SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS : CIVIL TERM : PART 28

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CARLOS PAIBA,

Plaintiff,

-against- Index No. 704365/2019

56-11 94TH STREET COMPANY LLC AND GINSBERG HOLDINGS L.P.,

JURY TRIAL

Defendants.

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Supreme Courthouse
88-11 Sutphin Boulevard
Jamaica, New York 11435
March 13, 2026

B E F O R E:

THE HONORABLE LAURENTINA MCKETNEY-BUTLER,
J U S T I C E of the Supreme Court

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

WILLIAM SCHWITZER ASSOCIATES
Attorneys for the Plaintiff
820 2nd Avenue - 10th Floor
New York, New York 10017
BY: RORY M. SHECTMAN, ESQ.

PERRY, VAN ETTEN, ROZANSKI & KUTNER, LLP
Attorneys for the Defendants
225 Broadhollow Road - Suite 430
Melville, New York 11747
BY: THOMAS F. MAHER, ESQ.

VALERIE MCNALLY
VICKY ZUBIRIA
Senior Court Reporters

THE COURT CLERK: All rise. The judge is entering. Queens Supreme Court Part 28 continues to be in session with the continued jury trial, Index 704365/2019, in matter of Carlos Paiba versus 56-11 94th Street Company LLC and Ginsberg Holdings LP.

Your Honor, all appearances remain the same.

THE COURT: Thank you. You can have a seat. Good morning all.

MR. MAHER: Good morning, Your Honor.

MR. SHECTMAN: Good morning.

THE COURT: Any issues we need to discuss before we bring in the jury?

MR. SHECTMAN: I don't believe so.

MR. MAHER: I don't believe so, no.

MR. SHECTMAN: May I approach for a moment?

THE COURT: What is the issue?

MR. SHECTMAN: Can we go off the record?

THE COURT: Yes.

(Whereupon, at this time, an off-the-record discussion was held.)

THE COURT: We're ready for the jury.

(Whereupon, there was a pause in the proceedings.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time, the jury entered the courtroom.)

THE COURT CLERK: All counsel stipulate to the presence and the seating of the jury?

MR. SHECTMAN: Yes.

MR. MAHER: Yes.

THE COURT: Good morning, jurors. You may have a seat. I hope you had a good evening.

Can we get the podium moved?

So, plaintiff is going to continue with their case this morning and I am going to turn it over to the plaintiff.

Are you ready?

MR. SHECTMAN: I am ready.

Good morning. May it please the Court, I would like to call Dr. Jeffrey Kaplan. I believe he is in the hallway, the second bench in the hallway.

(Whereupon, there was a pause in the proceedings.)

THE COURT CLERK: You can go to the witness stand. Remain standing to be sworn in.

Your Honor, may I swear in the witness?

THE COURT: Good morning. How are you?

Yes.

THE COURT CLERK: Raise your right hand. Do you swear or affirm that the testimony you are about to give shall be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE COURT CLERK: You can be seated. Adjust the mic. You can move it over and adjust it as you need to. Once you are ready, please state your first and last name and then spell your first and last name.

THE WITNESS: Jeffrey Kaplan, J-E-F-F-R-E-Y K-A-P-L-A-N.

THE COURT CLERK: Give your complete mailing address for the record.

THE WITNESS: Office is at 160 East 56th Street, New York, New York 10022.

THE COURT: Good morning, Doctor.

THE WITNESS: Hi. Good morning.

THE COURT: You may begin.

MR. SHECTMAN: Thank you.

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

DIRECT EXAMINATION

BY MR. SHECTMAN:

Q Good morning, Dr. Kaplan.

A Good morning.

Q Doctor, what is your current occupation?

A I am an orthopedic surgeon.

Q Would you kindly explain to the jury what it means to be an orthopedic surgeon? In other words, what is your area of specialty and what do you deal with on a day-to-day basis?

A Orthopedics is the study of bones and joints and the supporting structures of the bones and joints, so muscles, cartilage, tendons, ligaments, things like that.

And it has to do with injuries or abnormalities to those structures and then the treatment of those injuries or abnormalities, either with conservative measure, meaning things like medications, injections, physical therapy, or if those things don't work, then surgical treatment of those problems.

Q In your specialty now, is there a particular area of the body that you find yourself dealing with more than usual, one part of the body more than others?

A I do sports and trauma, so that's generally shoulders, knees, ankles for the most part.

Q Doctor, do you have experience reading MRI films?

A Yes.

Q Would you tell the jury in a given week how many different MRIs you read, whether it's an MRI of the knee or shoulder, how many MRIs in a week do you believe you read?

A I never thought of it that way. It's sort of random, depends on who I am seeing.

I probably look at 20 to 30 MRIs a week.

Q Are you licensed to practice medicine in the State of

New York?

A Yes.

Q When were you so licensed?

A 1994 in New York.

Q Could you tell us a little bit about your educational background, starting with college, medical school and any other schooling you have had prior to today?

A Surely. I went to college the Yale University. When I graduated from college, I went to medical school here in the City at Columbia University. When I graduated from medical school, I did a training program in orthopedic surgery; it was a five-year program. I did that at a place called the Campbell Clinic in Memphis, Tennessee. The Campbell Clinic was the first orthopedic training program in the United States.

Following that, I moved back in New York where I have been in private practice ever since.

Q Doctor, are you board-certified in any particular specialty?

A I am. I am board-certified in orthopedic surgery.

Q Would you explain -- withdrawn.

Is every orthopedic surgeon board-certified?

A No.

Q Is this somewhat of a higher credentialing, for lack of a better phrase?

A It's simply additional qualifications that you can

receive after college, medical school and a residency training program. You take a series of examinations over a number of years. They are given by a panel of expert physicians. In my case, it's the American Board of Orthopaedic Surgeons. You take both written exams and oral examinations and if that board feels that you've reached certain levels of expertise and knowledge, then you are deemed board-certified.

Q Doctor, do you currently have or have you ever had any hospital affiliations?

A Sure.

Q Could you tell us which hospitals you currently have or ever had privileges at?

A I am on staff presently at New York Presbyterian Hospital, Mount Sinai Hospital systems in the City. Those are my primary hospitals. I've been at numerous hospitals over the years.

Q Have you ever held teaching positions, either now or in the past?

A I have an academic appointment at Cornell, which is New York Presbyterian Hospital, where I teach residents techniques of surgery and things like that. I also teach at Mount Sinai and have a secondary academic position there.

Q Have you ever published any works in your specialty?

A I have. I've done articles having to do with anatomy, having to do with surgical techniques, having to do with

describing a new surgical technique for trauma to the knee.

Q Are you currently or have you ever been a member of any professional medical associations?

A Sure. I'm a member of the American Medical Association, American Trauma Association, American Board of Orthopaedic Surgeons. I'm a member of the New York State Athletic Commission. I am the orthopedist for the Boxing Commission.

Q When you say orthopedist for the Boxing Commission, what is that?

A I'm a ring doctor, so when there are boxing matches in New York, they have to be staffed by physicians and I'm an orthopedist.

Q Doctor, do you maintain an office for the practice of your specialty?

A Yes.

Q Would you tell the jury where is that office or if you have multiple, where those offices are?

A I have one office in Midtown Manhattan on East 56th street.

Q When patients come into that office that you have, any idea as to percentage of the patients coming to you as a result of trauma versus some type of nontraumatic event?

A My office is called New York Ortho Sports Medicine and Trauma. The majority of my patients are involved in some sort

of trauma, whether it's a sport injury or a traumatic injury from, say, a car accident or a construction accident or anything like that.

Q Doctor, are you familiar with the term meniscus?

A Yes.

Q Could you tell the jury what a meniscus is?

A Sure. Can I -- I have a model of a knee which I think is probably helpful.

MR. SHECTMAN: Your Honor, should I mark it? Whatever the Court prefers.

THE COURT: Have you seen it?

MR. MAHER: No, I haven't.

MR. SHECTMAN: I was going to mark it for ID.

THE COURT: It's a model or --

THE WITNESS: It's a model.

THE COURT: Any objection?

MR. MAHER: In principle I don't have any objection. I just do think -- I haven't seen it and he is just pulling it out. You know, it seems a little improper.

THE COURT: Please go further go ahead.

Q Did you bring a model with you of the knee?

A Yes.

Q Is that an anatomically correct model?

A Yes.

Q Would it help you in talking to the jury, meaning when

you are giving your testimony to the jury, would it help you to use the model in conjunction with your testimony?

A It would help demonstrate what the structures are in the knee.

MR. SHECTMAN: I would ask, Your Honor, if he could kindly show it to Mr. Maher to examine it to see if it's accurate.

THE COURT: We'll do it outside the jury. Can we excuse the jury for a moment so that Mr. Maher could look at the model?

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, at this time, the jury exited the courtroom.)

THE COURT: Off the record.

(Whereupon, at this time, an off-the-record discussion was held.)

MR. MAHER: Your Honor, now having had an opportunity to look at the model, for demonstrative purposes, I don't have any problem with Dr. Kaplan using it to illustrate. I would object to it being introduced into evidence, but I appreciate being afforded an opportunity to look at it before the Doctor is already testifying about what it shows.

THE COURT: Okay.

MR. SHECTMAN: I am only going to use it for

illustrative purposes, not to put into evidence.

THE COURT: Let's get the jury back in, please.

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time, the jury entered the courtroom.)

THE COURT CLERK: All counsel stipulate to the presence and seating of the jury?

MR. SHECTMAN: Yes.

MR. MAHER: Yes.

THE COURT: You can have a seat, jurors. Everyone could have a seat.

Counsel, you may proceed.

MR. SHECTMAN: Sure. As I was saying, I would like to mark the model for identification, just for the Doctor to illustrate as he is speaking to the jury.

THE COURT: Okay. Have you made any motion to move this doctor in as an expert?

MR. SHECTMAN: I will after the testimony regarding his familiarity with the meniscus and another part of the body, I will.

THE COURT: We don't need the illustrative evidence at this point.

MR. SHECTMAN: What I will do at this time, Your Honor, I will move to have Dr. Kaplan considered an expert in the field of orthopedic surgery.

THE COURT: Any objection?

MR. MAHER: No objection.

THE COURT: Very good. Then Dr. Kaplan is deemed an expert and you may proceed.

MR. SHECTMAN: Thank you, Your Honor. May we mark the model for identification?

THE COURT: What number are we up to?

THE COURT OFFICER: Going to be Number 8, Your Honor.

(Whereupon, at this time, the model of the knee was marked as Plaintiff's Exhibit 8 for identification, by the Reporter.)

THE COURT OFFICER: Marked Plaintiff's 8, model marked for ID.

BY MR. SHECTMAN:

Q Doctor, we have your model in front of you, correct?

A Yes.

Q Would you tell us, what is that a model of?

A It's a model of a right knee.

Q By the way, this injury is to the left knee. Is there any difference between the left or right knee?

A They are mirror opposites of one another.

Q It's just happens that one is the right knee?

A Mostly what they make the model of are right-sided. I am not exactly sure why.

Q Doctor, if you could you walk us through, holding up the model, the different structures we see on the knee.

A Sure. So the knee is the joint where the upper leg meets the lower leg. It's made up primarily of three bones; the thigh bone, called the femur; the shin bone, called the tibia; then on the front, the patella, which is the kneecap. All of those bones fit together to form a hinge.

Layered within the bones are supporting structures of the bones and joints. And I was asked about the meniscus. The meniscus is a piece of cartilage that sits inside the knee and there's one on the inside part of the knee, meaning the inside part of the knee, and one on the outside part of the knee. The inside part of any body structure is called the medial part and the outside is called the lateral part.

When we look in the knee, you see these represented here, the blue rings, there's the medical meniscus and a lateral meniscus. What they do is they serve to cushion between the thigh bone and shin bone as well as deepen the socket so that the thigh bone sits into those cartilages and allows for smooth motion with flexion and extension of the knee.

The kneecap sits on the front in a groove of the thigh bone, the end of the thigh bone, and it's connected to your thigh muscle, your quadricept. When the quadricept tightens, it straightens the knee. When the muscles on the back, called the hamstring, tighten, it bends the knee.

Also supporting the joint are some structures called ligaments. Ligaments are like little ropes that go from one bone to the other. You got one on each side of the knee, again the lateral and medial, so this would be the lateral collateral ligament; this would be the medial collateral ligament.

And there are two ligaments that cross inside the knee from front to back. The one you see in the front is called the anterior cruciate ligament, or ACL people call it. Anterior means front. There's one in the back called the PCL, which is the posterior or back cruciate, crossing, ligament.

Q You told us the functionality of the meniscus. What is the purpose of the anterior cruciate ligament?

A Any ligament which stretches, as I say, like a ligament from bone to bone, is to stabilize the joint further, so you have multiple structures that stabilize the joint, keep it in place. There's the shape of the bones, the cartilages inside which help support and pad.

And then the ligaments, by stretching from one bone to the other, it acts like a seatbelt or check brake, so the lateral collateral ligament here keeps the knee from bending over this way. The medial collateral ligament keeps the knee from bending this way.

The crossing ligaments, the ACL, keeps the knee from shifting forward so it won't shift forward. If you tear your ACL, you shift forward. If you tear your PCL, you'll shift

backwards.

Q Thank you, Doctor.

Now, Doctor, did I ask you to bring your chart with you reflecting your care and treatment of Carlos Paiba over the years?

A Yes.

Q With the Court's permission, I would ask you, Doctor, if I ask you a question and your memory fails of an event or occurrence or fact, you can look at your records to refresh your recollection.

A Okay.

MR. MAHER: Before we -- may we approach? I am not offering something, but I think it needs to be marked if it's going to be used by the Doctor to refresh his recollection.

THE COURT: We haven't gotten to the refreshing of the recollection. If you want to mark the record for ID, we can do that.

MR. SHECTMAN: Sure.

MR. MAHER: I think that would be appropriate.

THE COURT: You have had an opportunity --

MR. MAHER: No, I have not. I would like to have an opportunity to look at it.

THE COURT OFFICER: Marking Plaintiff's Exhibit 9.

THE COURT: Let's show it to the Defendant first,

please.

MR. MAHER: Could we take a brief recess, Your Honor?

THE COURT: Outside the presence of the jury?

MR. MAHER: Yes.

THE COURT: Jurors, you are going to get your steps in this morning. We're going excuse you for a moment.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, at this time, the jury exited the courtroom.)

(Whereupon, at this time, a brief recess was taken.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time, the jury entered the courtroom.)

THE COURT CLERK: All counsel stipulate to the presence and seating of the jury?

MR. SHECTMAN: Yes.

MR. MAHER: Yes.

THE COURT: You may have a seat. Everyone may have a seat.

Counsel, you may continue.

MR. SHECTMAN: Thank you, Your Honor.

BY MR. SHECTMAN:

Q Dr. Kaplan, can you tell us what was the very first date that Carlos came into your office for treatment?

A I'm going to have to look at my notes to tell you that. I first saw him on 3/14/19.

Q Is it your understanding that the date of accident is March 6, 2019?

A That's the history I received, yes.

Q So you saw him for the first time roughly a week after the accident?

A That's correct.

Q Doctor, what is a history when you take a history from the patient?

A History is just interviewing the patient to ask what brings them to the office today, what is bothering them, when it first occurred, things like that.

Q Could you tell me, Doctor, what was the history that you elicited from Mr. Paiba when he first came your office on 3/14/19?

A He indicated he was involved in an accident that occurred at work on March 6th of 2019. He indicated that it was a fall from a ladder. He indicated that he was taken by ambulance to Elmhurst Hospital. I did have some discharge papers from the hospital at that time which indicated the history and that he had undergone some studies, including CAT scans of the abdomen, pelvis, the neck, the low back, the chest,

the head and the left knee.

He also had multiple x-rays. He was told no fractures were present with all the x-rays. And he was advised, I believe, to follow-up with a doctor on the outside.

Q Could you tell me, Doctor, the very first visit, what if any complaint did he make to you regarding physical pain?

A At that time he was complaining primarily of knee pain on the left and low back pain.

Q Doctor, did he report to you a surgical history?

A His past medical history included -- let's see -- no medical illnesses; he had had a knee arthroscopy in 2012 on the right side and he had a --

Q I was going to stop you there, Doctor.

The report -- withdrawn.

When Mr. Paiba reported pain, which knee did he report pain to you?

A To me, it was the left side.

Q But he reported something happened to the right?

A That's correct.

Q In what year?

A 2012.

Q Do you know if he mentioned if it was from an assault or how it came to be he injured that right knee?

A That, I didn't make a record of.

Q Fair enough. Doctor --

MR. SHECTMAN: Actually, Your Honor, may I have the Elmhurst Hospital record, I believe it's in evidence by stipulation of counsel.

THE COURT: What number?

MR. SHECTMAN: It should be dated 3/6/19.

THE COURT: While you are looking for those records, we will mark for ID the Doctor's medical records.

(Whereupon, at this time, the record of Dr. Kaplan was marked as Plaintiff's Exhibit 9 for identification, by the Reporter.)

MR. SHECTMAN: Your Honor, could I be of assistance to help the officer find the records?

THE COURT: No.

MR. SHECTMAN: Your Honor, it should have an exhibit tab on it.

THE COURT: I believe the Court staff knows what they are looking for.

MR. SHECTMAN: I just wanted to help, that's all.

THE COURT OFFICER: Elmhurst Hospital Records.

MR. SHECTMAN: Your Honor, may I hand this, pages 11 and 12 of the hospital records to the Doctor and show it to counsel?

THE COURT: Let's keep the record intact. Give it to the court officer identifying the pages that you want the witness to --

MR. SHECTMAN: Could I put a sticky on it? Is that okay?

THE COURT: Sure. Give the whole record to the court officer. Thank you.

Q Doctor, I handed to you two pages from the record of Elmhurst Hospital with the date of 3/6/19. Could you turn to page 11?

A Okay.

Q There is a Post-It. Could you read what it says there?

THE COURT: Wait.

MR. MAHER: Objection.

THE COURT: Sustained. The purpose of the Post-It was not to identify what you wanted him to read.

MR. SHECTMAN: I want him to read the whole page.

THE COURT: They were to identify the pages. You did not show the defendant what you were looking at?

MR. SHECTMAN: Yes, I did, Judge. I showed him where I was going to read from.

THE COURT: What is your objection, Counsel?

MR. MAHER: There's not really a question. He is just asking him to read from the record. I don't --

MR. SHECTMAN: I will put it in the form of a question.

THE COURT: Counsel, one person at a time. We have had this conversation a number of times over the

course of the days we have been together.

MR. MAHER: If there's something about the record, did the doctor review it in connection with his treatments and diagnosis --

THE COURT: I don't need the full objection. I understood your objection. Your objection has been sustained.

Rephrase the question, plaintiff's counsel, please.

BY MR. SHECTMAN:

Q Doctor, you have reviewed this record?

A Yes.

Q Now, Doctor, as a question, could you tell me what, if any, complaints are made on page 11 that I have marked for you with a sticky?

MR. MAHER: Objection.

THE COURT: Sustained.

Q What, if any, complaints do you see in this certified hospital chart that is in evidence, Your Honor -- Doctor?

THE COURT: You can refer to the page number, Counsel. That's what was agreed.

MR. SHECTMAN: I just did that. I said on page 11.

THE COURT: Counsel, I am not going to entertain a back and forth with you. I made the ruling. I have given

you direction with how to ask the question. You can either ask the question or withdraw the question. That's where we are.

Q My question is: What, if any, complaints of pain were made by the patient on page 11 that you have in front of you?

MR. MAHER: Objection.

THE COURT: Overruled.

A There are complaints on this page recorded from the patient, complaints of entire body pain and left leg pain.

Q Doctor, could you go to page 12, please.

A Yes.

Q Same question regarding page 12. What, if any, complaints were made to the hospital workers in the hospital?

MR. MAHER: Objection.

THE COURT: Overruled.

A On page 12 it indicates complaints of pain of left knee status post fall.

Q Doctor, what is a pain scale?

A Pain scale is a way to try to standardize the amount of pain that someone is complaining of, so we often tell people on a scale of one to ten -- one being the least, ten being the worst -- where would your level of pain fall within that range.

Q Could you tell us, Doctor, what pain scale number was indicated by the plaintiff when asked that question out of ten?

MR. MAHER: Objection.

THE COURT: This is a document that's in evidence, Counsel.

MR. MAHER: Yes, it is.

THE COURT: Overruled.

A It does note that seven out of ten pain scale.

Q Regarding the left knee, correct?

A That's correct.

Q Doctor, could you now go back -- you can put that down for a moment. If you could go back to your office chart, please.

Now, Doctor, did you perform on that first visit of 3/14/19 a physical examination?

A Yes.

Q Could you tell us what you did, what you were looking for and what, if anything, you found?

A Sure. So I was examining to see if the pain that he was complaining to me about correlated to his physical findings and so I recorded the following:

He had tenderness along the lower lumbar processes; that's the bony prominences of the lower back. That he had forward flexion to about 60 degrees and extension to about ten degrees. The normal flexion is about 85 to 90 degrees; normal extension is about 30 degrees.

Q Let me stop you there, if you wouldn't mind.

When you talk about that you found forward flexion to

60 degrees, could you actually demonstrate, with the Court's permission, of course, the motion of forward flexion so we can see what forward flexion is?

THE COURT: He could explain.

MR. MAHER: Objection. I believe this witness is here to testify about treatment to the knee and we're talking about other body parts.

THE COURT: Overruled.

Q Can you demonstrate for us what flexion is with your body?

A Sure. So flexion that I was speaking of is flexion of the low back, which is forward. For example, this way. And extension this way.

Q When you found forward flexion to be 60 degrees, what percent restriction would that be of the normal?

A It's about two-thirds.

Q What percent would that be, if you have to convert to a percentage loss?

A Sixty-six percent.

Q You said extension was to ten degrees. What is normal?

A Normal is about 30 degrees.

Q So what percent limitation did --

A He would have 60 or 70 percent limitation.

Q Doctor, please continue. After checking flexion and extension, what else did you do and what did you find?

A Then I examined his lower extremities. About the knee on the left he had tenderness. Tenderness is complaint of pain when you touch it. He had what I call a positive McMurray test.

The McMurray test is a physical exam test to see if you can elicit a clicking that corresponds to a torn meniscus. So in the days before we had MRIs, we relied on a physical exam finding called a McMurray test, where you bend the knee up and twist side-to-side. If there is a tear in that cartilage that centers the joint, the bone will catch it and click over it. That's called a positive McMurray. He did have a positive McMurray test.

He had knee flexion on the left to 125 degrees. Again, flexion is bending the knee. Normal is about 145, so his was about 125. And he had full extension, which is basically to zero degrees.

There was no instability on testing of the ligaments and I also noted that he walked -- I am sorry. He had crepitus. Crepitus is cracking and popping that you hear when there's an abnormal joint. It could either be from damage to the joint surface, it could be from fluid in the joint or torn meniscus.

And he was walking with a antalgic gait, which means a limp, and at that time he was using cane for support.

Q Doctor, based on your physical findings, the limitation in flexion, the positive McMurray test, the crepitus, just on your physical findings alone, were you able to come up with some

type of differential diagnosis as to what you thought the problem might be without having seen the MRI at that point?

A I certainly in my mind thought I knew what was going on. The diagnosis I gave at that time was based on what we call triage. This was the first time I had seen the patient, so as I pointed out, I examined his back, his knee, just to get an overall picture. I don't generally treat backs, but it's part of the overall picture and the general diagnosis.

And my diagnosis with regard to the knee is a general term called internal derangement of the knee, which means there's something going on in the structures of the knee. Of course, in my mind, I assumed he had a meniscus tear because he had the positive McMurray's test and I assumed he may have some joint surface damage because he had the crepitus, but an MRI shows us with greater accuracy.

Q After your physical examination and the complaints he made to you, did you propose a treatment plan?

A I did.

Q What was your plan, Doctor?

A My plan was to send him for an MRI of the knee as well as an MRI of the low back and then refer him for pain management. A pain management specialist is one that generally specializes in pain that comes from the spine and I sent him to Dr. Matthew Grimm, who works in my office as well.

I advised him about the use of antiinflammatory

medications for pain and inflammation. I put him in a custom low back brace to help relieve some of the tenderness and perceived spasm in the back. And I gave him a prescription for physical therapy.

Q Doctor, are there known symptoms of a meniscal tear?

A Yes.

Q What are they?

A The prime symptom, the classic symptom of a meniscus day is buckling or giving-way at the knee. Buckling and giving-way of the knee, I describe it as the knee sort of jumping out from you as you are walking. It's a feeling of instability of the knee. It generally occurs because the meniscus, when it's torn, will get in between the two bones and your body perceives that reflexively and gives out. That's a classic sign of a meniscus tear.

Q Are there known symptoms for an anterior cruciate ligament tear?

A There are.

Q Could you please tell us what is those are?

A Sure. It depends on how torn the anterior cruciate ligament is. A ligament is a thick structure, like a rope; it's got many fibers. If you tear a couple of fibers, it could be associated with pain, associated with swelling if those fibers contain a blood vessel and it could be associated with instability if it's completely torn.

Q Now, you mentioned you referred Carlos for an MRI of his left knee, correct, among other body parts?

A That's correct.

Q And had you reviewed the MRI of the left knee after it was performed?

A Yes.

MR. SHECTMAN: Your Honor, at this time, if I may, I would like to set up the TV and the imaging so the Doctor can walk the jury through the imaging of the left knee taken on 3/14/19.

THE COURT: The court officer has that?

MR. SHECTMAN: Yes, Your Honor. It's the Kolb Radiology DVD that I see on the table that's in evidence. It would take me maybe a minute or minute and a half to set it up.

THE COURT: We're using the TV?

MR. SHECTMAN: Yes, Your Honor.

THE COURT: It's going to be more than a minute.

MR. SHECTMAN: I can do it quick, Your Honor. I practiced.

THE COURT: You can set up your stuff but the court personnel has to set up the TV.

I am sorry. What is that?

THE COURT OFFICER: It's in evidence Number 1.

MR. SHECTMAN: Plaintiff's 1 in evidence, Your

Honor.

THE COURT: Thank you.

(Whereupon, there was a pause in the proceedings.)

MR. MAHER: Your Honor, may I move this way?

THE COURT: Certainly.

MR. SHECTMAN: I am going to put it down until I get it on the screen.

THE COURT: Okay.

MR. SHECTMAN: Your Honor, with the Court's permission, may I ask the doctor to step down so he can walk us through the MRI imaging of 3/14/19?

THE COURT: Sure.

By MR. SHECTMAN:

Q Doctor, would you mind stepping down?

A It's going to take a bit. I wasn't aware I was going to be doing this.

You have to scroll through. I am not sure how you are set up here. How do you scroll through here? It's not a standard thing.

What we are looking at here is an MRI image of the knee. The MRI takes a three-dimensional structure.

THE COURT: Could we put on the record the date of the MRI? We are looking at the MRI of the left knee, but give us the information.

A This is the MRI of the knee with Carlo's name on it.

It was done on -- the date was --

Q It's on the right side.

A March 14, 2019. This is an MRI image. The MRI could take a three-dimensional object and open it up like a book, so I am just -- imaging that could pick up a three-dimensional object, the MRI can look as if it files through and look at an individual slice within a three-dimensional object.

So the picture here is a picture of the knee. It's the thigh bone on top, the shin bone on bottom. And in between the thigh bone and the shin bone, you see part of the meniscus that the knee joint is sitting in.

THE COURT: Doctor, if you could sit on this side.

MR. MAHER: The way the doctor is positioned, I can't see.

A So what we're looking at is from the outside of the knee, the lateral part, and I know that because I see the small bone there called the fibula starting to show up and the shin bone, the tibia, on top of it. And sitting on top of that is going to be the femur, as we roll through.

Here's the femur and here's the side of the meniscus that we're looking at. As we roll through, the meniscus. We start seeing the back of the meniscus. Rather than it being a black triangle, which is the normal look of a meniscus, you are going to see some fluid appearing against the white where it turns color there. That's a tear in the undersurface of the

meniscus.

As we roll through, the knee from the outside to the inside, we're going to eventually see this anterior cruciate ligament. It's going to appear and start here. It is going to start here and it's going to go up this way here. It's the anterior cruciate ligament like this.

It normally is going to have a very dark, black look. That's a normal look of a ligament, this here. In the mid portion, it's less dark. That means there's fluid in it and it has a partial tear of ligaments. It's basically stretched. It's in line with the normal orientation, but it has fluid in it, indicating that it's stretched, it's not fully torn.

As we move across the knee, we're going to see the lateral meniscus, which looks okay, no fluid in the lateral meniscus there. There is another finding beside the meniscus and the ligament in the bone, which is an injury to the joint surface, which is going to pop up right here. Rather than being a smooth surface, as you would expect, you have this fluid collection and irregularity of the joint surface. That's called an osteochondral injury. Osteo means bone, chondral means cartilage, so it's an injury to the bone surface where the cartilage meets the bone in that area.

Those are findings that are seen on this MRI.

This is the exact same images just put through the computer a different way so that you see the bone rather than

being white like it was in that, it's just the computer sees it differently and that shows better this osteochondral defect, the joint surface injury, as we roll through.

And again, actually it also shows better this very obvious tear in the meniscus here. You can see that white line that slices through the meniscus.

There's your findings.

(Whereupon, the following was recorded and transcribed by Official Court Reporter Vicky Zubiria.)

(Continued on following page.)

* * * * *

DIRECT EXAMINATION

BY MR. SHECTMAN:

Q Great, Doctor.

You can resume your position on the witness stand.

A Okay.

(At this time, the witness returned to the stand.)

THE COURT: Thank you, Doctor.

MR. SHECTMAN: Your Honor, I'm going to disconnect it because I don't need to use this right now, okay.

THE COURT: Okay.

Q Now, Doctor, I believe the next time you saw him was after the MRI was performed, and that was on 4/25/19?

A Let's see. Yes.

Q And can you tell me, did you conduct a physical examination at that time?

A I did.

Q What, if anything, did you do and what did you find?

A On exam he had a positive McMurray test corresponding to the meniscus tear. He had tenderness in the medial joint line which is where the meniscus lives, and he complained of pain with motion. He had 120 degrees of flexion and full extension at that time.

Q Now, Doctor, what was your plan at that point? Meaning, having seen the results of the MRI, he's coming back to you 4/25/19, what was your plan?

A He also was complaining of buckling and pain, which is an important thing, and at that time I asked him to continue physical therapy. But having seen the MRI, given the severity of his complaints, I felt that he was eventually likely gonna need a knee arthroscopy to address those problems, so I requested authorization for that, as well.

Q Doctor, when you said that about buckling, what is the significant, if any, of him still having buckling on the visit of 4/25/19?

A Again, buckling is a indication that there's a tear in the meniscus. Sometimes those will go away as the knee moves. You can -- I call it chew up the meniscus. It's like your bones or teeth and they can macerate the end of the torn portion. And sometimes people stop buckling after a period of time, that's why we do conservative treatment. But he was still having buckling and he was having associated pain with that buckling, so I did not have high hopes for his ability to normalize with the conservative measures even at that point.

Q Doctor, if I can turn to June 6th of '19.

A Okay.

Q And just to move things along, any difference from the 4/25/19 visit or more or less the same?

A Essentially the same.

Q What was your plan at that point?

A At that time, I gave him an injection of a

anti-inflammatory medication called a steroid; Celestone is the name of the medicine. We do that to get rid of any inflammation inside the joint that's caused by those abnormalities because those are productive of pain. And again, sometimes that's sufficient. I asked him to -- I'm sorry -- I again requested authorization for surgery to the knee.

Q Did you then see him again on 7/15/19?

A I did.

Q More or less the same complaints he had been having all along?

A Continued to complain of pain and buckling, yes.

Q Okay. If we can turn to 8/13/19.

A Okay.

Q And can you tell me, what were the complaints of that visit?

A At that time he continued to have pain and daily buckling episodes of the left knee. He had been in therapy for about three months. His exam was essentially unchanged. He had slightly more motion with 125 degrees of flexion but still had a positive McMurray. And at that point, we had gained authorization for surgery and I advised him regarding the surgery.

Q And at some point, was the surgery performed by yourself on that left knee?

A It was.

Q And what was the date of the surgery, Doctor?

A Sure. Surgery was performed on August 28th of 2019.

MR. SHECTMAN: Your Honor, I'm just going to have something marked in a moment. I just have to go through my boards, if it's okay.

Let the record reflect I'm showing the blow-up to defendant's counsel.

Your Honor, just for identification I would like to mark this as the next plaintiff's exhibit.

THE COURT OFFICER: Plaintiff's Exhibit 10.

THE COURT: Defendant?

MR. MAHER: I have no objection for it be marked, you know, for demonstrative purposes only. I would object to it being introduced as evidence.

THE COURT: Exhibit 10.

MR. SHECTMAN: Your Honor, do you know if there's access to an easel in the courtroom. Oh, I think I see it.

(Whereupon, at this time, the demonstrative blow-up was marked as Plaintiff's Exhibit 10 in evidence, by the Reporter.)

MR. SHECTMAN: Your Honor, with the Court's permission, may I ask the Doctor to step down so we can walk through the illustration.

THE COURT: Yes.

(At this time, the witness stepped down from

witness stand to continued testifying.)

Q Now, you have in front of you, is this an accurate depiction of the surgery that you performed on Mr. Paiba on August 28, 2019?

A This is an artist rendering of the knee and the type of surgery performed, yes.

Q Sure. Can you walk us through, if you wouldn't mind -- start with the far left and if you can walk us through the different steps of the procedure, please.

A Sure.

So the surgery that we did what's called a knee arthroscopy. An arthroscopy is to look inside the joint with an instrument called an arthroscope, which is a telescope that we look inside the joint with. We make an incision on the front of the knee, just on the side of the kneecap, and we put our telescope in. We make another incision, we put instruments in we can work with.

This is a picture of the normal knee that we showed you. So we are looking at the thigh bone, the shinbone, the meniscus and the ligaments. They have taken the kneecap and turned it over, this way, just for purposes of demonstration.

This is what we see inside the knee. Obviously, we are still just looking through tiny holes. The knee is not opened up this way. But this allows us to see the entire knee joint.

Inside the knee, we found a tear in the medial

meniscus. What's called the posterior horn of the medial meniscus. If you think of these like horns on top of a cow's head, the one in back is the posterior horn and the one in the front is the anterior horn. So we have a tear, and there was a complex tear. Meaning, it was torn not just straight across but also vertically and horizontally.

That's a tear that can't be fixed. The best way to address that is to shave that torn portion out with this trimming tool, leaving as much of the normal meniscus as we can but taking out any torn or unstable portion.

Also noted inside the knee were multiple small pieces of cartilage. And you see this -- these little white dots that look like snow -- that's damaged joint surface. The smooth end of the joint -- when you look at the end of a chicken bone you see a furry white end, that's the cartilage and that's normal. When it's damaged, it flakes off or falls off and disconnects from the bone and can be caught inside the joint as loose bodies. You have to find where that came from.

In Carlos's joint, it came from the end of the thigh bone as well as the top of the shinbone. Both of those areas had deep damage to the cartilage, and so we did a couple of things. One is to remove all of those loose bodies that were visible by pulling them out with a tool, with a rotary tool. The other is to shave the edges of the area of the damage, the crater, we call that, where the edges are damaged to try to

stabilize that.

That's the joint surface. It normally is smooth and normally it moves without friction and pain free. When you damage the joint surface like that, that's when you get cracking and popping and that's when you get arthritis. That's what you think of when someone says they have arthritis.

This is a finding that is consistent with arthritis. Arthritis is really not just this. It's the symptoms with pain, swelling, grinding, loss of motion that are caused by this damage to the joint surface.

Additionally, he had a partial tear of his anterior cruciate ligament, which we saw in the MRI. It was not a full tear, and we just cleaned that up. We debrided that. The ligament itself was primarily intact. There was no instability associated with that.

So the big problem really is the damage to the joint surface and the tear in the meniscus because, in order to fix those we have to permanently change his anatomy to allow him to try to function somewhat better.

Q Now, Doctor, when you -- I know you had conducted a physical examination on your first visit of 3/14/19, and I think you said you arrived at, I guess, a differential diagnosis before seeing the MRI?

A Yes.

Q When you then reviewed the MRI, was there any

difference from what you thought the conditions were than before having seen the MRI?

A It was more specific. You know, I thought there was probably some joint surface damage somewhere because of the grinding, the clicking and the popping, it turns out he had joint surface damage, as I showed you, in the top of the shinbone. He also had some damage in the end of the thigh bone.

And additionally, while I figured he had a meniscus tear, sometimes it's hard to tell whether it's the medial or the lateral of the meniscus or if it's the front or the back of the meniscus, so the MRI helps localize that and it was seen in the back part of the medial meniscus.

Q Now, Doctor, during the surgery when you were using your arthroscope, was there anything that you saw during surgery that was different from the MRI?

A Not specifically, no. Except in order -- you can't always see the loose bodies if they're small, and I don't recall noting those.

Q Now, Doctor, you note in your surgical report there was an articular surface injury full-thickness of the patellofemoral groove.

What is a full-thickness tear?

A Sure.

Full-thickness injury means that the cartilage that lays on top of the bone and is responsible for that smooth,

sliding, gliding motion, the entire plate of that cartilage is damaged all the way through the bone. So that -- again, a normal bone looks like this with a shiny cap on it. That's the normal shining cap, here. This is the area of full-thickness damage you can see right down the bone there.

Q Now, when you mentioned, Doctor, that there was a complex tear of the meniscus.

Is every tear of a meniscus a complex tear?

A It is not. You can have a horizontal tear, you can have a radial tear, you can have what's called a parrot beak tear. A complex tear means that there's more than one type of tear going on.

So in this case, you have a horizontal and chondral component to his tear; a radial component to his tear.

Q Now, the anterior cruciate ligament, was that a partial tear or a full tear?

A That was a very small tear. I really don't consider that significant.

Q Okay.

Doctor, you can resume your place on the witness stand, thank you.

(At this time, the witness returns to the stand.)

THE COURT: Are we finished with that, Counsel?

MR. SHECTMAN: Yes, your Honor. I'm going to take it down.

THE COURT: Thank you.

MR. SHECTMAN: Thank you, Officer.

Q Now, Doctor, you've continued to see Carlos postoperatively, correct?

A Yes.

Q Okay. I just want to move things along. Can you go to 10/3/19.

A Yes.

Q And this would be about a month and a half after the operation, correct?

A Usually about five weeks, yes.

Q And can you tell us, what were his complaints at that time?

A At that time he had no further buckling. He still complained of significant medial pain, meaning on the inside part of the knee.

Q Now, Doctor, the fact that there was no buckling on this visit five weeks after surgery, was that what you were hoping to achieve?

A Yes.

Q Okay, continue. I cut you off.

Objectively, what did you find?

A He had 120 degrees of flexion at that time. He had full extension. He did have some, what I noted as atrophy of his quadriceps. Which means that his thigh muscle, his

quadriceps, was shrinking a bit compared to the left. He did have severe crepitus of the knee. Crepitus is, again, the popping and cracking which you would expect with an abnormal joint surface.

Q Doctor, what is -- when you say there was atrophy, would that be objective or subjective?

A That's an objective finding. The difference between objective and subjective, which I was just asked, subjective means that the subject of the examination tells me what's going on. Objective means it's something that I see and that anyone else could see independent of the patient telling me about it.

Q So when you noted atrophy, that's based on something you saw, correct?

A Yes.

Q What about the crepitus, is that objective or subjective?

A That is also objective. I hear it, you'd hear it, the patient hears it.

Q Okay.

Can you tell us, what was your assessment on the visit of 10/3/19?

A With regard to the knee, he was status post left knee arthroscopy with a subtotal meniscectomy. So that term subtotal means I didn't take out the entire meniscus. I left as much as I could, but I did more than just a what's called a partial

meniscectomy, taking out the small portion. And that's because he had a complex tear. He had a tear that really needed to be debrided or cleaned up quite, quite significantly.

I also felt that he had posttraumatic arthritis of the left knee. Arthritis, again, is the symptoms of swelling, pain, limited motion of the knee. They're generally caused by irregularities of the joint surface.

There are several types of arthritis. There's wear-and-tear, old-age arthritis. There's blood-bone arthritis. Like rheumatoid arthritis, things like that. And there's posttraumatic arthritis, like in this case where the damage to the joint surface is not caused by just age, is not caused by some problem with your blood, but caused by an injury.

Q Thank you, Doctor.

We are not going to go through each visit, but I just want to ask, then you saw him on 12/5/19; is that correct?

A Yes.

Q 5/13/20, I believe you saw him as well?

A Yes.

Q 8/20/20?

A Yes.

Q I want to move to 2023; 4/24/23?

A Yes.

Q Now, on June 23rd of '23, what were his complaints when he had returned to your office? Or is was the reason for

returning to your office?

A At that time we had suggested that he have a series of injections in the knee with a medication with called Euflexxa. That medication is a lubricant that we inject into the knee. It's made of cartilage. We inject it into the knee to try to lubricate the knee and decrease some of the symptoms of arthritis. In this case posttraumatic arthritis. It does not rebuild cartilage. All it does is lubricate the knee and try to decrease some of the symptoms. That's a series of three injections that people can get usually about every six months to a year, depending on their response to it.

Q When Carlos came to you on 6/23/23, was he noted to still have crepitus?

A He did.

Q On that particular visit, had you given him that Euflexxa medication you just told us about?

A I'm sorry?

Q On that visit, have you given him the Euflexxa medication that you just told us about?

A I gave it to him that day, yes, the first of the series of three.

Q If you can turn to June 30, 2023.

A Yes.

Q Had he returned for a second injection?

A That's correct.

Q Still the crepitus?

A Yes.

Q 7/11/23?

A Yes.

Q What was the point of returning on that visit?

A That was the third injection of Euflexxa to the knee.

Q Now, going to the visit of October 12th, '23 -- actually, I'm sorry -- 11/16/23.

A Okay.

Q What were his complaints at that time?

A At that time he was having return of daily pain in the knee, including with walking and any periods of -- I'm sorry -- walking for any period of time. He had pain with stair climbing and he had pain with attempts at squatting and kneeling.

Q Did you conduct a physical examination?

A I did.

Q Now this would be over four years since the initial accident of 3/6/19, correct?

A That's correct.

Q Can you tell us, what did you look for and what, if anything, did you find?

A Sure.

He, again, had some limited motion of the knee. He was back to 120 degrees of motion both actively and passively. So actively and passively means, actively he moves the knee,

passively means I move the knee. And we do that to try to make it a more objective finding. I push until I can't move anymore. If it's the same as he shows me, it's a more objective finding.

He had what I graded as marked to serve crepitus at that time. He had a repeatable click with my McMurray's testing, and he had tenderness about both sides of the joint medially and laterally.

Q Can you tell us, Doctor, what the reasons would be, if any, of why someone would still be having symptoms even after the procedure, if done correctly, of course?

A Yeah, sure.

The procedure is done to improve the function of the knee. Get rid of the buckling, primarily. Decrease pain, if we can. It is not a cure for arthritis. It can smooth out the joint, but in doing so you thin out the remaining cartilage surface, the layer that protects the joint and makes the joint move smoothly.

So over time, this is gonna catch up to him again. And this is what we are seeing here. It's the reason we gave him the Euflexxa injections, to try to get rid of some of the grinding and pain associated with that from the posttraumatic arthritis. But arthritis, as I said, you can't cure with shaving down the joint with injections and things like that. You can treat the symptoms to a certain point but it -- it eventually gets worse and worse.

Q Now, Doctor, looking under the miscellaneous section of that report, what is your proposed plan at that point? What else were you going to do?

A Sure.

At that time, I advised that he continue some physical therapy. You know, physical therapy, exercise, motion, those are all helpful in maintaining the joint motion. But I also discussed with him that given the amount of arthritis he had, I felt that the only thing that would really help at that point was not another arthroscopy, the small surgery to shave things down, but a total knee replacement surgery.

Unfortunately, he was -- well, fortunately for him, he was too young for a total knee replacement surgery at that time, I felt. And I advised him that, while I thought he would have one in the future, he should wait as long as he could to do that.

Q And why would you recommend if someone is going to have that procedure to wait as long as they can?

A So there's a sweet spot, and while I say as long as you can, that doesn't mean until you're 95. It means a point where it's interfering with your daily activity and generally older than 60, 65 years old. Because what we're doing is taking off the joint surface and putting metal and plastic prosthesis pieces in there, gluing them in place, screwing them in place. They don't last forever, so you try to not put them in too early

and have them wear out and have to do the procedure again. You try to get the, as I say, the sweet spot where it's helpful and as you get into older age, your demands are less and you are able to use that knee replacement for the entirety of your life. That's the goal. These only really last 15 to 20 years.

So sometimes people do have revisions over their lifetime, but the attempt is to try to get it done in that sweet spot. And at this point he was only 56 years old so, that, I felt was a little young if he could withstand it.

Q That was my next question, Doctor. So at this point when you made that opinion, he was 56, correct?

A Yes.

Q Is there -- just so we can be more definitive, is there an approximate age at which you would believe him to need it? Meaning, when should he have it, I guess? If not at 56, when?

A Sure.

Well, he should have it when he feels he can't do what he's doing in daily life. There is no scenario in which I would say to someone you have to have this surgery done. It's something the patient comes to me. It's a big surgery. It's a big commitment. But as I say, later in life you try to hit a sweet spot when they're generally older than 65 and interfering with your daily activities.

Q Now, Doctor, if Carlos were to never have that total knee replacement, is there any other way to get rid of the

arthritis that you already saw?

A No. The arthritis, as I say, it's a permanent change in the joint. The cartilage does not grow up. The fact that the cartilage is not smooth causes it to degenerate over time, with the motion that occurs, the unsmooth surfaces will grind on the smooth surfaces, they'll both become unsmooth, they'll further grind on each other. It's just a -- it's a downhill cascade.

We all get arthritis over time. If you get it from wear and tear, it usual occurs slowly, it usually occurs symmetrically throughout your body. Meaning, you know, both your knees are about the same. That's opposed to if something like posttraumatic arthritis, which happens as an occurrence of an event and progresses, it usually happens quicker.

Q Can you walk us through how a knee replacement would be done for those of us who might not know.

A A knee replacement is done, the knee is exposed -- it's not like an arthroscopy through two tiny incisions -- the knee is -- an incision is made from the midthigh through the midshin. The kneecap is moved out of the way. The ends of the bone are marked, and then with a -- basic carpentry tools, really -- a saw, the bone surfaces are shaved off in a specific pattern that fits a pre-made prosthesis that looks very much like the shape of the bones. That is fit onto the prepared remnant of the bone and glued in place and then, additionally, sometimes screwed in

place. So it's a metal piece on the end of the thigh bone. There's a metal, basically a stage, that is placed on the end of the shinbone after the meniscus and the top of the shinbone are taken off, and then a plastic device in between that helps, again, center and support the thigh bone. Additionally, the back of the kneecap is reamed off, drilled off, and a plastic piece is put to keep that centered in the knee joint.

Q And what is the recovery like, Doctor, after that procedure?

A The recovery is -- it depends on the patient. It's usually six to 12 weeks of physical therapy and modified walking for a period of time.

Q Doctor, could we go to 9/27/24.

A Okay.

Q What, if anything, were his complaints on that particular visit?

A At that time he was complaining of severe pain in the knee. He had been, again, recommended to have a total knee replacement. He was having pain that prevented him sleeping through the night, getting about one to two hours of sleep because of pain. He was ambulating or walking in a painful way that required the use of a cane.

Q Now, Doctor, can you tell me, if you look at the Plans Transcription, at that point in time on 9/27/14 -- which would be over five years after the accident and about four-and-a-half

to five years after your operation -- can you tell us whether or not you believed he had reached maximum medical improvement at that point?

A I did not because I still felt he was a candidate for a knee replacement, which I thought should be done at some point.

Q Doctor, may I turn to 12/19/24.

A Sure.

Q Just, generally, what were his complaints at that time?

A I'm sorry?

Q What were his complaints at that time?

A Complaints. He was complaining of pain in the left knee. He -- again, we had discussed knee arthroscopy because of the significant findings on -- I'm sorry, a knee replacement because of the significant findings that we saw on arthroscopy. He was continuing to have intermittent giving way and catching of the knee again at that point, the buckling and catching. He even had some locking sensation, which means the knee gets stuck in one place and has to -- usually because some loose pieces are floating around and that has to get moved out of the way. Those were his complaints.

Q Thank you, Doctor.

Now, if we could can go to your last date of visit or the most recent and speak to that. What was the most recent date of your examination?

A I last saw him on 12/16/25.

Q His complaints at that time?

A He complained of what I said was rather severe left knee pain. He complained that his left leg was turning inward and that it was frequently swelling. He complained that he had difficulty walking more than one block at a time, and he had difficulty with stair climbing.

Q And can you tell me, Doctor, did you perform a physical examination at that time on the most recent visit?

A I did.

Q What did you find, Doctor?

A At that time he continued to have limited motion with a 120 degrees of flexion and full extension --

Q And, Doctor, just remind us, what is normal?

A Normal is about 145 degrees.

Q Okay. Continue, please. I cut you off.

A He had marked crepitus with motion. At that time he had, again was showing a positive McMurray, meaning the meniscus was tearing again. He had tenderness at the medial and lateral join line. And he had what I said was palpable osteophytes. That simply means that I could feel bone spurs about the knee, particularly at the medial joint line. I noted that he had a markedly antalgic gait; that means he was limping badly and he required the use of a cane.

Q Doctor, at this point, is there any particular reason to keep coming to you for treatment if he still has these

problems, other than to get a knee replacement?

A Well, I don't do knee replacements, and I had advised him some other -- given him some other doctors' names who do knee replacements and I told him to follow-up with those doctors at that point. So, no, there's no significant reason for him to come to me.

Q And Doctor, did you formulate an opinion based on all your treatment over the years based upon a reasonable degree of medical certainty as to the diagnosis of Mr. Carlos Paiba's condition following the accident of 3/6/19?

A Yes.

Q And what is your diagnosis?

A My diagnosis was he had an internal derangement of the knee with a torn medial meniscus and a injury to the joint surface. He had some other findings but those are the primary findings.

Q Now, Doctor, when you see a torn meniscus, for example, and a torn ACL, do you always perform surgery on a patient?

A Mostly do not perform surgery on those.

Q Do you believe that the surgery in his particular case was necessary?

A Yes.

Q Why is that?

A He had symptoms of buckling and locking of the knee. Besides that, being dangerous because it can cause you to fall

down unexpectedly -- you could fall down stairs, things like that -- the repeated buckling is an indication that the joint surface is getting damaged each time that happens with a piece of cartilage getting in between the joint, the moving joint symptoms. So we do the surgery to decrease the buckling, get rid of the buckling, if possible, to try to preserve the joint and to try to increase the patient's comfort, function and safety.

Q Doctor, I would like you to assume that Carlos testified to this jury that he began working at Algin Management construction company in November 2018, and that he had worked five days a week, 40 hours a week up to and including the date of the accident of 3/16/19. I would also ask you to assume that his work involves standing on a ladder, going up and down, plastering, painting. And that he testified to this jury, I would ask you to assume, that when he was doing that from November of '18 until the date of the accident, no issues going up the ladder, no issues working at all.

Doctor, do you have an opinion based upon a reasonable degree of medical certainty considering those facts that I gave you, and in addition to what you saw on the MRI, also based on your physical examinations over the years and what you saw during surgery, do you have an opinion as to what you believe to be the cause of these conditions based upon a reasonable degree of orthopaedic certainty?

A I do.

Q And what is that, Doctor?

A So my opinion is that the meniscus tear that I saw, I believe was caused by the accident. I don't believe he would have been able to work pain-free and functionally with that meniscus tear.

He also began having buckling after that, which is a clear indication to me that something occurred on that day and I believe it was the meniscus tear.

Someone who works that hard is likely to have some degenerative change, so I believe there was probably some degenerative change in the joint prior to the accident. But what I operated on, what I smoothed out and what I cleaned out and reconfigured, I believe was at least exacerbated by his fall because it wasn't symptomatic prior to the fall. He didn't have problems with it.

So I believe that what brought him to surgery was the accident. If it weren't for the accident, he wouldn't have had surgery, and that was the cause of the injuries that we addressed.

Q By the way, Doctor, we heard that CAT scans and x-rays were performed on March 6, 2019 at Elmhurst Hospital.

Are MRIs done at the hospital?

A MRIs can be done at the hospital. But he was at the emergency room, and by the nature of the emergency room, they

take care of emergency problems. So they're looking for broken bones. They're looking for things that need surgery. They're looking for things that need to keep you at the hospital.

The MRI looks more deeply at the soft tissue in addition to the bones, the cartilages, the ligaments, the tendons, which are not generally thought of as something that needs to be taken care of emergently in the orthopedic setting.

Q So Doctor, if MRIs were not conducted of the various parts of his body alleged to have been injured, if MRIs were not done on the day of the accident, would those workers at the hospital, the doctors, would they know about the tears that you saw in the knee?

A They would not have the MRI evidence of it, no.

Q Now Doctor, based upon your medical treatment of Carlos from March 14, 2019 until over six years later in December of '25, do you have an opinion based upon a reasonable degree of orthopedic certainty as to whether some degree of pain in that left knee is permanent?

A I do believe that he has permanent injuries to the knee that are painful, yes.

Q Same question, Doctor, regarding the limitation and movement of the knee, do you believe that to be permanent?

A I do, yes.

Q And what about restriction on activities, for example, walking and squatting I think you mentioned, things of that

nature?

A Yeah. Anything that modes the knee, which is squatting, walking, stair climbing, crawling, kneeling, those things will be painful and I believe that's permanent, yes.

Q Doctor, I want you to assume that in this particular case Carlos testified to this jury that on occasion he did miss physical therapy appointments, sometimes due to his diabetes, sometimes due to COVID in 2020, as well as sometimes being able to get out of bed to go to therapy. And then I would also like you to assume that, on those particular occasions, he did home exercises including stretching and using a TENS machine.

Do you have an opinion, Doctor, whether or not those were acceptable alternatives when you couldn't physically get to an office?

MR. MAHER: Objection.

THE COURT: Overruled.

A Obviously, I would prefer him to go to formal physical therapy, that's what I prescribed. Sometimes it doesn't happen. Doing home exercises is certainly helpful.

Q Now, Doctor, if Carlos had gone three to four times per week as prescribed and had not missed even one session all these years, would that have totally rid him of his knee pain?

A He still would have needed surgery and he'd still have the limitations he has now.

MR. SHECTMAN: Thank you, Doctor.

Nothing further.

THE COURT: Thank, you Counsel.

Cross-examination?

MR. MAHER: Would it be possible to take a brief recess before beginning cross?

THE COURT: Jurors, we are going to take a break.

Let's have the witness step down first.

(At this time, the witness leaves the stand.)

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, at this time, the jury exited the courtroom and a brief recess was taken.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time, the jury entered the courtroom.)

THE CLERK: Do all counsel stipulate to the presence and seating of the jury?

MR. SHECTMAN: Yes.

MR. MAHER: Yes.

THE COURT: Thank you. You can have a seat.

At this time, Jurors, the defense counsel is going to begin his cross-examination, okay.

MR. MAHER: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. MAHER:

Q Good morning, Dr. Kaplan.

A Good morning.

Q Is this the first time that you've appeared in court to testify?

A No.

Q And approximately how many times have you come to court to testify over the last ten years?

A You know, it's a random event, so I don't know exactly the number but it's usually about once a month or so.

Q And when you come to court, are you typically paid for your time?

A Always paid for my time, yeah.

Q Okay. And are you being compensated for your appearance here today?

A Of course.

Q Okay. And can you tell me how much you're being compensated for your appearance here today?

A Sure.

My office receives a fee of $8,500. So I take my salary out of that and I also pay the salary of my 16 staff workers and my rent and my electric. All of that comes out of that.

Q Okay. So your office charges a fee of $8,500 every time you come to court?

A That's correct.

Q And in addition to that, are you sometimes asked to

prepare narrative reports summarizing your patient's treatment at the request of plaintiff's personal injury lawyers?

A Sometimes, sure.

Q And approximately how many times a year would you say that you get requests like that?

A I don't even know, probably ten or 20 at least.

Q Okay, and how much do you charge for that?

A $450 for the report.

Q And would it be fair to say that you testify fairly frequently in court?

A Compared to what? I mean, I told you how often I am about, how often I'm here, right.

(Whereupon, the following was recorded and transcribed by Official Court Reporter Valerie McNally.)

(Continued on next page.)

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CROSS-EXAMINATION (Continued)

BY MR. MAHER:

Q Did you testify earlier this week?

A I did.

Q So this is your second court appearance in just this week where you are testifying in court?

A That's correct. As I say, it's a random event. Sometimes busy, sometimes it goes months at a time without ever coming to court.

Q When you have been coming to court over the last ten years, are you always coming into court to testify on the behalf of the person whose bringing a lawsuit or do you sometimes appear for people who are defending the lawsuit?

A I don't think of it that way. I come to court for patients that I've operated on, like Carlos, or patients I treated, for the most part, so I guess those are people bringing the lawsuit. But I've also done some expert testimony for defense firms on occasion, but it's definitely much, much more for the patient I operate on or treat.

Q The overwhelming majority of the times when you prepare reports, come to court to testify, is when you appear on behalf of the person bringing the lawsuit, correct?

A I am a treating physician so it's mostly for the people who I'm treating. I guess those are the people who bring the lawsuit, yeah.

Q Do plaintiff's personal injury law firms refer their clients to you for treatment?

A Sometimes, sure.

Q Is Gorayeb and Associates one of the law firms that refer their clients to you?

A They do.

Q Would it surprise you to learn in this case there has been testimony that representatives from Gorayeb and Associates contacted Mr. Paiba at the emergency a room on the day of the accident?

MR. SHECTMAN: Objection.

THE COURT: Overruled.

A I don't have any knowledge of that.

Q Would it surprise you to learn that a firm that refers its clients to you actually had somebody go to the emergency room on the day of the accident and try to sign Mr. Paiba up?

MR. SHECTMAN: Objection, Your Honor. That's not the testimony.

THE COURT: Sustained.

THE WITNESS: Answer that?

THE COURT: No.

Q If that happened, would that be something that would surprise you?

MR. SHECTMAN: Objection.

THE COURT: Sustained.

MR. SHECTMAN: It didn't happen.

Q In this instance, do you know how Mr. Paiba was referred to your office for treatment?

A I don't know how he was referred to my office. As I said, Mr. Gray's office sometimes --

THE COURT: Wait for a question.

THE WITNESS: Okay.

THE COURT: Thank you.

Q But Mr. Paiba, he was seen in your office almost immediately after his accident, correct?

A He was seen about a week later, yeah.

Q Were you aware at the time that you saw him for the first time that he already had a lawsuit pending?

A I don't know. I could tell you if he gave us an attorney's name to contact, to be able to contact if they needed medical information.

No, I have no record that he was involved in a lawsuit.

Q What portion of your file are you looking at in answering that question?

A I am looking at the intake sheet. There is a section which lists doctor, lawyer or other which are people that we can exchange information with.

Q There's no information contained there?

A There's no information contained there.

Q Is there any information contained in the intake sheet

about prior accidents involving the patient Mr. Paiba?

A That's in my first note. This is just a demographic sheet.

Q Okay, but nothing in the intake sheet?

A There's no section for that.

Q So you don't have a form that your office uses when a patient comes in for the first time, asks them to handwrite out what their complaints or prior medical history would be?

A No. I ask them that myself.

Q You don't have a --

A I do not. I ask them that myself.

Q Okay. No need to be argumentative.

A You obviously didn't hear me.

THE COURT: Okay, let's just have questions and answers, please.

Q In the past, Doctor, has your firm used an intake sheet which includes sections for the patient to write down personal information, such as prior accidents, underlying medical conditions, things of that nature?

A No.

Q Never, okay. Now, the patient, Mr. Paiba, he was seen in your office for the first time on March 14th of 2019?

A The first time, yes, March 14, 2019.

Q At that time did you take a history from Mr. Paiba?

A Yes.

Q And did you ask Mr. Paiba how his accident occurred?
A Yes.
Q And by the way, do you -- let me just clear this up.
As you sit here today, do you have an independent recollection of conversations that were had with Mr. Paiba during your office visits?
A Not all of them, no. That's why I refer to my notes.
Q So if we're referring to what transpired on March 14th of 2019, as you sit here now do you have an independent recollection of what Mr. Paiba said to you?
A No. I am relying on my notes for that.
Q I just wanted to clear that up. In any event, Dr. Kaplan, you asked Mr. Paiba how his accident occurred?
A Yes.
Q What did he tell you?
A Told me he had a fallen from a ladder.
Q Did Mr. Paiba describe for you the mechanism of his fall?
A Not that I recall, except for a fall from a ladder.
Q As you sit here now, you don't have any information or knowledge as to the mechanism of this fall from the ladder?
A Only a fall from a ladder.
Q You don't know whether he fell forward, backwards, sideways or anything like that?
A I don't.

Q In treatment and diagnosis, isn't it important to know what the mechanism of the injury is?

A Listen, in an ideal world, sure. But what happens when people have accidents, they often happen very quickly. I could ask them if any landed on their left foot or right foot and they often don't remember. I could ask them did they fall forward or backward and they often don't remember.

So the important thing to me is they had a fall from a ladder. It was backed up by his emergency room record, which I believe they said about ten feet, and that's enough to cause injuries, so I look for the injuries.

Q Right. But with respect to specific types of injuries, the mechanism of injury would be important to know to see if there was causal connection between the accident and the injury, correct?

A I disagree with you. What I am looking at is for the injuries that are going to clinically correlate to the complaints, the things that I find. I am going to find an injury, if it's there, and I am going to look for it based on his complaints at that time and then, of course, imaging studies.

Q Not to get ahead of ourselves, but meniscal tears, they can be caused by trauma and they could also be caused by aging and degeneration, correct?

A Absolutely.

Q And so the mechanism of these different types -- same condition?

A Uh-huh.

Q But knowing the mechanism of the injury might be important information to have if you are trying to figure out whether or not something was caused by age-related or by trauma; wouldn't you agree with that?

A I would not agree with that in the way that you put it. He didn't have symptoms of buckling and locking prior to the accident, according to his history. He had symptoms of buckling and locking following the accident. To me, that's a much more important piece of information than trying to ask someone who fell in the moment to tell me exactly how they fell. Did they twist, buckle? Those things people don't remember and so I don't necessarily always trust that.

What I do trust is symptoms they are telling me about, new onset buckling, new onset pain and findings.

Q Had you ever seen Mr. Paiba before the date of his accident?

A No.

Q So you don't have any personal knowledge as to what the condition of his left knee was before the accident that's the subject of this lawsuit?

A Which is why I ask him and I had to believe his history or I don't. His history was reasonable. I'd seen many people

fall off a ladder and injure themselves and not necessarily know exactly how they fell.

Q Have you ever described an injury or medical condition as being age indeterminate?

A Yes.

Q If an injury or condition is age indeterminant, would having as much information as possible regarding the mechanism of injury be important for you?

A Again, it would be important to have accurate information and I'm not relying on someone who fell ten feet off a ladder to know exactly what happened first or things like that.

So I base my findings primarily on their symptoms of new onset buckling and pain. As I said, it's, yes, possible he had degenerative change prior to this, but it wasn't symptomatic and that's the important thing in my mind, in my treatment.

Q Again, Mr. Paiba may have told you that it wasn't symptomatic, but you don't have any personal knowledge as to whether or not that pain was symptomatic before the incident?

A As I said just two seconds ago, I either believe him or I don't.

Q And degenerative changes, Doctor, of the knee in particular, they don't occur overnight, right?

A That's correct.

Q They can?

A No degenerative change occurs overnight by definition. Degeneration means it occurs over time.

Q Okay. I want to make sure we're on the same page. Very good.

Now, just if you refer to your notes of March 14th of 2019 for a moment.

A Sure.

Q When Mr. Paiba came to your office on that date, he made complaints of low back and left knee pain, correct?

A Yes.

Q At that time did he make any complaints of left hip pain?

A He did not.

Q Did he make any complaints of groin pain?

A He did not.

Q You ordered some diagnostic testing at the end of your examination, correct?

A That's correct.

Q And what diagnostic tests did you order at the time of your initial exam?

A An MRI of his low back and his left knee.

Q So no MRI of the left hip was ordered at that time?

A That's correct.

Q And that's because he wasn't making any complaint of hip pain?

A He was not.

Q And in conjunction with seeing the plaintiff, Mr. Paiba, for the first time, I believe you note that he was taken by ambulance to Elmhurst Hospital?

A Yes.

Q Did you review the records from Elmhurst Hospital in conjunction with your first visit?

A I reviewed the discharge summary that was available to me at the time.

Q Did you review any of the reports relating to x-rays or CT scans that were taken of Mr. Paiba's left knee on the day of the accident?

A Only the reports that the were in the discharge summary.

Q So you reviewed a report relating to a CT scan that was taken of the left knee?

A If it was in the discharge summary.

MR. MAHER: I believe the Doctor was asked about the Elmhurst Hospital records earlier. They are marked in evidence.

THE COURT OFFICER: He has them.

MR. MAHER: Your Honor, could I take a moment to find the page --

THE COURT: Sure.

MR. MAHER: -- where the CT scan is located.

(Whereupon, there was a pause in the proceedings.)

MR. MAHER: This is the page I wanted the Doctor to look at. Page 75 for the record.

MR. SHECTMAN: What page?

MR. MAHER: Page 75 of the Elmhurst Hospital record. It relates to the CT scan of the left knee.

A Okay.

Q So, Doctor, having looked at this portion of the Elmhurst Hospital record from the date of the accident, does it indicate that a CT scan of the left knee was taken at the hospital?

A Yes.

Q And there is a reporting radiologist, a Dr. Ashkar Desai, D-E-S-A-I?

A Is that a question?

Q I am asking you, Doctor, there is a report there, right? There is a radiologist report who read the film?

A Yes.

Q What was the radiologist's finding?

A It says, No fracture demonstrated. They say, Mild tricompartmental degenerative changes.

Q I also believe there was an x-ray, just to back up here.

CT scan date of accident shows mild tricompartmental degeneration changes in the left knee?

A That's correct.

Q That's not something that would have been caused by this accident?

A That's correct.

Q What does that mean, tricompartmental?

A So we talked about the three bones of the knee. Those are related to three compartments of the knee; the medial compartment between the thigh bone and shin bone; the lateral compartment between the thigh bone and shin bone; then the anterior compartment between the kneecap and the thigh bone where the joint surfaces come together.

MR. MAHER: And just if I could have the record back, there was another film study I just want to direct the Doctor's attention to, page 73.

THE COURT OFFICER: Page 73.

Q Dr. Kaplan, have you had an opportunity to look at page 73 of the record?

A Yes.

Q Does that reference that an x-ray of Mr. Paiba's left knee was taken in the emergency room on the day of his accident?

A This references an x-ray of the tibia and fibula. It does involve the knee, uh-huh.

Q What were the radiologist's finding?

A There was no fracture present, no visualized fracture.

Q Right. And there are additional findings there?

A That's the impression, which is what you asked me, no visualized fracture.

Q Is there a paragraph that begins --

THE COURT: One at a time.

A I am sorry. If there's something else you want me to look at, just tell me.

Q Of course. Is there a paragraph that says -- that begins, There is a chronic appearing deformity?

A Yes.

Q Could you read that?

A It says, There is a chronic appearing deformity of the lesser trochanter which may reflect sequelae of an old avulsion fracture. Anthema is otherwise normal.

Q So there was evidence of an old avulsion fracture in the knee joint?

A No.

Q Well, what is your interpretation of this report?

A Sure. There's the lesser trochanter, which is here at the top of the femur, and it says it may reflect sequelae of an old avulsion fracture. It does not say there was an old avulsion fracture. In fact, it says there's no fracture of the left knee.

Q Did you review the films that were taken at Elmhurst Hospital --

A No.

Q -- on the day of the accident?
A No.
Q You can give that record back to the officer.
Now, your appointment with Mr. Paiba on March 14th of 2019, did it also include a physical examination?
A Yes.
Q And did your examination include an evaluation of his lower extremity strength?
A Let's see. Yes.
Q What were your findings?
A I found he had five over five strength of the lower extremities. That's simply an indication there was normal strength.
Q And would that also be an indication that at the time of this examination, Mr. Paiba was not exhibiting any weakness in either of his legs?
A He had normal strength, yeah.
Q And when Mr. Paiba came to your office for the first time, was he using any assistive device?
A He was.
Q What assistive device was he using?
A He was utilizing a cane, which I believe was issued at the hospital.
Q And did you give him any instructions with respect to the use of that cane?

A I asked him to discontinue the use of the cane if he could.

Q Why did you make that recommendation?

A I like people to try to start improving, if they can, normalizing their gait, maintain their strength.

Q Right. But based upon your physical exam, you were not of the opinion that he needed a cane to get around at that time?

A From a structural point, he had no fractures so I felt that he could try to start weaning off the cane, that's right.

Q In other words, he made complaints of back pain and knee pain at the time of your examination and you felt he would be okay to walk around without a cane?

A My goal as a doctor is to get people to improve, so I always try to get people off assistive devices as quickly as possible.

He had normal strength and he had no fracture and I was trying to get him off a cane.

Q That was shortly after the accident, right?

A As soon as possible.

Q In other words, your conclusion that he wasn't -- didn't have a medical necessity to use a device to help him walk was made within days after the accident?

A That was my initial assessment, yeah, for sure.

Q Okay. And we mentioned earlier that you had suggested or referred plaintiff for an MRI of the lower back and the left

knee, correct?

A Yes.

Q And did you let the patient, Mr. Paiba, choose where he was going for his MRI or did you tell him where he was going for MRI?

A I have a stack of prescription pads in my office and I would pull one of those and write it on there. They are generally from different places.

It looks like I probably sent him to a place -- I will look at his prescription, if I have it.

Looks likes initially I sent him to Kolb Radiology.

Q And is Kolb Radiology a place that you frequently refer your patients to for MRI scans?

A It's one of the places, yeah. I've also referred this same guy to Lenox Hill Radiology, which is a different location.

Q But you frequently sent or send your patients for initial diagnostic images to Kolb Radiology; is that fair to say?

A I sometimes send them to Kolb Radiology, certainly. I send them to Stand Up, I send them to Lenox Hill. I send them to East River. There are a number of facilities I use.

Q You tell the patient where to go for the diagnostic imaging, whether it's Kolb Radiology or someplace else; you don't just say here's a prescription, go get the MRI where you want?

A Actually, I do say here's a script. It has a facility on it but you are free to go wherever you want.

Oftentimes I get patients from Staten Island and occasionally they don't want to come in to the City for tests and things, so they go somewhere else. I get people from Long Island, go somewhere else.

Q Let me ask it this way: Do you know where Mr. Paiba was living on the day of his accident?

A I don't.

Q You don't know?

A No. I could look it up for you.

He was living in Jersey City.

Q And Kolb Radiology, where are they located?

A They have multiple facilities.

Q But they are not in New Jersey?

A Not that I know of.

Q So you recommended that he go for an MRI someplace other than where he was living?

A You are giving me a lot of credit for looking at stuff like that. I wrote down what I would reliably get a report from, one of the four or five places.

Q When films are -- or rather, when a patient goes to Kolb Radiology, are the films always read by the same person?

A I don't think so.

Q No? Doctor Thomas Kolb?

A I know Dr. Kolb.

Q He doesn't prepare all the reports that are generated by his office?

A I don't think so. I think he got a couple of radiologists working there.

Q The findings in this case, were they read by Dr. Thomas Kolb?

A These were read by Dr. Kolb, yes, uh-huh.

THE COURT: Counsel, do you want to find a natural breaking point?

MR. MAHER: Sure, this would be fine.

MR. SHECTMAN: May I speak to Mr. Maher for a moment before the break?

THE COURT: Do you want to excuse the jury? I have to excuse my staff.

MR. SHECTMAN: I just need one moment, Your Honor.

THE COURT: Okay. I am going excuse the jury.

THE COURT OFFICER: All rise. Jury exiting.

THE COURT: I would ask the jury to come back at 2:00 o'clock.

(Whereupon, at this time, the jury exited the courtroom.)

THE COURT: Doctor, I am directing you to return at 2:00 o'clock to continue the examination. You can have that conversation with --

MR. SHECTMAN: Your Honor, this is what I was trying to tell you.

THE COURT: Counsel, we have had this witness -- Dr. Kaplan, you can step down and out of the room for a moment.

THE WITNESS: May I --

THE COURT: You can step down and out of the room for a moment.

MR. SHECTMAN: May I ask to step out for a minute with the Doctor? I want to put something on the record, if that's okay. I was speaking to Mr. Maher about something.

(Whereupon, at this time, the witness exited the courtroom.)

THE COURT: We have set the schedule awhile ago and this witness was scheduled to testify today. There was never any limit on the time that he would be available and for you to bring him in today at 10:00 and after you finished your direct examination and inform the Court that he can't stay for the afternoon is not acceptable by the Court.

He is directed to come back at 2:00 o'clock to complete the testimony.

MR. SHECTMAN: May I respond?

THE COURT: Sure.

MR. SHECTMAN: When I went outside during the

break and I said, Doctor, it doesn't look like we're going to finish, so you will have come back at 2:00 and I told the doctor that he would have to come back after lunch, for the very first time, I am representing to the Court, for the first time he said, I cannot, I have a doctor's appointment that I have to go to.

I just want to step out to find out what the situation is. Maybe he can go later. I did not know about this, Your Honor.

I am saying, you are right. I have him here, and the reason I didn't inform the Court is I didn't know. I can't inform the Court about something I didn't know. I want to ask him what it is. If it's something emergent, then I am going to put on the record it's an emergency. I have no idea what it is.

THE COURT: Defense, do you have anything?

MR. MAHER: Listen, I don't know what the situation is. I've told Counsel all along that I would work with him with respect to witness schedules and, you know, I'm going to stay with that. If there's an issue --

MR. SHECTMAN: I appreciate that.

THE COURT: I repeat, I indicated we set the schedule long ago with respect to when this doctor was going to come in and testify. You certainly had ample time to prepare him that he may be here all day. In fact, you

had time to -- you had ample time to frame your direct testimony so that it could fit within a particular time.

To come to the Court after you completed your direct and say, oh, now he is not available, then we'll have to strike his testimony. But we're going to proceed --

MR. SHECTMAN: That's why I want to find out what it is. I didn't know, Your Honor. When you say --

THE COURT: Counsel, that's your responsibility. It's your witness. You scheduled this witness and now I am repeating what I said three or four times. This is your witness that you told the Court back in February or early March when we started this trial that this doctor was going to testify today.

MR. SHECTMAN: Yes.

THE COURT: And so it was your responsibility to make sure that the witness was available to testify. Given the way that the testimony has been going and the length of time the attorneys have been using to question the witnesses, the repetitiveness of the questions that have been asked, I would expect that you would think that your testimony was going to take more than the morning. And you've actually pointed out the limited time that we had this morning, so I would --

MR. SHECTMAN: I didn't know. I've explained, I

didn't know.

THE COURT: Because you didn't make an inquiry to make sure and you didn't make the inquiry before the testimony started and we're going to proceed this afternoon.

MR. SHECTMAN: May I speak to the Doctor, please? May I step out?

THE COURT: I have to let my staff go.

MR. SHECTMAN: I just want to step out to the speak to the Doctor. Do I have permission to step out?

THE COURT: You will return at 2:00 o'clock. Whatever the response is, then you can let me know at 2:00 o'clock.

MR. SHECTMAN: I am going to run outside, okay?

THE COURT: As soon as I release you, everyone should return at 2:00 o'clock so that we can continue. We're going to have the jury return at 2:00 o'clock. Thank you.

The matter in recess until 2:00 o'clock this afternoon.

(Whereupon, at this time, a luncheon recess was taken.)

(Continued on following page.)

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A F T E R N O O N S E S S I O N

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THE COURT OFFICER: All rise. Part 28 now in session.

THE COURT: You can all have a seat. Are we ready to proceed?

MR. SHECTMAN: Your Honor, I would like to state something on the record, if I may.

THE COURT: Go ahead.

MR. SHECTMAN: So, Your Honor, as you know, today we had scheduled for testimony Dr. Jeffery Kaplan. We were told as the attorneys to be here by 9:30 to start at 10:00. Dr. Kaplan got here at about 9:15. I was here at 9:06. I know we eventually started. We did the direct examination of Dr. Kaplan and it went very smoothly, with minimal delay or interruption. In fact, it went very quick. I think I finished my direct in a little over an hour or so.

We then conducted -- well, Mr. Maher conducted his cross-examination and we probably got 15, 20 minutes in and we took a break so he could, I think, look at --

THE COURT: I'm going to stop you for a moment, simply because I don't want the record to reflect your interpretation of how this day went, because what I've heard so far isn't necessarily consistent with what has

happened and I am just putting this on the record now, before you finish, so that you understand that you're putting your interpretation of what occurred today thus far.

I have found several statements that you made to be inconsistent with what is going on in this courtroom.

Now you may continue.

MR. SHECTMAN: Your Honor, I would just ask clearly --

THE COURT: Just continue. We're on the record. You may continue.

MR. SHECTMAN: I just want to know -- I was in it middle of explaining my recitation of what happened. I would ask respectfully if I can do it.

THE COURT: I said continue, counsel.

MR. SHECTMAN: Everything I just said is on the record. When we took a break, it was a little after 12:00 o'clock and I saw Dr. Kaplan and he was pacing around and I said Doctor, we have a little bit more to go, we're going to break, I think, about 12:30, then we'll come back at 2:00. He then said to me, I cannot come back at 2:00, I have a doctor's appointment absolutely that I cannot miss.

And I said, which is the truth, Doctor, I had no idea you had a doctor's appointment. I am telling the Court on the record I had no idea that this doctor had a

doctor's appointment that he could not miss.

Although, which is on the record, the doctor then was told get back on the stand. I went out there and he was on the phone. He came back in and you could see in his face when we took the break, I said, Doctor -- you said you have to come back at 2:00. We could see if this is on the record, but Dr. Kaplan said Your Honor, I have a doctor's appointment.

THE COURT: Again I'm going to stop you because I don't want you to repeat stuff that is not accurate.

MR. SHECTMAN: The record will speak for itself.

THE COURT: Counsel, if I am speaking, then I want you to stop and this has been continuous throughout this trial.

MR. SHECTMAN: May I please make my record, Judge? I would like to finish my record, please.

THE COURT: Dr. Kaplan did not inform me. Continue.

MR. SHECTMAN: Judge, in the courtroom --

THE COURT: Counsel --

MR. SHECTMAN: I stand on the record that he turned -- when you said he has to come back at 2:00, he said I cannot come back, I have a doctor appointment. You said Doctor, you are instructed to come back at 2:00 or I may strike your testimony. The doctor then left the

courtroom. I asked him, can you come back on Monday and he said yes.

I immediately said to Mr. Maher, I said, Dr. Kaplan can come back on Monday morning at 9:30. I know we have a doctor coming back anyway on Monday, is that an issue for you? And graciously Mr. Maher said if we have to come back Monday, we can do Dr. Kaplan in the morning on Monday and his doctor immediately thereafter or the afternoon.

What I am stating to the Court, Your Honor, I did not know he had this doctor appointment. I had been ready everyday. We had trial everyday. We had Mr. Paiba over the course of, I think, two days. We had Dr. Merola, I think, two or three days. We had had doctors every day. We did have a doctor today but unexpectedly he told me he could not return in the afternoon. When the Court said why, didn't I inform you? I didn't inform you until I was told for the first time and I immediately came back inside and was told the Court was going to recess for lunch.

The reason I wanted to speak to the Court was could we get confirmation to bring him back Monday. I was saying that so we won't have to bring the jury back at 2:00, if we were in agreement we could come back on Monday morning.

What I want to state on the record, Your Honor, I

only found out -- the doctor told me during the break at about 12:00 o'clock. When I asked the doctor if you could tell me what the doctor's appointment is, I don't mean to pry, but I do want to state to the Court to put on the record what the condition is. Counsel, I am not disclosing what the medical problem is.

It's Friday. It's 2:15. Mr. Maher was to continue his cross. I have redirect. The likelihood, Your Honor, is we wouldn't finish anyway today and he would come back on Monday morning.

All I am saying, respectfully, if we can continue with his testimony on Monday morning because we have to come back Monday anyway for Mr. Maher's doctor, and graciously he agreed to do it in the afternoon.

There's no prejudice to the defense but there's prejudice to me because this doctor, he did a knee surgery, testified my client needs a future knee replacement, so we have to come back Monday anyway.

Like I said, I did not know. I am telling the Court, I didn't know. So I apologize to the Court if I have been talking or fighting with the Court, but imagine my frustration. I didn't know the problem.

So I would respectfully ask Your Honor if we can adjourn for a continuance. It's Friday afternoon; it's 2:20, if we can kindly adjourn until Monday. Dr. Kaplan

will be here on Monday morning and we'll finish Dr. Kaplan. He was a pretty straightforward witness. We can go into the defendant's doctor's testimony, Dr. Groslamer, and there won't be delays. But I am telling the Court I apologize and I didn't know. I really did not know.

THE COURT: Defendant, do you have anything to say?

MR. MAHER: Well, the only thing I have to say is, Counsel was accurate in stating that I consented to continuing the cross-examination of Dr. Kaplan on Monday if that was necessary. So long as there wasn't an interruption in witnesses, as long as he was the next person to take the stand, I would accommodate the doctor. But obviously that's not up to me, it's up to the Court.

THE COURT: I'll just put on the record that the Court does take exception to a number of inconsistent statements that were made by the plaintiff in his recitation or interpretation of how this day unfolded. And as I said prior to the recess, Dr. Kaplan was scheduled to appear here today by the plaintiff's attorney, I'll say as late -- we had him scheduled by the Court as of March 9th and I am sure that the doctor had to have been contacted before that date.

Testimony of expert witnesses can never really be estimated and that in scheduling your witnesses, as I

stated earlier today, there should be a conversation with the witness with respect to the timeframe, especially if we're talking about an expert witness in a trial that has been going on for almost two weeks now.

Plaintiff did not obtain the information that he needed from his witness in order to determine his availability for the day and to have the Court and the defendant under the impression that the doctor was going to be here and to state to the Court that he only found out about it, and this is not indicating that he only did find out today, my position is that the information should have been obtained from the witness prior to today as it wasn't an emergency situation that he had to step out on, it was a scheduled doctor's appointment that the witness had and knew about prior to today's date.

So he certainly could have put the plaintiff on notice with respect to his availability for today and how this trial was going to proceed.

So plaintiff, your witness is not testifying this afternoon?

MR. SHECTMAN: He told me that it's a doctor's appointment that's an hour away and he cannot miss this doctor's appointment.

THE COURT: It's a yes or no question.

MR. SHECTMAN: He said he could not miss it and

left.

THE COURT: It's a yes or no question.

MR. SHECTMAN: He is on the way to a doctor's appointment.

THE COURT: It's a yes or no question. Is your doctor appearing this afternoon?

MR. SHECTMAN: No. He is going to his necessary appointment.

THE COURT: Thank you. That has been the consistency of the answers that I have been getting from plaintiff's counsel during of the course of this trial.

I would also like the record to reflect a call was made into chambers at about 10:10 or so advising me that everyone was ready to proceeded. I don't know the times that the parties appeared or the times that the witnesses appeared.

Defendant, with respect to your witness, I'm going to call him Doctor G because I didn't get the full spelling of his name when you indicated the name of the witness that was going to testify.

MR. MAHER: Dr. Ronald Groslamer. He had agreed that he was going to appear on Monday morning. In fact, he e-mailed me the other day regarding that. Now, I will say this, Your Honor. I locked him in for that time. Obviously I want to finish Dr. Kaplan beforehand. Now, I

haven't had a follow-up conversation with Dr. Groslamer to know exactly -- I just want to be clear on this. I didn't have a follow-up conversation with him to know whether he got a problem in the afternoon. I think he would have told me if he did.

Originally he told me he would be available Monday or Tuesday. I would have to confirm with him that's still the case and I guess what I'm trying to do is work with plaintiff's attorney and see -- I am making a representation that Dr. Groslamer is available Monday based upon the fact he was going to be here at 9:00 o'clock in the morning or 9:30 on Monday. Beyond that, I would have to reconnect with him if there was some slight modification to the schedule. I don't want to make a representation that turns out to be wrong and it ends up being a problem for me because I am a trying to accommodate an unfortunate situation with Dr. Kaplan. That's all I am saying.

THE COURT: The Court will a take a brief recess. You can contact Dr. Groslamer and determine whether or not he is available for the full day on Monday for testimony or if he is available --

MR. MAHER: I don't know.

THE COURT: You can't know unless you make the phone call, Counsel, and let's see if that can work and if we can finish on Monday. Then if we don't finish on

Monday, then we're going to have an issue on Tuesday because plaintiff's other doctor that we were unable to complete that was supposed to return Tuesday at 11:30 may not be able to testify Tuesday at 11:30 because your doctor will be on the stand.

If you make the call, let's see what happens.

MR. MAHER: I will be happy to make the call. I can't guarantee that he may be with patients. I have no idea --

THE COURT: I understand that. I am asking you to make the call and the Court is in recess until you make the call.

(Whereupon, at this time, a brief recess was taken.)

THE COURT: Back on the record.

MR. MAHER: Okay, as the Court requested I reached out to Dr. Groslamer to see if I could get confirmation regarding his availability other than, you know, what we already agreed on. I was unable to speak with him and I sent him an e-mail and he has yet to respond.

I did get a message from my office that the Court was looking for me, so of course I returned immediately.

As we stand here right now, I don't have an answer one way or the other regarding his flexibility regarding his appearance, but I am willing to work with Counsel

regarding schedules because I know these things do come up.

THE COURT: I am going to take a recess and I will be back.

(Whereupon, at this time, a brief recess was taken.)

THE COURT OFFICER: All rise.

THE COURT: You can have a seat.

Defense, have you heard anything.

MR. MAHER: No, Your Honor. As I said, I reached out to the doctor and I haven't received any responsive texts or e-mail and the number that I had just went to a message, so what I said before -- if I could check one more time --

I don't have any response from the doctor.

THE COURT: Without any changes in my position taken earlier today with respect to the availability of Dr. Kaplan, in the interest of justice for the parties, not the expert's schedules, I will allow this matter and Dr. Kaplan to return on Monday morning to complete his testimony.

Dr. Groslamer, who is defendant's doctor that we're taking out of turn -- and Dr. Kaplan should be available for the whole day, I want him available for the whole day. Dr. Groslamer, you have put him on notice to appear at what time, Mr. Maher?

MR. MAHER: I had arranged with him to be here on

Monday at, I guess, 9:30. You know, obviously his testimony is not going to be -- I would just ask since we're accommodating plaintiff and Dr. Kaplan, that the Court permit me some flexibility as to when I can call Dr. Groslamer, because the scheduled time is now being taken by another physician and I will -- once I've spoken to the doctor, I will confer with you regarding when we can call him.

So perhaps it would be best to wait until Monday to know when he is going to testify. I don't know --

THE COURT: Dr. Groslamer should be here on Monday.

MR. MAHER: I can have him here on Monday. He is scheduled to be here. I will just tell him to be here on Monday. He will be here, but I don't know if you will be able to finish him.

THE COURT: I am sorry, I don't mean to cut you off.

MR. MAHER: Right. There's no issue with me having Dr. Groslamer physically present here on Monday morning because he is scheduled to be here. That would require no changes. The only thing I don't know is how long Dr. Kaplan is going to go and whether or not Dr. Groslamer is available in the afternoon. My presumption was that he was booking the whole day, but I didn't get

that detailed because, to be frank -- that's the answer. He wasn't planning on leaving for any emergency, so he'll be here on Monday, he will be here Monday morning.

THE COURT: Other than Monday, do you have any indication from him when his next available date is?

MR. MAHER: Well, when I originally contacted him, he told me he was available Monday and Tuesday and because of coordinating with counsel and knowing that the Court has a shorter day on Tuesday, given the fact I had an option for Monday or Tuesday, I chose Monday to book him because I wanted to avoid a situation where perhaps all of his testimony won't come in, so I picked Monday.

Now, I don't know if after I booked him for Monday he made schedules to testify somewhere else or appointments on Tuesday after I booked him on Monday, because it wasn't an issue until right now. That's why I need to reconfirm with him if he has some flexibility, but that's what my thought process was with booking him in on Monday, because he was available both days and I felt it would be better for Monday because the Court had a full day available Monday, not Tuesday.

THE COURT: So we'll have Dr. Kaplan on the 16th. You will speak with Dr. Groslamer and find out when his next available date is. On the 17th, let plaintiff finish his case and we'll let the plaintiff's doctor who is

scheduled for Tuesday at 11:30, I believe, to return and finish his testimony and you will let me know when Dr. Groslamer is available.

MR. MAHER: I should tell Dr. Groslamer not to come on Monday?

THE COURT: Correct.

MR. MAHER: Thank you, Your Honor.

THE COURT: So I am going to call the jury back in, unless there's anything else that needs to be addressed.

MR. SHECTMAN: No, Your Honor. I wanted to thank the Court for your courtesy. Thank you.

THE COURT: Okay. We can bring the jury in.

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, at this time, the jury entered the courtroom.)

THE COURT CLERK: All Counsel stipulate to the presence and seating of the jury?

MR. SHECTMAN: Yes.

MR. MAHER: Yes.

THE COURT: Good afternoon, jurors. Have a seat. I hope you enjoyed your lunch. I am sorry for your extended wait returning.

When we left for lunch, we had Dr. Kaplan on the stand who was unfortunately unable to return to the stand

this afternoon, and so therefore, we're going to -- plaintiff is going to stop and we'll excuse the jury for the weekend.

I ask you to return here Monday 9:30 where we will continue with the testimony of plaintiff's case and then I will give you an idea of how we're going to continue with that week.

Again, I want to thank you for your attention, your timeliness and your cooperation through this whole proceeding. As I told you, without you, the jurors, we couldn't do this. So thank you and enjoy your weekend.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, at this time, the jury exited the courtroom.)

THE COURT: So this matter is adjourned until Monday, March 16th at 10:00 o'clock. I would ask all parties to be here and ready to proceed at 10:00 o'clock. The jury is going to be here at 9:30.

If there is anything that needs to be discussed beforehand, if you need to discuss it beforehand, we'll do that. Otherwise, we are adjourned until Monday, March 16th at 9:30.

(Whereupon, the trial was adjourned until March 16, 2026.)

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