THE COURT: It is Tuesday. She starts Tuesday.

MR. PFLUGER: Okay.

THE COURT: So we can either keep her until Monday or release her Monday or we can release her at the end of the day.

MR. PFLUGER: Okay. Can we just keep her until Monday and they if she has to go then she has to go and see how we get done.

THE COURT: Is that acceptable to you, counsel?

MR. MORELLO: Either way, whatever the court prefers.

THE COURT: If you want her to be released Monday that will be fine. She's here until Monday. We'll release her Monday. We'll let her know after the fact.

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

THE COURT: Thank you. You may all have a seat.

Counsel, you may call your next witness.

MR. PFLUGER: Thank you very much.

Good morning, Judge. Dr. Thomas please.

THE CLERK: Just remain standing for me, Doctor, raise your right hand, place your left hand on the bible.

D O C T O R G A R Y P. T H O M A S, a witness called on behalf of the Plaintiff, having first been duly

sworn/affirm, took the stand and testified as follows:

THE CLERK: Thank you. You may be seated.

Please state your name.

THE WITNESS: Dr. Gary Thomas.

THE CLERK: Spell your last name please?

THE WITNESS: T-h-o-m-a-s.

THE CLERK: And your business address.

THE WITNESS: 10 Union Square East, Suite 4K, New York, New York 10003.

THE CLERK: Thank you.

MR. PFLUGER: Thank you, Judge.

DIRECT EXAMINATION

BY MR. PFLUGER:

Q. Good morning, sir.

A. Good morning.

Q. Are you a doctor?

A. Yes, I am.

Q. And where do you practice?

A. I currently practice at Beth Israel Medical Center and Methodist Medical Center.

Q. Can you give us your educational background?

A. I went to Mount Sinai Medical School ending in 1990 in New York City, I then did my internship in 1991 in internal medicine at Beth Israel Medical Center, then I returned to Mount Sinai for my residency in anesthesiology and pain management

ending in 1995 then I did my fellowship in interventional pain management ending in 1996. I'm currently board certified in anesthesiology and pain management. My practice is essentially exclusive to pain management at this time.

Q. What is pain management?

A. Pain management is the care, treatment and management of patients that have severe and debilitating pain problems. Oftentimes patients know this when a patient has cancer pain or traumatic injury, a loss of a limb or a fall or a trauma to the body. Also many types of diseases that affect the body such as neuropathy diabetes that can destroy certain nerves, certain damage with the nerves. This often is called chronic pain. Usually the tools that I use including medication such as antiinflammatory, muscle relaxer and neuropathic pain medications, medications that calm down the nerve pain. Also of course narcotic pain medicine for the patient that have severe pain.

The other two parts of my practice in taking care of these patients is that I'm often the doctor of almost the last resort where a patient has been seen by the orthopedist, the internist, the rheumatologist, the physical therapy doctor, the chiropractor and they have done what they could do for the patient then the patient just needs to be maintained. So I not only provide medication and treatment for the patient but I assume a primary care role management to the patient. Should

they go to the psychologist for depression or sleep medication, coordination of different physicians such as surgeons or physical therapist, the last part is interventional pain management where I do special procedures: Injections into joints, nerves, the spine, to help decrease the pain. The ones we're talking about are -- I'm sure most people heard about epidural injections, control for sciatica also knee joint lubrication injections also other specialized treatments that treat nerve pain, joint pain, traumatic pain in different parts of the body for different causes.

Q. Okay. Did there come a time that Mr. Andrew Flores became a patient of yours?

A. Yes, there was.

Q. And how did he come to your service?

A. He was referred to me by a chiropractor Dr. McGee.

Q. When did you see him for the first time?

A. I first saw him on April 30th, 2010 on a referral from Dr. McGee for the patient's severe back pain and radiculopathy, sciatic pain going down the leg. He had been under the care of Dr. McGee, the chiropractor. He had helped him a little bit. Due to the severe nerve pain, he wasn't able to progress in any of the treatments and the patient wasn't improving.

Q. You mentioned radiculopathy. Can you explain what the meaning of that is and what the potential causes are?

A. Inside the body, you have the spine and then from the

spine, nerves travel from the spine and the spinal cord out through between the discs and the bones to travel down into the leg. The most common cause of radiculopathy is sciatica would be irritation or damage of compression of the nerve root that goes down into the leg or into the arm Mr flores had a lumbar radiculopathy commonly known as sciatica which is a severe pain in the back, severe shooting, burning, tingling and numbness going down into the leg.

His pain, when it came to me, was nine out of ten. He was in severe pain and he was sent by the chiropractor because he was unable to participate in treatments that he wanted to provide and the patient was just, you know, unable to function or even sleep due to the pain that he had when he first came to me.

Q. I want you to assume that Mr. Flores told us that prior to March 22, 2007 he had never been treated for any back problems, had never been treated for any left knee problems and had no pain in either region prior to March 22, 2007.

A. That's what the patient told me as well.

Q. Okay. And I also you want to assume that Mr. Flores also told us that on March 22nd he was attempting to board a train at the lower level of a Manhattan bound number 2 train when he tripped on wood and his left leg went between the train and the platform. I want you to assume that, sir.

MR. MORELLO: Objection, your Honor. He's not an

expert in -- I don't want have a 3101(d). I'd just ask for the date of his records.

THE COURT: Step up please.

(Discussion off the record.)

Q. Sir, did you take a history when you first saw him in April?

A. Yes, I did.

Q. What was the history?

A. The history was that on March 22, 2007 while he was trying to get board a train he had an accident on the platform due to the wood connections between the train. His leg fell into, between the train and the wood on the platform and he injured his left ankle, left knee and low back.

Q. Okay.

A. He went to the emergency room. He was treated there and he followed up with care to different doctors to treat his ankle, knee and back.

Q. Okay. And, sir, did you look at the Lincoln Hospital record? Did you review that as an aid in assisting in the care and treatment of Mr. Flores?

A. Yes, I did, yes.

Q. So I'm just showing you Plaintiff's Exhibit 32.

A. Thank you.

Q. Under impression, what does it say, sir?

A. Under ah --

Q. Sir, is the hospital record in your chart?

A. Yes, it is.

Q. Could you read that please?

A. Forty-six year old male, alert and oriented times three lying on the platform. He was complaining of pain. This appears to be in the ambulance report. Patient states he tripped while getting onto train. Patient states his left leg went in between the train and the platform. At no time did the train move. Patient was helped out by bystanders. His physical exam: Lungs clear, no nausea, no vomiting and was able to ambulate on the scene.

Q. Okay. Sir, did you basically take that history when he came to see you?

A. Yes.

Q. Why is taking that history important?

A. History is important to know when an injury happened, the mechanism of accident, when the symptom presented, what symptoms presented, what treatment had been provided, what x-rays had been done and how the patient progressed over time. Also important things like past medical history,allergies and of course physical exam.

Q. What does preexisting status mean?

A. Preexisting status would be related to patient's injury, if there would be any other injuries to that part of the body prior to the injury that was being -- the patient was being

presented for and Mr. Flores had no previous injuries to the left leg and lumbar spine prior to this accident.

Q. Okay. Sir, did you conduct a physical examination on April 30th?

A. Yes, I did.

Q. Okay. Tell us the results of that examination?

A. The lungs, heart and abdomen within normal limits. The lumbar spine he had severe spasms from L-3 to S-1. He had deceased range of motion of the lumbar spine due to severe spasms and upon severe pain during the examination. He had deceased flexion at 60 degrees which is reduced approximately 40 percent, decreased extension to 20 degrees again reduced 40 percent. He had something called a positive straight leg raise, positive test which indicated that by elevating the leg and stretching the nerve root the nerve root had inflammation on it usually due to a compression or a trauma to the nerve root. This was on the L-5, S-1 dermatome, the classic sciatica dermatome traveled to the back down to the part of the leg down to the foot.

Q. Let me just stop you there. I apologize. What's an objective finding? What does that mean?

A. An objective finding is something that you can visualize, quantify, examine and it would be repeated from doctor to doctor, something you would observe or measure.

Q. Okay. What is subjective?

A. A subjective finding is a complaint that a patient makes such as he feels tired or he has pain. Some parts of the complaint of pain would be objective but the majority of the complaints of pain would be subjective.

Q. You just mention spasm?

A. Yes.

Q. Is that an objective test or a subjective test?

A. If you just examine with a quick examination of the patient, it would be partially objective and subjective but by doing flexion, extension examination of patient while examining the back, it becomes an objective test. For example, the muscles in the low back were locked, they're in very tight spasm and you can feel the budging of the muscle, the locked muscle. It was hard tender and painful. When the patient, by examining the back, when the patient bends forward, backwards and to the side if the muscle remains locked that's an objective finding. By bending the back backwards the back muscles, if there was, remains locked during forward flexion and backward extension. If it stays locked all the time then it's often due to an injury deeper inside the back such as a nerve root or a joint or a tendon damage. So he had objective findings of severe and trackable spasms in the lumbar spine radiating in the piriformis or the buttocks muscle.

Q. When you say "radiating," what does that mean and what caused it?

A. The lumbar spine is the lower part of the back but it's also secured into the leg via the gluteal muscles and the lumbar paravertebral. The muscle on either side of the back were in spasm. The muscle in the piriformis muscle also known as your buttocks muscles also were in spasm.

Q. You said straight leg raising. You said it was positive.

A. Positive straight leg raise. When by laying a patient flat on the table and lifting the legs in different directions the flexion, the leg foot extension, foot flexion and cross body testing it becomes a very objective test to know if the nerve roots are inflamed or damage or compressed up inside the lumbar spine. By combining the straight leg raise and cross body testing, it's a very precise clinical determination, nerve root irritation or damage also called radiculopathy.

Q. You mention forward flexion was 60 degrees?

A. Yes.

Q. And the normal is what?

A. The normal is for, um, it would be essentially 100, 110.

Q. Okay. And hyperextension what is that?

A. Extension is bending backwards. Normally, it would be 35 to 40 degrees. He was limit to 20.

Q. And what test did you perform in your examination of his left knee?

A. Left knee, we examined it with palpation, flexion of the knee and testing the -- looking for such as inflammation, swelling, the structure of the ligaments, holding the knee joint together. The patient had severe pain on palpation, the knee was swollen, the knee was very tender to touch and it was -- visually, it was red and swollen. Also upon flexion of the knee, the patient was only able to bend the knee about 30 percent of normal because of severe pain and even with that small degree of range of motion there was crepitus or a grinding sound or a grating sound inside the knee. In this case, there's structural damage or severe type of arthropathy which parts of the knee joint on the inside is grinding on each other, on a damaged knee joint.

Q. Okay. And did you come to a diagnosis after you examined Mr. Flores on April 30th?

A. Yes. The patient was sent over to me primarily that day for examination of his lumbar spine. He had lumbar spine injury with radiculopathy and myofascial pain. In my chart, it says lumbar degeneration. Degeneration could be either traumatic or age related when you get into the senior years of your life. So degeneration was either traumatic or age related. His was traumatic. Radiculopathy is the nerve pain going down into the leg. Myofascial pain is the severe spasm and pain on range of motion and palpation of the back and musculature. He also had left knee arthropathy which is a damage to the internal

structure of the knee joint basically knee joint usually has cartilage, synovium fluids, tendons. With the range of motion of with his knee, the obvious grating, grinding sound and the severe inflammation inability to have anything but partial range of motion indicated marked knee arthropathy or damage to the internal structures of the knee.

Q. What is the treatment plan? This is a general question.

A. I talked to his treating doctors, Dr. McGee, the chiropractor and Dr. Cohen, the orthopedic doctor. We kind of became the patient's treating team at that point. We started the patient on oral medications, a prescription antiinflammatory called Relafen which he takes twice a day to try to reduce the inflammation, swelling and pain in his knee and back. We gave the patient Zanaflex which is a strong muscle relaxer. He had severe spasms so we started immediately with the more stronger muscle relaxer. He's to take it twice a day along with the antiinflammatory to try to release the spasm in the back leg and also the knee musculature as well we started the patient on a mild pain medication Ultram which is typical for injuries to joints and back. It's a semi-narcotic opiate like pain medication used to treat moderate pain. We discussed with the patient the treatments for his type of injury most requested by the orthopedic and the chiropractor would be epidural steroid injection which would be an injection in the lumbar spine to

decrease the severe swelling and the inflammation of the traumatized nerve root, trigger points injections which are injections in the severe muscle spasms to try to release the spasm to try to help the patient to heal. A radiofrequency lumbar facet ablation is -- I can kind of describe it as a laser treatment to the arthritis in the patient's lower spine. He had a type of facet arthropathy or traumatic injury to the lateral stabilizing joints in his low back. After having range of motion of his spine, this is a typical treatment for traumatic injury to the lumbar spine. Basically, arthritic joint with a frequency of energy and it helps numb and heal joint arthritis.

For the knee, we recommended injection of Orthovisc which is a type of knee lubricant injection to try to allow the knee to heal, decrease the inflammation and try to decrease the grinding of the internal components of the joint. Physical therapy was to follow and follow up with Dr. McGee, the chiropractor once we calmed down the pain in the back and followed up with Dr. Cohen, the orthopedic doctor, or follow up for the knee.

Q. Sir, you've been referencing your handwritten notes.

A. Yes. I brought my medical records here, the chart here. These are my office notes. This is my medical record that I usually keep. We have gone to digital so these are partially handwritten notes and in 2011 converted to computer, electronic medical records as all doctors had to switch over.

This is my medical office record.

Q. Okay. Sir, are those records created on or about the time that you see a patient in this case Mr. Flores when he comes in and notes are taken?

A. Yes, they are.

Q. And is it the business practice to keep and maintain those records?

A. Yes, it is.

Q. And the records that are contained in that chart are just --

A. They are my initial intake paperwork, the daily office notes, the procedure notes of the injections to his lumbar musculature, the lumbar spine and the knee and it includes reports, some of the initial medical records from Dr. Cohen and the hospital. It includes some of the sonographic images of the injections we've done. It includes the required documentation for the patient's compliance with narcotic medications, the urine toxicology which is now required in New York State and the prescription monitoring program required in New York State which is just ensuring that the patient takes the medication as they are supposed to and Mr. Andrew Flores was in compliance at all times.

MR. PFLUGER: Judge, we're just offering the patient's chart into evidence.

MR. MORELLO: May I see it, Your Honor?

THE COURT: All right.

MR. MORELLO: May I have a quick voir dire?

THE COURT: Yes.

VOIR DIRE EXAMINATION

BY MR. MORELLO:

Q. Doctor, is this your original chart or a photocopy of your chart?

A. When we -- our records are now maintained in a digital format, the chart. All of our old medical records had been scanned through a certified service to a digital format and these are reprinted from the digital format for the first half of the chart. The second half of the chart is printed from the electronic medical records. We no longer maintain the paper records which are common in practice.

Q. So there would be no more of the original signatures of these documents?

A. That's the chart. What's your question?

Q. These appear to be photocopies of signatures and thing of that nature; is that correct?

A. It's a photocopy. It's reprinted out of the computer from this secured digital storage.

Q. What happened to the original of these?

A. It's been shredded after certified scanning and it's a service we pay quite a bit of money to have certified records maintained and then they shred it once the shredded copy has

been established and confirmed.

Q. And the records of Dr. Cohen and Lincoln Hospital do you know when those were obtained?

A. When the patient was sent over to me, I called Dr. McGee and Dr. Cohen. They were sent over to my office around the time of the first office visit. I don't recall the exact date. Very soon from the first date of the -- it was the first office visit maybe before if we were prepared.

Q. And were some of the care and treatment rendered by your partner Dr. Mandelbaum?

A. Yes.

Q. And there's treatment that was rendered by Dr. Mandelbaum?

A. Yes. I was the main doctor taking care of the patient. We share all of our patients. Maybe about 25 percent of the notes are with him. The more majority of the time I was in the office at the time the patient came in even though Dr. Mandelbaum had signed the note.

MR. MORELLO: I would just note again he's a treating. Dr. Mandelbaum is not here to testify. So we have the care and treatment rendered by Dr. Mandelbaum.

THE COURT: So subject to redaction.

MR. PFLUGER: Judge, respectfully, Dr. Mandelbaum is his partner. He's part of Comprehensive Pain Management. He's part of the group. It's a business

record.

MR. MORELLO: How could he testify what Dr. Mandelbaum did or say his interpretation --

THE COURT: Subject to redaction. As I said, subject to redactions.

THE COURT: This will be Plaintiff's Exhibit 29.

(Plaintiff's Exhibit 29 marked and received into evidence.)

DIRECT EXAMINATION (CONTINUED)

BY MR. PFLUGER:

Q. The April 30, 2010 you were referencing the initial office visit with the handwritten notes?

A. Those were handwritten notes on April 30, 2010 by myself and my physician assistant.

Q. Okay. And Comprehensive Pain Management physical exam was filled out, correct?

A. Yes.

Q. Okay. And a pain assessment form. Who filled that out?

A. The pain assessment form was filled out by the patient in the waiting area as part of the intake paperwork for the patient to write down their problems or medication they were on, the treatment they had, to speed the office visit along.

Q. So with reference to Mr. Flores, what is noted in your chart?

A. On the pain assessment form, it shows that the patient had a pain in his -- from 2007 to present -- he indicated on the graph of where the pain was, pain in his back going down his left leg and in his left knee. Those were the complaints which he drew on the graph and that's what he verbalized to myself as well. He also noted the description of his pain. He described it as sharp, crushing, stabbing and cutting mostly referring to the lumbar radiculopathy which is the primary pain at that time frame. He rated the pain as nine out of ten on a scale from zero to ten. Ten would be the worse pain of your life; zero would be no pain. He was in significant pain. He was visually very distressed. He was barely able to sit. He had difficulty going from sitting to standing and mounting the table.

The medications, he noted the medications that he would chronically take for his allergies and he noted the previous treatments. He circled chiropractic, physical therapy, TENS and electrical stimulation exercise program, back brace, Oxycodone like Percocet, Ibuprofen, Tylenol with codeine and he noted a few things on his past medical history: asthma, allergies, and he noted he was a nonsmoker at the time, no significant family history. That would be it.

Q. Okay. So the next time you saw him was that July 9th of 2010?

A. Yes, July 9, 2010, second time I saw Mr. Flores.

Q. Okay. And what complaints, if any, did he make?

A. He continued to complain about his left knee having constant aching sensation even while at rest with severe pain, sharp pain and cracking and crepitus with ambulation and range of motion. He noted the lumbar spine to have pain from the L-3 to S-1 which would be the lower lumbar spine with severe pain and chronic spasm. The pain radiated through the low back through the buttocks down the left lower extremities with weakness and tingling and sharp pain shooting into the leg as his primary complaints.

Q. Okay. Would you just stop there for one second? What significant, if any, does that have?

A. Tingling is one of the patient -- a term patients commonly use when you have nerve injury or a crushed injury to the nerve or an irritation to the nerve root. Tingling would be a neuropathic pain description or pain of the L5-S1 nerve root.

Q. Okay. Now, it says treatment outcomes and some writing?

A. It says that we had tried -- we started him on oral medications at the previous office visit. We had discussed the treatment option including the oral medications, knee injections and back injections. He described that the medications we had given him were partially effective to reduce the pain. The pain had reduced from nine out of ten down to six out of ten but he still had significant deceased ability to do his activities. His ADL's, which doctors also often call it, he couldn't take

out the trash, he had a hard time bending even in the bath or shower bathing himself because of the severe pain in the back and the leg. He had a hard time getting his medications. He continued to have a similar physical exam and I can go over it if you'd like.

Q. Well, the left knee in the July 9th visit, what was noted?

A. Left knee had severe pain on palpation and marked crepitus upon range of motion. He had severe pain with range of motion of the knee and he was able -- with the medication he had increased ability to bend the knee but is limited 110 degrees and limited at 0 degrees extension. The knee was a little bit less swelling at that time but the main problem crepitus and pain with range of motion was his main complaint for the left knee and he walked, you know, with an antalgic gait or a limp due to his knee and back and leg pain.

Q. Under impression plan, what was written there?

A. Left knee arthroscopy. At this time, I had gotten more information from the orthopedic doctor with the medical records that were sent. I had known about the previous diagnostic imaging at that point and his previous surgeries that had been done and despite the treatments that had been provided, medications, surgery, therapy he was still having a significant crepitus, grinding and dysfunction of the knee. This would be termed the knee arthropathy or damaged knee joint as a

diagnosis.

Q. Okay. Let me just take a step back a second. Before you see a patient like Mr. Flores, do you look at the chart to review what's happened in the past to assist you?

A. Frequently, yes.

Q. Okay. So if Dr. Mandelbaum wrote -- commented on an office visit, would you typically review it?

A. Always.

Q. And why would you want to do that?

A. Sharing the management of the patient, the patient is essentially my patient and when I wasn't available, when I was in the OR or on vacation or he was not able to arrange an appointment, he would see the patient for me. Sometimes my schedule is more full. About half the times, I was in the office and come in as well. So of all the time that he saw the patient over half the times I was present as well but I didn't do an extensive physical exam. I didn't write the prescriptions. I was just there to help manage the patient since it was my patient.

Q. Okay. Kind of a silly question. Why were office charts created for patients?

A. Couple of reasons. One, for our memory. We have a lot of patients and a lot patients have some details sometimes hard to remember. Often times, you get the patient in front of you. Most of the memory comes up and the facts of the patient

but looking back or reviewing a patient's name on a phone call sometimes it's hard to remember. So the patient's chart helps us doctors to remember and also helps us track things such as changes in response to treatment, prescriptions written when they are written, is the patient due for a refill. Also you unfortunately in the world you need legal records. Doctors are expected to keep a legal record of all of the medical care that we have provided. It's good for the doctors and good for the medical system to keep good records which we are now sharing electronically so we can see each other's records much easier instead of faxing and waiting for copies to come and get on line and see the records for patient's consent.

Q. Hospital charts and office charts are created so others can look at it and gain information to care for a patient if they see them?

A. Yes. In the past, it was all papers now with the goal of electronic medical records, they are hoping to speed the process along by using the computer system which is proven to be difficult. It's beginning to work.

Q. Sir, in your form for July 9th, 2010, you have chief complaint at the top of the form, up on the top?

A. On July 9th.

Q. Ninth, yeah.

A. Pain, was in severe pain.

Q. What is that term "chief complaint," what does that

mean because you only wrote pain?

A. That's the reason why the patient was coming into the office. We asked why you're here today. Patient says the pain. Immediately after that, we go into source of his pain, his knee pain, his back pain, he was having minor symptoms of left ankle.

Q. Sir, did you formulate a treatment plan after seeing him July 9th?

A. Yes. With response to medication and reviewing other medical records, we proceeded with the previous treatment plan discussed at the last office visit. The patient had severe back pain and leg pain and the knee pain. After being given the risks and benefits and description of the knee lubrication injection and the lumbar epidural steroid injection, we wanted to start with the knee lubrication injection to help decrease the knee pain and stop the creaking and grinding in his knee.

We did the first Orthovisc knee lubrication injection on that day while he was in the office. We adjusted his oral medications, changed it to Celebrex and Zanaflex due to his stomach irritation from the medication and the patient wanted to further discuss the risks and necessity due to the lumbar epidural steroid injection.

Q. I'm sorry. What are the lumbar epidural steroid injection?

A. The lumbar epidural steroid injection is a procedure that's done when the back has been damaged, traumatic injury,

severe fall, herniated disc. By inserting a needle in a sterile field into the spine, you have to go past the bones, the ligaments and you insert it into the spine itself. It's approximately a 9-inch needle about this long, about the size of the white center here. That's the size of an epidural needle. It needs to be thicker to help for the testing mechanism to ensure that the needle gets into the right location inside the patient's spine. If the needle goes too far or a patient has an adverse reaction to the medication or a complication, all patients we discuss in very great detail that this is the procedure.

Most notably the main risk of the procedure of the epidural steroid injection is nerve damage, leg weakness or paralysis this. Procedure is only done when patients are in severe pain and other treatments aren't working such as therapy, oral medications but when a patient really understands how dangerous the procedure can be they -- most of the patients including Mr. Flores, you know, attempt to do -- try all other options first because of the risk of nerve damage and paralysis should the patient have an adverse response to the medication or the needle was misplaced or the patient moved during the procedure having the needle enter into the spinal cord and making the nerves no longer function properly.

Q. Okay. You prepared an operative report?

A. The procedure note?

Q. Yes.

A. I have a procedure note for the knee lubrication injection done on July 9th, 2010. It's the sterile cleaning of the knee, Lydocaine to help numb the injection site. A needle is advanced into the knee cavity, the fluid removed from inside the knee. Usually a lot of water builds up inside the knee and the medication is injected, thick oral like substance to help give lubrication and try to start healing the damaged surfaces of the knee joint.

Q. Okay. What was your preoperative diagnosis?

A. Preoperative diagnosis was left knee arthropathy.

Q. In your report, it says left knee osteoarthritis?

A. Left knee osteoarthritis is a different, a different way of saying left knee damage. Arthropathy arthritis is the joint, the damage to it. It could be noted in degrees of severity. Usually doctors use the terms consistently. Sometimes they use a general term. Sometimes more specific term other the term such as internal knee derangement. You get into the ligamental tears such as the medial meniscal tear, the contusion to the joint surface and much more specific words could be used to describe his type of arthropathy.

Q. The next time you see him was September 30, 2010?

A. Yes. September 30, 2010 we saw Mr. Flores in the office visit. He complained of similar complaints in his back, his knee. His pain was rated ten out of ten. The first knee

lubrication injection had helped give relief then it started to fade as the benefits of lubrication shot -- the lubrication was used up. Usually, the lubrication shots are done as a series of three injections to try to load the gel with the joint with enough gel like lubricant to decrease the cracking, the friction of the joint. His main complaint was his lumbar spine and shooting leg pain. It had progressed since the last time we had seen him. It's now 8.5 out of 10 which is again getting severe. He was again notable distress at this office visit having a hard time walking, having a hard time mounting the table, difficulty to do his activities of every day living. Physical exam, we continued to treat him. Because his pain was so severe, we adjusted his medication to now include Percocet which is a type of Oxycontin, a narcotic or a morphine like pain medication and we did the second in the series of three knee lubrication, Orthovisc injections and I discussed the patient again didn't want to go over the risk of the lumbar upper steroid injection. He was having a hard time due to the spinal injection that he had to do. He wasn't pleased. The pain was so severe he didn't have any choice.

Q. There's a writing. Patient couldn't come back sooner?

A. The patient was supposed to return in four weeks and it took him I think it was six weeks if I do my math right.

Q. What was noted in your chart?

A. It reads: Patient could not come back sooner.

Secondary to -- he had to watch his grandchildren.

Q. Next to working?

A. He's not been able -- he was not working at that time. He had not been able to work.

MR. MORELLO: Objection, your Honor. His testimony is as to why he wasn't working, not because of the injury.

THE COURT: Sustained.

MR. MORELLO: Could you rephrase the question?

MR. PFLUGER: No.

Q. Now, what did you write -- what was written for musculoskeletal?

A. The musculoskeletal he had severe spasms of the L-3 to S-1 and severe pain on palpation of the lumbar spine, the piriformis muscle. He had a positive straight leg raise which corresponded to the nerve pain shooting down his leg. On the left knee, he had left knee pain with continued deceased range of motion and moderate swelling, continued moderate swelling.

Q. And your impression?

A. Impression: Lumbar spine degeneration with radiculopathy and mild facial pain. Left knee arthropathy and then we just proceeded with the plan left knee Orthovisc injection number two today, added the narcotic Percocet on the patient's pain medicine because he was in such discomfort. Continued to be treated on prescription of Zanaflex which is a

muscle relaxer Zipsor which is a prescription antiinflammatory and Pennsaid which is a tropical antiinflammatory to try to soak in the knee joint. We had to adjust the antiinflammatory medications due to gastric upset.

Q. Sir, the word degeneration was used for lumbosacral. Why was that word used?

A. Degeneration is a generalized term to account for traumatic injury, age related injury, arthritis, any type of change in the lumbar spine. It's also used as a bar code and the AMA kind of restricted the number of ways you have a prescription. We are just upgrading that October of this year for the changes but there's a very limited number of diagnostic codes you would use. Everything has to do with codes in medicine. Lumbar degeneration is a generalized code for lumbar spine injury, traumatic injury, arthritis. Some types of genetic inherited problems could be considered lumbar degeneration.

In Mr. Flores' case, it's traumatic which is lumbar radiculopathy which is a traumatized nerve root, lumbar arthropathy which is the lumbar facet, damage to the lumbar facet joints, the lateral stabilizing joint and myofascial pain and spasms which would be severe locked muscles that burn and hurt when you move.

Q. Sir, having taken a history and having examined Mr. Flores, do you have an opinion within a reasonable degree of

medical probability whether the lumbosacral radiculopathy was a result of the accident or something else?

MR. MORELLO: Objection, Your Honor. medical probability.

MR. PFLUGER: Medical probability is exactly --

THE COURT: Rephrase please.

Q. Sir, do you have an opinion within a reasonable degree of medical certainty whether the accident on March 22, 2007 was the competent producing cause of his lumbosacral radiculopathy?

A. To a reasonable degree of medical certainty the injury, noted injury in the March 2007 was the cause of his radiculopathy nerve pain and back spasms.

Q. Okay. Thank you, sir. Now, did you tell us March -- strike that.

September 30, 2010 there was another injection, correct?

A. I'm sorry?

Q. Was there another injection to his left knee?

A. On the 30th of September 2010, we did the second Orthovisc knee injection performed like the first one, sterilized the knee with Lydocaine, needle inserted, remove the water, inject the lubricant into the knee.

Q. And was the last time you saw him was November 1st?

A. Yes, it was.

Q. And what complaints, if any, was he making to you at

that time?

A. November 1st, he complained of continued pain of the lumbar spine from L-3 to S-1. And pain radiated into the bilateral extremity, the left greater than right. The pain in the back was progressing and getting worse. The pain in the knee had some improvement. He rated the back pain now as ten out of ten and now covering the entire lumbar spine and going into both legs with the left side being much greater, the severe radicular side. The pain had been decreased seven out of ten. He also had continued knee pain with continued deceased range of motion and with the deceased crepitus, the patient was noted that he feels significant weakness in his legs and his knees. With radiculopathy often comes leg weakness. Also the patient noted there was an instability feeling inside the left knee. Now, not that it was swollen. It wasn't so severe to just move it. That weak feeling of the joint was giving him a problem. He would say it would commonly give way or catch or slip inside the joint which were the terms he used.

Q. Do you have an opinion with a reasonable degree of medical certainty of whether the lumbosacral radiculopathy that you just told us about was permanent?

A. Along with the progression of his history, it is my opinion the lumbosacral radiculopathy is now permanent. He had a traumatic injury to the nerve root during the injury and the has chronic radiculopathy or nerve pain going down the leg.

Q. Okay. And you came to that opinion based on your examination of him and your objective findings?

A. Yes. The history, the physical exam, the attempted course of treatment, trying multiple different medications, in therapy, chiropractor very soon after this date of service. We did the lumbar epidural steroid injection although they able to reduce the pain down from severe to moderate, the pain continued. This indicates that the nerve was injured during the time when his leg was trapped at the train station and he had twisted and turned his knee and his back causing him to kind of a twisting crushing injury.

MR. MORELLO: Objection, your Honor.

THE COURT: Sustained.

Q. Sir, I want you to assume that Mr. Flores told us that when he was between the platform and the train he turned to try and open the doors. What, if any, significance does that have?

A. Both the knee and the back are significantly injured to a greater degree when turning force and compression are put onto the knee joint. Twist and turn when the leg was in the station, in the wood or the gap and then the body was turned. The knee joint sustained significant damage, contusion, disruption of the internal structure and the back as well, had a twisting compression of the spine compressing the left L5-S1 nerve root and compressing the lateral facet joint.

Q. Okay. Sir, what was your plan after November 1st,

2010?

A. At that day, we did the third Orthovisc injection he had after the second one. He was feeling some improvement in the knee. He was encouraged that he was finally going to get better. He received another prescription of medication Percocet pain medication which he used sparingly only taking two or three pills a day usually when he had to sleep at night and when he had to leave the house and walk is when he needed the medication the most. The third injection of Orthovisc went without problems and the patient was scheduled to return for the, if the back didn't get better, for the lumbar epidural steroid injections.

Q. And when was the next time you saw him December 16, 2010?

A. December 16, 2010 was the next office visit. The patient came in because of severe pain, continued pain in the back especially down the left leg also he gave a complaint of continued symptom that the knee continually has a giving. He described it as goes out. The knee has a laxity inside the knee joint upon going upstairs or standing or planting and turning as we normally do when we walk. The knee felt insecure. The crepitus had decreased partially with the knee injection. He was pleased about that but the weakness of the structure of the knee joint continued to bother him significantly. The lumbar spine was the big complaint and the leg complaint was the big

complaint of that day.

Q. It says -- well, it says plus gives out. What's buckling, sir?

A. Buckling would be an abnormal bending of the knee when strained or changing direction.

Q. Okay. Is there a difference between a knee giving out and a knee buckling?

A. Giving out is a sensation of the buckling. He feels that weakness. When he plants his leg on the ground and moves the leg, the instability of the knee feels like it's weak or gives out. Those are the words he used. Buckling would be another medical word you could use.

Q. And, sir, I see in your chart that spasms were noted and radiation left lower extremity?

A. Yes.

Q. What significance, if any, does that have?

A. His complaint continues to be the severe back and leg shooting pain, the tingling and burning pain with weakness into the left leg. He continued to have a positive straight leg test which indicates that the nerve root was not getting better even with medication and muscle relaxer and pain medication. It indicates that the nerve had been traumatized and swollen inside the back and continued to be a significant pain generator.

Q. What was the impression plan --

A. Impression --

Q. -- as of that day?

A. -- sustained lumbar radiculopathy myofascial nerve pain in the leg, myofascial pain would be the spasms in the back due to the nerve damage, left knee arthropathy. We renewed his medications and we performed the first lumbar epidural steroid injection on that day and 12/16, 2010.

Q. What is RBAR discussed?

A. Risks, benefits, alternatives and restrictions. The risks would be the risk of an allergic reaction, nerve damage, weakness, infection. Benefits we're hoping to achieve decreased nerve root and decrease in pain. The alternatives would be therapy medications, surgery. The restrictions, for example, when you take Percocet you're not allowed to lift heavy machinery because of the risk of becoming drowsy while taking the medication.

Q. What is Percocet?

A. Percocet is an opiate synthetic like medication.

Q. I see noted back exercises given. What does that mean?

A. It's common for doctors to prescribe the patient to have a period of rest of three to five days after the epidural steroid injection to allow the steroid to do its greatest work. It works within three or four days and then back stretching program, start out very essential, try to mobilize the lumbar spine, try to reduce the spasms and the radiating pain and

maximize the healing of the epidural steroid that we did on the patient on that day.

Q. In your report for that lumbar epidural steroid injection it is also noted trigger point injection. What does that mean?

A. Due to the nerve injury in Mr. Flores' back, it was causing severe spasms in the lumbar paravertebral muscle. The lumbar spine has a protective mechanism by locking down the muscle. It tries to stabilize the damaged part of the lumbar spine to allow it to heal or to prevent further damage to the nerve roots or the joint the discs.

Due to the severity of the spasm, they were locked intractable. They continue to pull the spine down. To have that much compression on the spine over time is not helpful. It actually makes the back problem worse and we did injections, a series of eight injections into the muscle of the lumbar spine and the piriformis muscle and the buttocks muscle to try to release the muscle it's an instant muscle relaxer. I injected it in and it only lasts for several days, allows the back to try to stop the lock down and the degeneration that the lock down causes.

Q. Sir, how was that lumbar epidural steroid? How was that? How were you able to locate that particular are?

A. By knowing the anatomy and the pain was traveling down the back of the leg. It's the left L5-S1 nerve root. By

knowing the anatomy, you choose the L5-S1 level, advance the needle down through the skin. The ligaments, the tendons, eventually will relieve tension in the intervertebral space via the detection device called loss of air detection like a cylinder device where you use to know where you are entering in the space. Going 3 millimeters too far would cause severe headaches, damage to the nervous system, loss of fluid, supporting the brain and damage to the nerve roots. So it needs to be a very precise injection. These injections were done in the office to try to relieve his radicular pain.

Q. How many of these procedures have you done in your career?

A. Ten to 20,000 maybe.

Q. The next time you saw Mr. Flores would that be February 17th?

A. Yes. February 17th, 2011, I saw Mr. Flores and should I go into it?

Q. Oh, absolutely.

A. Continued pain in the back going down into his leg with pain knee complaint. He also complained of continued knee pain and deceased range of motion and continued lack of function. He continued to have pain described as sharp, achy and shooting into the -- from the back into the leg, the Orthovisc injection, the knee lubricant injection had given a 75 percent decrease in the swelling and the pain in the knee

with marked decrease of the creaking or crepitus but there it continued to be a very unsettling, insecurity instability of the knee joint. When the patient walked, it felt weak. The knee was loose and always felt like it was about to give way. The lumbar epidural injection we had done on the previous office visit gave him some improvement for two weeks and then the symptoms started approximately 40 percent and then the pain started to return which is typical with these epidural steroid injections. Usually they are done in a series of three to try to decrease pain in a three-step process inside the lumbar spine. Patient was continued with his physical therapy and his chiropractic treatments and a loss of air detection and a knee injection. He was starting to have some improvement on his problem on his pain.

His physical exam: Continued pain in the lumbar paravertebral muscles his spasms are now rated as moderate not severe. He had continued deceased flexion at 45 degrees on a forward flexion, 15 degrees on back extension which was over 60 percent, decrease in the range of motion of his lumbar spine. He was still guarding the lumbar spine significantly and the spasms were still guarding the lumbar spine. The knee had improved, was improved but had still had tenderness especially on the knee joint itself, the essential knee joint and then I continued range of motion. On range of motion started to be more appreciated with the facet joint, arthropathy symptoms now

that the pain was starting to settle down some.

On physical exam: Doctors can examine for facet joint arthropathy. That's a lateral stabilizing joint where the pole of the spine connects into the box of the sacrum and oftentimes that connection of the disc into the pelvis, the lateral joint is typically damaged in these types of injuries. On the left-hand side, he had severe tenderness and pain on testing of that facet joint on the left L5-S1 side. He continued to have positive straight leg raising, 30 degrees on left-hand side but he appeared somewhat to have some improvement. He didn't limp as much and he did not have such an exhaustive look on his face when he presented.

Q. Sir, a quick question. The injection to his knee is that a permanent injury or is that a temporary benefit?

A. The lubrication only lasts for so long typically four to nine months, depends on the patient's severity of the knee joint, the grinding sensation that the lubricant simply masks or creates a slippery surface eventually that grinding destroys lubricant and reabsorbs into the body. So it's usually expected as with Mr. Flores' case to repeat the knee lubrication injections when it wears out from six to 18 months at a time.

Q. How about the lumbar injection, the steroid injection is that a permanent?

A. It's not permanent. Lumbar injections are completely acute with the inflammation and can suppress some of the return

of the inflammation for approximately six months but any time -- any type of strain or excessive range of motion lumbar spine after that time, it often reactivates the back pain, reactivates the radiculopathy. Again it's common for the patient to have the lumbar epidural steroid injections every six month to two years depending on trauma or a subsequent use of the back.

Q. The next time you saw him was April 28th, 2011, sir?

A. April 28, 2011, the patient had undergone all three of his epidural steroid injections. He had undergone the knee lubricant injections at that time. He was following up for a period of time later but he returned to the office having run out of medication, has the pain. Although the pain had improved, he still was required to take less but continued to need his Percocet pain medication. He continued to complain of pain in his low back still to the left lower extremity, continued spasms in the lumbar spine. The knee pain bothered him significantly at that office visit. He had intermittent episodes of sharp exacerbating stabbing pain in the knee especially when doing activities like walking up or down stairs or any time he encountered uneven flooring, stepping up or down or up in elevation causes severe shifting or giving out sensation in the knee with a severe stabbing sensation in the knee.

Q. Sir, just going back to February 17, 2011, there was an examination done, correct, and a range of motion for the

lumbosacral area?

A. February 17, 2011, the previous office visit we had talked about where he had the left epidural steroid injection. He had a deceased range of motion of his lumbar spine forward flexion 40 to 45 degrees.

Q. And normal is?

A. 110.

Q. Okay.

A. So this was a -- over a 60 percent reduction, 70 percent reduction in his ability to flex his spine and the posterior extension of bending his back was only 15 degrees. It had been a 50 percent reduction.

Q. And how about the knee? Was there an examination of the knee?

A. His knee continued to be tender to palpation with a deceased range of motion. He had about 30 percent of decreased range of motion. After the knee lubrication of the injection, it had improved. The most notable feature was a dulled creeky very dulled crepitus sensation had gone down markedly but was still present. Lubricating creaking sound is the best way to describe it. He's had a 30 to 40 percent decease in range of motion in his knee.

Q. Sir, did you come to an impression as to what his knee condition was? What was your impression final?

A. Continued to be left knee arthropathy. He was already

status post oral medication, status post physical therapy, status post knee surgery, status post knee lubrication injection and he continued to have knee pain and lack of function of internal derangement of the knee structures. It's a textbook of knee arthropathy or damaged knee joint crushed.

Q. Did you form an opinion within a -- strike that.

Do you have an opinion, a medical opinion, that the left knee arthropathy was caused by the accident of March 22, 2007?

MR. MORELLO: Objection usual.

THE COURT: Rephrase please.

Q. Sir, do you have an opinion within a reasonable degree of medical certainty whether the accident of March 22, 2007 was the competent producing cause of the left knee arthropathy?

A. In my opinion with a reasonable degree of medical certainty the injury of March 2007 was the cause of the patient's symptoms then in 2011 and current symptoms of knee pain, knee dysfunction and chronic arthropathy or damage to the knee joint.

MR. MORELLO: Move to strike as not responsive.

MR. PFLUGER: That is responsive.

THE COURT: I'll allow it.

Q. Sir, do you have an opinion within a reasonable degree of medical certainty that that injury is permanent?

A. With a reasonable degree of medical certainty, his

knee arthropathy and damaged knee joint was permanent in 2011 and it's still permanent in 2014.

MR. PFLUGER: Should we break now, Judge?

THE COURT: Okay. Are you done?

MR. PFLUGER: No. I'm not done. It's going to be --

THE WITNESS: Short break?

THE COURT: No. It will be a lunch break.

MR. PFLUGER: Okay.

THE COURT: Are you almost done with the doctor?

MR. PFLUGER: May we approach?

THE COURT: Yes. We're taking a lunch break. Come back at 2:15.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

(A luncheon recess was taken.)

* * * * * * * * *

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

(The trial continued.)

(Dr. Gary Thomas resumes the witness stand.)

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

THE COURT: You may all have a seat.

THE CLERK: Dr. Thomas, you're reminded that you

remain under oath. Okay, sir?

THE WITNESS: Yes.

THE CLERK: Thank you.

DIRECT EXAMINATION (CONTINUED)

BY MR. PFLUGER:

Q. Good afternoon, sir. Did you see Mr. Flores in 2012?

A. Yes.

Q. When was the last time you saw him in 2012, sir?

A. We're on February 17, 2011. We went to up to 2/20/12? 2011?

Q. 2012. What I'm trying to do is just to speed it up. Can you take a look at various office visits and tell us what his complaints were for that year if there were any changes. I'm just trying to speed things along.

A. Through 2011, he complained of the same back and leg pain, pain going down his left leg and knee pain, pain ranging from seven, nine -- seven, eight, nine out of ten. He continued taking Percocet, muscle relaxer and the antiinflammatory at every office visit.

Q. Is that 2012 you're talking about?

A. 2011. Starting in 2012, again the same complaints of back pain shooting down the leg, knee pain, pain was rated six out of ten for the legs, out of ten for the back again medications, the same.

Q. Medication meaning what?

A. The antiinflammatory in 2012 was a prescription, a medication called Relafen and the muscle relaxer Zanaflex and then he had Percocet. He was up to four pills a day because of continued pain whenever he did activities.

Going through 2012 in February, it was the same, same pain February, March, April, May, June, July. Essentially these -- the meds of 2012 was dedicated to the same symptoms and medication renewals. He was still maintaining some benefit from the knee injections and the back injections. In July 2012 all the way into November 2012 when he started the -- the first set of the injections began to wear off and in November 29, 2012 he started --

MR. MORELLO: Objection, your Honor. May I approach?

(Discussion off the record.)

A. November 29th 2012, he continued to have the same symptoms of back pain, pain down his leg and knee pain. At this time, the knee injections which were performed early in his treatment course were beginning to wear off and the main pain was becoming severe again with increased crepitus and increased severe pain upon ambulation.

On the Orthovics injection, the first injection of the second series was on November 29, 2012 were injected Orthovics into the left knee on the first day and he refilled his pain medications.

Q. In February 22nd?

A. February 22, 2,012, we did the next knee Orthovics injection and we filled the medications and March 14, 2013, we did the third in the series of three Orthovics lubrication injections that would be March 14, 2013. Again his pain number was seven out of ten for his lower back and seven out of ten for his knees. We refilled his Percocet, Zanaflex and the antibiotic inflammatory Relafen.

In March 8, 2013, he had a follow-up visit where we refilled his medications and his main complaint, pain scale was seven out of ten, seven out of ten.

March 23, 2013, patient was having significant increase in this low back pain and we started to -- the pain was much severe going down the back of the left leg, sciatic symptoms were returning, he was rated now eight out of ten.

Q. Was that March or April?

A. This is April 23, 2013. And his prescription of his leg pain changed from moderate to severe. It was describe as sharp, electric shooting rated eight out of ten and he came in needing the repeat of the lumbar epidural steroid injection which we did on that date March 23, 2013. He felt about 50 percent better with the knee injections. The crepitus and the sharp decreased about 50 percent.

Q. You said March. You mean April?

A. April.

Q. It's a little bit fast.

A. May 6, 2013, same complaints of back, leg and knee pain. From the first epidural, he had deceased intensity in severity of pain, rated seven out of ten. And we refilled his pain medication May 6, 2013. Pain was rated seven out of ten.

Q. How about range of motion?

A. Range of motion, physical exam was done as was done in all of these office visits. Physical exam was very similar varying a little intensity depending on the severity of his pain. The knee he had pain on range of motion, crepitus on range of motion. His flexion was at 80 degrees. Normal would be 90 to 100, normally 120. The lumbar spine spasms from L3-S1 pain and flexion at 80 degrees. Normally, it would be about 110. He had positive straight leg raise test on the left-hand side, similar exam, most of the visits he came in with slight exacerbation when he had severe attacks.

Q. Okay.

A. June --

Q. He was seen on June 18, 2013?

A. June 18, 2013, he had same complaint, low back pain, knee pain. The low back pain was shifting into his bilateral lower extremities, left much worse than his right. The sciatic was on his right. At this point, his pain was rated eight of 8.5 out of ten with the sciatic becoming dominant. The knee pain was continued and left knee medial aspect description of

the knee pain was intermittent, throbbing, sharp. What makes it better was rest and injections what makes the knee pain worse range of motion, going up and down the stairs, stepping on uneven surfaces. Range of motion was several limited due to pain. Injections, Orthovics injections were. It continued to give him benefit but they are started to fade. He continued his medications of the antiinflammatory Relafen, the Percocet and the muscle relaxer. This month was Flexeril which I rotated and he followed up in July of 2013.

In July 2013, July 24, 2013, the low back pain was continuing to increase. He was having now severe pain in the low back. He was having a hard time ambulating, numbness radiating down in the lower extremities. Pain was eight out of ten. And at that point, the pain was so severe we proceeded with the next lumbar epidural steroid injection.

On July 24, 2013, I believe we went up on his pain medicine and we're still on four Percocets a day on an average. We refilled the other medications. He did the epidural without incident.

Going to September 5th, 2013, he was falling off the last epidural. He had temporary benefit. The severe pain calmed down his back with moderate pain, moderate, chronic pain. His pain on that day was down to six out of ten and he had pain in his lower back going down the left lower extremity with the knee continued to have pain intermittent throbbing, sharp. The

Orthovics injections, it continued to have some benefit but they are fading. We refilled his pain medications and his other medications and he followed up. We gave him a couple months' supply of pain medications. He followed up in early March -- February 2014.

Q. February 15th?

A. We're on February 5th, 2014.

Q. Okay.

A. February 5th, 2014. Sorry. Back pain going into the left lower extremity, spasm down the posterior left thigh, pain in the groin area, sharp pain, pain rated eight out of ten -- eight to nine on a visual analogue scale. For the low back, the lumbar epidural steroid injection was given last month was beginning to fade, the knee pain continued. The benefit for Orthovics was fading. The knee was rated seven out of ten and on that day we did the next lumbar epidural steroid injection. If I did my math correct, this is the third lumbar epidural in a second set of three and we did two sets of three of the Orthovics. We refilled his pain medications and he followed up most recently a couple days ago on March 18, 2014 coming into the office with continued back pain, rated eight out of ten. This is the last office date for his care so far, eight out of ten on a visual analoga scale, continues pain of severe lumbar pain with stiffness, spasm, sharp aching radiation of the pain to the left lower extremity with weakness. He also had numbness

and tingling down the leg, reports left knee pain worse with ambulation. He is on stabilized medications without side effects. He reported difficulty in activities of day-to-day living such as due to his ongoing pain. He has trouble with long walking, trouble getting on and off stairs, into transportation. He continued to have knee pain, left knee medial aspect worse with range of motion going up and down stairs, walking on uneven surfaces, weather changes. He continues to complain of inability to do activities of daily living due to knee buckling. Continues not to work as of March 18 --

MR. MORELLO: Objection, Your Honor. He continues not to work?

MR. PFLUGER: We have testimony that he returned to work since the accident, Judge.

MR. MORELLO: He did return after the accident. He lost his job because he was laid off.

MR. PFLUGER: He also worked in a kitchen and was unable to perform that job.

THE COURT: To the extent that the doctor can read those comments that took place to his pain management is acceptable. With regards to the conversations that have nothing to do with treatment, I would appreciate the doctor not read.

MR. PFLUGER: Fine, Judge.

THE COURT: Thank you.

A. Should I continue with physical exam?

Q. Yes, please.

A. The physical exam was March 18, 2014: Chest, lung, abdomen within normal limits, the lumbar spine from L3 to S1 continues to have spasms, bilateral, limited to the left than on the right, deceased range of motion in all directions. Flexion is limited to 60 degrees. Normal is 100 degrees. Extension is limited to 15 degrees. Normal is 30, 35 degrees bilateral is limited to 20 degrees. Normal is 30. He has a left lower extremity four out of five strength. Right lower extremity is five out of five so the left lower extremity has a medium loss of strength on the left-hand side.

The mild atrophy noted his left quadriceps. The neurologic exam positive straight leg raise at 45 degrees on the left side. There was a deceased of pinprick sensation down the L4,5 and L5-S1 dermatome, light touch to pinprick. Reflexes were normal.

On the left leg, left knee, patient had pain on palpation of knee joint especially mid joint, worse on the medial side. Range of motion was limed due to pain, continued pain crepitus on range of motion of the knee, the complaint of pain essentially continue the medications antiinflammatory, muscle relaxer, pain medication and topical Voltaren gel like a topical Motrin cream and to repeat the lumbar epidural steroid injections and the knee Orthovics injections as needed. Also

discussed with the patient that due to the situation of the knee patient followed up with Dr. Cohen. Upon conversation with Dr. Cohen and the patient we both concurred that the patient needs further knee surgery either arthroscopy or knee replacement to be determined by Greater Graphic Studies.

Q. Sir, did you formulate an impression as to his diagnosis as of March 18, 2014?

A. Diagnosis. He has, going by the codes, lumbar spine, traumatic degeneration, lumbar radiculopathy, on the left-hand side lumbar mild fascia pain and lumbar arthropathy, facet joint traumatic, degeneration. The knee was -- left leg knee arthropathy. Those are the diagnosis.

Q. Sir, you mention pinprick. Is that that an objective test?

A. Yes. The patient is not observing where we do the sensation testing, very discreet lines of dermatomes that go down the arms and legs and across the body. Unless a patient has medical change, it's an objective test because being down one dermatome is very discreet and patients either they feel it or they don't. Along the nerve roots that were traumatized, he has numbness or deceased sensation to pinprick on bilateral testing and mass testing, also light to sensation usually using a Q-tips or an alcohol wipe.

Q. Okay. You told us earlier that Mr. Flores has sustained injuries to his back and his knee that are permanent

in nature.

As of March 18, 2014, do you have do you have an opinion within a reasonable degree of medical certainty whether Mr. Flores' injuries are permanent?

A. It's my opinion Mr. Flores --

MR. MORELLO: Objection, Judge.

THE COURT: Sustained.

MR. PFLUGER: Well, it's not as of the 14th. I didn't ask --

MR. MORELLO: You asked if they were permanent.

MR. PFLUGER: Okay.

Q. Sir, have you formulated an opinion as to whether Mr. Flores will require future care and treatment?

A. Yes, he will.

Q. And what would entail that future care and treatment?

A. Essentially, mirroring the current treatment plan that he's been getting. He's going to require office visits to provide this medications, evaluate his condition and decide upon treatment plan. Once a month for a lifetime duration, he'll need follow up with myself or one of the other medical providers it cost $200 per office visit for providing medications, maintenance and decision-making and providing the treatments we discussed. The medications that he's been receiving at the lower cost of the scale would be approximately for $400 a month for lifetime duration, for the medications he receives: The

muscle relaxer, antiinflammatory, opiate pain medication. He needs the Orthovics injections at a cost of $500 per injection, three injections approximately every two years for lifetime duration. He needs the series of three lumbar epidural injections which would be $2,000 for the injection part, for the hospital and for the doctor three injections every two years for a lifetime duration. He requires physical therapy to maintain his strength, prevent weakness, maintain the stability of his joints and decrease spasms and control his pain at the cost of $120 per session twice per month for lifetime duration. He'll need follow up x-rays and MRI's for his knee to monitor --

MR. MORELLO: Objection, Your Honor. That's beyond his field.

THE COURT: Sustained.

Q. So what does chronic mean?

A. Continue on going symptom.

Q. Have you formulated an opinion as whether Mr. Flores' lumbar radiculopathy is chronic in nature?

A. Mr. Flores has chronic lumbar radiculopathy and chronic spasm in his low back and leg.

Q. What is his prognosis, sir?

A. Continued pain in his back, spasms, pain down the leg, with the radicular pain being chronic and constant with episodic and severe. To treat this, he'll need the steroid and muscle injections to calm down the exacerbation of his condition. This

is typical for a patient who has his types of injuries. For his knees, he has chronic pain in his knee. The crepitus and grinding is partially treated by the lubrication injection brought him to the point where he can tolerate with the medications and minimal activity level but as a lubrication, he'll needed repeated lubrication injections. He also required knee surgery.

MR. MORELLO: Objection, your Honor.

THE COURT: Sustained.

Q. Sir, accelerated degeneration is what?

A. Due to the grinding and crepitus of the knee joint, the knee arthropathy, the friction of the damaged tissue in there, he will have accelerated degeneration and the knee joint will fail over the coming years.

Q. Thank you, sir.

A. Thank you.

CROSS EXAMINATION

BY MR. MORELLO:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Have you testified before?

A. Yes, I have.

Q. How often have you testified?

A. I'd say 12 to 15 times over the last 18 years.

Q. And when you testified, it's on behalf of injured

parties plaintiffs.

A. I testify only for my patients, just the patients I treat.

Q. And in that behalf, you always testify on behalf of the injured party, the plaintiffs. Is that fair to say?

A. Yes. I have patients. I testify when they have decisions with Medicare or Workers' Comp. Things like this, I'm called in to state what their injuries are.

Q. When I say testify, in a courtroom setting, like this. Do you testify in other forums or is that 12 to 15 in total?

A. In a courtroom setting like this, 12 to 15. I don't keep track. That's an approximation. Sometimes Medicare wants paperwork done; Workers' Comp wants paperwork done. It's part of the practice, of rehab, orthopedics and pain management.

Q. But you never testified on behalf of examining people and you testified on behalf of the defendants. Would that be fair to say? There are doctors that do that?

A. I only testify for my patients. I assume that's what you're talking about.

Q. Now, your practice where is it?

A. I have two offices. One is in Union Square at Beth Israel Medical Center and Phillips Ambulatory Care Center at the pain management group. The second one is at the Methodist Hospital on Seventh in Brooklyn.

Q. And where did you see Mr. Flores?

A. In the Manhattan office.

Q. And in 2010, about how many patients would your office see in a given day?

A. Forty, fifty.

Q. How many doctors are there?

A. There's myself, Dr. Mandelbaum and 3 PA's.

Q. And you have different examining rooms?

A. Yes.

Q. About how often would you spend with Mr. Flores on a given visit?

A. If I was doing the exam with a physician's assistant the physician's assistant would usually spend 10, 20 minutes then I would come in the room for approximately 15 minutes depending on the treatment and the discussion. If I was to see the patient by myself, 25 minutes to see the patient and the paperwork. Unless there's other procedures being done on the same day then the time would probably be doubled.

Q. Now, the first time you saw Mr. Flores was in April 30th of 2010?

A. Yes.

Q. And that was a referral from the chiropractor?

A. Doctor McGee.

Q. Correct. That's about three years after the incident. Is that fair to say?

A. Yes.

Q. Just one thing I want to cover just very quickly. There was no complaints made of depression or anxiety in any of your records; is that correct.

A. Every one with chronic pain has some depression but that's not a predominant symptom with Mr. Flores.

Q. Well, as a matter of fact, there was a box when he first came in or he could have circled depression in the box to check. It wasn't checked. Is that fair to say?

A. He doesn't have a history of, you know, clinical depression.

Q. And then on each visit, there's a place where you could write down psychological and there's no mention of depression in any of the visits that I have records of. Is that fair to say?

MR. PFLUGER: Objection. The records he's referencing I don't know if it's created by someone in the office, not by --

MR. MORELLO: You're right.

Q. There's nowhere in your records where it mentions depression. Is that fair to say?

A. I don't recall writing, writing in my records regarding depression. The pain takes the strength away. He's not a happy person. I wouldn't call him depressed.

MR. MORELLO: Move to strike as nonresponsive.

Q. There are some places where you could write if someone

is suffering from depression here. Is that correct?

A. I have a full piece of paper to write on or a full computer screen. I can write anywhere I want.

Q. Where it says psych on there you can write depression?

A. If there is a complaint of depression, I usually write it down.

Q. And it's not written here. Is it fair to say?

A. I don't recall writing it when I was doing the chart on this patient.

Q. If I were to tell you in the records that I've received and I don't have it complete to date, there's no mention of depression. Would that be an accurate statement? If you want to take a quick look through?

A. As I said, I don't recall writing depression down on this patient's chart.

Q. As a matter of fact, there was a visit where it specifically wrote -- it's a circle with a line through it -- depression, the visit of February 17, 2011.

A. Yes. That says no depression.

Q. Okay. So he was asked if he was depressed and he wrote no?

MR. PFLUGER: He didn't write it.

Q. He was asked if and it was documented that the response was negative.

MR. PFLUGER: Well, objection. He wasn't there.

THE COURT: Overruled. You may answer the question.

A. On that date of service, it was documented that the patient wasn't significantly depressed on that day.

Q. Wasn't significantly depressed or wasn't depressed?

A. He didn't have any signs to -- the symptoms to qualify for a full diagnosis of depression. Chronic pain isn't a happy state but it wouldn't qualify as a state of depression.

Q. Now, you saw Mr. Flores for the first time about three years after the accident?

A. Yes.

Q. And it's your opinion that the back injury and the knee injury were caused by the fall in the subway. Is that correct?

A. Yes.

Q. Subway platform?

A. Yes.

Q. Now, with respect to the back injury, you said -- testified earlier that you based your findings on the records that you received, is that fair to say, along with the conversations with Mr. Flores?

A. Most of my opinions are based on the patient's exam and the history. The things that I used to back it up are -- some of that would be records and from other doctors.

Q. Including Lincoln Hospital, would be that be correct?

A. I have some records from I believe it's Lincoln Hospital.

Q. Can you just look to those please?

A. I believe these are those records.

Q. The ambulance call report, is there any mention of back injury?

A. I don't recall if he has a back injury on here. My copy is vague. It is a poor copy but I don't recall specifically a back injury on that day.

Q. I'm sorry.

A. I don't remember -- I don't see -- I have a very poor copy. I don't see if there is or is not any description of back injury on that ambulatory record.

(Handing)

A. Much better. His main complaint was of his left leg on initial ambulatory -- ambulance writing for approximately a paragraph.

Q. No mention of the back there, correct?

A. Not on the ambulance record.

Q. And then you said it's not in any physical description. Is that correct? Toward the end?

A. Other than the fact that he's lying on the ground in pain which it clearly sets the entire paragraph. Not any physical distress is written there but the first nine -- nine lines all state how much the pain he's in and the problem he's

having.

Q. Well, it says patient was able to ambulate on scene. That means he was walking around. Is that what that means?

A. I believe he was lying on the platform when they arrived.

Q. And then later on it says patient was able to ambulate on scene. He was walking around?

A. Yes. That's what it says here.

Q. Okay. So he was lying when they got there then he was walking around and he was not in any physical distress. Is that what it says?

A. Except all the other lines noting the pain in his leg.

Q. Correct, pain in his leg. Then he's taken by the hospital and he sees a nurse. What complaints did he make to the nurse at the hospital? What parts of his body did he make complaints about?

A. Direct me to the page that you're looking at. There's a long set of records here.

Q. Triage note, emergency department.

A. Which page would you like me to look at?

Q. The records that you based your opinion upon were from Lincoln Hospital. It indicates in the triage that the only complaints were of the left leg. Is that correct?

MR. PFLUGER: I object to form. That's not what he based his opinion on.

THE COURT: Overruled.

Q. Is that correct, Doctor?

A. It says here left ankle, left knee, left leg, trip fell subway platform.

Q. Right, no back. The parts of the body that were injured there's no mention of the back. Is that correct?

A. Left leg is part of the radiculopathy of the back. I don't know if the patient is referring to that as part of his leg pain at that point or not.

Q. The pain to left knee and right ankle?

A. Left leg.

Q. Well, later on it says left knee, right ankle. What's the pain level?

A. Pain level three.

Q. Three out of ten. It was right after the accident. It's three out of ten.

A. It doesn't give the rating of the scale. That's possible.

Q. Are you aware of any other scale that doctors and hospital use to rate pain other than to zero to ten?

A. Nurses often use one -- zero to five scale. I don't know if this is a zero to five or zero to ten. I don't think it matters that much.

Q. It doesn't matter that much and then later on he sees -- Mr. Flores sees a doctor; is that correct?

A. I would assume he saw a doctor.

Q. And then he makes a complaint of knee pain and ankle pain; is that correct?

A. I see knee pain and ankle pain on the next page.

Q. Nothing about a back to the doctor either. Is that correct?

A. He does not make any -- I don't see on this page -- I don't see any notation on this page about a back pain.

Q. Correct. And he's given Motrin?

A. Motrin.

Q. And Motrin is over the encounter. You can buy that at CVS?

A. Not this dose but, yes, Motrin and Ibuprofen can be bought over the counter.

Q. And x-rays were taken?

A. I believe -- I remember x-rays being taken but I don't see it on this page.

Q. If you flip through.

A. X-ray was taken.

Q. What parts of his body?

A. Left knee, right ankle.

Q. Nothing about his back; is that correct?

A. I don't see any of it on his back.

Q. Is there, if you want to flip through it, one mention of a back injury anywhere in the Lincoln Hospital records that

you're aware of?

A. I have not reviewed all these pages so I don't see it at an initial glance.

Q. If you want to look through it, you could look through it.

A. I'm sure if you say they're not there, I probably won't find it.

Q. And is it your opinion that when Mr. Flores fell he sustained this traumatic debilitating injury to his back; is that correct?

A. That's what he told me and that's --

Q. That's what he told you?

A. Yes.

MR. PFLUGER: Can he finish the answer, Judge, please.

A. That's what the patient stated: his leg got pinned, he injured his ankle and his knee were hurting the most, his back was also hurting him, the knee -- the ankle calmed down, the knee didn't and the back got worse.

Q. And you based it on that's what he told you, his back injury?

A. And what he stated to Dr. Cohen as well.

Q. We'll get to that in a second but there's nothing in the Lincoln Hospital records at all to indicate there was an injury to Mr. Flores' back on March 22nd of 2007?

MR. PFLUGER: Objection, asked and answered several times.

THE COURT: Sustained.

Q. And after the Motrin and upon Mr. Flores' discharge, did it give a pain level?

A. Pain level states zero.

Q. Zero and what does zero mean.

A. If he's zero means no pain.

Q. Okay. So he goes to the hospital, they take x-rays, there's no fractures, he's given Motrin and he's discharged with zero pain?

A. That's not what the patient states but that's what the nursing records reflect.

MR. PFLUGER: Objection.

THE COURT: Nonresponsive to the question.

Q. Now --

MR. PFLUGER: Sustained?

THE COURT: Thank you, counsel.

Q. You testified that you relate the back -- the fall to a back injury to his present complaints. This hospital record does not support any back injury. Would that be fair to say?

A. It's not -- a back injury is not mentioned in this record.

Q. Correct. As a matter of fact, there's a discharged summary on there. Can you flip to that?

A. Again, show me which page you are referring to? I don't believe I have that page.

(Handing)

Q. It's actually -- it's signed by the patient when he was discharged from the hospital; is that correct?

A. It appears to be signed by a nurse. I can't tell who signed this.

Q. This box is checked which tells you what the injury is. Is that fair to say?

A. There's a box checked: sprains and bruises.

Q. Okay. Is there a box there for back?

A. There's a box for back and that's not checked.

Q. Okay. Would the fact that the box that says back pain on discharge be not check, would that indicate to you that upon Mr. Flores' release from the hospital made no complaints of back pain whatsoever at Lincoln Hospital?

MR. PFLUGER: Objection, Judge.

THE COURT: Overruled.

A. Can you repeat the question.

MR. MORELLO: Can you read it back please? I'm sorry.

A. The box isn't checked. I wouldn't make any more inferences past that.

Q. I'm sorry?

A. The box is not checked. I wouldn't make any more

inferences past that. I wasn't there.

Q. But you used that record to formulate your opinion. Is that fair to say?

A. As part of my opinion.

Q. Okay. Well, part of this is what he tells you, Mr. Flores tells you; is that correct?

A. Parts of those records since he left with zero pain even though he had significant trauma to his knee makes me take all documents in the light that they're given. It's an emergency room setting. They treat acute and most apparently at that time anything not acute and traumatic is left to the outpatient doctor such as fractures, bleeding.

Q. So, it's your belief that in all the documentation in there about four or five places where it says the part of body that are injured it was all -- the back complaints were all overlooked.

MR. PFLUGER: Objection.

THE COURT: Overruled. You may answer.

A. I don't think they were focusing on the back. I think they were focusing on the leg and ankle where he had his most severe pain and the back was a secondary complaint and obviously not fractured and did not need any emergency room care. It wasn't treated in the emergency room, it wasn't discussed. The ankle and knee which could be a fracture is what emergency rooms treat.

Q. But there was five places at least that the complaints, complaints were documented and not one of them mention the back?

MR. PFLUGER: Objection. This is about ten times now, Judge, we are going over the same thing over and over, Judge.

THE COURT: Sustained.

MR. PFLUGER: Asked and answered.

Q. And in your opinion as to connecting the back injury to the fall is based in part of this record?

A. All the records put together are the basis -- and the physical exams and the patient's story help me make my opinion.

Q. Okay. And then the other record is the record of Dr. Cohen?

A. As part of it, yes.

Q. And when did you obtain Dr. Cohen's records?

A. I believe that was sent over to my office very soon after the first either with or very soon after the first office visit is my recollection but I'm not confident.

Q. And Dr. Cohen does mention back pain. Is that correct?

A. That's my recollection that after -- I would have to review it to see the exact places where he said that.

Q. Dr. Cohen never treated Mr. Flores' back. Is that fair to say? No treatment was ever rendered by Dr. Cohen of Mr.

Flores' back?

A. Dr. Cohen evaluated his back. Dr. Mandelbaum evaluated his back.

Q. Dr. Cohen?

A. Dr. Cohen. He examined it, he took the history that he had back injury of the accident site. This is a week after the injury. The patient noted he injured his right ankle, left knee and back at the accident site.

MR. MORELLO: Move to strike as nonresponsive.

THE COURT: Sustained.

Q. Did Dr. Cohen ever treat Mr. Flores' back, not a history, not a mention. Did he ever treat Mr. Flores' back?

A. He provided the patient with Daypro for his three injury sites. One medication would treat all three.

Q. He gave him a pain killer?

A. Yes.

Q. Now, Dr. Cohen had an MRI performed of Mr. Flores. Is that correct?

MR. PFLUGER: Objection.

Q. He ordered an MRI?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q. Is there an MRI in your records --

MR. PFLUGER: Objection.

Q. -- MRI report?

A. I don't have it in my records, no.

Q. Are you aware that an MRI was --

MR. PFLUGER: Objection.

Q. Are you aware --

THE COURT: Sustained.

Q. From the last two visits with Dr. Cohen May 2nd of 2007, could you flip to that?

A. I may not have that. I've only received a few pages from Dr. Cohen when he first came. I have May 2nd. Was that your --

Q. Yes, May 2nd?

A. May 2nd, yes.

Q. Does Dr. Cohen mention Mr. Flores' back anywhere in that visit?

A. All Right. He focused on the knee. I don't see any reference to the back on the May 2nd date of service.

Q. When you say he focused on the knee, the treatment was for the knee, not for the back. There's nothing -- the word "back" is not mentioned in there?

A. He's an orthopedic doctor. He treats knees and ankles. That's why I focused on it.

Q. Orthopedist don't treat backs?

A. Usually the spine is left to orthopedic surgeons. Usually orthopedic doctors commonly focus on knees, joints, breaks; some doctors focus on spines. I don't believe this was

Dr. Cohen's focus.

Q. But that focus is not mentioned. When you say "focus," it's not mentioned?

A. Not on this day but he mentioned it on the other dates of service.

Q. Do you May 23rd?

A. This was a follow-up visit from his knee arthroscopy. The entire note was about the postoperative visit patient and doctor were focused on the knee since he was -- it looks like when he was freshly out of surgery.

Q. And there's no mention of the back again. Is that correct?

A. No.

Q. And that's May of 2007?

A. Yes.

Q. From May of 2007 up until April of 2010 when you first saw Mr. Flores, are you aware of any medical doctor that treated him, an MD or a DO.

A. You're not talking about chiropractor?

Q. No, a medical doctor that treated Mr. Flores for his back from May of 2007 until April of 2010?

A. He went to Dr. McGee. He's a chiropractor, not a medical doctor.

MR. MORELLO: Move to strike.

THE COURT: So struck.

Q. Any doctor?

A. I am not aware of any medical doctor he was treating with after Dr. Cohen.

Q. For three years, there's no medical doctor who treated Mr. Flores' back, is that correct, that you're aware of?

A. Not that I'm aware of. He had an internist, just to review his notes.

(Pause in proceedings)

A. It Was September 8, 2009, part of that was with Dr. Rabinowitz. Dr. Rabinowitz September 8, 2009, previously injured right ankle and low back, complaints of severe -- just notes the back pain.

Q. He did not treat it. Is that fair to say?

A. I guess. I guess he didn't treat it. He was treating -- seeing the patient for the other problem. He wasn't treating the patient for the back at that time. It was done by other practitioners.

Q. He was treating him for -- he was his primary care doctor?

A. He was his primary care doctor, yes.

Q. From May of 2007 to April of 2010, do you have any record of Mr. Flores ever going to a walk-in clinic or an emergency room because of severe and debilitating back pain?

A. No, I don't.

Q. Now, with respect to the back, the anatomy of the

back, are you familiar with it?

A. Yes.

Q. And the vertebrae which is the bones?

A. Usually.

Q. Are there people that don't have vertebrae?

A. Not yet.

Q. In between there are discs that are like the shock absorbers, would that be fair to say?

A. In A young patient, yes.

Q. What happens in a older patient?

A. When people get into their 70s and 80s, they slowly desiccate and become more fibrotic.

Q. They degenerate?

A. Degeneration is one word. All backs degenerate one way or another, traumatic or age related. In the 70s and 80s, there's age related degeneration versus traumatic degeneration.

Q. Would it be fair to say that people younger than 70 or 80 develop bad backs?

A. Anyone with injury to the back can develop a bad back.

Q. Is all back pain injury related or people just develop back pain over time as part of getting old?

A. In the 70s and 80s, you can develop back pain as part of getting old. Most if not all back pain is injury related.

Q. Doctor, not all back pain is injury related. Is that fair to say?

A. Most, if not all, is injury related.

Q. Doctor, most, if not all, is injured related?

A. Until you get up into your 70s or 80s. Why do you think it hurts? You injured it.

Q. And you've never treated a patient in their 50s with back pain that wasn't injury related?

A. How do you define injury?

Q. Traumatic injury?

A. Not car accidents or --

Q. fall?

A. Fall from a building but lifting heavy objects usually predates back symptoms. A patient's back, if treated right, last until the elder years, elder years of your life. We usually don't treat our backs very well.

Q. And what types of things would affect how quickly the back degenerates?

A. Trauma.

Q. No. I'm talking about degenerative. I'm not talking about trauma. I'm not talking about someone that falls and hurts their back. I'm talking about a back wearing out as part of the aging process?

A. Can you please be more specific?

Q. If somebody worked in construction, would they be more susceptible to have a bad back?

MR. PFLUGER: Objection.

THE COURT: Overruled.

THE WITNESS: Answer?

THE COURT: You may answer the question, yes.

A. Construction workers have constant repeated trauma to their back hence they have more back problems.

Q. When you say "trauma," maybe we're talking about different things. A construction worker is working with their back all day. Do you consider trauma in lifting, carrying?

A. Have you done heavy construction?

Q. I've never done heavy construction.

A. Injuries happen.

Q. I'm sorry?

A. Injuries happen, accidents happen with heavy construction on a yearly basis.

Q. I'm not talking about accidents. I'm talking about just the wear and tear on the back. Would construction increase the wear and tear on somebody's back?

A. Because they have more injuries, they can develop more traumatic changes in the back.

Q. What about a construction worker who never has an injury but lifts and digs for years? Would that person be more susceptible to have having a bad back?

A. I have many construction workers without back problems who have worked their entire lives in heavy construction and it was the knee they injured through a traumatic injury. If you

treat your back right, use proper form, don't be lucky enough to have any traumatic injuries, your back usually survives as our species have survive.

Q. You're not aware of anybody who does heavy lifting, carrying more susceptible to a back problems?

MR. PFLUGER: Objection. It was asked and answered, Judge.

THE COURT: Sustained.

Q. And how about playing sports, football? Would somebody who's been playing sports for a number of years be more susceptible to a low back problem?

A. Sports, athletes especially professional in hard intense athletic sports often have injuries. Have you ever seen a football player getting taken down on the field you can understand where their injuries come from very easily.

Q. But just increased wear and tear on the back. Would sports increase the wear and tear on the back?

MR. PFLUGER: Objection, Judge.

THE COURT: Overruled.

A. Normal use of the back usually does not cause traumatic injury or injury to the back. When you're 80 or 90 slow settle in the back can relate some problems but most blown discs are because there's a traumatic force doing it. Most crushed nerves is because there is a traumatic force crushing it. Most fractures, facet fractures are from the depressions of

the spine.

Q. What was the last one, the last thing you said?

A. Facet damage, facet fractures, damage arthroscopy.

Q. Now, we are up to the 80s and 90s it takes to develop back problems?

MR. PFLUGER: Objection.

THE COURT: Overruled. What's your question?

Q. Earlier you said people don't have back problems in the 70s and 80s. Now you say the 80s and 90s. Which is it?

A. 70s, 80s and 90s.

Q. And before that people with back problems usually are pretty good?

A. Unless you have traumatic injuries. I've seen many -- the majority of patients having had significant traumatic have problems with their backs. Most structural changes can be contributed to trauma. I see this on a regular basis. This is what I do everyday.

Q. And then there are tests available to study the lower back. Would that be fair to say?

A. There's test available to study the low back.

Q. And among those tests would be an x-ray?

A. That's one of the test used to study the lower back.

Q. An MRI?

A. That's one of the test used to study the lower back.

Q. So if the patient has an x-ray or MRI, you physically

can see what is going on in the lower back?

A. Each study shows different things, can show different changes in the low back if that study is the proper study to see that change.

Q. Have you ever sent patients for an x-ray for low back pain?

A. Not for simple low back pain but, yes, I have, yes, not commonly.

Q. Have you ever sent patients for an MRI who have a history of chronic low back pain?

A. Yes.

Q. Did you ever send Mr. Flores for an MRI?

A. No.

Q. Why.

A. I wasn't able to get authorization for it.

Q. Wasn't able to get authorization for it?

A. I couldn't get it authorized.

Q. By whom?

A. Any one.

Q. You had all these tests. You had the epidural injections into the knee. Was that all authorized?

A. What?

Q. Were the injections authorized?

A. They were performed in my office. I did those injections. They were done by someone -- another -- another --

-- someone else. I don't do MRI's.

Q. But you can send someone out there for a MRI. Would that fair to say?

A. I send people out for MRI's.

Q. You could have sent Mr. Flores for an MRI?

A. Yes.

Q. And had you sent him out, we would have known what's going on in his lower back. Is that fair to say?

A. It would be one of the tools I could use to assess his low back.

Q. And when you have someone seven years post accident whose got chronic debilitating back pain and you never sent for an MRI?

A. It was desired but I couldn't achieve it.

Q. You couldn't achieve it?

A. I can't -- I don't do MRI's in my office. I can't magically make it get done.

Q. Dr. Cohen got it done. Would that be fair to say?

MR. PFLUGER: Objection.

THE COURT: Overruled.

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. I don't know what Dr. Cohen did. I'm sorry.

Q. Okay. Have you ever had a problem -- I mean maybe I'm mistaken -- did you actually pick up the phone and call the MRI

facility and say I'm sending Mr. Floors and they said no don't send him?

A. I wanted to get an MRI.

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. I wanted to get an MRI. I did not have any ability to get it done.

Q. You didn't know a facility to send him to?

A. I didn't -- I can't get an MRI magically done. It takes authorization. I don't have -- I didn't have that.

Q. You testified that you send people for MRI's and x-rays before; is that correct?

A. Yes.

Q. Did you ever send Mr. Flores for an MRI or an x-ray?

MR. PFLUGER: Objection, asked and answered, Judge.

THE COURT: Sustained.

Q. What prevented Mr. Flores from having an MRI of his back to tell us what was going on down there?

A. I didn't have authorization to get it done.

Q. Authorization from?

A. Anyone, from Medicare, hospital, Medicaid. I don't have -- I didn't have these tools here.

Q. You did treat him though?

A. Yes.

Q. And you have a patient with pain at times ten out of ten. Is that a concern to you?

A. Yes. He had pain. I treated him.

Q. Would you want to find out what's going on in his back?

A. It was pretty clear what was going on. He had radiculopathy pain in his back. It went down his leg. It's a very common syndrome in people with injured backs after car accidents and trauma.

Q. Very common, correct?

A. After a traumatic injury, yes, this type of injury I should say.

Q. Or degenerative injury?

A. After trauma?

Q. No. The back does wear out at times would you accept that premise that the back wears out over time?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q. Is the lower back more susceptible to degeneration than the upper back?

A. The transition points are more susceptible cervical to thoracic, thoracic to lumbar, lumbar to sacral. Those are the transition points where traumatic forces often versus the sheer forces of traumatic injury.

Q. I'm not talking about traumatic injury. I'm just

talking about backs that wear out. Is it more likely that they wear out in the lower sacrum area?

A. Cervical and lumbar without trauma wear out about equally.

Q. I'm sorry?

A. Cervical/lumbar wear out about equally without trauma.

Q. Just with respect to the back, it usually develops in the lower area?

A. That's one of the most common areas of traumatic force and sheer planes and trauma hitting the body.

MR. MORELLO: Move to strike as nonresponsive.

THE COURT: Sustain.

Q. I'm not talking about a traumatic injury. Somebody in their 80s, to use your example, that develops a lower back is more likely to happen -- develop a back injury -- I'm sorry -- is more likely to happen in the lower back?

A. Simplify it?

Q. I'm not talking about a traumatic injury. You said people's back last in their 80s and 90s.

A. 70s, 80s and 90s.

Q. So somebody in their 70s develops lower back pain would be more likely it would be the lower, the lower sacral area?

A. It's usually consistent throughout the whole spine as the spine starts to settle, desiccates and final stenosis and

fibrosis set in.

Q. What's desiccate.

A. Discs are shock absorbers in the body. They can lose hydration a number of ways. One way is through old age where there's no trauma to the disc and the hydration in all parts of the body including the disc start to decline, the skin, the muscle, the disc and that forms a more fibrotic desiccating without fluids central to the disc in the 70s, 80s and 90s. That compression could lead to spinal stenosis, arthritis, pain, pain of an aging back.

Q. And a disc can be damaged traumatically as a result of a fall or something of that nature?

A. Discs, nerves, tendons, facets can all --

Q. But a disk can, correct?

A. Repeat the question please?

Q. A disc in the back can be injured as a result of something traumatic such as a fall?

A. Yes.

Q. Would you expect that person to have severe back pain if they blew out a disc when they fell?

A. That's one of the symptoms that you can have blowing out a disc. Sometimes you have severe back pain; sometimes you don't.

Q. You could fall and injure a disc and not have any back pain?

A. Usually you have backache. Sometimes depending on location of the compression, the disc can blowout anterior to posterior, posterior results in radiculopathy or a crush to the spine results in radiculopathy. If it goes the other way, it results in axial back pain rather than radiculopathy.

Q. But you would expect someone to have traumatic injury to the lower back experience some type of reportable pain when they go to the hospital?

A. Usually back pain -- usually back pain is an injury to the back is reported. Almost always in all records that I've reviewed, the emergency room focuses on head, cardiovascular broken bone. That's the job of the emergency room.

Q. If somebody makes a complaint, it's their duty to write it down. Is that fair to say?

A. Yes, they should write it down.

Q. Now, when you first saw Mr. Flores in April of 2010, you made a diagnosis of his lower back; is that correct, April 2010?

A. April 30, 2010, yes.

Q. And what's the diagnosis?

A. Lumbar degeneration.

Q. That's lumbar degeneration?

A. Yes.

Q. Is that fair to say?

A. Yes. It's a general term at that point, yes.

Q. And degeneration means wearing out?

A. Degeneration is a general term. It can be from traumatic, it can be from many different sources. It's just a general term.

Q. Is it fair to say in the medical field you have traumatic injuries and degenerative injuries?

A. It's not black and white. It's not A or B. The body is not usually dealt with in that way.

Q. If somebody was in a car accident and herniated the disc, would you write that it was a degenerative injury?

A. That's how you code it, degeneration with radiculopathy.

Q. You would wrote degeneration down if somebody was in a car accident?

A. It's a code you have to use. The system is changing in October 2014. As of 2000 -- as of the age of this, there is a locked in coding system that we're -- we have to use. I review it with you and the jury if you'd like.

Q. What do you mean that there's a coding system?

A. The code for that part of the back, lumbar degeneration of all types, is diagnosis code 722.52. You have to use either 722.52, lumbar degeneration of lumbar sacral spine or you can use the degeneration of the disc. You can use radiculopathy code but there is no codes that refer to at this time on type of trauma induced into the back. You have to

choose one of those codes.

Q. I'm not talking about a code. I'm talking about what you wrote down. You can code it any way you want but you wrote down lumbar degeneration. Is that fair to say?

A. He had lumbar degeneration with radiculopathy and facet pain.

Q. And degenerative injury is different than a traumatic injury. Is that fair to say?

A. There's the word "degenerative" and it could be -- is a generalized term just like back pain and then it could be traumatic disc, facet, tendon, spasm, degeneration often refers to the following statement such as radiculopathy or facet or compression fracture or degeneration is a general term to be followed by more specific terms and codes. That's how it's done in medicine. I'm sure you're aware of this.

Q. I'm aware of somebody's traumatic injury such as someone falls, was in a car accident and has a trauma as opposed to a degeneration which implies that over time over use things wear out and you're saying that a lumbar degeneration is the same as a trauma to the spine. Is that your testimony?

A. Obviously, you're not familiar with the coding system.

Q. I'm not talking about coding.

A. I am. This is what you have to do. This is how it goes. You say he has the injury and then you have to put it down in the assessment, you got to fit it in these categories.

It's the way it's done. You can't get it around it. Otherwise you won't get paid. You can't bill it. You can't code it. You can't do it in the computer system. It won't work. This is how it's done in the medicine. You got to classify things. This is how modern medicine works. It's a whole field of study of how to study and how to classify medical injuries, medical events.

Q. But there is something called degenerative disc disease?

A. Degenerative disc disease takes all types of disc events in their -- in that. It's one code for all types of disc events. The new system, about to come out, differentiates between traumatic, age related and other reasons, infectious. Many things can damage discs. Trauma is one of them. Age is another one. Infection I need a medical condition. They all can be the outcome or the subclassification on disc degeneration of the lumbar spine.

Q. The reason you write down medical records is some other doctor in your office or someone in the facility gets a cop of your record they know what's going on with that; is that correct?

A. That's why we have a whole page. You can't just take out one word without reading the top word or reading the word after it. You want to dissect out degeneration until you turn blue, go ahead but it clearly says accident where the injury happened. This is a whole page taken as a whole. You can't

dissect out one word like you're trying to do. It's just not the way doctors work. It's not the way patients or medicine work. It's the way you work.

Q. So your diagnosis or your putting the back injury that Mr. Flores claims to have sustained in March of 2007 when you first saw him in April of 2010 is based upon what he told you. Is that fair to say?

A. Yes.

Q. Okay. Now, you testified earlier that you work with Dr. Cohen as a team?

A. In the treatment of this patient, it's standard practice to link the orthopedic doctor, the chiropractor, the rehab doctor, the pain management doctor, so two sets of doctors aren't giving two sets of antiinflammatories, two sets of pain medications. There's no conflict in multiple surgical decisions unless that's what's appropriate. Usually doctors work in teams to benefit the patient. Sometimes it doesn't work out this way. Better doctors try to communicate with their other physicians when necessary.

Q. When did you first speak to Dr. Cohen about Mr. Flores?

A. Within the few days around this first office visit is my recollection.

Q. Is that noted in your records?

A. No. I received the records from him from his office

after I talked to him, sent over a section of his records.

Q. Did you have a specific recollection of that conversation with Dr. Cohen?

A. Briefly and Dr. McGee.

Q. Just Dr. Cohen. I'm just talking about Dr. Cohen.

A. Dr. Cohen, brief recollection is not specific. He focused more on his knee, state of the ankle, you know, had improved by itself, the surgery was partially successful but he had continued knee pain. It made the doctor pleased that he got over to me. He had no problem with doing the Orthovics injection and agreed with me the lumbar steroid injections. We didn't go over the back in detail other than he agreed with the lumbar epidural steroid injection.

Q. Is it common for doctors where they refer or talk to other doctors to write that down in their records?

A. I usually -- I don't come into that, not unless there's something of big significance in conversation with those other doctors such as a significant finding that needs to be documented for some reason. Everything that needs to be documented was documented.

Q. Is it common for doctors to keep other doctors apprised of the care such as writing letters?

A. We usually don't do that unfortunately.

Q. You usually don't do that?

A. No. It has to be faxed over office notes when

significant events happen.

Q. Are you aware that Dr. Cohen testified yesterday?

A. I believe I was told that. I don't know exactly if he did or not.

Q. If I were to tell you that Dr. Cohen testified that the first time he became aware of Mr. Flores was having problems with his knee following May of 2007 was in February of 2012 when the lawyers told him. Would that be a correct statement?

MR. PFLUGER: Objection. That's improper, Judge.

THE COURT: Thank you. Sustained.

Q. Is it your testimony that you were in constant contact with Dr. Cohen during this procedure?

A. No. I talked to the doctor in the initial stages and one time after regarding some medication there's a previous communication with the PA. I was not in constant contact with Dr. Cohen but we were in contact regarding medications. We knew we were both treating. I was doing the narcotic pain medications. That way patients didn't get double supply of medications. It's for those reasons.

Q. There's no documentation anywhere in your records --

A. No.

Q. -- of that? And if Dr. Cohen were to testify that he never recalled ever speaking to you, if he had testified to that yesterday, would that be an accurate statement?

MR. PFLUGER: Objection. That's not the

remember some question about medications that the PA had some communication with him. Doctors are not good about communicating with each other. That's why we are trying to develop electronic records. We can see each other's records and integrate better and not waste so much money and cause problems.

Q. Are all doctors not good at communicating or just some doctors?

A. In my opinion, most doctors are very poor at communicating because of their busy schedules?

Q. Did Dr. Cohen express any concern to you that three years post arthroscopy that his patient was in debilitating pain in his knee?

A. I'll refer to the patient was in pain. He was glad the patient was coming over. That was almost the extent or part of this conversation.

Q. And can you assume the care and treatment of Mr. Flores' knee as well as his back from April of 2010?

A. One of the reasons I called Dr. Cohen not only Dr. McGee is that he was planning on doing the knee lubrication injections, the Orthovics injections. It's a slight stepping on his turf. It was proper for me to call to make sure that there wasn't any problems with that. He agreed. He agreed with the epidurals, he agreed with the Orthovics and didn't have much more to say other than that. He didn't say that the patient was -- he didn't remember well.

Q. Did you ever send those records to Dr. Cohen?

A. I don't know. I don't know.

Q. Dr. Cohen ever ask for them?

A. Not that I know of.

Q. Are you aware that at some upon in time Mr. Flores returned to work after the accident?

A. I don't remember specific events but I remember he wanted to than more once try to return to work. He basically wasn't able. I don't recall the details of his getting to work. I know he wanted to try but he wasn't able to.

Q. Did Mr. Flores ever tell you he wasn't treating with Dr. Cohen because he couldn't afford it, he couldn't pay?

A. Never came up.

Q. Now, with respect to the injections into the knee about how long does that procedure take?

A. Knee injection is brief, ten minutes.

Q. Is that done in your office?

A. Yes.

Q. You do it yourself or would you have a nurse or a physician assistant?

A. I do it with an assistant helping me open up stuff, drop medications. Several medicines are involved.

Q. About how many a day would you do or a week in your office?

A. Because I have the assistance of the PA's and medical

assistants I see 40, 45, 50 patients a day for procedures. I see 12, 15 patients in a day.

Q. You would see 12 to 15 patients a day?

A. Spine injections a day.

Q. What about the Orthovics injections?

A. Most in a day maybe four, three or four into joints in general, Orthovics in the joints in general. Any joints with articular surfaces, orthovics injections knees, shoulders, hips.

Q. And you have a preprinted form that you use in your office?

A. Yeah, that's my form and my signature.

Q. Okay. And it says left, right and you circle which one?

A. Yes.

Q. Okay. And then you have the four medications and you check off the box for the medications that you use?

A. There is five different brands of knee lubricants at this time.

Q. Knee, you circle left, right?

A. I hope so.

Q. And then you're supposed to put down how much fluid was exasperated but I guess in July 9th of 2010 you didn't fill that in?

A. I didn't feel that in.

Q. Now, turning to the preoperative diagnosis on July 9,

2010 operative report, what does it say for the preoperative diagnosis?

A. Preoperative diagnosis, it's only one line left -- right or left. Left is circled knee osteoarthritis.

Q. Osteoarthritis?

A. Yes.

Q. Okay. And arthritis is what?

A. Damage to the joint.

Q. That's all it means?

A. It's a general term.

Q. Did you ever send Mr. Flores out for an MRI of his knee to find out what was going on?

A. No, I did not.

Q. Did you send him out for an x-ray of his knee?

A. No.

Q. This is a man who has chronic, debilitating pain at times ten out of ten. Were you concerned as to what was going on in the knee?

A. Is that a question?

Q. Yes. Were you concerned?

A. I treated the patient, provided medication injections to calm his pain. That was my part of the team's effort.

Q. But did you want to know what was causing the pain?

A. I've already had a good idea from previous work. Just it wasn't that hard to figure out what was wrong with his knee.

It was injured.

Q. It was injured?

A. The previous studies here, the report of Dr. Cohen. He was inside the knee looking at it when he did the surgery. I have the findings of that. That's usually the best, the more accurate.

Q. You didn't have the MRI report; is that correct of the knee?

A. I'm not sure. I thought -- I think I did. I don't recall. I can try to find out if you'd like. At one time, I reviewed the MRI report of April 4th, 2007: MRI left knee, an abbreviated -- very abbreviated summary, two lines. Focal region marrow, edema, bony contusion associated with medial femoral condyle trauma. It's a very short sentence for the result of the full report.

Q. Do you have the report in there or just --

A. I don't recall seeing the report in this. I don't have the report. I can review it if you have it.

Q. And what you read indicates from the MRI a contusion, a bang to the knee?

A. Part of his findings very very abbreviated assessment. That was part of it, yes.

Q. And there was no damage in either ligament?

MR. PFLUGER: Well, objection. He didn't look at the film.

THE COURT: Sustained.

Q. Well, you just testified you had a previous good idea of what was going on with the knee. Is that correct?

A. I read the operative report of Dr. Cohen. Damage to the meniscus, internal damage inside the knee along with his summary of the MRI reports. I had a good idea of what was going on in the knee.

Q. And Dr. Cohen's procedure as far as you could see was successful. Would that be fair to say?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q. Do you have any indication that the work that Dr. Cohen did if anything went wrong in the surgery?

MR. PFLUGER: Same objection, Judge.

THE COURT: Overruled.

A. I don't think anything went wrong in the surgery, no.

Q. An arthroscopy of the knee is a very common procedure?

A. Yes. It's pretty common.

Q. I'm sorry?

A. For knee trauma, yes.

Q. It's a very common procedure for knee trauma and degenerative conditions of the knee as well?

MR. PFLUGER: Objection.

THE COURT: Overruled.

THE WITNESS: Answer?

THE COURT: Yes.

A. A more generalized topic, focused diagnosis. I think Dr. Cohen put it well in his operative report if I can refer to it? Is what --

Q. No. My question is --

A. -- in better terms to use --

MR. PFLUGER: Objection. He's trying to answer the question.

Q. No, my question is --

THE COURT: Nonresponsive to the question. It is struck.

Q. An arthroscopic procedure to repair the meniscus of the knee is a very common procedure; is that correct?

A. For a knee meniscus damage, yes.

Q. It's both for traumatic injury as well as degenerative injury; is that correct?

MR. PFLUGER: Judge, objection. He's a pain management doctor.

THE COURT: Overruled, overruled.

MR. PFLUGER: Can we approach. He's a pain management doctor. He's not an orthopedic surgeon.

THE COURT: He has testified profusely with regard to the injections so I'm going to allow it.

A. More patients with knee meniscal damage, it's a common procedure.

Q. And ordinarily without complications, people within six weeks are back living their life and doing what they're doing?

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. That's not my findings with most knee arthroscopic procedures. There's still a long recovery after a knee arthroscopic procedure.

Q. But eventually the purpose of the procedure is to alleviate the pain and have people get back to their routine of daily living?

A. The purpose of the procedure, the knee arthroscopy procedure with torn meniscus is to remove the floating piece of meniscus that keeps getting trapped inside the joint causing the pain upon the trapping of the piece because further damage and to allow decreased function of the joint.

Q. Correct?

A. It often doesn't address the roughness or the traumatized cartilage surface. It often doesn't address the other parts of the knee. Arthroscopy only addresses certain parts of the knee, changes in the knee structure.

Q. But you have Dr. Cohen's report in there?

A. I have his surgical report right here, yes, right in front of me.

Q. His operative report?

A. Yes.

Q. And Dr. Cohen fixed what he was in there to fix remove the damage to the meniscus. Would that be fair to say?

MR. PFLUGER: Objection.

THE COURT: Sustained.

Q. Typically when somebody has a meniscus surgery, what's the recovery time?

A. It depends on the severity of the problem in the patient. It very much depends on the severity of the problem of the patient.

Q. And would it be fair to say that from May of 2007 -- withdraw the question.

From May of 2007 up until April of 2010, there's no indication from a medical doctor of any knee problems on behalf of Mr. Flores for those three years?

A. I don't know of any medical records other than records we discussed.

Q. Okay. So for three years, you're not aware of any treatment rendered to Mr. Flores' left, knee after, the surgery in May of 2010?

A. I only know about the records we discussed. Of course McGee's records. I believe there was some physical therapy. Beyond that, I don't know.

Q. Did you ever refer Mr. Flores back to Dr. Cohen to find out what was wrong with his knee?

A. My recollection is he followed up with Dr. Cohen. I don't have the recollection when or what that follow up pertained to other than the discussion of possible recommended repeat surgery.

Q. But you don't know -- there's been no MRI's so you don't know what the surgery would be?

A. Not that I know of.

Q. Now, with respect to the injection into the back, the epidural, how long does that procedure take?

A. Twenty, 20 to 40 minutes.

Q. Did you do that yourself?

A. Yes.

Q. And that's done in your office?

A. Yes.

Q. Now, every time you injected Mr. Flores' knee you have the same diagnosis, osteoarthritis; is that correct?

A. Yes.

Q. It's same on every form: osteoarthritis?

A. It's a generalized term for articular surface changes in the knee that respond to this type of joint lubrication injection things such as tendons and tendon ligament tears don't respond to knee lubrication. The osteoarthritis components of his knee arthroscopy would be expected to respond and it did and that part improved for extended periods of time.

Q. Now, with respect to the epidurals, the injections

into the back, that 20-minute procedure, you use the same kind of form where you just check off the boxes?

A. Yes.

Q. This is the standard form that you have?

A. Yes. As long as the procedure conforms to the standard procedure it's done relatively similar each team.

Q. It's done in your office?

A. Yes.

Q. With the patient either sitting lateral or prone?

A. Yes.

Q. And you check off which one and there's no sedation used, there's no anesthesia used?

A. Not for this procedure on Mr. Flores.

Q. And then there's an injection made and you check off where -- you didn't check the box but you write down what medication -- then you say without incident and then you sign it?

A. Yes.

Q. And this is the same for everyone?

A. Unless there is an unusual procedure then it would be dictated.

Q. Ten to 20,000 of these?

A. I've done a lot of spine injections, yes.

Q. But you said about ten to 20,000?

A. That was spine injections in total. I would have to

refer to my records how many specifically. I do a lot of back injections. That's the primary part of my practice.

Q. I'm sorry?

A. It's one of the primary aspects of my practice, spine care and procedures for the spine. That's my specialty.

Q. This is your specialty, these injections?

A. That and others.

Q. And again what is the diagnosis, the preoperative diagnosis on your form?

A. This patient lumbar radiculopathy for the epidural. On the form -- I'm sure you'll find out -- that there's is a preprinted line of something general.

Q. I'm sorry?

A. For this patient lumbar radiculopathy.

Q. The first, the first line?

A. Which page? Which date?

Q. Preoperative diagnosis.

A. Preoperative diagnosis is the line --

Q. The first one, the first line?

A. Lumbar disc degeneration.

Q. It's the first line lumbar disc degeneration?

A. Lumbar radiculopathy, third myofascia.

Q. Degeneration is the wearing out over time of something; is that correct?

MR. PFLUGER: Objection. Asked and answered.

THE COURT: Sustained.

Q. And the radiculopathy is sciatica; is that correct?

A. Yes.

Q. And not every time people have sciatica. It's a result of trauma. Is that correct?

A. There's different causes of nerve pain. Sciatica -- different causes of nerve pain, different kinds of sciatic. Nerve roots is the -- nerve root irritation, inflammation, compression is by far the greatest cause.

Q. What would cause that, that irritation or inflammation?

A. Compression of the nerve root is a typical cause. Mr. Flores, the twisting and bending of his spine compresses the nerve root, causing nerve root irritation and damage ending up in the symptom of lumbar radiculopathy.

Q. And that's based upon what he told you?

A. And his physical findings.

Q. Your physical findings when you examined him two years later?

A. Of the patient, yes.

Q. And complaints of pain are subjective. Is that fair to say?

A. There's large subjective components. There's some subjective but I would say pain could be mostly subjective.

Q. And on a pain scale, if I were to say -- if I were to

tell you right now that I'm experiencing a pain in my knee eight out of ten, you don't know whether that's the truth or not. Basically, you would have to take my word for it. Is it fair to say?

A. When -- if a patient in this situation were to go to a number that's outside of what the objective component would refer, the patient be reeducated on the use of the scale and he would give an appropriate -- reeducated him to get the number appropriate for the use of the scale. Ten out of ten being the worse pain of your life, eight out of ten pain means you're having problems moving, hard time focusing. So if you're sitting there with no limp, no grimace, no symptoms, the patient being reeducated to have a more appropriate number to bring it to the norms of the scale.

Q. So when Mr. Flores was at the hospital he gives you zero out of ten and then three years later he's at your facility he's eight out of ten. Is that correct?

A. I don't know what to say about the nurse giving a zero at the time of discharge. I assume she didn't -- my assumption she didn't check the box but --

Q. Well, they were checked earlier. They said three.

A. They were indeed checked earlier, yes.

Q. And with respect to the range of motion we went as far as how far he could bend forward and bend backwards and bend your leg, is there certain subjective component to that as well?

A. There's partially subjective, partially objective component to that as well.

Q. So if I were to -- you asked me to bend right back, I don't give it a good effort, I could show maybe ten or 20 degrees loss of bending. Would that be fair to say?

A. A patient can put in 10, 20, 20, 10, 25, 10, 25 percent of the subjective component. Usually, the objective component, the spasm, the rigidity of the muscle, the involuntary guardian is the objective component. If the patient just won't move, you know, you can document it noncompliant rather than any accurate range of motion.

Q. But somebody were to move and not just give their full effort you could knock off about 10, 20 degrees?

MR. PFLUGER: Objection.

Q. It's a subjective point of reference?

MR. PFLUGER: It's improper, Judge.

THE COURT: I'll allow it.

Doctor, you may answer.

A. There's a subjective component partially subjective, partially objective. The patient was in severe pain. He had involuntary guard, spasm of his muscles. The objective component corresponded to the subjective answers and it correlated. I don't think the patient was giving any subjective additional symptomology to his pain. He's a very stoic man. He suffers in quiet. He isn't overly dramatic about his symptoms.

Q. My question was when you do the range of motion there's a certain subjective component to it is; is that correct?

MR. PFLUGER: Asked and answered.

THE COURT: Sustained.

MR. MORELLO: I didn't get an answer.

MR. PFLUGER: He was asked that about five times.

THE WITNESS: I believe I answered it.

Q. Yes or no, is there a subjective component?

MR. PFLUGER: Objection. He already answered it.

COURT OFFICER: Sustained.

MR. PFLUGER: Thank you.

Q. A person could just not give a full effort and not 10 to 20 degrees off of a range of motion?

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. Can you repeat that?

Q. A person, yes or no, a person when you ask them to bend forward cannot bend all the way right down, they don't have full range of motion? Could that happen.

A. Anything could happen. What happened in Mr Flores' case --

Q. No, no, no.

A. -- I'll be happy to review.

Q. And if a person tells you I'm in pain eight out of ten

and you wrote it down, that doesn't necessarily mean that they're experiencing pain eight out of ten per say?

A. I believe I answered already. That if the patient is answered out of the context about their symptomology and objective component of the examination they would either be noncompliant or a patient inappropriately answers. I wrote that many times when patients had a psychological event going on as well but this patient didn't. He was very -- his symptoms, his objective and subjective all matched. I believe there was an accurate answer.

Q. He gave very high numbers seven, eight, nine out of ten. Would you consider those very high?

A. He had pain in his back and legs. Whenever he moves, whenever he steps, whenever he walks it hurts.

Q. Are you aware five months after the incident Mr. Flores returned to work?

A. Repeat that.

Q. Five months after he fell Mr. Flores returned to work at the YMCA?

A. I don't recall five months after the injury. I know after. I don't remember that exact time frame. I'm sorry.

Q. Say about five or six months, are you aware that five or six months after the incident Mr. Flores returned to work at the YMCA?

A. I don't remember the time frame in our discussions.

I'm sorry.

Q. That never came up?

A. He discussed more of when the accident happened. He couldn't go to work. He tried to work, return to work a couple of times, try to find different work and he was unable due to the pain. I don't recall if he returned -- I wasn't part of his care until 2010 so I don't have a independent knowledge of those earlier dates. I'm sorry.

Q. Would you want to take an accurate history of a patient when you treat them?

A. I believe the history I got he couldn't work initially afterward. He tried to go back to work and he couldn't. I didn't get into a month-by-month account.

Q. Well, it says in the chart he worked until September of 2009, is that correct?

MR. PFLUGER: Judge, so just so we're clear --

THE COURT: Overruled.

MR. PFLUGER: Okay.

A. I'm sorry.

THE COURT: You may answer the question.

A. What date of service are you referring to?

Q. Earlier you started to testify -- it's actually on 9/30/10?

A. 9/30/10.

Q. And it says working, no since 9/2009 is that correct?

A. That's what we wrote.

Q. So from the date of the incident at some point after until September of 2009 Mr. Flores was able to work?

A. I know he returned to work but he wasn't able to continue it. I don't know the date.

Q. It's your understanding that he wasn't able to continue to work or something happened that he lost his job?

A. Combination. He wasn't able get keep the job and not being able to work with the job and find other work is a significant component of it.

Q. You don't know what's wrong with Mr. Flores, is that correct?

A. I don't agree with that statement.

Q. Other than him saying it hurts -- other than saying it hurts, you don't know what's wrong with his knee; is that correct?

A. I don't agree with that statement.

Q. Well, you never had a MRI which could tell you what's wrong; is that correct?

MR. PFLUGER: Objection. He's already answered it.

THE COURT: Overruled.

A. By reviewing the diagnostic testing of Dr. Cohen, I have a good idea of what the issues are inside of his knee. The diagnostic tests were there, the surgery was done, I see the

results. I had an idea. I examined the patient. The knee was traumatized. He had a joint arthropathy. I'm not sure what you're referring to that I don't know what's going on with the patient. I treated him everyday for four years.

Q. Why somebody who had what's considered a common routine, arthroscopic repair of the meniscus, is in exquisite knee pain seven years later?

MR. PFLUGER: Objection but that's not his injury.

COURT OFFICER: Overruled.

MR. PFLUGER: Improper, Judge.

THE COURT: Overruled, counsel. Thank you. Overruled.

A. Ask it again. I'm sorry.

Q. Someone who's had a very common arthroscopic repair of a meniscus is in exquisite eight out of ten, nine out of ten, ten out of ten knee pain seven years later, why?

THE COURT: Overruled.

A. Because of his joint arthropathy, the internal surface of his knee is damaged and when he takes steps the crepitus and grinding of the internal structures of the knee causing pain and inflammation and the laxity in the knee causes the joint giving way and shifting from the structures that were damaged and removed during the surgery.

THE COURT: Counsel, ten more minutes.

Q. Okay. That's just based upon your feeling. You never did any test to confirm that?

MR. PFLUGER: Objection. Asked and answered.

THE COURT: Overruled.

Q. And the same thing with his back. Why is Mr. Flores having pain ten out of ten in his back?

A. Mr. Flores has a lumbar radiculopathy, compression of the spine, nerve root is chronically irritated. I treat many backs. There's only so many ways a back can go.

Q. But no tests were ever done so you can tell the jury this is what wrong with his knee, this is what is wrong with his back?

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. The diagnosis in the chart lumbar radiculopathy, knee arthropathy and what's wrong with the knee and the back.

Q. There's no objective testing done?

MR. PFLUGER: Objection.

A. Except testing done by Dr. Cohen and Dr. McGee.

Q. I'm not talking about the chiropractor. The orthopedist Dr. Cohen. He had a test from 2007 which show a --

A. Damaged knee.

Q. -- a contusion to the knee and then an arthroscopic procedure.

A. Damage to the knee joint surface.

Q. Now, seven years later, we have exquisite knee and exquisite low back pain but you don't know, you can't tell the jury exactly what's wrong with him --

MR. PFLUGER: Objection.

Q. -- because no objective tests such as an MRI or an x-ray were done --

MR. PFLUGER: Objection.

THE COURT: Overruled.

Q. -- so we're left upon -- rely upon what you had to say?

MR. PFLUGER: Objection, Judge.

THE COURT: Overruled.

A. The physical exams are objective tests. It's very clear to me the lumbar spine in the lower area has been traumatized with lumbar root damage given the chronic radiculopathy, the severe and trackable spasms, these are objective tests that indicate what's going on inside the lumbar spine. There's is a compression, twist and compression in the spine during the injury which is a common cause of -- common mechanism of injury for lumbar spine and he has consistent and typical response to the patient with that type of injury and this type of chronic radiculopathy. It's how his back was injured, it's how his back was treated. If I had the luxury of more studies, it would be nice but I didn't.

Q. It would be nice. So could you tell the jury. We got

a herniated disc. We got arthritis, an x-ray would show arthritis; is that correct?

A. The main symptom in this patient is the chronic and trackable radiculopathy, improved partially with the steroid shots and therapy and meds but it continues and it's easy to re-inflame.

Q. But --

A. It's the main symptom in what I'm treating him for.

Q. A simple x-ray would show degenerative changes; a simple x-ray would show arthritis; is that correct?

A. Simple x-rays are not very informative of the lumbar spine.

Q. An x-ray would show arthritis?

A. Certain types of -- in these types of patients, they're not good diagnostic tools in these patients.

Q. Would an MRI be a good diagnostic tool?

A. Different tests show different types of study different types of problems all the way up to discogram and other tests. This patient was being treated with the medications and the epidural surgery was not indicated by myself and not desired by the patient and there wasn't any feasible way to do it. An MRI would have given me the diagnostic changes in the course of the treatment so it wasn't pressed or I didn't force it when I didn't have a way to achieve it.

Q. There's a lot of tests that could have been done, is

it fair to say, discogram and other things?

A. Nothing for this patient and this treatment. There's -- this is the way they're treated: meds, physical therapy and injections. Until they're going to go to surgery which is not recommended by myself in most cases unless severe loss of function occurs, we weren't -- this patient is not progressing to surgery I hope. If he does, those will become necessary. We'll have to find a need to get them done. Hopefully, after this proceeding, they'll be done.

Q. So none of the tests, other tests that were available were done either?

MR. PFLUGER: Objection.

Q. None of the other objective tests that you testified to earlier are available were done either?

MR. PFLUGER: Objection, Judge.

THE COURT: Sustained. You don't have to answer.

Q. So the only thing you can tell the jury is what Mr. Flores says and what you say but we have nothing to say what the diagnosis is?

MR. PFLUGER: Objection.

THE COURT: Overruled.

A. Except for a physical exam which tells me what's wrong with the patient.

Q. Your physical exam.

A. And the doctor functions before, you know, other

tests. This patient's radiculopathy in my office is a very common problem. I take care of a lot of car accidents and falls from heights. It's routine in my office, not routine in most doctor's office but routine in my office.

Q. Is it routine to send him out for tests too?

A. If I have a diagnostic -- if I have a decision to make, I give the diagnostic test to get. When I don't have the finances or the authorization and there's no decision being made I am not forced to do a test that isn't authorized. I don't have to force to give.

Q. You're getting paid to testify today?

A. All doctors get paid to testify. Yes, I am.

Q. How much are you getting paid?

A. I believe 350 an hour to prep and testify today.

Q. Okay. About how much have you prepped for? How many hours?

A. Ten hours.

Q. $3,500?

A. Yes.

Q. Okay. That's not counting --

A. Unless I come back tomorrow.

Q. That's not counting today?

A. I guess counting today, yes, prepped yesterday and today, I get more I guess 12.

Q. Thank you.

A. And rescheduled, yes.

Q. April 13th -- I'm sorry -- July 13, 2011, missed appointment?

A. And rescheduled it, yes.

THE COURT: Thank you, Doctor.

MR. MORELLO: Thank you, Doctor.

THE COURT: As I indicated to you before yesterday, we're not going to have court tomorrow but we'll have court Monday at 11:00 a.m. Thank you very much.

MR. MORELLO: May we approach?

(Discussion off the record.)

THE COURT: Thank you. You are excused.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

* * * * *

(This matter was adjourned to March 24, 2014 at 11:00 a.m.)