DIRECT EXAMINATION
BY MR. GUNZBURG:

Q. Good morning, Dr. Kahn

A. Good morning.

Q. What field of medicine do you specialize in?

A. Board certified specialties in two fields, Physical Medicine and Rehabilitation, also Pain Management.

Q. And explain to us what does physical medicine involve?

A. Physical medicine rehab is basically the field of medicine that deals with taking care of patients with disabilities, their lack of function, their pain related musculoskeletal conditions, pain related disabilities related to neurological conditions, taking care of the consequences of arthritis, taking care of patients on for example, inpatient rehabilitation unit, taking care of people with life-long disabilities, making them functionable as possible.

Q. What about the pain management portion of your practice?

A. Pain management, you can do one or two fields today in pain management specialty with additional training. You can be a rehab doctor like I am, anesthesiology or neurology if you do one year additional training and practice in pain management type of practice for at least one more year, then you can sit for a straight Board exam.

Q. Now you -- there is – do you know what a life care planner is?

A. Yes.

Q. Could you explain to the Court what a life care planner does?

A. A life care planner, you become a life care planner in two weeks if you're not a doctor of rehabilitation medicine, or physiatrist, you can take an additional course at least you're RN, social worker. Certain people can take the course and become a certified life care planner physician in rehabilitation medicine, as you can take a course, you don't need to sit for certification exam because you're being certified in a specialty credentialed to do that.

Life care basically look at, based on medical knowledge that we have, the natural course of medical illness, the natural course of what treatment the patient is going to need based on those medical illnesses. You put together a plan of what is suspected to be the patients medical needs, supportive health care needs including things like; aids, assisted devices, medication, all the things you need for the rest of their life presumably, because no one knows a hundred percent sure. You based that on other people history and other people that have the same disease state. What happened to them over time, and you base that on, you know what you think you will need and then you research what the costs are.

Basically hospitals list their fees, doctors list their fees, agency health care providers for home care and aids and assistants list their fees. Medical equipment, you just go on line and see the average price and define certain things of that nature.

Q. Now have you ever testified in any cases before today as life care planner?

A. Yes, I have.

Q. What kind of cases have you evaluated in terms of disabilities and impairment in connection with your testimony?

A. It's been as serious as a quadriplegic with traumatic brain injury, so someone who had cognitive impairment as well as you know full quadriplegic wheelchair, 24 hours, seven days a week supervision care. To cases like this where there are single musculoskeletal injury that impair patients lives and care and anything in between.

Q. Does your practice involve people who are disabled and have disabilities?

A. I would say a mix. Most of the cases I'm handling and treating are not life-threatening illness. On the other hand, seem to be the illness disrupt people lives. I am dealing with people disabilities. Not all the patients are in pain, acute, or disabled, but have some degree of function and limitation and I deal with that on a daily bases.

Q. Are you licensed in New York state to practice medicine?

A. Yes, I am.
Q. And when did you receive your license?
A. 1992.
Q. And where did you go to college?
A. Went to college in New York State, University of Brighton, went to medical school State University of Stony Brook and I train -- I trained at Beth Israel and Columbia Presbyterian Hospital for four years and first I did a year of general medicine at one of Columbia's affiliated hospitals in New Jersey. Then I spent three years at Presbyterian campus specializing in medicine.
Q. Do you have any privileges?
A. Yes. Medical Center in New York, also where I practice.
Q. Where is your practice situated physically?
A. Beth Israel Rehab Center in manhattan.
Q. And are you Board certified?
A. I am.
Q. And what are you Board certified in?
A. I am Board certified in physical medical as a physiatrist and also Board certified in pain management.
Q. And how do you become Board certified?
A. After medical school if you want to practice, you have to have some training. Minimum training you can have is one year. To be licensable in any state, but New York. If you want to specialize, you do a residency in specialty training and mine is called Physical Medicine and Rehabilitation and do that for three years. At the end of those three years you have to take a nation wide exam given by the ACG, America College of Graduate Medical Rehabilitation, a federal regulated national organization that basically governs all of health care education and if you pass that test, then a year later you get to come back for an oral exam before you practice for a year. If you past that test, you get Board certified for every ten years. Since then, for me, it happened twice. You have to recertify with a written exam.
Q. Now, do you lecture?
A. I do lecture. I run a teaching program at Beth Israel Director of the pain -- we have two pain management

programs. I am director of everyone of them, so if two post-graduate students, meaning they've done their residency rehab and want to become pain management specialists, they would spend a full year under supervision with me and two other doctors, and work with us one-on-one. So not only do we supervise, but we lecture throughout the year to them and sometimes invited guest lecturers in the facility.

Q. What do you give lectures on?

A. Mostly musculoskeletal injuries, pain syndromes, intervention for pain, such as epidural and pain block technics.

Q. Do you have training as a physician with knee injuries?

A. Yes. A substantial amount early in my career, also now, but earlier in my career I ran a joint replacement for knees and hips and a few shoulder and ankles. But the rehabilitation unit, that was just for patients with knee and hip injuries who underwent joint replacement. So not only do I have the privilege of taking care of them after joint replacement in rehab institute, but helping them beforehand trying to deal with the pain and arthritis, and wear and tear and that was then. And for the last 12 years where I have been back, I'm sure, thirteen years where I was practicing spine in Beth Israel, I basically taking care of joint aches and pain that goes along with patients as you're treat them. They may be referred to me as back, but we take care of the whole patient.

Q. Have you ever done any consultations in the hospital with other doctors in connection with the treatment of patients?

A. Oh, that's what I do all day long.

Q. And who did you consult with?

A. I'm part of the orthopedic department. Most of the people I will consult with are other Orthopedic Surgeons. I'm not in Orthopedic Surgery. I'm a rehab doctor in an Orthopedic Department. Neurologist call me for knowledge and assistance, and the pain management team will ask me to do a rehab plan.

Q. Speaking of orthopedic surgery, have you ever heard of Dr. Stuart Hershon?

A. I know Stuart Hershon reputation well. We share

very generously, two of Yankees patients that had spinal injections. He has a very good reputation.

Q. Have you ever testified in court before today?

A. Yes, I have.

Q. Have you ever testified for plaintiff's?

A. Yes, I have.

Q. Have you ever testified for defendants?

A. Yes, I have.

Q. And what percentage of your practice is devoted to treating patients versus doing other things?

A. I would say if you calculate on a number of patient visits, it's probably 0.1 percent. Maybe I do this three times a year at most. If you calculate it on a financial basis, it will probably, in legal revenue, like a legal revenue expert witness writing board, counts to 3 percent of my annual revenue.

Q. What is 90 percent of your revenue attributed to?

A. Taking care of patients.

Q. Have you ever testified for me before today?

A. One time.

Q. And did you have to cancel your schedule this morning to come here?

A. Yes, I did.

Q. And what did you have to cancel? What type of schedule?

A. A couple of spinal injection procedures and new patient evaluations and a couple of follow up patients.

Q. And as a result are you spending time here in connection on this matter?

A. Yes, we are.

Q. And you're getting compensated in connection with your time?

A. Yes, I am.

Q. Could you tell me how much you're getting paid in terms of time spending in connection with this case?

A. $7,500.

MR. GUNZBURG: At this point, Your Honor, I like to offer Dr. Kahn as an expert in the field of Physical Medicine, Pain Management as a Life Care Planner?

THE COURT: Any objection Mr. Reynoso?

MR. REYNOSO: Can I approach, Judge? May we approach?

THE COURT: You may.

(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and plaintiff's attorney.)

THE COURT: Dr. Kahn is qualified as a expert in the field of Physical Medicine and Rehabilitation Pain Management and the care that comes associated with that.

Q. Okay, Dr. Kahn, how did you come to evaluate Ms. Luna?

A. Early in April, your secretary asked if I was available to see a patient and evaluate them and prepare a life care plan.

Q. Okay, and did you review any records in connection with this matter?

A. Yes, I did.

Q. Tell us what did you review?

A. Sure. I reviewed the records which are sent to me, my office. I was able to review Dr. Hershon's records; her records from Jacoby Hospital the day after the accident; the operative report; the records from Roosevelt Hospital and the patients Bill of Particulars and amended Bill of Particulars, and the EMG study of the records, and imaging studies themselves.

Q. Did you see the physical therapy record too?

A. Yes.

Q. From Bronx Physical Therapy?

A. Yes.

Q. And did you meet with Ms. Luna?

A. Yes.

Q. And when did you meet with Ms. Luna?

A. On April 9th, 2012.

Q. And did you have and opportunity to evaluate her condition?

A. Yes. We spent about an hour and a half together and got to talk. For me, the most important part of medical interaction is the medical history. That's where you really learn, not just what the patient is complaining about, also planning a life care plan, how it effects them on every level

from the physical pain they have, to their, you know, how it effect their gates and ability to function; their ability to interact in the environment whether they have stairs in their house difficult to climb; whether they work as much as they use to and you try to get as much information as you could.

I performed my own physical examination to try to figure out what brought on the pain; what the aggravators were for the pain. The history was consistent with what I saw when I questioned her then. I took into account the records I reviewed, whether the day before, or two days before, and put my impression and plan together, and then came up with what I thought were reasonable medical, future medical needs.

Q. Okay, now when you took her physical examine when did you do that?

A. The same day, April 9, 2012.

Q. Okay, and what were your findings at that time?

A. By the way, and about two or three weeks ago. Yes.

Q. Okay.

A. So, that the first important thing I found is that her knee angle, what we call varus would be the little inward from the knee down, varus outward; that her right knee had a greater varus deformity. What that means, where the knee is suppose to sit flatly on each other, it's tilting outward. The lower part of the leg is tilting outward. Based on the history that I had, her alar aspect of her knee joint was a little thinner, so the knee sets like that. That was the first finding from looking and observing. If you see something like that, you take the goniometer and measure down. In her case, three degrees difference, not enormous.

Q. I'm sorry, you said goniometer --

A. Goniometer. Basically like a protractor, has two heads. You can measure an angle. In both knees, worse on right knee. She had crepitus. When you move the knee cap around, one thing you do when you examine the knee when feeling for swelling, you basically move the knee, you want to feel if it's overly used, or a knee cap should have a certain amount of the mobility. You want to assess that. You put pressure on it as you move it around and you feel what's called crepitant, which is like a vibratory sensation from the tissuing

rubbing on the knee, so basically a none smooth surface. A normal joint is one of the smoothest surfaces known to mankind. It should just rub smoothly, and she had a lot of crepitus below her knee and loss crepitant when she bent her knee. She had 140 degrees. That's when the pain got excruciating. Then we performed a test called a McMurray's test. A McMurray's test is when the physician hold the thigh and the ankle. You start it with the knee in a bent position and rotate it. The first doesn't matter if you do first, outside of the knee or inside. What you're trying to do is purposely grind the outer aspect of the knee joint and inner aspect of the knee joint and the thing you're looking for that makes it abnormal is not just the click, but a click associated with pain, or a grinding sensation associated with pain, because a lot of people have clicking and grinding, but they have no pain.

So she was very positive with lateral McMurray's test, meaning the outer or lateral aspect of the knee has the clicking sensation and the inner aspect of the knee did not. We tested the ligaments of the knee. So then the physician would hold their hand on the inner thigh and outer calf and check like that. Then do the other and see if the integrity of the knee is loose. The integrity wasn't, but the outer ligament, there was pain around the internal lateral ligaments.

Also when she was lying face up on the table and I think this was the first time she was made aware of this, there was gross wasting of one calf versus other. Meaning her right calf was smaller than the left calf, which could happen for several reasons. Someone with nerve injury to the leg; happens with someone limping and not using that leg as much as it could; happen with a muscle tear. Things like that. Then the cause of that, I measured the size of the calf on both sides and the size of the thighs on both sides and indeed, her right leg, the affected leg was three centimeter smaller which is about an inch and a half; inch and a quarter, inch and a half in circumference, and the thigh one centimeter. All that means and I'm not here to claim she has any kind of neurologically deficit in the leg, meaning she's not using that leg as much as the other leg and the muscle is not

standing strong.

So again, it showed me there was consistency in the complaint. Complaints of not using the leg as much, and relying on the leg as much, and there is evidence of that.

And I believe I did one last test to check the meniscus, consistent with the McMurray's test. I talked about the patient lays face down and you actually bend 90 degrees and grind to see if they experience clicking and pain. We observe it to be, and I believe that was the majority of the physical exam.

Q. Were you aware that – did you know Ms. Luna before you met her in your office?

A. No.

Q. When was the first time you met Ms. Luna?

A. That same day, April 9, 2012.

Q. Had you ever spoken to her before that date?

A. No.

Q. Do you know that she is a pediatrician?

A. She told me. That was part of my history.

Q. Did you have any prior relationship with her?

A. No.

Q. After you conducted your physical and you did a history, also did she tell you she had a prior injury to her left knee?

A. Yes, that's part of the pass medical history. She had some surgery on it as well.

Q. And do you know what impact her left knee injury had in connection with her right knee, if any?

A. Well, probably during the immediate post-op period. Normally in the normal course of events, you want weight on the right knee. She never complained of the right knee. I never saw that in the medical care of her right knee. I think it was more or less long time, in my opinion.

Q. What about arthritis? Are you familiar with arthritis?

A. Yes, I am.

Q. What is arthritis?

A. That's a funny question. What is arthritis? Arthritis

is any abnormity of the joints which you use. Artho is a Latin word for joint. Itis is inflammation, put them together, inflammation of the joint. Arthritis can be anything from softened cartilage, to wearing down of the joint space cartilage, to bony spurs inside the joints. Basically when you use the term arthritis, it implies something not normal, or perfectly normal with that joint.

Q. Okay now, if I told you that Ms. -- or one of the claims in this case is Ms. Luna had preexisting joint disease, arthritis in her knee, could you explain to the jury what that means for the average person, including Ms. Luna and also whether that's symptomatic or asymptomatic?

A. Sure. As I said, arthritis of the knee, or any joint could be a mild one, little things you pick up on, and be completely asymptomatic, or as severe to the point where a patient can't use that inner joint any more, and needs to take the weight off of it, or have it replaced. It could be someone could have the slightest bit of arthritis and be in severe pain and need attention addressed to that, and someone could have the more severe form of arthritis and walk around and be asymptomatic. Not just the knee. We see it in the spine. As I said, that's my main degree of specialty, the spine. I see people come in with six or seven disc herniations. Doesn't mean it's the first time they had pain in the spine. Something new happens like a trauma, a cough, turn your head the wrong way and the arthritis start to hurt.

It's my opinion in Ms. Luna's case, it's clear since her left knee was hurt, she went to the doctor and got it fix. She went to the doctor and went on with her life. It's pretty clear to her history and her knowledge, and there was never a previous complaint of right knee pain. So I think what they found on the x-ray, underlying arthritis was asymptomatic. It was there and didn't really interfere with her life in any way. To her history, she didn't take any over-the-counter meds for it, or required any meds to treat it. She was fully unaware of it.

Q. I want you to assume Dr. Hershon told the jury yesterday, that with a reasonable degree of medical certainty Ms. Luna is a possible candidate for right knee replacement in the future. Based on your physical and the history you took of

Ms. Luna, do you have an opinion with a reasonable degree of medical certainty as to whether Ms. Luna will require future knee surgery?

A. I do have an opinion. Not only surgery, but other care until that time. I do have an opinion with a reasonable degree of medical certainty that Ms. Luna will required knee replacement surgery in the future.

Q. Why do you say that?

A. You base that on not just for the purpose of the report, but also inform the patient what likely the natural course is. You base that on the, probably again, once the arthritis becomes symptomatic, you're now treating the joint. You have to look at what the joint looks like. She has had a very large meniscectomy, meaning they took out a large part of the meniscus, which now the bones, because of the way it's pointing out in the knee, the line with the lower part of the right leg being more outward because there is more force on the actual cartilage, that the meniscus is now at the point where it's bone on bone. She wasn't what I called an overwhelming candidate, because of the surgery, she did it on the side she limped. She is symptomatic. She take antiinflammatory most days. She uses skin patches. Some days she has weight off the muscle, so she is not using the leg enough and she is going to get weaker over time and just going to continue to deteriorate.

Q. I will ask you to assume certain facts in evidence and ask you your opinion, okay?

I want you to assume October 25, 2008, around 9:30, 10:00, a woman board the Q44, at Archer Avenue, and Southern Boulevard, Jamaica, New York. After she paid her fare, firmly held on to the pole and with her right dominate hand, as the bus suddenly, violently and without warning accelerated causing her to be pulled away from the pole and fall down hard on her right knee with her weight -- by the way, how much does she weigh?

A. I don't remember.

Q. You don't recall. Do you have it in your report?

A. I don't think I do.

Q. Okay. And she fell down to her knee, and as she was

on her knee, several people came to her aid and they helped her up. She was in excruciating pain, she testified 10 out of 30 sharp, constant, and wasn't able to physically lift herself from the position she was in. Several good samaritans, including Ms. Innocent, an ex-police officer came to her aid. Together they lifted her up under her arms and carried her to the seat, where she rode with her right leg extended, and when the bus arrived at her stop at Parkchester, she testified she limped off the bus and she got down onto the street, the curb area, and walked home, and what normally would take two to three minutes, took her 40 minutes to walk home. And when she got home she elevated her legs and put ice on her knee, and she took Motrin and tried to sleep but couldn't that night.

The next morning she went to the emergency room at Jacobi Hospital where she waited several hours like everyone else and entered into the emergency room, and saw a physician and had some x-rays taken of her right leg which showed effusion and swelling around her right knee, but no fractures in the knee, and they gave her an ace bandage and a cane and some medication, and they referred her, told her to go see and orthopedic surgeon.

I want you to assume that Ms -- or the woman in this case got a referral from a fellow physician at work for an MRI, went to Doshi Diagnostic in the Bronx, where she received an MRI on her right knee and based on the results of those MRI's which is in evidence, she had complex tears of the lateral meniscus. She then went to Dr. Hershon who was here yesterday in court, and he testified that he conducted a physical examine, reviewed the MRI, took an extensive history and he recommended she undergo arthroscopic right knee surgery. Ms. Luna wanted to consider her options and so she explored conducting physical therapy. She went for several sections. Those sessions worsened, or made her knee unbearably painful and she decided her only option at that point was to undergo arthroscopic knee surgery, and December 10th, 2008, she went to Roosevelt Hospital, Dr. Hershon who was here yesterday testified that he performed a surgery on Ms. Luna and I know you haven't had the chance to see these before today –

A. I have.

Q. Oh, you have?

A. I have seen the operative reports?

Q. Dr. Hershon was in court yesterday and he described to the jury the previous operative condition of Ms. Luna based on the surgery that he performed and indicated that her tears were actually at the location which is closer to the center and there was a very large complex tear of the medial meniscus basically tares and flag away of the meniscus of her right knee on the lateral position of her right knee.

MR. REYNOSO: I object to the form of the question and the length of the question. Doesn't seem like a question to me. Seems to me like counsel is testifying. I object to the question. I'd like a question.

MR. GUNZBURG: Dr. Kahn wasn't here today and doesn't know what Dr. Hershon said.

MR. REYNOSO: That's my objection.

THE COURT: Overruled.

MR. GUNZBURG: Thank you, Your Honor.

Q. And Dr. Hershon testified that he essentially examined also the sinovium which was basically like a piece of aluminum foil he told the jury, a piece of lubricating material and he had to remove a portion around the knee, and that Ms. Luna also had arthritis there, around the condyle, and also he indicated – oh, he also indicated in this diagram she also had arthritis inside the knee, and that would be where, doctor, in the bone itself?

A. Would be in the bone, the loss of cartilage.

Q. So he testified to that, and he also testified that he removed like I said sinovium and chondromalacia, which is arthritis, he removed as well, this large section of the meniscus as well during the surgery. And after the surgery he immobilized the leg and it was wrapped in an ace bandage. She was discharged from the hospital in a wheelchair, went home convalescent for a period of time. After the woman was at home and immobilized and unable to work or to do anything, she testified that she had to take sponge baths for over a month because she couldn't even get into the shower and couldn't attend to her personal care. She also told the

jury that she had difficulty performing her functions, couldn't go out, shop and many of the things had to be done by her husband at that time, and after she was able to get out of the house she went for physical therapy, and she testified that she went to Bronx Physical Therapy. This is in evidence. And she testified that she did various different modalities of exercises at the Physical Therapy Center for about a dozen times, that she was then given a home exercise program based on this chart which she did and continues to do until today at least three times a week in an effort to extend and give herself stability and mobility to obviously relief some pain?

I want you to assume that Dr. Hershon testified and told the jury that in his opinion with a reasonable degree of medical certainty, that the accident of 10-25-2008, was the cause of Ms. Luna's right knee injuries.

I want you to assume that Dr. Hershon told the jury yesterday that in his opinion with a reasonable degree of medical certain that Ms. Luna has permanent partial disability to her right knee. I want you to assume that Dr. Hershon also told the jury yesterday that her prognosis within a reasonable degree of medical certainty is guarded and that she will possibly need future surgery, including right knee surgery around sixty years old and then revision surgery sometime thereafter.

Now doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Ms. Luna has any permanent injuries?

A. Yes, I do.

Q. And what is your opinion?

A. In my opinion within a reasonable degree of medical certainty that she has permanently injured her meniscus which has been – it's been surgically removed; that she has permanently aggravated and activated arthritis in her knee that is progressive. It is my opinion that she suffers from daily chronic pain that fluctuates to the point that she needs to medicate and alter her functioning level.

THE COURT: Keep your voice up, doctor.

THE WITNESS: Sure.

A. Chronically, being she has chronic disability and loss

of function in her knee and chronic function-ability daily, based on activities from the day before to the point she needs to take medication, medicated skin patches, prescription based, use her own exercise program and limit her activities.

Q. Now doctor, do you have an opinion with a reasonable degree of medical certainty as to what caused Ms. Luna's right knee injury? Yes, based on the information I got from Ms. Luna for her medical history, the consistency with her examine, the consistency of the MRI with the type of complex tear it was, the amount of acute inflammation synovitis in the knee when Dr. Hershon went in, it's my opinion with a reasonable degree of medical certain it was the fall on the bus and not the preexisting finding on x-ray that cause Ms. Luna's injury and prove to be the event that changed the natural course of her knee.

Now doctor do you have an opinion with a reasonable degree of certain as to whether Ms. Luna will require any future medical care and treatment?

A. Yes, I do.

Q. Now what's your opinion?

A. So, you know again one of the things I was asked to do was to come up with a future medical care plan, health care plan and so I have a lot of opinions that I base on patients I have treated over twenty years, based on medical literature and the natural course of arthritic knees once they are on the down slope cascade. What's it's going to take to get her feeling better functioning at the best level, although it will never be back where it was, so I have several opinions created in this report.

Q. Did you prepare a chart in connection with your appearance today?

A. Yes.

Q. And that's part of your record and your report that was part of your report?

A. Yes, it is.

Q. And can I just show you, is this a copy?

MR. GUNZBURG: I'm not introducing it yet.

Q. Is this a copy of your report?

A. It is. You showed it to me earlier. It's a blow up of

the last two pages of my report.

MR. GUNZBURG: Can we have this marked as an exhibit?

THE COURT: Plaintiff's Exhibit 11.

(Whereupon, the item referred to is marked Plaintiff Exhibit 11 for identification.)

Q. Now doctor, this chart you prepared this chart?

A. You blew that up.

Q. You prepared the one in your charts?

A. Yes.

Q. Is that a fair and accurate copy of the one in your notes?

A. Yes.

Q. Would this chart help you explain to the jury the nature of the future medical care you project in this case for Ms. Luna?

A. Yes. Most of the items are on there. Learning a few new things about what Dr. Hershon thought about the time for the knee replacement, which I thought might be sooner. Some of the things are greater, some of the other care would be greater.

Q. Could you explain to the jury what those items are?

A. Correct.

MR. GUNZBURG: At this time, I like to offer this in evidence, Your Honor.

MR. REYNOSO: I do object to it, Judge. May we approach?

THE COURT: Come up.

(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and plaintiff's attorney.)

THE COURT: Objection overruled. We will admit it in evidence.

Plaintiffs 11 in evidence. This is a blow up representation of what was contained in submissions prior to the trial, am I correct?

MR. GUNZBURG: Yes, it was exchanged with defense counsel.

THE COURT: No more colloquy is necessary.

We spoke about that. Okay, we are going to mark that in evidence.

(Whereupon, the item previously marked for identification is marked in evidence as Plaintiffs Exhibit 11 in evidence.)

Q. Dr. Kahn, with the Judge's permission, come down off the witness stand and explain.

THE COURT: Mr. Reynoso, if you want to move back to see what they are talking about, you're welcome to do that. As well, I think I'm going to take a walk over there and see what that looks like.

A. No, basically there is the bottom line. The picture would require Ms. Luna --

Q. Let me ask you this. What is this?

A. This is basically in my report, the written part of the report, or basically my recommendation what I think she will need to help promote the best functional level she can have, which means treating her pain, treating her arthritis as it gets worst, trying to minimize the pain and the arthritis, trying to prepare for surgery, get her through the surgery that she will need in the future and basically to cover the medical consequences of what's occurred.

Q. Okay, and what are each? Could you go through each one of the items on the chart and explain to the jury first of all, what they are and why they are necessary in this case for Ms. Luna?

A. Yes. So, basically, Ms. Luna has what I consider to be a chronic pain condition at this point, and she does, even though it's over the counter meds, one of medication she takes are prescribed patches for her knee pain; that she should be seen by pain management specialist a couple of times a year to manage her medication. Even though she is a physician, it's highly irregular for physicians to prescribe their own medication, especially pain medication, and to visit a physician for one a year, the annual cost in this row "potential", I put that down as potential because if she really can limit herself to the over-the-counter meds then she wouldn't need that, but if the pain continues to be severe or worsen where she continues to take prescription medication, or prescription patches, that

would have to be seen.

Medications over-the-counter monthly cost of medication itself and monthly cost of what she could use on an average month is about 12 to 16 of these medicated patches and they are about five bucks a patch $200 a month or $1200 a year.

Q. Where does she use those physically?

A. The patch, right over the knee itself. It's called Lidoderm the one she uses, a Novocaine, or Lidocaine type medicine. It can be used to treat locally. I put down for the next four years since I kind of anticipated that she'd require a knee replacement, 50, if not 50 or sixty, medication called supartz and sinvisc.

Q. What is that?

A. It's basically like a liquid cartilage, injecting a liquid cartilage into the knee and you get about six months of reasonable pain relief from that if it works, if it's successful, if your body doesn't reject, or have an allergy to it. It's continual treatment where every six months you go to an Orthopedic Surgery and get an injection. This one is more expensive. You only have to have one shot every six months rather than three shot every six months. What you spend on medication you save on physician bills because you only need to see a physician once for the medication, runs between $6,800, figure $200, $250 the cost of a joint injection in the office because this is not an injection that has to be done under an x-ray guided system. I wrote $2,000,00 per year. I wrote if no knee replacement occurs, this cost could continue indefinitely as long as the patient benefit. Because she is on the over-the-counter antiinflammatory, whether over-the-counter or prescribed, not so much the Lidoderm patches, she is on it on a fairly constant bases; three doses, what she told me, three to four days a week. That's enough to start threatening your kidney. I think everyone knows even aspirin taken to much can hurt your kidney, at least a once a year blood to test kidney function, level function to see if are cellular affects and those tests are in the $200 range. They vary from labs. It's less at my hospital. It would run about $190. It's a higher potential because if she is on -- if she is on it and at any point needed to

revert to taking pain medication, meaning Percocet, the Vicodin family, codeine family, which she has at times after surgery, initially after the injury, but fortunately, and especially because she tries to be more awake and alert and function, she doesn't. But if she does by New York state guidelines you have to have a random urine screening once a year, a blood test will be the same. The urine screening, the lab, I have $150. Runs in the $150 range to the more sophisticated labs. I just mentioned based on what I think most Orthopedic Surgeon pain doctor tests for the knee when the stage is getting closer to knee replacement, you want to keep your eye on the knee joint swelling, bone swelling, bone deterioration, so I estimated over the course of a lifetime $15,000 for x-rays, MRI's, maybe ultrasounds of the knee at some point if she needs to have sometimes injections guided by ultrasound and that's probably very much on the low side.

Q. Now your chart also says it's based on from today until the rest of her life?

A. Her life expectancy, I hope longer, but life expectancy of a 47, 48 year old woman, doesn't have a lot of health issues and this is a functional and pain issue, but not fortunately a medical disease. Her life expectancy is 82.

Q. And the numbers, you projected those annually?

A. Annual except for the knee replacement.

Q. That's the next page?

A. Yes. So I think when she needs a knee replacement, I rounded it to $50,000 per surgery. The average price for the surgery and the hospitalization in New York State is $13,000. On that include the implant device itself runs about $4 or $5,000; OR fee $18 or $23,000 depending on which hospital and two nights or three nights of hospitalization and surgeon's fees are usually between, depending on the surgeon, $11 to $23,000. So I took about $13,000 to $14,000 as an average and it averages around $5,000 in knee replacement in today dollars.

What I didn't put if she need to go inpatient rehabilitation. See I didn't put it because it's not optional based on patient choice, based on usually the younger patient can handle going home. Especially Ms. Luna has a child at home and I anticipated four years from now, not 12 to 13 years

from now, but again if her son's no longer at home, if she chooses to go to a rehab hospital a day is $30,000 away rehab, less than a regular hospital stay for replacement four days; between two surgeries add $8,000 to the bottom line over here, life time. I think she will need I perceive physical therapy twice per year, none-operative state to make sure she's doing her exercises right, to tweak it if she get worse, if she needs a different exercise and then for periods post-operatively, whether she goes to inpatient rehab or not. With knee replacement, you need a good six weeks of physical therapy, whether at home, or out patient environment over her lifetime. I thought this would end up being in $300,000 a year for the rest of her life, plus 12,000, visits she will need post-op each time?

Q. Can I ask you a question? Knee replacement provide for one knee replace and one revision?

A. Yes.

Q. What's that based on?

A. The average span of all joint replacement actually improved over the last decade. When I was running a unit they used to tell me 10 to 12 years for replacement. The material has gotten better. Surgery techniques have gotten better and patient are getting 12 and 20 years out of it. Do we know for a fact? No, because you're doing it today, but we are seeing patients last longer and longer as the technology improve. So I kind of calculated age 51, 52 if you calculated close to 60, she's still going to need a revision.

Q. In terms of the additional, you said there was additional items that wasn't included?

A. A couple of additional items weren't included were if she doesn't have a knee replacement until age 60, the cost of her radiology is going to go up, because once you get the knee replace, you can get an MRI, it's not dangerous, you just won't see anything through the metal. Chances are she is going to need every year, every other year an MRI, $1500, or so per study until she get the knee replacement. That will be added on the figure, four extra MRIs, add an extra approximately $6,000 of extra cost. If she does not have the knee replacement for another six to eight years and she does use

those liquid cartilage injections, that will add about $6 instead of $8 that adds about $12,000 to her costs.

Q. Now, have you ever had any patient's knee replaced?

A. Hundreds.

Q. What is it like for them, the patients you treated to undergo knee replacement on one knee?

THE COURT: What's the question?

Q. What's it like for a patient to undergo replacement on one knee?

THE COURT: Rephrase the question.

Sustained.

Q. You've treated patients with knee replacements, right?

A. Yes, and continue to.

Q. So what type of therapy do you provide to your patients that have had knee replacement?

A. As I said, depending if the patient is going home. Usually post-op, four to seven from the knee replacement, or if they are going to rehabilitation stay --

THE COURT: Are you finish with the chart?

MR. GUNZBURG: No.

A. The most important part in my opinion of a good rehabilitation program for a knee is taking care of the patient's pain and post knee replacement pain. Probably of all joint replacements, knees are the worst. I'm not trying to be dramatic, it's just the hardest joint. The knee has one of the highest levels of nerve receptors and very involved joints, a lot of muscle and freezes up very quickly. Patients need to have a CPM machine, continuous motion machine. They stay in for 12 hours a day and she will need to have physical therapy.

Nowadays you get physical therapy the morning after surgery, and then the first two or three weeks it's daily and the therapist is fighting the scar tissue that forms instantly to get the range of motion back. The goal of successful with the knee the first few weeks of pos-knee replacement, you want to get the patient back at least 90 degree, 90 degrees right angle. If someone can't get like that, it's failure. They can't get in and out of cars, buses, up and down stairs. Can't sit comfortably without their leg being out, so everything is

done to achieve that. So you manage the patient's pain, get the pain under control enough so the therapy can work on the knee and tear through the scar tissue that's forming.

Q. How do you do that pain, how do you get a patient's pain under control?

A. The first two or three days after surgery, some physicians will leave a spinal catheter in and I'm sure you all have seen on tv, the button the patient presses for pain control every 48 hours and switch to narcotics.

Q. Such as Vicodin?

A. Probably start with a shorter acting Oxycontin, Percocet, Vicodin. If pain was unmanageable with that, you go to Oxycontin, basically the same meds, but longer acting forms. The goal of using narcotics in any pain management, as much as you need to control the pain or as little, when you have to take the patient off it's that much easier.

Q. Why?

A. It's addictive.

Q. It's addictive, and people get addicted to painkillers?

A. Yes. That doesn't mean she'll become a street addict. Her body becomes dependent on it and she has to be tapered off in a reasonable fashion.

Q. In terms of time period, how long does it take for a person to go through physical therapy and become active again after knee replacement surgery?

A. Despite the improvements I talked about, the quality of the knee joint replacement, a knee replacement is 30 days of living heck, so to speak. The first two weeks are dreadful. After that, probably got about two to six more weeks until you are really functional. Most people returned to work between six weeks and three months. You're still using a cane. About six weeks you start to shed using the cane. Most people stop using the cane at home first because they are comfortable in their environment. Usually three to four months people are achey, but start to have enough improvement checked to get back to what the pre-surgical level of function was, which as we know Ms. Luna's case is not normal. Usually six months they start to improve and your hope is they do better than they did before knee replacement.

Q. Even with the knee replacement, will Ms. Luna's knee be normal?

A. No, it will not.

Q. Just referring back to the chart, Doctor, do you have an opinion -- lift it up -- do you have and opinion with a reasonable degree of medical certain as to the future cost Ms. Luna is going to need in connection with her current injuries?

A. Yes. As I said, I think you know, I think actually prolonging the knee replacement actually increases the cost, as to the care she will need between this point and the knee replacement. So I think between the two items, we add it was about another, it will be $219,500 and then I think if we include an inpatient rehabilitation stay after the knee replacement versus her going home only, add another $8,000 which would bring us to about ($227,000. The reason there are two numbers here, the two numbers are, if you remember early on, I mentioned if her pain gets worse, she starts to take any kind of addictive meds, Tylenol with Codeine being on the list, stronger of the categories all the way up to Oxycontin, morphine, by New York State Law she needs to be monitored quarterly by a physician and need to be at minimum, once a year drug testing, even if she is the most honest patient in the world.

So those additional costs over the course of her life-time add about, what I thought, about another $65,000 with the urine screen testing an additional physician visits and cost of medications being about anywhere from $100 to $300 a month.

Q. So when you say it's $266,000, does that include --

A. No, would be an additional. Either way, those other items are potential, so I think the real numbers are closer to $225,000 to $227,000 and the high end probably just inching up to $300,000.

And these are all expenses pertaining to care of this injury, not her general health for the rest of her life.

Q. Are these numbers unreasonable, or excessive?

A. Not in my opinion. It's a lot of money, don't get me wrong, but healthcare is extremely, insanely expensive.

Q. Tell us about healthcare. Is healthcare going up in

the future?

A. I'm sure it's going up. Healthcare has gone up in the double digits, inflation last year, the first year came around, it's 10 percent usually, but it's been about 18 percent a year.

Q. In average, the cost of medical care is rising at least 10 percent every year?

A. Well, beyond 10 percent last year. The cost of healthcare in the United States has doubled every six years in the last twenty five years.

Q. So the number you just gave the jury, $227,000 to $300,000, is that in today's dollars?

A. That is in today's dollars.

Q. Which means what, assuming that she needs surgery 10 years, 15 years, whatever it is, what does that mean to them?

A. Probably going to be substantially higher, five hundred range, six hundred range.

Q. That's because of?

A. Medical inflation.

Q. Dr. Hershon, do you have an opinion with a reasonable degree of certainty as to Ms. Luna's progress?

A. I do.

Q. What is it?

A. I think it's guarded. I don't think it's poor, because I think there are things we can do to help her, but I think it's guarded because she is going to need those items that's well beyond a reasonable degree of certainty. I mean it's over, it's guarded.

MR. REYNOSO: I have no further questions, Your Honor. I'm finished.

THE COURT: Ladies and gentlemen, in keeping with my promise to you, we will take a five minute break. Do not discuss this case among yourselves or anyone else. See you in five minutes.

(Whereupon, the jury enters the courtroom.)

COURT OFFICER: All rise. Jurors entering.

THE COURT: Sit. Sit. Make yourselves comfortable. Just wait till everybody's seated and

relaxed.

We are going to continue the trial.
Mr. Reynoso, you may inquire.
MR. REYNOSO: Thank you, Judge.

CROSS-EXAMINATION
BY MR. REYNOSO:

Q. How you doing?

A. Good morning.

Q. You were asked how often you testify a year. Honestly I didn't hear the number. What was it?

A. Averages about three times a year.

Q. Is it always for plaintiff's attorney?

A. It's not always, probably 80 percent for plaintiff's so.

Q. Okay. And you said this is the second time you've testified for Mr. Gunzburg?

A. Yes, it is.

Q. And for this case, you were retained first time, when?

A. As I said, first week of April.

Q. Fairly recently, this month?

A. Correct.

Q. Now, do you have your own -- you have your own patients, right?

A. Yes.

Q. You don't just do this?

A. No.

Q. This is three percent of your income?

A. Correct.

Q. And of your patience, are some referred to you by attorneys?

A. Very small percent, occasionally.

Q. Okay, and of those, of all your patients, how many have personal injuries like this one?

A. Like this one meaning the knee.

Q. Meaning they were hurt in an accident and they are going to bring suit?

A. Most of my referrals are from other doctors, patients. Five percent of my patients come in for no-fault, or other injuries, may be 7 percent.

Q. Now obviously you talked about Dr. Hershon, correct? He was plaintiff's treating physician in

this case

A. Did you ask if I talked a lot about him.

Q. No, no. You spoke about him when you were questioned? Not a lot. He was mentioned?

A. Absolutely.

Q. So he was her treating doctor in this case, correct?

A. Yes.

Q. And you saw plaintiff one time about two, or three weeks ago, correct?

A. Yes.

Q. Who would you say is more qualified to comment on her progress, you, or Dr. Hershon?

A. Probably Dr. Hershon.

Q. You said probably? You're not sure, or, probably?

A. Probably Dr. Hershon.

Q. Why?

A. Why probably? Because I think different people are going to get different information. Different people have different insights into pain conditions. I mean he is clearly an Orthopedic Surgeon who was in there, inside her joint visualizing it and have a very good understanding of what he did and what her pain is.

My scope and my practice, although I do deal with joint replacements and you know, helping people prepare as to when, is more of that, how to help them with their functional level and determine when they are going to need joint replacement; when they need the surgery; when not to do the surgery, and that's part of what rehab doctors do, is work more functional, although I think he has the upper hand. He has knowledge of her knee anatomy, actually in there, in the knee and have treated her over the years. I think I have more insight as to what a patient need based on history, physical, what the course of their medical condition has been and based on years of experience with my patients, what usually

happens.

Q. Now, I heard you say, and if I'm saying it wrong, or misrepresenting it, correct me, that your specialty is actually the spine, not necessarily the knee?

A. My specialty is pain management. I am now practicing at part of the Spine Center.

Q. Now that's what I heard. What do you mostly deal with, spinal problems, back, neck problems, or mostly deal with knees?

A. Mostly deal with muscle skeletal system, within that. 60 percent of what I do is taking care of the spine. The other 40 percent is taking care of joints connected and relating to the spine; so shoulder, knees, elbows, hips ankle, generalize arthritic condition related to pain management.

Q. So the majority focus of your function is the spine?

A. Yes.

Q. And the rest, 40 percent or so, the rest of the body; shoulder, knees, etcetera; correct?

A. Correct.

Q. Now, I asked those questions because I heard you say when you were being questioned by Mr. Gunzburg that it isn't merely a possibility that Ms. Luna will need a knee replacement, but probability. Do you remember saying something to that effect?

A. I said my opinion within a reasonable degree of medical certain she will need a knee replacement. I don't remember if I used the word probable, or possible, but I think it is probable.

Q. Is it probable? You said, actually you said it's not only probable, you said it's not a matter of if, it's a matter of when. Those actually are your words. Do you remember that?

A. Correct.

Q. And is that your opinion?

A. That is my opinion.

Q. What if I were to tell you that, or assume that yesterday, Dr. Hershon testified that several times there was merely a possibility that she will need a knee replacement. What is your opinion on that, his testimony?

A. I think it's highly possible, or highly likely that she will. That's what my opinion is.

Q. He did not use the word highly, but you're using the word highly?

A. That's my opinion.

Q. But you agree he is more qualified to make a prognosis than you are with respect to Ms. Luna since he was the treating doctor?

A. Probably, or possibly more qualified, but that's still my opinion.

Q. Now, you mentioned, again, if I misrepresent what you said, you correct me, okay?

A. Thank you.

Q. Something to the effect that there's been a diminishment in Ms. Luna's, I guess right leg, correct, or muscle, because she's been, I guess, using the left leg more, or something like that. Could you repeat what you said.

A. What I stated there was three centimeters, a substantial measurement decrease in the size of her right calf compared to her left calf. It's not accounted by swelling. The left calf, I checked for swelling in the left calf, so it's not artificial numbers. And I stated specifically that could be from several causes. The most common one being disuse, or less use of that leg than the other leg. Could be from a neurological injury to the muscle. The muscle is not getting a signal to work. Could be direct trauma to the muscle. Things like that.

Q. Now you're aware that before this surgery to the right knee, she had surgery to her left knee, you're aware of that, right?

A. I'm very aware of that, yes.

Q. Do you know if the same thing happened

before? In other words, the opposite. Did she, did the opposite happen? Did she use before she injured her right knee in this accident, as she claims, did she then use her right leg more than her left leg because of her prior knee condition?

A. For that period of time, yes.

Q. And how would you explain the fact that, that -- withdrawn.

If that's the case, at this point shouldn't one leg muscle have -- should the leg muscle have caught up to the other given that she had problems with both knees at different times?

A. No. In my medical opinion, that's totally incorrect. What it implies to me is her left leg has recovered and caught up and probably achieved the size of the calf muscle regrown or atrophied, gotten bigger. If you don't use muscles they get smaller. It implies the left side is functioning up to par, and she has no more disability or less disability, or she is favoring that side, and the right side is working down and not pushing up as she go upstairs and downstairs and that's-

Q. So you can tell her left leg is completely recovered, or left knee? It was the left knee, completely recovered, but the right knee she is going to suffer with that the rest of her life, is that what you're saying?

A. It's my opinion, until the knee replacement, she is going to suffer progressively worse until a point she needs a knee replacement, even after the knee replacement there are patients that don't recover a hundred percent, so there are issues with the knee replacement functions and limitations.

Q. Now, you did examine the patient on April 9th, correct?

A. Yes, I did.

MR. REYNOSO: Can I have that report. I guess I'll have it marked as Defendant's 8, or 9.

(Whereupon, the item referred to is marked Defendants Exhibit A for identification.)

Q. Doctor, I want to show you a narrative report, an addendum to that report from Dr. Hershon marked in evidence as Defendants Exhibit A.

MR. REYNOSO: May I, Judge. Oh, officer, thank you.

A. Thank you.

Q. Okay, Doctor, can you turn to the third page, please?

A. Yes.

Q. Okay, at the end, the doctor talks about his examination of December 8, 2009. Do you see that?

A. Yes.

Q. Okay. Now, apparently around that time according to his testimony is when he stopped actively treating the plaintiff, okay. Now, as you see he performed the same tests you performed a few weeks ago. Similar, McMurray's Test, Valgus test, correct.

A. Yes.

Q. Are his findings and your findings the same, or different?

A. He didn't perform according to this, he did not perform a McMurray's test to check her cartilage, or bone. He performed the Lachman's test and posterior and anterior drawer tests, tests I didn't perform because the ligaments are not in question. He also performed a ligament test, her knee was stable to the valgus, varus test, pushing on ankle and pull knee slightly turn it. He didn't state whether or not it was pain. On my exam the outer aspect --

Q. Let me ask, did you see in there he found any abnormalities? Were any tests positive, were any positive findings, any motion limited, anything like that when he -- when he last treated her in December of 2009?

A. No. He did not find any abnormalities on what he listed.

Q. Now you were asked by Mr. Gunzburg what's arthritis and you gave a definition?

A. Correct.

Q. Did you ever have occasion to review Ms. Luna's MRI films, or x-rays from her right knee.

A. Yes, I did.

Q. Okay, did you see degenerative findings in those x-rays and, or MRI's?

A. Yes, I did.

Q. Now, could you explain what degenerative finding means are, generally speaking?

A. As I said earlier, any abnormalities in the cartilage bone thinning of joint space. She actually had that, as well implies abnormalities in the joint as I discussed earlier. The term abnormalities in the joint is arthritis.

Q. Now, in term of degenerative findings, are those findings things that occur because of an accident, or are those things that have been there for a while due to wear and tear, it happens over time?

A. Degenerative findings I think, believe are due to wear and tear.

Q. Let me ask you this. Your prediction is that plaintiff will definitely, or most likely need a knee replacement, correct?

A. Yes.

MR. GUNZBURG: Objection to form.

THE COURT: Overruled.

Q. And you also gave numbers as to what her future costs for medical expenses will be, correct?

A. Correct.

Q. Now, if -- now is there a possibility that plaintiff will never treat again for the right knee, is that possible?

A. That is possible.

Q. Would that surprise you?

A. Surprise me, yes.

Q. Is it a possibility that plaintiff -- withdrawn. Would you be surprise if two years passed from today and she did not treat at all for her right knee?

A. I would be surprised because she is taking medication every three days, or ever two days and pain patches for the knee, does exercises every two days. That is treatment. She is protecting the knee, exercising on the treadmill, stationary bike, so these are continuing treatment.

Q. I limited treatment to going to the doctor, not self-treatment; can we agree to that?

A. I don't agree. That's what treatment is. That doesn't surprise me if she does not seek out medical treatment over the next two years.

Q. How do you explain she has not treated actively since December of 2009?

A. Treated with a physician?

Q. Yes. I mean going to a doctor and treating with a physician, yes?

A. Because I think her condition is painful, but stable and she has been able to manage the pain as I pointed out, with the medication, Lidoderm patches and doing exercises. And she doesn't have appropriate coverage for some of the interventions such as physical therapy program, which I recommended. Things like that.

Q. She testified that she has insurance?

MR. GUNZBURG: Objection, Your Honor.

THE COURT: Sustained.

MR. GUNZBURG: Then I move to strike the doctor's last response. He said she can't afford -- she's not covered?

THE COURT: We are going to disregard anything about coverage. This is not relevant to what we are doing now.

Q. So despite the fact that she hasn't treated with a Doctor in over two and a half years, you're predicting in the future she is going to continue to

treat and need all of these medical treatments and surgeries, is that what you're saying?

A. That's what I testified to and I still believe that, yes.

Q. Based on the history, the fact she has not treated in so long and only treated actively for three months, how do you know this? How could you -- how do you know this? How do you justify your opinion?

A. Based on her complaints, based on the history, speaking with her that she likely do things that would lessen her pain level. She was eager to learn more about some of the things she can do for her pain. I believe her condition will worsen over time which would require she continue to see a physician based on the natural course of a anatomy in women. It is greater than in men because of the shape of the pelvis and strain and pressure on the outer aspect of the knee in women are usually higher because of the area of their pelvis and width of the pelvis. That's standard knowledge. My twenty years experience seeing people with chronic knee pain, taking care of this at home reaches a turning point and wanting to treat and go after that treatment.

Q. Now, are you aware that Ms. Luna has worked full-time continuously for at lease the last two and a half years?

A. I'm aware.

Q. And as a pediatrician she walks around on her feet a lot, are you aware of that as well?

A. I'm aware of that and aware she has to have assistant at times and -- things like that.

Q. Did she tell you that? She didn't say that. She said in the beginning she needed help. The last two and a half years she has not needed assistant?

MR. GUNZBURG: Objection, Your Honor.

THE COURT: Ladies and gentlemen, what Dr. Luna testified, your recollection is what

counts. If you are not sure during deliberations, you can ask to have that portion of the testimony read back for the purpose of this question.

Overruled. Go ahead. That's Mr. Reynoso's recollection. That's Mr. Reynoso's recollection. It's ultimately your recollection that matter. If you find it necessary you can have that testimony portion read back to you during the deliberations.

MR. REYNOSO: There was a question? It's fine.

Q. Mr. Gunzburg asked you whether or not when you saw Ms. Luna, he actually asked you what her weight was, and you said that --

A. What?

Q. Asked what her weight was and you said you did not weigh her?

A. No, I did not weigh her.

Q. Is a person's weight and height not important with respect to a knee condition?

A. Once someone has arthritis, it might not be as important. The weight for their height is important.

Q. If it's important why don't you take their weight?

A. Because I think she is a heavy set woman. Not morbidly obese, falls in the normal category of an average American.

Q. Did you take that into account when you made your projections; height and weight?

A. I don't think it effects my projections in any way whatsoever. I think had she been morbidly obese, you know, several hundred pounds over weight, that would hugely effect in a negative way my projection recommendation. But as we sit here today, I don't think that effects her.

MR. REYNOSO: That's all, Judge.

THE COURT: Anything else

Mr. Gunzburg?

MR. GUNZBURG: Yes, Your Honor.

REDIRECT EXAMINATION
BY MR. GUNZBURG:

Q. Doctor, I want you to assume for the purposes of this question that Dr. Hershon was here today and told the jury that in his opinion with a reasonable degree of medical certainty that Ms. Luna would possibly require a future knee replacement. Does his opinion differ from your opinion at all?

A. I think from the sound of it I stated it a little more strongly. My experiences might be somewhat different from Dr. Hershon. I don't know what he means by possibly. I stated it's my opinion within a reasonable degree of reasonable certainty is what I indicated. What that means is more likely than not. I stated my opinion is just a matter of time. Just a natural course of the joints, cartilage, underlying arthritis, which in my opinion was asymptomatic. Doesn't mean it's not taken into account once someone is injured. Once you're injured, you are dealing not only with the consequences of the injury, but what the base line of the anatomy was and it's my experience from 20 years of practice to have a knee replacement. He is the physician in there and can see the anatomy and he felt it was.

Q. What is your opinion with regard to Ms. Luna requirements in the future with regards to knee replacement?

A. As I stated, it's a certain high degree of medical, reasonable degree certainty she will require future surgery replacement unless something comes along better than the current technology. I think she should start to, as her Dr. Hershon noted the Sinvisc injections. I put in my notes very limited amount of physical therapy. I think she will benefit, maybe prolong the time. She needs that. If she gets physical therapy to strengthen her leg, but I think pretty much, I still very strongly think it's a very conservative prognostic plan.

Q. Now defense counsel asked you if you would be surprise if Ms. Luna did not get surgery in the future for knee replacement. Tell us why you would be surprised if she didn't get a replacement in the future?

A. I don't claim you know, Ms. Luna -- well, I spent an hour and a half with her. She is motivated enough. The first

surgery, first knee, she was able to recover and get back to work. She stated in the social history, I didn't go over one of the big things. She can't walk far, she can't exercise, she can't even do a stationary bike for a few minutes, which she used to.

One of the things she told me her son was with her the day she came. She doesn't physically get to play with him much. Get on her knees, go play ball with him, things she use to do. Although he was younger then.

So I think she is motivated to feel good and function. The thing about a knee replacement, hip replacement, shoulder replacement, it is not a disease stage that cause you to die, or get sicker if you don't do it. The more pain she has, the longer you wait. There are people who choose never to have joint replacement. I have people I recommend spine surgery for and they won't go for it and they eventually end up in a wheelchair and they won't take that risk. As a physician, you have to work with that patient's individual preferences and try to support their decisions even if they -- you get the wrong decision. Educate them. You can only do what you can do.

I will be surprised following the history of Ms. Luna, the fact she, herself having surgery and not becoming a chronic person saying, I can't work, I can't get out of the house. She got better. Got better to the point she is still treating herself several times a week. She will start getting MRI's, whenever she get to the point when the pain is no longer bearable, she will have the knee replacement.

Q. Counsel indicated Dr. Hershon's report, 2009, he indicated there were no positive findings at that time. It was a little more than two years ago. Then he asked you about your findings and you had a lot of positive findings, right?

A. Yes.

Q. And that was done about two weeks ago?

A. That's correct.

Q. Tell the jury what does that mean to you, you have all these positive findings two weeks ago and she didn't have any of those findings after the surgery approximately two years ago. What does that mean to you today as you sit here?

A. Well, just give me one second before I answer that. First thing, I point out in Dr. Hershon notes, he listed his

findings. He also in the same paragraph pointed to the fact that possibly she is going to need these injections and possibly she is going to need surgery. I can't imagine he found a cure, or he would have listed that.

To answer your direct question, it's already said that either he didn't report positive findings and only reported negative findings. That was a narrative and she does have substantial limitations, substantial pain and provocative pain on maneuver.

Q. Could it possibly get worse after --

A. It could. I can't speak on Dr. Hershon. Generally, in my exam she has substantial findings.

Q. Now, when defense counsel asked you also about Ms. Luna, you assume to limit it to her going to a medical doctor for treatment. You know she's a doctor, right?

A. Yes.

Q. And she is a Board certified pediatrician and treats here in the clinic in south Bronx?

A. Yes.

Q. Tell us what treatment can she get for her knee condition? What does she do for herself in order to treat her condition today?

MR. REYNOSO: Objection.

THE COURT: Sustained.

Q. Could you tell us based on other than the medical treatment at a doctor's office, based on your physical and your history and your evaluation of this case, what is Ms. Luna doing to treat her knee condition today?

MR. REYNOSO: Same objection.

THE COURT: Overruled.

A. From a medical history she is taking medications, sometimes three or four doses a day, several days a week when her knee bothers her. She is limiting herself to lifting, sports activities, elevators her legs and sometimes ice at night, using Lidoderm medication patches when it gets bad which is couple of times a week. She is doing what any normal person would do. You try to manage your pain and try to get by and function at the best level you can with what you got.

MR. GUNZBURG: I have no further questions.

Thank you.

THE COURT: Anything else, Mr. Reynoso?

MR. REYNOSO: Yes, Judge.

RECROSS EXAMINATION
BY MR. REYNOSO:

Q. Now, going back to that narrative December 8, 2009, of Dr. Hershon?

A. Ah-huh.

Q. Again, you seem to speculate that maybe he wrote this down and that down, but what he did write down, there were no positive findings on range of motion, the movement was full, is that correct?

A. He never use the words, no positive findings anywhere in that report. He did write the word range of motion, full. He didn't write 0 to 140, which is full range of motion.

Q. Why did he say there were no positive findings? All the tests he performed he said were negative?

A. Those tests were negative.

Q. If they were positive that means there was something wrong. He found some sort of problem with the knee, correct?

A. Right.

Q. So, okay --

A. That is correct.

Q. So when I say he made no positive findings, I'm sort of summarizing the OPs. What he did, right? I'm not mistaken, am I?

A. I don't think you're mistaking. I don't think to state something written on paper you said was and it wasn't.

Q. Less than a year after this incident her treating doctor makes no positive findings. You see her three and a half years later and you see positive findings. Under those circumstances, how can you attribute, or causal relate; how do you attribute her problem now to the accident given that she had no positive findings a year after?

A. That's obvious and simple. As I stated earlier, with arthritis, whether underlying arthritic findings in the knee, once you take out the enlarge chunk of the cartilage and scrape away some of the other cartilage that was injured, you're basically setting her up to deteriorate faster than

others.

Q. She had deterioration before accident?

A. She was asymptomatic and may have stayed that way.

Q. You know it was asymptomatic because she told you, not because you saw that?

A. Unless someone can prove a patient is lying, meaning if there is any medical records to show sort care for the left knee, or she told me she never saw a doctor for the right knee, I'm sure when she went for the left leg someone examined the pair. That's some of the things doctors do. Yes, basing everything I said today is based on the information I have.

Q. Basically, based on the fact there is no history, according to what you were told by the patient, Ms. Luna, of a right knee problem, the summation is she had no prior right knee problem, correct, fair statement?

A. I think you're mixing it.

Q. Let me rephrase that.

A. Other than the findings on an x-ray, to my knowledge, there are no more major right knee problems.

Q. In other words, she may have had arthritis, but was asymptomatic based on the history?

A. Based on history.

Q. Before this accident she was functioning, she was working, correct?

A. Correct.

Q. How about the fact she worked continuously the last two and a half years? Doesn't that mean she maybe had gotten better; does it mean she healed; does it mean the same thing?

A. It doesn't mean her employment suffered. You have to pick and choose in this world what you can and can't do with limitation. There are a lot of people who have the same injury as Ms. Luna and just say I can't work anymore. If she was a laborer, or construction worker, she may not be able to return to her previous line of work. She is a physician and may be able to function with limitations with her work. She exercise, can't play as much with her kid, takes medication three or four times a week, using skin patches, elevating her leg at night. She is managing. Doesn't mean she does it the way she was before the accident.

Q. You're stating she was asymptomatic the way she was before the accident; stating she is working and functioning. The fact she was working and functioning the last five years doesn't tell me if she is healed, or recovered, or gotten better?

A. I don't know how better to state she is function at a different level than she was prior to the injury.

Q. Do you have records, any reports of her prior to this accident?

A. I have her medical history.

Q. Do you have records from before this accident? Do you have medical records of Ms. Luna from before this accident?

A. No. I have her medical history and I'm assuming she is an honest person which she exhibited her whole life, based on my testimony today and beliefs on what I learned, the fact that I think if she was making this stuff up, she wouldn't have gotten any better from the surgery. She is not like that.

THE COURT: Anything else Mr. Gunzburg?

MR. GUNZBURG: Just one, or two.

RE-REDIRECT EXAMINATION

BY MR. GUNZBURG:

Q. Now counsel keeps asking you about these negative findings by Dr. Hershon in his report, can you explain why Dr. Hershon made all negative findings and in the same report he mention surgery?

MR. REYNOSO: Objection.

THE COURT: Sustained.

Q. Could you read from that report, that narrative report that counsel asked you to read in.

MR. GUNZBURG: Can I have that Exhibit 1, please.

THE COURT: Defendant's A.

Q. Let me show you Defense's Exhibit A.

MR. GUNZBURG: It's in evidence, right, Judge?
THE COURT: Yes, it is.

Q. Do you see that addendum report?

A. Yes, I do.

Q. And you can read it. What does it say? It's evidence.

A. In reference to the narrative on Betty Luna, this will serve as addendum. Dated March 9, 2010. It's my opinion that Ms. Luna's symptoms and findings and the subsequent surgery were related to the accident that had been reported. There is also the possibility that in the future surgical intervention may again be necessary. This will either be in the form of a repeat arthroscopic surgery or conceivably if she develops significant arthritis, possibility of knee replacement will have to be considered.

Q. Now if Dr. Hershon indicated that she needed a knee replacement, possibility of a knee replacement, yet counsel keeps asking you about all negative findings, would a doctor ever recommend, or suggest a patient may need a knee replacement if he thought they didn't need one?

MR. REYNOSO: Objection.
THE COURT: Sustained.

Q. Do you know why Dr. Hershon recommended Ms. Luna undergo, he has "possibility" of a knee replacement?

MR. REYNOSO: Objection.
THE COURT: Sustained.

Q. Could you tell us based on that report, does that change any of your opinions in this case?

A. No, it does not.

Q. And have you seen any medical records offered by defense counsel, or that are in evidence that would suggest that Ms. Luna had any right knee complaints, injuries treatment, or anything to her right knee before the accident involving this bus?

A. No, I have not.

MR. GUNZBURG: Thank you.
THE COURT: Mr. Reynoso?
MR. REYNOSO: Nothing Judge.

THE COURT: You may step down, doctor. Thank you very much. Counsels, step up.
(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and Plaintiff's attorney.)
THE COURT: Ladies and gentlemen of the jury, we are going to break now for lunch. Please, 1:45. We have another doctor coming. I want to make sure we get through with him today. 1:45, we will break a little early and come back a little early as well.
Keep an opened mind. Do not discuss this case among yourselves or anyone else. Like I said yesterday, I'm not vouching for the quality of food, but there are a lot of choices here for lunch.
(Whereupon, the jury exits the courtroom.)
(Whereupon the Court recessed for lunch and resumed at 1:45,)
(Whereupon, the jury enters the courtroom.)
THE COURT: You guys are professionals. Everybody's back. I got to court reporter back. No one bailed on me today, so that's good. Hope you enjoyed you're lunch.