SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF THE BRONX:TRIAL TERM PART 23

----------X

WILBERT E. ANDERSON,	:	INDEX NUMBER 8863-00
Plaintiff,	:	
-against-	:	KENNETH HAYES DR. J.J. LEV W. ANDERSON
NEIGHBORHOOD YOUTH & FAMILY SERVICES	:	DR. KAPLAN R. SHUSTER
Defendant.	:	

----------X

851 Grand Concourse
Bronx, New York 10451
September 19th, 2003

B E F O R E:

HONORABLE ALEXANDER HUNTER, JSC,

and Jury.

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

GORAYEB & ASSOCIATES, P.C.
Attorneys for Plaintiff
136 Church Street
New York, New York 10007
BY: CHRISTOPHER GORAYEB, ESQ.

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP
Attorneys for Defendant
150 East 42nd Street
New York, New York 10017
BY: EUGENE T. BOULE', ESQ.

FAYE MOORE
Senior Court Reporte

FORM FED PENGAD • 1-800-631-6989

THE COURT: Jury down.

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jurors enter the courtroom at ten forty-five AM.)

THE COURT: Good morning, everybody. Please be seated.

THE JURORS: Good morning.

THE COURT: Good morning again, counsel. Mr. Gorayeb, please call your next witness.

MR. GORAYEB: Yes, Your Honor, plaintiff calls EMS technician Kenneth Hayes.

(Whereupon, the witness is sworn by the clerk at ten forty-five AM.)

K E N N E T H H A Y E S, having been called as a witness by and on behalf of the Plaintiff, having been first duly sworn by the clerk was examined and testified as follows:

THE CLERK: State your full name, spelling your last name, and your address. And keep your voice up.

THE WITNESS: Kenneth Hayes, H-A-Y-E-S; Address: 140-13 Benchley Place, Bronx, New York.

THE COURT: Good morning, sir. Please keep your voice up.

FORM FED PENGAD • 1-800-631-6989

mentioned to you during my preliminary remarks, sometimes witnesses are presented out of turn to accommodate other witnesses and that is what will happen in a few moments. Mr. Anderson's testimony is not complete, we will resume with Mr. Anderson on Monday.

MR. GORAYEB: Thank you, Your Honor. Plaintiff calls Doctor Jeffrey Kaplan to the stand.

(Whereupon, the witness is sworn by the clerk at two twenty-two P.M.)

D O C T O R J E F F R E Y K A P L A N, having been called as a witness by and on behalf of the Plaintiff, having been first duly sworn by the clerk was examined and testified as follows:

THE CLERK: State your full name, spelling your last name, your address and keep your voice up.

THE WITNESS: My name is Jeffrey Kaplan, K-A-P-L-A-N, office is 159 East 69th Street in Manhattan.

DIRECT EXAMINATION

BY MR. GORAYEB:

Q. Good afternoon, Doctor Kaplan.

A. Good afternoon.

FORM FED PENGAD • 1-800-631-6989

Q. Are you a physician duly licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. What is your field of specialty?

A. Orthopedic surgeon.

Q. Would you please tell the Court and jury where your office is located?

A. My office is on 69th Street in Manhattan.

Q. And would you please tell the Court and jury your educational background and professional background?

A. Education, I went to college at Yale University. After graduating there I went to medical school here in the city at Columbia University. When I graduated there I did a training program in orthopedic surgery that was a five year program specifically in orthopedic surgery. I did that in a place called the Campbell Clinic which is in Memphis, Tennessee the first orthopedic training institution in the county. Following that I practiced in Memphis, in Mississippi for a short period of time. Then I moved back to New York in 1995 where I have been licensed to practice ever since.

Q. Now, Doctor, is there a particular -- withdrawn.

FORM FED PENGAD • 1-800-631-6989

Do you perform surgery?

A. Yes, I do, that's part of orthopedic surgery.

Q. How frequently do you perform surgery?

A. I usually do anywhere between six to ten cases a week, so that's one to two days of surgery per day, depending on how things happen. Orthopedic surgery is the study of bones and joints and injuries to the bones and joints. So a lot of my cases are unpredictable coming through the emergency room or things like that.

Q. And do you often operate on wrists?

A. Fracture of the wrist, tears and ligaments and cartilage of the wrist are things that we operate on and I operate reasonably frequently, yes.

Q. Doctor Kaplan, did there come a time when Mr. Anderson came to your office seeking treatment for injuries that he sustained?

A. Yes.

Q. And did you create certain records concerning his care and treatment?

A. Yes.

Q. Do you have them with you?

A. Yes, I have my chart.

MR. GORAYEB: I would ask this be marked the next exhibit.

FORM FED PENGAD • 1-800-631-6989

(Whereupon, the chart is received and marked as Plaintiff's Exhibit 11 for identification.)

Q. Doctor Kaplan, other than the x-rays, which we have already admitted into evidence from your office, is that a completed chart of Mr. Anderson?

A. Yes, this is his medical record.

Q. Those records were created and maintained in your office in the regular course of business?

A. Yes.

Q. They were accurate when created?

A. I believe so, yes.

Q. They were brought directly from your office today to the courthouse?

A. Yes.

MR. GORAYEB: I offer them into evidence, Your Honor, subject to redaction.

THE COURT: Would you like to see them?

MR. BOULE': Thank you, Your Honor.

(Whereupon the file is handed to Mr. Boule'.)

MR. BOULE': I have no objection. I will take some time later to review it, subject to redaction.

THE COURT: They are admitted.

(Whereupon, the chart is received and marked as Plaintiff's Exhibit 11 in evidence.)

FORM FED ® PENGAD • 1-800-631-6989

Q. Doctor Kaplan, using your chart as necessary would you please tell the Court and jury what history was taken from Mr. Anderson when he first visited your office?

A. Sure. When he first came to the office he was seen on February 14th, 2000, and he indicated that he had had an injury at work on February 8th, 2000. That he had had injuries to his face and mouth, as well as to his right wrist. He indicated that he had been taken initially to Lincoln Hospital emergency room, had some stitching of the face and had had what's called a closed reduction of the arm. Closed reduction means that when you are talking about a broken arm it has a deformity. There is an orthopedic term, a medical term to reduce the size of the deformity that simply means to straighten the arm up in this case or straighten the bone up. He had that done in the emergency room, they had given him a shot into the blood clot where the fracture had occurred. And then pulled the arm so that the bend, the deformity was reduced and then put him in a splint in the interim. He came to our office a couple of days later. And that was the history that we had gotten from him.

Q. Once you took the history from Mr. Anderson what did you understand that to do as far as

FORM FED PIENGAD • 1-800-631-6989

examination?

A. An examination was performed and he was, as I say, in a splint holding this fresh fracture in place. So that the splint was left on to not move the fracture, not let it move but we were able to poke around the splint. And he had a lot of swelling of the right arm. He had tenderness over the bone that you could touch through the splint. He had good motion in his shoulder, and motion in his elbow within the limits of the splint which actually goes all the way up to the elbow. Because even though Mr. Anderson broke the bone at the wrist, this is the same bone that makes part of the elbow joint. So you have to partially immobilize the elbow in order that that doesn't wiggle off, immobilizing just the wrist is not enough.

Then we took some x-rays to see what we were dealing with. And the x-rays were taken and they showed this fracture of the wrist.

Q. Doctor Kaplan, we have all the x-rays in evidence, and blowups so if it would assist you in using them for the jury.

A. Sure. Absolutely.

MR. BOULE': I object to that as cumulative, Your Honor. We saw all the x-rays yesterday.

FORM FED PENGAD • 1-800-631-6989

THE COURT: Overruled.

Q. Doctor Kaplan, these are the blowups.

A. This is an x-ray of Mr. Anderson's right wrist and hand.

MR. BOULE': What exhibit number?

MR. GORAYEB: Plaintiff's 4H in evidence.

A. I have a model if I could use that.

This is a model of a wrist, the hand, forearm and this would be the elbow. So this would be like this, this would be the thumb here and the hand. So it is looking sort of like this. (Model placed on 4H demonstrating.)

And what you are seeing, this is the joint where the forearm meets the hand called the wrist joint. The wrist is made up of many different small bones. The major joint of the wrist is this where these bones meet between the forearm bones and the smaller bones are called the carpal bones. Mr. Anderson's fracture is approximately a fracture that you can see across the wrist here and involving all of this bone that acts as a pedestal or platform for the hand to sit on. The purpose of a joint is that it allows motion and in this case at the wrist. And it relies on smooth action between the two bones that

FORM FED PENGAD • 1-800-631-6989

touch one another and the cartilage that goes over those bones which is like a teflon coating to allow for smooth, painless, sliding position.

In this x-ray, just looking from the top, you see that the radius which is the big bone at the forearm has a crack across it and it is broken into small pieces here. You see a number of different small pieces and a large crack here. And those small pieces are called comminuted fracture, many pieces. Comminuted means that the bone is broken up into many small pieces. And this fracture not only goes across the long portion of the bone but also extends into the joint. And makes this surface that was once smooth and allowed for motion, makes it broken into small pieces and you can see irregularities throughout the joint here.

You can also see that where the break occurred, the radius, the bigger bone is now shortened and you can see that because this line of the radius normally matches up with this line of the small bone, the ulna. You can see in this model that they match up smoothly and that's the normal. So, this is the hand, in fact, this is the hand from the fracture, from the top. This is 4I.

It doesn't add much but again you see the

FORM FED PENGAD • 1-800-631-6989

split in the bone broken and how short the ulna is, sorry the radius is compared to the ulna where it should be. That is a very large step off. So that would classify it in medical terms as being a fracture of the radius at the wrist that was comminuted, which means the bone is broken up into small pieces and intra-articular, which means it goes into the joint. And both of these things have great significance in that if it is broken up into small pieces no matter how good a reduction or straightening of the bone you get you don't have solid bone-on-bone. So it is likely to settle over time and that usually indicates that some sort of surgery is going to be needed to stabilize the fracture. The fact that it is intra-articular, going into the joint, you are at a high risk of having an irregular joint surface that leads to problems down the road as the bones would move smoothly on one side and you have rough bone surfaces which produces loss of motion and pain.

Q. Doctor Kaplan, you used the phrase, "step off", what does that mean?

A. Step off is simply describing the shape of the joint surface. Normally a joint surfaces, as I say, are smooth surface that sit on top of the other. In the wrist it is the end of the two forearm bones

FORM FED PENGAD • 1-800-631-6989

that meet and normally are smooth with the end of the wrist bone, the end of the hand. If there is a step off it simply describes a shape where in this case the radius, the forearm bone is smooth until the bone is broken. So you have what look like a step here which leads to a sharp edge, and as I said this acts like a platform for the hand to sit on. And the hand now sort of tilts into the void, into the area where there is not bone. So it makes a mechanically unstable and architecturally unstable area of the joint; meaning the shape is not right so it doesn't work right.

Q. Was that hand tilted in one direction or another because of the step off?

A. You can see, I say you can see but I look at these all the time. But normally the hand is like, as I say, flat on this platform. Like this, flat. (Model) This side has been punched down and is now shorter instead of the hands more tilted to the side. This bone should be here, but in fact it has fallen a little towards the thumb.

Q. You say this carpal bone here should be in contact with the bone here?

A. This should be shifted so that it sit on top of both bones.

Q. Go ahead, Doctor, tell us after taking an

FORM FED ⊗ PENGAD • 1-800-631-6989

x-ray and seeing what Mr. Anderson's injuries were, what steps do you do next for treatment?

A. At that point we advised Mr. Anderson that he would need to do some surgery of the hand. We advised him that at this point his hand was too swollen to really do anything surgically. That he should do some care to his hand which is basically elevate it, icing it down trying to get some of the swelling out. And then that we would take him to surgery several days later once the swelling had gone down and place him when in what's called an external fixator. An external fixator is like a scaffold that you put on a building to hold it up. This is something that you put on the bone to hold it to its normal shape.

I have some x-rays to show that external fixator.

Q. Doctor Kaplan, when was that surgery done?

A. His surgery was performed on February 18th.

Q. At what hospital?

A. Four days after we saw him that was done at Cabrini Medical Center.

Q. Who actually did the surgery?

A. That was done by my partner, Doctor Crone.

Q. Go ahead, tell us what was done by Doctor Crone?

FORM FED PENGAD • 1-800-631-6989

A. Doctor Crone did a surgery I called placing it in an external fixator, that's like adding some scaffolding or support to the bone. The way that that's performed is that pins, metal pins are drilled into the bone on either side of the fracture. The fracture is here, you drill two pins into the bone here, two pins into the index finger bone here. And then you place a bar in between those pins and you lock it in the place that you want it. It is like building a bridge over the bone to hold it in place. Once you do that with the metal bar there is very little motion at the fracture site and it also holds it in place. As I said this was comminuted bone, it was broken into small pieces without being able to really hold this out to length, hold it separated by this bridge, simply putting it in a cast you would expect that things would shorten over time. A cast doesn't have a good grip on the bone, it just grips the skin. So that's the purpose of doing that surgery.

Doctor Crone also found that he was unable simply by putting the pins in and forming that bridge outside of the body over the fracture to get a joint surface in an acceptable shape, back to smooth. So in fact he did what's called an open reduction. I told you a reduction is reducing the deformity. This is

FORM FED PENGAD • 1-800-631-6989

open reduction, he actually made an incision on the skin, went down through the skin, moved the tendons of the finger out of the way, and looked down on the fracture. And with metal pins was able to move the fracture pieces around into a more acceptable position and pin them into place. And so he ended up with an x-ray that looks like this. And this is Plaintiff's number 4G.

And here is Doctor Crone's x-ray after the surgery. And what we are seeing are three different pictures of the wrist.

I'm going to go two weeks down the road here to March 15th, which is number 4E.

And this sort of shows us what the external fixator look like, it is a metal bar that's outside the skin. And it is held in place with locking bolts to two big metal screws that are drilled into the index finger, and the index finger here and into the forearm bone here and then the bridge is structured. You can see the external fixator here, it actually holds it in place.

And I'm going back to the immediate post-op, again number 4G, to show you where the pins were put in place to try to hold things. This is three pictures of the same wrist taken at different angles. This is from

FORM FED PENGAD • 1-800-631-6989

the side, this is straight slightly turned and this is straight on. And then you can see the two metal pins in the forearm, two metal pins in the index finger, the bridge across the top. And you can see the metal wires that have been driven into the bone to hold it in place. You see it nicely here. The radius bone, the one that was broken, you remember from the other x-ray was way down here. That step off has been elevated, moved up and pinned into place. There is still a gap here because the bone was so broken up but pins are put into place and held there.

Q. Doctor, how are those pins put in, pushed in or had to be drilled?

A. People say surgeons are glorified carpenters. They are literally drilled in with an electric drill just as if it was a piece of wood trying to hold it in place.

Q. Doctor, would you tell us after the surgery was done, would you describe for us what treatment was given to Mr. Anderson and what the progression of his condition was?

A. After that surgery is done I saw him back shortly after the surgery, I took his stitches out, he had these pins, the two cross pins that you saw sticking out of the skin. They had a small area where

FORM FED PENGAD • 1-800-631-6989

they were draining a little bit. I cleaned them up, I started him on antibiotics. We saw him back, they had cleaned up no longer draining. About two weeks later back to this x-ray, the pins are removed in the office. And the way we do that is just the way you pull a nail out of a piece of wood, you take a surgical plier and you back them out. And that's a fairly painful procedure that Mr. Anderson went through. And at that point we feel that we did simply hold the piece at length and keep the reduction.

You can see that, with the pins out you can actually see how badly broken the bone is. You can see this is normal bone. And as you get up into this area it is washed out, it doesn't have the same density or hardness of the bone here. And this is the effect of the fracture, you can see this sharp line going through here. That is actually a piece of bone that would normal be like this and give you this white look that has turned like this. As you are seeing it ninety degrees from what it normally is and little broken up pieces of bone in there. Still a fracture line is visible which is why you have to leave the bridge on.

Q. Doctor, would you describe for us why is this shadow here, what does this indicate?

FORM FED PENGAD • 1-800-631-6989

A. This as Mr. Gorayeb mentioned is obviously where the fracture is, looking at the arm from the side. The fracture is not only going across this way but it exist in several ways through the bone so that if the skins and muscles were not on this, this would be a piece, meaning that it is not just one shot across. What this is, is another step off that you are seeing. Even though this is surgically repaired to the best of Doctor Crone's ability, we had small broken up pieces. The goal is to try to get this as smooth as possible and sometimes it is not completely possible to get it completely smooth. If you follow the contours of the bone up, this piece is somewhat out of place. If you look you can still see a gap here, and if you look from the front you can see this would be the normal surface here and here, that white line should match up so that this area in here is irregular. One thing you can see Doctor Crone has done, has been able to do is move the hand back so that it is more over the ulna, if you remember the other one it was shifting somewhat.

Q. Doctor Kaplan, would you put the other film up for a second. One of these pins actually goes through the radius and into the ulna. What was the reason for that?

FORM FED PENGAD • 1-800-631-6989

A. The reason for doing that is just, just again like some types of construction, you need something to hold this. Again this was so badly broken up if you simply elevated it, pushed it up to the right level it would probably collapse. The natural pull of the muscles is up the arm. That's why you are stronger making a grip than just putting your fingers out. The muscles that pull toward you are stronger in a grip. Even with this bridge in place over time the muscles that are in a normal arm exert some force as you grip causing these muscles to be pulled up. This ulna is a good structure and this other side are pinned to that to hold this up. Again this coming back here you can see that even after the surgery and this is shortly after the surgery, you see that step off of bone which is simply an indication of an inability even with open surgery to get this, to get all the pieces back together again.

Q. Doctor Kaplan, yesterday we heard testimony from Doctor Kolb, the radiologist, that there was a fracture also of the ulna?

A. Right. The ulna is this bone, this smaller bone of the wrist. He fractured the tip of the ulna which is called the ulna styloid, and can you see a nice picture of the ulna styloid on 4A, here this hook.

FORM FED PENGAD • 1-800-631-6989

And it is difficult to see the fracture through this unless you look very closely. You will have the opportunity to do that later. There is a line through there. And you can see it easily on here after manipulation. You can see the fracture even more clearly here. This ulna styloid is displaced upward.

Q. What is the orthopedic significance, if any, of an ulna styloid fracture?

A. The orthopedic significance, this is an area where the hand is anchored to the forearm. There are many ligaments that hook on to this little piece of bone, this little point. The ligaments are rope-like structures that go from bone to bone and help stabilize joints. And there are many ligaments that go there, the wrist bones to the ulna styloid,a fracture through there frequently doesn't heal, doesn't grow back together. Because the ligaments pull that way, pull away from the major bone structure. But also it can be a painful fracture because it is constantly moving as you are trying to rehabilitate the hand and it is often an area of continued pain on the ulna side of the wrist.

Q. Thank you, Doctor Kaplan.

For how long a period of time did you and Doctor Crone continue to follow Mr. Anderson?

FORM FED PENGAD • 1-800-631-6989

A. Mr. Anderson has been seen in the office many times since the incident. He was in the office fairly recently. He was seen throughout 2000, 2001, and to the end of 2002, and then most recently seen in the office September of 2003.

Q. And Doctor, we have in evidence all of the x-rays throughout the course of his treatment, can you briefly review those x-rays for the jury and describe the progression of Mr. Anderson's condition?

MR. BOULE': Objection.

THE COURT: Overruled.

Q. There is a shadow box available.

A. I'm going through these quickly in order. This is 4D and this is from April, so this would be approximately two months after the surgery. You still see the bridge or external fixator in place with the screws and the bones. You are starting to see some filling in of the fracture site here. This bone is starting to look a little more normal. I don't know if you remember it was very light, starting to look and have a normal color. You still see the fracture line especially over here. And you also still see irregularity of the joint, the joint surface comes to here, and a little fuzzy here. That's an indication that things are not meeting up normally to make that

FORM FED PENGAD • 1-800-631-6989

platform, that smooth surface that you might see in a normal joint.

You are also able to see sclerosis, whitening of the bone around the joint, which is an indication of wearing and changes in the bone.

Q. Why would that wearing be occurring?

A. That wearing is actually there because probably at this point because of the original injury, which even though this is the bone that broke, the way that bone breaks is by having it literally pushed into itself and fractured off by the hand and wrist as the weight of the body lands on it. You see sometimes trauma to this bone even through it doesn't break but the cartilage, the cartilage surface which is the teflon coating surface start to show some wearing. I can still see the step off here, that's in April.

A. That's the April external fixation still on. In May the external fixator comes off and you can see where the screws were in the bone. These lines across here that held the bone where the screws were but they have been removed. Again you see some increased sclerosis, whitening of this bone indicating bone damage, irregular joint surface, step off, the joint line goes down and back up again. That's that step off that we continue to look at. Some more consolidation

FORM FED PENGAD • 1-800-631-6989

or growing of the bone although the fracture site is still quite visible. You are seeing progress towards union, the bone growing together but very slowly and other changes going on in the bone.

Q. In that x-ray, Doctor, is there any evidence that the radius is compressed in comparison to the other?

A. Yes, actually there is. This is the one from before, you can see again the radius is still a little bit short but it is meeting up with the ulna. For the most part here this level is suppressed a little bit here but it is meeting up. And here after you take the fixator off you do get a little bit of settling early on where the ulna and radius do not meet up with respect to this area.

Q. And Doctor, in that x-ray that is taken are the carpal bones in anatomical alignment with the ulna?

A. At this point for the most part they are, for the most part they are. This is, again they are washed out. Pretty good here. When I say washed out, from disuse, from being in that external fixator you get some loss of the calcium of the bones. You start to seek that form of washing out. As he started to try to move his fingers to use the hand. So at this point he

FORM FED PENGAD • 1-800-631-6989

really has not used the hand very much.

Here is June, July rather of 2001; this is 4C; and again you see irregularity of the joint surface. You can see this step off here, the joint surface there. He has a joint surface there that's a sharp step off. See again this tilted angle of the radius, meaning even after the surgery the bridging, the pins, the screws you still have this collapse so that there is a shortening of the radius in comparison to the ulna. The ulna should be here, and these two should be level.

Q. Doctor, why is that collapse significant for use of that joint?

A. It is, again at this point I should talk to you about the motions of the wrist joint. Everyone realizes of course that the wrist flexes and bends this way and this way. It does other motions, side-to-side, which is when you move toward the smaller bone towards the ulna it is called ulnar deviation. When you move toward the big bone, the radius, it is called radial deviation. The other thing that happen at the wrist is that you turn the forearm and hand over and down. This is called supination, turning the hand up, I remember in medical school I used to say that's like holding a cup of soup. Then we have pronation which is turning the hand down. That motion occurs through the joint

FORM FED PENGAD • 1-800-631-6989

between the radius and the ulna here at the wrist. And you can see it when I turn the hand over watch this point, this bone. Most of the motion occurs through that joint; it occurs right there through that joint. And so a miss-match in that joint is like having a door that doesn't fit into the door jamb. It won't slide the normal way, it gets stuck. And so when this joint, this bone which is normally smooth sunk into the radius here, where it meets here, it causes problems. When that bone is relatively long the radius will not turn over in the normal fashion. And so you see pronation and supination of the hand and forearm. The fact that the ulnar is longer, the ulna is longer and the fact that the radius is now tilted this way rather than flat the way that you would expect it normally to be also affects the ability of the hand to move side-to-side. You have now got a tilted radius here, and in Mr. Anderson he has limited motion this way because it hooks. He also has limited motion this way because this is relatively longer and it gets impingement as you try to go to the side to the ulna. The irregularity of the joint surface of the platform means that he also has decreased extension and flexion. So this type of injury has effected all of his motions of his wrist; flexion, extension, supination,

FORM FED PENGAD • 1-800-631-6989

pronation, ulnar deviation and radial deviation, that's because the shape of the joint is no longer normal not only between the wrist and hand but also between the forearm and the wrist.

Q. Doctor Kaplan, in addition to what you just described to us does this sort of injury also affect the grip of a person, the ability to flex one's fingers?

A. In fact it does. Mr. Anderson has had several things occur. The way that you open and close the hand is by moving the muscles here in your forearm. And tendons or leaders, as some people call them, run down the fingers when there is a fracture in the wrist where the leaders are typically bound down and the shape is changed, it often changes the way that the leaders pull on the fingers. Mr. Anderson has difficulty bending completely his small finger and to a lesser degree his ring finger. In addition, he has weakness of grip on this side compared to the other side of about half. And that is not only because of the shape here, which has now changed so that when he grips his hand doesn't do what mine and yours would normally do. You make a power grip it goes to the side because he has limited motion going to the side. And if you just do that, you can see it if you really grip

FORM FED PENGAD • 1-800-631-6989

tightly you always move to the ulnar side. I am doing this a little bit exaggerated just to show it to you, but you can see that on yourself. But it changed the shape of his wrist, he had the shape of his wrist changed now he doesn't have a good power grip. His strength has left because he can't power grip and because he had loss of flexion of the muscles and tendons ability to pull these fingers down.

Q. Doctor, why don't we go to the most recent x-ray and show us that progression.

A. This is the x-ray that was taken 9-2-03. And again, over time you have consolidation of the bone, meaning that bone grew together and you no longer see that fracture site here. Amazing thing the body can do. But what it didn't do is change the shape of his joint. You can still see the step off here, the joint surface, and here is a joint surface. The step off in the joint surface you can see looking at it from the side, same way looking at it from the side you see an area here in the joint surface where there are changes, joint and surface. You also see that the ulnar is still more prominent, longer than the radius, the radius rather than being flat like a platform, it is tilted down. The joint between the radius or ulna is subluxed or out of place. Out of place so that there

FORM FED PENGAD • 1-800-631-6989

is no, there is limited ability to turn the wrist over. There are those two bones out of these--

Q. What are these?

A. This bone is comminuted, it is a fracture broken up in small pieces and even with the best technology that we have, which is this external fixator, as well as open surgery and pinning, there is some collapse occuring over time as they grow together.

Q. Doctor Kaplan, I want you to assume that we heard yesterday from Doctor Finkel, the neurologist, that there is continued evidence of washing out of Mr. Anderson's bones.

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to why that will be continuing to occur?

A. Absolutely. It is an indication that he is not using the hand normally. The way that that works, the reason you get good calcification of your bones is by using them and loading them. We have all heard of people doing weight bearing exercises, high impact arobics or low impact arobics, that's the impact causing the body to respond by putting down calcium in bones and making you strong. Same thing occurs

FORM FED PENGAD • 1-800-631-6989

although your hands are not thought of as weight bearing extremities, they still put down bone in response to the demand or the use of the part. So that the inability to use this part in a normal way, get full flexion, full motion, full grip, means that the body doesn't calcify as much as it would the other side on the normal wrist.

Q. Doctor, does the lack of calcification predispose a bone to either deterioration or further injury?

A. It does make the bone less strong. In fact, the reason that you do weight bearing exercises is to guard against hip fractures at old age, it makes the bones stronger. It does make the bone less strong if there is no exercise. Since we are dealing with an abnormal joint surface I guess the reason that I keep mentioning that abnormal joint surface is because this will have not only be problematic because of the shape but at least the problem over time. This is an injury that occurs at one point but then is progressive over time. The joint is a moving structure, you have one bone moving against another smooth bone. If you disrupt that smooth surface in any way then you have a step off like we have seen and a sharp edge. The healthy bone is going to be damaged over time as it

FORM FED PENGAD • 1-800-631-6989

move, as it is called upon to move with normal motion. And you get an erosion effect, basically the unsmooth bone is like a piece of sand that files away at the smooth bone and causes progressive problems over time. When the bone itself is not as strong that can progress more rapidly, the bone can't stand up to that type of wear and tear over time.

Q. Doctor, is there any evidence that there has been erosion or deterioration of the adjacent bones in Mr. Anderson's hand?

A. You do see less of a joint space here. The space between the bones on an x-ray is representative of the cartilage cap or teflon cap on the end of every joint bone. You can think of that if you look at the end of a chicken bone you see that smooth pearly surface, the shiny bone, that's the cartilage, that's the joint cap, that teflon coating. It doesn't show up on x-ray, it shows up as a space. When there is loss of space where you can see there is basically no space here compared to these spaces you see around it. In general they should always all be about equal. That shows progression of the erosion of the joint over time.

Q. Okay, Doctor, take your seat.

Doctor Kaplan, at some time did Mr. Anderson

FORM FED ● PENGAD • 1-800-631-6989

indicate to you a desire to return to work?

A. Yes, he did.

Q. And were you aware that he did, in fact, return to work?

A. Yes, I was.

Q. And after he returned to work did he come to you with any complaints of pain and disability?

A. He indicated that he had attempted to return to work and that was on our visit of 5-30-01; that he attempted to return to work at a light duty position. However, he had to do some lifting and he had increased pain across the wrist and was unable to return to work the following day. That was in May of 2001.

Q. Doctor Kaplan, I want you to assume that we are going to hear probably on Monday from Mr. Anderson that he returned to work approximately five months.

A. Uh huh.

Q. And that progressively over the course of time the pain in his wrist got worse and that even after stopping work his wrist now hurts him more than it did before he went back to work.

A. Right.

Q. Do you have an opinion, Doctor, with a reasonable degree of medical certainty why after attempting to go back to work Mr. Anderson's wrist

FORM FED PENGAD • 1-800-631-6989

would be bothering him more?

MR. BOULE': Objection.

THE COURT: Overruled.

Go ahead please.

A. Sure. Of course, it really speaks to what I was describing before, which is he has an abnormal wrist. I have in my notes that in fact he attempted to work for about five months. That puts more stress on an abnormal wrist and over time that is going to worsen. You have to think of a joint sort of like a machine, it is constantly moving when it is called to work. If the pieces of the machine don't fit there will be wear and tear and increased wear and tear. In this case on the wrist joint increased wear and tear leads to abnormality in the bone and changes in the bone which leads to arthritis. And arthritis is the clinical finding of pain in the wrist. In this case pain in the wrist with bony changes, pain that is made worse by inactivity, accompanied by limited motion and that is a progressive problem. As you know there is no cure for arthritis and there this is not normal wear and tear this is a post traumatic arthritis developed because of an incident that gets worse over time like any arthritis does.

Q. Doctor Kaplan, I want you to assume further

FORM FED PENGAD • 1-800-631-6989

that we are going to hear from Mr. Anderson that the pain in his wrist is relatively still constant, and that what happens is that if he doesn't use it he has less pain, but if it remains immobile for an extended period of time and he then tries to move it, it becomes extremely painful. On the other hand, if he does use the wrist frequently he has chronic pain. What in your opinion is the medical reason for that?

MR. BOULE': Objection.

THE COURT: Overruled.

A. Mr. Gorayeb pointed out two things that we see in people with this type of problem, whether it is post traumatic arthritis or every day wear and tear arthritis; people who tell you that they have arthritis, they are very stiff getting up in the morning and after they have been sitting for a period of time they have trouble getting up. They have something called a factor, the joint sort of settle and because the joint surfaces are not normal you will get an area of bone touching bone or bone-on-bone where there is no lubrication, no joint fluid between the bones. And as you start to get up moving an unlubricated bone is very painful. So that not doing anything for a while and then initiating an activity, you have a lag time between before the joint

FORM FED PENGAD • 1-800-631-6989

fluid gets moved around, and after the fluid is moved around then it feels a little bit better. But initially after resting for a period of time people with arthritis are painful upon starting activities.

The other problem that he mentioned is that if he works all the time he has constant pain. And that is because it is irritating to the joint and bones after doing such activities when your joint is not normal.

Q. Doctor Kaplan, what is your prognosis for Mr. Anderson?

A. The prognosis is sort of a medical term meaning looking into a medical crystal ball looking at something that is going to happen to Mr. Anderson in the future. His prognosis is poor in that he does have arthritis in the wrist, he has an abnormally shaped wrist joint, he's got uneven surfaces that rub on each other and will continue to rub and erode each other. And he will need future treatment and likely future surgery to the wrist to deal with the problems as they progress over time.

Q. What types of future treatment do you foresee Mr. Anderson needing?

A. There are two types of treatment in orthopedic surgery, one is conservative which is treating with supportive care. And he can use

FORM FED • PENGAD • 1-800-631-6989

anti-inflammatory medications, he can use bracing, like a wrist brace when he has a lot of pain. He can use injections of steroid medication when he has a lot of pain. And non-conservative treatment which is surgery and there are several medical options for Mr. Anderson.

As we talked about he's got damage to multiple surfaces of the wrist. One of the problems is that the joint that allows for flexion an extension is abnormal, and short, and the joint surface has arthritis and it is painful. So that the limited motion that he does have now can be removed because that would also get rid of the pain associated with the limited motion and that's called a wrist fusion. And what we do is take the remaining joint surfaces off the bone of the radius and wrist bones, the carpal bones, and put a metal nail down the long finger and down the radius and screw it in with screws and it makes the hand stiff for flexion and extension. It won't move this way and this way. You do that when over time any motion he has is painful because it is better not to have the pain and not have the motion than to have the motion and have pain every time you use it.

Another surgery that Mr. Anderson is a candidate for---

MR. BOULE': Objection.

FORM PED PENGAD • 1-800-631-6989

Can we approach for a moment, judge?

THE COURT: In the middle of what he's testifying to?

MR. BOULE': Yes.

THE COURT: Denied.

Go ahead and finish then you can come up.

A. Another surgical intervention that he is a candidate for is trying to give him more supination and pronation, that motion I showed you that occurs through the joint here that is now abnormal at the end of the bone. And there is a procedure where you actually make a false joint. You take off, cut off the end of this bone, and without that door stop effect that I was telling you about, this action can occur more normally because it is not running into an abnormal shape. And that's called a distal radial, distal ulnar resection. This is the ulna and the end of it is called the distal part; it is a distal ulnar resection. These are two types of surgery that he would be a candidate for.

The fusion is really the end stage surgery you do take when every motion is painful and the motion is very limited. It is likely he would benefit first from a distal radial ulnar resection because that would give him more twisting motion. And then if you fuse his wrist over time later down the road he would still

FORM FED PENGAD • 1-800-631-6989

have this motion, he just would not have the flexion and extension.

Q. Doctor Kaplan, given that Mr. Anderson is presently fifty-one years old and has the conditions in his wrist as you have described, do you have an opinion as an orthopedist as to whether he will require a resection of his wrist at some point in the future?

MR. BOULE': Objection.

THE COURT: Overruled.

A. Yes, I do. And my opinion is he is about three years out from his injury, he has had progressive pain over time. Three years is a relatively short period of time and, yes, I think he will need that surgery in the future.

Q. Doctor Kaplan, have you performed those surgeries in the past?

A. Yes, I have.

Q. What is the approximate cost of a resection surgery?

A. This type of surgery is, depending on if the bone needs to be pinned because it is unstable things like that that has a cost of approximately five thousand to seventy-five hundred dollars.

Q. And Doctor Kaplan, what is the approximate cost of fusion surgery that Mr. Anderson requires?

FORM FED PENGAD • 1-800-631-6989

A. Fusion surgery is about eight thousand to ten thousand dollars, depending on the hardware that's used and things like that.

Q. Doctor Kaplan, do you have an opinion as to whether Mr. Anderson --- withdrawn.

In your opinion what future orthopedic care does Mr. Anderson require?

A. Again, Mr. Anderson requires anti-inflammatory medicines, those are medications, a broad spectrum of things you can get over the counter or by prescription ranging from Motrin to things like Vioxx or Celebrex, you've probably heard of that. He has in the past needed narcotic medications. If he has the surgery, when he has the surgery he will need those for a period of time afterwards, he will need physical therapy following surgery. Generally after surgery of course therapy is six to twelve weeks, twice a week or so depending on how he regains his strength and ability to use his hand.

He will need bracing after the surgery in order to allow for proper healing and comfort. And he will see the physician on a routine basis until these things are stabilized. And the visits can be spread out and then when he has trouble come back.

Q. Doctor, do you have an opinion as to whether

FORM FED PENGAD • 1-800-631-6989

Mr. Anderson will require orthopedic care for the condition of his wrist for the remainder of his life?

MR. BOULE': Objection.

THE COURT: Overruled.

Go ahead please.

A. Yes, he will.

Q. And how frequently in your opinion would Mr. Anderson be required, generally speaking, to see an orthopedist?

A. Again, it will be more frequent at the time he has surgery in the early phases as he is healing and each of those phases would probably be about six months. He would need to be seen every four to six weeks in that period of time. After the surgery has had time to settle down and he is feeling better, he is back to functioning, he should probably be seen by an orthopedist at least once a year for about two years, and then whenever things flare up. This is not a perfect surgery; with the surgery you do loose some grip strength, generally thought to loose about twenty-five percent of your grip strength. He has already started to loose about fifty percent of his normal grip strength.

Additionally, as I told you, you put a flat metal plate on the radius down the long finger and

FORM FED PENGAD • 1-800-631-6989

there is underneath that a tendon, and there is a high incidence of tendonitis, which is irritation and inflammation of the tendons. Often times the tendons get irritated as they ride over the plate and that frequently needs medication, the anti-inflammatory medication and bracing.

Q. Doctor, other than his undergoing the surgery that you described for us, is there anything that would cause Mr. Anderson to alleviate his pain and give him more function?

A. Things like anti-inflammatory medication alleviates some pain. The important thing in my mind is, is there anything to stop the progression of the arthritis or stop the arthritis after surgery. And the unfortunate fact is there is no cure of arthritis and there is no way to stop it from occurring besides the surgery.

Q. Doctor, have you over the course of your profession had an opportunity to treat other carpenters?

MR. BOULE': Objection.

THE COURT: Overruled.

Go ahead.

A. Yes.

Q. Are you familiar with activities the

FORM FED PENGAD • 1-800-631-6989

carpenters engage in?

A. In general yes.

Q. Do you have an opinion, Doctor, to a reasonable degree of medical certainty as to whether Mr. Anderson, knowing what you know about him, is capable to return to work as a carpenter; what is your opinion?

A. My opinion is as I understand carpentry in general terms, use of a hammer, use of pneumatic or air tools, carrying of lumber or metal; it would be impossible for him to do this on a sustained basis. He has weak grip of his dominant hand, his right hand. It would be unsafe for him to climb ladders, to carry heavy tools, to carry heavy equipment and so I do not believe that he can perform that job.

Q. And Doctor, do you have an opinion as to the amount of weight that Mr. Anderson could comfortably lift with his right hand at any time?

A. In a one shot burst he could probably lift upwards of twenty pounds or so. And on a repetitive basis I would think it would be five to ten pounds.

Q. Repetitive basis, when you say repetitive, do you contemplate that as being throughout the work day, five or six hours every day?

A. No, that to me is constantly. Repetitive to

FORM FED PENGAD • 1-800-631-6989

me is several times in a row.

Q. Several times in a row?

A. Yeah.

Q. How many times do you think he could lift, five times each and every day, say he was working on a job?

A. I think it would be very difficult for him to do that without significant amounts of pain.

Q. I see. So, do you have an opinion, Doctor, as to whether he could engage in a job where he had to lift something with his right hand weighing five pounds constantly over the course of the work day?

A. I don't think he could reliably do that. I think he would have a significant amount of pain and again, thinking of the problem, thinking of what's causing the problem which is an abnormal joint surface, that wear and tear, bones wearing each other out, the more he stresses the wrist the quicker it is going to wear out.

Q. Doctor, do the injuries that Mr. Anderson have sustained affect his ability to manipulate objects or use the fingers?

A. Absolutely. He's got an inability to completely close his small finger and to some degree his ring finger. Additionally, he's got weakening of

FORM FED PENGAD • 1-800-631-6989

grip, so those things are affected.

Q. And Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether if he attempted to work on a regular basis it would have some negative affect upon the condition of his wrist and hand?

A. Again, we are talking about exactly what I said five seconds ago. The abnormal joint surfaces will wear each other out. The other thing is when you use your hand and as I described the muscles that go to the hand are down here in the forearm. In order to use your hand effectively to do things, especially to grip and pick up, you have to clinch your wrist down. When your hand is loose your wrist can move pretty easily. If you make a fist it is pretty hard to make a tight fist with your hand although you are not trying to hold your wrist steady. When you start to move your hand backward or forward you can see that it is harder to make a real tight fist. And so yes, absolutely, gripping, use of the hand has an effect on the wrist. And when you make a fist it brings the bones in a more stable position, closer together, and that is a position that is productive of pain and wear.

Q. Doctor, is there anything that can be done to improve the functioning of Mr. Anderson's ring and

FORM FED PENGAD • 1-800-631-6989

pinky finger?

A. Not reliably, no.

Q. Do you have an opinion, Doctor, as to whether that condition is static or whether it is progressive over time?

A. I believe it is a permanent condition, that it will not change significantly over time.

Q. Doctor, I want you to assume the following hypothetical, I want you to assume that prior to February 8th, 2000, Wilbert Anderson was a healthy, forty-six year old male, no history of any medical problem other than hypertension, he was capable of working five or six days a week as a carpenter, didn't see a physician for any problem, and was a healthy human being. And on February 8th while working he fell from a scaffold which collapsed, that Mr. Anderson sustained immediate and severe pain in his right wrist and in his face, and that he underwent hospitalization, surgery and treatment that you have described for us, that he presently has the aftermath of the fracture of his wrist, the disabilities and conditions that you have described. Do you have an opinion, Doctor, with a reasonable degree of medical certainty as to whether the injury and conditions that you have explained to the jury are causally related to the accident of

FORM FED PENGAD • 1-800-631-6989

February 8th, 2000?

A. I do.

MR. BOULE': Objection.

THE COURT: Overruled.

Go ahead.

Q. What's your opinion?.

A. I do have an opinion. I think given the state which I saw him come into my office several days after the accident and the history that we have there is no question that what was described in the injury, including the problems that have progressed since the time of the injury and are still present now, came from that accident.

Q. And Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the conditions as described are permanent?

A. There is no question they are permanent. Not only permanent but progressive as I have been describing.

Q. Doctor, did you have to rearrange your office schedule to come here today?

A. I had to cancel my office schedule to be here today.

Q. Are you being compensated for your time?

A. I'm being compensated for rescheduling and

FORM FED PENGAD • 1-800-631-6989

canceling the office, fifty-five hundred dollars.

Q. And Doctor Kaplan, have you had occasion to treat other clients that have been represented by my office?

A. Absolutely.

Q. And have you also at my request on behalf of these individuals come to court to testify?

A. When it has been necessary, sure.

MR. GORAYEB: Thank you, Doctor Kaplan. Nothing further.

THE COURT: Members of the jury, do any of you need a break? You need five minutes?

MR. BOULE': I need some time to look at the doctor's file.

THE COURT: All right, we will take a few minutes. Please don't discuss the case.

(Whereupon, the jurors are excused at three twenty-five PM.)

(R-E-C-E-S-S.)

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jurors enter the courtroom at three thirty-five P.M.)

THE COURT: Please be seated and welcome back.

FORM FED PENGAD • 1-800-631-6989

MR. BOULE': Thank you.

CROSS-EXAMINATION

BY MR. BOULE':

Q. Good afternoon, Doctor Kaplan.

A. Good afternoon.

Q. You have testified in court before, Doctor?

A. That's correct.

Q. You have testified for Gorayeb and Associates in a case that I was the attorney, haven't you, Doctor?

A. I don't recall you being there but, yes, okay.

Q. Do you remember that case?

A. Yes.

Q. Doctor Kolb was involved in that trial as well, correct?

A. I don't remember if he was or not.

Q. How many reports have you performed for Mr. Gorayeb's office in the past?

A. I don't know exactly.

Q. Do you recall testifying in a case involving Mr. Severe early this year?

A. Yes.

Q. Do you recall Doctor Kolb being involved in that trial as well?

A. I don't recall specifically. Doctor Kolb is

FORM FED PENGAD • 1-800-631-6989

a radiologist who has an office near my office and I send a fair number of patients there.

Q. And so it's at least possible that you and Doctor Kolb have testified on behalf of the same injured individual in the past, correct?

A. Both of these guys were patient of mine for a long time. I operated or actually Mr. Severe was operated on by someone I sent him to. He had most of his testing work-up done through my office so it's very possible.

Q. Did you do the surgery on Mr. Severe?

A. No, I said someone who I sent him to, he had spine surgery which is surgery I don't do.

Q. Do you recall testifying for Mr. Gorayeb's with regard to Juan Garcia?

A. Juan Garcia is a patient of mine, I did operate on him. I don't recall if I testified for him, if you tell me I did, then I did.

Q. Doctor, do you recall Doctor Kolb being involved?

A. I don't recollect that. I certainly may have sent him to Doctor Kolb for a test, like an MRI of his knee.

Q. You frequently send patients to Doctor Kolb for diagnostic testing?

FORM FED PENGAD • 1-800-631-6989

for diagnostic testing?

A. And he sends patients to me for treatment. Part of being an orthopedic surgeon is diagnosing things and that requires MRIs, a radiologist, and Doctor Kolb is one of those people.

Q. How many times have you testified in the year 2003?

A. I have no idea.

Q. When did you last testify before today?

A. I believe the week before last, I think. I believe I testified last week.

Q. What about before that?

A. I don't keep track of things like that, most of my time is spent in my office or in surgery. And if I am asked to testify and I can do it, I do.

Q. If I told you that from the beginning of the year, January until May of 2003 you testified twelve times; would that sound about right?

A. Could be, sure. Once or twice a month sure.

Q. Once or twice a month is your average amount of testimony?

A. There is no average. There is no average, when it occurs I do it especially if it is a patient of mine.

Q. Sometimes if it is not a patient of yours?

FORM FED PENGAD • 1-800-631-6989

A. Sure, I have testified for defendants sometimes if they ask me to be an expert witness. Or I testify if someone ask me for some reason they don't have a physician who can testify in their behalf. If I have been asked to do that, sure. I have been asked to testify by federal judges on cases for the state.

Q. Each time you testify is your fee five thousand five hundred dollars?

A. Generally, yeah.

Q. Now, in addition to being paid fifty-five hundred dollars for today, have you been paid any other amounts of money from Mr. Gorayeb's office?

A. Sure.

Q. And what were those sums for?

A. Talking about in this case?

Q. Yes, in this case?

A. In this case, writing a report which is something that, if someone has a suit they have to have a report made so that it can be exchanged with the defendant. Those cost two hundred fifty dollars, two hundred seventy-five dollars. I believe we did a couple of those. If you give me my chart back I can tell you exactly how many.

A report which reviewed what's going on requires a chart review, and going over the x-rays, and

FORM FED PENGAD • 1-800-631-6989

coming to conclusions. And we wrote, looks like three reports in this case.

Q. When you say "we", is that you and someone else?

A. My partner, I have two other orthopedists in my office, these reports were written by myself and Doctor Crone. Doctor Crone is the surgeon who operated on Mr. Anderson and so he wrote part of the reports, yeah.

Q. Wrote part of the reports?

A. Yes.

Q. You both signed them?

A. That's correct.

Q. And Doctor Crone is a physician who actually performed the surgery?

A. That's correct.

Q. Is it fair to say that you can look at your chart and the large majority of time that Mr. Anderson was seen in the office it was Doctor Crone who saw him?

A. It was Doctor Crone who dictated the notes and probably who saw him most. Usually the physician who operates write the notes. I certainly saw Mr. Anderson a number of times including the first time he came in and post-operative period.

FORM FED PENGAD • 1-800-631-6989

Q. In addition to the first time he came in, as reflected on your notes, how many other times did you see him?

A. The first time he came in, I saw him the third time he came.

Q. What is the date of that, the third time?

A. What's that?

Q. The date.

A. Of what?

Q. The third time he came in, I am asking you the date of that visit?

A. That was 2-25-2000. And let's see if there is any other time I dictated. And then Doctor Crone dictated all other notes so I am not sure whether I saw the patient that day or not.

Q. But the other notes do contain reference to Doctor Crone and then followed by the notation?

A. That means he dictated the note.

Q. And that he saw the patient?

A. It's possible that both of us saw the patient but certainly he saw the patient if he dictated it.

Q. Is it fair to say that the large majority of the care Mr. Anderson received from your practice was given by Doctor Crone?

A. Yes, that's fire to say, Doctor Crone did

FORM FED PENGAD • 1-800-631-6989

the operation.

Q. Most of the follow-up visits were with Doctor Crone?

A. Doctor Crone or both of us, sure.

Q. Now, you talked about a report, you just prepared a report September 2nd, 2003, correct?

A. Yes, I have that.

Q. And that was based upon an examination on that day?

A. That's correct.

Q. Was that an examination that you performed?

A. I believe we were both present for that exam.

Q. And you both signed the report, both being you and Doctor Crone?

A. That's correct.

Q. Now, the last time he was in your office before then was, if I am not mistaken, February of 2003?

A. That's correct.

Q. Is that correct?

A. Yes.

Q. And at that time Doctor Crone saw him, according to the note?

A. Doctor Crone dictated that note look like, yeah.

FORM FED ● PENGAD • 1-800-631-6989

Q. At that time, the February '03 visit, was the appointment for September 2nd, 2003 already scheduled?

A. I don't know the answer to that.

Q. You don't know when that appointment was scheduled?

A. No, I don't.

Q. Do you know who scheduled it?

A. No, I don't.

Q. Do you know the purpose of Mr. Anderson coming to you except for examination?

A. I don't.

Q. Do you know if it was for this trial to prepare for litigation?

A. I assume if they knew the trial was coming up he would need an updated examination so that we could speak intelligently about how he's doing, sure.

Q. There was no treatment rendered during that visit; is that fair to say?

A. Well, in orthopedic surgery part of treatment of course is giving advise. You can't operate on someone every time they are there. So when you discuss with a patient what the findings are and their x-rays when x-rays are taken, that is treatment, it is not active treatment.

Q. Was a referral made for physical therapy?

FORM FED PENGAD • 1-800-631-6989

A. No, not at that time.

Q. Was medication prescribed?

A. None was prescribed. As I said he is mostly using over the counter medication.

Q. That wasn't my question. You have already answered it, thanks.

A. Okay.

Q. Now, you testified on direct examination about surgery that may be in Mr. Anderson's future. And you talked about radial ulnar resection; is that correct?

A. Yes, that's correct.

Q. Doctor, in the report that you prepared two weeks ago--

A. Uh huh.

Q. --where does it say Mr. Anderson is a candidate for radial ulnar resection?

A. I think it says that he's a candidate for future surgery that could include fusion, I don't know that we say that he could use a distal radial ulnar resection. It is not specifically mentioned.

Q. So it is an opinion that you are giving for the first time here today. It wasn't contained in your report, right?

A. Simply because it is not contained in my

FORM FED ⊗ PENGAD • 1-800-631-6989

report doesn't mean I haven't expressed that opinion before but it is certainly not in my report in specific terms.

Q. Doctor, if you are talking to the patient about his future care, giving advice is part of the orthopedic treatment?

A. That's right.

Q. Wouldn't you discuss with him the radial ulnar resection surgery that you are telling the jury about?

A. We told him that he could benefit from future surgery, one of those things could include a wrist fusion. It doesn't exclude a distal radial ulnar resection.

Q. It is not mentioned in the report?

A. It is not mentioned in the report.

Q. With respect to the fusion, your report says that it cannot be ruled out?

A. That's correct.

Q. That means that it may happen, it may not happen?

A. That's correct.

Q. The same with the ulnar radial resection, I hope I'm saying it right.

A. It is distal ulnar resection.

FORM FED PENGAD • 1-800-631-6989

Q. And it cannot be ruled out?

A. No, it cannot be ruled out. As a result is it likely? Yes, it is likely for the reason that I spoke to you about before.

Q. Well, do you have any date scheduled for surgery on Mr. Anderson at this time?

A. No, I try to hold out as long as possible.

Q. When is that surgery going to happen?

A. I can't give a hundred percent certainty, obviously.

Q. Your opinion is that that surgery will happen?

A. Yeah, I believe it will.

Q. And that's an opinion you gave the Court but is not contained in your report, correct?

A. It is not contained in the report. That's correct.

Q. Doctor, in the notes starting with June 11th, 2002, Doctor Crone's note, on that date and then September 3rd, 2002, and October 15th, 2002---

A. Right.

Q. ---there is mention of vocational rehabilitation suggested or requested, right?

A. Yeap.

Q. That would be an opinion or piece of advice

FORM FED ● PENGAD • 1-800-631-6989

that Doctor Crone gave to Mr. Anderson?

A. No, that would be a request made on Mr. Anderson's behalf to have some future therapy and rehabilitation, which is vocational rehabilitation which simply means directed at finding something that he could do because he felt clearly he could not go back to his normal job.

Q. And is there any reference in the file follow-up notes or anything that you are aware of that such vocational rehabilitation has been undertaken by Mr. Anderson?

A. As far as I know that has not been offered.

Q. My question is has it been undertaken?

A. Not that I know of. But in practical terms, as I said, that has not been offered.

MR. BOULE': Thank you. That's all I have.

THE COURT: Anything further?

MR. GORAYEB: Nothing, Your Honor. Thank you, doctor.

THE COURT: Thank you, Doctor Kaplan.

(Whereupon, the witness is excused at three forty-five PM.)

THE COURT: Call your next witness. We have one more relatively short witness.

FORM FED PENGAD • 1-800-631-6989