COURT CLERK: You're welcome.

MR. RONEMUS: Can we mark Dr. Friedman's chart as an exhibit please.

THE COURT: The one he has in front of him?

MR. RONEMUS: Yes.

THE COURT: Okay. We're going to take just one second. Go right ahead.

Do you need some water?

THE JUROR: No.

(Juror excused.)

(Pause in the proceedings.)

COURT OFFICER: Which one are we marking?

MR. RONEMUS: This one, this chart.

COURT OFFICER: You want specific or the whole thing?

THE COURT: The whole thing for I.D.

COURT OFFICER: Plaintiff's 29 for identification.

DIRECT EXAMINATION BY MR. RONEMUS:

Q Good afternoon, doctor.

A Hello.

Q The chart that we have that's marked Exhibit 29 for identification, are those records kept in the ordinary course of your business?

A Yes, sir.

Q Is it the ordinary course of your business to keep those records?

A Yes, sir.

Q Do those records pertain to your care and treatment of Leslie Lariviere?

A They're all records I used in treating her.

MR. RONEMUS: I offer this chart in evidence.

THE COURT: Any objection?

MS. SCIARETTA: I'd like to see it, your Honor.

THE COURT: Yes.

(Handing.)

(Counsel reviewing documentation.)

MS. SCIARETTA: May we approach?

THE COURT: Sure.

(Bench conference off the record.)

THE COURT: Plaintiff's 29 is in evidence subject to redaction.

Q If it would assist you, you can refer to your chart during the course of your testimony?

A Thank you.

Q Let's talk --

THE COURT: There are a whole series of reports from other doctors in your chart.

THE WITNESS: Yes, your Honor.

THE COURT: Don't read from them in the course

of your testimony.

THE WITNESS: Correct. Deal.

Q Tell us, what type of a doctor are you?

A I'm a neurologist. I deal with illnesses and injuries of the brain, spinal cord, nerves and muscles.

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

A Yes, sir, I have been licensed since 1976.

Q Can you give us your background and education that qualifies you to be a neurologist?

A Yes, sir. I'm a graduate of Downstate Medical Center here in Brooklyn, class of '75. I did an internship at Maimonides Hospital in Brooklyn from '75 to '76. I did a neurology residency at Kings County in Brooklyn from '76 to '78. I was chief resident of neurology at Kings County from '78 to '79. I then taught at the medical school I graduated from '79 to '82. My official title at that time was a clinical assistant professor of neurology. I have an active clinical practice for more than thirty years. I see patients ever day. And I am board-certified by the American Board of Psychiatry and Neurology 1980. I'm also board-certified by the American Board of neurophysiology, 1979.

Q What does that mean?

A Neurophysiology. Neurophysiology are the computerized tests that are available to test the brain, the

spinal cord, nerves and muscles. Brain wave tests, nerve conduction studies, etc. there are many different types -- it's actually a separate board exam.

Q I didn't mean to interrupt you. Go ahead.

A So if you pass the exam, if one passes the exam, they get a title called a diplomat. Technically I'm a double diplomat, psychology in neurology and neurophysiology. That's my thirty-plus year in five sentences.

Q Where did you come from when you came to court today?

A I took the F train from Kings Highway from my office.

Q Were you working in the office this morning?

A Of course.

Q When we're done today, where do you intend to go?

A I have patients and secretaries waiting for me. I plan on getting the F train and going pack.

Q Have you testified in court before?

A Oh, many, many times.

Q Have you testified on behalf of both plaintiff and defendants?

A Behalf of both but the overwhelming majority are plaintiffs. In the last six times that I testified two were defendants and four were plaintiff.

Q By the way have you ever testified on behalf of the

Transit Authority?

A As a matter of fact, yes, and -- last week as a matter of fact.

Q The Transit Authority hired you to be an expert to come into court to testify on behalf of the Transit Authority --

MS. SCIARETTA: Note my objection.

Q -- last week?

THE COURT: It's leading, but I'm going to allow it.

A That's correct.

Q Are you compensated for your time in court out of your office?

A Yes, I charge for my time. I charge what it costs to run a neurology practice in 2012, about five hundred dollars an hour. I charge for my traveling time and I charge for time preparation per hour.

Q Okay. Have you treated Leslie Karen Lariviere?

A I have been treating Ms. Lariviere --

Q It's been pronounced a number of ways.

A I will just go with Leslie. I have been treating her for more than three years on a regular basis.

Q So why don't you tell us about your treatment of Ms. Lariviere and your diagnoses and findings regarding her injuries?

A I will stick to the pertinent positives. My first visit was in December 12/22/08, that was the first time I saw her. Her history is very simple. She has no medical history. She's not a diabetic. She not hypertensive. She has two adult children. She worked at multiple jobs, nanny and waitressing, etc. And she reported an injury 12/9/08 approximately two weeks before I saw her the first time. She told me about going to Lutheran Hospital. They evaluated her and sent her home. Her chief complaints on the first visit --

Q What's that mean chief complaint?

A You get a history from the patient. It's important to know what happened to them before, whether they have any chronic illnesses, whether the symptoms they're having now is something they had before or they're denovo, something new and then going to why they came to see you. I'm not the first physician she had seen. She had already seen numerous physicians before coming to see me and that led to the chief complaint which was violent headaches, vertigo or dizziness, uncontrolled crying, poor concentration. And, basically, she told me she had been laying in bed crying the whole time, not able to function.

Q So 12/22/08 you are thirteen, fourteen days after the accident?

A That's correct. That's my first visit.

Q Okay.

A I have seen her regularly since that time. I will go into more detail in a moment. I have seen her about twenty times give or take ten times 2009, six times 2010, six times 2011. She comes regularly, not just for neurologic assessment, but for medication. She has never come to my office unattended. She's not capable of traveling alone physically or emotionally. One of her daughters or her husband was always present, not in the exam room, but was always bringing her to the office and taking her home, and that's been true for every single visit. The last visit was a few weeks ago. The next visit is scheduled in a week. She has had numerous diagnostic studies, evaluations. She has chronic headaches, major difficulty with concentration. She has vertigo or episodes where she loses her balance. She's afraid to leave her house. For the first few months that I took care of her she didn't even do minimal housework. Her daughters and her were caring for her. And she actually did somewhat improve over a three-year period. She went from laying in bed crying, doing minimal amount of housework, but spends a hot of the time in bed with extreme fatigue. She has had numerous panic episodes where she has palpitations. She feels like she's going to pass out. She has passed out many times, and requires medication to control these episodes. In April of 2009 about five months following her reported injury she was hospitalized at Lutheran for about four days. She had

what's called a grand mal seizure. She was foaming at the mouth. She bit her tongue. And she was admitted to the hospital and was placed on a drug called Keppra, K-E-P-P-R-A, which is to prevent seizures. It's an anticonvulsant. All this time I have had her on numerous medications, but the four basic once are Keppra to prevent seizures, 500 milligrams twice a day, Dopamax, 50 to a 100 milligrams twice a day to prevent recurring headaches, Neurontin 100 milligrams up to 300 milligrams four times a day for chronic pain and for her mood stabilization. Finally Xanax X-A-N-A-X, 2 milligrams four times a day for extreme anxiety and panic. The most important medicine in her mind is the Xanax because it helps her to relax a little bit. She takes it on a daily basis. She cannot sleep without it and she cannot think coherently without it. She is complaint with her medications.

Q What does that mean?

A She is trusting to take the medication. She's a very angry lady. I have seen her 20 times. She's mostly angry with herself, a working person with her family who has become totally dependent and lost her independence. She cannot travel alone. She can only do minimal housework. She can only concentrate for a short while. Lights and noises bother her to the extreme. The technical term is phonophobia and phonophobia, translation, bright lights annoy her. That would not normally -- she has to wear sunglasses all the time

and noises annoy her. That's part of what we call the post-concussion syndrome. A lot of her symptoms if not all of her symptoms are related to a head and neck, spinal trauma. She has unrelenting daily headaches. She takes numerous painkillers for her medications over the counter in addition to the medications I just mentioned. She has had a CAT scan done a few times. A CT scan is an X-ray with a computer. The letters stand for computerized tomography. They real legal term, what's called soft tissue swelling. When she got hit she had a big bump on her head, but the brain itself was clear. She has had a few brain wave tests, what we call EEG, electroencephalogram. None of them have been normal. They either showed -- it's a measure of the spontaneous electrical activity of the brain. The patient sits in a chair, they can relax and wires are put on their head. They're connected to a computer. They do not have to cooperate. They just have to sit still and we know what normal brain waves are. There's a thing called alpha waives in a relaxed adult in the posterior portion of the head.

Q What does that mean?

A The back of the head, occipital region, sorry. And she has never had alpha waves on two EEGs that I have done or EEGs that were done in Lutheran or by another neurologist, Dr. Hausknecht. None of her seizures have shown -- none of her EEGs have shown bona fide seizure activity.

Q What's that mean?

A I have to explain that. Sorry. Okay.

Q Go ahead.

A I'm going to do a three-hour lecture in thirty seconds. No. It's complicated. I want to give the headlines only. I don't want to bore everybody.

A seizure, the term seizure or epileptic attack, Epilepsy, refers to an electronic explosion in the brain or short circuit in the brain. The brain has wires, thousands, millions of wires with billions of connections, billions, and it runs in a pattern. Just for me to move my finger just like that takes thousands and thousands of wires and chemical reactions and physical reactions to perform just to do that. To speak takes that much more. A seizure or an epileptic attack is where the electrical pattern goes haywire, short circuit. That's the cause of a seizure. She's never had seizures before. She's only developed them from 12/9/08 and further. The EEG only measures the surface -- the wires are put on the scalp and they measure the surface electricity. They cannot and do not measure the electricity deep in the brain. And the basic line is that one can have bona fide seizures where there is an electronic explosion. The EEG does not necessarily pick it up, record it. The EEG, the most common finding is what's called slowing of the background, which is what she's had on numerous EEG's.

Q What does that indicate?

A Brain damage, in layman's terms it indicates damage to the cortex, to the part of the brain that generates electricity. She has had an M.R.I. which was normal, but in more recently had a specific M.R.I. with what's called DTI.

Q Did you refer her for that?

MS. SCIARETTA: Objection. Cumulative. We've heard on DTI from other witnesses and --

THE COURT: Doctor, we've had other doctors come in and tell us what DTI is, so if you would not go through that part of your testimony.

You want to ask a question?

MR. RONEMUS: Let me just limit that.

Q Did you refer her for the DTI to Dr. Michael Lipton?

A Yes, I did.

Q He testified yesterday morning in great length about the tests he performed, so you don't have to cover all that.

A Oh, okay. Sorry.

THE COURT: That's okay.

Q So just what's your understanding of what the finding of the DTI M.R.I. was with respect to your care and treatment of Karen Lariviere?

A Very briefly to a layman it can be hard to

understand how a head trauma can cause seizures and memory disturbances and headaches and major personality changes when the CAT scan is reported normal. If the CAT scan is reported normal, to a layman the brain is normal. That's just not true.

MS. SCIARETTA: Objection. This is --

THE COURT: Overruled. I'm going to allow this far.

A There can be damage -- there is damage to the wiring of the brain. It's called shear force damage where the connections are damaged. This is not picked up on a routine CTR M.R.I. It can be picked up with an M.R.I. with specific engineering principals, which was talked about. I'm not going to go into that. That explains to a layman and to a patient why they may have seizures. They know they have headaches. They may be confused. Their personality has changed. And the doctor is looking at them and saying, but your CAT scan is normal. That can be extremely frustrating. There's a very simple explanation that goes on. I've watch her slowly, steadily improve. She doesn't lay in bed all day. She tries to walk around a little bit. She tries to do some minimal housework, but she cannot go anywhere unattended. She has frequent episodes where she feels like she's choking. She feels like she's going to pass out. She has episodes where she passed out. She has episodes where she has uncontrolled

shaking. Most of them respond to Xanax. Xanax is a muscle relaxant, it's a tranquilizer, it's an anti-anxiety agent. And I have her on a high dose of Xanax for an extended period of time. That is not typical -- one does not like to keep a patient on -- she's on up to 8 or 10 milligrams per day. That's a high dose. And it should not be continued long term except for the risks versus benefits. Every medicine you give any patient, I don't scare if it's Tylenol or a narcotic, it's benefits versus risks. The benefits to her, it helps her to calm down. It helps her to relax. She gets a little bit of sleep. The down side is she gets used to it and her body gets used to it. It's a quality of life issue. Without this medication this patient is much, much more miserable than she is, has much more attacks, will have and has had many other attacks or seizures, which is another point. And again very briefly one can watch Ms. Lariviere have a shaking episode where she shakes uncontrollably, I witnessed this in the office, and she'll lean back and you can try and talk her out of it or she may or may not hear you. The Xanax works to control those. It doesn't abolish them, but it works to control those. It -- the scientific issue is that a bona fide seizure, is that an electronic explosion in their brain or is that just a severe panic attack or severe anxiety attack? And I can hear the argument from both sides. As a practicing clinician I have to treat the patient, I treat them both the

same. To be blunt, she's being treated for both. She's on Keppra to prevent these electronic explosions, but she's also on Xanax for severe panic attacks. I'm a treating physician. To me I'm treating both and I clearly believe she has both.

Q Do you have an opinion with a reasonable degree of medical certainty whether those are a result of the blow to the head she sustained from the bus accident?

MS. SCIARETTA: Note my objection.

THE COURT: Overruled.

A I have an opinion.

Q What's your opinion?

A By history prior to 12/9/08 she was working, rasing two kids, has been incapacitated physically, emotionally since that time so to me there is a clear relationship between the head trauma and the development of these symptoms. I treated her for more than three years. I watched her somewhat improve. I was hoping she would improve a lot more. She has become a little more alert, a little more talkative. She can concentrate a little better, but she's nowhere near the person she was before, and that is very frustrating to the patient and to the treating physician.

Q You mentioned personality changes. How does the type of brain injury that she had affect one's personality?

A Yes. Again previously, it affects concentration ability, it affects whether they smile or not, how quickly

they get upset, whether they get agitated or not. It affects how they can recall things. Something that previously would never have upset the patient may upset them very, very much. They may find themselves yelling, screaming or agitated. And usually it's to family members because those are the ones who are caring for her or the patient more than they would be before. And this has to do with damage in different areas of the brain, frontal lobe mostly.

The front part of the brain is the executive director of the human personality. It's where emotions are controlled. When a baby learns to be potty trained or a baby learns not to hit a sibling or a baby learns what the word yes or no means, usually at eighteen months to two years, that is the frontal lobe. That's where they become a mature adult. That's the executive portion of the brain. And that clearly has -- she has clinical manifestations of significant frontal lobe damage. She cries uncontrollably. She'll cry for the wrong reason. She'll smile or laugh inappropriately. She will yell and scream for a minor point. She'll have a lot of panic attacks. These are all manifestations of a traumatic brain injury, TBI, and they are manifestations of structural damage to the pain which I have been treating all this time.

Q You mentioned the side effects of Xanax. Do the other medications that you prescribed, do they have potential side effects as well?

A Well, yes. The main one is the Xanax as far as tiredness, fatigue and dependency. The other medications have the side effects of excessive fatigue, dizziness. They can cause liver damage and kidney damage. They should be monitored with blood tests. The least toxic of the four is the Neurontin and that helps in chronic pain management and it also helps as a mood stabilizer. All of the medications have side effects, but there's I don't believe, my opinion, one medicine alone would not improve this patient's quality of life. I think this combination has given her a modicum of improvement. I've suggested to her that we try other psychotropic drugs. Translation I've suggested to her and her family that we try different types of psychiatric medications to help with more control of her emotions and more control of her personality. And her answer is: I don't want to be a zombie. I don't want to be spaced out. I want to do the best I can. This is a personal decision. And it's trial and error. There's no cookbook. It's not like the patient has a pneumonia, give him penicillin; cardiac pain, give him nitroglycerin. It's trial and error. This combination somehow has worked up to a point. And she's certainly not comfortable taking medication, but her life would be much, much, more miserable without any medication at all. And that's a personal decision between her and her family.

Q Have you recommended any type or do you recommend

any type of psychiatric or psychological treatment in the future?

A The one word answer is yes. And a brief explanation. I'm a neurologist. I do a lot of neuropsychiatry. I treat a lot of depressed people. A lot of Parkinson's patients, brain tumor patients, stroke patients get depressed, have other emotional issues I treat, but I am not a, quote, formal psychiatrist. I will not sit with Ms. Lariviere for an hour, go over her childhood, her relationship with her family, etc. That is very important in such a patient to help her control her feelings and control her emotions. And I've suggested that very strongly to her. I've also suggested very strongly to her what's called cognitive rehabilitation. They are special centers for traumatic brain injury patients that help them to improve their memory. This lady can only do simple calculations. She cannot do complex calculations. If she goes to a story, even with a family member, she doesn't know if she's getting the right change. She'll have to think about it three or four times. So there are exercises the patients can do to improve their recall, improve their memory. And there's a formal neuro-psyche process that should be done and this has not been done, mostly for economic reasons.

Q Did you refer her to Dr. Greenwald at Mt. Sinai?

A Yes.

Q I want you to assume there was some testimony that Dr. Greenwald had her see a psychologist, Akamatsu, at Mt. Sinai and she had a short period of neuro-cognitive counseling I gues you call it, and she said that that at that time that was helping her and then that was cut off when there was no way to pay for that. Is that something you recommend she continue to have in the future?

A Oh, definitely. I can give you the poor man's substitute for neuro-cog rehab, that's doing a Soduko puzzle or crossword muscle. Ms. Lariviere cannot even attempt that on the simplest -- Soduko or the simplest crossword because she doesn't have the processing to do it. She has to be trained to do that. That's obviously frustrating to her.

Q Is that something that would cure her of her brain injury or is that something that would assist her in her day-to-day living?

A In a very simple answer there is no cure. Part of the damage she has sustained is permanent. Part of the structural short circuitry of the brain is permanent, but the patient -- she has recovered, she has made a partial recovery. She's not laying in a fetal position in bed vomiting, yelling and screaming and crying all day, but she's still not a functional person as a mother, a wife and a worker. To a layman the explanation that the brain is a bunch of wires with electrical patterns seems very simplistic. The truth is

that's what it is, it's a very complex computer with millions of fibers and billions of connections and hers had been disconnected is the term we use. Some of it has partially returned, but I'm watching her three years after an accident. She's reached a plateau, a certain point. Yes, she can get into a car. Yes, she still gets dizzy sitting in a car. No, she's not going to try to drive a car because she's afraid she will have a panic attack or a seizure, so she has a very low level of function which to her and to her family is extremely frustrating.

Q You mention that there was injury to her neck. Let's talk about that briefly. Did she have injuries to other -- other than her head at the time of the accident? And, did you treat her for any of that?

A Yes. Briefly, she had significant neck and low back pain following this trauma. Patients with direct head trauma can and do have what's called flex extension history, they either have forward or backward rapid movement or roto-movement. They -- those are called para-spinal muscles. She had severe cervical, neck and lumbar lower back spasm on the first few visits. She went for some treatments.

Q When you say "spasm," what does that mean?

A Okay, spasm is tightness of the muscle. One can feel that. If a patient has no spasm or tightness, one can press on the para-spinals, rotate the head and the patient

will not complain. On the first few visits, minimal flexion, minimal rotation of Ms. Lariviere's neck caused her to have extreme pain. Increased headaches made her more do dizzy. One of the reasons she stopped going for physical therapy even though it might have temporarily improved the spasm of the muscles, it made her much nor vertiginous, it made her much more dizzy. That's true even to this day she still has episodes of vertigo with any rapid movement.

Q Did you refer her to a doctor or physical therapist?

A Dr. Licciardi. She went for a few sessions, not many. I discussed that with her and she felt worse afterwards. She just went home went to bed and didn't feel it gave her any significant relief.

Q Have her neck and back symptoms improved over time?

A They have improved much more than her cerebral and brain symptoms. They're not normal, but they have improved much more than her memory, personality and speech problems.

Q Do you have an opinion with a reasonable degree of medical certainty whether all the injuries you discussed were the result of the bus accident of December 9, 2008?

A I have an opinion.

Q What's your opinion?

MS. SCIARETTA: Objection.

THE COURT: Overruled.

A I think that with a reasonable degree of medical certainty there's a clear correlation between an injury and her neurologic and neuropsychiatric deficits. It started suddenly. It has been persistent. She has persistent depression, anxiety, panic, concentration difficulties. She never had that before. She has responded minimally to numerous medications. She's still fearful of having seizures. And I'm convinced with a reasonable degree of neurologic certainty she has both panic attacks and electronic explosions of the brain. And again I'm treating both. She's not happy with the results over an extended period of time. She has -- again, the person that I saw a few weeks ago is not the personality I saw three years ago. The personality I saw three years ago had to be carried in my office or wheel-chaired into my office. She can walk. She ask get around. She can have a conversation, but she has turned nowhere near back to baseline. And with a reasonable degree of certainty this is induced by a trauma by an injury.

Q By the way have you been paid for these services you're providing?

A Oh, the answer is the first few visits, yes. There's about twenty visits and some testing. And then her insurance, whatever, lapsed. I have been seeing her on a lien basis, which means she has no way of paying me. I will get paid if she gets --

THE COURT: Don't say that.

A I'm seeing her. If I don't get paid, I really don't give a damn. I know the patients. I know her a long time. I'm not not going to see a patient because they don't have medical coverage.

Q Why are you treating her?

A I do it -- why am I treating her? I'm responsible for her. She has some confidence in me. I trust her as a patient. If I felt she was not reliable or if I felt --

MS. SCIARETTA: Objection.

THE COURT: Overruled. You may continue.

A If I thought she was not cooperating with me, I would discharge her. She's tried very hard. Her family tries very hard. She does have confidence in me. I could afford to do a substantial amount of pro bono work, and I do. I don't have to excuse why I'm seeing her.

Q I didn't mean that. I'm just asking.

A I see a lot of patients who don't have coverage. Welcome to modern medicine in the United States today. I'm a busy neurologist. Frankly, I don't get involved with billing. I don't care what insurance people have. I have staff who worries about that. And, yes, they yell and scream at me we can't see this one, we can't see this one. I have no time for that, and I don't make time for that. If that sounds -- I don't know -- naive, too bad on me.

Q Let's talk about Karen's future.

Do you have and opinion with a reasonable degree of neurological certainty what her prognosis is?

A Yes, sir, I do.

Q Tell us what that is.

A Briefly the definition of prognosis based on her history, her physical exam, her lab data and my experience with similar patients what I predict for the future for this patient and in one word, her prognosis is poor. I'm hoping for a slow, steady improvement. I have seen it, but as I mentioned earlier, she has plateaued, she has not gone to the next level. She can't go shopping by herself. She's afraid to be in the house by herself. She has not reached the next level of independence. And being that it's three years later, three years plus later, her prognosis for any significant future improvement in my opinion with a reasonable degree of medical certainty is not good. She will be dependent on her family for the remainder of her life. That's caused her endless grief. She doesn't want to be babied by her daughters, but they are supportive and they help a lot as well as her husband and her other family members.

Q Do you have an opinion whether she will ever be able to work again as a hostess?

A I have an opinion.

Q What's your opinion?

A I don't believe she will ever be able to work as a hostess. I don't think she will be ever able sit at a cash register to handle funds. I don't think she can concentrate more than five or ten minutes on -- focus on one object before her mind wanders.

Q Have you recommended that she not drive?

A Yes, I specifically recommend that she not drive. She can go to an open field where there's no people and try and see if she can go forward or backward. She cannot drive in traffic and she cannot drive where there are other people. It's way too dangerous.

Q Why is that?

A Whether she has a panic attack or if she has an electric seizure, she does not have control of her vision, of her thoughts and her coordination. She's not -- on a good day she's not coordinated. She's losing her balance and has vertigo. I would not allow such a patient to drive. I think it's way too dangerous.

Q Have you recommended that she use a cane?

A Yes.

Q Why is that?

A Simple. She's had frequent falls. She will loss her balance, especially with rapid movements. She cannot walk where there's lots of people because the jostling, it's too much sensory input, walking in the street of Brooklyn or New

York with lots of people coming and going is a huge amount of sensory input that the brain has to decipher. She cannot do that. She needs the cane for physical support and psychological support. And, of course, she's embarrassed by it, but I didn't give her a great alternative. I don't have a specific pill for dizziness and for post-traumatic vertigo. The pill is the cane.

Q You say that she has tried hard. Have you found she's made good efforts to do whatever she can to rehabilitate herself?

A I think the person she's most angry at is herself.

Q What do you mean by that?

A She would love to do more and she wants to do more and can't and feels extremely frustrated. That has been true since the first visit three-plus years ago.

Q Have you reviewed the lifecare plan that Dr. Schuster recommended?

A Yes, I have.

Q I'm going to just ask you a couple -- well, do you have that in front of you?

A Yes, sir.

Q And he recommended that she have part-time assistance around the home. I think it's toward the end of his report page 31 or 32.

A Well I agree with that. Frankly, she's afraid to

be for even a short while, she is afraid she will choke or have an attack, and she needs someone to be there or at least someone that can be immediately called.

Q So if he recommended two different types of assistance around the home -- do you have those in front of you?

A Yes, sir.

Q And do you agree with what he recommended?

A The companion housekeeper, yes, yes, and someone to supervise her, yes.

Q Do you have an opinion with a reasonable degree of medical certainty whether she will be on medications for the rest of her life?

A I have an opinion.

Q What's your opinion?

A With a reasonable degree of medical certainty she needs continued medications to prevent headaches, prevent panic attacks, prevent seizures and to help stabilize her mood. She could try different psychotropic drugs. There are many on the market. This combination she has found most tolerant and her body has gotten used to it. It's going to be hard to change.

Q Do you have an opinion whether she will need those for the rest of her life, those are some other similar medications?

A I don't believe she will ever be without medication. And if she is slowly withdrawn from this medication, which would be the process that would take three, six, nine months, this cannot be stopped abruptly. Her quality of life would diminish dramatically if she -- that's going to be the remainder of her life.

Q I want you to assume that if she had not had this accident December 9, 2008 do you have an opinion whether she would need the medications she's on now?

A She might need a Tylenol or Advil or migraine medication PRN.

MS. SCIARETTA: Objection.

THE COURT: Overruled.

A She would use standard over the counter medications. I don't believe she would need a physician. She's not diabetic, she's not hypotensive, does not have any chronic medical illnesses. She'd forty-something years old. I don't think she would see a physician, unless she had a cold or, you know, something like that.

Q Do you have an opinion within a reasonable degree medical certainty that if she had not had this accident whether she would be working?

A She would love to go to work tomorrow.

THE COURT: Overruled.

A She desperately wants to be the person she was

before. I don't think she ever will. I think she's really realizing that now. The medicine helps her control her thoughts about that, but that's extremely frustrating to her and to her family.

Q Thank you, doctor.

I have no further questions.

THE COURT: Cross? --

Ladies and gentlemen, do you need a break?

THE JURORS: No.

CROSS-EXAMINATION BY MS. SCIARETTA:

Q Hi.

A Hello.

Q You told this court that you testified for the New York City Transit Authority about a week ago.

A Yes, ma'am.

Q Would I be correct that you were hired through an independent agency to do physical examines and that the Transit Authority did not personally call you and say: Please do this exam?

A That's a fair statement.

Q So that Juris Solutions, Inc. or Excellent Management Services selected you?

A Correct.

Q That's the basis of how you came to do you say maybe two examinations for Transit; right?

A Two appearances in the courtroom over the last six months, that is correct, through that company if you will

Q Doctor, you did not know Ms. Lariviere before she came to see you on December 22, 2008; correct?

A That is correct. That's the first time I saw her.

Q When she came to see you, you said that she was -- had to almost be carried in or something to that affect, a wheelchair?

A You are talking three years ago, plus. Yes, she had been given codeine in the emergency room and she had been vomiting a lot and she actually needed help to walk into the office, yes.

Q I want you to assume that she was seen by other doctors before she got to you.

A Yes, I mentioned that.

Q Right. And with respect to the other doctors you know that basically three days before she got to your office or on December 19th she was seen by another neurologist named Anthony Maniscalco. Are you aware of that?

A I know she saw Dr. Maniscalco. I just didn't know what date. She told me that.

Q And that basically when she saw him, he did a physical examination, a neurological physical examination?

A Okay. Okay.

Q And at that examination she was -- do you have his

records? Did you ever get a copy? Is that what are you looking for?

A I know she saw Dr. Maniscalco. I don't believe I have a copy of his consult.

Q Okay. It would have looked like this (indicating).

A I don't have it. I didn't review it in my records and I don't have a copy of it.

Q Did you ever speak to him about -- because he's a neurologist also, did you ever speak to him about what his findings were just merely three days before she came to see you?

A No, I did not.

MS. SCIARETTA: I'm just going to look through the record that is in evidence.

May I, officer, please hand it.

Don't mix it up.

THE COURT: What exhibit number is this?

COURT OFFICER: Plaintiff's 2 in evidence.

THE WITNESS: 2.

THE COURT: Thank you.

Q Doctor, when a Subpoena was served on you buy the New York City Transit Authority, specifically me, this is what was returned to the Subpoenaed record room, I see you have a much fatter file in front of you, is this the pertinent information you want to give us --

MS. SCIARETTA: Objection.

THE COURT: Sustained. Approach.

(Bench conference off the record.)

THE COURT: Let's rephrase the question.

Q Doctor, I'm going to pass this up.

THE COURT: You want to mark that? Is it marked?

MS. SCIARETTA: It's marked already.

THE COURT: What is it marked as?

MR. RONEMUS: It's not marked.

MS. SCIARETTA: It's not marked yet. Whatever that was marked, this is --

THE COURT: No. They're going to be different.

MS. SCIARETTA: Counsel, can you please come here.

MR. RONEMUS: The last exhibit was 29. You want to mark it, mark it.

THE COURT: Let's mark this as Defendant's -- what are we up to?

MR. RONEMUS: A.

THE COURT: Defendant's A.

Q Doctor, Dr. Maniscalco, you have his record now in front of you?

A Yes, I do.

Q He examined the plaintiff on the 19th of December

and he -- do you see on the second page when he goes into the neurological examination, do you have that?

A Yes, I do, I have it in front of me.

Q It says here under --

THE COURT: Is this in evidence?

MR. RONEMUS: Yes, Exhibit 2.

Q "The gate exam revealed normal heel, toe and tandem walking. Romberg sign was negative." Now, when you described to us three days later she arrived in your office, did you -- did you have the same identical findings of normal heel, toe and tandem walking?

A Not at all. I agree with a lot of his findings, but I vigorously disagree with some of his findings. I'm going to go by my exam and I didn't find her to have -- he has her walking normal, toe in front of her. She could not do that when I saw her.

Q Did you review hospital records in addition to --

A A good chunk of this is the Lutheran records.

Q So then in the Lutheran record of April 19th, 2009 which encompassed about a three-day hospitalization did you happen to read how they judged her gate and her ability to walk without assistance?

A I wouldn't have an independent recollection. It says she's alert.

Q When you go through the chart, doctor, if you would

be so kind to look at some of the entries made by the nurses and --

A It says she needs outpatient treatment for mobility and balance. That's on 4/20/09.

MS. SCIARETTA: May I approach, your Honor?

THE COURT: You may.

Q It says here "D.C." meaning discontinued --

A Discharge.

Q Okay, "for home. Outpatient with mobility and balance." In that chart do you also see that her gate is considered normal?

A I have "patient moving all extremities. Patient follows commands" and a suggestion for physical therapy.

Q Can you see at the beginning of that chart through the -- I believe it's in the emergency room record.

A I got it.

Q "Normal gate. No focal deficits." Do you see that?

A No, but I will accept your word for it instead of me hooking for it, normal gate, no focal deficits, I will accept that.

Q So would you also agree, doctor, that since you last saw the plaintiff that her gate has improved from the date that you first saw her on December 22nd?

A Yes. I mentioned that a few times. She has some

improvement. Her gate has improved. She has been walking independently. I have asked her to walk with a cane the first time I saw her. She could not walk independently and certainly could not do what's called tandem gate where you ask the patient to put one foot in front of the other, not on my first exam.

Q With respect to Dr. Maniscalco's further findings he felt that her vertigo or her complaints of vertigo according to his record dissipated when he did this Epley maneuver, E-P-L-E-Y, and she had no vertigo, do you see that on the page?

A Epley maneuver is twisting the patient's head in a certain way to help improve balance in some patients. He says she did have vertigo, she did have nystagmus, which means her eyes were jumping, but that improved after he did a certain maneuver. I will accept that. An improvement in the office at that time, that's -- I will accept that.

Q Would you agree with him that vastibular, which is therapy, will be performed if the symptoms persist?

A That's a very fair statement, vastibular therapy will be performed in symptoms persist. I totally agree with that.

Q Did you ever recommend that?

A Oh, sure. That's part of neuro-cognitive training and part of the treatment for traumatic brain injury is not

just the mind, it's the balance, coordination and balance training is very much a part of treating TBI patients. I agree fully with that.

Q While we're -- just before we leave, this exhibit when you reviewed the hospital record of April 19, 2009 did you happen to read that in the emergency room record as well in some of the consultations that there was no tongue biting, because I think you said that she had bit her tongue?

A I'm reading from the emergency room records tonic clonic with foaming. I will agree -- it says no tongue biting. And I can -- I will agree that there -- foaming at the mouth and tongue biting did look the same. It says clearly with foaming, but then it says a few lines later "woke up at the ER, no tongue biting."

Q Did you also read the ambulance call report where she was alert in the ambulance and that she was -- could respond to their questions?

A Yes. She had involvement put was responding to their questions, correct.

Q Did you also read that she denied that she had vomited when she reached triage?

A I have "patient vomiting at triage, denies fever." I'm reading from the triage note.

Q The note before that, doctor.

A Would you point me to a page I will --

Q I will tell you what. We'll get back to that. We'll move on and I will look into the record.

A Okay.

Q Now, when you --

A I apologize. This is a note, positive nausea, no vomiting, positive nausea, no vomiting on a different note.

Q Doctor, when you see a patient are you -- part of your office practice would be -- maybe you don't do it, but people in your office do the billing; right?

A For sure.

Q And they have to write down codes for what the diagnosis is?

A Correct.

Q And the information for the codes is given to them by you or someone else?

A The information for the codes is based on my notes and my dictations.

Q So that the first time did you -- do you have your billing records in front of you, doctor?

A I have some billing records. If you give me a date, I will find it.

Q The first day you saw her, December 22, 2008?

A Okay. I've got it.

Q Do you see the billing code there?

A I see numbers.

Q Is it 3788.12?

A I have 434.1, 388.12. There are multiple codes for different symptoms. One is for headache. One is for vertigo. One is for traumatic brain injury.

Q On this date, the first date you have two sheets. One of them says noise induced hearing loss.

A Correct. That's 388.12.

Q And the other one says cerebral embolism with cerebra?

A That for translation to layman is a stroke.

Q Did she have a stroke?

A Definitely not.

Q Do you have anymore billing records for this day, December 22, 2008?

A Yes, I do. I have cervical radiculopathy, 723.4, and cervical myofascitis 723.8.

Q So basically you have neck, you said noise induced hearing loss and a cerebral embolism as the first visit?

A Correct.

Q Did she ever have noise induced hearing loss?

A Partially, yes, she has some hearing loss. It goes along with her vertigo.

Q The noise?

A Noise aggravates her. She has phonophobia. She does not tolerate loud noises.

Q It didn't say anything about any kind of traumatic brain injury; correct?

A Correct.

MR. RONEMUS: Just so we're clear you are talking about in the billing numbers?

THE COURT: That's what the questions were about.

MS. SCIARETTA: Yes.

Q Now, in your office records you also write a note; correct?

A I have many notes.

Q I know, but for each visit you do a note; right?

A Sure.

Q And on that date did you do any tests?

A Did I do any diagnostic studies on that date? Yes.

Q Do you have a note for that date or is that note the --

A That's the typed report of 12/22/08. I have a few hand scribblings of what I put down, but this dictation was done that date.

Q Okay. Was this dictation made to go to an attorney? Because it's on your letterhead and it says "Re:," and, "to whom it may concern"?

A "To whom it may concern," no specific attorney.

Q Would you normally do this versus these kind of

papers that you have your notes on?

A Oh, I have papers like that for every date including 12/22/08, but I have three reports which you should have a copy of which I sent you, 12/22/08, 4/24/09 and 11/10/09 which puts together my thoughts about the patient, but I do have a separate handwritten note for every visit.

Q With respect to the December 22nd note, the report?

A Yes, ma'am.

Q -- her EOMs are full, what is that?

A That means her eye -- she can move her eyes left right, up and down.

Q There's no nystagmus?

A Nystagmus is when the eyes jump. I did not elicit any -- no.

Q No facial asymmetry?

A That means her facial muscles move normally and tongue movements, from mid-line, her tongue movements were normal.

Q You didn't put in this report, doctor, that she was in a wheelchair; did you?

MR. RONEMUS: Objection.

THE COURT: Basis?

MR. RONEMUS: I'm not sure he testified she was in a wheelchair that day.

THE COURT: I'm not sure he did either. Why

don't you ask the question differently.

Q Dr. Friedman, when she came into your office on the 22nd of December, 2008 you said she could hardly walk and she was in a wheelchair?

MR. RONEMUS: Objection.

THE COURT: Sustained.

Q I didn't see that in the report.

THE COURT: Rephrase the question.

Q When you saw her was she in a wheelchair when you saw her on the first time?

A I comment on her walking on page 2.

THE COURT: Ask the question being asked.

THE WITNESS: I'm sorry, your Honor. I missed the whole point here.

Q Was she in a wheelchair on that date?

A No.

Q Did you just tell us she was in a wheelchair?

A She had to be helped to walk, and that's what it says, the patient was not able to tandem walking. The patient was not able to walk alternating on toes and heels. She required assistance to get on and off the examination table. That's on page 2. I didn't mention wheelchair. I mentioned that she required assistance and could not walk independently on the first visit.

Q Did you find it medically significant that only

three days earlier Dr. Maniscalco, a board-certified neurologist found her able to walk tandem, walk heel, toe and that in three days she's not able to do this for you?

A I didn't have Dr. Maniscalco's report that day, but I will respectfully but vigorously disagree with him. He is a colleague of mine and he's entitled to his opinion, but on that particular point I will very vigorously disagree based on my exam of that date.

Q While you're seeing Ms. Lariviere over the course of these last three years does she give you a lot of what they call self-reporting as far as what her condition is and what her symptoms are, or do you get some of that information or most of that information from professional colleagues?

A Most of the -- some of it is from her, some of it is review records, but some of it is from her husband and daughters. She's never been in my office without a family member. And they will have certain complaints, and she will have certain complaints.

THE COURT: Hold on a second. Changing of the guard.

(Whereupon Jennifer Sampugnaro replaced Diane Hughes-Glynn as the Official Court Reporter.)

Q Doctor, were you made aware, during the course of the treatment of this patient, that no health professional has seen another grand mal seizure like she claims to have had on April 19th, 2009?

A Yes, ma'am. The April 19th episode was witnessed by the husband who described it to the staff. She did not have any further seizures at the hospital.

Q I want you to assume for the following question that she has never had another seizure like that again. She has, what she described to this jury and to the Court, these triggered panic/anxiety attacks?

MR. RONEMUS: Objection.

THE COURT: Sustained. You are characterizing these things in a way that she did not characterize them.

Q Have you looked at all the records that pertain to seizure description?

A Well, I have the Lutheran records, and I have records from other treating physicians. I also have my own observations. I have seen some of her attacks, if you will, generic term attacks.

Q Those attacks that you have seen, would you call them grand mal seizures?

A No, there is no tongue biting. There is confusion. There is confusion following the episode, but there is no shaking, what is called tonic clonic involuntary movements.

There is movement, but it's not tonic clonic. It is not violent muscular movements.

Q And she says that she is aware of these -- she calls it seizures, but these movements while she is undergoing them?

A She generally responds to voice, yes, but it takes her a while to come out of it.

Q And that sometimes she stutters?

A She stutters a lot intermittently, depending on how tired she is and how frustrated she. She can do a few sentences without stuttering, but I have never had her do a full paragraph without having some type of speech impediment of some kind.

Q Would you consider stuttering a type of a seizure?

A It can be. I don't think her stuttering is a seizure.

Q With respect to panic attacks and anxiety attacks, would you consider any of them to be a seizure or are they an entity onto themselves?

A Yes, ma'am, I tried to explain that earlier. They can be hard to tell apart. I believe most of her episodes are panic disorder, severe anxiety. She gets muscle spasms. She feels like she is choking. Palpitations, short of breath. Feels the room spinning. She's had episodes where she fell down.

All of those can be severe panic anxiety disorder

attack. They can be a manifestation of an electrical short circuit of the brain, and even impossible for an experienced neurologist to differentiate.

I mentioned a few times I am treating both. One of the scientific ways to differentiate is to do what is called a video EEG. Keep the patient in the hospital for 12 or 24 hours, hook them up to a brain waive monitor and video them at the same time. That has not been done. I doubt it will ever get done.

Even in those cases, you can have neurologists arguing is it a real seizure or is it just a panic attack that can look exactly alike. And I mentioned earlier one can have an electronic explosion or short circuit and the surface EEG does not record it. That is extremely common.

I am sorry if it sounds complicated. It is very complicated. I just gave you the headlines.

Q Doctor, did you review the orthopedic record from the end of December 2008?

A You are talking about Dr. Licciardi's records?

Q Right.

A I did not review his records. I don't believe I have them.

Q Did you recommend Dr. Licciardi or did someone else?

A I recommended physical therapy. I recommended an orthopedic evaluation. I suggested Dr. Licciardi, but I told

them that they should go where they are comfortable and where they can get an appointment.

Q Did you ever get a verbal report from Dr. Licciardi about her condition?

A A verbal, no, ma'am. Not that I recall.

Q So as you sit here today, you do not know what Dr. Licciardi found as far as her physical abilities, her abilities to walk?

A Correct.

Q Her complaints about --

A That is correct.

Q Were you aware, at any time up until taking the stand today, that Dr. Licciardi's records say that on February 9th, 2009, he reported that she returned to work because of financial reasons? Were you aware of that?

THE COURT: Are you aware that he said that?

Q Are you aware of that -- that that was alleged to have occurred up until today?

MR. RONEMUS: Objection.

THE COURT: I think you need to make this question clearer.

Q Doctor, prior to taking the stand, did anyone advise you that there was a document in evidence where a doctor said, Dr. Licciardi to be specific, that the plaintiff returned to work and this is a note dated February 9th, 2009?

A I have no such knowledge, and I was never told such a thing.

Q Doctor, did you ever ask her specifically about prior bouts of anxiety?

A I have no history of any significant prior emotional disease or seeing a psychiatrist or a psychologist.

Q Back in November of 2005, she was seeing her primary care physician, Dr. Alrei and she complained of anxiety, palpitations, sweating and that her eyes were a little bulging. He did tests for thyroid. You have to say yes or no.

THE COURT: Is there a question?

MS. SCIRETTA: I am not there yet.

Q Doctor, did you ever confirm with the patient if she had ever had symptoms that appeared to be anxiety related?

A No, ma'am.

Q Would that have been part of your history to know when a patient presents to you with what you deem to be anxiety and needs medication such as Xanax, that whether she had this before?

A It would be very important to know if she was seeing a psychiatrist or psychologist or going for therapy. If she went to her family doctor and got 10 or 20 Xanax tablets five years ago, it is a piece of history. I can't really call it a very important piece of history. But, no, I did not have that.

Q Doctor, with respect to your chart, you went on to

see her again the end of December, December 29th, right?

A What year.

Q '08.

A Sure. That was my first follow-up visit.

Q And basically in that visit, she gives you subjective complaints, right?

A She was crying. She had headaches. She could not sleep. I had given her a drug called Lorazepam. I am reading from my notes of that date. It did not help her sleep. She had neck and back pain and her hands were numb. Those are her complaints on that date.

Q When you saw her on that date, did it occur to you that you would like to have this particular patient also seen by a psychiatrist?

A Yes.

Q Did you ask her to see a psychiatrist on more than one occasion?

A Yes.

Q Did she ever explain to you why she didn't follow your directive or recommendation that she see a psychiatrist?

A Yes, economic reasons.

Q This is in the beginning of her treatment with you?

A That is correct. The first few visits.

Q Wasn't she still on No-Fault at this time?

A For sure she was.

Q And No-Fault would have paid for this?

A Very controversial. Not so simple.

Q Doctor, her husband was working at the time that you saw her for this initially; correct?

A I don't have independent knowledge, but I believe he was.

Q And when she first came to you, did she ever tell you that she also had GHI insurance coverage?

A No, ma'am.

Q Did you ask her?

A I don't ask billing questions. I leave -- I don't get involved in that even remotely.

Q So I want you to assume that she had GHI coverage, as well as No-Fault coverage, at the time that you made the recommendation to see a psychiatrist.

A Okay.

Q Knowing that, Doctor, were there any other reasons that you can think of that she didn't follow-up with seeing a psychiatrist at the time that you had suggested?

A No, ma'am. Yes, I actually have a copy of her GHI card. So she did have some other medical coverage initially.

Q Would that have been significant to you, as a treating physician, that you make a recommendation that appears to go to actually your opinion that something else must be going on here that I would like to --

MR. RONEMUS: Objection. That is not what he said.

THE COURT: Sustained. You need to rephrase that question.

Q Doctor, when you wanted her to see the psychiatrist, was it because --

MR. RONEMUS: Objection. He didn't say he wanted her to. He said it was a recommendation.

THE COURT: That is parsing a little too close. Continue.

Q Doctor, when you recommended that she see a psychiatrist, what -- for what reason do you think the psychiatrist would have been of some assistance to this patient?

A In laymen's terms, to help her talk out her problems and to deal with her extreme frustration and anger.

Q When someone has an injury and you claim it is a permanent injury to her brain; correct? Do you think that the recommendation to see the psychiatrist would have made a difference if the injury is basically organic and not something that you can respond to in therapy?

A The answer is, I believe it would have helped her to come. I did my best to help her cope with medication. I did spend time speaking with her. I still believe she should have formal psychologist or psychiatrist help for her to deal with

her problems. But would that have occurred here or would that have dramatically changed the damage to her brain, no. It would have helped her to deal with it with a reasonable degree of neurological certainty.

Q If she claims to have short-term memory impairment?

A She definitely does.

Q Do you, sitting here as a trained neurologist with some overlap in psychiatry, do you believe, Doctor, that that intervention by a psychiatrist would overcome her feelings that she claims are now related to a lack of short-term memory?

A I believe I was asked that before. You are talking about a psychiatrist and a psychologist. I was asked before about cognitive rehabilitation, cognitive neuro-psych evaluation. There are special treatments for short-term memory that have very little to do with a psychiatrist or psychologist. I believe she would benefit from all of that. I believe it would somewhat improve her quality of life. I don't think it would change her requirement for medication. And I don't believe it would change her requirement to see me on a regular basis for medication control.

Q When you give medication such as Xanax and Keppra, did you discuss with the patient what the side effects might be so that they would be aware that, oh, I am having this feeling or I can't remember or I am feeling dizzy?

A Very much so. I discussed that both with her and her

family members.

Q So when she reports to you her symptoms, did you try to determine at that time, is it related to the high dose of Xanax or the effects of Keppra or Topamax or Gabapentin or anything like that?

A To rephrase your question in one sentence, did I factor in the medications in her neurologic and neuro-psych exam? Of course. And, again, risk versus benefits.

I spoke earlier about, yes, she is on four different medications. I have seen her quality of life without the medication. Her quality of life is substantially improved with the medication. Can the medication be part of the reason for her fatigue and memory problems, absolutely.

Q Could it be also part of the problems for her dizziness?

A Partially yes.

Q How about fatigue?

A Yes.

Q And how about nausea?

A Yes.

Q Phonophobia?

A Phonophobia, I don't believe her medications in that particular sub type, I don't believe her medications have any relationship. If you want to show me the PDR on all the four medications, there is no one medication in the PDR that cannot

cause phono and phonophobia. But I factor that in when seeing the patient.

I have hundreds on Topamax, Keppra, et cetera. I have never seen it cause phono or phonophobia. But again, that is only one sub type of all the other things you mentioned.

Q How about poor concentration and poor cognitive problems?

A Xanax alone can do that.

Q How about confusion and thinking abnormally?

A Forget the other three, Xanax alone can do that. The other three are not famous for doing that.

Q You said you upped her dosage of Xanax; correct?

A Yes.

Q Would you say it went up to the upper limits as far as what you felt comfortable in prescribing?

A Yes, I mentioned that early on. It is a high dose, but it is her quality of life and her reaction to it. She does not respond to a half milligram or to one milligram.

Q Did you see any increase in some of her complaints because of the higher dosage of Xanax?

A No, I saw less anxiety and less palpitations and less fear.

Q How about concentration and dizziness and confusion? Did you see more of that because of the Xanax?

A No, ma'am. If anything, the reverse. I am following

this patient three years plus. She has become more alert, more intelligent, more coherent. Again, I mentioned this earlier, nowhere near her baseline, but I have watched her somewhat improve over a three year period. I believe the medication has helped her. Does it have side effects? Absolutely. Again, you have to weigh the benefits versus risk.

Q You said more intelligent. Did you have any verification of her pre-accident intelligence?

A Pre-accident intelligence, no. She is not a high school graduate, but she worked two full-time jobs and was a nanny. I don't have any IQ testing prior to 12/9/08. I do have IQ testing following.

Q With respect to two full-time jobs and being a nanny, couldn't that be done with somebody with a low to average intelligence?

A Yes, sure. I said she is not -- I don't even think she finished high school. To my knowledge, I don't believe she is a high school graduate. I don't mean that in a negative way, but those are the facts the way they are.

Q With respect to blood work, did you do blood work for this patient?

A None.

Q With respect to blood work, would it have been important to know what the therapeutic levels were of the antiseizure medication?

A Yes, if she had further grand mal seizures. She did not. And I kept her on a high average dose of 500 milligrams twice a day. If the patient has break through seizures and has major motor seizures, then the levels are important.

Levels are also important if you are worried about patient compliance. This patient is very compliant based on her family and herself.

Q Did you get reports from other doctors where she would have or complain of symptoms that she related not being related to missing the medication? Do you understand that question?

A I missed that, Your Honor.

THE COURT: Could you rephrase.

Q Were you aware that she missed medication on occasion?

A Yes.

Q That wouldn't be compliant, would it?

A That is so typical. It is four medications. I over the years have gotten hysterical phone calls from the family or from Mrs. Lariviere that she ran out of pills, to please call the pharmacy.

I just got a call from a pharmacy last week that she cannot come to the office, she's scheduled to come next week and she needs a Xanax prescription. Knowing her, knowing her family, I allowed it on the phone. That is a judgment call on

my part. Is that a problem with compliance? It is a very blood and guts problem every day in practice.

Q Doctor, when you saw her in March of 2009, do you have that billing slip?

A You are on a clinical note or a billing slip?

Q Billing slip.

A I will look for it. Go ahead.

Q You billed for the diagnosis and concurrent condition of cervical radiculopathy?

A Okay.

Q You didn't list the other conditions that you were treating her for?

A I didn't list ten conditions on every billing paper, that is a fair statement.

Q Well, actually on the visit of April 24th, 2009 which would be after her seizure and after her discharge from Lutheran, you did not bill for seizure disorder?

A I have a billing note from 5/13/10 seizures.

Q I am just talking about the very next visit after her discharge.

A I can't find it, but I will agree that that is a fair statement.

Q Doctor, with respect to the EEG you spoke about, you said you had taken an EEG in your office?

A I did an EEG on 12/22/08. First day.

Q Do you have the tracing in your file?

A Oh, no, I just have the report.

Q What happened to the tracing?

A Oh, the tracing is a large block of paper, two to three times this. It is on file in my office.

Q And so if we wanted to see it, you would make it available?

MR. RONEMUS: Objection.

THE COURT: Sustained. That is not a proper question to the doctor.

Q Doctor, as part of the record of your medical treatment of this patient, wouldn't it be a good medical practice to keep the test results in your file so that anyone who wanted to look at it could say, well, this verifies that report?

MR. RONEMUS: Objection. There's been three and a half years to look at it. If they wanted to look at it, they could have looked at it. I object.

MS. SCIRETTA: This comment is not appropriate.

THE COURT: Approach.

(Whereupon a discussion was held off the record, at the sidebar, between the Court and counsel.)

THE COURT: The jurors need a break. Let's take a brief recess.

(Whereupon the sworn jurors exit the courtroom.)

THE COURT: All rise.

COURT OFFICER: Jury entering.

(Whereupon the sworn jurors enter the courtroom.)

THE COURT: Let's continue.

Q Doctor, did you ever -- did you refer the patient to Dr. Hausknecht or did she go to him through some other channel?

A I don't recall referring Mrs. Lariviere to Dr. Hausknecht at all.

Q Did you ever speak to Dr. Hausknecht about your patient?

A No, ma'am.

Q With respect to the first time you saw her, did you do some tests, you said, besides the EEG?

A Correct.

Q With respect to the test of the transcranial doppler report?

A Yes.

Q What was -- that was normal, right?

A Yes, ma'am, that was normal.

Q What was that supposed to show?

A That checks on the blood flow of the brain. It checks the vessels and the flow. That was normal.

Q What about the evoke potential -- brainstem auditory evoked, the BAER?

A BAER, that was also performed the same date. That was normal.

Q What does that measure?

A That measures the electrical condition along the cochlear and vestibular nerve, the hearing and the balance nerve.

Q Now, I see that part of that test, well, that test result is comprised of two pages, right?

A The whole test is that computerized sheet, yes.

Q That Nicolet Biomedical in Madison Wisconsin, did they interpret the test for you?

A No, that is the name of the company that manufactured. The interpretation is by me.

Q Now, with respect to the next test, the ataxia vertigo?

A That is vestibular testing, special testing of balance. That was performed 1/9/09, about three weeks later -- two weeks later.

Q Did you ever review the tracings of the EEG from Lutheran Hospital that was deemed to be normal?

A I did not.

Q So what is it that you reviewed, the report?

A Sure.

Q And do you agree with the report?

A It's a report. It speaks for itself. Did I not

personally review the tracing? The only tracing I reviewed is the one I performed in my office.

Q So that when that doctor said her EEG was normal, would you accept that as accurate?

A I will accept it for a piece of evidence and put that into the pot with all the other evidence, yes. But I did not personally review the tracing.

Q Now, with your tracing, you said there was some slowing of background activity which was minimal?

A Correct, minimal.

Q Now, there is something under motion artifact, motion muscle artifact?

A Severe.

Q Would that have related to her movement or something else?

A I will give you a textbook in two sentences. It can be the computer, the patient, her hair. It could be the electrode, telephone recording. That calls for a very long lecture which I think I will bore the jury with.

The answer is, it could be many different things. It can be the patient as well.

Q But it can be outside of the patient's brain? It could be hair?

A Electrical interference, correct.

Q So, would that have been the basis of why you

indicated there was minimal cerebral dysfunction?

A No, the background is seen clearly. The artifact is present. What the artifact would do is make it more difficult to see any seizure activity, but the background activity being slow can still be seen, even though there is artifact.

Q So you didn't see seizure activity when you --

A No, I specifically did not, correct.

Q Would you have liked to have had her go -- as far as your evaluation of this patient and treatment of her, have her go for a video EEG?

A I would love for her to go for a video EEG, but I can tell you now that I am going to keep her on Keppra and Xanax, regardless of the results because I have been burned both ways. I have seen patients have a normal video EEG and have grand mal seizures, and I have seen patients have terrible EEGs with all kind of abnormal electrical patterns, and they have high level executive functioning jobs.

You have to treat the patient and the data. It doesn't mean that everyone with a normal EEG can never have a seizure, but the reverse is true too. I have patients with very pathological electrical patterns who function very well in society. And that's why medicine is still a little bit of an art, as much as it is a science.

Q Now, in this particular case because no medical person saw the grand mal seizure --

MR. RONEMUS: Objection.

THE COURT: While it was happening.

MR. RONEMUS: There was a medical person who testified this morning that she saw it happen. She worked in a doctor's office for 25 years.

THE COURT: Rephrase your question.

Q No one at Lutheran Hospital, according to the record, saw any evidence of seizure activity while in the hospital, okay. Would you agree with that when you read the record?

A That's a fair statement.

Q You never saw a grand mal seizure?

A Correct.

Q Her other doctors did not report, according to Mrs. Lariviere who was here on the stand, see a grand mal seizure?

A I will accept that.

Q And if you spoke to her husband, which you say you do, and you get a history from him, he has never seen another grand mal seizure like he did on April 19th, 2009; correct?

A Correct. He describes her becoming limp or floppy or shaky, but not a grand mal seizure, correct.

Q And he also describes that he can talk her out of it?

A Correct again.

Q Wouldn't it be good practice to take this particular patient who has had limited health care personnel observing this seizure, and take her off her seizure medication and put

her in that lab where they would at least document that when there are -- can duplicate a grand mal seizure and that they will know exactly what part of the brain it is coming from? Wouldn't that be a good medicine?

MR. RONEMUS: Objection as to who can duplicate a grand mal seizure.

THE COURT: Well, I am going to allow the doctor to respond to the question.

A Yes, Your Honor. I believe I have the question. Would it be good practice to stop Keppra, put her in a hospital and observe her?

Q To find out the other data.

A Fine, I hear your question. That is extremely controversial. I personally would never stop her Keppra. She tolerates it. It controls her episodes. Call the episodes generic. I would not take the risk of stopping it and putting her in a hospital.

You can be in a hospital for 12 or 24 hours. Someone has to take responsibility when she goes home. That ends up being me.

Number three, I am not here to confuse the jury. It is a controversial area. Keppra the seizure medication happens to also be used by psychiatrists as a mood stabilizer. I am killing two birds with one stone. That is the reason I would never consider stopping it and putting her in a hospital,

unless she wants to learn to be an airline pilot or something and she has to have absolutely no seizures. That is far fetched, but that would be a reason to put her in a hospital to do it.

THE COURT: Wrap it up, counsel.

Q Do you know of a Dr. Robert April?

A Sure.

Q Do you know that he examined the plaintiff?

A Sure.

Q Were you -- did you read his report?

A I don't think so. I have Hausknecht. I have Mount Sinai records. I have Dr. Greenwald's records. I don't have Dr. April's report, but I was told that he examined the patient.

Q Were you also told that in his opinion --

MR. RONEMUS: Objection.

THE COURT: Sustained.

Q Doctor, ever hear of a condition called psychological non-epileptic seizures? Have you ever heard of that?

A PNES, very well described. None --

THE COURT: Are we wrapping this up or are we going to a whole new area?

MS. SCIRETTA: We are going to wrap it up.

A One sentence, Your Honor.

THE COURT: I don't know that there is a

question.

Q You have heard of that?

A Yes.

Q After your examination of this patient, knowing her medical history and her progress and what she complains of and what other people who have lived with her or who live with her have told you, would you consider as a diagnosis PNES, psychological non-seizures?

A Yes, I would and treat it. It requires treatment.

Q Have you -- what is the treatment for that?

A Anti-anxiety agents. Antidepressants, tranquilizers. Intense psychological therapy. Up to one-third patients who come for EEGs have non-epileptic seizures. Up to one-third depending -- it is 25 to 33 percent.

Q And in her case, would it be fair to say that she does not have epileptic seizures?

A Impossible to say. I can't clinically say it.

MS. SCIRETTA: Thank you, Your Honor.

THE COURT: Redirect.

MR. RONEMUS: I have a couple questions, Doctor.

REDIRECT EXAMINATION

BY MR. RONEMUS:

Q Does it matter to you as you have testified, whether it is a seizure or something else that triggers these episodes that she's had? Does it matter to you in how you treat her and

what her prognosis is?

MS. SCIRETTA: Confusing question.

THE COURT: Overruled.

A Without repeating myself, I am treating both. I don't think scientifically we will ever know. I am not doing a brain biopsy and I am not going to do recordings. We can put leads into a patient's brain. She is not a candidate for that.

Bottom line is, I am treating both and I am comfortable that way. I would like to see more improvement. There hasn't been. I never object to a second, third and fourth opinion, but I have watched this patient slowly come out of her cacoon.

Q Have any questions asked by Ms. Sciretta or any answers given by you, change your opinions that you gave to the jury about the fact that she has the injuries that you have described as a result of the accident?

A Of course not.

Q I am going to go over a couple records with you that were asked by Ms. Sciretta. First of all, Dr. Maniscalco saw her on December 19th, 2008, and I want you to assume that Dr. Maniscalco's impression is the following. This is in evidence. This is three days before you saw her.

A Yes, sir.

Q Mrs. Lariviere may have had a concussion without loss of consciousness because of complaint of cognitive disturbances

and headache. Certainly the headache is at least in part due to blunt trauma of the head. At this time she is being prescribed Clonopin .25 milligrams, three times a day, PRN and refused Ibuprofen for pain.

Further evaluation recommended by him will include EEG, an MRI of the brain, brain stem evoke potential, video EEG testing. Physical therapy for the neck and shoulder is being provided if necessary. Vestibular therapy will be performed if the symptoms persist.

Is that impression consistent with your impression and your diagnosis when you saw her?

A It is almost a twin.

Q Let's talk about Dr. Licciardi. You referred her to Dr. Licciardi. He is an orthopedist?

A Yes, sir.

Q You referred her for her neck symptoms?

A Her spinal symptoms.

THE COURT: Is this in evidence?

MR. RONEMUS: This is in evidence. Exhibit No. 3. These are his records.

Q Did you refer her to him for treatment of the neck and back pain that you described that she was having?

A Yes, sir.

Q I want you to assume that Dr. Licciardi has written the following. The first time he saw her was December 29th, a

week after you first saw her, 2008. Impression, status post acute trauma in the cervical spine. Some early evidence of left shoulder rotator cuff tendonitis and left sciatica.

Is that consistent with the orthopedic injuries that you treated her for and you diagnosed?

A Yes, sir.

Q Then I want you to assume he saw her again on January 6th, 2009. So about a week later. His diagnosis at that time, the patient came in today because she is unable to sleep. She was struck by a bus a few weeks ago and has been in a lot of pain. I gave her a prescription for Lunesta.

Is that consistent with your diagnosis of her injuries?

A Yes, sir.

Q I want you to assume he saw her February 9th, 2009, about a month later. He wrote the following impression. The patient's prior history and examination have been reviewed. Mrs. Lariviere status post motor vehicle accident versus pedestrian on December 9th, 2008. The patient continues to be symptomatic with severe neck pain, usually accompanied by severe headaches, especially in the occipital region.

She has been seeing a neurologist. That is you I guess, right? She continues to have pain in her left shoulder radiating into the left paracervical area. That is up in the neck area?

A Yes, sir.

Q Causing difficulty with overhead activities, sleeping on her left side and carrying out activities of daily living. The patient is left-handed. The patient continues to present paresthesias in the left upper extremity. What is that?

A Abnormal sensitivity, numbness, tingling.

Q On examination of the left shoulder there is AC joint tenderness. What is that?

A That means when you squeeze on a certain joint, the patient is tender. It stands for acromioclavicular.

Q Is that consistent with the orthopedic injuries that you treated her for?

A Yes, sir.

MS. SCIRETTA: Objection. That he treated her for? He is not an orthopedist.

Q That you diagnosed in her?

THE COURT: Sustained. Rephrase.

Q Is that report of Dr. Licciardi consistent with your findings?

A Yes, sir.

Q One other note, March 24th, 2009. I want you to assume he wrote the following. She continues to be in excruciating pain in the cervical region, more in the left paracervical area, left shoulder burning sensation. She can barely stand her clothes. She cannot tolerate either moist

heat or cold. Physical therapy worsens her symptoms. She ends up with migraine headaches and throwing up after the ultrasound and TENS machine. Is that what she reported to you?

A Yes.

Q Are these findings consistent with your findings of her injuries after the bus accident?

A Yes, sir.

MR. RONEMUS: I have no further questions.

THE COURT: Recross.

RECROSS EXAMINATION

BY MS. SCIRETTA:

Q Because she had complained about her shoulder injury or shoulder pains, Dr. Licciardi had an MRI taken of her shoulder. Were you aware of that?

A No, ma'am.

Q And the MRI report was normal, MRI of the left shoulder. Did the patient plaintiff tell you that she underwent an MRI and that it came back normal?

A No, ma'am.

Q There was no evidence of impingement, no rotator cuff tendon tear. The quanoid labrum is intact. The biceps tendon is in normal position.

A That's fresh information to me as I sit here now.

Q She is allergic to codeine, right?

A She was vomiting on her codeine, correct.

Q Were you aware that she gave that history at the hospital as a known allergy, codeine?

A I just quote the patient on my first visit, on her first visit. "If I take codeine I throw up."

Q Were you aware that after she had her accident of December 8th, 2009, she took codeine and was -- and vomited?

MR. RONEMUS: Objection.

THE COURT: This is beyond the scope.

MS. SCIRETTA: Thank you.

THE COURT: You may step down, Doctor.

THE WITNESS: Thank you, very much, Your Honor.

THE COURT: Okay. Tomorrow morning?

MR. RONEMUS: Yes.

THE COURT: Ladies and gentlemen, this week because I have my normal Thursday motion day and I also have something to do in the courthouse Friday and Monday, we are going to be off Thursday, Friday and Monday, but we are going to be on tomorrow. At least tomorrow morning.

So I will see you tomorrow morning at 9:30 and then you will have three days off and I will see -- well, you will have five days off because you will have the weekend. I will see you next after tomorrow on Tuesday morning, okay. Good. 9:30. Always 9:30.

I know this is a long trial. Some of the length of the trial is because I have these days that I have to

take off. I schedule things in advance and then a long trial comes up and this gets in the way. So I apologize to you for the time off, although I am sure you will enjoy the time off. But it just makes it so that the trial takes that much longer. But we can't do this without you.

I thank you for being here and for mostly being prompt. And I think we are all working very hard to get this done in as concise a way as possible. So, thank you again. All rise rice. The jury may exit.

(Whereupon the sworn jurors exit the courtroom.)

THE COURT: See you tomorrow morning, counsel.

(Whereupon the trial is adjourned to Wednesday, March 21, 2012 at 9:30 a.m.)

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Certified to be a true and accurate transcript of the foregoing proceedings.

JENNIFER SAMPUGNARO, RPR

OFFICIAL COURT REPORTER

DIANE HUGHES-GLYNN

OFFICIAL COURT REPORTER