

**TRIAL TRANSCRIPT OF DR. EDWIN FRANK RICHTER, M.D.; 1997 Trial
Trans. LEXIS 1467**

Supreme Court of New York, New York County

Case No. 103042-1995

June 1, 1997

Reporter

1997 Trial Trans. LEXIS 1467 *

Fusun S. Ateser, et al. v. Robert F. Becker, et al.

Expert Name: Dr. FRANK RICHTER, III, M.D.

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Proceedings

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[1]

[2]the hearing of the jury.)

[3](Whereupon, Mr. Ronemus leaves the

[4]courtroom.))

[5](Whereupon, Mr. Ronemus returns to

[6]the courtroom.)

[7]E D W I N F. R I C H T E R, III, 11 Trotter

[8]Drive, North Salem, New York, having

[9]been first duly sworn, was examined and

[10]testified as follows:

[11]THE COURT: You may inquire.

[12]DIRECT EXAMINATION

[13]BY MR. RONEMUS:

[14]Q. Good afternoon, Dr. Richter?

[15]A. Good afternoon.

[16]Q. Would you please give the jury your
[17]background and starting with your education and
[18]training?

[19]A. Yes, I pursued undergraduate education
[20]at Harvard College receiving a bachelors degree
[21]cum laude in biology graduating in 1983.
[22]I then attended New York
[23]University Medical School graduating in 1987.
[24]At the conclusion of medical
[25]school I [*2] began a four year training program, a
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[2]residency in rehabilitation medical. This
[3]consisted of a one year internship. This is a
[4]rotating training program spending six months on
[5]internal medical, two months on orthopedics, two
[6]months on neurology and one month on
[7]neurosurgery.

[8]Subsequent to completing the
[9]internship which was under the supervision of the
[10]department of rehabilitation medical at N.Y.U.,
[11]started my residency training. This was training
[12]in the specialty of physical, medical and
[13]rehabilitation done at the Rusk Institute, which
[14]is a part of New York University Medical Center.

[15]Q. Okay. When did you complete your
[16]residency?

[17]A. In 1991.

[18]Q. And are you board certified?

[19]A. Yes, I am.

[20]Q. What does that mean?

[21]A. Being board certified means I have

[22]passed a special series of examinations in my

[23]field that designates me as a fellow of the board

[24]and the academic organization that governs the

[25]specialty.

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[2]At the completion of my residency

[3]in the spring of that year of 1991, I took a

[4]written examination. Since I [*3] passed the written

[5]examination and completed a year of practice

[6]was then eligible to take the oral examination

[7]the following year, in the spring of 1992, which

[8]I also passed, making me a diplomate of the board

[9]and board certified.

[10]Q. You said you are a physiatrist?

[11]A. Yes, that is correct.

[12]Q. What is that?

[13]A. Physiatrist, perhaps more popularly is

[14]known as a rehab doctor, a doctor specializing in

[15]physical, medical and rehabilitation. Meaning we

[16]deal with patients with disabilities. This

[17]involves assessing the problems and then treating

[18]them for patients with disabling conditions.

[19]This would include patients with neurologic or

[20]orthopedic injuries as the main focus of the

[21]field.

[22]Q. As part of your training and career

[23]have you ever treated a patient with reflex

[24]sympathy dystrophy?

[25]A. Yes, I have.

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[2]Q. Approximately, how many such patients

[3]have you treated?

[4]A. Approximately one hundred such

[5]patients.

[6]Q. Of those one hundred patients, have you

[7]diagnosed them with RSD, or have they been

[8]diagnosed before coming to [*4] you?

[9]A. In about half of the cases I was the

[10]first physician to make the diagnosis of RSD. In

[11]the other approximate half the diagnosis had been

[12]made by somebody else and I was being asked to

[13]provide treatment.

[14]Q. Can you please tell us what reflex

[15]sympathy dystrophy is?

[16]A. Yes, reflex sympathy dystrophy is a

[17]painful syndrome and it has two main features.

[18]One is it is a chronic pain not a short lived

[19]pain you would expect after an injury. This is a

[20]pain that lives on for an inappropriate length of

[21]time after an injury. If indeed there is an

[22]injury you can point to at the beginning of the

[23]case.

[24]The other main factor, aside from

[25]it being a chronic pain, long term pain, more

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[2]than three to six months lasting, the fact there

[3]is abnormality of the sympathetic nervous system
[4]that is where it comes from in RSD. The
[5]sympathetic nervous system has a very important
[6]role in governing temperature control and blood
[7]flow.

[8]So the things we might see in
[9]terms of disturbance of sympathetic function
101 would be changes in temperature, changes in blood
[11]flow [*5] and we might see a redirection of blood flow
[12]from the surface, from the outer part of the limb
[13]down to the deeper circulation. We might see a
[14]temperature change and or an associated color
[15]change. We also may see changes in things like
[16]sweating, which is governed by this system or
[17]skin or hair growth.

[18]Q. How is a diagnosis of reflex sympathy
[19]dystrophy made in a patient?

[20]A. There are several factors taken into
[21]account --

[22]MR. MEHRTENS: I have an
[23]objection, this is cumulative to Dr.
[24]Hanline's testimony.

[25]THE COURT: I will permit some of
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[2]it, briefly.

[3]THE WITNESS: The main focus is
[4]clinical assessment; taking a careful
[5]history, doing a physical examination,
[6]looking for the signs of sympathetic
[7]change. Reviewing the diagnostic

[8]workup to make sure no competing
[9]diagnosis is not in fact the reason for
[10]the problems and then cross referencing
[11]with whatever tests are available.
[12]There are some tests we can use,
[13]such as bone scan, which in a little
[14]over half the cases may give you the
[15]diagnosis.
[16]We also sometimes use a test
[17]called [*6] thermography, which is a test
[18]very sensitive for very small subtle
[19]differences in temperature. The tests
[20]can pick up the differences less than
[21]one tenth of a degrees centigrade, if
[22]you are looking for a very subtle
[23]temperature change, which can be a sign
[24]of RSD.

[25]There are other tests such as
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[2]using starch or other methods to test
[3]for the amount of sweating, which are
[4]tests not so commonly used anymore. We
[5]can test the electroconductivity of the
[6]skin which may change in somebody who
[7]has an ongoing RSD.

[8](Continued on next page.)

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[2]Q Do you know Doctor Brian Hainline?

[3]A I know him by reputation. And I have

[4]spoken to him. And I certainly know of his

[5]reputation as a neurologist specializing in pain

[6]problems.

[7]Q Have you had occasion to treat Fusun

[8]Ateser?

[9]A Yes, I have.

[10]Q And can you tell us how or when you first

[11]met her?

[12]A Yes. I first met her on September 12,

[13]1995.

[14]She had been initially referred to a

[15]colleague in my department [*7] or a colleague in my

[16]department had been asked if she could see the
[17]patient.

[18]But, since this colleague was

[19]unavailable to take on new patients she had

[20]recommended me as an alternative.

[21]Q Have you treated her since September 12,

[22]1995 and to the present?

[23]A Yes, I have continued to treat her.

[24]Q Have you overseen her treatment by nurses

[25]and therapists at the VNS?

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[2]A Yes, I have.

[3]Q Have you worked in conjunction with those

[4]personnel?

[5]A Yes, I have worked particularly closely

[6]with the personnel in her case. More so than I

[7]commonly do because of the complexity of the many

[8]issues going on.

[9]Q And who in particular from VNS have you

[10]worked with?

[11]A Primarily, Martin Spollen, the physical

[12]therapist.

[13]I have spoken to Glen Gillen

[14](Phonetics), an occupational therapist who has

[15]treated her.

[16]But, Martin Spollen and I have been on

[17]frequent contact by phone and on some occasions in

[18]person when he would accompany the patient for and

[19]examination.

[20]Q He has actually come to your office with

[21]her?

[22]A Yes, [*8] he has on, I believe, 2 or 3

[23]occasions.

[24]On other occasions when I have seen

[25]her, which is usually on a monthly basis, we touch

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[2]base by phone or either after.

[3]Q Do you know who Bonnie Lauder is?

[4]A Yes. She is one of the nurses who is

[5]taking care of her through the visiting nurse

[6]service.

[7]Q Have you had any discussions with Bonnie

[8]Lauder about this case or not?

[9]A Yes, I have. We have also reviewed what

[10]has been going on with the patient.

[11]Q When you first met Ms. Ateser where was

[12]that?

[13]A That was in my office at The Rusk

[14]Institute at NYU Medical Center.

[15]Q What was her condition at that time?

[16]A At that time, she came into the office

[17]using a wheel chair. And she was essentially

[18]wheel chair bound for her mobility.

[19]She had a number of problems ongoing.

[20]She had problems involving the right and left

[21]shoulder and the left leg.

[22]The problem with the left leg, which

[23]was our primary focus, is the area where the

[24]reflex sympathetic dystrophy was diagnosed.

[25]She carried that diagnosis. And
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[2]agreed with [*9] it based upon my clinical assessment.

[3]She had an area of extreme hyper

[4]sensitivity about the outside of the left ankle,

[5]this was exquisitely sensitive to even a light

[6]touch and it was very painful to her.

[7]She had other areas of temperature

[8]change and color change, primarily, coolness

[9]within the left leg.

[10]Q Is that something you could tell or is

[11]that what she told you?

[12]A That is something that I could appreciate.

[13]In examining her, part of the exam was

[14]to lay my hand on the parts where she was

[15]complaining of having a problem and comparing it

[16]to the opposite side.

[17]We have the advantage of knowing that

[18]the normal human condition is to have essentially

[19]symmetrical temperature within less than one

[20]degree centigrade. That has been very well

[21]documented in medical literature.

[22]We also know that the human touch of

[23]another person can discern differences which are

[24]greater than two degrees centigrade, which would

[25]be a pathological difference, meaning a different

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[2]that is significant.

[3]We consider differences less than one
[4]degree centigrade [*10] to be perhaps a normal
[5]variation.

[6]But given that I could appreciate it
[7]by touching, I was convinced that she had a
[8]substantial difference in temperature.

[9]Q Have you ever conducted thermography tests
[10]on her?

[11]A Know, I did not.

[12]I can readily access our thermography
[13]unit at NYU. And I have done so in cases where I
[14]am not certain if there is a temperature
[15]difference, since that is helpful in diagnosing
[16]RSD.

[17]Given that I could appreciate it by
[18]touch, I felt no need to use the equipment.

[19]Q Have you noticed changes in appearance of
[20]the two lower legs?

[21]A Yes, I have noticed significant color
[22]changes which will come and go.

[23]That is consistent with a neurologic
[24]problem, the sympathetic abnormality where you can
[25]see fluctuations not consistent with a skin
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[2]problem like a skin Cancer which always stays the
[3]same. In a variable change of color in the range
[4]of purple to red, which is what we typically see
[5]when someone has the skin changes going on with
[6]RSD.

[7]Q I am just going to show you a picture.

[8]MR. RONEMUS: Excuse [*11] me for a

[9]second.

[10](Short pause)

[11]THE COURT: Would any of the jurors

[12]care for any water?

[13]JUROR: Yes, please.

[14]THE COURT: Did you locate the

[15]photograph?

[16]MR. RONEMUS: Not yet.

[17]THE COURT: Is this the one this

[18]evidence?

[19]MR. RONEMUS: Yes. It was out

[20]earlier today.

[21](Short pause)

[22]MR. RONEMUS: I have got it. I am

[23]sorry.

[24]Q Doctor I am going to show you a photograph

[25]which has been previously marked exhibit 19A in
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[2]evidence.

[3]I ask to you take a look at that,

[4]sir.

[5]And does that photograph fairly and

[6]accurately represent the differences in color that

[7]you have noticed in Ms. Ateser's lower limbs?

[8]A Yes. It certainly represents the

[9]difference in color that I have seen. The shade

[10]of the color change is the same.

[11]At times, I have seen the extent go
[12]further up the leg. This is mainly involving the
[13]foot. I have seen it involve the lower half of
[14]the lower leg. The lower half of the shin, as
[15]well.

[16]Q Now, after you, when you met her did you
[17]take a history of what her condition was?

[18] [*12] A Yes, I did.

[19]Q What did you learn in that regard?

[20]A We reviewed the history of the injury.

[21]She related that she had been in an
[22]accident on September 13th of the previous year,
[23]1994. At that time, riding a bicycle which was
[24]struck by a motor vehicle.

[25]She stated that she had complained
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[2]subsequent to that of left lower extremity pain,
[3]primarily in the knee and ankle. And she
[4]described being seen by Doctor Hecht for
[5]orthopedic evaluation because of persistent pain
[6]for which she had arthroscopy of the left knee, at
[7]which time she had the partial medial
[8]meniscectomy, removal of some of the cartilage on
[9]the inner side of the knee. And also having an
[10]injection for Achilles tendonitis of the left
[11]ankle.

[12]She noticed that since having those
[13]things done she was continuing to have pain.
[14]And the pain was persisting up until

[15]the time I saw her, despite what other
[16]interventions she had been receiving.
[17]She had seen a number of physicians
[18]prior to my examination.
[19]She had an in patient stay at The
[20]Hospital for Joint Diseases.
[21]However, [*13] she had some physical therapy
[22]and some anesthetic blocks.
[23]Her course there had, unfortunately,
[24]been complicated by an injury to her right 5th
[25]toe, which had been something of a set back.
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[2]She also had noted that she had been
[3]developing low back burning pain, which was
[4]exacerbated by sitting or prolonged standing. So,
[5]that she only had about an hour of fairly
[6]comfortable sitting tolerance before the pain
[7]would start to get overwhelming.
[8]And she had concerns about the extent
[9]of the involvement of her left leg at that time
[10]with reflex sympathetic dystrophy.
[11]She had also been complaining of
[12]problems with her right shoulder, that she had
[13]been getting pain in the shoulder.
[14]And she was getting pain running down
[15]the arm to the 4th and 5th digits to the ring and
[16]little finger of the right hand, which could be
[17]accompanied by some numbness and tingling. And
[18]this was sometimes aggravating by turning her

[19]head.

[20]She also told me that she had some

[21]problems with concentration and word finding for a

[22]period of time after the accident. Although, she

[23]said [*14] that those things had been improving. And

[24]she felt those were better.

[25]But, she was continuing to complain of

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[2]the color and temperature changes in the left leg,

[3]as well as pain there and extensive pain in the

[4]right shoulder. And to a lesser extent, she was

[5]having some pain problems with the left shoulder.

[6]Q Did you have a diagnosis as to what the

[7]condition of the right shoulder was?

[8]A Yes. Actually, I had multiple diagnosis

[9]pertaining to the right shoulder.

[10]I was very concerned that the pain

[11]radiating down the arm with the numbness and

[12]tingling going into the 4th and 5th digits was a

[13]neurologic problem.

[14]Q When you say, 4th and 5th?

[15]A That is the little finger and the ring

[16]finger.

[17]And with pain radiating down in that

[18]manner that is characteristic of a neurological

[19]problem.

[20]This was consistent with her having a

[21]thoracic outlet problem.

[22]That means, essentially, the nerve

[23]that is moving from the area of the neck to the
[24]area of the shoulder can be squeezed or pressed
[25]upon at times with motion.
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[1]

[2]This could [*15] also have been secondary to
[3]pinched nerves in the neck.

[4]But, given that the diagnostic tests
[5]for the nerves of her neck were eventually
[6]negative, we were able to rule that possibility
[7]out. And therefore localize the problem more to
[8]what we call the thoracic outlet, the area around
[9]the neck and shoulder.

[10]There was also concern about the pain
[11]in the shoulder itself, which is more of a
[12]mechanical problem aggravated by movement.
[13]She had limitations on how far she
[14]could move the shoulder and was getting pain.
[15]This subsequently actually got worse
[16]where she wound up having more pain for a period
[17]of time, very severe restrictions and in how much
[18]she could move the shoulder.

[19]We had done a number of tests.

[20]We did actually multiple MRI. All of
[21]the time trying to get at what was going on here.

[22]We did see in terms of the bony
[23]situation that she did have a small developing
[24]bone spur.

[25]A bone spur coming off the inside of
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[1]

[2]the shoulder pointing downward can give you some
[3]pressure on one of the tendons of the rotator
[4]cuff, a tendon which [*16] is connecting a muscle in the
[5]back of the shoulder that rubs across and over to
[6]the top of the upper arm to help initiate moving
[7]the shoulder away from the body.

[8]So, there is a concern about a dynamic
[9]impingement. Meaning, that if she moves, although
[10]that spur may not be very large, it can cause
[11]pressure.

[12]Because the signs of her exam are
[13]consistent with having a rotator cuff problem,
[14]there was also concern about her biceps tendon,
[15]the tendon connecting the big muscle of the arm up
[16]to the shoulder.

[17]And on one of the MRI we were able to
[18]pick up, going over it very carefully with the
[19]radiologist, that there was an area where the
[20]biceps tendon showed a splitting.

[21]This may have been related directly to
[20]the original trauma from the motor vehicle
[23]accident. This may have been related, as some of
[24]the other shoulder problems are, to the fact that
[25]she has been using her arms for mobility, because
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[1]
[2]she has not been able to tolerate walking on the
[3]left leg because of pain. She has been using
[4]primarily a wheel chair.
[5]When we try to teach her to walk we

[6] **[*17]** have been using devices like walkers or crutches.

[7] So, for any of those things to get

[8] around it is putting a load on the shoulder for

[9] which it is not designed.

[10] Our shoulders are designed to be very

[11] flexible and mobile. They are not designed to

[12] bear weight the way that, say, our hip joint is

[13] designed.

[14] And in over use from use of the wheel

[15] chair and other assisted devices is a likely

[16] exacerbating factor for all of the problems to the

[17] right shoulder.

[18] She also has a number of what we call

[19] trigger points, very painful areas in the muscle

[20] around the shoulder girdle.

[21] These are areas whereby palpations by

[22] pressing simply, we do so with a thumb in

[23] examining the patient, it can be exquisitely

[24] tender. And the pain can be right there at point

[25] of contact or it can radiate to other parts of the

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[2] shoulder girdle.

[3] She has had a number of injections for

[4] treatment of that, which can give her portions of

[5] relief for a period of time after the injection.

[6] She also, on the right arm, developed

[7] an area of hard swelling within the substance of

[8] the arm. **[*18]**

[9] We have been unable to determine

[10]exactly what that is from. This may have been
[11]from an bursitis or from a muscle tear with some
[12]bleeding or fluid may have tracked downward.
[13]But, we have been unable to pin down
[14]exactly what caused that.
[15]She also developed an olecranon
[16]bursitis, a right elbow bursitis, a swelling about
[17]the right elbow.
[18]Fortunately, that problem has cleared
[19]up.
[20]Q Okay. Doctor, do you have an opinion with
[21]a reasonable degree of medical certainty, whether
[22]the conditions of the right shoulder and right arm
[23]that you have just described were related to the
[24]automobile accident on September 13, 1994?
[25]A Yes. It is my opinion that they are
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[1]
[2]causedly related to that accident.
[3]As T mentioned before, elements may be
[4]from the direct trauma.
[5]Other elements may be from the change
[6]in her mobility caused by the affects on her leg.
[7]And thus causing affects on the right shoulder.
[8]Q And do you have an opinion with a
[9]reasonable degree of medical certainty, whether
[10]the condition of the left leg which you have
[11]described to [*19] us already was caused by the
[12]automobile accident on September 13, 1994?
[13]A Yes. It is my opinion with a reasonable

[14]degree of medical certainty, that this was caused
[15]by the accident.

[16]This was a patient who was fully
[17]mobile, who was able to ride a bicycle, able to
[18]perform her normal activities of daily living,
[19]able to climb stairs and to function like a normal
[20]adult.

[21]She had clear loss of these functions
[22]with signs and symptoms consistent with the
[23]injury.

[24]Q Were you informed about an accident that
[25]she had been involved in in 1982?
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[2]A Yes.

[3]Q What did you know about that?

[4]A That she had had some pain relating to
[5]that accident, primarily around the area of the
[6]tail bone. In medical terms, the coccyx, the
[7]lowest area of the spine.

[8]And that she had had the coccyx
[9]removed, surgically.

[10]She did have a period of pain and
[11]difficulty relating to that accident.

[12]However, she had become fully
[13]functional. She was able to work, able to
[14]participate in recreation or sports and to walk
[15]and to do other normal activities without
[16] [*20] impairment.

[17]Q Did you learn whether she had sustained a

[18]herniated disk in that accident?

[19]A There was some question as to whether she

[20]might have. But, not definitively.

[21]Q Okay. Do you have an opinion with a

[22]reasonable degree of medical certainty whether any

[23]of the problems and conditions that you have

[24]treated her for were the result of the accident in

[25]1982?

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[2]MS. VILLARREAL: Objection.

[3]THE COURT: Overruled.

[4]A No. None of the things for which we were

[5]treating her were consistent with the 1982

[6]accident.

[7]Q Why, why is that?

[8]A The fact that she had had her coccyx

[9]removed is of no great functional importance.

[10]She had no signs and symptoms relating

[11]to that area.

[12]She has significant problems relating

[13]to the area around the left sacroiliac joint,

[14]around the left knee, for which we have clear

[15]evidence of injury, and around the left ankle

[16]where we have the signs and symptoms of reflex

[17]sympathetic dystrophy.

[18]We also have been treating her for

[19]problems relating to the right shoulder, as we

[20]discussed. And also problems [***21**] relating to the left

[21]shoulder, where she has developed some problems

[22]with the bursitis in the front of the shoulder.

[23]But, none of those are consistent with

[24]the history of that accident and her subsequent

[25]ability to perform her normal activities without
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[2]limitation.

[3]Q What problems have you noticed in the left

[4]shoulder?

[5]A At the left shoulder she has had an area

[6]of bogginess, which is an area where there is a

[7]fullness with a soft feeling and some swelling.

[8]This is in the front of the shoulder. This

[9]fluctuates over time. And sometimes it is more

[10]evident than others.

[11]And it can be tender, painful to

[12]pressure. More so at some times than others.

[13]Q Do you have an opinion with a reasonable

[14]degree of medical certainty whether that condition

[15]was related or caused by the accident of

[16]September 13, 1994?

[17]A Yes. That is entirely consistent with an

[18]over use related to her use of the wheel chair and

[19]assisted ambulatory devices for mobility.

[20]So, by using the left shoulder in that

[21]manner that it is not designed for, this is

[22]brought on by the accident. **[*22]**

[23]Q Now, can you please describe for us the

[24]care and treatment that you have rendered since

[25]the time that you first met her?

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[2]A Yes. On my initial evaluation it was my
[3]conclusion that she had multiple problems
[4]involving multiple limbs. And that we should
[5]start with a course of in patient treatment to get
[6]a better handle on her troubles, to get things
[7]going in the right direction.

[8]So, we had her admitted at The Rusk
[9]Institute NYU Medical Center for a period of about
[10]two months.

[11]Subsequent to that, she was discharged
[12]at home. And we made the referral to the visiting
[13]nurse service for her to receive the therapy.

[14]She continued to see a number of
[15]physicians, including myself, afterwards for
[16]outpatient follow up during this time.

[17]Q And what was the course of her progress,
[18]if any, while she was in Rusk?

[19]A She made some progress.

[20]We were able to get her in a pool, a
[21]therapeutic pool, where she was able to move
[22]around more easily.

[23]This makes sense, since there are
[24]therapeutic effects from the warm water, as well
[25]as the mechanical [*23] effect. When you are in water
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[2]it supports about a third of your body weight.

[3]So, she was able to move more easily.

[4]There was less strain on her left leg and her

[5]shoulder.

[6]We were able to work on giving her

[7]exercise regiments.

[8]The goal was to prevent atrophy, to

[9]prevent developing weakness of the effected

[10]limbs.

[11]And this has been done with at least

[12]some success.

[13]She has been able to carry this

[14]forward to avoid contracture, which is a loss of

[15]ability to range a joint to move it through its

[16]normal range of motion and to prevent atrophy, to

[17]prevent shriveling up of the muscle.

[18]In terms of pain control, she

[19]continued to have significant super sensitivity

[20]around the left ankle. And to have pain in the

[21]low back area and pain around the knee.

[22]The pain in the lower back area being

[23]exacerbated, aggravated by sitting.

[24]The right shoulder for awhile was

[25]behaving reasonably well. But, then had an

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[2]exacerbation over the course of last summer where

[3]it got worse.

[4]Q Do you know what led to that?

[5]A Well, we don't [*24] know for sure what would

[6]exactly cause an exacerbation.

[7]It may have been aggravated during a

[8]transfer or during mobility of some sort.

[9]She certainly recalled a very dramatic
[10]worsening with some of her transfers.
[11]And we have found that we are able to
[12]now get her moving a little bit better by working
[13]on the control of the scapula. That she had been
[14]substituting some movement of the scapula, which
[15]is the shoulder blade, to try and compensate for
[16]some of the deficits within the shoulder.
[17]And by working on, essentially, her
[18]mechanics of how she moves the shoulder to improve
[19]the efficiency, she has made modest gains in the
[20]last few months.

[21]Q How about the progress of her left lower
[22]leg? How has that gone since her release from
[23]Rusk?

[24]A Well, we have tried a number of measures
[25]at achieving pain control. We have found that
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[2]when she is using the tens unit, which is an
[3]electrical stimulating device, that she has less
[4]pain than when she does not use it.

[5]So, that has been a successful
[6]modality in reducing her pain.

[7]Q How does a tens [*25] unit work?

[8]A A tens unit delivers a very small
[9]electrical stimulus.
[10]We use a concept called, gait theory,
[11]to explain why this small non painful stimulus
[12]blocks the feel of pain.

[13]Pain is brought in by some nerve
[14]fibers which are specialized for bringing in pain,
[15]specifically. And these fibers carry a message up
[16]from the effected body part into the spinal cord
[17]and essentially up into the brain.
[18]The tens unit, activates different
[19]nerve fibers. They are a different size. They
[20]have insulation whereas the pain fibers don't have
[21]insulation. And they are distinct types of
[22]fibers.

[23]Those nerve fibers, which are like
[24]wires bring a different electrical signal into the
[25]spinal cord and they will compete with the pain
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[2]signal as it is trying to go up to the attention
[3]of the part of the brain that is conscious of
[4]pain.

[5]So, it can block the perception of the
[6]pain.

[7]Q Okay. And that you say has shown some
[8]effect in Ms. Ateser?

[9]A Yes, it has.

[10]Q All right. How has the progress of her
[11]shoulder gone since she was released from Rusk? **[*26]**

[12]A Since release from Rusk she had a period
[13]of exacerbation where the pain was worse.

[14]Of late it has improved from that
[15]period of exacerbation.

[16]But, it is not at the best that it has

[17]been for her.

[18]So, it is unclear as to whether it

[19]will get back to that base line, the base line at

[20]which I had seen her at her best.

[21]Q So, it is not as good as you have seen it

[22]since you started treating her?

[23]A Yes. I have seen it in better shape

[24]during the time that I have been treating her.

[25]But, it is better now than it had been

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[2]during the fall and winter of '96.

[3]Q Okay. Can you tell us what tests, if any,

[4]you have ordered for Ms. Ateser?

[5]A I have obtained electric diagnostic

[6]testing.

[7]We looked at the EMG of the right leg,

[8]electrical testing of the right leg, so to make

[9]sure that there were no problems developing

[10]there.

[11]That, fortunately, was normal.

[12]We also looked at the testing of the

[13]right side of the neck and the arm, doing

[14]electrical testing, looking for a pinched nerve in

[15]the neck to see if that could explain [*27] the problem

[16]she was having.

[17]We found no such evidence. There is

[18]no reason to believe that she as a pinched nerve

[19]in the neck mimicking the other things that we

[20]have diagnosed her with.

[21]We have also looked at MRIs.

[22]And looking at MRIs of the right

[23]shoulder led us to the information about the

[24]tendons of the right shoulder having a problem.

[25]Her having the small bone spur within the right
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[2]shoulder.

[3]She has had other, an MRI of the area

[4]of the scapula, the shoulder blade. And no

[5]abnormality was seen in that region of the

[6]shoulder.

[7]Q Is that consistent with the complaints

[8]that she has had?

[9]A Yes, it is.

[10]The complaints that she has in that

[11]area where she has those trigger points, those

[12]very painful tender muscles, don't have any

[13]findings that you see on MRIs.

[14]So, we wouldn't expect to see them.

[15]Q Have you conducted any bone scans? Did

[16]you mention bone scans?

[17]A I believe, I mentioned bone scan.

[18]I have reviewed reports. I did not

[19]order them, myself.

[20]I don't routinely order them in cases

[21]of RSD. [*28]

[22]Q Why is that?

[23]A Because, it can miss a number of patients

[24]who do have RSD. And it can give you abnormal

[25]findings in a lot of patients who don't have RSD.

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[2]Arthritis is one thing that will show

[3]up in a bone scan.

[4]In her case, the bone scan is

[5]abnormal. It lights up, we would say, around the

[6]left knee, which is very consistent with her

[7]history of a left knee injury.

[8]And with the MRI evidence that we have

[9]of ligamentous and cartilage problems in the left

[10]knee.

[11]So, it doesn't tell us necessarily

[12]very much about RSD, if that is our interest.

[13]Q So, the bone scan has not changed--

[14]MR. MEHRTENS: Objection to the form

[15]of the question.

[16]Q Have the results of any bone scans changed

[17]your opinion about whether or not she has RSD?

[18]A No, it had no effect on my opinion.

[19]Q Were there any other tests that you have

[20]ordered or reviewed that you can recall?

[21]A Not that I can recall.

[22]Q And after reviewing the tests that you

[23]have conducted or reviewed on Ms. Ateser has your

[24]diagnosis that you have told us about changed **[*29]** in

[25]any way?

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[2]A No, it has not.

[3]Q Are there any tests at this time that you

[4]plan to do to assist in a further diagnosis?

[5]A Not at this time, no.

[6]Q What would you consider her condition to

[7]be at this time?

[8]A At this time, she has disfunction of 3

[9]limbs, of the left leg, with the RSD, with the

[10]residual affects of the knee injury and with a

[11]painful sacroiliac joint.

[12]She has disfunction of the right

[13]shoulder with a dynamic impingement syndrome, with

[14]tendon problems and with muscle problems there.

[15]She also has problems with the left

[16]shoulder with the bursitis there.

[17]She therefore has very significant

[18]limitations in terms of function.

[19]She is wheel chair bound for practical

[20]purposes, unless someone carries her.

[21]And for her to propel the wheel chair

[22]is problematic in that she has to make use of her

[23]shoulder to get around. She can do some with the

[24]uninvolved right leg to move a wheel chair. But

[25]you can't do very much with just one leg to propel

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[2]a chair.

[3]When it comes to transferring, from

[4]going from **[*30]** the chair to the bed, or into the

[5]bathroom or out to a toilet, she has to make use

[6]of the arms to make up for the fact that she

[7]doesn't tolerate weight bearing on the left leg

[8]effectively.

[9]So, she has a real problem.

[10]Someone who has a problem with just

[11]the left leg, if their arms are functioning well,

[12]especially, if they can build up the strength and

[13]the muscle bulk, may get around quite well and

[14]have only partial functioning limitations.

[15]Given that she has the 3 limbs

[16]involved, she is dependent on others for any major

[17]mobility other than just getting around within her

[18]apartment or within her room.

[19]And she has a great amount of

[20]difficulty with activities of daily living.

[21]Things like bathing and getting dressed are a real

[22]challenge for her.

[23]More advanced or ambitious things like

[24]doing chores, going shopping are not realistically

[25]possible for her.

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[2]In terms of work, she is severely

[3]limited.

[4]Mobility problems preclude her from

[5]doing what you would consider manual labor or work

[6]that involves getting around.

[7]And her limitations [***31**] in sitting

[8]tolerance, the pain problems with moving the right

[9]shoulder, all make it very difficult for her to

[10]perform even routine tasks for more than a very

[11]short period of time.

[12]Q What would you consider her prognosis to

[13]be at this time?

[14]A She has a very poor prognosis for any

[15]significant improvement.

[16]I do think there is a fair prognosis

[17]for improvement of the right shoulder with the

[18]recent gains that have been seen. There is some

[19]trend there.

[20]But, in terms of the overall picture

[21]of the right shoulder, where she has had

[22]significant problems for a long time, in terms of

[23]the left lower extremity where she has had

[24]significant problems for well over two years now

[25]with not much of a favorable trend, the prognosis

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[2]is very poor for any meaningful change in what is

[3]going on with her.

[4]Q Doctor, do you know, approximately, what

[5]your bills have been for treatment of Ms. Ateser,

[6]to date?

[7]A I would say, that the bills for myself and

[8]for members of my team, physician team, would be

[9]in the order of about \$ 5,000 for this patient and

[10]out patient [*32] care.

[11]That would not include bills for other

[12]consultants from other departments.

[13]Q Would you consider those to be a

[14]reasonable amount for the service provided?

[15]A Yes.

[16]Q I want you to assume, that there has been
[17]testimony that the charges amounted a day for
[18]Bonnie Lauder to go to Ms. Ateser's apartment are
[19]\$ 100 per visit for a therapist and \$ 100 per visit
[20]for a home health aid.

[21]Would you consider those to be
[22]reasonable charges for those services?

[23]A Yes, those are reasonable and prevailing
[24]charges in New York City.

[25]Q I want to you assume, that the bill for
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[2]her admission to Rusk Institute was \$ 66,000.

[3]Would you consider that to be a
[4]reasonable charge for the two month stay when she
[5]was in the hospital?

[6]A Yes, it is.

[7]Rusk Institute is a relatively low
[8]cost provider with cheaper per deem rates than
[9]some of the other comparable facilities around
[10]town.

[11]So, it is well within the going rate
[12]for this treatment.

[13]Q Doctor, do know what somatization is?

[14]A Yes, I do.

[15]Q Can you tell us what that [*33] means?

[16]A Somatization is when a patient will
[17]essentially take some of their emotional problems
[18]and translate those into a physical problem.
[19]So, that they will have a complaint of

[20]a physical trouble which relates to an emotional

[21]rather than a physical basis.

[22]Q Have you ever had an opinion with a

[23]reasonable degree of medical certainty that Ms.

[24]Ateser's problems were the result of somatization?

[25]A My opinion was, that they were not the

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[2]result of somatization. That they were on a

[3]physiological basis.

[4]Q Why is that?

[5]A Because, we have correlating signs and

[6]appropriate patterns of symptoms for each of the

[7]problems of which she is complaining.

[8]That we do have evidence, whether it

[9]be through tests or through physical exam, that

[10]she has a problem.

[11]She has also been very consistent.

[12]That is the advantage of having seen a

[13]patient for a period of time, now, that she is

[14]very consistent. Which is consistent with having

[15]a physical basis, since if the person complaining

[16]on the basis of physical problems, the complaints

[17]will remain in [*34] the same pattern. They won't be

[18]contradictory.

[19]So, both on the direct and indirect

[20]basis, there is no sign for somatization

[21]disorder.

[22]Q Do you know what a conversion reaction is?

[23]A Yes.

[24]Q What is a conversion reaction?

[25]A A conversion reaction is when a typically
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[2]psychiatric disfunction or a psychiatric problem

[3]causes a person to develop the symptoms of a

[4]particular disease.

[5]The person with the conversion

[6]reaction fully believes that they have this

[7]problem, whatever it may be, and will act

[8]accordingly.

[9]This is a psychiatric problem with

[10]physical manifestations, that if the person

[11]believes they can't move their hand, they

[12]won't.

[13]And because of the psychiatric

[14]barrier, because of the mental problem in one

[15]sense they can't move the hand. Because, their

[16]mental problem doesn't allow them to. Although

[17]physically, they would be perfectly capable of

[18]doing so.

[19]Q Have you ever had an opinion with a

[20]reasonable degree of medical certainty that Ms.

[21]Ateser was suffering from a conversion reaction?

[22]A My opinion has [*35] been that she is not.

[23]Patients with a conversion reaction

[24]are not consistent and they will follow their

[25]understanding of what a condition might be like,

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[2]not acting in accordance with what a doctor who

[3]knows the condition would say the condition should

[4]be like.

[5]Also, with a conversion reaction you

[6]should have no abnormal test results. The tests

[7]should be normal.

[8]Q How about the discoloration of the lower

[9]leg or the change in temperature. Are those

[10]consistent with a conversion reaction?

[11]A No, they are not.

[12]That is not something that is under

[13]mental control.

[14]Something like not moving, if someone

[15]simulates paralysis, that is involuntary control.

[16]Although, someone may forget or make a

[17]lapse at some point.

[18]But, things like color and temperature

[19]change, you don't have the ability to do through

[20]your own control.

[21]Q Do you know what malingering means?

[22]A Yes, I do.

[23]Q What is that?

[24]A Malingering is a deliberate attempt to

[25]simulate an injury or an illness.

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2:----It differs very significantly from the

[3] **[*36]** other concepts of somatization or a conversion

[4]reaction.

[5]Somatization or a conversion are very

[6]legitimate medical illnesses. Those are very real

[7]problems for which people need the help of the

[8]appropriate doctor and therapist.

[9]Malingering is a deliberate attempt to

[10]fake that a person has a problem when they in

[11]fact know that they don't have the problem.

[12]Q Have you ever had an opinion with a

[13]reasonable degree of medical certainty that Ms.

[14]Ateser was a malingerer?

[15]MR. MEHRTENS: Objection.

[16]THE COURT: Sustained.

[17]Q Do you have an opinion that Ms. Ateser is

[18]malingering the problems that you have described?

[19]MR. MEHRTENS: Objection, Judge. How

[20]many times do we have to --

[21]THE COURT: Step up, please.

[22](DISCUSSION AT THE BENCH).

[23]THE COURT: Overruled. You may

[24]answer the question.

[25]A It is my opinion, that she is not

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[2]malingering.

[3]Q Is that--

[4]MR. MEHRTENS: Objection.

[5]THE COURT: Sustained. Next

[6]question.

[7]Q Doctor, the condition that you have seen

[8]in her left leg where it develops redness **[*37]** such as

[9]shown in this photograph there, have you ever

[10]considered that to be an allergic reaction to a

[11]Cortisone injection that she received on January

[12]20th of 1995?

[13]A No, I have not.

[14]Q Why?

[15]A The time course for one is all wrong.

[16]An allergic reaction happens after

[17]someone is exposed to the allergen, the subject to

[18]which they are allergic.

[19]There may be a brief blank period of

[20]time when your body's immune system gears up. The

[21]illness fighting mechanism may mistake whatever--

[22](One juror now entering)

[23]THE COURT: All right, one moment.

[24]MR. RONEMUS: I am sorry.

[25]THE COURT: I am sorry.

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[2]What I am going to ask is for the

[3]court reporter -- we are going to

[4]interrupt your response at this point.

[5]I am going to ask the court reporter

[6]to read the question immediately before

[7]the attorneys approach the bench, the

[8]answer and the testimony to this point,

[9]please.

[10](Record read).

[11]THE COURT: All right, you may

[12]continue.

[13]A When a substance to which a person is

[14]allergic, there is the body, the immune [***38**] system

[15]which is an infection or disease fighting system,

[16]will become active after sometimes a very brief
[17]period of time to start a reaction to try and
[18]fight it off.

[19]This may cause some harm to the area.

[20]It may cause redness. It may cause some

[21]swelling. It may cause hives, itching. And it

[22]can generalize around the whole body to cause

[23]breathing trouble.

[24]But, that is something that happens

[25]within a fairly short period of time after the

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[2]exposure to this substance that the body perceives

[3]as foreign and tries to attack.

[4]This is not something that will keep

[5]coming and going over a long period of time as

[6]this color and temperature change has.

[7]It is not associated with coolness.

[8]If anything it is only seen with

[9]warmth.

[10]And you would expect to see a more

[11]characteristic redness with hives and an angry red

[12]color.

[13]You wouldn't see any of the mottled

[14]purple color that has also been seen in this

[15]patient.

[16](Continued on the next page)

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[2]MR. RONEUMUS: Thank you, Doctor.

[3]I have [*39] no further questions.

[4](Witness excused.)

[5]THE COURT: All right. We will

[6]take a short recess.

[7](Whereupon, the jury leaves the

[8]courtroom.)

[9](Whereupon, the trial takes a

[10]recess.)

[11](Whereupon, the trial resumes.)

[12]THE COURT: All right. Please be

[13]seated.

[14]All right, please bring the jury

[15]in.

[16](Whereupon, the jury enters the

[17]courtroom.)

[18]THE COURT: You may cross

[19]examine.

[20]MR. MEHRTENS: Thank you, your

[21]Honor.

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[23]CROSS EXAMINATION

[24]BY MR. MEHRTENS:

[25]Q. Good afternoon, Doctor?

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[2]A. Good afternoon.

[3]Q. What is your fee for testifying here

[4]today?

[5]A. \$ 1,500.

[6]Q. And what about your fee for testifying

[7]at the deposition on video a few weeks back?

[8]A. The same \$ 1,500.

[9]Q. Aside from testifying at the video and

[10]testifying here in court, what were your charges

[11]for preparing reports and consulting with the

[12]attorney for Ms. Ateser approximately, if you

[13]don't remember?

[14]A. Approximately \$ 500 for the two reports

[15]and no set fee for discussions previously.

[16] **[*40]** Q. Okay. So your medical treatment has

[17]been about \$ 5000. Your medical treatment and

[18]your offers treatment?

[19]A. Yes my group.

[20]Q. Your group has been \$ 5000 and your fee

[21]for testifying on her behalf at the deposition

[22]and here in court has been about \$ 3,500, is that

[23]correct?

[24]A. That is correct.

[25]Q. Now, you told the jury that her

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[2]prognosis is poor because she has had this

[3]condition for two years and doesn't seem to be
[4]getting any better.

[5]Does that sum it up?

[6]A. That is a major part of it, yes.

[7]Q. I will ask you to assume that Ms.

[8]Ateser was totally disabled for three years eight

[9]months after her 1982 accident, couldn't work,

[10]couldn't do her laundry, couldn't sit for more

[11]than ten minutes without having to move, was only

[12]comfortable in the lying down position, when she

[13]was on a bus she had to lay out across two seats,

[14]and that was three years, eight months after her

[15]car accident. Would you say she had a poor

[16]prognosis for recovering from those injuries?

[17]A. Yes, under those circumstances.

[18]Q. And let's assume she made a complete

[19] [*41] recovery after that poor prognosis that she had.

[20]Wouldn't it stand to reason that she very likely

[21]could make a complete recovery after the injury

[22]she sustained in 1994?

[23]A. No, one unlikely occurrence doesn't

[24]make a second unlikely occurrence became likely.

[25]Q. Let's talk about the 1994 case then.

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[2]We know that she has change in temperature in her

[3]legs because you felt it yourself?

[4]A. Yes.

[5]Q. We know she had change in color because

[6]we had a number of people come in and say they

[7]have seen her left leg redder or purpler than the
[8]other. Those are signs that are put in a
[9]category called reflex sympathy dystrophy,
[10]correct?

[11]A. That is correct.

[12]Q. You don't know what is causing that
[13]leg, that left leg to be colder at times from the
[14]right leg, correct?

[15]A. The diagnosis is reflex sympathetic
[16]dystrophy.

[17]Q. That is the name given to the grouping
[18]of symptoms?

[19]A. Yes.

[20]Q. You don't know why the leg is cooler at
[21]times, do you?

[22]A. How it makes it happen, no.

[23]Q. You don't know what causes the leg to
[24]became a different [*42] color, do you?

[25]A. Well, on a mechanical basis we know
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[2]this is a change of blood flow.

[3]Q. What is causing the blood flow?

[4]A. Ultimately, we don't know the
[5]mechanism.

[6]Q. Since you don't know what causes the
[7]blood flow and mechanism and you don't know what
[8]causes it to became colder, it could disappear
[9]tomorrow, couldn't it?

[10]A. There is no reason to believe it

[11]could.

[12]Q. You told us you don't believe there is
[13]a somatization component in this case or a
[14]conversion reaction in this case, is that
[15]correct?

[16]A. That is correct.

[17]Q. That is something you didn't consider
[18]initially in your diagnosis, correct?

[19]A. It is something I always consider when
[20]seeing a patient with chronic pain.

[21]Q. In order to consider it, don't you have
[22]to know the patient's psychological history in
[23]order to consider whether there is a
2d somatization --

[25]A. Psychological history is part of the
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[2]assessment.

[3]Q. Isn't it a true fact you didn't know
[4]anything about her psychological history, other
[5]than what she told you on [*43] your exam?

[6]A. That is correct.

[7]Q. You didn't examine any of her
[8]psychological records from when she started
[9]seeing a psychiatrist in October of 1994, did
[10]you?

[11]A. Not at that time.

[12]Q. You didn't examine any of her records
[13]from her prior accident when she couldn't sit for
[14]more than ten minutes at a time without being in
[15]pain, when she was out of work for three years

[16]and eight months and beyond that and was totally
[17]disabled, you didn't know anything about that,
[18]did you?

[19]A. We discussed the accident but I did not
[20]need to examine records at that point because she
[21]made a full recovery.

[22]Q. In order to determine whether there is
[23]somatization or conversion reaction you rely on
[24]what the patient tells you?

[25]A. At that point, yes.
1220

[1]

[2]Q. You didn't know anything about the
[3]death of her mother or how it affected her?

[4]A. Not at that time, no.

[5]Q. Okay. You don't know whether there are
[6]any other events in her life that have caused her
[7]severe emotional upset, do you?

[8]A. Not specifically, no.

[9]Q. Do you know how the [*44] separation from her
[10]husband has affected her life?

[11]A. Not specifically, no.

[12]Q. Now, you told us that you don't think
[13]it was conversion reaction because the patients
[14]generally are not consistent because they don't
[15]know what the symptoms are supposed to be and
[16]also that the tests are usually negative?

[17]A. That is correct.

[18]Q. Now, in this case you know Ms. Ateser
[19]had been studying up on RSD for many months

[20]before she came to you?

[21]A. Yes, she is very knowledgeable about

[22]it.

[23]Q. In this case, all of the tests

[24]regarding her left leg were negative, correct?

[25]A. Not all tests.

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[1]

[2]Q. Except for the knee, where she had the

[3]torn meniscus, but the vascular studies done by

[4]Dr. Rosi were negative?

[5]A. Correct.

[6]Q. The MRTs, to see if there are any

[7]injuries to the leg other than the torn meniscus,

[8]they were all negative?

[9]A. Yes.

[10]Q. The bone scan -- the bone scan not only

[11]was negative, but the results state that it was

[12]inconsistent with reflex sympathy dystrophy,

[13]correct or incorrect?

[14]A. I believe that is incorrect. **[*45]** There is

[15]a difference between inconsistent versus not

[16]consistent with. Inconsistent would mean that it

[17]suggests that it does not exist. Not consistent

[18]with means it does not support the existence.

[19]Q. Do you have the bone scan results

[20]there?

[21]A. I believe I do. I do have a copy of

[22]that.

[23]Q. May I see it, please?

[24]A. Yes.

[25]Q. So the bone scan -- I will read it
1222

[1]

[2]again. Correlation with plain films suggests

[3]that the findings are not consistent with RSD.

[4]So you are saying that is different with being

[5]inconsistent with RSD?

[6]A. Yes.

[7]Q. Okay. It is certainly not a positive

[8]test, is it?

[9]A. Correct.

[10]Q. So there are no positive tests

[11]specifically to rule in RSD, correct?

[12]A. That is correct.

[13]Q. All of the tests have been to rule it

[14]out?

[15]A. Yes.

[16]Q. So the patient comes to you, and let's

[17]put aside her complaints, okay, her symptoms and

[18]just concentrate on the signs.

[19]The signs are the change in color

[20]and change in temperature, correct?

[21]A. That is correct.

[22]Q. What about the other [*46] signs, the

[23]sweating, did you do any sweat tests on Ms.

[24]Atesar?

[25]A. No, I don't. We don't routinely do
1223

[1]

[2]sweat tests.

[3]Q. What was the other, the hair looks or
[4]hair growth?

[5]A. Yes. And she does appear to have some
[6]asymmetry, but since she does not have an
[7]extensive distribution of hair on either side it
[8]is very difficult to make any specific
[9]conclusions about that in her.

[10]Q. Now, I think you have told us -- strike
[11]that.

[12]Approximately how many patients
[13]have you seen since you started practicing
[14]medicine, the last five years you have practiced
[15]medicine?

[16]A. Yes.

[17]Q. How many patients would you say, a
[18]ballpark figure?

[19]A. I would see on the average perhaps
[20]20,000 patients in total.

[21]Q. 20,000?

[22]A. In total.

[23]Q. Out of those 20,000 patients you have
[24]seen fifty where you have made the diagnosis of
[25]RSD, correct?

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[1]

[2]A. That is correct.

[3]Q. And out of those 50 patients, out of
[4]the 20,000 patients that you have seen, did you
[5]get psychological background or look into the
[6]psychological [*47] histories of the other fifty

[7]patients?

[8]A. In some cases, yes.

[9]Q. Okay. Now, in this case, in Ms.

[10]Atesar's case did you review the St. Vincent's

[11]Hospital record?

[12]A. At one point, yes.

[13]Q. Is that since your last deposition?

[14]A. No, I have not reviewed any record

[15]since that deposition.

[16]Q. Well, didn't you remember telling me at

[17]your deposition you didn't review any St.

[18]Vincent's Hospital record?

[19]A. I have reviewed the record of Dr.

[20]Hecht's treatment. I don't recall which hospital

[21]that is now.

[22]Q. That is Cabrini?

[23]A. Cabrini, no, I did not. I did not

[24]review St. Vincent's.

[25]Q. Your earlier testimony about the

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[1]

[2]shoulder problem is based on Ms. Ateser telling

[3]you what happened to her right shoulder in the

[4]car accident and not based on any record you have

[5]seen?

[6]A. Based on that and her history and

[7]function prior to the accident.

[8]Q. Now, Dr. Ochoa has told us that doctors

[9]are not considering the diagnosis of somatization

[10]or conversion reaction and that they have started

[11]a mill (sic), do you concur or [*48] disagree with
[12]that?

[13]A. It's a general statement, I would
[14]disagree.

[15]Q. Okay. Would you agree that when Ms.
[16]Ateser got out of Rusk Institute under your care
[17]her condition -- strike that. Her signs and
[18]symptoms were virtually unchanged?

[19]A. Yes, I agree.

[20]Q. And her bill for being there for two
[21]months was \$ 66,000, correct?

[22]A. That is correct.

[23]Q. During that stay there she did things
[24]like occupational therapy, correct?

[25]A. Yes.
1226

[1]

[2]Q. And the record from Rusk Institute
[3]shows she was a terrible compliant patient. She
[4]missed her appointment for occupational therapy
[5]on a regular basis, isn't that right?

[6]A. For that particular subset of her
[7]treatment, yes. She did miss a number of
[8]appointments.

[9]Q. The other treatment she was there
[10]running up the \$ 66,000 bill was things like
[11]horticulture, where they go into the greenhouse?

[12]A. That is only a trivial part of her
[13]treatment.

[14]Q. The record shows when she did go into

[15]the horticulture department she was able to
[16]function quite nicely with both hands and arms,
[17] [*49] correct?

[18]A. Using both hands. She was not required
[19]to move her shoulders to do that. That is done
[20]at a table height activity.

[21]Q. Now, do you agree with Dr. Hecht that
[22]the impingement of the right shoulder is
[23]something that is congenital to Ms. Ateser and
[24]has nothing to do with the accident?

[25]A. I would not call it congenital no.
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[1]

[2]Q. Would you agree it has nothing to do
[3]with the accident?

[4]A. The anatomy has nothing to do with the
[5]accident. The dynamic impingement I would
[6]say is related.

[7]A JUROR: Can you ask the witness
[8]to speak up?

[9]THE COURT: All right.

[10]Do you need to have some of the
[11]testimony repeated?

[12]A JUROR: No.

[13]THE COURT: If you can't hear him
[14]raise your hands and I will have it
[15]repeated.

[16]Please read the last question and
[17]answer.

[18](Whereupon, the Court Reporter

[19]read back the last question and

[20]answer.)

[21]Q. Now, did you review the

[22]electrodiagnostic studies you told us about

[23]earlier?

[24]A. Yes.

[25]Q. Was that from Dr. Nelson?

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[1]

[2]A. Yes.

[3]MR. MEHRTENS: **[*50]** Your Honor, at this

[4]time I would like to introduce into

[5]evidence Dr. Nelson's electromyography

[6]report previously marked as Defendant's

[7]Exhibit K for identification.

[8]MR. RONEUMUS: I have no
objection.

[10]THE COURT: All right, in
111 evidence. Please mark it in evidence.

[12]Are there other reports?

[13]MR. MEHRTENS: Yes. Shall I go

[14]through them?

[15]THE COURT: Yes.

[16]Q. Doctor, did you review the radiological

[17]reports of December 9, 1995 performed at Rusk

[18]Institute of Rehabilitation Medicine?

[19]A. Yes.

[20]Q. And do you agree the report shows there

[21]is no radiographic abnormality of the osseous,

[22]that is bone or soft tissue structure and there

[23]is no evidence for fracture or dislocation that

[24]is the right shoulder?

[25]A. Yes, that is correct.

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[2]MR. MEHRTENS: That is Defendant's

[3]Exhibit V for identification. I move

[4]that into evidence.

[5]MR. RONEUMUS: What is the date on

[6]that?

[7]MR. MEHRTENS: That is December 9,

[8]1995.

[9]MR. RONEUMUS: Right shoulder?

[10]MR. MEHRTENS: No x-ray.

[11]MR. RONEUMUS: I have no

[12]objection. **[*51]**

[13]Q. Did you review the report of the MRI of

[14]the right shoulder performed on February 6, 1996

[15]by Dr. Jonathan Klug, and his reports to Dr.

[16]Agus?

[17]A. Yes, I did. That is the study of the

[18]scapula?

[19]Q. I will read it.

[20]"Impression normal. Appearance

[21]of the right scapula and surrounding soft tissue

[22]structures. No evidence of bony hypertrophy.

[23]Posttraumatic deformity or soft tissue mass along

[24]the path of the long thoracic nerve. Anatomic

[25]appearance of both scapula and shoulder girdles

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[1]

[2]is bilaterally symmetrical."

[3]I move that into evidence, your

[4]Honor. That is Defendants' Exhibit G for

[5]identification.

[6]MR. RONEUMUS: I have no

[7]objection.

[8]THE COURT: All right.

[9]Q. Did you review the MRI of the right

[10]shoulder taken on December 14, 1995?

[11]A. Yes.

[12]Q. And reading from that --

[13]MR. RONEUMUS: Is that E?

[14]MR. MEHRTENS: Defendants' Exhibit

[15]E.

[16]Q. "Degenerative disease is present in the

[17]supraspinatus tendon. It is manifested as

[18]thinning of the mid segment of the tendon and

[19]some irregular contour. No definite [*52] tear is

[20]detected. The intraspinatus, the subscapularis

[21]and the biceps tendon are normal. There is no

[22]evidence of joint effusion. The

[23]acromioclavicular joints appears unremarkable.

[24]Impression: Minimal degenerative disease of the

[25]supraspinatus tendon."

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[2]Did you review that report?

[3]A. Yes.

[4]Q. Do you agree with it?

[5]A. All except one in particular, the

[6]comments regarding the biceps tendon.

[7]Q. I will get to that.

[8]MR. MEHRTENS: Your Honor, at this

[9]time I move Defendant's Exhibit E into

[10]evidence.

[11]MR. RONEUMUS: I have no

[12]objection.

[13]Q. Let's talk about the degenerative

[14]disease. What does degenerative disease mean?

[15]A. Changes related to wear and tear.

[16]Q. Thank you.

[17]She had some wear and tear of the

[18]supraspinatus tendon, correct?

[19]A. Yes.

[20]Q. You were going to make some note about

[21]your -- you were going to make some remarks about

[22]the biceps tendon, which this report says are

[23]normal?

[24]A. Yes. Subsequently, when we obtained a

[25]followup MRI and noticed evidence of a split, a

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[1]

[2]long [*53] longitudinal tear. I reviewed some of the

[3]old images with the radiologist and it is at

[4]least quite possible that it could be seen on

[5]this exam as well.

[6]An MRI, it is not a global

[7]picture, it is a series of slices, but there is

[8]some evidence for that on the previous MRIs as

[9]well.

[10]Q. Was there ever an amended report

[11]prepared as to what the MRI of December 14, 1995

[12]of the right shoulder showed?

[13]A. No, there was not.

[14]Q. Okay. So it is also entirely possible

[15]if she has a tear of the biceps tendon it

[16]happened after December 14, 1995, correct?

[17]A. It is possible, but there is at least a

[18]strong possibility it is visible on the skin as

[19]well, even though it was apparently missed on the

[20]interpretation of this scan.

[21]Q. You talked about the overuse of the

[22]right arm as being one of the causes for her

[23]shoulder problems and did that exist when you saw

[24]her for the first time?

[25]A. She had complaints at that time, yes,
1233

[1]

[2]relating to the right shoulder.

Q. That was September of 1995 you saw her

[4]for the first time?

[5]A. Yes.

[6]Q. How long **[*54]** had she been overusing this

[7]right arm in the wheelchair before she saw you?

[8]A. Since she had been using the wheelchair

[9]after her accident.

[10]Q. When was that that she was using her

[11]wheelchair after the accident?

[12]A. I don't know the exact dates of when

[13]she started using the chair. But she had

[14]indicated to me that she had been wheelchair

[16]bound.

[16]Q. Can we agree that part of her problem
[17]with the right shoulder, when you saw her for the
[18]first time in 1995, was from overuse. Whether it
[19]was from being in the wheelchair or not you don't
[20]know since you don't know when she was in the
[21]wheelchair?

[22]A. It certainly is from overuse, yes.

[23]Q. Okay. I want you to assume Ms.

[24]Atesar's, again back in 1982, '83, and '84, had
[25]complaints of constant back pain and couldn't sit
1234

[1]

[2]for long periods of time, and had to lay down in
[3]order to become comfortable and could not ride
[4]her bicycle and could not do her laundry and had
[5]this constant pain, and had burning pain in her
[6]upper back and was receiving treatment at her
[7]trigger point in her upper back, is it possible
[8] **[*55]** that she had RSD back then?

[9]A. Those things alone don't make it
[10]certain, but yes, it is certainly possible she
[11]had RSD at that time.

[12]Q. How would you go about ruling out, or I
[13]should say how would you go about ruling in that
[14]she had RSD back in 1982, '83 and '84?

[15]A. At this point after the fact you
[16]couldn't rule it in or out.

[17]Q. Well, if she had certain tests done
[18]back then?

[19]A. Yes, if she had the tests done at that

[20]time.

[21]Q. Like MRIs of the neck and back?

[22]A. MRIs would only be useful in that if

[23]they were normal, so you were ruling out other

[24]things to give people pain.

[25]Q. What if EMGs back then?

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[1]

[2]A. EMGs, again, if you had evidence of a

[3]pinched nerve, a radiculopathy, although it does

[4]not rule out a RSD, the fact you have a common

[5]condition that would well explain pain would make

[6]it most likely to diagnose an RSD.

[7]Q. What common conditions are there that

[8]cause constant pain in the neck and back to the

[9]extent where someone can't sit for more than ten

[10]minutes?

[11]A. The most common would be pinched

[12]nerves, [*56] the medical term is radiculopathy

[13]pinching of the nerve roots. You can also have

[14]spinal stenosis pressure on the spinal cord

[15]itself.

[16]Those are the most common things

[17]that would give somebody that type of disabling

[18]pain in the neck and back.

[19]Q. And what you just described, is that

[20]the type of think that goes away?

[21]A. It would not just go away. Over a

[22]period of time it can improve.

[23]Q. When you say improve, would it

[24]disappear completely?

[25]A. It can. It certainly can.

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[1]

[2]Q. And the same way that the signs and

[3]symptoms of RSD could just go away over time?

[4]A. They can go away over time, yes.

[5](Continued on next page.)

[6]

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[2]BY MR. MEHRTENS:

[3]Q Did you review the electro diagnostic
[4]examination from Doctor Ma, M-A, in December, on
[5]December 11, 1995?

[6]A Yes, I did.

[7]Q Okay. The finding on that report,
[8]"electro diagnostic examination, reveals no
[9]evidence of motor route or peripheral nerve
[10]involvement in the right lower extremity, complex
[11] [*57] repetitive discharges found in the right lumbar
[12]paraspinal muscle at the L4, L5 level may be a non
[13]specific finding.
[14]In addition, sympathetic skin response
[15]studies are normal."

[16]Do you agree with those results?

[17]A Yes.

[18]MR. MEHRTENS: Okay. I offer that
[19]into evidence, your Honor.

[20]MR. RONEMUS: I have no objection.

[21]THE COURT: Defendant's J, it's in
[22]evidence without objection.

[23]I don't know whether I stated on the
[24]record, the prior exhibits are in evidence
[25]without objection; marked C,F,E and G,
1238

[1]

[2]defendants.

[3]Q Did you review the MRI study of Ms.

[4]Ateser's left shoulder?

[5]I am looking for the date. Oh,

[6]12/14/95?

[7]A Yes, I did.

[8]Q And that was , "Impression, normal

[9]imaging of the shoulder joint," correct?

[10]A Yes.

[11]Q That is the left shoulder?

[12]A Correct.

[13]MR. MEHRTENS: I move that into

[14]evidence, your Honor, as Defendant's

[15]exhibit D.

[16]THE COURT: Any objection?

[17]MR. RONEMUS: It is not in

[18]evidence?

[19]MR. MEHRTENS: No. It says, ID,

[20]here.

[21]MR. RONEMUS: No objection. **[*58]**

[22]THE COURT: It is in evidence without

[23]objection.

[24]Q Did you review the lumbosacral and

[25]cortical somatosensory report from Doctor Hughs

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[1]

[2](Phonetics), dated July 24, 1995?

[3]This would be before she saw you.

[4]A I don't recall if I saw that or not.

[5]Q All right. Then, we won't talk about it.

[6]MR. MEHRTENS: Let me just have one

[7]moment, Judge.

[8](DISCUSSION AT THE BENCH)

[9]MR. MEHRTENS: I am sorry, Judge.

[10]Just one second. I think I am through.

[11](Short pause)

[12]Q Doctor, are you aware of any injury to Ms.

[13]Ateser's left shoulder prior to the car accident

[14]of September, 1994?

[15]A No, I am not.

[16]Q In giving your opinions to this jury about

[17]the condition, her current condition of her left

[18]shoulder and the prognosis into the future, would

[19]you agree, that it would be something that you

[20]would need to know, about prior injuries to the

[21]left shoulder?

[22]A It would be relevant, yes.

[23]MR. MEHRTENS: Okay. I have no

[24]further questions, your Honor.

[25]REDIRECT EXAMINATION

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[2]BY MR. RONEMUS:

[3]Q Doctor I am **[*59]** going to ask you one by one

[4]about these reports that have just been moved into

[5]evidence.

[6]And I ask you to please look at them

[7]and explain the results, what they mean and

[8]whether or not they effect your diagnosis as you

[9]have told us.

[10]We will start with defendant's exhibit

[11]D.

[12]If you can just tell us what it is.

[13]And what if anything it means?

[14]A This is the MRI of the left shoulder,

[15]dated 12/15/95.

[16]And this has a normal MRI imaging of

[17]the shoulder joint. This is of the left

[18]shoulder.

[19]This does not make any significant

[20]change in my diagnosis, since I have not diagnosed

[21]any structural abnormality.

[22]MRI shows us the structures. Some of

[23]them, they show very nicely.

[24]But, what she has is an inflammatory

[25]irritation of the soft tissue in the front of the
1241

[1]

[2]shoulder, not a change in the bone or the joints.

[3]So, it doesn't change.

[4]Q Okay. If you learn that in the 1982

[5]accident she suffered a herniated cervical disk

[6]and radiculopathy into the left shoulder and the

[7]left arm, would that effect your diagnosis of the

[8] **[*60]** bursitis of the left shoulder that you made?

[9]A Not at all. No relevance.

[10]Q Why is that?

[11]A The cervical radiculopathy is essentially

[12]a pinched nerve.

[13]And when the nerve is pinched at the

[14]neck, such as from a herniated disk, it can

[15]certainly in fact classically radiate the pain

[16]down the shoulder and arm.

[17]It implies nothing about an actual

[18]problem of the shoulder or the arm itself.

[19]In the same manner that the pain from
[20]a heart attack is often felt in the left shoulder
[21]of the arm, but has nothing do with the limb. It
[22]is almost a coincidence in that regard.

[23]Q I am going to show you what has been
[24]marked into evidence--

[25]THE COURT: They have been deemed
1242

[1]

[2]marked.

[3]MR. RONEMUS: Okay, just deemed.

[4]Q Defendant's exhibit J.

[5]I ask you please to describe what that
[6]is and your interpretation.

[7]A This is an electro diagnosis examination
[8]dated, December 11, 1995, by Doctor Ma.

[9]Q Is that while she was in Rusk?

[10]A Yes.

[11]Q Is that something that you requested?

[12]A Yes, it is.

[13]We wanted to evaluate [*61] her right leg.

[14]And it says, that there was no
[15]evidence of motor route or peripheral nerve
[16]involvement in the right leg, the right lower
[17]extremity.

[18]It does mention something, an
[19]electrical abnormality in the muscle of right side
[20]of the low back that may be a non specific
[21]finding, something that you might see in a normal
[22]person.

[23]And the sympathetic skin responses

[24]were normal.

[25]Essentially, this was to make sure
1243

[1]

[2]there was nothing wrong with the right leg.

[3]With which I would agree clinically at

[4]this time.

[5]She had a concern that she was

[6]developing some symptoms there.

[7]And we were able to relay those

[8]concerns.

[9]The only problem she had in the right

[10]leg was in fact the dislocation of the toe, which

[11]has by now pretty well resolved.

[12]Q What does that mean, the sympathetic skin

[13]response is normal?

[14]A Sympathetic skin response is a way of

[15]looking at the conductivity, the electrical

[16]properties of the skin which can be changed in

[17]reflex sympathetic dystrophy.

[18]It can be positive at times in cases

[19]of RSD. Not [*62] at all times.

[20]Q So, you were checking to determine whether

[21]the RSD had spread in the right leg?

[22]A Correct.

[23]Q Okay. And based upon that test, what was

[24]your conclusion?

[25]A That the RSD had not spread in the right
1244

[1]

[2]leg.

[3]That any symptoms she was having

[4]mainly around the right foot at time were related

[5]to the trauma that she had received during her

[6]therapy at The Hospital for Joint Diseases. And

[7]was not related to RSD.

[8]Q Let me show you what has been marked as

[9]defendant's exhibit C for identification.

[10]And I ask you to please describe for

[11]us what that is?

[12]A This is an x-ray report. It is an MRI of

[13]the left ankle.

[14]It shows a small joint fusion.

[15]Q What is the date?

[16]A I am sorry. The date is 10/19/95, is the

[17]date the exam was performed.

[18]Q So, was that while she was in Rusk, as

[19]well?

[20]A Yes, it is.

[21]This shows a small joint effusion.

[22]That is, some fluid within the ankle joint. And

[23]no evidence for subcutaneous edema. That would be

[24]water under the skin. Tendonitis or tear or

[25]osseous abnormality. [*63] Osseous meaning, bones.

1245

[1]

[2]So, no abnormality of the bone or

[3]tendons.

[4]Q What, if any, effect on diagnosis does

[5]that have?

[6]A That helps to point us back to the RSD in
[7]showing that there is no evidence for competing
[8]theories as to what the injury might be in the
[9]ankle causing the signs and symptoms.

[10]Q Why did you order that test?

[11]A To help to narrow down the field of
[12]possibilities of what could be going on with the
[13]left ankle.

[14]Q Let me show you what has been marked as
[15]defendant's E in evidence.

[16]Can you explain that one, please?

[17]A This is an MRI of the right shoulder.

[18]It was performed, December 14, 1995.

[19]Q While she was in Rusk?

[20]A Yes, while she was in Rusk.

[21]It describes the degenerative diseases
[22]present in the supraspinatus tendon, manifested as
[23]thinning of the middle segment of the tendon and
[24]some irrelevant contour.

[25]No definite tear is detected.

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[1]

[2]It should be noted, it mentions here
[3]on the report that there were some problems with
[4]motion artifact.

[5]The patient was coughing during [*64] the
[6]exam. She had a cold during part of her stay at
[7]the hospital.

[8]And it is the impression is of minute
[9]degenerative disease of the supraspinatus tendon.

[10]When people have problems with their
[11]rotator cuff and the most common component of the
[12]rotator cuff, it can be a problem of the
[13]supraspinatus tendon.

[14]You may have in some cases a complete
[15]tear where that tendon is ripped apart, pulled
[16]completely in two.

[17]In other cases people may have, when
[18]we do MRI or someone looks inside of the scope,
[19]they may have some thing or irregularity which
[20]can be from degenerative changes.

[21]It can be from a partial tear that is
[22]no longer acute. So, you no longer have swelling
[23]or any other clue as to it being a new thing that
[24]has just happened.

[25]It certainly is consistent with having
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[1]
[2]some problems from the rotator cuff pathology.
[3]It doesn't look at other problems that
[4]we are concerned about. Neurological problems
[5]from the thoracic outlet or pain from trigger
[6]points, for example.

[7]Q So, was that test consistent, the results
[8]of that test consistent [***65**] with your diagnosis?

[9]A Yes, it is consistent with over use
[10]problems with the right shoulder.

[11]Q Doctor, are you aware, by the way, that
[12]Doctor Hecht had diagnosed her as having a frozen
[13]shoulder?

[14]A Not the specific term, frozen shoulder.

[15]But, I would agree with that.

[16]Q What is a frozen shoulder?

[17]A A frozen shoulder is--

[18]MR. MEHRTENS: Objection, your

[19]Honor.

[20]Both cumulative and beyond the scope

[21]of direct.

[22]THE COURT: Overruled.

[23]A A frozen shoulder is a loss of range of

[24]motion of the shoulder.

[25]You can get a loss of range of any

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[1]

[2]joint.

[3]But, because it is a particularly

[4]common and potentially serious problem with the

[5]shoulder, that term has come into our usage.

[6]People may initially not be moving the

[7]shoulder freely because of something like pain,

[8]where it simply hurts to move it.

[9]But, over time the shoulder joint,

[10]which normally has freedom of motion, several

[11]different planes, is very susceptible to losing

[12]range.

[13]And when you lose that range we call

[14]it a frozen shoulder.

[15] **[*66]** Q Do you have an opinion with a reasonable

[16]degree of medical certainty, that problems in the

[17]right shoulder were the result solely of her

[18]congenital condition?

[19]A My opinion is, no.

[20]She has, although she does have very

[21]good mobility of her joints, that per se is not a

[22]pathology.

[23]She does have evidence not so clear on

[24]this MRI and a subsequent one of some small

[25]spurring, little bone spurs and osteophyte

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[1]

[2]effecting the shoulder. But, it is fairly small.

[3]This is not a congenitally strange

[4]looking shoulder.

[5]And she was able to move it quite well

[6]prior to her accident.

[7]Q How did the bone spur get there?. Is that

[8]something that was there before the accident or

[9]as a result of the accident?

[10]A The bone spur is something that we see

[11]when you get an irritation.

[12]The spurring just is a local

[13]inflammatory response in that area, which can

[14]eventually become calcified.

[15]So, it may be developing for a period

[16]of time.

[17]And then, eventually, when it is

[18]calcified, when it has become bony, you can see it

[19]better on an x-ray.

[20] **[*67]** There is no suggestion that it was

[21]there previously.

[22]And in fact, since we didn't see it
[23]for some time, it is entirely consistent with the
[24]process that was developed subsequent to the
[25]accident.
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[2]Q As a result of accident?

[3]A As a result of it.

[4]Q I show what you has been marked,

[5]Defendant's Exhibit C -- maybe, that is G.

[6]It is a result of an MR1 of the right

[7]shoulder.

[8]I guess it is G.

[9]Can you tell us what that is, please?

[10]A This is specifically an MRI of the

[11]scapula, not a standard shoulder. Since that was

[12]the area of special attention requested.

[13]And it says, normal appearance of the

[14]right scapula, the shoulder blade of the bone in

[15]the back of the shoulder and surrounding soft

[16]tissue structures. And essentially, normal MRI

[17]study of this area.

[18]Given that the problems that she has

[19]around the scapula are muscular in nature, I

[20]wouldn't expect it to show up on an MRI.

[21]Q So, is that consistent with your

[22]diagnosis?

[23]A Yes, it is.

[24]Q I am showing you what has been marked,

[25]Defendant's Exhibit K.

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[2] [***68**] If you can describe that for us,

[3]please?

[4]A This is an electro diagnostic study.

[5]And this is of the right upper

[6]extremity.

[7]And it shows no definite evidence of

[8]peripheral nerve or route involvement.

[9]It shows no sickness of the nerves.

[10]And it shows no evidence of a pinched nerve.

[11]And again, that is fully consistent

[12]with my diagnosis.

[13]Q Okay. Why was that test taken?

[14]A Again, to make sure that we were not

[15]overlooking something that could mimic some of the

[16]symptoms of the diagnosis that we were attaching

[17]to this patient.

[18]If she did have a pinched nerve in the

[19]neck, such as from a herniated disk, that would

[20]show up on the EMG.

[21]Q And one more, Defendant's Exhibit F.

[22]Can you tell us about that one,

[23]please?

[24]A This is an x-ray of the right shoulder.

[25]And the x-ray looking at the bones

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[2]shows no abnormality of the osseous, the bone or

[3]soft tissue structures. No evidence of fracture

[4]or dislocation.

[5]And again, that is consistent with our

[6]assessment of the patient.

[7]Q Okay. So, have any of these [*69] test results

[8]that Mr. Mehrtens has asked you about changed your

[9]opinion in any regard?

[10]A No, they haven't changed my opinion.

[11]Q You say, you gave a video tape deposition

[12]previously in this case?

[13]A Yes, that's correct.

[14]Q About how long ago was that?

[15]A That was on March 17th.

[16]Q Where did that take place?

[17]A That was at your office.

[18]Q What was your understanding of the purpose

[19]of that video tape deposition?

[20]A The purpose of that deposition was for me

[21]to give testimony such as I am giving today, given

[22]that the scheduled trial date was during a period

[23]of time when I was going to be at a conference in

[24]Hong Kong.

[25]Q And how long were you in Hong Kong?

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[2]A A little over two weeks, about 16 days.

[3]Q And did you later learn that when you got

[4]back the trial had not taken place and therefore

[5]asked you to come in and testify?

[6]A That's correct.

[7]Q Now often do you testify in court, doctor?

[8]A I have testified 5 times in court.

[9]And on two occasions have given video

[10]tape depositions, one of which being [*70] that time on

[11]March 17th.

[12]Q Is this something that you do regularly as

[13]a means of increasing your income?

[14]A No, it is not.

[15]I am not one of the doctors who makes

[16]his living by this way.

[17]I make my living primarily by patient

[18]care. And also for teaching of residents and

[19]medical students.

[20]Q Now, you testified that you do not know,

[21]we don't know specifically what causes the

[22]symptoms of RSD?

[23]A Correct.

[24]Q Are you aware of any other diseases where

[25]its specific cause of the symptoms or signs are
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[2]not known?

[3]A Yes. There are a great many diseases

[4]where we know that there are certain symptoms

[5]associated with them, we don't know the exact

[6]mechanism. But, they are well accepted.

[7]An example would be polymyalgia

[8]rheumatica, known as PMR, which is a very painful

[9]condition.

[10]We know that it gives pain in many

[11]different joints and it is associated with an

[12]abnormal blood test.

[13]But, we really have no idea why this
[14]disease causes that problem.
[15]We know that there are certain methods
[16]that make you get better.
[17] [*71] And again, we don't really know why
[18]those methods in particular make you get better.
[19]That is just one example of many
[20]diseases.
[21]Q Okay. And the fact that we don't know the
[22]specific mechanism or causes for the change in
[23]that color or the change in that temperature or
[24]the pain in an RSD patient, does that change your
[25]diagnosis of Ms. Ateser's condition?
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[2]A No, it does not.
[3]There is no competing diagnosis that
[4]would appear more accurate.
[5]Q Okay. You were asked about your prognosis
[6]as being poor.
[7]And I believe you testified, that that
[8]was based in part on at least the two year
[9]history of the disease?
[10]A Yes. At this point over two and a half
[11]years.
[12]Q You said, that some RSD patients do
[13]recover?
[14]A Yes, they do.
[15]Q Under what circumstances is that likely to
[16]happen?

[17]A Early diagnosis and treatment may be

[18]helpful.

[19]Certainly, establishing a trend for

[20]improvement is a significant prognostic sign.

[21]But, many patients do not improve,

[22]despite having those attempts, the best attempts

[23]at early diagnosis [***72**] and treatment.

[24]Q Have you spoken to Ms. Ateser's

[25]psychiatrist, Doctor Parkin?

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[2]A Yes, I have.

[3]Q And have your discussions with him changed

[4]your opinion in any regard?

[5]MR. MEHRTENS: Objection.

[6]THE COURT: You may answer the

[7]question.

[8]A No, they did not change my opinion in any

[9]regard.

[10]We discussed her--

[11]THE COURT: You may not go into the

[12]substance of the discussion.

[13]A I am sorry.

[14]Q Did you discuss her psychological

[15]history?

[16]Don't tell us what you said.

[17]Is that something you discussed?

[18]A Yes.

[19]Q And based upon what you learned from those

[20]conversations, has your opinion changed in any

[21]way?

[22]A No.

[23]Q You mentioned, that she missed some

[24]appointments while she was an inpatient at Rusk?

[25]A Yes.

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[2]Q Can you tell us about those appointments?

[3]A Yes. In particular, she missed a number

[4]of appointments for occupational therapy.

[5]Occupational therapy is involved in

[6]working on activities of daily living and upper

[7]extremity function in particular. **[*73]**

[8]The name is a misnomer. It doesn't

[9]have that much to do with occupations.

[10]And in part, I think she was having a

[11]personality conflict with a particular therapist,

[12]which was unfortunately.

[13]I think also, she felt that she had

[14]been given some of the same training on previous

[15]treatments. And was less interested in pursuing

[16]that further.

[17]I would have preferred, like with any

[18]other patient, that they have 100% attendance.

[19]But, the occupational therapy was a

[20]comparatively small component of her care when

[21]compared to things like physical therapy.

[22]Q And would you consider her to a compliant

[23]patient?

[24]A Yes. With the exception of that

[25]particular area, she has been very compliant.

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[2]She has worked extremely well with the

[3]therapists who have been treating her, as an

[4]outpatient.

[5]MR. RONEMUS: Thank you, doctor.

[6]I have no further questions sir.

[7]THE COURT: Re-cross.

[8]RE-CROSS EXAMINATION

[9]BY MR. MEHRTENS:

[10]Q Doctor, again, we know that the medical

[11]field does not know the cause of RSD.

[12]I think we just said that, [*74] again?

[13]A Yes.

[14]Q Another way of stating that is, we don't

[15]know the cause of the change in temperature and

[16]the change in color, correct?

[17]A No. We know that it is directed, a very

[18]direct cause via the sympathetic system.

[19]But, we don't know why that is

[20]happening.

[21]Q And since we don't know that, what is your

[22]basis for saying that it was caused by the car

[23]accident of September of 1994?

[24]A Because, we do know that RSD is frequently

[25]one of the follow up events from trauma of varying

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[2]degrees of severity.

[3]And this patient had a temporal

[4]relationship between her accident and between some
[5]of the treatments she received in the course of
[6]that and her development of these symptoms.

[7]Q The treatment in the course that you were
[8]just talking about is the surgery on her left
[9]knee, correct?

[10]A Yes, that's correct.

[11]Q Okay. So, and we agree that the color
[12]changes in her leg started after the surgery in
[13]the left knee, correct?

[14]A Yes.

[15]Q Okay. So, the color changes we can at
[16]least say were not directly caused by the car
[17] [*75] accident, because the color changes happened many
[18]months after the car accident, correct?

[19]MR. RONEMUS: Objection.

[20]THE COURT: Overruled.

[21]A No, we can't say--

[22]I am sorry. Would you repeat the
[23]question, please.

[24]Q The color changes occurred after the
[25]surgery of the left knee?

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[2]So, there were no color changes noted,
[3]to your knowledge in September or October or
[4]November or December of 1994, correct?

[5]A Yes.

[6]Q Okay. There were some notations of a
[7]change in temperature of her leg following the car

[8]accident.

[9]And those would be consistent with a

[10]traumatic injury to the left leg, correct?

[11]A Not typically for that duration, no.

[12]Q What duration are you talking about?

[13]A One may have a difference in temperature

[14]for a few days.

[15]But, my understanding is, that it was

[16]going on on an ongoing basis after the accident,

[17]not just for a few days.

[18]Q And you didn't get that understanding from

[19]reviewing The Saint Vincent's Hospital records, is

[20]that correct?

[21]A No, that was from the patient.

[22]Q In fact, [*76] you didn't get that understanding

[23]from reviewing any records, it was always from the

[24]patient that you got that understanding?

[25]A That part, yes.

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[1]Proceedings

[2]Q Okay. By the way, a herniated disk in the

[3]neck could be a mechanism of precipitating reflex

[4]sympathetic dystrophy, could it not?

[5]A Yes, it could.

[6]Q And you have no knowledge about what

[7]portions of Ms. Ateser's body were directly

[8]injured in the car accident, aside from what she

[9]told you, correct?

[10]A Correct.

[11]Okay.

[12]MR. MEHRTENS: All right. I don't

[13]want to beat it anymore.

[14]Thank you, Judge. No further

[15]questions.

[16]MR. RONEMUS: I have nothing

[17]further.

[18]THE COURT: All right. You may step

[19]down.

[20](Witness leaves the stand).

[21]THE COURT: Jurors, that concludes

[22]the proceedings for today.

[23]The projected trial schedule, it

[24]appears that we will be working through

[25]next week.

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