TRIAL TRANSCRIPT OF ALI ERAJ GUY, M.D., F.A.A.P.M.R.; 1992 Trial Trans. LEXIS 901

Supreme Court of New York, Bronx County

INDEX NO. 7230-90

December 1, 1992

Reporter
1992 Trial Trans. LEXIS 901 *

ELSIE JIMINEZ, Plaintiff, -against- STATESIDE CONSTRUCTION CORP. and COSMOPOLITAN DECORATING CO. INC., Defendants.; STATESIDE CONSTRUCTION CORP., Third-Party Plaintiff, -against- EUROPEAN AMERICAN BANK and COSMOPOLITAN DECORATING CO., INC., Third-Party Defendants.

Expert Name: Dr. ERAJ GUY, M.D., F.A.A.P.M.R.

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Counsel

[*1] FRANK P. MANGIATORDI, ESQ., Attorney for Plaintiff, New York, N.Y., BY: EDWARD LEMMO, ESQ.

THURM & HELLER, Attorneys for Stateside, New York, N.Y., BY: JOHN TOMASZEWSKI, ESQ.

CALLAHAN REGENSTREICH & KESTER, Attorneys for Cosmopolitan, New York, N.Y., BY: ALTHEA GARVEY, ESQ.

BURKE & LIPTON, Attorneys for European American, White Plains, New York, BY: GAIL, NEW YORK, ESQ.

Judges

BEFORE HON. JERRY L. CRISPINO, Justice.

Proceedings

3

[1]
[2]A L I G U Y , M. D. , called as a witness on behalf of

[3]plaintiff, having first been duly sworn,

[4]testified as follows:

[5]THE CLERK: State your name and

[6]professional address for the record.

[7]THE WITNESS: Doctor Ali Guy. Office

[8]address is 7 Gramacy Park, New York, New York.

[9]THE COURT: Your witness.

[10]DIRECT EXAMINATION

[11]BY MR. LEMMO:

[12] **[*2]** Q Dr. Guy, as I've mentioned to all of the

[13]witnesses and the jury knows what I'm going to say,

[14]please, try to keep your voice up because the accoustics

[15]in this room are bad. All right, sir?

[16]A Okay.

[17]Q Dr. Guy, are you duly licensed to practice

[16]medicine in the State of New York?

[19]A I am.

[20]Q Can you tell us your background and training,

[21]sir?

[22]A Yes. I received my license to practice medicine

[23]in the State of New York in July of 1985. I did my

[24]undergraduate at Queens College. I went to medical school

[25]at the Universidad Nordestana in Dominican Republic. I

[4]
[1]
[2]did my residency in internal medicine at Mount Sinai

[3]School of Medicine for a period of 13 months. I did one

[4]year of general surgery at Cabrini Medical Center. I did

[5]3 years of physical medicine and rehabilitation at Mount

[5]Sinai Medical Center. I'm Board certified in the field of

[7]physical medicine and rehabilitation.

[8]Q What does that mean, Board certified?

[9]A Board certification is the highest degree you

[10]can attain in your level of specialization. It's

[11]equivalent to Ph.D. to a non-medical person.

[12] **[*3]** In order to obtain board certification, first you

[13]have to complete a three year accredited residency

[14]training program. You then have to take a written

[15]examination which is about eight hours long. You would

[16]then have to be in private practice for a period of one

[17]year to acquire more knowledge. Then you fly out to the

[13]Mayo Clinic, where all the research is done in this field,

[19]and then you are examined by all the people who do most of

[20]the research and you are questioned orally on orthopedic

[21]and neurological areas, as well as internal medicine

[22]areas. If you prove to these doctors that your knowledge

[23]is equal or better than theirs, they consider you passing

[24]the exam and being Board certified.

[25]Q Do you have any specialty?

[5]
[1]
[2]A Yes.

[3]Q What is that?

[4]A It's call physiatry.

[5]Q What does that mean in layman's terms?

[6]A Physiatrist is a doctor that practices the

[7]specially of physical medicine and rehabilitation which

[8]deals with orthopedic problems, neurological problems,

[9]deals with rehabilitating injured patients, whether it be

[10]from a car accident or whether it be from **[*4]** a stroke or

[11]amputation.

[12]Our job is to return the patient back to optimum

[13]level of function prior to injuries. We are also experts

[14]in the field of electric diagnosis or better known as

[15]EMG's.

[16]Q And, Doctor, do you have any specific training

[17]in reading, administering and interpreting EMG's?

[18]A Yes.

[19]Q Doctor, if you could, just tell us simply what

[20]is neurology? What does that mean?

[21]A Neurology is the specialty that deals with the

[22]nervous system.

[23]Q And, Doctor, have you, in the past, treated

[24]patients and examined patients on behalf of both

[25]plaintiffs and defendants?

[6]
[1]
[2]A I have.

[3]Q Can you tell us, Doctor, if you know, or if you

[4]can estimate, what percentage of your practice is devoted

[5]to treating patients?

[5]A A rough guess-- estimate would be 10 percent is

[7]devoted to teaching residents from two different

[8]hospitals, N.Y.U. Medical Center and New York Medical

[9]College, and I would say the other 30 percent is devoted

[10]to treating patients.

[11]Q What percentage, if you know, is -- deals with

[12]having to come to court to testify in behalf **[*5]** of patients?

[13]A Well, because of the nature of my specialty

[14]dealing with traumatic injuries, whenever there is a

[15]trauma, there is accidents, there are lawsuits, there are

[16]lawyers and litigation, and I would have to say about

[17]roughly less than 10 percent.

[18]Q now, Doctor, did there come a time when you

[19]examined Elsie Jiminez?

[20]A Yes.

[21]Q Can you tell us, Doctor, what was the date of

[22]that examination?

[23]A The first time I saw Miss Elsie Jiminez was on

[24]April 23, 1990 as was referred from Dr. Lambert.

[25]Q Now, Doctor, at that time, did you take any

[7]
[1]
[2]history?

[3]A I did.

[4]Q And can you tell us, Doctor, what was the

[5]history?

[6]A The history was that at the time patient was a

[7]41 year old Hispanic female with no history of significant

[8]past medical history or significant prior neck or back

[9]problems; that she was working for a bank as a specialist

[10]and was while working in her job she tripped and fell and

[11]lost her balance and hurt her back.

[12]Q Now, Doctor, what do you mean by no significant

[13]medical history with respect to neck or back problems?

[14] **[*6]** A Well, she does have some neck problems, but

[15]when --

[16]Q Do you have any knowledge, from your records,

[17]Doctor, as to when those neck problems, when they came

[18]about?

[19]A Yes. I have some medical records that --

[20]Q And let. me just mark your records for

[21]identification, if I can.

[22]MR. TOHASZEWSKI: May counsel see them?

[23]THE COURT: Okay. Plaintiff's 4.

[24](So marked.)

[25]Q Doctor, your records have been marked as

[8]
[1]
[2]Plaintiff's Exhibit 4 for identification. Please feel

[3]free, if necessary, to refresh your recollection by any of

[4]the items contained within your file concerning this

[5]patient, Doctor.

[6]Now, Doctor, as I was saying, what do you mean,

[7]Doctor, when you say no significant medical history with

[8]respect to her neck and back?

[9]A Nothing significant in terms of affecting the

[10]diagnosis and treatment in this particular accident

[11]relating to the episode of 5/2/83.

[12]Q And, Doctor, your -- does your file reflect --

[13]your history that you took reflect whether Miss Jiminez

[14]did have any prior neck trauma?

[15]A She did.

[16]Q When approximately **[*7]** was that?

[17]A I believe sometime in 1985.

[18]Q And at the time -- and, Doctor, does your file

[19]reflect whether at the time of your examination, Miss

[20]Jiminez presented any complaints referable to her neck?

[21]A To me?

[22]Q Yes.

[23]A No. I saw her on 4/23/90. I have no record of

[24]any complaints referring to the neck.

[25]Q Did she, in fact, at that time have any physical

[9]
[1]
[2]complaints?

[3]A She did.

[4]Q What were they?

[5]A They were basically to the back.

[6]Q What part of the back?

[7]A Lower back.

[8]Q What is the difference between the cervical

[9]area, Doctor, and the lumbar area?

[10]A Well, cervical means neck. Lumbar means the

[11]lower back.

[12]Q And how many vertebrae are there, Doctor, in the

[13]lumbar area?

[14]A Five.

[15]Q And what is a vertebrae? What does that mean?

[16]A I have a model I can show you.

[17]Q Can we see what it looks like then?

[18]A (Witness exhibits model.)

[19]MR. LEMMO: flay I have that model deem

[20]marked or if it can be marked for identification

[21]purposes?

[22]THE COURT: It can be marked.

[23]Any **[*8]** objection? Are you going to put it in

[24]evidence?

[25]MR. LEMMO: I'm going to have to put it in

[10]
[1]
[2]evidence, I suppose.

[3]MR. TOMASZEWSKI: No objection.

[4]MS. GARVEY: No objection.

[5](Exhibit so marked.)

[6]Q Doctor, looking at what has been marked in

[7]evidence as Plaintiff's Exhibit 5, can you identify what

[8]that is, Doctor?

[9]A Well, this is a rough diagram of the spine, the

[10]vertebra, the disks between each vertebra, other

[11]structures of the vertebra, the spinal cord, the nerve

[12]roots.

[13]Q Is that the entire spine?

[14]A No. This is just three vertebra.

[15]Q Is that anatomically accurate?

[16]A Yes.

[17]Q Will that assist your explanation to this jury

[18]concerning your testimony?

[19]A Yes.

[20]Q Now, Doctor, as I was saying, can you tell this

[21]jury what the vertebra means?

[22]A Vertebra is a part of the bony structures of the

[23]spine where it is separated by two disks and covers the

[24]spinal cord right behind the vertebra, inside the spinal

[25]canal.

[11]
[1]
[2]Q And, Doctor, what are disks?

[3]A A disk is like a shock absorber between each

[4] **[*9]** vertebra. In the lower lumbar spine you have five

[5]vertebra. Between -- maybe I should stand up. Between

[6]each vertebra we have a disk. A disk is like a shock

[7]absorber. It has two parts.

[8]Picture a disk like a jelly donut. The outer part is

[9]cartilaginous, that is analagous to the dough of the jelly

[10]donut. The inner part has a gelatinous material inside

[11]called the nucleus pulposus, that is analagous to the

[12]jelly part of the donut.

[13]When the disk, the outer part tears or herniates, the

[14]gelatinous material leaks out and does this to the nerve

[15]root (indicating), pinches a nerve root.

[16]Now, the material that leaks out is gelatinous

[17]material. It sticks to the nerve root and sticks to the

[18]bone. That's a permanent jury, permanent problem that

[19]never will be corrected unless you surgically go in and

[20]suck out that disk. So that is basically what a disk is.

[21]Q Where are these nerves coming from that you

[22]refer to? Where do they come from?

[23]A Right behind the vertebra we have a canal called

[24]the spinal canal. The spinal cord sits right inside here

[25]protected by the bones all around. This is the **[*10]** back of--

[12]
[1]
[2]this is your bak. This is called the spinous process,

[3]and when you touch your back, you are touching this. So

[4]this is the back. This is the front. And the spinal cord

[5]is like a big tree, runs from the lower portion of your

[6]back all the way up to the brain. As it goes up, it gives

[7]rise to nerve roots on the right and left sides. These

[8]nerve roots give further branches. These branches give

[9]more branches and supply power and sensation to the

[10]different parts of the muscles in the leg.

[11]So each muscle in the leg is supplied by a specific

[12]nerve root from the lower spine and we identify these

[13]nerve roots with reference to which vertebra they are

[14]between. For instance, if we say L4-L5 nerve root, that

[15]means the nerve root between the fourth and fifth lumbar

[16]vertebra.

[17]Q And, Doctor, what happens if a nerve root

[18]becomes impinged or pressed? What is the result of that?

[19]A What happens? The nerve root is like a power

[20]supply. It's like a strong battery. It supplies how the

[21]electrical activity-- it supplies sensation. Picture a

[22]weak battery cranking a car over in the winter. **[*11]** If your

[23]power supply is decreased or cut off, what happens is the

[24]engine won't crank over. If this nerve root is

[25]compressed, you have this function from this nerve root.

[13]
[1]
[2]The first symptom is radiating pain, traveling pain down

[3]the legs. Then comes numbness and tingling and then comes

[4]weakness. It all depends how severely this nerve is

[5]compressed or damaged.

[6]Q Doctor, are there any standard neurological

[7]tests that are used that help determine whether there is,

[8]in fact, a nerve injury?

[9]A Yes.

[10]Q When the patient, Elsie Jiminez, came to you

[11]back on April 23, 1990, did she present any physical

[12]complaints at that time?

[13]A She did.

[14]Q What were those?

[15]A She complained of lower back pain which traveled

[16]down the left buttocks area and down the left leg.

[17]Q And did you conduct an examination at that time,

[18]Doctor?

[19]A I did.

[20]Q And what did you do?

[21]A I -- the patient was disrobed. I gave her the

[22]gown to put on. I examined her back. The back was tender

[23]diffusely, which means wherever you touched it was painful

[24]and it was also widespread **[*12]** spasm, and spasm is defined as

[25]involuntary prolonged contraction of a muscle. That means

[14]
[1]
[2]a patient has no control over that muscle spasm. normally

[3]when you touch a normal muscle, when you touch it, it's

[4]supposed to be soft. When you touch a muscle in spasm,

[5]it's hard like a rock, it has no give, no soft

[6]consistency. What happens is the fibers shorten and as a

[7]result, you lose the normal range of motion and

[8]flexibility of that specific area.

[9]Q Doctor, what were the results of your physical

[10]examination of this patient?

[11]A Just to continue. The back was, as I mentioned,

[12]tender. There was widespread spasm. There were multiple

[13]trigger points, and trigger points are defined as pinpoint

[14]areas of tenderness within the muscle fibers. They are

[15]very, very painful.

[16]You need two criteria to identify the trigger point.

[17]First, we have to have pinpoint tenderness. When you

[18]touch it, you feel like there's a little marble inside the

[19]muscle fibers, and all the waste products of the normal

[20]muscle creates a substance, such as lactate, and those of

[21]you that run, lactate is what gets trapped **[*13]** in your calf

[22]muscles. You get a cramping sensation. Lactate trapped

[23]in the back area causes spasm and that causes pain and

[24]it's a vicious cycle that continues.

[25]Q Now, Doctor, these findings, what area of Miss

[15]
[1]
[2]Jiminez' back are we talking about?

[3]A Upper and lower. Specifically the lower.

[4]Q Lower. And, Doctor, what other -- I'm sorry.

[5]Did your exam reveal any other findings with respect to

[6]her low back?

[7]A Her range of motion was one half normal.

[8]Q What does that mean?

[9]A That means when you conduct a range of motion of

[10]the spine, you have --

[11]Q Can you demonstrate to us?

[12]A Yes.

[13]Q What is normal range of motion?

[14]A When you ask a patient to bend and touch the

[15]floor, this is called flexion. A normal person is able to

[16]bend down, touch the floor and at least come close, at

[17]least go to ninety degrees, that is normal. Then you ask

[18]the patient to bend as far back as possible. What does

[19]that mean "back"?

[20]A This is extension. Then you ask the person to

[21]turn to the sides, this is called lateral bending.

[22]Q In Hiss Jiminez' **[*14]** case did you ask her to do

[23]these specific bends and moves?

[24]A Yes.

[25]Q And could she?

[16]
[1]
[2]A Well, it was decreased by one half normal range

[3]of motion.

[4]Q Was that in all parameters?

[5]A Yes.

[6]Q Forward flexion?

[7]A That is correct.

[8]Q So forth. Doctor, did you conduct any other

[9]types of tests, Doctor, with respect to your examination?

[10]A Yes.

[11]Q What did you do?

[12]A The straight leg raising.

[13]Q What is that? What is the significance of

[14]straight leg raising?

[15]A It's indicative of a nerve root irritation or

[16]disk problem in the lower back.

[17]Q What was the result of Miss Jiminez' straight

[18]leg raising test?

[19]A Again, diminished to 75 degrees with lower back

[20]pain.

[21]Q And what would normal straight leg raising be?

[22]A 90 to 110 degrees without any lower back pain.

[23]Q Now, Doctor, did Miss Jiminez have any other

[24]findings during your examination that you can tell us

[25]about?

[17]
[1]
[2]A Her active range of motion and muscle power

[3]testing was within normal limits for all four extremities,

[4] **[*15]** arms and legs; sensation to pin prick and touch was

[5]decreased in left lateral calf.

[6]Q What does that mean?

[7]A Decreased pin prick sensation? Well, the calf

[8]muscle is supplied by the L5-S1 nerve root distribution.

[9]So if you touch --

[10]Q Where is that specifically, the L5-S1 nerve root

[11]distribution, if you can tell us? Anatomically where

[12]would that be? What part of the body?

[13]A This is fifth lumbar vertebra. This is fourth.

[14]This is the third lumbar vertebra. Right after the lumbar

[15]vertebra ends your tailbone or sacrum begins, so the S

[16]stands for sacrum. So L5-S1 means the nerve root between

[17]the fifth lumbar vertebra and the first sacral bone.

[18]Q And what did this diminished pin prick -- what

[19]was that a sign of?

[20]A A sign of the calf, supplied by the L5-S1 nerve

[21]distribution, and if you have decreased sensation, it

[22]means there is some sort of pathology pointing to L5-S1

[23]nerve root.

[24]Q Now, Doctor, is spasm, is that a sign of an

[25]injury to the low back?

[18]
[1]
[2]A Yes. Spasm is a sign of either a direct trauma

[3]or some sort of a pathological or increased stressing

[4] **[*16]** condition to the muscle or nerve root injury or

[5]irritation.

[6]Q And, Doctor, is diminished sensation to pin

[7]prick, is that objective finding a sign of injury to the

[8]low back?

[9]A Yes.

[10]Q Loss of range of motion, Doctor, is that an

[11]objective finding or sign of injury to low back?

[12]A That's an objective sign -- that is objective

[13]finding and can be a sign of injury as well.

[14]Q Now, Doctor, did you, in fact, Doctor, conduct

[15]an EMS study with respect to this patient Elsie Jiminez?

[16]A Yes, I did.

[17]Q When was that done?

[18]A On April 23, 1990.

[19]Q And, Doctor, can you just explain briefly what

[20]is an EMS test? How is that administered?

[21]A Okay. An EMS stands for electromyography and

[22]has two basic components. If I can show the jurors, I

[23]have some material I brought with me to show.

[24]Q Can I see it?

[25]A This is a sterile disposable needle. This is

[19]
[1]
[2]the electrodes for the ground to nerve conduction.

[3]MR. LEMMO: Could we have those marked

[4]Plaintiff's Exhibit 6.

[5](So marked.)

[6]Q Doctor, just describe what are those items **[*17]** in

[7]your hand?

[8]A This is a sterile EMG needle. These are the

[9]electrodes that you use for nerve conduction.

[10]Q Doctor, are those components of the EMG test,

[11]those items?

[12]A Yes.

[13]Q And, Doctor, are those fair and accurate

[14]components of the EMG test?

[15]A Yes.

[16]Q In other words, would those be found on every

[17]EMG model that is used to be conducted?

[18]A That's right.

[19]Q What type of EMG was used in this case? Are

[20]there different types?

[21]A There is only one standard EMG.

[22]Q Standard EMG?

[23]A Yes.

[24]MR. LEMMO: I would move to admit those

[25]items into evidence.

[20]
[1]
[2]MR. TOMASZEWSKI: I don't know whether it's

[3]standard or not until I get an opportunity to

[4]show them to one of our doctors.

[5]I have no objection to the witness

[6]utilizing them in presentation, but I really

[7]don't know what they are at this point.

[8]THE COURT: Well, we are going to admit

[9]them into evidence based on this expert's

[10]opinion.

[11]Of course, when you have your physician in

[12]court, if you do, during your case, they'll be

[13]here to be referred **[*18]** to.

[14]MR. TOMASZEWSKI: Fair enough. Thank you.

[15]THE COURT: Admitted into evidence.

[16](So marked .)

[17]Q Now, Doctor, can you describe how does a

[18]standard EMG test work? If you have to use your needles

[19]and whatever they are, describe it and explain it to us.

[20]A I think it would be easier for the jurors to

[21]understand as I'm explaining it to refer to the actual

[22]tracing and the actual work sheets from my EMG report.

[23]Q Why don't you refer to those items and then

[24]demonstrate to us--

[25]A Fine.

[21]
[1]
[2]Q what in fact you did with respect to this

[3]particular patient?

[4]A Okay. Before we do an EMG you have to

[5]understand there are two types of nerves. One is called

[6]the peripheral nerve or the ending of a nerve. The other

[7]one is the nerve root. This is the nerve root, and the

[8]peripheral nerve is the last terminal branch of this

[9]specific nerve root. In other words, an example of a

[10]peripheral nerve is the nerve in the wrist (indicating),

[11]that is a peripheral nerve. So the EMG checks the

[12]peripheral nerve as well as the proximal nerve or nerve

[13]root.

[14]Usually, **[*19]** in a herniated disk or radiculopathy --

[15]which means a nerve root compression-- the peripheral

[16]nerve or the nerve connection studies are normal.

[17]When we do an EMG, we have a work sheet something

[18]like this. It tells you the nerve conduction studies,

[19]motor and sensory. That's usually normal, as was this

[20]case.

[21]The way that test is done, we have these electrodes.

[22]If we are doing the lower back, the lower back correlates

[23]to the legs. We place these surface electrodes over the

[24]muscles in the leg, inner and outer part, and we have a

[25]stimulator, which we stimulate a specific nerve again in

[22]
[1]
[2]the inner part and outer part of the ankle and we look at

[3]the response on the oscillating scope machine; that is a

[4]four by four inch thick scops and it gives you the actual

[5]tracing of these nerves.

[6]Q What is it called?

[7]A Oscilloscope. And you look for amplitude or

[8]size of the response. You look for the latency or the

[9]time it took to stimulate the nerve until the nerve

[10]responds and you also look for conduction velocity, the

[11]speed by which the nerve travels, in other words. Again,

[12]all **[*20]** of those were normal.

[13]Then we go on to the actual needle EMG test that

[14]checks the problems to the nerve root. What you do is

[15]test specific muscle groups. We have the muscle in the

[16]inner part of your thigh and it's called the vastus

[17]medialis. That correlates to L3-L4 nerve root.

[18]Then we do the muscle in the shin called the tibialis

[19]anterior muscle. What you do is open up this sterile

[20]needle, for the EMG-- these are all disposable needles--

[21]and it gets hooked to the amplifier box of the EMG and you

[22]insert a needle which looks like this. You can all see

[23]this. These are sterile needles. Then you insert them to

[24]the tibialis anterior muscle in the shin and you look at

[25]the EMG oscilloscope. You look for certain abnormalities.

[23]
[1]
[2]Normally you should see no activity or flat line when you

[3]insert a needle. If you see increased activity with

[4]insertion, that is pathological.

[5]Q What does that mean pathological?

[5]A Means it's abnormal.

[7]So if you have increased activity when you are.

[8]inserting the needle in the muscle, that shows you there

[9]is something that is going on that is **[*21]** wrong.

[10]Second, you look for another abnormality which is

[11]called a positive sharp wave, which looks like this

[12](indicating).

[13]Q What does that mean?

[14]A These downward deflections here, this is from

[15]the L5-S1 nerve root on the left side.

[16]MR. TOHASZEWSKI: May I see what you are

[17]referring to?

[18]THE WITNESS: This is the EMG tracer.

[19]Q Now, Doctor, the EMG tracer there is part of

[20]your EMG report?

[21]A That's right.

[22]Q And that is a report, that EMG report is kept in

[23]the regular course of your business?

[24]A Yes.

[25]Q Is it part of your duties, as a doctor, and part

[24]
[1]
[2]of your business, as a physician, to keep such records?

[3]A Yes.

[4]MR. LEMMO: I would move into evidence at

[5]this time just the EMG report and since the

[6]entire folder was marked for identification

[7]a: Exhibit 4, I ask that be marked as Exhibit

[8]4A.

[9]THE COURT: Okay.

[10](So marked in evidence.)

[11]A This is a work sheet from the actual EMG. As

[12]you can see, there are five different abnormal headings

[13]here. The first one says insertional activity. Second

[14]one **[*22]** says fibrillation.

[15]Q What is fibrillation?

[16]A I'm going to come to it.

[17]Q Continue.

[18]A Third, it says positive waves or positive sharp

[19]waves. Fourth, it says other discharges. Lastly, it says

[20]voluntary motor unit action potentials and interference

[21]pattern. Usually these are all normal in a nerve problem.

[22]Sometimes they can be abnormal, but usually they are

[23]normal.

[24]Again, I mentioned insertional activity. After you

[25]insert the needle, if there is increased activity with

[25]
[1]
[2]each insertion, that is pathological.

[3]In our work sheets we find that the left tibia

[4]anterior muscle showed increased insertional activity, and

[5]the other muscle was the extensor hallucis longus. The

[6]abbreviation for that is EHL.

[7]Q What is that muscle?

[8]A That is the muscle right here (indicating).

[9]Q Now, even though that muscle is right there on

[10]the leg, does that -- where does it refer to the damage?

[11]A It correlates to the L5 nerve root.

[12]Q In the back; is that correct?

[13]A That is correct. All these muscles and

[14]ligaments correlate to nerve root in the back. **[*23]**
[15]First, we do the muscles in the leg and then we go to

[16]the muscles in the back. So that again showed increased

[17]insertional activity. The gastrocnemius muscle, the calf

[18]muscle, showed increased insertional activity. Other two

[19]muscles were normal, vastus medialis and the L3-L4

[20]paraspinal muscles. Then we go to the last two paraspinal

[21]muscles, namely, L4-L5 and L5-S1. These both showed

[22]increased insertional activity.

[23]Q Where are the paraspinal muscles located?

[24]A Right in the lower back. If you put your hand

[25]over your iliac crest, this bone right here and go

[26]
[1]
[2]straight across to the back, you will find it and that is

[3]the L4 spinous process, correlates to the L4 level and

[4]each finger or two fingers down goes to the next level.

[5]We go to fibrillation potentials which, again, shows

[5]pathological problems relating to a nerve root. If you

[7]find fibrillation potentials, means two things: Either

[8]the condition is very severe or, two, it's a long-standing

[9]condition. So if the condition is long-standing, you'd

[10]expect to see some abnormal fibrillation potentials. And

[11]then, third, are **[*24]** the positive waves which we showed you

[12]here on the tracing and that was present on the left,

[13]L5-S1 level.

[14]Q Doctor, lot me go back a moment, if I can, to

[15]the fibrillation potentials. What was indicated in this

[16]test with respect to that?

[17]A It was negative. There weren't any.

[18]Q So, Doctor, based upon that finding of the EMG

[19]test, could you say whether Miss Jiminez' back injury was

[20]of a long-standing nature?

[21]A No. Based on that you can't say it was not of a

[22]long-standing nature.

[23]Q Continue.

[24]A The rest of the exam was normal. So you had

[25]enough abnormal findings to show that there was an L5-S1.
27

[1]
[2]Now, the way it is worded in the report, I put down

[3]the studies reveal electrical evidence suggestive of loft

[4]L5-S1 radiculopathy.

[5]Q Why did you word it that way?

[6]A Okay. Because I have my criteria and there are

[7]doctors-- there is two criteria used. If you have

[8]positive sharp waves at the L5-51, one school of thought

[9]says that's enough. You have definite L5-S1

[10]radiculopathy. My criteria is more rigid. I would expect

[11]to find some positive sharp **[*25]** waves in the limb muscles,

[12]which I did not find. All I found was some increased

[13]insertional activity, which means it's a mild nerve root

[14]compression effecting the muscles in the lower extremity.

[15]So that's why I call it suggestive, but it's still --

[16]Q What was the other criteria that you used in

[17]forming your diagnosis, Doctor?

[18]A Well, to document or to formulate the diagnosis

[19]you go by the history, you go by physical exam findings

[20]and the actual tracings. When you put it altogether, my

[21]overall impression was this patient did in fact have a

[22]definite L5-S1 radiculopathy.

[23]Q And once again, radiculopathy, what does that

[24]mean in lay terms?

[25]A It means pathological condition relating to
28

[1]
[2]nerve root or nerve root compression.

[3]Q Now, Doctor, did you recommend any treatment

[4]with respect to this patient?

[5]A Yes. I was only a consulting in this case. The

[6]patient was referred to me by Dr. Lambert who is a

[7]chiropractor and in my report I recommend to him to

[8]explain to the patient to try a series of paraspinal

[9]injections followed--

[10]Q Explain briefly what are **[*26]** these paraspinal

[11]injections?

[12]A Well, you have a nerve root irritation at L5-31

[13]level. Paraspinal injection is a cocktail of injections

[14]that goes through the back muscles to go right above a

[15]nerve root. It consists of three cc.'s of one percent

[16]lidocaine which is a local anesthetic; one cc of a short

[17]acting cortisone derivative and another one cc of a long

[18]acting cortisone derivative. You give it to both sides

[19]through the paraspinal muscles. It's a little bit painful

[20]and has some side effects.

[21]Q What types of side effects or dangers, if any,

[22]can be caused by making these injections in the paraspine?

[23]A Well, one, cortisone can destroy muscles. It

[24]can cause gastrointestinal bleeding or bleeding inside

[25]your stomach, can cause skin discoloration and atrophy of
29

[1]
[2]the muscle. Atrophy means the muscle actually thins and

[3]loses the bulk of the muscle and you get this

[4]discoloration around the site.

[5]Q Now, Doctor, do you have any knowledge as to

[6]whether Hiss Jiminez went for these injections?

[7]A She did not.

[8]Q And, Doctor, can you tell us what is a CAT scan?

[9] **[*27]** A CAT scan stands for computerized axial

[10]tomography. It is a test that checks the disks, the bones

[11]and some of the soft tissue structures in the area that is

[12]being studied.

[13]Q Now, Doctor, can you tell us, Doctor, whether

[14]Miss Jiminez had a CAT scan performed on her?

[15]MR. TOMASZEWSKI: Counsel approach.

[16](An off-the-record discussion was held at the

[17]bench.)

[18]Q Doctor, does a review of your office records

[19]indicate whether there was a CAT scan performed of this

[20]patient?

[21]A Yes, it does.

[22]Q And what is the date of that report, Doctor?

[23]A September 12, 1909.

[24]Q And, Doctor, who performed that CAT scan?

[25]A You want all the names?

30

[1]
[2]Q Mo, the -- is there a group or what medical

[3]group, if any?

[4]A Well there's one, two, three, four, five, six

[5]names. Six doctor's names.

[6]Q What are they?

[7]A Maklansky, Grunther, Kurzban, Stoll, Cohen and

[8]Zimmer, M.D. P.C.

[9]Q And, Doctor, what CAT scan did they review?

[10]What was the date of the CAT scan on the specific date

[11]they reviewed?

[12]A 3/25/83.

[13]Q Doctor, what, if anything, **[*28]** does

[14]that indicate, CAT scan report?

[15]A It indicates impression: small right

[16]para-central L5-S1 disk herniation.

[17]Q And, Doctor, as part of your training, have you

[18]had occasion to review CAT scan reports?

[19]A Yes.

[20]Q Do you understand what is being said in that

[21]report?

[22]A Yes.

[23]Q Can you explain to the jury what that means?

[24]A Very simply means that there's a disk herniation

[25]at the lowest portion of the lower back, the fifth lumbar

[31]
[1]
[2]vertebra between the first sacral bone; that the disk is

[3]herniated, as I showed you earlier; that the outer rings

[4]have ruptured and the gelatinous material has leaked out.

[5]That's a disk herniation. EMG showed that nerve root is

[6]being compressed partially.

[7]Q Now, Doctor, is your diagnosis consistent with

[8]the findings in that CAT scan report?

[9]A I'm sorry?

[10]Q Is your diagnosis of L5-31 radiculopathy

[11]consistent with the findings in that CAT scan report?

[12]A Yes, it is.

[13]Q Can a patient have both the L5-S1 radiculopathy

[14]and a herniated disk at that level of L5-S1?

[15]A That's how you get a radiculopathy **[*29]** from a

[16]herniated disk.

[17]Q Now, Doctor, did you ever review the actual CAT

[18]scan films?

[19]A No.

[20]Q Doctor, can a patient have a --

[21]MR. LEMMO: Withdrawn.

[22]Q Can you tell us what is an MRI, Doctor?

[23]A MRI stands for magnetic resonance imaging. It

[24]studies the disks and other soft tissues in the spine;

[25]namely, in the neck or the lower back area.

[32]
[1]
[2]Q And, Doctor, can someone with a negative MRI

[3]still have a neurological injury?

[4]A Yes.

[5]Q Can there be occasions, Doctor, where a CAT scan

[6]is positive and where an MRI is negative with respect to

[7]one particular patient?

[8]A It happens in the normal practice of many, many

[9]physicians.

[10]MR. TOMASZEWSKI: I object.

[11]Can we approach?

[12](An off-the-record discussion was held at the

[13]bench.)

[14]THE COURT: Good time for a break, ladies

[15]and gentlemen of the jury.

[16](Recess taken.)

[17]THE COURT: We are in the robing room out

[18]of the presence of the jury. So as to not

[19]prejudice the jury in any way.

[20]MR. TOMASZEWSKI: This is voir dire on

[21]his expertise in the radiology **[*30]** field.

[22]THE COURT: Okay.

[23]MR. LEMMO: Let me ask some questions,

[24]Judge.

[25]MR. TOMASZEWSKI: It's a voir dire.
33

[1]
[2]VOIR DIRE

[3]BY MR. TOMASZEWSKI:

[4]Q Dr. Guy, have you over interpreted an actual MRI

[5]film?

[6]A Yes.

[7]Q How many times in the post?

[8]A During the normal training period we nave actual

[9]training sessions with interpretations of MRI films. We

[10]put them up on the screen. We interpret them and then

[11]they are verified by our preceptors.

[12]Q During the training period where was this?

[13]A Mount Sinai.

[14]Q When -- what amount of your time at Mount Sinai,

[15]which I believe you said was an internship in

[16]rehabilitative medicine?

[17]A No. Residency in internal medicine 18 months, 3

[18]years in physical medicine, rotation four and a half

[19]years.

[20]Q Did you have course studies in interpretation of

[21]MRI's or CAT scans?

[22]A Course studies?

[23]Q Actual medical school tests?

[24]A Yes, absolutely.

[25]Q What percentage of your time in the hospital

[34]
[1]
[2]involved interpretation of CAT scans and MRI's?

[3]A Almost everyday. **[*31]**
[4]Q And what specific knowledge do you have

[5]regarding the variations and differences between a CAT

[6]scan and MRI.

[7]MR. LEMMO: Can I hear that question back?

[8]Q What knowledge do you have and where did you

[9]arrive at your knowledge of the differences in what a CAT

[10]scan reveals and MRI?

[11]A This is standard stuff and any doctor who deals

[12]with the spine gets training during his residency.

[13]In addition, I prepared for my boards. Our boards is

[14]actual interpretation of MRI films. They give you an MRI

[15]film, they ask you to interpret it, then give you a case

[16]history. They tell you to correlate MRI with this EMG

[17]finding or vice versa. It's part of our training period

[18]and we get tested on it.

[19]Q Did you ever see the CAT scans or MRI films of

[20]Elsie Jiminez?

[21]A No.

[22]Q Did you ever see an MRI report of Elsie Jiminez?

[23]A The actual report, no.

[24]Q The only thing you saw was C.T. scan report?

[25]A I saw the C.T. report.

35

[1]
[2]Q Did you ever see the C.T. scan?

[3]A I think I mentioned, no.

[4]Q So to make determination as to whether there is

[5] **[*32]** patnology on a C.T. scan, and on the came patient in the

[6]same area there is no pathology shown on MRI scan, would

[7]you have to at least compare Both reports and both films?

[8]A You can compare it or compare the reports.

[9]Either way. If it was read by a neuroradiologist and you

[10]have the report, you could use that, or you could actually

[11]do it the other way. Either way is okay.

[12]Q You're saying you never did that in this case?

[13]A I never did --

[14]Q With this patient, you never compared the C.T.

[15]and the MRI reports?

[16]A The MRI report, no, I did not see.

[17]MR. TOMASZEWSKI: I renew objection on a

[18]slightly different ground that I believe Mr.

[19]Lemmo's line of questioning was something to the

[20]effect, well, the C.T. scan report is positive

[21]and then there was this negative MRI and can

[22]there be a difference between the two and under

[23]what circumstances can there there be a

[24]difference between the two modalities of

[25]testing. He admits he's never seen the MRI
36

[1]
[2]report. Yet, Mr. Lemmo is trying to elicit an

[3]opinion as to the differences between two

[4]modalities of x-ray diagnosis. **[*33]** He's never scon

[5]the MRI and has no idea what the MRI showed or

[6]didn't show.

[7]MR. LEMMO: Do you have have to see MRI to

[8]make that conclusion?

[9]THE WITNESS: No.

[10]MR. TOMASZEWSKI: Do you have to see MRI

[11]report?

[12]THE WITNESS: I know it was negative.

[13]MR. LEMMO: Do you have to actually see the

[14]report? Other than a generalized statement that

[15]the MRI report is negative, can you make that

[16]conclusion? Can you testify, with a reasonable

[17]degree of medical certainty, as to that

[18]conclusion without seeing the actual MRI report,

[19]if it was negative?

[20]THE WITNESS: If it was read by a

[21]radiologist, I can safely assume it was

[22]negative.

[23]MR. TOMASZEWSKI: Who told you it was

[24]negative?

[25]THE WITNESS: Patient and Dr. Lambert.
37

[1]
[2]Q Dr. Lambert is not a medical doctor; correct?

[3]He's a chiropractor?

[4]A Right.

[5]Q He's not a medical doctor, correct?

[6]A If you let me talk. He's a chiropractor, but he

[7]has -- the report told me it was negative and he sent me

[8]over a copy of the CAT scan.

[9]MR. TOMASZEWSKI: Again, it's hearsay.

[10] **[*34]** He's basing his expert opinion -- this is on the

[11]difference between a report that is going to go

[12]into evidence, assuming Mr. Lemmo brings in the

[13]radiologist, and a report that is based on total

[14]hearsay. What the patient got from a

[15]chiropractor who got it from, supposedly, the

[16]radiologist who took the MRI.

[17]MR. LEMMO: No. He said the

[18]chiropractor --

[19]THE COURT: Do you have a copy of the MRI

[20]report?

[21]MS. GARVEY: No, he doesn't have the MRI

[22]report, your Honor.

[23]THE COURT: I'm asking the doctor.

[24]THE WITNESS: Mo, I don't have it.

[25]THE COURT: Have you seen a copy of the MRI

38

[1]
[2]report?

[3]THE WITNESS: No, I have not.

[4]THE COURT: Have you seen a CAT scan

[5]report?

[6]THE WITNESS: Yes.

[7]THE COURT: And you have a copy of that?

[8]THE WITNESS: Yes.

[9]THE COURT: It's the Court's ruling that

[10]I'm not going to permit Dr. Guy to testify as to

[11]the MRI report, which he does not have in his

[12]file and which he's not seen.

[13]Regarding the CAT scan report that he does

[14]have in his file, he does have a copy of the

[15]report. He can interpret **[*35]** that which he's

[16]already done. So I'll leave that evidence in.

[17]I'll not strike that testimony on which

[18]testimony was already made. Okay.

[19]MR. LEMMO: Yes.

[20]THE COURT: Are there any other

[21]applications?

[22]MR. TOMASZEWSKI: No.

[23]THE COURT: Off the record.

[24](Out of the presence of the jury and

[25]witness.)

39

[1]
[2]MR. TOMASZEWSKI: In an off-the-record

[3]conversation, counsel for defendants and counsel

[4]for plaintiff, stipulated and agree that the MRI

[5]report and MRI films of February 23, 1989 of

[6]Maklansky , Grunther, Kurzban, Stoll, and Cohen

[7]are admitted into evidence and can be utilized

[8]for cross-examination and direct examination

[9]purposes of the respective doctors who will

[10]testify.

[11]I have the MRI films which I will show to

[12]counsel tomorrow morning. He can have an

[13]opportunity to look at the films and to meet

[14]with his doctor or doctors prior to the films

[15]being shown to the jury to go over any

[16]discrepancies that might result from the

[17]examination of the films.

[18]MR. LEMMO: What about the CAT scan report?

[19]MR. TOMASZEWSKI: The CAT scan report **[*36]** as

[20]well is --

[21]MR. LEMMO: Of September --

[22]THE COURT: How are they being admitted,

[23]defendant or plaintiff?

[24]MR. LEMMO: The CAT scan report is -- I

[25]think we are up to 7 for plaintiff.

40

[1]

[2]MS. GARVEY: University Diagnostic Imaging

[3]of August 25, 1983 is likewise admitted into

[4]evidence.

[5]MR. LEMMO: What about the other one? The

[6]other CAT scan?

[7]MR. TOMASZEWSKI: This is the only one I

[8]have.

[9]THE COURT: Defendant's F will be the MRI

[10]report. Plaintiff's 7 is the CAT scan report,

[11]Admitted into evidence by stipulation.

[12]MR. LEMMO: There are two reports.

[13]THE COURT: For what the CAT scan?

[14]MR. LEMMO: Yes.

[15]THE COURT: Are they both being admitted?

[16]MR. LEMMO: Yes. Based upon the same CAT

[17]scan, one dated September 12, 1989 and the other

[18]one is August 25, 1988.

[19]THE COURT: Are you stipulating on both of

[20]them?

[21]MR. TOMASZEWSKI: To both.

[22]THE COURT: So mark them.

[23]MR. LEMMO: 7 and 8.

[24]THE COURT: 7A and B both in evidence.

[25]Doctor resume the stand.

[41]
[1]
[2](Jury present.)

[3]THE COURT: **[*37]** Please continue your inquiry.

[4]MR. LEMMO: Thank you.

[5]Q Dr. Guy, do you have an opinion, based upon your

[6]examination, history and EMG findings, with a reasonable

[7]degree of medical certainty whether the accident of June

[8]2, 1988 was the competent, producing cause of the L5-S1

[9]radiculopathy found?

[10]A Yes, I do have an opinion and I believe that was

[11]the competent, producing cause of the radiculopathy.

[12]Q What is the basis of that opinion?

[13]A Based on the history, physical exam findings and

[14]ENG results.

[15]Q Doctor, do you have an opinion, with a

[16]reasonable degree of medical certainty, whether in fact

[17]the accident of June 2, 1983 was the cause of the

[18]herniated disk at L5-S1?

[19]A Yes. By history, by physical exam, CAT scan

[20]report, EMG studies, again I believe that was the

[21]competent, producing cause of this injury.

[22]Q In your opinion, are these injuries permanent in

[23]nature?

[24]A They are.

[25]Q And, Doctor, in your opinion, with a reasonable

[42]
[1]
[2]degree of medical certainty, will those injuries be the

[3]competent, producing cause of pain?

[4]A Yes. **[*38]**
[5]Q And what about weakness?

[6]A Also weakness.

[7]Q What about limitation of motion?

[8]A Yes, as well.

[9]Q Doctor, I want you to assume that Elsie Jiminez

[10]testified that since your evaluation and treatment she has

[11]gone to other doctors; namely, a chiropractor, a Dr.

[12]Lambert, orthopedist, Dr. Post, and that the treatment

[13]that she's received to her lumbar area provides her with

[14]only temporary relief, that she still experiences pain in

[15]her low back and numbness down her left leg, and is unable

[16]to work as a service specialist at a bank where she was

[17]employed and do her usual activities, such as shopping and

[18]cleaning and dancing and standing for long periods of

[19]time. Doctor, do you have an opinion whether the accident

[20]of June 2nd of 1988 was the cause of Hiss Jiminez'

[21]inability to do these things?

[22]A Yes.

[23]Q What is that opinion, Doctor?

[24]A Again, based on the history, physical exam

[25]findings, results of the CAT scans and EMG results.

43

[1]
[2]Q Doctor, in your opinion, will this patient Elsie

[3]Jiminez require future medical treatment?

[4]A Yes, she will. **[*39]**
[5]Q And, Doctor, can you tell us, are you being

[6]compensated today for your time?

[7]A I am.

[8]Q And, Doctor, is that your standard practice to

[9]be compensated when you come to court to testify?

[10]A Yes.

[11]Q And do you do that on behalf of both plaintiffs

[12]and defendants?

[13]A Yes.

[14]Q Doctor, do you have any outstanding bill with

[15]respect to this patient?

[16]A Yes.

[17]Q Was that bill paid by any source, any other

[18]source? Yes or no?

[19]A No.

[20]Q Can you tell us what is the amount of the bill?

[21]A One thousand fifty-seven dollars and twenty-two

[22]cents.

[23]Q Is that bill, Doctor, in your opinion, fair and

[24]reasonable based upon the services that you performed for

[25]this patient?

44

[1]
[2]A Yes.

[3]MR. LEMMO: Thank you very much.

[4]CROSS-EXAMINATION

[5]BY MR. TOMASZEWSKI :

[6]Q How much are you getting paid for being nerc

[7]today?

[8]A I'm being compensated for this three thousand

[9]dollars.

[10]Q Your bill for Miss Jiminez was $ 1,057. How much

[11]time did you spend with her?

[12]A Approximately one hour.

[13]Q How **[*40]** much?

[14]A One hour.

[15]Q Do you charge all your patients a thousand

[16]dollars an hour?

[17]A That is not my fee schedule.

[18]Q Just asking the question.

[19]A I'm answering the question. That is not my fee

[20]schedule. That is the workman's comp fee schedule.

[21]Q Now, your medical chart that you have here today

[22]has some records from St. Vincent's Hospital back in 1985;

[23]is that correct?

[24]A That is correct.

[25]Q When for the first time did you see those

[45]
[1]
[2]records?

[3]A I believe it was last night.

[4]Q Last night?

[5]A That's right.

[6]Q And how did you get a hold of those records last

[7]night?

[8]A The attorney.

[9]Q Who?

[10]A Mr. Lemmo.

[11]Q Did you meet with him?

[12]A Yes.

[13]Q Was that the first time in your life that you

[14]ever saw those records?

[15]A Yes.

[16]Q Incidentally, you rendered a report to the

[17]chiropractor, Dr. Lambert; is that correct?

[18]A That is correct.

[19]Q It was dated April 23, 1990, the day you

[20]examined the plaintiff; is that correct?

[21]A That is correct.

[22]Q And you wrote **[*41]** in here, in part, and I'm

[23]referring to the fifth line--

[24]MR. LEMMO: Can I see the report?

[25]MR. TOMASZEWSKI: Sure.

46

[1]

[2]Q I'll start on the third line of the report.

[3]MR. LEMMO: I object to the attorney

[4]reading from a document that is not in evidence.

[5]That was marked for identification purposes, the

[6]doctor's report.

[7]MR. TOMASZEWSKI: Move to have it admitted

[8]into evidence.

[9]MR. LEMMO: I object.

[10]MR. TOMASZEWSKI: His doctor prepared his

[11]report.

[12]MR. LEMMO: It's for identification

[13]purposes.

[14]THE COURT: Give me a sidebar here.

[15](An off-the-record discussion was held at the

[16]bench.)

[17]MR. TOMASZEWSKI: I move to have it

[18]admitted into evidence, your Honor.

[19]MR. LEMMO: I object.

[20]THE COURT: Lay the foundation first.

[21]Q Dr. Guy, did you prepare this report to Dr.

[22]Lambert?

[23]A I did.

[24]Q And is this a report prepared in the ordinary

[25]course of your business as a physician?
47

[1]
[2]A It is.

[3]MR. TOMASZEWSKI: I move to have it

[4]admitted.

[5]Q Is that part of your office chart?

[6] **[*42]** A Yes.

[7]MR. TOMASZEWSKI: Move it into evidence.

[8]THE COURT: That will be Defendant's 2.

[9]What is the date of that?

[10]MR. TOMASZEWSKI: April 23, 1990.

[11](So marked.)

[12]Q Now, referring to line three did you write in

[13]your report, as you know patient is a 41 year old female

[14]who presents with no significant medical history, no prior

[15]injuries to neck or back.

[16]A That is correct.

[17]Q Now, is it important, sir, in your practice as a

[18]physician to take a medical history?

[19]A Excuse me?

[20]Q Is it important in your practice as a physician

[21]to take a thorough medical history?

[22]A Yes.

[23]Q Why is that, sir?

[24]A To enable you to arrive at the complete

[25]diagnosis.

48

[1]
[2]Q It would be significant to you as a physician in

[3]your formulation of your treatment plan to know whether

[4]your patient had ever been disabled before with a back

[5]injury; isn't that correct?

[6]A I'm not the treating physician. I'm a

[7]consultant, patient referred for EMG.

[8]Q You're not treating?

[9]A That is correct. So my responsibilities are

[10]different.

[11] **[*43]** Q What is the responsibility of a consulting

[12]physician as opposed to a treating?

[13]A To perform that specific test that you're asked

[14]to do; namely, EMG and only EMG.

[15]Q You're saying that a consulting physician

[16]doesn't have to take a medical history that a treating

[17]physician does?

[18]A That's not what I'm saying. I'm saying a

[19]consulting physician is not required to take as detailed a

[20]history as a treating physician is and he's also not

[21]obligated to obtain all past medical records, as a

[22]treating physician would be, because I'm not going to be

[23]treating. All I'm doing is is rendering an opinion as to

[24]the EMG findings; that is it.

[25]Q In any event, did you take a medical history?
49

[1]
[2]A Part of it.

[3]Q Did you ask her about her neck?

[4]A Part of the EMG is to obtain history, physical

[5]exam, neurological exam and EMG.

[6]Q Did you did ask her about her neck and back?

[7]A Yes.

[8]Q As you sit here today, you remember asking Miss

[9]Jiminez did you ever sustain an injury to your neck before

[10]coming here today. Do you remember that?

[11]A I remember -- I told **[*44]** you that she mentioned

[12]nothing significant. No significant injury to the neck.

[13]Q All right. Sir, in your medical expert opinion,

[14]do you consider an injury that lands you in the hospital

[15]for two weeks, in cervical traction, to be a significant

[16]injury? Yes or no?

[17]A It depends.

[18]Q It depends on what?

[19]A It depends on the severity or the nature of the

[20]injury. You can be --

[21]Q Why don't you take a look at the St. Vincent's

[22]medical records?

[23]A I did.

[24]Q Is that a severe injury, two weeks in the

[25]hospital in cervical traction? Is that a significant
50

[1]
[2]injury?

[3]A Now, that question can bo answered with a nice

[4]explanation. Back in 19 --

[5]Q Why don't we start with a yes or no, if that is

[6]possible. Is that a significant injury? Yes or no?

[7]MR. LEMMO: I'd appreciate if counsel

[8]doesn't yell at the witness.

[9]THE COURT: Counsel please refrain, if you

[10]can, from raising your voice.

[11]MR. TOMASZEWSKI: Yes.

[12]A To answer your question, the diagnosis here is

[13]cervical spasm. If you ask me if cervical spasm is a

[14]significant injury, I **[*45]** would have to tell you, no, it's not

[15]a significant injury.

[16]Q Would you put a patient in the hospital for two

[17]weeks in cervical traction with a minor injury?

[18]A Me personally?

[19]Q Yes.

[20]A No.

[21]Q Are you criticizing the care of her prior doctor

[22]then?

[23]MR. LEMMO: Objection, your Honor.

[24]MR. TOMASZEWSKI: Cross-examination.

[25]THE COURT: As to the word criticized.

[51]
[1]
[2]Q Do you dispute the care rendered by her prior

[3]treating doctor, sir?

[4]A I am not. You asked me what I would do. I told

[5]you what I would do.

[6]There are many different ways of treating a patient

[7]and the treating physician has the right to treat the

[8]patient anyway he feels it's optimal. You asked mo

[9]personally. I would not have put the patient in with that

[10]diagnosis.

[11]Q When you wrote here no prior injuries to neck,

[12]were you aware of that hospitalization?

[13]A At that particular hospitalization, no.

[14]Q Were you aware of any other hospitalizations?

[15]A No.

[16]Q Were you aware that she had been disabled as a

[17]result of that?

[18]MR. LEMMO: Objection **[*46]** to the form of the

[19]question.

[20]A No.

[21]MR. LEMMO: This witness is not here to

[22]render opinions as to disability. Disability is

[23]a term of art.

[24]THE COURT: Rephrase.

[25]MR. TOMASZEWSKI: Withdraw.

[52]
[1]
[2]Q Are you aware that she received an abnormal, as

[3]you've eloquently described to the jury, EMG at about that

[4]time of that injury, following that injury?

[5]A No, I was not aware of that.

[6]Q Would that have been significant to you, sir?

[7]A I'm not mentioning anything about the neck here.

[8]The problem here is the lower back. So this is

[9]insignificant to this present situation.

[10]Q A severe injury to the neck is totally

[11]insignificant, to you in regard to this patient?

[12]MR. LEMMO: Objection to the form of the

[13]question.

[14]MR. TOMASZEWSKI: Cross-examination.

[15]MR. LEMMO: Your Honor, he's terming the

[16]injury significant. Doctor's opinion is it's

[17]not significant with respect to the neck.

[18]MR. TOMASZEWSKI: Let him say it.

[19]MR. LEMMO: He did.

[20]Q Would you answer the question?

[21]A Please repeat the question.

[22]MR. TOMASZEWSKI: **[*47]** Would you read it back

[23]please?

[24](Question read back.)

[25]A I don't know what a severe injury to the neck
53

[1]
[2]is. What is the diagnosis?

[3]Q Look at the records in front of you, St.

[4]Vincent's Hospital.

[5]A I read the record. Final diagnosis is cervical

[6]spasm.

[7]Q After two weeks in traction that is not

[8]significant injury?

[9]A Cervical spasm is significant injury?

[10]Q Two weeks in traction?

[11]A You asked me is it significant injury. I'm

[12]going on the diagnosis. Cervical spasm, in my opinion, is

[13]not significant injury.

[14]Q The treatment rendered was two weeks in the

[15]hospital in cervical traction, with pain-killing

[16]prescription medications. That does not indicate to you

[17]that she sustained a serious injury?

[18]A The nature of a serious injury depends on the

[19]diagnosis. If you have spasm, sure, spasm could take two

[20]weeks, three weeks, four weeks. Is it significant injury?

[21]In my opinion, no, because eventually spasm should get

[22]better.

[23]Q What about cervical -- you've used the term

[24]radiculopathy; correct?

[25]A Yes.

54

[1]

[2]Q Is **[*48]** that a permanent injury?

[3]A If it's a cervical radiculopathy documented by

[4]EMG , yes, that's a permanent injury.

[5]Q And if the plaintiff in -- sir, I'm going to

[6]show you a document that, has been admitted into evidence

[7]Defendant's Exhibit F. I ask you to take a look at this,

[8]sir.

[9]A Okay.

[10]Q What is that?

[11]A That's an MRI report of the lumbar spine

[12]performed on Miss Jiminez on February 23, 1989.

[13]Q What does the report say in regard to her lower

[14]back, sir?

[15]A Impression: normal examination, other than mild

[16]degenerative changes.

[17]Q Normal examination, other than mild degenerative

[18]changes.

[19]And is that report regarding a specific area of her

[20]back where you say she has this radiculopathy based on

[21]your EMG test?

[22]A This is the interspaces tested from L3 to S1.

[23]Q That is the same area that you say she has

[24]radiculopathy?

[25]A That is correct.

55

[1]
[2]Q What is degenerative change, sir?

[3]A I can show you on my model.

[4]Q I'd ask you to explain it.

[5]A Degenerative changes are arthritic changes which

[6]happens **[*49]** in the normal aging process of normal bone age.

[7]Q Right. And is it fair to say if you take any

[8]sample of the population, in their thirties or forties,

[9]that you'll find that half the people walking around have

[10]degenerative changes and if they took an MRI, that MRI

[11]would show degenerative changes in the very areas of the

[12]spine you pointed out earlier?

[13]A I don't agree with the number half the patients.

[14]Q How many?

[15]A I would say depends on the age group.

[16]Q Forty?

[17]A Forty men or women?

[18]Q Women.

[19]A Women get arthritis much earlier than men

[20]because of hormonal reasons.

[21]Q Okay. So how many reasons, in any give given

[22]percentage of the population, would have degenerative

[23]arthritic changes in that area of the back at the age of

[24]40?

[25]A In my opinion, about one-third.

[56]
[1]
[2]Q One-third?

[3]A One-third or less.

[4]Q One out of every three people -- every three

[5]women that age walking on the street, you take then in,

[6]you give them this advanced test and it's going to show

[7]some abnormality; is that correct?

[8]A Well, depends **[*50]** on abnormality. If you are

[9]talking about degenerative changes, it may show some

[10]degenerative changes.

[11]Q What is more diagnostic, sir, to determine if a

[12]herniated disk is present in someone's lower back, an EMG

[13]or MRI?

[14]A Okay. The most definitive test for herniated

[15]disk is a myelogram with a CAT scan.

[16]Q Are you familiar with the Journal of The

[17]American Medical Association?

[18]A I'm familiar with it, but I don't hold it to be

[19]authoritative.

[20]Q That is a journal published by doctors about

[21]various topics of medicine?

[22]A Yes.

[23]Q Would you consider certain portions of certain

[24]articles authoritative? Hot the whole journal, but

[25]certain portions of articles?
57

[1]
[2]A It would depend on what that portion is and what

[3]other journals and what other studies have said about that

[4]specific item.

[5]MR. TOMASZEWSKI: I'd like to mark this

[6]document for identification.

[7]THE COURT: That is Defendant's II for

[8]identification.

[9](So marked.)

[10]Q Sir, I'm going to read you a brief excerpt from

[11]the --

[12]MR. LEMMO: I object to any reading from

[13] **[*51]** document that is not in evidence.

[14]MR. TOMASZEWSKI: He said that -- may we

[15]approach? He said he recognized certain

[16]portions of certain articles as authoritative?

[17]A I did not. I said no one source is

[18]authoritative.

[19]Q Fine.

[20]A There is no such thing as one source always

[21]being the authoritative, absolute bible on that area.

[22]There are other studies and things change from time to

[23]time and other studies disprove other studies.

[24]For instance, now, what we learn from nutrition

[25]contradicts everything we learned about nutrition five,
58

[1]
[2]ten years ago.

[3]Q Sir, do you consider some writings, for example,

[4]in the American Medical Association Journal to be correct

[5]or authoritative on certain topics?

[6]MR. LEMMO: I object to the form of the

[7]question. It's very obscure and speculative.

[8]MR. TOMASZEWSKI: Certainly is not.

[9]MR. LEMMO: Certain articles? Why doesn't

[10]he tell him the article?

[11]MR. TOMASZEWSKI: I'll tell him. I want to

[12]read it. You won't let me.

[13]MR. LEMMO: I object.

[14]May we approach?

[15]THE COURT: I don't think so.

[16]Show the **[*52]** doctor the article, counsel.

[17]MR. TOMASZEWSKI: I want to read him a

[18]section.

[19]THE COURT: Show him the section you want

[20]to read.

[21]MR. TOMASZEWSKI: Fine.

[22]THE COURT: Let him read it to himself

[23]first.

[24]Q The section on degenerative disk disease.

[25]A I strongly disagree with this.
59

[1]
[2]Q You don't believe that an MRI is more diagnostic

[3]than a CAT scan in the lumbar spine?

[4]A Not lumbar spine.

[5]Q Sir, what is your training in radiology? Have

[6]you ever, hands on, taken and MRI or CAT scan? Yes or no?

[7]A No radiologist does a hands on MRI or CAT scan.

[8]Q Do you have any training, any idea how to take

[9]MRI or CAT scan?

[10]A No, that is the technician's job. No doctor

[11]does that.

[12]Q What does it mean when you say a complaint is

[13]objective or subjective?

[14]A Subjective is what the patient complains of.

[15]Objective is what the doctor finds on his clinical

[16]assessment; namely, on his physical examination or through

[17]other testing.

[18]Q Okay. Pain is subjective; right?

[19]A Pain is subjective, yes.

[20]Q That means if a person **[*53]** wants to, wants you to

[21]think they are in pain, they can sometimes fool you; is

[22]that correct?

[23]A Yes, but EMG does not fool you.

[24]Q I'm not asking you about EMG. Stick to the

[25]topic. We are talking about complaints.
60

[1]
[2]A I'm trying to answer you.

[3]Q If someone bends down and they don't want to go

[4]to the floor, they can fool you; is that correct? They

[5]don't have to go all the way down to the floor?

[6]A If they have tight spasm and they can't go to

[7]the floor, that is not fooling me.

[8]Q Could you answer the question yes or no?

[9]A I'm trying.

[10]Q If someone wants to fool you and bend down half

[11]way, as opposed to all the way, they can fool you;

[12]correct?

[13]MR. LEMMO: I object to the fooled.

[14]MR. TOMASZEWSKI: Fooled or hoodwinked. I

[15]don't know the word.

[16]MR. LEMMO: I object.

[17]THE COURT: Rephrase.

[18]Q If someone wants to let you think --

[19]THE COURT: I think you've asked the

[20]question sufficient times and the doctor has

[21]answered.

[22]MR. TOMASZEWSKI: I don't remember the

[23]answer, but I'll move on.

[24]THE COURT: I think **[*54]** the jury remembers the

[25]answer. Move on.

[61]
[1]
[2]Q Now, you indicated something about degenerative

[3]disks, degenerative arthritic changes in the disks found

[4]in one-third of all women the age of 40; correct?

[5]A I don't know if I said disk. I road the report.

[6]It said degenerative changes. I don't believe it said

[7]where.

[8]Q Where would you find degenerative changes?

[9]A Why don't you let me have the report back so I

[10]can answer your question?

[11]Okay. It says mild degenerative changes; mild,

[12]marginal lipping involves the zygapophyseal joints

[13]bilaterally and also mentions there is slight disk

[14]desiccation noted at L5-S1.

[15]Did I answer your question?

[16]Q Well, my question was generally where would you

[17]find degenerative changes in any given person? Would you

[18]find them in the disks?

[19]A You can find them in the disks, in the

[20]apophyseal joints, in the vertebra, in neuro foramina.

[21]Q You said there was positive or abnormal CAT

[22]scan; is that correct?

[23]A I said I reviewed a CAT scan report, yes. It

[24]was abnormal.

[25]Q You have the CAT scan report in your **[*55]** file.
62

[1]
[2]Would you pull it out please?

[3]A Okay.

[4]Q Please refer to line five of that report. It

[5]says there is no evidence of spinal stenosis?

[6]A What is spinal stenosis?

[7]A I can show you on the model.

[8]Q It will be quicker if you tell me.

[9]A I disagree.

[10]Q Can you tell me?

[11]A Spinal stenosis means narrowing of the spinal

[12]canal.

[13]Q That is a serious or significant problem?

[14]A It could be or -- yes or no, it depends.

[15]Q Also says there is no evidence of foraminal

[16]stenosis?

[17]A What is the foramen?

[18]A That is the space where the nerves come out.

[19]Q And when you have pathology from a disk, the

[20]disk material is pressing on the nerve; is that correct?

[21]A That is correct.

[22]Q In this CAT scan -- stenosis is a narrowing or

[23]compression of the nerve; is that correct? That's

[24]stenosis?

[25]A Sorry?
63

[1]
[2]Q What is stenosis?

[3]A Stenosis means narrowing.

[4]Q Narrowing or compression of the nerves?

[5]A No. Don't put words in.

[6]Q I'm not. I ask you to explain.

[7]A If you want **[*56]** me to explain, let me explain it so

[8]people can understand it.

[9]Q Let's go on to the next sentence and you can

[10]explain.

[11]And the exiting lumbar nerve roots appear intact at

[12]the level -- where?

[13]A Where do you see that?

[14]Q I see that on line 7 and 8 of the report?

[15]A Mine only goes up to line 6. I don't know how

[16]you get line 7.

[17]Q Well, there is another CAT scan report that is

[18]in evidence. That's the same CAT scan, by the way,

[19]Doctor. Look. It's just two reports interpreting the

[20]same CAT scan?

[21]A You told me to read it from my report. I read

[22]it. Now I'll read it from your report.

[23]MR. LEMMO: Is that report the same report,

[24]Doctor?

[25]THE WITNESS: It's not the same.

64

[1]
[2]MR. LEMMO: What's the date of that report?

[3]THE WITNESS: This one is August 25, '88.

[4]Date of this is September 12, 1989. This says

[5]review of C.T. scan performed elsewhere.

[6]Q Of the one you have in your other hand--

[7]A Okay.

[8]Q -- what does it mean when it says exiting lumbar

[9]nerve roots are intact? Means no compression; right?

[10]A Wait, wait, **[*57]** wait. Let me read it. Where does

[11]it say that?

[12]Q Line 7 and 8?

[13]A There is no evidence of foraminal stenosis and

[14]exiting lumbar nerve roots appear to be intact. Of course

[15]they are intact. I'm saying they are intact.

[16]All I'm saying there is radiculopathy. There is

[17]something causing a problem to the nerve root. I'm not

[18]saying they are not intact. If they weren't intact, she

[19]would have no power in the legs.

[20]Q C.T. scan is an excellent tool to determine back

[21]pathology, to determine if there is compression of the

[22]nerve roots; isn't that correct?

[23]A Absolutely not. That is where you are mistaken.

[24]The only test that is the most efficient way to determine

[25]damage to nerve root is EMG or --

65

[1]

[2]Q You're telling us that CAT scan taken of a nerve

[3]and disk was not going to show compression?

[4]A I'm telling you that a CAT scan, is not -- in no

[5]way studies a nerve. It's not a test that studies a

[6]nerve. It can tell you if the nerve root -- like what it

[7]says-- if a nerve is intact or it's cut off. I'm not

[8]saying a nerve was not intact.

[9]Q Can a CAT scan show compression **[*58]** of a nerve root?

[10]Yes or no?

[11]A In some situations, yes. In many situations,

[12]no.

[13]Q So it can. And in that report it doesn't; is

[14]that correct?

[15]A According to this report, all it says is--

[16]listen very carefully to what it says-- the exiting

[17]lumbar nerve root appears intact. That's all it says.

[18]Q Can I have my report?

[19]Now, you indicated in your EMG there was some

[20]abnormal findings; is that correct?

[21]A That is correct.

[22]Q And you indicated that those abnormal findings

[23]may have been the result of a problem at L5-S1?

[24]A I said that's where the problem is.

[25]Q What other pathology could cause the abnormal
66

[1]
[2]findings in your EMG?

[3]A Causes of radiculopathy are as follows: Fracture

[4]compressing on nerve root, an arthritic spur or spicule

[5]sticking inside the canal compressing on nerve root, a

[6]tumor, and herniated disk and also the shearing force of a

[7]significant blew can also cause a radiculopathy.

[8]Q Well, what about degenerative changes?

[9]A I just mentioned to you if you had a spur

[10]sticking into the canal, hitting a nerve root, **[*59]** that can

[11]cause it. But according to the CAT scan report, which you

[12]had me read, there was no neural-foramina stenosis.

[13]Q You're not an orthopedist; right?

[14]A No.

[15]Q You're not a neurologist who specializes in the

[16]study of nerves?

[17]A I am a specialist that studies nerves. I'm not

[18]a neurologist.

[19]Q You're not a Board certified neurologist; is

[20]that correct?

[21]A No.

[22]Q Did you check this patient's Babinski sign?

[23]A Why would I check Babinski?

[24]Q Did you check Chaddock's sign?

[25]A Why would I?

[67]
[1]
[2]Q I ask if you did?

[3]A No.

[4]Q Did you check patient's Lasegue's sign?

[5]A Lasegue's sign?

[6]Q Yes.

[7]A I don't understand. I don't know if anybody

[8]does a Lasegue's sign.

[9]Q What is it?

[10]A I'm not familiar with it.

[11]MR. TOMASZEWSKI: No further questions.

[12]THE COURT: Counsel?

[13]MS. GARVEY: May I inquire?

[14]CROSS-EXAMINATION

[15]BY MS. GARVEY:

[16]Q Good evening, Doctor?

[17]A Good evening.

[18]Q Would you explain the difference between an MRI

[19]and a CAT scan?

[20]A Yes. **[*60]** CAT scan uses x-ray beams to study the

[21]spine. MRI uses magnetic resonance imaging by using a

[22]magnetic field. One has radiation, one has no radiation.

[23]They both do the studies of the spine. The CAT scan is

[24]superior in studying bones. MRI is superior is studying

[25]soft tissue problems. That's basically the differences.
68

[1]
[2]MRI is more superior than the CAT scan in certain areas

[3]and vice versa. CAT scan is more superior than the MRI in

[4]other areas.

[5]Q What areas would MRI be superior to a CAT scan?

[6]A In the cervical neck region, in the lower back,

[7]I believe, and many other radiologists believe, because

[8]I've spoken to them, they believe that CAT scan is more

[9]superior than MRI, especially in the lumbar spine. Again,

[10]in the brain area the MRI is more superior than a CAT

[11]scan.

[12]Q Well, Doctor, in your opinion, is it true that

[13]a -- correct me if I'm wrong-- that a CAT scan gives a two

[14]dimensional picture x-ray and MRI would gives a three

[15]dimensional; is that correct?

[16]A Certain MRI's give three dimensional and one

[17]is -- MRI gives you sagittal and axial. CAT scan gives

[18]you more **[*61]** axial.

[19]Q Can you explain the difference of those two

[20]terms for the jury?

[21]A Well, it's the way you cut. I'm trying -- it's

[22]very difficult to explain.

[23]Q Would it be helpful if you had the model?

[24]A Unfortunately with that you can't explain on the

[25]model. It's the way you direct the beams to study the
69

[1]
[2]slide.

[3]Let's say you have -- let me refer to my model.

[4]Perhaps I can try to explain it. CAT scan takes beams

[5]like this, like so. MRI does saggital and also axially,

[6]so looks at them in more dimensions.

[7]Q How, you mentioned before that a finding of

[8]cervical radiculopathy is a permanent injury; is that

[9]correct?

[10]A Yes.

[11]Q Now, you also mentioned before that you

[12]conducted certain SI1G tests on Miss Jiminez; is that

[13]correct?

[14]A That is correct.

[15]Q Do you know what Graves' disease is?

[16]A Yes.

[17]Q What is that?

[18]A It's called thyrotoxicosis. It's a thyroid

[19]dysfunction where the thyroid gland is under increased

[20]metabolism.

[21]Q Now, isn't it true that a thyroid condition can

[22]affect EMG readings?

[23]A Not in **[*62]** radiculopathy.

[24]Q Not in radiculopathy?

[25]A It can affect muscle problems from the EMG.

70

[1]
[2]Muscle, not a nerve root problem.

[3]Q Now at the time you explained to the jury when

[4]you inserted the needle, did you insert it into the nerve

[5]or did you insert it into the muscle?

[6]A Okay. Let me explain to everybody. When you

[7]insert a needle, if you insert it into a nerve, the

[8]patient is goinq to hit the ceiling. You insert it into a

[9]muscle. The patient already hits the ceiling from just

[10]inserting it into the muscle, but a nerve, forget about

[11]it.

[12]Q Now, Doctor, isn't it true that a person with

[13]Graves' disease would have approximately a 90 percent

[14]chance of having fluctuations in their EMG readings?

[15]A Again, not with radiculopathy. Has absolutely

[16]no affect on nerve roots. Muscles, yes, but not nerve

[17]root.

[18]Q How would you be able to distinguish from the .

[19]muscle and the nerves in an EMG test?

[20]A Very simple. When you insert a needle into the

[21]muscles in the limbs, you would expect to find no

[22]abnormalities in the paraspinal muscles. It only affects

[23]the proximal **[*63]** muscles, not the distal muscles.

[24]In this case, all the distal muscles were involved;

[25]the vastus medialis, and proximal muscles were studied and

[71]
[1]
[2]normal. That, I know, rules out the possibility of the

[3]muscles being involved by Graves' disease and based on my

[4]examination of her muscle power, her muscle power is

[5]normal. Again Graves1 disease, if it affects the muscles,

[6]you would expect to find some weaknesses.

[7]Q Would radiation treatments affect EMG?

[8]A You mean from chemotherapy for tumors?

[9]Q Chemotherapy for tumors, thyroid?

[10]A Radiation therapy to the spine?

[11]Q Radiation therapy.

[12]A It can affect the nerve roots. It won't be

[13]isolated. One nerve can affect all of them. So if it

[14]affects all of them, you may have an argument, but one

[15]single nerve root, no. It's not specific to only isolate

[16]one specific nerve root and save all the others.

[17]Q But it could affect one side. Is that what your

[18]testimony is?

[19]A No. When you give radiation, when you direct

[20]the beam, it's to a large area. Even if you make it to a

[21]specific area, you are still giving both **[*64]** sides of the

[22]nerve roots -- you cannot get one side and save the other.

[23]Q Were you able to pinpoint, based on the history,

[24]examination, the CAT scan review, when this cervical

[25]radiculopathy actually occurred on Miss Jiminez?

72

[1]

[2]A That when the -- I can pinpoint it to a certain

[3]period. I can't pinpoint it exactly. I don't think any

[4]doctor can pinpoint it exactly.

[5]Q Well, you said that she didn't have it. You

[6]said confidently that Hiss Jiminez did not have a

[7]long-standing back problem; is that, right?

[8]A Because there were no fibrillation potentials.

[9]Q Are you able to tell within what time frame the

[10]cervical radiculopathy occurred?

[11]A Cervical radiculopathy?

[12]Q Withdrawn. Her lumbar radiculopathy?

[13]A Well, I can tell you it happened within less

[14]than two years.

[15]MS. GARVEY: I'd like to have four

[16]documents marked for identification.

[17]THE COURT: Will counsel approach please?

[18](So marked.)

[19]Q Doctor, in the meantime, are you familiar with a

[20]Dr. Leon Sultan Board certified orthopedist?

[21]A Yes. I've come across his reports.

[22] **[*65]** Q I ask you to look at the reports you have in

[23]your hand.

[24]A Okay.

[25]Q Those reports are in 1985; is that correct?
73

[1]
[2]A That is correct.

[3]Q Is there a finding that plaintiff was diagnosed

[4]as having chronic cervical radiculopathy at that time?

[5]MR. LEMMO: Objection. As far as the

[6]reports, the reports are hearsay. They are not

[7]in evidence. She's asking the doctor to recite

[8]from a report that is not in evidence. That was

[9]done in 1935, supposedly.

[10]MS. GARVEY: Your Honor, do you want me to

[11]respond in open court?

[12]THE COURT: I think you should respond at

[13]the sidebar.

[14](An off-the-record discussion was held at the

[15]bench.)

[16]Strike that last question.

[17]Q Doctor, did you examine Miss Jiminez when she

[18]came to your office?

[19]A Yes, I did.

[20]Q Did you observe that one of her calves was

[21]smaller than the other?

[22]A Did somebody take my report out of the chart?

[23]MR. LEMMO: It's in evidence.

[24]THE COURT: Your report is G in evidence.

[25]A No, I did not.
74

[1]
[2]MS. GARVEY: I have no further questions.

[3] **[*66]** THE COURT: Miss Lipton.

[4]MS. LIPTON: No questions.

[5]REDIRECT EXAMINATION

[6]BY MR. LEMMO:

[7]Q Could you tell us, Doctor, is a herniated disk,

[8]Doctor, at L5-S1 a normal, expected finding of a 39 year

[9]old woman with no prior history of low back trauma?

[10]A I'm sorry. I didn't get the whole question.

[11]Q Is a herniated disk at L5-S1, Doctor, is that a

[12]normal, expected finding of a 39 year old woman with no

[13]prior history of low back trauma?

[14]A Absolutely not.

[15]Q Doctor is EMG an objective, recognized test in

[16]the field of neurology?

[17]A Yes.

[18]Q And, Doctor, can a patient fake this test if

[19]it's administered properly?

[20]A No way.

[21]Q Doctor, looking at that MRI report, what does it

[22]mean when it says mild?

[23]A MRI report or CAT scan report?

[24]Q Let me look at the report.

[25]A That's the CAT scan.
75

[1]
[2]Q No. It was the other report.

[3]A It's not here.

[4]Q It's over here. All right. On paragraph two it

[5]says mild. What does that mean? Mild-marginal, what does

[6]that mean?

[7]A Mild-marginal lipping. This is a mild-marginal

[8] **[*67]** lipping right here. As you can see, this is normal. This

[9]is abnormal, bone grout from natural aging, arthritis.

[10]This is lipping.

[11]Q In your opinion, does the arthritis, if any,

[12]does that have anything to do with the trauma from the

[13]accident, Doctor?

[14]A No.

[15]MR. LEMMO: No further.

[16]MR. TOMASZEWSKI: One question.

[17]RECROSS-EXAMINATION

[18]BY MR. TOMASZEWSKI:

[19]Q You didn't find any atrophy, did you?

[20]A No.

[21]Q Atrophy is muscle waste?

[22]A Yes.

[23]Q Both of her legs and feet you -- there was no

[24]atrophy. You found no atrophy in the lower legs or feet?

[25]A I did not.
76

[1]
[2]Q Atrophy is wasting away of muscle?

[3]A That's right.

[4]Q But all muscles in her lower extremities, they

[5]were normal and fine; is that correct?

[6]A As far as I can recall, yes.

[7]MR. LEMMO: One other question.

[8]REDIRECT EXAMINATION

[9]BY MR. LEMMO:

[10]Q Would that be significant in your diagnosis

[11]whether there is atrophy of the muscles?

[12]A It's irrelevant. You can get atrophy after

[13]radiculopathy is severe and long-standing. Again, it

[14]depends **[*68]** on the degree of the radiculopathy. If it's

[15]severe radiculopathy, you may or may not have atrophy.

[16]With a mild radiculopathy, you don't usually expect to

[17]have atrophy of the muscles.

[18]Q Wild you don't expect atrophy?

[19]A Mild you don't expect atrophy.

[20]Q If I didn't walk on my leg or limped heavily on

[21]one leg, I would expect atrophy in the other leg I was

[22]favoring; is that correct?

[23]A Sorry?

[24]Q If I limped or favored one leg heavily, you

[25]would expect atrophy in the other leg?
77

[1]
[2]A No, not necessarily.

[3]MS. GARVEY: One question.

[4]Q Leftside L5 radiculopathy, could you tell us

[5]exactly when that occurred in between June 2, 1988--

[6]A No.

[7]Q -- and --

[8]A No, I can't tell you when it occurred.

[9]Q It's possible it occurred sometime in 1989; is

[10]that correct?

[11]A I told you all I can tell you is that it was

[12]less than two years.

[13]Q But you have no idea when in the two years?

[14]A Exact time, I do not.

[15]MS. GARVEY: No further questions.

[16]THE COURT: All right. Doctor, you may

[17]step down.

[18]THE COURT: Ladies **[*69]** and gentlemen of the .

[19]jury, we will recess until tomorrow morning.

[20]Please remember not to discuss the case

[21]among yourselves. Please keep an open mind.

[22]Report back here at 9:30 tomorrow morning.

[23]See you tomorrow morning.

[24](Whereupon, the case stands in recess until

[25]December 2, 1992.)

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