SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS: CIVIL PART 32

- -X

SU YUE HU,

Plaintiff,

- against -

251 West 36th Street Owner, LLC,

Defendant.

INDEX NUMBER: 700293/2018

TRIAL DAMAGES

- -X

Supreme Court
25-10 Court Square
Long Island City, New York 11101
April 4, 2025

B E F O R E :

HONORABLE LUMARIE MALDONADO-CRUZ,
Justice of the Supreme Court

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CAROLINE MANDATO
VANESSA CASTILLO
SENIOR COURT REPORTERS

THE CLERK: Queens Supreme Part 32 is now in session. The Honorable Maldonado-Cruz is presiding.

THE COURT: Good afternoon everyone. Please be seated.

THE CLERK: We are on the record with the continued case on trial index number 700293 of 2018 Su Yue Hu versus 251 West 36th Street Owner, LLC. All counsel are all the same.

THE COURT: Anything we should discuss?

MR. PELUSO: Yes, your Honor. I didn't think this was going to be an issue because of the long-standing precedent in trial courts throughout this city. I have all of the decisions.

Just to give your Honor a brief background, the treating doctor, Dr. Jeffrey Kaplan was named in a civil lawsuit, a civil RICO lawsuit that is currently pending in the Eastern District. There have been no dispositive findings. There have been no absolutely no depositions. There have been no admissions. There have been attempts -- And mind you, he's one of fifty facilities or physicians who have been named in this lawsuit, okay. P.

There of have been attempts by defense counsel in every single trial court to try to elicit through the questioning as simple as isn't it true, Doctor, that you are a named defendant in a lawsuit. That question in and

of itself is grounds for an immediate mistrial and it's been across the board precluded.

I have decisions, which I can hand up, which I can hand up to your Honor, from not only the trial courts in the City of New York. And the theory is always -- And the legal precedent has always been, your Honor, this is the equivalent of an allegation.

THE COURT: I'm sorry, give me that so you don't have to come twice. Thank you.

MR. PELUSO: And, your Honor, I was handed -- When I had this conversation earlier in the day, because I anticipated it with Mr. Pearsall, and he didn't give an indication. He said, I haven't made a decision as to whether or not I'm going to go down this road; and I said that I have to make this record.

Now, I was just handed a memorandum from Mr. Pearsall with regards to why they should be allowed to use allegations. Not one case that's in there deals with an allegation of --

THE COURT: You don't have to go any further. You know what, I'm sorry, what is your contention?

MR. PEARSALL: It goes right to his credibility, your Honor. He's been named in multiple lawsuits, it's not just one. They have the complaints here that he's engaged in a series of fraudulent acts, performed unnecessary

surgeries, not in this case but in other matters which goes right to his credibility as to a physician.

MR. PELUSO: And, your Honor, with --

THE COURT: I'm not going to entertain it. You could appeal whatever decision or whatever outcome of this case. The Appellate Division or the Court of Appeals will then have to rule based on -- There's no findings. So I have to agree with other judges and I'm going to allow it. So please do not ask the question.

Anything else?

MR. PEARSALL: Just note my exception.

THE COURT: Duly noted.

MR. PELUSO: And, your Honor, with regard, because we're on the record, I had the prior conversation with Mr. Pearsall with regards to any insinuation about things that have already been litigated with regards to liability. If there's going to be any questioning with regards to how this happened or any indication of any notes with regards to how this happened that has been litigated and that has been decided.

There are no more liability questions and Mr. Pearsall has told me before, your Honor, that he doesn't intend to go into any of those things.

THE COURT: We shouldn't. We already litigated that.

MR. PEARSALL: And I said, yeah, I'm not going to.

THE COURT: Okay.

MR. PELUSO: I just want to make the record completely clear, your Honor, with regards to questioning Dr. Kaplan that's all precluded and anything that's already been decided in this Court he's not going to go down that road.

THE COURT: And I have to take your word for it. We're all professionals. Like I said at the beginning of the trial, I expect everybody to keep the same level of professionalism that we entertain and show this Court throughout this entire trial. I've been very easygoing and very accommodating. I don't want to change my demeanor because we don't follow what we agreed we will not do.

All right. So having said that, there's no questioning or any insinuation with regards to the pending litigation, the RICO case that everybody's familiar with, nor are we going to relitigate liability.

MR. PEARSALL: All understood, your Honor.

THE COURT: All right.

MR. PELUSO: Thank you, your Honor.

MR. PEARSALL: Your Honor, just with regard to the schedule, I was able to lock Dr. Toriello in for Tuesday afternoon.

THE COURT: Okay.

MR. PEARSALL: So that would be our last witness.

THE COURT: Okay. Let me just pull my handy dandy notebook. That would be Tuesday?

MR. PEARSALL: Tuesday afternoon. Just to recap, your Honor, Monday the plaintiff at 11:30. Tuesday Dr. Goldwyn in the morning, Dr. Toriello in the afternoon and that will complete the witnesses.

THE COURT: Okay, wonderful. All right. Anything else?

MR. PEARSALL: No, Judge.

MR. PELUSO: I think that's it, your Honor.

THE COURT: Thank you.

MR. PELUSO: Thank you.

THE COURT: All right.

MR. PELUSO: Your Honor, I just want to make sure Dr. Kaplan's out in the hall and not downstairs. Your Honor, can I have him come to the courtroom?

THE COURT: Is he testifying?

MR. PELUSO: He is.

THE COURT: So bring him in.

MR. PELUSO: Okay, thank you.

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated.

THE CLERK: All jurors are present and in their

proper seats.

THE COURT: Counsel.

MR. PELUSO: Thank you, your Honor. Your Honor, plaintiff calls Dr. Jeffrey Kaplan.

(Whereupon, the witness stepped up to the witness stand.)

THE COURT OFFICER: And just remain standing.

THE WITNESS: Thank you.

THE CLERK: Please raise your right hand. Do you solemnly swear or affirm the testimony you give shall be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE CLERK: Please be seated.

THE WITNESS: Thank you.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Hi. How are you?

THE CLERK: Just make sure you're speaking directly into the mic.

THE WITNESS: Okay.

THE CLERK: Please state your name and current address.

THE WITNESS: My name is Jeffrey Kaplan K-A-P-L-A-N. My office is at 160 East 56th Street, Manhattan 10022.

THE CLERK: Your Honor, the witness has been sworn

in.

THE COURT: Thank you. Counsel.

MR. PELUSO: May I, your Honor?

THE COURT: Yes, please.

MR. PELUSO: Thank you.

J E F F R E Y K A PL A N, M.D., called as a witness on behalf of the Plaintiff, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

MR. PELUSO:

Q. Doctor, I'm just going to ask if you could just speak into the microphone in response to my questions. I know the acoustics in here are a little --

A. Yeah.

Q. Good afternoon, Doctor. Before today, have you and I ever met in person?

A. No.

Q. Before today, have you and I ever spoken on the phone in any way?

A. No.

Q. Okay. Now with regards to your qualifications, what is it that you currently do?

A. I'm an orthopaedic surgeon.

Q. Okay. And what is it --

Do you have a practice in the City of New York?

A. I do.
Q. Okay. Where is that located?
A. It's on East 56th Street.
Q. Okay. And how long have you been an orthopaedic surgeon?
A. Almost forty years.
Q. Okay. And with regards to your background, where is it you went to undergrad?
A. I went to Yale University.
Q. Okay. That's up in Connecticut?
A. Yeah.
Q. And where is it that you went to medical school?
A. Columbia University.
Q. In Manhattan?
A. Yes. Yeah.
Q. And after medical school, did you do any residencies?
A. I did a residency in a place called the Campbell Clinic which is in Memphis, Tennessee, actually the first orthopaedic training program in the United States.
Q. And after you did your --
After you graduated from medical school and did residency, did you go straight to orthopaedic surgery?
A. I did.
Q. Other than practicing in you said the Campbell Institute --

A. Um-hum.

Q. -- what did you do after that? Did you have any fellowships?

A. I went back to New York and I've been in private practice ever since.

Q. Okay. And are you currently a practicing orthopaedic surgeon?

A. Yes.

Q. And approximately how many orthopaedic surgeries would you say you do in a given week?

A. It varies, orthopaedics, really. You know, a lot of just emergency room work. So it can be anywhere from two days a week surgical cases to ten on average I would say.

Q. Okay. And sir, are you currently licensed to practice medicine in the State of New York?

A. Yes.

Q. And do you hold any board certifications?

A. I'm board certified by the American Board of Orthopaedic Surgery.

Q. And what does it mean to be board certified?

A. Board certification is an additional qualification you can get after college, medical school and a residency training program. You're eligible to take a series of examinations over a number of years. If you are deemed competent and an expert in the field of orthopaedics, they deem you board certified.

Q. And when is it that you were first board certified as an orthopaedic surgeon?

A. 1994 I believe.

Q. And have you held board certification consistently up until today's date?

A. Yes.

Q. And are there times that you have to renew, renew or reapply for board certification?

A. It does have to be renewed every ten years.

Q. And what is the process with regards to the renewal of board certification?

A. It's taking another series of examinations slightly different. The first examinations are mostly knowledge based. Following that there's both clinically based, meaning they have the opportunity to ask about your practice and your surgical decision makings, your outcomes, things like that, and then there's some additional book learning.

Q. Now, are you a member of any professional associations?

A. American -- Member of the American Trauma Association, the American Board of Orthopaedic Surgeons. I'm the orthopaedic surgeon for the New York State Athletic Commission in the boxing division.

Q. And have you ever held any academic positions?

A. I'm on the staff with several hospitals in town. Primarily my academic appointment is at New York Presbyterian

Hospital.

Q. Is that New York Presbyterian in Manhattan or Queens? I know they're similar.

A. Manhattan, yeah.

Q. All right. Doctor, are you being compensated for your time here in court today?

A. Yes.

Q. And how much are you being compensated?

A. My office is paid a fee of $7,500. So part of that goes to me, part of that goes to rent, secretaries, assistants, things like that. Just pays the bills.

Q. Okay. And if you weren't here in court testifying --

A. Um-hum.

Q. -- what is it you would be doing?

A. Friday afternoons either a clinic day or surgery day, depending on what the schedule demands.

Q. Now, I know that you and I have never personally met before but have you ever testified in court for injured parties?

A. Yes.

Q. Okay. And approximately how many times would you say that you've done that over the course of your career?

A. I can't give you a great estimate because it really varies tremendously. You know, sometimes it's a couple times a year, sometimes it's a couple dozen times a year.

Q. And with regards to the testimony that you give in

court, is that only with regards to your patients who are injured?

A. It's primarily in regards to patients that I've been treating for a period of time but I've been called as an expert witness both by plaintiffs and defense counsels.

Q. Okay. And what would you say the percentage is with regards to how many times you testified for plaintiffs and how many times you testified for defendants?

A. If you break it down like that, it's heavily weighed towards plaintiffs because those are my patients and that, as I say primarily, I'm called to testify regarding my patients.

Q. And with regards to patients that you've had that have been represented by my law firm --

A. Um-hum.

Q. -- have you ever testified on behalf of my law firm?

A. I have.

Q. Okay. And approximately when was the last time you testified on behalf of my law firm for one of our clients?

A. I was trying to remember that. It's got to be at least five or six years.

Q. And the testimony that you give in court is that a primary source of income for you?

A. Clearly it's a small part of my business.

Q. And what would you say would be the percentage of your testifying in court?

A. I have no idea. Again, it varies wildly, as does my, you know, time in the OR.

Q. Sure. And currently, can you give me a number how many patients do you have?

A. Again, I can't even give you a number on that.

Q. Hundreds?

A. Oh, for sure. For sure, yeah.

Q. And you're currently active in treating those patients, right?

A. Yes. Yeah.

Q. And did you bring any notes with you today with regards to Ms. Hu?

A. I did. I brought a chart.

Q. Okay. And just with regards to background --

A. Um-hum.

Q. -- you're familiar with my client, Ms. Hu?

A. Yes.

Q. And at some point in the past did you begin treating her for orthopaedic injuries?

A. I did.

Q. Okay. And approximately when is it that you first saw Ms. Hu?

A. Let me just pull out this chart and give you an exact date. Let's see, I first treated her on 12/14/17.

Q. Okay. And just to give some background, this is in

connection with further treatment that she received for an injury that she had back in May of 2016, correct?

A. That's correct, May 28, 2016.

Q. Okay. And by the time that she came to you for treatment --

A. Um-hum.

Q. -- she had already had the surgery to her right ankle, correct?

A. She had had the initial surgery to her ankle. I also performed surgery on her ankle.

Q. Yeah, but before she came to you, she had an open reduction internal fixation surgery?

A. That's correct.

Q. Okay. And you're familiar with the surgery that was initially performed on Ms. Hu, correct?

A. Yes.

Q. And is that a surgery that --

Can you just explain what the open reduction internal fixation surgery is.

A. Sure. Open reduction and internal fixation is correcting a fracture deformity or instability. So the term open reduction means that the fracture is -- the deformity is reduced, open reduction, reducing the deformity, caused by a fracture in an open way. Meaning not just manipulating the skin but actually cutting through the skin, exposing the bones so

it's open.

And then internal fixation, once it's straight you put inside the body metal to hold the bones in place in a stable way. So open reduction internal fixation it's one of the most common terms used in orthopaedic surgery for doing this type of work.

Q. And with regards to the injury that Ms. Hu sustained --

A. Um-hum.

Q. -- that's what's known as a bimalleolar ankle fracture, correct?

A. Right. So can I just pull out a model?

Q. Sure. I have a model here. You're happy to use yours if you want. Just for demonstrative purposes --

A. Yeah.

Q. -- in order to explain to the jury, would it help for you to use a demonstrative --

THE COURT: Leg.

Q. -- leg, foot, ankle?

A. Foot and ankle.

MR. PELUSO: Your Honor, if I could, please.

THE COURT: Yes, please. Court Officer, if you can get it.

A. Just the small one.

MR. PELUSO: And with your Honor's permission, if Dr. Kaplan would be more comfortable stepping down. I

don't know if --

THE COURT: I don't have any objections if that's what he prefers.

Q. It's up to you, Doctor.

A. Just to show this.

THE COURT: Sure, whatever you prefer.

(Whereupon, the witness stepped down from the witness stand.)

A. So this is a model of an ankle. Right, foot is what hits the floor. The leg comes down and the joint between the leg and the foot it's called the ankle joint. It's made up of three bones. One is the talus, which we often call the ankle bone, see it's sort of a dome shaped bone, it allows the ankle to move back and forth. The shin bone is called the tibia and the smaller bone on the outside of the leg is called the fibula.

These little bumps that you see on the side of the ankle, and there's also one in back but there's more soft tissue here so we don't think of that, they're called the malleoli. It comes from the Greek word that means hills. Bumps on either side.

The types of fractures that occur in ankles are described by what's broken. In Ms. Hu's case, she had what's called a bimalleolar fracture, meaning she broke off two of the bumps. That is inherently an unstable fracture, meaning that if you just left it there and she were to walk on it her foot would

move out of place, it wouldn't stay under the body, and that's why the surgery's required.

Q. So, Doctor, with regards to --

I'm referring your attention to --

A. Yeah.

Q. -- films, radiological films from New York Presbyterian --

A. Yes.

Q. -- taken on, it looks like, three -- 5/29/2016.

A. Yes.

Q. This is Exhibit 6 --

A. Um-hum.

Q. -- in evidence. If you can just, with regards to the model that you're seeing --

A. Yep.

Q. -- explain what we're seeing on the radiographical films.

A. What you're looking at is the fibula, the tibia and the talus. So you're looking at this area blown up. Is there one additional film here on the side? While we're doing that, you can see this fibula is broken. There's a fracture through the fibula and it's actually got what's called a butterfly piece, and that's this triangular piece, as well as a fracture through the fibula which looks spiral. And that's very common that they come off spiral.

There's an additional x-ray that I hope we can get up where we're looking from the side which would show in more detail an additional fracture which you don't see well here but you can definitely make it out. That's in the tibia but it's back here so we're looking at it through the tibia and that's this point. You see here, that is a fracture. You see it here as well just not as well as -- Can I help you with that?

MR. PELUSO: It's just not on the screen yet.

A. That's it right there. Get that up there. Perfect. Okay. So that's looking from the side. Here's the heel in the back. The foot hanging down. The talus dome shaped bone. This is the fibula here. And that fracture we saw earlier -- and this is the tibia. This is the back of the tibia. This little malleolus called the posterior malleolus and you can see it's split down into the joint.

So when I would describe this to another colleague I would call this a bimalleolar, two of the malleoli are broken off, bimalleolar intraarticular meaning a fracture that goes into the joint as opposed to a, you know, straight fracture across the bone, bimalleolar intraarticular displaced fracture and it's unstable.

And so a fracture like that requires. The surgery that we described, the open reduction, meaning reducing the deformity, and internal fixation with metal hardware. We have some other pictures if you want.

Q. Doctor, if you want any other specific films that you want to explain to the jury.

A. I can show the open reduction internal fixation now or we can do it whenever.

(Whereupon, the witness stepped up to the witness stand.)

Q. Sure, that's fine. So, Doctor, as a result of this injury --

A. Um-hum.

Q. -- there was a certain surgery that was performed on Ms. Hu in the hospital, correct?

A. That's correct.

Q. Okay. What you're seeing here as collectively these films are going to be in evidence as Exhibit 10. But if you can just explain what you're seeing here side by side, the images?

A. So this is an x-ray of the fracture side by side to the fracture with the open reduction and internal fixation. This is a postoperative film, meaning after surgery is done. This is the preoperative film, before the surgery was done.

What's been done is that this fibula has been moved into place and a plate has been placed on the back portion, the posterior portion of the bone affixed with one, two, three, four, five screws holding it in place. So it's like a scaffolding placed on a fracture.

One thing you do notice is this butterfly fragment here

is still out of place. Okay. That is not in the joint, it is sitting in the soft tissues. Ideally I would prefer this to be in place. It's not. It actually ended up causing trouble for Ms. Hu later and we addressed that in the surgery I did.

You also see a plate that is affixed to the posterior tibia and that -- Again, you can sort of see that fracture line there. This plate spans that and holds it in place, it's affixed to the bone with three screws. This is an excellent -- We were looking like this before. This is from the side.

So you can see these two plates are on the back of the bone. The tibia is back in place. You can see still see the fracture going into the joint but it's reduced, it's not as wide as it was, and the fibula is stable.

Q. Okay, thank you, Doctor.

Okay. Now, Dr. Kaplan, when Ms. Hu came to you for the first time, do you recall what type of complaints she was making when she first came to you for treatment?

A. Well, what I recorded was pain on both the inside and outside part of the joint as well as pain in the front of the joint when walking. She noted that she was unable to do things like run, she had swelling on a daily basis. She complained of pain and stiffness, difficulty with stair climbing, particularly going downstairs because of a stabbing pain in the ankle.

Q. And when you first --

When you first saw her at the end of 2017, did you make

any recommendations with regards to her treatment?

A. Yes. Initially we talked about the use of antiinflammatory medications. She was using those on a near daily basis. We talked about initiating some additional physical therapy to try to get her motion a little more comfortable and a little more close to normal as she had fairly significant reduced motion in the ankle.

The ankle motion's primarily up and down, which is called dorsiflexion and plantarflexion, but it also involves inverting and everting of the foot, meaning in and out, and she had lost motion in every one of those planes.

Q. Okay. Doctor, when she first came to your office --

A. Um-hum.

Q. -- did you personally have x-rays taken of her right foot?

A. I did.

Q. Okay. And after you reviewed those x-rays, did you have a treatment plan for Ms. Hu after that initial encounter?

A. That initial encounter we talked about the physical therapy and the range of motion.

Q. And did there come a time where you made a recommendation for further surgery?

A. There did.

Q. And do you know approximately when that was?

A. Yeah. So I performed surgery on Mrs. Hu on 5/23/18.

Q. Okay. And you briefly touched on the flexion, the dorsiflexion --

A. Um-hum.

Q. -- the plantarflexion. When you first saw Ms. Hu, did she have limitations with regards to the mobility in her ankle?

A. She did.

Q. Okay. And the --

What were those limitations when you first saw her?

A. Sure. So we measure dorsiflexion, which in the normal ankle and in Ms. Hu's ankle we use her uninvolved side as the normal was twenty degrees but in this side she can only go five degrees up. Okay, plantarflexion, which is going down, in Ms. Hu's normal was sixty degrees, in her injured side it was only thirty degrees. So she lost half her motion in that plane.

In inversion and eversion, which is moving the foot in and out, she had ten degrees of inversion versus fifteen degrees on the uninvolved side and as far as eversion, going out, she had no motion going out. That was where her -- the primary fracture and pain was. No motion going out versus normal five degrees on the left.

Q. And within a reasonable degree of medical certainty, were these limitations in motion directly caused by the injury that she sustained as well as the subsequent surgery that she was forced to undergo?

A. I believe without question that those limitations of

motion were caused by the initial injury and the continued pain she was having and the abnormality in the joint that occurred at the time of the accident.

Q. Okay. And with regards to the limitations and the range of motion, how did you perform those tests?

A. Those tests are measured -- We have a standard way of doing things, which is using an instrument called a goniometer. It's basically a tool that measures ankles. You hold it centered about the joint and then you ask the patient to move. We also do something that's called active motion, meaning the patient actively does it.

We do something called passive motion which is to try to move it further. I usually take that motion as the real motion because it's irrespective of pain or fright, things like that. It's the motion that I can get out of the joint and that's what we recorded.

Q. And the limitations with regards to the range of motion --

A. Um-hum.

Q. -- throughout her entire -- essentially in every direction that her ankle would move that would affect her ability to walk?

A. It does, yes.

Q. Okay. And with regards to the treatment plan that you provided her for surgery, when is it that she eventually

underwent the surgery that you personally conducted?

A. Yeah, so about six months after I first saw her we decided surgery was a good option for her. So on 5/23/18 I performed a surgery to remove the lateral plate, the plate that was over the fibula, and the screws associated with it, as well as remove a bone spur that was caused by that butterfly fragment that healed sort of sticking out and it was painful to her.

Q. And so that was --

The surgery that you performed was only to remove a portion of the hardware that was inside of her ankle, correct?

A. That's correct. Hardware, it's fine if you leave it in. There are risks with having hardware in your body but there are also risks with surgical dissection and things like that. So I usually only recommend taking out hardware if it's what we call offending hardware, meaning it's giving you a problem.

I also felt that this bone spur, which was a sharp piece of bone that you could feel through the skin and was obviously irritating the skin and the tendons around it, needed to come out in order to try to improve her situation.

Q. Okay. And other than the limitations in the range of motion --

A. Yeah.

Q. -- were there any auditory problems that she had with regards to cracking and popping, things like that?

A. She does have cracking and popping still in her ankle,

that's called crepitus. Crepitus is the medical term for what you hear in an abnormal joint. Normally our joints move smoothly, they slide and glide. When you fracture the joint surface it becomes irregular. Even if you put it back as best as you can it's not a hundred percent normal and it is usually associated with cracking and popping just as an indication of an abnormal joint.

It's also one of the key indicators of post-traumatic arthritis of a joint. Meaning a joint that's associated with not smooth motion, it's associated with limited motion, it's associated with pain, swelling, crack, popping.

Q. Okay. And with regards to --

You indicated there was a trauma related arthritis; is that correct?

A. Yeah.

Q. And did you --

What is it that you found with regards to traumatically induced --

A. Um-hum.

Q. -- arthritis with regards to Ms. Hu?

A. So Ms. Hu continues to have -- I most recently saw her a couple of months ago. She continues to complain of pain. She continues to have popping and cracking in the joint. She continues to have limited motion. Those are all findings associated with this post-traumatic arthritis.

Arthritis, again is a general term that's associated with irregularity of the joint surface and causes pain, swelling, limited motion. It's associated with activities and weather changes, things like that. And there are many different types of arthritis. There's arthritis from getting old. There's arthritis from rheumatoid problems.

That's not the case here. This is called post-traumatic arthritis meaning the arthritis and the associated symptoms are from the trauma.

Q. Okay. And with regards to the progression of arthritis --

A. Um-hum.

Q. -- does trauma related arthritis progress faster than age related arthritis?

A. I'm not sure I know how to answer that question. What I will tell you is that any arthritis once it's there progresses. Ms. Hu has no symptoms or signs of arthritis on her uninvolved joint. So the fact that she has arthritis in the joint that she fractured is an indication not only that it was caused by that fracture, that's when it started, but it's also permanent. She still has symptoms of it.

And the natural history of any arthritis is that it's progressive over time. So, you know, in May of 2016 that's when her arthritis started in that ankle and it's progressed over time and it will continue to progress. It's permanent and it

will worsen over time.

Q. And within a reasonable degree of medical certainty, was the competent producing factor of the traumatically related arthritis that she has and will continue to have is that caused by the injury that she sustained in May of 2016?

A. Yeah, I think it started exactly with that injury, that's right.

Q. Okay. And how is it that you're able to determine that?

A. With a reasonable degree of medical certainty. She has no symptoms or signs of arthritis in her normal joint. She has signs and symptoms of arthritis in her fractured ankle which began on the day of the accident, so I mean it seems to follow.

Q. And with regards to arthritis, is that essentially just bone-on-bone --

A. No.

Q. -- grinding or is it something else?

A. Yeah, it's any irregularity of the joint. The end stage of it is bone-on-bone. Meaning when you look at an x-ray it looks like the two bones are touching. If we can put one of those x-rays back up.

Q. Sure.

A. Can we put any x-ray up.

Q. Any x-ray?

A. Yeah, that's fine.

In an x-ray you see there appears to be a space between the bones. That's not air and it's not fluid. What's in-between those bones is a layer of cartilage. When you look at the end of a chicken bone you see a smooth, shiny, pearly white end, that's called cartilage.

That's the joint surface and it's very smooth, you know, like a chicken bone. It's smooth, it looks like a pearl and it moves without friction, without noise. When you break that surface, the cells, which are living cells, cartilage, some of them will die off and they will not be smooth anymore and that's what you hear when you hear an abnormal joint cracking with motion.

When we describe bone-on-bone arthritis, we've all heard that term, what that means is that cartilage layer which is in-between those two bones is wearing away and the bones are getting closer together so that the x-ray picture appears to be bone-on-bone as opposed to having a space between it. So over time the end stage of any type of arthritis is usually bone-on-bone arthritis.

Q. And now, Doctor, Ms. Hu from 2017 up until --

MR. PELUSO: I'll withdraw the question.

Q. You last saw Ms. Hu, you testified, in January of 2025, correct?

A. Yes, correct.

Q. And before that, when was the last time that you saw

her?

A. Before that, I had seen her in the summer of 2003.

Q. Okay. Summer of 2023?

A. Twenty three. Twenty three, sorry, yes.

Q. Now, with regards to treatment for this arthritis, what are her options here moving forward?

A. Sure. So let's start with the -- Well, we already said which is arthritis is permanent and it's progressive, it gets worse over time. So what do you do? You can treat it as the symptoms come. You can treat it with antiinflammatory medicines because inflammation is the root cause of the pain. Irritation in the joint causes inflammation, inflammation causes pain. Treat it with antiinflammatory medications either by pill, by gel or by injection.

You can treat it with physical therapy which is to keep the joint moving and to keep the joint -- the muscles around the joint as strong as possible so it feels stable. At the end stage of arthritis you can do surgery. If it's bone-on-bone you can do what's called a fusion surgery to remove any motion between the two bones because that's what the irritant is, the abnormal motion. You can do ankle replacement surgery, although it is not commonly done. But basically those are your options.

Q. And with regards to the treatment that she has received from you --

A. Um-hum.

Q. -- it's when there are complaints she comes to you and that's it?

A. Yeah. I mean again, there's not much for me to do at this point except watch it over time. If she has a specific problem, if it's a time of increased pain we can talk about additional antiinflammatory medications, different types of antiinflammatory medications. We can talk about exercises to do at home or formal physical therapy but there's not active treatment to say, it's more of an observational treatment at this point.

Q. So, in other words, the damage is done and now she just has to deal with it?

A. Again, in May of 2016 the damage was done, yeah, and it's just this is the sequela of that injury.

Q. From this point going forward all she can do is manage the pain?

A. That's correct.

Q. And the pain is caused by the arthritis that is permanent and progressive, correct?

A. That's correct.

Q. Is there any way to cure arthritis?

A. No matter what type of arthritis we're talking about you cannot cure arthritis, you can treat symptoms.

Q. And other than --

You mentioned about home exercises.

A. Um-hum.

Q. Would that include stretching and things like that?

A. That's what it is; stretching, balancing.

Q. And over-the-counter medications, when there are flare-ups or it's worse than it usually is is that when you take over-the-counter medications?

A. Yeah. I mean, people discount over-the-counter medications saying it's not a prescription but basically Motrin that you buy over the counter is what I would prescribe just different doses.

Q. And with regards to Ms. Hu's prognosis --

A. Um-hum.

Q. -- what would you say with regards to her prognosis moving forward?

A. Well, prognosis means looking into the medical future and predicting what will be based on what has been. And Ms. Hu does not have a good prognosis. She has poor prognosis because she does have post-traumatic arthritis. Post-traumatic arthritis, feel like I'm a broken record, but it's permanent and it's progressive, it gets worse over time.

And so we just have to see what the sequela of that will be and to what degree it will be over time but it is not going away. It is continuing to bother her and she still has limited motion, pain and limited function.

Q. And when you actually performed the surgery that

removed the hardware --

A. Um-hum.

Q. -- from her ankle --

A. Yeah.

Q. -- were there voids that were left in her ankle?

A. There are voids left in the bone where the screws come out. In fact, probably in my most recent x-rays if you have them you can still see those voids. They do fill in with fibrous tissue, sometimes they will calcify. But, yeah, they're still there.

Q. So, Doctor, I think you can see on the right, is this?

A. Oh, is that my post-op film?

Q. Sure. Yeah, this is the post-op film from June of 2018.

A. Right. So this is with the hardware. This is without the hardware. This chunk of bone is taken off. This chunk of bone has been taken off. It's still pointy a little bit but not like it was. Here's where the plate was, see the screw holes right there.

Q. All right. And the limitations that Ms. Hu had in reference to her range of motion, those --

A. Um-hum.

Q. -- those have been somewhat consistent throughout? Does she still experience those limited range of motion?

A. She still has limited range of motion. We were able to

improve the range of motion by taking the hardware and that offending piece of bone out but she still has, you know, less than -- she still has about half normal motion in her ankle.

Q. So, Doctor, just with regards to the number of times that you've testified in court --

A. Um-hum.

Q. -- for orthopaedic injuries. Has there ever been a time where you have been denied qualification as an expert witness?

A. No.

MR. PELUSO: Your Honor, with the Court's permission, I'd just like to, as a formality, recognize Dr. Kaplan as an expert witness.

MR. PEARSALL: No objection.

MR. PELUSO: In the field of orthopaedics.

THE COURT: So ordered.

MR. PELUSO: Thank you, your Honor. Thank you, Doctor, I don't have anything else for you at this time. Thank you, Judge.

THE COURT: Thank you, counsel.

MR. PEARSALL: Thank you, your Honor.

CROSS-EXAMINATION

MR. PEARSALL:

Q. Doctor, how are you?

A. How are you?

Q. Good.
A. Good.
Q. Now, Doctor, when you first saw Ms. Hu --
A. Um-hum.
Q. -- in December 2017 --
A. Yeah.
Q. -- how was she referred to you? How did she come to you?
A. I don't know the answer to that.
Q. And what was her occupation in December of 2017 when you first saw her?
A. Let's see. I do not have that written down.
Q. Is that a piece of information that an orthopaedic surgeon such as yourself would like to know if this is an ankle injury?
A. Not necessarily.
Q. If she's a person who works on her feet a lot, like a waitress, is that something that you would have liked to have known at that time?
A. Again, not necessarily. It's more important to me that we get her back walking and things like that, yeah.
Q. Okay. Was there any indication when you saw her in December 2017 that she couldn't walk?
A. No.
Q. She was ambulating?

A. She was ambulating. She was able to walk, um-hum.

(Whereupon, Senior Court Reporter Vanessa Castillo relieved Senior Court Reporter Caroline Mandato.)

Q. And up until the time that she saw you in December of 2017, had she had any physical therapy up until that time?

A. I don't believe she had physical therapy yet.

Q. And would physical therapy have been medically necessary from May 2016 when she had the initial surgery up until she saw you?

A. That's really up to the physician who initially treated her. I tend to do it.

Q. Okay. So -- and but in your opinion as an orthopedic surgeon, it would be something that would be medically recommended?

A. It's something that I feel would be helpful but, again, it's up to the doctor that's treating her. I'm not second-guessing.

Q. When she saw you in December of 2017 what medications was she taking?

A. She was using Ibuprofen on a nearly daily basis.

Q. Is that an over-the-counter medication or is that a prescription?

A. It can be both. As I said earlier, Motrin is Ibuprofen, 200 milligrams you can buy over the counter. As a prescription I will very often prescribe it as six or 800 milligrams. If you're using over-the-counter, you can simply take three tablets and that's a 600-milligram dose.

Q. And what dosage was she taking when she first saw you?

A. I don't recall.
Q. Is it in your notes?
A. It does not look like it's in my notes.
Q. Now, at what point did you prescribe physical therapy for her?
A. Initially, when I first saw her.
Q. And how many sessions of physical therapy did you prescribe for her?
A. Generally, we prescribe initially 12 visits. So, twice a week for six weeks.
Q. Did she go to physical therapy?
A. She did.
Q. Did she complete your prescription?
A. She did, yes, twice a week for six weeks.
Q. And when was the physical therapy completed, the course of physical therapy?
A. The date?
Q. Yeah.
A. I don't know.
Q. And how do you know that she completed the course of physical therapy?
A. Because I did not know that she did not do physical therapy.
Q. I'm sorry?
A. I had no notes indicating she didn't do the therapy.

Q. You have notes that she did do physical therapy?

A. That was the plan so, no, I would've likely noted that she did not.

Q. Did you receive any kind of communication from the physical therapist that the patient is progressing, what her status is, does she need more? Any communication from the physical therapist?

A. In the ideal world, yes, but in the practical world, we often don't get stuff and in this case I don't have any records from the physical therapist.

Q. Did you ask her at some point, are you going to physical therapy?

A. I'm sure I did. I don't have it written in my notes. Again, I would have likely noted that she had not done therapy because I would've encouraged her to do it again.

Q. Okay. But fair to say you don't have any record in your chart whether she went or not?

A. That's correct.

Q. Whether she didn't go?

A. Correct.

Q. Whether you asked her?

A. I don't have a note of that, that's correct. That's not my standard.

Q. And this lady, I understand speaks Mandarin?

A. She does.

Q. Did you have difficulty communicating with her?

A. No. She always came with a translator.

Q. And had she seen any other doctors from the time that she had her surgery at New York Presbyterian, the initial open reduction internal fixation, up until the time that she saw you?

A. Not that I'm aware of. Just the doctor who operated on her.

Q. Did she, if you know, did she receive any opioid, pain medications following the open reduction internal fixation?

A. I would have to go through her record from New York Presbyterian. I would suspect she did. She certainly had opioid pain medication after my surgery, it's pretty standard.

Q. After your surgery in May 2018 was it?

A. Yes.

Q. You prescribed opioid medication for her?

A. I did.

Q. What did you prescribe for her?

A. I prescribed --

Q. Was it Percocet?

A. Usually, yes. Let's see. Yes, Percocet 525, 40 tablets.

Q. And for how long did she take that?

A. That's supposed to be about a week's worth.

Q. Do you know if she completed that prescription?

A. Don't know. Don't recall.

Q. Did you refill the prescription for her?
A. I never refill a post operative prescription. Narcotics is a one-shot deal in my practice.
Q. After the May 2018 surgery where you removed the hardware, did you refer her for any other physical therapy?
A. I did.
Q. And for what length of time was that?
A. Um, let's see. She had physical therapy two other times for, again, six weeks, twice a week in my prescription.
Q. I'm sorry, Dr. Kaplan, I lost you. Six weeks?
A. Twice a week at my prescription.
Q. And same as before, did you ever determine whether or not she was attending physical therapy?
A. It was my understanding that she was but, again, I don't have a record from -- no therapist has sent me notes.
Q. Okay. If the physical therapist don't send you notes, how is it that you know that the patient is benefitting from the physical therapy?
A. I examine her.
Q. And how many times in all did you see her in 2018?
A. Let's see. 2018, looks like seven times.
Q. And, Dr. Kaplan, did you see her in 2019 at all?
A. No.
Q. How about 2020?
A. Did not see her in 2020.

Q. How about 2021?
A. Not in 2021.
Q. 2022?
A. No.
Q. You did see her in August of 2023?
A. I did.
Q. Do you know how that visit came about, how she came to you at that time?
A. I'm not sure what you're asking.
Q. In other words, why did she see you at that time after several years?
A. She called and made an appointment and we took some X-rays of her ankle. At that time she was still having discomfort.
Q. Had the complaints that she reported to you in August 2023 changed at all from when you initially saw her?
A. Certainly. The removal of the hardware had been somewhat helpful for her as far as the pain complaints but she still had the arthritis in the ankle.
Q. Aside from the complaints of pain, any improvement with her ability to go up and down stairs cases?
A. I don't recall. I didn't note that one way or the other.
Q. How about distance that she could walk?
A. I didn't record that either.

Q. Any activities that she enjoyed prior to this accident that she had difficulty doing when she saw you -- that she reported having difficulty doing when she saw you in August 2023?

A. I do not recall. I did not record that. This was primarily an X-ray visit to check on her fracture.

Q. Now, according to your chart notes, I think it's the March 8, 2018 entry document, you indicate that this lady has good EHL and FHL strength?

A. Yes.

Q. Could you just tell us what that is?

A. Sure. Those are the two tendons that work the big toe. EHL is extensor hallucis longus, FHL is the flexor hallucis longus.

Q. Is that a significant finding for you that you would put in your notes?

A. It depends on the day and what the complaints were. Yeah, it helps with the stability of the ankle.

Q. I guess --

A. It helps with the stability of the ankle and so I put it in my note that day.

Q. So, I guess my question is, what does that mean in lay terms that she has good EHL and FHL strength, what does that mean?

A. It means she can move her toe up and down and that

indicates she can push off her toe which usually I would record it.

Q. Is that a test or measurement that you would do with a patient who does have an ankle fracture?

A. Say that again?

Q. Is that a common test that you would do for a patient who has an ankle fracture like this?

A. Yes and no. Depends on the complaints.

Q. Well, what particular complaints did she have that cause you to take that measurement?

A. She was probably complaining about pain at that time.

Q. Does the EHL and FHL strength have anything to do with arthritis?

A. Not in her ankle, no.

Q. Did you note my atrophy about the ankle when you examined her?

A. I think you mean swelling about the ankle?

Q. No, atrophy. Did you notice any atrophy?

A. Atrophy is a measure of the muscle bulk. There's no muscle at the ankle so that question doesn't track for me. There is atrophy of her calf muscle but not the ankle itself.

Q. Did you find atrophy in her calf?

A. She has -- when you measure around the calf she's got a centimeter-and-a-half of atrophy.

Q. And did you take the same measurement on the left-hand

side?

A. Yes. That's how I noted the difference. So, you measure one side versus the other. On her right side, 37 centimeters around; on the left side, 38-and-a-half centimeters around.

Q. And were you paid for her medical treatment?

A. I believe so, yeah.

Q. Okay. Do you have a lien, are you holding a lien or did you get paid out of it?

A. I have not looked at her bill but it's possible to have a lien of some amount but I was certainly paid for a portion of her medical treatment.

Q. With respect to the range of motion findings that you had, I think you said the better test or the more telling test is it the active or the passive?

A. The less subjective, meaning in the patient's control, is the passive motion.

Q. Is that where you actually move her foot with your hand?

A. That's correct.

Q. Is it still not possible for the patient to restrict motion even when you're doing that?

A. Is it possible? Yeah. But it's, you know, I've been doing this for years, I can tell the difference.

Q. In other words, you're not going to force her?

A. That's the whole point.
Q. Even to the point of pain?
A. Yes.
Q. And did you do that with this lady?
A. I pushed it as far as I could, yeah. She had discomfort complaints when she did it, she had discomfort complaints when I did it but my range of motion is as objective as possible in my opinion.
Q. Now, you prepared a narrative report in this case?
A. I did.
Q. For Ms. Hu's attorney?
A. That's correct.
Q. And anywhere in that report, did you tell her attorneys that she needs surgery in the future?
A. I didn't -- this was not written to tell her attorneys anything, this was a medical report. I don't specifically outline surgery because I can't guarantee that she's going to need surgery but what I did indicate which is what I indicated here, the post traumatic arthritis of the right ankle is not only permanent but progressive in nature and will worsen over time and she requires ongoing treatment and observation. So, surgery is certainly a possibility but I can't tell you for sure she's going to need it.
Q. But you didn't note that that's a possibility?
A. I noted she had a permanent ongoing problem that

required continued observation. So, no, I didn't mention surgery again because I'm not in the business of saying she needs surgery or she doesn't but it's certainly a possibility.

Q. Okay. Do you have any plans scheduled for this lady currently for surgery?

A. No.

Q. And the last time you saw her was in January of 2025?

A. That's correct.

Q. Okay.

MR. PEARSALL: Thank you, Doctor.

THE COURT: Thank you.

MR. PELUSO: Brief re-direct, your Honor?

THE COURT: Yes.

RE-DIRECT EXAMINATION

BY MR. PELUSO:

Q. Now, Doctor, with regards to physical therapy, in a perfect world somebody could have physical therapy as much as they want, right?

A. In a perfect world, yeah.

Q. And with regards to physical therapy itself, there are certain techniques that are learned during physical therapy, is that fair to say?

A. By the patient?

Q. By the patient.

A. I mean, a whole portion of physical therapy is being

taught what to do at home. You know, in the ideal world you go to therapy every day but that's not practical, you just don't do that. You go to therapy for a couple of weeks and then you do what they teach you at home. You learn what to do.

Q. You learn what to do to keep yourself somewhat mobile, right?

A. What feels good, yeah.

Q. Understood. And you were questioned with regards to atrophy, correct?

A. Yes.

Q. Now, what is atrophy, that's muscle loss?

A. It's loss of muscle bulk. So, it's measured by, in this case, by measuring around the calf muscle which is the muscle that works the ankle. Since there is limited motion of the ankle, the muscle sees limited motion and exertion so it doesn't build up as much as the normal side which sees more motion. And the best way that we have to note that is just measuring around the equivalent points, normal versus abnormal.

Q. And the calf muscle which is above the ankle that was injured and that had multiple surgeries to it --

A. Right.

Q. -- that atrophied, correct?

A. It is smaller on the right than the left.

Q. What would that indicate to you?

A. That indicates that there's an ongoing problem. It's

an objective finding that means it's not in the patient's control, it's not in my control. It's an objective finding, that there's less motion in the joint that is being used abnormally and that she's got weakness as less muscle.

Q. Okay.

MR. PELUSO: Thank you, Doctor.

MR. PEARSALL: Nothing else, Judge.

THE COURT: Thank you, Doctor.

(At this time, the witness was excused and left the courtroom.)

THE COURT: Have a great weekend, I'll see you guys on Monday.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exited the courtroom.)

MR. PELUSO: Your Honor, we consolidated the films that were admitted by your Honor into evidence, just so there's a physical record of it.

THE COURT: I'll take it.

MR. PELUSO: In the event that anyone wants to look at it, this will be Plaintiff's Exhibit 10.

(Whereupon, the above-mentioned document was marked as Plaintiff's Exhibit 10 in evidence.)

THE COURT: Okay.

MR. PELUSO: Thank you, Judge.

THE COURT: You want to give it to me or?

MR. PELUSO: Yes.

MR. PEARSALL: Judge, you're good with the charges, the damages charges?

THE COURT: I haven't taken a look at them but --

MR. PEARSALL: As long as you have them.

THE COURT: Yes. Yes.

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CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE ORIGINAL STENOGRAPHIC MINUTES TAKEN OF THIS PROCEEDING.

_____
CAROLINE MANDATO
Senior Court Reporter

_____
VANESSA CASTILLO
Senior Court Reporter

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