2003 WL 25551723 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Ethan RUBY, Plaintiff,
v.
BUDGET RENT-A-CAR CORPORATION, Budget Rent-A-Car Systems, Inc., NYRAC, Inc., d/b/a Budget Rent-A-Car, and Hector Enrique Carias-Clavarria, Defendants.

No. 103786/01.
December 8, 2003.

(Transcript of Dr. Edwin Richter)

Case Type: Negligent Hiring & Supervision >> Negligent Entrustment
Case Type: Vehicle Negligence >> Crosswalk
Case Type: Vehicle Negligence >> Pedestrian
Jurisdiction: New York County, New York
Name of Expert: Dr. Edwin Richter
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine

Representing: Unknown

Appearances.

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Honorable Milton A. Tingling Justice.

60 Centre Street

New York, New York 10007

David Teich RPR

Official Court Reporter.

THE COURT: I let Ms. Brenner go Friday afternoon. The jury doesn't know. They're still looking for her, so I'm going to tell them she's gone.

MR. SCHWAB: Since I'll be calling Dr. Richter, and I understand that plaintiff has rested, but hasn't rested because there's still the open issue of resolving the damages on the matter, okay? I would like to reserve my right of making a motion addressed to the plaintiff's entire case until such time as we have rested all sides and make a motion at that time, if you will, nunc pro tunc, so to speak, so that the record is properly protected because there are some motions that I would like to make at an appropriate time when all sides have rested.

THE COURT: Any objections, Counselor?

MR. MOLLER: Nope.

THE COURT: Fine. The application is granted.

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: All right. Jury satisfactory?

MR. MOLLER: Yes, your Honor.

MR. SCHWAB: Yes, your Honor.

THE COURT: I'm going to solve the mystery for you. You are of course wondering why there are now two empty seats and we're beginning the trial.

Friday afternoon, after the rest of you had left, I met with Ms. Brenner, and I have dismissed her from the jury. The reason for her dismissal are not relevant to this trial.

There is one thing that I must caution all of you about, and that is I am directing that until the end of the deliberations, that I don't know if you were planning to, or if -- well, let's just say, I don't know if you were planning to, but you may have no contact with Ms. Brenner, okay? Afterwards, that's fine. You can meet for a drink, go out, party, meet her at the club, that's fine. But until then, thank you.

And with that, Mr. Schwab.

MR. SCHWAB: Yes, your Honor.

We call as our next witness Dr. Richter.

(whereupon, the witness takes the stand.)

COURT OFFICER: Please raise your right hand.

DR. EDWIN RICHTER,

A witness called on behalf of the Defendant, after being duly sworn in by the clerk of the court, testifies as follows:

COURT OFFICER: You may be seated.

In a loud, clear voice, can you please state your name and address for the record?

THE WITNESS: Dr. Edwin Richter, 400 East 34th Street, New York, New York.

COURT OFFICER: Spell your last name.

THE WITNESS: R-I-C-H-T-E-R.

DIRECT EXAMINATION

BY MR. SCHWAB:

Q Try to keep your voice up. It sounds pretty good there. Acoustics are very poor in this courtroom.

A I'll try.

Q The address you give, 400 East 34th Street, what medical facility is located there?

A That's the Rusk Institute of Rehabilitation Medicine. It's the rehabilitation institute of New York University School of Medicine and NYU Medical Center.

Q And what positions do you occupy at Rusk?

A I have several positions there. I'm the associate clinical director. That's an administrative position. I'm also the chief of service of the first floor service, so I supervise a number of other doctors. I am the doctor of the adult spasticity clinic, so I run a clinic where we treat a medical problem called spasticity.

And I also serve on the teaching faculty. I'm a clinical associate professor of rehabilitation medicine, so I do teaching of residents and students, as well as other doctors who are already in practice.

And I also work with the chronic pain laboratory as an associate director.

Q Would you tell the jury your educational background, please.

A Starting with college, that was at Harvard, I graduated in 1983 with honors with the degree in biology.

I then went to NYU Medical School, graduating in 1987. After that, I started postgraduate training. The first year was an internship at Tisch Hospital and Bellevue Hospital doing internal medicine, neurology, neurosurgery and orthopedics.

I then did three years within my field itself of physical medicine and rehabilitation. That consisted of three years of training in that field, with rotation at Rusk Institute, Tisch Hospital, Bellevue, the Manhattan VA Hospital, the Hospital for Joint Diseases, and Goldwater Hospital.

Q Would you tell us what professional societies or organizations you are a member of?

A I'm a member of several organizations: The American Medical Association, the American Academy of Physical Medicine and Rehabilitation, the Association of Academic Physiatrists -- another word for my specialty -- the New York Pain Society, the Brain Injury ??ciety, and several others.

Q And how does one become a member of the American Academy of Physical Medicine and Rehabilitation?

A In order to become a full member, one has to become board-certified. That's a process where, when you do the residency, the three years of training that I spoke of earlier, in the last year is the first time you're eligible to take a written test.

And if you pass that test successfully, as I did, you then have to practice in the field for at least one year and get recommendations from two people who themselves are board-certified.

After getting those recommendations, you can take an oral exam. If you pass that, as I did, the following year, when first eligible, you then are considered to become a diplomats of the board, or in other words, you're considered board-certified. Once you're board-certified, you can become a full member fellow of the academy.

Q And Dr. Richter, does your -- so the word “physiatrist,” are you then a board-certified physiatrist? Is that another way of --

A Yes, I am.

Q Okay -- describing your position?

A Yes.

Q Have you authored papers dealing with rehabilitation medicine?

A Yes, I have. I've authored over 40 papers. I've also written three textbook chapters, and I'm currently editing the latest edition of a textbook called “Medical Aspects of Disability.”

Q Have you given presentations on the subject area of rehabilitation medicine dealing with severely injured persons?

A Yes. I've given hundreds of presentations. Some of these are at our own academic facilities or at other medical centers, where I'm often invited to speak.

I've also given lectures and presentations at national and international meetings, both within my field, as well as in other fields, such as orthopedics or occupational therapy.

Q And Dr. Richter, have there been occasions when you have testified in court?

A Yes.

Q Could you tell the jury about how many times have you been called to testify in court?

A About 40 times.

Q All right. And will you tell us to what extent those are cases on behalf of persons who are bringing a lawsuit, and to what extent cases or matters on behalf of people who are being sued?

A I would say about two-thirds to three-quarters of the time I'm testifying on behalf of a person who's bringing a lawsuit, typically one of my patients who happens to be involve in a lawsuit.

On one occasion I was called as an expert witness by the district attorney of Staten Island to serve as an expert.

And the remainder of the times that I have testified will be testifying on behalf of defendants in lawsuits.

Q To what extent does -- do litigation matters you can tell us percent-wise constitute your overall work frame of life?

A I'd say it's less than 5 percent of my typical work week.

Q And the law firm on Park Row is Lester, Schwab, Katz, Dwyer. Can you tell us, have you been retained on any other cases by my law firm, and if so, how many other cases?

A By my recollection, I was retained directly by your law firm on one occasion, and then another occasion I was retained by a different firm, but you were also involved in the case.

Q Dr. Richter, would you tell us the extent of your involvement with spinal cord injury -- I think that's called SCI -- spinal cord injury patients and individuals?

MR. HOLLER: Objection. Just too broad.

THE COURT: Overruled.

A Yes. With spinal cord injury, which is indeed abbreviated SCI, I am very involved with that. That's one of the major activities within my field.

We sometimes define ourselves as doctors who treat disabling condi??ns, and we sometimes use a term, neuro-musculoskeletal system, because a lot of patients we treat have problems with nerves, muscles or their skeletons.

Specifically, spinal cord injury is an area where I've treated a lot of patients. I've treated, in my practice, hundreds of patients with spinal cord injury, at various stages from patients who I see in the acute care hospital to patients who I would take care of under my own service in the Rusk Institute, patients who I see in follow-up in my office.

I also formerly worked in a clinic at Bellevue part-time, and I saw a lot of spinal cord injured patients there at various stages of their recovery.

And in my spasticity clinic, I see a large number of spinal cord injured patients specifically for their problems with spasticity.

Q Two terms: You talk about seeing spinal cord injury persons in acute care. What does the term acute care” mean in layman's terms?

A Acute care is, as I was using it there, refers to people in the regular hospital, the hospitals where I spend most of my time. Rusk is a rehab hospital, but we're physically attached in our case to Tisch Hospital, which is an acute care hospital where someone might be brought in by an ambulance for treatment of an injury.

Q You talked about a spasticity clinic. The individuals you see in the spasticity clinic, what is their primary disability?

A Well, they have -- they share a problem of what we call spasticity. Spasticity refers to hyperactive reflexes. In particular, there's what we call a velocity-dependent stretch reflex, so that if a joint is moved suddenly, there is a reflex that tries to oppose that sudden motion.

Now, in this case (demonstrating), I voluntarily moved my arm quickly, and since my brain and spinal cord are intact, I can tell that reflex to be S quiet so it doesn't interfere with my ability to make this motion.

If you have a loss of connection of some of these controlling signals from the brain that run down through the spinal cord to the nerves and muscles of the arms and legs, you can get reflexes that are not controlled and can be hyperactive, so people can get an involuntary motion.

They may get a contraction like this. They may get a sustained beating motion, which we call clonus, and they may have difficulty, for example, being positioned in a wheelchair or difficulty with their arms or legs moving on their own without the control of the person who has the condition. That condition we call spasticity.

The patient may have this because of a spinal cord injury or a stroke or a head injury. But in this particular case, the problem of spasticity is common to all those different types of patient.

Q Your clinic addresses that condition?

A Yes.

Q Dr. Richter, would you tell us when it was that you were retained by my law firm to evaluate the situation of Ethan Ruby?

A I was asked to do a few things. One was to review a variety of medical records, some prior to my examination of him and then some that became available later. I was asked to review some videotapes. And I was asked to conduct an examination and prepare a report based on that.

Q And did you also do an analysis of a life care plan submitted by a person by the name of Mona Yudkoff on behalf of the plaintiff?

A Yes, I did.

Q So would you tell us first of all, Doctor, without talking about the contents, just -- withdrawn.

When were you initially retained in this regard?

A I was retained in the spring of 2002.

Q All right. And would you tell us, Doctor, speaking now -- and by the way, you authored two reports is that correct, sir?

A That's correct.

Q And just so the jury has a timeframe, would you give us the dates of those reports, not the contents but the dates?

A The first was May 2, 2002. The second was June 23, 2002.

Q And would you tell us for purposes of those reports what records -- not the contents yet -- but what records did you review?

A Records of Bellevue Hospital; Burke Rehabilitation Hospital; office records of a Dr. Govonlu; out-patient records of Mt. Sinai Hospital, including Dr. David Thomas; a neurology report from the University of Miami by Dr. Martinez-Arizala; also report of Dr. Vapnek, a report of Dr. Bar-Chama; a report of Dr. Koslow; report and records of Dr. Riccobono; the life care plan by Ms. Yudkoff.

Those were at the time the main records. And then, as additional records became available later on, I saw some additional records from some of those same doctors.

Q And did there come a time that you reviewed certain transcripts of the testimony of Ethan Ruby?

A Yes, I did.

Q Also, earlier this morning did I show you certain more recent reports of a Dr. Vapnek, and I think of a Dr. Fried?

A Yes.

Q Now, would you tell us what the basic contents were of the records of Ethan Ruby at Bellevue Hospital? That would be his initial admission, obviously.

A Yes.

MR. MOLLER: Objection. Question is too broad, non-specific. The records are in evidence.

MR. SCHWAB: Withdraw the question and rephrase it.

Q were there certain items or -- withdrawn.

Did the records at Bellevue Hospital establish certain events taking place that you considered to be of significance?

A Yes.

Q And what were they, please?

A Well, Mr. Ruby's status post-pedestrian motor vehicle accident on November 29.

He had a variety of injuries that were documented: Pneumothoraces, or dropped lung; T6 fracture dislocation with complete paraplegia was the most important diagnosis; and he was documented as undergoing fusion from T2 to T10 with hard -- called CD rods, and also with a piece of bone from his iliac crest.

He also had some treatment for urinary tract infections and suspected pulmonary embolism. Those would be among the important facts that are documented.

Q And with regard to Burke, were there particular items in the records of Burke that you consider to be of significance?

A Yes.

Q With regard to his rehabilitation?

A Yes.

Q What were they, sir?

A In particular, the chief concern was the frequent documentation of a lack of cooperation, failure to follow advice of the rehabilitation professional there, refusing a blood drawing, being later missing therapies, refusing to learn a bowel regimen that they were trying to teach him, refusing to accept psychiatric intervention, delayed acceptance of psychological services.

There was documentation by the treating physician of the party's mother not providing enough autonomy and some conflicts in that regard.

Resistance to accepting referral for home visiting nursing office was a matter of certain.

Another matter of concern was a burn occurred while the patient was there while a heating pad was being applied for what was described as musculoskeletal pain, although this was at a level where the patient, by virtue of his diagnosis, should not have feeling and was later documented to not feel pain from the burn itself. And at times, wound care was refused relative to that burn injury.

Another area of concern was erectile dysfunction, the inability to have erection. He had documented consideration of using injection therapy to see if that would work, but that had to be delayed because he was taking a blood thinner, Coumadin, to prevent blood clots.

On the other hand, pain management did not seem to be documented as a major issue.

And I reviewed the discharge summary by Dr. David, which summarizes concerns about some of the matters I just spoke about and concerns about mood and adjustment issues.

Q Tell us, with regard to the review of the Mt. Sinai out-patient records, what did you find there to be of particular interest to you?

A There's a documentation from the initial visit with Dr. Thom ?? of abdominal discomfort, that at the time he wrote, “May be functional.”

An upper GI series -- that's swallowing some barium and taking an X-Ray -- raised a question of small pre-pyloric ulcer, small ulcer in the stomach -- with manual disimpaction. The patient needs to put his finger in his rectum to remove stool. That was documented as being needed on several visits in the category of bowel management, although, at least on the September 6 visit, no accident was documented by Dr. Thomas.

Use of intermittent catheterization, putting a catheter in and out to remove bladder wastes.

Documented a lack of response to Caverject. That was the injection to try and help achieve an erection, was documented.

A recurrence of a deep vein thrombosis, a blood clot in the leg, was documented that required a period of restarting Coumadin, the blood thinner.

Dr. Thomas had started Wellbutrin, an antidepressant, which was discontinued by the patient.

An MRI of the spinal cord was very interesting and showing a thin appearance of the cord below the level of the injury.

Bone density was found to be normal.

He also made a note of some unilateral gynecomastia, enlargement of the male breast on one side, which would be of course important, although I don't see it as being connected to the accident.

Q Let me ask you some questions about a couple of items you reference there.

You refer to a record of Dr. David Thomas indicating abdominal discomfort may be functional.

What does the medical term “may be functional” mean in layman's terms?

A In this context, “functional” does not mean what we use it for in everyday English. It would refer that it might not be based on an abnormality of the stomach itself, that there might not be a physical basis for it, that it might be related to something else, like an emotional basis.

Q And you spoke about no accidents being documented on a September 6th visit. September -- can you tell us of what year that September 6th visit was, where it indicated no accidents?

A 2001.

Q All right. You also referenced to some finding in those records that bone density was normal. There's a term that's been used in this case, I think at least one or two occasions, but maybe by Mr. Ruby, of osteoporosis. Are you familiar with that term?

A Yes, I am.

Q What is osteoporosis, and does bone density have any correlation to osteoporosis?

A Yes, it does. Osteoporosis means having less than normal -- I should say significantly less than normal bone density.

It is a concern in people with spinal cord injuries that over time, because they may not be standing and bearing weight on all of their bones, that they may develop some osteoporosis in some of the bones below the level of their injury.

Q And bone density being normal means?

A If someone has normal bone density, by definition they do not have osteoporosis.

Q Now, did you take a history from Mr. Ruby himself prior to the examination you performed on him?

A Yes, I did.

Q And would you tell us, was there any limitation placed upon you with regard to getting a history from the patient?

A Yes, there was.

Q What was that limitation?

A His attorney had accompanied him to the exam and indicated that we could not ask questions about items that had already been covered in a previous deposition, which I believe had been done in December of the previous year. And therefore we focused primarily on what might have changed in terms of symptoms since that time.

Q So, would you tell us then, if you would -- and feel free to refer to your notes and records if you need to -- what history did you obtain from Mr. Ruby on the day that you conducted his physical examination?

A He indicated that he's right-handed. His baseline height was five-foot-11 and he weighed 170 pounds.

He reported a chief complaint of constant stomach pain as being his worst pain, although he also had some frequent back pain, the back pain being a few times a week; the stomach being every day.

He said eating specifically more than, say, half a sandwich at a time aggravated his stomach pain. Lying down sometimes helped it. Percocet, a pain medication, helped some, but it also could increase his constipation.

He had been up to 3800 milligrams of a drug called Neurontin. He felt that had not helped and that he had stopped it and said he felt less tired since being off the Neurontin.

He had at that point still deferred having a colonoscopy because he anticipated he would have a lot of diarrhea associated with the preparation, the cleaning-out of the bowels for that procedure.

At the time he was --

Q Just stop you right there.

In a colonoscopy, whether you be a spinal cord injury patient or not, is there diarrhea associated in that sense with having a colonoscopy?

MR. MOLLER: Objection.

THE COURT: It's a good question. Overruled.

You can answer that.

A By nature of the preparation, when people are given laxative by mouth and typically an enema below, as well, it is essentially cleaning out the stool, so there would be some diarrhea for the average person.

Q Would you continue with your -- anything further that Mr. Ruby told you by way of history?

A Yes. He said he was doing the manual stimulation, putting a finger in his rectum to help him remove stool, but that he, despite that, was having bowel incontinence.

He said he catheterizes himself for removal of urine every four hours but says he's constantly or frequently wet in between the catheterizations.

MR. MOLLER: I object. It appears the doctor is simply reading a report. There's no evidence yet that the doctor doesn't recall. If he has to read a report, I'd like that necessity identified,

THE COURT: All right. I'm going to overrule that objection. However, I'm going to sustain your other one.

MR. MOLLER: The one I didn't make?

THE COURT: Yes. I'm going to sustain that objection in that Mr. Schwab, please, if you're going to do this, where is the relevance? Let's get to something. Basically, we're hearing what we've already heard.

MR. SCHWAB: Well, this is part of the examination that goes into -- I think we should approach the sidebar, your Honor. I'm making a speech in front the jury.

THE COURT: No problem.

(Discussion at Bench off the Record.)

Q Dr. Richter, I'm going try to tailor some of my questions to specific aspects of your examination and findings of that examination, okay?

Did you take a history of Mr. Ruby as to whether he had any skin ulcers?

A Yes, I did.

Q What did he tell you as regards skin ulcers?

A He ??ad no skin ulcers.

Q Did Mr. Ruby as of this time -- by the way, the actual date of your exam was when?

A April 26, 2002.

Q Okay. Now, on April 26, 2002, did Mr. Ruby tell you the manner in which he was able to transfer from a wheelchair to some other object, such as a bed or an automobile seat?

A Yes. He was doing at that time what we call a popover transfer.

Q And what is a popover transfer that he ind a??ted he was able to do at that time?

That relies on the ability of a person to push down with their arms When you push down with your arms, you can boost your body up off the seat and pop yourself over to the other chair that you're going to.

He had previously used a sliding board, which involves putting a smooth board, a special piece of equipment, between the two seats and sliding over, but he was not doing the popover transfer.

Q Did Mr. Ruby tell you what he was doing by way of employment at that time?

A Yes. He was working as a day trader and helping to manage a firm relating to day trading.

Q Did Mr. Ruby tell you what medications he was then taking in April of 2002?

A Yes.

Q What were they?

A His medications at that time were Coumadin, which is a blood thinner; heparin, which is a drug to help keep the urine clean; a multiple vitamin, calcium; Senakot, which is a bowel ??cine to promote bowel movements; Colace, which is a stool softener; Ultraject, which is a combination of two drugs; Ultram, which is a mild pain killer combined with acetaminophen, which is Tylenol; and occasionally Percocet, which is a combination of Tylenol with a different painkiller, a narcotic called Oxycodone.

Q Did you make any observations regarding the wheelchair that Mr. Ruby was using at the time of your examination?

A Yes, I did.

Q Tell us what observations you made regarding his wheelchair.

A This is what we might call a performance wheelchair. Wheelchairs come in various shapes and sizes, and some of the smaller wheelchairs are designed to be very lightweight and very maneuverable.

This type of wheelchair such as he had has somewhat less hardware, doesn't have the raised side rails some of the other chairs do, doesn't have the high backrest that some of the other chairs do.

It's more what we might call a low profile chair, which is something that is lighter and more maneuverable and certainly faster.

Q Faster?

A Yes. Implying, when a given person propels a chair, you or I might propel a chair at different speeds, but for a given person propelling different types of wheelchairs, that type of chair which is lightweight and maneuverable, the person can get better speed.

Q Just going to show you a picture here. Just going to show you this photograph, Exhibit Z in evidence.

Have you ever seen this photograph before?

A I believe I've seen it, yes.

Q Ethan Ruby is the young man with the sunglasses.

A Yes.

Q In a wheelchair. Can you tell from what you see of that wheelchair whether that's the same wheelchair or the same type as the one when he was in your office?

A It certainly looks similar.

Q Okay. That doesn't have any -- appear to have any --

MR. MOLLER: Objection.

Q Withdrawn. Does this wheelchair in this photograph, as you see it, have any raised arms on it?

A Not that I can see, no.

Q Now, can one have a performance wheelchair with some sort of raised arms to give one better support or stability?

MR. MOLLER: Objection.

Q Is that available?

MR. MOLLER: Objection.

THE COURT: Overruled.

A Yes. There are many different types of wheelchairs along the spectrum, and one can have a wheelchair which is lightweight and maneuverable which could have either armrests or a somewhat higher back. So one can compromise a little bit, perhaps, to get a little bit more weight but to get more stability.

Q And with regard to armrests, are those, if one wants to trans -- if one has a wheelchair with armrests, how does one then transfer, do a popover into an automobile or into a bed?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. HOLLER: Relevance.

MR. SCHWAB: Very relevant, based upon Ethan Ruby's own testimony.

THE COURT: I'll allow it.

A The wheelchairs with arms, those are typically removable, so if the person is otherwise capable of doing a popover or sliding board transfer, they, or someone with them, can remove the armrest and set it aside and then do the popover transfer.

Q You spoke about wheelchairs that have more of a backrest. What do you mean by that?

A Well, the backrest can came up higher. It can be contoured more to give more support. For people who have very severe problems with positioning, we can do custom seating solutions.

But there's, again, a wide spectrum from the low-profile, low back, and that we see on performance wheelchairs like Mr. Ruby has used, to ones that have a more extended backrest.

Q What did you observe about Mr. Ruby's ability to utilize the wheelchair at the time of your examination?

A In particular, I noticed how he was able to came into the exam room, which requires making a fairly tight 90-degree turn and then maneuvering past some furniture. And he was certainly proficient, consistent with someone knowing how to use the wheelchair well.

Q Well, would you tell us, sir, what your findings were on physical examination of Ethan Ruby?

A He is noted to be a well-developed and well-nourished man seated in the manual wheelchair. His general appearance was otherwise within normal limits. His hands were well callused, consistent with wheelchair propulsion.

Upper extremity motor power strength was within normal limits, and the ranges of motion of the joints of the arms, the upper extremities were within normal limits, but he did complain of right shoulder pain at 120 degrees of flexion.

Q What is that, now?

A That's bringing the arm forward, like this, and getting up to about this level, would be about 120 degrees, that he complained of shoulder pain on that particular motion.

On a couple of other maneuvers, spinatus test, which is raising the arm in this position, or Yergson's test, which is having the arm in this position and trying to bring the hand over, palm up against resistance. Those were negative. Those did not cause pain.

Q What do you mean when you say those were negative? Negative meaning what in the medical profession?

A Those maneuvers for Mr. Ruby did not cause pain at the shoulder.

He did have some mild tenderness, which is he complained of it hurting if I pressed over the extensor tendons of the right wrist. Extension is this motion.

Phelan's and Tinel's, which are maneuvers to check for carpal tunnel at rest, were normal, negative.

Q Tell us about carpal tunnel of the wrist with a little more specificity, the Phelan's and Tinel's, if you would.

A Carpal tunnel syndrome refers to the fact that one of the nerves that comes down to the hand has to run through a constricted area in the wrist here, and we can check for problems there by maneuvering, tapping over the areas, which is called Tinel's.

And we do a Phelan's maneuver. We put the wrist in both this position and also put it in this position, which narrows the opening for that tunnel, that pathway for the nerve.

And if that brings about symptoms, complaints of pain or numbness in a particular part of the hand, we will call that positive, and that would be suggestive of carpal tunnel syndrome.

If someone doesn't have that, that suggests they do not have carpal tunnel syndrome.

Q Continue with regard to your examination and your findings, please?

A I looked at his trunk balance, his ability to keep his body stable and upright. And statically, it was good. In other words, he could sit in the chair and was not toppling as he sat there.

Dynamically, when he would try to do things, to lean or reach for something, it was only fair, it was not as good, and it required him to compensate by helping himself with one hand to help stabilize himself at times.

But he was able to remove and put back on a shirt while seated in the chair by himself.

Q What significance is that in terms of trunk balance?

A Well, it's very important that a person with T6 paraplegia would be expected to have some reduction in ability to balance their trunk, to keep their body stabilized while seated.

And with training, and certainly within the abilities of the person, you'd like to see them be able to compensate well enough so that he can do activities of daily living, one of which would be putting on or taking off a shirt. So it's important in that regard.

Once his shirt was off, he had well-healed scars, thoracic, meaning in the mid-part of the back, on his back and iliac crest. That's down in the pelvis, where they had taken some bone to help stabilize the repair of the spine.

He complained of some tenderness, again, pain to me pressing on the pectoral muscles, which would be the big muscles of the chest here and mid-thoracic paraspinal muscles. Those are the muscles on either side of the spine.

He complained of pain on relatively light palpation, not pressing hard, but more lighter touching at the base of the sternum, the sternum being the breastbone. It's somewhat light touching there. And also over the abdomen, the belly, he complained of some discomfort or pain if I would feel in this area.

In terms of sensation by light touch or pinprick, it was at the T6 level, meaning that in mid-chest, above that level, he can feel things. Below that level, both front and back, he does not feel.

Lower extremities, I talked earlier about spasticity. A problem some of my patients have is flaccidity, the opposite. That means the muscles are loose or limp.

Deep tendon reflexes were absent. When the doctor taps below your knee. Normally, your knee jerks up somewhat because you're activating a reflex, kind of like the reflexes we talked about before. Those were 0 of 0. There was no response.

Clonus, meaning a beating motion if I were to move it quickly, was absent. That was not seen. Again, no useful sensation throughout the legs.

Q Now, Dr. Richter, I want to address your review of the life care plan that was presented to you, okay?

A Yes.

Q And let me go down various categories. There was one category of the Yudkoff life care plan referred to, as I think, Physician Services?

MR. MOLLER: Objection, your Honor. May we approach?

THE COURT: Yes.

(Discussion at Bench off the Record.) Objection overruled.

Q Dr. Richter, I'm going to back up just for a second.

As a diplomate in the field of rehabilitation medicine, are you involved in analyzing what various of your patients require in the future?

A Yes, routinely.

Q Excuse me?

A Yes, routinely.

Q Routinely. And are you familiar with what are called life care plans?

A Yes.

Q Have you been involved in life care plane for your own patients over the years?

A Yes.

MR. MOLLER: Objection. I don't know what “involved” means.

Q Tell us to what extent you -- I withdraw the question, then.

Tell us to what extent you have anything to do with life care plans for your own patients.

MR. MOLLER: My objection's withdrawn.

A For many of my patients, many of my patients are significantly injured, and they're going to have either long-term disability or long-term needs for health care services, or often both.

And we sometimes have to prepare what's called the life care plan. And in this scenario, as a physiatrist or rehabilitation doctor, I'm the captain of the team of the rehab personnel, so I would be the personal who directs and in fact prescribes therapies. I also prescribe medications, and I make referrals to various specialists.

So for the things that are outside of my own field, I have a responsibility for directing the traffic to direct the patient to various other services that they would need beyond what I myself could provide.

So, I do that of course in daily life in terms of directing the care. But at times, when we need to make a plan for the future needs, I would specify what sort of service the person would need, based on their particular condition.

And in the case of a formal life care plan having to be prepared, I would provide that information to a person who writes up life care plans. These are usually physically written up by nurses who specialize in that area.

They would then provide me with that information and may ask me some questions as they're doing it. They would provide this for my review, and I would determine if I did in fact agree with it or felt some changes had to be made. So that would be my involvement with my own patient's life care plans.

Q Now, did you have occasion to analyze the section of Mona Yudkoff's life care plan that dealt with primary care physician, physiatrist, acupuncture?

A Yes.

Q And would you tell us what conclusions you arrived at in analyzing that portion of the Yudkoff plan?

A One conclusion was that a couple of things that were involved in the life care plan, while reasonable, would be things that, for example, after the age of 40, are done at a physical check-up.

Certain routine bloodwork, CBC, would be done routinely. After the age of 50, most men are recommended to have an anal coloscopy, or at least a regular colonoscopy after the age 50. So that would be appropriate but not necessarily specific to

the spinal cord injury, although certainly, given that there were some recommendations from treating physicians to have a colonoscopy and upper endoscopy, now those would be appropriate to do now.

There are some miscellaneous studies listed there which again are not specific to the spinal cord injury, except the issue of bone density, which in a male patient with spinal cord injury is a concern, less so than with women because men tend to start out with higher bone density. But that would be more timely done about every five years or so, not on an annual basis.

And in terms of the acupuncture, acupuncture in 2002 or even today, in 2003, would not be considered part of the standard of care for spinal cord injury. It certainly does not treat the spinal cord injury itself. It would not change the paraplegia in terms of treatment for pain. It would be considered a form of alternative medicine, but not necessarily what we call standard of care. So that it would not be the typical thing that we recommend for spinal cord injured patients.

Q So let me go back to some of the items just so I understand them. You spoke about at age 40 it would be routine to have certain annual CBC and chemistry done?

A Yes.

Q What do you mean by that?

A CBC means a complete ?? count to check for anemia, to check for white count. Once a year that would be done routinely as part of a physical. Any additional tests that were being done would be more specific to perhaps complications of the spinal cord injury.

Q So if we're talking about someone who was not injured, did not have a spinal cord injury, then you consider that, starting at age 40 --

MR. MOLLER: Objection. It's irrelevant.

MR. SCHWAB: I withdraw that question, and I'll ask another question.

Q What is the relevancy, in terms of analyzing the dollars and cents in a life care plan, to the fact that certain of his bloodwork you consider to be routine after age 40?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: It's mischaracterizing the doctor's previous testimony. He said -- that's all I'm going to say.

THE COURT: Overruled.

A Well, there are certain routine health maintenance expenses that a healthy person might need at different stages of their life. There are other additional expenses that a person would now be expected to have if they have something like a spinal cord injury happen to them. So that's where there are some distinctions between routine health-maintenance type tests or procedures versus things that are being done specifically because of the spinal cord injury.

Q So then you spoke about colonoscopy at age, starting age 50, would be routine; is that correct?

A Yes.

Q That's something you would recommend for everybody?

A Yes. In Mr. Ruby's case, should have one sooner because of specific complaints.

Q So, insofar as the spinal cord injury he sustained warrants a colonoscopy, for what years does the spinal cord injury justify a colonoscopy, and where is it not a result of spinal cord injury?

MR. MOLLER: Objection. Asked and answered.

MR. SCHWAB: Not at all.

THE COURT: Okay. The question was very convoluted. I understood it, and I'm going to overrule it. You can answer.

A One colonoscopy in particular should be done sooner rather than later because of specific complaints. And since they arose after the spinal cord injury, I would consider it relevant to the spinal cord injury.

But routine colonoscopy done after the age of 50 I would consider to be more of a future health maintenance, health screening type of procedure, as opposed to being done for a particular complaint, like the one that should be done now.

Q And then there's something you said should be done every five years and is not required to be done every year. What item is that?

A That would be testing for bone density, a typical test is DEXA. It's essentially a non-invasive test to measure bone densities, and it is a concern in spinal cord injury patients. But early on, especially for a previously young robust man, it would not be an immediate concern.

Q So, the areas you address, the chemistry blood work-up or chemistry work-up, the colonoscopy and the bone density and the acupuncture, are those all areas where you disagree with Mona Yudkoff's life care plan?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: Asked and answered. It's repetitious. It's leading.

THE COURT: All good objections.

Rephrase it, Mr. Schwab.

Q Are the items which you just now discussed with the jury, are those areas where you take exception to Mona Yudkoff's life care plan?

MR. MOLLER: Objection.

THE COURT: Okay. Sustained.

Q Do you agree with Mona Yudkoff with regard to those areas you just discussed in her life care plan?

MR. MOLLER: Objection.

THE COURT: Sustained.

Q Let me go to the subject of urology, or the urologist. Did you arrive at any opinions where you disagreed with Mona Yudkoff's life care plan on urology costs?

A Yes.

Q What items did you disagree with, with regard to her urology life care plan?

A Well, specifically, the idea of doing the urodynamics, doing the tests every year, well, while in the first year it's not unusual to do them annually, going forwards after that every two to three years is a much more typical time course.

Typically for the first few years you might do it every two years, and then on average more like every three because the situation doesn't change that much after the first couple of years when the person's system gets to a steady state.

Q Well, how long would it be where -- let's say, ten years later, how often would urodynamic testing be required?

A Typically, no more often than every three years.

Q With regard to the portion of the Yudkoff life care plan dealing with fertility and sexual function, were there areas in that plan that you disagreed with?

A Yes.

Q What are they?

A Specifically there was reference to some medications or treatments to cause potency to counteract the impotence. But if those are not working -- and to my knowledge they've been documented as not being successful -- then you would not continue to keep giving them. So if Viagra doesn't work for someone, you don't keep prescribing it. It's worth giving it a try, of course, but if it's not successful, it would not be part of your plan.

Q There's an area dealing with physical and occupational and massage therapy. Are there costs that she has in her life care plan in that regard that you disagreed with?

A Yes, I do.

Q What is that, sir?

A Well in terms of ongoing exercise, for a person with a chronic disability, regular exercise is typically part of the prescription. But that is not the same as doing physical therapy. Physical therapy involves working with a particular type of professional, a licensed physical therapist who works typically one-on-one with a patient.

And while that is very important in the recovery from spinal cord injury, it's not something done lifelong. It's something done for a finite period of time to train the person how do their transfers and mobility and to participate in activities of daily living and to address specific complaints they may have.

But that's finite. See, that is not something that you continue on a programmed basis. You would certainly try to teach a person how to use some appropriate exercise equipment that they could use by themselves, but they would not be on constant professional physical therapy.

There may be incidents that happen down the road where someone may develop, for example, a bout of shoulder pain. They might need a course of physical therapy, but typically that's every two to three years. That's not year after year, week after week.

Q I'd like you to assume that Mr. Ruby has testified on redirect examination in this case that he is no longer undergoing physical therapy or occupational therapy. Is that consistent in your opinion with his having arrived at a finite time period to conclude that type of therapy in?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: Completely mischaracterizes Ethan Ruby's testimony.

MR. SCHWAB: Not so.

THE COURT: I'm sorry. Counsel, step up.

(Discussion at the bench off the record.)

You have that question still in your mind, Dr. Richter?

THE WITNESS: I could use it again, please.

MR. SCHWAB: Your Honor, with the Court's permission, could the reporter read back the question to Dr. Richter?

THE COURT: Yes, David, we would.

(Whereupon, the reporter reads the referred-to Question.)

A Three years post-onset of injury, that is a time when most patients have completed physical and occupational therapy. They're usually at what we call a relative plateau, meaning a relatively steady state of affairs, so that would be consistent.

MR. MOLLER: Objection. Move to strike as not responsive.

THE COURT: Okay. Objection overruled. You have an exception.

Q And Dr. Richter, the fact that Mr. Ruby does not have spasticity, is there any relevance in that regard to the need or lack of need for massage therapy?

A Yes, there is. Massage is sometimes used as a form of treatment for spasticity among various other types of therapy. But in the absence of spasticity, you would not have a need for anti-spasticity treatments.

Q There was a reference in Mona Yudkoff's plan to case management. Did you arrive at any conclusions regarding the extent of case management?

A Yes.

Q And to that extent, is there in any way you disagree with Mona Yudkoff, who has that for life?

A Yes, I would disagree. Certainly the first two to three years, case management services could be highly appropriate. And in this case, you know, it could have been certainly appropriate. But lifetime, no, again because people tend after a few years to get to a relative steady state, and they don't need that particular professional service on a monthly basis.

Q Let's go to counselling, which is discussed there, Dr. Richter. Do you take exception with the extent of counselling as recommended by Mona Yudkoff in her life care plan?

A Yes.

Q And then tell us what is the basis for your taking exception and the extent to which you disagree with it?

A The psychological counselling that we arrange for people after the onset of a disabling condition like spinal cord injury is often weekly for a period of time. Again, two to three years would not be unusual, but certainly at least two years is reasonable.

And then it's typically tapered off. The person might be seen monthly for say, another year or so to help with the transition to their routines of everyday life. And then thereafter, the person would not stay on a lifelong regularly programmed schedule of counselling.

It is certainly possible that specific events in their future might warrant brief resumption of some additional services, so someone might need several sessions every five to ten years to deal with setbacks occurring in life. But it would not be something occurring on the basis of disabling condition is done lifelong. Basically, it reaches a limit as to how much it can help the person.

Q As regards future hospitalization, Miss Yudkoff projected six days of hospitalization a year for life and an annual cost of $13,812.

Do you agree with her analysis in that regard?

A I would disagree with that. There is data from the National Spinal Cord Injury Database, which is a collection of information from the top spinal cord injury centers around the country, which dates back for decades.

But the statistics as long ago as 1987 were showing 4.78 days per year, a little bit under five days a year by the fifth year post-injury, and then less than that with subsequent years, the idea being that in the first five years or so people have various complications and then typically they require fewer days, if any, than that.

So it's more appropriate to estimate about three days per year of hospitalization based on modern ways of utilizing the hospital. We have to keep in mind that we used to put people in hospital for a lot of things we now feel are just as well, if sometimes better, treated out-patient.

MR. MOLLER: Objection.

THE COURT: Sustained. Jurors disregard the last part of the answer.

MR. SCHWAB: That was the section we have to keep in mind, that portion, your Honor.

THE COURT: Just the last part of it.

MR. SCHWAB: Thank you.

Q And you talked about the National Spinal Cord Injury Database. What is the National Spinal Cord Injury Database?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: Asked and answered.

THE COURT: Well, not by this particular witness, but I think the jury has heard about the database previously.

MR. SCHWAB: Just want to make sure we're talking about the same database, Judge.

THE COURT, I think we are.

MR. SCHWAB: Okay.

Q There is reference to transportation and housing by Ms. Yudkoff. Did you yourself make certain analyses in that regard?

A Yes.

MR. MOLLER: Objection.

THE COURT: That one is sustained. That's why you asked about housing.

Q Are you familiar with something known as the ADA, Americans for Disability Act, sir?

A Yes.

Q And would you tell us what is the ADA? Don't give a legal lecture, but what is the ADA?

A Well, it's an act that essentially prohibits or tries to prohibit discrimination against people with disabilities; in particular to allow them to have access to facilities, access to workplaces, so that there are no unnecessary barriers being placed in front of them.

And it also, in terms of employment, pertains to the fact that people cannot be denied employment simply on the basis of having a disability. They could only be denied a particular job request if their disability truly prevented them from doing it, but not merely because they have a disability.

Q And Dr. Richter, only if you know, do the ADA requirements in any way relate to buildings that people either rent or buy?

MR. MOLLER: objection.

Q In New York City?

MR. MOLLER: objection.

THE COURT: All right. I'm going to overrule it right now. If you know, Doctor.

THE WITNESS: Yes, I do.

THE COURT: You do?

THE WITNESS: Yes.

THE COURT: All right. You can answer.

Q What do you know?

A Because among other things, the buildings may indeed -- the work spaces for disabled work as well as being space that has to be accessible to the tenants themselves. It does affect modern apartment buildings, that they have to be designed with what's sometimes called handicapped accessibility.

THE COURT: Are you talking about new construction?

THE WITNESS: Yes, since the act was created.

THE COURT: Okay. Now I'm going to sustain the objection. The jury will disregard the answer, and that portion of it is stricken. We've not established whether or not that testimony would be relevant to the testimony concerning housing that was previously admitted at this trial.

MR. SCHWAB: I'd like to approach at sidebar at a break to discuss that before Dr. Richter leaves the witness stand.

THE COURT: We will. NOt a problem.

MR. SCHWAB: Okay.

Q There is a reference by Mona Yudkoff, under an area dealing with equipment, to the purchase of a power wheelchair at cost of $6,000 every five years for life.

Do you agree with that portion of her life care plan?

A Well, I would agree with future use of a power wheelchair, but I would recommend that that be deferred until age 50.

THE COURT: That it be deferred until what?

THE WITNESS: Until age 50.

MR. MOLLER: Age 50.

Q And why do you say that, sir?

A Because one of the chief advantages of a person using a manual wheelchair as opposed to a power wheel chair is that they will continue to get regular exercise. Yes, they can, as I mentioned before, do certain other types of exercise. However, this is a sustained daily activity that is one of the beet things that they can do in terms of conditioning.

It also gives them the advantage that the manual chair is more maneuverable, at least with current technology, as compared to the best power chairs. So therefore they have the most maneuverability, and it is the most efficient way, therefore, to move.

So to the extent that this can be deferred at least to age 50, is preferred. Subsequent to that age, there are many paraplegics who do get around well enough with their manual chairs.

So it's not that they have to, but just in terms of what may happen in terms of the aging process, we'd like to defer it until at least age 50.

Q Under Equipment, Mona Yudkoff has various items, such as an Environmental Control Unit computer, at a cost of $2,750, to be replaced every ten years, and other items. Do you agree with all of her what I will call equipment recommendations?

MR. MOLLER: Objection. Compound.

THE COURT: I'll allow it.

A Well, in terms of the Environmental Control Unit, or ECU, that was a very popular option in particular for patients with limited mobility. Given that now more devices can be operated with their own remote cells, they're becoming less and less standard as a prescription of any sort, and they're more typically observed now for a patient who had, say, who has very limited ability to access standard remote-control devices in terms of other things, like being able to turn lights on or off.

It is now much more possible to have standard remote control, but in the case of somebody who has satisfactory wheelchair mobility, such as a paraplegia, you can get around in your own apartment to the accessible parts of your apartment.

So if you have home modifications done so that you can reach the appliances and things like that, then the ECU would not be necessary. So there are better ways of getting around the problem than the traditional computerized Environmental Control Unit.

In terms of other types of equipment that were recommended, there was a recommendation for a particular type of home exercise system, a para-gym. And indeed, there are other alternative ways of doing this. We can provide people with various types of home exercise equipment that are more readily available than the para-gym. So I would say that I recommend those alternatives as being more easily obtained.

Q With regard to the category of medications which she has included in her life care plan, do you have any observations regarding various of those items and the cost that she has included?

A Yes.

Q What is that?

A Well, first of all, in terms of the Coumadin, which is listed in the life care plan as lifelong medication, that is more typically used for only six to 12 months, at most.

In terms of some of the other medications, Prilosec, which was being taken at one point, although I believe not at the time of my exam, since that time has become eligible for generic manufacture, as most medications do after several years they came off of patents. And as generic, and in some cases over-the-counter variations become available, so those need to be taken into account in terms of life care plan.

Hiprex, which I mentioned before, which is a medicine that helps to keep the bladder clean, is a variation of an old medicine called Mandel, meaning once that comes off of patent, that will probably be replaced completely by Mandel.

So therefore, some of the prices will be less. Neurontin, at the time of my exam, that medicine has been discontinued. Certainly there are some other alternative medicines that might be tried. These are often antiseizure or antidepressant medicines that work against spinal cord pain, so there might be some substitution possible there.

And in terms of the Percocet that he was taking on occasion, that certainly is an effective pain reliever. But again, there's a generic version of that that would work the same.

Q Well, first of all, with regard to Prilosec that you mentioned in her life care plan for the entire life of Mr. Ruby, she has a figure of $2,538 a year. You spoke about that not being a generic medication under the name --

A Brand-name Prilosec is a brand-name drug covered under patent, but soon to expire, and as with other medicine, they become eligible for generic versions which are considerably less expensive.

Q And what is Prilosec used for?

A Prilosec is an anti-ulcer medication.

Q Anti-ulcer?

A Yes,

Q And if Prilosec is not taken by the plaintiff at all, or a patient at all, that's an item to be subtracted completely from the plan?

MR. MOLLER: Objection.

THE COURT: Sustained.

Q And Neurontin, which you said he's not taking at the time you examined him, it goes for $1,233 a year. Is that something that's coming off, if you know?

MR. MOLLER: Objection.

Q Coming out of patent.

A Eventually, as with all drugs, yes.

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: “Eventually” is not an answer to the question. Do you know or don't you know?

MR. SCHWAB: That's what he's --

THE COURT: Again, answered, but now your objection is sustained. Let's move on.

Q Did you recommend active pain management for Mr. Ruby?

A Yes.

Q And what was your conclusion in that regard?

A Well, Mr. Ruby had stated to me and had stated in some of his depositions that he was having these various pains, stomach pain, pins and needles in his legs and some shoulder and back pains, which have been going on at that point for at least a couple of years.

And therefore, given that he was still having these complaints of pain, had tried some medicines but had not really been under the active, direct supervision of a pain management specialist, that I would recommend that that be part of his plan of care.

He had seen a doctor in Massachusetts a couple of times. He had consulted with a neurologist a couple of times who had included recommendations about it as part of their -- part of the neurologist's visit. But he was not actively treating with a pain management doctor at the time.

Q Mona Yudkoff had an item under medications and supplies for what she references as the McNeil closed catheter system. Are you familiar with that?

A Yes, I am.

Q Did you arrive at any opinions regarding the propriety or need for using a closed catheter system based upon the records that were supplied to you at the time of your exam and any record you may have seen in the last 24 hours?

MR. MOLLER: Objection.

THE COURT: Yes?

MR. MOLLER: Could we approach?

THE COURT: Yes.

(Discussion at Bench off the Record.) Ladies and gentlemen, perfect timing. One o'clock. Okay. All right. 2:20.

(Whereupon, the Court Takes Lunch Recess.)

AFTERNOON SESSION

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

DIRECT EXAMINATION (Resumed)

BY MR. SCHWAB:

Q Dr. Richter, I want to step back just a little bit. With regard to yourself as a diplomats, where you see patients who have already been discharged from hospitals who are spinal cord injury patients, is there some norm or average as to how often you see a spinal cord injury person?

A Yes.

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: Relevance.

THE COURT: Overruled.

A Initially, when someone first goes home, I might see them monthly during the first year, or perhaps every other month next year or so. Then, after that, we taper down to about a twice-a-year long-term maintenance schedule.

Q All right. And as part of your management of a spinal cord injury patient's case, do you get involved in issues such as bowel and bladder programs?

A Yes.

Q Do you get involved in issues such as the utilization of catheters?

A Yes.

Q Do you write prescriptions with regard to catheters?

A Yes.

Q Why is that?

A Well, these are prescription items, and we have to decide what's the right type of catheter for a person to use. There are certainly different designs and several different techniques for using them, and we have to prescribe and direct the use of them.

Q And are you familiar with those designs and techniques?

A Yes, I am.

Q All right. And during part of your testimony this morning you referred to a recovery period. What does that mean?

A In terms of spinal cord injury, some people do get what we might call a natural improvement. People who have incomplete injuries may actually have some healing, where they start to get back some motion and some sensation.

Others don't. They may have a complete injury and don't get motion or sensation back, but may get to a certain level of getting that back, and then that stops.

But there's also the recovery of how the person functions, not how much, how their legs may or may not move, but how a person functions in everyday life, whether taking care of themselves, going to work, transferring, things of that nature.

And so there is a recovery phase. Of course, when someone is in the rehab hospital, that's a very intense period of treatment and, hopefully, an intense period of improvement of function.

After they go home, they may start out with home care, with therapists and nurses coming into their own home, and that's another period of recovery, where they may learn some additional techniques or build some further abilities.

Then they would typically come to out-patient therapy, traveling from their home to a therapy center, where they would undergo additional therapies, basically learning how to do new things and building their skill set to the best level possible.

And then they reach a point where they have a relative plateau. They've learned what they can learn from the therapy and carry on with their life, but the period up to that point would be considered a period of active recovery of function if their condition doesn't go away.

MR. MOLLER: Objection. Move to strike.

THE COURT: Grounds?

MR. MOLLER: Because the doctor's not rendering opinions about Ethan Ruby, and the question is not what happens to the world at large. He's here to render opinions in this case, to this plaintiff. I suggest that everything we just heard is irrelevant.

THE COURT: Overruled.

Q And can you tell us what is the norm or typical recovery period?

MR. MOLLER: Objection.

THE COURT: Overruled.

A Two to three years is typical.

Q And with regard to the Ruby case, can you opine, what in your opinion, would be the -- or was the recovery period for someone such as Ethan Ruby in his case and condition?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: No foundation for the opinion.

THE COURT: Overruled.

A Well, in terms of basic functions, again we're looking at about a two- to three-year course to achieve a relative steady state.

Q And by the way, without getting in specific dollars and cents, are the annual costs during the recovery period greater, the same, or less than to be expected than the annual cost after the recovery period?

MR. MOLLER: Objection. It's standing without foundation or relationship to the issues in this case.

THE COURT: I thought the question was specifically related to the life care plan for Ethan Ruby.

MR. MOLLER: No.

MR. SCHWAB: I will get down to that. I would get down to that.

THE COURT: Well, then ask it. I'll sustain the objection.

Q I'd like you to assume that the actual costs of overall care and treatment of Ethan Ruby on an average yearly basis are of a certain amount, obviously from November of 2000 up until the present time, a certain period of three years.

In your opinion, based upon your years of experience in this field and your knowledge of this case, would you expect his annual costs in the future to be the same, greater or less than the annual costs up to now?

MR. MOLLER: Objection.

THE COURT: Overruled.

A Annual costs would be less in the future.

Q And why could you say that, Doctor?

A Well, in the first three years spinal cord injured patients are getting a lot of consultations. They and their doctors are trying to figure out the details of what's wrong with them, so they may need to undergo, for example, bladder test or may need to undergo an MRI of their spinal cord to see what's happening to it, such as were done in this case.

And those tests are done in the first few years, the therapies are done in the first few years, and those are necessary and justifiable expenses.

But then the patient typically enters a stable period where they only need what we would consider the ongoing maintenance care.

Q Did you note in any records the name of a doctor by the name of Adam Stein?

A Yes, I did.

Q And who is Adam Stein?

A Dr. Stein is the director of spinal cord rehabilitation as well as the director of residency training at Mt. Sinai.

Q He's like the top man in rehab at Mt. Sinai?

MR. MOLLER: Objection.

THE COURT: Grounds?

MR. MOLLER: Leading.

THE COURT: I'll allow it.

A He is certainly one of the leaders of the department, and in particular, he's considered their spinal cord treatment expert.

Q And do you recall where it was you saw his name referenced in the records?

A Yes. It was in the discharge summary from Burke that a referral was being made to Dr. Adam Stein.

Q Did you see any out-patient records or reports or notes from Dr. Stein in this case?

A No, I did not.

Q Did you look for them in particular?

A Yes, I did.

Q Why?

MR. MOLLER: Objection -- withdrawn.

A In following the time course of treatment, I had read through the Bellevue records and Burke records, and the next step that I wanted to look at was the out-patient piece of the recovery process. And since Dr. Stein is known to me to be an expert in this area, I was looking for his notes to see what happened.

Q I think we left off this morning, and I was discussing or raised the subject of catheters with you, if you remember that, sir?

A Uh-huh.

Q All right? Did you arrive at an opinion with regard to the appropriate catheters to be used in the case of Ethan Ruby?

A Yes, I did.

Q And would you tell us what opinion or opinions you arrived at in that regard, sir?

A Actually would be opinions because, based on the initial review of records, my opinion would have been that he could have used the standard conventional catheter. However, based on review of a report from his urologist which indicated that he is doing better recently in terms of avoiding urinary tract infections using the closed catheter system, I think it's reasonable for him to continue to use those catheters.

Q So the closed catheter system would be a more expensive system than the other one?

A It is. It's certainly more e??ensive. Many patients with paraplegia do very well with the less expensive variations, but if a patient's actual experience has been that they seem to do better with the other one, then it's reasonable to go with what's happening.

Q And the recent document you saw, is that a document I showed you today of a recent report of Dr. Vapnek?

A Yes.

Q That I told you went into evidence?

A Yes.

Q Thank you. And did you arrive at an opinion regarding bowel management programs for, or a bowel management program for Ethan Ruby?

A Yes.

Q What is that, sir?

A Well currently, based on his description of having bowel accidents, he has suboptimal management of his bowels.

And therefore, it would be appropriate to do some additional adjustment, trying different methods, different techniques of bowel management, perhaps trying different medications, perhaps using devices such as Thera-Vac, to facilitate emptying the bowels.

The goal with the person with spinal cord injury is not to cure the bowel problem. We can't. We can't make them have normal control of the bowels. But the idea is to have them evacuate their bowels completely every day, or perhaps every other day so that they don't have accidents in between.

So the idea is basically to get a good effective cleaning out during a bowel regimen and then, hopefully, not to have accidents in between. Since he's reporting accidents, you would want to see some changes.

Q Let me ask you questions about health care or home health care. That was a portion of Mona Yudkoff's plan, also; is that correct?

A Yes.

Q And what opinions or conclusions did you arrive at in that regard, sir?

A Well, certainly, initially, on return from the hospital, it would be, you know, quite normal to have home health care workers coming into the home so that the person can make their transition to being able to be managed at home, as opposed to being in a hospital setting.

At this point, which is fairly far out, he wouldn't need the -- you might consider the home health care services provided by someone with specific health care training. It would be appropriate for him to have homemaking or housekeeping services, given the nature of his disability.

Q Now -- oh, doctor, there was evidence in this case regarding rode that were placed in Mr. Ruby's back from T6 through -- to T10, I believe, or maybe lower down to T10.

A Two. T2 to 10.

Q Two to ten, but the rods that were from six to ten, that upper portion would be above the level where sensation was cut off; is that correct?

A That's correct.

Q All right. And are you familiar with the type of rods that are utilized in that type of spine stabilization?

A Yes. I'm familiar with CD rods.

Q Those are what they're called, CD rods?

A Yes.

Q You know what they're made out of?

A The main ingredient would be titanium.

Q And I'd like you to assume that there has been some testimony in this case about these rods bending. Do these titanium rods bends, to your knowledge, Doctor?

A No. These rods would not bend. They're very strong.

Q Do they move?

A Not normally, no.

Q I just have a few more questions, sir. There has been received in evidence as Exhibit 28 some records from Dr. Bar-Chama, although the top record is actually the report of Dr. Vapnek of '01.

But in the Exhibit 28 there appears a page or series of pages. One is filled out by Ethan Ruby with the date of August 19, '03 on it.

And on that, it identifies various medications. That's what I want to ask you about. It says -- this is August 19, 2003 -- “Have you been taking all of your medication?” Circled Yes. And then it says, “Please explain.” And he's written in, “Hyprex.”

What is Hyprex again?

A Hyprex --

MR. MOLLER: Asked and answered about an hour --

MR. SCHWAB: I'm now asking about the documents and the medications shown in this exhibit that plaintiff offered into evidence --

MR. MOLLER: I reassert the objection because if it's in evidence, the document already is there. We don't need this witness to tell us what's in it.

THE COURT: You'an answer, Doctor.

A Hyprex is a medicine that's used to keep the urine clean. It's not an antibiotic, but it's something that would act against getting a bladder infection.

Q The next one is indicated Multiple V, which would stand for multiple vitamin?

A Yes.

Q The next one, Calcium with/D. What are we talking about there?

A That's calcium with Vitamin D to help maintain bone density.

Q What?

A Calcium with Vitamin D to help maintain bone density.

Q And the next one says Ultracef.

A That's a pain reliever.

Q And the neck one is Ambien. What is that?

A That's a sleeping medication.

Q Finally it says another printed question: “Have you added any medication? If yes, please explain.” And then it says Ciprofloxacin LCL, 500 MG, and it says something-or-other daily. What is that?

A That's an antibiotic.

Q Well, Doctor, also there is reference contained in Exhibit 28 are certain laboratory reports?

MR. SCHWAB: And I've had those enlarged, your, Honor, most respectfully, and I would offer into evidence the enlargements from Exhibit 28. They have been marked as II, JJ and KK for identification.

(Whereupon, Defendant's Exhibits II, JJ, and KK were previously marked for identification.)

MR. MOLLER: No objection.

MR. SCHWAB: Afterwards, your Honor?

THE COURT: Which exhibit is it?

MR. SCHWAB: These are II, JJ and KK, which are actually enlargements of certain pages from Exhibit 28 in evidence, your Honor.

THE COURT: Okay. No objection.

Q And Doctor, I don't know -- I want to hold this closer to the jury. If maybe you could just step down for a second with the Court's permission. Won't take long on this.

(Witness leaves stand.)

Exhibit II has the date of the report of June 29, 2001, correct?

A Yes.

Q All right. Now, in this clinical laboratory report there's a section here entitled, “Total testosterone.” You see that?

A Yes, I do.

Q And it has various numbers across the way at columns. And would you please explain that to the jury, who maybe have never seen a lab report previously.

A As we look across, first you have the result, and the result happened to be 406. This happens to be the units. It's nanograms per deciliter, and this is the normal range, 260 to 1,000. So therefore, 406 is somewhere in the middle of the normal range.

Q And as regards the low, which is 260, and high, that's 1,000. That's clearly closer to the lower side, right, of the normal range?

A Yes, it is.

Q Now, there's something below that called “Free Testosterone.” Could you do the same thing with us on that?

A Under the testosterone -- under the section of Free Testosterone, there is a testosterone percentage. Free -- in this case 1.4 percent of it -- is free and in the bloodstream, and the normal range is 1.0 to 2.7, so it's within the normal range.

Q And that's under normal range, is this Reference Range, they call it; is that correct?

A Yes, Reference Range is the range that you would expect to see in a group of normal people.

Q Okay. And then let me just move on, if I may.

Here's another one of November 22, 2001. It's Exhibit JJ. Would you just correlate those same items again for us, please?

A It's again, total is 416, the normal range being 260 to 1,000.

And underneath free it's percentage, it's 1.6, which is again within the range of 1.0 to 2.7 percent.

Q And finally we have a more recent one, of June 22, 2003. Would you please correlate that for the jury?

A And here we have total testosterone of 545, which is still within the reference range of 260 to 1,000. As far as percentage free, it's 2.1 percent, which is still within the normal range of 1.0 to 2.7 percent.

(Whereupon, the witness resumes the stand.)

Q Dr. Richter, I'm going to a different subject now. At the time of your report on May 2, 2002, did you yourself analyze what the life expectancy was of Ethan Ruby, spinal cord injury individual?

A Yes, I did.

Q And would you tell us, what did you utilize as the basis for your opinion as to his life expectancy?

MR. MOLLER: Objection.

THE COURT: Okay. Okay. I'll allow you to answer. Overruled.

A The information that -- the information that I used was data from the National Model Spinal Cord Injury Systems Database.

Q And does that Model Spinal Cord Injury Systems Database give an evaluation of life expectancy of given categories of spinal cord injured people?

MR. MOLLER: Objection.

THE COURT: That's sustained. That's all the information you used?

Q Did you utilize anything else besides that, Doctor?

A In terms of determining the life expectancy, I looked at his past medical history and the available medical records, as well as the data from that database.

Q Is the National Model Spinal Cord Injury System Database, is that something that's relied upon by experts in the field?

MR. MOLLER: Objection.

THE COURT: Grounds for that one?

MR. MOLLER: It's cumulative. I thought we had an expert here put on to discuss this and was cross-examined, and that's the best authority they have.

THE COURT: Overruled.

A Yes. It is relied upon by experts.

Q And it is published data also, air?

A Yes, it is.

MR. MOLLER: May I renew the objection?

THE COURT: Yes, you can now. What field is that? Your question was, “Is it relied upon by experts in the field?” I have no idea what field.

Q In what field is it relied upon?

MR. SCHWAB: Thank you, your Honor.

A It's relied upon by experts in the field of physical medicine and rehabilitation, and it's also relied upon by experts in life expectancy.

Q All right. And as expert in the field of rehabilitation medicine, Doctor, would you tell us what your opinion is as of the time of your report in 2002 regarding the life expectancy of Ethan Ruby?

MR. MOLLER: Objection.

THE COURT: Sustained.

Q Would you tell us what the data from the Model Spinal Cord Injury Systems Database reflects as the life expectancy of Ethan Ruby --

MR. MOLLER: Objection.

Q -- as of the time you looked at it?

MR. MOLLER: Objection.

THE COURT: Is there one, Doctor?

THE WITNESS: I'm sorry, your Honor?

THE COURT: Is there a projected life expectancy for Ethan Ruby in the National Data Bank of Spinal Cord Injury?

THE WITNESS: There's a projection for people of his age who have survived one year after their injury.

THE COURT: Okay. Your objection is sustained.

MR. SCHWAB: I'll go on to a different subject then, your Honor. Most respectfully except.

THE COURT: Oh, of course.

Q Dr. Richter, do you know a person by the name of Barbara Scheffel?

A Yes, I do.

Q Who's Barbara Scheffel?

A She's a rehabilitation nurse and life care planner.

Q All right. And have you had any communications with Barbara Scheffel with regard to Ethan Ruby?

MR. MOLLER: Objection. May I approach, your Honor?

THE COURT: Yes. (Discussion at Bench off the Record.)

Q Dr. Richter, I'm going to ask the question again: Did you have conversations with Barbara Scheffel with regard to a life care plan of Ethan Ruby?

A Yes, I did.

Q And I don't want to you tell us anything as to what you said substantively in the conversations, but what was the purpose of conversations with Miss Scheffel?

A So we could discuss the clinical situation, we could discuss my exam findings, material in the medical records, so that we would arrive at a life care plan that we would both agree with.

Q And was that one conversation you had with Miss Scheffel, or more than one?

A Several.

Q And did you convey to her your own opinions regarding appropriate life care plan for Ethan Ruby?

A Yes.

MR. SCHWAB: I have no further questions of Dr. Richter at this time.

THE COURT: Okay. Ten minutes.

(Whereupon, the jury exits the courtroom.)

(Whereupon, Court takes a recess.)

MR. SCHWAB: Your Honor, I would like to make an offer of proof that if the Court had permitted questions concerning life expectancy, Dr. Richter would have stated that the Model Spinal Cord Injury Systems Database showed that a person aged 25 at injury who survives at least one year after injury with paraplegia in a cohort, including incomplete injuries less severe than Mr. Ruby's, would have an additional life expectancy of 38.1 years, leading to a statistical life expectancy of 63.1 years rather than a 74-year life expectancy.

I would also like to put on the record my stated further objection to the Court's striking out the testimony of Dr. Richter regarding the fact that ADA requirements as regards paraplegics in new buildings have to be met, or words to that effect.

Since -- and the Court seemed to be taken by the fact that this may apply only to new buildings and not necessarily older buildings, but I submit the fact that ADA requirements must be met, even with regard to new construction -- and we haven't gotten into even when that now becomes effective, new construction should properly be before the jury. No proof that Mr. Ruby is going to be limited to old building construction.

And going back to life expectancy, Dr. Richter did state that as part of his practice and that of other persons in the field of rehabilitation medicine, but certainly of him -- to advise patients of their expectancy, and that that is principally, I think, based upon those tables as well as certain specifics about the individuals.

So I submit he's adequately and eminently qualified to give an opinion, certainly a lot more so than plaintiff's expert in the case, who did testify.

MR. COOK: Even though my response is not necessary, I believe once again defense misreads their own report from a witness. The data, the information of Model Spinal Cord Injury Systems relied upon by this witness is the only database that he relies upon, and he relies upon as statistical life expectancy with no relationship whatsoever based upon Ethan Ruby's individual circumstances. And his report on page four, the top paragraph, indicates that clearly.

THE COURT: Okay.

MR. SCHWAB: Just would like to respond. I thought I had read from that page four, so I don't want to leave this hanging in the lurch.

THE COURT: I'm sorry. Page four of what?

MR. SCHWAB: Page four, report of Dr. Richter dated May 2, 2002. And I'm going to read, with the Court's permission, the entirety of that paragraph.

THE COURT: It's all right. Is that exhibit in evidence?

MR. SCHWAB: It is not, your Honor.

THE COURT: Can't read it.

MR. SCHWAB: I'd like to read it, since counsel is saying I misread or took something out of context in that regard.

THE COURT: Counsel's objection on that basis would not be sustained. However, unless I'm mistaken, your objection and your wishing to place your objection on the record was that the Court's ruling, which was not based upon any reading of Dr. Richter's report which is not in evidence, and therefore, for the record, the Court's ruling in declining to accept the offer of proof regarding Dr. Richter and his attempt to place into evidence the life expectancy tables from the Spinal Cord Injury Institute was rejected because defense has already placed an expert on the stand whose testimony and under direct examination of defense counsel was based on the life expectancy projections as specifically regards Ethan Ruby.

On cross-examination, plaintiff's counsel attempted in many ways to discredit that life expectancy projection on the basis that it was not specifically directed at or relevant to Ethan Ruby. The Court rejected that attempt at cross-examination.

Had I allowed Dr. Richter to testify as to the spinal cord injury life expectancy, defense counsel would have two, or rather would have attempted to place two experts on the testimony stand whose testimony would have been totally in conflict with each other because Dr. Scheffel's testimony was that Ethan Ruby would only be expected to live 36.5, and Dr. Richter would have testified he would have been expected to live longer.

That I would not allow. He said 38.6 years according to the table. I would not allow that, those two conflicting pieces of evidence from two proffered experts on the same subject from the same party, and it was on that basis that it was rejected.

You have an exception to my ruling.

Now, I'm sorry. What was your other one?

MR. SCHWAB: I made reference to the ADA issue --

THE COURT: Yes.

MR. SCHWAB: -- as regards new building construction.

THE COURT: Thank you. Okay. I rejected that on one simple ground, and that was there has been testimony in this case that Mr. Ruby lives at 25 Broad Street. There has been no testimony in this case that that building was built or is subject to the ADA.

As to the search for or the request in the Bill of Particulars for moneys for new housing for Mr. Ruby, there has been no testimony in this case that at any time during Mrs. Ruby's or Miss Yudkoff's Internet search or the other attempts that she made in terms of looking for housing for Mr. Ruby as to whether or not they were new buildings, old buildings, or whether or not there was any inquiry at all as to any requirements under ADA.

Also, there is no evidence in this case that Mr. Ruby may end up in a building at all. And therefore, it was rejected on that basis. It was totally speculative. It may have been relevant had there been any evidence in this case from either side as to any search for a proposed building or any facility that may have been subject to ADA regulations, and it was rejected for that reason.

You have an exception to my ruling.

I'm going to take five minutes.

(Whereupon, Court takes a recess.)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

CROSS EXAMINATION

BY MR. MOLLER:

Q Good afternoon, Doctor.

A Good afternoon.

Q Before I get into the Ethan Ruby analysis that you've made, I'd like to see if we can agree on some medical principals that you would apply as a doctor of rehabilitation medicine, okay?

A Uh-huh.

Q You agree that the first principle in making any assessment of a patient in need of rehabilitation care is to examine the patient?

A It's one of the first.

Q The first thing you have to do is find out who you're talking about and who you're treating, correct?

A Exactly.

Q So you have to examine the patient and look at his medical history and be really familiar with that patient's status, medical and psychological status, at the time you begin to form some conclusions and draw up a treatment plan?

MR. SCHWAB: Objection to form of the question.

Q Is that right?

THE COURT: I'll allow it.

A Yes.

Q The second principle of rehabilitation medicine if you're asked to treat a compromised injured person like Ethan Ruby, is first to try to restore him to the beet condition you can, correct?

A Yes.

Q The third principle would be to develop a treatment plan which enables that compromised patient to achieve the highest level of recovery possible, correct?

A Yes.

Q The next principle would be to monitor the patient, correct?

A Yes.

Q And that's monitor the patient regularly and continuously to be certain that things do not develop that then can no longer be corrected, right?

A Yes.

Q The next principle would be to intervene when necessary to stop deterioration of the patient's condition?

A Yes.

Q And the last principle that I would like to ask you about is, you agree that if a course of treatment is prescribed for a patient like Ethan Ruby that works, that has a positive benefit, you don't take it away?

A As long as it's still working, yes.

Q Okay. You also agree, Doctor, that it would be inconsistent with your obligation as a physician of rehabilitation medicine to deprive Ethan Ruby of the best care, to give him the best chance at a quality life in his compromised state?

A Yes.

Q And it wouldn't be fair to your oath as a physician and the one taken today to leave something critical out of your analysis that is relevant to the future care and treatment and prospects of Ethan Ruby?

A Yes.

Q Now, if I told you that the director -- this is your file, by the way, and I'll get back to it in a moment, and if you need it to answer any question while it's sitting over here, I'll be glad to give to you.

A Sure.

Q Do you know Dr. Guy Fried?

A Not personally.

Q You know of him?

A Yes, I do.

Q What do you know about him?

MR. SCHWAB: Objection.

MR. MOLLER: Withdrawn.

Q Do you know what the -- withdrawn. He's the director of rehabilitation medicine at Maghee?

MR. SCHWAB: Objection.

THE COURT: It's already in evidence. If you know that.

A I didn't know his specific title.

Q And never had a conversation with him?

MR. SCHWAB: Objection.

A Grounds?

MR. SCHWAB: Irrelevant.

THE COURT: Overruled.

A No.

Q Do you know about the Maghee Rehabilitation Institute?

MR. SCHWAB: Objection.

THE COURT: Grounds?

MR. SCHWAB: That would be irrelevant to the issue in this case. Dr. Fried is testifying.

THE COURT: Overruled.

A I know of it.

Q Do you know what they do there?

A In general, yes.

Q They do there what you do at Rusk?

A Similarly, yes.

Q Would you agree that t?? director of rehabilitation medicine at Maghee must certainly know rehabilitation medicine?

MR. SCHWAB: Objection.

THE COURT: Grounds?

MR. SCHWAB: Asking for opinion testimony by this doctor of another doctor. I submit this is improper, and we have not presented Dr. Richter for these purposes.

THE COURT: Okay. I'm going to overrule your objection on those grounds. However, I'm going to sustain your objection and ask you to phrase another question and get to the point. Thank you.

MR. MOLLER: Yes, your Honor.

Q If Dr. Fried testified here that “Aging for Ethan Ruby will not be pretty” --

MR. SCHWAB: I object to any statement by counsel as to what one other expert witness or someone presented as expert witness testified in this case.

THE COURT: Overruled.

Q “Aging for Ethan Ruby will not be pretty.” You agree with that?

A I'm not sure what that means, “not be pretty.”

Q Is it going to be a tough road for Ethan Ruby ahead as he gets older?

MR. SCHWAB: Objection to the form of the question.

THE COURT: Sustained.

Q Is Ethan Ruby going to have to cope with urological problems for the rest of his life?

A Yes.

Q Is Ethan Ruby going to have to cope with pain and discomfort for the rest of his life?

A He may.

Q He may. What's going to change?

A If he was under the care of aggressive pain management, there are certainly things that could change. He could have a different medication regimen. He could undergo epidural steroid injections. He could have a epidural catheter placed to deliver pain medication. He could have a spinal cord stimulator. So many things that could change. That is why I can't say for sure whether or not he will have pain in the future.

Q Are you a urologist?

A No, I'm not.

Q Would you have deferred to a board-certified urological analysis of Ethan Ruby?

A In terms of urological analysis, yes.

Q In terms of urological function?

A In terms of his ability to function on a daily basis, physiatrists often have more expertise in terms of their day-to-day functioning. In terms of the bladder testing, the urologist often has more knowledge.

Q What about a urologist who treats Ethan Ruby on an ongoing basis? Do you know more than that doctor about Ethan Ruby?

MR. SCHWAB: Objection. Argumentative.

THE COURT: Sustained.

Q You wrote -- you conducted a physical examination of Ethan Ruby that lasted about 20 minutes in May or April of 2002, right?

A I believe we spent more time than 20 minutes together, but that was the time when we met, was in April or May 2002.

Q He came to your office; I don't remember the calendar day. But he sat in your waiting room from about 11:03 to 11:15. You remember that?

A More or less, yes.

Q You took a history that lasted about 12 to 14 minutes?

A Yes.

Q Then they came into your examining room, both Mr. Cook and Mr. David Kochman (phonetic), an associate of Mr. Schwab, and you examined the gentleman, Ethan Ruby, for about 15 or 20 minutes. You remember that?

A I remember examining him. I wasn't timing it.

Q And you haven't seen Ethan Ruby since that time, have you?

A That's correct.

Q So you do not know today what Ethan Ruby's condition is?

A I have reviewed recent medical records.

Q What did you review this morning?

A In addition to what I saw this morning, I've periodically received updated medical records from Mr. Schwab's firm.

Q One of the updated medical records that you received from Mr. Schwab's firm was from Miami Physical Therapy Associates, Inc., correct? And you got that on May 8, 2003?

A Yes.

Q You did not refer to that at any time in your conversation with Mr. Schwab this morning, did you?

A No, I did not.

Q Okay. Would you read the January 24, 2003 recommendations that are in that document?

MR. SCHWAB: Objection. I'd like to approach the sidebar. (Discussion at Bench off the Record.)

MR. MOLLER: May I have the document back?

THE WITNESS: Sure.

Q Is it correct to say that you were sent on May 8, 2003 a report from the Miami Physical Therapy Associates, Inc., with respect to Ethan Ruby?

A Yes.

Q Are you aware of the fact that the Miami Physical Therapy Associates recommendations for his therapy treatment included physical therapy treatment --

MR. SCHWAB: Objection.

Q -- three times per week?

MR. SCHWAB: Counsel is violating the court order.

THE COURT: Sustained.

Q You had this in your file now for six months?

A Yes.

Q You didn't amend your report to reflect anything that you learned from Miami Physical Therapy Associates?

A Wasn't asked to.

Q Pardon?

A I wasn't asked to.

Q I see. Then there is also a report attached to this cover letter of March 19, 2003. Did you read that?

A Yes, I did.

Q Were you asked to take these findings into consideration when you testified today?

A No, I was not.

Q As of March 19, 2003, was Ethan Ruby compliant with all treatment recommendations made for the improvement of his condition?

MR. SCHWAB: Objection.

THE COURT: All recommendations from who?

MR. HOLLER: Miami Physical Therapy Associates, Inc.

MR. SCHWAB: Objection.

THE COURT: Doctor, when did you examine Ethan Ruby?

THE WITNESS: April or May 2002.

THE COURT: Have you seen him since?

THE WITNESS: No, I have not.

THE COURT: Have you spoken to him since?

THE WITNESS: No. I have not.

THE COURT: Have you received any updated reports on any of his conditions or whatever programs have been recommended to him?

THE WITNESS: Yes, I have.

THE COURT: And have you had any access to daily activities as recorded in those reports?

THE WITNESS: Only as a --

THE COURT: Those recommendations?

THE WITNESS: Only as reflected in the medical records themselves.

THE COURT: In the 2002 report?

THE WITNESS: I'm sorry. In terms of his compliance with the recommendations since that report.

THE COURT: Those recommendations come from 2003?

THE WITNESS: Yes.

THE COURT: How would you know whether he was compliant with them or not?

THE WITNESS: Only to the extent that it shows up in a medical record.

THE COURT: Objection is overruled. You can ask the question.

MR. MOLLER: Can I trouble you to read the question back?

(Whereupon, the reporter reads the referred-to Question.)

THE COURT: You said pursuant to Miami Clinic Rehabilitation report?

MR. MOLLER: Yeah.

THE COURT: You can answer, if you know.

A Specifically, in terms of the physical therapist's note, I believe -- and I couldn't pronounce her name -- but I believe she documents him as being compliant with her recommendations.

Q Do you have any basis for disagreeing with that whatsoever?

A In terms of that, no.

Q Do you have any basis for assessing the pain that Ethan Ruby is in, as we speak?

A Pain he's in as we speak, no, I do not.

Q Do you have any basis for assessing his ability to do work today, as we speak?

A That I could have.

Q Do you have any ability to determine the way his shoulders function as we speak?

A Based on records I've seen, I have that ability.

Q What record do you have, sir?

A I've seen whatever records have been forwarded to me.

Q What's the last record that tells you anything about the pain in his shoulder?

A That, I am not sure of. I don't recall.

Q Well, is it 2002?

A No, I believe I've seen some 2003 records as well, regarding --

Q Would it be in here, sir?

A No, I don't have all of my records with me. It's a very large file.

Q There's more than this?

A Uh-huh. Yes.

Q On May 12, 2003, do you recall getting a package of documents from the Schwab office enclosing records from Angela Riccobono?

A Yes, I do.

Q Do you credit Angela Riccobono with knowing her patient?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q would you say that Angela Riccobono understands Ethan Ruby in the years 2002 and 2003 better than you?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q Are you a board-certificate psychiatrist?

A No, I'm not.

Q Are you a psychologist?

A No, I'm not.

Q Do you recall seeing in Dr. Richter's file the progress notes for June 26, 2002, which says, “Patient seen” --

MR. SCHWAB: I object, unless counsel is reading from a document that's in evidence. Now, certain of the records of Dr. Richter went into evidence.

MR. MOLLER: This is in evidence. Trust me, I'm not reading anything that's not in evidence.

MR. SCHWAB: I don't know without looking at the documents in evidence.

THE COURT: Show counsel what you propose to read from.

MR. SCHWAB: I want to see the one that's going to be in evidence.

(Counsels confer together.)

Q Referring to Exhibit 23 in evidence, which is a redacted copy of what's in your file.

A Uh-huh.

Q Do you recall seeing this June 26, 2002 progress note: “Patient seen for 60 minutes. Psychotherapy session focussed on patient's feeling of depression and hopelessness re: limitations imposed by his injury, chronic pain and diminished quality of life.”

A Yes.

Q Remember reading that?

A Yes.

Q Do you credit that as being an accurate assessment by the person who's treating Ethan Ruby?

MR. SCHWAB: Objection to the form of the question. Objection to the substance of the question, also.

THE COURT: Sustained.

Q Do you have any basis for disagreeing with this assessment and observation?

A No.

Q I don't want to read them all. Do you recall seeing this, a note of 10/25/02:

“Patient seen for 60-minute psychotherapy. Session focussed on patient's increased depression with report of increased sleeping and increased spending time in bed. Patient remaining resistant to antidepressant medication due to what he reports as adverse side effects.”

You have any basis for disagreeing with that observation?

A No.

Q Skip to 4/25/03:

“Patient seen for 60-minute psychotherapy. Session focussed on patient's report of a pervasive sense of apathy toward all aspects of his life and its negative impact on significant relationships in his life.”

Any reason to disagree with that?

A No.

Q How do you treat depression?

A Combination of ways. One is with antidepressant medication, and the other one is with psychotherapy.

Q You say or said in direct examination that you're the captain of a team, right?

A That's right.

Q The fact of the matter is that you send people to specialists in urology, psychology, psychiatry, correct?

A Yes.

Q And you listen to what they have to say?

A Yes.

Q And because they are specialists in their field, routinely you would accept what they say because they know more than you do, right?

A Routinely, yes.

Q So that you are not really the captain of the team; you're a coordinator?

A No, I would disagree.

Q You would overrule a psychotherapist telling a patient -- telling you that this is good for my patient; this is the treatment plan that I suggest? Is that the way you would function?

A On occasion, I might.

Q Is that the exception or the rule?

A The exception.

Q That's right. Are you an expert in reproductive medicine, Doctor?

A No, I'm not.

Q If so if Dr. Bar-Chama works out a treatment plan for how to give this person, this Ethan Ruby, a young man injured on November 29, 2000, the best chance of being part of a father relationship, you would refer to Dr. Bar-Chama, right?

A Unless some aspect of the plan did not make sense to me as a physiatrist, I would.

Q As a physiatrist, you have no reproductive medicine experience?

A In terms of reproductive medicine itself, no.

Q Now, at the very least, if I understand your report correctly, you agree with the fertilization plan that Dr. Bar-Chama recommended?

A In general, yes.

Q Do you know anything about the costs?

A I have reviewed figures. They were -- I don't recall them off the top of my head.

Q But you would agree, would you not, that Dr. Bar-Chama, who is engaged on a day-to-day basis in the science of reproductive medicine, knows more about how to advance somebody's fertilization prospects and what it costs, right?

MR. SCHWAB: Objection.

THE COURT: Overruled.

Q Right?

A Most likely, yes.

Q Now, let's go to urology for a moment.

Do you know who Ethan Ruby's urologist is?

A Yes Dr. Vapneck.

Q Dr. Vapneck sees Ethan Ruby on a regular basis, right?

A Based on the report that I saw, there has been a lengthy hiatus in treatment, but he is his urologist.

Q So Dr. Vapnek knows Ethan's urological condition, its progress, better than you, right?

A One would expect so.

Q And Dr. Vapnek is in a better position to recommend long-term catheterization programs than you for this young man, right?

A At this point in time, yes.

Q Now, you only came to a modification of your view with respect to catheterization for Ethan Ruby this morning when you're sitting over there in the corner, correct?

A When I saw the new report.

Q But that's when you came to your changed position, this morning, correct?

A Yes.

Q So, but for somebody showing you a report by Dr. Vapnek, you would still be holding to the old catheterization program that you criticized in the report that you sent to us?

A That's right.

Q Now, if I remember correctly, at the beginning of your conversation with Mr. Schwab, you said that with respect to your practice, and the amount -- the number of times you've testified in court, two-thirds of the occasions that you have testified in court were with respect to patients that you treated. They were your patients; you weren't testifying as an expert. Is that fair?

A That's correct.

Q So when you testified about those two-thirds of your litigation experience, you're talking about people that you felt you knew best because they were your patients, correct?

A Among other reasons, yes.

Q With respect to the other third, break that down for us. In how many of those cases were you testifying as an expert for the plaintiff?

A I don't know the exact number. I would say there were probably a few where I testified for a plaintiff without having treated the patient.

Q And how many for the defendant?

A About ten, I'd say.

Q Pardon?

A About ten, I would say.

Q What does that ten represent of the two-thirds? Is that 80 percent of the remaining third, rather?

A I guess it's about three-quarters of the third.

Q So basically, you're either talking about patients who were your patients, or your litigation experience is largely testifying for the defendants; isn't that right?

A If we excluded the patients who were my patients, then, yes, the majority are for defendants.

Q And every time you testified for the defendant, if you disagree with a treatment program that's laid out by the plaintiff's experts and the plaintiff's treating physicians, the effect of your testimony ultimately is to try to save the defendant money?

MR. SCHWAB: Objection to the form of that question, your Honor.

THE COURT: Sustained.

Q Do you know how many bowel accidents Ethan Ruby has had since you wrote your report?

A No.

Q Do you know when he's had them?

A No.

Q Would you agree that they are unpredictable?

MR. SCHWAB: Objection.

Q In terms of when they occur?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q Do you have any way to predict when his bowel accidents will occur?

MR. SCHWAB: Objection.

THE COURT: Overruled.

A Predict when they would happen? No.

Q Would you agree, sir, that it is awfully humiliating to have that kind of an experience?

THE COURT: Sustained.

Q Let's go to the wheelchair for a moment.

A Uh-huh.

Q Mr. Schwab offered you defendant's Exhibit Z, right?

A Yes.

Q Which one of these young men is Ethan Ruby?

A Sitting there.

Q Do you know how he got that to that spot on that day when that photograph was taken?

A No, I do not.

Q Do you know how it was determined that that wheelchair is the one that he should be in, why it was prescribed for him?

A No, I couldn't say that.

Q I asked you, do you know why that par??cular wheelchair was prescribed for him?

A Do I know why? No.

Q Do you know the details of how that wheelchair is constructed?

A Yes.

Q Do you know its weight?

A Not the exact weight, no. It's a lightweight chair.

Q Isn't there a relationship between weight and physical ability to move it?

A That's right. That's right.

Q Is it light or is it heavy?

A It's light.

Q Do you know what has happened to Ethan Ruby's shoulders as a result of moving around in that wheelchair?

A He has a complaint of chronic shoulder pain.

Q Is it legitimate?

A That's for him to say that he has shoulder pain. I can't say whether or not it's legitimate or not.

Q You can't criticize anybody -- you certainly have no criticism of Ethan Ruby for now suffering shoulder pain?

MR. SCHWAB: Objection to form of the question.

THE COURT: Sustained.

Q Do you know whether his shoulder pain now is worse than it was when you examined him?

MR. SCHWAB: Objection to the form of the question.

THE COURT: Sustained.

Q How has Ethan Ruby's shoulder changed since the accident?

MR. SCHWAB: Objection to the form of the question. It's assuming facts not yet in evidence.

THE COURT: Sustained.

Q Is Ethan Ruby's shoulder going to continue to deteriorate as result of having to move around in a wheelchair?

MR. SCHWAB: Objection.

THE COURT: Okay. I have to sustain that. But you can get it in if you rephrase it.

Q What impact will moving around in a wheelchair have upon Ethan Ruby's shoulder, Doctor?

THE COURT: Okay. So that don't get another objection, you have to change your question to moving around in that wheelchair, not in a wheelchair, because it may be a different one.

MR. MOLLER: I got you. A wheelchair?

THE COURT: No, in the wheelchair he has.

Q In the wheelchair he's in now.

A I can't say with certainty what will happen to his shoulders moving around in that chair.

Q Pardon?

A I cannot say ?? certainty what will happen to his shoulders moving around in that chair.

Q Would you agree, Doctor, that a treatment plan has to be developed to insure that the functioning part of Ethan's body, from the nipples up, are preserved to the best extent possible?

A Yes.

Q Would you -- let's go to bone density issues. You referred to a bone density study that I believe was done approximately 12 months after he suffered his injury?

A Yes.

Q In 12 months, would you expect significant deterioration of his bone -- Ethan Ruby's bone density?

A No.

Q Okay. What about five years after?

A Possibly.

Q How would you find out whether his bones deteriorated?

A One would do periodic bone density studies.

Q What about -- what is his bone density condition today?

A Based on the normal level from a couple of years ago, the probability is that it's still within the normal level.

Q How did you determine whether or not it is probably still within the normal level?

A Because eventually he'll need retesting.

Q How do you determine today whether there has been an adverse change in his bone density?

A You don't det??tine it every single day.

Q I didn't say every single day. It's now three years post-injury. How would you determine what his bone density situation is today?

A You can do a bone density test.

Q If his condition deteriorates and you don't do a bone density test, is there any way of recouping the bone density loss?

MR. SCHWAB: Objection.

THE COURT: I have to sustain it. That's not what his testimony was.

Q If you do not do a bone density test now, you don't know what changes, if any, have occurred to his bones, right?

A Right.

Q So you can't take any preventative measures to inhibit deterioration, right?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q Is there any way to take or prescribe preventative action, preventive treatment for bone deterioration without testing to find out what his condition is?

A Yes.

Q What is that, sir?

A He's already on calcium and Vitamin D, which is a preventative measure, so he's already taking that.

Q How do you know it's working?

A You can follow his lab work over time, and periodically you do bone density testing.

Q How often?

A I would say every five years.

Q Do you know what's happened to his bones in the past three years?

A In the past two years?

Q Three years?

A In the past three years, not specifically.

Q Do you know what's happened to his joints in the past three years?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q Is there any way that you can tell us what his shoulder conditions are today?

MR. SCHWAB: Objection.

THE COURT: Overruled. He can answer.

A He has a complaint of chronic pain in his shoulder.

Q Do you know it's legitimate?

MR. SCHWAB: Objection.

THE COURT: Sustained. Asked and answered.

Q Are you a neurologist?

A No, I'm not.

Q Do you understand the subject of neuropathic pain?

A Yes, I do.

Q Could you tell the jury what it is?

A Yes. You can develop pain in a body part if you have an interruption from the nerve Supply to that body part. An extreme example, if an amputee has a leg cut off, someone may have pain in the foot that's missing. Now, that's a neuropathic pain.

Q Do you credit Ethan Ruby with having neuropathic pain based upon your 15-minute examination of him?

MR. SCHWAB: Objection to the form of the question.

THE COURT: I'll allow it.

A Based upon his complaints and the records, his complaints are consistent with neuropathic pain in the lower extremities.

Q Are his complaints consistent with injuries he sustained on November 29, 2000?

MR. SCHWAB: Objection.

THE COURT: Overruled. If you know.

A In terms of lower extremities pain, yes.

Q What's lower, now?

A Below the level of his lesion, he had complaints of, I believe he said, some burning pain with pins and needles, I think was his term.

Q Is that consistent with this kind of injury?

A Yes, it is,

Q Is it ever going to go away?

A Depends upon the treatment plan.

Q Let's talk about skin ulceration. Do you remember that discussion you had with Mr. Schwab?

A Yes.

Q How do you prevent skin ulceration?

A Good nutritional status, pressure relief, doing things like pushing up off the chair, turning from aide to side periodically.

Q How often would you recommend pushing yourself off the chair?

A At least every hour is ideal.

Q Just once an hour, like 24 times a day?

A Someone hopefully is not sitting in their chair for 24 hours straight, but while someone is up sitting, you'd like them to do at least once an hour. If they can do more, I would encourage them to do more.

Q What do you think of consistent sitting in a chair? Would it be safe?

MR. SCHWAB: Objection to form.

Q Withdrawn. How long do you determine Ethan Ruby stay in his wheelchair before getting out of it to some other position, to stretch?

A In terms of skin breakdown, since to my knowledge he has not had decubitus ulcers on his sacrum, he can sit for eight to 12 hours a day as long as he maintains good skin integrity.

Q Eight to 12 hours a day; is that what you're saying?

A Yes.

Q In a chair?

A Yes.

Q Now, you talked about the popover technique, okay?

A Yes.

Q This popover technique is simply not using a slide, right? It's not some jump that he is going to make. It's not a pop. Right?

A Well, he's not using his legs. He's using his arms, and he is popping his --

Q What is the popover technique? Is it sort of push down and you're free in the air and over some space and into the chair?

MR. SCHWAB: I object to counsel --

Q What's the popover?

MR. SCHWAB: I object to counsel's gesticulations, which unfortunately do not show up on the record.

Q No gesticulation. Tell us what the popover technique is.

A He's not going through empty space. His wheelchair, if he is he going from the chair, would be next to a commode, a toilet, a regular chair, whatever he's going onto, so he'd be next to it, and he'd pop up and over.

Q How much weight does Ethan have to lift to do that?

A His baseline weight I know is 170 pounds. I don't know what his most recent weight is.

Q Does he weigh more or less?

A I don't know what his current weight is.

Q If his shoulder is compromised further, is his ability to pop compromised further?

MR. SCHWAB: Objection to the form of the question.

THE COURT: Overruled.

A It could be.

Q If his shoulder gets deteriorated, he may not be able to pop at all, right?

A That's possible.

Q He may be back to that board that he had at Burke, right?

A He might.

Q Can he pop into a tub?

A Not into the bottom of a tub. He can transfer into a tub bench.

Q Can he drive a car?

A Yes.

Q Can he pop into the car?

A Yes.

Q As long as his shoulder doesn't make that impossible, right?

A That's right.

Q So if his shoulder goes, all of this popping goes, right?

A Yes.

Q So we've got to do everything we can collectively in this room to preserve his ability to use his shoulder because that's his locomotion instrument, right?

A Yes.

Q When he left Burke, was he independent?

A Nope.

Q You said, if I remember correctly, that on your examination you could get his right arm up about 120 degrees, correct?

A At which point he would get pain.

Q How much pain? Have a way of quantifying pain?

A Pain is the experience of a person who has it, so while people may try to attach a number to it, it's really unique to that person's experience.

Q How far off the ground can Ethan Ruby raise his hand when he's sitting in a chair, his wheelchair?

A Well, if I tried to approximate 120 degrees of flexion, that would be to about here (indicating).

Q Off the ground, say about four and a half feet?

A Something like that.

Q So for him to reach anything in his home, everything's got to be brought down to four and a half feet or less, right?

A Either that, or he has to use a reacher or other device.

Q A what?

A A reacher. He'd need to use a mechanical device to reach anything higher than that.

Q Like a dish?

A Right.

Q So everything in his house basically has to be brought down to a level of 4-foot something and up?

MR. SCHWAB: Objection to the form of that question based upon the last couple of answers.

THE COURT: I'm going to sustain it. We're way away from direct examination.

Q You know what Ethan Ruby did for a living?

A Yes.

Q Do you ever visit his workplace?

Q Do you ever have a discussion with anybody in the financial services industry about what it takes to be effective in that business?

A That I have, yes.

Q Have you ever seen a trading -- a stock-trading operation?

MR. SCHWAB: Objection.

THE COURT: Relevancy?

MR. MOLLER: Employment. Ability to do things.

THE COURT: what does that have to do with a stock report?

MR. MOLLER: I didn't say stock report.

THE COURT: What did you say? I'm sorry.

MR. MOLLER: Think I said -- I didn't say “report.” Hope I didn't say report.

THE COURT: Dave?

MR. SCHWAB: I object to this line of inquiry. Like to approach the sidebar.

THE COURT: Okay.

MR. MOLLER: Withdraw the line. Go at it another way.

Q You agree or disagree that Ethan Ruby suffers from chronic depression?

MR. SCHWAB: Objection. Thought we already covered this.

MR. MOLLER: No.

THE COURT: Overruled.

A At this time, yes.

Q Does chronic depression have a debilitating effect upon a person's ability to do things?

MR. SCHWAB: Objection.

THE COURT: All right. Now, sidebar.

(Discussion at Bench off the Record.)

Q Doctor, you saw Ethan Ruby in April 2002, right?

A Yes.

Q And in May 2003 he reached a stable plateau?

MR. SCHWAB: May the doctor have his file if ?? needs to it to refer to any documents?

MR. MOLLER: It's just his report.

MR. SCHWAB Or report.

Q Before you look at your report, could you answer that question for me? If you need to read your report, be glad to have you refer to it. By May 2003, had Ethan Ruby reached a stable plateau?

A In terms of rehabilitation issues? I would say yes.

Q What does that mean, just --

A He had participated in courses of physical and occupational therapy. He was at that point independent in things like wheelchair mobility. So, in those regards, yes, he would be stable.

Q was he stable in terms of pain level?

A I couldn't say what his pain level what at that point.

Q Was he stable in terms of physical strength?

A He certainly should be stable in terms of physical strength, yes.

Q Was he?

A I have no reason to think he wouldn't be.

Q You didn't examine him in May of 2003, so how would you know?

MR. SCHWAB: Objection. Argumentative, now.

THE COURT: I'm going to sustain it. He said stable plateau. The doctor gave his definition.

Q In November of 2003, just this past month, it's about 18 months from the time that you examined him, Ethan achieved a stable plateau?

A He certainly should be.

Q Do you know whether he does or doesn't? Has he reached a stable plateau?

MR. SCHWAB: Objection. Argumentative.

THE COURT: Overruled.

A He should have already reached a -- he should have indeed already reached a stable plateau, so he should still be on it.

Q Okay.

THE COURT: You can ask it, Mr. Moller. You can ask it.

Q Would he be able to do any work on a full-time basis?

A Certain types of work, yes.

Q Like what?

A He can do sedentary work.

Q What does sedentary work mean?

A That would mean, in layman's terms, a desk job.

Q Well, what kind of a desk job?

MR. SCHWAB: Objection.

THE COURT: Fair question.

Q What are we talking about? What kind of a job?

A He can do work that involves using his intellect. He cannot do heavy physical work.

Q You moan like being a builder? What are you talking about? What's heavy work?

MR. SCHWAB: Objection.

Q What's heavy work?

A Heavy work involves frequent lifting; for example, carrying, climbing ladders, all things that he could not do. But he could do sedentary or office work.

Q Is Ethan Ruby in constant pain? How do you think that would influence his ability to do any kind of work?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q How much time does it take to change catheters?

MR. SCHWAB: Objection.

Q How much time does it take Ethan Ruby to change catheters?

THE COURT: That's sustained, Counsel.

Q How much time -- I'll withdraw the line.

THE COURT: That's all right. Come on. It's getting toward the end of the day, ?? got to get there.

(Discussion at Ben?? off the Record.)

Q Can Et' an Ruby do day trading?

MR. SCHWAB: Objection.

THE COURT: Overruled.

A From my perspective, yes.

Q What do you know about what a day trader does in the course of his day, sir?

MR. SCHWAB: Objection.

THE COURT: Overruled.

A Day traders monitor stock information. They look at trend for what's going on in the stock markets. They at ??mpt anticipate those. They attempt to do rapid short-term trades to make more income.

Q Have you ever seen a day trader do his work?

A Specifically, a day trader, I don't know that I have seen one, no.

Q No. Have you ever seen a day trader do his work?

MR. SCHWAB: Objection. Just --

Q Yes or no?

MR. SCHWAB: Just answered a second ago. I ask that the last question and answer be read back.

THE COURT: Not necessary. I heard it.

Q Doctor, you have to answer yes or no on this one.

A No.

Q Do you know the level of attention required to trade securities?

MR. SCHWAB: Objection.

THE COURT: Overruled.

A Yes.

Q From what?

A I have had a number of patients in the financial service industry, a number of whom are traders.

Q Who told you what?

A Not only what they told me, but in cases where we're looking at returning them to work, I have contact with their supervisors and work with them when there's a question of return to work.

Q Such as what kind of work, what kind of trading, sir, are you talking about?

A Currency trading, commodities trading, stock trading, quite a few different areas within the financial service field. Not specifically day trading, that I recall.

Q How many patients have you had that you had to make those judgments about?

MR. SCHWAB: I think this entire line's going far afield now.

THE COURT: You have a standing objection, Mr. Schwab, and they're all overruled.

MR. SCHWAB: Thank you.

Q How many people do you know who were involved in that kind of business?

A How many people do I know who are involved in the business as my patients?

Q Yeah.

A Hundreds.

Q Hundreds in the financial services industry?

A Yes.

Q Describe the equipment that they use.

A The equipment that they use, they use computer terminals.

Q No, what's on it?

A Data.

Q How fast does it change?

A Well, if they're looking at data, changes rapidly.

Q What data?

A Stock prices, trades, market activity.

Q What else?

A Those are the main things I would think of.

Q Do you know how it's used?

A In terms of how they make their decisions?

Q Yeah.

A There are a lot of different methods, and I can't say how each one of them does it.

Q Do you know any models?

A Not specifically of how the model works, no.

Q You mentioned currency trading.

A Yes.

Q How does that work?

A Because --

Q How does it work? Not the specifics of it. How does currency --

MR. SCHWAB: Objection.

THE COURT: Your objection is sustained.

Q Have you ever had a patient with a spinal cord T6 injury --

A Yes.

THE COURT: He didn't finish the question.

Q I didn't finish my question.

A I'm sorry.

Q Did you ever have a patient with spinal court T6 injury who was in constant pain?

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q Do you believe that Ethan Ruby's capacity to make a living has been damaged by his injury?

MR. SCHWAB: Objection. May we approach the sidebar, please?

THE COURT: Okay. (Discussion at Bench off the Record.)

Q Has Ethan Ruby's ability to conduct his daily activities has been compromised by his injury?

MR. SCHWAB: Objection -- I withdraw that objection.

A Yes.

MR. HOLLER: Just give me a moment. I just have a few more questions, Doctor.

Q Would a normal consequence of Ethan Ruby's spinal cord injury be sleep deprivation?

MR. SCHWAB: Objection. Not proper cross.

THE COURT: Correct. Sustained.

Q You wrote in your report that accompanied the 3101(d), “He complains of decreased sleep and decreased concentration.”

MR. SCHWAB: Objection.

THE COURT: Sustained.

Q In your report --

MR. SCHWAB: I object to counsel referring to a document not in evidence.

THE COURT: Sustained.

Q In the 3101(d) --

MR. SCHWAB: Objection to counsel referring to a document not in evidence which is also a legal document.

MR. MOLLER: Let's approach. I can be finished in a minute if we go through these.

MR. SCHWAB: Finish now.

(Discussion at Bench off the Record.)

Q When you examined Ethan Ruby, did he report to you lack of sleep?

A Yes.

Q Did he report to you depression?

A Yes.

Q Did he report to you pain?

A Yes.

Q Lack of sleep would affect his ability to concentrate?

MR. SCHWAB: Objection.

THE COURT: Rephrase it.

Q What impact -- strike that. You will agree, will you not, that if somebody can't sleep and is depressed, it certainly affects his capacity to do a normal day's activity, correct?

MR. SCHWAB: Objection.

THE COURT: I'll overrule that.

A It might.

Q It might.

A Yes. There are some people who have chronic depression, and/or sleep disorders, which I think were the things you mentioned --

Q Is --

MR. SCHWAB: No. May the witness finish without being cut off?

MR. MOLLER: Move to strike the answer as not being responsive.

MR. SCHWAB: Counsel cuts off a witness and now moves to strike it out as being unresponsive at five minutes to five.

THE COURT: Okay. I'm going to sustain the objection. Ask the question, and then we'll go from there.

Q Is Ethan Ruby's inability to sleep and his depression and his pain factors which will compromise Ethan Ruby's ability to live a normal life?

MR. SCHWAB: Objection to the form of the question.

THE COURT: Overruled.

A They certainly may affect his ability to lead a normal life.

MR. MOLLER: Just give me one more second.

Q You realize, don't you, Doctor, that your testimony bears upon the issues about how much care Ethan needs in the future and how he should be treated?

A Yes.

Q Correct?

A Yes.

Q And if your view of or perception of his status is wrong, and he has not reached a stable plateau, and if his physical conditions deteriorate, and your optimism is therefore misplaced, all of the risks of your mistakes fall on Ethan Ruby.

MR. SCHWAB: Objection to the form of the question.

THE COURT: Sustained:

MR. MOLLER: No further questions.

MR. SCHWAB: I believe I have two questions on redirect examination only, your Honor -- lawyer's two questions. Finished before five.

REDIRECT EXAMINATION

BY MR. SCHWAB:

Q Dr. Richter, do any of the documents that Mr. Moller referred to and the various physicians and doctors that Mr. Moller referred to, does any of that alter your findings on physical examination as a physiatrist of Ethan Ruby?

MR. MOLLER: Objection.

THE COURT: Overruled.

A No.

Q All right. Do any of the documents that opposing counsel's referred to and the doctors that he has referred to in any way alter your opinions regarding the correctness or incorrectness of various aspects of the Mona Yudkoff life plan?

A No.

MR. SCHWAB: Nothing further.

RECROSS EXAMINATION

BY MR. MOLLER:

Q Doctor, how much have you been paid to render testimony and opinions in this case?

MR. SCHWAB: Improper recross-examination.

MR. MOLLER: Not at all.

THE COURT: Allow it.

A $3,000.

MR. MOLLER: Thanks.

MR. SCHWAB: No re-redirect examination, your Honor.

THE COURT: Okay. Doctor, thank you. You're excused.

Counsels, need to see you.

(Discussion at Bench off the Record.)

(Whereupon, the jury exits the courtroom.)

(Trial resumes 12/9/03.)

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