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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: TRIAL TERM PART IA-4

-----X
BERNARD VERDON,

TESTIMONY
Dr. Aric Hauscknecht
Plaintiff, Dr. Andrew Merola

- against - :

PORT AUTHORITY OF THE CITY OF NEW
YORK, :
Defendant. :

-----X
Index No. 309654/2009

Bronx Supreme Civil Court
851 Grand Concourse
Bronx, New York 10451
April 8, 2014

B E F O R E: HONORABLE HOWARD H. SHERMAN
Justice of the Supreme Court

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RENÉE SCOTT, RPR, CSR
Official Court Reporter

1 MR. McCORIE: Your Honor, just as we did with
2 the anatomy of the vertebral column, which went into
3 evidence, Plaintiff's 28 is for ID. It's the anatomy of
4 the nerves of the lumbar, not in any damaged condition, in
5 the correct condition. So it's just the anatomy of the
6 nerves. I was just going to put it into evidence after
7 asking does it fairly and accurately depict the anatomy as
8 it exists.

9 MR. GANNON: Your Honor, I think I had objected
10 to the other -- I don't recall if I did or didn't, I may
11 have -- to another illustration of the anatomy. I have a
12 similar objection to this. This is just for demonstrative
13 purposes. It's not a piece of evidence that should go into
14 the jury deliberations.

15 THE COURT: Okay. Because I think there was also
16 one where there was a question, an objection about and I
17 think there was an objection for even using this for even
18 demonstrative purposes.

19 MR. McCORIE: That was for future that was kept
20 out.

21 THE COURT: Right. So you're objecting to it
22 going into evidence but you don't want it to go off in the
23 jury room but you don't object to the doctor using it for
24 demonstrative purposes on his testimony?

25 MR. GANNON: Correct.

1 THE COURT: So if that's your main purpose is to
2 have the doctor point out things to the jury and he doesn't
3 care if he shows it to the jury during the trial as an ID,
4 do you need it in evidence?

5 MR. McCORIE: I'd like it in evidence because
6 the regular anatomy doesn't show the radicular nature of
7 nerves that go from here to here. So it's just the anatomy
8 of the nerves which aren't on the other illustration.

9 THE COURT: So in the interest of moving this
10 along right now, we'll leave it for ID, show it and let the
11 doctor testify and we'll talk about whether it goes in
12 afterwards.

13 MR. GANNON: Thank you.

14 MR. McCORIE: Sure. I won't do it in front of
15 the jury.

16 THE COURT: No, no. He's not objecting to you're
17 using it in front of the jury.

18 MR. McCORIE: I understand that. I wouldn't
19 move it into evidence. We'll talk about at the --

20 THE COURT: Right. I'm reserving decision on the
21 in evidence for now but it can be used for the testimony.

22 MR. McCORIE: Yes, Your Honor.

23 THE COURT: Okay.

24 COURT OFFICER: All rise. Jury entering.

25 (Jury enters courtroom; the following

1 occurred:)

2 THE COURT: Good morning.

3 THE JURORS: Good morning.

4 THE COURT: Have a seat. Welcome back. Hope you
5 had a good weekend. You remember we didn't finish the last
6 doctor but we're going to take another doctor and then
7 finish the last doctor.

8 So your next witness is?

9 MR. McCORIE: Plaintiff calls Aric Hausknech,
10 MD.

11 (Witness approaches witness stand.)

12 THE COURT OFFICER: Stand here, raise your right
13 hand.

14 D O C T O R A R I C H A U S K N E C H T, a witness
15 called on behalf of the Plaintiff, having first been duly
16 sworn/affirm, took the stand and testified as follows:

17 THE COURT OFFICER: Please have a seat. In a loud
18 and clear voice, please state your name, title and business
19 address.

20 THE WITNESS: My name is Aric Hausknecht, MD. My
21 place of business is 2488 Grand Concourse, Bronx New York,
22 10458.

23 THE COURT REPORTER: Can you please spell your
24 name?

25 THE WITNESS: Sure. H-a-u-s-k-n-e-c-h-t, first

1 name is A-r-i-c.

2 THE COURT: Good morning, Doctor, just please
3 keep your voice up because it's hard to hear.

4 THE WITNESS: I'll try. I'm just getting over a
5 cold so I'm having a hard time projecting.

6 THE COURT: The level you're at right now is
7 great.

8 MR. McCORIE: May I proceed, Your Honor?

9 THE COURT: Go ahead.

10 MR. McCORIE: Thank you.

11 DIRECT EXAMINATION

12 BY MR. McCORIE:

13 Q. Good morning, Dr. Hausknecht.

14 A. Good morning.

15 Q. Can you tell the jury when you became licensed to
16 practice medicine in the State of New York?

17 A. Sure. I received my license to practice medicine and
18 surgery in New York State in 1992.

19 Q. Starting with your educational background, can you
20 tell them where you went to undergraduate and what your major
21 was, what your degree was in?

22 A. I graduated from Duke University in 1987 majoring in
23 physical anthropology then I graduated from Mount Sinai Medical
24 School in 1991 with a medical degree.

25 Q. The jury has already heard the terms and been defined

1 "residency," "fellowship." Could you please tell the jury more
2 about your background starting with your residency and any
3 fellowships and positions you've held up until your current
4 position?

5 A. I completed a year of medical internship at Beth
6 Israel Medical Center in Manhattan in 1992. I completed my
7 neurology residency training program at New York Hospital,
8 Cornell Medical Center and Memorial Sloane Kettering Cancer
9 Center in 1995 where I've been in private practice since 1995.

10 My private practice includes an office here in the
11 Bronx as well Manhattan and Queens. I'm affiliated with several
12 different hospitals including Beth Israel Medical Center and New
13 York Hospital. And I'm currently board certified in neurology
14 by the American Board of Psychiatry and Neurology and I'm also
15 certified in pain management by the American Academy of Pain
16 Management.

17 Q. Can you please tell the jury -- they heard from an
18 orthopedic spine surgeon -- can you please tell them what a
19 neurologist is?

20 A. A neurologist is a physician that specializes in the
21 treatment of the disorders of the nervous system. The nervous
22 system includes the brain, the spinal cord and the peripheral
23 nerves. So there is a lot of crossover between an orthopedist I
24 guess and a neurologist when it comes to the spine. Because the
25 spine is made up of both bones as well nerves.

1 So as a neurologist and a pain management specialist,
2 I deal with a lot of people that have neck and back pain. It's
3 my job to figure out what's causing that pain. It's my job to
4 figure what's the best type of treatment for that pain is such
5 as physical therapy or medications or some type of injection or
6 surgery.

7 Q. And can you please tell the jury, although the words
8 might be self-explanatory, about the field of pain management,
9 what that entails?

10 A. Pain management is the field of medicine that deals
11 with the treatment and evaluation of pain and the consequences
12 that that pain has on a person. So as a pain management
13 specialist, it's my job to try and treat that pain by whatever
14 means are available to improve the quality of that person's
15 life, that is, to say to reduce that pain as much possible as
16 and to increase their ability to perform daily activities to
17 function on a day-to-day basis.

18 Q. Have you ever testified in court before?

19 A. Yes, I have.

20 Q. Can you tell the jury a little bit more about your
21 practice and what it entails?

22 A. I have a neurology and pain management practice.
23 Generally, I see adult patients. I don't see pediatrics. I see
24 a lot of people with neck and back pain. Some of it is from
25 accidents whether it's a car accidents or a construction

1 accident, some of it's from other causes such as wear and tear
2 like arthritis or some other type of rheumatological disorder?

3 It's my job once again to try and figure out what's
4 causing that person's pain. Oftentimes, different types of
5 imagining studies are employed so I might send a patient for an
6 Ms, CAT scans or x-rays different types of tests are done. We
7 do nerve tests in the office and then I would monitor a
8 patient's response to treatment. So, for example, I might send
9 a patient for physical therapy, for chiropractic treatments or
10 prescribe various medications and then have them come back in to
11 see how they are responding to that treatment.

12 Q. You sort of answered in the last answer but can you
13 tell the jury whether or not your practice accepts work-related
14 accidents and all of the rules and procedures that go along with
15 accepting such patients?

16 A. Yes. We don't discriminate. We take almost all types
17 of patients. There are different rules that have to be followed
18 in the office depending on what type of patient it is but we
19 comply with those.

20 Q. Are you being paid for your time away from your
21 practice?

22 A. I am. Normally, I would be in Manhattan this morning
23 seeing patients. I had to cancel all of those patients. I'm
24 being compensated for that. My fee for time away from the
25 office is \$500 per hour.

1 Q. And did we, myself and Mr. Mayar, did we meet with you
2 approximately a week or so ago to go over your anticipated
3 testimony, your file, the enlargements that Dr. Merola picked
4 out?

5 A. Yes.

6 Q. And certainly certain medical illustrations?

7 A. Yes.

8 Q. Regarding MRI's and x-rays and CAT scans, can you tell
9 the jury whether or not you view and interpret those on a
10 recognize basis in your practice?

11 A. Yes. That's an important part of the diagnostic
12 process in my office. So as a clinician, I'm sort of like a
13 detective. I try to take all the different pieces of the
14 puzzle: what a person is saying, what I find on examination,
15 what a MRI or an x-ray or CAT scans shows, what a nerve test
16 shows, put all those pieces of the puzzle together to get the
17 big picture.

18 So imaging studies like MRI's CAT scans, x-rays are
19 important in helping to establish the structural pathology, what
20 it looks like. So part of my training, part of my board
21 examination, part of what do on a daily basis is prescribing and
22 reviewing different MRI's and x-rays and CAT scans, something I
23 do everyday.

24 Q. And do you employ a radiologist to read those for you
25 or do you read them yourself in your practice?

1 A. Well, I don't employ. A radiologist doesn't work for
2 me put a radiologist generally owns the facility that does the
3 MRI or the CAT scans. So when I'm seeing a patient, two pieces
4 of information will be available. One would be the actual film
5 which I look at; another would be the radiologist report and
6 generally I rely on both and usually I'm in agreement with the
7 radiologist

8 Q. Your file is deemed in evidence so you can read from
9 any notes that you've personally made.

10 Is Brian Verdon a patient of yours?

11 A. Yes.

12 Q. When did you first -- withdrawn.

13 Have you reviewed your file in anticipation knowing
14 that you were going to come here this morning to testify?

15 A. Yes.

16 Q. Can you tell us from your file when Brian Verdon first
17 became a patient of yours?

18 A. It was in 2009, specifically November 17, 2009.

19 Q. And do you know or can you tell us from your note how
20 it is Mr. Verdon became a patient of yours?

21 A. He had been referred by the spinal surgeon Dr. Merola.

22 Q. Is that common in the interplay between you said
23 orthopedist and neurology that you would refer patients to an
24 orthopedist or a orthopedist would refer patients to you?

25 A. That's pretty common.

1 Q. The jury already knows what a history is but could you
2 please tell the jury, going through the history of the first
3 visit, what was the history that Mr. Verdon gave to you, what
4 had happened, what was going on since the accident?

5 A. Mr. Verdon came in the first time accompanied by his
6 wife. She was helping to give some of the history. He also had
7 some medical records with him but basically he had been injured
8 on the job 8/11/09 when he had fallen off a scaffold and
9 sustained a head injury. He was bleeding from his scalp, had
10 been taken to Bellevue Hospital where he was found to have
11 multiple fractures of the spinal column, by a burst fracture at
12 T12 which was retropulsed meaning the bone fragments had moved
13 into the spinal canal which required emergency surgery so he had
14 undergone surgery in the hospital. He was in a hospital for a
15 few days then he was transferred to a rehab facility and had
16 been taken to rehabilitation.

17 When I saw him, he indicated that he was still having
18 pain and stiffness, specifically in his neck, mid and lower
19 back. At times, he had what he called a stinging pain which
20 went down the back of his left leg. He was having numbness in
21 his right thigh and calf and this seemed to be provoked by
22 activity or use of the leg. Both of his arms had been feeling
23 weak. At that time, he denied any autonomic symptoms.
24 Autonomic symptoms would refer to loss of bowel or bladder
25 control or loss of sexual function. He was having problems with

1 his activities of daily living, specifically sitting, standing,
2 bending, lifting and walking. He was in a back brace and he was
3 using a cane.

4 He denied any prior history of spinal injury or spinal
5 trauma or spinal problems. He had been taking Ibuprofen for
6 pain because he was trying to avoid taking pain medications. He
7 had been unable --

8 Q. Let me just stop you for one second. Did you actually
9 indicate in your notes he wanted to avoid taking medication?

10 A. That's what he told me, yes.

11 Q. Okay, and it's indicated so in your note?

12 A. That's correct.

13 Q. Please continue.

14 A. I performed a physical examination. At that point, I
15 found that was there some weakness in his arms and legs. There
16 was a five minus weakness of the shoulder inductors. The
17 shoulder inductors are the muscles that raise the arms up.
18 Motor strength is rated on a scale of zero to five with five
19 being full strength, five minus would be one grade below full
20 strength. So he had lost some strength in his arms. He was far
21 from paralyzed.

22 Q. What, if anything, was medically significant to you
23 about that finding?

24 A. Loss of motor strength in the extremities can be an
25 indication of neurological dysfunction or nerve damage. There

1 was a potential that he had sustained either a spinal cord
2 injury or injury to one of the nerve roots coming from the spine
3 to the arms.

4 There was motor weakness also in the left hand which I
5 found to be four plus, in the right hip which I found to be four
6 plus, in the left hip which I found to be five minus, in both
7 knees which I found to be five minus and in the left ankle which
8 was a five minus. There was also atrophy which is a shrinking
9 of the muscle and decrease muscle tone in both of the legs. The
10 reflexes I found to be brisk or hyperactive in the lower
11 extremities at the knees and the ankles and the sensory exam I
12 noted there was a loss of feeling in his lower back around the
13 area of the surgery.

14 Q. What, if anything, was of medical significance about
15 the atrophy and the weakness in the lower extremity?

16 A. Once again these are signs of potential nerve damage
17 either a spinal cord injury or a peripheral nerve damage. In
18 the case of brisk reflexes, it's usually a sign of upper motor
19 neuron dysfunction and upper motor neuron we're typically
20 referring to the spinal cord or to the brain itself. In this
21 case, I was concerned that he had sustained a spinal cord injury
22 and, in fact, he did have a T12 burst fracture that went into
23 the spinal canal.

24 The mechanical exam when I examined his neck and back
25 I found that there was a cervical paravertebral tenderness and

1 associated muscular spasm as well as throughout the lumbar
2 paravertebral tenderness associated with muscle spasm.

3 Q. If you could tell the jury, Doctor, whether or not
4 those findings of spasm in both the neck and the mid back, low
5 back, whether they were objective or subjective and how you
6 determined whether or not they was spasm present in these areas?

7 A. Sure. First, let me explain the cervical is the neck.
8 Thoracic is the middle back. Lumbar is the lower back.
9 Paravertebral would refer to the tissues around that area. It
10 would be the skin, the subcutaneous tissue and the muscle.
11 Spasm is the involuntary tightening of a muscle due to an
12 underlying injury such as a disc or a pinched nerve or a broken
13 bone.

14 In this case, when I was palpating the spine, when I
15 was like physically examining him, I found that the muscles had
16 gone into spasm. This is an objective finding as posed to a
17 subjective complaint. So, for example, if a person comes in and
18 says my neck and back feel very tight, that is subjective.
19 That's what they're saying. I, as an outside observer, don't
20 know whether or not their neck and back is actually tight or
21 whether or not there's actual spasm. But if I now exam them and
22 I find that the muscle are locked up, they are in spasm. If I
23 find that his neck and back doesn't move the way that it should,
24 that would be an objective finding, a sign that will confirm or
25 corroborate his subjective complaint.

1 So he did complain of stiffness and when I examined
2 him, I found that there was tenderness and spasm in the neck and
3 back. The Spurling maneuver was positive on the right. the
4 Spurling test is performed by taking a person's head in your
5 hands, turning it, extending it and putting pressure down on
6 top. If there's an area of the spine that's been compromised
7 such as a slipped disc or a pinched nerve, this maneuver can put
8 stress on that injured area and in this case it was positive on
9 the right side.

10 The straight leg raise test was positive on the right
11 side at 60 degrees and the left side at 45 degrees. The
12 straight leg raised test was performed by slowly raising a
13 person leg upwards. Normally a person could get to 80 or
14 90 degrees without any problem. In this case, at 45 degrees on
15 the left, it caused a shooting down his left leg and 60 degrees
16 on his right it caused a shooting pain down his right leg.

17 Once again this is a sign of pathology or damage to
18 the lower back. So if there was a portion of the lower back
19 that's been damaged, pinched nerve or the pressure on the spinal
20 cord and when you perform this maneuver, it stresses that area
21 and can reproduce the patient's symptoms in which it did in this
22 case.

23 I checked the range of motion to his neck and back
24 actively and passively using a tool known as a goniometer.
25 Active range of motion depends on the activity of the patient.

1 Passive range of motion is performed manually by the examiner.

2 So, for example, if I say to a patient bend your neck
3 to the left as far as it will go and I measure that angle that
4 would be active left lateral flexion of the cervical spine.
5 That depends on the activity of the patient.

6 If I take that person's head in my hands and I push it
7 to the left until it doesn't any further that would be passive
8 left lateral flexion of the cervical spine. It's objective.
9 It's performed by the examiner. In this case, there was no
10 discrepancy between the active and passive movements.

11 I asked Bernard to bend his head to the left. When I
12 physically pushed his head to the left I got the same
13 measurement. So we got a pretty good idea of the movement of
14 his neck and back. This was measured using this tool and he had
15 significant restrictions. In the neck, there was left lateral
16 flexion or the ability to bend to the left. He had lost 40
17 percent of the movement; right lateral flexion, the ability to
18 bend to the right, he had lost 30 percent of the movement; left
19 rotation, the ability to turn his head to the left, he had lost
20 about 28 percent; right rotation, he had lost about 18 percent;
21 forward flexion, his ability to put his chin to his chest, was
22 relatively maintained. He had almost full motion there and
23 extension ability to bend backwards, he had lost about
24 18 percent. In his lower back, it is more significant
25 restrictions. His ability to bend forward at the waist was

1 limited by almost 50 percent. His ability to bend backwards at
2 the waist was limited by 60 percent. So he could only get to
3 10 degrees. Normal he would get to 25 degrees.

4 Left lateral flexion, the ability to bend to the left,
5 right lateral flexion, the ability to bend to the right, left
6 rotation, the ability to twist to the left, right rotation the
7 ability to twist to the right, these are all limited by
8 approximately 50 percent.

9 I noted that his gait was antalgic meaning he was
10 limping. He had difficulty dressing and undressing. He had
11 problems getting on and off of the examination table and he was
12 relying on his cane at that point for walking.

13 Q. The difficulty with dressing and undressing that's
14 something you observed. You're talking about during the
15 examination?

16 A. During the exam, yes.

17 Q. Doctor, before we go further there, I just wanted to
18 know if you did this. Did you ask him, seeing him for the first
19 time, whether or not there was any past medical history?

20 A. I did.

21 Q. Could you tell the jury why that's significant when
22 you first see a trauma patient and when you're eventually going
23 to be determining the cause of something whether or not someone
24 has past medical history?

25 A. Well, in order to determine what's causing a problem,

1 it's important to know if the person ever had that type of
2 problem before. In this case, Mr. Verdon indicated that he
3 never had a problem with his neck or back before, never treated
4 with a doctor for his neck or back before, never missed work
5 because of his neck or back before but it was until this
6 accident that he started having neck and back pain.

7 Q. One other thing I failed to ask you. In accepting
8 work-related accidents and you said construction accidents, have
9 you, in fact, treated patients that have been Sacks and Sacks
10 clients before?

11 A. I have. I'm one of the doctors.

12 Q. And have you testified, in fact, in court before on
13 behalf of patient's of yours that were also clients of ours?

14 A. Yes.

15 Q. Okay. If you could just please continue. I'm sorry I
16 didn't ask you that. Just going over, you talked about the
17 functional examination. Did you have any testing results or
18 what kind of tests, diagnostic testing knowledge did you have on
19 the first visit?

20 A. On the first visit, I had the -- some of the hospital
21 records, I had some of the CAT scan reports specifically of the
22 head which showed some swelling in the scalp but really no
23 injury to the brain itself. There were x-rays and CAT scans of
24 the neck and back which showed a little bit of arthritis which
25 was common for his age and occupation but most notably showed

1 multiple fractures in the -- throughout the lumbar spine.

2 Q. Is that arthritis what's known as degenerative
3 changes?

4 MR. GANNON: Objection.

5 Q. Is there a --

6 THE COURT: Overruled.

7 A. Yeah. Osteoarthritis or degenerative joint disease is
8 also what's known as wear and tear. So all adults throughout
9 the course of their lifetime will develop osteoarthritis or wear
10 and tear on the parts of the body that we use the most, our
11 spine our hands, our knees, our shoulders. Over the course of
12 time, these tend to wear out and what happens is you get bone
13 spurs or osteophytes. All adults will have osteoarthritis.
14 It's not to say that all adults will have symptoms. It may not
15 bother you at all. You may not even know it but this is just
16 something that happens to our body as we grow old.

17 Q. If you could tell the jury what the term -- they heard
18 it the other day but "asymptomatic degenerative changes." What
19 does that mean, those three words together?

20 A. Asymptomatic degenerative changes would mean that you
21 have some arthritis in your body that you don't even know. You
22 might have some degeneration through your neck and back but it
23 doesn't affect you. You're still working. You don't have neck
24 or back pain. You don't have to go for treatment. You're not
25 missing work because of your neck or back. It's just something

1 that's there that you don't know it.

2 Q. Okay. Will you could continue please, Doctor?

3 A. So after reviewing the -- after taking the history and
4 performing the physical exam, I reviewed some of the CAT scans,
5 most specifically the CAT scan of the thoracic lumbar spine
6 which showed multiple fractures affecting the spinous at T7, T8,
7 T9, T10, T11; compression fracture of the body at T10,
8 transverse fracture at L1 with a hard disc complex at T12-L1 and
9 acute burst fracture of the T12. Vertebral body with
10 retropulsion meaning that the bone was basically just pulverized
11 and some of the fragments went back into the spinal canal.

12 Q. What was your impression, that's as you call it in
13 your note or diagnosis, your first initial working diagnosis?

14 A. Initially, I was impressed that he had sustained a
15 closed head trauma.

16 Q. Which is what?

17 A. Just that he hit his head but based upon the history
18 and the examination that I took from him that took place as well
19 subsequent days it didn't appear that he had sustained any
20 significant sequella from the head trauma although clearly he
21 did sustain a head trauma.

22 There was a cervical, thoracic and lumbar derangement
23 with multiple fractures requiring surgical repair as well as
24 exacerbation of previously asymptomatic underlying degenerative
25 joint disease.

1 Q. Can you tell the jury what exacerbation means,
2 medically?

3 A. It means basically it was activated. It was there
4 before but it wasn't bothering him. This accident is what made
5 it become symptomatic.

6 Q. What was your plan on that first visit?

7 A. That date I recommended that he attend physical
8 therapy, that he take medications and I suggested that we do
9 diagnostic testing, specifically some nerve testing and some
10 MRI's.

11 Q. And just because your notes will be in evidence and
12 are in evidence, if at all in your notes, it says in your note
13 that you're requesting formal authorization for treatment or
14 testing, is that required in the work accident system, a request
15 in your notes?

16 MR. GANNON: Objection.

17 Q. Well, without telling us the entity you were
18 requesting it from, did you in all cases put formal requests in
19 your notes?

20 MR. GANNON: Objection.

21 MR. McCORIE: Withdrawn.

22 Q. What testing did you request on the first date if any?

23 A. Nerve testing of the neck and back which is what's
24 known as the SSEP and NCV-EMG study.

25 Q. Can you just tell the jury what that's an acronym for

1 why you were ordering those specific tests with the symptoms Mr.
2 Verdon had?

3 A. SSEP stands for Somatosensory Evoked Potential.
4 NCV-EMG stands for Nerve Conduction Velocity and EMG stands for
5 Electromyography. These are computer generated tests that
6 measure the function or the integrity of the nervous system.

7 The human nervous system functions by transmitting
8 small electrode impulse. So, for example, if a person decides
9 they want to make a fist in their right hand somewhere on the
10 left side of the brain, one of the neurons, the nerve cells,
11 fire off releases electricity and causes a chain reaction. That
12 electricity is transmitted across the brain down the spinal cord
13 into the nerve root that goes to the muscle causing one side of
14 the muscles to contract and another set of muscles to relax.
15 This all happens within about one to two tenths of a second. So
16 the SSEP and the NCV portion of the test is performed by putting
17 an electric shock on the nerve and then measuring how quickly
18 that electricity either gets to the muscle or to the brain. The
19 EMG portion is performed by placing needles into the muscles and
20 measuring the electrical activity.

21 So, for example, in this courtroom, if there are 17
22 recessed lights and there are five switches back there that
23 control, you turn on all five switches and four of the lights
24 don't go on, it means there's either a problem with the switch,
25 the brain; there's a problem with the wiring, the spinal cord or

1 the nerve root or there's a problem with the fixture or the bulb
2 which would be the muscle or the neuromuscular junction. So
3 this test determines objectively whether or not there's nerve
4 damage, where that nerve damage is coming from, how severe it
5 is, how long it's been there.

6 Q. And can you tell the jury further on your plan what
7 your prognosis was and what you instructed Mr. Verdon, if
8 anything, before the end of his exam?

9 A. The prognosis at that point was guarded meaning that
10 this was a pretty serious injury. I was concerned about his
11 ability to recovery, to recover. I was concerned about his need
12 for further care and then I told him to restrict his activities.

13 Q. Was he wearing a brace when he first saw you?

14 A. Yes.

15 Q. Dr. Hausknecht, when did you next see Mr. Verdon?

16 A. He returned to the office on 12/22/09 at which time
17 the nerve testing was performed and then he came back again on
18 2/2/10.

19 Q. Was authorization, in fact, given to you to do that
20 exam?

21 MR. GANNON: Objection.

22 THE COURT: Sustained.

23 Q. Has all of your treatment to date been authorized?

24 MR. GANNON: Objection.

25 THE COURT: Sustained.

1 Q. Did you do the exams that you sought authorization for
2 on the first exam?

3 MR. GANNON: Objection.

4 Q. Did you perform them?

5 THE COURT: Sustained. The exams did you do it?

6 THE WITNESS: Yes.

7 Q. Can you tell the jury the results of those exams?

8 A. The exams showed, in fact, that there was nerve damage
9 that was coming from his back and going down his right leg.

10 Q. Go to the -- we're not going to go through every note.
11 Some of your notes are typed, some of your notes are
12 handwritten.

13 On all of your notes, are they signed by yourself
14 whether typed or handwritten?

15 A. Yes.

16 Q. Just go to the next exam February 2nd, 2010. Can you
17 just go through -- you don't have to go through the whole
18 history. What, if any, complaints was Mr. Verdon making to in
19 February of 2010.

20 A. His complaints were similar. He was still having neck
21 and back pain. His right thigh was feeling numb. His arms and
22 legs were feeling weak. He noticed in his left foot he was
23 cramping up in the morning. Once again he denied any autonomic
24 symptoms. He had been taking physical therapy and that seemed
25 to be helping. He was seeing an orthopedist for his right

1 shoulder. He was taking Vicodin for pain which is a narcotic
2 analgesic. He was having problems with his activities of
3 day-to-day living as we discussed before, the sitting, the
4 standing. He was using the back brace as well as the cane.

5 Q. Just going back to the first exam. What, if any -- I
6 know you had recommended that he restrict his activities but
7 what, if any, recommendations did you make regarding returning
8 to work as a carpenter?

9 A. He could not return to work.

10 Q. Okay. So continue with the -- was he taking any
11 medications in February?

12 A. He was taking Vicodin.

13 Q. Do you know who was writing the prescriptions for
14 those Vicodin?

15 A. On that particular date, I'm not sure if -- he had
16 gotten those prescriptions from my office on other occasions but
17 I'm not sure if that came from my office or not.

18 Q. And when you said "from your office," you're the
19 medical physician that prescribes them?

20 A. Yes.

21 Q. Okay. The physical examination in February of 2010
22 was there any difference from the prior examination, anything of
23 medical significance?

24 A. It was not identical but similar. He still had
25 weakness in the arms and legs, atrophy and decreased tone in the

1 legs, loss of mobility in the neck and back. I noted a
2 exaggerated kyphosis of the thoracic spine. His gait was still
3 antalgic. He was limping. He had problems dressing and
4 undressing. He had problems getting on and off the exam table.
5 He was using a back brace. He was using a cane.

6 Q. Can you tell the jury -- you told them what atrophy
7 was in connection with the first exam -- can you tell them what
8 the medical significance, if any, of atrophy is in the lower
9 extremities?

10 A. Well, once again, this a sign of nerve damage. It's
11 an indication that he sustained either trauma or damage to the
12 spinal cord as well as to the nerve roots in the lumbar region.

13 Q. The exaggerated kyphosis of the thoracic spine, can
14 you please tell the jury what that is?

15 A. Sure. There is a normal, normal curvature to the
16 spine, a convexity. So normally the spine curves in a little
17 bit like this and then curves forward. The kyphosis in this
18 case was in the thoracic region where the fractures had
19 occurred. The spine was starting to collapse so he was
20 basically hunching forward.

21 Q. And the EMG, what is -- can you tell the jury what --
22 you said lower extremity nerve damage. Can you tell them what
23 radiculopathy is and means?

24 A. Radiculopathy refers to a pinched nerve. A
25 radiculopathy can be a clinical syndrome meaning what the person

1 presents with to the doctor. So sciatic is a type of
2 radiculopathy. If a patient comes in and they say I'm having a
3 burning pain down my leg or a stinging type of electric pain and
4 the doctor finds that there is loss of power, changes in the
5 sensation, changes in the reflexes, positive straight leg raise
6 test, these would all be signs and symptoms of a radiculopathy.
7 Radiculopathy is also electric diagnostic findings. So in this
8 case on the EMG, there was pathology abnormalities that were
9 indicative of radiculopathy or nerve damage.

10 Q. I would like you to assume that in evidence and in Dr.
11 Merola's notes and in his testimony the other day that on
12 November 9, 2009 Mr. Verdon was referred to a Dr. Touliopoulos
13 for appendicular injuries, one of them being the right shoulder.

14 Do you have any knowledge that Mr. -- what, if any,
15 knowledge did you have of Mr. Verdon having right shoulder
16 injury --

17 MR. GANNON: Objection.

18 Q. -- back in February of 2010?

19 MR. GANNON: Objection.

20 THE COURT: Overruled.

21 A. I was aware that he had a right shoulder injury. That
22 was one of my diagnoses. I was aware that he was treating with
23 the orthopedist Dr. Touliopoulos for the shoulder and this was a
24 team approach. Dr. Touliopoulos was taking care of his
25 shoulder. Dr. Merola and I had been taking care of his spine.

1 Q. Just in the impression, can you tell the jury what the
2 word right shoulder arthropathy. Is that arthropathy?

3 A. Correct.

4 Q. Can you tell them what that means?

5 A. Arthropathy basically means dysfunction of the joint.
6 So the shoulder -- the shoulder had been injured. It wasn't
7 functioning properly.

8 Q. And your plan at that time in February of 2010.

9 A. 2010, my plan was conservative management. I wanted
10 him to continue to restrict his activities, do the therapy and
11 try and heal up from the fractures and the surgeries and to take
12 the medications as needed to relieve his pain.

13 Q. Did there come a time when you yourself reviewed Mr.
14 Verdon's MRI films in 2009 regarding his neck and back?

15 A. Yes.

16 Q. And over the course of your treatment, did there come
17 a time when you reviewed the MRI films of the neck and back in
18 2011 as far as 2013 and the thoracic films in 2013?

19 A. Yes. Basically, he's had three sets of his films for
20 his neck and back: 2009, 2011, 2013, that were either ordered
21 by myself or Dr. Merola. So we had been able to monitor his
22 condition and progress over the course of the past four years or
23 so.

24 MR. McCORIE: With the court's permission, I'm
25 not going to go through the whole thing with Dr. Merola but

1 I would ask that Dr. Hausknecht be able to step down and
2 I'll get the easel.

3 THE COURT: Go ahead.

4 MR. GANNON: Your Honor, I apologize. Before we
5 start questioning, could we have a side bar?

6 THE COURT: Sure.

7 (Discussion off the record.)

8 Q. Dr. Hausknecht, if you could step down. The jury has
9 already been given the anatomy, the basic anatomy of the spine
10 and in Plaintiff's 16 they have the model -- I think the sticker
11 fell off -- it's Plaintiff's 17. Can you use a new diagram in
12 conjunction with it's Plaintiff's 28 for identification in
13 discussing with the jury radiculopathy and how a radiculopathy
14 occurs. So understanding that -- 16 doesn't have nerve roots
15 coming out of it -- using the lower extremity and 28 is for
16 identification.

17 First, before you even comment on it, does 28,
18 Plaintiff's 28 fairly and accurately depict the normal anatomy
19 of the spine and the exiting nerve roots as they go down in the
20 lower extremity?

21 A. Yes.

22 Q. And is that a fair and accurate depiction of
23 Plaintiff's 28 of the normal anatomy as related to the spine and
24 the exiting nerve roots?

25 A. Yes.

1 Q. Okay. Please continue, Doctor.

2 A. This is a plastic model of a portion of the human
3 spinal column. This would be the top, this is the bottom, this
4 is the front, this is the back. Referring specifically to the
5 lumbar spine or the lower spine, you can see that it attaches to
6 the sacrum which is the tail bone which is attached to the
7 pelvis.

8 The spinal column is divided up into three separate
9 parts: the cervical, the thoracic and the lumbar region.

10 In the thoracic spine, there are 12 vertebrae numbered
11 from T1 through T12. In the lumbar spine, there are five
12 vertebrae and they're numbered L1 through L5. The disc sits
13 between the bones and inside the spinal column there are a
14 number of separate openings. Running from the top to the bottom
15 is the spinal canal and the spinal cord itself is located right
16 within that spinal canal.

17 And at each level, the neuroforamin that's the level
18 of the neuroforamin, the nerve roots come out. So in the lower
19 back, those nerve roots come out and they go down to the leg,
20 the thigh, the calf and the foot and they provide information to
21 the muscles either to contract or relax and they also provide
22 information back to the spinal cord and the brain.

23 Q. I know you gave the jury the analogy of the light
24 switch and you talked about EMG. Is the EMG test in anything
25 that we see in Plaintiff's 28?

1 A. Yes. So the EMG tests these nerves as they come down
2 the leg. So this nerve could be damaged either in the leg
3 itself or it can be damaged within the spinal cord, the
4 neuroforamen and this test could determine at what level that
5 nerve damage has occurred. It shows within the spinal cord
6 itself that those nerves were being damaged.

7 Q. Continue if you want to say anything else about the
8 anatomy?

9 A. Well, I'm not sure --

10 Q. Well --

11 A. -- how much is going to be --

12 Q. -- let's do this just before we have you sit down.

13 You said that you actually interpreted and looked at
14 the films of November 17, 2009, the lumbar?

15 A. Correct.

16 Q. If you could just tell the jury -- it's been marked up
17 by someone else's red pen -- if you could tell the jury any
18 significant medical findings?

19 A. This is the --

20 Q. And it's Plaintiff's 5A.

21 A. This is the lumbar MRI. This one is will be T1
22 sagittal view. We're looking at the spine from side to side.
23 So if you can imagine that you take somebody's spine, turn it
24 90 degrees and then cut it from left to right. What you're
25 looking at is one of the slices, the long way through the spine.

1 So here is the tail bone down here and each of these large
2 squares is a vertebral body and each of these wedge shapes in
3 between is the disc material. And what you see in looking at
4 this MRI is one -- these spikes over here are actually the
5 screws that are going into the bone. On the MRI, you don't see
6 the metal but what you do see are the bones themselves and these
7 are starting to swatch down as well as the discs which are
8 starting to push it out. You see these disc is pushing out here
9 and over here and this is where the spinal column and the nerve
10 roots are.

11 Q. And what is the disc with the arrow, the two arrows?
12 What is it pushing against in the back?

13 A. These would be the nerve roots coming down in what's
14 known as the cauda equina, the horse's tail. So the spinal cord
15 ends at approximately the level T12-L1 and from that point on
16 all the nerve roots go down through the spinal column and exits
17 at their respective level.

18 Q. What, if anything, is the disc material called?

19 A. It would be a disc protrusion either a bulge or
20 herniation. These nerve roots are within the spinal column
21 themselves. If there's anything in there that's not supposed to
22 be in there such as disc material or bone fragments, it can put
23 pressure and damage or irritation or inflammation on those
24 nerves.

25 Q. I'm just going to skip over the 2011 and just go a

1 little quicker.

2 Looking at the 2013, lumbar film of the same area, I
3 would like you to assume that Dr. Merola has testified that it
4 progressed as a protrusion called herniation at that level where
5 the arrow is the facet joint.

6 Do you agree or disagree with that interpretation?

7 A. It looks like it has gotten worse at these two levels.

8 Q. Can you explain to the jury the progressive nature of
9 a protrusion or herniation? This is 10A.

10 A. Once the discs slips out of place, it can never go
11 back to its normal healthy state. Sometimes it gets worse,
12 sometimes it can dry out and get better but in this case because
13 there's been stabilization so you see the screws here, the
14 screws here, the screws here, that means that these bones, these
15 joints don't move at all. They're basically fused together. So
16 what happens is all the movement, all of the weight of gravity
17 from standing up, it's transmitted to the levels above and
18 below. Those levels become more susceptible to wearing out.

19 So in this case because these levels have been fused,
20 the major stress that's on his spine from standing up, sitting
21 down and walking is translated to the levels above and below the
22 surgery. And as you can see, this is causing a progressive
23 deterioration at those levels.

24 Q. Let me show you Plaintiff's 7A, which is October 9,
25 2011 cervical MRI being the sagittal view and I note it's been

1 circles in red by Dr. Merola. Can you tell the jury what is
2 circled in red?

3 MR. GANNON: Objection, your Honor. May we
4 approach?

5 THE COURT: Yes.

6 (Discussion off the record.)

7 Q. Doctor, can you just point out any findings of medical
8 significance that you see on that exhibit?

9 A. Sure. So this is the cervical MRI. Once again it's
10 the sagittal image. It's a different magnetic image called a T2
11 but each of these is a separate slice. So will this is the top,
12 this is the bottom, this is the front, this is the back, this is
13 actually the base of the brain with the brain stem and the
14 cerebellum and this becomes the spinal cord. This is the spinal
15 cord coming down. Each of these square ish shape with the
16 vertebral body and the wedge shape between it is the disc. And
17 you see at the level of C2, 4 that the disc material is pressed
18 backwards. That's a disc herniation and it's putting pressure
19 on the spinal cord itself. You can see how far the cord buckles
20 around that disc herniation and you see it again in the image in
21 front of it as well is not as clear as this one.

22 Q. So I'm going to put up 4B. This is the 2009 axial
23 view of the cervical. Would you just point out to the jury any
24 findings of medical significance?

25 A. Sure. Now, this is a different perspective. So if

1 you can now imagine that a person is laying flat on the table
2 and you're taking short slices through the spine. Each one of
3 these is the short slice. So this is the vertebral body with
4 the transverse process to the left and right and the lamina
5 process behind it. So the bone itself would look like that,
6 like the vertebra. This opening here is as such is the spinal
7 canal. The heart shape is the CSF or the cerebral spinal fluid
8 and that central oblong shape is the spinal cord itself.

9 If you go up to the level of C3-4, you see how
10 something is pressing backwards right there and that's the disc
11 material that's putting pressure on the spinal cord and
12 displacing the CSF. It's the same thing that we saw in that
13 other picture. We're just looking at it from a different
14 perspective.

15 Q. Okay. Thank you, Doctor. I'm going to have you sit
16 down now.

17 (Continued on the next page ...)

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1 Q From the time you first saw Mr. Verdon in 2009 until
2 present, have you seen him on a regular basis?

3 A Yes.

4 Q Approximately how often?

5 A Initially, he was seen approximately every month, for
6 the first year or two. Since then, he's been seen every other
7 month, more or less.

8 Q And, regarding Mr. Verdon speaking from a neurological
9 and pain management perspective, have his symptoms gotten
10 better, worse, something else?

11 A His condition has deteriorated slowly. He's a very
12 stoic individual. He doesn't like to complain. He doesn't like
13 to take medication but over the course of time, his condition
14 has deteriorated.

15 Q And despite Mr. Verdon being stoic, and have you in
16 fact indicated whether or not he has complained of pain on each
17 and every occasion, is that noted?

18 A He's always had pain, yes.

19 Q And have you always noted that he complained of pain?

20 A Yes.

21 Q To what areas of the body has he complained of pain to
22 each and every visit he had with you?

23 A Every time, he's got pain in his mid or lower back.
24 Most of the time he has neck pain as well, that's not been quite
25 as severe as the pain in the mid and lower back.

1 Q You previously said, in reviewing the, your first note,
2 that at that time you don't know if you were prescribing the
3 medication, who prescribes his medication these days and for the
4 past few years?

5 MR. GANNON: Objection.

6 Q Well, you said you prescribed medication to him?

7 A He's been prescribed medication in my office throughout
8 this course of treatment. On that particular day, who
9 prescribed that actual Vicodin, I can't say for sure, but I have
10 been prescribing him medications each time he's been in the
11 office, more or less.

12 Q And can you tell the Jury the difference between
13 Vicodin and Norco?

14 A They're similar mediations, they are both narcotic
15 analgesic, they contain a morphine derivative, known as
16 Hydrocodone with a variable amount of Tylenol, but they are both
17 very similar types of medicines.

18 Q And each time in your handwritten notes and your
19 typewritten notes, there is a section that says Rx. So, the
20 Jury can know, does that mean that on that occasion you
21 prescribed whatever is in the box after Rx?

22 A No, the Rx on the note will indicate what medications
23 he was taking, in the impression or attached to the note would
24 be a prescription for what we are renewing or changing.
25 Generally, in this case it was just renewing.

1 Q Did there come a time you noted in the first visit that
2 I was in physical therapy, did there come a time when you had
3 any knowledge as to whether or not physical therapy in the
4 program had stopped with Mr. Verdon?

5 A Yes.

6 Q Can you tell the Jury what home physical therapy is?

7 A Well, in this case, I instructed him on certain
8 exercises, stretching, strengthening, that he is to do on his
9 own because he was no longer eligible for supervised physical
10 therapy. Also prescribed for him what's known as a TENS Unit
11 which is electrical stimulation unit, similar to the one that
12 they would use in a physical therapy facility so that he could
13 use it at home on his own.

14 Q Can you tell the Jury the purpose of physical therapy,
15 as a board certified pain management physician in connection
16 with spinal injuries or disks injuries?

17 A Physical therapy can have several different positive
18 effects. One is symptomatic relief. So, doing physical
19 therapy, heat, electrical stimulation, it can help alleviate
20 some of the pain. It helps to, it helps injured parts of the
21 body recover. For example, the nerves in the muscle have been
22 damaged, exercising those limbs will help other muscle groups
23 overcome those impairments and also helps to prevent any
24 deterioration of the condition. So, in this case, there were
25 several different purposes for doing physical therapy, as well

1 as the exercises afterwards.

2 Q And, you said you prescribed a TENS Unit. Did Mr.
3 Verdon eventually get a TENS Unit to your knowledge?

4 A Eventually, he did, yes.

5 Q Can you tell the Jury the, tell them what it is, can
6 you tell them in a little more detail what it is, what it looks
7 like, how it works and you know, what purpose it serves?

8 A A TENS Unit looks almost like a little beeper and it's
9 got some wires that come off it, with a small electrodes that
10 transmit small electrical impulses to the skin and the
11 superficial muscles. Nobody is really sure how it works. But
12 the theory is that the small electrical impulses that are
13 generated help to block some of the pain signals that are going
14 to the spinal cord and to the brain and help the muscles and the
15 nerves to reset themselves. It can be very effective. But
16 generally, it's only temporary.

17 Q Does the TENS Unit itself, does it need to be replaced?

18 A Yes.

19 Q How often with a reasonable degree of medical certainty
20 would the actual unit need to be replaced?

21 A The unit is variable. Depending upon how much you use
22 it and the type, but probably every three to five years you need
23 a new unit, the electrodes themselves probably have to be
24 replaced every six months or something.

25 Q I'm going to skip to a note, June 25th, 2013, the rest

1 of your notes are in evidence. It's one of the typewritten
2 notes. If you could just go over the findings during that
3 visit?

4 A Sure.

5 Q Any ones that are medically significant?

6 A His complaints as well as the findings were similar.
7 He was still having neck and back pain. The neck pain was going
8 into his right arm. The back pain was going into both of his
9 legs. Both of his hands were feeling tingly, both of his feet
10 have been feeling numb when he was waking up in the morning. He
11 had lost power in his arms. He was also experiencing some
12 urinary incontinence, meaning he was having problems controlling
13 his bladder as well as erectile dysfunction.

14 Q Can you tell the Jury the significance of the urinary
15 incontinence and erectile dysfunction regarding spinal injuries?

16 A The ability to enjoy your bowel, and bladder, and to
17 obtain and maintain erection are all depending upon the nerve
18 roots within the lumbar region. So, in this case it was an
19 indication he was having progressive deterioration of those
20 nerves.

21 Q If you can continue?

22 A Sure. He was having problems with daily activities
23 especially sitting, standing, bending, lifting and walking. He
24 was still using a cane and the support but not all the time, but
25 like he was initially. He was having problems sleeping and

1 indicated the pain would wake him up every forty-five minutes or
2 so from sleep. He was doing some exercises at home. He was
3 still seeing Doctor Touliopoulos and Doctor Merola. He was
4 considering lower back surgery with Doctor Merola. He didn't
5 really want it. The injections which we discussed previously,
6 he was taking Norco for pain, which is like the Vicodin and
7 indicated at times it made him feel drowsy, so he didn't like to
8 take it.

9 Q And if you could just go back to handwritten note of a
10 few notes before, January 18th, 2013. When it says N-S-A-I-D-S,
11 ineffective, what does that mean?

12 A NSAID would be non-steroidal, anti-inflammatory.
13 Motrin, Advil Aleve. These are all over the counter NSAIDS. He
14 had tried those medications which are not as potent as a
15 narcotic pain killer and they basically did nothing for him.

16 Q Okay. And what if any medications was he taking when
17 he required it?

18 A I'm sorry.

19 Q Right above that, it says what he was taking?

20 A On 1/18/13, he was taking Norco which once again is
21 that narcotic pain killer.

22 Q And just so we go into the bottom right. When it says,
23 he declines ESIS, what is that?

24 A Epidural steroidal injections. This was a pain
25 management procedure that I had discussed with him, that might

1 give him some temporary relief. Basically, it's an injection of
2 steroid into the spinal canal to help reduce any inflammation or
3 irritation that was occurring and affecting the nerve roots.

4 Q And typically when epidural steroid injections are
5 given in the neck and back, are they done one or a series of
6 them?

7 A Generally they are done in a series of three.

8 Q And when they are done on the neck, where the spinal
9 cord is a full spinal cord as opposed to the back where the
10 cauda equina is there, is there a different way the procedure is
11 done when it's up by the spinal cord?

12 A It depends. It depends on the person doing the
13 injections, but generally these are all done under X-ray
14 guidance with sedation. So, the patient is placed on a special
15 table, and in a special position and the needle is advanced
16 using X-ray into the epidural space and then the solution is
17 injected into that area.

18 Q Just your physical findings on that date in June, 2013,
19 going back to that and right above it, you can tell them what
20 medications he was taking and what if any effects that had on
21 him?

22 A He was taking Norco, which is that narcotic pain killer
23 but once again it made him feel drowsy. He tried to avoid
24 taking it. On physical exam, there was some pain, limited
25 weakness in the arms and legs. Approximately meaning of the

1 shoulders and the hips. There was weakness of the right ankle,
2 reflex of his knees and ankles were diminished, there was loss
3 of sensation in the right thigh. There was cervical and
4 paravertebral tenderness and spasm, Spurling maneuver was
5 positive on the right, straight leg test was positive bi-
6 laterally. There was kyphoscoliosis of the spine, spine was now
7 hunched and also twisted. His gait was antalgic, moving slowly.
8 He was having problems dressing, undressing, getting on and off
9 the exam table.

10 Q I'm going to have you go to the last typewritten note,
11 I know there are other notes, handwritten after that, but the
12 typewritten note of August 6th, 2013. Could you tell the Jury
13 on that, in August 6th, 2013, what if any complaints Mr. Verdon
14 had to you?

15 A Pretty much the same. He was having neck and back
16 pain, with shooting pains down both his arms and down both his
17 legs.

18 Q Is the shooting pains, is that what you described
19 before, radiculopathy?

20 A Yes.

21 Q Okay. Had that condition of the shooting pains down
22 Mr. Verdon's arms and specifically legs, had that condition
23 gotten better, worse or stayed the same from the time he started
24 seeing you in November of 2009 until August of 2013?

25 A In general, it had gotten worse and it deteriorated.

1 There were certainly some days he was better and some days that
2 he was worse. His exam was not identical each time but over the
3 course of the four years or so that I was monitoring his
4 condition, he had deteriorated, he had gotten worse.

5 Q Okay. And in fact, moving up to his neck, singling it
6 out from the back, was there ever any improvement to the neck
7 pain?

8 A Sure. There were times where his neck pain was not as
9 severe as his mid and lower back pain, that was a more
10 consistent problem, his mid and lower back.

11 Q Okay, if you just continue with your findings on that
12 date. I stopped you at the shooting pains?

13 A We, we had gone over some of the findings, pain,
14 limited weakness in the shoulders and the ankles. I'm sorry,
15 shoulders and hips. There was a five minus weakness of the
16 right ankle. The reflexes in his legs were decreased down,
17 there was loss of sensation, I'm sorry, sensation on that date
18 was intact. There was cervical and lumbar spasm and tenderness.
19 Spurling maneuver was positive. The straight leg raise testing
20 was positive. His gait was antalgic, his movements were slow,
21 he had problems dressing, undressing, getting on and off the
22 exam table. There was a loss of mobility in the cervical and
23 lumbar region.

24 Q Was he still experiencing the urinary urgency?

25 A On that date, he was having urinary urgency as well as

1 erectile dysfunction.

2 Q The activities of daily living, can you go over whether
3 or not there were any complaints made regarding sitting,
4 standing?

5 A Yes, he was still having problems sitting, standing,
6 walking, bending, lifting, and he used the lumbar support and
7 the cane at times, not always, but at times.

8 Q And the medications on that date, in addition to Norco,
9 were there other medications and if so, what were they for?

10 A I prescribed other medications to him in an attempt to
11 try to minimize some of the side effects he was having from the
12 Norco. Medications I prescribed was Naprosyn, which is an
13 anti-inflammatory, Flexoril which is a muscle relaxer and the
14 Norco which is the narcotic analgesic. And what I explained to
15 him was to try to take the Naprosyn if the pain was mild,
16 especially during the day. Norco, if the pain was strong and he
17 is to take the Flexoril, the muscle relaxer, tends to make
18 people drowsy, especially at night, if he was having spasms and
19 problems sleeping, I wanted to him to be on all three
20 medications, in combination.

21 Q Go over the physical examination on that date, take us
22 right through the range of motion and tell us whether or not
23 that stayed the same, got worse or something different from the
24 course of your treatment from the beginning?

25 A He had still some antalgic weakness in both upper and

1 lower extremities proximally, five minus weakness in the right
2 ankle. Reflexes were diminished, essential sensory exam was
3 intact and there was tenderness and spasm in the neck and back.
4 Spurling maneuver was positive, straight leg raising testing was
5 positive. Loss of motion in the neck and back. His gait was
6 antalgic, he was having difficulty removing around, difficulty
7 dressing and undressing, difficulty getting on and off the exam
8 table.

9 Q And did you quantify the thoracolumbar spine?

10 A In terms of his ability to bend forward at the waist,
11 normally a person can get to 90 degrees. In this case, he can
12 only get to 30 degrees which would be a sixty-six percent loss
13 of his ability to bend forward.

14 Q During the course of your treatment with of Mr. Verdon,
15 did you in fact have the Bellevue Hospital record that's entered
16 into evidence here as Plaintiff's 1? Did you in fact review
17 that Bellevue medical record?

18 A Yes.

19 Q And have you in fact reviewed that record prior to
20 coming here today in anticipation of rendering opinions?

21 A Yes.

22 Q To cut down on time going through the whole thing, from
23 a neurological standpoint, what if anything was of medical
24 significance in the Bellevue medical record?

25 A I'm not sure I understand the question.

1 Q Well, what is your understanding of Mr. Verdon's
2 injuries as contained in the medical record of Bellevue?

3 A Well, he sustained significant trauma to his spine, as
4 well as other parts of his body, but specifically the spine and
5 multiple fractures. There was a T-12 vertebral fracture with
6 retropulsion of the fragments, meaning this was an unstable
7 fracture within the spinal canal, and this was a potential
8 neurological emergency, for which they did emergency surgery and
9 stabilized it.

10 Q Can you tell the Jury what a plural effusion is?

11 MR. GANNON: Objection, cumulative.

12 THE COURT: Didn't Doctor Merola go over that?

13 MR. MCCRORIE: Yes.

14 THE COURT: Sustained.

15 MR. MCCRORIE: Your Honor, with the Court's
16 permission, I would just like to, instead of going through
17 the actual records to save time, just show the Doctor the
18 October, 2009?

19 MR. GANNON: If I can just see that again.

20 MR. MCCRORIE: In Bellevue, and August 14th.

21 Q I'm just going to show you what is contained as part of
22 the larger record in evidence, I'm just going to show you the
23 October 16th, 2009 record as well as an August 14th, 2009
24 record, Plaintiff's Exhibit 1. Can you tell the Jury what if
25 any findings of neurological significance are contained on those

1 records?

2 (Whereupon, the exhibit was handed to the
3 Witness)

4 A On 8/14/09, there was basically a rehabilitation
5 evaluation, physical therapy evaluation while he was in the
6 hospital and indicates that he had the fall and undergone the
7 surgery, that he was complaining of back pain that was graded as
8 a 7 over 10 in severity. That, on examination, there was
9 significant loss of strength, and in both the arms and legs, as
10 well as loss of mobility and had difficulty getting around. And
11 another page where they recommend different types of treatments
12 to improve his symptomology.

13 Q And just looking at the other document from October
14 16th, just on the, any medical significance as from a
15 neurological standpoint?

16 A October 16th, 2009, this is the clinic notes. So, he
17 had gone back out to Bellevue Rehabilitation Clinic, and they
18 examined him and they noted that he had been getting physical
19 therapy at Kessler, that he was still wearing his back support,
20 that he was walking with a cane, that he was still having mid
21 and lower back pain which was graded as a five over ten. That
22 he was taking various medications including Ibuprofen which is
23 Motrin, the Flexeril, which is the muscle relaxer we discussed
24 before, as well as oxycodone which is Percocet similar to the
25 Vicodin and Norco. He had been experiencing numbness in his

1 right thigh that was most notable when he was walking or when he
2 was sitting and also having some numbness in his left second
3 toe, since the surgery. Otherwise was doing okay. And, on
4 examination, they noted that he was wearing his back support.
5 There was motor weakness throughout in both the arms and the
6 legs. There was loss of sensation in the left second toe and
7 that he was able to walk with a cane. They found that he was
8 stable and recommended continued therapy.

9 Q Thank you, Doctor. Doctor, contained within your
10 handwritten notes, when there is a section called overall pain
11 level and you give a number out of 10. Can you explain to the
12 Jury what that is on each of your notes?

13 A Basically, it's a pain scale that helps us to monitor
14 the patient's level of pain from visit to visit. It's a self
15 reporting scale. So, I'll say to a patient, on a scale of zero
16 to 10, zero being no pain at all and 10 being the worst pain,
17 generally over the course of the past month, with the treatment
18 and the medications or injections, whatever type of treatment
19 you've received, how would you grade your pain, and they would
20 give a number. And it just helps us to monitor the patient's
21 condition over time, to make sure that this treatments are
22 effective.

23 Q And, on any of your notes where it indicates functional
24 ADL, can you just tell them what ADL stands for since it will be
25 in evidence?

1 A ADL refers to activities of daily living. So, one of
2 our jobs as doctors, to try and make sure that things,
3 activities that people do on a daily basis are being done
4 without causing a great deal of pain and discomfort. So,
5 generally, when I ask patients, what types of things are you
6 having problems with, sitting, standing, bending, lifting,
7 walking, we can try to focus our treatment on those particular
8 activities, whether it be physical therapy or bracing or
9 something to that effect.

10 Q And words contained within your assessments,
11 cervicalgia and lumbago, can you please tell the Jury what those
12 words mean?

13 A Cervicalgia is a fancy word for neck pain and lumbago,
14 fancy word for lower back pain, general tightness.

15 Q And, progressive thoracic, kyphoscoliosis can you tell
16 them what that means contained in the assessment?

17 A In this case, I was concerned, basically his spine is
18 collapsing, getting progressively hunched over and twisted. The
19 bones, the joints in the spine are breaking down.

20 Q When did you last see Mr. Verdon prior to your
21 testimony here today?

22 A March 11th.

23 Q And what were the complaints at that time?

24 A Primarily mid and lower back pain, radiating pain down
25 both legs, numbness in both of his feet in the morning. Both of

1 his legs were feeling weak. Having incontinence, his pain was 6
2 over 10. He was taking Naprosyn, Flexeril and Norco, physical
3 findings were essentially unchanged. I recommended that he
4 continue his home exercise program, continue using the TENS
5 Unit, continue taking the medications, and to consider the
6 spinal surgery.

7 Q Doctor, I'm going to be asking you a series of
8 questions now and I would like you to assume the following as
9 true?

10 MR. GANNON: Objection.

11 THE COURT: I'll sustain. You want him to assume
12 certain facts in evidence.

13 MR. MCCRORIE: Yes.

14 THE COURT: Whether or not they are true.

15 MR. MCCRORIE: Assume the following, take the
16 word true out of it.

17 THE COURT: Okay.

18 Q I'd like you to assume that on August 11th, 2009, Mr.
19 Verdon had fallen from the height you see in the photograph,
20 Plaintiff's Exhibit 14. That he landed on his back on the rebar
21 below, the rebar below. I'd like you to assume that a witness
22 testified here that he was unconscious, that he was bleeding
23 from the back of his head. I'd like you to further assume that
24 there were a number of staples put into the back of his head at
25 Bellevue Hospital. I'd like you to further assume he was

1 admitted to Bellevue Hospital and all the findings that were in
2 the record in Plaintiff's 1 that you have reviewed prior to
3 testifying here today, most notably the T-12 and T-10 fractures
4 as well as the spinous process fractures were sustained. I'd
5 like you to further assume that Mr. Verdon underwent a cervical
6 spinal, a lumbar thoracic spinal fusion on 8/12/09, at seven
7 levels. They skipped the one level of the T-12. I'd like you
8 to further assume that within weeks of being released from the
9 hospital, Mr. Verdon was back at Bellevue, and that some of his
10 complaints as you just read to the Jury were right thigh
11 numbness and numbness into his toes, the lower extremities. I'd
12 like you to further assume that all of the treatment you've
13 done, that you can assume everything you've done when he came to
14 you in November and made the complaints and all of the findings
15 that you told the Jury about, the findings from the MRI, the
16 CT's, EMGs, all of the findings as you discussed with the Jury
17 today, and that are in your notes were found. That you don't
18 have to assume. That's what you found.

19 Do you have an opinion within a reasonable degree of
20 medical certainty as to the cause, first of the symptoms that
21 Mr. Verdon has been complaining to you about, the radiating pain
22 down the legs, the pain in the lower back, and the pain going
23 into his arms?

24 A I do.

25 Q Can you please tell the Jury what your opinion is?

1 MR. GANNON: Objection.

2 THE COURT: Overruled.

3 A In my opinion, his neck and back pain, shooting pains,
4 numbness, the weakness problems with his bladder, erectile
5 dysfunction are all related to the spinal injuries that he
6 sustained from the fall.

7 Q As I'm required to do, please tell the Jury the basis
8 of the opinion that you just gave to them?

9 A Never had a problem with his neck and back before he
10 fell. Sustained multiple acute fractures, clear, that there was
11 trauma to the spine, and that the trauma to the spine that
12 caused these problems.

13 Q Do you have an opinion, we talked about the symptoms,
14 within a reasonable degree of medical certainty as to the cause
15 of the protrusion that you pointed out to the Jury as exhibited
16 on 5A and 10A in the lumbar spine?

17 A I do.

18 Q And can you please tell the Jury your opinion and the
19 basis for same?

20 MR. GANNON: Objection.

21 Q Well, first tell them your opinion?

22 MR. GANNON: Objection, also cumulative.

23 THE COURT: Overruled.

24 A In my opinion, there was trauma from a fall that was
25 substantial cause for that protrusion. Protrusions can occur

1 sometimes because of degenerative joint disease, but he never
2 had any problems before and I think it was the accident that
3 caused this problem.

4 Q Do you have an opinion with a reasonable degree of
5 medical certainty as to the protrusion you pointed out on the
6 cervical spinal cord on the axial view to the Jury?

7 A I do. Likewise, I think it was the fall that caused
8 it. Once again, sometimes you can have an asymptomatic
9 protrusion. In this, but in this case, it's not asymptomatic.
10 In this case, protrusion is pretty significant, causing spinal
11 cord impingement. I think it was the fall that was the
12 substantial cause of his problem.

13 Q Can you tell the Jury whether or not, we told them, you
14 told them that arthritis can be asymptomatic, can a herniation
15 be asymptomatic? Or a protrusion of the disk, can that be
16 asymptomatic?

17 A Osteoarthritis, degenerative, joint disease can be
18 asymptomatic, meaning that you don't know if you have it.
19 Sometimes along with that, osteoarthritis of the spine you can
20 have a disk bulge or less likely, a disk herniation, and it is
21 possible that that can be asymptomatic, meaning you don't know,
22 but in this case it's not asymptomatic, is the cause of the
23 problems and I think it's the accident that caused these
24 problems.

25 Q And let's go under the assumption that, let's assume

1 this to be true. That prior to the, there are no tests to show
2 it, but prior to the accident date, Mr. Verdon as you said had
3 pre-existing degenerative joint disease, as you said, we all do,
4 but that he also had a pre-existing herniation that was
5 asymptomatic, both in the neck and the back. Do you have an
6 opinion with a reasonable degree of medical certainty as to
7 whether or not a fall such as the one that Mr. Verdon sustained
8 from the height depicted in the photograph I'm showing you,
9 Plaintiff's 14, and the subsequent findings in the
10 hospitalization in Plaintiff's Exhibit 1 in Bellevue, do you
11 have an opinion as to whether or not such a fall could activate
12 and or aggravate any pre-existing asymptomatic herniations?

13 MR. GANNON: Objection.

14 Q First just activate an asymptomatic previous
15 herniation?

16 MR. GANNON: Objection, outside the scope of the
17 disclosure.

18 MR. MCCRORIE: Within the BP.

19 MR. GANNON: Outside the scope of expert
20 disclosure.

21 MR. MCCRORIE: I just wanted to bring it up.

22 THE COURT: Why don't we go in the back.

23 MR. MCCRORIE: I got it right here.

24 THE COURT: Why don't we go back here?

25 (The following occurred in the Judge's robing

1 room, on the record, among the Court and Counsel, but
2 outside the presence of the Witness, the parties and the
3 sworn Jury)

4 THE COURT: It's in the BP, not in the
5 disclosure.

6 MR. MCCRORIE: Exacerbation of Plaintiff's
7 asymptomatic underlying. The general Disclosure, BP,
8 activation of previous asymptomatic states a claim.
9 Activation degenerative, entirely asymptomatic before.
10 Under the charge that we have to have, it has to be pled
11 and proven. Their claim is its degenerative. I'm just
12 giving the alternative hypothetically.

13 MR. GANNON: It's the wrong expert. This should
14 be Doctor Merola who is coming back on the stand.

15 THE COURT: Dr. Merola, you didn't ask about
16 that.

17 MR. MCCRORIE: I didn't do opinions with Dr.
18 Merola.

19 THE COURT: Are you going to ask him about it
20 also, apart from the fact he's objecting to everything
21 because it's cumulative or become cumulative this
22 afternoon.

23 MR. MCCRORIE: Under the neurological, I know
24 Mr. Gannon certainly has the right, but my point would be,
25 there is an orthopedic injury and a neurological injury.

1 Both of them have such a close interplay, it's my position
2 that they could have hired a neurologist as well. I
3 believe we have the right to put forth the opinion from a
4 neurological standpoint and an orthopedic standpoint. I
5 don't believe we're trying to sneak it in as double.

6 THE COURT: Okay, let me ask you, apart from the
7 cumulative, with what he just pointed out is in the BP and
8 the notice about activation exacerbation, other than the
9 cumulative, are you objecting?

10 MR. GANNON: I'd have to look at the expert
11 disclosure.

12 THE COURT: Let him look at it.

13 MR. MCCRORIE: I think it's in his notes.

14 MR. GANNON: That's my point.

15 THE COURT: I thought that was part of it.

16 MR. MCCRORIE: It's in the BP.

17 THE COURT: No, he's talking about the actual
18 3101.

19 MR. MCCRORIE: He is a treating authorization,
20 given medical records, in addition to that, we pled it, we
21 wouldn't even have to, because it's in the --

22 THE COURT: I actually lost sight of the fact
23 he's his Doctor.

24 MR. GANNON: I only raised it that Mr. McCrorie
25 pointed to it at the 3101.

1 THE COURT: To the extent it's the treating and
2 in his notes.

3 MR. GANNON: Again, we've been down the road
4 where Mr. McCrorie has gotten a double shot at the exact
5 same testimony. I understand the close coordination of
6 these two experts, but I think that question he asked him
7 was clearly an orthopedic question. What the effect of
8 that is, and the issue of degeneration, is really more
9 proper for Doctor Merola.

10 MR. MCCRORIE: However, it's in Doctor
11 Hausknecht's notes and his opinion.

12 THE COURT: I'm going to overrule the objection.

13 MR. GANNON: Objection, thank you, your Honor.

14 (Whereupon, the following occurred in open
15 court)

16 THE COURT: The objection is overruled. You
17 remember the question.

18 MR. MCCRORIE: I'll try to re-ask it, succinctly.

19 DIRECT EXAMINATION CONT'D

20 BY MR. MCCRORIE:

21 Q I'd like you to assume, although that's not the
22 opinion, but I'd like you to assume that there was a
23 pre-existing herniation in both Mr. Verdon's neck and back prior
24 to the accident, but as you told the Jury, it was one of those
25 asymptomatic herniations. Do you have an opinion, given the

1 same facts in the hypothetical, the first hypothetical, the same
2 accident, the same findings in the hospital, the same findings
3 on the MRI, do you have an opinion as to whether or not such an
4 accident could have activated any, activated any latent or
5 asymptomatic herniation to become symptomatic?

6 A Yes.

7 Q Can you please the tell the Jury under that
8 hypothetical your opinion and the basis for same?

9 A Once again, I don't believe that these were there
10 before the accident, but assuming that they were, it's possible
11 that they could have been there and been asymptomatic, with the
12 trauma, causing inflammation and irritation causing them to
13 become larger and become activated and cause the symptoms and
14 the problems that he has.

15 Q Can you tell the Jury what adjacent level breakdown is
16 from a neurological standpoint?

17 A Adjacent level breakdown which would be what we
18 referred to before, if you have a portion of the spine that's
19 been fused together so it doesn't move, all the movement, all
20 the stress of the spine gets translated to the level above and
21 below, because there is increased stress at these levels, they
22 are more susceptible to breakdown.

23 Q Do you have an opinion with a reasonable degree of
24 medical certainty as to what you've told the Jury on the
25 findings from 2009 to 2013 on the lumbar spine, the progressive

1 nature of that breakdown, do you have an opinion as to the cause
2 of that?

3 A In my opinion, it was the trauma to the spine, with
4 resultant fractures, requiring the stabilization, so there are
5 now numerous portions of his spine that no longer move properly.
6 They are starting to collapse, putting abnormal pressures on
7 different parts of the spine and causing them to deteriorate.

8 Q Is that both in the neck and the back, Doctor?

9 A More so in the back but in the neck as well.

10 Q Have all your opinions today been with a reasonable
11 degree of medical certainty so far?

12 A Yes.

13 Q Do you have an opinion with a reasonable degree of
14 medical certainty as to whether or not it would be advisable for
15 a man with Mr. Verdon's conditions to ever return to manual
16 labor or any form of construction work?

17 A No, he cannot do that.

18 Q If it's the same, just say for the record, just give
19 the basis?

20 A The spine is unstable, it would be potentially
21 dangerous for him to do any type of manual labor, lifting,
22 carrying, pulling, pushing, put himself at risk of falling and
23 twisting and to potentially aggravate his condition and make it
24 worse.

25 Q How about any position whatsoever that would require

1 standing, sitting, bending, lifting for any long period of time?

2 A Sitting and standing per se is not going to make him
3 worse, but he can't tolerate. It causes him pain, he can't do
4 it. Bending and lifting could make it worse.

5 Q With a reasonable degree of medical certainty, have the
6 conditions that you've told this Jury that were caused by this
7 accident permanent in both the neck and the back?

8 A Yes, they are.

9 Q With a reasonable degree of medical certainty, would
10 you, as a board certified pain management physician and
11 neurologist, expect a man with Mr. Verdon's progressive
12 conditions to have pain in the future?

13 A Yes. He's going to have pain, he's going to have good
14 days, he's going to have bad days, depending on his activity,
15 whether or not he's taking treatment or medications, but this is
16 going to be a chronic condition.

17 Q For the record, for what period of time?

18 A For the rest of his life.

19 Q With a reasonable degree of medical certainty, would
20 you, do you have an opinion as to whether or not his condition
21 that's progressed from the accident until today, whether or not
22 it will continue to progress into the future, deteriorate in
23 both the neck and the back?

24 A I don't have a crystal ball but based upon what's
25 transpired in my office over the past couple of months, he's

1 getting worse and I would expect that he continues to get worse
2 and I think that sooner or later he's going to need that
3 stabilization surgery with Doctor Merola.

4 MR. GANNON: Objection, move to strike.

5 THE COURT: Stricken.

6 Q With a reasonable degree of medical certainty, can you
7 give us the basis, not for the last part that you said, but just
8 that it will continue to progress in your opinion?

9 A Yes.

10 MR. GANNON: Objection.

11 THE COURT: Overruled.

12 A Based upon my clinical evaluations, especially
13 autonomic symptoms that he developed, serial imaging studies,
14 MRIs, X-ray which shows progressive kyphoscoliosis, it's a
15 progressive condition that it's going to require further
16 intervention.

17 Q Has Mr. Verdon been offered something as an alternative
18 to the epidurals and the all the medications?

19 A We've talked about another option, which is a spinal
20 cord stimulator type of pain management procedure.

21 Q These are in for ID only, Plaintiff's 23 and 24, as a
22 board certified pain management physician and neurologist, can
23 you just tell the Jury how a spinal cord stimulator works and
24 why that would avoid the need for medication if someone chose to
25 do that route?

1 A I don't know if it would avoid the need for medication.
2 Basically, a spinal cord stimulator is a type of interventional
3 tool, similar to the TENS Unit. So, there is a small battery
4 operated generator that emits small electrical impulses and the
5 electrodes are inserted into the spinal column and placed upon
6 different nerve roots, in the different parts of the spinal cord
7 itself. And these electrical impulses basically override the
8 pain impulses, so instead of feeling pain all the time, you feel
9 a sort of buzzing of electric sensation which most people would
10 prefer to pain. So, still not a pleasant feeling, but it's much
11 better being in chronic pain.

12 Q And I just wanted to ask you, the pulse generator, it
13 may not be clear on this, is that inside the body or implanted
14 or outside the body?

15 MR. GANNON: Objection, cumulative.

16 THE COURT: Overruled.

17 A It's inside the body, sort of like a pacemaker. Where
18 the pacemaker is the generator unit in the chest wall itself,
19 and the electrodes and the leads are on the heart. It's the
20 same type of thing but it's in the spine.

21 Q And just, the other image.

22 (Whereupon, that is displayed to the Jury)

23 A This would just be a depiction of the unit with the
24 different electrodes up and down the spine, and once again, this
25 goes to what's known as the voltage gated theory of pain, that

1 the spinal cord can only handle so many different sensory
2 stimuli, so that if you overwhelm the pain pathways with this
3 electrical stimulation, that you can help block some of that,
4 those pain signals, from getting to the brain itself.

5 Q And finally, Doctor, we don't need the frequency, but I
6 just want to ask, another Doctor will come later in the week, do
7 you have an opinion with a reasonable degree of medical
8 certainty as to whether or not Mr. Verdon will require pain
9 medications into the future?

10 A Yes.

11 Q For what period of time?

12 A For the rest of his life.

13 Q Do you have an opinion with a reasonable degree of
14 medical certainty as to whether or not Mr. Verdon, whether it's
15 just you or a physician similar to you, should continue to see a
16 board certified pain management physician and a neurologist?

17 MR. GANNON: Objection.

18 Q Or a neurologist, and or neurologist?

19 MR. GANNON: Objection.

20 THE COURT: Overruled.

21 A Yes.

22 Q And for what period of time, another doctor will handle
23 that, but what period of time into the future?

24 A For the rest of his life, every two to three months,
25 more or less, depending upon his condition, depending upon

1 what's going on.

2 Q And setting aside authorization or any requests for
3 same, can you, do you have an opinion with a reasonable degree
4 of medical certainty as to whether or not Mr. Verdon would
5 benefit from physical therapy into the future to both his neck
6 and his back?

7 A I believe he would.

8 Q One last thing. You talked about serial, I think you
9 said serial diagnostic testing. That means over the period of
10 time, multiple tests?

11 A Yes, for example, in the course of his treatment, he's
12 had three sets of MRIs for neck and back, he's had three sets of
13 EMGs for neck and back and would require this going forward and
14 not quite as frequent, but similar.

15 Q So, with a reasonable degree of medical certainty, will
16 he require diagnostic testing, either EMG, MRI, CT scans to both
17 his neck and his back?

18 A Yes, he will.

19 MR. MCCRORIE: That's it.

20 THE COURT: We'll take a ten minute break and
21 then prepare for the cross-examination. Don't discuss the
22 case.

23 (Whereupon, a recess was taken in this matter, and
24 after the recess, the following took place in open court,
25 with the Court and all parties being present)

1 (Whereupon, the Jury entered the courtroom.

2 THE COURT: Have a seat.

3 CROSS EXAMINATION

4 BY MR. GANNON:

5 Q Dr. Hausknecht, how are you?

6 A Good afternoon, Counsel.

7 Q My name is Chris Gannon. We met briefly this morning
8 before you took the stand. I represent the Defendants in the
9 case, okay. We've never met before, correct?

10 A Not that I know of.

11 Q Okay. And you've testified on behalf of the Sacks law
12 firm in the past?

13 A I have.

14 Q How many times have you done that?

15 A I've been in practice for twenty years, maybe a dozen
16 times, more or less.

17 Q Have you ever testified on behalf of the defense
18 counsel?

19 A On occasion, yes.

20 Q What percentage would you say you testified for
21 plaintiffs versus defendants?

22 A Most of time that I testify, it's on behalf of the
23 plaintiff, meaning that it's a patient that I've been treating
24 in my office.

25 Q And but you've also testified on behalf of a

1 plaintiff's law firm for an individual that you had not been
2 treating, correct?

3 A On occasion.

4 Q What's the percentage breakdown you would say for that?

5 A I would say ninety percent of the time that I've
6 testified, it's on behalf of a patient that I've treated in the
7 office, maybe ten percent is as an expert and most of the time
8 it's on the plaintiff. Sometimes it's on the defendant.

9 Q Would you say seventy-five percent of the time you've
10 testified on behalf of plaintiffs?

11 A More.

12 Q More?

13 A More.

14 Q What percentage of time you testified on behalf of
15 plaintiffs?

16 A As I said, usually I'm testifying on behalf of a
17 patient that I treated so it would be ninety percent.

18 Q The ninety percent, also, and I think you made
19 reference to yourself, and I may have the phrase wrong, you are
20 a union Doctor?

21 A Correct.

22 Q What does that mean?

23 A It's mean I'm in the plan for their health coverage.

24 Q So, that means if someone in a given union is injured,
25 you are one of the doctors identified in the plan that they

1 could go see?

2 A Yes. Or even if they are not injured, if they have
3 some type of neurologic condition, they can come see me.

4 Q Okay, you so know that Mr. Verdon is a carpenter?

5 A Yes.

6 Q And the plan that you are referring to is the union
7 agreement. When you said plan, what did you mean?

8 A His health coverage.

9 Q His health coverage, which is provided through the
10 union?

11 A Right.

12 Q Now, Dr. Hausknecht, you agree that you come in here to
13 testify as an expert, obviously, you are here to tell the truth,
14 correct?

15 A Correct.

16 Q You want to get access to as much information as you
17 can, prior to testifying, so you can give the best testimony you
18 are able to this Jury, correct?

19 A In general, yes.

20 Q Now, the records that you have reviewed for testifying
21 today, you had your own office records, correct?

22 A Correct.

23 Q And, you have obviously more in that file than just
24 your office records, correct?

25 A Correct.

1 Q And who supplied those records to you?

2 A Some of them were supplied by the patient, some of them
3 were supplied by the doctors, some of them came from MRI
4 facilities. I think some of them might have come from the
5 lawyer's office, a combination. It's an accumulation.

6 Q Are you able to tell from looking at your file which
7 records came from the lawyer's office?

8 A Only if there was a fax letterhead or something.

9 Q In there, do you have any type of correspondence from
10 Plaintiff's Counsel?

11 A Just a subpoena.

12 Q Okay, that's a subpoena for you to come here today?

13 A No, I think it was a records subpoena.

14 Q Okay, to produce records. You are charging five
15 hundred dollars an hour to testify today?

16 A That's correct.

17 Q So, do you also charge a rate for the full day, if you
18 go past a certain time?

19 A It goes by the hour. But, if it was eight hours, it
20 would be eight times five hundred.

21 Q And, what amount of your income do you have each year
22 from testifying in court?

23 A I'm not sure exactly, less than five percent.

24 Q What's the number?

25 A The total dollar amount?

1 Q Yes?

2 A I testify approximately a dozen times a year. Figure
3 the average testimony would be around three thousand dollars,
4 something to that effect, maybe about forty thousand dollars a
5 year.

6 Q That's for testifying in court, does that also include
7 time you spend preparing to testify?

8 A That would include all of it.

9 Q What's the number again?

10 A About forty thousand.

11 Q How many times have you testified in 2013?

12 A I don't know exactly, but ten.

13 Q And how many times of those ten times, how many of
14 those were for Sacks and Sacks?

15 A Zero, as I recollect.

16 Q None at all?

17 A No.

18 Q Now, Dr. Hausknecht, I want to get right into your
19 records, if I could, okay. Could you pull out your, you said
20 your initial evaluation of Mr. Verdon was November 17th, 2009?

21 A Correct.

22 Q How did Mr. Verdon come to see you, do you know that?

23 A He had been referred by his orthopedist, Doctor Merola.

24 Q Okay. And in your note, you mentioned that you
25 reviewed all available records and diagnostic testing, that you

1 would review further records when they become available,
2 correct?

3 A Correct.

4 Q Now, to move it along, you may know and I should have
5 said from the beginning, to the extent you can answer a question
6 yes or no, you can do that, if you need to expand beyond that,
7 let me know.

8 A Sure.

9 Q Okay. You indicate in here that he's been attending
10 physical therapy at Kessler in New Jersey?

11 A Correct.

12 Q Did you review any of the Kessler records?

13 A Yes.

14 Q What is in your file from Kessler, what dates does that
15 cover?

16 A 9/2/09, and a few other dates but the first one is
17 9/2/09.

18 Q What are the other dates you have 3/23/11. 1/31/11.

19 A That looks like it.

20 Q So, you have three notes from Kessler?

21 A Yes.

22 Q You understand that Mr. Verdon was attending Kessler
23 from approximately 2009, and you understand he finished in March
24 of 2011?

25 A Yes.

1 Q You don't know the number of times he went to physical
2 therapy?

3 A I do not.

4 Q And you didn't review any of the other records from
5 physical therapy from Kessler other than the three that are in
6 your file, correct?

7 A Not that I recall.

8 Q Did you request all of the records for Kessler Physical
9 Therapy before you came here today to testify?

10 A Probably not.

11 Q Okay. You know that he complained of pain on his first
12 visit to you, correct, November 17th, 2009?

13 A Correct.

14 Q And, he denied any headaches, any dizziness or any
15 memory problems, correct?

16 A That's correct.

17 Q And the medication he was taking at that time was
18 ibuprofen, correct?

19 A Correct.

20 Q What is ibuprofen?

21 A Anti-inflammatory like Motrin or Advil.

22 Q Is it a narcotic drug?

23 A No.

24 Q Is it an over the counter drug?

25 A No.

1 Q And what is the purpose of it, why would someone take
2 that?

3 A In this particular case, it would be prescribed for
4 pain, or taken for pain.

5 Q Okay. You did a general physical examination of him,
6 correct?

7 A Yes.

8 Q His vital signs were within normal limits?

9 A Yes.

10 Q What do you mean by vital signs?

11 A Blood pressure, heart rate, respiratory rate.

12 Q You also did a pulmonary examination which was
13 unremarkable, correct?

14 A Correct.

15 Q A cardiac examination which was unremarkable, correct?

16 A Correct.

17 Q A vascular and a gastrointestinal systems examination,
18 both of which were unremarkable?

19 A Correct.

20 Q Unremarkable means what?

21 A I didn't see any gross abnormality of the structure.

22 Q His short term memory was intact?

23 A Yes.

24 Q Long term memory was intact?

25 A Yes.

1 Q What is receptive aphasia?

2 A It's the ability to understand what's being said to
3 him.

4 Q He had no problems there, right?

5 A Right.

6 Q You had him spell backwards?

7 A Yes.

8 Q And that was normal. Within normal limits?

9 A Yes.

10 Q You did a mental status examination. Also that was
11 normal?

12 A Yes.

13 Q You also did a cranial nerve, you have a section in
14 here cranial nerves. No problems there, correct?

15 A Correct.

16 Q Now, what is that examination, what are you doing?

17 A Cranial nerves checks the function of basically the
18 eyes, the ears, the nose, the throat, the face. And in this
19 case he had sustained a head injury, so I was concerned about
20 the sensory sequela, memory, speech injury, problems with
21 hearing and speaking, no problems.

22 Q Your typewritten reports are broken down into various
23 sections and you kind of use that as your guide when you meet
24 with the patient each time, correct?

25 A More or less, yes.

1 Q Okay. And, we'll go through some of them, but you also
2 have, you obviously got past family history, social history,
3 general physical examination, cranial nerves which we just did,
4 eventually you get to sensory mechanical range of motion,
5 testing, and impression. Impression in your report is after all
6 these examinations, impression is what you write down and you
7 find to be significant, correct?

8 A More or less.

9 Q Okay. So, if we continue with that first report, under
10 motor system you do note weaknesses in the shoulder, left hand,
11 correct?

12 A Correct.

13 Q The remainder of the motor strength you note in the
14 upper and lower extremities, other than what's identified is
15 five out of five.

16 A Yes, but he didn't identify all the abnormalities but
17 yes.

18 Q You did it with Mr. McCrorie, we can go through it.
19 You saw some weakness in the shoulders, weakness in the left
20 hand, why don't you tell us where you found weakness?

21 A There was weakness in both shoulders, the left hands,
22 both hips, both knees, and the left ankle.

23 Q Other than that, the motor strength in the upper and
24 lower extremities was a five out of five, correct?

25 A Yes.

1 Q And, myotomal groups, you tested all myotomal groups,
2 what does that mean?

3 A The group of muscles innervated by the specific nerve
4 roots, so C5/C6, L4/L5.

5 Q So, you did the muscle groups both arms and legs, upper
6 and lower extremities, correct?

7 A Correct.

8 Q In other words, other than what we just identified,
9 everything else was normal?

10 A Yes.

11 Q Now, under sensory, in that report, you noticed a
12 patchy hypesthesia in the posterior thoracic, adjacent to the
13 surgical scars, what does that mean?

14 A Hypesthesia would be loss of feeling; patchy meaning
15 there were some areas that he had some area that he couldn't,
16 feel, in his back around the scar he had lost feeling.

17 Q That's not abnormal for someone who underwent surgical
18 intervention to have that type of effect around the scar area?

19 A I don't know what you mean by abnormal. Loss of
20 feeling is always abnormal, but it's relatively common when you
21 do a surgery, you are cutting nerves.

22 Q Okay, but the remainder of the testing there, so you
23 did remainder of pain temperature, vibration and light touch
24 perception, they were within the normal limit in the trunk,
25 right, this is the thorax area and his arms and his legs?

1 Q. And again following the first visit after the full
2 examination with Mr. Verdon, your recommendation and the plan
3 was that he continue his current course of outpatient physical
4 therapy, correct?

5 A. Correct.

6 Q. That's what he's doing at Kessler?

7 A. Correct.

8 Q. And you recommended that he take Ibuprofen as needed
9 for pain, correct?

10 A. Correct.

11 Q. So you didn't at this point prescribe any narcotic
12 medication?

13 A. That's correct.

14 Q. And the impression are also in here as well, correct?

15 A. Correct.

16 Q. Let's go to your next report February 2nd, 2010. Are
17 you there?

18 A. Yeah.

19 Q. Okay. Here again you are noting that the patient
20 attends physical therapy, correct?

21 A. Correct.

22 Q. And the history in this part of the report is Mr.
23 Verdon telling you, correct?

24 A. Yes.

25 Q. And Mr. Verdon indicates to you the physical therapy