SUPREME COURT OF THE STATE OF NEW YORK

TRIAL TERM PART IA-6 : COUNTY OF BRONX

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ANA FERNANDEZ,

Plaintiff(s), Index # 302486/10

-against-

LAUREN BETH ROSENTHAL, as the EXECUTRIX of the Estate of TED A. SCHAEVITZ, HARRISON REDD, PLAKOTO TRANSPORT, INC., OUSMANE DIABY, and G TRANSPORTATION,

Defendant(s).

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851 Grand Concourse
Bronx, New York, 10451
March 6, 2017

B E F O R E:

HON. JAMES W. HUBERT,
J U S T I C E.

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Michele Henley,
SENIOR COURT REPORTER

(Whereupon, the following proceedings take place on the record, in open court, out of the hearing and presence of the jury:)

(Whereupon, Plaintiff's exhibits 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36, respectively, for Identification.)

THE CLERK: Docket 302486 of 2010. Anna Fernandez against Lauren Beth Rosenthal, as the Executrix of the

Estate of Ted A. Schaevitz, Harrison Redd, Plakoto Transport, Inc., Ousmane Diaby and G Transportation.

THE COURT: All right.

Are all sides ready to proceed, plaintiff?

MR. MULLANEY: Yes.

THE COURT: Counsel for defendants?

MR. VEILLEUX: Yes, Your Honor.

MR. CALDERON: Yes, Your Honor.

MR. MAILLOUX: Yes, Your Honor.

THE COURT: Preliminarily, anything before we bring the jury down?

MR. MULLANEY: Yes, Judge.

We spent the last block of time premarking the exhibits, all the medical records that came into the subpoena medical records room.

My question for Your Honor was, before we were on the record, if have you a preference if I move them in in

front of the jury or before they come down?

THE COURT: I don't think moving them in front of the jury is, you know, significant to the outcome of the case one way or another. If the exhibit is utilized during the testimony of a witness or is published to the jury in some manner, or is referenced in some manner, the jury will understand that it is in evidence.

Other than that, seeing it in evidence, go into evidence doesn't inform them of the contact of it or anything like that.

MR. MULLANEY: Okay.

THE COURT: To expedite the matter and to not create disruption during the taking of testimony, why don't you just tell us-- go down the list of what the exhibits are, how they're identified by name of some sort or another and stipulate that they've been received-- that all sides consent to their admission and have been received and marked. Okay. Why don't we just do that.

MR. MULLANEY: Okay. I'll start with

what's been
marked Plaintiff's 28. It's Doctor Arden Kaisman's medical
chart.
THE COURT: Okay. So Plaintiff's 28 is a medical
chart by Doctor Kaisman, presumably of the plaintiff?
MR. MULLANEY: Yes, Judge.
MR. VEILLEUX: No objection.

MR. CALDERON: No objection.
MR. MAILLOUX: No objection.
THE COURT: Okay. So Plaintiff's 28, I assume it
has not yet been marked but that will be marked as received
in evidence.
MR. MULLANEY: Correct.
THE COURT: Next?
MR. MULLANEY: 29 is a certified medical report of
Surgicare Ambulatory Medical Center.
THE COURT: Have they seen it?
You might want to share it with them.

MR. VEILLEUX: Judge, I think there's some redaction that's going to be need to be done with at least this record that's been offered.

THE COURT: All right. To be redacted.

MR. MULLANEY: Judge, I'll offer it in evidence subject to any redactions.

THE COURT: Okay.

Is that fine with the counsel for the defendants?

MR. VEILLEUX: No objection.

MR. CALDERON: No objection.

THE COURT: Okay.

MR. MULLANEY: 30 is the Bellevue Hospital certified billing records.

THE COURT: So where are we at on the Bellevue

billing records. Good?

MR. VEILLEUX: No objection.

THE COURT: No objection. Go ahead. Next.

MR. MULLANEY: 31. Plaintiff's 31 is the St. Barnabas certified billing records.

THE COURT: Counsel?

MR. MULLANEY: I would object, Judge. There's reference to No Fault insurance on this, would certainly have to be redacted, and all these bills were covered by No Fault.

THE COURT: Right. I understand.

They're not special damages if they were covered by No Fault but-- look, I don't have any problem with them being marked into evidence, I guess, but once they're in evidence they can be used in some manner obviously.

MR. VEILLEUX: My objection is there's reference to insurance, No Fault.

THE COURT: I get it. But the issue of materiality and relevance is also appropriate. What is the point of billing records from, I guess, Bellevue or St. Barnabas if they're covered by No Fault?

MR. MULLANEY: Sure.

Judge, again, billing records it's not

with this
witness. We have a claim for future medical expenses, the
costs that No Fault covers for certain medical treatment

could differ from the costs that Doctor Dassa testifies to
for the future procedures that he's going to testify about.
So, again--
THE COURT: That's true. Okay. Probably will but,
you know, that's not my question.
My question, what is the relevance of past bills,
that have nothing to do with, I assume-- is there some kind
of claim that there would be a lien against any recovery by
No Fault, does No Fault have a lien?
MR. MULLANEY: No, Judge.
It's relevant to the jury's determination as to
the validity of the future cost as testified to by Doctor
Dassa and any other defense witnesses.

THE COURT: I'm going to reserve on 30 and 31. I don't know about that. I'm not seeing that connection quite frankly. A doctor can come in that--

It is possible for a doctor to come in and make commentary about costs of medical procedures. It is possible to do that. Sometimes they're going a little bit beyond their-- the scope of their expertise or even their own knowledge in that regard but let's take an example.

Certainly there are plenty of experts who come in and say things like the witness, the plaintiff, whoever, is going to need knee surgery and probably a knee replacement, and so someone may solicit from them and say, okay, well

what is the surgical operation typically cost and they'll say it costs, I don't know, thirty thousand dollars. I'm

just throwing a number out there. And then somebody else will come and say no. That's ridiculous. It will only cost ten thousand dollars, something like that. Then-- what about a knee replacement, how much does that cost, a hundred and twenty-five thousand dollars. Someone else, oh, that's ridiculous.

MR. MULLANEY: I'll address it when we get to it--

THE COURT: Without any reference to well you know in the past some of her expenses or some of the witnesses or plaintiff's expenses were covered by No Fault and this is what they billed to No Fault, so that's the actual number.

MR. MULLANEY: That's not true, Judge--

THE COURT: I'm just saying. I'm just saying. I have never heard that kind of testimony. I don't know how necessarily it would be admissible in that regard but I don't know.

MR. MULLANEY: All right.

THE COURT: I'm going to reserve on those

two.

We'll take it up later. Next. 32?

MR. MULLANEY: I'm at 32. Plaintiff's 32 is offered into evidence as a St. Barnabas medical chart, the films.

THE COURT: So Plaintiff's 32 is St. Barnabas medical charts. Okay.

MR. VEILLEUX: No objection.

THE COURT: Okay.

MR. MULLANEY: 33, Your Honor, is the St. Barnabas Hospital medical chart, the documentary records.

THE COURT: St. Barnabas medical records. Right?

MR. MULLANEY: Correct.

THE COURT: Counsels?

MR. CALDERON: Judge, subject to redaction, I have no objection.

MR. MULLANEY: Yes.

MR. VEILLEUX: Subject to redaction, Your

Honor,

and this document does not appear to be certified. The certification page is blank.

THE COURT: Okay.

MR. VEILLEUX: There is no certification.

THE COURT: I don't have it.

So this is 33. Is that what you're talking about?

MR. VEILLEUX: No objection, Your Honor. Subject to redaction of insurance information.

THE COURT: So 33 is subject to redaction. 34?

MR. MULLANEY: 34, Your Honor, is the certified All Med Medical and Rehabilitation Center chart. I

apologize. Plaintiff's 34 is the Bellevue chart.

MR. VEILLEUX: No objection subject to redaction, of course.

THE COURT: Subject to redaction. Okay.

MR. MULLANEY: Plaintiff's Exhibit 35 is

the All
Med Medical and Rehabilitation Center, certified medical
chart.
MR. VEILLEUX: Judge, I think if we-- I think this
record should be offered with the doctor. These are his
records. Doctor Dassa is affiliated with All Med. I think
they should come in with him.
THE COURT: As opposed to certified medical
records per se.
MR. MULLANEY: We complied with the CPLR. It
comes in as a certified office record just like all the
other ones. I have a live witness whose going to testify
about certain portions but I don't want to have to go
through the process of going through each record.
In the interest of time I'll try to get Doctor
Dassa out here by lunch.
THE COURT: Right.
You know, off the top of my head it may be
admissible, certified I have to look. I can't always

remember these things off the top of my head.

MR. MULLANEY: It's admissible under 45:18 just

like all the other business records that come in.

MR. VEILLEUX: There is a certification, Your Honor.

THE COURT: Does it need to be redacted in some way?

MR. VEILLEUX: Subject to redaction. I didn't see any insurance information.

THE COURT: It on the safe side. Okay. Next. 36?

MR. MULLANEY: Plaintiff's 36 are the Doshi Diagnostic films.

THE COURT: What are they, MRI films?

MR. MULLANEY: Yes, Judge. MRI films.

THE COURT: Is any of this stuff going to need the shadow box?

MR. MULLANEY: No.

MR. VEILLEUX: No objection, Your Honor.

MR. MULLANEY: One last one, Judge. Plaintiff's 37. It's the Bainbridge Avenue MRI films.

MR. VEILLEUX: No objection, Your Honor.

THE COURT: All right. Without objection.

MR. MULLANEY: That's it, Judge.

(Whereupon, the items previously referred to are received and marked as Plaintiff's Exhibits 21, 22, 23, 24, 25, 26, 27, 28, 32, 33, 34, 35, 36 and 47, in Evidence, respectively.)

MR. MULLANEY: Judge, I have two models to mark.

(Whereupon, the items previously referred to are received and marked as Plaintiff's Exhibits 38 and 39 for Identification.).

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the following proceedings take place

on the record, in open court, in the hearing and presence of the jury:)

THE COURT: You may be seated. All right.

Ladies and gentlemen of the jury, we are going to resume with the presentation of evidence by the plaintiff.

By the way, good morning.

THE JURY: Good morning.

THE COURT: I hope you had a good weekend.

Counsel, you may call your next witness.

MR. MULLANEY: Thank you, Your Honor.

At this time the Plaintiff calls Doctor Gabriel Dassa.

G A B R I E L D A S S A, M.D.,

a witness called by and on behalf of the Plaintiff, having first been duly sworn, testified as follows:

THE WITNESS: Gabriel Dassa. 2770 Third Avenue. Bronx, New York. 10455.

THE COURT: All right.

Doctor, during your testimony, please keep your

voice up so that the jurors and everyone else can hear your testimony. Also speak slowly enough so that the reporter, seated in front of me, can accurately record your testimony. Please wait until the question has been fully asked before giving your response so that the question and answer may be accurately recorded.

If at any time you do not understand the question, please so indicate and we'll have it rephrased.

Counsel, you may inquire.

MR. MULLANEY: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. MULLANEY:

Q Good morning doctor.

A Good morning.

Q Are you licensed to practice medicine in the State of New York?

A Yes, I am.

Q When were you licensed?

A 1992.

Q Can you please describe for the jury your education,

training and experience, please?

A Yes. I did complete a four year premedical training

program at Fordham University in the Bronx, New York. I

completed that in 1986. I attended medical school at New York

College of Osteopathic Medicine in 1986 where I commenced and I

completed it in 1991.

I had applied to and was accepted to an orthopedic

surgery residency at the Albert Einstein College of Medicine

program in orthopedic surgery. Prior to commencing that training

I had to complete a year of internship year training which I did

in internal medicine at Coney Island hospital in Brooklyn, New

York.

I then had to do a presurgical year of general

surgery at St. Barnabas Hospital that I did complete and that

was from 1992 to 1993 and, then, I commenced my orthopedic surgery residency program at the Albert Einstein College of Medicine program and then opted out of graduating from that year to do an extra year in subspeciality training in hand surgery at New York Joint Disease, NYU medical program.

Q Can you briefly describe for the jury and court what the field of orthopedics is?

A Yes.

Well, there are several specialties in medicine. There are different areas of focus in the human body. My focus is the musculoskeletal system. So that would be conditions or traumas that would effect joints, tendons, ligaments, bones in the spine and neck, fractures, conditions of all those areas, and I perform surgery, on a weekly basis, on those areas.

Q Are you board certified?

A Yes, sir.

Q In orthopedic surgery?

A Yes, sir.

Q And just please briefly describe for the jury, because they haven't heard that term yet, what does board certification mean?

A There are different types of medical training where you complete what is considered to be accredited medical training and you are deemed to be board eligible.

The program that I completed was an accredited program which deemed me to be board eligible or stating that I was trained sufficiently to sit for an exam.

I did complete an exam which consisted of several parts. One part was a written part, then there was an oral part. I achieved my certification in 1991 and then-- I'm sorry--

in 2001 and then I had to recertify in 2010.

So I did that process twice and that indicates that your training and your medical knowledge is up to date and you're functioning as a physician in keeping with the standard

that is set forth by the peers in the field.

Q All right.

Can you just describe your current practice, your current medical practice?

A Yes, sir.

Well, I have a practice of general orthopedic surgery. I do that approximately sixty-five to seventy percent

of my practice and I'm also a hand specialist so I do, at times, see hand problems that other orthopedic surgeons who do not have comfort with hand problems they refer those patients to me.

Q And what about knee joint problems and lumbar spine problems, do you treat those, sir?

A Yes, sir.

Q Okay.

On an average week or month, however you want to put it, how many surgeries do you perform?

A I mean it's hard to quantify on a week or

month. I would say over the last three years it's been between five hundred and fifty to six hundred surgeries a year of which at least fifty percent were on the knee, and I don't operate on the spine. So I treat the spine in my office but I don't do surgery on the spine.

Q Okay.

Now at some point were you affiliated with a medical clinic, a practice call All Med here in the Bronx?

A Yes.

Q And while you were an orthopedic surgeon at All Med, did Ana Fernandez come under your care?

A Yes.

Q Do you have your office chart with you today?

A I do.

Q All right.

MR. MULLANEY: The All Med chart is marked into

evidence, just for purposes of the record, as Plaintiff's 35.

Q I want to direct your attention to the first date that you saw Ana Fernandez?

A Yes, sir.

Q And when was that?

A That was September 4th, 2009.

Q And when she came to you, what problems or complaints did she make?

A She presented with complaints of bilateral knee pain as well as pain in her lower back which was being referred to her lower extremities associated with numbness and tingling.

Q When you say bilateral, can you just describe that term, please?

A Well, you have two legs and it's effecting both legs.

Q So bilateral just means both legs?

A Yes.

Q Okay.

Did you take a history from her on that date?

A Yes.

Q And what did you learn?

A She presented with a history that she was 35 years old at the time. She reported that she was involved in a accident on 8/31 of 2009. She had reported that she was struck by a car and

essentially began feeling pain in her lower back, both hips and both knees.

Her history was that she was taken to the hospital and essentially had x-rays taken which were essentially negative for fractures and presented with complaints of back pain.

She described back pain as being exacerbated by prolonged sitting and walking. She also had pain in both hips and both knees which she described that was made worst with going up and down the stairs or getting up from a chair.

She denied any prior history of complaints to those areas. She stated that she was utilizing Motrin

for pain

that was prescribed by the hospital with minimal relief of those symptoms and she presented because of persistence symptoms she described.

Q Now, after you took a history from Anna and learned about her accident and her medical course prior to getting to you, what did you do next in your initial approach?

A We had a physical examination.

Q And what does that consist of?

A Well, we did an exam of her lower back, her lumbar spine, her hips and both knees.

Essentially with the lower back we did what is called palpation which is actually physically touching the soft tissues of the spine and that revealed that she had tenderness to palpation from L1 through L5 and at the L5-S1 there was

paraspinal muscle spasm.

Q All right. We'll define those terms in a little bit.

But spasms, you felt them with your own hands when you palpated her?

A Yes. When the muscles were palpated and touched. They were tight and indicated spasm.

Q Is that something that can be faked?

A No, sir.

Q Okay. All right.

Doctor Dassa, I'm trying to do my best to get you out of here by 1. So I'm going to try to condense now. Can you just tell the jury about your positive findings on range of motion and any other tests that you directed to the knees and to the lumbar spine?

A Yes. Well, for the range of motion, the flexion--again, we're describing motion of the lower back, the lumbar spine. So flexion would be bending forward at the waist. Extension would be bending back, rotation and then side bending to the right and left.

Her ability to flex was measured to be 50 and

normal is 90. Her extension was 15 and normal is 30. The lateral bending was 20 and normal is 40 and the lateral rotation was 15 and normal is 30. She did have a knee exam done. Pertinent to the range of motion, both knees were able to bend.

So if this is a straight knee bending, the knee

would be bending at this knuckle. Normally it's one hundred and forty degrees. She was only able to bend both knees to one hundred and twenty degrees. So there was loss of twenty degrees of movement to both knees. It was also a moderate amount of swelling noted to the right and left knee, and there was also tenderness. So when the knee was palpated or touched there was tenderness noted around the knee diffusely and the left knee was found to be more severe in tenderness than the right knee.

Q Okay.

And did you do a visual inspection of her

legs,

knees?

A Yes, sir.

Q And what did it reveal?

A Again, she did have a large bruise which was described as an ecchymosis over the right leg measuring 8 centimeters by 4 centimeters. So there was a large black and blue over the right leg.

Q What does that indicate to you?

A There was some type of trauma or impact to the leg.

Q Doctor, with the Court's permission, this might be a good time to use the knee model marked as Plaintiff's 39 for Identification just to describe the different parts of the anatomy of the knee joint that you just went through.

A Yes, sir.

THE COURT: If you'll give it to the court officer, she will give it to the witness.

Q Can you step down and just show--

Now, that model, is that anatomically correct?

A Yes.

Q Okay.

A So what we're looking at here is an anatomical model of the knee joint, and it's facing you. You could see it's the right knee. How do you know that because of the fibula bone which is the skinny bone is on the outside part, on the right side. So when you get is a look at the construct of a knee, the joint.

The joint is a connection of bones that are held together by ligaments and what it does, it's a point of movement at the joint. So it's similar to a hinge of a door. So it facilitates movement. So the components of the knee joint are broken down into individual bones. So the major bone on the bottom of the knee is the top of your shinbone. Okay. And that is call your tibia and the bottom of your thigh bone, which is on the right knee, which is your femur and, again, the fibula

which is another component and then you have the small circular bone which is called your patella or your kneecap and they all together form this compartment called the knee joint which allows movement between your thigh bone and your shinbone.

Q And what is that disc? It looks like it sits in the middle of those two bones?

A So when you look at the things that comprise the joint, in addition to the bony structures you have soft tissue structures. So on the outside of the knee you have ligamentous structures. These are your collateral ligaments. So on the outside of the knee which is the collateral, the lateral collateral ligaments and inside is it the knee collateral ligaments, so inside of the body is medial, outside is lateral.

As we come inside you now have internal ligaments

which are your cruciate ligaments. This would the be internal ligaments that give stability to the knee and then the structures that separate the bones are these thick cartilages which is called meniscus. So you have a medial meniscus on the inside and a lateral meniscus on the outside.

And, then, on the surface of the bone you have another cartilage which is articular cartilage, or joint surface cartilage, and that would be on the surface of all the bones that form the knee.

Q What purpose does the meniscus serve?

A Well, you know, the meniscus is a very dense tissue and the function of the meniscus is to attenuate or to cushion the knee from the forces so when you're walking-- and again if you imagine a person can go out and run a marathon for 26 miles, if he didn't have that meniscus that's distributing those forces and cushioning the knee, you would have two bones wearing each other out.

So basically it serves as a surface for cushioning force. It allows you to walk on your knees, hopefully, for five or six decades and not have damage.

Q Now, you mentioned a little while ago, when you were going through your clinical exam that she had-- Anna had a positive McMurray's Test. What would that indicate to you as far as potential injury or condition?

A Well, the note of September 4th of 2009 makes reference to two provocative orthopedic tests. So specifically we're speaking of McMurray's compression. Those two tests were positive, would suggest on a clinical basis, and that would be on exam findings of a meniscus tear. Or a torn meniscus that we showed earlier.

Q All right.

Now, as a result of the history that you took and the exam results, did you form any working diagnoses or impressions or opinions?

A Yes, sir.

Q And please describe them briefly to the jury after that first visit?

A Well, one would be muscular ligamentous injury to the lumbar spine, the lower back, and it would be lumbar sprain,, rule out disc displacement, bilateral hip sprain, bilateral knee sprain,, rule out internal derangement. And, again, the diagnosis makes reference to the bruise on the right leg. So it

was a right leg interior ecchymosis.

Q Okay.

And did you prescribe future treatment?

A Yes, sir.

Q And what was the treatment plan?

A Well, you know, as would be customary in the absence of a broken bone, she was sent for some physical therapy to try to manage her pain symptoms.

She was referred out for diagnostic

testing, MRI

for lower back, both hips and both knees. She was prescribed a narcotic painkiller for her pain and a muscle relaxant. She was given a lumbar brace for her back and she was also sent out for x-rays of both knees.

Q All right.

Now, skipping ahead to the next time you saw her, October 2nd, 2009.

A Yes, sir.

Q By that time did you--

Were the MRIs done of the body parts that you just described?

A Yes, sir.

Q Did you review the findings with her on that day?

A Yes, I did.

Q And please share with the jury what your findings were?

A Well, you know, she did the diagnostic studies. An MRI is a test that we utilize to identify soft tissue injuries. So in the case of the spine we're looking for damage to the ligaments and the discs. In the case of the knee we would be looking for ligamentous damage, cartilage damage, meniscus damage.

In the case of the back there was a disc herniation noted on that MRI that was done on September 16 of 2009. The report and the study revealed that the disc--

And when we look at discs in the spine the analogy I'll use is that of the jelly donut. So the disc is around structure that is made up of a wall of connective tissue and in the center that have disc is fluid.

So when the spine is maintaining a posture the pressure that gravity and the weight of the spine excerpts on itself will be supported by the disc, similar to the meniscus, and then that central fluid portion pressure rises to maintain that support. And in the case where the wall of the disc is

torn, the disc material, that liquid will squirt through the tear.

So if you every bit into a jelly donut and the jelly squirted out the side from the pressure, you know, the disc in a similar manner violates the wall through the tear and it actually leaks out of the central portion where it would normally be, and in the particular case of the spine it causes

pressure on the nerves where they exit the spine and this specific level that it found-- because there are five levels in the spine so at the L4 or between the fourth and fifth lumbar segment was where the disc material was found to be herniated or out of place pressing on the nerve root on the left side.

MR. MULLANEY: Judge, with your permission, I'd like to show you the doctor what's been marked Plaintiff's

26 for Identification?

THE COURT: Yes. For the record, 26 is?

MR. VEILLEUX: For identification, no objection.

THE COURT: Plaintiff's 26 being shown to the--

for Identification being shown to the witness.

Q Doctor, I want you to take a look at Plaintiff's 26 for Identification and ask you if you're familiar with what appears on that board?

A Yes, sir.

Q Okay.

Have you seen this board prior to today?

A Yes.

Q I shared it with you prior to your appearance here today. Right?

A Yes, sir.

Q And we reviewed it together?

A Yes, we did.

Q And the film images of the September 16th, 2009 lumbar

MRI, that you were just referencing the film image as they appeared on Plaintiff's 26, are they true, identical and exact copies of the film images from the original September 16th, 2009 MRI?

A Yes.

Q And they have all the personal identifying information of Miss Fernandez in the margins?

A Yes, sir.

Q And the illustration that appears beside it and above it, those are not-- that's not Ana Fernandez' body. Correct?

A That is correct.

Q Those are medical illustrations. Correct?

A Yes, they are.

Q And would those medical illustrations, made in explaining your testimony to the jury, and would it-- would those illustrations aid the jury in understanding your testimony?

A Yes, sir.

MR. MULLANEY: Okay.

Judge, at this time I offer Plaintiff's 26 into evidence for the films only. The illustrations are

demonstrative only.

THE COURT: Counsels?

MR. VEILLEUX: Subject to redaction of the illustrations that appear on that exhibit, Judge. I don't

have an objection to the films themselves.

THE COURT: Okay.

Ladies and gentlemen of the jury, we're going to admit this into evidence. I want to-- you to understand that the illustrations are not evidence upon which you can draw any conclusions regarding injury or anything of that nature.

Obviously any testimony of the witness to the extent that that testimony is based upon the actual MRI evidence or his own observations, let's say, of the MRI. His testimony of course would be admissible but what is depicted in the illustration is just a depiction and is not to be

relied upon by you. The MRI copies that are depicted upon the exhibit, those are to be treated the same as if it was an actual MRI shown to you here by some mechanism during the course of the trial.

MR. MULLANEY: Thank you, Judge.

THE COURT: And it may be marked.

(Whereupon, the item previously referred to is received and marked as Plaintiff's Exhibit 26 in Evidence.)

THE COURT OFFICER: Plaintiff's 26 is marked into evidence.

Q Doctor Dassa, if you could describe-- whatever order you want, the anatomy and the findings of the MRI. Please speak up so everybody on the jury could hear you.

THE COURT: Before you do that, let me just

ascertain, can you gentlemen see it because if you'd rather

move your position up here, you may do that.

MR. VEILLEUX: That would be better, Judge. Thank you.

THE COURT: Yes.

A Okay. We're essentially looking at two forms of information. One is a copy of the MRI films done on 9/26 of 2009 on the lumbar spine or the lower back of Ana Fernandez.

So, as I stated earlier, going to the graphic now, which is not her. It's just a drawing.

The lumbar spine is the lower back. So there are one, two, three, four, five lumbar segments that are bone scaffolding and between those segments are soft tissues which are call intravertebral discs.

So what are we looking at on this side is just the drawing of a disc. This is the outside connective tissue wall and in the center you have the fluid. So you have the annulus and then you have the nucleus which is the center of the disc.

Now, in a normal spinal anatomy you have a spinal cord that travels inside this cage and that's the analogy that

is made of the bone that protects the spinal cord. And from the spinal cord comes nerve roots which exit on each side of the bone.

So in this particular case you can see the spinal nerve roots. Now in the case where the disc is contained in

normal anatomy, the windows are the foramens, are the nerves exit, the spine are clear and there's nothing inhibiting the nerve or pressing on the nerve.

So in the case of a disc injury, and again this lower graphic shows the disc wall which is the annulus with a tear, and this fluid now seeps out of the disc and now presses on the nerve root causing a pinched nerve in layman terms.

So if you compare the two where the disc is intact and you can see the space is open versus where the disc is

injured and the disc material now is pressing on the nerve root,

you can see graphically the difference between the two.

Now, if we go to the MRI, what are we looking at.

We're looking at, again, the anatomic version of this drawing

which is actually the patient's anatomy. So we have the five,

four, three, two. So it's cut off on the upper level there but

you can see at the L4-5 disc and, again, we use comparisons. So

the L3-4 disc you can see number one, it's healthy in appearance

so it appears as this bright, white structure whereas the one

that is injured you can see it's darker and gray and you can see

that the disc material is contained in the disc up here whereas

this disc material is actually leaching out into the space.

MR. VEILLEUX: Judge, can we have a brief

sidebar?

THE COURT: Yes. You may be seated, doctor.

(Whereupon, a discussion takes place off the

record, at the sidebar, among the Court and counsel:)

(Whereupon, the following proceedings take place on the record, in open court, in the hearing and presence of the jury:)

THE COURT: Ladies and gentlemen of the jury, I have been advised that you could use a brief recess at this time. This is a good time to do it. So if you would please follow the directions of the court officer, she will escort you to your normal resting place and we will call you back here within the next five or ten minutes.

(Whereupon, the jury exited the courtroom.)

(Whereupon, a recess was taken.)

(Whereupon, the following proceedings take place on the record, in open court, out of the hearing and presence of the jury:)

THE COURT: The jury is not present in the courtroom.

There is an objection raised by counsel for the defendant Schaevitz, that contained within this exhibit, which is Plaintiff's Exhibit 26, of course are both MRIs. I'll call them graphs-- that's probably not the exact term for it but MRI graphic images which are actually the images from the MRI and there are three of them.

In addition to the MRI images there are, how shall I say, images, illustrative images much like an artist's

rendering, if you will, of certain regions of the lumbar anatomy and they depict certain things.

Now, there are three MRI images which are simply the MRI images. However, there are also two MRI images overlaid by artist's renderings, illustrations and the objection, I assume, is going to be as to both of the MRI images that are overlaid with artist's

illustrations

illustrating in one instance a lateral view of the lower lumbar region specifically the area between-- starting at the L4 level and extending down to the L5 level and the S-- S1?

MR. VEILLEUX: Yes.

THE COURT: And S1 region underneath there. That's a lateral view, a side view. The other is what I would call a cross section view from above of the L5-- or make it an axial image. An axial image of the L5, L4 disc and in both of these two images, MRI images overridden or, if you will, or enhanced by an artistic imaging are what are called or what appear to be, in the instance of the cross sectional view, the herniation of the disc at L4-L5 and in the axial view, the herniation of the L4-L5 disc.

The objection is that the jury should not be allowed to view much less draw any assumption from the artistic rendering.

Is that stating your objection?

MR. VEILLEUX: Yes, Judge.

THE COURT: I'll hear you, counsel.

MR. MULLANEY: Thank you, Judge.

Again, I think the charge at the end of the case, that they're going to get regarding demonstrative is that they're not to draw any inferences.

The foundation that I laid with Doctor Dassa is the textbook foundation is these are illustrations, that these illustrations are anatomically correct--

THE COURT: Well, they're not anatomically correct if they're showing a disc herniation that doesn't appear or is not-- or is different from what is actually on the MRI.

MR. MULLANEY: Okay.

THE COURT: So we don't spend all day on this.

For example, the MRI image, I would say that to

the lay person viewing it, I don't see in the actual image what is depicted artistically in the film next to it.

MR. MULLANEY: I understand.

THE COURT: Now, you can argue, perhaps, that oh yeah, it's there. You got to look really closely, Judge. But the fact that you might have to look really closely is probably part of the issue in the case as to whether or not it's positive or negative, and I have a funny feeling that at some point there will be expert testimony that's going to

say exactly that.

MR. MULLANEY: Sure. Judge--

THE COURT: Well not sure, yeah.

MR. MULLANEY: I'm just saying my foundation--

THE COURT: Stop. Stop. Stop. I know what your interest of time is but I also have an interest in other

things as well as your time. I have an interest in the jury's time and accurate representation.

The same thing is true of the sagittal-- I guess it's called the cross section image that has on top of it the artistic enhancement, if you will. Again, is there something there that could suggest in the actual MRI image that there is a secretion into-- out of the disc and into the nerve root area, yeah. I would say it's a little better or more-- it's a little more evident in the MRI than it is in the axial view but it's not the same. And, again, it's an enhancement.

MR. MULLANEY: Judge, I haven't finished saying my foundation. Judge, that doesn't matter.

THE COURT: I'm sorry.

MR. MULLANEY: He could make a drawing on a napkin. If he answers the question that that would aid his explanation to the jury, and it would aid the jury's understanding of his testimony to the jury. It's

demonstrative proof.

THE COURT: No. It's not demonstrative proof.

You're wrong. Hold it. Stop. You are wrong. Now don't tell me you could do it--

MR. MULLANEY: I said--

THE COURT: Stop. Stop. And don't tell me anything about a napkin. I don't want to hear about that.

This is not a demonstrative thing. This is a representation of what actually is there.

Unless you're prepared to say to the witness now, doctor, you can't see that in the MRI so this is just a demonstrative exhibit of what it would be if that was true.

MR. MULLANEY: No, Judge--

THE COURT: But you don't see that in the MRI. If you're not prepared to say that then my instructions to the jury will be they are to ignore what is depicted

artistically in these two sections and they will have to judge for themselves whether from the exhibits shown of the MRI there indeed is a herniation. Okay. That's what is going to happen.

MR. MULLANEY: I understand that, Judge.

THE COURT: Then good--

MR. MULLANEY: But you gave me--

THE COURT: Let's have the jury.

MR. VEILLEUX: I would ask that you instruct the jury about the other blow ups.

THE COURT: Yes, sir, go ahead put it on the record?

MR. MULLANEY: For the record, the-- when I offered this into evidence you said just that to the jury--

THE COURT: No, I didn't say that because I didn't see-- I said they are no ignore the artistic

rendering.

MR. MULLANEY: Right.

THE COURT: But the testimony that's being done now to show, you just said this is an accurate enhancement of what is in the MRI.

MR. MULLANEY: No, I didn't, Judge. This is a medical illustration, that's not Ana Fernandez. This is a medical illustration.

THE COURT: Then it's a medical illustration of what might be, not what is.

MR. MULLANEY: It goes to the weight of his testimony--

THE COURT: No it doesn't. It goes to admissibility.

MR. MULLANEY: I'm not asking for it to be admitted. Wait--

THE COURT: Don't use the word wait.

MR. MULLANEY: Judge--

THE COURT: You're confusing apples and oranges.

I'm pretty versed on what the rules of evidence are.

MR. MULLANEY: I understand that, Judge.

THE COURT: Believe it or not.

MR. MULLANEY: All I'm saying is these are the only images so this is an exhibit that they can take to the juryroom. You explained that to them.

THE COURT: Right. But he's asking for something more. He's asking for something that is what he says is prejudicial that needs to be cured and clarified. Forget about cured but clarified to the jury and I'm prepared to do that.

MR. MULLANEY: All right.

THE COURT: All right. Let's have jury back.

THE COURT: Please bring the jury in.

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the following proceedings take place on the record, in open court, in the hearing and presence of

the jury:)

THE COURT: The jury of course may be seated.

If I could have your assistance, officer. If you could hand me that chart right there, please.

Ladies and gentlemen of the jury, just for clarification. As I have indicated to you previously, these are artistic renderings, okay, and they are not to be regarded as evidence in this case.

The artistic rendering located here on the lower--

I'll call it as you're facing the item on the lower right hand is basically an artistic overlay on top of what is immediately to its left, and I'm calling that the axial view of the disc between the L4 and L5 structural vertebras, the vertebral members. So you're looking down. And this is a cross section of the side view of the same thing.

So you have L4, L5 vertebral members and a disc herniation. These are not the evidence to be considered by you in the case. This is the vertebral cross section L4, L5. This is the axial view of the disc between them, these two things.

It will be for you to determine, from all of the evidence in the case. Again, this not being evidence, whether there are disc herniations or not. The artistic rendering showing what a disc herniation might look like as overlaid over her spine.

Same here, what an axial view of a disc herniation might look like overlaid over the axial view MRI. Okay. But that's not proof of what actually was there or wasn't there.

Okay.

MR. MULLANEY: May I continue, Your Honor?

THE COURT: Yes, you may in continue.

MR. MULLANEY: Thank you very much.

Q Doctor Dassa, that's not Ana Fernandez. That's not a

picture of her. That's an illustration?

A Yes, sir.

Q Illustration?

A Yes, sir.

Q Illustration?

A Yes.

Q Real MRI. That's her body?

A Yes.

Q This is her body?

A Yes.

Q This is her body?

A Yes.

Q Okay.

The herniation that's illustrated over here and that's illustrated over here, do you see the herniation such as that in the real MRI?

A Yes, I do.

Q Okay. Can you please just point to it for the jury?

A Well, again, if we're looking at the segments this

would be lumbar five, four, three, two. Between four and five you can see the disc herniation. Okay.

This view is the transverse view or axial view. On the right side you can see the nerve root where it comes out of the spinal cord, all around it is the spinal fluid which is this white. Okay. On the left side you don't see the root. It's

completely obliterated by the disc material so that it's being pinched and actually pushed to the side by the disc material.

So if we look at this top view, and we are looking at the sagittal view now, the spinal cord is bathed in fluid which is this white signal on the MRI.

Now, the fluid travels from the brain all the way down the neck into the mid back all the way down to the lower back.

Now, if you see where the discs are above the

level of L4-5, you can see they're central and they're in the space and the appearance of the disc is white and healthy. At the L4-5 level you can see the disc is darker and it's actually translated to the back part of the spine, and as you see this column of fluid, it's like a free-floating river. There's no obstruction to that fluid.

As you get to the 4-5 level you can see that that fluid starts to become pinched and dammed up. So there's something physically in the space that's effecting the flow of that fluid which is the disc herniation.

And if you come down on the nerve root level, here the nerve root is seen plainly and clearly. You don't see it here because it's being pinched and translocated and a bigger blow up of this would be a blow up L4-5 level, the disc is pinching the fluid where above it it's patent and open and below it you start to see the fluid but at that level the fluid column

is pinched.

Q Now, just in case the jury didn't-- this axial.

What view is that they're looking at?

A This would be, again, if I took a slice through the disc this way. You're looking at this disc at the L4-5 level.

Q Okay.

Now, L4-5 you said has a herniation. Did you see any other defects whether herniations or bulges at any other levels of Ana's spine?

A No, sir.

Q Okay.

All right. Thank you.

After you got the MRIs back and you reviewed them with Ana Fernandez on that next October 2nd, 2009 visit, you continued treating her?

A Yes, sir.

Q You did an additional physical exam that day?

A Yes.

Q With more positive findings?

A I think basically her exam findings were unchanged from her initial visit.

Q Okay.

What further treatment program did you recommend?

A Well, most notably was the fact that she had this finding on MRI.

She was sent to a neurologist which is Doctor Zao for a nerve testing to assess if there was any nerve damage that correlated with the disc herniation. Also she was sent for continued physical therapy. She was continued on the narcotic pain medication and she was advised to continue her lumbar brace.

Q Okay.

Did she go see the neurologist?

A Yes, sir.

Q Did she have the nerve testing done?

A Yes, sir.

Q Was that an EMG NCV?

A Nerve conduction velocity.

Q And did you learn the results?

A Yes, sir.

Q What were the results?

A Well, she completed a nerve test on 11/3 of 2009 and that was consistent with left sided L5 radiculopathy.

Q Okay.

What is radiculopathy?

A It is a term that describes dysfunction of the nerve root which causes certain symptoms which she was presenting with and essentially the patient will get nerve dysfunction and can have sensory impairment. You can have numbness and tingling. You can have burning or pain down the leg. So basically this is

as it pertains to electrodiagnostic study there was dysfunction at the L5 nerve root.

Q All right. Is that consistent with the MRI findings of L4-5 disc herniation with encroachment extending into the nerve root?

A Yes, sir.

Q Okay.

So there was a positive EMG for nerve injury?

A Yes, sir.

Q Okay.

Now, did you continue treating her for her knee injuries?

A Yes, sir.

Q Okay.

And she had MRIs of both of her knees. Right?

A Yes, sir.

Q Were the MRI findings negative or positive?

A They were negative.

Q Meaning they were normal. Right?

A Well, again, if the MRIs did not show any diagnostic damage to her knee joints.

Q Okay.

Now, did she continue to make-- withdrawn. She continued to see you personally at least once a month

for the
25 next couple of years.

1 Correct?
2 A Yes, sir.
3 Q Okay.
4 And in the interim, in the days that she didn't
5 see you, she only saw you once a month. She was going to
6 physical therapy?
7 A Yes, sir.
8 Q And other treatment?
9 A Yes, sir.
10 Q When you next saw her did she make any additional
11 complaints about her left and right knee? The December 10th,
12 2009?
13 A Yes.
14 Q And you put her through the physical exam you described
15 a little while ago?
16 A Yes, sir.

Q Were there significant range of motion restrictions?

A Yes, sir.

Q In her lumbar spine?

A Yes.

Q As well as her knees?

A Yes, sir.

Q Okay.

Now, just to direct your attention to page 2 of that December 2009 report. When you performed a visual

inspection, did you see any swelling?

A Yes, sir.

Q Okay.

And you did a palpation exam, did you feel any tenderness?

A Yes.

Q And she was making persistent complaints of pain to her left and right knee?

A Yes.

Q All right.

Did you form any clinical diagnosis as a result of the persistent complaints of pain and dysfunction to the left and right knee?

A Yes, sir.

Q And what was that?

A Bilateral knee sprain with internal derangement.

Q Okay.

And at some point did you recommend an additional treatment option to Anna?

A Yes, sir.

Q Which was?

A She was advised for surgery diagnostic arthroscopy to check about why her knees continued to hurt in spite of having normal MRIs.

Q Now, before we get to your surgeries. Had you ever

treated patients who had negative MRIs but positive findings on

clinical exam?

A Yes, sir.

Q And had you ever done arthroscopies on those patients?

A Yes, sir.

Q And had you ever found that there was indeed damage to the joint that was not detected on the MRI when you went in surgically?

A Yes, sir.

Q Are MRIs a hundred percent accurate?

A No, sir.

Q All right.

I'm going to have to skip ahead now to your first knee surgery.

MR. MULLANEY: With Your Honor's permission, I'm just going to put up Plaintiff's Exhibit 22 for Identification.

THE COURT: Yes.

MR. MULLANEY: I show counsel. Your Honor, this is an enlargement of the operation report.

THE COURT: Okay.

MR. MULLANEY: Of this surgery. It's already in evidence as part of the All Med chart.

THE COURT: Any objection?

MR. VEILLEUX: No objection.

MR. CALDERON: No objection.

MR. MAILLOUX: No objection.

THE COURT: All right.

MR. MULLANEY: Your Honor, also with your permission, I'd like to put up an illustration, medical illustration that corresponds to the opt report and I showed it to my adversaries before we got started his morning and I'm going to show it to them again.

THE COURT: What number is this that you're showing them?

MR. MULLANEY: Plaintiff's 23, Your Honor. I'm offering it for demonstrative purposes. I'm not offering it into evidence because these are illustrations.

THE COURT: Have you had an opportunity to view that?

MR. VEILLEUX: I would object since the jury's already seen the exemplar of the human knee. I think this is cumulative number two and it's somewhat prejudicial, Your Honor.

MR. MULLANEY: Judge, the exemplar of the human knee is just that, a human knee. This goes to the surgery that he's about to testify to as well as the opt report that only has written words on it, Your Honor.

If I might, Your Honor, can I ask the doctor if this would aid his explanation of the surgery and perhaps

aid the jury in his understanding of the testimony.

THE COURT: The answer is I'm sure it would aid his testimony. He's indicating that there's some prejudice. I don't know what that is at the moment because I can't tell just from looking at it if there is any prejudice.

Let me just see both sides over here for a moment.

(Whereupon, a discussion takes place off the record, at the sidebar, among the Court and counsel:)

(Whereupon, the following proceedings take place on the record, in open court, in the hearing and presence of the jury:)

THE COURT: All right. Let's proceed.

We'll hold off on the illustration for the time being.

Q Doctor Dassa, Plaintiff's Exhibit 2. This is your opt report for the May 12th, 2010 left knee surgery.

A Yes, sir.

Q Before we get into the procedures, can you tell us what your post operative diagnosis was, what you found when you went inside her knee and looked at the joint with your own eyes?

THE COURT: Doctor, it's in evidence. So if you need to read it, you can do that if that would help you. Whatever you're comfortable.

A Well, the term was severe chondromalacia with

25 osteochondral fragmentation of the medial femoral condyle

posttraumatic.

Q Okay.

Would an illustration aid your description of what chondromalacia looks like, where you found it and what you did when you found it?

A Yes, sir.

MR. MULLANEY: Your Honor, at this time I'd like to show Doctor Dassa did a Plaintiff's 23, again just for demonstrative purposes?

THE COURT: Again, this is not a depiction of what was there, ladies and gentlemen. This is an illustration to explain what he has verbally recited to you in detail.

MR. MULLANEY: Thank you.

Q For the purposes of clarity these are Ana Fernandez' left knee. Please describe the surgery you performed?

A Yes, sir. So the--

Q I'm handing Doctor Dassa Plaintiff's Exhibit 39, the knee model.

A So basically this is a model of the right knee. We were speaking of the left knee. Just so you know, the fibula's on the other side which represents the left knee. So what we're looking at on top is a graphic drawing of the type of operation that she had in this arthroscopy surgery.

So surgery that is arthroscopically done with small incisions where we insert the scope or a camera and

instruments that are utilized to, number one, look around the knee which is the scope on the camera and also any instrument is done through the other hole.

So when we're looking at the knee itself, as I stated, there are three surfaces that is we're looking at. We're

looking at the top of the shin, the bottom of the thigh bone, under the kneecap. We're looking at cartilages between the bones and the ligaments that are between the bones as well as the cartilages on the surfaces of the bones.

Now, when we got into the knee, again we did the visual inspection to see if there was any reason that we can find out why there was pain in that knee for a long period of time. So when going into the knee the first thing we look are the surfaces of the bone. So if you look at this drawing, this is a graphic drawing of what a normal knee would look like.

So if you look at the cartilage on the surface of the bone, it's nice and smooth. There's no breaks in that cartilage. It's not worn or frayed. If you look at the ligaments, the ligaments have a healthy appearance. If you look at the cartilages that separate the bones, which are meniscus, those meniscus tissues are found to be normal and healthy.

So when we got into this knee, the thing that was

most notable is if you look at the condyle, which is the medial femoral condyle, there was a big piece of cartilage that was missing off of the bone.

So if you go to the drawing, now this would represent what that could appear like and you can see on the normal bone there's cartilage that's normal. Here the cartilage is not normal because this is showing a more degenerative process which is not what was found during surgery. But if you look at the cartilage that was on the femoral condyle it was a big defect. So when we look at the defect it was actually bone exposed at the base of that defect. So you had an osteochondral fragmentation meaning there was bone and cartilage loss from the end of the bone.

When we looked at the meniscus tissue and the ligaments, there was no damage to any other areas. So

this was
largely the main pathology that was found in the knee.
Q Okay. Can you describe how you went about repairing
it?
A Well, again, when cartilage is damaged it doesn't grow
back. So--
Q Why not?
A Because firstly the circulation to the tissue is not
very good and cartilage is one of those tissues that does not
regenerate. So if it's injured severe enough the cells die and
there's no way for it to grow back. There's multiple ways to
approach it.
With all the science today nothing is perfected
how to fix this problem so you're left with a significant

problem. In this particular case the way we approached it was we
did what is called a microfracture chondroplasty. So we actually

put picks in the knee which are sharp pointed things. It's like an ice pick but a little bit more refined, and we actually placed the pick on the point where the bone is exposed and we take a hammer and we make holes in the bone at certain signed distance and what that essentially does is it brings in blood and circulation to create a clot in this area and what the clot does, it theoretically bring in stem cells. And if you bring a stem sell in this area it's suppose to promote the filling in of this defect. So, again, we make holes in the bone in order to bring in blood and, again, the function of this procedure is similar to a crack in the sidewalk and we fill in the crack with a grout or cement. It's suppose to fill in the space but it fills in what is called fibrocartilage, not hyaline cartilage. Hyaline cartilage is what we're born with. The fibrocartilage is a temporary fix for this problem, to fill in that space to hopefully reduce some of the inflammation and the friction.

Q So the fibrocartilage that's replaced, is that

scar

tissue also?

A Yes.

Q And fibrocartilage, is it as smooth and does it have as low coefficient of friction the type that we're born with?

A No. It's the best solution that we have to fix it. But because it's not the same as the cartilage that was there. It

does not-- it's not resistant to the forces of stress so over time, in a similar way that you fill the crack in the sidewalk, that crack will pop out and you'll have to redo it.

Similarly biologically as you continue to walk on it, that will wear out and eventually the defect will reoccur.

Q Doctor, I want to direct your attention back to your opt report, Plaintiff's Exhibit 22. You described it, did you not, as a severe large osteocondyle defect in the patient's

femoral condyle that communicated all the way down to the bone?

A Yes.

Q What does that mean, communicated all the way down to the bone?

A Well, again, if you look at cartilage injuries, they can be partial or they could be complete or full thickness. Anything that communicates all the way down to the bone is full thickness and there's no cartilage present.

Q So for the time between the accident and leading up to the surgery, was the bone exposed-- it could have been potentially exposed and rubbing against the meniscus on that side?

A Well, I think that, again, she had an injury. I think there was an insult. One of two things could have happened, either it could have ripped off the bone at the time of the accident or it could have been an impact where the cartilage cells die slowly over time.

The MRI that was done didn't show that it was actually torn off the bone at the time of impact otherwise it should have shown on the MRI.

I believe this was an impact that slowly over time the cells died creating this defect. So to answer your question correctly, did she have this bone on bone rub, this bone exposed during the entire time, no. It probably developed sometime a few months down the road.

Q So there's roughly ten months in between the August 31st, 2009 accident and your May 12th, 2010 surgery?

A Yes.

Q Assuming that Ana Fernandez was using her knees, meaning that she was walking throughout that ten months, could it have made this condyle defect worst over that ten month period?

A Yes.

Q Okay.

Is there anything else you want to do describe

about that surgery or should we go to the next one?

A That's pretty complete.

Q Okay.

You saw her postoperatively?

A Yes, sir.

Q And roughly a week later?

A Yes.

Q And what was the purpose of that, was that just for a wound check?

A Well, it was to check her wounds also, you know, to assess her post operatively which would be routine, to take out the stitches, prescribe physical therapy, to assess whether she needed more medication for pain.

Q Okay.

And you prescribed her medication for pain?

A Yes.

Q By the way, back when you initially saw her, your

initial visit five days after the accident, did you prescribe pain medication?

A Yes, sir.

Q And did you continue to prescribe pain medication through the course of physical therapy leading up to the surgery?

A Yes, sir.

Q Did she undergo post opt physical therapy at the All Med facility?

A Yes.

Q And then you began seeing her after the first couple of weeks after her surgery?

A Yes, sir.

Q Was she still making complaints about her right knee?

A Yes, sir.

Q And you were still examining it once a month every time you saw her?

A Yes.

Well again, you know, immediately after surgery we did the left knee because that was the most pressing issue because it was recently post opt but we always examine the left knee in the context of the right knee and she continued to complain of right knee pain.

Q At some point did you recommend arthroscopy on the right knee?

A Yes, sir.

Q At some point did you do that surgery?

A Yes.

Q Okay.

Was that in September of 2010?

A Exactly. September 22nd, 2010.

MR. MULLANEY: Judge, with your permission, I'm just going to put the opt report, Plaintiff's Exhibit 21 up on the easel. It's a blow up.

THE COURT: Any objection?

MR. VEILLEUX: No objection.

MR. CALDERON: No objection.

MR. MAILLOUX: No objection.

THE COURT: You may show it.

25 Q Please describe what you found when you went in, in

terms of postoperative diagnoses before we get to the procedure?

A Yes, sir.

So as opposed to left knee, the right knee surgery found different types of damage. So if you look at the first postoperative diagnosis, it was tears of the medial lateral meniscus. So there were tears of the cartilage that separated the knee and bones.

In addition, under the kneecap there was similar damage to the cartilage like-- similar to the prior surgery on the left knee but it wasn't a full thickness tear. It was partial thickness damage.

Q Okay.

Doctor, I'm going to show you what's been marked Plaintiff's Exhibit 24 for Identification. Have you

seen this illustration before?

A Yes, sir.

Q All right. Would this illustration aid you in your testimony and explanation to the jury about the September surgery?

A Yes, sir.

Q And potentially aid the jury in understanding it?

A Yes, sir.

MR. MULLANEY: Your Honor, I'd like to use Plaintiff's Exhibit 24 for demonstrative purposes only.

THE COURT: Counsels?

MR. VEILLEUX: No objection, Your Honor, subject to it being only offered for demonstrative purposes only.

THE COURT: Subject to the same admonitions I have given.

Q Doctor Dassa--

THE COURT: One of the problems is that because of the dimensions of the board are long, part of it tends to rest on the-- this thing, whatever that is but now you got it where it's suppose to be. So continue.

Q Please, doctor. Can you walk the jury or run the jury through the procedure and what you found?

A So again we're looking at arthroscopic surgery, the same type of procedure that was done on the left knee. This is just a representation of normal structures.

So when we got into the knee we did find damage to the medial and lateral meniscus. When we say anatomy, there was actual physical tearing of these structures. In instances where the tears are more on the outside you can repair them.

When they're more on the inside, this cartilage, you have to actually remove the tissue because it will not heal if you try to sew it back together. So what we did with shavers and blighters, we removed the damaged cartilage that was present. Secondly, what we found also is under the kneecap the

25 term that I used is called chondromalacia and that term is-- it

1 describes softening of the cartilage on the surface of the bone.

2 Now, when you have the term chondromalacia,

3 there's many causes for chondromalacia. You can have a long-term

4 wear and tear phenomenon. You can have chondromalacia from

5 breakdown, from some type of injury.

6 When we got to the part under the kneecap where

7 the cartilage was damaged there was actual a discoloration of

8 the cartilage around the rim where the cartilage is not normal

9 which indicated that there was some type of bleeding event which

10 left a tattooing of that cartilage from blood.

11 So in the absence of other, you know, cartilage

12 problems in the knee, on the surface of the bone this

13 represented a traumatic chondromalacia to the patella.

14 What we did, as opposed to making holes in the

bones because it wasn't a full thickness tear, we shaved it with the use of a mechanical shaver and then we utilized a radio frequency device which also can treat the cartilage cells which stimulates the healing of the defect and filling in the fibrocartilage.

Q Okay. Thank you.

Now, just to direct your attention back to the opt report.

THE COURT: One thing I just want to advise you.

Because you have it rested there, that's what tends to make it tip over. It needs to it fully on the easel itself.

MR. MULLANEY: Sorry about that.

THE COURT: No problem.

Q When you were describing the tattooing, it looks like a bleeding event. Would you read that to the jury?

A This area of condyle damage had a posttraumatic

appearance with significant cartilaginous discoloration indicating recent bleeding.

Q Now, that type of appearance led you to believe that it was posttraumatic and related to the accident as opposed to something that happened due to wear and tear over time?

A Yes.

Q Okay.

And you followed Ana's recovery post operatively. You saw her postoperatively?

A Yes.

Q And at some point she began a post opt physical therapy?

A Yes.

Q And you continued seeing her. Is that correct?

A Yes, sir.

Q Now, before we go further with the current condition of the knees, I just want to circle back to the lumbar spine.

Other than referring her to a neurologist for the nerve testing that turned out to be positive, did you refer her to any other specialists with regard to her back pain?

A Yes, sir.

Q And where did you refer her?

A She was sent for pain management.

Q For what purpose?

A Well, again, the available treatment, methods for disc herniation would first initially be a conservative course of physical therapy. If therapy doesn't help you send the patient to a specialist who can do what is called interventional pain management or epidural injections.

She was sent for evaluation to assess whether she was a candidate for epidural injections.

Q Do you recall the specialist's name?

A Yes.

Q Who was that?

A One was Doctor Kaisman, I believe, and the other one was Doctor Ford.

Q Let's starter with Doctor Kaisman.

MR. MULLANEY: Judge, with your permission, I'm

going to put up Exhibit-- another medical illustration, Judge, for demonstrative purposes only.

MR. VEILLEUX: Judge, I have the same objection as we discussed in the back. We need an instruction, once again, to the jury.

THE COURT: Ladies and gentlemen of the jury, with any medical illustration that's being shown to you, it does

not constitute evidence of what was or wasn't done, what did or didn't exist at the time.

It is an illustration designed to photographically show you what words alone apparently cannot necessarily fully describe to you. Think of it as a picture book. There are the words and there are the pictures but in this case it is the words that matter, not the pictures. So under that limitation you may show it to the jury.

Counsel, is there anything else you want to say?

MR. VEILLEUX: No, Your Honor.

THE COURT: Go ahead.

Q First I'll show you the procedure note marked Plaintiff's Exhibit 25. This is in evidence. This is Doctor Kaisman, the surgeon?

A Yes.

Q Dated April 5th, 2010. Okay. And this is also part of your chart. Right?

A Yes.

Q Now I'm going to show you the illustration, Exhibit 25 for demonstrative purposes only. If you can very briefly just walk through what is being shown here, what Doctor Kaisman did?

A Yes, sir.

Well, again, this is one of the treatments that a pain specialist would do for a person with a herniated disc, and what it entails-- and, again, this is a photographic

representation of what is considered an epidural injection.

So a spinal needle is inserted in the spine. They do that under what's called fluoroscopic guidance. So they actually have an x-ray machine that identifies the correct level and essentially the needle's inserted at that level down to the area where the nerve is pinched from the disc herniation, and you can see photographically the needle is inserted.

And, again, this shows you the position of the patient because you are laying on your belly when you're doing this, and what they do is inject medication which is a combination of an anesthetic and steroid, and the steroid is an antiinflammatory, and the purpose of the injection is to calm inflammation of that nerve root and in a statistically significant number of people you can actually improve the symptoms of radiculopathy or pain that shoots down the leg.

Q Okay.

Now I believe you already alluded to it. You referred Anna to another specialist, Doctor Ford at St.

Barnabas
Hospital?
A Yes.
Q She had a second epidural?
A Yes.
Q And you continued to treat her after both of those
epidural injection procedures?
A Yes, sir.

Q And she continued to make complaints of pain and
discomfort to her lumbar spine?
A Yes, sir.
Q I want to direct your attention to June 24th, 2010.
Your treatment note. I just want to discuss briefly one of the
observations that's listed in your treatment report.
A Yes, sir.
Q Where you observed quadriceps dysfunction. Is that
atrophy?
MR. VEILLEUX: Objection, Your Honor.

THE COURT: As to the form?

MR. MULLANEY: I'll withdraw it, Judge. That was a bad question.

THE COURT: All right. Question withdrawn.

Q Can you tell us--

A She was noted to have a healed surgical incision. There was no infection. Her range of motion was assessed with some pain from zero to full extension to bending to one hundred and twenty-five degrees and there was what we found on palpation exam to be quadriceps dysfunction which is characterized as mild.

Q Okay.

Now, July 30th, 2010 you observed what--

Did you observe any quadriceps atrophy?

A Yes.

Q Please just describe to the jury what atrophy is and why it's significant?

A Well, I mean the atrophy is when there is actually reduction in the size of a muscle. So when a muscle shrinks that term is called atrophy.

I mean what is significant about it is that, you know, if you look at her visit from 2000-- I mean from June 24th of 2010 it was a mild quadriceps dysfunction which meant that after surgery her quadriceps was not contracting the way it would normally contract and that was a consequence of the surgery and the injury.

And if you look at the comparison exam on July 30th, which was a month later, the dysfunction of the muscle continued not just from not contracting properly, it started to show a decrease in size of that muscle.

Q Okay.

Now, after the two surgeries that you performed on Ana's knees-- withdrawn.

The surgeries that you performed on Ana Fernandez' knees, did they alter the geometry of the joint?

A Yes, sir.

Q And did they change the configuration of the joint permanently?

A Yes, sir.

Q All right.

Now, as a result of those permanent changes to the geometry of the joint, what potential conditions would you anticipate Ana Fernandez developing?

A Well, I don't think it's an issue of potential conditions. She has developed other conditions as a consequence of the injuries and the surgery. So she has traumatic arthritis in both knees.

Q That's what I want to talk about. If you look at your chart, I believe--

When did you first diagnosis-- I want to direct your attention to October-- withdrawn.

October 5th, 2012?

MR. MULLANEY: I have a copy of it.

Q Just in the interest of time, doctor. Here's my copy.

A Yes, sir.

Q Okay. And can you describe what, if any, posttraumatic arthritic changes you diagnosed on that office visit?

A Well this is a note from October 5th, 2012. She-- it states here it should be noted she does have posttraumatic arthritis to the left knee which resulted from the accident.

Q Okay.

Now, what is arthritis?

A Well arthritis is a general term to describe any breakdown of the articular cartilage. I mean there's several types of arthritis or several causes for that breakdown.

In the lay public's perception, mostly it's from wear and tear or from old age but there are other causes other than old age for arthritis. One of them can be arthritis that

occurs from an injury to cartilage which we call traumatic arthritis. You can get arthritis from infection that damages the cartilage. You can have arthritis from inflammatory reasons, rheumatoid arthritis, lupus. There's arthritis that come from inflammatory conditions such as gout.

So when you speak of arthritis in general, it is an inflammation or breakdown of the articular cartilage and, again, you have to clarify the different causes for that.

Q Is there a way to cure it?

A No, sir.

Q Now, what was the last time you saw Ana Fernandez?

A February 28th, 2017.

Q Okay.

And when you last saw her, did you do a physical exam?

A Yes, sir.

Q And can you please just briefly tell us what the exam consisted of and what the findings were?

A We did do an exam of the lumbar spine and knees and

hips. Her knee exam was significant for swelling for both the right and left knee. There was no signs of infection.

If you look at the range of motion as compared to

her prior evaluations, there was a significant reduction in the range of motion. So when we speak of flexion, which is the bending of the knee, she was able to bend to one hundred and fifteen degrees on the right and one hundred and ten on the left and normal is one hundred and forty, and she was able to fully straighten the knee at zero degrees.

She was limping. She had an antalgic gait because of pain in her knee and also she had is a positive patella femoral compression test which is another clinical exam of findings of arthritis which would be consistent with her process that developed after her injury.

As far as the lumbar spine goes, her bending at

the waist, which is flexion, was measured to be fifty and normal is ninety. Her extension was fifteen and normal is thirty. Her lateral bending was twenty and normal is forty and her lateral rotation was fifteen and normal is thirty and, in essence, compared to her prior exams, with all the treatment she had, it was about the same with impairment.

She had muscle spasm-- actually there's a type there-- L1 through L5 and then the straight leg raising test was found to be positive on the right side at ten degrees indicating that she still had a significant amount of sciatic nerve inflammation consistent with a pinched nerve of the lumbar spine.

Q Okay.

And did you provide any treatment options to Ana with regard to any future care?

A Well, I-- again, in discussing her condition we spoke of her continued radiculopathy, or pain that was going down her legs and physical findings. I felt she could benefit from additional epidurals.

She was advised to reach out to the pain management specialist to discuss that and also to, you know, given her condition with the deterioration in her knee range of motion, though it wasn't recommended on that date, she was advised that she has a high potential for needing a knee replacement especially for the left knee.

Q Let's talk about that. What's a knee replacement?

A Well, you know, a knee replacement is surgery where the knee is actually physically opened and you go down to the articular surfaces, or the surfaces that are covered by cartilage, and you actually cut off the surfaces of the bone to create a shape that an artificial surface is glued to the surface of the bone to create an artificial knee basically.

Q Okay.

Now, as far as the timing for the time frame when you expect Ana Fernandez to need that first surgery, I think you said it was to her left knee a total replacement of the left knee?

A Yes, sir.

Q What kind of approximate time frame can you give us given her conditions as you describe them on the last visit?

A Again, it's always going to be symptom dependent and her response to conservative treatment. The issue with the knee or hip replacement surgery, it's a timing issue.

You would like to-- theoretically like to do sixty-five is the optimum age because we generally get about fifteen to twenty years out of the prosthesis or artificial knee.

If you did a knee replacement at 42 or 43 years

old you're talking at least two surgeries in her lifetime. To predict when she would need it, you know, I don't have a crystal ball but, you know, with the degree of breakdown of her knee, with a significant range of motion reduction as noted on her subsequent visit to her last visit, I would say it's a high probability within the next five years for the left knee.

Q And if she has her first knee replacement procedures performed to the left knee in five years, that would make her 48. Can you approximate what the shelf life would be for that first prosthetic limb?

MR. VEILLEUX: Note my objection, Your Honor.

THE COURT: Duly noted.

A In today's science, you know, knee replacement done on somebody at the optimum age lasts between fifteen and twenty years. The issue also about doing knee replacements on a younger

person, they tend to be more active. So I think that would be ten to fifteen years.

Q All right. And why is that, is that--

A Because there's a wear and tear factor. It's not a biologic tissue that you're putting in there. It's a mechanical device and when you have mechanical devices rubbing on each other, especially in a knee replacement you have metal on the surfaces of the bone and you insert a plastic spacer, which is like teflon, and that would wear out. At time you could get loosening of the prosthesis from bone. So those are things you would expect to look for.

Q So if a younger person were more active, with children or with job activities and walked more, using the joint more, it could shorten the shelf life of prosthetic device. Is that what you're saying?

A Yes.

Q How much is the approximate current today costs for the current today knee replacement?

MR. VEILLEUX: Objection.

THE COURT: Grounds?

MR. VEILLEUX: Could we have a sidebar, Judge?

THE COURT: Sure.

(Whereupon, a discussion takes place off the record, at the sidebar, among the Court and counsel:)

(Whereupon, the following proceedings take place on the record, in open court, in the hearing and presence of the jury:)

THE COURT: All right. Rephrase the question.

Q Doctor Dassa, in today's dollars, what is the cost of a knee replacement procedure? ?

THE COURT: And your objection is duly noted.

MR. VEILLEUX: Thank you, Judge.

A It would be between sixty-five and seventy thousand dollars and that would depend on the prosthesis. I mean a lot of

cost is determined by the prosthetic that's used.

Q Okay.

After a patient of yours has a knee replacement, would you see them postoperatively?

A Yes, sir.

Q Can you give us an idea how many times per year for the first year?

A I mean generally a patient is seen for six months. There's lots of things that can happen after a knee replacement surgery and you want to follow a person to assess that they're progressing in the healing process, also they're not developing any type of problems.

When you have knee replacements you're very prone to getting blood clots. That's something that needs to be observed for. You could get an infection.

You also have to assess whether the patient's

developing loss of mobility from other factors. You have to follow them closely for six months and then at least a minimum of once a year.

Q Okay.

What is the current today cost of an office visit for you?

A I mean follow-up because x-rays would need to be done, about two hundred dollars.

Q Okay.

Now, do you have an opinion, within a reasonable degree of medical orthopedic certainty, as to whether or not the accident of August 31st, 2009 was a substantial factor in causing the injuries that you just testified to this jury?

A I do.

MR. VEILLEUX: Objection.

THE COURT: Overruled.

Q What is your opinion?

A My opinion is that that was the cause of her injuries and impairments.

Q And what do you base that opinion on?

A Well, again, it's focusing on historical details. There's no other history prior to the date of this accident or any subsequent injuries to the date of accident that would correlate with the development of those symptoms. Number one. Number two, when I got into her knees there were

clear findings of trauma, at least in the recent past, connected to the surgical dates. You know, for those two reasons there's nothing else to point to but that outset.

Q Doctor, Miss Fernandez hasn't testified yet so I want you to assume her testimony's going to be related to her pre-accident employment, that she worked for three years as a seamstress in a Chinese textile factory. She worked for ten years as a housekeeper, half the day spent cleaning, half the day prepping food for bosses and clients at a building in

Manhattan. Another four years working as a cleaner at various hotels, and on the day of the accident she was employed as a hotel cleaner as well.

I want you to assume she's going to testify, on average, she worked full-time at least forty hours a week and that she never missed any work related to any knee injuries, back injuries or any traumatic injuries whatsoever.

Do you have an opinion as to whether somebody performing those types of jobs on a full-time basis, unrestricted, could indeed perform those jobs with the injuries that were diagnosed after this accident?

MR. VEILLEUX: Objection.

THE COURT: I'm going to allow the question.

Overruled.

A Again, you describe a functional capacity that would not be consistent with these injuries. I mean it would be very

difficult for her to do that type of strenuous work as a cleaner or work on repetitive basis with these type of injuries.

Q The severe chondromalacia defect that you found, that communicated all the way to the bone, would that present any difficulties for somebody performing the types of jobs that I outlined?

MR. VEILLEUX: He's not a vocational rehabilitation expert, Your Honor.

THE COURT: Allowed. Overruled.

A Again, it would pretty difficulty for her to walk. In turn it would be very difficult for her to do that under the activity that you described.

Q Same question for the L4-L5 herniation pinched on the nerve as a doctor treating patients over the last fifteen years with such injuries, would you anticipate that the symptoms would prevent them from working full-time, unrestricted for almost two decades?

MR. VEILLEUX: Objection.

THE COURT: Could you read that back.

(Whereupon, the question is read back by the reporter.)

THE COURT: Well, why don't you try it this way. Would you anticipate that it would prevent her from working full-time. You can answer that question, if you can.

THE WITNESS: Before the accident, after the

accident?

THE COURT: After the accident.

THE WITNESS: Well, again, it's apparent that she would not be able to do that after the accident and at least on the basis of a functional prospective it's the same as for the knees. It would be difficult for me to imagine doing that description with a back condition as described if it was there before as well as any condition on top of it.

Q I have just a couple of more questions about causation.

Again, Ana Fernandez hasn't testified yet but I want you to assume that she's going to testify that she did not see the vehicle or what struck her before she fell. Okay. Would the causation--

Would your causation opinion of that accident cause the injuries that you testified about?

Would your causation opinion change if you learned that she were struck by a metal garbage can or a bumper that had torn off the car that had ended up on the sidewalk?

MR. VEILLEUX: Objection.

THE COURT: Yes. Sustained.

MR. MULLANEY: Sure.

Q The injuries that you described, that you diagnosed. Could they have been caused by-- withdrawn.

Doctor, are you being compensated for your appearance here today?

A Yes.

Q And what are you being compensated? How much are you being paid?

A Sixty-five hundred dollars.

Q And if you weren't here testifying what would you be doing?

A I have seven surgeries that I cancelled this morning.

Q Have you ever testified in court before?

A Yes, sir.

Q Were those on behalf of your patients?

A Yes, sir.

Q Have you ever been hired by any of the defense companies to perform any medical consultation?

A Yes, sir.

Q Okay.

Have you ever testified in court where your patient happened to be my client?

A Yes, sir.

Q Approximately how many times?

A I don't know. It's more than once but I don't know exactly.

MR. MULLANEY: Okay. I have no further questions,

Judge.

THE COURT: Cross examination.

MR. VEILLEUX: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. VEILLEUX:

Q Good afternoon, Doctor Dassa?

A Good afternoon.

Q You and I we've never met before?

A No, sir.

Q Other than exchanging pleasantries earlier this morning. Never saw each other?

A That is correct.

Q Okay.

You testified before on behalf of plaintiffs, people who were injured in accidents. Correct?

A Yes, sir.

Q And sometimes those people they happen to be your patients but other times you're hired by Plaintiff's attorneys to testify solely as an expert based upon your review

of records

and perhaps an examination of the plaintiff.

Correct?

A Yes, sir.

Q Now, in fact, I'm in this building almost everyday of the week and I have seen you here before.

In fact, you're testifying in this building on another case. I think Friday you did?

A I was here Friday?

Q Were you here last way?

A I was here last week. I don't know the exact date.

Q In fact, you're testifying I believe, correct me if I'm wrong, you're testifying on a case down on the 4th floor where the Plaintiff's name is Marino Santos?

A Yes, sir.

Q And you're testifying for a Mr. George Plfuger, I believe. Correct?

A Yes, sir.

Q Now, you testified in this building before and did you ever hear what is called Verdict Search, where attorneys run your name through a data base to see how many times you've been retained on behalf of plaintiffs as opposed to defendants?

A I'm not familiar with that, sir.

Q Well, I did such a search and you it turned up a hundred and seventeen pages where you were either retained as an expert witness, where you didn't treat the plaintiff but on a number of occasions you testified on behalf of your patient--

MR. MULLANEY: Objection, Your Honor. Pages or cases.

THE COURT: I don't know.

MR. VEILLEUX: Pages.

THE COURT: You can answer the question.

A What is the question?

Q You testified here as well as some other venues, New York County perhaps. I saw a few of those. Queens, where you

testified where you were retained by a plaintiff as an expert witness where you were not the treating physician. Is that correct?

A Yes, sir.

Q And you've also testified on behalf of patients that you treat such as in this case Miss Fernandez.

Correct?

A Yes, sir.

Q Now, when you examine a patient, when they come in your office, particularly with a complaint of knee pain to the left knee, right knee or both knees. When you do a history, do you take into consideration things like the plaintiff's weight, is that something you're concerned about?

A Again, as it would impact the condition, it would be a consideration but if weight based upon the history has no impact on the history. It varies from patient to patient.

Q Would you agree with me, that if a person is heavier, is bearing more weight on the lower extremities, over

time that

could cause some wear and tear on the knee joints.

Would you agree with me?

A Yes, sir.

Q And is there a reason why you didn't make a notation of

Miss Fernandez' weight when you first saw her back in September

of 2009, September 4th of 2009?

A Yes, sir.

Q Is it referred to in your record there?

A Again.

Q Take a look at it. Sure.

A If you're asking me if there was a reason, no.

Q Do you see it in your report?

A There was no weight mentioned there.

Q Now, when you first met Miss Fernandez--

By the way, was she referred to you by someone?

A I don't recall. It was a long time ago. I'm not sure.

Q Do you know if she was referred to you by Mr. Oresky's

office, the attorney of record for the plaintiff?

A I don't remember. I'm not sure.

Q In regard to Mr. Oresky, have you testified on behalf of clients that he represents?

A Yes.

Q And do you recall testifying in a case where the Plaintiff's name was Elsie Heyford.

Do you remember that name?

A Not independently, no.

Q What about Hilario Garcia?

A No, sir.

Q By the way, have you ever testified on behalf of a case where Mr. Mullaney and his partner, Mr. Gjelaj represented the plaintiff?

A Yes, sir.

Q And when was the most recent time you testified at their request?

A It was many years ago. I don't recall the exact date.

Q That was here in this building as well?

A Yes.

Q Now, you mentioned on direct examination that you had a speciality in hand injuries.

Correct?

A Subspeciality, yes.

Q It's a subspeciality.

Would it be fair to say that example, the injuries involving the knees in the field of orthopedic surgery, there are orthopedic surgeons who solely limit their practice to treating lower extremities or the knees.

Right?

A Yes, sir.

Q And conversely, there's also orthopedic surgeons-- if I have a problem with my should, I have problems moving it, I would go to an upper extremity orthopedic expert for a shoulder problem. Correct?

A Not necessarily.

Q But there are such orthopedic surgeons who limit their practice to that particular location of the body.

Correct?

A Yes, sir.

Q And would it be fair to say the same for back injuries, whether it be a lumbar injury, cervical spine injury. You would go many times to an orthopedic surgeon and they do exist to solely treat people in regard to claims of back injury.

Correct?

A Not necessarily.

Q But there are such specialties, they would limit their practice to that. Would you agree?

A There are doctors who do limit their practice to just the spine, yes.

Q Now, when you first met Miss Fernandez, as a clinician you conducted a history and you gathered certain information from her.

Correct?

A Yes, sir.

Q And you learned that she--

In your report, in your initial notes of your first encounter with this plaintiff, that she claimed involvement with a car or a motor vehicle.

A Yes, sir.

Q Okay.

Now, when you had this conversation with her, did you communicate with her in English or Spanish?

A Well, I don't speak Spanish, it would have been with a translator or interpreter.

Q Now, is there anywhere reflected in your records that there was a translator present in your office when you initially met Miss Fernandez?

A No, sir.

Q What about the subsequent visits, the follow-up visits. Is there any reference whatsoever in your notes that a translator was present?

A No, sir.

Q As you sit here today, do you know if you spoke English to Miss Fernandez?

A I couldn't speak English to her. She doesn't speak English.

Q Is it possible therefore that you communicated with her in English and she spoke to you in English?

A No, sir.

Q You're certain that she does not speak English. Correct?

A Yes, sir.

Q Was there a representative of Mr. Oresky's office present when you first met Miss Fernandez who acted as a translator?

A To my recollection, no.

Q Now, you discussed a lot based upon your various reports that you have that testing was done-- we'll talk now about the lumbar spine first. I'll try to move as fast as I can.

You did various tests called range of motion tests. Right?

A Yes.

Q By the way, did you use a goniometer to do those tests?

A Yes.

Q Okay.

And when a patient is asked to perform a range of motion test, such as if you're testing the range of motion of the lumbar spine, you're looking for rotation to the left, to the right, forward and back. Correct?

A Yes.

Q Now, if a patient comes to you, in this case Miss Fernandez, and you ask her to move her back to the left, to the right and forward. The results of that test are what are known as a subjective test.

Correct?

A Again, as you describe it. If she was asked to do that, that would be subjective.

Q And for example, if a plaintiff comes to your office and you ask them to perform a range of motion test-- I'm not saying it happened in this case but a plaintiff could certainly fool you. They could decline to move forward without pain. They could say I can't move at all based upon your request that they move forward, move to the side, rotate left and right. Some

people could do that. That's why it's called a subjective test. Correct?

A Are you speaking of my range of motion assessment?

Q I'm speaking of the phrase in medical terminology. In range of motion, is it subject or objective in nature?

A It depends how you're doing it and describing it. If you're describe speaking of active range of motion then that would be subjective. If you're dealing with passive range of motion, which is what I do during my

physical

exams, unless the person interferes with your doing it then

that's an objective assessment.

But, yes, active range of motion that is

subjective because the person will stop when they say it hurts

and in that case that's why it's as an active assessment as

active range of motion, they could fool up.

Q And same discussion with regard to pain. When a

patient tells you I have pain when I move forward, I have pain

when I bring my left knee up. Would that statement be a

subjective complaint or would that be an objective complaint?

A That would be subjective.

Q Now, when Miss Fernandez first walked into your office,

do you recall if she had any type of device when she came in

like a cane or a walker?

A To my recollection, she had no devices.

Q By the way, did you have the opportunity to observe her

gait when you first met her?

Was she walking normally, do you have any recollection?

A May I refer to my note?

Q Yes.

A There was no gait abnormality.

Q You used the phrase in your records there was no gait abnormality. She was walking normally as a person.

Correct?

A Yes.

Q Now, you're not a radiologist.

Correct?

A I am not, sir.

Q In fact, you're board certified as an osteopath?

A No. I'm board certified as an orthopedic surgeon.

Q But you're not a medical doctor. You're an osteopath?

A I'm a medical doctor with a degree as an osteopath. So I'm a board certified surgeon.

Q And when you first saw Miss Fernandez, was she fully weight bearing. I mean you observed normal gait, she could carry her weight. Correct?

A Yes, sir.

Q Now, let's talk about the MRI studies from I believe the facility in Bainbridge. Those were the first studies of the lumbar spine. Left knee. Right knee.

Correct?

A Yes, sir.

Q And in regard to the knees. Both of those studies were normal.

Correct?

A Yes, they were recorded as normal.

Q I believe there was a cyst that was seen-- I believe on-- on both studies of the left knee, right knee there was a cyst but other than that there were no findings of any injury that could be considered related to any type of traumatic injury.

Correct?

A That's correct.

Q Now, the first surgery that you did was on the left knee. Right. That's the one that was done May 12th, 2010. Correct?

A Yes, sir.

Q Now, as a clinician in the field of orthopedics, when arthroscopic procedure is done, is it normal to take what are known as intraoperative films?

A Pictures, yes.

Q Pictures. Okay.

And, in fact, that's something that as a clinician in the field of orthopedics you would want to do in order to verify the condition that allegedly existed as you see through

the arthroscope.

Right?

A Yes, sir.

Q Now, in regard to the left knee surgery, did you take

any intraoperative films?

A Again, as a routine course of doing arthroscopy I would taken pictures, yes.

Q In this particular case, did you take intraoperative films?

A Yes, sir.

Q Do you have them in your file?

A Again, those wouldn't be in my file. Those would be in the Surgicare files. They're part of the surgical record.

Q Same questions total right knee. Do you recall if you took intraoperative films in regard to the right knee?

A Again, it's a normal course of business I would taken the pictures. I do not recall not taking pictures.

Q Do you recall that you did take pictures. Correct?

A Again it was a while ago so if I did actually take pictures, I cannot tell you a hundred percent, but as a normal course of doing these surgeries, on a weekly basis, I always take pictures. Unless there was an equipment failure that date, there would have been pictures taken.

Q Now, in regard to the lumbar spine region

we're talking
about lower back, L4--

A L4-5?
Q Just above the coccyx area?
A It would be more correct above the sacrum.
Q Okay.
And in your experience, as an orthopedist, you see a number of people who come to your office for complaints of lower back pain that are not related to any type of traumatic injury.
Correct?
A Yes, sir.
Q And would it be fair to say the lumbar spine--in fact, the entire spine, as you get older, I think Mr. Mullaney used the phrase wear and tear but I would like to use the phrase degeneration. That occurs and it's part of the living process as you get older. Correct?

A It does occur as part of the aging process.

Q In fact, doctor, to find a mild herniation at L4-5, the very bottom, the level we're discussing, in fact. That's a normal finding on a then-- I believe she would have been 37 years old back at the time this accident occurred. That's not an abnormal finding. Correct?

A Again, any herniated disc is an abnormal finding. Any disc displacement is not normal.

Q Normal population, for a 37 year old, you would find quite high percentage of people that have bulging discs and

herniated discs at that level with no encroachment on the spinal cord, you would see that?

A You could see disc bulges and herniation, yes.

Q In fact that level, that level we've been discussing today, this morning, that's where you would expect to find this degenerative process to begin, in the lower lumbar

spine
region.
Correct?
A Again, if you're speaking of degenerative processes, that particular segment would be the segment that you would usually see the degeneration occur first. So if it was degenerative it would be at that level, yes.
Q Doctor, you've gone to the claim mechanism of the injury in this case.
Other than being told by the plaintiff that she was struck by a car, do you know anything else?
A That she fell to her knees.
Q And once again, do you know if she was actually struck by a motor vehicle, was-- was she startled and fell to her knees or something else?
A I mean to my understanding of the history that she presented, she was hit by a car.
Q And did she tell you what part of her body was struck by the car?
A I believe her back.

Q The back?

A The back of her body, back of her knees, her legs.

Q By the way, when you first evaluated the plaintiff, did you look at her feet, her heels?

A Again, I didn't look at it because she had a laceration but she was managed by the hospital for that so I did not put that in in my notes.

Q Now, in regards to the left knee. You stated that you didn't find any degenerative processes in the left knee. Correct?

A Well, again, I didn't find a degenerative process in the knee, I found a traumatic process. It was no significant degeneration in the knee that would be consistent with degenerative arthritis. She had damage to the condyle. There was degeneration of that cartilage which would normally occur with trauma but it was not degenerative arthritis.

Q There were no meniscal tears whatsoever.

Correct?

A That is correct.

Q The ACL, the anterior cruciate ligament completely intact.

Correct?

A Yes, sir.

Q So other than the cartilage injury that you claim, there was no tears whatsoever to any of the ligaments, any meniscal tears whatsoever in that left knee.

Correct?

A Correct.

Q Now, the right knee, the particular tears that you claim were observed--

By the way, have you see any intraoperative photographs at all prior to today on either knee?

A Not recently, no.

Q Do you know, in fact, if they exist?

MR. MULLANEY: Objection, Judge. Asked and

answered about four times.

THE COURT: Overruled.

Intraoperative photographs--

Q In regard to the right knee, talking about the medial Meniscus you found a slight tear in the horn.

Correct?

A Yes.

Q Would you agree with me, that's a part of the meniscus, where beginnings of degeneration usually start in that anterior horn?

A If you're speaking of finding as degenerative part that would be the part where it starts.

Q That's where you found a tear in the anterior horn, you would agree with me that's where the degeneration process would start in that particular location, correct?

MR. MULLANEY: Objection.

Q The lateral meniscus, that was the other meniscus that

you claim there was a slight tear. Correct?

A Yes, sir.

Q And specifically the part of the meniscus we're talking about where you found a slight tear was the posterior horn of the lateral meniscus.

Correct?

A Yes, sir.

Q And, once again, isn't that the location of the meniscus where one would expect to find the beginnings of degeneration, wear and tear as Mr. Mullaney referred to it at the start, that particular location?

A Again, if you're speaking of purely degenerative finding, that would be the location where it would start.

Q Now today, the plaintiff, she's fully weight bearing, correct, she can walk around. She doesn't need any kind of assistive devices.

Correct?

A Correct.

Q In fact, I think we've all observed her walk around the court house. We've seen her walk in hallways. Her gait

appears

to be perfectly normal to the lay person.

Would you agree?

A Again, I didn't see her walk today. I can speak when I saw her on February 28th but, again, symptoms will be variable

from day to day. If you're telling me she's walking without a limp today, I will concede that if that's accurate. I haven't seen her walk today.

Q By the way, when you saw her back on February 28th, 2017 which was last Tuesday, when had you seen her prior to that?

A March 18th, 2016.

Q So a period of time, considerable period of time elapsed between March and February 28th, 2017 with no treatment by you.

Correct?

A Yes, sir.

Q And, by the way, the purpose of the visit on February 28th, 2017, was that for purposes of this litigation? Were you asked to see Miss Fernandez at the request of the plaintiff's attorneys?

A Yes, sir.

Q And that was Mr. Oresky's office?

A Yes, sir.

Q So an attorney asked you to-- said doctor, I want you to see my client. She's going to come in the following to testify. Now, that was basically the reason you saw her last week, isn't that true?

MR. MULLANEY: Objection.

Asked and answered the third time.

THE COURT: No. I'll allow it.

A Yes.

MR. VEILLEUX: No further questions.

MR. CALDERON: No questions.

THE COURT: Counsel?

MR. MAILLOUX: I have some questions.

THE COURT: Go ahead.

CROSS-EXAMINATION

BY MR. MAILLOUX:

Q Good afternoon, doctor.

A Good afternoon, sir.

Q You indicated that you met with the plaintiff on September 4th, 2009.

A Yes, sir.

Q And you did an initial inquiry?

A Yes, sir.

Q And did you give Miss Fernandez an intake form for her to fill out?

A It would have been done, yes.

Q And do you have a copy of that intake form?

A No. I would not have that copy.

Q Okay.

When a patient generate rates an intake form, does that become part of your file?

A Again, it would become part of the file but that's not

my file. It was All Med's file. I stopped working in All Med in November of 2010. They are still the keepers of the records. I would not have the intake form and they never sent it to me.

Q So you were at All Med for a period of time and then you left?

A Yes.

Q And the file that you have is your personal file on the case?

A Well, I have my personal notes that were created in my office as a result of encounters. I also have copies of some of the All Med records that were forwarded to me from Mr. Mullaney and Mr. Oresky but I don't have the file from All Med treatment physically in my office.

Q Could you distinguish, as you're sitting here today, which records that you have with you were records that you had versus which records that were provided to you by Mr. Oresky and Mr. Mullaney?

A Yes. Would you like me to do that.

Q If you can.

A Okay.

Anything before November 1st and including November 1st of 2010 would be All Med records and anything subsequent to that, so the time I saw her after that, because she did continue to treat at All Med with replacements. I saw her in my office the first time July 12th, 2013 and everything

from 12 was my records.

Q Your replacements at All Med was Doctor Kenneth Poke?

A Kenneth Macome. There was a doctor Grasiosa and also Mitchell Kaplan and Stotela Gasse. Four doctors.

Q You're familiar with the practices of All Med?

A Again, only on the medical practice side. As far as other practices, I'm not familiar with.

Q So when they were treating with Miss Fernandez, as far

as your practicing with All Med, they would look at your records

and the entire file in evaluating the patient?

A Yes.

Q At All Med, after you left, presumably isn't it true

that Miss Fernandez' condition in both the right and left knee

were classified as degenerative?

A Yes.

Q And also referring to your initial evaluation on

September 4th, 2009. You found signs of degeneration in Miss

Fernandez' lumbar spine.

Correct?

A Yes.

Q And in fact those were at the L5-S1 level.

Correct?

A Yes, sir.

Q And, doctor, I want you to assume, hypothetically, that

an individual has a pathology at one level in the lumbar spine.

Would that pathology then create or furnish the circumstance for destabilization or pathology at another level of the lumbar spine?

A It depends on the extent of the involvement. If it's a mild degeneration it really doesn't impact the rest of the spine. If you start to see disc space collapsed, the answer would be yes.

Q When you're assessing an MRI of the individual, you used the phrase brightness. Is that correct?

A Yes, sir.

Q That's because when you're looking at MRIs, the MRIs either showed water content or fat contempt.

Is that correct?

A Again, it would depend on the sequences that are enhanced. There are sequences that enhance water and that would be called the T2 sequence and, then, there are sequences that enhance fat but you see fat and water on all sequences. It's just the amount of enhancement and the type of enhancement that are done.

Q The T1 sequence would enhance fat. Correct?

A Yes.

Q And we were looking at T T2 sequences before?

A Yes, sir.

Q And when a doctor, or radiologist, is looking at MRI films of the lumbar of the disc, they're looking at the

brightness in order to get an idea of what the water content is for the disc.

Correct?

A Yes, sir.

Q And if a disc degenerates over time in an MRI, under a T2 sequence, that disc will appear to be a darker shade, you know, depending on how much water content is missing. Correct?

A Again, decreased signal on a T2 image is representative of loss of water. It doesn't necessarily have to be from degeneration. If you're speaking of degeneration in its pure form, yes, you would have a darker signal but losing

fluid by

trauma could would always give you the same signal but loss of

signal is always degenerative.

Q When you look at the disc it would also be inaccurate

to say that the loss of signal is always traumatic.

Fair to say?

A Yes, sir.

Q Now, turning to the findings of chondromalacia in the

plaintiff's left knee.

A Yes, sir.

Q Chondromalacia can come about through normal wear and

tear. Correct?

A Yes, sir.

Q In fact, in some circles it's known as runner's knee.

Is that correct?

A Again, all people can chondromalacia. You know, we can

use the term runner's knee but anybody can get chondromalacia

just from walking if you're prone to having arthritis.

Q And when you looked in the knee and you performed the surgery in May of 2010, the contents of what you took out were sent to the lab to be analyzed.

Correct?

A Yes, sir.

Q And, in fact, those contents with regard to the left knee were found to be degenerative cartilage.

Correct?

A Yes, sir.

Q And there's no way that you could tell whether or not that degeneration began on August 31st, 2009 or before that date.

Correct?

A I could tell.

Q You could tell.

And what would be the indications to you that would indicate that it was degeneration that came after the surgical procedure?

A Well, if you are speaking of degeneration that would be prior to the injury. You know, when you're dealing with

arthritis from wear and tear it doesn't usually effect one location in one specific part of the joint. It's generally a

defused process. When you--

When I got into the knee there was a crater in the bone. It wasn't a worn piece of cartilage. The cartilage was completely off of the bone, and if I compare that area to the rest of the knee, which is pristine, there was no degeneration visually in any other part of the knee. So there was some type of traumatic insult to that condyle, and when cartilage is injured it degenerates as well. There's nothing in that to suggest that any degeneration existed prior to this accident.

Q You indicated that your findings, when you looked at the left knee, that the portion of cartilage was missing. It was your opinion that it wasn't ripped off. That it took place

over a period.

Correct?

A A period of time after the accident, yes.

Q And degeneration takes place over a period of time as well.

Correct?

A Again, if you're speaking of degenerative arthritis, that would be a period of time of years as opposed to weeks or months.

Q And, in fact, chondromalacia can be associated with degeneration.

Correct?

A Yes, sir.

Q And for the surgery that was performed on September 22nd, 2010 regarding Miss Fernandez' right knee, the contents of the knee were analyzed by the pathology lab as well.

Correct?

A Yes, sir.

Q And those contents were also found to be degenerative.

Correct?

A Yes, sir.

Q Now, doctor, as we sit here today is Miss Fernandez a

candidate for bilateral knee replacement?

A Presently?

Q Presently.

A No, sir.

Q And, doctor, if she were to undergo bilateral knee

replacements, that would be performed by another doctor not you.

Correct?

A Yes, sir.

Q You performed two arthroscopic surgeries. One on the

left knee. One on the right knee. Correct?

A Yes, sir.

Q Arthroscopic surgeries, a common procedure today.

Correct?

A Yes, sir.

Q You also indicated that when you reviewed the MRIs, you

found cysts in each one of the plaintiff's knees. Correct?

A Yes, sir.

Q And when Mr. Veilleux was questioning you, you had noted that those cysts were not related to trauma.

A I didn't say that.

He said there was no other traumatic findings to the knee. I did not state specifically whether the cysts were or were not related to trauma.

Q Cysts also take time to develop. Correct?

A It depends. You know ganglion cysts, which occur in joints, can occur over time. They can occur over long periods of time. They can occur over a short period of time if the knee or any joint is inflamed, so it depends on the clinical scenario. Again, if I had to assess those MRIs, there was no traumatic findings on those MRIs of the knees.

Q The cysts that you saw, would you classify them as traumatic or not traumatic?

A Again, my notes speak of traumatic ganglion

cysts.

There's no reason for her to have one as far historical details go. Again, that in itself was not a reason for her to have surgery. That's not the damage to the knees.

Q Doctor, you used the phrase passive range of motion before?

A Yes, sir.

Q Could you describe for the jury what you mean when you use the phrase, passive range of motion?

A Well, as opposed to what counsel was describing where a person tries to bend their knee and they stop when it hurts or straightens it out. That would be active range of motion.

On passive range of motion say this is a knee joint. I'm bending the knee until it stops, or it doesn't move anymore, and take the measurement with the goniometer and straighten it where it stops. And in most occasions

the

patients do not interfere with that and that is truly an assessment.

In cases where patients interfere that would be less objective and that didn't occur here. When you're dealing with passive range of motion it's the operator moving the joint or the examiner moving the joint as opposed to the patient moving it for you.

Q So when you're testing for passive range of motion, the test that you're doing involve you actually manipulating the joint?

A Yes, sir.

Q Now, if the patient at some point in time indicated to you that they were in pain, in that instance would you stop manipulating the joint?

A I mean in the instance where the patient would prevent me from going further, I would stop and it would be noted in the note.

Q You were asked by Mr. Veilleux about testifying last

week in this building.

A Yes, sir.

Q And when you testified, was that at a fee of sixty-five hundred dollars as well?

A Yes, sir.

Q That's your standard fee?

A Flat fee. Yes, sir.

Q How many times have you testified in court on behalf of patients in 2017?

A I couldn't give you and accurate number. I'm not sure.

Q More or less than ten?

A It would be less than ten.

Q More or less than five?

A I couldn't accurately answer you.

Q Well, you were here today and you were here last week?

A Yes, sir.

MR. MAILLOUX: I have no further questions.

THE COURT: Anything else?

MR. MULLANEY: Judge, do I have a minute to ask one question.

THE COURT: I'll give you a minute. Sure.

REDIRECT EXAMINATION

BY MR. MULLANEY:

Q Doctor, you were asked questions about the mechanism of the injury. Just describe what the mechanism of the injury is?

Of the knee injuries?

A There was something that hit the patient, and to my understanding it was a car that knocked her to the ground.

The mechanism of injury is an impact to the knee and the cartilage. That would be when the impact cumulative force or whatever hit her from behind and her hitting the ground.

Q And if the, as the defendants they've been arguing that it was not a car, it was the bumper it was debris, a

garbage

can, something else. Would that change your opinion regarding the mechanism of the injury that she suffered to her knee and her back?

A No, sir.

MR. MULLANEY: No further questions.

THE COURT: Anything else?

MR. VEILLEUX: No, Your Honor.

MR. MAILLOUX: No, Your Honor.

THE COURT: You may step down, sir.

THE COURT: Ladies and gentlemen, we're going to break for lunch. We went over our normal time so we could finish with this witness. We'll resume at 2:30. So during that time period do not discuss anything among yourselves or with anyone else, if anyone approaches you or attempts to discuss anything about the case with you, report that to me and of course do not engage in that discussion. Keep an open

mind. Do not do any independent research regarding this matter whether on electronic media or otherwise and we'll see you back here at 2:30.

(Whereupon, the jury exited the courtroom.)

THE COURT: All right. 2:30.

(Whereupon, the luncheon recess was taken.)

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This is to certify that the foregoing is a true and accurate transcript of the stenographic minutes taken within.

MICHELE HENLEY,
Senior Court Reporter