1994 WL 16448250 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.

SOBHA,
v.
ANTHOS COAT CO.

No. 9778/94.
1994.

(Transcript of Dr. Ali Guy)

Case Type: Vehicle Negligence >> Inattention
Case Type: Vehicle Negligence >> Motor Vehicle v. Motor Vehicle
Case Type: Vehicle Negligence >> Parked/Stalled/Stopped Vehicle
Case Type: Vehicle Negligence >> Rear-End
Case Type: Vicarious Liability >> N/A
Case Type: Vehicle Negligence >> Passenger
Jurisdiction: New York
Name of Expert: Dr. **Ali Guy**
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine

Representing: Unknown

record please.

THE WITNESS: My name is Dr. Ali Guy. My office address is 7 Gramercy Park, New York, New York 10003.

THE COURT CLERK: Thank you.

DR. ALI GUY, a witness called on behalf of the Plaintiff, having been first duly sworn by the Court Clerk, was examined and testified under oath as follows:

DIRECT EXAMINATION

BY MR. VESNAVER:

Q Good morning, Dr. Guy.

A Good morning.

Q Dr. Guy, are you a duly licensed doctor, licensed to practice medicine in the State of New York?

A I am.

Q And when did you receive your license?

A 1985.

Q Could you briefly go over your educational background.

A Yes. Undergraduate, I went to Queens College. Medical School, I went to the Dominican Republic. I graduated in June of 1981. Afterwards I did three residencies. The first one was in the field of internal medicine for a period of eighteen months and then one year of general surgery at Cabrini Medical Center. And then I did three years physical medicine and rehabilitation at Mount Sinai School of Medicine, Mount Sinai Medical Center.

I'm a clinical instructor to the residents from the NYU Medical Center at the Hospital for Joint Diseases, Orthopedic Institute. I'm the Director of Neuromuscular Equipment Clinic at the same hospital; also on staff at the Cabrini Medical Center. I'm board certified in the field of physical medicine and rehabilitation.

Q Are you board certified?

A Yes, I am.

Q And what does it mean to be board certified?

A Board certification is the highest degree which you can obtain in your level of specialty. It is the equivalent of a Ph d. to a non-medical person. In order to be qualified for a board certification, you must have fulfilled the following prerequisites:

Number 1. A minimum of one year prerequisite in another specialty other than physical medicine and rehabilitation.

You must have passed all your yearly examinations in the field of physical medicine and rehabilitation, scored seventy percent or higher.

You then sit in for an eight hour examination, which encompasses all your training in the past several years. And once you pass that, then you must be in private practice for a period of no less than eighteen months.

You must be sponsored by two other doctors that are already board certified, that know you very closely, both professionally and practically.

There must have been no complaints against you in any capacity; ethically, criminally, or legally.

You must then fly to the Mayo Clinic in Minnesota -- that's where all of the research is done and all the text books are written -- you are then tested by a group of doctors orally in the field of orthopedics, physical medicine, electromyography, kinesiology, which is the study of motion, the study of movement. And once you prove to these doctors that your knowledge is equivalent to theirs, or better, they pass you and give you the title of a ‘Diplomate,’ which means you are board certified, which is the highest degree of qualification or training that you can attain in your level of specialty.

Q How did you obtain your board certification?

A By passing these examinations.

Q Are you a clinical instructor in any major teaching hospital?

A Yes, at the Hospital For Joint Diseases, Orthopedic Institute, and also Cabrini Medical Center.

Q Are you a member of any medical organizations?

A Yes, I am a Diplomate and a Fellow of the American Board of Physical Medicine and Rehabilitation.

I am a member of the New York State Medical Society.

I am a member of the New York County Medical Society.

Q Could you explain for the jury what the field of physical medicine and rehabilitation is.

A The field of physical medicine and rehabilitation is a medical specialty started shortly after World War II. It's a combination of orthopedics and neurology -- it's an overlap. The job of a doctor of physical medicine and rehabilitation, better known as a physiatrist -- not a psychiatrist but a “physiatrist” -- our job is to rehabilitate a patient that was involved in an accident, whether it's from a car accident, from a fall, from a job related injury, whether it's from a sports injury, or from a stroke, or from an amputation, or from a heart or lung problem; our job is to restore them and bring them to the optimal level of care prior to their injury.

We use many different sciences. We use internal medicine, we use cardiology, pulmonolgy, orthopedics, neurology, physical therapy, and other agents in doing so. And we are also experts in the field of electromyography, which is the study of electrical activity in the muscle fibers. Electromyography is analogous to the EKG of the heart; that is what the EKG does for the heart, the EKG does to muscle and nerves.

Q What is the difference between a physiatric neurologist and an orthopedic surgeon?

A Well, physical medicine is another name for orthopedic medicine -- non-surgical orthopedics. The difference between us and orthopedic surgeons are they concentrate more on surgery and bone problems. We concentrate not only on bone problems but we try to avoid surgery. We concentrate on muscle, bone and nerve. And we concentrate mostly on the peripheral nervous system; that means the nervous system from the spine, the nerves to the hands, arms and legs. And we are not the experts in central neurology. A neurologist is more of an expert in central neurology; that is diseases of the brain like Parkinson's disease, like migraine headaches, demyeloating (phonetic) diseases like Lou Gherig's disease, Alzheimer's disease, -- these are all what the neurologists do. Also seizures. That goes more into a neurologist's field. A neurologist and physiatrist cross-refer to each other. Physiatrists are considered experts in spinal treatments in most teaching hospitals.

Q As part of your training, did you receive formal training in neurology, orthopedics, internal medicine, and the interpretation of x-rays and MRI'S?

A Yes.

Q Does your field deal with traumatic injuries and are you considered a trauma expert?

A Yes, it does. And yes, we are considered trauma experts.

Q Is it true that because you deal with a lot of patients who were victims of trauma, the patients you treat lead you into the legal system; having to come to court on a number of occasions?

MR. PATTERSON: Objection, Your Honor.

THE COURT: Let's get to his expertise and get to the meat of it. I will allow it.

THE WITNESS: The answer is yes.

Q How many times have you testified in court?

A On the average, I testify for my patients that I treat between six to eight times a year, sometimes more, sometimes less. But that's the average.

Q And what percentage of your practice is devoted to actually treating patients?

A Ninety-eight percent.

Q What percentage of your practice is devoted to teaching other doctors?

A Of that ninety-eight percent, I devote a half a day teaching the residents from NYU; I make teaching rounds with them, we see patients together. I run the whole clinic with three residents and they also rotate through my offices on the weekends and also sometimes during the week. So, I would say maybe fifteen, twenty percent of my time is devoted to teaching.

Q What percentage of your time is devoted to doing consultations for other doctors?

A I do a lot of consultations to other doctors. The exact percentage I can't give you. I do consultations to orthopedic surgeons, neurosurgeons, internists, cardiologists, chiropractors, and the list goes on. Just about every specialty.

Q What type of consultations do you do?

A Basically, EMG consultation, evaluating a complex picture and recommending different treatment options, especially patients that have had surgeries on disc herniations that have not improved. I recommend other treatment options and also in terms of pain management.

Q Have you ever done any hospital consultations?

A Yes.

Q And have you testified in the New York State Supreme Court before?

A Many times, yes.

Q And how about Federal Court of the State of New York?

A Yes, many times.

Q Have you ever been turned down as an expert witness in the field of physical medicine and rehabilitation?

A Never.

MR. VESNAVER: Your Honor, I now wish to introduce the doctor as an expert witness in the field of physical medicine and rehabilitation.

MR. PATTERSON: I have no objection.

THE COURT: Proceed.

Q Dr. Guy, are you being compensated for your time to appear in court here today?

A Yes.

Q How much are you being compensated for your time?

A The pretrial consultation and to cancel my patients, all together, four thousand for a half a day.

Q Do you know if that fee is comparable to the fair market value of an expert witness?

MR. PATTERSON: Objection.

THE COURT: Sustained.

Q Who referred this patient to you?

A Dr. Lambert.

Q Tell us briefly about the patient's history; the pertinent physical examination findings. And please explain what your findings mean.

A I saw the patient for the first time November 3rd, 1993, almost three years ago. The history obtained was that the patient was twenty-four years of age at the time with no history of any prior significant injuries. He had a prior history of a right shoulder dislocation, secondary to a bicycle accident many years ago.

On 9/17/93, when he was in the back seat of his car, he was hit from the rear with a severe impact. Be sustained injuries to his lower back. When he saw me for the first time, he was complaining of lower back pain with radiation down the right leg and he was being referred by Dr. Lambert for the EMG to rule out if there was any radiculopathy, which means a pinched nerve, in the lower back.

Continue with my examination?

Q Please. Go ahead.

A The physical examination was significant for the back. When I was examining his back, I found areas of diffuse tenderness, which means that the whole area was tender to touch. There were multiple tender points and trigger points. “Trigger points” are defined as areas of muscle scar tissue. When the muscle is traumatized you have microscopic bleeding in the muscle fibers and it heals with permanent scaring. The criteria for detecting trigger points is pinpoint tenderness with a palpable nodule. When you touch certain muscles, it feels like a marble inside the muscle fibers. I have microscopic pictures of trigger points. If I could be allowed, I could show it to the jurors. These are the biopsy specimen of a trigger point.

Q What is a biopsy specimens

A You cut a piece of it out, put it under a microscope, and you magnify it.

MR. PATTERSON: This is not from the plaintiff. This is a textbook; isn't it?

THE WITNESS: Yes. I can draw it also.

MR. VESNAVER: Okay. Why don't you do that.

MR. PATTERSON: Objection.

THE COURT: I'm not going to allow textbook photostats into evidence at all. We are talking about plaintiff's condition.

Q All right. Can you illustrate for us, Dr. Guy, how these trigger points would look and explain, while you are doing that, what those findings of trigger points mean with relation to the plaintiff's condition.

A A trigger point is caused by trauma. When you have a trauma, a flexion extension injury, a sudden movement in the muscle fibers, the muscles only have a certain amount of pull or elasticity. Once overextended, that ability to stretch, the muscle fibers tear. And once they tear, you get a microscopic bleeding in the muscle fibers and it heals with scar formation.

Q Can you draw a picture of it for us so the jury might better understand your explanation, doctor?

A Sure. When you look at a piece of muscle under a microscope, you see millions and millions of straight strands. When a muscle is damaged with a permanent scarring, it's going to look like this. (Indicating.) (Witness drawing it.) These (indicating) are all normal strands, normal strands of a normal muscle. And when you have trigger points you see large oval black-shaped circular objects like this. (Indicating.) These are called nuclei, which indicate muscle fibrosis, muscle ischemia, or muscle destruction. This is considered a permanent injury to the muscle fibers. This muscle will never improve. Now, as time goes on, it gets progressively worse. In fact, if you were to insert a needle into some of these areas, or trigger points, you would see there is no activity on an EMG, that that -- excuse me. When you insert a needle into these trigger point areas, sometimes you could see no electrical activity. That means the muscle is dead. And this area (indicating) -- because the ischemia means decreased blood supply to the area -- because of the decreased blood supply to the area, the area is always painful. It hurts a lot and you have build-up of lactic acid. That is the product of abnormal muscle metabolism, which is the equivalent of when you rub and get a Charlie-horse cramp in the calf muscle, that's the build-up of the lactic acid when it builds up. It goes into a spasm and it hurts. Once the lactic acid is squeezed out, the muscle relaxes here. (Indicating) You have not only build-up of histamine, bradykinin, leukotrienes -- these are all areas of waste products and inflammatory products trapped in the muscle fibers, which causes pain and spasm.

Q Thank you, doctor. For that illustration, you were in the process of telling us about your findings during your examination.

A The range of motion was one half normal extension. The muscle power of the lower back was 4 or 5, which means it was two grades weaker.

Straight leg raising was seventy-five degrees, with complaints of lower back pain.

The way a straight leg raising is done is you lay the patient flat on the examining table, you grab the patient's foot in your hand, and you raise it. A normal, healthy twenty-four, thirty year old male should be able to go to a hundred and ten degrees without any complaints of pain in the lower-back. If you were to go to just seventy-five degrees, that is abnormal. It indicates that there might be a possibility of a nerve root irritation in the lower back, or a disc bulge, or herniation. And from your other diagnostic tests you must prove what that is coming from.

Sensation was diminished to pinprick and touch, right lateral thigh. The right lateral thigh part of the body is supplied by the nerve roots from the L-2 to L-4. In the lower back we have five lumbar vertebrae. Between each vertebrae we have a disc. And a disc is like a shock absorber. It's like a jelly donut. It has two parts. Outside is cartilage and inside is a gelatinous material called

the nucleus pulposus. Right behind the vertebrae is the spinal cord. The spinal cord takes all the messages up from the lower portion of the body to the brain. As it goes up to the brain, it gives rise to nerve roots on the right and left sides. Each nerve root branches out. It gives rise to a motor branch which controls movement. It gives rise to a sensory branch which controls sensation; the pinprick. So, when you have a decreased sensation to pinprick and touch, right lateral thigh, that correlates to the nerve roots from the L-2 all the way down to the L-4 nerve roots. The L-4 means the fourth lumbar, vertebrae 4. L-2 means the second lumbar, vertebrae 2. 'L' means lumbar; '2' means the second. So, the nerve roots come off with correlation to the actual numbers of the vertebrae in the lumbar region. L-5 is the fifth nerve root in the lumbar region, L-4 is the fourth.

With reference to the rest of my examination, other than the sensory loss in the right lateral thigh, the rest of the exam is unremarkable.

I then went ahead and did EMG studies of the lower extremities.

Q Explain again what the EMG is. You went over that quick.

A EMG stands for electromyography. It checks to see if there is any muscle or nerve abnormality. A test has three parts. The first part is the motor part. The second is the sensory conduction part. The third is the actual needle EMG part, which checks the actual nerve root. The first part checks the peripheral nerves, which are almost always normal in a radiculopathy.

"Radiculopathy" means the following - "Radic" from the Latin word radic, meaning nerve root. "Opathy" meaning any kind of pathological condition relating to a nerve root. So, in this case, it means a pinched nerve or nerve root damage. The first part of the test, you place electrodes over different muscles in the field. Each muscle group correlates to a specific nerve root in the lower back. You stimulate it. It feels like a tiny little zap, which lasts two seconds. You record the distal latency, which is the time you stimulate and the time the nerve responds. You record that and then you do the sensory -- you do the same thing. And the last part you actually insert a sterile needle two inches long into several muscles in the legs and several muscles in the lower back. From anatomy you know which muscle correlates to which specific nerve root from the lower back. For instance, the calf muscle, the gastrocnemius muscle, is supplied by the L-5 S-1 nerve root distribution. The nerve roots in the quadriceps are supplied by the nerve roots from the L-2 through L-4 nerve roots. And then you go to the lower back. You insert the needle into the paraspinal muscles. Each paraspinal muscle correlates to a specific nerve root. When you touch the iliac crest, which is right here (indicating) and go straight back, that's 1, 4, 1 beginning below here, (indicating) the L-5, S-1, and so forth and so on down, and so forth and so on up. So, from the anatomy you know what correlates to what specific nerve root.

And you look for three criteria of abnormality on the screen. When you insert a needle into a normal muscle, the electrical activity on the screen is quiet. When you insert a needle into an abnormal muscle, you find increased activity present on the screen. You find positive sharp waives, which are large downward deflections. And sometimes you could find fibrillation potentials, which indicate that the problem is either severe or it has been longstanding for one year or longer. And you record these abnormalities. In fact, I have the tracings, if I may be allowed to show them.

MR. VESNAVER: Any objection to him showing the results of the EMG test?

MR. PATTERSON: I've never seen them so I would like to see them before he does it.

THE COURT: Show it to the attorney.

A There are actual tracings also. I have two sets. This one here is the old one.

MR. PATTERSON: No objection.

MR. VESNAVER: If there is no objection, I ask that they be shown to the jury.

THE WITNESS: May I stand and show the jury?

THE COURT: Yes.

THE WITNESS: This is the normal tracing of an EMG. Normally, everything is base line flat. When you see these large downward deflections, it indicates a pathological condition or abnormality; the pathological condition or abnormality indicating a nerve root damage at the level of the right L-4 L-5. And this is the level of the right L-5 S-1. These large downward deflections are abnormal and this (indicating) is normal. You could pass it around so everyone can see it better.

THE COURT: Excuse me, is that in evidence?

MR. PATTERSON: Note my objection. No.

THE COURT: Please give it back.

Q You can show it to the jury for the purposes of explaining your testimony.

THE COURT: Do not pass that around, doctor. It's not in evidence.

A These are the large downward --

THE COURT: Excuse me. You are serving the same purpose if he is doing it a double time. It's like passing it around. Please sit down, doctor.

Q Doctor, before you sit down, you have been talking about L-4 L-5, L-5 S-1, and all these other things. With the permission of the Court, we have a full model of the spine. Could you indicate to the jury exactly what part of the back you are talking about.

A This is a diagram of the spine showing the skeletal system, including the disk and the nerve roots. And in the neck region, known as the cervical spine, we have seven vertebrae. The next level is the thoracic spine or mid-back. We have twelve vertebrae. Lastly, we have the lumbar region, which has five vertebrae. The low back ends with what is called the tailbone or the sacral bone. Each part of the bone structures has a curve. The neck has a concavity. It's concaved. It's something like this. (Indicating) The lower back is convex. It's more out like this. (Indicating.) In the lower back it becomes concave again. And the lower back is held in a straight alignment with these curves. And between each vertebrae we have a disk. A disk is like a jelly donut. Outside is cartilage called the annulus fibrosis. Inside is a gelatinous material called a nucleus pulposus. Between each vertebrae and right behind the disk, the nerve roots come out. These nerve roots supply power and sensation to the muscles in the arms, and the muscles in the legs. The muscles in the arms come off the nerve roots in the cervical region and the muscles in the legs, it comes off from the nerve roots in the lower back region and each nerve root branches off into the other branches; motor, sensory, and so forth and so on. Whenever you have a disc bulge, the outer rings stretch. When the outer rings stretch -- a disc has millions and millions and millions of rings around and around and around.

MR. PATTERSON: Note my objection, Your Honor. I believe he asked him to look at the spine. This is not responsive.

THE COURT: We are sort of going astray with respect to this, doctor. Let's concentrate on one thing at a time. We are on the skeletal structure. Explain that aspect. If there are any other questions in relation to that, we'll go by the question.

A So, to conclude, the nerve roots are right behind the discs and the space by which they come out from is called the neural foramina. And each nerve root is designated with the correlation to the specific vertebrae.

Q The area that you found some positive findings in your EMG was what area on the spine?

A This being L-5, the last vertebrae, I found most of my pathology between the L-4 L-5 region in the lower back.

Q Thank you, doctor.

Now, doctor, did you also find spasm in your examination of Mr. Sobha?

A Yes.

Q And what is the significance of spasm?

A First of all, spasm is defined as prolonged and involuntary contraction of the muscle fiber; “involuntary” meaning that the patient has no control of it. Normally, when you touch a normal muscle, it's soft to touch. When a muscle goes into spasm, it becomes hard and if it's severe enough, sometimes it feels like this wood. It's that hard. When a muscle goes into spasm, it indicates some sort of a trauma, some sort of an insult to the muscle fibers. Muscle fibers shorten. You lose the longevity, the long length. And when the fibers shorten, you lose range of motion. Stiffness sets in. And when stiffness sets in, pain starts to accumulate. Pain causes more stiffness, more stiffness causes more spasm, and a vicious cycle continues.

Q Okay. And where, over what regions of Mr. Sobha's body, did you find spasm?

A In the lower back region. Mostly in the lower back region and the upper trapezious region.

Q Now, Dr. Guy, you told us earlier that you had the normal training in reading MRI films and x-rays.

A Yes.

MR. VESNAVER: Your Honor, these were films previously exchanged with the defendant. The defendant has had an opportunity to review them and I don't think there is any objection to introducing the MRI films.

MR. PATTERSON: Well, I have no objection based on the affidavit of Dr. Payne. I believe he didn't take these films.

These aren't your films; right, doctor?

THE WITNESS: No.

MR. VESNAVER: I am introducing these into evidence.

THE COURT: Do you have any objection?

MR. PATTERSON: I have no objection but this doctor didn't take those films. The doctor who did take the films, did give a report and did give an affidavit exactly as to the fact that those films are his films.

THE COURT: Which doctor is this?

MR. PATTERSON: This is Dr., I believe, David Payne - his doctor.

MR. VESNAVER: Our radiologist.

So, we are offering these into evidence.

THE COURT: Why don't we mark those as 7 and -- how many are there?

MR. VESNAVER: Six sheets.

THE COURT: We'll mark them 7, 8, 9, 10, 11 and 12.

THE COURT CLERK: Plaintiff's 7 to 12 marked and received into evidence.

Q Dr. Guy, before putting it on the shadow box, I would like you to look through those various sheets of film and see if there are any that demonstrate the type of pathological condition you have been describing for the jury - the bulging disc.

A These two.

Q Indicating Plaintiff's 7 and 12 in evidence.

Starting with Plaintiff's 7, could you please utilize the shadow box and explain to the jury what it is you are talking about.

A This is the MRI picture of Mr. Sobha taken on September 27, 1993. “MRI” stands for magnetic resonance imaging. The way it is done -- the MRI was invented by Dr. Daminian (phonetic) back in the seventies, in 1976. It takes asymptomatic particles, protons, and transforms it to real life images showing actual soft tissues in the spine. As you could see, these are the vertebrae, (indicating) this is the tailbone (indicating) or the sacrum. Between each vertebrae is the disk. Exactly right behind it is the spinal cord, which goes up all the way from the lower back up to the spine. And this is the thoracic area. (Indicating.) This is L-5, L-4, L-3, L-2, L-1. And what this shows is we have L-3-L-4, L-4-L-5, L-5-S-1 slight bulges. The bulge at L-4-5 is more pronounced than the other two. In fact, the last one you don't see it hitting the spinal cord at all. But the L-4-L-5 is touching the spinal cord over here. (Indicating.) And I think if we use the other films that are blown up, you could see it much better.

Q Now, doctor, one of these is a photographic replication of the one you were just describing; is that correct?

A Yes, that's correct.

Q And which one is the one you were just looking at?

A This one.

MR. VESNAVER: Your Honor, I would like to mark this as Plaintiff's 7-A in evidence.

THE COURT: That is the blow-up --

MR. VESNAVER: This is the positive of the MRI.

THE COURT: Any objection?

MR. PATTERSON: No objection.

(Marked.)

Q All right. Now, Dr. Guy, this is in evidence. This you can give to the jury to see and, if you could, explain to them how you make a positive from an MRI film. It may help them to understand what that is.

A You take this actual MRI film to a photo lab. These are the negatives. They do a blow-up of each section of the area you want and they blow it up to this magnification so you could see it much clearer than this view.

To review for you, this is the sacrum, these are the vertebrae, the white spot between each vertebrae is the disk; right back here is the spinal cord. Okay? And the nerve roots come off somewhere back here. Okay? This is the L-5, -- yes, this is the L-5 and this is the sacrum. Over here at L-4-L-5 you see this little round object here. It's part of a disc sticking out and hitting the spinal cord but you only see it hitting the spinal cord at this level. (Indicating.)

Q Which is what level?

A L-5 S-1. You see a clear white. You see a clear white margin here, which means that the disk is not sticking out to hit the spinal cord. Do you all see this white spot? But here you don't see it. It gets lost because this is hitting the spinal cord.

Now, bulge, protrusion, herniation; what does that mean? A lot of experts differ in their definition of what a bulge, protrusion, definition is. It's all semantics. What one doctor may call a bulge, a different doctor may call a herniation, and visa-a-versa. The medical community has not been able to fine tune a definition of a bulge versus a herniation. But it is agreed unanimously that any time you have a disk sticking out of its place hitting a nerve root or a spinal cord, it is considered a serious injury.

Q Now, doctor, I would like you to take this pen and just circle for the jury where you are saying the bulge is.

MR. PATTERSON: Note my objection.

THE COURT: Before you make the circle, are you making a circle in the area that he is testifying to as a bulge?

MR. VESNAVER: As the bulge that is specifically in contact with the spinal cord.

THE COURT: You have an objection?

MR. PATTERSON: I object to his circling the document, Your Honor. It speaks for itself.

THE COURT: Well, he can pinpoint what he is referring to. I will allow it. You can make your circle.

Q Make your circle, doctor.

A Right there. (Doctor showing it to the jury.) Over here you don't see the white margin. It's lost. Here it is hitting the spinal cord. (Indicating.)

Q Now, Dr. Guy, you said on film number 12, Plaintiff's 12 in evidence, you also have a good picture of the area we are talking about; is that correct?

A Actually in this slide you see 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 different sections. This section and this section here (indicating) are seen in other slides as well. So, you see them in duplication and perhaps in a better context.

So, the next film I am going to put up, it's almost identical to this view and to this view. So you see a repetition of it. This here is almost identical to this view and this is almost identical to this view. (Indicating.) But again you see the L-4-L-5 hitting the spinal cord at this level. The other two bulges are not significant. They do not cause any serious damage. It's only the L-4 L-5 that is.

Q Okay. And now doctor we had another positive made from that film which you can mark. Is that 12?

A That was 12, yes.

MR. VESNAVER: I'm offering this, Judge, as Plaintiff's 12-A.

THE COURT: Any objection?

MR. PATTERSON: No objection.

A This is another view that shows the same pathology at L-4-L-5 hitting the spinal cord. This is another view of the same MRI indicating a different approach, a different angle. And it pretty much shows the same thing. In my opinion, I think the first one showed the anatomy better. Again, this shows the L-4-L-5 hitting the spinal cord.

Q Thank you, doctor.

Now, doctor, I'm looking at these films that are in evidence and the curvature in these positives does not seem to be as pronounced in the lower spine, according to the description you gave us with the model --

A That's exactly correct. You have the complete loss of normal lordotic curvature, the normal concavity of the back. That indicates a severe muscle spasm. And the muscle spasm and trigger points all correlate to a recent injury.

Q Now, doctor, are the bulges that are shown by the MRI films, would you say they're abnormal findings?

A Yes. The first one and the last one are not clinically significant. The L-4-L-5 is clinically significant.

Q So you are saying there is more than one bulge?

A There are three bulges. L-3-L-4, L-4-L-5, L-5-S-1. The last three in the lower back region.

Q Are these abnormalities ever going to get better?

MR. PATTERSON: Objection, Your Honor --

THE COURT: Yes, this is now leading to excess. So, I am going to sustain the objection.

MR. VESNAVER: I am sorry, Your Honor. I will try to rephrase the question.

Q Within a reasonable degree of medical certainty, Dr. Guy, do you have an opinion as to whether or not these MRI films show a permanent condition?

A In my opinion they do, especially at the level of L-4-L-5.

Q How do the MRI films that are in evidence that you reviewed for the jury correlate with your EMG findings?

A My EMG findings show there is irritation at the level of L-4-L-5, L-5-S-1, with the most pronounced abnormality at the level of right L-4-L-5. And when you put the whole picture together, you get the answer that you want - the L-4-L-5 on the MRI shows the most abnormality and the ERG shows nerve root compression at the level of L-4-L-5.

Q Okay. How, doctor, you said earlier that in examining Mr. Sobha you found a fifty percent restriction in motion in some part. Could you explain that in a little more detail.

A The lower-back has several movements; forward flexion, backward extension, lateral rotation, and lateral bending.

Backward extension, if you cannot go to full-range of motion, it indicates there might be an obstruction in the normal pathway of bending backwards from a disc or nerve root problem. And that prevents you from bending all the way backwards. And also along with it, muscle spasm. But also backwards extension is a strong indicator of a disc problem in the lower-back, especially with the straight leg raising test.

Q You also said straight leg raising was limited to seventy-five degrees. Does that indicate some kind of quantifiable loss of motion?

A Yes.

Q What percentage of motion had he lost as a result of that test result?

A Approximately, thirty-five percent loss of motion.

Q Now, Dr. Guy, assume for the moment that there was testimony that he could not play basketball, soccer, work on cars, couldn't even look for a job because of his claimed injury. Based on your examination, your review of the medical diagnostic tests, and in your opinion, within a reasonable degree of medical certainty, would there be a medically determined reason why he would not be able to do those activities?

A Yes, there would be a very good medical reason.

Q And what would that reason be?

A A combination of the severe muscle spasm, the trigger points, the nerve root compression, the multiple disc bulges, especially the one at the L-4-L-5 region.

Q Now, Dr. Guy, based on your examination and your findings and the tests that were conducted, that you reviewed, how long would he have been prevented from performing his usual activities with relation to the date of the accident?

A Disc bulges with nerve root compression take on the average of approximately four to six months to get better, to a point that the spasm quiets down and the pain quiets down and then you restrict the patient's activities and let the patient go back to some sort of work schedule, but with limited activity, avoiding prolonged standing and sitting because prolonged sitting could aggravate the pressure on the disk and heavy lifting, such as 20 or 25 pounds or more, could also aggravate the disk in the lower back. So, these are the basic restrictions which you allow after the healing phase sets in.

Q Now, just so I am clear on this, you say “get better.” When you say “get better,” I thought this was a permanent condition.

A No. The pain and the spasm to quiet down. For the pain and spasm to quiet. The condition is permanent. The condition never gets better.

Q Thank you, doctor.

Now, doctor, I am going to show you some pictures that have previously been marked in evidence as Plaintiff's 3-A, Plaintiff's 1-A, and Plaintiff's 2-A. Now, Dr. Guy, have you ever seen these photographs before?

MR. PATTERSON: Objection, Your Honor.

A No.

MR. PATTERSON: I object to this line of questioning. I believe he cannot testify to the accident.

THE COURT: Well, I'm just going to let him say if he saw the pictures before. I don't know where you are going with this, counselor.

MR. VESNAVER: Well, can we approach, Your Honor?

THE COURT: Sure.

(Whereupon, at this time, there was an off the record discussion between Court and counsel.)

Q Okay, doctor. Forget that last question. I will ask you this, doctor: Based on your examination of David Sobha, your review of the test results, and within a reasonable degree of medical certainty, would a car accident be a competent producing cause of this type of injury?

A In my opinion, yes.

Q Now, doctor, when you normally testify, do you testify for plaintiffs or defendants?

A I testify mostly for the patients I treat. I guess, by that criteria, it would fall under the purview of what you would call as a plaintiff.

Q Okay. Bad you ever testified for defendants before?

A On rare occasions. Once or twice.

Q When was the last time?

A About six months ago there was a young lady that had a case, a claim against NYU Medical Center, and I was the doctor representing NYU Medical Center.

Q Do you do any independent medical examinations for defense firms?

A Yes, I do.

Q And do all the cases that you do independent medical examinations for defendants, do they go to trial those cases?

A Most do not.

Q But if a case were to go to trial, would you be willing to come to court and testify?

A Sure.

MR. VESNAVER: Objection.

THE COURT: Sustained. That answer is stricken.

MR. VESNAVER: Just give me a moment, Judge.

THE COURT: Take your time.

MR. VESNAVER: Thank you, doctor. I have no further questions at this time.

CROSS-EXAMINATION

BY MR. PATTERSON:

Q Doctor, did you bring a file with you in regard to the patient?

A I did.

MR. PATTERSON: At this time, I would like to review the file, Your Honor, and I ask for a five minute recess.

THE COURT: Why don't you do this: Get the file to review it. I'll give you five to ten minutes to stretch your legs upstairs and let him review the file before he examines the doctor. Fair enough. Take them upstairs for five or ten minutes.

Doctor, you may step down. You might want to give your file to Mr. Patterson.

At this point there will be no conversation with Dr. Guy, counsel. Let's take a five minute. break. Thank you.

(Whereupon, at this time, a short recess was taken.)

THE COURT OFFICER: Jury entering.

THE COURT: All right, Mr. Patterson.

Q Dr. Guy, you have testified about six to eight times a year you said?

A On the average. Sometimes more, sometimes less.

Q And you have testified since '88?

A I believe it was either '88 or '89.

Q So, between that time and today, you testified roughly about fifty times?

A If the arithmetic is correct, that's the answer.

Q If you say you have testified fifty times and at four thousand dollars a pop, doctor, wouldn't that be roughly two hundred thousand dollars you get for testifying?

A Yes.

Q So, wouldn't you say a large -- not two percent but a large part of your income is derived from testifying?

A That is not correct.

Q Okay. That is your testimony?

A That is correct.

Q And furthermore, doctor, you told us all about your qualifications but you are not a radiologist; are you?

A That is correct.

Q And these films you didn't take these films; did you, doctor?

A I did not.

Q And it was a doctor - Chiropractor Lambert - who sent the patient to see a specialist in taking these films and that wasn't you, doctor; was it?

A That is correct.

Q And this is a radiologist; is that correct?

A That's correct.

Q And a radiologist, their only specialty is taking films and diagnosing what is going on in the films; isn't that true?

A That's correct.

Q And furthermore, in another area of medicine, orthopedics, you spoke about that and you said you do everything that an orthopedist does except operate?

A I said the difference between myself and an orthopedic surgeon is an orthopedist operates. My job is to prevent surgery. An orthopedist concentrates more on bone pathology and structures, which I do not. I concentrate more on muscles, nerves, and the physiology of the spine.

Q But the bottom line is this patient was also sent to an orthopedist and that was not you; is that right?

A That's correct.

Q So, he was sent to an orthopedist and to a radiologist; is that correct?

A That's correct.

Q And also, doctor, you spoke earlier about the field of radiology -- I believe the field of back injuries. And you said there are contradictions as to what is a bulge and what is a herniation; right? A Controversy. Not contradictions.

Q Well, aren't there some leaders in the field?

A Excuse me?

Q Aren't there some leaders or experts that publish, that are in the field?

A There are many leaders or authorities in the field but no one is considered authoritative or having the last word.

Q Could you give me -- are there any authorities you would cite?

A Again, in the field of medicine there are no authoritative persons because it's everyone's different opinion. If doctor “x” has his opinion, doctor “y” has his opinion and they're both renowned and both have completely contradictory opinions. That's why medicine is not an exact science. It's an art, not a science.

Q But you would say that in the whole field of spinal injury there is not one expert you would cite or look to.

A There are many experts.

Q Name one. Give me one name.

A In terms of what?

Q In terms of anything; in terms of experts in the field.

A There is a doctor at NYU - Dr. Fussia?? (phonetic) who does a lot of defense work. There is Dr. Leachy. (Phonetic.) There is Dr. Milbauer. (Phonetic.)

Q Any others?

A There are many.

Q What about Dr. Baden?

A Dr. Baden the pathologist?

Q Yes.

A What about him? He's not a radiologist. He's a pathologist.

Q But is he an expert in the field of spinal injury?

A He's a pathologist.

THE COURT: The answer is either yes or no.

A The answer is no, he's not. He is not an expert -- a pathologist is not an expert in the field of spinal specialty.

Q And doctor, are you aware of Dr. Baden's study in regard to abnormal MRI studies in which he found that thirty-two percent --

MR. VESNAVER: Objection.

Q I mean thirty-three percent of the patients -

THE COURT: Aware. Be's asking if he's aware of it.

MR. VESNAVER: Aware of the study would be sufficient. I don't need him to read the actual study to the jury.

THE COURT: The question is a study of what.

Q Doctor, are you aware of a study conducted by Dr. Baden in regard to abnormal MRI's in which thirty-five percent of the subjects between twenty and thirty-nine years old have bulges that were asymptomatic?

MR. VESNAVER: Objection.

THE COURT: The answer is yes or no.

THE WITNESS: Yes. But he's had other studies -- yes.

Q So, basically is it --

THE COURT: Gentlemen, please, we have to take it easy. Let's not override sentences.

Doctor, when the answer calls for a yes or no, just give a yes or no. Counsel, will, if he feels it necessary on his re-direct, will bring back your response.

Q Now, doctor, isn't it true that bulges -- that one out of three people have bulges and they don't even know it? Isn't that true?

A Yes, there are some patients that have bulges that are asymptomatic and there are also people that have bulges that are symptomatic, as I indicated earlier.

Q And doctor, in regards to the films, isn't it true that you found a bulge not only at this location (indicating) but at this location (indicating) and at this location; right?

A L-3-L-4. L-3 and L --

Q L-4-L-5 and L-5-S-1?

A Yes.

Q And isn't it true that this is the bone and you are saying that L-4-L-5 in this place in between is basically just -- basically each bone is numbered L-1, 2, 3, 4, 5; right? Lumbar 1 through 5, going down; isn't that true, doctor?

A You almost got the anatomy correct.

Q But that's the way it works; right?

A Yes, correct.

Q And in between -- you say L-4-L-5. You are talking about in between L-4 and L-5 and that would be here; (indicating) right, doctor?

A That's correct.

Q So, this would L-3 and L-4, and L-3-L-4 would be here? (Indicating.)

A L-3-L-4 would be there, yes.

Q It's just in between. And you found a bulge here (indicating) too?

A Yes.

Q And you found a bulge here (indicating) too?

A Yes.

Q And you said down here there's white, so there is no impingement.

A Correct.

Q But look up here in this black area where it is pushing out. Isn't it true that there would be a bulge here?

A No, there is no bulge here.

Q Doctor, you are telling this jury that this area over here (indicating) that is pushing out as opposed to this area over here pushing out, there is some white area in between?

A No.

THE COURT: Gentlemen, let's clarify what you mean by “here” and “here.” The first here and here, are you talking L-5-S-1?

MR. PATTERSON: L-4-L-5.

THE COURT: All right. L-4-L-5, in comparison to which?

MR. PATTERSON: Up here.

THE COURT: Which is what?

Q I don't know. You tell me doctor. Where is it?

A That's L-2-L-1.

Q You don't think that, doctor, this similar dark area (indicating) is similar to this dark area?

THE WITNESS: Your Honor, may I approach to show --

THE COURT: No. Just answer if it's similar or not, in your opinion.

A No. There's a small little piece that is thickened all the way out on the L-4-L-5 level, which you do not see on any other level.

Q You are telling me I don't see a piece pushing out here?

THE COURT: Let's not get argumentative. If there is one, the jury will determine it.

Q Furthermore, doctor, isn't it true that even if you have a bulge, you really can't tell to look at it; you have to do an EMG; right doctor?

A A bulge, for it to be significant, you have to correlate it to the clinical picture; if it is causing any sensory problems, if it is causing any muscle problems, if it is causing any neurological problems, which are tested by an EMG, yes.

Q And doctor, isn't it true Dr. Payne, who took these films in regard to the bulges, he gave a report and his impression was that disc bulges are identified at L-3 L-4 through L-5 to S-1 without significant or foramenal stenosis. Isn't “stenosis” narrowing?

A Yes.

Q And isn't the canal he's talking about, this spinal canal, over here? Isn't that what he's talking about?

A No, that's not the canal. That's the spinal cord canal. This is the spinal cord canal. What he is talking about is this canal. (Indicating) The neuro foramena (phonetic.) This canal.

Q Well, doctor, didn't he talk about -- didn't he talk about the canal or the foramenal stenosis?

A Foremen means that nerve root space.

Q Doctor, the nerves come out on the sides?

A That's right.

Q And basically when they come out on the sides, they go down the legs; right, doctor?

A Yes.

Q If they're pinched, you get shooting pains; right?

A If the nerve is damaged, yes, you get shooting pains.

Q It's then damaged by the bulge pushing on it; isn't it true?

A That's correct.

Q In this case he found that there was no foramenal stenosis; there was no bulge pushing on that nerve.

A He found posterior element hypertrophy. You are missing a major important factor. Here you go. (Indicating.)

Q I'm talking about his impression.

THE COURT: He's not answering. He's giving a further explanation. I want the answer first and then we'll clarify.

Q His impression was it was without significant canal or foramenal stenosis; isn't that true? His impression.

A Yes, that's what it says.

Q As a matter of fact, he said there was an L-4 -- “a bulging disk is identified with early posterior elementary hypertrophy with no resulting canal or foramenal stenosis.” So, in that sentence, he too found no canal or foramenal stenosis; that in the canal there was no narrowing, and over here in the foramenal, there was no narrowing or pinching; isn't that true?

A That's what the report says, yes.

Q So, wouldn't you say that the bulge didn't press on the nerve; isn't that what this doctor found?

A That's what it says, yes.

Q Okay.

THE COURT: Doctor, did you find that it pinched on the nerve; yes or no?

THE WITNESS: The answer is yes, based on my EMG.

Q You found it based on the EMG.

Now, the EMG, you conducted a study, doctor, right?

A Yes.

Q Now, didn't you make a report in regards to that study, doctor?

A Yes.

Q Now, in the report, in the end, you said this: “EMG studies of the lower extremities performed today and results sent to you under separate cover revealed abnormal findings suggestive of a right L-4-L-5 radiculopathy.”

A No. It says “L-4 to S-1 radiculopathy.”

Q And you say recommend “SEP studies.”

A That's correct.

Q Now, doctor, when you did this you have a few pages; right, doctor?

A Yes.

Q And there are results of the studies.

A Yes.

Q And most of it is plus, minus, and there are various numbers in regard to your findings; right?

A Yes.

Q Now, doctor, you wrote your report after you did this study on November 3rd.

A Yes.

Q And this is a September 1993 accident; right.

A That's correct.

Q Well, doctor, it is suggestive of the right radiculopathy; right?

A It looks like it could be radiculopathy. The EMG is suggestive. Whenever you want to conclude, you take the EMG findings, you correlate them with your objective clinical findings, and you render an opinion. In my report --

Q Excuse me, doctor. Very simply, didn't you bring him back, the plaintiff, for yet another study at the end of the month; on 11/23 you brought him back for the SEP study?

A Yes.

Q You brought him back for the somatosensory evoked potential study. Didn't you bring him back?

A Yes.

Q So you didn't mention that when the plaintiff's attorney questioned you; that after you wrote the report and after you conducted the EMG, you called him back and you did a second study; didn't you, doctor?

A Yes. It's in the record. It's right in the EMG.

Q And this study is very detailed. This has ten different types of exams and four different numeric results.

A Yes.

Q Isn't that true, doctor?

A Yes. SEP stands for somatosensory evoked potentials. It picks up the sensory branch in a nerve root.

Q And doctor, when you brought him back for this, wasn't it your impression that he had no sensory radiculopathy?

A Yes, that is correct.

Q So, you found that when you brought him back for the second test, he didn't have sensory radiculopathy.

A That's correct.

Q Okay, doctor. And now after you conducted the second test, you did a report; didn't you? I believe there's another report if you look through your records, and I believe it's dated January 25, 1994. Doctor, in regards to the --

THE COURT: Wait a minute. Did you find that report, doctor?

THE WITNESS: I'm looking for it. Did you take it out?

Q In regards to the SEP study, doctor, do you have that in front of you?

A Yes, I do.

Q Is that your study that you have in front of you?

A Yes.

MR. PATTERSON: I would like to offer that into evidence.

MR. VESNAVER: Can we offer the EMG into evidence as well?

THE COURT: I'm not going to take this as a contest as to who is going to offer more.

MR. VESNAVER: I have no objection.

THE COURT: All right. Let's offer that into evidence as Defendant's, I think it is, C. Defendant's C in evidence. That's the study on the SEP; is that correct?

MR. PATTERSON: Yes, it is.

(Marked.)

Q Right here behind it. (Indicating.)

A That is not a report.

Q We'll discuss it, doctor.

And in regard to the SEP study, doctor, in your impression, no sensory radiculopathy, doctor?

A That's correct.

Q You found no other impression other than no sensory radiculopathy; you didn't find any other problems, any other radiculopathy, any other impairment. Isn't that the only impression you found?

A That's the only -- that was the only road of that particular test. Each test has a particular indication and checks for only a specific thing. For instance, SEP --

Q I just asked you if that was the only finding of that test.

A The answer is yes.

Q And isn't it true that in your report it was suggestive of radiculopathy and then you brought him back for yet another test?

A That's correct.

Q Wouldn't that be to confirm or deny the suggested radiculopathy? Yes or no, doctor.

THE COURT: Doctor, if you can answer yes or no, say so. If you cannot, then just say that you can't answer it.

A That question cannot be answered with a simple yes or no. With an explanation it can be answered.

Q That's all right, doctor. Your attorney will help you explain this one, doctor.

Next, doctor, in regard to the document, didn't you create a document on January 25, 1994, which would be after the EMG study?

A This is a document not produced by me but by my office. In fact, it's not my signature here either. It's my staff's signature.

Q Doctor, on the bottom of the page it says, “Date, 1/25/94.”

A Yes.

Q The next box it says, “Physician's name, print.” What does it say? It says, “Physician's name, print.” What does it say?

A Ali E. Guy.

Q Is that your name, doctor?

A Yes.

Q And it says, “physician's signature,” doctor. Isn't there a physician's signature right there?

A Yes.

Q And what is the signature, doctor?

A That's my signature done by my staff.

Q Okay. Doctor, so isn't that -- in essence, didn't you give them the power to sign your name?

A Yes, it's the bill. This goes with a bill. It's not part of the medical record.

Q Doctor, if you look at the top of the page, number six, it says, “Diagnosis and concurrent conditions.” Doctor, could you tell me, doctor, after you took these films and after all your treatment was done, what was your diagnosis and concurrent conditions, doctor?

A What I see here is --

THE COURT: Just read it.

THE WITNESS: It says, “lumbosacral radiculopathy,” which is whited out, and then it says, “lumbosacral strain.”

Q And isn't it true somebody thought it was lumbosacral radiculopathy but they changed it, they whited it out, and put down it's not radiculopathy but that it was a strain; isn't the true, doctor?

A No, that is not correct.

Q Doctor, all I'm asking is isn't it true that on January 25, 1994, after these treatments, a document that has your name on it and your signature, was there for a diagnosis and it says, “lumbosacral strain,” not “radiculopathy”? Back strain; isn't that true, doctor?

A Yes, that is true.

Q That's all.

And let's look at number 12. It says -- the question is, “Will injury result in permanent disfigurement or disability” and, doctor, what is written as your response?

A It says, “Not determinable at this time.”

Q Doctor, after your treatment you couldn't determine whether it was permanent; isn't that true?

A I never treated this patient.

Q After the two times that you saw this patient --

A I just finished telling you I didn't fill this out.

Q It's signed by you.

A It is not signed by me. It is not signed by me.

Q Doctor, it's your name on it and your signature.

A Yes, it's my name. My clerical people fill this out. They're not medical people.

Q And doctor, number 19, question number 19, “may any health services be required for more than one year from this date of the accident”? And it says a box, “probably yes” and there is a box “probably no.” What did you type in, doctor?

A What my staff typed in is, “undetermined,” which is what they usually do.

Q And the next one doctor, number 20, “Estimated duration of future treatment.” How much more treatment is there needed, doctor? What was your response?

A My staff's response is “not determinable at this time.”

Q Are you saying, doctor, this jury should believe that your documents, prepared by your office, signed, in essence, with your name, this is all wrong?

A No. This is the standard way that the clerical people fill out these no-fault billing forms.

Q Doctor, don't you check documents signed by you?

A Let me finish.

Q Doctor, I don't need your response. Your lawyer will have you explain how this document --

MR. VESNAVER: Objection.

THE COURT: It's not his lawyer. Let's understand something.

MR. VESNAVER: I let the first one go.

THE COURT: The attorney represents the plaintiff in this action - Mr. Sobha. The doctor is here as an expert witness, which I will explain later on.

Proceed.

MR. PATTERSON: I would like to offer that document in evidence.

MR. VESNAVER: I am objecting to that document.

THE COURT: I would like to see it.

Tell me why.

(Whereupon, at this time, there was an off the record discussion between Court and counsel.)

THE COURT: All right, subject to redaction of matters which are not before the Court, this will be allowed in as evidence as Defendant's D.

(Marked.)

MR. PATTERSON: Doctor, in regard to your EMG study -- I would like that offered in evidence. I believe plaintiff's attorney was going to offer it and I have no problem with putting that in evidence.

THE COURT: We'll mark that as Defendant's E. That's the EMG study.

(Marked.)

Q And lastly, doctor, are you aware of Dr. Leonard R. Harrison. Do you know who he is?

A I know who he is, yes.

Q And isn't he the orthopedist -- actually, he's a diplomate of the American Board of Orthopedic Surgery who treated actually David Sobha. Are you aware of that?

A No.

Q Doctor, did you ever look at his report that he prepared?

A I did not.

Q Okay, doctor. Well, if I told you that in his report his diagnosis says, “The diagnosis in this patient was traumatic lumbosacral myofascitis with sequelae,” would that be correct, doctor?

A No, because he has -- because he didn't have the opportunity to review the EMG. He mentioned nothing about EMG in his report.

Q Right. He mentions nothing about it; doesn't it, doctor?

A Right. It does not.

Q Furthermore, myofascitis, doctor, isn't myofascitis a muscle problem?

MR. VESNAVER: Could I see a copy of what he is looking at?

THE COURT: Go ahead.

Q Doctor, isn't myofascitis a muscle problem?

A Yes.

MR. PATTERSON: Nothing further.

THE COURT: Redirect?

MR. VESNAVER: Yes, Your Honor.

REDIRECT EXAMINATION BY MR. VESNAVER:

Q I'm going to give you back, Dr. Harrison's report. In addition to the diagnosis referred to by the defendant, wasn't there an addendum to that report?

A Yes.

Q What was the diagnosis he reached in that addendum?

MR. PATTERSON: Objection, Your Honor.

MR. VESNAVER: He opened the door.

MR. PATTERSON: I didn't open the door for him to read his own doctor's report. Let him bring in the doctor.

MR. VESNAVER: He opened the door to this particular report.

THE COURT: You questioned him on the aspect of a report. Is that report all one document or is it --

MR. VESNAVER: Yes, it is.

MR. PATTERSON: I believe, Your Honor -- I don't know, first of all, because this doctor I've never spoken to but I believe he has a report with a diagnosis which was read --

MR. VESNAVER: And the addendum is on the report that counsel has.

MR. PATTERSON: We don't know when it was made, to what purpose, or anything to that effect.

(Shown to the judge.)

THE COURT: Well, if you read from page 2 as the diagnosis, I mean on page 2 it has an addendum below the signature. Does your copy have that?

MR. PATTERSON: Yes, I have no problem. It says, “Bulges.” I have no problem with that.

THE COURT: Does your copy have that paragraph?

MR. PATTERSON: Yes. But it doesn't talk about radiculopathy there either, Your Honor.

THE COURT: No comments.

You can inquire.

Q And Dr. Guy, in the addendum does Dr. Harrison reach a further diagnosis?

A Yes.

Q And what was that diagnosis?

A It was a decrease of the lumbar lordosis and disc bulges at L-3 L-4 through L-5 S-1.

Q And what was the basis for that diagnosis?

MR. PATTERSON: Objection. He did' not tell the basis --

Q Is there anything in the report that indicates -- withdrawn.

THE COURT: Just read the report. I don't want his opinion.

Q Does the report state --

THE COURT: Why don't you read that last paragraph in the addendum.

A Okay. “Addendum. After the patient left, I received copies of an MRI of the lumbar spine which showed a decrease of the lumbar lordosis and disc bulges at L-3 L-4 through L-5 S-1. There was no noted significant canal or foraminal stenosis. The diagnosis of lumbar spine should be amended to include disc bulges from L-3 L-4 through L-5 S-1.”

Q Thank you, doctor.

I believe it was your testimony that you didn't even know Dr. Harrison had treated David Sobha; isn't that correct?

A Yes.

Q Did you ever send the results of your EMG study to Dr. Harrison for his review?

A No. How could I? I never knew he was treating the patient. None was requested of me.

Q Doctor, did the EMG study test a different aspect of the person's spine than the MRI?

A Yes. MRI simply tests the discs. EMG checks the nerve roots. In the same way that an EMG cannot check disc bulges or herniations, the MRI cannot check nerve root problems. That's why we have different tests for different reasons. EMG's are for nerves and MRI's are for discs and other soft tissues.

Q Now, doctor, let's talk about that bill that has been introduced into evidence --

MR. PATTERSON: Objection to the --

MR. VESNAVER: The bill?

MR. PATTERSON: To the report as to a bill.

THE COURT: The report. The yellow sheet you are talking about?

MR. VESNAVER: Yes, the yellow sheet.

THE COURT: Well, that's a form that was filled out by his office.

Q Doctor, did you ever review that sheet before you left your office?

A No.

Q Would you consider that a medical report?

A No, it's not a medical report.

Q What would you consider that particular document?

A It's a billing form.

MR. PATTERSON: Objection.

THE COURT: Overruled.

Q It's a billing form?

A Yes.

Q Is it your practice to review bills before it goes out?

A No.

Q Do you have staff that does that?

A Yes, I do.

Q Doctor, more importantly, the defense raised an issue with regards to a difference in conclusions between SEP studies and the EMG studies. Could you please explain to the jury how could you possibly get these two seemingly opposite --

MR. PATTERSON: Objection to him leading the witness.

THE COURT: Give us the question as a hypothetical. It's a lot easier. Proceed on that basis.

MR. VESNAVER: Let me rephrase it simpler.

Q Doctor, could you please explain to the jury why the different results were reached in those two tests.

A The EMG checks the motor branch of the nerve root. The SEP checks the sensory branch of the nerve root. Sometimes you could have one positive, one negative. Sometimes you could have both positive. Sometimes you could have both negative. But whenever an EMG is borderline, or abnormal, or suggestive of a radiculopathy and is not confirmatory, you can rely on other, additional tests. Now, an EMG has much more sophistication and is much more accepted in the medical field. In fact, an SEP has no CPT code for it. In other words, it is not accepted as widely as an EMG is. EMG is much more authoritative. So, an EMG doesn't always show you all the pathology. You have to resort to your clinical picture as well and put it all together. In fact, the EMG was repeated down the record and it confirmed the radiculopathy.

Q When was the EMG repeated?

MR. PATTERSON: Objection, Your Honor. There is no foundation that this was done, Your Honor.

HR. VESNAVER: Judge, he started asking questions about reports conducted after Dr. Guy's narrative.

THE COURT: Please. The SEP was conducted on a given date and the EMG was on a given date. What is your question?

Q There was a second EMG done; isn't that correct?

MR. PATTERSON: It was never provided. Even the plaintiff said --

THE COURT: There has never been any testimony of a second EMG and this is improper cross. There is no examination at all on a second EMG.

MR. VESNAVER: Okay. Let's withdraw that question.

Q Doctor, did you reevaluate David Sobha prior to testifying here?

MR. PATTERSON: Objection.

THE COURT: I am going to allow the question but I will not allow any testimony on something that has not been previously testified to on direct. He did not open the door on any secondary treatment.

MR. VESNAVER: May I make a record? I mean I believe by asking questions about tests conducted after the report, the narrative, that counsel has opened the door to subsequent testing --

THE COURT: The testing was limited to the SEP, which was done post-EMG, and was done, if I recall correctly, based on his report that an SEP should have been performed. There was nothing about any further testing.

MR. PATTERSON: Further, Your Honor, he gave -- they provided us with the SEP report. You gave us the SEP report.

THE COURT: That's fine. There is no other testimony on direct whatsoever.

MR. VESNAVER: Are we allowing the question about his reevaluation?

THE COURT: You can ask it but I'm not going to let you tell me what he found.

Q You had an opportunity to reevaluate Mr. Sobha prior to testifying?

A Yes.

Q And when was that?

MR. PATTERSON: Objection.

THE COURT: No. Sustained.

Q Now, of the EMG and the SEP, which is the one that involves needles? Do they both involve needles?

A No.

Q Which one?

A Only the EMG.

Q What do you do with the needles when you perform the EMG?

A You insert them into different muscle areas; muscles in the legs, muscles in the lower-back.

Q And the SEP, how do you perform that test?

A You place electrodes over the muscles in the legs with the other electrodes are picked up on the skull in the scalp. You stimulate and you record the responses.

Q So, those are like little pads you are talking about?

A Yes, little electro-pads.

Q You said earlier there are three different parts of the neurological system that are tested by the EMG's.

A Yes.

Q Which part of the system is the SEP designed to test?

A Only the sensory.

Q What does that mean when you say that?

A It means, as I indicated to you, the nerve root has two branches - the motor and the sensory. The EMG picks up mostly motor and some sensory but the SEP only picks up sensory. So, if there's a problem with the motor nerve root, it does not pick it up.

Q You have to forgive me, doctor. I know you know what you are talking about but could you explain, in layman's terms, what the difference is between the sensory and the motor nerves.

MR. PATTERSON: Objection. Asked and answered. Be just explained it, Your Honor.

THE COURT: Well, he sort of side-swiped it. I'll give him an opportunity -- very short. Let's not go into a long dissertation.

A Okay. The motor branch of a nerve root controls the movement of the muscles. The sensory controls perception of pinprick touch.

Q So, the EMG is the test that tests the motor or the ability to move the muscle.

A Yes.

Q Now, doctor, with regard to the report of Dr. David Payne, the radiologist, did you have an opportunity to review that report in connection with reaching your conclusions?

A Yes.

Q And that report, what is the significance of that report to you?

A Well, it shows --It says “straightening of the lumbar lordosis?? compatible with muscle spasm, indicating a rec??t injury.” And it mentions disc bulges from L-3 through S-1. And it does mention “without significant canal or foraminal stenosis.” I'm not saying it's significant canal or foraminal stenosis. I'm simply saying there's a radiculopathy here from the disk bulge going backwards and touching or irritating the nerve root, causing a radiculopathy.

Q Do you need stenosis, foraminal stenosis, to have a radiculopathy?

A Absolutely not.

MR. PATTERSON: Objection.

THE COURT: Overruled. Keep going.

Q All right. You also mentioned something about an earlier posterior element hypertrophy. What is that?

A Posterior means the back of. Right behind the disk we have a ligament called the posterior longitudinal ligaments. Bypertrophy means to get bigger. It gets bigger to try to hold the bulge back into place. That's why it gets bigger; because of the pressure squeezing against it. And the posterior longitudinal ligament pushes back against it to hold it back in place.

Q And tell us about Dr. Baden's second study.

A He found that -

MR. PATTERSON: Objection.

THE COURT: Which study?

MR. VESNAVBR: He asked him about Dr. Baden's first study and he wouldn't let the doctor talk about Dr. Baden's second study.

THE COURT: Well, I'm concerned about he doesn't find Dr. Baden to be authoritative on anything with respect to the spine.

MR. VESNAVER: I think the jury has an inference from counsel's question about the first study. I would like to know if the second study shows any different finding.

THE COURT: He can explain his reasoning on the study that he was asked, but I know he found him not to be authoritative because he's a pathologist.

Q All right. Explain to the jury, Dr. Guy, what impact Dr. Baden's study has on your opinion regarding spinal injuries.

A Michael Baden is a forensic pathologist. Be does autopsies. And in his studies, he found that many patients that had bulges, they had no symptoms. And he found also that some of the bulges that were reported on MRI's as bulges were in fact herniations or tears at the time of an autopsy. And in his report he concludes that not every disc bulge or herniation causes symptoms and vice-versa. And some of the bulges that show up on MRI's are actually herniations, which are confirmed by autopsy.

Q Doctor, what is your prognosis with regard to David Sobha's condition?

MR. PATTERSON: Objection. I believe it has been asked and answered.

THE COURT: Well, I know that he explained his diagnosis. Where are you going with this?

MR. VESNAVER: I just wa?? to know if he has a prognosis.

THE COURT: Well, he already answered that question, counsel. He discussed it previously.

MR. VESNAVER: Can we approach for one minute please?

(Whereupon, at this time, there was an off the record discussion between Court and counsel.)

MR. VESNAVER: I have no further redirect. Thank you.

RECROSS EXAMINATION BY MR. PATTERSON:

Q Doctor, in regards to your report, did you state, “Active range of motion is within normal limits for all four extremities,” doctor?

A Yes.

Q And aren't the four extremities the arms and the legs?

A Yes.

Q And didn't you say, “Manual muscle power testing is within normal limits for all four extremities”? Didn't you say that also?

A Except for the back muscle.

THE COURT: The question is this, doctor --

A Yes, I said that.

MR. PATTERSON: Nothing further.

RE-REDIRECT EXAMINATION BY MR. VESNAVER:

Q Doctor, how do you fit that together with the opinion you've offered today at the trial?

A In a radiculopathy?

MR. PATTERSON: Objection.

A The range of motion in the arms and legs are normal, as expected. The muscle power of the arms and legs were normal. The radiculopathy is not in the neck. It's in the lower back. And that was normal. The only thing that was abnormal was the muscle power of the lower-back, which was two grades weaker.

THE COURT: I'm a little confused. If in the lower-back you have a bulge which impinges on a root nerve causing the radiculopathy, doesn't that cause it in the leg?

THE WITNESS: Yes. You don't always have --

THE COURT: It causes it in the leg.

THE WITNESS: Yes.

THE COURT: So, when you say radiculopathy, you are referring to his leg.

THE WITNESS: Yes. But the radiculopathy is not in the leg. It is in the lower-back.

THE COURT: But it affects the leg.

THE WITNESS: Yes, it affects the leg depending on the severity of radiculopathy. If it is severe, it causes motor weakness. If it is mild, it doesn't cause motor weakness.

THE COURT: Look, I'm not taking a position on either side. But only for purposes of explanation, you found the extremities normal and you found the radiculopathy. I think that was the question counsel imposed. How do you justify the two?

THE WITNESS: The range of motion is always normal in a radiculopathy because the range of motion is not affected by the radiculopathy. The muscle power is sometimes weaker and sometimes it's not.

THE COURT: Does that mean that the straight leg test is within normal powers or not?

THE WITNESS: No. The straight leg is not within normal boundaries.

THE COURT: We are getting into an area where counsel wants an explanation.

MR. VESNAVER: Let me clarify it, Judge.

Q You told us earlier there was a fifty percent loss of normal extension. What part of the body was there a fifty percent loss of normal extension?

MR. PATTERSON: Objection.

THE COURT: That has been asked and answered. That was the lower-back. His re-cross was extremities, the limitation.

Q Dr. Guy, finding a radiculopathy, the nerves that come out of the lumbar spine, do they run from the lower-back to the lower legs?

A They branch off, and each branch branches off further, and each branch goes to the specific muscle group.

Q In this instance, you found positive EMG's; is that correct?

A Yes.

Q What did that indicate to you?

MR. PATTERSON: Objection.

THE COURT: You better go into one of the extremities. Only on the extremities.

A That it was a right-sided L-4 S-1 radiculopathy with a sensory deficit in the right lateral thigh.

Q Now, you are saying it is a sensory deficit in the right lateral thigh --

MR. PATTERSON: Objection. All he asked about was is the movement normal, and the right lateral thigh is part of --

THE COURT: I want an explanation as to singularly why it is within normal limits when you have a radiculopathy that leads to the right leg.

THE WITNESS: The range of motion is not affected by radiculopathy. The muscle power can be affected. It could be weaker or it could be normal. If the radiculopathy is longstanding, then the muscle power can become weaker. It doesn't happen overnight. It takes twenty-one days minimum for a nerve injury to occur. In fact, if you do an EMG test sooner, it will not show the problem. So, a radiculopathy doesn't happen overnight. And the power, and the muscle power, for the weakness to last, could take months and months of persistence; months and months of persistence to cause significant weakness in the legs. If the person is exercising, they're walking around, they're slowing down that process of weakness. Okay? So, with a radiculopathy you don't always have to have muscle weakness. You could have a radiculopathy with a normal muscle power. That's the reason.

MR. PATTERSON: Thank you.

THE COURT: Thank you, doctor. Anything else?

All right, doctor, you may step down.

I am going to recess for lunch. Yesterday you came in late but today you get to experience the gourmet food of Sutphin Boulevard. So, I want you to enjoy your one hour plus of lunchtime.

We have a doctor, I believe, coming in at 2:00?

MR. VESNAVER: Yes, Your Honor.

THE COURT: So, try and be back at 2:00.

End of Document

© 2015 Thomson Reuters. No claim to original U.S. Government Works.