2006 WL 6224081 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Miguel Angel BURGOS, Plaintiff,
v.
213 WEST 23rd STREET GROUP, LLC, Tionex-New York, Inc. and Belen Masonry Corp., Defendants.

No. 119821/03.
July 6, 2006.

Continued Jury Trial

(Transcript of Jeffrey Kaplan, M.D.)

Case Type: Premises Liability >> Fall from Elevation
Jurisdiction: New York County, New York
Name of Expert: Jeffrey Kaplan, M.D.
Area of Expertise: Health Care-Physicians & Health Professionals >> Orthopedic Surgeon

Representing: Plaintiff

Appearances:

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The Honorable Karen S. Smith, Justice.

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jury, because of scheduling, so we are not completing plaintiff's direct and cross-examination right now. Instead, we are

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taking a new witness called by plaintiff. A doctor, I believe.

MR. MADONNA: Yes, your Honor. Plaintiff calls Dr. Jeffrey Kaplan.

THE COURT: Raise your right hand.

JEFFREY KAPLAN, called as a witness herein, after having first been duly sworn, was examined and testified as follows:

THE COURT: Please be seated.

THE COURT OFFICER: In a loud and clear voice, state your name and spell your name, for the record.

THE WITNESS: My name is Jeffrey Kaplan, KAPLAN.

THE COURT OFFICER: And your address, business?

THE WITNESS: My office is 160 East 56th Street, Manhattan 10022.

THE COURT: All right, you may inquire.

MR. MADONNA: Thank you, Judge.

DIRECT EXAMINATION BY

MR. MADONNA.

Q Good afternoon, Doctor.

A Hi.

Q Doctor, are you licensed to practice medicine?

A Yes, I am.

Q And where are you licensed to practice?

A Currently in New York.

Q Have you ever been licensed in any other state?

A I was licensed in Tennessee and Mississippi in the '90s.

Q And when were you licensed in New York?

A In New York, in 1991.

Q Can you tell the jury a little bit about your educational background, starting from your undergraduate training?

A Sure.

I went to college at Yale University. After graduating there, I went to medical school here in the city at Columbia.

After four years of medical school, I did a training program in orthopedic surgery. That's a five-year training program. I did that at a place called the Campbell Clinic, which is in Memphis, Tennessee, which is the first orthopedic training program in

the country.

Following that I practiced in Memphis, Tennessee for a short period of time and I moved back to New York in 1995 where I have been practice ever since.

Q Doctor, can you explain to the jury a little bit more about your professional background, any hospital affiliations and the private practice of medicine that you are in now?

A I am an orthopedic surgeon. Orthopedics is the study of hones and joints and the supporting structures of the bones and joints so, muscles, ligaments, nerves, cartilages, discs; things like that.

And it studies the injuries or abnormalities to those structures and then the treatment of those, either conservative measures, meaning medications, injections, physical therapy, advice, and then if those things come up short or aren't going to work, surgery.

Orthopedic surgery I do at several hospitals around the city where I am on staff, and those include Cabrini Medical Center, Roosevelt-St. Luke's Hospital and New York University and Downtown Hospital.

I am board certified in orthopedic surgery.

Q What does that mean?

A Board certification --

THE COURT: Doctor, you are talking even faster than I do. Slow down.

A Board certification is an extra qualification that you can receive after completing college, medical school, internship, residency and then taking a series of examinations over a number of years given by a panel of expert physicians. They are called, in my case, the American Board of Orthopedic Surgery.

If you complete those examinations and the board feels that you have reached a certain amount of knowledge and expertise, then they deem you board certified and make you what's called a diplomate, which is a holder of a diploma from that organization.

Q And when were you board certified?

A Board certified in 1997.

Q And have you had to be recertified since then?

A I have not had to be recertified. Next year. Every ten years.

Q Now, the practice of medicine that you are in now in the field of orthopedic surgery, do you have a name for that facility?

A I didn't hear your question.

Q The name of your practice?

A My practice is called NY Ortho Sports Medicine and Trauma.

Q And you mentioned your office is located in midtown Manhattan?

A That's right.

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Q Do you practice with other physicians?

A I do.

Q How many other physicians are on your staff?

A Currently we have myself and another orthopedic surgeon. There is a neurologist that works with us and we have a physician in pain management that also works with us.

Q And is one of the physicians Dr. Eric Crone?

A Yes.

Q And he is an orthopedic surgeon, as well?

A Yes, correct.

Q Doctor, can you explain to the jury, with regard to your practice, how your office staff treats the patients of your practice?

A You mean all of the physicians?

Q Yes. Does one doctor see every patient, the same patient every time?

A No. We cover each other's patients as well as our own, which means that if I am out of town or I am in surgery and a patient needs to be seen, I will see -- another physician will see my patients for me if they need to be seen on that day.

Additionally, Dr. Crone does a lot of our upper extremity work -- hands, wrists, shoulders. While I also do those things, a lot of the evaluations will be reevaluated by Dr. Crone in order to get sort of a second opinion, but within the office.

And then we make notes in a chart, like every other doctor does, and we rely on each other's notes and conversations to keep track of patients.

Q. And your practice, I think you indicated, was limited to orthopedics?

A My practice is limited to orthopedics, yes.

Q And orthopedics being the study, as you said, of bones and joints in the human body?

A Right.

Q Do you come across treating patients who are injured as a result of trauma?

A Yes, that's a large part of my practice.

Q About what percent of the patients that come into your practice are patients who have trauma-related injuries?

A Probably 90 percent.

Q And other than trauma-related injuries, what would be the other way that a patient would have an orthopedic need?

A You can have orthopedic problems either from developmental problems that children have. You can have basically wear-and-tear problems that we all sort of get over time. So, any abnormality of the musculoskeletal system can be treated by an orthopedic surgeon.

Q And, just by definition, what is a trauma injury, a trauma-related injury?

A A trauma is an injury that occurs as a result of an accident or the force of an accident. And, again, that can be anything from a contusion or a bruise to a major fracture of a bone or a fracture of a joint.

Q Now, Doctor, in your practice, have you treated patients with fractures of their wrists?

A Yes, many times.

Q Have you treated patients with fractures of their hips and pelvis?

A Yes.

Q Have you treated patients who have had multiple fractures to different parts of their body?

A Yes, absolutely.

Q Doctor, have you performed actual surgery yourself, actually done the surgery yourself to repair wrist fractures, pelvic fractures and other joint fractures?

A Yes, many times.

Q How often do you do surgery?

A I do surgery -- I have scheduled surgery days once a week and then I usually add on another, a second day, depending on what the schedule is. Orthopedic surgery sort of lives and dies by the emergency room because that's what -- how most of the traumatic cases get to us. So, I am in surgery usually one to two days a week.

Q Now, Doctor, are you being compensated to take time away from your practice to come here to testify today on behalf of Mr. Burgos?

A My office is being compensated and, of course, I am compensated through the office, sure.

Q How much is the office being compensated for your time?

A The office receives a fee of $6500.

Q Now, Doctor, in the course of treating trauma-related patients in your practice, have you had the opportunity to come to court and testify on behalf of patients -- on behalf of people who are -- plaintiffs who are patients of your offices

A Yes.

Q How often do you come to court to testify in that instance?

A There is no set schedule of that either, but it usually averages out to about once or twice a month, in general.

Q In addition to testifying on behalf of patients who have litigation or lawsuits, are you also called upon by law firms and law offices to do evaluations or examinations of a patient on a one-time basis?

A I am.

Q And in those instances, do you come to court and testify on occasion for those evaluations?

A If it does come to court, sure.

Q In instances where you are testifying on behalf of a law firm who asked you to evaluate a particular litigant, is there a porcentage that you examine on behalf of plaintiff's firms as opposed to defendant's firms?

A For an expert opinion, it's about 50-50.

Q Now, Doctor, have you also treated patients of yours who are clients of my office?

A Yes.

Q And we have met before?

A We have.

Q And have you testified in a case where I was the attorney representing the patient?

A Yes, I believe so.

Q Now, Doctor, in the past, have you been qualified by the courts in the State of New York as an expert in the field of orthopedic surgery?

A Yes.

MR. LAMBERT: Your Honor, we'll stipulate that he is an expert.

THE COURT: Thank you.

Q Now, Doctor, did there come a time when Miguel Burgos came under the care of your office for medical treatment?

A Yes.

Q When did he come under the care of your office?

A He was first seen in our office on January 15th of 2004.

Q I see that you have taken out a file.

A Right.

Q In your practice at your office for orthopedic surgery, do you keep records, you and the physicians on your staff, regarding the visits of your patients each and every time that they came in?

A Yes.

Q In fact, are you required by law to keep a medical chart --

A Yes.

Q -- as to the findings and complaints of the patient when they come in?

A Yes.

Q And are those records made at or around the time of each visit?

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A Yes.

Q And are they done by the doctor who specifically sees the patient that day?

A Yes.

Q Do you have those records with you today?

A I do.

Q And they are kept and maintained in your office?

A Yes.

MR. MADONNA: Your Honor, at this time I would like to have Dr. Kaplan's file marked for identification and then moved into evidence as --

THE COURT: Plaintiff's Exhibit 6, I believe.

MR. MADONNA: 9, I think.

THE COURT OFFICER: We are up to 10.

THE COURT: Plaintiff's Exhibit 10. We are marking it for ID. I don't know -- are you going to want to put it in evidence?

MR. MADONNA: Yes, I would move to have it in evidence.

THE COURT: Any objection, subject to redaction?

MR. LAMBERT: Can we look through it quickly?

THE COURT: Yes.

(Defense counsel handed file.)

MR. LAMBERT: No objection, your Honor.

THE COURT: All right, it's in evidence as Plaintiff's Exhibit 10.

(Said exhibit received and marked in evidence as Plaintiff's Exhibit 10.)

Q Now, Doctor, if you need to refer to your chart, you can do so. That's in evidence at this point.

In addition to keeping a medical chart and records on behalf of the patients that you are treating, does your office also perform diagnostic testing such as X-rays, nerve conduction studies or other things?

A Yes.

Q And are those done in your office?

A Yes, they are.

Q Are they done at the direction of the physicians who are seeing the patients?

A Yes.

Q And are those X-rays read by the physicians and used in the course of the treatment for those patients?

A Yes.

Q And do you have X-rays that were taken of Mr. Burgos through the course of his treatment at your office?

A I do.

Q And do you have those with you, as well?

A I do.

MR. MADONNA: Your Honor, at this time I would like to have the X-rays marked as a separate exhibit, as Plaintiff's Exhibit 11 for identification.

THE COURT: Okay.

MR. MADONNA: And I will then move them into evidence.

THE COURT: Okay.

How many are there?

THE WITNESS: A number.

THE COURT: So you have the disk and the printed X-rays. We will mark all of them Plaintiff's Exhibit 11 for ID.

The ones that you are going to be referring to during your testimony, pull out those, because those I want to mark specifically 11A, B, C, D.

MR. LAMBERT: May we approach?

THE COURT: Yes.

(Whereupon, a sidebar discussion was held off the record out of the presence of the jury)

THE WITNESS: These are the most recent X-rays. There are 9.

THE COURT: And the X-rays from right after the accident?

THE WITNESS: Three.

THE COURT: So these will be 11A, B and C.

Exhibit 11A, B and C will be X-rays taken by the doctor the first time he saw the patient.

(Said exhibit marked for identification as Plaintiff's Exhibits No. 11A, B and C.)

THE COURT: what are the dates on these now?

THE WITNESS: 3/21/06.

THE COURT: These are plaintiff's X-rays, which will be Exhibit 12, dated 3/21/06.

They will be 12A, B, C, D, E, F, G, H, i. So, 12A through I.

(Said exhibits marked for identification as Plaintiff's Exhibits No. 12A through 121.)

(Witness handed exhibits.)

MR. LAMBERT: Just so that I am sure, did I hear a date with respect to Exhibit 12 of --

THE COURT: March 21st, '06.

MR. LAMBERT: May we approach, your Honor?

THE COURT: Come up.

(Whereupon, a sidebar discussion was held off the record out of the presence of the jury)

THE COURT: There is an objection over Exhibit 12 and the objection is overruled.

Okay.

CONTINUED DIRECT EXAMINATION BY

MR. MADONNA:

Q Now, Doctor, in addition to -- sorry. I think you indicated that Mr. Burgos came under your office's care in January of 2001?

A Right, correct.

Q Now, prior to that, he had been treated at St. Vincent's Hospital in Manhattan for emergency room stay and then an admission for approximately a month; correct?

A Yes.

Q Now, is it your practice or is it generally accepted in the field for physicians and orthopedic surgeons to obtain the prior medical records for the treatment that the patient that they are undertaking care for received?

A If they are available, yes.

Q And the reason is that you would obtain those records to see what the prior treatment was and what the condition was initially before you saw them; correct?

A Yes.

Q And do you rely on those records when you do obtain them to assist you in your care and treatment, in your practice, of these patients?

A Yes.

Q Did you, in fact, Doctor, or your office, in fact, obtain the hospital chart from St. Vincent's Hospital on behalf of Mr.

Burgos at some point in time during your care and treatment?

A Yes, we did.

Q And did you make that hospital record, once you obtained it, part of your file and part of your office record?

A It's part of our record and it was reviewed.

THE COURT: Aren't the St. Vincent's files in evidence already?

MR. MADONNA: It is in evidence, as well.

THE COURT: Exhibit what?

MS. BROWN: Exhibit 4.

THE COURT: Subject, of course, to redaction.

MR. MADONNA: Your Honor, I may as well, at this time -- Exhibit 4, the certified nospital record, also came with the X-rays and radiological films from that facility with the same certification. They are in a separate folder. Would I need to have those marked -

THE COURT: For safekeeping, let's have them marked as Plaintiff's Exhibit 4A.

MR. MADONNA: In evidence? They have the same certification so --

THE COURT: I'm just marking them 4A. St. Vincent's Exhibits were 4 and the X-rays that came are 4A.

MR. MADONNA: For identification?

THE COURT: No, they are in evidence. If it's part of the certification, they come into evidence under the CPLR.

(Said exhibit received and marked in evidence as Plaintiff's Exhibit 4A.)

THE COURT: After he identifies them, because it comes from his facility and he took it, you can move for those to be in evidence, but not yet. Let's go through the ones you are going to be using.

Q Now, Doctor, if you will, I would like you to take a look at the hospital chart, particularly the emergency room admission.

A Okay. Do you have a specific page?

Q Actually, do you have the discharge sheet? That should be on the top.

A I believe so. The hospital discharge sheet?

Q Yes.

A Yes, uh-huh.

Q The hospital discharge sheet, discharge summary, is that generally a summary of the initial assessment, the care and treatment and the diagnosis at discharge?

A Yes.

Q And just taking a look at that or any other portion of the record that you need, can you explain to the jury what Mr. Burgos presented with, what injuries he presented with to the emergency room staff at St. Vincent's Hospital?

A Yes.

The principal diagnosis that they give are the following: 1: Multiple trauma, which means injuries to multiple areas. And, in this case, a fracture of the left acetabulum. The acetabulum is the pelvis and the pelvis is made up of, like, a ball and socket joint -- sorry, the hip is made up of, like, a ball and socket joint. The ball is the top part of the leg bone, the femur, and the socket is the acetabulum, that part of the pelvis that makes the cup of the ball and socket joint of the hip.

Additionally, he had fractures and dislocations of both of his wrists. He had a fracture to a bone called the scaphoid and a dislocation of the small bones of the wrist such that the hand was no longer aligned with the forearm. They were dislocated.

Additionally, they indicate that he had surgery to both -- those three areas: Both wrists and the hip.

And it's a surgery called an open reduction and internal fixation, and what that means is that this is not a surgery -- this is a surgery for a fracture but it's not a surgery that can be done simply by manipulating the bones that are broken. It has -- the body has to be open, that's what the surgery is, and the deformity that's caused by the fracture is then reduced, made smaller; meaning, when the bones are split apart, you reduce the amount of deformity in the bones and you internally fixate them. And in orthopedics, we do that with orthopedic hardware, which are, in this case, metal screws and plates.

And I can show you sort of what was done in X-rays in a minute, and it might be helpful if I show you what the bones looked like --

Q I was going to do that, Doctor. Do you have with you any anatomic models of the pelvis, hip and wrist?

A I do.

THE COURT: Just for ID purposes, we will have -- let's mark Plaintiff's Exhibit 13, just for ID, and let's do them separately. Tell me which ones you are going to use.

THE WITNESS: I guess first I will use the wrist.

THE COURT: So 13 for ID is the wrist model and Plaintiff's Exhibit 14 for ID only is the pelvis?

THE WITNESS: Yes, uh-huh.

THE COURT: Okay, I am deeming it, though. We don't have to put stickers on it.

(Whereupon, said exhibits were received for identification as Plaintiff's Exhibits 13 and 14.)

A This is a model. This is a right hand --

MR. MADONNA: Doctor, before you continue, would it also assist you in the demonstration of the wrist to use a chart?

THE COURT: Okay, let's make the chart 13A for ID. This is a wrist chart.

(Whereupon, said exhibit was received for identification as Plaintiff's Exhibit 13A.)

A This chart is simply an enlargement of this area, which would be the end of the forearm bone, the bones of the forearm. The wrist, which is called the carpus, is made up of eight smaller bones and then the hand, which obviously are the rays that make the palm and go down to the fingers.

The bone that Miguel broke is the this bone here in the wrist called the scaphoid. You can see it here. That bone is a bone that

is shaped, they say, like a boat. That's what a scaphoid is.

That bone makes a joint surface with many different bones. You can see here it touches the forearm bone, it touches -- it makes a joint with the lunate, it makes a joint with the capitate, it makes a joint with the trapezoid, it makes a joint with the trapezium. So, that bone is a very complex bone that is responsible for a lot of motion in the wrist.

Unfortunately, it's also a very vulnerable bone to being broken and it's actually one of more broken bones in the body when someone lands either with their wrist out flat or bent this way. It can bend either way.

MR. LAMBERT: Your Honor, objection to this testimony.

THE COURT: Objection overruled.

A That's sort of what this schematic is showing. This is a wrist flexed and this is a wrist out forward (indicating).

THE COURT: Can I have the lawyers up so I can explain something.

(Whereupon, the following sidebar discussion was held out of the hearing of the jury:)

THE COURT: My guess is the basis for your objection is because he is now testifying as an expert.

MR. LAMBERT: Yes.

THE COURT: Case law is very clear. When a treating doctor is called, the treating doctor is allowed to give expert opinions without 3101(d). That's why I am permitting it.

MR. LAMBERT: However, your Honor, you ruled that the series of X-rays that were taken post authorization were for treatment only and, therefore, they are not expert's X-rays.

THE COURT: 1 don't understand. I just ruled that the 3/21/06 X-rays were not excluded, that they could come in. I did not say anything other than they were not excluded.

MR. LAMBERT: Based upon the fact that he was not testifying as an expert as to --

THE COURT: That's not what I said. It's part of the business record.

MR. LAMBERT: Objection.

THE COURT: Okay.

(Short recess taken.)

A Okay, so, the bone that Miguel broke is the scaphoid bone in the wrist, and if there is a flexion-type injury to the wrist, that bone will break, and usually it breaks through what's called the waist portion, through this portion.

Now, as I showed, that bone has a lot of joint surface and is involved in many of the moving parts of the wrist and if it breaks, you can destabilize the wrist and have what Miguel had, which is called a wrist dislocation, as well, where the alignment of the bones goes out of place, as well. And he had a scaphoid fracture with a dislocation through the what is called the scapho-perilunate dislocation, indicating that these bones were out of place and required a surgical procedure to not only straighten the wrist back up, put the dislocated bones back in place, but also to fix this bone in place.

THE COURT: Was this in both wrists or only --

THE WITNESS: This is in both wrists, both the right and left wrist.

A And one of the reasons that this bone must be -- when it breaks must be put back in good alignment is because the blood supply to this bone comes in through one end of the bone and if you break across the bone, the end that doesn't have the blood supply can die off, and that happens over time. It doesn't happen immediately or you don't see the effects of it immediately, but you see it over time. And, so, the best chance of having that bone grow back together and having the blood supply revascularize the bone is trying to reduce the deformity, putting it back into place and running the screw across it like Miguel had done in both wrists.

Additionally, he had a fracture through the end of the forearm bone, called the radius, that required pinning of that bone in place, as well.

Q Was that both wrists too?

A I believe that was one wrist. Let me just refresh my memory here.

(Brief pause.)

A That was, I believe, the right wrist. Yes, that was on the right he had the fracture not only in the scaphoid bone of the wrist but also in the radius, which is the end of the forearm in the wrist.

The forearm has two bones. The one on the thumb side, the larger one at the wrist is called the radius, the smaller one is called the ulna. That was his fracture there (indicating)

Q And what about the pelvic fracture? What was the pelvic Fracture that he presented with?

A This is a fracture of the pelvis and he actually had a fracture, as I said, of the acetabulum, which is the socket of the ball and socket joint of the hip.

So, this is the pelvis and the hip joint is responsible for many motions of the hip. One is flexion, one is extension, one is abduction, which is moving the hip away from the body, one is adduction, crossing the hip over; one is external rotation, the other is internal rotation, and those are all motions that occur in a normal hip joint.

When you have a fracture, as Miguel did, both in his wrists and his hip, which is called an intraarticular fracture, a fracture that goes into the joint, oftentimes you have reduced motion associated with that --

Q Excuse me, Doctor. What is the significance of the fracture being intraarticular?

A There are many types of fractures, obviously. There are fractures through long bones and those often require open reduction and internal fixation. Then we need to get the bone lined up in a position it can heal, but oftentimes those can also be placed in a cast and allowed to heal. That is a fracture to a long bone. Usually those heal with some consequence but not problems with arthritis and things like that.

A fracture that goes into the joint is a fracture that disrupts the moving mechanism of the musculoskeletal system. And even when that fracture goes together, when the bony portion of that fracture grows together, you have to consider the other structure around the joint. And, specifically, the thing that we worry about most is the smooth surface that allows the joint to move.

Each bone is covered with a cartilage cap. Cartilage is a softer tissue than bone and it is also a smoother tissue than bone and it has a high water content so it makes a very slick, low-friction surface for our joints. You have probably all looked at the end of a chicken bone and have seen that pearly end on the chicken bone. That is the cartilage surface that you are seeing. That allows for an unobstructed, low friction in the joint. If I disrupt that cartilage surface, you have roughening in the joint and that leads to clicking and popping in the joint, it leads to pain in the joint, it can lead to loss of motion and it leads to a progressive problem that's associated with arthritis in the joint.

If you have irregularity on one side of the joint, a nonsmooth surface rubbing on what would normally be a smooth surface, then you cause erosion or wear-and-tear changes on both sides of the joint.

THE COURT: That break in the pelvis, was that both sides or only one side? Was that the right and left side?

THE WITNESS: No, that's on the left side only.

A And this is what's called -- they classified it as a two-column fracture of the acetabulum.

If you look at the acetabulum, the way that it is built from the time we were born -- actually in development before we were born, several bones come together. It's actually three bones come together and form the acetabulum. For practical purposes, you have a front column on the acetabulum and you have a back column. And medical terms are the "anterior" means front and "posterior" means back.

So, the anterior and posterior column. And these two structures join together as we are developing as a fetus and form the acetabular ring or socket.

Miguel's fracture was called a two-column fracture, which means that the acetabulum was split in such a way that it involved both a fracture of the posterior column and a fracture of the anterior column. And so it's a rather big injury to the smooth joint surface of the hip.

Now, when you disrupt the cartilage surface, that surface does not regrow like bone does and that's why when there is a long bone fracture that breaks, the bone will grow together and in Miguel's case certainly the bone grew together.

But, as I say, what you worry about is the joint surface. The cartilage cells does not regrow the way bone regrows. Once those are disrupted, they are damaged for good. The problem is not only are they damaged for good, but because this is a moving mechanism where you have a roughened surface working on a smooth surface, this becomes a progressive problem because it wears over time.

Now, we all get some wear-and-tear changes in our joints. Everybody does. When you have this type of situation, both in the wrist and in the hip, you deteriorate at a more rapidly progressive rate than you would with just normal wear and tear.

Q Now, in addition to these fractures -- and before we get to the course of treatment for them -- was there a CAT scan or a CT scan done of Mr. Burgos' face and head in the hospital, as well?

A Yes.

Q And did he sustain an injury to that part of his body?

A He also had a fracture of one of the bones in the skull called the zygomatic arch, which supports your upper cheek. That is not a Fracture that requires orthopedic surgery. If it's displaced, it can require a plastic surgeon to what we call jack it up and put a plate on it, but in Mr. Burgos's case it did not and that was not an intraarticular fracture and that healed, grew together without consequence, orthopedic consequence, as we talked about.

Q Now, can you explain -- we'll get to the surgical procedures in a minute, but what was their plan at St. Vincent's Hospital for his course of treatment during his admission at the hospital?

A The plan, as with any multiple trauma case, is basically to stabilize the patient. The orthopedic plan would be to stabilize the fractures, fix those fractures that needed to be fixed, in this case the pelvis, both wrists; to reduce the dislocations, the deformity of the dislocations and stabilize them, pin them or fix them in place.

He then had some rehabilitation following that to try to strengthen him up, regain his motion, teach him to bear weight again.

This is a very difficult situation, and one of the reasons he is in the hospital for so long, a month, is that clearly, with a pelvis

fracture, you can't bear weight fully immediately, but with two wrist fractures you can't use crutches, so it is a very debilitating pattern of injury and that's one of the things that one of us who see a lot of trauma patients look at; the sort of pattern of injury and the disability that it causes.

Q Doctor, I want you to assume that there is evidence in the record or that there will be evidence in the record that Mr. Burgos sustained the injuries that he sustained from a fall from a scaffold on October 31st, 2003. Are the injuries that were presented to the emergency room consistent with a fall from a scaffold?

A Yes, absolutely.

Q Now, Doctor, is it important for the physicians who treated Mr. Burgos initially in the emergency room -- is the height of the fall important for their diagnosis and treatment of those injuries?

A The height of the fall simply gives you an indication of, in general terms, how much force was required for an injury.

Now, there are certain heights which can cause certain fractures and there is a very broad range, and the answer is you don't have to know exactly what the height was, but people generally take a history which includes the height of the fall simply to categorize how much force was involved.

Q Would there be -- would it matter ten feet as opposed to 20 feet?

A You know, you can get this pattern of injuries, certainly in the wrists, when you just stumble. A fracture of the pelvis takes a great deal of force and certainly would be within that range of 10 to 20 feet.

Q Now, Doctor, I would like you to, if you don't mind, see if you can pull out the operative report for the wrist surgeries.

A Yes.

(Brief pause.)

A Okay.

Q When was that surgery performed?

A That surgery was performed on 11/14/03.

Q And what was the type of procedure that was done?

A The type of procedure that was done was called a closed reduction and percutaneous pinning --

THE COURT: And what pinning?

THE WITNESS: Percutaneous pinning, which means pinning through the skin as opposed to making a large opening. You take a sharp orthopedic wire or pin and literally just drive it through the skin without the need for making an incision, because it really makes its own incision.

A -- and closed reduction, as I indicated before.

One of the primary goals is to reduce any deformity of the fracture, so this is a reduction and it's closed. It's done by manipulating the fracture - one person pulling on the forearm, one person pulling on the hand - and then, again, percutaneously pinning first the distal radius fracture and then an open reduction which is, again, making an incision to reduce the what they call the perilunate dislocation, the dislocation of the wrist that was required.

THE COURT: Do you want to put up the shadowbox?

MR. MADONNA: Yes.

(Brief pause.)

Q Doctor, these are the X-rays of the wrists from St. Vincent's Hospital. If you can, can you take a look through some of those and show the jury, if it's possible, the injury, the way it looked prior, and the surgical procedure, open reduction, that you just explained a little bit about?

(Brief pause.)

A Well, I don't have a good preoperative X-ray to show because everything preoperative that would really -- has a cast over the fracture site. And, again, the small bones of the wrist are very difficult to see.

THE COURT: We'll make that 4A-1.

A This looks like it's going to be the left wrist.

And what we are looking at is --

THE COURT: Is that pre-op?

THE WITNESS: This is actually an intraoperative X-ray.

A And what this shows best -- we are looking at a view very similar to this. Here is the thumb, here is the radius.

And what you see best on this X-ray is this fracture through the scaphoid. The scaphoid bone is this sort of figure-of-8-shaped bone here, and that's this bone here, which has clearly got a fracture across it.

And you can see that this bone looks darker than the other side of it and that's because it is fractured and rotated, and that is part of the dislocation that you see.

Now, it's actually easier to see on the postoperative films when you see what had to be done in order to fix these fractures in place.

This is the left wrist and you can see there is a large orthopedic screw across the scaphoid. There are multiple pins holding the dislocated and disrupted carpal bones. The eight bones that were out of place, they have to be pinned one to the other to keep them in place. You can pin them as a row and this configuration stabilizes the wrist. And, with the scaphoid intact, that also stabilizes the wrist. That has so many surfaces that it's really the cornerstone of the wrist. That's the left -- sorry, that's the right.

THE COURT: The one you just showed them was the right?

THE WITNESS: This is the right. I may have misspoken.

THE COURT: That's the right wrist post-op; right?

THE WITNESS: Correct.

A And this is the left wrist postoperatively, which is the wrist that had the -- in addition to the wrist dislocation, the scaphoid fracture. It also had a fracture of this radial styloid, the end of the forearm bone, and that has been pinned into place, and that is the only way that I know the difference between the wrists because the left wrist additionally had this pin in it.

So, you see the orthopedic screw in the scaphoid, you see the multiple pins required to stabilize the wrist and the pin required

to stabilize this end of the wrist bone, the radial styloid.

Now, after a period of time, the cast which was put on this, the immobilization was taken off and these pins are removed. They are simply pulled out. They actually stick up above the skin and you pull them out with a pair of pliers in an office setting or in a bedside setting.

So, that's the right.

THE COURT: That's 4A-3.

A Now, I guess my X-rays that I took when I first saw him also saw these injuries, but this is after a period of time when the casts have come off and the pins have come out.

THE COURT: Please refer, when you show them --

A This is 11A. This is the left wrist. And this is three views of the wrist.

Q What date is that X-ray from?

A 1/15/04.

And what you are looking at is an X-ray like this, one slightly turned and one completely turned. And that allows you to see the bone -- sort of get a three-dimensional view of what it looked like.

This is the orthopedic screw. This is a fully threaded screw that's driven into the top of the bone. You can actually see the notch where it was driven in and it catches the other side of the fracture and pulls the two pieces together. You can see it there in the wrist.

You can still see where the fracture was of the styloid and actually you can see that there has not been a lot of motion in this wrist. It's got what we call disuse atrophy of bone.

And this is the normal quality of bone and you can see this is sort of gray and moth eaten. And that's simply a finding in early injury, so that's about three months following the accident.

On the right -- this is 11B -- you see, again, an orthopedic screw in place. The wrist bones are lined up following the pinning and you still see the fracture of the bone, you can still see the fracture line. Even though there is a large screw crossing through it, you can still see the fracture line.

So, those are both of his wrists with the screws across.

Again, this fracture line goes into the surfaces of the joint. There is a fracture that exits where the radial styloid -- the radius, rather, the end of the forearm bone meets the wrist joint. There are fractures that go where the wrist bones meet, and so this is an intraarticular fracture. There is clearly disruption of the joint and joint surface and this has consequences for Miguel which he has today and will have permanent problems with over time.

THE COURT: What problems over time?

THE WITNESS: The permanent problems over time are the abnormal joint surfaces that will cause progressive wear and tear in the wrists at a rate much faster, in this case, than you would see in someone who had -- did not have these fractures.

As I say, everyone gets a little arthritis, a little wear and tear in the wrist. This is different than the wear-and-tear arthritis that we all get. This is post-traumatic arthritis. This is arthritis that's caused by the fracture and the disruption of the joint surfaces that is permanent and causes a permanent irregularity in the wrist; that because there is motion in the wrist not only is present at the time of the injury, but actually each after the bone heals, it gets worse over time.

Q Doctor, while you are mentioning that, you mentioned arthritis.

A Right.

Q I think we have all heard that term, but what does that mean medically to you as a physician? Can you explain that?

A Sure. Arthritis is a clinical description of problems with the joint and those problems are pain, irregular B joint surfaces often associated with popping and clicking in the joint; can be associated with swelling in the joint; usually made worse by activities, weather changes or position and usually associated with X-ray findings such as irregular surfaces of the bones.

Now, again, on an X-ray, we're not seeing the bone. We are seeing -- sorry, we are not seeing the cartilage surface. We are seeing the bone, so you have to infer what the cartilage looks like above it and clearly with irregular bone there is going to be irregular cartilage above it when makes the joint surface.

Q There is a term "arthrosis." What is that?

A Arthrosis is the X-ray finding that is associated with arthritis.

Q Arthritis would be the clinical finding?

A Right. Arthrosis is an X-ray picture of arthritis.

Q Why don't we stay with the wrist injuries.

Mr. Burgos continued under the care of your office after the initial hospital stay; correct?

A Yes.

Q And, in fact, is he still a patient of your office?

A Yes.

Q When was the last time that he visited?

A The last time he was in our office was May 16th of this year.

Q And does he have any scheduled visits coming up, that you are aware of?

A I didn't look this morning. I don't know. Usually every six weeks or so he is seen.

THE COURT: Why?

THE WITNESS: For a checkup, and it's required by the carrier.

THE COURT: For checkup --

THE WITNESS: Check his progress, medication.

THE COURT: Is he going through physical therapy with you?

THE WITNESS: We have requested authorization many times for physical therapy. That's one of the reasons that he needs to be seen.

THE COURT: And the purpose of the physical therapy is to minimize the arthritis or what?

THE WITNESS: At this point, it's really to maintain his strength and motion that he has as best as possible and decrease symptoms that are associated with activities.

THE COURT: Okay, go ahead.

Q Now, Doctor, shortly after your initial visit with Mr. Burgos, he had another surgical procedure done at St. Vincent's Hospital, which is part of the same chart. I am going to point out to you, if I may approach, the operative record.

A Yes.

Q Actually, it was just prior to your visit.

A Right.

Q There was an operation again on the wrist?

A Again, this is the operation that I discussed, which is removal of the pins, and they actually did this under general anesthesia because they actually -- they had to make an incision to remove these pins. They couldn't just pull them out through the skin, so I misspoke before.

THE COURT: When was that?

THE WITNESS: That was on 1/2/04.

Q Is there a reason indicated in this record -- and I will point out the abstract summary of this report. Is there a reason indicated in that hospital chart as to why Mr. Burgos went for that procedure?

A Well, the diagnosis is that it was painful hardware. That's what they call it, painful hardware.

Q What does that mean?

A That means hardware that causes pain either by, as in this case, restriction of motion or because it sticks into the skin from the inside out, which causes pain, just as if you were sticking from the outside in, and that was removed in January of '04.

THE COURT: That was the hardware inside?

THE WITNESS: The hardware for both wrists, yes. Except for the screw. Just the pins.

Q Now, Doctor, I would like you to, if you can, explain to the jury -- and I want to stick with the care and treatment for the wrist injuries -- can you explain to the jury what your office's course of treatment was for him in the first part of 2004 when you started seeing him?

A Essentially, in the first part of 2004 it was supportive care.

Q What does that mean?

A Meaning we instructed him with home exercises as well as oral medications. We followed the fracture. That was, again, the first X-rays we took. We followed them over time with X-rays, with progressive X-rays, and that's really all the care that he required at that point.

Q Now, how have Mr. Burgos' wrists injuries progressed to the present time, particularly to the point of your last visit in May of 2006?

A lie continues to have loss of motion in the wrist.

Q Can you explain what the different motions are of the wrist and the extent of normal range of motion, what that would be and what his is?

A Sure.

The motions in the wrist, if this is a wrist like this -- I'll do it on my hand, actually -- are flexion; extension; ulnar deviation, which is going towards the small bone of the wrist, the ulna; radial deviation, which is going towards the radius, and there is some degree of what's called supination and pronation.

But mainly the wrist is flexion, extension, ulnar deviation and radial deviation.

And, in general, we have about 85 to 90 degrees of extension, 80 to 90 degrees of flexion and usually about 45 to 50 degrees, some people have 60 degrees, of ulnar deviation and usually about 45, 50 degrees of radial deviation.

And Mr. Burgos' wrists, the last time we saw him, continued to show limited range of motion, especially in extension.

THE COURT: What was it?

THE WITNESS: On the left he has about 35 to 40 degrees of extension, which is about half to a third of what he should have. On the right he has about 60 degrees of extension, which, again, is about two -- lacks about a third of what he should have.

Flexion, on the right, is about 40 degrees and on the left flexion was about 20 degrees. So, those are both significant losses of range of motion.

Supination and pronation were much better, but he still lost about five degrees of pronation, which is the ability to turn the wrist down. Most of us can get it flat. He still has a lack of about five degrees on the left.

On the right, he lacks about five degrees of pronation and about ten degrees of full supination.

Supination is the ability to --

THE COURT: On the pronation he lost five percent on the left and what on the right?

THE WITNESS: The same, five degrees.

Q Five degrees or percent?

A Degrees.

THE COURT: And supination?

THE WITNESS: Supination, he lost ten degrees on the right and he has full supination on the left.

Q What are the --

THE COURT: What about the ulnar and radial deviation? You didn't say.

THE WITNESS; Ulnar deviation is 25 degrees and radial deviation is said to be just past neutral, which neutral is straight ahead and, again, it should be 30 to 45 degrees. I believe that's both sides -- sorry, no. That's on the left -- on the right. And ulnar deviation is actually the same: 25 degrees and just past neutral on both sides.

Q Was the progression or the loss of motion in one wrist greater than the other?

A It appears that the loss of motion is greater on the left than on the right.

Q When you cared for Mr. Burgos over the course of the last two-and-a-half years with regard to the wrist injuries, what were you treating him for, what were you doing?

A Again, basically supportive care. We have given him pain medications. We have taught him home exercises, we have requested authorization for formal physical therapy. We have spoken to him about what the future course will be for him. We suspect that he will need what are called wrist fusions.

A wrist fusion, or a fusion of any joint, is basically to take the motion out of the joint. The reason you do that is because most of the pain that people have is associated with motion. It also stabilizes the joint. It's like the ultimate stabilization of the joint.

To fuse a wrist, you make an incision on the back of the wrist. You take the cartilage surface off of the bones, the end of the forearm and the small bones of the wrist, as well as the end of the ring finger, and you put an orthopedic plate from the middle finger all the way down to the wrist.

Now, that takes away all the flexion and extension in the wrist. It actually does allow you some supination and pronation of the wrist, but it allows you to grip without as much pain, it allows you to push off without as much pain and it stabilizes the joints of the wrist.

Clearly, that is a salvage procedure. That is not something you do until people reach the point that they really can't tolerate the pain in their wrist.

Q Did you treat Mr. Burgos with medication?

A Yes.

Q What type of medication?

A He has had prescriptions for and also advice for use with anti-inflammatory medications. Those include things like Motrin and Advil, as well as aspirin. Those are all anti-inflammatory medications. We have given him prescription for ibuprofen, which is anti-inflammatory, also prescription for narcotic medication, codeine, Vicodin, depending on his level of pain.

Q Did you continue to take X-rays and other diagnostic tests during the last two-and-a-half years of his treatment?

A Yes.

Q Did you notice any progression with regard to his wrist injuries?

A Yes. As far as his X-rays go, he does have progressively worse-appearing X-rays of the wrist. Not only the development of additional bony prominences, bone spurs and calcification of the soft tissue, all abnormalities in the wrist, but also what appears to be problems with regrowth of this fractured styloid bone.

When we look at it here, as I said, the bone, the goal is to put the bone back together. But, you can disrupt the blood supply, like I said, and even putting it back together doesn't guarantee that the blood supply goes together. And when you look at it initially right after the fracture occurred, you see the shape of the bone the way it normally should be. But, over time, if there is no blood supply to the bone, that bone will actually deform and collapse down.

I often tell patients, because they look at their X-rays and say, "Well, it looked better before. What have you done to me since it has gotten worse?" And the fact is, I give them the example it's like taking an apple off the tree. When you take an apple off the tree, you disconnect it from its nutrition. You set it on the shelf and it looks fine for a week or two. It looks like it did

when it came off the tree. But over time, without nutrition, the apple will rot and collapse and the bone does the same type of thing, especially when it is a loaded bone, meaning one that has force when you move it.

The bone literally collapses a bit. And especially a bone that is in a joint and is all joint surface like the scaphoid bone. And that leads to progressive changes in the joint, progressive arthritis, progressive destruction of the bone as we see in the X-rays.

Q You see that in the X-rays, actually?

A Yes.

Q And those symptoms that you see in the X-rays, are they being manifested by complaints that Mr. Burgos is making to you on these visits?

A The signs that we see in the X-ray, the findings in the X-ray manifest in the fact that he has not gotten improved motion. In fact, he has even lost some notion; that he continues to have pain and disability with his wrist, both wrists.

Q Now, the future, the prognosis for these injuries, do you have an opinion, with a reasonable degree of medical certainty, as to what Mr. Burgos' wrist injury -- what his prognosis is with regard to both wrist injuries?

A Yes.

Q What is that opinion?

A The prognosis is looking into the medical crystal ball and sort of predicts what is going to happen. Again, I feel he has a poor prognosis with his wrist. Clearly, the wrists are not going to get any better. He has permanent architectural structural changes in the wrist. He continues to use his wrists in daily activities, which are required by daily activities, really, using your hands. In his case, since it's both hands, he has to use them.

The type of changes.that he has leads to progressive accelerated wear-and-tear changes in the wrist, so this will only get worse over time.

As I spoke about before, I do believe that he will need at least one wrist fusion to stabilize him and make him more functional over time, and possibly two wrist fusions.

Q Well, you say "at least one." Do you think that's inevitable in his prognosis?

A I do, given the amount of destruction in the wrist joint itself.

Q Which wrist is that?

A Well, that is a -- something you can't predict, and that is both wrists have changes that would make him an appropriate candidate for a fusion. You have to come up with a functional plan, meaning which wrist is hurting most at the time. Sometimes you can't predict the way that they are going to deteriorate, one faster than the other, and taking all the flexion and extension out of a wrist is also a pretty debilitating thing in and of itself.

So, in my mind - and the orthopedic literature supports me - you try not to do bilateral wrist fusions. If the person can tolerate one flexible wrist and stabilizing one wrist, fusing one wrist to make it more stable and less painful, that is the course that I would prefer to take, clearly.

Q Let's move to the hip fracture, the acetabular fracture that he sustained, for a moment.

If we can, can we go back to the hospital chart and the operative procedure that was performed by the surgeons there?

A Sure.

Q Can you explain to the jury what that operative procedure consisted of, what they did during that procedure to fix the fracture or fractures?

A This, again, was a procedure for the fracture that was called a both-column fracture of the acetabulum, involving the hip joint.

And the procedure they performed was, again, this open reduction, reduction of the deformity and internal fixation, and they did that with a series of screws and a metal, what is called a reconstruction plate.

And that's done through the pelvis and the pelvis is exposed and the screws are drilled into the pelvis and the plate is put along the pelvic rim here, and in his case a screw is driven through.

And I think it's easier just to show the X-rays so that you get a sense of that procedure.

Q Do you want the operative X-rays or --

A Either way. The X-rays that I have today are fine.

THE COURT: Let's do both.

A What 1 was looking at was just to give you a sense of what type of procedure this is and the size of it.

This is the operative anesthesia record from the ORIF, open reduction internal fixation, of the pelvis fracture.

This indicates that they started anesthesia at, it looks like, 8:15 a.m. and they ended at 12:15 p.m, so that's about a seven-hour procedure.

THE COURT: They started 8:15 and ended 12:15 p.m. or --

THE WITNESS: Sorry, it's 2:15 p.m. Sorry.

A So, this is an X-ray taken on January 2nd of '04; an X-ray of --

THE COURT: We're going to call it 4A-4.

A This is of Miguel Burgos and this is an X-ray of the pelvis.

Again, we are looking sort of like this, which would be his left side (indicating).

And you can see the reconstruction plate that's laid across the pelvis, and that actually is from here, midway here, laid across this top portion of the pelvis, called the pelvic brim, and that's held in place with multiple screws, as well as a screw placed from the anterior column into the posterior column as I described it before, sort of across here, reconstituting this arch.

This is an orthopedic screw driven this way from here to here and then the plate across (indicating)

This is a slightly oblique view, or one that's turned slightly to the side.

THE COURT: This will be 4A-5.

A This is from the same date, and these appear to be -- this is the pelvis turned slightly to the side, so you are looking down the iliac wing here.

And the only reason I show this is to give you a sense of this is that large screw that we saw from front to back, this is the plate along the pelvic brim and this is fixed in place with multiple screws including one (indicating). I just wanted to show you the length of this screw which is driven from up top all the way down this posterior column like that.

So, people say that orthopedics is sort of glorified carpentry. That's the best example I can give you. You have got metal screws and plates holding this together.

Q Now, Doctor, the fracture that was sustained here, I think you mentioned it had articular-surface involvement, as well?

A That's right. The joint surface of the cup, the acetabulum, was split into multiple pieces.

Q Now, is that any more or less significant in the joint like the hip and pelvis here, which is a joint that is a weight-bearing joint?

A As opposed to the wrist?

Q Yes.

A Well, it's certainly -- it certainly sees more force than the wrist. It's a weight-bearing joint.

The wrist, in some cases, is a weight-bearing joint when you push up off a chair, when you push a door, but the hip is always a weight-bearing joint. Injury to the hip joint surface, especially when the surface is -- when the cartilage surface is broken as well, almost always leads to arthritis changes, as you will see in Mr. Burgos's hip, and those are associated, again, with some loss of motion, with pain with certain activities and things like that.

Now, the other thing that Michael has, and has developed over time, is some low back pain, and that is a very common finding.

You saw that plate goes from here all the way along the ilium, part of the pelvis bone. And this is a joint called the SI joint, or the sacroiliac joint, which is where the low back meets the pelvis, and it is very common for people who, number one, have had a fracture of the pelvis because the SI joint is part of the pelvis, an integral part of the pelvis, as well as people who have required surgery to have disruptions of the SI joint, which cause back pain. And that's been a problem with him, which is only made worse by the arthritis that is present in the hip, because it causes an abnormal gait at times.

Q Now, did you treat Mr. Burgos for the pelvic fracture over the last two-and-a-half years, as well?

A Basically, it's the same type of treatment. The surgery was done to stabilize the hip joint. He has received the oral medication both for the pain in the wrist and the pelvis and hip and low back. We have requested authorization for physical therapy. He has basically had supportive care for those things.

Q How would you describe his progress or his healing from that injury from the time that the surgery was done up until the present time?

A Well, immediately after the surgery, clearly, he -- from that point forward he got a good deal of improvement because, again, the bones were put back together and the bone healed and he walks, walks unsupported without cane, without crutches, things like that. He has made pretty good progress. He still has loss of motion. He still has atrophy or loss of muscle bulk in his leg and he still has clinical signs and X-ray findings associated with arthritis and those will progress over time, just like in the wrist.

Q You mentioned "atrophy." What is that?

A Atrophy is loss of muscle bulk. And the way that you tell atrophy, sometimes you can look at it and see atrophy and sometimes you have to measure it.

In Miguel's case, he has got about a centimeter of atrophy, about a half inch of atrophy on the thigh on the left compared to the right.

Q And what are the causes of atrophy?

A The causes of atrophy are abnormal use of a group of muscles compared to, say, the other side in this case. Atrophy occurs when either you don't use the full range of joints, that is, the entire muscle isn't worked, or that there is simply less force put on one side versus the other.

Usually in the legs, in the hip, it has to do with pain and loss of range of motion.

Q And what are the ranges of motion for the hip joint for Mr. Burgos?

A He continues to have some limited range of motion in the hip. His range of motion has been characterized as -- he has a 20-degree loss of external rotation of the hip, which is the ability to turn the leg out. And normally, when we externally rotate the hip, that's the motion that allows us to cross one leg over the other. And most people get about 90 degrees of external rotation of the hip (indicating). Most people have about 30 degrees of internal rotation of the hip and he has about 5 degrees of internal rotation of the hip.

His hip extension, which is the ability to put the leg behind you, is about 20 degrees and most of us have about 30 to 45 degrees. That's pretty variable depending on who you are.

THE COURT: And 30 to 45 is normal in what?

THE WITNESS: In extension.

THE COURT: And he has 20?

THE WITNESS: Yes.

A Abduction is bringing the hip away from the body, and he lacks about 10 degrees on the left compared to the right. And with that motion, he has pain referred to that joint, that SI joint, which is the low back pain he has.

With a motion called adduction, which is bringing your leg across your body, again, most people have about 30 degrees. He has about 5 degrees in that plane.

And those are his losses of motion in the hip.

Q Have they been -- have they remained fairly constant at this point?

A They have remained pretty constant. They actually, from when we first saw him, he had about 90 degrees of flexion in the hip and his hip flexion is pretty good now. So, he has made some progress from when we first saw him, but he certainly has not progressed in quite awhile.

THE COURT: Can I have the lawyers up, please?

(Whereupon, a sidebar discussion was held off the record out of the presence of the jury)

Q Doctor, you talked about your prognosis for Mr. Burgos' wrist injuries. Did you formulate a prognosis for his hip injury?

A I did.

Q What is that opinion --

THE COURT: An opinion with a reasonable degree of medical certainty.

THE WITNESS: Sure.

A Essentially, it as the same type of prognosis. He does have X-ray findings consistent with post-traumatic arthritis of the hip. He has clinical complaints consistent with post-traumatic arthritis of the hip and he had a big injury to his hip joint and that will progress over time.

He is a relatively young man, so he has got a lot of time to put stress across this joint. We have requested authorization for therapy. I think he needs that to maintain any motion he has, try to fight off atrophy and try to fight off further loss of motion. I think he at some point will likely need injections at the hip, as the hip becomes more irritable over time, and I suspect he will need a total hip replacement at some point in his life, given the differences and the findings on the left hip versus the right hip and the loss of joint surface, joint space and irregularity noted in the bone about the joint.

Q Doctor, do you think the necessity for a hip replacement is something that's more probable than not for his future?

A Oh, I think it's likely, yes, absolutely.

Q Now, hip replacements, that would be taking the whole joint out and putting in a -- well, why don't you explain it.

A Sure.

A hip replacement, total hip replacement involves replacing both the ball and the socket of the hip joint. Basically, a saw is used to cut away the top portion of the hip. A metal stem with a ball and a stem that seats or like a potted plant into the inside of the femur bone is put here. The cup portion is reamed out with a special drill-like tool that is shaped like a cone and takes out the cartilage here, and then a metal cup is placed into the hip socket and screwed in place, and then the metal pin, -- metal ball, rather, and the prosthetic cup are put together and that forms a new joint surface.

Now, it's made of metal and plastic and it's something that lasts about 15 to 20 years at best. One of the things that concerns me about Mr. Burgos is that given his young age and given that I feel very strongly that he will need a total hip replacement, again, you're walking a tightrope in replacing it too early, meaning as ha starts to develop pain. If you replace it in his 50s, then he is going to probably need a total hip replacement again by the time he is 70.

But, clearly, you want to hold off as long as possible, but he is a young guy so I can't rule out the possibility of needing a hip replacement and a revision hip replacement later in life.

Q Doctor, I want you to assume for the following questions that there is evidence in the record that Mr. Burgos was injured as a result of a fall from a scaffold back on October 31st of 2006.

I want you to further assume that there is evidence in the record that, as a result of that fall, he sustained fractures to the scaphoid bones bilaterally, in both wrists, and dislocations to those bones.

I want you to assume that he also sustained a fracture to the acetabulum hip, as you described; that these injuries were initially treated during the course of a month's hospital stay at St. Vincent's Hospital with open reduction, internal fixation to the three parts of his body.

I want you to assume that in addition he sustained a fracture to a portion of his skull, the zygomatic arch on the left side.

Doctor, assuming that that evidence is in the record, would you have an opinion, with a reasonable degree of medical certainty, as to what the diagnosis of Mr. Burgos's injuries are?

A Yes.

Q What is that?

A The diagnosis, the orthopedic diagnosis are bilateral right and left fracture dislocations of the wrist requiring open reduction, internal fixation, a fracture -- intraarticular fracture of the left hip involving the acetabulum, which requires open reduction, internal fixation, and a fracture of the zygomatic arch which united on its own.

Q And what are those opinions based on, Doctor?

A Those opinions are based on the medical records that I reviewed, as well as the X-rays that are taken in the physical examinations that I performed.

Q Doctor, those injuries, each and every one of them, do you have an opinion, with a reasonable degree of medical certainty, as to whether those injuries are the competent producing cause of pain?

A Yes, I believe all those injuries are painful.

Q And do you have an opinion, with a reasonable degree of medical certainty, as to whether the injuries they sustained and the surgical procedures that Mr. Burgos underwent to his wrists and his hip, are they a competent producing cause of the loss of range of motion that you found over the course of treatment that you --

A I believe the injuries are responsible for that, yes.

Q Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not the fall from the scaffold - assuming that fact is in evidence - was a competent-producing cause of the injuries to the wrist and the injury to the hip?

A Yes, I believe they are.

Q And what is that opinion based on?

A That opinion is based on the medical records, as well as the history that I developed with Mr. Burgos over the course of treatment with him.

Q Now, Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether Mr. Burgos has a disability in relation to any of these injuries?

A Yes, I do.

Q And what is that opinion?

A Clearly he has a disability to the wrist on both sides, as well as the hip. That disability is his limited range of motion and the pain that occurs because of those injuries to the wrist.

Q Doctor, Mr. Burgos doesn't have any problem walking, though; does he?

A He has pain when he walks, but he certainly walks unsupported at this point, yes.

Q Would he have a problem, in your opinion, with the injuries that he sustained, again, with a reasonable degree of medical certainty, of doing certain daily activities like taking care of his own hygiene now, washing his clothes, going to the Laundromat?

A No, I don't believe he would have a disability with regard to that. He certainly does a lot of activities that he feels are necessary, things like personal hygiene, small things around the house Now, those things can produce pain, but they are not -- he is not strictly limited from doing those things.

Q Now, Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether or not the injuries that