2007 WL 7291731 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Kahndakar ALI and Laila Mahmud, Plaintiffs,
v.
CONSOLIDATED EDISON CO. OF NEW YORK and Trump International Hotel and Condominium, Defendants.

No. 2003-102041.
June 19, 2007.

Testimony of Plaintiffs' Expert Witness, Dr. Jeffrey Kaplan

Case Type: Premises Liability >> Residential Property
Case Type: Premises Liability >> Paved Surface/Curb
Jurisdiction: New York County, New York
Name of Expert: Dr. Jeffrey Kaplan
Area of Expertise: Health Care-Physicians & Health Professionals >> Orthopedic Surgeon

Representing: Plaintiff

For the Plaintiffs: Michael W. Gunzburg, Esq.
271 Madison Avenue New York, New York 10016.

For the Defendant Con Edison: Richard W. Babinecz, Esq. by: Michael McNulty, Esq.
Four Irving Place New York, New York 10003.

For the Defendant Trump: Lester Schwab Katz & O'Dwyer by: John O'Dwyer, Esq.
120 Broadway New York, New York 10271.

Hon. Nicholas Figueroa.

MR. GUNZBURG: I call my next witness, Dr. Jeffrey Kaplan.

JEFFREY KAPLAN, having been called on behalf of Plaintiff, first having been duly sworn, was examined and testified as follows:

THE CLERK: For the record, Doctor, please state your name and business address.

THE WITNESS: My name is Jeffrey Kaplan. My office is 160 East 56 Street, Manhattan, 10022.

THE COURT: Your witness.

MR. GUNZBURG: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. GUNZBURG:

 © 2016 Thomson Reuters. No claim to original U.S. Government Works.

Q Dr. Kaplan, what type of medicine do you specialize in?

A I'm an orthopedic surgeon.

Q And where do you currently work?

A My offices are in Manhattan on 56 Street. I am on the staff of several hospitals around the city. Those include Roosevelt and St. Luke's Hospital, Mount Sinai, Cabrini Medical Center and New York Downtown Hospital.

Q And where did you obtain your undergraduate degree from?

A I went to Yale University.

Q What about medical school?

A I went to medical school here in the city at Columbia University.

Q Did you do any internships?

A I did an internship and residency in a place called the Campbell Clinic which is an orthopedic training program. It's in Memphis, Tennessee. It's a five year training program in orthopedic surgery.

Q Are you board certified?

A Yes, I am.

Q In what areas are you board certified in?

A I'm board certified by the American Board of Orthopedic Surgeons and Orthopedic Surgery.

Q What does that mean?

A Board certification is an extra certification you can get after college and medical training and residency training program. It entails taking a number of tests over a number of years. These tests were given by a panel of expert physicians in my case called the American Board of Orthopedic Surgeons. If they feel that you have demonstrated a certain level of knowledge and expertise in your field -- in my case orthopedics -- then they give you a diploma and deem you board certified or diplomate holder of diploma from the American Board of Orthopedic Surgeons.

Q Do you have any experience in performing surgery?

A Certainly.

Q What kind of experience do you have?

A I have two days a week of surgery, generally between three to ten surgical cases a week.

Q Have you ever done surgery on the right arm?

A Yes, many times.

Q Open reductions, internal fixations?

A Yes.

Q What about the lower back?

A Yes.

Q What about any surgeries on the knees?

A Yes, many.

Q What kind of surgeries have you done on the knees?

A On the knees I have done fracture surgeries, reconstruction surgeries, joint replacement surgeries, joint fusion surgeries. Many different types of surgeries.

Q Have you ever testified in court before?

A Yes.

Q Have you ever testified for defendants as well as plaintiffs?

A Yes.

MR. GUNZBURG: Your Honor, I would like to offer Dr. Kaplan as an expert orthopedic surgeon.

THE COURT: Good. I mean it's not really necessary to offer him. He has presented his credentials and there's no challenge to that which means really that the doctor will be enabled to give his opinion as distinguished from usual witnesses who can only give you what he or she saw or heard. He is entitled to give an opinion by virtue of his training in a particular science. In this instance it is orthopedics.

Q Now, Doctor, did you cancel your schedule to come here this afternoon?

MR. McNULTY: Objection.

A Yes.

THE COURT: Overruled.

A Yes, I cancelled my afternoon patients in order to be here.

Q And what type of schedule would you typically have had you not been here today?

MR. McNULTY: Objection.

THE COURT: Sustained. I mean, you see patients --

THE WITNESS: Yes.

THE COURT: --right?

You gave up these appointments?

THE WITNESS: Tuesday afternoon I see patients.

THE COURT: You gave up those appointments?

THE WITNESS: Yes.

THE COURT: Because of your dedication to the law?

THE WITNESS: No, because I was asked to.

THE COURT: In part?

THE WITNESS: Yes.

THE COURT: Go ahead.

Q Doctor, are you being compensated for your time in connection with this matter?

A Yes.

Q Can you tell us how much are you being compensated?

A My office fee is a fee of $5500. My salary is paid out of that as people are still working in my office when I am not seeing patients. Some portion of that fee.

Q Did there come a time where you met with Mr. Khandaker Ali?

A Yes.

Q How many times did you meet with Mr. Ali?

A I met him once in my office again today.

Q And did you review any medical records in connection with this matter?

A Yes, I did.

Q What medical -- let -- excuse me.

MR. GUNZBURG: If I just may approach?

Thank you, your Honor.

Q Can you tell us what medical records you reviewed in connection with Mr. Ali's matter?

A I reviewed records from St. Luke's-Roosevelt Hospital which was where he was taken and had surgery. I also reviewed records from Long Island Pain Management and Rehabilitation Offices where he had therapy and treatment. That included several doctors. I reviewed MRI reports and films regarding Mr. Ali's treatment and I reviewed the reports of several physicians who have treated him over time.

Q Can you tell us based on your review what type of treatment Mr. Ali had immediately following his accident?

A Sure. Following his accident the records indicate that he was taken to Roosevelt-St. Luke's Hospital. He had an evaluation there. He had x-rays of his knees, x-rays of his elbow. He had actually had an MRI of his elbow. He was found to have a fracture of his elbow which required surgery. Surgery that was required was called open reduction and internal fixation type surgery and what that means is to open the skin and reduce a deformity that is caused by an injury and then fix it in place with in this case something called a fiber wire which is a suture that holds in this case a piece of bone from his elbow which

is connected to a muscle called the triceps back in place.

Q Doctor, let me show you these you illustrations which have been marked for identification. I just ask you to take a look at them.

These illustrations I gave you are in reference to Mr. Ali's surgery in connection to his right elbow?

A Yes.

Q First of all, have you seen those before today?

A Yes.

Q And are those illustrations fair and accurate depictions of Mr. Ali's injuries and the surgical repair that he underwent at the hospital?

A Yes, I believe they are.

Q Will those illustrations help you in explaining to the jury the nature of Mr. Ali's injuries and the surgery that he underwent?

A Yes, I think they would.

MR. GUNZBURG: At this time I ask those illustrations be published to the jury.

THE COURT: He has to say something about them so the jury will know what their value is.

MR. GUNZBURG: I'm going to use those on the screen with your permission, your Honor.

THE COURT: Show them to the jury. It doesn't mean anything unless they know what they entail.

I mean they are very nice photos and all that.

Why don't you show them on the screen then we'll show them to the jury. I think that would be more useful.

MR. GUNZBURG: Show them on the screen?

THE COURT: Go ahead.

Does anybody have an objection towards these?

MR. McNULTY: No, your Honor. Either way is fine. They are illustrations. The screen, everybody can see.

MR. O'DWYER: Your Honor, can I just see them before --

THE COURT: Certainly.

MR. O'DWYER: If you don't mind.

THE COURT: It doesn't make you a bad guy.

MR. O'DWYER: That doesn't.

Can we approach for one second, Judge?

(Bench conference.)

MR. O'DWYER: I just note my objection to the portion of the chart which is not the diagram -- not the actual MRI.

THE COURT: It is noted.

Q Dr. Kaplan, just referring you to the screen may be easier for everyone to see.

Do you want to come down if you like, with the Court's permission.

THE COURT: Yes.

A What was the question?

Q My question is, using this diagram can you explain to the jury the anatomy of the right arm in connection with Mr. Ali's condition?

A This is a diagram of a right elbow and it's this portion of the arm -- this would be the upper arm and the bone of the upper arm is called the humerus and this would be the elbow joint where the forearm, the radius and the ulna meet the humerus.

The muscles which cross the elbow make it go in motion. There is a muscle in back when it contracts that straightens the elbow. That's the triceps muscle, and muscles in front being the biceps and brachial radicula which contracts and makes the elbow flex.

I always find the models are somewhat helpful as well.

This is a right arm. This is the -- it is a hand -- the forearm. The forearm is made up of two bones. One is the radius and one is the ulna. Those meet up with the humerus, the upper arm bone, to make the elbow. The triceps is connected to this ulna and when it contracts it pulls the arm in extension.

Like any joint the surfaces of the joint are very smooth and they work in a very smooth sliding gliding fashion. It depends on the bones maintaining the proper shape.

You can imagine that if this was not semicircular and didn't accept the humerus well it wouldn't move well.

Additionally, if the triceps, which is really the motor of the elbow, is not connected in this case to the ulna to allow it to straighten out to pull against it the elbow will not move well in extension.

Q Let me go onto the next diagram for you, if I may.

Now what does this diagram represent?

A This is a diagram again of an elbow and this would be the humerus, the upper arm. This would be the forearm, the radius and ulna.

And this medical illustration is actually made on top of an MRI film. This is a film study that is done and this is annotated with Mr. Ali's name, and it shows in the MRI the triceps tendon which is here is not connected to where it should be down at the ulna. In fact, it is sort of recoiled with a small chip of bone here and this illustration simply outlines that so that we can see it better.

This is a chip of bone that is normally on the end of the olecranon and it has been pulled off. It has been avulsed from the olecranon and it is connected to the triceps which you can see is coiled out just as you see in the MRI film.

So this represents Mr. All's injury with the avulsion fracture, the fracture of the bone being fractured off of the olecranon here in the elbow which would disconnect the extensor mechanism, the motor that drives the extension of the arm.

Q Let me take you to the next diagram.

A This is a diagram looking at the back of the elbow and you can see this is what it would look like in the human.

As you look over here, what they have done --

THE COURT: Doctor, could you use a pointer because you are masking the exhibit?

THE WITNESS: I'm sorry.

A (Continuing) What they have done here is blown up what is in this box, remove the skin and you are looking at the triceps muscle.

It's called the triceps because it has one, two, three distinct heads. Three-part muscle. And it hooks into the olecranon here and again you are looking from behind like this. The muscle on top would collect into the olecranon there.

This is a representation of basically the picture that we looked at before.

Following an avulsion fracture of the olecranon a piece of bone is literally pulled off the back of the olecranon and retracts with the triceps muscle.

Now, when we look at x-rays we can see the piece of bone that has been pulled off, but when you look at the MRI what this picture also shows you is that in order for the triceps to retract not only is the bone chipped off, but the supporting soft tissue structures are torn throughout the elbow.

Q And would that be -- when you say that the soft tissue structures are torn throughout the elbow, does that include all the muscles of the triceps?

A That includes -- it looks like the -- in order for this to retract you would get the lateral portion, the medial portion and the middle portion. Lateral, medial, middle portion of the triceps tendon which would tear completely across in order for it to detract like that.

Q What kind of force would have to occur for that to happen to someone?

MR. O'DWYER: Objection, your Honor.

THE COURT: Overruled.

A In order for this to occur generally there's a pretty big force, and there's an injury like this with the body weight falling from a position to land on the upper extremities. The mechanism of this injury is that the triceps muscle contracts in order to try to absorb the force and the force simply overwhelms this triceps muscle and pulls the bone right off.

You can imagine -- you all seen chicken bones which are much less strong than this and you try to break that it takes quite a force.

This is a representation of the beginning of surgery for this type of injury. Again, this is the upper arm that they sort of done a see-through with the muscles and the bone underneath the skin and an incision is made on the back of the arm from about the end third of the upper arm to the end third of the forearm crossing the elbow directly. The skin is opened up. The blood, the soft tissue is moved out of the way and cleaned out to expose the avulsed tendon and the bone and then a series of drill holes are made into the end of the bone with a pneumatic drill. This is a drill that will drill right through bone to make a series of drill holes and the reason for doing that is in the next picture -- through those drill holes a series of what are called fiber wire

-- and fiber wire is a very high strength thread, basically a suture that has the strength of wire. It's actually made of fiber. It's not metallic. It's made of a Teflon-like material.

In order to get an anchor in the bone those wires are passed through these holes looped around the tendon, just like sewing with a needle, passed back through the hole and then the tendon and bone are anchored back down into the area of fracture to hold it in place.

Q In terms of this type of surgery is that -- what's the permanency of this surgery?

A I'm not sure what you are asking me.

Q In terms of the wiring to the tendons and to the triceps --

A Does the wire stay there? The wiring stays in place. This is a wire that stays in place and is not taken out.

Q And also there was on the bottom it shows an additional wire was inserted as well?

A This is actually I believe a crossing of these wires and they are tied over the top. So there are several wires that are placed and they are -- some of them are tied together in order to hold the bone piece down to the olecranon tied over the top.

Q I think that covers these illustrations.

After Mr. Ali had surgery did he have any type of further treatment such as casting at the hospital?

A Following the surgery he was placed in a splint which is a hardback dressing in order to keep the arm in a position where the tendon will not come loose and it won't avulse again and he was placed in that for several weeks. He was discharged with narcotic pain medication -- medication called Vicodin -- for postoperative and posttraumatic pain.

Q Did Mr. Ali receive any PCA or patient control anesthetic?

A In the hospital following his surgery he received pain medications as well and that's narcotic pain medication. They did use a device called PCA which is patient controlled anesthetic which means the patient is given a certain dose of medication which they can administer to themselves over time as they feel pain coming on. It will only give a certain dose so it keeps it safe. The patient cannot overdose themselves, but they can administer medications to themselves.

Q After Mr. Ali was discharged did he also go to receive a type of therapy?

A He had a good deal of therapy at a location called Long Island City Pain Management and Rehabilitation.

Q And what type of therapy did Mr. Ali receive at Long Island Pain Management?

A His therapy included electrical stimulation, range of motion therapy, massage, modalities which means heat and ice and things like that, attempts at stretching and strengthening. This case specifically the elbow but also other locations where he had pain and injuries.

Q Did Mr. Ali, based on the medical records at Long Island Pain Management, receive any type of injections?

A He did. He had a number of injections that were administered at Long Island City and those included nerve blocks in the neck, in the low back.

Q Now, did your report indicate that he had injections?

A My report actually indicated -- I had asked him had he had injections and that was --

MR. McNULTY: Objection.

THE COURT: Overruled.

A My report indicates I asked him if he had injections. He indicated to me that he did not have injections. I assume there was a language barrier. This was before I had the opportunity to go through the medical records extensively.

Q Now did Mr. Ali also have any types of tests performed while he was being treated at Long Island City Pain Management?

A He did. He had tests including electrodiagnostic studies which are studies of nerves. He had tests including range of motion type studies and things like that.

Q Now, in connection with Mr. Ali's right arm did you perform any x-rays while he visited with you in your office?

A I did.

Q Did you bring those x-rays with you?

A I did.

MR. GUNZBURG: Do we have a shadowbox, your Honor?

THE COURT: Yes, I think we have one up here.

COURT OFFICER: Yes.

Q If you could show the jury the x-rays, Doctor, and explain what those x-rays are and when they were taken and what they show?

A Sure.

This is a series of x-rays taken in my office on 3/12 2007, and what we are looking at is an x-ray of the right elbow. This is an x-ray of the elbow taken from the side. And the normal elbow, as we saw before in the illustrations, you would expect to see the elbow which looks like this. You have the radius and ulna from the forearm. You have the humerus and you have the elbow joint.

Now, in this x-ray there's an abnormality that you can see which is a sequelae of his fracture. The normal back of the elbow is rounded and -- I'm going to draw where we see the normal back of the elbow here. And what you see is that on the back of the humerus in this model there is a gap in the humerus in the arm bone called the olecranon fossa. This is the olecranon. This end of the olecranon bone, and this is a recess in the arm that you can't really see well on this view except that you can see the shadow of it right here through the bone. You are looking at it sort of through the bone here. You can see that olecranon fossa here.

What happens in the normal elbow is that as you straighten the arm the olecranon dips into the olecranon fossa. Fits in there.

This x-ray we see a large bone spur, a large calcified body that has developed behind the olecranon. This represent s either that avulsion fracture that has been pulled off a little bit -- it had definitely united to the olecranon. It may have pulled off some, or it can represent calcification in the triceps tendon.

The body uses calcium sometimes like glue to solidify an area that has been injured.

Nonetheless, whichever it is, either an avulsion fracture or -- I am sorry, piece of the avulsion fracture or the calcification of the ligament it represents a large area of very hard tissue calcified connected to the end of the bone that doesn't be??ng there and you can see that as the arm would straighten out this is going to abut the humerus. It sits here. And it's going to abut the

humerus and it's going to block the full extension of the arm.

And that's an x-ray representation of one of the findings when I examined Mr. Ali is that he cannot straighten his arm all the way. Additionally, he can't bend his arm all the way and that is because the length of the tendon is such that it is not allowing for full flexion. So that's a finding we see on the elbow.

Here's another picture of the same abnormality. This is the right elbow. This is taken at an oblique angle. This would be the normal end of the olecranon here. This is all new calcification that has formed on the end of the olecranon.

This here is the olecranon fossa here. You can see if the arm was to straighten out it would strike above that and not allow for full extension.

Q So the impact of that calcification is what with regard to Mr. Ali as of today?

A The impact of this calcification is two things; number one is mechanical is that it blocks normal motion of the elbow. That's a permanent block to normal motion. If you wanted to try to correct that you would have to take this calcification out which would require taking out some normal tendon and doing basically a repeat of the same surgery. However, as I said, this may represent calcification within the tendon and in it a piece of the fracture and the risk is that this will simply reform. This is how his body deals with a tear in the tendon and so I personally would not suggest that that surgery be done at this point because the results are at best iffy. He may reform the exact same problem.

Q In your opinion is that a permanent condition?

A Absolutely a permanent condition. Absolutely.

Q Now, do you have any other films that you want to show at this time?

A Those are good films of the elbow.

Q In terms of your physical examination, first, what kind of complaint did Mr. Ali make -- if you would like to go back to the witness box?

MR. O'DWYER: Object to this. May we approach on this?

THE COURT: Yes.

(Bench conference).

MR. O'DWYER: I note my objection.

THE COURT: Certainly.

Q Doctor, when you met with Mr. Ali what type of complaints did he make at that time?

THE COURT: No. That's a no no. Try a history from an untreating physician brought by a plaintiff cannot give a -- no pain -- he could give you a brief description of a history but no pain and suffering type of testimony.

MR. GUNZBURG: I will withdraw the question.

Q Doctor, could you just tell us when you met with Mr. Ali what areas of the body did he complain that he had problems with?

MR. O'DWYER: Objection.

 © 2016 Thomson Reuters. No claim to original U.S. Government Works.

A Sure.

THE COURT: I will permit it.

A He had complaints regarding the right elbow. He had complaint regarding the low back and pain radiating into his legs from his low back. He had complaints regarding his knee and --

Q Which knee?

A Certain difficulties --

Q Which knee?

A -- using the knee. The knee is the right knee.

Q And did you conduct a physical exam?

A I did.

Q What did you do in connection with your physical exam?

A With regard to the exa?? I looked at his areas of complaint. I did certain maneuvers, took him through certain testing with regard to his right elbow. I took him through a range of motion of the elbow.

Again, the motions of the elbow with regard to the olecranon are flexion, bending the elbow up, and extension, bending the elbow down. Mr. Ali had limited motion in flexion. Normally we can flex to about 135 to 145 degrees. Mr. Ali could flex to 120 degrees. With regard to extension we can normally put our arm out straight and Mr. Ali could not straighten his arm all the way out and lacked 10 degrees of full extension. He also had symptoms about the elbow with some of the soft tissue that runs across the elbow. In fact, there are nerves that run across, obviously, from the brain out of the neck into the arm and he had what we call a positive Tinel's Sign which is an irritable nerve at elbow. When you tapped on his elbow here he had tingling sensations down to the hand.

THE COURT: Would you come to sidebar, please?

(Bench conference.)

Q Dr Kaplan, with regard to your physical exam can you tell us what physical findings you made based on your examination of Mr. Ali?

A Sure. Again, limited motion of the right elbow is present. I told you the degrees. He had a positive Tinel's sign at the elbow. He had atrophy of his forearm and swelling of his elbow on the right.

With regard to the right knee he had a positive McMurray's Test. A McMurray's test is a test where the knee is bent and twisted back and forth and there is clicking inside the knee. If this is a repeatable click it indicates a tear of soft tissue inside the knee. He had a positive Drawer Sign of the knee. A Drawer Sign again is a test of soft tissue in the knee and in this case specifically a test of the stability of the anterior cruciate ligament of the knee.

The anterior cruciate ligament is a structure deep inside the knee that prevents the knee from sliding in an abnormal way. It keeps the thigh bone on top of the shin bone and prevents it from sliding back and forth.

In this case you could hold Mr. Ali's lower leg and pull forward and literally pull the shin and the tibia the lower leg out from underneath the femur the upper leg the thigh bone in an abnormal way which is an indication of instability of the knee. It was not as stable as it should be and generally that's due to an injury to the anterior cruciate ligament one of the supporting structures of the knee. He had muscular spasm in his low back. He had a positive straight leg raising test which is a test of the

irritability of the nerves as they run out of the back and down the legs. And that was present on the right meaning that when we straightened his right leg when he's in a sitting position which in effect stretches the muscles as they come out of the back into the leg he had replication of symptoms. Pain traveling from his back down into his leg. He had limited motion of his lumbar spine. He had 60 degrees of forward flexion, normal being 30 to 90 degrees. The ability to bend forward. He had limited extension and he had 10 degrees of extension. The normal is about 20 to 30 degrees of extensor bending back at the lumbar spine.

Q Now, did you have the opportunity to review any MRI films in connection with Mr. Ali?

A I did.

Q And can we just have the shadowbox?

The films.

Are the films here?

A Yes.

These are several MRI films that have been taken of Mr. Ali. These are films that were taken. The MRI of the knee, that was taken on February 27th of 2007. This is an MRI of a cervical spine that was also taken on February 22, 2007 and MRI of the lumbar spine taken on February 23 of 2007.

An MRI is an another imaging study. The advantage in certain cases of MRI's is not only does it show the bones but it also shows the soft tissues. The hones are supported by soft tissues, ligaments tendons, discs, ??, things like that. This MRI test has the ability to look not only front to back, like we were seeing in the plain x-ray film from one side to ??e other, but it can look inside the structures because of some computer manipulation of the images. If you think -- this is how I describe it to patients, if you think the bone is like we look at the bone meaning the knee and we look at the spine, but if you think of a bone as a solid structure like this (indicating) the MRI has the ability to literally look inside at a piece of inside and then simply by ?? ating the computer it can continue to look inside at the bone as you go across from one side of the solid bone or in this case the spine to the other. You can look at different levels as if you are peeling back the pages of a book.

Q Do you use the MRI's in your practice?

A Absolutely.

Q What do you use them for?

A MRI's show us again not only bones but soft tissue structures that support the bones and joints and abnormalities can help search out abnormalities in the ??ft tissue and their relationship to the bone in order that we can treat patients.

Q How do you use them in connection with your practice as a surgeon?

A MR's are a supporting test. Now, a lot of it what we do in medicine is building evidence of a certain injury. I can examine Mr. Ali's knee, as I told you, and I can take his tibia and lowering the leg and pull it forward and push it backward on his thigh bone and that tells me he had an interior cruciate ligament tear.

In the world of today's medicine an MRI can show me a picture of that anterior cruciate ligament tear as opposed to my simple clinical examination. But an MRI is a supportive test of that.

I wouldn't operate on someone based solely on the MRI and based on my clinical examination I can be directed to order certain tests simply to prove, again, what my feeling is and demonstrate more directly what is going on in the case like this in Mr. Ali.

Q Which MRI would you like to show first?

A We got the MRI of the right knee.

Q Okay.

A This is an MRI of the knee.

Q This is Mr. Ali's knee?

A This is Mr. Ali's knee. Khandaker Ali. And, again, this is a series of photographs or series of images of the knee and again if you think of this as a series of pages stacked one on top of the other basically we are starting here on the outside of the knee and moving -- flipping through the pages as we go across and here we are actually sort of in the center of the knee as far as we make it on this film and because I know the anatomy of the knee and I know we are on the outside because like even the form -- there are two bones in the lower leg. The smaller bone is on th outside and we are at that timing to see it right here. That's called the fibula head. That's the head of this long bone. It is basically the outside portion of that long bone.

As we travel across we are seeing the outside portion of the bone here and as we move towards the midline we start to see the entire fibula that is visible here.

We get then passed the fibula and we are seeing the tibia which is here and this is the thigh bone on top, the femur on top and the tibia.

This is the kneecap or patellar in front.

As we come to the middle of the joint here I'm just going to show you an abnormality. I can't show you what the normal is because I don't have a picture of a normal knee. But, basically, there's a ligament inside the knee and a ligament is a structure that goes from one bone to another that acts like a rope basically holding the relationship between two bones. In this case holding the relationship between the thigh bone and the shin bone and it normally sits in the middle of the knee and it would be a stripe of tissue that looks sort of like this to form the thigh bone to the shin bone. You would -- imagine if this was a rope. You wouldn't be able to pull the leg fo??ard in this case.

What we see here is where this rope like stru??ture should be right here, you just see a lot of -- you see a large lump of scar tissue and you don't really see a competent anterior cruciate ligament.

Again, the anterior cruciate ligament if it were normal would go from the tibia about this thick to the femur. Instead we got this mass of scar tissue and torn ligament tissue. That's an anterior cruciate ligament.

Q Car. I just interrupt you for a second?

Let me show you these three illustrations. I ask you to take a look at them -- of the knee.

By the way, are those fair and accurate depictions of Mr. All's conditions and injuries?

A Yes.

Q Those illustrations help you explain to the jury the nature of his condition and his injuries?

A Yes.

Q Let me just put those up on the screen and you will be able to use those to explain to the jury.

A This is essentially the similar slice to the MRI that I showed you before. This is the thigh bone or the femur. This is the shin bone, the tibia.

The normal anterior cruciate ligament is a ligament that goes between the shin bone and actually hooks in right there to the back of the thigh bone and it prevents forward slipping of the shin bone onto the thigh bone. This is all abnormal tissue. You would like to see a clean striped tissue here and what this represents is the thigh bone, the shin bone and this is a mass of torn tissue here.

Again, that actually shows the insertion side as you see here and the way that these MRI's work, they work by showing the different water content between tissue. This is the anterior cruciate ligament stump which actually probably still has a good blood supply through the tibia and is dark, almost grayish black. That's what a normal anterior cruciate ligament should look like. This big mass of whitish is a sort of a vascular torn up anterior cruciate ligament tissue.

Q What does it mean to have a complete tear of the ACL?

A Not being a total tear of the ACL can allow some stability to the joint. When you tear it completely the joint is very unstable and that's a mechanical finding again where I can take his shin and pull it forward onto his -- off of his femur and I have some x-rays that actually show -- that's what I am talking about.

Q Is the ACL ligament something that can grow back?

A They generally retract into a mass of torn tissue like we have here.

Q Let me show you the next illustration.

A This is another ligament. There are two ligaments in the knee, one in front and one in back. The anterior cruciate ligament goes from the shin to the thigh this way, preventing the shin from coming forward.

There's a second ligament called the posterior cruciate ligament, again, from the shin to the thigh in a different direction which prevents the shin from moving backwards.

If you think back to the slide before this this is what a normal ligament should look like. It should be a nice black stripe like that. In this you see both areas of a nice black stripe and partial tearing of the posterior cruciate ligament. This is an artist's representation here done right on top of the MRI to get the contours right. But that's a picture of a partially formed posterior cruciate ligament.

So the two ligaments inside the knee which cross and give stability to the knee in the front and back plane, the anterior and posterior plane of stability, one is completely torn and one is partially torn.

Q What is this?

A This is a representation just so you can see in medical illustration terms what the anterior and posterior cruciate and ligament look like.

What you are looking at is a knee flexed up like this. The kneecap, it's on top of the knee and you are looking inside what's called the notch of the thigh, the end of the thigh bone sort of like two nickles like this, you are looking inside.

Normally the anterior cruciate ligament goes from front to back. The posterior cruciate ligament goes from back to front. The posterior cruciate ligament is behind the anterior or front ligament. That would be in a normal situation.

This is an artist's representation of Mr. Ali's knee which shows the tear complete there of anterior cruciate ligament and partial tear of the posterior cruciate ligament.

Q What does that mean in terms of Mr. Ali's right knee?

A He has an unstable knee and again that's a mechanical finding. The knee is loose and looser than it should be. That means

that the knee has -- this is a term that we all use -- not really a medical term -- has a lot of slop in it.

Most joints move smoothly in a very tight way. He has slop so that when he moves his knee his knee joint surfaces see abnormal forces. They don't move in the way they are suppose to. That puts extra stresses across the delicate surface of the joint.

A joint surface has a coating of cartilage which you see here represented as pearly white tissue. That is living tissue that slides with very low friction. As this slops around this tissue is irritated, is eroded and is degraded over time and that leads to abnormalities in the abnormal irregular joint surfaces and that's the cause of arthritic pain and arthritis in the knee.

Q What does that mean in terms of Mr. Ali's right knee?

MR. McNULTY: Objection.

THE COURT: Overruled.

A A gentleman like this who has an unstable knee has a delicate situation in his knee. Basically the knee can give out at anytime. You subject this to more force than you are able to compensate for with your muscles and the knee will give out. The knee will buckle. The knee can lock. And this limits the amount of force that you can put on a knee without it having an abnormal situation of giving out, locking, buckling or trauma to the joint surfaces.

Q Let me show you these illustrations as well while we are here. I just ask you if this would help you explain to the jury the nature of Mr. Ali's injuries to his lumbar spine?

A Sure.

Q Are these fair and accurate depictions of his condition?

A They are.

Q Now, what does this diagram show?

A This is an MRI picture of Mr. Ali's lumbar spine. The lumbar spine is a series of bones which are called the vertebra that are stacked one on top of the other and there are five lumbar vertebrae and they are named for purposes of location, starting at lumbar 1, L2, L3, L4, L5 and they stop on top of the sacrum which is in this case is number S1. Between each of the vertebra in the back there is a soft tissue structure called a disc. That disc allows-- acts like a pad and also acts like an area that slows motion through the bone. Obviously if it's one big motion bone there would be no motion in your back. This allows for some motion in the low back.

Inside the spinal column which is made up of bone, this is the front of the bone and then it makes a circle of bone around a structure which is the nerve cord or the spinal cord, and so the spinal cord is protected by bone on either side which is a good protection of the spinal cord and there -- generally in a normal situation there is no pressure on the spinal cord and it is well protected by the bony caves that it lives in. There could be a problem when the soft tissue structures sufficient as the disc here get out of place. Because if they get out of place and they push into the area where the spinal cord lives or the nerve roots live, which are just the branches off the spinal cord, it pushes the soft nerves into the hard bone and you get what is called a bony impingement. Some people called it a pinched nerve. You can also have irritation of the nerve, irritation of the spinal cord in a situation like this.

Mr. Ali had an MRI which demonstrated disc herniations at two levels, level L4 and L5 and level L5 and S1, and I have MRI films that show that even more dramatically than you can see on this photo illustration.

Q What does it mean to have two herniated disc compressing the spinal canal?

A The consequence of this is that the nerve roots around these areas of spinal cord compromises and spinal root compromise

cause irritation and pain, weakness and dysfunction of the nerve as it travels from the back and in this case down the leg. You heard people having a pinched nerve. They have back pain. They have pain in the leg.

Mr. Ali has complaint of back pain, pain in the leg. When I do a straight leg raising test it produces the back pain and the pain down the leg and the reason I'm literally pulling his leg out which has the nerve in it and pulling it straight and lengthening it across this area where the nerve -- I am sorry -- where the disc is is preventing its motion and irritating that. Again, this is area of abnormal anatomy that is a source of pain, a source of dysfunction. He has limited motion in his spine and limits the amount that he can do without causing Further injury to this would limit from a medicals perspective the amount that I ask him to bend, lift, carry things and activities such as that.

Q Is it fair to say that your physical examinations are consistent with your findings on the MRI's?

A Yes.

Q Is that both for the right knee and for his lumbar spine?

A Absolutely.

Q All right. If you just take the stand.

(Witness complies.)

Q Doctor, do you wish to use anymore of the MRI's or is that sufficient?

A There certainly are MRI findings which this is of the lumbar spine in which again this is the MRI of 2/23/07 Mr. Ali had. The spinal cord is this bright white signal running down the back of the vertebra. The discs are in between. This is what I think is a more visible picture of the herniated disc at L4 and again just flipping through the book because discs can herniate anywhere so you have to flip through the pages to see it. A more visible representation of the disc herniation at L5-S1 is here as well. So these are areas of disc herniation. I wild mark it so you can see it with disc rather than being flat against the spinal cord actually making a big indentation into the spinal cord at these levels.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty as what caused Mr. Ali's right rm injury, his lower back injury and his right knee injury?

MR. McNULTY: Objection.

MR. O'DWYER: Objection.

THE COURT: Sustained.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty as to the cause of Mr. Ali's injuries?

MR. McNULTY: Objection.

MR. O'DWYER: Objection.

THE COURT: Are his injuries consistent with a fall forward?

THE WITNESS: Yes.

Q Now, Doctor, do you have any recommendations with regard to Mr. Ali's either right knee condition or lower back condition?

MR. O'DWYER. Objection.

THE COURT: Any what?

MR. GUNZBURG: Recommendations with regard to his condition.

THE COURT: I don't know what that means.

Q Doctor, did you discuss a surgery with regard to Mr. Ali's right knee or lower back?

MR. McNULTY: Objection.

THE COURT: Overruled.

A I did.

Q What surgery did you propose in connection with Mr. Ali's injuries?

A With regard to his right knee I propose that he have a knee arthroscopy. This is a surgery where when we look in the knee. We make two incisions on the knee. We place a telescope like device inside the knee and we can examine the knee. We also through another incision place working tools which are trimming tools, are heat probes, different types of instrumentation we can use to address the tear in Mr. Ali's anterior and posterior cruciate ligament as well as examine the surfaces of the joint which for several years have been subjected to these abnormal forces that I talked about which can damage the joint surface.

I have told him that I believe he is a candidate for that surgery and that it may be a surgery which could reduce his symptoms for a period of time. I made it quite clear to him this is not a curative surgery. This cannot cure the symptoms and, in fact, in a case like this which is several years old I would not even recommend necessarily recon??ting the anterior cruciate ligament in a 47 year-old gentleman but debriding or cleaning up the tissues, trying to shrink the anterior cruciate ligament a bit, tighten up the knee with different techniques in order to reduce the symptoms.

The way that we do this is a palliate treatment, meaning it can help get rid of the symptoms for a period of time. However, I expect that he will still have symptoms with regard to the damage to the joint surface and the fact I don't believe he is a good candidate for reconstruction of the ACL.

Q With regard to his lower back do you have any recommendations or suggestions other than surgery at this point in time?

MR. McNULTY: Objection.

THE COURT: Overruled.

Will he need future surgery for his back?

A I don't believe he is a candidate for back surgery. I do know that he could benefit from some other treatments, including physical therapy, including epidural steroid injections which is a series of injections into the area of the lumbar spine to help decrease inflammation and irritation and create scar tissue around the disc which continues to give him problems and I know those things again would be palliative treatments for him.

Q Based on your review of the medical records of Mr. Ali, did Mr. Ali have any prior medical history that suggested any injuries to his right arm, his lower back or his right knee?

MR. McNULTY: Objection.

MR. O'DWYER: Objection.

THE COURT: Do you know of any history that may have contributed to his present condition?

THE WITNESS: My understanding is that he had no prior medical complaint or treatments to those areas.

Q Now, how much does it cost to undergo arthroscopic knee surgery?

MR. McNULTY: Objection.

THE COURT: What was this?

MR. GUNZBURG: The cost involved in the arthroscopic surgery.

THE COURT: Overruled.

A Arthroscopic knee -- surgical cost is about $7500 depending what is done. There's an additional hospital fee which is about $2500 and anesthesia fee which is about $1200. Then, of course, someone would need follow-up physical therapy which would be twice a week for about 12 weeks at a cost of 100 to $150 a visit.

Q Now, in your opinion does Mr. Ali have any permanent disabilities?

A Absolutely.

Q What are those?

A His permanent disabilities -- at this point he's got low back injuries and symptoms related that which in my mind are permanent. They have been there for much greater than a year. Usually at about a year we can determine that certain parts of that are permanent. I believe these are permanent in him.

With regard to his elbow, he certainly has permanent loss of motion, permanent atrophy, permanent swelling.

At the knee he has a permanent disruption of his ACL and partial disruption of the PCL and he has mechanical symptoms of instability of the knee which I also believe is permanent, and not only is it permanent, but as I describe it sort of leads to progressive problems in the knee as the knee joint is subjected to abnormal forces which wear away at the joint surfaces and lead to arthritis of the knee.

Q Doctor, I would like you to take a look at invoices that were submitted with the certified medical bills -- certified medical records and just if I may approach, your Honor?

THE COURT: Yes.

Q Let's start with the one from St. Luke's Hospital. If you just take a look at the charges.

Do you see the invoice attached to the St. Luke's Hospital?

A Yes.

Q By the way, you have privileges at St. Luke's, too, don't you?

A Yes.

Q You ever do surgery at that hospital?

A I'm doing surgery there tomorrow.

Q Do the invoices that are attached appear fair and reasonable?

A Yes.

MR. McNULTY: Objection.

THE COURT: Overruled.

A Yes.

Q What type of treatment did St. Luke's invoice bill Mr. Ali for in connection with their treatment?

A He has invoice for a hospital admission from 11/17/02 through 11/22/02. He has operating room costs, recovery room costs, pharmacy costs, laboratory costs having to do with blood drawing. He has costs related to a CAT scan that was done, physical therapy that was given to him post surgery and a bill from the emergency room.

Q How much did the entire invoice come to?

A The charges 30,965.28.

MR. GUNZBURG: Your Honor, at this time I would like to offer into evidence the certified hospital records as well as the certified hospital bills from all hospitals at this time as well as the illustrations that were just marked and shown to the jury.

MR. McNULTY: Your Honor, on the hospital records I have no objection other than the possibility of redaction with respect to anything that might be submitted to the jury.

THE COURT: Certainly.

MR. O'DWYER: I have no objection, your Honor.

THE COURT: Okay. Proceed.

Q Let me show you the invoices from Long Island City Pain Management. I just ask you to take a look at that as well.

Can you just tell us based on that invoice what was the time period that Mr. Ali received therapy?

A He received therapy -- looks like his first visit was 12/17/02 and he received therapy up until 5/19/05 it appears.

Q Based on that the bill you have in front of you?

A Yes.

Q And what type of treatments did he receive based on those invoices?

MR. O'DWYER: I object to that.

THE COURT: No, let me see that.

I have to sustain that objection.

MR. GUNZBURG: They are in evidence. I won't ask anymore questions about them.

Thank you, Doctor.

THE COURT: Why don't we take a short recess, ten minutes. Please don't discuss the case.

(Whereupon, the jury leaves the courtroom.)

(Whereupon, said exhibits were received in evidence as Plaintiff's Exhibits 9 through 14.)

(Whereupon, said exhibits were received in evidence as Plaintiff's Exhibits 16A-16M.)

(Recess.)

(Whereupon, the jury enters the courtroom.)

THE COURT: Please be seated.

Mr. McNulty.

MR. McNULTY: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. McNULTY:

Q Good afternoon, Doctor. My name is Michael McNulty. I am representing Con Ed here today.

Let me ask you a question. You mentioned something about degenerative changes or changes in the knee.

A Uh-hum.

Q Degenerative changes. Tell us what that is all about.

A Degenerative changes simply means a change that occurs over time.

Q So that if somebody had an accident and was treated the day of the accident you would not get degenerative changes from the accident visible on that day?

A That's correct. In this case the x-rays that were taken of Mr. Ali's knees showed some age appropriate de??enerative changes in the knees, some changes that you see on x-ray. Generally you start to see those with anyone over the age of 30 or 40.

What I was talking -- my description of his right knee is that he has this laxity which will cause continuing wear and tear changes over time directly related to the instability of the knee as opposed to just normal wear and tear changes.

Q Okay. But my point is here -- and of course you anticipated what it is -- that when he was x-rayed at the hospital on the night of the accident they found degenerative changes?

A Mild degenerative changes age appropriate.

Q In fact, the word was "minor degenerative changes."

And you looked at the record. In fact, you got the page where it says that, of course?

A Yes.

Q Now, by the way, it does not say on that page age appropriate, does it?

A No. That's my interpretation. Because as I say, anyone over the age of 30 or 40 will have some -- as they say minor -- I would say mild degenerative changes. We all age over time.

Q Let me ask you this, a guy who puts a lot of mileage on his legs like a busboy or waiter will wear out his knees faster than somebody who say sits behind a desk or the bench?

A Well, there are many reasons that you have degenerative changes.

Q Well, my question is just comparison between the two.

A You can't make that comparison.

MR. GUNZBURG: Objection, your Honor.

Q Sir, my question is this --

THE COURT: Overruled.

Q When one compares somebody who has a job where they are constantly walking around as opposed to a job where they are constantly sitting one would expect the person who has a job where they are constantly walking around to get degenerative changes earlier, correct?

A That is not correct, sir. There are many reasons you can have degenerative changes. There are a lot of people by nature of their genetics very strong, muscular, that takes a lot of shock on absorption of the surfaces of the joint that can be someone who walks around or someone who sits all day. That correlation is not very true.

Q Certainly could be one factor?

A Absolutely could be one factor.

Q So if all the factors were equal you might expect the one who walks around more and carries heavy things all day to show more degenerative changes than the one who sits all day if all other things were equal?

A Hypothetically if there were no genetic factors, mechanical factors?

Q Correct. I don't need a recount. I said --

A I'm simply --

Q Let me just put it to you. You can answer a hypothetical question.

If all other things were equal the guy that walks more is going to have more degeneration than the guy who sits all the time, correct?

A Yes. I am simply trying to outline those things that you are neglecting.

Q I asked a simple question and I got a simple answer. Thank you. Okay.

Now, let me ask another question here. The spine -- the spine also undergoes degenerative change process over aging?

A The entire body.

Q Correct. The spine is part of the picture of the entire body. That spine undergoes degenerative changes?

A Yes.

Q As one ages?

A That's co??ect.

Q As one uses it?

A That's correct.

Q So that once again a person who is more active bending, lifting, etcetera, they very well with all other factors hypothetically being equal have more degenerative changes than somebody who is just sitting around a lot?

A Again, if you --

Q With all other things being equal?

A Let me finish my answer, sir.

Q Sure.

A Again --

Q Make sure you understand the postulation.

A That postulation includes excluding every other possible factor.

Q Any other way they are equally genetically --

A I just want to be clear. These are hypothetical and none reproducible questions and the answer is yes, if all things being equal that is a factor. If that's the only factor you are talking then absolutely.

Q The guy that works harder is going to wind up with more degeneration than the guy who sits around, all other things being equal?

A If that's the thing you are considering I would expect you are correct.

Q In a perfect world that isn't so. There are other factors and I understand that and your answer -- but you can answer a hypothetical question?

A I'm answering a hypothetical question. Even in an imperfect world as this one is you can't make that hypothetical sell.

Q Very good. Let me ask you this one, the 5,000 that you are being paid today, have you received that already?

A My office has, yes.

Q Who did they receive that from?

A Mr. Gunzburg's office.

Q And when you got Mr. Ali isn't it true he was referred to you by Mr. Gunzburg?

A Yes.

Q In fact, your intake sheet reflects that that Mr. Ali filled out in Mr. Ali's own hand?

A I don't know if it refers -- I see it simply says Mr. Gunzburg is his attorney. It simply says is his attorney. My understanding he was referred by Mr. Gunzburg's office.

Q Were you paid for that visit?

Let me take it back a step. How many times did you see Mr. Ali at all?

A I saw Mr. Ali one time.

Q What were you paid for that one visit?

A That would have been $500 for an orthopedic consultation and the x-rays and things like that?

Q 500?

A That's right.

Q Who paid you that $500?

A That would have been paid by Mr. Gunzburg's office.

Q For Mr. Gunzburg?

A For the report, correct.

Q When did this office visit take place?

A March 12, 2007.

Q Did you know at that time what stage the court proceedings were at?

A No.

Q Now let me ask you another question, as part of your review, as part of your -- how should we say -- process here, you review the medical records, correct?

A That's correct.

Q And according to those medical records when was the last time before coming to you that Mr. Ali had seen a doctor?

Let's say, for example, Long Island Pain Management, when was the last time before Mr. Ali came to see you that he had been to Long Island Pain Management?

A It would have been the date I indicated earlier.

Do we have that?

I have that bill. I don't recall the exact date. Whatever we said earlier.

Do you have that?

Q Actually the record is up there. It's the big --

MR. McNULTY: May I assist, your Honor, in locating that?

THE COURT: Certainly. I think it was May 19 of '05.

MR. GUNZBURG: That was only the invoice not the actual record.

Q Here's the record, Doctor, right here.

A Okay. Let's see the last time that -- I would find it probably easier to go by the invoice. So I think would think '05 would have been his last visit at that location.

THE COURT: Off the record.

(Off-the-record discussion.)

THE COURT: Looks like the last date of the treatment note that I have is July 18 of 2005.

Q July 18, 2005 was the last date of treatment?

A That is what it looks like on this.

Q Now, did you examine any other records of treating physicians other than Long Island Pain Management?

A I examined the records of Dr. Catalano who treated him surgically and then again a number of physicians from Long Island Pain Management.

Q Okay. As far as Long Island Pain Management goes we already know the last time he was treated was July of '05, correct?

A Correct.

Q That date of treatment appears in the records that you have before you and that you reviewed before your testimony today, correct?

A Correct.

Q Who provided you with the records that you reviewed before you came here today?

A The records would have come from Mr. Gunzburg's office to help me prepare this report to exchange with your offices.

Q Those included the records of Long Island Pain Management?

A That's correct.

Q The other doctor that you mentioned, Dr. Catalano, was he the attending surgeon here?

A He was.

Q You know him?

A I know him well. In fact I spoke to him yesterday about Mr. Ali.

Q You discussed this case with him?

A I did

Q He still works over at St. Roosevelt?

A He's a hospital physician at St. Luke's-Roosevelt.

Q You saw him yesterday at work there?

A Yes.

Q Working as a doctor?

A That's correct.

Q In fact, does he reside in New York?

A I have no idea.

Q In any case, you saw him yesterday. Do you know where he is today?

A No idea. I haven't seen him today.

Q He's still doing surgeries at St. Luke's Roosevelt?

A He does surgeries, that's correct.

Q Now, he actually performed the surgery here?

A That's right.

Q And he saw him after the surgery?

A Right.

Q When was the last time that Dr. Catalano him?

A I don't have the exact date. That would have been six, 12 weeks after the surgery, I imagine.

Q According to the records that you reviewed, was Mr. Ali treated by anybody, any doctor after July of 2005 that last visit that you indicated to Long Island Pain Management?

A He was not at pain management. He was not.

Q Based on your review of the records from July of 2005 until he was referred to you by Mr. Gunzburg he was not seen by any other physicians?

A He was not treated by other physicians. He was referred to me for evaluation, that's correct.

Q And do you know where the MRI was done?

A The MRI was done -- the MRI's were performed at All County Imaging.

Q When was that done?

A That was done 2/26/07, 2/22/07 and 2/23/07.

Q When did you see Mr. Ali?

A I saw him 3/12/07.

Q March 12, '07?

A Yes.

Q Do you know who paid for the MRI's?

A No idea.

Q Doctor, let me ask you this, in the last year how many people have you examined in connection with legal cases whether for a defendant or for a plaintiff?

A I don't know. I don't keep track of that. But I see people every now and then for evaluations, both from defendant's firms and plaintiff's firms. It is part of orthopedic surgery to evaluate a patient who has been injured.

Q Let me ask, if you give us an estimate -- within the past six months -- it's June now. Go back to January. Between January and now, approximately, how many people have you examined whether for plaintiffs or for defendants?

A There's really no way I could tell you. I mean, it's probably, you know, one to two a month and it breaks down for exams like this where I'm evaluating a patient as opposed to treating a patient about 50/50 defendant versus plaintiff.

Q Well, Doctor, let me direct your attention to your intake sheet --

A Yes.

Q -- right at the beginning of your file?

A Right.

Q And is it not true that there are basically three categories listed on your intake sheet of sources of patients?

A I'm not sure what you are referring to. You are referring to this contact sheet here?

Q Yes, the contact sheet.

A You might call the intake sheet. That has nothing to do with where patients are referred from. Those are simply contacts.

Q Well, are listed as the contacts. There's a checklist there, right?

A Yes.

Q And on that checklist you call it contacts?

A That's correct.

Q What are the three boxes that the patient could check off or the person could check off?

A Patient can check off attorney, doctor, or other which would be family, friends, other referral source, computer, internet.

Q By contact you mean the source of contact with your office, correct?

A Absolutely not. I said that three times.

Q What is --

A It's not a referral sheet.

Q Why is that listed there?

A That is listed there because in this case where I'm evaluating a patient for Mr. Gunzburg I put his name down here so I can find quickly who you have to send information to, things like that.

Q Doctor, actually I'm asking about the line where there are three boxes across.

A That's correct.

Q And the three choices that -- what would you call that line?

A I would call that a contact line.

Q What do you mean by a contact line?

A It's a quick reference to where medical information or in this case information regarding my evaluation would be sent.

Q And there are only three choices?

A One of them is "other" which is pretty broad.

Q But the first choice is attorney?

A They are alphabetical. A attorney, D doctor, O other.

Q They are alphabetical?

A Correct.

Q But you don't have hospital on there?

A That falls under doctor.

Q You don't have word of mouth, friend?

A That falls under other. You expect me to put word of mouth or friend or cousin? This is a simple sheet that you are trying to read a lot into. There's no conspiracy.

Q I am not looking for a conspiracy. Let me --

A -- validate for you.

Q That is a sheet that was designed for use in your office, is that correct?

A That's correct.

Q It's a sheet -- you designed that or someone else in your office?

A Someone else.

Q Who did that?

A I don't know. It has been there for years.

Q Isn't it true that most people find a doctor by recommendation of a doctor, friend? You go to the friend and you say, "Hey, who's a good orthopedist"?

A No, there are --

Q Isn't it normal for people to ask a friend who's good on that?

THE COURT: Let him finish his answer.

MR. McNULTY: Okay.

THE WITNESS: Thank you.

THE COURT: What's your next question?

THE WITNESS: I'll answer this question.

A Here are several ways that patients come to me. Some and most of them by doctors and hospitals. A good number of patients come either from the internet or from friends recommendations. And in orthopedics where people have been injured, no question that some of our patients come from attorney's offices and that's any orthopedist. That's not simply my office.

Now, I wouldn't expect an internist, someone who deals with high blood pressure and things like that, has referrals from attorneys.

This is simply a contact sheet. If I have to write a report as in the case as what I have done for Con Edison, I would put down here Con Edison. That's who I would send the information to.

Q Doctor, let me look at the form again for a second.

MR. McNULTY: If I might approach, your Honor?

THE COURT: Okay.

Q Doctor, on this form it has Mr. Gunzburg's phone number?

A That's correct.

Q But it does not have his address?

A It does not have his address, that's correct.

Q What percentage -- now since we have talked about all these different sources of pa??ients, underneath word of mouth, what percentage of your business comes in from attorneys then?

A Not a large.

Q Check off that box attorneys?

A Not a large percentage.

Q What would you estimate ballpark?

A I would have no way to estimate. It's not something I estimate or track.

Q Don't you care where your business comes from in the marketing sense, make a few bucks?

A I don't do marketing.

Q No?

A No, I have a very busy practice and it doesn't require marketing.

Q If you sat back and said what percent of my business comes in from attorneys --

A That's correct.

Q -- you couldn't put that say at 20 or 10 percent?

A I wouldn't be able to put it in numbers.

Q How about doctors then, what percentage referred by doctors?

A A much larger percentage that is referred than attorneys.

Q Can you give us a ballpark on that?

A You are asking me the same question over and over. The answer is I don't track.

Q That's my stock and trade.

MR. McNULTY: I am reporting to the editorial comment, your Honor, rather than the answer.

THE COURT: Let him finish. What's your next question?

Q Well, my next question is as far as others go that would encompass everything; word of mouth, internet and every other potential source of a patient?

A That is correct.

Q You wouldn't be interested in knowing you were being highly recommended by other patients?

A I have a sense of what patients recommend me over and over.

Q Would you --

A Let me finish, please.

Q Go ahead.

A I have a sense when I speak to patients and talk to patients of whose recommending me over and over, but it's not something I track. It's not like I'm going to send them a gift for recommending a patient to me. So it's not something I track.

Q Well, you might not want to call them and thank them if Mrs. Jones recommended a patient to you?

A That would be completely illegal for me to call them and say thank you, I have seen so and so as a patient. I just violated a HIPAA regulation and I'm subjected to a $25,000 fine.

Q For your own education you wouldn't know Mrs. Jones thought highly of you to send a patient?

A I know that. Patients tell me where they come from. That's part of a doctor/patient relationship.

MR. McNULTY: Thank you.

THE COURT: Yes.

MR. O'DWYER: A few questions, your Honor.

CROSS-EXAMINATION

BY MR. O'DWYER:

Q Dr. Kaplan, good afternoon.

A Hi.

Q Before you testified today at some point prior to this date you prepared a report in connection with this litigation, right?

A Yes.

Q And the report listed what you reviewed, the records that you reviewed, the findings that you came up with on your physical examination of Mr. Ali in that case?

A Yes.

Q And your conclusions?

A Correct.

Q And when you wrote this report obviously you wrote it to Mr. Gunzburg, corre??t, you addressed it to him and sent it to him?

A Yes.

Q And you knew that even when you prepared the report you would include everything that you thought was significant in this case because you ultimately are going to come in and testify and your report is going to be exchanged?

A I know the report I write goes to defense firms that's the reason for writing the reports, disclosure of what my findings are. I can't put in everything I feel is significant.

Q I mean you wouldn't leave out something that you thought was incredibly significant to the case, right, if you are going to put it into a report that is going to be exchanged among counsel and ultimately be used in court, is that fair enough?

A I would try to at least mention that I had reviewed records that I considered significant things but, again, you know, we are talking about piles and piles of records here. I can't go through everything.

Q I understand. That's not really what I am suggesting. I am just suggesting that you would -- your intention in writing the report to put in the things that you find significant to the case?

A Right. It's my intention to put in how I came to my conclusions and things like that.

Q And what your conclusions were?

A That's right.

Q Do you have a copy of your report?

A I do.

Q Would you take it out?

You have the report in front of you, sir?

A Yes.

Q It's dated March 12, 2007, correct?

A Correct.

THE COURT: This is a report to whom?

MR. O'DWYER: I apologize, your Honor. This is -- I thought that I had -- apparently I didn't make it quite clear. This is a report that doctor prepared to be exchanged among counsel.

MR. GUNZBURG: Judge, there's no addressee on the report. It's just a report.

THE COURT: Okay.

MR. GUNZBURG: It's not addressed to anyone.

MR. O'DWYER: That's really not my point, Judge.

Q But as long as it is brought out, when you finish the report and you had dictated and it was typed, what do you do with it?

A It was sent to Mr. Gunzburg for exchange with everyone.

Q I just want to direct your attention to page 3 of your report and where you note toward the bottom of the page -- it starts on physical examination, that paragraph?

A Yes.

Q And in that paragraph you list what your physical findings were concerning the plaintiff's right elbow, correct?

A Yes.

Q And /AUPBD mention some of these things on your direct testimony but I would like to go through some of the things you have in your report, fair enough?

A Yes.

Q You talked about -- one of the things you talk about is the degree of flexion that he has in his arm?

A Right.

Q And would you just tell us what you mean by flexion?

A Flexion is bending the arm this way in.

Q Or pulling it back toward you?

A Right.

Q And you note that upon your physical examination of the right elbow he has flexion to 120 degrees?

A That's correct.

Q Can you show us what you mean by that?

A 120 degrees is approximately here (Indicating.)

Q And you also note a finding with respect to his extension of that elbow. Tell us what that is.

A Extension is straightening out this way.

Q You note that he lacks 10 degrees of extension?

A Right.

Q Show us basically what that is.

A About there.

Q And when you are talking the degrees you are talking about the angle at the elbow, fair enough?

A Yes.

Q So this straight ahead would be 180 degrees?

A Or zero.

Q However, you want to --

A Yes.

Q Calculate it?

A Exactly.

Q The same thing?

A Yes.

Q You talk about he lacks 10. So there is a lack of 10 degrees in the elbow that he can extend, fair enough?

A Right.

Q Now, what is atrophy?

A Atrophy is loss of muscle bulk.

Q And atrophy is something that you are interested in as an orthopedic surgeon in examining somebody because it indicates what?

A It indicates abnormal use of a joint at times, especially the joint that is moved by muscles.

Q And when someone -- when there is atrophy to muscle that means the muscle has actually gotten smaller --

A Correct.

Q -- correct?

A Yes.

Q And that could be for a number of reasons, but one of them would be lack of use, correct?

A That's right.

Q So when we are talking atrophy you are saying in essence that the muscle was one size prior to some point at some prior point in time and at this point it's something less?

A That's right.

Q Now, when you -- and in this same paragraph you talk about measuring certain muscles of the right arm, correct?

A That's correct.

Q And the reason why you did that is to -- you are looking for atrophy, is that right?

A Or swelling as there is in this case.

Q Now, you just -- first of all, let me just backup before I get to that point.

One of the other things you looked at was pronation and supination which are moves of the arm. Those are movements of the forearm which is turning the hand down, pronation, or turning the hand up. So that is supination.

That is pronation and this is supination, correct?

A Yes.

Q You found the plaintiff in this case had full pronation and supination. He could go back and forth like this?

A He could move his forearm.

Q Normal, right?

 © 2016 Thomson Reuters. No claim to original U.S. Government Works.

A Yes.

Q You measured the circumference of the right biceps?

A Right.

Q Just show us what the biceps is.

A Upper arm here.

Q The muscle that Popeye was always showing everybody?

A That's the one with the ship on it.

Q And when you measured that back in 2007 you found that the circumference of that muscle was 27 centimeters?

A Yes the upper arm, that's correct.

Q Then you compared that to the left which was 26.5?

A That's correct.

Q You would expect -- you knew that when you did this examination that Mr. Ali was right-handed, right hand dominant?

A Yes.

Q You would expect that the right biceps would generally be in a right-handed person larger than the left?

A It IS usually equal to or larger than, yes.

Q That's what the situation was here. There was a .5 centimeter difference and the right muscle was -- actually the right biceps was actually larger?

A The right upper arm, that's right.

Q You also measured the forearm?

A Right.

Q And for the right you found the circumference of the forearm to be 25 centimeters?

A That's correct.

Q And for the left forearm 24 centimeters?

A The other way around. The circumferential measure of the right forearm is 24 centimeters.

Q So the report that I have dated March 12, 2007 which says 24 centimeters -- well, it says 25 centimeters to the right, you say that should be the left?

A Read the report as I read it which circumferential measurement of the right form arm is 24 centimeters versus my report which has been hand corrected prior to coming here says 25 on the left. He has atrophy of the right forearm versus the left forearm.

Q You corrected that by hand on your sheet?

A That's the only way I can correct a typographical error.

Q There's a difference of one centimeter between the right and left forearm?

A That's correct.

Q Now, I want to talk to you a little bit about your findings about the right knee.

A Okay.

Q First of all, will you agree with me that one of the things you reviewed -- and we talk about this -- one of the things you reviewed is the EMT report. The hospital report. The ambulance report?

A That's right.

Q And isn't it accurate that in this report there's no complaint with respect to the right knee and, first of all, this is the ambulance call report. These are the people who went to the scene and first administered any type of medical treatment, correct?

A The ambulance call is from the scene, yes.

Q And that report does not indicate anything about complaint with respect to the right knee, am I right?

A It does not indicate complaint to the right knee.

Q But it does actually indicate he made some complaint with respect to the left knee, am I right about that?

A Yes, that's correct.

Q Now, while he was in the hospital for those number of days that he was in there, the vast majority -- essentially all of the treatment that he received was with respect to the right elbow, am I right about that?

A The vast majority was to the right elbow. He had x-rays of the right elbow, MRI of of the right elbow, surgery of the right elbow.

He had x-rays in both the right and left knee in the emergency room.

He had physical therapy to the elbow as well as with help with walking because of instability walking.

The vast majority, yes, was to the right elbow.

Q Now, you mentioned there were x-rays taken of both knees?

A That's correct.

Q And am I correct that - and I think that you testified about this on direct -- that the findings with respect to both knees on x-ray was the finding were I should say mild degenerative changes?

A That's correct.

Q And you already testified that degenerative changes coming from the word degeneration, right?

A Right.

Q Essentially means a wearing down.

A Wear and tear changes that occur over time.

Q And that's what they found on both knees at that point on x-ray?

A That was the only finding they noted, what's mild or I guess they called it minor degenerative changes. Again, that would be age appropriate in my mind.

Q Did you review the radiology report concerning the findings of the knees?

A Yes.

Q And in addition to -- I mean it says mild degenerative changes, but it also notes spurring, am I right about that?

A That's degenerative change.

Q But it's one form of degeneration, correct?

A That's right. That's a form of degenerative change.

Q What is spurring?

A Spurring is just a change in the shape of the normal bone which in this case would be a peak of the bone -- a peaking of the bone or a spurring of the bone which would be identified as a degenerative change.

Q What causes that?

A Wear and tear, change over time.

Q But physically how does it happen? What causes the calcification onto the bone where the bone actually has these spurs?

A Spurring can be caused by a couple of reasons. It would be a growth of bone. It would be called a bone spur. One could be the changing of a shape of the bone to accommodate for different weight distributions.

Q X-rays generally are used to view bones and not soft tissues, am I right about that?

A In general, yes.

Q But they are useful also in making a diagnosis with respect to soft tissue injury such as a ligament?

A They can be.

Q They can be?

A Yes.

Q They may not be the definitive way to do it?

A Right.

Q But they can be used?

A Can be.

Q As a matter of fact, when you saw the plaintiff, I guess, in March of 2007 you told us that you took certain x-rays, correct?

A That's correct, I took stress views. Stress view is a mechanical manipulation of the joint which shows the relationship of the bones with stress on them as opposed -- these x-rays would not be useful in showing ligament injuries, the ones taken in the hospital.

Q The thing is when you did this examination you took these stress views you knew that the claim that that was being made had to do with ligaments and not bone, right?

A I did know that, yes. I knew Mr. Ali claimed that he injured a ligament, yes.

Q And is it accurate to say that based upon the x-rays that were taken the day after the accident on November 18, 2002, that there was no indication from those x-rays that there was any problem with either of the knees other than degenerative changes?

A That's correct. These were plain x-rays. These were not stress x-rays that were not taken. They would have only been useful --

Q My question is this, there's no indication in the report or in the x-rays that there's any problem with the soft tissue, correct?

A These are not soft tissue x-rays. That's like asking if a cardiogram indicates an injury to a ligament in the knee. It's not the test for that.

Q Here's my question -- I am not trying --

A I understand. What I am --

Q You understand my question?

A I understand. I find it misleading. It's not a test.

MR. O'DWYER: I move to strike.

THE COURT: Yes.

Q Here is the question, Doctor; there's no indication in those diagnostic studies that there was any problem with any soft tissue of either knee, am I right?

A Absolutely correct.

Q Now, I want to ask you some questions about the neck and the back, just a couple.

First of all, you told us earlier that like all portions of the body the vertebrae and the discs between the vertebrae are subject to degeneration?

A Yes.

Q And would you agree with me that you would expect to find a certain amount of degeneration in a person's spine when they reach a certain age?

A Yes.

Q Now, just to backup a minute, in the -- did you review the triage records?

A Yes.

Q At St. Luke's-Roosevelt Hospital?

A Yes.

Q Triage assessment is called --

A I believe I do. Yes.

MR. O'DWYER: Can I approach, Judge?

THE COURT: Certainly.

Q That's it.

Is it accurate, Doctor, that in that triage assessment -- first of all, what is triage?

A Triage is a way of staging the ??tients. It's basically the first plan on the patien??d then deciding the severity of injuries or the emery ??cy nature of injuries.

Q And is it accurate that in this triage assessment form -- in that triage assessment report there's an entry that the patient denies neck pain?

A Yes.

Q Correct?

A Yes.

Q Now, would you -- now we talked a little bit earlier about herniated discs and why those can be a problem?

A Yes.

Q And, now, if you have a herniated disc that's impinging on a nerve in the spine --

A Yes.

Q -- you would expect to find -- depending on which vertebrae or which disc you are talking about -- you would expect to find certain findings, symptoms, findings in a particular portion of the body depending on the location of the disc, am I right?

A It depends. Again, MRI's are simply a test. You would never treat a patient based solely on the MRI's.

Q That's not my question. My question is more general. Let me ask it ask it even more general.

The nerves -- the nerves that come off of the spinal cord, right, these nerves innervate portions of the body, correct?

A That's correct.

Q You would find nerves in the cervical ??sc areas that would essentially effect the upper body; the arms, perhaps?

A Correct.

Q Particular portions of the arms depending on which disc?

A That's right.

Q In some case it may be a particular finger or a particular portion of the hand?

A Right.

Q Depending on the disc?

A Right.

Q When you have a nerve impinging upon a particular disc you might -- you would expect to have some objective findings to the portion of the body that that nerve is innervating -- if that's a word -- that nerve goes to, correct?

A If it's causing symptoms.

Q Right. And symptoms -- symptoms are, for example, complaint?

A That's right.

Q And but there are other types of symptoms also. Objective symptoms like physical finding?

A Objective findings.

Q So one might expect to find, for example, if you have a herniated lumbar disc -- lumbar being the lower portion of your back?

A Right.

Q You might expect to find -- have some findings with respect to the leg or a portion of a leg, correct?

A You would have a complaint and you may have findings, depending on how severely the nerve is being pinched, and if the nerve flow is being interrupted.

Q Right. One of the things you might expect to find is atrophy?

A If the nerve flow is being interrupted you can find atrophy. That's a late stage finding.

Q If the nerve flow is being interrupted you would expect to find atrophy?

A You could, yes.

Q Did you measure, Doctor, for atrophy in any of the portions of the body where the plaintiff claims to have -- that would be effected by the herniated discs that the patient claims to have in the cervical--

A I don't believe I found that tree in that distribution.

MR. O'DWYER: Thank you. I have nothing further.

REDIRECT EXAMINATION

BY MR. GUNZBURG:

Q I just have a few questions for you, Doctor.

The attorney for Con Ed asked you about degenerative changes. What factors do you consider in considering degenerative changes?

A Degenerative changes again occur for many reasons. They can occur from activity as we discussed. They can occur from simply genetics meaning the way that people are built. Generally you would expect someone heavier, all other things removed, you know in the hypothetical word if you had a heavy guy and thin guy the thin guy would have fewer degenerative changes. People have blood born arthritis that affect the joints that are not related to activity that are related genetics there are multiple, multiple reasons. Food people eat, alcohol intake, many, many things can affect the amount of degeneration that people have in their joint. That is an expected amount of degeneration and it's not strict. It's just appropriate. As we say you can't age someone by the degeneration in their joints, but in a 40, 45, 47 year-old guy to have what they are reporting as minor degenerative changes that would not send up any red flags to me.

Q What does it mean to you that this finding notation in the medical record that Mr. Ali had a degenerative change, for example, either in his right knee or had in his lower back in connection with your findings based on your physical findings and the MRI's that he has a torn ACL and herniated disc in the lower back?

MR. McNULTY: Objection.

THE COURT: I just must ask you --

MR. GUNZBURG: I'll rephrase it, Judge.

Q Do those notations of degenerative change impact on your opinion that you gave the jury before?

A They don't impact on my opinion. If I consider them, obviously, I had seen this note but they don't impact on my note that the injury to the ACL was caused by the fall. That is not an injury that occurs without a tear in the ACL is not something that occurs just as a degenerative change that occurs because of an impact because of a trauma.

Q What about the lower back?

A With regard to the lower back I have to consider that he's never had injuries, he never had a complaint. He never had treatment to the lower back. My conclusion in a finding of limited motion and straight leg raising are related to the accident and liking the changes on the MRI they are seeing including the herniated disc on two levels.

Q What about his right elbow?

A In my mind it's well documented the injury to the right elbow, the knee surgery, persistent and permanent limit.d motion are related to the accident.

Q The fact that the patient made no complaint with regard to his neck or lower back in the triage notes, what impact does that have on your opinion, if any?

MR. O'DWYER: Objection, your Honor.

THE COURT: Does it have an impact?

THE WITNESS: It has some impact.

THE COURT: Tell us about it.

THE WITNESS: Unfortunately the triage notes are a record that someone else has made based on their interview with Mr. Ali, and I can tell you that as noted triage is trying to assess the patient in regards to what the emergency problems are and what problems should be dealt with first. It is a very common thing in my experience to see.

MR. O'DWYER: Objection.

THE COURT: He's an expert. He can testify to triage procedure.

THE WITNESS: That the things like fractures are -- as in this case get the majority of the attention. The guy is going to have to have surgery for this. That gets the majority of the attention. They certainly indicated he had no neck pain. If they ask him about his neck or back is not documented. They didn't document his knees either but they took x-rays of them.

In my mind here they are focusing, as a triage station does, on the most emergent problems, and what kind of x-rays did they take at the emergency room or at the hospital. At the hospital they took x-rays of the elbow, x-rays of the knee. I believe they took x-rays -- if my recollection is correct they took an x-ray of one of the hands. They took x-rays that are called plain x-rays, front to back x-rays like we showed before. Those are x-rays for assessment of fractures, of dislocations, of abnormalities in the bone that are not used to show abnormalities of the soft tissue. Evidence of that is they didn't follow-up with MRI of the elbow to show the retraction of the ligament even though you can imply of the tendon -- even you can imply that the triceps tendon is avulsed given the x-ray finding.

Q So you are saying that they followed up with the MRI because they suspected a ligament or tendon tear?

A Soft tissue injury as well, yes.

Q Do you know why they didn't follow-up based on your review of the records with any other MRI's on any other parts of his body?

MR. O'DWYER: Objection.

THE COURT: Sustained.

MR. GUNZBURG: I have no further questions, your Honor.

MR. McNULTY: If I might?

RECROSS-EXAMINATION

BY MR. McNULTY:

Q You had mentioned something about the triage process at St. Luke's-Roosevelt.

A I'm sorry, is that a question?

THE COURT: What's the question?

Q On your responses to Mr. Gunzburg you mentioned something about a triage process?

A At the hospital in general.

Q Are you familiar with the triage process at St. Luke's-Roosevelt?

A Some degree.

Q Is it important in that process to learn about the patient's injuries?

A Absolutely.

Q And you are familiar about the procedure at St. Luke's-Roosevelt?

A In general, yes.

Q Well, in general would the procedure include getting a history of the injury from the patient?

A It should, yes.

Q If the procedure is followed correctly that would be from the patient themselves, correct?

A Usually, but they will sometimes ask other people.

Q Well, but -- if the procedure is followed from the patient himself, correct?

A Should be.

Q And indeed you don't see and you did not see any indication in these procedures -- in these records that you reviewed that anybody deviated from the procedure, did you?

A There's no indication whether they did or didn't?

Q Could you locate the triage form, please?

A Sure.

MR. GUNZBURG: Object. Objection. This is going beyond the scope of the direct and redirect. The direct, cross and recross.

THE COURT: Triage was covered in the redirect.

MR. GUNZBURG: Now we are opening an area not covered by the medical treatment. We are covering an area that deals with something completely different.

THE COURT: I don't know you can cut it that fine.

How much do you have on it?

MR. McNULTY: Not that much. He did bring it up so I am going to follow-up on it.

THE WITNESS: Okay.

MR. McNULTY: So now if I may approach the witness, your Honor?

THE COURT: Yes.

MR. McNULTY: Just to see the form there.

Q This is a copy of it here, what I got here?

A Yes, it is.

 © 2016 Thomson Reuters. No claim to original U.S. Government Works.

Q Now, that form is something that is filled out for medical reasons, right?

A Portions of it are medical reasons, yes.

Q It's for -- the information is taken down because it is necessary for the proper patient care?

A It's helpful in the care of the patient.

Q Helpful?

A Yes.

Q Proper care of the patient, correct?

A In the care of the patient, sure.

Q So that, for example, where it says reason for visit, paren subjective. Subjective meaning that come from the patient himself. If what the patient says about himself correct?

A In general, yes.

Q And it's necessary to get information there about the mechanism of the injury, correct?

A Sometimes they put it down. In this case they wrote down what they interpreted, yes.

Q If they followed the correct procedure they wrote down what they were told by the patient, correct?

A Sure.

Q And you don't see any indication on this form that the procedure was deviated from, correct?

A I will read this to you.

MR. GUNZBURG: Objection, your Honor.

It's hearsay, your Honor.

THE COURT: I don't know. I don't have a copy of the report before me if, but if it was pertinent to diagnosis and treatment it's not hearsay. Now you could make that judgment as well as anyone else. Was it pertinent?

MR. GUNZBURG: I think the doctor would make that -- the doctor would be the one and he has already said that.

THE COURT: He has?

MR. GUNZBURG: The records are in evidence. The jury can read it themselves.

THE COURT: If they are in evidence anyone can read them.

MR. McNULTY: I'll move it into evidence at this time.

Q That recitation bit by the patient is a necessary part of treatment, isn't it?

A Well, it's my belief this is not a recitation by the patient. It's interpretation because of what it says is his -- there are words

that I don't even think he would use. There are medical terms here. This is an interpretation of what he says.

Q Of course they wrote down what they were told, correct, not verbatim?

A I don't believe they write down what they are told verbatim but their interpretation.

Q What does it say?

A He has right elbow laceration, slip down a ramp. Now laceration is a medical interpretation meaning a cut on the skin.

Q But slipped is certainly plain English -- one would not get from anybody other than the patient, correct?

A It appears that the person who wrote this down is putting down his or her interpretation of what she heard.

Q Le me ask you this, if the patient said trip wouldn't the person who wrote it down say trip? There's no need for interpretation if a guy says trip or slipped?

A I have no idea how they interpret a person's voice or accent.

Q That box has to be filled out to get a proper diagnosis, correct, as part of the diagnostic process?

A The mechanism is not diagnostic.

Q It's not. This is not filled out as part of a procedure to establish a diagnosis what the patient tells you?

A The mechanism is not part of the diagnosis, sir.

Q That would be important to know?

A It helps in knowing. It's not the most important thing. It is important in these records since you are asking for my interpretation. He has a laceration at the elbow, that is helpful in the diagnosis.

Q But knowing how it happened would also be helpful?

A As I say it is helpful.

Q To some degree?

A That is correct.

Q To some degree help forming a diagnosis, to some degree?

A I don't see how in this case slipped and tripped would make a difference in the diagnosis whether he slipped or tripped.

MR. GUNZBURG: Excuse me. Let him answer the question.

THE COURT: Make the point and let's go on.

MR. McNULTY: My point -- I want to make the point.

Q It may not be in this case, but in general knowledge of mechanism of injury can be helpful in performing medical diagnosis?

A Are we speaking in the ideal word? Hypothetical, sure.

Q You are the expert.

MR. McNULTY: At this time I move the document into evidence as Con Ed C or D.

MR. GUNZBURG: I'm going to -- I offered the documents into evidence and counsel already raised an objection subject to redaction. I consent to that. I don't have any objection to his redactions.

THE COURT: We'll look them over.

MR. McNULTY: Nothing further, your Honor. Thank you.

MR. O'DWYER: Nothing, your Honor.

THE COURT: What do you have now?

MR. GUNZBURG: He opened the door.

THE COURT: No. No forget about opening doors. He examined the doctor on one sliver.

MR. GUNZBURG: I'll only keep to that.

THE COURT: One point.

MR. GUNZBURG: I promise I won't deviate from his sliver.

Where is that triage note?

REDIRECT EXAMINATION

BY MR. GUNZBURG:

Q Doctor, do you know based on your review of that note whether it was provided to the triage nurse, by Mr. Ali or perhaps by a coworkers?

MR. McNULTY: Objection.

THE COURT: That's pertinent.

A Let's see. I don't believe it indicates who gave the history.

THE COURT: The answer is no, is that correct?

THE WITNESS: That's correct.

Q Can you tell who provided the information at contained on that report?

A I cannot tell.

Q Is there any notations on the report that would indicate or confirm the source?

A No.

Q Are any of those words in quotations?

A No.

MR. GUNZBURG: Thank you.

THE COURT: All right. Gentlemen, Doctor, you are a free man.

THE WITNESS: Thank you.

THE COURT: All right. Gentlemen, could I see you at the sidebar?

(Conference.)

THE COURT: Ladies and gentlemen, the end is near. Friday is what we are aiming for. Tomorrow come in at 10:00. It should not be too tough a day for you tomorrow. 10:00. Be prompt. Get off to a good start.

(Whereupon, the jury leaves the courtroom.)

(Whereupon, the trial is continued to June 20, 2007, at 10:00 a.m.)

End of Document

© 2016 Thomson Reuters. No claim to original U.S. Government Works.