A So an MRI is a -- it's a test whereby your body is
14 placed into a very strong magnet and that magnet exerts a field,
15 so there's a magnetic field that your body under -- feels,
16 undergoes this magnetic field application. And the molecules of
17 water that are in your tissues respond to that magnetic field.
18 And the response that those molecules of water have is
19 translated into images.

20 The images are on a gray scale from dark to light.
21 That gray scale -- those are known as, Signals, so a darkness is
22 a dark signal. White is a light signal. And those signals can
23 tell you something about the soft tissues in your body.

24 And, in this case, if you're looking at an MRI of the
25 neck, which we're looking at right now, you can see that there

1 are, in the center portion of the image, gray squares. The gray
2 squares are the bones of your neck. And they appear to be gray
3 because they have a moderate amount of water in them, so the
4 right of the gray squares, you see a gray and white stripe.

5 The white and gray stripe that you're looking at is the
6 spinal cord, and the fluid that the spinal cord is contained
7 inside of, so the gray cord is floating in white fluid.
8 Directly to the left of that in between the bones, you can see
9 that there are some oblong structures.

10 And those are structures that contain intermediate
11 signals and those are the discs or the cartilage components of
12 your spine.

13 Q Just so the record's clear: We're looking -- you're
14 pointing -- you're referring at this time to the image on the
15 left --

16 A Yes.

17 Q -- of the screen?

18 A I am. Yes.

19 MR. STOLZMAN: If I may, your Honor?

20 THE COURT: Go ahead.

21 Q Doctor, these -- the gray matters that you indicated
22 are the -- as the vertebrae, these are these matters here?

23 A That is -- that's correct. Gray squares are the bones.

24 Q And this -- the white and gray line right to the right
25 of that, just for our record, Doctor?

1 A Yes.

2 Q That's the spinal column?

3 A That is the spinal cord within the spinal fluid in the
4 spinal canal. Yes.

5 Q Okay. And these oblong spaces in between the gray
6 squares, those are the discs?

7 A Yes. That's correct.

8 Q Okay. Now, Doctor, you mentioned in your testimony
9 that you found that there -- can you tell the jury what you
10 found as it relates to Mr. Avila's spine, in particular, at
11 C5-C6?

12 A Sure, so the image to the left, which is the side-view
13 central image of the neck shows you -- I'll point out two things
14 that that image shows you. The first thing is that the cervical
15 spine or the neck is -- is straightened out or flattened out.

16 Normal cervical spines should be bent backwards, so
17 they should be lordotic, so there should be a C-shaped curve to
18 the cervical spine. And, in this case, that is not there. It's
19 flattened out.

20 Between C5 and C6, those two bones are actually pitched
21 forward to a certain extent, so there's an amount of kyphosis,
22 or pitching, forward at C5-C6.

23 Q Okay. And just so we're clear, Doctor, can you tell us
24 which -- as it relates to which -- lost my image here. Just a
25 second -- there's a purple line on the left image. Do you see

1 that, Doctor?

2 A You know, it's a little tough for me to see --

3 Q Okay.

4 A -- from here.

5 Q Okay. Would it help if you came -- stepped down?

6 A Sure. Yeah.

7 THE COURT: Go ahead. You can step down, Doctor.

8 Go ahead.

9 THE WITNESS: Yes. I see it now.

10 MR. STOLZMAN: Okay.

11 Q Can you tell the jury where the C5-C6 is.

12 A Right there.

13 MR. STOLZMAN: Okay.

14 THE WITNESS: That's perfect.

15 MR. STOLZMAN: Okay.

16 A So the way these things work is there are multiple
17 different -- picture your body on a baloney slicer; right, so,
18 you know, you're slicing your baloney and all these little
19 slices are coming out -- the baloney is a three dimensional
20 tube; right, so each one of these cups is a slice of your neck.

21 This purple line is right in between C5 and C6 right on
22 the disc of C5-C6. And that corresponds to this image on this
23 side of the MRI. This is a side-view image. This is a topdown
24 image, so picture yourself standing on top of the patient's head
25 and you're looking down the spinal canal, like, if you were

1 looking down an elevator shaft; right, with the elevator not
2 there.

3 The top -- the very top of this is your trachea, that's
4 why it's dark, because it's full of air. The very back is your
5 skin, which is also kind of dark on the back of your neck. And
6 there's this little thing that looks like a Y. This Y-area is
7 what's known as the lamina or the roof of the spinal canal.

8 The spinal cord is an almond-shaped object, floating in
9 this white stuff, that's your spinal fluid. And then on top of
10 this where the purple line is, is the disc. And what you see --
11 and this tells you the disc is sticking out and that the bones
12 are pitched forward a little bit.

13 This image tells you that the disc that's sticking out
14 is coming into the area where the nerve openings are. These are
15 called the, Neuro, nerve, foramina, or openings, so it gives you
16 a little bit more of an image of where there is disc material
17 coming into an area where the nerves are.

18 Q And what, if anything, Doctor -- you told us before
19 about how your findings that -- Mr. Avila's symptoms were
20 related to -- part of your diagnosis was related to these MRIs.
21 What does this MRI tell you or this slide here tell you as it
22 relates to the status of Mr. Avila's disc at the C5-C6 level?

23 A So I told you that a patient who has symptoms in his
24 neck, the symptoms go into the arms and hands. He has physical
25 findings that show there's sixth nerve root sensory abnormality.

1 He's got an EMG that shows C5-C6. And he's got an MRI that
2 shows C5-C6 is indeed abnormal, so you take A, plus B, plus C,
3 plus D, and you can add that up, and say, I've got an idea -- I
4 got a real good idea for why you're having the symptoms that
5 you're having.

6 It all adds up to an abnormality at the C5-C6 disc
7 that's touching your nerves. That's causing your systems.

8 Q Doctor, can you tell the jury what a disc herniation
9 is?

10 A So the term, Herniation, is best explained if you think
11 about your belly and a hernia -- abdominal hernia that you may
12 have; right, so if there's a defect in your abdominal wall, and
13 there's a protrusion of your abdomen in one area more than
14 another, that's a hernia; right, so a hernia is a -- is an
15 abnormal protrusion.

16 And it's asymmetrical. A bulge would be like a bulge
17 in your abnormal wall. It would be symmetrical; right? When
18 we're talking about disc herniation, you're talking about
19 abnormal asymmetrical protrusions of disc beyond the confines of
20 the vertebral bodies.

21 Q And is that what you found Mr. Avila's at the C5-C6
22 disc?

23 A Yes.

24 MR. FREIRE: Objection. He just described both
25 herniation and both.

1 Q Oh, with respect to --

2 THE COURT: Rephrase.

3 MR. STOLZMAN: I'll rephrase.

4 Q Doctor, did you find a herniation at plaintiff's C5-C6?

5 A Yes. I saw an abnormal -- an asymmetrical protrusion
6 of disc material at C5-C6.

7 Q And when you say, Protrusion, what does it protrude
8 upon?

9 A So it protrudes into the -- you know, it protrudes in
10 different ways; right? Like, it can come forward, or it can
11 come into the area where the nerve and canal are, and, in this
12 case, it's coming into the area where the nerve and the canal
13 are.

14 Q And as a result -- would that be called, Impingement,
15 Doctor?

16 A Yes. That can be called a, Nerve impingement. Yes.

17 Q And was that also what you found with respect to Mr.
18 Avila at the C5-C6?

19 A It goes hand in hand with the abnormal protrusion of
20 disc or herniation. Yes.

21 MR. STOLZMAN: I think you can sit down, Doctor.

22 Thank you very much. I'll leave this open just in case we
23 need this later.

24 Q Doctor, what can be the long-term effects of a person
25 having a protrusion or impingement as you described Mr. Avila

1 have?

2 A So a couple of different things, number one, you can
3 develop -- depending upon how long you're having nerve
4 impingement for, you can begin to develop chronic pain in this
5 nerve distribution.

6 THE COURT: Just explain the word, Chronic.

7 THE WITNESS: Sure. Yeah.

8 A So, Chronic, meaning, long-term or long-lasting, you
9 know, typically, pain that lasts over three-to-six months would
10 be considered chronic. Chronic, can also be lifetime, so
11 chronic pain is a potential issue.

12 The other issue is the nerves that travel into your
13 arms and hands do a couple of different things. They're
14 responsible for sensation, so you feel things, they're
15 responsible for the way your reflexes work in your tendons.

16 They're responsible for the way your muscles move;
17 right? Those are the major responsibilities that those nerves
18 have.

19 Long-term compression of those nerves, because the
20 nerve does not receive an appropriate blood supply, so that
21 nerve starts to have some damage to it, can cause any one of or
22 multiple problems with any of those functions, so the issue that
23 you worry about is that the nerves can get worse.

24 And a worsening of that condition could lead to
25 problems with the way your arms and hands or your legs and feet

1 are working.

2 Q When you say, The way your legs and feet are working,
3 what does that mean?

4 A Well, you know, for example, the way you're walking and
5 the way you move your legs.

6 Q So after your May 23rd examination of Mr. Avila, did
7 you treat him again --

8 A Yes.

9 Q -- or did you see him again?

10 A Yes, I did.

11 Q And what happened -- when was that exam, Doctor?

12 A End of June. June 27th of 2022.

13 Q And did you do the same examination of Mr. Avila at
14 that time?

15 A Yes.

16 Q And what, if any, -- what were the results of those
17 examinations?

18 A It was pretty consistent with the previous examination.

19 Q And did you, again, have the same opinion as to the
20 causation of those symptoms?

21 A Yes.

22 Q And just so we're clear, Doctor, that was the fall that
23 he had in January of 2022?

24 A Yes.

25 Q And what was your plan after that June visit?

1 A So by that time, I had the results of the EMG. Patient
2 had been symptomatic for going on months five months at this
3 point in time. And at that point in time, he's considered a
4 surgical candidate; right?

5 A surgical candidate is someone who you can now offer
6 surgery to, because there is a very good chance that you can
7 make them better by taking that disc out, putting those bones
8 into a better position, and getting pressure off those nerves,
9 so if you can offer that to a patient, they would be considered
10 a surgical candidate. And, at this point in time, he was a
11 surgical candidate.

12 Q A surgical candidate for which part of his body?

13 A His neck.

14 Q Doctor, at that time, that both the first visit and at
15 that visit, did you also do an examination as to his lower back,
16 his lumbar spine?

17 A Yes.

18 Q And what, if anything, did you find there?

19 A So in his lumbar spine, the test that we talked about
20 before called, a phalanx test was positive, so that's bending
21 backwards, reproducing pain down the legs.

22 And also another test -- another provocative test
23 called a, Femoral stretch test, which is, basically, you're
24 pulling on the femoral nerve, it goes down your legs.

25 Also produced irritation, so those were signs and

1 symptoms that were consistent with low back, or lumbar
2 radiculopathy.

3 Q And where would -- what sensations or what would -- or
4 what pain or what would be the symptoms that Mr. Avila would
5 feel as it relates to lumbar radiculopathy?

6 A So just like the neck travels into your arms and hands,
7 your lower back travels down into your legs and feet.

8 Q And then, after the June visit, you saw him again in
9 August; is that right?

10 A Yes.

11 Q And did you do a full examination -- an examination
12 then, Doctor?

13 A Yes.

14 Q And did any of your findings change as a result of that
15 August exam?

16 A Not significantly. No.

17 Q And what was the plan after the August exam?

18 A The plan was to do a surgical procedure. To remove the
19 disc and reposition the bones in order to get pressure off those
20 nerves to improve the patient's condition.

21 Q And did that procedure happen?

22 A Yes.

23 Q And what procedure was that?

24 A That's a procedure called, An anterior, which means,
25 through the front, cervical, which means, your neck, discectomy,

1 which means, removal of the disc and spinal fusion, which means,
2 reconstructing or rebuilding the neck.

3 To put it into a better position and to hold it in
4 place so that it does not continue to cause anymore damage.

5 Q And when you say, Damage, damage to what part of his
6 body?

7 A The nerves going into your arms and hands.

8 Q And what's the -- strike that.

9 Would the surgery remove all of the symptoms that he
10 was having as it relates to his neck?

11 A The surgery would help decrease his symptoms and it
12 would also prevent the condition from getting worse.

13 Q And when did you conduct that surgery?

14 A That was done on October 13th of 20 -- no. Hang on one
15 second. That was done on September 9th of 2022.

16 Q And where did you do that surgery, Doctor?

17 A I did it at an ambulatory surgery center.

18 Q And is it an inpatient or an outpatient procedure?

19 A Ambulatory, so it's outpatient.

20 Q And is the patient under general anesthesia or local?
21 How does that work?

22 A It's a general anesthetic.

23 MR. STOLZMAN: Just a moment, Judge. I need to
24 grab the easel.

25 THE COURT: Go ahead.

1 (Whereupon, there's a brief pause in the
2 proceedings.)

3 MR. STOLZMAN: Sorry, Counsel. I will put it here -

4 Q And when you did that procedure, Doctor, that includes
5 -- there's an operative report for that; correct?

6 A Yes.

7 Q And that operative report is in evidence and it's in
8 your chart with you now; right?

9 A Yes.

10 MR. STOLZMAN: This is in evidence already.

11 Q So we'll start with page one of your operative report.

12 MR. STOLZMAN: We'll call this for ID. This will
13 be 12A.

14 (Whereupon, Plaintiff's Exhibit 12A, is marked for
15 identification.)

16 Q You have your report there to; right, Doctor?

17 A Yes.

18 Q Okay. We'll start with the first page. Tell us,
19 what's the -- what it means for a, Preoperative and a
20 postoperative diagnosis?

21 A Preoperative diagnosis is what you have anticipated is
22 wrong with the patient. Your postoperative diagnosis is based
23 upon, not only what you think is wrong with the patient, but
24 what you find intraoperatively, so if you come up with the
25 correct surgical plan for the correct reasons, your prep and

1 your postop are the same.

2 Q Okay. And was that the case with this procedure?

3 A Yes.

4 Q And on your operation, it indicates the operation
5 performed, placement of a biomedical device. Can you explain to
6 the jury what that biomedical device was here?

7 A That's a fancy way of saying that you placed a shim in
8 between the C5 and C6 bones to put them back into their more
9 normal position.

10 Q And what's that shim made of?

11 A It is made out of carbon fiber and titanium.

12 Q And then you also indicated on the report that there
13 was a spinal instrumentation. What's that, Doctor?

14 A That is a small plate that is made out of titanium that
15 then maintains the bones in their proper alignment while the
16 spine heals.

17 Q And you mentioned a plate. And then there's -- what
18 are the screws for, Doctor, that's also indicated in your
19 report?

20 A Yeah. The plate and the screws hold the entire
21 construct in place. You know, like, if you were to think about
22 a hinge on a door, the hinge is held onto the door by the screws
23 that connect it to the door and the wall, so it's the same kind
24 of thing.

25 Q With that analogy, Doctor, so when you're -- screws

1 that are going in here, the wall, is Mr. Avila's vertebrae;
2 correct?

3 A That's right. Yes.

4 Q And then you also indicated that there is a biomedical
5 device in place. And then there's also, Locally-harvested bone
6 graft. What is that and what's the purpose of it, Doctor?

7 A So when you're removing the disc, you're also removing
8 portions of the vertebrae. And you take that bone that you've
9 removed, and you mix it in with some donated bone, so you make,
10 like a little bit of a bone glue in order to get the area that
11 you operated on to heal together.

12 Q Doctor, would it be helpful for the jury for -- I would
13 like to show you what will be marked as --

14 MR. STOLZMAN: What number are we on?

15 THE COURT REPORTER: 14.

16 Q -- 14 for identification. Various diagrams. We'll do
17 it will be 14, 15 and 16, before I show the jury.

18 (Whereupon, Plaintiff's Exhibits 14 and 15, are marked
19 for identification.)

20 Q Doctor, is this a fair and accurate representation of
21 the procedures that you just told us about?

22 A Yes.

23 Q And would this illustration be helpful for the
24 explanation of the jury of what you did?

25 A Sure.

1 Q And what about number 15, Doctor?

2 A Yes.

3 Q Okay. And as well for -- we'll wait on number 16, so
4 for the --

5 MR. FREIRE: For demonstrative purposes only.

6 MR. STOLZMAN: Yeah. For demonstrative purposes --

7 THE COURT: What is the exhibit number on this?

8 MR. STOLZMAN: This is 14. And this is the --

9 THE COURT: Demonstrative evidence is evidence
10 that's used to help explain stuff. It doesn't in the in the
11 jury. It's just for ID to make it easier to explain things
12 to you. Okay.

13 MR. STOLZMAN: This is number 14.

14 THE COURT: If you need the doctor to step down.

15 MR. STOLZMAN: Doctor, would it be helpful for you
16 to step down?

17 THE WITNESS: Yeah. Okay.

18 MR. STOLZMAN: Olay.

19 THE COURT: Up to you. If it's easier to stay
20 there, stay there.

21 THE WITNESS: Yeah. I mean, it's -- you know, I
22 can -- I can kind of do it from here. It's an illustration.

23 Q So we'll start with A. This is, obviously -- this is
24 the plaintiff's spinal cord; correct -- or a diagram of a spinal
25 cord; correct, Doctor?

1 A Well, it's actually the diagram -- it's a -- yeah.
2 It's a diagrammatic illustration of the steps involved in the
3 surgical procedure.

4 Q So what's happening in step B?

5 A That's an exposure, so every surgical procedure needs
6 to have an exposure, which means, you need to be able to look at
7 the area that you had to operate on, so you make an incision.
8 You expose the area between C5-C6.

9 Q And when you look now at part C, it indicates -- well,
10 what's this part of the diagram, Doctor, where it says,
11 Herniated disc through the annulus tear. What's that?

12 A So that's an illustration of that side-view MRI image
13 to give you some idea of what the -- where the disc is located
14 in between the two bones.

15 Q And what's an annulus tear?

16 A So every disc that protrudes abnormally has to have
17 some type of disruption within the substance of disc in order
18 for it to be able to protrude. That disruption is typically
19 called a, Tear. The annulus, is the area of the ring of the
20 disc where the tear occurs.

21 Q And can you tell us what's described in Section D of
22 the illustration?

23 A That is an illustration of the way the bones are shaved
24 down in order to start the process of reconstructing the area to
25 be able to accommodate the biomechanical device.

1 Q And in Section D, is the disc still present in that
2 section?

3 A No.

4 Q And now what's happening, Doctor, can you tell us
5 what's going on in Section E of the diagram?

6 A It's another view of the way you're removing the bones
7 in order to construct the area.

8 Q And now, in Section F, we have something what's called
9 a, Biomedical intervertebral device. That's the device you told
10 us about before; Doctor?

11 A Yes.

12 Q And -- and now in G, these are the plates and the
13 screws that you described for the jury before; correct?

14 A Yes.

15 MR. STOLZMAN: And for purposes of illustration,
16 I'll now show to the jury what's been marked as for ID
17 Number 15.

18 Q So what do we see here, Doctor, in H and I?

19 A It's a front-view illustration of the final procedure.
20 And the bottom is the side-view of the final procedure.

21 Q And also, in J, what are these images?

22 A Those are x-rays of the patient.

23 Q And it indicates, 2/20/24, which would be two years or
24 almost a year-and-a-half after the procedure; right, Doctor?

25 A Yes.

1 Q And why are x-rays taken after the procedure?

2 A So these x-rays show a stable, well-healing surgery.

3 Q And just, lastly, what is number 16?

4 A Those are the same x-rays, front-and-back -- front,
5 back and side view.

6 Q And what do these x-rays tell you, Doctor, or what did
7 they tell you as it relates to Mr. Avila?

8 A Stable, successful, fusion at C5-C6.

9 MR. STOLZMAN: Your Honor, would now be a good time
10 for a break or?

11 THE COURT: Sure. All right. Members of the jury,
12 do not discuss the case. Follow the officer. We'll take
13 about ten minutes. Thank you.

14 THE COURT OFFICER: All rise. Jurors exiting.

15 (Whereupon, the jury is dismissed for a recess.)

16 (Whereupon, a recess is taken.)

17 THE COURT: We have an issue that your colleague
18 wants to bring up.

19 MR. FREIRE: No, it's actually the plaintiff.

20 THE COURT: Oh, you want to bring up?

21 MR. FREIRE: Plaintiff's counsel wants to bring up.

22 MR. STOLZMAN: Yes, your Honor. There are
23 radiology images and records that have been subpoenaed here
24 to the courthouse. Defendant have been notified of these
25 records properly. They've been here in the courthouse for

1 going on two weeks. They are referenced. The reports
2 therein are referenced in Dr. Merola's chart that he brought
3 here today. I would like to move them into evidence as they
4 have been properly provided to the Court and defendant has
5 been given notice of them. As well, the Doctor --

6 THE COURT: And they're noticed, ten-day extra
7 notice?

8 MR. STOLZMAN: 4532-A, yes, your Honor.

9 MR. FREIRE: I would like conformation of that,
10 please. Sorry, I don't recall that offhand. If counsel can
11 just point me to that.

12 MR. STOLZMAN: Okay.

13 MR. FREIRE: Which facility?

14 MR. STOLZMAN: Lenox Hill and for that matter --
15 and Kolb.

16 MR. FREIRE: But notwithstanding that, if counsel
17 can continue his application, I guess.

18 THE COURT: Did you find it?

19 MR. STOLZMAN: Not yet, Judge, but I can continue
20 with my examination on other areas. If we need to continue
21 with it during the lunch break, we can --

22 THE COURT: Maybe someone in your office can look
23 for it in the meantime.

24 MR. STOLZMAN: That's what's happening.

25 THE COURT: Okay.

1 MR. FREIRE: I'll state that, we've looked in our
2 electronic file and there's no such disclosure for the
3 films.

4 I would also note that the -- although counsel
5 stated that they are with the witness's records today, that
6 he has with him, they are not contained within his chart
7 that was provided by his office in response to subpoena,
8 nor, is there any reference to those films within his
9 subpoenaed-records chart, therefore, as a treating
10 physician, without any expert disclosure, there was -- there
11 was required to be a narrative or some disclosure that would
12 be relying upon those films that are not otherwise in his
13 records as part of expert opinion testimony.

14 And, for those reasons, in addition to the very
15 foundational issue that we already have with 4532-A
16 disclosure, we would object to the -- any testimony that he
17 would seek to provide on those films as well as the films
18 going into evidence at this time.

19 THE COURT: Let me ask you this: Does he say in
20 any of his reports, I know there's no narrative exchanged.
21 There was no narrative exchanged; correct?

22 MR. FREIRE: There was no narrative exchanged.

23 MR. STOLZMAN: There was a narrative that was
24 exchanged.

25 MR. FREIRE: No that included this direct --

1 MR. STOLZMAN: Oh, that's correct.

2 THE COURT: He never says any place that he looked
3 at the films?

4 MR. FREIRE: In the last month, judge, so --

5 MR. STOLZMAN: Yes. It's more recent, your Honor.

6 THE COURT: That -- oh, these are recent films?

7 MR. STOLZMAN: Correct.

8 MR. FREIRE: And not by him. By another physician.

9 THE COURT: No, I understand, but there's no
10 reference to any of his paperwork that he relied on? Were
11 they done at his request or the films done? In other words,
12 did he order those films?

13 MR. FREIRE: That's part of the problem. I have no
14 idea. They're not within any sort of narrative and they're
15 not part of his chart, so there's reference to him ordering
16 the films earlier this month.

17 MR. STOLZMAN: They are in his chart that he
18 brought here today.

19 THE COURT: Right, but that doesn't help him.

20 MR. STOLZMAN: I understand that. I just want to
21 clarify that. It's indicated they were from a different
22 provider. They were ordered by a different provider.

23 THE COURT: And you would like to ask him: Did you
24 review the films and what did you find or something along
25 those lines.

1 MR. STOLZMAN: Yes, as it relates to the
2 plaintiff's prognosis and overall diagnosis of future
3 treatment needs.

4 THE COURT: All right, so you're going to get into
5 that now before lunch or?

6 MR. STOLZMAN: No. I'm going to go into a
7 different area for now.

8 THE COURT: All right, so let's see if we can
9 resolve this during the lunch break, but it's only
10 50 minutes away. We'll bring the jury in and see what we
11 can do in the meantime.

12 MR. STOLZMAN: That's fine, your Honor. That's
13 okay.

14 THE COURT: Let's bring the jury, please.

15 MR. FREIRE: May I ask for the -- I don't know if
16 it's a courtesy, or if it's an impediment on the Court, or
17 the jury, but is there any way to keep the lunch break to an
18 hour?

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

20 THE COURT: All right. We can bring them in.

21 MR. STOLZMAN: Yes, your Honor.

22 THE COURT: All right. We can bring in the jury.

23 THE COURT OFFICER: All rise. Jurors entering.

24 (Whereupon, the jury enters the courtroom.)

25 THE COURT: Okay. Please, be seated everyone. Let

1 the record reflect that all jurors and alternates are
2 present and in their assigned seats. Doctor, you are
3 reminded you're still under oath. Counsel, you may inquire.

4 MR. STOLZMAN: Thank you, your Honor. Forgive me
5 for my back to the Court. Just want to go back to your
6 operative report, Doctor. This is second -- this was for
7 identification. I believe this is number, I believe, 14A.
8 I think. I'll double-check.

9 Q Going back to your operative report, Doctor, from
10 September 9th, 2022, with respect to approach, you stated in
11 your report the operative report that -- you drafted this
12 document, Doctor?

13 A Yes.

14 Q You stated: We clearly identified the disc and then we
15 meticulously dissected the C5-C6 disc. What did you see with
16 your eyes or how did you -- when you were able to -- when you
17 had Mr. Avila on the operating table, what did you see at it
18 relates to that disc, at the C5-C6?

19 A Exactly what it says in the operative report, Torn
20 annulus and disc herniation.

21 Q Okay.

22 MR. STOLZMAN: Thank you, Doctor.

23 THE WITNESS: Yes.

24 Q And then after the September 9th surgery, you saw Mr.
25 Avila again for a postoperative exam?

1 A Yes.

2 Q And -- and what happened at that exam, Doctor?

3 A That's the first postop visit, so that's a visit to
4 make sure that he's healing appropriately.

5 Q And what did you find at that visit -- that was in
6 object; right?

7 A Yes.

8 Q And what did you find at that visit?

9 A That he was healing appropriately with no
10 complications.

11 Q And, again, Doctor, when we say, Healing without
12 complications, would that mean that his neck is now pain-free or
13 something else?

14 A It would mean that he's proceeding according to his
15 normal postoperative course, getting better and the acute
16 healing process.

17 Q How long does that acute healing process last?

18 A So, typically, it's broken up into several stages. The
19 first stage is the first three days, and that's typically as
20 long as it takes you to recover from the incision, tenderness
21 and pain that you typically have, as well as to overcome the
22 effects of your general anesthetic is the first 30 days.

23 The first three months, you're about 25 to 33 percent
24 healed. The next three months, you're looking at about -- at
25 six months, so that would be in six-months time, you're about

1 60 percent or so healed. And then, at about a year, you're
2 about at your maximum medical healing.

3 Q And just so the jury's clear: When you say, Healing,
4 do you mean healing as in recovered from the fall or healing
5 from the surgery?

6 A Everything, so, you know, you're -- you're gaining
7 function based on the outcome of the -- the surgery and the
8 surgery itself is also fusing, growing together and stabilizing
9 itself.

10 Q Does that mean that after that one year, that Mr. Avila
11 would be symptom-free?

12 A It means that he's going to be as good as it gets.
13 Typically, at one year, postsurgery.

14 Q And what would be the typical symptomology as, As good
15 at it gets after one year?

16 A Everybody's different, so it depends on the patient.

17 Q Okay. Before we get there, Doctor, before the surgery
18 that we talked about, the fusion to his neck, Mr. Avila was
19 recommended to have a epidural spine injection to his cervical
20 -- to his neck?

21 A Yes.

22 Q But instead, he had the surgery. Can you explain to
23 the jury why that decision was made?

24 A No. That's completely and entirely up to the patient,
25 so there's -- you know, every time you do any kind of a

1 procedure, it's up to the patient to know what they're getting
2 into, why they're getting into it and make a decision about
3 whether or not they want to go forward with any particular kind
4 of procedure.

5 What I can tell you is that, from a reconstructive
6 perspective, if you have a structural abnormality in the
7 cervical spine that is causing a nerve problem where you have
8 nerve damage into the muscle groups with spinal cord nerve root
9 impingement, cervical epidural steroid injections under those
10 situations are not significantly helpful in preventing further
11 and neurological deterioration.

12 They can sometimes help decrease some symptoms, but
13 they are not a structural fix, if you will, for these particular
14 kinds of cervical problems.

15 Q And just so it's understood: When you say, Structural
16 problem -- let me ask it a different way: Would the epidural
17 spinal injections affixes the herniated disc in any way?

18 A No.

19 Q So after the epidural -- if he had had the epidural
20 injection to his neck, what would have been the physical state
21 of that disc at the C5-C6 after?

22 A Yeah, so at this point in time, you're still going to
23 have a kyphotic segment, with disc protrusion.

24 Q And would that disc protrusion still lead or
25 potentially to the various complications you told this jury

1 about before?

2 A Sure.

3 Q And by the way, Doctor, for all of your testimony
4 today, can we agree that it's to a reasonable degree of medical
5 certainty?

6 A Sure.

7 Q Okay. And if it's not, please, tell us.

8 A Will do.

9 Q You continued to treat Mr. Avila after that
10 postoperative visit for the spine surgery -- the neck surgery;
11 correct?

12 A Yes.

13 Q And what did you treat him for after that?

14 A Of course, I was following him for the neck surgery,
15 which was done. And I was also continuing to follow him for his
16 low back condition.

17 Q Let's talk about the low back condition. What findings
18 did you have or what was his low back condition by this time?

19 A He continued to have pain radiating down the legs, that
20 had been unresolved with conservative care.

21 Q And, in fact, did he have a lumbar injection, a lumbar
22 epidural spinal injection at some point?

23 A In the low back, lumbar epidural. That's correct.

24 Q And you told us before about what you would expect with
25 a cervical injection. Would that be the same thing for a lumbar

1 injection?

2 A Lumbar is a touch different than the neck is. The
3 major difference is that the neck -- the neck contains spine
4 cord, which is part of your brain proper, central nervous
5 system.

6 The lower back canal only contains nerve roots.
7 There's a difference between your central nervous system and
8 your never roots, insomuch as, your central nervous system is
9 much more prone to damage and progressive problems than your
10 nerve roots are, so in your lower back, lumbar epidural steroid
11 injections show some better -- probably better treatment
12 options, if you will, in terms of being able to decrease
13 symptoms, so there -- in that -- in those cases, they can be
14 more helpful.

15 Q You told us earlier that you reviewed the MRI of -- you
16 reviewed the MRIs of Mr. Avila's lumbar spine as well; correct?

17 A Yes.

18 Q And what did you find when you reviewed those MRIs?

19 A So those MRIs demonstrated that there was a disc
20 protrusion most prominently around L4-L5, which is the lower
21 portion of the low back area. And, in addition to that, I
22 believe I also obtained some CT imaging and some EMGs as well.

23 Q Let's talk about the EMGs. What were EMG results that
24 you observed?

25 A So the EMGs for the lower back showed that there were

1 abnormalities in the nerves travelling down the legs, which
2 included, L4-L5, and S-1. S-1 is the nerve that goes all the
3 wall down the back of your legs.

4 MR. STOLZMAN: Okay. Let me just move some things
5 around. I'd like to show the jury the MRIs.

6 Q Same rules apply; right, Doctor? An MRI of the lumbar
7 spine is going to have the same level of detection, that that's
8 the same thing of the cervical spine; correct?

9 A Yes.

10 Q Okay. Can you walk us through here the herniation and
11 protrusion that you told the jury about?

12 MR. STOLZMAN: And if it makes sense to step down,
13 please, do so.

14 THE WITNESS: Sure. I'll -- let me come down
15 there.

16 THE COURT: Go ahead, Doctor.

17 A So can you scroll this -- yeah. Scroll down. Wait.
18 There. Okay. Good, so the same thing. This is the same kind
19 of images, side-view image here on the left of the screen,
20 topdown image view on the right of the screen.

21 The squares are the bones. And then in between the
22 bones are the discs. And then, right here, between L4 and L5,
23 on the topdown-view, this dark line here that's kind of -- looks
24 like a crescent. And that dark line is impinging upon this
25 circle and these openings.

1 And that circle is the canal. And these are the area
2 where the nerve roots are that travel down into your legs and
3 feet.

4 Q When we talk about impingement, can you tell the jury
5 what that means with respect to this part of the spinal cord?

6 A So very -- well, there's no spinal cord here. It's
7 just nerve roots.

8 Q Nerve roots. I'm sorry?

9 A That's the difference between the neck and the back.
10 That's also one of the differences between that epidural
11 question that you has previously asked me.

12 What we're seeing here, again, there is the spine has
13 the same basic architecture, where the nerves travel through
14 openings that go down into your legs. And those openings on the
15 topdown-view are located on both sides.

16 And if you see that there -- the gray stuff here, the
17 gray things in those openings are the nerves and the nerve cell
18 bodies. And you can see that there's a crescent of disc
19 material that's kind of sticking in that area, impinging upon,
20 leaning on, pressing on -- whatever term you may want to use --
21 on the nerve roots.

22 Q Thank you, Doctor. Is there anything else on this
23 image that -- with respect to what you reviewed for the Mr.
24 Avila's MRIs?

25 A No. Not really.

1 Q With respect to his lumbar? Okay. Just wanted to make
2 sure.

3 A Yeah.

4 MR. STOLZMAN: Okay. Thank you, Doctor.

5 Q And at some point, did you recommend for Mr. Avila to
6 have an additional procedure?

7 A Yeah, that was done in May of 2023, so that's about a
8 year-and-a-half or so after 2022. And at that point in time, I
9 had recommended a low back decompression.

10 If you think about discs compressing nerves, they're
11 putting pressure on them. If you do a procedure to take
12 pressure off, you're decompressing. And those decompressions
13 have a very good success rate for decreasing nerve pain and
14 preventing further nerve damage.

15 Q And so what procedure did you recommend?

16 A A decompression of the L4, L5 and S-1 nerve roots.

17 Q And did that procedure take place?

18 A Yes.

19 Q And when did you do that procedure, Doctor?

20 A That was done on October 13th of 2023.

21 (Whereupon, there is a brief pause in the proceedings.)

22 MR. STOLZMAN: Forgive me, Judge. Lots of moving
23 parts.

24 Q Once again, Doctor, was that procedure done at -- where
25 was that procedure done?

1 A Ambulatory Surgical Center as well.

2 Q And was that also done under general or local
3 anesthetic?

4 A General anesthetic.

5 Q And was it an inpatient procedure or an outpatient
6 procedure?

7 A Ambulatory, outpatient procedure.

8 Q How long did it take?

9 A Typically, about an hour or so.

10 Q By the way, how long did the surgery that you did on
11 Mr. Avila's neck, the fusion, how long did that take?

12 A About an hour.

13 Q And I'd like to show you now, Doctor, these are already
14 in evidence. This is the operative report that you did for that
15 procedure. I think I'm up to 17. And we'll mark this as 17 for
16 ID. The report's already in evidence.

17 Doctor, you mentioned here under, Operation performed,
18 decompressive lumbar laminectomy? What's a laminectomy?

19 A It a removal, partial or complete, of the lamina, which
20 is the covering of the spinal canal.

21 Q And what's the difference between -- just so the jury
22 understands -- between the fusion surgery and the laminectomy
23 that was done here for Mr. Avila's lumbar spine?

24 A Fusion involves stabilizing bones, so that they're
25 locked into position. This involves just a taking pressure off

1 of the nerves and letting the bones continue to do their normal
2 activities without locking them together.

3 Q And on your preoperative diagnosis for this
4 procedure, the laminectomy, you indicated herniations at L4-L5
5 and S-1?

6 A Yes.

7 Q Okay. Was that also found on the MRI that we
8 discussed?

9 A Yeah. In fact, the MRI, combined with a CT scan that
10 was also subsequently done to get a better idea for how much
11 bone needed to be resected in the L4-L5 and S-1 levels.

12 Q You indicated also, just so it's clear, on this
13 operative report, Indication, patient sustained traumatic, low
14 back injury. Is that the same injury that we've been talking
15 about, his fall, from 2022?

16 A Yes.

17 Q Okay. For demonstrative purposes, Doctor --

18 MR. STOLZMAN: I would -- this is number 18 for ID.

19 Q Is this a fair and accurate illustration of the
20 procedure that you did on October 13th of 2023?

21 A Yes.

22 Q And would this illustration assist you in your
23 testimony to the jury?

24 A Yes.

25 THE COURT: Yeah. Mark for ID.

1 MR. STOLZMAN: Mark for ID without objection.

2 Thank you.

3 (Whereupon, Plaintiff's Exhibit 18, is marked for
4 identification.)

5 Q So let's start, Doctor, with Section A. What's
6 happened -- or what's portrayed in Section A of this
7 illustration?

8 A Let's see, so that is an approach similar to the neck,
9 only in the lower back, it's done in the low back area, on the
10 backside rather than the frontside.

11 Q And you indicated on Section B, Facet joints and
12 lamina. Can you explain to the jury what that is?

13 A So the way the bones are put together in your lower
14 back, they come together or they articulate. Articulation,
15 means where they touch each other and they come together at
16 these things called the, Facet joints, which is where these
17 bones, typically, slide up and down or from side to side, upon
18 each other as they're lying in your lower back.

19 Q And how, if at all, was the herniations that you
20 discussed at the L4-L5, S-1, what impact, if anything, did they
21 have on the facet joints?

22 A So the facet joints are areas that also comprise a
23 portion of the canal, so if there's disc material that's
24 protruding into the canal, that disc material comes up into
25 contact with the area where with the facet joints are, so by

1 shaving away portions of those facet joints, you can make more
2 room for the nerves.

3 Q And is that what -- what's shown in Section C of the --
4 the illustration?

5 A Yeah, that's essentially, shaving away the boney
6 elements just enough that are necessary in order to make sure
7 that the nerves have free and clear exits without any
8 impingement.

9 Q And then, in D, what do we see here?

10 A That's just -- that's kind of, like an oblique
11 side-view of the same procedure. Where the cord -- the nerve
12 roots are having some impingement, where the facet joints and
13 the discs are.

14 Q And it's indicated also, just so the jury's
15 understanding, that there was an annular tear also at the L4-L5;
16 is that correct?

17 A Yeah, so for discs to abnormally protrude, there has to
18 be some kind of a tear within the annulus, typically.

19 Q And what do we see here, Doctor, in Section E? What's
20 happening in this image?

21 A This is just -- you know, removal of whatever material
22 was impinging upon the nerves.

23 Q And after the material is removed, what happens next?

24 A That's it. You wash things out, make sure there's no
25 bleeding and you sew things back together again.

1 Q And why is it that you can do this without having to do
2 the plates and screws that we saw on the plaintiff's neck?

3 A The majority is stability in your spine is secondary to
4 the discs themselves. And when you have maintained disc spaces,
5 and there is no abnormal slippage of one bone on another, and
6 you can leave the boney elements that articulate intact without
7 destabilizing the spine, you can allow those bones to maintain
8 their normal articulations.

9 In the neck, because there's a spinal cord, you
10 approach the depression from the front, which means, you need to
11 remove the disc and portions of the bones which produce an
12 instability that then requires you to rebuild or reconstruct the
13 area that you've decompressed.

14 Q And just so the jury's clear, Doctor, there was -- you
15 found tears also at the L5-S1; correct?

16 A Yes.

17 Q And were they also -- okay, so going back to our
18 timeline, this was in October of 2023?

19 A Yes.

20 Q Did you continue to treat Mr. Avila after this surgery?

21 A Yes.

22 Q And he came back to visit you; is that right, Doctor?

23 A Yes.

24 Q And when was that?

25 A His first postoperative visit was on October 26th.

1 Q And at that time was he wearing any assistive devices
2 or braces?

3 A Let's see -- I don't know if I recorded anything. No.

4 Q Okay. Would that be a typical assistive device that
5 you have recommend to a postlumbar laminectomy patient?

6 MR. FREIRE: Objection.

7 A Yeah. We typically recommend a --

8 MR. FREIRE: Objection, your Honor.

9 THE COURT: Any --

10 MR. FREIRE: To form, your Honor.

11 THE COURT: Rephrase the question, please.

12 Q What, if any, recommendations do you give a patient
13 after a lumbar laminectomy as it relates to supportive devices?

14 A Use a low back brace if it helps make them feel better.

15 Q And for how long do you recommend that back brace?

16 A For as long they -- it assists them in feeling
17 comfortable with respect to their lower back.

18 Q And what is -- you told us before about the recovery
19 period for the cervical surgery that you did. What's the
20 recovery period for after the lumbar surgery that you did?

21 A Yeah. It's typically the same, so the first three days
22 you're getting over the effects of the actual procedure itself.
23 The first three months, the tissues that you've sewn back
24 together again are starting to heal back together again.

25 And then, by about a year, you are at a hundred percent

1 what we would consider your maximum medical improvement results
2 of the surgery as far as the nerves are concerned.

3 Q And, again, with the maximum medical improvement, does
4 that mean that Mr. Avila would be free and clear one year after
5 this surgery from the symptoms that he started to have after the
6 fall?

7 A No. It -- it essentially means that he's going to be
8 as good as it gets at that point in time.

9 Q And does, As good as it gets, could that also -- could
10 that include pain?

11 A Patients can continue to have some symptoms. That is
12 correct.

13 Q And would that also include restrictions of his ability
14 -- range of motion?

15 A Sure.

16 Q In fact, you did range of motion tests during your
17 exams of Mr. Avila; correct?

18 A Yes.

19 Q And throughout the course of your treatment of Mr.
20 Avila, what did those range of motion studies show or tests show
21 you as it relates to his neck and his back?

22 A I can tell you that between January of 2024 through
23 April of 2025, he did have some improvements in his lumbar
24 ranges of motion.

25 Q By, Some improvements, was he -- was his range of

1 motion normal?

2 A He went from a -- he went from preoperatively, less
3 than 20 degrees, to postoperatively, up 40 degrees, where 60
4 degrees -- 60 to 65 degrees is normal.

5 Q So doing my math, 40 over 60, does that mean he was
6 one-third impaired for that -- that motion?

7 A Sure. Yes.

8 Q So that would be less than normal?

9 A Correct.

10 Q And what about for his neck?

11 A The neck ranges of motion weren't done, but the
12 provocative signs and symptoms were done, which became negative,
13 postop.

14 Q After somebody has a cervical fusion, what are the
15 long-term effects on the rest of the spinal cord at that --
16 those adjacent areas?

17 A So after -- you know, after a fusion, you've protected
18 the area that was causing the majority of problems. You've
19 altered the biomechanics of the spine, so you need to kind of
20 watch the way your neck behaves after the fusion's done. You
21 know, in general mechanical reconstructions, like a total joint,
22 or any other kind of mechanical process that you put the body
23 through, there's certain amount of wear and tear that happens as
24 time goes on.

25 Q And wear and tear -- well, for example, with Mr. Avila,

1 he had his surgery to the fusion at the C5-C6?

2 A Yes.

3 Q When you say, Wear and tear, would it be at the C5 and
4 6 or someplace else in the cervical spine?

5 A So the other portions of the neck that are attached to
6 C5 and C6 can undergo increased wear overtime.

7 Q And what about with respect to his lumbar spine? After
8 you did the surgery of the laminectomy at the three levels of
9 the spine that you told us about, the back, what can he expect
10 with respect to the wear and tear to those areas and the
11 adjacent areas?

12 A Well, not so much the adjacent areas after a
13 decompression, because you're not doing a fusion, so you avoid
14 any adjacent segment issues by maintaining motion in the lower
15 back.

16 The only major consideration for this is when there are
17 torn discs with disc problems, those discs are made out of
18 cartilage. Their blood supply is very minimal and when those
19 discs -- as those discs age overtime, you need to look for
20 either, recurrent herniations, or disc space collapse, or any
21 other abnormalities that can occur to those discs that were
22 responsible for the initial procedure that you actually did.

23 Q You told us a moment ago about the limitations that --
24 that Mr. Avila had and has had since the cervical surgery and
25 the lumbar surgery regarding range of motion. And, fair to say:

1 Would those limitations be permanent?

2 A I mean, based on my last visit with the patient, which
3 was in April of 2025, I would say that he did have some
4 permanent restrictions. Yes.

5 Q And can you describe to the jury what those permanent
6 restrictions are?

7 A So they're what are known as mechanical. As you might
8 imagine, that involves the mechanics of the way your neck and
9 back work; right, so if you're bending at the waist, bending
10 forward at the neck, you're doing things that involve using your
11 neck or your back, such as lifting and twisting, and doing all
12 those activities.

13 Those activities can reproduce symptoms, so you have to
14 curtail those activities in order to decrease your symptoms.

15 Q Would those activities that he will have to curtail
16 include heavy labor?

17 A Well, decreasing repetitive motion and decreasing
18 stress are good ways to prevent further problems with the neck
19 and the back with these conditions.

20 Q And when you say, Stress, can you explain to the jury
21 what you mean by that?

22 A Mechanical, bending, lifting and twisting. Those are
23 conditions that produce stress on your neck and back.

24 Q And what would happen if, for example, Mr. Avila
25 decided to do those activities and experience pain at the same

1 time. What is the risk factor there?

2 A I mean, depends on how long you're doing those
3 activities. You know, typically, I tell patients that they can
4 perform activities as long as they can tolerate them. Let pain
5 be your guide and let your body tell you what you can and can't
6 do.

7 Typically, these patients avoiding repetitive motion to
8 the neck and back and avoid heavy lifting, for him, it's about
9 20 pounds or so, is -- is the typical -- what I advise patients
10 to maintain in order to maintain the lowest amount of stress and
11 strain possible on their neck and back.

12 Q After his surgery you had indicated that he was
13 100 percent disabled from heavy labor?

14 A Yes.

15 Q As -- since the surgery, is he still one-hundred
16 percent disabled from heavy labor?

17 A As of April of 2025, I had indicated that he was
18 disabled from heavy labor. Correct.

19 Q And what about an overall disability? Did you give a
20 diagnosis as to that?

21 A Yeah. Overall, I indicated that he would be able to do
22 something in a sedentary capacity to a light-duty capacity,
23 maximum.

24 Q And did you provide a numeric overall disability?

25 A Yeah, so sedentary, light duty, if you're going to

1 estimate that -- and these are just rough estimates --
2 75 percent.

3 Q And just so we're clear: Mr. Avila, as you know, was a
4 roofer before he had his fall and injury. Is a roofer
5 considered heavy labor or light duty?

6 A Heavy labor.

7 Q Okay. Let's talk about the symptomology that he
8 presented to you when you first met him and what his activity
9 was before the fall. The pain and the symptomology that -- and
10 regarding the spasm, the pinprick, all the diagnostic testing
11 that you did when you first met him, first examined him and
12 thereafter, would a person be able to do roofing work with those
13 symptoms?

14 MR. FREIRE: Objection. Can we approach?

15 THE COURT: Yeah. Come on up.

16 (Whereupon, there is an off-the-record discussion
17 held at the bench between the Court, Mr. Stolzman, Mr.
18 Freire and Ms. Scibetta.)

19 THE COURT: Rephrase the question, Counsel.

20 MR. STOLZMAN: Yeah, Judge.

21 Q Dr. Merola, this jury has heard testimony that Mr.
22 Avila was -- had spent several years as a roofer prior to this
23 incident -- prior to his fall. Given the symptomology and the
24 testing that you did, that you've already gone through with this
25 jury, what opinion, if any, do you have as to this incident, his

1 fall, causing these symptoms given that he was able to work
2 before the fall?

3 MR. FREIRE: Objection to form.

4 THE COURT: Read it back.

5 (Whereupon, the requested testimony was read back.)

6 THE COURT: Rephrase the question.

7 MR. STOLZMAN: Okay.

8 Q I want to ask you about causation specifically, Doctor.
9 Given that Mr. Avila was able to work, based on his
10 testimony, pain-free, before this incident, what, if any, is
11 your opinion as it relates to the fall causing the injuries that
12 you've described today?

13 THE COURT: I'll allow that.

14 A So as indicated before, based on what I know, and the
15 fact that there was no significant symptoms prior to the
16 accident, that's one of the things that I use to relate the
17 accident to his condition.

18 Q I suspect that at some point the jury might hear
19 evidence from the Osborn as it relates to degeneration -- can
20 you -- with respect to Mr. Avila's -- the discs in question
21 where you found herniations.

22 Can you explain for the jury what impact, if any, or
23 did you find any findings of degeneration?

24 MR. FREIRE: Objection to form.

25 MR. STOLZMAN: I'll rephrase.

1 Q Based on your review of the MRIs of Mr. Avila for his
2 lumbar and his cervical, did you see any instances of
3 degeneration?

4 A Yes, so if you look at degeneration, the first signs of
5 degeneration are, on an MRI, loss of some signal, so you do see
6 some losses of signal that happen on MRIs in adults. And that's
7 something that's pretty consistent for all adults.

8 Q And what, if anything, would a fall of ten feet, what
9 impact would you expect of a fall of ten feet as Mr. Avila
10 described, how would that result in somebody who might have had
11 degeneration up until that moment?

12 MR. FREIRE: Objection to form.

13 THE COURT: I'll allow that. Go ahead. You can
14 answer.

15 A It would, of course, make any of those conditions
16 worse.

17 Q And what if he was asymptomatic prior to the incident?
18 What, if anything, would you attribute the degeneration to his
19 symptoms then?

20 A I don't understand when you say --

21 THE COURT: Yeah. I was going to say.

22 MR. STOLZMAN: I'll rephrase.

23 Q If Mr. Avila was, by all accounts, asymptomatic prior
24 to this fall, would that degeneration, if any, have had caused
25 him any pain or any symptoms?

1 THE COURT: You know, it's not clear what you're
2 talking about. The prior degeneration or the new injury?

3 MR. STOLZMAN: I'm sorry, your Honor. Getting
4 close to lunch.

5 THE COURT: It's okay.

6 Q With respect to degeneration, Doctor, if a patient,
7 such as Mr. Avila, was able to do roofing work and construction,
8 would you -- what would your opinion be as to if that
9 degeneration was causing him any limitations prior to the fall?

10 A So if he was working full time, full duty, as a roofer,
11 the degeneration wouldn't have any impact on his work.

12 Q And would the degeneration make him or less susceptible
13 to further injury after he suffered the fall?

14 A Degeneration can make you more susceptible to injury.
15 Yes.

16 Q And do you have any opinion as it relates to Mr. Avila
17 and the degeneration, if any, that this fall that he had from a
18 roof into a wall beneath him?

19 A As I've said before, as best I can tell, I would relate
20 his condition to the fall.

21 MR. STOLZMAN: I think, your Honor, if I may, I
22 think now might be a good time for lunch.

23 THE COURT: Okay, so we'll come back. We're going
24 to have a shorter lunch today, so we're going come back at
25 1:30. All right. We'll come back at 1:30, so do not

1 discuss this case with each other or anyone else, including,
2 family or friends.

3 Do not speak to anyone or permit anyone else to
4 speak with you regarding this case. If anyone approaches
5 you or tries to speak with you concerning this case, do not
6 discuss this with your fellow jurors and report it to the
7 Court through the officer.

8 Do not use internet websites or any other source to
9 research the case. Do not visit any of the locations
10 pertaining to the case. When you return to Court, report to
11 the location to which you've been instructed to by the
12 officer.

13 Do not speak with any of the parties in this case.
14 They've been directed not to speak with you. Do not form or
15 express an opinion or come to any conclusion as to the facts
16 of this case during the course of the trial. Wait until the
17 entire case has been submitted to you by the Court.

18 You know, I'm not sure, but if any of are you aware
19 that the library around the corner has a lunch place there,
20 so if you want to get just go around the corner, it's the
21 far end of the library. There's other places as well.
22 We'll see you back here at 1:30. Thank you.

23 THE COURT OFFICER: All rise. Jurors exiting.

24 (Whereupon, the jury is dismissed for a lunch
25 break.)

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THE COURT: Okay. We'll see everybody at 1:30.
(Whereupon, a lunch recess is taken.)

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

2 THE COURT: As soon as you're ready, we can have
3 the doctor come up.

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

5 THE COURT OFFICER: All rise. Jurors entering.

6 (Whereupon, the jury enters the courtroom.)

7 THE COURT: Okay. Please, be seated everyone. Let
8 the record reflect that all the jurors and alternates are
9 present and in their assigned seats.

10 Doctor, you are reminded you're still under oath.
11 Counsel, you may inquire.

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

13 CONTINUED DIRECT EXAMINATION

14 BY MR. STOLZMAN:

15 Q Dr. Merola, I just want to go over with you for the
16 jury all of the visits that you had with -- or all of the
17 examinations that you had with Mr. Avila after the laminectomy
18 surgery that you told us about. Again, that was in October of
19 2023. Just to get our timeline correct. And you saw him for a
20 postoperative visit after that; correct?

21 A Yes.

22 Q And then you saw him again in January of 2024?

23 A Yes.

24 Q And what were your findings or did you do an exam on
25 that day, Doctor?

1 A Yes.

2 Q And what were your findings as a result of that exam?

3 A The cervical spine, essentially, remains stable and the
4 lower back, he had some quadriceps and achilles tendon reflex
5 loss, and some residual L4-L5 and S1 sensory loss.

6 Q And he was still at that time a hundred-percent
7 disabled; right, Doctor?

8 A Yes.

9 Q And was his prognosis the same; still guarded?

10 A Yes.

11 Q And you still had the same opinion as to the
12 causally-related -- his injury was still causally-related to the
13 fall of 2022; correct?

14 A Yes.

15 Q And just to keep up, Doctor, you then saw him again on
16 April of 2024; right?

17 A Yes.

18 THE WITNESS: Hang on one second.

19 MR. STOLZMAN: Okay.

20 THE WITNESS: My next -- I have, in my notes, at
21 least, I have the January 22nd, 2024. And then I go to
22 May 13, 2024.

23 MR. STOLZMAN: Yes. Correct. I'm sorry. May
24 2024. Yes. I stand corrected, Doctor.

25 Q Can you tell us what -- you did an exam on May 2024?

1 A Yes.

2 Q And what were the results of that exam, Doctor?

3 A So on that, again, he was once again stable with
4 respect to his neck. No further deficits. Decreased C6
5 sensation --

6 (Cellphone interruption.)

7 A And also had continued decreased L4-L5 and S1
8 sensation.

9 Q And when you say, Decreased sensation, can you explain
10 to the jury what that means?

11 A Loss of sensation.

12 Q And, Loss of sensation, where -- or how would you
13 measure that and what would -- where would that sensation be?

14 A Same thing we talked about with the dermatomes, C6,
15 L4-L5 and S1.

16 Q And did you have the same -- in that May of 2024 exam,
17 was he still a hundred-percent disabled?

18 A Yes.

19 Q Had his prognosis changed?

20 A No.

21 Q And your opinion as to causality was the same at that
22 time?

23 A Yes.

24 Q Okay. Now, in September, you saw him again on
25 September 16th, 2024?

1 A Yes.

2 Q Is that right?

3 A Yes.

4 MR. STOLZMAN: I just want to make sure I'm not
5 getting the dates wrong. Thank you very much, Doctor.

6 Q And at that time, you conducted an exam again?

7 A Yes.

8 Q Now, Doctor, can you tell the jury why it was necessary
9 for you to see him with this frequency at this time?

10 A Just following up on how he was recovering from
11 surgery.

12 Q And what were your findings based on the exam on this
13 date?

14 A Some residual loss of C6 in the arms and hands and
15 L4-L5 and S1 in the legs and feet.

16 Q And the residual C6 that you mentioned, was that a
17 change from his prior examination?

18 A No.

19 Q Okay. And then you mentioned you saw him in April --
20 your next visit or examination of him was April of 2025?

21 A Yes.

22 Q Based on the records that you have with you right now?

23 A Yes.

24 Q And what were the results of your examination on that
25 day?

1 A Essentially, the same, so he was stable, that is say,
2 no progressive deficits, but residual C6 sensory loss in the
3 arms and hands and residual L4-L5 and S1 sensory loss in the
4 legs.

5 Q Now, since that examination, Doctor, have you reviewed
6 any additional medical records as it relates to your patient,
7 Mr. Avila?

8 A I've had -- I was sent some updated MRIs from Lenox
9 Hill.

10 Q And who requested those MRIs?

11 A Dr. Roberts.

12 Q And do you have an understanding of what -- why was the
13 plaintiff seeing Dr. Roberts?

14 A He's another orthopedic surgeon who also does spine.

15 Q And based on your review of those records, Doctor, can
16 you tell us, what, if anything, is the condition of -- we'll
17 start with Mr. Avila's neck, with respect to his cervical spine?

18 MR. FREIRE: Objection.

19 THE COURT: Read it back.

20 (Whereupon, the requested testimony was read back.)

21 THE COURT: Just rephrase the question.

22 Q As a result of reviewing those records, Doctor, do you
23 have an opinion today as it relates to Mr. Avila's spine -- his
24 cervical spine?

25 THE COURT: As of when? As of now?

1 MR. STOLZMAN: As of now.

2 Q As you sit here now.

3 A Again, I haven't had these -- these updated
4 diagnostics.

5 Q And as you sit here today, Doctor, can you tell us what
6 is your opinion as it relates to the prognosis with respect to
7 Mr. Avila's cervical spine?

8 A I would say his prognosis remains the same, which is
9 guarded, which is to say, he continues to require treatment.

10 Q And what about with respect to his lumbar, his back?

11 A I would agree, that it also continues to require
12 treatments, so it's guarded.

13 Q And you told us before, Doctor, about -- well, strike
14 that.

15 Given that his prognosis was guarded, do you have an
16 opinion as to whether or not he will need future treatment?
17 We'll start with his neck -- or for both parts?

18 A You know, I would defer to his treating physician right
19 now.

20 Q And that would be, Dr. Roberts?

21 A Sure. And I believe he's continuing pain management as
22 well.

23 Q Dr. Lerner?

24 A Yes.

25 Q Okay. You continue to treat him yourself; right,

1 Doctor?

2 A Yeah. I -- I did see him as we went over all those
3 notes. That's correct.

4 Q Based on your experience, Doctor, as 30 years as an
5 orthopedic surgeon, board-certified, can this -- is it your --
6 can you give an opinion to a reasonable degree of medical
7 certainty as to whether or not Mr. Avila will require future
8 MRIs?

9 A I would certainly say future MRIs are reasonable.
10 Sure.

11 Q And can you give an opinion as to how often he would
12 need to have those MRIs?

13 A Depends on his clinical course and situation. You
14 know, every three years is not unreasonable, depending upon how
15 he's doing clinically.

16 Q And would that be for both his neck and his back?

17 A Sure.

18 Q And based on your experience, Doctor, as a
19 board-certified physician, orthopedic surgeon, can you tell the
20 jury what your understanding is to what the costs of those MRIs
21 are?

22 A You know, MRI cost can vary. It's really -- it can be
23 variable. It can be anywhere between \$500 to \$1,000, depending
24 upon facility.

25 Q And with respect to additional observation --

1 additional care, visits for his orthopedic -- for his back to an
2 orthopedic doctor, based on your 30-years experience as a spine
3 surgeon, to a reasonable degree of medical certainty, what can
4 you expect Mr. Avila is going to need as it relates to ongoing
5 visits or doctors' care?

6 A Well, it depends on the doctor. It depends on what
7 kind of specialty we're talking about.

8 Q Well, as it relates to a spine surgeon for his neck and
9 his back.

10 A Every -- you know, once you're stable, as long as
11 you're not having any issues, every couple of years to three
12 years would be reasonable.

13 Q And based on your experience, Doctor, what's the cost
14 of those visits?

15 A Depends on how much time you're spending with a
16 patient. If you do a full exam and a full counselling session,
17 it can be \$275 or so.

18 Q And what about physical therapy, Doctor? To a
19 reasonable degree of medical certainty, what will Mr. Avila need
20 as it relates to physical therapy?

21 A It also depends on his clinical course, and, you know,
22 physical therapy depends on whether he's having symptoms or not.

23 Q And when you last saw him, was he still having symptoms
24 -- he was still having symptoms; correct?

25 A Yes.

1 Q As he's testified to this jury that he's still having
2 symptoms today. Based on that, Doctor, can -- what can -- to a
3 reasonable degree of medical certainty, can you tell us what you
4 would expect his need for physical therapy to be going forward?

5 A Physical therapy can be helpful on a maintenance basis,
6 at least a couple of times per month.

7 Q And what's your experience, Doctor, as to the cost of
8 those physical therapy visits?

9 A Typically, around \$50 or so.

10 Q And he's already -- strike that.

11 You've told us already, Doctor, regarding when a
12 patient has -- we'll start with the cervical spine. When they
13 have a fusion surgery, as Mr. Avila had, that it can cause wear
14 and tear on the rest of the cervical spine; correct? Did I
15 understand that correctly?

16 A Yes.

17 Q Going forward?

18 A Yes.

19 Q To a reasonable degree of medical certainty, Doctor, do
20 you expect that Mr. Avila will need an additional surgery to his
21 neck based off of that wear and tear that we can expect?

22 A It's hard to predict the future. You can never really
23 say for certain, but, you know, those are things that we look
24 out for as time goes on.

25 Q And -- and by that, Doctor, I don't mean, necessarily,

1 we'd ask for you to look at a crystal ball, needless to say, but
2 in terms of what his optimal care would be, would that be
3 something to a reasonable degree of medical certainty that he
4 would need for his optimal care?

5 MR. FREIRE: Objection.

6 THE COURT: Overruled. Go ahead.

7 A Sure.

8 Q And what about with respect to his -- his lumbar, his
9 lower back, same question, Doctor: Would he, based off of what
10 you told us before about the stress that his spine will undergo,
11 particularly, after the three-level laminectomy that you told us
12 about, for his optimal care, would it be to a reasonable degree
13 of medical certainty, can he expect to need additional surgery
14 to his lumbar spine?

15 A You know, with the low back, we preserve motion, so
16 it's one of those situations that's not as pressing as where
17 you're doing a fusion for the lower back.

18 Q When you say, It's not as pressing?

19 A Yes.

20 Q Does that mean that it would not be part of his optimal
21 care in the future or something else?

22 A Well, like I said, I think you still need to follow
23 this patient out into the future to see what his overall
24 clinical course is going to be, which is why, continued therapy
25 and pain management diagnostics are necessary. Sure.

1 Q And what about as it relates to surgery, Doctor? To a
2 reasonable degree of medical certainty?

3 A Yeah. It's a little less likely to predict when you're
4 doing laminectomies on patients and not fusions.

5 Q When you say, Less likely, does that mean not likely or
6 just different than the neck?

7 MR. FREIRE: Objection.

8 THE COURT: Sustained.

9 Q Doctor, in your experience, in 30 years as a spine
10 surgeon, what's the cost for an additional -- for a revision
11 surgery to his -- for his cervical spine?

12 A A cervical revision can be, for all, full-on cost,
13 total, including implants in the hospital and everything, in the
14 neighborhood of about 75 to a 100.

15 THE COURT: Thousand dollars?

16 THE WITNESS: Yes.

17 THE COURT: Just so the record is clear.

18 Q And what about if he should need a revision surgery to
19 his lumbar?

20 MR. FREIRE: Objection.

21 THE COURT: Sustained. Rephrase it. You have to
22 lay a foundation. Go ahead.

23 Q Doctor, based on your experience as a spine surgeon for
24 the last 30 years, can you give the jury, to a reasonable degree
25 of medical certainty, how much it would cost for the revision

1 surgery?

2 MR. FREIRE: Objection. May we approach?

3 THE COURT: Yeah. Come on up.

4 (Whereupon, there is an off-the-record discussion
5 held at the bench between the Court, Mr. Stolzman, Mr.
6 Freire and Ms. Scibetta.)

7 THE COURT: The objection is sustained.

8 MR. STOLZMAN: I would like to mark for
9 identification, 19.

10 (Whereupon, Plaintiff's Exhibit 19, is marked for
11 identification.)

12 THE COURT OFFICER: Plaintiff's Exhibit 19 to the
13 witness for ID.

14 THE COURT: Thank you.

15 Q All right. Doctor, you've been given Plaintiff's
16 Exhibit 19 for identification. Just yes or no, Doctor: Do you
17 recognize that document?

18 A Yes.

19 Q And that document has been signed and attested to by
20 you?

21 A Yes.

22 Q And based off of that document, Doctor, do you have an
23 opinion to a medical -- reasonable degree of medical certainty,
24 as to whether or not Mr. Avila will need an additional surgery
25 or revision surgery to his lumbar spine?

1 MR. FREIRE: Objection. Already asked and
2 answered.

3 THE COURT: Yes. I believe it was asked and
4 answered.

5 MR. STOLZMAN: May I approach, Judge?

6 THE COURT: All right. You know what, I'll allow
7 it. Go ahead. Read it back.

8 (Whereupon, the requested testimony was read back.)

9 THE COURT: Overrule the objection.

10 A Yes.

11 Q And what is that opinion?

12 A That based on this, optimal future care would include
13 revision, potential future surgery.

14 Q And to a reasonable degree of medical certainty --

15 THE COURT: I just want to make sure -- re-read.

16 (Whereupon, the requested testimony was read back.)

17 THE WITNESS: Correct.

18 THE COURT: Can you clarify that for the jury?

19 THE WITNESS: That given his age, there is a
20 potential for future surgery to both the neck and back.

21 Q And for his back, Doctor, based on your experience as a
22 spine surgeon, can you tell the jury to a reasonable degree of
23 medical certainty, how much that surgery for his back would
24 cost?

25 A So all-in for the lower back, I had estimated 150.

1 150,000.

2 MR. STOLZMAN: Thank you, Doctor. Just allow me to
3 review my notes.

4 (Whereupon, there is a brief pause in the proceedings.)

5 Q You told us before, Doctor, about, your opinions as to
6 whether or not Mr. Avila can do work as a roofer. And just so
7 we're clear: You're not a vocal rehabilitation specialist;
8 right?

9 A Correct.

10 Q Okay. Doctor, do you have an opinion about whether or
11 not, based off your treatment and the symptomology and
12 everything you've told this jury, as to whether or not Mr. Avila
13 would be -- you would clear him to do work in any type of
14 construction?

15 A Depends upon what that work would entail. As I said,
16 anything up to light duty is okay, so nothing regarding
17 repetitive motion to the neck or back.

18 Q And when you say, Repetitive motion, can you just be a
19 little bit more clear about what a repetitive motion is, like,
20 will it take a while --

21 A I think we're all familiar with repetitive motion:
22 Bending, lifting and twisting.

23 Q Okay. Okay. And the plaintiff has testified, Doctor,
24 and has told his pain management specialist that, as he sits
25 here today, he still has pain to his neck and back. Do you have

1 an opinion as to why that would be?

2 A It would be chronic pain.

3 Q And when you say, Chronic pain, would that be chronic
4 pain related to the trauma sustained and the subsequent
5 treatment thereafter?

6 A Yes.

7 Q Okay.

8 MR. STOLZMAN: Those are all my questions. Thank
9 you, Doctor.

10 THE COURT: Cross-examination, please.

11 MR. FREIRE: Yes, your Honor. Thank you. And with
12 your Honor's permission, Ms. Scibetta is going to be sitting
13 here. Okay, Judge, if I can move here?

14 THE COURT: Yeah. Absolutely.

15 MR. FREIRE: Thank you.

16 THE COURT OFFICER: You need me to move this,
17 Counselor?

18 MR. FREIRE: Please. Thank you so much. I'm going
19 to try to do it from here, your Honor, if that's okay?

20 THE COURT: That's fine. Sure.

21 MR. FREIRE: May it please the Court.

22 THE COURT: Sure.

23 CROSS-EXAMINATION

24 BY MR. FREIRE:

25 Q Good afternoon, Doctor.

1 A Good afternoon.

2 Q Doctor, I think you mentioned during your direct
3 testimony that you've held teaching positions; correct?

4 A Yes.

5 Q At several hospitals?

6 A Correct. Yes.

7 Q And in that regard, you teach residents?

8 A Yes.

9 Q And residents are doctors that are clinically trained,
10 that are supervised by an attending or senior physician?

11 A Yes.

12 Q And you also teach and have taught throughout your
13 career medical students. Is that true?

14 A Yes.

15 Q And can we agree that you teach your residents and your
16 medical students to conduct thorough examinations on patients?

17 A Yes.

18 Q And that you also strive to yourself always conduct
19 thorough examinations of your patient. Can we agree on that?

20 A Yes.

21 Q You also teach residents and medical students the
22 importance of a patient's chart; am I correct?

23 A Yes.

24 Q You teach them how to document a patient's chart
25 correctly; yes?

1 A Yes.

2 Q And you teach them the -- how to be thorough in
3 documenting a patient's chart?

4 A Yeah. I would use the word, Pertinent, in terms of
5 documenting the problem that you're taking care of. Yes.

6 Q And you teach them to be accurate in what they write
7 down in the patient's chart. Do you agree with me?

8 A Sure. Yes.

9 Q You also would agree that it's accurate, pertinent
10 chart -- to use your word, is important?

11 A Sure.

12 Q You have referred to your medical chart in your
13 testimony today, is that true?

14 A Yes.

15 Q Can we agree that you don't have an independent
16 recollection of Mr. Avila's visits to you since 2022; is that
17 fair to say?

18 A Yes.

19 Q So you are relying on the accuracy of your medical
20 chart that you have in front of you this morning -- today, yes?

21 A To help refresh my recollection. Yes.

22 Q And is that recollection, to be clear, you don't have
23 an independent recollection; correct?

24 A Yes.

25 Q So you are relying on the accuracy and the thoroughness

1 of your chart in giving testimony today, can we agree on that?

2 A Yes.

3 Q Doctor, will you agree that more than one medical
4 professional will at times look at a patient's chart; correct?

5 A Sure.

6 Q So, for example, when patient is referred to you by
7 another physician, you may have a reason to review that
8 patient's chart that was filled out by that other physician;
9 correct?

10 A That's possible. Yes.

11 Q Okay. And also possible that your chart can then be
12 reviewed by some other medical professional in the course of
13 treatment of a patient; correct?

14 A Yes.

15 Q And you'll also, within that vein, agree with me that
16 the chart becomes very important to be accurate and thorough;
17 correct?

18 A It's a part of what goes into taking care of the
19 patient. Yes.

20 Q A less than thorough medical chart, though, could omit
21 something that ultimately may be important to the patient's
22 care. Can we agree on that?

23 A Well, not if you're pertinent in terms of what you're
24 treating the patient for, but, you know, certainly, things can
25 be in there and things might not be in there, so in a general

1 sense, sure.

2 Q How about -- can we agree that an inaccurate medical
3 chart would not be ideal?

4 MR. STOLZMAN: Objection.

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

6 A I mean, I would -- I would agree with you that you want
7 to have a clear understanding of what's happening to the patient
8 to the best of your ability.

9 Q And you would impart that to your residents and medical
10 students when you teach them; correct?

11 A Sure.

12 Q That you would strive to have as accurate and thorough
13 and pertinent medical chart on a patient; correct?

14 A You want to have something that's functional, that
15 helps you take care of the patient. Yes.

16 Q That wasn't my question, Doctor, so can we agree that
17 you would teach your medical students and residents to try to
18 keep as accurate and thorough a medical chart as possible on
19 these. Fair?

20 A Yes, but -- yeah. Sure.

21 Q Okay. Thank you.

22 Doctor, can we agree that being thorough also means not
23 taking shortcuts. Can we agree on that?

24 A I -- I would say that you don't want to take a shortcut
25 if that is going to interfere with your ability to treat a

1 patient.

2 Q And you would teach that to your residents and medical
3 students also; correct?

4 A Sure.

5 Q And I'm sure you practice what you preach, so we can
6 agree that you strive to avoid taking shortcuts insofar as it
7 could be harmful to the patient's care. Can we agree on that?

8 A Yes. You would not ever do anything that's going to be
9 harmful to a patient's care. No.

10 Q Because that is part of the code of medical ethics;
11 correct?

12 A Of course. We want to take the best care possible of
13 our patients.

14 Q So that's true that it's part of the code of ethics;
15 yes?

16 A Sure. That we want to take absolutely as best of care
17 as we can possibly take care of for our patients. Yes.

18 Q And part of that is using as good a chart as you can so
19 you can track the progress and course of treatment of your
20 patients; correct?

21 A In an appropriate manner. Yes.

22 Q Okay, so, Doctor, let's go ahead and talk about the
23 medical record. Your medical chart of Mr. Avila in this case.
24 And I would like you to take a look at that first visit from May
25 23rd, 2022. Do you have that in front of you?

1 A Yes.

2 MR. FREIRE: Can you bring up page nine. I'm going
3 to go ahead and show it on the screen for the jury.

4 Q And, Doctor, before I get to specific questions about
5 that, can we agree that plaintiff was not -- Mr. Avila was not
6 your patient before the alleged incident on January 21st, 2022;
7 correct?

8 A Yes.

9 Q Or I think, January 24th. I'm sorry.
10 The first time you saw him was in May of 2022; correct,
11 several months later?

12 A Yes.

13 Q And when you saw him, if I understand your initial
14 report correctly, you took a history from him as to how the
15 accident occurred; correct?

16 A Yes.

17 Q For that history, you relied on what the plaintiff told
18 you; yes?

19 A Yes.

20 Q You had no other source of information regarding how
21 his accident happened, other than what Mr. Avila told you; true?

22 A Yes.

23 Q And what you documented in your initial report was
24 simply a, Fall from height, if I'm reading that correctly. Yes?

25 (Cellphone interruption.)

1 A Yes.

2 Q So fair to say, you had no idea if he fell one foot or
3 he fell 20 feet; correct?

4 A Yes.

5 Q You had no idea if he fell from a ladder or some other
6 device; correct?

7 A Yes.

8 Q And at that point, during the initial report, you did
9 not have the benefit of any other records regarding the actual
10 happening of this accident. Can we agree on that?

11 A Yes.

12 Q In terms of your note in the first -- in the initial
13 report there, that the plaintiff had no medical or surgical
14 history, would you agree, Doctor, that that was based solely on
15 what plaintiff told you that day; correct?

16 A Yes.

17 Q You had no other source of information regarding
18 whether plaintiff had some relevant medical or surgical history,
19 did you?

20 A Correct.

21 Q And to this day, you have never seen any of the
22 plaintiff's medical records from before the accident. In fact,
23 if there were any to verify whether he had any relevant medical
24 or surgical history before that. Can we agree on that?

25 MR. STOLZMAN: Objection. May I approach, your

1 Honor?

2 THE COURT: All right. Come on up.

3 (Whereupon, there is an off-the-record discussion
4 held at the bench between the Court, Mr. Stolzman, Mr.
5 Freire and Ms. Scibetta.)

6 THE COURT: Just take a quick break. Don't discuss
7 the case. Go to the jury room, please.

8 THE COURT OFFICER: All rise. Jurors exiting.

9 (Whereupon, the jury is dismissed for a recess.)

10 THE COURT: Doctor, you can step out, please.

11 (Whereupon, the witness exits the witness stand.)

12 THE COURT: I'm paraphrasing, Doctor, in making
13 whatever conclusions you did, you relied solely on what the
14 plaintiff told you; is that correct -- yes. You had no way
15 of independently verifying whether or not he had ever been
16 in an accident before; is that correct -- yes.

17 MR. FREIRE: And, your Honor, I'm just -- more
18 broadly speaking, because -- and my question, to be clear, I
19 never said anything about him being in a prior accident.
20 That seems to be where plaintiff counsel thinks I'm going.

21 THE COURT: Say, Prior injury. Whatever.

22 MR. FREIRE: But just any prior relevant medical or
23 surgical history: You had no way of independently verifying
24 any -- the absence of any relevant prior medical or surgical
25 history. That's it.

1 THE COURT: Okay. That's the question we're going
2 to go with. And I'm going to say to the jury, just give an
3 instruction. You've heard similar testimony, you heard
4 testimony from this witness, you've heard the answer to that
5 last question. You also had similar testimony from Dr.
6 Lerner. I'm allowing that question just for what it says.
7 The doctor made his determination based on what he was told
8 by the plaintiff. And did not have the ability to
9 independently verify it. And that's it.

10 MR. STOLZMAN: And you should draw no inference.

11 THE COURT: That you should not draw any inference
12 one way or the other whether he had, you know, any prior,
13 whatever you say.

14 MR. STOLZMAN: History.

15 THE COURT: Any prior history.

16 MR. FREIRE: That's fine.

17 THE COURT: I think that's fair.

18 MR. STOLZMAN: Thank you, Judge.

19 THE COURT: Because you know what, and this can be
20 off.

21 (Whereupon, an off-the-record discussion is held.)

22 THE COURT OFFICER: All rise. Jurors entering.

23 (Whereupon, the jury enters the courtroom.)

24 THE COURT: Okay. Please, be seated everyone. Let
25 the record reflect that all jurors and alternates are

1 present and in their assigned seats. Doctor, you're still
2 under oath.

3 You're withdrawing the last question; correct?

4 MR. FREIRE: Yes, your Honor. I'll ask a
5 foundational question.

6 Q Doctor, is it fair to say that you had no way of
7 independently verifying what the plaintiff, Mr. Avila, told you
8 in terms of his -- any relevant surgical or medical history; is
9 that fair?

10 A Yes.

11 THE COURT: So let me just explain. I've allowed
12 that question and there was a similar question asked to Dr.
13 Lerner, okay, about prior medical history, so, in essence,
14 the doctor, you heard what the doctor just said. I don't
15 have to summarize it for you, but you can't speculate or
16 guess about any prior medical history, whether there was or
17 wasn't. There's no evidence of that.

18 The reason I let the question in is just so you
19 know that the doctor based his opinion, his determination or
20 his opinion, on certain information plaintiff gave him
21 during the course of the examination, taking of the history,
22 et cetera, without his being able to independently verify
23 the voracity of truth of that statement. Okay.

24 MR. FREIRE: Thank you, Doctor -- thank you, your
25 Honor. May I continue?

1 THE COURT: Sure. Go right ahead.

2 Q Doctor, so going back now to this first visit that you
3 had -- his first visit with you in May of 2022. I'm going to go
4 ahead and point out that this first area here ask you to within
5 a reasonable degree of medical certainty. That next -- that
6 next paragraph that starts with, Patient presents to the office
7 today; correct?

8 A Yes.

9 Q Okay. And that means that he presented to your office
10 on May 23rd, 2022; correct?

11 A Yes.

12 Q Okay. And so these are your notes from that date; is
13 that correct?

14 A Yes.

15 Q How do you go about making these notes, by the way?

16 A I dictate it.

17 Q You dictate?

18 A Yes.

19 Q So for every visit, you dictate and then that's
20 transcribed for you?

21 A Correct.

22 Q So this is something you dictated on May 23rd or about
23 thereabouts?

24 A Yeah. I dictated my actual -- either when I'm with the
25 patient or right after I see the patient.

1 Q And you do that as pattern or practice for all your
2 visits?

3 A Yes.

4 Q So on that day, you -- he came to your office; right,
5 and you mentioned earlier that -- in your direct testimony that
6 he reported to you a pain on a scale of one to ten, a nine out
7 of ten; correct?

8 A Yes.

9 Q And I believe you testified on direct that your ten --
10 how did you describe it for the jury? What would ten be the
11 equivalent of?

12 A Severe pain that is severely limiting or preventing you
13 from doing, you know, your normal activities of daily living.

14 Q I want you to assume for a moment that the plaintiff's
15 pain management specialist, Dr. Lerner, testified last week and
16 he told the jury that the pain scale he used of one to ten, ten
17 is if you're literally on fire. We would agree that that's
18 different; correct, you're -- the way you've characterized ten
19 on the one to ten and the way he does; correct?

20 A Yes.

21 Q But for your purposes, he reported a nine out of ten;
22 correct?

23 A Yes.

24 Q And on that day, he arrived to you with -- accompanied
25 by friends and family members. Did I -- am I reading that

1 correct -- correctly?

2 A Yes.

3 Q He -- that's how he arrived to you on May 23rd, 2022?

4 A Yes.

5 Q Okay. Do you know who those friends are?

6 A No.

7 Q You mentioned that he was under the auspices of Dr.
8 Lerner and Dr. Dassa, meaning that he was under their care at
9 that point?

10 A Yes.

11 Q Okay. And at this point, it's a few months after this
12 accident, you were aware that he had started physical therapy;
13 correct?

14 A Yes.

15 Q He had been attending physical therapy for about three
16 months at that point; is that fair?

17 A Yes.

18 Q Doctor, is it fair to say that activity modification
19 and physical therapy are very helpful within the first six weeks
20 after an injury?

21 A Sure. They absolutely can be.

22 Q But you've also expressed the opinion that after that,
23 it kind of falls off overtime?

24 A It can. Sure.

25 Q I want us to just take note of that -- that paragraph

1 and that wording that we just went over, but I just want to
2 continue going up, if we could. And we'll go to the physical
3 examination. These are your notes that you made that day
4 regarding the physical examination?

5 A Yes.

6 THE COURT: Counsel, just slow down. Just try to
7 slow down.

8 MR. FREIRE: Oh, sure. I apologize.

9 Q And as it continues on the next page, these are also
10 notes that you made contemporaneous to that visit regarding the
11 various findings on physical examination. Can we agree on that?

12 A Yes.

13 Q When you note, Spasm, as plaintiff's counsel was
14 telling you on direct -- was asking you on direct, spasm is when
15 the muscle contracts; correct?

16 A Yes.

17 Q That's something you feel on a physical examination?

18 A Yes.

19 Q Okay. Do you take any sort of recording, video,
20 photos, anything during physical examinations of your patients?

21 A No.

22 Q So in that regard, we are relying on your chart
23 regarding what you observed on that day; correct?

24 A Yes.

25 Q And now we get to the MRI films section. Question,

1 Doctor: When it discusses the films here, did you review the
2 films or the reports?

3 A Both.

4 Q Both. The reports are in your medical chart; correct?

5 A Should be, yes.

6 Q Okay. They are actually there; right?

7 A I think they are.

8 Q Okay. And they're there because that is part of what
9 you reviewed during -- during your course of treatment for the
10 plaintiff?

11 A Yes.

12 Q And here where you talk about the MRIs that you
13 reviewed, I want to go over something -- go over some topics
14 with you. First of all, Doctor, are you a radiologist?

15 A No.

16 Q There's board certification for radiology; correct?

17 A Yes.

18 Q You're not a board-certified radiologist; correct?

19 A Correct.

20 Q In terms of what we are discussing here in terms of
21 cervical disc protrusions and any other sort of abnormalities, I
22 want to ask you some -- some general questions. First of all, a
23 -- I want the jury to understand and reiterate a little bit
24 about what you're talking about on direct about bulges versus
25 herniations. A bulge, as I think you mentioned, is a have a

1 symmetrical bulging of the disc?

2 A Correct.

3 Q As compared to a herniation which is an asymmetrical,
4 meaning, not symmetrical protrusion; is that fair?

5 A Yes.

6 Q And in fact, a herniation is often categorized by an
7 annular tear?

8 A Yes.

9 Q If we could visualize the disc as a jelly doughnut;
10 right, you've heard this before?

11 A Sure.

12 Q A bulge is when the jelly doughnut just kind of gets
13 flat, but it's still intact; correct?

14 A Yes.

15 Q Whereas, a herniation, is when the jelly has come out
16 of the doughnut?

17 A Yes.

18 Q That's annular tear?

19 A Correct.

20 Q And that creates the asymmetrical production; correct?

21 A Yes.

22 Q But we can agree that a bulge can be degenerative;
23 correct?

24 A Yes.

25 Q A herniation can be degenerative; yes?

1 A Yes.

2 Q So a disc can herniate overtime as part of the natural
3 degeneration process; correct?

4 A Yes.

5 Q And we can agree also that a bulge or a herniation on a
6 radiological film, such as an MRI, doesn't necessarily mean that
7 the patient requires surgery; correct?

8 A Yes.

9 Q It also -- the mere presence of either a bulge or a
10 herniation, doesn't in and of itself mean that there was some
11 acute trauma that caused that condition. Can we agree on that?

12 A Yes.

13 Q But there are certain indicators of acute trauma that
14 show up on films. Doctor, I'll ask you specifically, edema,
15 swelling --

16 A Yes.

17 Q -- that can be an indicator of a acute trauma; correct?

18 A Yes.

19 Q Bleeding, of course?

20 A Yes.

21 Q In the generation process, agree with me, Doctor, that
22 that begins, generally speaking, after the age of skeletal
23 maturity; correct?

24 A Yes.

25 Q In men, in males, that is sometime in the teen-years;

1 correct?

2 A Yes.

3 Q And I believe it's in your opinion that degeneration
4 starts to show -- it starts to be visualized on films around the
5 age of 30; correct?

6 A Yes.

7 Q Give or take a few years?

8 A Sure. Yes.

9 Q And you also would agree, Doctor, that a person's
10 occupation can be a risk factor for developing degenerative disc
11 disease; correct?

12 A Sure.

13 Q So, for example, someone that's in the construction
14 field, or some sort of heavy, physical labor field, that can be
15 a risk factor for accelerating the onset of degenerative disc
16 disease. Can we agree?

17 A Yes.

18 Q So with that, let's go through the MRI reports that you
19 reviewed when you first saw the plaintiff in May of 2022. And
20 we'll come back to that first report, but going back to direct
21 your attention now to the CitiMed complete care MRI report. Do
22 you have it?

23 A Yes, I do.

24 Q And this was one of the MRI reports that you reviewed
25 when you first saw the patient; am I correct?

1 A Yes.

2 Q I want to go through some of the verbiage here in the
3 MRI report, so I want to start here. The marrow signal does not
4 demonstrate any evidence of infiltrated or disruptive marrow
5 process. That's tested more with the bones; correct?

6 A Yes.

7 Q And the cervical spine, of course, demonstrates a
8 normal course caliber and signal intensity. Do you see that?

9 A Yes.

10 Q Do you have reason to disagree with what was in that
11 MRI report in that regard?

12 A No.

13 Q And then, The visualized where he will soft tissues are
14 grossly unremarkable. And, grossly unremarkable, is really a
15 medical way of saying they're unremarkable; correct, they're
16 normal?

17 A Yes.

18 Q And did you have any reason to disagree with that
19 portion of the MRI report?

20 A No.

21 Q Can we agree, by the way, that MRI films are subject to
22 interpretation?

23 A Sure.

24 Q Now, to get to this next spot right here where it says,
25 C2 through C3, or C2 through C3 and C7 through T1, those are two

1 distinct levels; correct --

2 A Yes.

3 Q -- in the neck? The highest level of the neck, C2-C3
4 and then the lowest that heads towards the thoracic spine;
5 correct?

6 A Yes.

7 Q Those levels of the MRI report indicates there's no
8 evidence of a disc herniation. You would agree with that;
9 correct?

10 A Yes.

11 Q And the neural foramina are patent. Patent, meaning,
12 open; correct?

13 A Yes.

14 Q Meaning that there's no obstruction?

15 A Correct.

16 Q Same thing with the facet joints are within normal
17 limits. You would agree with that as well?

18 A Yes.

19 Q So now let's get to this next section, which says that
20 C3-C4, C4-C5, C5-C6, and C6-C7, there's a disc bulging exerting
21 pressure on the fecal sac. Do you see that?

22 A Yes.

23 Q So we can agree that, according to this MRI film,
24 rather than one specific level that's some sort of indicator of
25 an acute traumatic injury, where we have, according to this MRI

1 report, are several levels of a -- of bulging discs; is that
2 fair?

3 A Yes.

4 Q And that, although there's some pressure on the fecal
5 sac -- by the way, what is a fecal sac?

6 A It's the covering of the spinal -- in this case, the
7 spinal cord.

8 Q Cord.

9 A And the nerve roots. Yes.

10 Q Right. What -- that would be the -- when you say said
11 that there was a -- what was visualized as gray inside a white
12 sheath, that would have been the white part of it?

13 A Yeah. It's actually -- it's really thin, so it's --
14 it's what's holding the fluid. It's like, the skin of a
15 balloon.

16 Q And so there was some pressure on it, but the neural
17 foramina, again, that's the opening; right, to the nerves, that
18 was open; right, that was patent, meaning open. Yes?

19 A Yes.

20 Q Meaning, no impingement on that; correct?

21 A Yes.

22 Q And lastly, that the facet joints were within normal
23 limits. Can you explain, again, what the facet joints are?

24 A It's on the backside of your neck or the backside of
25 your lower back. It's where the bones slide past one another

1 when they're moving.

2 Q Along those lines, by the way, you talked on direct
3 examination about how in the lumbar spine, when you're looking
4 at someone's lumbar spine, the MRIs, that the boney alignment
5 was still maintained. Do you remember that testimony?

6 A Yes.

7 Q When it's not maintained, that's called
8 spondylolisthesis?

9 A Correct.

10 Q And it's really when you have the boney displacement,
11 meaning, that the vertebrae are now not aligned the way they
12 should be, is when you have the danger of some instability;
13 correct?

14 A Correct. It can be a harbinger of instability. Yes.

15 Q And it would be a indicator of the need for a fusion
16 surgery?

17 A Potentially, yes.

18 Q It's -- it is one of the reasons why you elected not to
19 perform fusion surgery upon plaintiff's lumbar spine; correct?

20 A Correct.

21 Q Because the boney alignments are still -- were still
22 intact; yes?

23 A Yes.

24 Q So as to impression overall, do you disagree with the
25 MRIs, the report from CitiMed, that there's disc bulging

1 throughout the cervical spine from C3 through C7?

2 A Yes.

3 Q You disagree with that?

4 A No.

5 Q You don't disagree with that?

6 A Correct.

7 Q Okay. Thank you. And that there was a straightening
8 suggesting muscle spasm, yes?

9 A Yes.

10 Q Okay. But that is only a suggestion based on film;
11 correct?

12 A Yes.

13 Q We'd agree that that would have to be clinically
14 correlated on physical examination. Yes?

15 A Yes.

16 Q Am now if we can bring up the Stand-Up MRI, page 37.
17 This was another one of the MRI reports that you reviewed in
18 connection with your first consult with Mr. Avila, so this,
19 Doctor, you would agree is another MRI of the cervical spine
20 that was performed in -- I think a month later -- yep.
21 March 3rd. Yes?

22 A Correct.

23 Q By the way, you did not order either of these MRIs;
24 correct?

25 A Correct.

1 Q You don't know why the plaintiff was referred to do not
2 one, but two MRIs of his -- of his cervical spine within a month
3 of each other, do you?

4 A No.

5 Q But in any event, this was done in early March. And if
6 we could go through this a little bit, we would agree that this
7 note says there's no fracture on the MRI of the cervical spine?

8 A Yes.

9 Q Right. The fracture, by the way, is an indicator of an
10 acute injury; correct?

11 A Sure.

12 Q So in that sense, that was not present on MRI?

13 A Correct.

14 Q There's also no significant spondylolisthesis -- which
15 is what we just talked about; right?

16 A Yes.

17 Q In other words, the boney alignment in the cervical
18 spine also was maintained, according to this MRI?

19 A Yes.

20 Q And do you have reason to disagree with that particular
21 part of the MRI report?

22 A No.

23 Q And there's no loss of -- loss in height of the
24 vertebral bodies according to this MRI; correct?

25 A Yes.

1 Q Now, the loss of height, what is the significance when
2 there is a loss of height of the vertebral bodies? Not of the
3 discs, but of the vertebral bodies, the bones?

4 A So it can come from a number of different causes. The
5 first potential cause is that you're born with a deformity of
6 the bodies, like, for example, if you had some type of dwarfism,
7 you might have a loss of vertebral body height or the vertebral
8 bodies might be shaped abnormally.

9 The other way you can get a loss of vertebral body
10 height, is you can have an infection in the bone or you can have
11 a tumor in the bone or you can have a fracture inside the bone.
12 Most commonly occurring in older folks who have osteopetrosis,
13 where you develop an osteopetrotic compression fracture, so
14 anything that interferes with the normal boney formation of the
15 vertebral body can result in a loss of vertebral body height.

16 Q Thank you, Doctor, so we can agree that that was not
17 present in plaintiff's cervical spine on this MRI; correct?

18 A Correct.

19 Q Now, the next sentence is, There's disc desiccation
20 from C3-4 through C6-7. Do you see that?

21 A Yes.

22 Q Okay. Disc desiccation, means that the disc has
23 started to lose some water content; correct?

24 A Yes.

25 Q But when your discs haven't lost water content, they

1 show up as a brighter -- a whiter color on MRI; correct?

2 A Yes.

3 Q Once the discs start losing water content, it appears
4 more gray on MRI. Can we agree on that?

5 A Yes.

6 Q And disc desiccation occurs overtime; correct?

7 A Yes.

8 Q It is a form of degenerative disc disease?

9 A Yes. It's a form of --

10 Q Degeneration --

11 A -- degeneration. Yes.

12 Q A form of degeneration. And that, by definition, takes
13 place overtime; correct?

14 A Yes.

15 Q Disc desiccation is not an acute condition; correct?

16 A Correct.

17 Q And can we agree that the MRI of the cervical spine
18 from Stand-Up MRI, did in fact show disc desiccation from C3-4
19 through C6-7. Can we agree on that?

20 A Yes.

21 Q When you looked at the MRIs when you were showing the
22 jury the MRIs that -- from this facility of the plaintiff's
23 cervical spine --

24 A Yes.

25 Q -- you did note that there was some flattening --

1 flattening out of the -- of the cervical spine in this MRI;
2 correct?

3 A Yes.

4 Q Doctor, we can agree that that MRI was taken at a
5 Stand-Up MRI facility?

6 A Yes.

7 Q That's actually the name of the facility, Stand-Up MRI?

8 A Yes.

9 Q Okay. Can we also agree that the patient's position of
10 their head can at times contribute to what will appear in an MRI
11 as a -- as a flattening?

12 A Yeah. Positioning can -- depends upon how you position
13 your neck, yes. It can contribute to the way you're looking at
14 the alignment of the cervical spine.

15 Q All right. And, Doctor, going back to your initial
16 test of --

17 MR. FREIRE: And that's page nine. I think we're
18 back to page nine. Thank you.

19 Q So the last thing I just want to point out as to that
20 first report is that, in this report -- I think it's on the
21 second page -- but in this report you recommended an EMG test;
22 correct?

23 A Yes.

24 Q You testified about that on direct; correct?

25 A Yes.

1 Q Agree, Doctor, that you do not perform that EMGs;
2 correct?

3 A Correct.

4 Q And, in fact, EMG is subject to how it's administered
5 to some -- to some degree. Yes?

6 A Can be, sure.

7 Q Before we move on, I just want to go ahead and go back
8 a little bit. And I just want us to take a look at this section
9 here that starts that, There is a positive impression disc
10 traction maneuver. Do you see that part?

11 A Yes.

12 Q And there's that -- that paragraph, the thoracic spine,
13 the lumbar extension, and if you go up even further, some of the
14 initial physical examinations. We can agree, Doctor, that those
15 are all of the notes that you made on May 23rd, 2022, yes?

16 A Yes.

17 Q Okay, so if we go now to the next visit that Mr. Avila
18 had with you, on June 27th, 2022. And I want to go back now to
19 and I want to point your attention now to this first paragraph.
20 And believe you testified on direct that your findings on this
21 date, which is June 27th, 2022, on direct examination you said,
22 Were pretty consistent -- quote unquote, "pretty consistent"
23 from your first visit of May 23rd. Yes?

24 A Yes.

25 Q So we, Doctor, that this paragraph right here, that

1 starts, Patient presents to the office today, it is identical to
2 the language from your first report. Yes?

3 A Yes.

4 Q Okay. According to this report of June 27th, 2022, the
5 patient also reported a nine to ten on a zero to ten scale. He
6 was also accompanied by friends and family members and you
7 pointed out, once again, that he's under the auspices of Dr.
8 Lerner and Dassa, among other information here. Yes?

9 A Yes.

10 Q If we move up, though, the part that I want to
11 emphasize is that, Doctor, you would agree that on every exam
12 that you had with Mr. Avila, you were performing a separate
13 physical examination. Yes?

14 A Yes.

15 Q A new physical examination?

16 A Correct.

17 Q A thorough physical examination?

18 A Yeah. Pertinent.

19 Q Pertinent --

20 A For that exam and his other body parts or systems.

21 Q Of course.

22 A Right.

23 Q For his -- for the different body parts that you were
24 treating; right?

25 A Sure. Yes.

1 Q And that you were then contemporaneously making notes
2 on each visit, as you said?

3 A Yes.

4 Q Doctor, you would agree with me that the notes
5 regarding your physical examination on June 27th, 2022, are
6 identical in verbiage to the May 28th, 2022, report, yes?

7 A Yes.

8 MR. FREIRE: If we can go up a little bit more. If
9 we go to page 13, August 8th, 2022.

10 Q You testified on direct that your findings on that date
11 did not change significantly from the prior visit of June 27th,
12 2022?

13 A Correct.

14 Q We can agree that, again, the introductory paragraph,
15 as I'll call it, is exactly the same as it was in the prior two
16 reports. Yes?

17 A Yes.

18 Q Meaning that, according to this, on May 28th, 2022, on
19 June 27th, 2022, and on August 8th, 2022, the patient arrived
20 each of those occasions with friends and family members, driven
21 and utilizing private transportation. Am I correct?

22 A Yes.

23 Q That's what's reflected in your report?

24 A Yes.

25 Q And in terms of physical examination, you would also

1 agree with me, that that language, that verbiage about what you
2 did on that day, is identical to the language that's in both
3 your report of June 27th, 2022 and May 28th, 2022; correct?

4 A Yes.

5 Q In other words, you dictated the exact verbiage for
6 that visit as you did for the two prior visits; is that fair?

7 A Correct.

8 Q Doctor, can we agree that you took a shortcut in your
9 chart, by simply copying and pasting your notes from each visit?

10 A No.

11 Q You're telling this jury that you dictated on each
12 visit, you happened to dictate the exact same verbiage,
13 line-by-line, word-for-word; yes or no? Yes or no?

14 A Yes. Correct.

15 Q Okay. I want to now go to page 42 if we can. Your
16 operative report of the cervical fusion. We can also agree that
17 you drafted this operative report; correct?

18 A Yes.

19 Q Your operative report, as plaintiff's counsel mentioned
20 during direct, states that you observed an annular tear at C5/C6
21 during the operation; correct?

22 A Yes.

23 Q That is not a finding that was listed in the CitiMed
24 MRI report of February 15th, '22 -- 2022, is it?

25 A No.

1 Q So it is your testimony that you were able to visualize
2 during the surgery something that didn't otherwise come up on
3 MRI; correct?

4 A Yes.

5 Q You are familiar with the term, Intraoperative imaging,
6 Doctor?

7 A Yes.

8 Q Intraoperative, meaning, during the operation?

9 A Yes.

10 Q And that refers to the imaging that helps you perform
11 the surgery. Yes?

12 A Yes.

13 Q And as a result of intraoperative imager, can we agree
14 that there are -- there are -- there is the ability to take
15 intraoperative photos during a surgery?

16 A Not for this particular kind of surgery. No.

17 Q So for this surgery there is no ability to take
18 intraoperative photos?

19 A No. They're x-rays.

20 Q But not during the surgery?

21 A During the surgery, yes.

22 Q Are there x-rays that were taken during the surgery?

23 A Yes.

24 Q Where are they?

25 A It's in the section under, Fluoroscopy.

1 Q Oh, okay. Well, not a report. What I'm trying to get
2 to is whether or not they're actually photos that show the
3 annular tear that you saw, according to your operative report,
4 during the operation?

5 A Yeah. There's not -- there were no photographs. No.

6 Q All right, so there is -- there are no photographs that
7 the -- that you can show the jury to show them the annular tear
8 that your operative says you visualized during the surgery; is
9 that fair?

10 A Yes.

11 Q By the way, the demonstrative exhibit of the cervical
12 surgery -- if it's here somewhere -- we'd agree that this is --
13 you had a specific term for -- what was it -- what was the term
14 you used for?

15 A Illustration.

16 Q Illustration. In fact, there was illustration, some
17 sort of -- not biomechanical illustration. Well, we'll leave it
18 as illustration. Yeah?

19 A Yes.

20 Q Okay, so it is just an illustration; correct?

21 A Yes.

22 Q The -- there are other demonstrative exhibits there
23 that had the -- some of the radiological films side-by-side, but
24 this one's purely an illustration. Can we agree?

25 A Yes.

1 Q And I think as you mentioned during the direct, it's
2 really meant to illustrate the type of surgery that was done;
3 correct?

4 A Yes.

5 Q We'll agree that where you see in this illustration,
6 this impingement into the -- is this the neurocanal? Did I get
7 that right?

8 A Yes.

9 Q Okay. And that as well?

10 A Yes.

11 Q We agree that this is not actually accurately
12 illustrating the extent of impingement that you saw on the
13 cervical MRIs; correct?

14 A Yes.

15 Q Right. We agree that the cervical MRI that you showed
16 the jury, did not show that level of impingement. Can we agree
17 on that?

18 A Yeah. Like I said, that's an illustration.

19 Q And, if I understand your direct testimony correctly,
20 the cervical spine MRI that plaintiff's counsel brought up on
21 the screen earlier, it is your testimony that that cervical
22 spine MRI visualized a herniation in the cervical spine?

23 A Correct.

24 Q Not a bulge?

25 A Yes.

1 Q You agree with me that the postoperative x-rays that
2 were shown to you by plaintiff's counsel, do show a stable,
3 successful surgery in the plaintiff's cervical spine?

4 A Yes.

5 Q No complications were encountered during the cervical
6 spine surgery; correct?

7 A Correct.

8 Q And a few general questions regarding cervical fusion:
9 Doctor, you agree with me that people can recover from cervical
10 fusion; yes?

11 A Yes.

12 Q And people can go on to have a normal life after
13 cervical fusion; yes?

14 A Yes.

15 Q Doctor, about 90 percent of the -- of the -- excuse me.
16 90 percent of the time, fusion can decrease radiating pain
17 symptoms, yes?

18 A Yes.

19 Q So unless plaintiff is in the ten percent, he should
20 experience a decrease in his radiating pain. Can we agree on
21 that?

22 A Yes.

23 Q Okay. If plaintiff claims he still has radiating pain,
24 that would put him in the rare ten percent of the people that
25 did that not experience at least some decrease in his pain and

1 symptoms. Can we agree with that?

2 A Yes.

3 Q And, Doctor, most patients can return to work within
4 about two years after a fusion surgery; correct?

5 A Yeah. Depending upon the kind of work.

6 Q You testified on direct that your opinion as of
7 April 2025, so a year ago, was that plaintiff could return to
8 work in a light duty or sedentary-capacity; correct?

9 A Yes.

10 Q So when plaintiff's counsel asked you about your
11 findings on your reports that plaintiff is a hundred percent
12 disabled, you intended that to mean a hundred percent or fully
13 disabled from construction, heavy labor work. Can we agree on
14 that?

15 A Yes.

16 Q Not as to any work?

17 A Correct.

18 Q And so if plaintiff's claims he still cannot return to
19 work in any capacity, okay, that would also put him in the
20 minority of patients on whom you have performed cervical fusion.
21 Can we agree on that?

22 A Sure.

23 Q Doctor, in fact, the majority of such spinal fusion
24 patients recover well enough that they can perform most, if not
25 all, of their activities of daily living. Can we agree?

1 A Should be able to, yes.

2 Q So plaintiff claims that, to this day, he cannot
3 perform his daily activities, he would be in the minority of
4 most patients on whom you perform cervical fusion; correct?

5 A I would say it has to depend on the activity.

6 Q But activities of daily living, you would expect that
7 two-and-a-half years postsurgery, he would be able to go back to
8 his activities of daily living?

9 A In some way, yes.

10 Q You mentioned, by the way, that there could be wear and
11 tear on the adjacent levels of the cervical spine; correct?

12 A Yes.

13 Q To be clear, though, you are not saying that plaintiff
14 will have issues with the adjacent levels of his spine?

15 A Yes. Correct.

16 Q Doctor, are you familiar with a --

17 MR. FREIRE: You can turn it off.

18 Q Doctor, are you familiar with the concept of, Secondary
19 gain?

20 A Yes.

21 Q Individuals in litigation can exaggerate their symptoms
22 because of the prospects of financial gain. Is that true?

23 MR. STOLZMAN: Objection.

24 Q Have you ever heard of that?

25 THE COURT: I think it's self-evident that

1 sometimes people do that, so I don't know. Doctor, you can
2 answer the question.

3 A That's possible. Yes.

4 Q Doctor, a physician who continues to receive payment
5 for ongoing treatment of a patient, could also be susceptible to
6 secondary gain; couldn't he?

7 A I mean, physicians take care of patients and sometimes
8 we get paid and sometimes we don't get paid, so --

9 Q Did you get paid in this case?

10 A I don't know.

11 Q You don't have the billing records?

12 A I do not.

13 Q Along the lines of secondary gain, are you familiar
14 with the concept of, Symptom magnification?

15 A Yes.

16 Q And you use words that I think you have in the past;
17 Sometimes patients can make complaints that are not entirely in
18 line with everything that's going on. Would you agree with
19 that?

20 A Yes.

21 Q That's a polite way of saying, that symptom
22 magnification is when a person is exaggerating their symptoms;
23 correct?

24 A Yes.

25 Q Doctor, would you agree that if plaintiff is like most

1 of your patients after his surgeries, at this point,
2 two-and-a-half years since the last surgery, he should be
3 capable of returning to work in some capacity?

4 A Based on his -- based on his neck and back, yes.

5 Q I want to fast forward now to --

6 You know what, no -- can we bring up Merola 1.

7 And, Doctor, I'm going to go back now to the records
8 that you had from those visits before your surgery, before the
9 first surgery.

10 MR. FREIRE: And I'll have it marked as a separate
11 exhibit, if needed, your Honor, but I'm just going to show
12 it on the screen for now.

13 THE COURT: Okay.

14 Q I'll represent to you, Doctor, that what I did here was
15 copied and pasted?

16 MR. STOLZMAN: Hold on.

17 MR. FREIRE: Here you go.

18 Q From your -- from your reports that are in evidence, am
19 I correct that -- am I correct that I accurately copied and
20 pasted this section of your reports from May 28th, 2022, June
21 22nd, 2022, and August 8th, 2022?

22 A Yes.

23 Q Identical; correct?

24 A Yes.

25 Q Every single word?

1 A Sure.

2 Q Okay.

3 MR. FREIRE: Merola 2.

4 Q And, am I also correct that I accurately and fairly
5 copied and pasted the physical examination portion of each of
6 your reports from May, June and August of 2022 here?

7 A Yes.

8 Q And that it is identical, down to the word?

9 A Yes.

10 Q It is still your testimony that you individually and
11 contemporaneously at each visit dictated this exact verbiage
12 every time?

13 A Yes.

14 Q Okay.

15 MR. FREIRE: Merola three.

16 Q I am correct that I've fairly and accurately copied and
17 pasted this exact verbiage from each of those reports?

18 A Yes.

19 Q And notably here, Doctor, this is a portion of each
20 report that indicates that you on each and every occasion noted
21 some severe spasm?

22 A Yes.

23 Q And on each occasion, you noted the exact same
24 findings?

25 A Yes.

1 Q And dictated them exactly the same way?

2 A Correct.

3 MR. FREIRE: Merola 4.

4 Q Did I fairly and accurately copy and paste this portion
5 of each report as well?

6 A Yes.

7 Q So where you had the exact same positive compression
8 disc traction maneuver, a decrease pinprick, positive Hoffman's
9 sign, those were independent examination findings on each of
10 those dates?

11 A Yes.

12 Q And then you -- and you then dictated those
13 word-for-word identically on each occasion?

14 A Yes.

15 MR. FREIRE: Merola 5, please.

16 Q And lastly, this section of your report, on each and
17 every report, did I fairly and accurately copy and paste those
18 sections?

19 A Yes.

20 Q Identical, down to the word, yes?

21 A Yes.

22 Q So now if we could go to your first postoperative visit
23 after the, Cervical surgery.

24 THE COURT: Counsel, I want to take a brief recess
25 here.

1 MR. FREIRE: Sure. Of course. Thank you, your
2 Honor.

3 THE COURT: Members of the jury, don't discuss the
4 case. Please follow the officer.

5 THE COURT OFFICER: All rise. Jurors exiting.

6 (Whereupon, the jury is dismissed for a recess.)

7 THE COURT: Doctor, you may step down.

8 (Whereupon, the witness steps down from the witness stand.)

9 (Whereupon, a recess is taken.)

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

11 THE COURT OFFICER: Remain seated. Come to order.

12 THE COURT: Okay. We all set? Let's bring them
13 in, please.

14 THE COURT OFFICER: All rise. Jurors entering.

15 (Whereupon, the jury reenters the courtroom.)

16 THE COURT: Okay. Please, be seated everyone. Let
17 the record reflect that all jurors and alternates are
18 present and in their assigned seats. Doctor, you're
19 reminded you're still under oath. Please, continue.

20 MR. FREIRE: Thank you, your Honor.

21 Q Doctor, I want to show you the October 3rd, 2202. We
22 would agree, Doctor, that that's your first -- that was the
23 first visit following the cervical procedure; correct?

24 A Yes.

25 Q And feel free to look at your notes. We would agree

1 that there was, at that time, no mention of a kyphotic gait?

2 A Yes.

3 Q And kyphotic gait, again, is where the curvature is
4 forwarded instead of backwards as it should be?

5 A Yes.

6 Q And there was no mention of an antalgic gait, so, no
7 mention of any limping at that time; correct?

8 A Correct.

9 Q And I will direct your attention now, and we'll come
10 back to it later, but this physical examination component of the
11 October 3rd, 2022, those are notes you made contemporaneous with
12 that visit?

13 A Yes.

14 Q Now, I want to just fast forward to the October 13th,
15 lumbar procedure, page 45. As with the cervical procedure,
16 there are no intraoperative photos for that surgery; correct?

17 A Correct.

18 Q And -- but you would agree, Doctor, that compared to a
19 fusion, the lamin -- the decompression that you performed on
20 October 13th, 2023, is a -- it's a simpler procedure; correct?

21 A Yes.

22 Q Okay. And it's meant to remove pressure from the
23 nerves; right, in order to give the nerves an opportunity to
24 heal; correct?

25 A Yes.

1 Q And to give them more room; correct?

2 A Yes.

3 Q If we go to the -- your first postop visit -- I'm sorry
4 -- Mr. Avila's first postop visit with you after the lumbar
5 procedure, page 18. And, again, drawing your attention to that
6 physical examination part of the October 26th, 2023, record,
7 those are notes you made contemporaneous to the -- that visit --

8 A Yes.

9 Q -- on that day?

10 A Correct.

11 MR. FREIRE: So if we can pull up Merola post-note.

12 Q Did I fairly and accurately copy and paste the physical
13 examination and impression and plan sections from both those
14 reports, both your first -- the first postop visit after the
15 cervical procedure and the first postop visit after the lumbar
16 procedure?

17 A Yes.

18 Q You'd agree with me that the language is -- the
19 verbiage in those two reports, the two postop visit reports, are
20 identical; yes?

21 A Yes.

22 Q Word-for-word; correct?

23 A Yes.

24 Q Did you copy and paste that language?

25 A No.

1 Q And, Doctor, you testify about six times a year;
2 correct?

3 A Yes.

4 Q And for approximately the past 20 years, you have
5 testified exclusively on behalf of plaintiffs. True?

6 A Yes.

7 Q As far back as 2004, if I told you the six cases on
8 which you testified that year were all for -- on behalf of a
9 plaintiff, would you have reason to dispute that?

10 A No.

11 Q If I told you I found 59 cases since 2004, in which
12 you've testified on behalf of a plaintiff, would you have reason
13 to dispute that?

14 A No.

15 Q If I told you I was unable to find a single case in the
16 last 20 years where you testified on behalf of a defendant,
17 would you dispute that?

18 A No.

19 Q For those cases, Doctor, you typically are compensated
20 \$750 an hour for your time away from your practice to testify;
21 correct?

22 A Yes.

23 Q That includes; reviewing records, meeting with
24 attorneys and travel time; correct?

25 A Yes.

1 Q And, on average, you charge about \$7,500 per case when
2 you appear in Court to testify -- when you appear in Court to
3 testify; correct?

4 A Yeah. I guess it depends on how much time I'm spending
5 in court.

6 Q Average; six to ten hours a case, yes?

7 A Yeah. I mean, sometimes more, sometimes less.

8 Q And you testify about six times a year, yes?

9 A Yes.

10 Q For the last 30 years, yes?

11 A Sure.

12 Q Rough math: \$7500, by six cases a year, equals \$45,000
13 a year, times 30 years, that's roughly \$1.35-million on those
14 cases on which you've testified on behalf of plaintiffs
15 exclusively. Am I correct on that math, more or less?

16 A Okay.

17 Q In addition to the cases where -- in which you've
18 testified in Court, you also have patients who have litigation
19 claims for which you write a narrative report; correct?

20 A Yes.

21 Q You wrote a narrative report in this case?

22 A Yes.

23 Q And you write narrative reports on cases that sometimes
24 don't get up going to trial; correct?

25 A Yes.

1 Q And for those cases, you charge \$750 to \$1,100 for each
2 of those reports; correct?

3 A Yes.

4 MR. STOLZMAN: Your Honor, may I approach?

5 THE COURT: Yes.

6 (Whereupon, there is an off-the-record discussion
7 held at the bench between the Court, Mr. Stolzman, Mr.
8 Freire and Ms. Scibetta.)

9 THE COURT: Please, continue.

10 MR. FREIRE: Thank you, Judge.

11 Q So as I was saying -- saying, Doctor, that you charge
12 about -- anywhere from \$750 to \$1,100 for each of those
13 narrative reports; correct?

14 A Yes.

15 Q So that's, conservatively, at least another
16 couple-of-hundred-thousand dollars in reports that you have
17 drafted throughout your career for patients with a court case.
18 Can we agree on that?

19 A Sure.

20 Q So when we speak of secondary gain, Doctor, can we
21 agree that a doctor who receives referrals involved in
22 litigation which generates, literally, millions of dollars in
23 fees can have a secondary gain?

24 MR. STOLZMAN: Objection, Judge. May we approach,
25 your Honor?

1 (Whereupon, there is an off-the-record discussion
2 held at the bench between the Court, Mr. Stolzman, Mr.
3 Freire and Ms. Scibetta.)

4 THE COURT: Read the question back.

5 (Whereupon, the requested testimony was read back.)

6 MR. FREIRE: I'll withdraw that.

7 Q Doctor, you are not, however, being compensated for
8 your time today, are you?

9 A No, I'm not.

10 Q Doctor, you've been appearing, half-a-dozen-times a
11 year, for 30 years, charging for your time, for all of these
12 cases, to the tune of well over a million dollars, but, today,
13 you had to be subpoenaed to testify; correct?

14 A Yes.

15 Q And you're not being compensated for your time today;
16 correct?

17 A Correct.

18 Q Just one month ago, you appeared on a case entitled,
19 Paiba, in Queens County, isn't that true?

20 A Yes.

21 Q In that case, your patient was referred by a pain
22 management specialist as well; right?

23 A Yes.

24 MR. STOLZMAN: Your Honor?

25 THE COURT: Come on up.

1 (Whereupon, there is an off-the-record discussion
2 held at the bench between the Court, Mr. Stolzman, Mr.
3 Freire and Ms. Scibetta.)

4 Q Doctor, you have had patients who had claims where they
5 were represented by plaintiff's counsel of record in this case,
6 William Schwitzer's office; correct?

7 A Yes.

8 Q In fact, the case that you appeared on last month in
9 Queens County, the Paiba case, that patient was a client of the
10 Schwitzer law firm?

11 A Yes.

12 Q And in that case, Doctor, you also had to be subpoenaed
13 to testify; correct?

14 A Yes.

15 Q So why is it that suddenly you've had to have a
16 subpoena to testify --

17 MR. STOLZMAN: Objection.

18 THE COURT: Why don't you come up?

19 MR. FREIRE: I'll withdraw it.

20 MR. STOLZMAN: Your Honor, may I approach?

21 MR. FREIRE: I withdrew it.

22 MR. STOLZMAN: Your Honor, I'd like to approach.

23 THE COURT: Come on up. Come on up.

24 (Whereupon, there is an off-the-record discussion
25 held at the bench between the Court, Mr. Stolzman, Mr.

1 Freire and Ms. Scibetta.)

2 THE COURT: Read back the question, Michael.

3 (Whereupon, the requested testimony is read back.)

4 THE COURT: Sustained. Members of the jury, you
5 heard a partial question. I'm going to ask you to fully
6 disregard it. Okay. Just like I said, it's the question
7 and the answer that is the evidence. If it's not the
8 question or a part of a question is not evidence, so just
9 put it out of your minds. Disregard it, please. Go ahead.

10 Q My last question, Doctor: Several of your patients
11 throughout your career have been referred by plaintiff's law
12 firms; correct?

13 A Yes.

14 MR. FREIRE: Nothing further. Thank you.

15 THE COURT: Redirect?

16 MR. STOLZMAN: Thank you, Dr. Merola. May it
17 please the Court.

18 THE COURT: Sure.

19 RE-DIRECT EXAMINATION

20 BY MR. STOLZMAN:

21 Q Dr. Merola, on cross-examination, you were asked some
22 questions by the Osborn's attorney, similar questions to what
23 they asked Dr. Lerner regarding the investigation, if any, that
24 you do when you first meet a patient.

25 Doctor, if a patient presents with and gives you a

1 history, do you need a police report or any other records in
2 order to give them the treatment that they need as it relates to
3 how the injury happened?

4 A No.

5 Q And why is that?

6 A I mean, you're taking -- you're taking care of a
7 patient. You know, you're seeing and dealing with another
8 person. And so you're interviewing that person and you're
9 taking them at their word.

10 Q And would that be the same thing for when you take
11 their history; correct?

12 A Sure.

13 Q When you took Mr. Avila's history, did you have a
14 translator in the room?

15 A No.

16 Q How were you able to communicate with him?

17 A Spanish.

18 Q You speak Spanish, Doctor?

19 A Yes.

20 Q Okay. And what about -- you were asked on cross by the
21 Osborn's attorney about taking photographs of your patient when
22 they present. Is that part of your practice?

23 A No.

24 Q And why not?

25 A I'm -- I mean, we're focussing on taking care of the

1 patient an doing an examination, but we're not taking
2 photographs or doing any of that stuff. That would interfere
3 with what you're trying to accomplish as a doctor.

4 Q And would there be anything to take a photograph of?

5 A You know, I mean, plastic surgeons take photographs all
6 the time, because they want the before and after. Not the same
7 in orthopedic spine surgery.

8 Q Fair to say that MRI is the only -- or MRI and CT
9 scans, those are the images that matter most as opposed to an
10 exterior image?

11 A Well, yeah, that and your physical exam as well.

12 Q With respect to the finding of the herniation of the --
13 Mr. Avila C5/C6 disc, you indicated in your operative report --

14 MR. STOLZMAN: If you don't mind, your Honor, I'll
15 just hold it to keep things moving.

16 THE COURT: Go ahead.

17 Q Pathological specimen sent disc herniation. Can you
18 explain to the jury what that means?

19 A Just the stuff that you're taking out, you're sending
20 it to pathology.

21 Q And you were asked questions by the Osborn's attorney
22 as to taking photographs or images while you're doing the
23 surgery of the inside of the plaintiff's body. You told this
24 jury that you can't do that. Why is that?

25 A Yeah. We typically don't do that. We -- we're taking

1 x-rays because if we're doing a -- well, a couple of reasons.
2 Number one, when you're operating on a spine, you want to make
3 sure you're at the right level, so the only way to know that is
4 to take an x-ray.

5 I mean, a picture wouldn't tell that you, because
6 pretty much they all look like the same level, so you need to
7 take an x-ray to know where you are. And that's why we use
8 x-rays, and not photographs.

9 Q And what about a picture or in any sort of image of the
10 disc itself?

11 A Yes, so this procedure is done with loop magnification
12 and a headlight; right, so there's -- we don't have any cameras
13 attached to our loops or our headlights.

14 Q And when you say, The x-rays, that's to find the proper
15 vertebrae; correct?

16 A Yes. It's to make sure that you're at the correct
17 level, so you're always doing a level verification with an x-ray
18 intraoperatively. And then the other thing you're doing is
19 you're putting implants in, you want to make sure you placed the
20 implants appropriately, so you take an image of that, so those
21 are the two main reasons that you're doing an intraoperative
22 x-ray or a fluoroscopy.

23 Q You were asked questions again on cross by the Osborn's
24 attorney regarding if it was a successful surgery. Fair to say,
25 that a successful surgery, your patient can still have symptoms

1 after a successful surgery?

2 A Yes.

3 Q And you were also asked questions about if his pain had
4 decreased or not?

5 A Yes.

6 Q Does, Decrease, mean gone?

7 A No. It means, less.

8 Q It means, Less; right?

9 A Sure.

10 Q Okay. And when you talked about being able to do
11 certain -- well, the activities of daily life, ADLs; right?

12 A Sure.

13 Q Being able to, does that mean, Without pain?

14 A Not necessarily. No.

15 Q And is that what you meant when you said, In some way?

16 A Sure.

17 Q Osborn's counsel showed you some records -- some of
18 your notes after the lumbar procedure, which indicated that he
19 was -- that Mr. Avila was set to come back every eight to
20 12 months, if you recall. Every eight to 12 weeks -- strike
21 that.

22 A Sure.

23 Q Isn't it true that, in fact, Mr. Avila did exactly
24 that? He came back every eight to 12 weeks as we went over,
25 when we talked about the visits?

1 MR. FREIRE: Objection. Beyond the scope.

2 THE COURT: I'll allow that.

3 A Yes.

4 Q You were asked questions by Osborn's counsel regarding
5 -- that you've testified on behalf of plaintiffs. Were those
6 plaintiffs your patients or somebody else's?

7 A Patients.

8 Q You were also asked by counsel about using the pain
9 scale nine out of ten. That you indicated or that Mr. Avila
10 indicated to you when he came to see that you first time and for
11 the visits thereafter.

12 Doctor, is that nine out of ten that the plaintiff told
13 you, consistent with the incident that he experienced with the
14 fall, the diagnostic testing that you did with respect to the
15 objective testing, as well as the MRI and the EMGs that you
16 reviewed in order to do your exams?

17 A Yes.

18 Q And, again, you were asked by degeneration on
19 cross-examination by the Osborn. And I just want to ask again:
20 Doctor, the symptoms that -- and the diagnostic testing that we
21 talked about, the EMGs, MRIs, as well as the symptoms, and the
22 testing that you did when you examined the plaintiff. All of
23 those positive signs, was that, in your opinion, from
24 degeneration or from the fall?

25 A From the fall.

1 Q With respect to your language being the same each time,
2 Doctor, why is that with these various records that you've been
3 shown?

4 A When you've been doing this for 36 years, you're doing
5 things and it's also makes me safer when you do the same thing,
6 the same way, every time, and there's no variation. If there's
7 any variation in what you're doing, when you alter the way
8 you're doing things, that's when you have a tendency to make
9 mistakes, so 36 years of doing it, my verbiage is oftentimes,
10 pretty close or spot on.

11 Plus, I'm also looking at the previous notes to see
12 whether or not there are any changes from my prior notes. And
13 if I said something efficiently, accurately and appropriately,
14 there's no reason to really change the way I've said it.

15 Q Is that to say that, Doctor, that as you do an exam,
16 you keep in mind the prior examination that you did as well?

17 A Sure. You have your -- I mean, you have to -- you're
18 comparing one exam from another and you want to see whether or
19 not the exam is the same, better or different. And if you look
20 at the postoperative stuff, as time went on, things actually got
21 better.

22 MR. STOLZMAN: Thank you, Doctor.

23 MR. FREIRE: Very briefly, Judge.

24 THE COURT: Only something that he's gone over the
25 first time.

1 MR. FREIRE: Yes. Of course.

2 RE-CROSS EXAMINATION

3 MR. FREIRE:

4 Q Doctor, I wasn't meaning to suggest that you need a
5 police report to treat a patient, but we would agree that when
6 it comes to making a causation determination, in this case, you
7 took the patient, Mr. Avila, at his word regarding how the
8 incident occurred; correct?

9 A Yes.

10 Q And that informed you, in part, that was part of the
11 puzzle before you made a causation determination; correct?

12 A Yes.

13 Q The history of the accident, the mechanism of the fall,
14 that comes exclusively from the patient; correct?

15 A Yes.

16 Q The pathology that plaintiff's counsel just mentioned
17 of a disc herniation, we agree that that refers to just the disc
18 material; correct?

19 A Yes.

20 Q The actual herniation would have been something that,
21 as you put in your operative report, you visualize during the
22 surgery?

23 A Yes.

24 Q The pathology that comes out of it, the specimen that
25 you then submit, that's just the actual disc material; correct?

1 A Yes.

2 Q And in terms of your verbiage being pretty close, as
3 you just mentioned, we can agree it's more than press close;
4 right?

5 A Well, those examinations were the same. Yes.

6 Q So when you say, Pretty close, you mean identical;
7 correct?

8 A Yes.

9 MR. FREIRE: Thank you. Nothing further.

10 THE COURT: All right. Let me see counsel at the
11 bench, please.

12 (Whereupon, there is an off-the-record discussion
13 held at the bench between the Court, Mr. Stolzman, Mr.
14 Freire and Ms. Scibetta.)

15 THE COURT: Okay. So, Doctor, you can step down.
16 Thank you.

17 THE WITNESS: Okay.

18 (Whereupon, the witness steps down from the witness stand.)

19 THE COURT: Okay, so here's what we're going to do;
20 you're done for the day. Because of some scheduling
21 situation, instead of coming in at 9:30 tomorrow, come in at
22 1:30. And we will finish with the witness tomorrow who's
23 going to be here at 1:30. All right. And then you'll be
24 off Thursday, and then back Friday. We'll tell you what
25 time on Friday to be here. Okay, but that's, essentially,

1 it. Okay.

2 So do not discuss this case with each other or
3 anyone else, including, family or friends.

4 Do not speak to anyone or permit anyone else to
5 speak with you regarding this case.

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

9 Do not use internet websites or any other source to
10 research the case. Do not visit any of the locations
11 pertaining to the case.

12 When you return to Court, report to the location to
13 which you've been instructed to by the officer.

14 Do not speak with any of the parties in this case.
15 They've been directed not to speak with you.

16 Do not form or express an opinion or come to any
17 conclusion as to the facts of this case during the course of
18 the trial.

19 Wait until the entire case has been submitted to
20 you by the Court.

21 So see you tomorrow at 1:30.

22 Have a nice evening. Just follow the officer,
23 please.

24 THE COURT OFFICER: All rise.

25 Jurors exiting.

1 (Whereupon, the jury is dismissed for the day.)

2 THE COURT: So I'll see you folks here at 1:00.

3 Anything anyone wants to put on the record? No. All right.

4 (Whereupon, the trial is concluded for the day and
5 is set to resume tomorrow, Wednesday, April 29th, 2026, at
6 1:30 p.m.)

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