TESTIMONY OF DR. ALI GUY; 1997 Trial Trans. LEXIS 790

NEW YORK SUPREME COURT, BRONX COUNTY

15201/94

March 14, 1997

Reporter
1997 Trial Trans. LEXIS 790 *

CATHERINE IASELLO AND PETER IASELLO, Plaintiff v. MORTIMER H FRANK, Defendant

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

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Counsel

BONNIE L. FISHER, ESQ. Attorney for the Plaintiff, FRANCIS J. SCAHILL, ESQ. Attorney for the Defendant

Proceedings

2 COURT CLERK: Case on trial.

[3]MRS. FISHER: Your Honor, there is a motion

[4]in liminae with respect to the testimony of Dr.

[5]Ali Guy. During yesterday's cross-examination

[6]of the plaintiff it was disclosed that a further

[7]evaluation was conducted by Dr. Guy of this

[8]plaintiff in January of 1997 at the instructions

[9]of her attorney because the case was coming up

[10]for trial. It was also **[*2]** further disclosed that

[11]the only visit that this plaintiff had with Dr.
a

[12]guy was in December of 1993, approximately 1

[13]month post accident for evaluation and

[14]treatment.

[15]The defendant served together with their

[16]answer a demand for discovery and inspection

[17]including the requisits set forth in 31.01d of

[18]the C.P.L.R., namely, this identification of the

[19]expert witness.

? 20 THE COURT: Counsel, let me now short

[21]circuit you, counsel.

[22]MRS. FISHER: Yes.

[23]THE COURT: Is your doctor going to testify

[24]to any devistating injuries that is outside the

[25]medical report you exchanged.

I

[2]MRS. FISHER: No, Judge.

[3]MR. SCAHILL: That's the point of the

[4]motion, Judge. The plaintiff served a 31.01d

[5]notice in response in January of 1997 indicating

[6]that Dr. Guy was going to testify with respect

[7]to his reports dated December 17, 1994 and

[8]December 12, 1993. The motion ad liminae is to

[9]prevent Dr. Guy from testifying with respect to

[10]his re-evaluation of the plaintiff in January of

[11]1997 for the purposes of this litigation.

[0]

[12]THE COURT: Your motion is denied in that

[13]respect. **[*3]** It's granted only insofar as he is

[14]going to be precluded from testifying to any

[15]devistating illness or sequelli that is not

[16]really within the four corners of the two

[17]medical reports.

[18]MRS. FISHER: He is not testifying to any

[19]new injuries, Judge. Nothing along that line.

W
? 20 THE COURT: So that's it.

[21]MR. SCAHILL: Thank you, Your Honor. There
s

[22]is also a question with respect to scheduling

[23]that I believe we can do off the record if Your

[24]Honor wishes.

[25]THE COURT: Okay.

[2]Off the record.

[3](Off the record discussion between Court

[4]and counsel)

[5](Jury entering courtroom at 10:35 a.m.)

[6]THE COURT: Good morning, ladies and

[7]gentlemen of the jury.

[8]THE JURY: Good morning.

[9]THE COURT: Glad to see that everyone got

[10]here safely in light of the inclement weather

[11]that we are having. The Court appreciates your

[0]
Z 12 efforts particularly on a day like this.

[13]Counsel for the plaintiff, are you ready to

[14]proceed with plaintiff's case.

[15]MRS. FISHER: Yes.

[16]THE COURT: You may proceed.

[17]MRS. FISHER: The plaintiff calls Dr. Ali

[18]Guy.

[19]A L I G U Y, having **[*4]** been called as a witness by and on
? 20 behalf of the Plaintiff in this case, having

[21]been first duly sworn, testified as follows:
a

[22]THE WITNESS: I do.

[23]COURT CLERK: Please be seated.

[24]Bless state your name and office address,

[25]spelling your last name.

[2]THE WITNESS: My name is Dr. Ali Guy.

[3]COURT CLERK: And your office address,

[4]doctor.

[5]THE WITNESS: Currently 1234 Central Park

[6]Avenue, Yonkers. Also 7 Gramercy Park, New

[7]York, New York.

[8]MRS. FISHER: If Your Honor pleases, if the

[9]Court will permit me to voir dire my witness and

[10]have him qualified as an expert with the Court's

[11]permission.

[0]
[12]THE COURT: You can voir dire him in that

[13]respect.

[14]DIRECT EXAMINATION

[15]BY MRS. FISHER:

[16]Q. Doctor Guy, good morning.

[17]A. Good morning.
a

[18]Q. Dr. Guy are you a duly licensed physician in the

[19]State of New York?
W
? 20 A. I am.

[21]Q. And when were you so licensed?

[22]A. 1985.

[23]Q. And could you go over your educational

[24]background?

[25]A. Yes, my undergraduate training I did at Queens

[2] **[*5]** College, Medical College. I went to the Dominican

[3]Republic. After I finished my graduation was in June of

[4]1981. 1 did three separate residencies. My first one in

[5]the field of internal medicine at the Mt. Sinai School of

[6]Medicine, Mt. Sinai Medical Center for a period of 18

[7]months and then I did one year of general surgery at

[8]Cabrini Medical Center and then 3 years of physical

[9]medicine and rehabilitation at Mt. Sinai School of

[10]Medicine, Mt. Sinai Medical Center.

[11]I am board certified in the field of physical

[0]
Z, 12 medicine and rehabilitation. I became board certified in

[13]May of 1989. I am a clinical instructor at the Hospital

[14]for Joint Diseases, Orthopedic Institute. I teach the

[15]residents from the NYU Medical Center. I am also the

[16]director of the neuro-muscular equipment clinic at the

[17]Hospital for Joint Diseases. I am on staff at 3 teaching
s

[18]hospitals; Cabrini Medical Center, Hospital for Joint

[19]Diseases, Orthopedic Institute and Maimonides Hospital in
? 20 Brooklyn.

[21]Q. Can you tell us what board certification means?
s

[22]A. Boardcertfication is the highest degree which

[23]you can **[*6]** obtain in your level of specialty. It's the

[24]equivalent of a Phd to a none medical person.

[25]In order to become board certified you have to
f

[2]fulfill the following requirements: You have to have had

[3]at least 1 or 2 years prior training in a different field

[4]other than physical medicine and rehabilitation. You must

[5]then satisfactorilly complete a 3 year training program in

[6]physical medicine and rehabilitation, pass the yearly

[7]examinations given by the Department. You then -- once

[8]you are a graduate of the program you must sit in for an 8

[9]hour written examination. You must then be in private

[10]practice for a period of no less than 18 months, be

[11]sponsered by two other doctors that are already board

[0]
Z 12 certified who know you closely. You have to have no

[13]convictions of any capacity. You then fly to the Mayo

[14]Clinic in Minnesota where all the research is done. You

[15]then get tested orally by a battery of doctors in the

[16]fields of orthopedics, neurology, physical medicine,

[17]electro-myography interpretations of x-rays, Cat Scans,

[18]M.R.I.'s and if you prove to these doctors that your **[*7]**
[19]knowledge is up to par, they pass you and you are given a

[4]
? 20 title of a Diplomate and a Fellow of the American Board of

[21]Physical Medicine and Rehabilitation.
s

[22]Q. And when did you receive your certification to

[23]become a Diplomate in Physical Medicine?

[24]A. May of 89.

[25]Q. Now, what other requirements to be a clinical

[2]instructor and to teach other doctors, medical students?

[3]A. You have to first be board certified. You have

[4]to have knowledge. You have to have character and ethics

[5]that measure up to the hospital standards. And basically

[6]be able to teach.

[7]Q. Where do you teach now, doctor?

[8]A. Hospital for Joint Diseases, Orthopedic

[9]Institute.

[10]Q. Is that in Manhattan?

[11]A. Yes.
a

e 12 Q. Okay.

[13]Can you describe what the field of physical

[14]medicine encompasses?

[15]A. Yes. Another name for the word physical

[16]medicine would be orthopedic medicine, non-surgical

[17]orthopedics. Rehabilitation, the job of a specialist in

[18]this field would called physiatrist. Our job is to

[19]restore function, to **[*8]** bring the patient to the optimal
? 20 level of care prior to their injuries, whether their

[21]injury is from a car accident, from a skiing accident, a
a '

[22]sports accident, a fall injury, a cerebral vascular

[23]accident like a stroke, an amputation or a spinal cord

[24]injury, and our training is in orthopedics, neurology,

[25]internal medicine, kinesiology which is the study of

[2]motion, physical therapy and other principals that deal

[3]with the neurological and the musculo-skeletal system.

[4]Our difference from orthopedic surgery is that we don't

[5]concentrate on injuries the bone system. We concentrate

[6]on the entire body from head to toe, and we do not do

[7]surgery. We try do avoid surgery. The difference between

[8]us and a neurologist is a neurologist concentrates more on

[9]central neurology meaning neurology of the brain. And

[10]some of us overlap. A physiatrist concentrates on

[11]neurology of the peripheral system, the nerves from the

[0]
[12]spine to the hands and the arms and as well as the nerves

[13]of the spine. We treat problems like disc problems, nerve

[14]problems, muscular problems, neck pain, back **[*9]** pain, knee

[15]pain, etcetera.

[16]Q. Dr. Guy, are you a member of any medical

[17]organizations?

[18]A. Yes.

[19]Q. Which medical organizations?
? 20 A. I am a member of the New York County Medical

[21]Association, the New York State Medical Association.
s

[22]Q. Now, as part of your training did you receive

[23]formal training in neurology, internal medical and formal

[24]training in interpretation of x-rays and M.R.I.'s?
251 A. Yes.

[2]Q. Can you describe what formal training you

[3]received?

[4]A. Surely. During my 18 month training at Mt.

[5]Sinai School of Medicine when I was doing internal

[6]medicine every Monday and Friday we had a radiology round

[7]and we view Cat Scans and x-rays every time you have an

[8]admission and when you are on call you are on call every

[9]third night, you have six to seven admissions. You have

[10]x-rays, Cat Scans, M.R.I.'s. You review them with your

[11]attending, your preceptor or your teacher and when you

[0]
[12]present the history to your teacher you have to present

[13]the x-rays and Cat Scans and M.R.I.'s as well. You get

[14]additional **[*10]** teaching in that as well.

[15]Also, during my internal medicine I did two

[16]months of formal training in neurology which is all Cat

[17]Scans, M.R.I.'s, E.M.G.'s, E.E.G.'s, things of that

[18]nature.

[19]Then during my 12 months training in general

[4]
? 20 surgery you cover the emergency room and you cover the

[21]surgical I.C.U.. It's all trauma. It's all fractures.

[22]Cat Scans, x-rays, M.R.I.'s.

[23]Then in the field of, physical medicine and

[24]rotation again, the same thing. Repetition of that. Plus
251 formal training again in the interpretations of Cat Scans,

[2]M.R.I.'s and x-rays and formal teaching rounds every one,

[3]once or twice a week for about 2 to 3 hours each time.

[4]Q. Okay.

[5]But in your practice, doctor, you are an expert

[6]in trauma related injury?

[7]A. Yes.

[8]Q. Now, have you previously testified in Court as a

[9]result of your treatment of patients for trauma induced

[10]injuries?

[11]A. Yes, I have, many times.

[0]
[12]Q. Can you approximate how many times you have

[13]testified, doctor?

[14]A. On the average I testify about five to eight

[15] **[*11]** times; sometimes more, sometimes less and during any early

[16]years of training I testified a lot less. Now,

[17]approximately around 8 times a year. Sometimes less,

[18]sometimes more.

[19]Q. And what percentage of your practice is devoted
? 20 to treating patients?

[21]A. The majority. I would say over 90 percent is
a

[22]devoted to treating patients, and out of that 90 percent I

[23]would say about 15 to 20 percent is devoted to teaching

[24]doctors, residents and having teaching rounds with them at

[25]the hospital.

[2]Q. Of the patients that you treat, what percentage

[3]of those patients call on you to testify on their behalf

[4]for litigation purposes?

[5]A. Well, my field deals with trauma. When you deal

[6]with trauma, inevitably I get pulled into the legal

[7]system. There are depositions, there are court

[8]proceedings and sometimes I am asked to come and testify

[9]on the treatment I render to my patient.

[10]That is the same numbers I gave you earlier.

[11]Q. What percentage of your practice is devoted to

[4]
[12]teaching, doctor?

[13]A. Approximately 15 to 20 percent. **[*12]** Sometimes a
I

[14]little bit more because the residents rotate through my

[15]offices as well during the week days, as well as the week

[16]end. I have office hours on Saturdays also, so sometimes

[17]they come and spend the whole day with me.
s

[18]Q. What percentage is devoted to consultations with

[19]other physicians?
W

[6]
? 20 A. Out of that 90 percent I'd say about 15 to 20

[21]percent.

[22]Q. Do you also do hospital consultations?

[23]A. Yes.

[24]Q. Okay.

[25]MRS. FISHER: Your Honor, at this time I

[2]would ask that Dr. Ali Guy be qualified to

[3]testify as an expert in the field of physical

[4]medicine, orthopedics, neurology and all the

[5]physical medicine specialties encompassed in

[6]regard to this case.

[7]THE COURT: The witness may testify.

[8]MRS. FISHER: Thank you.

[9]Q. Dr. Guy, are you being compensated for your

[10]testimony here in court today?

[11]A. I am being compensated for cancelling my office
a

[12]schedule. Cancelling my schedule and to be here, yes.

[13]Q. Can you tell the jury how much you are getting

[14]paid to testify today?

[15]A. **[*13]** I charge $ 3, 000 for half a day and $ 1, 000 for

[16]pre-trial consultation including up to 2 hours prior to

[17]coming to testify.
e

[18]Q. And Dr. Guy,

[19]THE COURT: Is that $ 4, 000 you are being
? 20 paid.

[21]THE WITNESS: Yes, total, yes.
s

[22]Q. Dr. Guy, can you tell us if you are familiar

[23]with the patient Catherine Iacello?

[24]A. I am.

[25]Q. And can you tell us how Catherine Iacello was

[2]referred to you for treatment?

[3]A. Doctor Striano, the chiropractor.

[4]Q. Now, could you briefly describe when is the

[5]first time you saw and treated or evaluated Catherine

[6]Iacello?

[7]A. The first time was on December 12, 1993?

[8]Q. And Dr. Guy, can you describe when Catherine

[9]first came to you what did you do?

,

[10]A. I obtained a history and then I examined her and

[11]I did an E.M.G.

[0]
[12]Q. Can you describe the significance of a patient's

[13]history and the taking of a history?

[14]A. A doctor derives the majority of his diagnosis

[15]from a history. I would say approximately 75 to 80

[16]percent from the history. **[*14]** The history guides you in the

[17]right direction. For instance, if a patient complains to

[18]you of neck pain, you will elaborate. Does the pain

[19]travel down the arms? Is there any numbness and tingling?
? 20 You don't ask questions like do you have abdominal pains

[21]or nausea or vomiting. You stay in the system where the

[22]injury is and vice versa. And then you concentrate on the

[23]area where the chief complaints of pain or problem is, and

[24]your history guides you as to what the next series of

[25]questions should be and what the next physical exam should

[2]concentrate on and what additional tests that you have to

[3]order.

[4]Q. What percentage of a physical examination of a

[5]patient contributes to your ability to diagnosis the

[6]patient?

[7]A. I would say as I said the history is the most

[8]important, 75 to 80 percent. Additional 10 percent from

[9]the physical examination and the other 10 percent from

[10]other diagnostic tests which you may obtain which only

[11]confirm or disconfirm your working initial diagnosis.

[0]
A

[12]Q. And, Dr. Guy, when was the first time that you **[*15]**
[13]saw Catherine Iacello?

[14]A. December 2, 1993.

[15]Q. And can you describe what the physical

[16]examination you conducted consisted of?

[17]A. Yes. She was disrobed. She was given a gown

[18]and I examined her head, and I examined her neck, her

[19]back. The neck revealed diffuse tenderness. It was
? 20 painful to touch the whole entire neck region.

[21]Q. What does diffuse mean?
s

[22]A. It means all over, the whole entire area.

[23]There was diffuse spasm. Spasm is defined as a

[24]prolonged involuntary contraction of a muscle fiber.

[25]Normally when you touch a normal muscle it's supposed to

[2]be soft to touch. When it is in spasm, it becomes hard.

[3]The fiber is shortened and you lose range of motion

[4]depending on the severity of the spasm. So spasms can be

[5]as hard as this board, and you lose significant range of

[6]motion. Stiffness sets in and more pain sets in so you

[7]have a pain spasm cycle and then I checked her for range

[8]of motion and muscle power testing of the neck.

[9]The range of motion of the neck was 1 half

[10]normal in all directions. Forwards, backwards, **[*16]** sideways

[11]and lateral rotation to the left and right. And the

[0]
[12]muscle power testing was 2 grades weaker. It was 4 over

[13]5. Then I examined her lower back, upper back, and the

[14]lower back it was again diffusely tender to spasm. There

[15]was --

[16]THE COURT: The lower back was this way,

[17]doctor?
a

[18]THE WITNESS: Yes. As-well the back was

[19]diffusely tender with diffuse spasm and range of
W
d
? 20 motion was one half normal.

[21]THE COURT: In the lower back?

[4]
[22]THE WITNESS: Yes, correct.

[23]THE COURT: Did she make complaints of the

[24]lower back at the time you examined her.

[25]THE WITNESS: She did.

[2]THE COURT: Proceed, doctor.

[3]Q. Dr. Guy, can you describe how you can

[4]objectively determine whether or not there is a muscle

[5]spasm?

[6]A. After you have been doing something for more

[7]than 12-15 years, your fingers become a computer. You

[8]don't have to be a rocket scientist to palpate hardness of

[9]a muscle. Normal muscle when you touch it is soft. When

[10]you touch the normal muscle it's soft. When you touch

[11]your muscles to the upper back, it's supposed **[*17]** -- when you

[0]
[12]press it, it is supposed to give in. When it's hard, it

[13]feels very tight. It doesn't give in. It has no

[14]resilience. It doesn't bounce back when you press on it.

[15]It's hard.

[16]Q. Is that an objective finding or a subjective

[17]finding?

[18]A. That's an objective finding.

[3]19 Q. What other tests did you perform on Cathy?
? 20 A. I checked for range of motion, sensation,

[21]reflexes and gait, and then I did an E.M.G..

[22]Q. And can you describe your findings after you did

[23]this test?

[24]A. The sensation was decreased to pin prick and

[25]touch. The right biceps area and the left laterally I

[2]think and the left medial arm. The rest of the exam was

[3]unremarkable.

[4]Q. Can you describe the significance of your

[5]findings, doctor?

[6]A. The biceps is an area that's supplied by the

[7]nerve roots which come off the neck. And if I can review

[8]some basic anatomy, the jury can basically understand.

[9]Q. Sure.

[10]THE WITNESS: May I be allowed, Your Honor?

[11]THE COURT: Yes.

[0]
A

[12]A. This is a model of the spine.

[13] **[*18]** MR. SCAHILL: Doctor, perhaps if you can

[14]stand at the top so I can see also.

[15]THE WITNESS: Stand over here?

[16]MR. SCAHILL: If you would.

[17](Off the record)

[18](Whereupon, there is a short pause

[19]in the proceedings.)
w
d
? 20 A. This is a model of the spine. In the neck we

[21]have 7 vertebra. The neck is called the cervical spine

[22]area. The mid back is known as the thoracic spine. We

[23]have 12 vertebrae. The lower back is known as the lumbar

[24]area. We have 5 vertebrae. Between each vertebrae we

[25]have a disc. A disc serves as a function of a shock

[2]absorber to protect bones from hitting each other. A disc

[3]is analogous to a jelly donut. It has two parts. Outside

[4]is cartilage analogous to the doughy part of the jelly

[5]donut, and inside it was a gelatinous permanent material,

[6]a nucleus pulposis which is the outside of the jelly

[7]donut.

[8]Now, behind the vertebrae we have the spinal

[9]canal. The spinal cord runs through the spinal canal in

[10]the lower portion of the lower back all the way up to the

[11]brain. It attaches itself to the brain by way of the

[0]
[12] **[*19]** brain stem or the medula ablongata and as the spinal cord

[13]goes up through from the lower back to the brain it gives

[14]rise to nerve roots on the right and on the left side.

[15]These nerve roots in turn branch off. You have motor and

[16]sensory brain. Motor controls movement and sensory

[17]controls perception. And all the nerves that go to your
s

[18]arms come off the nerve roots in the neck. All the nerves
a 19 that go though your lower back come off the nerve root in
W

[6]
? 20 the lower back.

[21]Now, we label the nerve roots in terms of their

[22]anatomical position. If I say C5 C6, it means the nerve

[23]root between the fifth and sixth cervical vertebrae. If I

[24]say L5-S1, it means the nerve root between the fifth

[25]lumbar vertebrae and the first sacral vertebrae which is

[2]the tail bone. If I say C6 C7, it means the disc between

[3]the last vertebrae in your neck.

[4]Now, from anatomy a physician knows what parts

[5]of the body is controlled by which nerve roots. Biceps is

[6]supplied by the nerve roots in the C5 C6 distribution in

[7]your neck. The muscles in the forearm, the flexor

[8]corpiradialus is supplied **[*20]** from the nerve root from C 6 and

[9]7, cervical vertebrae, and the flexor corpiulnaris is

[10]supplied from the nerve roots from the C6 and C7 and first

[11]thoracic vertebrae.

[0]
[12]Most muscles have duel innervation. It means it

[13]is supplied by two nerve roots. Some more than others.

[14]The triceps has four nerves that go though it C6-C7, T1

[15]and some fibers of C5 and some from T2 but mostly from

[16]C6-C7 and Tl.

[17]Okay.

[18]There is only one muscle in the entire body that

[19]has only one nerve root innervation and that's the
W
s
? 20 extensor halgus longus. That's a board of examination

[21]question.
a

[22]Now, whenever you have a patient that has a

[23]problem with the neck, the hallmark of a nerve root

[24]problem is shooting pain. Radiating pain down the arms

[25]with or without numbness or tingling with or without loss

[2]of a reflex.

[3]THE COURT: What about the lower back,

[4]doctor?

[5]THE WITNESS: The lower back as well. You

[6]get-- as I said earlier.

[7]THE COURT: Shooting pains in the arm.

[8]THE WITNESS: In the arm.

[9]No, the legs. The legs and bottom area --

[10]the bottom is L5-S1-

[11] **[*21]** THE COURT: So whenever you have shooting

[0]
e 12 pains down the arms, that comes from the neck.

[13]Whenever you have shooting pains down the leg,

[14]it comes from the lower back. And from the

[15]anatomy you know what nerve goes to what area.

[16]Q. From your physical examination of Cathy in

[17]December of 1993 were any tests indicated to be performed?

[18]A. Yes.

[19]Q. And can you explain what tests you were of the
W

[6]
? 20 opinion should be performed?

[21]A. E.M.G.
s

[22]Q. Can you desribe for the jury what an E.M.G. is?

[23]A. E.M.G. stands for electro-myography. It's a

[24]test analogous to the E.K.G. of the heart. Everyone is

[25]familiar with the E.K.G. of the heart. This checks the

[2]E.K.G. of the muscle and the nerves. You -- the test has

[3]three parts. The first two parts is the motor and sensory

[4]branch which checks the peripheral nerve from the nerve

[5]root. This peripheral nerve is the nerve from the arms

[6]and the legs. The last part is the actual needle E.M.G.

[7]when I insert the top of a small sterile needle into

[8]several muscles in the arms and in the **[*22]** several muscles in

[9]the neck looking for abnormalities in the form of

[10]increased insertional activity, positive sharp waives,

[11]fibrillation potetial or any other bizarre problems.
v

[12]If I can use the board, I can draw what these

[13]abnormalities are.

[14]May I.

[15]THE COURT: Go ahead.

[16](Whereupon, there is a short pause

[17]in the proceedings.)

[18]A. An E.M.G. has a screen in it, a siloscope screen

[19]which is about 4 inches by 4 inches. It has a wire
W
n
? 20 attached to it and has an amplifier box. When you insert

[21]the needle into several muscles into the arm, the

[22]amplifier box records the activity present in the muscle

[23]fibers, and that activity appears on this screen. A

[24]normal tracing, normal. This is a normal motor unit. It

[25]goes up and then down. That's normal. This is a positive

[2]sharp waive. It goes down first instead of up. It goes

[3]back up and back to base line. This is abnormal.

[4]Positive sharp waive. You then have fibrillation

[5]potential which look like so. I call fibrillation fibs

[6]1 for short.

[7]1 MRS. FISHER: I don't know if we can see

[8]that.

[9]A. **[*23]** All right. I will use a blue pen. Fibrillation

[10]potential are very very short, a track of the size of this

[11]positive sharp waive and a track of this motor unit

[0]
[12]potential. It goes first down and up and to base line,

[13]and so, on your screen you hear it has a very crinkly

[14]sound. An E.M.G. also produces sounds the sound of an

[15]actual motor unit and if you have bizzare findings you are

[16]also see it and you hear it. It's both.

[17]Now, fibrillation potential if you see on your
a

[18]E.M.G. it indicates either a longstanding problem or a

[19]severe problem, and if you see polyphasics where the
W

[6]
[20]normal motor unit has multiple phases. This indicates a

[21]longstanding problem. So the combination of fibrillation

[22]potential and a combination of polyphasics indicates a

[23]longstanding problem present in the muscle fibers or the

[24]nerves. Normal 12 months or over. When this patient was

[25]tested the right biceps revealed increased insertional

[2]activity. A lot of activity on the screen and it

[3]indicated positive sharp waves and then when the bilateral

[4]C5-C6 nerve roots were tested in the neck **[*24]** it indicated

[5]increased insertional activity and positive sharp waives

[6]indicating a radiculopathy present at the bilateral C5-C6

[7]mostly the right side. The word radiculopathy comes from

[8]Latin. Radic means nerve root. Lopathy means any type of

[9]a pathological condition relating to a nerve root. You

[10]can have a radiculopathy from a disc herniation. You

[11]could have it from a spur formation from a tumor
a

[12]compression, from an impingement in the sheering forces

[13]working on the spine.

[14]Now, there were no fibrillation potential.

[15]There were no polyphasics. There were no only sharp waves

[16]and increased insertional activity indicating a recent

[17]radiculopathy.

[18]Q. In other words, doctor, the objective findings

[19]from the E.M.G. studies told you that this was a recent
? 20 injury as opposed to one of long standing duration?

[21]A. That's correct.
a

[22]Q. And these findings are objective findings as

[23]opposed to objective?

[24]A. That's correct.

[25]Q. Okay.
r
211 Do you need to use the --

[3]A. No.

[4]Q. Okay.

[5](Witness resuming **[*25]** stand)

[6]Q. Dr. Guy, did you perform the E.M.G. test on

[7]Cathy I acello?

[8]A. Yes, I myself performed that E.M.G..

[9]Q. And what conclusions did you come to from the

[10]results of the E.M.G. study?

[11]A. That she was suffering from a bilateral C5 C6

[0]
[12]cervical radiculopathy.

[13]Q. And in combination with the history that you

[14]took what were your conclusions as to the cause of this

[15]radicul opathy?

[16]A. That it was sustained in the traumatic event of

[17]her car accident on 11-18-93.

[18]Q. Now, Dr. Guy, did you perform any other tests on

[19]Cathy Iacello the first time you saw her?
W
? 20 A. The first time, no.

[21]Q. Did you order any other testing to be done?
s

[22]A. Doctor Striano had already ordered an M.R.I. of

[23]her cervical spine.

[24]Q. And did you have use of the M.R.I. report when

[25]you did the E.M.G. and made your conclusions regarding

[2]that?

[3]A. No. The first time I performed the E.M.G. the

[4]M.R.I. had not yet been performed.

[5]Q. Dr. Guy, when is the next time that you saw

[6]Cathy **[*26]** lacello?

[7]A. The next time she was seen was on 12-23-93.

[8]THE COURT: Doctor, Dr. Guy, with respect

[9]to the lower back?

[10]THE WITNESS: Yes.

[11]THE COURT: Did you conduct any E.M.G?
v

[12]Studies?

[13]THE WITNESS: Yes, yes I did.

[14]THE COURT: What were the results of those

[15]studies,

[16]THE WITNESS: The results showed bilateral

[17]L5-S1 radiculopathy.

[18]THE COURT: What?

[19]THE WITNESS: The results showed bilateral
? 20 L5-S1 radiculopathy.

[21]THE COURT: How would an E.M.G. test

[22]performed on the lower back, doctor --

[23]THE WITNESS: The same principal, Your

[24]Honor.

[25]THE COURT: I guess instead of using the

[2]arm you used the foot.

[3]THE WITNESS: The foot and instead of using

[4]the neck, you use the lower back.

[5]THE COURT: Okay.

[6]And what were the results of the E.M.G.

[7]study of the lower back reveal?

[8]THE WITNESS: Bilateral L5-S1

[9]radiculopathy.

[10]THE COURT: Based upon the history that you

[11]had what was --

[0]
[12]THE WITNESS: That there was also a problem

[13]with the lower back as well.

[14]THE COURT: Thank you.

[15]Q. Dr. Guy, the next time that you saw **[*27]** Cathy

[16]Iacello was December 23rd, is that correct, of 93?

[17]A. Yes.

[18]Q. And could you tell us what your examination

[19]consisted of at that time?
? 20 A. The examination and an E.M.G. of the lower

[21]extremities.
a

[22]Q. And did you also do examinations of her cervical

[23]region at that time?

[24]A. Yes.

[25]Q. And what were the results of your examination of

[2]her cervical region?

[3]A. Basically the same; still diffuse tenderness,

[4]still diffuse spasm and still reduced range of motion?

[5]THE COURT: And the lower back.

[6]THE WITNESS: The same. Still difussed

[7]spasm, diffused tenderness and reduced range of

[8]motion in extension.

[9]Q. Dr. Guy, did you read or have the M.R.I. films

[10]to review the second time that you saw Cathy lacello?

[11]A. Yes.

[0]
[12]Q. And did you review throws M.R.I. films?

[13]A. I did.

[14]Q. Do you have a copy of those M.R.I.'s with you.

[15]A. I do.

[16]Q. If I may.

[17](Whereupon, there is a short pause
a 18 in the proceedings.)

[19]Q. Dr. Guy, are these five films?

[4] **[*28]**
? 20 A. Yes.

[21]Q. These are the studies performed on Cathy
s

[22]Iacello?

[23]A. Yes.

[24]MRS. FISHER: Can I have them in some way

[25]deemed marked.
.I

[2]MR. SCAHILL: Judge, perhaps we can

[3]shortcut this. I stipulate that they go into

[4]evidence. I also subpoenaed the M.R.I. films.

[5]Are the ones you have, doctor, copies or

[6]originals?

[7]THE WITNESS: I am not sure, copies or

[8]originals.

[9]MR. SCAHILL! Okay.

[10]I think I subpoenaed the originals. I ask

[11]that they be put into evidence, the same are

[0]
[12]M.R.I. for this plaintiff.

[13]MRS. FISHER: Well, if we might, Your

[14]Honor, just.

[15]MR. SCAHILL: I stipulate that they go into

[16]evidence. I rather use the ones that we

[17]subpoenaed which are the originals.

[18]MRS. FISHER: I just like to have the

[19]doctor make a comparison of the -- and
? 20 verification.

[21]MR. SCAHILL: Sure.
s

[22]MRS. FISHER: Why not take a short break.

[23]THE COURT: Okay.

[24]We will take a 5 minute recess. No

[25]problem.

[2](Jury leaving courtroom at 11:10 a.m.)

[3](Recess)

[4](Jury entering courtroom at 11:25 **[*29]** a.m.)

[5]THE COURT: You could proceed, counsel.

[6]MRS. FISHER: Thank you.

[7]Q. Dr. Guy, did you examine the M.R.I. films that

[8]have been offered in evidence and explain the sigificance

[9]of the M.R.I. to the jury please?

[10]A. Yes.

[11]Q. Dr. Guy when you explain each of the films just

[0]
[12]give the letter or number designation?

[13]A. This is Exhibit number 8, Plaintiff Exhibit

[14]number 8.

[15]Q. Thank you.

[16]A. You're welcome:

[17]This is the M.R.I. of the cervical spine on the
v

[18]patient. M.R.I. stands for magnetic resinence imaging by

[19]way of a very sophisticated magnet you take the patients

[6]
? 20 protons and you transform to axium images of the area. An

[21]M.R.I. is a special term to detect soft tissue problems.
a

[22]It's not a test to pick up bony problems. It's not a test

[23]to detect nerve problems. Every test in medicine has it's

[24]indications and it's limitations. The purpose of the

[25]M.R.I. in this situation is to assess the condition of the

[2]discs and the spine.

[3]Q. Doctor, how is an M.R.I. different from an

[4]x-ray?

[5]A. **[*30]** X-ray, you shoot an x-ray beam and you

[6]concentrate on bones. There is no x-ray beam. There is

[7]magnets. You take the body's magnetic field, and you

[8]transform them into real life images. So this is the

[9]patient's M.R.I. film. There is the brain. Continuation

[10]of the brain is the spinal cord all the way down, and

[11]these are the vertebrae. This is the seventh vertebrae,
v

[12]the sixth, the fifth, the fourth, the third, the second

[13]and the first. Between each vertebra you see a darkly

[14]shaded line. That's the disc: A M.R.I. has a sagital

[15]view.

[16]Q. Can you explain what a sagital view is?

[17]A. And has an axial view. You look at-the

[18]pathology from the top down like in this fashion. Sagital

[19]is sideways and axial is from the top up like that. So
? 20 right now we are looking at the spine side ways.

[21]Okay.
a

[22]At the level of C6-C7 we see the disc is

[23]sticking out and coming very close to the spine at this

[24]level. I don't know if you can all see it from back

[25]there. Can you all see it from back there? -

[2]Now, the other discs are not coming out at this

[3]level. Only **[*31]** the C6-C7 and so that's the herniation, and

[4]right, behind here we have what is called the posterior

[5]longitudinal ligament, the posterior longitudinal ligament

[6]holds the disc in this patient in place, but here you see

[7]it is pushing backwards and behind so this disc is

[8]herniated. I am going to show you other views.
,

[9]This is --

[10]THE COURT: What exhibit is that, doctor?

[11]THE WITNESS: Exhibit number 10.

[0]
[12]THE COURT: Thank you.

[13]THE WITNESS: You're welcome.

[14]A. In this exhibit again at the level of C6-C7

[15]again you see this fine line sticking out past the mid

[16]line. The margin that is part of the disc herniation

[17]fragment.

[18]Can you all see it from back there?

[19]Okay.
W
s
? 20 Now, next view. This is Exhibit number 9. This

[21]is the axial view. At the axial view we are looking at

s

[22]things this way. This is -- make believe this is off and

[23]this is the disc. And that's-the spinal cord.

[24]Q. Doctor, not to get morbid but if you were to cut
25, somebody's head off and shoot the camera down, that's the

[2]axial view?

[3]A. That's correct, that's **[*32]** right.

[4]Q. At?

[5]A. The axial view -- you want the sagital view and

[6]the axial view so you have a full picture of the anatomy

[7]from every angle. So now you are looking at the disc from

[8]this angle. This is again make believe this vertebrae is

[9]out of the way and this is the disc right here. This is

[10]the spinal cord. This is the spinal cord. Normally when

[11]you look at a normal disc on the M.R.I. scan the border of

[0]
[12]the disc should be completely clear. This elliptical

[13]border and the disc should also be the spinaal cord should

[14]also be clear here. As you can see here, you cannot see

[15]the clear margins of this because the herniation is

[16]sticking through and it's just on top of the spinal cord.

[17]Right over here. To give you comparison. Here is a view
v

[18]of a normal disc and the spinal cord as you will see the

[19]spinal cord is not crunched here. Look at this one. This
? 20 is semilunar and this is nice and round. This is not

[21]crunched and here it's crunched. This is crystal clear.

[22]This is a disc herniation. we have a disc bulge. We have

[23]a disc protrusion, and we have a disc herniation. **[*33]** A disc

[24]herniation is the most severe form. A herniation means

[25]rupture. It means the outer part, the doughy part of the

[2]jelly donut has ruptured. The gelatinous material of the

[3]jelly donut is leaking backwards. The outer part, the

[4]cartilage the anulous fibrosis is cartilage. Once you

[5]tear cartilage, it is a permanent irreversible structure.

[6]Cartilage does not have the ability to repair itself.

[7]Muscle does and bone does. In fact, when you break a

[8]bone, it heals with callous formation or bone cement. It

[9]becomes the strongest part of the body. If you break

[10]every part of the body, that site would never break again.

[11]Ask Evil Kinevil, he will tell you.

[0]
[12]Q. And --

[13]A. Muscle regenerates with scaring. Nerve

[14]regenerates with t'o a degree neurons in the brain do not

[15]generate, but nerves in the arm and leg regenerate 1

[16]millimeter per month and that's very very small and this

[17]is a herniation.

[18]Q. Can you describe, doctor, the difference between

[19]a herniation and a bulge?
W
s
? 20 A. Yes.

[21]Q. Clinically?
Q

[22]A. The bulge **[*34]** simply means that the disc is

[23]completely pushed backwards but the outer annulous

[24]fibrosis is not ruptured and a bulge doesn't come that far

[25]out as far as this herniation does. A disc herniation is

[2]assymetrical. It's not completely round when you see it

[3]on the axial or the sagital view. A disc bulge you will

[4]not have disc, this unclear border. Look at the other

[5]one. You can see the spinal cord with a much clearer

[6]border. Here it's cut and also sometimes we use other

[7]criteria to know if a disc herniation is new or old. When

[8]a disc herniation is old, that herniation it forms

[9]osteophytes around it. Osteophytes look like this. You

[10]have these bone spurs that stick out. Out of the place

[11]around the vertebral body and into the neuroforamen where

[0]
[12]the nerve root exits: So this is a pre-existing disc or a

[13]disc degeneration which is shriveled up without

[14]osteophytes and this is a normal disc. You can see the

[15]two in comparison. This is how you know in medicine what

[16]is pre-existing and old and what is new.

[17]Q. How can you tell whether or not Cathy Iacello's **[*35]**
[18]herniation is recent or old from the M.R.I.'s?
I

[19]A. From the M.R.I.'s you can tell that there is no
W
d
? 20 degeneration at the C6-C7 level. We have a normal disc

[21]the same size as all the other discs between it so there
a

[22]is no degeneration. This is a normal disc --. It means

[23]that the thickness is normal so it's not old. It's not

[24]pre-existing. This is a new disc herniation.

[25]Q. Can you tell from the M.R.I.'s whether or not

[2]the disc herniation was induced by trauma?

[3]A. Okay.

[4]Nobody can tell through an M.R.I. whether it's

[5]induced by trauma. You have to put the whole picture

[6]together; the history, the physical exam findings and any

[7]other tests. If somebody comes here and says I look at

[8]this M.R.I. without the history and say this came from a

[9]herniation, I would tell you -- am I allowed to say you

[10]are a liar? You cannot say that. You cannot say -- you

[11]have to put the whole picture together.

[0]
[12]THE COURT: But, doctor, if you had an

[13]M.R.I. that was conducted of the plaintiff prior

[14]to the accident, that would be objective

[15]evidence **[*36]** that this was as you compare it the

[16]M.R.I. prior to the accident and this M.R.I.

[17]that would lead you to believe whether or not

[18]this was induced by trauma, would it not?

[19]A. If you have an M.R.I. prior to the accident and
d
? 20 you compart the two, that's another way as His Honor the

[21]Judge says, you can compare it to if there was such an
Q

[22]M.R.I.

[23]Q. But Cathy Iacello didn't have a prior M.R.I.,

[24]did she, Dr. Guy?

[25]A. As far as I know, no.

[2]Q. Okay.

[3]And according to the history that you took from

[4]her did you come to any conclusions about the cause of

[5]this C6-7 herniated disc?

[6]A. Yes, I did.

[7]Q. And what conclusions did you come to as a

[8]physician treating, a treating physician?

[9]A. A 29 year old patient should not have a disc

[10]herniation as pre-existing. This herniation usually come

[11]from trauma. If the patient was 80, 70 or 60 you could

[0]
e 12 have -- I say yes it was from wear and tear, the disc

[13]herniation was present from just natural aging process but

[14]this girl is only 29, and there is no degeneration. **[*37]** There

[15]is no osteophytes in there in my opinion this disc

[16]herniation came from trauma which is the most competent

[17]producing cause of a disc herniation. In fact, C6-C7 is
e

[18]the most common injury from a motor vehicle accident;

[19]flexion, extension and rotational forces working on the
d
? 20 spine.

[21]Q. Explain the significance of a C6-7 level?
a

[22]A. As I indicated to you in the neck you have 7

[23]vertebra. C7 is the last one. This C6 is the one before

[24]last so C6-C7 is the last level in the neck. It's the

[25]foundation of the neck. In your body the normal body has

[2]a curve the neck curve is like so concave and then the

[3]thoracic it comes convex and then the lumbar spine it

[4]becomes concave.

[5]Okay, cervical and lumbar have the same

[6]configuration. The thorax has the opposite configuration,

[7]so this is the foundation. It is like building a

[8]building, a skyscraper. If your foundation is strong,

[9]what happens when I build the building with a foundation

[10]that's strong, as you go higher and higher and higher, you
I

[11]are able to maintain proper alignment **[*38]** of that foundation.

[0]
[12]What happens if your foundation is weak or unstable. As

[13]you go higher and higher you have instability. You have

[14]movement. You have problems. So you are at high risk of

[15]developing further herniations at the level above it and

[16]at the level below it. That's what happens when you have

[17]instability at the foundation. In the lower back the

[18]foundation is the L5-S1. In the thorax area the

[19]foundation area is T12-L1. So any injury at these levels
? 20 is a very bad injury.
K

[21]Q. Dr. Guy, can you describe how a herniated disc

[22]causes pain?

[23]MR. SCAHILL: Doctor, are you finished with

[24]the films?

[25]THE WITNESS: I don't know. It depends on

[2]--

[3]Q. Do you need the films to explain how the pain is

[4]caused by the herniated disc?

[5]A. At this point, no.

[6]Q. Okay.

[7]Then --

[8]A. Thank you.

[9](Whereupon, 'there is a short pause

[10]in the proceedings.)

[11]A. May I answer.

[0]
[12]Yes.

[13]Q. Yes?

[14]A. You asked me how does a disc herniation cause

[15]pain. When a disc herniates it ruptures. It **[*39]** has chemical

[16]mediators inside it. You have nitric oxide NO. You have

[17]leukotriene, and you have prosteglandin E2 which is a

[18]substance of inflammation and pain. When these are

[19]released from inside the contentys of a closed capsule
W
O

? 20 what happens. You irritate, you inflame the whole area.

[21]The outer one third of a disc has sensory nerve endings.
s

[22]When you stretch it or when you tear it it produces pain.

[23]The posterior longitudinal ligament which holds the disc

[24]in place when it is stretched or when it is torn it causes

[25]tremendous amounts of pain and it irritates all the
r

[2]structures around it, so these are the ways by which it

[3]produces pain. Also the muscles going into spasm from

[4]irritation of these inflammatory substances that are

[5]produced and when the muscle goes into spasm that causes

[6]pain that causes pain, stiffness and reduction of range of

[7]motion. That reduction of range of motion aggrivates the

[8]spasm. You have a pain spasm pain spasm cycle which

[9]continues and then from trauma you have a rapid accelorant

[10]form of arthritis which starts to set from now. **[*40]** The

[11]normal arthritic process which takes years to occur now is

[0]
[12]going to occur much much earlier. You are going to have

[13]these osteophytes forming and you are going to have these

[14]spurs from the vertebral bodies sticking out and hitting

[15]the nerve roots causing further problems to the nerve

[16]roots.

[17]Q. Dr. Guy, in your opinion in dealing with trauma

[18]injuries as you do does nerve pain happen immediately

[19]after a trauma?
? 20 A. It does not. It takes minimum 10 to 21 days for

[21]a nerve injury to manifest itself. It never, I repeat it
a

[22]never manifests itself immediately. In fact, if you were

[23]to do a test after E.M.G. to document nerve problem if you

[24]do it sooner than 14 days, the carrier will not reimburse

[25]you for it. They tell you it was done too soon.

[2]THE COURT: What about 24 hours?

[3]THE WITNESS: In terms of nerve injuries it

[4]will not occur within 24 hours.

[5]Q. Now, in terms of injuries to the muscles and the

[6]soft tissues, how long does that generally take to show

[7]1 up?

[8]MR. SCAHILL: Objection, Your Honor, to

[9]that question. Is it pertaining **[*41]** to this patient

[10]or a hypothetical?

[11]MRS. FISHER: No, it's a hypothetical

[4]
[12]question in general.

[13]THE COURT: Okay.

[14]Q. Is it in your opinion, doctor?

[15]THE COURT: Overruled. The doctor can

[16]answer the question.

[17]Q. In your opinion, doctor, does neck pain

[18]associated with trauma happen instantly?

[19]A. Generally it does not. It takes minimum 48 to
e 20 72 hours for the full picture to begin and it's tail end

[21]starts to continue to manifest itself up until 2 to 3
a

[22]weeks later. So you have the beginning 48 to 72 hours and

[23]the tail end 2 to 3 weeks later.

[24]THE COURT: Where would be the threshold,

[25]doctor, where the person would be experiencing

[2]the maximum amount of pain after the trauma

[3]induced injury, how many hours are we talking

[4]about?

[5]THE WITNESS: How many hours?

[6]Q. Maximum amount of pain?

[7]THE COURT: Yes, that's what I am asking.

[8]THE WITNESS: When you are saying the

[9]maximum amount of pain, pain can come from

[10]muscle spasm. Pain can come from tightness.

[11]Pain can come from subluxation. Pain can come

[0]
[12]from loss **[*42]** of the normal curvature in the spine.

[13]So pain can start as early as several hours from

[14]an accident or as early as immediately, but

[15]generally it starts 48 to 72 hours.

[16]THE COURT: Thank you, doctor.

[17]THE WITNESS: You're welcome.

[18]Q. We are talking about pain from Cathy Iacello's

[19]accident on November 18, 1993. Dr. Guy, is it your
? 20 opinion that immediately after the impact or the collision

[21]that Cathy would have had to have felt immediate pain?

[22]A. Generally, no. Because the reasons I explained

[23]to you earlier when a disc herniates those substances,

[24]those toxins or inflammatory substances start to become

[25]secreted. They don't cause the full blown effect on the

[2]body until 14 to 21 days later at their peak effect they

[3]start from 48 to 72 hours later. But the peak effect is

[4]14 to 21 days later.

[5]Q. Can you describe the effect of other substances

[6]such as Adrenalin, endorphins in terms of trauma related

[7]occurrences?

[8]A. Well, endorphins are opposite to these pain

[9]medians. Endorphins are your own body's opiates which

[10]help to decrease pain. **[*43]** When ever you have these

[11]substances that are released, your body tries to produce

[0]
[12]endorphins which are natural pain killers and they

[13]quiet down these pains. You have release of a Green that

[14]hits the release of certain glucocortocoid hormones. They

[15]help to diminish the pain and to reduce the inflammation

[16]by combating the pain and the inflammation so it's a

[17]cycle. One is an inflammation cycle and one is the quiet

[18]inflammation cycle they both work against eash other to --

[19]one helps the other fight the other inflammation.
? 20 Q. So that if someone was in an accident and under

[21]the immediate stress and shock from an accident, there
s

[22]would be forces within the body which might be commonly

[23]produced to match whatever symptoms of pain there were?

[24]A. Initially --

[25]MR. SCAHILL: Judge, I object to that.

[2]Objection on my part. I don't know if that's a

[3]hypothetical or pertaining to this patient.

[4]THE COURT: Just answer the question.

[5]A. The answer is in the beginning when ever you get

[6]into an accident you have what is called in medicine the

[7]fight or flight **[*44]** situation. The fight or flight situation

[8]is when ever a body is confronted with an emergency or

[9]serious traumatic injury you have the following defense

[10]mechanisms which start into motion release Adrenalin a

[11]release of glucocortocoid hormones, epinephrine is release

[0]
[12]your glucose is released. Insulin from the pancreas is

[13]released. All of these help to quiet down the stress.

[14]Q. In your opinion, doctor, is it medically common

[15]for a patient to wake up the next day after an accident

[16]and at that point feel pain?

[17]A. Generally, based on my vast experience over 12

[18]to 15 years experience working with trauma, almost always

[19]the full blown doesn't show itself up right away. It's
W
? 20 almost always later 1, 2 to 3 days later and the peak

[21]effect I said as I said is 2 to 3 weeks later.

[22]THE COURT: Are you saying that a person

[23]wouldn't wake up, doctor?

[24]THE WITNESS: No, no I am not saying doctor

[25]they would wake up they can wake up with pain

[2]the next day and more pain than he ever had

[3]before and the next day after that or the second

[4]or third day they can **[*45]** have more pain and the day

[5]and than the previous day and the fourth day

[6]they can have even more pain than the third and

[7]the second day. I am saying the inflammatory

[8]process it doesn't occur immediately. It takes

[9]48 to 72 hours to begin and it ends 14 to 21

[10]days later.

[11]THE COURT: So let me ask you another

[0]
[12]question. With all the like bodily hormones we

[13]have to reduce pain in our body would it be

[14]unusual for a person to say that several years

[15]after an accident they are experiencing the same

[16]level of pain that they experienced let's say

[17]during that period in which you say the
e

[18]threshhold pain is going to be existing.

[19]THE WITNESS: Okay.
? 20 The answer to your question, Your Honor, is
K

[21]that there is 2, 2 things that are working._

[22]This disc is constantly producing -- a herniated

[23]disc is constantly producing toxins. The

[24]lucotrienes, the prostiglandins, nitric oxide,

[25]and other inflammatory substances and after

2 producing more than the body can produce

[3]opiates, of course, you are going to have pain

[4]and that generally is what happens. If there **[*46]** is

[5]a radiculopathy and nerve root injury which is

[6]constantly being irritated that is not going to

[7]go away. If the radiculopathy were, can it be

[8]able to improve itself, it would do so within

[9]the first 3 months. If it lasts after 3 months,

[10]then it's considered a permanent injury.

[11]So the answer to your question is if you

[0]
[12]have more inflammation than the body can produce

13 natural opiates, endorphines to combat,

[14]obviously the body is not going to be able to

[15]fight it. That's why you take anti-inflammatory

[16]medications. That's why you take cortisone or

[17]prednisone or the pills to diminish the pain or

[18]the inflammation because the body doesn't have

[19]enough endorphines to fight that inflammation or
? 20 that pathological situation.

[21]THE COURT: So is it usual.

[3]22 THE WITNESS: This is usual. That's

[23]usually the course. The body generally does not

[24]have enough endorphines to fight it. When you

[25]give the patient electrical stimulation therapy
r

[2]and massage you produce more endorphines from

[3]the skin receptors. Endorphines are released by

[4]any kind of **[*47]** a rub or electrical stimulation to

[5]the muscle skin receptors that's how you produce

[6]more endorphines. That's why people get better

[7]after massage and heat and electrical

[8]stimulation because they cause increased

[9]additional secretions of endorphines.

[10]Q. Dr. Guy, is it your opinion that after a period

[11]of approximately three months if a patient such as Cathy

[12]Iacello did not experience any great improvement that in

[13]fact her condition was and is permanent?

[14]A. In my opinion her condition is permanent

[15]irregardless of the improvement because once you tear a

[16]disc, once you rupture a disc, the disc will never repair

[17]itself. It's a permanent irreversable injury. Any time

[18]you injure cartilage whether it is in your neck, in the

[19]discs or in your knees it's a permanent irreversable
s
? 20 injury.

[21]Q. Can you give us a diagnosis of Cathy Iacello's

[22]injuries?

[23]A. Diagnosis or prognosis?

[24]Q. Well diagnosis and prognosis.

[25]A. Diagnosis; she has a C6-C7 disc herniation. She

[2]has a bilateral C5-C6 cervical radiculopathy. She has a

[3]traumatic **[*48]** myofacial pain syndrome and she has a bilateral

[4]L5-S1 radiculopathy.

[5]Q. Can you describe the myophasial pain syndrome?

[6]A. That's when the soft tissues overlying the area

[7]has been damaged from this disc herniation?

[8]Q. What is the effect of scarring on soft tissue

[9]1 doctor?

[10]A. When a muscle gets injured you have microscopic

[11]bleeding within the muscle fibers and once that

[0]
[12]microscopic bleeding heals itself, the muscle gets scared.

[13]And the muscle consistency changes. Over time you get

[14]trigger points that start to form. Trigger points are

[15]defined as pin point areas of muscle degeneration. There

[16]is a lot of lactic acid trapped in the surrounding areas

[17]with other inflammatory substances.
P

[18]Q. Dr. Guy, can you give us a prognosis for Cathy?

[19]A. Yes, she has a permanent injury.
? 20 Q. Will her injury get better?

[21]A. Her injury will get better and worse, but her

[22]C6-C7 herniation will get progressively worse over time

[23]because of the traumatic arthritis that will set in around

[24]it with the osteophytes starting to form the disc starting

[25]to **[*49]** shift up and ostephytes going into the neural canal

[2]where the nerve roots exit you will have progressive

[3]impingement on this nerve root. Eventually you need a

[4]surgical procedure to relieve the compression on the disc.

[5]MR. SCAHILL: Objection to any future

[6]possible surgery, Judge. There's been no

[7]allegation of that up until this doctor's

[8]discussion.

[9]THE COURT: Sustained.

[10]MRS. FISHER: Your Honor, may we approach.

[11]THE COURT: Sure.

[0]
[12](Whereupon, a discussion was held at the

[13]Bench between Court and Counsel.)

[14]THE COURT: Objection sustained.

[15]Q. Dr. Guy, can you describe hypothetically what

[16]the course of treatment for a herniated disc would be?

[17]A. Electrical stimulation, massage, theraputic

[18]exercises, stretching exercises, accupuncture, nerve

[19]blocks, trigger point injections and lastly surgery.
? 20 Q. Is surgery if all else fails?

[21]MR. SCAHILL: Objection, Your Honor.
s

[22]Q. Hypothetically speaking?

[23]THE COURT: The witness can answer the

[24]question.

[25]A. Yes, surgery is the last resort if everything

[21]else fails. **[*50]**
[3]THE COURT: Has she undergone all the

[4]regimes of treatment that you have mentioned?

[5]THE WITNESS: She has not done the

[6]injections yet. She has not done the

[7]accupuncture, the trigger point injections and

[8]the epidurals.

[9]Q. Did you recommend a course of treatment for

[10]Cathy Iacello?

[11]A. Yes.

[0]
[12]Q. What course of treatment did you recommend?

[13]A. I said in addition to the current treatment

[14]she's getting we can try trigger point injections and

1S para-spinal injections. She is definitely afraid of

[16]needles. I had difficulty doing the E.M.G.'s on her.

[17]Q. Did Cathy indicate to you that she did not want

[18]to undergo accupuncture and the treatment involving needle

[19]and trigger point injections because of her fear?
W
? 20 A. Yes.

[21]MR. SCAHILL: Objection, Your honor.

[22]THE COURT: Overruled.

[23]A. The answer is yes.

[24]Q. Did you discuss at any time with Cathy the

[25]possibility of a future need for surgical intervention?

[2]MR. SCAHILL: Objection, Your Honor. You

[3]already made a ruling on that.

[4]THE COURT: Sustained.

[5]Q. **[*51]** Dr. Guy, if I will give you a hypothetical

[6]situation. If an individual is sitting in an automobile

[7]and that automobile is stopped and they are struck by

[8]another automobile at a speed of 15 miles an hour, is the

[9]force of that impact sufficient to cause a herniated disc

[10]injury.

[11]MR. SCAHILL: Objection, Your Honor. He is

[0]
[12]not qualified to testify with respect to this

[13]item. He is not an engineer. He is a

[14]physician.

[15]THE COURT: The witness can give his

[16]answer.

[17]A. The answer is yes. When you have a force the
s

[18]laws of physics -- physics is part of my training, vectors

[19]and forces. If you have a force that weighs 3, 000 pounds,
e 20 a car, hits another object at 10, 15, 20 miles an hour in

[21]my book, that's a serious injury. If that force were-not

[22]the -- were not 3, 000 pounds in weight, was maybe 2 pounds

[23]in weight and it strikes that person at 15 miles an hour

[24]it would have much less impact, but a force with a weight

[25]of 3, 000, 15 miles an hour is a very significant force.

[2]Q. Is it possible for a, I don't know how to

[3]explain it. Maybe you can **[*52]** help me out here. The type of

[4]an injury where the neck is whipped back and forth to

[5]occur as a result of an impact to a vehicle at 15 miles an

[6]hour?

[7]MR. SCAHILL: Same objection, Judge.

[8]THE COURT: Back and forth we are assuming

[9]we are assuming that it's a rear end collision,

[10]is that correct.

[11]THE WITNESS: Your Honor in you get in the

[0]
?' 12 vehicle you get rotational forces that work on

[13]the spine. Rotational force is a rotational

[14]force nd with a rotational force you get

[15]sometimes a flexion extension injury but is most

[16]common is a rotational force.

[17]Q. And could such a rotational force exerted with
a

[18]that amount of weight, over 3 thousand pounds at 15 miles

[19]an hour, be enough to have caused Cathy Iacello to have
W

[6]
[20]suffered a herniated disc?

[21]MR. SCAHILL: Objection.
a

[22]A. In my --

[23]THE COURT: The, witness can answer the

[24]question?
2S A. In my opinion the answer is yes, it happens all
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[2]from the side, that rotational force will have

[3]more of an impact, so it depends on the angle in

[4]which **[*53]** your neck is positioned in and the angle

[5]from the force whether it's from the side from

[6]the front or from the rear. So to summarize if

[7]your neck is in extension you get right, hit in

[8]the rear, you have a tremendous impact far more

[9]worse than from the side and if you are on the

[10]side you get hit on the side of the car the

[11]rotational forces it have more of an impact than

[0]
Z, 12 if your neck was in flexion or extension.

[13]THE COURT: Dr. Guy, u e past two

[14]years I have had 2 rear end collisions. The

[15]person has run into the back of me. It's always

[16]when my wife is driving, okay. I had the bumpe

[17]replaced, the trunk straightened out of the car.

[18]I can be walking around with a herniated disc

[19]that's asymptomatic, is that not correct?

[20]A:the witness Well, yes, you can be walking around

[21]tare, a disc that's asymptomatic. It is possible, but. it's

[22]are, but it's possible.

[23]THE COURT: Thank you.

[24]THE WITNESS: You're welcome.

[25]Q. Dr. Guy, do the forces that come into play

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[21]Cathy Iacello?

[3]A. 3-5-97.

[4]Q. **[*54]** And prior to that time when was the time

[5]previous to March 5, 1997 that you examined Cathy?

[6]A. January 3, 1997.

[7]Q. Can you describe what your examination consisted

[8]of in January of this year.

[9]MR. SCAHILL: Judge, we had a prior ruling

[10]with respect to this. I just note my continuing

[11]objection to this.

[0]
[12]THE COURT: Okay.

[13]So duly noted.

[14]A. My finding was the patient had severe diffuse

[15]spasm, many trigger points, one half normal range of

[16]motion.

[17]Q. And did you perform any additional testing on

[18]Cathy?

[19]A. Not on January 30, 97.
? 20 Q. On March 5, 1997 can you describe your
i

[21]examination and findings?
Q

[22]A. I examined the patient again. She still had

[23]moderate to severe spasm, many trigger points, range of

[24]motion of the neck was one half lateral rotation and

[25]flexion. Muscle power testing of the left shoulder was 4

[2]plus over 5. The left biceps reflex was trace. And then

[3]I performed an additional test on her as well.

[4]Q. What additional test was that?

[5]A. I performed an E.M.G.

[6]Q. **[*55]** And can you describe the findings of the E.M.G.

[7]that was performed at that time?

[8]A. Bilateral C5-C6 cervical radiculopathy. The

[9]left side was worse when compared to the E.M.G.'s of 1993

[10]and I have the tracings. It goes downwards deflections]

[11]that we spoke about.

[0]
[12]THE COURT: It's not in evidence. Don't

[13]show it to the jury.

[14]MRS. FISHER: Well, can we have this

[15]marked, Judge, for identification.

[16]MR. SCAHILL: I have an objection, Judge.

[17]THE COURT: You never served that on him so
18 definitely, you know.

[19]MRS. FISHER: Well, for identification
W
d
a 20 purposes so that we can refer to it. I am not

[21]offering the report, Judge. This doctor is.
a

[22]testifying. I just wanted it marked for

[23]identification so that the record would be clear

[24]on what he was referring to, Judge.

[25]THE COURT:. Do you have any objection

[2]counsel.

[3]MR. SCAHILL: For identification, Judge,

[4]no.

[5]THE COURT: Okay.

[6]Mark it, mark if E.M.G. report for I.D.

[7]Plaintiff's 15 for identification so

[8]marked.

[9]A. May I explain.,

[10]Q. Yes.

[11]MR. SCAHILL: Judge. **[*56]**
[0]
[12]MRS. FISHER: Without showing it to the

[13]jury.

[14]MR. SCAHILL: Based on Your Honor's ruling.

[15]THE COURT: It's not in evidence.

[16]Q. It's not in evidence?

[17]A. Basically at the same right C5-C6 and on the

[18]left C5-C6 and the biceps area we found the large positive

[19]sharp waives that I was explaining to you earlier. This
? 20 time there were numerous -- this time it shows polyphasics

[21]especially at the right C5-C6. This E.M.G. is 3-5-97.

[22]The accident is 1993. So it sshows polyphasics now it

[23]shows the problem is longstanding.

[24]THE COURT: Did you examine the lower back

[25]at any of these examinations that you did in
" 1 I

[2]1997, doctor.

[3]THE WITNESS: I did.

[4]THE COURT: What were your findings in the

[5]lower back?

[6]THE WITNESS: She still had some spasm and

[7]she still had some trigger points and she still

[8]had reduction or range of motion in her lower

[9]back.

[10]THE COURT: Did you do any testing of the
110 lower back in 1997.

[0]
[12]THE WITNESS: I did not. The lower ack was

[13]getting better according to the patient.

[14]Q. So, doctor, the history **[*57]** that you took with

[15]regard to Cathy with regard to the lower back she

[16]indicated to you that her lower back was better, is that

[17]correct?
s

[18]A. Yes, was getting better.

[19]Q. Therefore, you saw no need to do any additional
? 20 testing on her lower back?

[21]A. That's correct.

[22]Q. Dr. Guy, after re-evaluating Catherine Iacello

[23]in January and March of this year and doing the additional

[24]testing that you have described have you come to any

[25]conclusions about her condition and prognosis?

[2]A. Yes.

[3]Q. What conclusions have you reached?

[4]A. She still has the spasm. She still has the

[5]reduction of range of motion. She still had the

[6]radiculopathy on E.M.G. and it's now considered a

[7]permanent injury by any criteria.

[8]Q. Is it the same reduction in the range of motion

[9]as your prior test in 1993, doctor.

[10]A. Let me take a look.

[11]The range of motion in the neck was one half

[0]
e 12 normal in each direction. Now, it is only one half in

[13]only lateral flexion and lateral rotation. Flexion and

[14]extension is normal **[*58]** now. That has improved. Just the

[15]lateral flexion extension and lateral rotation to the

[16]right and left that's the only two range of motion that's

[17]diminished still.
v

[18]Q. And insofar as the nerve conduction studies the

[19]comparison between the current studies that were done and
? 20 the prior studies that were done, what conclusions have

[21]you reached from those?
a

[22]A. The C5-C6 has worsened.

[23]Q. And based upon your examination of the patient,

[24]the history that you took recently, doctor, after

[25]discussing with her and your examination did you come to

[2]any conclusions about the cause of her present conditions?

[3]A. The cause of her present conditions?

[4]Q. Yes.

[5]A. Yes, from the accident of 11-18-93.

[6]Q. Is there any doubt in your mind, Dr. Guy.

[7]MR. SCAHILL: Objection to the form of the

[8]question.

[9]MRS. FISHER: Your Honor, may I be

[10]permitted to finish the question?

[11]THE COURT: Finish your question.

[0]
[12]Q. Is there any doubt in your mind, Dr. Guy, after

[13]all your examinations, tests, evaluations and your **[*59]**
[14]consideration of your patient as a whole, that the injury

[15]that she sustained in November of 1993 is the competent

[16]producing cause of the pain that she now suffers.

[17]MR. SCAHILL: Objection to form.

[18]THE COURT: The witness can answer.

[19]A. No, there is no doubt in my mind as to the casue
W

? 20 for all the reasons I explained to you earlier when you

[21]put the whole jig saw puzzle together there's only been
a
s 22 one cause. That's the trauma, and again, if you like I

[23]can repeat everything again, but it's for the same

[24]reasons.

[25]Q. Will Cathy Iacello ever be cured?

[2]A. You cannot cure a disc herniation no more than

[3]you can cure an arthritis condition. You can treat it.

[4]You cannot cure it.

[5]Q. In your expert medical opinion, Dr. Guy, has

[6]Cathy Iacello suffered a permanent and significant severe

[7]limitation of the use of her neck and cervical area?

[8]A. In my opinion, yes.

[9]Q. Thank you very much, doctor.

[10]THE COURT: Okay.

[11]We will take a 5 minute recess.
Q

[12](Jury leaving courtroom at 12:20 p.m.)

[13](Recess)

[14](Jury **[*60]** entering court room at 1230 p.m.)

[15]CROSS EXAMINATION

[16]BY MR. SCAHILL:

[17]THE COURT: Counsel, you may proceed with

[18]your cross-examination.

[9]
[19]MR. SCAHILL: Thank you, Your Honor.
? 20 Q. Good afternoon, doctor.

[21]A. Good afternoon.
s

[22]Q. Doctor, you told us on your direct examination

[23]that you relied on the history given by the patient to

[24]insure an accurate diagnosis. Is that correct?

[25]A. Pretty much, yes.
l
Q. In fact, you gave percentages in terms of how
factor your diagnosis and you said 75 to 80 percent of
diagnosis is based on the history that's given to you
he patient?
A. That is correct.
Q. And when a patient comes into your office and
_s you something, you take that to be true at face
lie, is that also correct?
A. That's correct.
Q. And you said that your diagnosis is made up of
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r office on
ORIGINAL DOCUMENT
red by an
yers?
ferra3.s by
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rdic
on December
t injuries,
:r back pain
correct?
auto
ised by a --

[2]Q. Well, **[*61]** doctor.

[3]A. I am trying to answer. I am trying to explain.

[4]Q. I will ask you questions on this.

[5]A. I am not finished?

[6]THE COURT: Let him finish his answer.

[7]A. A patient when they come to a doctor they give

[8]you a history. They don't tell you what it's caused by.

[9]They -- they just tell you what is bothering them. It is

[10]for me to tell them what it's caused by.

[11]Q. Well, you gave an impression after your first

[0]
[12]visit with this patient, is that correct?

[13]A. Yes.

[14]Q. And your impression was that she was suffering

[15]from lumbosacral radiculopathy, is that correct?

[16]A. That's right.

[17]Q. And your impression was that this was caused by

[18]the motor vehicle accident of november 18, 1993, is that

[19]also correct?
W

[6]
e 20 A. That's not what it says in my report,
t

[21]counsellor. I? you look --

[22]Q. Well, doctor, I ask you to look at your report?

[23]A. I am looking at my report, page 2?

[24]Q. And on the first page of the report which says

[25]she is also having lower back pain radiating bilaterally **[*62]**
[2]into the lower extremities, left greater than right, was

[3]that part of the history that you took?

[4]A. Yes, it is.

[5]Q. And on page 2 where you gave an impression, you

[6]noted lumbosacral radiculopathy, is that also correct.

[7]A. Yes, that's correct.

[8]Q. Now, doctor, lumbosacral, what part of the body

[9]is that? I

[10]A. Lower back.

[11]Q. You talked before about L5-S1?
I

[0]
[12]A. Yes, that's right.

[13]Q. L5-S1, is that the lower back?

[14]A. Yes.

[15]Q. What is S1.

[16]A. The tail bone. When the lower back ends it

[17]begins with the tail bone which is the sacrum.

[18]Q. Now, you tested her that day and she had

[19]diffused tenderness of the lower back, is that correct?
r
? 20 A. That's correct.

[21]Q. You also had asked that she undergo studies --

[22]E.M.G. studies of the lower back, is that correct?

[23]A. That is correct.

[24]Q. And the E.M.G. studies was a diagnostic tool, a

[25]test that you asked her to undergo to help, to help you in

[2]your diagnosis, is that correct?

[3]A. **[*63]** That is correct, yes.

[4]Q. When did she undergo the test?

[5]A. For the lumbar spine?

[6]Q. Yes.

[7]A. 12-23-93.

[8]Q. And as a result of your E.M.G. Testing 12-23-93

[9]did you come to an impression whether or not the patient

[10]was suffering from L5-S1 radiculopathy?

[11]A. Yes.
a

[12]Q. And what was your impression at that point,

[13]doctor?

[14]A. The patient was suffering from a bilateral L5-S1

[15]radiculopathy?

[16]Q. Now, doctor, you indicated that the patient also

[17]was complaining of neck pain, is that right?

[18]A. Yes.

[19]Q. And you also had her undergo an E.M.G. test for
? 20 the neck pain, is that also correct?

[21]A. That is also correct.

[22]Q. Now, your E.M.G. test of the lower back they

[23]were definite with respect to-L5-S1 radiculopathy, is that

[24]correct?

[25]A. Yes.
S

[2]Q. Now, I ask you to look at your E.M.G. testing

[3]for the cervical spine that was performed on December 23,

[4]1993 doctor?

[5]A. Yes.

[6]Q. You also gave an impression with respect to the **[*64]**
[7]E.M.G. testing for the cervical spine, is that right?

[8]A. Yes, that's correct.

[9]Q. And your impression of the cervical spine was

[10]suggestive of C5-C6 radiculopathy?

[11]A. Electrically, electrically.
c

[12]Q. Is that what you wrote there suggestive of

[13]bilateral C5-C6?

[14]A. I will read the whole sentence for you. It says

[15]study reveals electrical evidence suggestive of bilateral

[16]C5-C6 nerve root disfuction?

[17]Q. That word suestive, you didn't use that when
s

[18]you did the lower back E.M.G., did you?

[19]A. That is correct.
? 20 Q. You just said bilateral L5-S1 radiculopathy?

[21]A. That is correct.
s

[22]Q. But when you did the E.M.G. studies for the neck

[23]you put down suggestive, is th-at right?

[24]A. That's right. Would you like to know why?

[25]Q. No. Your attorney or the counsel for plaintiff

[2]can ask any questions she wants and she will do that on

[3]redirect, sir?

[4]A. Fine.

[5]Q. Now, doctor, you indicated that a percentage of

[6]your practice deals with personal injury cases, is that **[*65]**
[7]right?

[8]A. I said trauma.

[9]Q. Now, is a percentage of your patients that you

[10]see in personal injury litigation?

[11]A. As I indicated to you earlier when you handle,

[0]
k, 12 treat a patient with trauma eventually you get pulled into

[13]the legal system. So the answer to your question is yes.

[14]Q. What percentage of your practice involves

[15]patients that have a personal injury case pending?

[16]A. I can tell you that a good 40 to 50 percent of

[17]my patients are involved with trauma, so if they have

[18]cases pending that I don't keep tabs of, but what I can

[19]tell you is about 40 to 50 percent of my practice is
? 20 treating patients with injuries.

[21]Q. Would it also be fair to say that 40 to 50

[22]percent of your practice involves patients that have

[23]personal injury litigation pending?

[24]A. Again I believe I answered that question to you.

[25]1 do not know whether they have cases, litigation pending
i
i

[2]or not. Sometimes they get settled, sometimes they don't

[3]go forward with it. Sometimes you don't meet the No Fault

[4]threshold system. **[*66]** Sometimes they just don't continue with

[5]it. I cannot --

[6]Q. You sound very familiar with this personal

[7]injury litigation practice?

[8]A. I am a trauma specialist I have testified

[9]earlier. I have testified many times. I am not a --

[10]Q. Let me ask you a question about that.

[11]That $ 4, 000 who pays that?

[0]
[12]A. Eventually the patient pays for it.

[13]Q. The patient pays that? In fact, in this case

[14]you had the patient sign a guarantee that he'd get that

[15]$ 4, 000 out of any award that this jury might give you, is

[16]that right?

[17]A. You are wrong, counsellor.
v

[18]Q. Doctor, I'd ask you to look at --

[19]A. I have been paid already.
? 20 Q. Doctor, I ask you to look at a line form in your

[21]papers and ask you if you have -- you had this patient
a

[22]assign -- sign an assignment of benefits.

[23]MRS. FISHER: Your Honor, I am going to

[24]object at this point.

[25]MR. SCAHILL: I didn't finish my question.

[2]MRS. FISHER: May we approach on this, Your

[3]Honor. He is treading on grounds for a

[4]mistrial.

[5]MR. SCAHILL: Please, please. **[*67]**
[6]THE COURT: Let him finish his question.

[7]Q. I ask you to look -- to look at your papers in

[8]front of you. Is there an assignment of benefits form

[9]that you had Mrs. iasello sign?

[10]A. Yes.

[11]Q. Can you take that out?

[0]
[12]A. Sure.

[13]MRS. FISHER: Judge, may we approach.

[14]THE COURT: Come on up.

[15](Whereupon, a discussion was held at the

[16]Bench between Court and Counsel.)

[17]THE COURT: Can I see what you have there?

[18]THE WITNESS: Sure. That's an assignment,

[19]Your Honor.
W
d
? 20 THE COURT: Yes.

[21](Whereupon, there is a short pause
a

[22]in the proceedings.)

[23]MRS. FISHER: Can we approach again.

[24](Whereupon, a discussion was held at the

[25]Bench between Court and Counsel.)

[2]THE COURT: The objection is overruled.

[3]Q. Doctor, I am referring to the assignment of

[4]recovery proceeds that you had Mrs. Iacello sign. Did you

[5]have her sign that when she came to your office on January

[6]30, 1997?

[7]A. Yes, this is a standard form.

[8]Q. Doctor, I just asked you if you had her sign it.

[9]MRS. FISHER: Let the witness -- I object. **[*68]**
[10]He is not letting the witness finish answering

[11]the question.

[0]
e 12 MR. SCAHILL: He didn't finish answering

[13]the question?

[14]THE COURT: Finish answering the question.

[15]A. This is a standard form that I give all my

[16]patients to sign.

[17]Q. Doctor. I am not finished. All this says.

[18]MR. SCAHILL: Objection too, to what he

[19]says, Judge. I will move it into evidence and
W
s
? 20 the jury can read it. I don't want the doctor

[21]interpreting this?

[22]MRS. FISHER: Your Honor, I object to his

[23]not allowing the witness to finish answering the

[24]question.

[25]THE COURT: Finish answering your question,

[2]doctor.

[3]A. This is a standard form. Most doctors that --

[4]MR. SCAHILL: Objection as to what most

[5]doctors are doing.

[6]MRS. FISHER: Your Honor, he is doing it

[7]again.

[8]THE COURT: Finish answering your question.

[9]A. This is a standard form that doctors including

[10]myself give patients to sign to insure that they get paid

[11]for the medical treatment they give to their patients in

[0]
[12]case they have no insurance or any other forms of payment.

[13] **[*69]** Most of my bills have been completely paid. My court

[14]testimony has been paid. There is a very little

[15]outstanding balance that the patient is owing -- very

little. It is approximately $ 1, 200. For the most part,

everything has been paid.

THE COURT: Okay.

Q. And, doctor, when did Mrs. Iasello sign that
? 20 form, that assignment form?

A. She signed one the first time she saw me.
a

Q. I am talking about the form that is right in

front of you, when did she sign that?

A. I am answering your question. She signed two
251 forms.

Q. When did she sign this one?

A. This one, January 30, 1997.

Q. And before January 30, 1997 when was the last

time you saw her?

A. 12-23-93 I saw her a total of 4 times.

Q. 12-23-93 and the next time you saw this patient

that was seriously injured with a personal injury -- with

a possibility of surgery, that has restrictions of motion,

that has inability to move her neck, that's in permanent

pain, you her treating physician?

[0]
Z 12 A. I am not her treating **[*70]** doctor.

Q. You?

A. I am not her treating doctor. I am a

consultant.

Q. You are a consultant for the lawsuit or for her

treatment?

A. I am a consultant to Dr. Striano, okay and I am

not a treating doctor.
? 20 Q. Doctor, her treating doctor, her consulting

doctor that found all these serious medical problems: In

[22]ability to move her neck. Inability to move her back.
LL

[23]Radiculopathy radiating down into her arms. All these

[24]problems you didn't see her for 3 years, is that right?

[25]A. That's right.

[2]Q. Doctor, when you saw her on January 30, 1997 did

[3]you know this case was coming up for trial?

[4]A. It may have been coming up for trial. I don't

[5]know if I did or I didn't know.

[6]Q. Did you have that information?

[7]A. I just answered you. I said I am not sure.

[8]Q. Mrs. Iasello testified yesterday that her lawyer

[9]told her to go back to you

[10]MRS. FISHER: Objection as to what Mrs.

[11]Iasello testified or her characterization of

[0]
[12]what Mrs. Iasello testified. Mr. Scahill is not

[13]testifying **[*71]** here.

[14]MR. SCAHILL: It's part of the record,

[15]Judge.

[16]MRS. FISHER: It doesn't matter whether it

[17]is part of the record. You don't have the right
s

[18]to repeat it.

[19]THE COURT: You could pose -- it's agreed
W

[6]
? 20 to the degree that that's an objection, I

[21]sustain it as to form.

[22]Q. If Mrs Iasello said that her lawyer told her to

[23]go back to you in January of 97 would that be accurate?

[24]A. She never told me that.

[25]Q. Okay.

[2]Do you have any indication why you didn't see

[3]her for the 3 year period from December 93 to January 97?

[4]A. Again let me clear it up for you once and for

[5]all. I was not her treating doctor. Dr. Striano has been

[6]her treating doctor. I cannot steal a patient from a

[7]treating doctor. I am a consultant. All I can do is

[8]consult; consult with the treating doctor. Dr. Striano

[9]has been treating her.,

[10]Q. So the person most familiar with Mrs. Iasello's

[11]treatment would be Dr. Striano?

Q

e 12 A. You could say that.

[13]Q. He is the person that has -- would have the most

[14]accurate information about her condition? **[*72]**

[15]MRS. FISHER: Objection, Your Honor.

[16]THE COURT: If that's the -- overruled. If

[17]that's a question, you can answer it?

[18]A. I guess if he is the one that's been treating

[19]her the most he should have the most.

W

d

? 20 Q. Because you only saw her four times, twice in 93

[21]and then twice again in 97?

a

[22]A. I have enough information about her diagnosis,

Y

[23]but about her treatment records, you would have to consult

[24]with Dr. Striano.

[25]Q. Okay.

[2]That information that you were talking about,

[3]you have every patient that's involved in personal injury

[4]litigation sign that type of a form?

[5]A. Yes. Not only I, every doctor that deals with

[6]this type --

[7]Q. I am asking about you?

[8]A. The answer is yes.

[9]Q. You also have the attorney sign a guarantee that

[10]you will get paid?

[11]A. He doesn't sign a guarantee. I send a guarantee

[0]
[12]that he will not release funds until he checks to see what

[13]my outstanding bill is and then fulfill the outstanding

[14]balance before he releases funds.

[15]MRS. FISHER: That's for medical **[*73]** treatment.

[16]THE COURT: Is that an objection, counsel?

[17]MRS. FISHER: Yes, I am sorry.

[18]MR. SCAHILL: Judge, if Miss fisher is

[19]going to testify I think she should be sworn.
W
d
? 20 THE COURT: What was the objection?

[21]MRS. FISHER: I withdraw my objection.
a

[22]MR. SCAHILL: If Mrs. Fisher is going to

[23]testify, I ask that she be sworn.

[24]MRS. FISHER: To the extent the -- Mr.

[25]Scahill.

[2]THE COURT: State an objection counsel.

[3]MRS. FISHER: I withdrew my objection,

[4]counsel.

[5]THE COURT: Go ahead, counsel.

[6]Q. So, doctor, every time that you have a patient

[7]that's involved in a personal injury litigation you make

[8]sure that they sign a guarantee and that their lawyer

[9]signs a guarantee that you are the first one to get paid

[10]if a jury awards anything?

[11]A. No.

[0]
[12]Q. That's what you just said, that $ 1, 200 you are

[13]talking about is going to come out of anything that-these

[14]jurors award, is that right?

[15]MRS. FISHER: Your Honor, I object.

[16]THE COURT: Sustained.

[17]Answer the question.

[18]A. Any patient that comes to a doctor I give them **[*74]** a

[19]choice. You can pay for the office visit at each time
W

[6]
? 20 that it's due or if you don't have the money or if you

[21]want us to use your health insurance, whatever, we will

[22]gladly do so but you have to sign a guarantee in the event

[23]the insurance company doesn't pay the bills or you have no

[24]funds to play the bills, that medical bills will be

[25]secured by some way and there is one such way in exchange
i

[2]for waiting for the doctor to receive payment.

[3]Nobody works for free in this country.

[4]Q. So 40 to 50 percent of your patients, your

[5]trauma patients that are involved in personal injury

[6]litigation have one of those assignment letters in the

[7]file and one of those attorney guarantee letters in the

[8]file.

[9]A. If you were listening I said that if they choose

[10]not to pay up front. So choose to pay up front and there

[11]is no need to sign this form.

[0]
[12]Q. There is no need to get abrupt?

[13]MRS. FISHER: Your Honor, I object.

[14]THE COURT: Sustained.

[15]Counsel, just don't comment on the doctor's

[16]testimony.

[17]MR. SCAHILL: I move for that **[*75]** assignment
s

[18]letter to be placed into evidence, Your Honor.

[19]MRS. FISHER: I object, Your Honor.
W
0.
? 20 Irrelevant, immaterial. And totally collateral.

[21]MR. SCAHILL: Judge --

[22]MRS. FISHER: And there is no foundation.

[23]MR. SCAHILL: If he has a --

[24]THE COURT: In litigation then it attacks

[25]his credibility.

[2]MRS. FISHER: There is no foundation for

[3]it's introduction and no relevance. The doctor

[4]has testified.

[5]THE COURT: You say there is an outstanding

[6]balance that still owes you about $ 1, 200.

[7]THE WITNESS: Yes, Your Honor.

[8]THE COURT: You can mark that into

[9]evidence.

[10](Exhibit marked into evidence by the Court

[11]Reporter)

[0]
RM 12 COURT CLERK: Defendants I in Evidence so

[13]marked.

[14]Q. That $ 4, 000 that you got you said, you testified

[15]5 to 8 times per year, is that right?

[16]A. That's correct.

[17]Q. And each one of those times in court the fee is
s

[18]$ 4, 000?

[19]A. The fee is 3 thousand for half a day and I
W

[6]
e 20 thousand for pre-trial consultation.

[21]Q. But every time you take the stand you have a
a

[22] **[*76]** pre-trial consultation?

[23]A. Not every time. Not every time.

[24]Q. Sometimes you don't talk to the lawyer before

[25]you get on the stand?

[2]A. That's what happens. It happened to me one time

[3]last year. There was no time for preparation. I was

[4]called to come in. A Federal Judge wanted me then, and I

[5]came with a lab coat. I didn't even have a chance to put

[6]a jacket on.

[7]Q. That would be a rarity. Most times you get the

[8]full $ 4, 000?

[9]A. Yes, that's correct.

[10]Q. Now, all those times that you testified 5 to 8

[11]times a year that's always for Plaintiff's, correct?

[0]
[12]A. Generally, yes. It is for the plaintiff for my

[13]patients.

[14]Q. How many times last year did you testify for

[15]anybody else but for the plaintiff in the -- in a personal

[16]injury case?

[17]A. Once.
P

[18]Q. And in the year prior?

[19]A. The majority. It's all been for my patients.
W
? 20 Q. More than 90 percent?

[21]A. Yes.
S 22 Q. More than 95 percent?

[23]A. The majority. Let's say 99 point 9 percent.

[24]Q. **[*77]** It's for the plaintiff?

[25]A. For my patients.

[2]Q. Okay?

[3]A. Okay. I am a treating doctor.

[4]Q. You said here you are a consulting doctor?

[5]A. In this case I am a consulting doctor, yes. So

[6]that would make me Miss Iasello my patient as well even

[7]though I am consulting.

[8]Q. The only cases where you testify are you always

[9]the consulting doctor?

[10]A. No. Most of the time I am the treating doctor.

[11]Q. So it's rare in this situation that you are a

[0]
[12]consulting doctor asked to testify?

[13]A. You could say that.

[14]Q. So this is unusual for a personal injury case

[15]that in the past that you have been involved with where

[16]the consulting doctor is asked to testify?

[17]A. Unusual, no. Many times I have been asked to

[18]testify based on my treatment given to the patient

[0]19 whatever tests that I did whatever questions I may have to
? 20 be asked to answer.

[21]Q. Now, doctor, you said you were Board certified

[22]in 89, is that right?

[23]A. Yes.

[24]Q. And when did you graduate from medical **[*78]** school?

[25]A. June of 81.

[2]Q. And the medical school again?

[3]A. University of Northeast. That's what it means

[4]in English.

[5]Q. The training that you had has all been in

[6]rehabilitatio?

[7]A. No, you heard my training; internal medicine,

[8]general surgery, and physical medicine and rehabilitation.

[9]Q. You are Board certified in Physical Medicine and

[10]Rehabilitation?

[11]A. Yes.

[0]
e 12 Q. Now, when you first saw Mrs. Iacello December 2,

[13]1993 you told us that she had diffused tenderness in her

[14]lower back, is that right?

[15]A. On physical exam, yes.

[16]Q. And she had decreased range of motion in her

[17]lower back, is that right?

[18]A. That's correct.

[19]Q. Okay.
d
? 20 What does that mean, decreased range of motion

[21]in her lower back, doctor?

[22]A. It means that the movements in forward and

[23]backward bending and side bending was decreased.

[24]Q. So you had her to bend forward and back and bend

[25]to side and that's an objective finding of a problem?

[2]A. **[*79]** Yes.

[3]Q. Okay.

[4]And, doctor, you questioned her about her past

[5]medical history when you first saw her, correct?

[6]A. Yes.

[7]Q. And is it true that she denied any history of

[8]significant past medical problems, no history of any

[9]significant injuries? 0

[10]A. Significant, yes.

[11]Q. Now, you also did a test on her lower back

[4]
[12]called a straight-leg raising test, is that right?

[13]A. Yes.

[14]Q. Explain that to the jury, doctor.

[15]A. A straight-leg raising test is where you lay the

[16]patient flat on the table. You grab the patient's foot

[17]and ankle in your hand and you bring it up. A normal

[18]healthy 29 year old patient should be able to go to at

[19]least 90 degrees without complaint of lower back pain. On

[4]
? 20 my examination she was only able to go to 75 degrees with
i

[21]complaints of bilateral lower back pain.

[22]Q. So you would consider that a significant

[23]limitation of use of her lower back?

[24]A. Significant limitation, it's a limitation.

[25]Q. Well it's 25 or 15 degrees -- I am sorry.

[2]A. **[*80]** Yes.

[3]Q. Would you say that's significant?

[4]A. It's a significant decrease initially, yes.

[5]Q. So when you say here on December 2, 1993 she had

[6]significant limitation of use of her lower back?

[7]A. Right.

[8]Q. She had diffused tenderness in her lower back,

[9]slight spasm in her lower back, correct?

[10]A. Yes.

[11]Q. And you diagnose lumbosacral radiculopathy, is

[0]
[12]that right?

[13]A. Yes, that's correct.

[14]Q. And based on the history where she indicated she

[15]had denies any history of any significant past medical

[16]problems, no history of any prior significant injuries you

[17]diagnosed her with that lumbosacral radiculopathy, is that

[18]right?

[19]A. Yes, that's right.
s
? 20 Q. Okay.

[21]Now, you spoke about before with the injury a
s

[22]subjective complaint as opposed to an objective complaint.

[23]Could you describe the difference between the two,

[24]subjective and objective?

[25]MRS. FISHER: Objection, Your Honor. It

[2]wasn't objective complaints. That was a

[3]mis-statement of the characterization.

[4]THE COURT: **[*81]** I will sustain that objection

[5]and with that we will take our luncheon recess

[6]at this point in time. I would direct that the

[7]jury return here promptly at 2:00 at which time

[8]the trial will resume.

[9]Have a good lunch.

[10](Jury leaving courtroom at 1 p.m.)

[11](Luncheon Recess)

c

e 12

[13](Continued on next page)

[14]
[15]
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[18]
[19]
? 20

[21]
[22]
[23]
[24]
[25]
[2]CROSS EXAMINATION

[3]BY MR. SCAHILL: (Continuing)

[4](Afternoon session)

[5](Jury entering courtroom at 2:15 p.m.)

[6]THE COURT: Good afternoon, ladies and

[7]1 gentlemen.

[8]Proceed with your cross-examination,

[9]counsel.

[10]MR. SCAHILL: Thank you, Your Honor.

[11]Q. Dr. Guy, you wrote a report in December of 1994

[12]in connection with this patient, is that correct?

[13]A. Yes.

[14]Q. And that report, doctor, is dated December 27,

[15]1994 was based on two visits that you had with the patie*

[16]in December of 1993, a year earlier, is that also correct.

[17]A. That in addition to the results of the M.R.I.'

[18]and E.M.G.'s, yes.

[19]Q. So the last time when you wrote that report in

it 20 December of 94 the last **[*82]** time you saw the patient

[21]physically was December of 93?

[22]A. That's correct.

[23]Q. And you are sure that you saw her twice in

[24]December of 93, correct?

[25]A. Yes.

[2]Q. If Mrs. Iacello was asked how many times did you

[3]see Dr. Guy and she answered once, that would be in error?

[4]A. I saw her the first time December 12th, 93 and

[5]then I saw her again 12-23 -- twice.

[6]Q. That report that you wrote in December of 1993

[7]you gave a diagnosis, is that right?
S A. Yes.

[9]Q. Was this report in connection with the personal
/

[10]injury law suit?

[11]A. Any time a report that has opinion, the answer

[0]
[12]is yes.

[13]Q. So this was written for Mrs. lasello's lawyers

[14]in connection with this claim?

[15]A. That's right.

[16]Q. Now, in that report you diagnosed her with

[17]bilateral L5-S1 radiculopathy, is that correct?
w

[18]A. Yes.

[19]Q. And you also indicated that it's your
? 20 professional opinion that this patient had sustained a

[21]permanent partial disability causally related to the

[22]accident of **[*83]** November 28, 1993?

[23]MRS. FISHER: Your Honor, I am going to

[24]object and ask that the question' be stricken

[25]and a curative instruction be given to the jur

[2]that Mr. Scahill is reading from a document no

[3]in evidence.

[4]MR. SCAHILL: I will move it into evidenc

[5]Judge.

[6]MRS. FISHER: I object to its introductic

[7]into evidence because you haven't laid a propE

[8]foundation --

[9]THE COURT: This is the doctor's report,

[10]you are talking about?

[11]MRS. FISHER: The narrative report, Judg-

[0]
[12]THE COURT: Your objection is overruled.

[13]MRS. FISHER: I am not going -- well,

[14]overruled, Your Honor, as to reading a docume

[15]not in evidence or overruled as to my objecti

[16]-- I don't object to it's introduction into

[17]evidence, but I do object to it's being read

[18]counsel.

[19]THE COURT: He is posing a question to I
? 20 Guy about his findings in the report.

[21]MRS. FISHER: Then let him not read the
s

[22]report.

[23]THE COURT: His entire testimony was us

[24]to utilize the report to testify.

[25]MRS. FISHER: Let Mr. Scahill not read

[2]a report or a document **[*84]** not in evidence.

[3]MR. SCAHILL: Judge, I will move it into

[4]evidence.

[5]There is no objection, counsel?

[6]MRS. FISHER: No.

[7]MR. SCAHILL: Okay, Judge.

[8]THE COURT: Okay.

[9]No objection.

[10]COURT CLERK: Defendant's Exhibit J in

[11]evidence.

[0]
[12]Q. Dr. Guy, you have a copy of this in your recor

[13]also?

[14]A. Yes, I do.

[15]Q. And what I was referring to before the number

[16]on your diagnosis was bilateral S1, L5-S1 radiculopathy,

[17]correct?

[18]A. Yes.

[19]Q. And as you explained earlier that's radiating

[20]pain from the lower back in the L5-S1 disc radiating do

[21]to the leg?

[22]A. From the L5-S1 level.

[23]Q. Radiating down to the leg?

[24]A. Yes.

[25]Q. And your opinion as also stated in that recor

[2]that's it's my professional opinion that this patient has

[3]sustained a permanent partial disability causally related

[4]to the accident of 11-28-93, correct?

[5]A. Yes.

[6]Q. And that was referring to your diagnosis,

[7]1 correct?

[8]A. That's correct.

[9]Q. Including the lower back bilateral L5-Si

[10] **[*85]** radiculopathy?

[11]A. The L5-S1 radiculopathy may have been

[0]
[12]pre-existing because Dr. Striano told me this patient had

[13]prior back problems so let me finish?

[14]Q. Let me ask you --

[15]MRS. FISHER: May he finish his answer,

[16]doctor.

[17]THE COURT: Finish, doctor.

[18]A. Doctor Striano had indicated to me that the

[19]patient had a prior lower back problem which he was
W
d
? 20 treating her for. So the lower back problem was a

[21]pre-existing problem but not of any caliber.

[22]The accident may have made it worse.

[23]Q. I see, and that's what the patient told you?

[24]A. Doctor Striano.

[25]Q. Is that what the patient also told you?

[2]A. The patient doesn't tell me what they have from

[3]what accident or what is from what. They tell me what

[4]hurts them, and I decide what the diagnosis is and what

[5]the causal relationship is.

[6]Q. I see in your reports of December 12, 1993 under

[7]past medical history you made no mention of the past lower

[8]back pain; did you, doctor?

[9]A. It says significant. Many people have normal

[10]sprains and **[*86]** strains that do I call that significant? No.

[11]I have had back problems. I sleep the wrong way -- if I

[0]
Q 12 sleep on my stomach, I wake up in the morning with a stiff

[13]back. That's not a problem. When he mentions past

[14]medical hhistory, past medical history means diagnosis,

[15]anything of significance. Disc herniation, radiculopathy,

[16]fracture, tumors, things of that caliber.

[17]Q. Would you also agree, doctor, that if a patient
s

[18]was being treated for a lower back problem, that that

[19]should be included in a past medical history?
? 20 A. If it's significant, yes. If it's not

[21]significant, I decide what is significant and what is

[22]insignificant.

[23]Q. You didn't put that in under past medical

[24]history, is that right?

[25]A. Again, if you read my past medical history, it

[2]says no significant past medical problems or significant

[3]injuries.

[4]Q. Okay.

[5]You didn't mention that in the opinion where you

[6]said it was my professional opinion that this patient had

[7]sustained a permanent partial disability referring to

[8]number 3 bilateral L5-Si radiculopathy, you **[*87]** didn't mention

[9]anything about prior injuries or prior problems that she

[10]had, did you?

[11]A. That's not to purview of that report. The

[0]
e 12 purview of that report is to simply list my diagnosis, my

[13]opinion as to causal and the prognosis. That's all.

[14]Q. You said the L5-Si radiculopathy was causally

[15]related to the accident of 11-18-93. You want to change

[16]that now?

[17]A. No, no, don't play with words.

[18]Q. Doctor, I ask you to answer the question.

[19]MRS. FISHER: Can I have the witness finish
W
? 20 his answer, Judge.

[21]THE COURT: Finish your answer, doctor.
a

[22]A. I listed all my diagnoses, all the diagnoses

[23]that the patient has. I give my opinion. If you want to

[24]ask me one by one what came from what accident or what

[25]problem I would gladly do it for you.

[2]Q. You said that this diagnosis number 1, the C5-C6

[3]disc herniation?

[4]A. No, no, you got it wrong. The C6-C7 disc

[5]herniation.

[6]Q. If you look at your report of December 18, 1994?

[7]A. I am looking at it.

[8]MRS. FISHER: And so am I.

[9]Q. **[*88]** Under number 1 does it say C5-C6 disc
I

[10]herniation?

[11]MRS. FISHER: Not on mine.

[0]
[12]THE COURT: Counsel, are you going to

[13]testify.

[14]MRS. FISHER: Sorry, Judge.

[15]A. I have December 1994. Let me see what you have

[16]Mr. Scahill.
I

[17]Q. This is the one that's in evidence, doctor.

[18]Does it say under number 1 C5-C6 disc herniation?

[19]A. This is obviously a mistake. This is hisnote.
W

[6]
? 20 Q. Is that your signature on the bottom of that?

[21]A. I am sorry.

[22](Whereupon, there is a short pause

[23]in the proceedings.)

[24]A. It looks like my signature, but on my report and

[25]this is the same report that I have from State Farm

[2]stamped by State Farm it says C6-C7 disc herniation.

[3]MRS. FISHER: Your Honor, I would like to

[4]approach the Bench and furthermore, inquire

[5]whether or not that's an original file and where

[6]it came from.

[7]MR. SCAHILL: Hold on, Judge.

[8]MRS. FISHER: Before we continue with this

[9]line of questioning.

[10]THE COURT: Counsel, it was marked in

[11]evidence. You had no objection to it being

[0]
[12]marked in evidence. Do you **[*89]** want to mark the

[13]other one in evidence? If there is no objection

[14]to that being marked in evidence, it can be

[15]marked in evidence.

[16]MRS. FISHER: That's fine, Judge, but what

[17]I'd like to do is take a look at that. I was
s

[18]under the assumption that that was a different

[19]document. That was a document that was provided
? 20 by my -- that we provided. Not that -- in so

[21]far as this was marked into evidence you had no

[22]outstanding objection, counsel.

[23]MRS. FISHER: No, I am not objecting to

[24]that. I'd like to see the document, Judge.

[25]That's all, before we continue.
i

[2]MR. SCAHILL: Judge, this is my cross.

[3]THE COURT: See which document, counsel?

[4]MRS. FISHER: Judge, can we approach and I

[5]will explain this.

[6]THE COURT: Yes.

[7](Whereupon, a discussion was held at the

[8]Bench between Court and Counsel.)

[9]THE COURT: Proceed.

[10]Q. Doctor, this is the copy that's in evidence
ill number 1 on the diagnosis it's C5-C6 disc herniation,

[0]
[12]correct?

[13]A. That's what it says.

[14]Q. Okay.
1S And I will show you another copy of this which

[16]we obtained **[*90]** from Hudson Valley Chiropractic.

[17]MRS. FISHER: Objection, Your Honor.

[18]Q. Can you take a look at this document.

[19]MRS. FISHER: Objection, Your Honor.
? 20 THE WITNESS: Can I clarify this?

[21]MRS. FISHER: Which?
a

[22]THE COURT: I will sustain the objection

[23]without you asking him a question about a

[24]document that's not marked in evidence.

[25]MR. SCAHILL: Judge, I ask that the

[2]document I just handed to Dr. Guy be marked for

[3]identification.

[4]THE COURT: You can mark it for I.D.

[5](Exhibit marked for I.D. by the Court

[6]Reporter)

[7]COURT CLERK: Defendant's K for

[8]identification.,

[9]MR. SCAHILL: Can you show that to the
io witness.

[11](Whereupon, there is a short pause

[0]
[12]in the proceedings.)

[13]Q. Doctor who was Hudson Valley Chiropractic?

[14]A. That's Dr. Striano's office.

[15]Q. I'd ask you to look at what's been marked as

[16]Defendant's K for identification. Is that also indicated

[17]under number 1 C5-C6 disc herniation?
e

[18]A. It does.

[19]MR. SCAHILL: Can I have that document

[20]back, officer.

[21]COURT OFFICER: Surely.
a

[22]MRS. FISHER: **[*91]** Judge, Your Honor, I object

[23]to reading from a document not in evidence even

[24]though it's marked for identification, and I ask

[25]that the question as well as the answer be

[2]stricken and the jury instructed to disregard

[3]it.

[4]THE COURT: Your objection is sustained.

[5]MRS. FISHER: Thank you, Judge.

[6]THE COURT: The jury is instructed to

[7]disregard the last remark, the last question and

[8]the last answer.

[9]Q. Doctor, your E.M.G. test was suggestive of

[10]bilateral C5-C6 nerve root injury, is that right?

[11]A. The E.M.G. electrically suggestive, yes.

[4]
[12]Q. Okay.

I

[13]And the document that's in evidence the
I

[14]herniation is noted at C5-C6, is that correct?

[15]A. You are going backwards and forwards, counsel.

[16]The herniation is C6-C7. In my record I have the correct

[17]diagnosis. C6-C7.
r

[18]THE COURT: He is asking you about the

[19]document that's marked for evidence.

[20]A. This is obviously a mistake, okay. I am not
K

[21]infallable. I could have made a mistake with the level.
a

[22]Q. That's something that you signed, though,

[23]correct? **[*92]**
[24]A. It looks like my signature.

[25]Q. And that's a document that you prepared for thi:

[2]litigation plus you prepared it for Mrs Iasello's lawyers

[3]is that correct?

[4]A. Yes. Obviously I created another one because I

[5]picked up on my mistake. Here's the correct report?

[6]Q. When did you pick up on that mistake, doctor?

[7]Did you do that this morning?

[8]A. Come on.

[9]MRS. FISHER Oh, Your Honor, I object.

[10]THE WITNESS: Even I object.

[11]THE COURT: Objection is sustained.

[0]
[12]You are just a witness, doctor.

[13]A. But there is a limit that I can take sitting

[14]here also. This is dated December 17.

[15]Q. Doctor, there is no question, doctor.

[16]THE COURT: He is doing his job the same
i

[17]way she asked you questions, he is just doing

[18]his job and there is nothing personal.

[19]Q. I am going to ask you about the M.R.I.
? 20 examination, doctor. And when was that completed, the

[21]M.R.I. examination?
a

[22]A. I believe it was 12-4-93.

[23]Q. Do you have a copy of that report. Doctor?

[24]MRS. FISHER: I believe the M.R.I. **[*93]** report

[25]was also admitted into evidence where the film

[2]is.

[3]Q. Do you have a copy in your records?

[4]A. I thought I did.

[5]Q. I will show you a copy that's been marked into

[6]evidence.

[7]Can I approach the witness, Judge?

[8]THE COURT: Go ahead, counsel.

[9]Q. This was performed at Central Imaging, is that

[10]right?

[11]A. Yes.

[0]
[12]Q. Is that a radiology office?

[13]A. Yes it is.

[14]Q. What is the field of radiology, doctor?

[15]A. The field of radiology is the field that deals

[16]with the diagnosis and interpretation of x-rays,

[17]ultra-sounds, Cat Scans, M.R.I.'s.

[18]Q. And is that the field that you are Board

[19]certified in?
W

[6]
? 20 A. No.

[21]Q. And do you regularly send patients for M.R.I.

[22]exams?

[23]A. I do.

[24]Q. And do you send them for to radiology offices

[25]such as Central Imaging for radiology tests?

[2]A. Yes.

[3]Q. Such as the M.R.I.?

[4]A. Yes.

[5]Q. And the reason you do that, doctor, is because

[6]you rely **[*94]** on the expertise of a board certified radiologist

[7]to interpret the films?

[8]A. No.

[9]MRS. FISHER: Objection, Your Honor.

[10]Never mind, I withdraw the objection.

[11]THE COURT: The witness can answer.

[0]
[12]A. No, because I don't have $ 2 million to buy my

[13]own M.R.I. machine because I can interpret my own M.R.I.

[14]films.

[15]Q. In the normal course of your practice do you

[16]send your patients to radiologists and rely on their

[17]interpretation of the films, correct?

[18]A. I don't send my patients to a radiologist. I
s 19 send my patients to a radiology facility where they have

[6]
? 20 Cat Scans, M.R.I. facilities which I do not have. They

[21]automatically are required to render a report. Yes, I do
a

[22]rely upon the report to a degree. I also review the
V
[23]M.R.I. films myself. If I disagree with them, I will call
[24]them back and say I disagree with this and it has happened
[25]where I disagree with their interpretations, and I was
[2]right. They sent me a new corrected report. Radiologists
[3]read the films fast. They put them up on the shadow box
[4]-- boom, boom, boom, **[*95]** and that's it. They read hundreds of
[5]films on a daily basis, where I don't read 100 films on a
[6]daily basis. I read much less, but I take more caution
[7]and more care in reading throws M.R.I.'s because I know my
[8]whole patient's history. I had a patient once that had a
[9]radiculopathy.
[10]Q. I just asked you if you rely on the radiology
[11]report?
[0]
e 12 A. I am trying to tell you to a degree not when it
[13]contradicts my list and my physical examination and my
[14]E.M.G.'s if I find that it contradicts it and I look at
[15]the films myself, and I see a different view. I am not
[16]going to stop and get on the phone and ask him to re-read
[17]the films and give me a corrected report, and this has
[18]happened not only to me and to many doctors, it happens
[19]all the time?
? 20 Q. But it didn't happen here?
[21]A. In this particular case, no.
a
[22]Q. Would it be fair to say that you relied on this
[23]report in forming your diagnosis?
[24]A. I relied on this report along with my own
[25]consultation along with my history and my own physical

[2]exam findings. Completely everything together. **[*96]**
[3]Q. Okay.

[4]Now, with respect to this M.R.I. exam it's dated

[5]December of 93. Would it be fair to assume that that's

[6]the date that the M.R.I.'s were taken?

[7]A. Date of exam, December 3, 1993.

[8]Q. That's the date that the test was taken?

[9]A. It tells you date of exam December 3, 1993?

[10]Q. That was approximately 3 weeks post accident?

[11]A. 11/18 was the accident. 1, 2, 3 -- 15 days

[0]
[12]post accident.

[13]Q. Now, the M.R.I. exam you told us shows the soft

[14]tissues surrounding the cervical spine, correct?

[15]A. To a degree, yes.

[16]Q. And that's the reason the M.R.I., one of the

[17]reasons the M.R.I. is asked for because not only can it

[18]show bone like a plain x-ray, but it can also show the

[19]other tissues surrounding the cervical spine?
d
? 20 A. Let me correct you right there because you made

[21]a big mistake. M.R.I. does not show bone like x-ray.. It

[22]does show bone to a degree but not like x-ray. If an

[23]M.R.I. shows bone like x-ray,, we wouldn't be taking x-rays

[24]exposing the patients to radiation where as M.R.I. there

[25]is no radiation, **[*97]** so M.R.I. is not a test to show bone

[2]problems. It does show bone to some degree.

[3]Q. How about the soft tissue surrounding the bone?

[4]A. Yes, that's why you do it.

[5]Q. That was the reason I asked the question?

[6]A. It is for the soft tissue.

[7]Q. What is the reason when you say in medical

[8]terminology when you say unremarkable, what does that

[9]mean?

[10]A. That means there is nothing wrong, nothing to

[11]comment about.
a

[12]Q. There is an indication in this report the

[13]remaining para-vertebral soft tissues are unremarkable.

[14]Can you tell the jury what that means?

[15]A. The remaining disc levels are unremarkable. It

[16]means that they are normal.

[17]Q. Where it says the remaining para-vertebral soft
s

[18]tissues are unremarkable as is visualized in this study,

[19]does that mean that the surrounding materials to the
d
? 20 cervical spine were normal?
K

[21]A. Except for the last paragraph where it says.

[22]there is straightening of the normal cervical lordosis.

[23]Q. Okay.

[24]So absent that, the soft tissues, **[*98]** the ligaments

[25]surrounding the neck were normal?

[2]A. Yes.

[3]Q. So when you talked about earlier that there may

[4]be torn ligaments and they tape the heel that wasn't the

[5]case here, is that correct?

[6]A. I said the posterior longitudinal ligament was

[7]torn and you can see that clearly visible on the M.R.I..

[8]When you have a disc herniation the posterior longitudinal

[9]ligament gets torn with it. That's why you get the

[10]herniation -- the defnition.

[11]Q. Is that noted anywhere in this report, doctor?

[0]
[12]A. Many radiologists do not note that.

[13]Q. I didn't ask you that, doctor.

[14]A. If they don't note it, of course, not.

[15]Q. So what you are saying now is not noted anywhere

[16]in this report, is that correct?

[17]A. No, that is not noted?
a

[18]Q. Now, there is an indication about the disc

[19]herniation that you are talking about. What level is that
W

[4]
? 20 disc herniation as found in the report?

[21]A. C6-C7.

[22]Q. And your diagnosis in December 17, 94 as it's

[23]stated in the defendant's Exhibit J **[*99]** is C5-C6 disc

[24]herniation, is that not correct?

[25]MRS. FISHER: Objection, Your Honor.

[2]THE COURT: Overruled.

[3]A. The way you phrased the question, yes, but

[4]that's not the true fact.

[5]Q. That's up to the jury to decide.

[6]A. That's exactly right.

[7]Q. Now, your E.M.G. studies that we talked about

[8]earlier was suggestive of C5-C6 nerve root disfunction, is

[9]that right?,

[10]A. That's correct.

[11]Q. And that wasn't correlated in the report. This
v
Z, 12 report indicated a C6-C7, the next level down, is that

[13]right?

[14]A. I am sorry.

[15]MRS. FISHER: Objection, Your Honor. He is

[16]talking about apples and oranges.

[17]MR. SCAHILL: She said that yesterday. I
a

[18]am not sure what she means.

[19]MRS. FISHER: It means the question doesn't
a 20 have anything to do --

[21]MR. SCAHILL: I think that's up to the jury

[22]also.

[23]MRS. FISHER: No, that has to do with the

[24]question.

[25]THE COURT: Overruled.

[2]Q. The report did not correlate your E.M.G.

[3]studies, is that correct, doctor?

[4]A. **[*100]** No, this is where you are wrong. I explained it

[5]earlier. When Miss fisher asked me is there any

[6]discrepancy between the level of herniation and the level

[7]of your E.M.G. is there any discrepacny I explained it, I

[8]said the nerve roots that come off from the neck to the

[9]muscles in the arm you have duel innervation. Each muscle

[10]has at least 2 nerve roots attached to it. Except for the

[11]triceps where it has 3 to 4. So the C6 nerve root is

[0]
[12]common to both those levels.

[13]Q. Where is that on the arm?

[14]A. The C6 level?

[15]Q. Yes.

[16]A. Ciceps is C5 and C6. Triceps is C6 and C7 and

[17]Ti. This portion of the arm is C6 mostly. Up to here.

[18]C6 ends here. C7 begins here. This portion of the arm

[19]has some C6 and some C7 distribution from here on. This
? 20 is mostly C7 and then it starts beginning T1.

[21]Q. Now, this herniation that was diagnosed through

[22]the M.R.I. study is there an indication as to it's degree?

[23]A. On the report, yes,, a small central disc

[24]herniation.

[25]Q. Okay.

[2]And did you correlate that in your clinical

[3]findings, **[*101]** doctor?

[4]A. Correlate it how?

[5]Q. Indicating that it's a small central C6-C7?

[6]A. I didn't elaborate one way or the other. Once

[7]you have a herniation, it's a heriation. I left it at

[8]that, a C6-C7 disc herniation.

[9]Q. So when this radiologist notes that it's small,

[10]that has no medical sigificance?

[11]A. Once you have a tear of a disc, once it is

[0]
[12]heriated, to me it doesn't matter one way or the other.

[13]Whether it is small or large -- now, a surgeon may decide

[14]what to do with that information if he wants to do

[15]surgery. But from a treatment point of view, once you

[16]have a herniation, it's a herniation. Some radiologists

[17]put an adjective small, moderate, large. Some don't.
v

[18]Q. Okay.

[19]In this case they characterized it as small?
W
s
? 20 A. Yes.

[21]Q. Now, you talked before about the neural foramen

Q

[22]can you tell the jury what those are?

[23]A. The neural foramen is the tunnel by which the

[24]nerve root exits off the spinal cord.

j 25 Q. Is that an opening for the nerve to go through?

[2]A. Yes, **[*102]** it is an opening.

[3]Q. And one of the ways that pain can be caused by a

[4]disc herniation is if the nucleus pulposis or the disc

[5]material presses in and narrows that opening, is that

[6]right?

[7]A. No, you said two things wrong here. You were

[8]almost correct with your first part. You were definitely

[9]wrong with the second part'of your question. You can have

[10]pain produced by a disc herniation if it compresses on the

[11]nerve root. Absolutely. There's other ways by which a

[12]nerve is produced by a disc, why pain is produced by a

[13]disc herniation. I said those earlier.

[14]Q. But I am talking about this particular case?

[15]A. You don't have to have stenosis to have pain.

i

[16]Q. Stenosis is a narrowing of that canal?

[17]A. That's right. That's an opening.

[18]Q. And by stenosis we are talking about narrowing

[19]of that canal, is that right?

[20]A. Yes.

[21]Q. And in this case and there is an indication

[22]about the neural foramen that it's a normal caliber. What

[23]does that mean, doctor?

[24]A. It is normal. I agree the neural formen is

[25]normal, right. Now, **[*103]** that's not where the problem is.

[2]Q. Is it your testimony that there is no

[3]impingement of the nerve root passing through the neural

[4]foramen at C6-C7 as shown by this M.R.I.?

[5]A. That's correct. I agree with that.

[6]Q. So that nerve root that we are talking about

[7]that goes down the arm that goes through the canal there,

[8]there is no impingement of that nerve root by this disc,

[9]is that right?

[10]A. Okay.

[11]If you are asking me at the neural foramen, yes,
o

[12]I agree with you 100 percent.

[13]Q. Okay.

[14]A. But if you asked me before that where it exits

[15]off the spinal cord a M.R.I. is not a test that can tell

[16]you that.
i
i

[17]Q. I will ask you about that because there is an
a
g 18 indication in the report that no mass effect upon the

[19]cord. Is that referring to the spinal cord.
w

[20]A. That's right, yes.

[21]Q. When they say no mass effect upon the cord, does
Q

[22]that not mean, doctor, that there is no impingement upon

[23]the cord at that level?

[24]A. Generally, mass effect means significant

[25]compression. **[*104]** You can have touching and not have a mass

[2]effect. You can have a touching of the spinal cord and it

[3]can cause a chemical irritation on the spinal cord and --

[4]let me finish, on the M.R.I. In my view I saw touching of

[5]the spinal cord and I think this jury also saw touching of

[6]the spinal cord.

[7]Q. I ask you not to comment on what this jury

[8]found. I think that's up to them.

[9]A. There is no mass effect. I am not claiming

[10]there is mass effect. Mass effect means significant

[11]compression. It doesn't say about not touching the spinal

[0]
[12]cord.

[13]Q. Because it says in this report the central

[14]canal, is that referring to the spinal canal?

[15]A. No, the central canal is the column. The spinal

[16]canal the column, not the spinal cord.

[17]Q. The central canal is of normal caliber. What

[18]does that mean, doctor?

[19]A. Normal caliber -- you are born with normal
W
e 20 caliber, normal size. Normal caliber.

[21]Q. When we talk about a disc that's herniated, does
a

[22]that mean that it's also flattened?
LL

[23]A. If a disc is flattened? **[*105]**
[24]Q. When it is herniated it can be flattened, is

[25]that right?

[2]A. It can be flattened, it can be oval,

[3]postero-lateral, it can be different directions and

[4]shapes.

[5]Q. Normally when a disc herniates is it true that

[6]the disc flattens?

[7]A. Depends on the angle of the herniation. The

[8]most common angle of herniation is posteriorally and

[9]laterally.,

[10]Q. In this case?

[11]A. Central.
in

[91]12 Q. And would you agree, doctor, that a central

[13]herniation even a small central C6-C7 disc herniation

[14]would cause the disc to lose height and squish down a

[15]little bit?

[16]A. Not in this early state.

[17]Q. Not in the early stages?
s

[18]A. Not in the early stages. That's the key here.
g 19 Q. Is there any indication in this report about the
S
W
? 20 height of the disc, th height of the vertebra -- I am

[21]referring specifically where it says intervertebral discs

[22]are of appropriate height.

[23]A. That's the key. You just gave the key. The

[24]fact that it's of normal height means that it was not

[25]pre-existing **[*106]** or long standing. If it was, it would have

[2]been shriveled up and desicated and look like this as

[3]opposed to this.

[4]Q. I am just asking whether it says inter-vertebral

[5]discs are of appropriate height. Does that mean that the

[6]height of the discs are normal?

[7]A. Yes.

[8]Q. Okay.

[9]Now, you took this report into consideration

[10]before you made your diagnosis; correct, doctor?

[11]MRS. FISHER: Asked and answered, Your

[0]
[12]Honor.

[13]THE COURT: Overruled.

[14]A. The answer is yes.

[15]Q. Now, I was asking you earlier, doctor, about the

[16]difference between subjective and objective and objective

[17]test would be something like an M.R.I., correct?

[18]A. Yes.

[19]Q. A subjective test is something the patient tells
W
? 20 you that could be influenced by the patient's own

[21]subjective thinking, their own thought process, is that

[22]right?

[23]MRS. FISHER: Objection as to form.

[24]THE COURT: Overruled.

[25]A. I am explaining to you what subjective is.

[2]Subjective is what a patient complains of irregardless of **[*107]**
[3]the latter part of what you said. Subjective is what a

[4]patient complains of, period.

[5]Q. So when a patient tells you that their neck only

[6]bends over to a certain extent and then they have pain or

[7]that they can move their head to a certain extent and then

[8]they have pain, is that something that is subjective?

[9]A. No, that's objective because once a patient can

[10]no longer go further, the doctor pushes it to see if he

[11]can push it to go further, that's why it becomes objective
o 12 as opposed to subjective.

[13]Q. But aren't you still relying on what the patient

[14]is telling you in terms of live movement?

[15]A. You can rely on the patient's, on what the

[16]patient tells you, but in this case you rely on your own

[17]hands to see if you have resistance with pushing the

v

[18]patient further forward.

[19]For instance, if the patient can't turn the neck
? 20 to the side, you turn the patient first, turn it to the

[21]side. If they can only go this way, you then have to grab
a

[5]
[22]the neck and see if you can push it to see if it can go

[23]further. If you can, then you report the full range of

[24]motion. **[*108]** If you cannot, then you, that's when you record

[25]the abnormality. That's the difference between subjective

[2]and objective.

[3]Q. Now, you indicated that when you saw Mrs.

[4]Iacello on December 2nd you performed range of motion

[5]testing?

[6]A. Yes.

[7]Q. Is that correct?

[8]A. That's correct.

[9]Q. And you tested all of the areas of her body that

[10]she was complaining about?

[11]A. Yes.

[0]
[12]Q. And the range of motion for her hands and her

[13]wrists and her hands and her shoulders, they were all

[14]normal?

[15]A. All normal as expected.

[16]Q. And how do you do those tests, the arm, the

[17]wrist, the shoulder and the hands?
s 18 A. Arms, shoulder flexion, extension, abduction,

[19]adduction, external rotation, internal rotation.
? 20 Q. That was all normal?

[21]A. All normal as expected.

[22]Q. The deficit you found was in her neck, is that

[23]right?

[24]A. That's correct.

[25]Q. She had decreased range of motion?

[2]A. Yes.

[3]Q. And that you repeated that **[*109]** test when you saw her

[4]in 1997, correct?

[5]A. Yes.

[6]Q. And you found some improvement, is that right?

[7]A. There was improvement in flexion and extension.

[8]Lateral rotation and lateral flexion left and to right was

[9]still diminished by one half.

[10]Q. So you said there was some improvement in the

[11]patient when you saw her.

[0]
[12]A. There was improvement in flexion and extension,

[13]yes.

[14]Q. Now, after you conducted your test in December

[15]of 93, after you did your physical exam and after you took

[16]a history did you recommend a course of treatment to the

[17]patient?

[18]A. I am not the treating doctor, so I don't
s 19 recommend a course of treatment. I spoke with Dr.
s
? 20 Striano. I told him about my findings and the plan was he

[21]would continue with treatments. If there was anything he

[22]needed to do or any additional information he wanted for
k

[23]me he would send me the patient back for additional

[24]consultation.

[25]Q. So you didn't recommend anything to her?

[2]A. Continue with her current therapy and see how **[*110]**
[3]she does. If she doesn't get better, she should come back

[4]and see me.

[5]Q. Did you recommend any medications?

[6]A. I did not recommend any medications. I believe

[7]she was taking Advil on her own.

[8]Q. Over the counter Advil?
i

[9]A. Yes, over the counter Advil?

[10]Q. How about a neck collar, did you recommend a

[11]neck collar?

[0]
[12]A. I am strongly against neck collars because it

[13]causes more stiffness.

[14]Q. Did you recommend any hospitalization, bed rest,

[15]any traction?

[16]A. Are you kidding me? Hospitalization? The new

[17]standards of care in hospitals --

[18]Q. I didn't ask you that. I asked you if you

[19]recommended that?
? 20 A. You can't bring a patient into the hospital for

[21]cervical traction. They will not allow you. They will
C.

[22]not pay you for it. They consider that improper medical

[23]conduct.

[24]Q. Is it fair to say you didn't recommend it?

[25]A. For the reasons I gave you, yes.

[2]Q. Now did you ask the to see the patient again?

[3]A. I don't ask to see the patient again **[*111]** I simply

[4]leave it as treat with your own doctor. If you don't get

[5]better, come back and see me.

[6]Q. And you didn't see her again until January of 97

[7]as you told us earlier?

[8]A. That's right.

[9]Q. Okay.

[10]Did you tell her to continue the course of

[11]treatment because you had confidence in Dr. Striano's

[0]
[12]abilities?

[13]A. There you go again, counsel. I am not the

[14]treating doctor. I am not al lowed to tell the patient to

[15]do this and this. I can only advise and recommend. I

[16]recommended to her to continue the same treatment. If you

[17]don't get better, come back and see me. That's it?

[18]Q. Well, I am talking about continuing the same

[19]treatment. Did you tell her to do that because you had
? 20 confidence in Dr. striano's abilities?

[21]MRS. FISHER: Objection.
a

[22]THE COURT: I will sustain the objection.

[23]Q. Did you fell, doctor, when you saw the patient

[24]in December of 1993 that the chiropractic care that was

[25]being given to her at that time as adequate?

[2]MRS. FISHER: Objection.

[3]THE COURT: I will sustain that objection.

[4]Q. **[*112]** Doctor, in your experience did you ever see any

[5]other patients with similar complaints of neck pain that

[6]you referred to chiropractic care?

[7]A. I don't refer patients to chiropractors. They

[8]refer them to me. This is an M.D.. I don't go backwards.

[9]I go forwards. There is nothing a chiropractor can do

[10]that I can't do including manipulations, including

[11]manipulations. I do not do manipulations in certain

[0]
[12]conditions.

[13]Q. You would consider chiropractors going

[14]backwards?

[15]A. No, you asked me if I would -- I am an expert in

[16]the field of physical medicine. It encompasses physical

[17]therapy, adjustments mobilizations, diagnostic and

[18]theraputic treatment. It's for spinal disorders,

[19]musculo-skeletal dissorders. Why in God's name would I
a
? 20 refer a patient to a chiropractor. I don't know for what

[21]reason if I do everything myself.
a

[22]Q. Well, doctor, at that time did you feel the

[23]course of chiropractic care that was being given to her

[24]was adequate?

[25]MRS. FISHER: Objection.

[2]A. Yes, because --

[3]MRS. FISHER: Objection.

[4] **[*113]** THE COURT: I will sustain that objection.

[5]Q. Doctor did you know Dr. Striano professionally?

[6]A. When you say professsionally.

[7]Q. Did he refer other patients to you?

[8]A. Yes.

[9]Q. And you consulted' with him on other cases?

[10]A. He sent patients to me for consultation, not I

[11]consult with him. He consults with me.

[0]
[12]Q. I'm sorry.

[13]A. Okay.

[14]Q. He has consulted with you on other patients?

[15]A. Yes.

[16]Q. And did you feel the conservative course of

[17]treatment that he was giving to Mrs. Iacello was going to

[18]help her condition?

[19]A. Yes.

? 20 MRS. FISHER: Objection.

[21]THE COURT: I will sustain that objection

[22]as to form. I think we have a doctor here

[23]that's a medical doctor. Doctor Striano is a

[24]doctor of chiropractic medicine. I don't think

[25]Dr. Guy is qualified to comment on the care of a

[2]chiropractor.

[3]MRS. FISHER: Your Honor, my objection is

[4]that Dr. Guy is not here to testify as an expert

[5]as to his opinion of Dr. Striano.

[6]Q. Did you feel when you saw her **[*114]** in December of

[7]1993 that Mrs. Iacello would benefit from a course of

[8]conservative treatment?

[9]A. That's the standard of care for a disc

[10]herniation. You always go with conservative treatment.

[11]Q. And by conservative treatment we are referring

a

[12]to massage, spinal manipulation, heat treatment?

[13]A. I don't believe she was getting spinal

[14]manipulations. I believe Dr. Striano also told me she was

[15]not getting manipulations, cervical manipulations. She --

[16]he was giving her the heat, electrical stim., the massage

[17]and exercises. He was not manipulating her neck.

[18]Q. That's considered conservative treatment?

[19]A. Yes.

W

? 20 Q. And the reason that is the prescribed course of

[21]conduct for a physician because is because in your
a

[22]experience you found that patients improve with that

[23]course of therapy, correct?

[24]A. They improve to some degree. Some improve.

[25]Some don't. Some improve for a short course. They have

[2]remissions and exacerbations which means they have good

[3]days and bad days which is the natural course of this

[4]condition **[*115]** but progressively over time it progressively

[5]gets worsened for the reasons I explained earlier this

[6]morning.

[7]Q. Well the reason you prescribed conservative

[8]treatment is because in your experience the patients do in

[9]fact improve with that typd of treatment?

[10]A. They do, absolutely.

[11]Q. Now, in terms of this particular patient if her
a

[12]complaints were the same as they are the same today as

[13]they were 3 years ago and in some ways worse, would you

[14]say she had benefited from the conservative treatment that

[15]was given?

[16]A. Conservative treatment always helps. It never,

[17]never doesn't help to any degree. Will it be enough to

[18]get her out of what her needs are, that's a different

[19]situation, but conservative treatment always helps.
? 20 Q. Do you know what the medical terminology

[21]secondary gain is, doctor?
a

[22]A. I know what a secondary gain is, yes.

[23]Q. Can you tell the jury what is meant by secondary

[24]gain?

[25]A. Secondary gain means you have and alterior

[2]motive to still be in pain. For legal purposes, for

[3]litigation **[*116]** purposes.

[4]Q. Have you -- have you ever found that in any of

[5]your patients?

[6]MRS. FISHER: Objection, Your Honor.

[7]THE COURT: Overruled.

[8]A. Also yes, I have found it in some of my

[9]patients, and I discharge such patients. I send them to a

[10]pain clinic where a team of doctors can assess the

[11]psychological situations and let them determine if this

[12]patient is just truthfully injured truthfully benefited or

[13]they have so gain. It's not my position to second guess

[14]those patients. If I have any doubts, I refer them out

[15]and I refer many patients to pain centers.

[16]Q. Okay.

[17]With him -- you didn't treat this woman over the

[18]3 year period from 93 to 97, is that right?

[19]A. I have answered that question many times but for
? 20 the last time, yes, you are right. I did not treat her.

[21]I only saw her 4 times.
a

[22]Q. The herniation, the disc injuries that you are

[23]talking about you indicated that they only occur with

[24]traumatic events, is that right?

[25]A. I said the most common, I repeat, the most

[2]common cause of a disc herniation in **[*117]** a young healthy

[3]female ptient is trauma.

[4]Q. Now, the judge asked you a question about a disc

[5]herniation being asymptomic?

[6]A. A disc herniation can be asymptomatic, but it is

[7]rare?

[8]Q. What is asymptomic?

[9]A. It means it cannot produce symptoms.

[10]Q. So are you aware of sstudies where a random

[11]sample of the population is tested for disc herniations in

[12]the neck and the lower back. Are you aware of the studies

[13]that were done?

[14]A. You are strongly mistaken. That study you are

[15]talking about in the New England Journal of Medicine in

[16]August of 194 where they took a random of 100 patients

[17]where they M.R.I. them and the purpose to that study was

[18]not the fact about herniations but it was about bulges,

[19]not herniations. And that patient population was not
? 20 involved in traumatic injuries. A big, big difference.

[21]Q. Well, doctor, is it true that if we took a

[22]random sampling of the population and submitted them to

[23]cervical M.R.I. studies, at least 50 percent would have

[24]disc herniations in their necks similar to Mrs. Iasello?

[25]A. You **[*118]** are strongly mistaken. That is wrong. It's

[2]absolutely mis-representing what that report says.

[3]MRS. FISHER: Objection.

[4]Q. Well, doctor, forget the report for the moment.

[5]A. It is wrong.

[6]Q. In your opinion, in your opinion if we took a

[7]random sampling of the population, if we took everyone on

[8]the jury and everybody in the courtroom, if we took a

[9]random sampling of the population, would they show disc

[10]herniations even if they are asymptomatic?

[11]MRS. FISHER: I object to this questioning.

[0]
[12]It doesn't matter whether or not you have a disc

[13]herniation or I have a disc herniation, Mr.

[14]Scahill has a disc herniation. We are here to

[15]discuss Mrs. Iasello and this is --

[16]MR. SCAHILL: Judge, no speeches, please.

[17]THE COURT: Finish, counsel.

[18]Your objection- are you finished?

[19]Overruled.
a
? 20 The doctor can answer the question.

[21]A. That's a very good question, and I will give you

[22]a very good answer.

[23]I Send about 30 M.R.I.'s a week for study.

[24]Only, only less than 2 of them come back with herniations.

[25]Does that answer your **[*119]** question.

[2]Q. Well, doctor, those are part of your patient

[3]population that have law suits pending. I am talking

[4]about people who don't have law suits?

[5]MRS. FISHER: Objection.

[6]Q. Random sampling of the population.

[7]THE COURT: I will sustain that objection.

[8]MR. SCAHILL: No further questions.

[9]Thank you.

[10]THE COURT: We willtake a 5 minute recess.

[11](Jury leaving courtroom at 3:00 p.m.)
v

[12](Recess)

[13](Jury entering courtroom at 3:15 p.m.)

[14]THE COURT: Counsel for the plaintiff, you

[15]can proceed with your redirect.

[16]MRS. FISHER: Thank you, Judge.

[17]REDIRECT EXAMINATION

[18]BY MRS FISHER:

[19]Q. Dr. Guy, do you have your own copy of your
W

[6]
? 20 report dated September -- excuse me, December 17, 1994?

[21]A. I do.
a

[22]Q. Can I take a look at it, please?

[23]A. Yes.

[24](Whereupon, a discussion was held at the

[25]Bench between Court and Counsel.)

[2]Q. Dr. Guy, your report dated December 17, 1994

[3]which I am handing you back --

[4]By the way, that hasn't yet been marked, Your

[5]Honor.

[6] **[*120]** THE COURT: We will mark it for I.D.

[7]MRS. FISHER: Okay.

[8]Q. Dr. Guy, that would be what is commonly known as

[9]a Xerox copy, but -- am I '- I am not allowed to say

[10]1 Xerox, but it is a copy, not an original record, is that

[11]correct?
v
Z, 12 A. Yes, that's correct.

[13]Q. Was that also true of the same report that Mr.

[14]Scahill had marked into evidence that that was not an

[15]original record but a photo copy -- that's the proper

[16]terminology, is that correct?

[17]A. Yes.

[18]Q. And on your report Dr. Guy, the C6-7 under the

[19]first diagnosis is properly correlated to your treatment
? 20 notes and your office notes and the M.R.I. report, as well

[21]as to the M.R.I. films that the jury has seen earlier this

a

[22]morning, is that correct?

[23]A. Absolutely correct.

[24]Q. So that if there were a report that says C5-6,

[25]that would be incorrect, is that true?

[2]A. That's correct.

[3]Q. Also, incidentally, it indicates on the report

[4]that disability is causally related to the accident of

[5]11-28-93 as opposed to the indication **[*121]** on the top of the

[6]report stating the accident 11-18-93?

[7]A. Yes, that's a typo.

[8]Q. So, in other words, the 2 should be a 1, is that

[9]right?

[10]A. That's right.

[11]Q. Thank you.

[0]
[12]Dr. Guy, is there any such thing as a subjective

[13]test that you perform?

[14]A. No, not that I know of.

[15]THE COURT: Are you going to move that into

[16]evidence, counsel.

[17]MRS. FISHER: Yes, Judge, I will.

[2]
a 18 THE COURT: Okay.

[19]MRS. FISHER: We might as well do it now.
? 20 MR. SCAHILL: Can I have a short voir dire

[21]on that, Your Honor.
s

[22]THE COURT: Go ahead, counsel.

[23]MRS. FISHER: Subject to what we discussed

[24]at the Bench.

[25]THE COURT: Subject to the understanding

[2]about what is going to be redacted.

[3]MR. SCAHILL: Doctor, Plaintiff's 16 for

[4]identification the document that you just

[5]referred to.

[6]THE WITNESS: Yes.

[7]MR. SCAHILL: That indicates C6-C7.

[8]THE WITNESS: Yes.

[9]MR. SCAHILL:' Is that part of your records?

[10]THE WITNESS: Yes, it is.

[11]MR. SCAHILL: That's kept in the ordinary
Q

[12]course of your business?

[13]THE **[*122]** WITNESS: This is a photo copy of my

[14]records..

[15]MR. SCAHILL: Can I see that for a second,

[16]doctor.

[17]THE WITNESS: Yes.

[18]MR. SCAHILL: The document that's in

[19]evidence the same copy of the report December
W
? 20 17, 1994 it's your position where it says C5-C6

[21]disc herniation, that's a typo.

[22]THE WITNESS: I don't know if it is a typo

[23]or it's not a typo. It's a mistake. There is

[24]no C5-C6 herniation. It is a C6-C7 disc

[25]herniation. That's a correct report in my

[2]possession, and that's what the pathology is,

[3]C6-C7 herniation.

[4]MR. SCAHILL: The report that's in evidence

[5]indicates C5-C6. Is that something that was

[6]also generated by your office?

[7]THE WITNESS: It's not in my possession.

[8]MRS. FISHER: Your Honor, it's not a

[9]different report.' It's the same report that's

[10]been photo copied numerous times and shows up in

[11]numerous different places.

[0]
[12]MR. SCAHILL: Judge, I think counsel is

[13]testifying again.

[14]THE COURT: Insofar as that's an objection,

[15]counsel, it is overruled.

[16]THE WITNESS: Any way you want to look at

[17]it, it's either a typo or it's **[*123]** a mistake. There
a 18 is no C5-C6 disc herniation.

[19]MR. SCAHILL: May I see the report that is
d
? 20 in evidence. This is Defendant's J. Is that

[21]generated by your office?

[22]THE WITNESS: It looks like it.

[23]MR. SCAHILL: And that's your signature on

[24]the bottom?

[25]THE WITNESS: It looks like it.

[2]MR. SCAHILL: I have no other objection to

[3]the other report subject to the redaction that's

[4]indicated.

[5]THE COURT: Okay.

[6]You can mark that other item 16 into

[7]evidence.

[8](Exhibit marked by the Court Reporter in

[9]evidence)

[10]Q. Doctor, is physical or body damage to a vehicle

[11]of any significance in regard to diagnosis that you make

[0]
[12]for a patient?

[13]A. Not with reference to diagnosis. Mechanism of

[14]injury, sometimes.it's helpful.

[15]Q. And is it your opinion and testimony, doctor,

[16]that an individual can be severely injured in a motor

[17]vehicle collision absent apparent body damage to the
e

[18]vehicle?

[19]A. I have seen it many times.
? 20 MR. SCAHILL: Objection as improper

[21]remember direct, Judge.

[22]THE COURT: I will sustain that objection **[*124]**
[23]the jury is instructed to disregard that

[24]question and answer.

[25]MRS. FISHER: Your Honor, may we approach.

[2]THE COURT: Come on up here, counsel.

[3](Whereupon, a discussion was held at the

[4]Bench between Court and Counsel.)

[5]THE COURT: The objection is overruled.

[6]The witness can answer the question.

[7]THE WITNESS: I forgot the question, Your

[8]Honor.

[9]THE COURT: It Can you repeat it, counsel.

[10]Q. Do you -- have you seen patients, doctor, who

[11]have been severely injured in an automobile accident

[0]
[12]without severe body damage to a vehicle?

[13]MR. SCAHILL: Same objection, Judge.

[14]THE COURT: Overruled.

[15]A. The answer is yes. I can give you an example.

[16]A good example how forces sometimes go through a vehicle

[17]without any apparent damage to the vehicle. An example is
s

[18]you can take a telephone book, put it againsat this

[19]gentleman right here and hit the telephone book. There
? 20 will be no damage to the telephone book, but he will hurt
K

[21]inside. There will not be a scratch on him. That's how
a

[22]you separate from the old days.

[23]THE COURT: **[*125]** Doctor, let me ask you a

[24]question. Based upon the stated technology with

[25]automobiles and the fact that automobiles

[2]produced today are supposed to be able to

[3]sustain 5 whatever miles an hour collision

[4]without showing extensive damage -- what you

[5]are saying is this. Two cars and this is, I

[6]know that this is not the case in this

[7]particular case, two cars can have a bumper to

[8]bumper collision and if they are new cars and

[9]supposedly they can sustain 5 mile per hour

[10]collision, and someone could be in some sort of

[11]collision like that and have severe neck

[0]
[12]problems.

[13]THE WITNESS: If you are asking me, Your

[14]Honor, if it is possible, it's possible to both

[15]sides of the coin. It's possible they can have

[16]injuries. It is possible they can have no

[17]injuries.

[18]THE COURT: Okay.

[19]MRS. FISHER: Okay.

? 20 Q. Dr. Guy, when you examine patients whether as a

[21]consulting physician or a treating physician and you give
a

[22]a patient instructions that -- to what they should do

[23]including coming back to see you, how do you follow up on

[24]those instructions to a **[*126]** patient?

[25]A. If it's a life threatening situation, I keep

[2]index cards in my own pockets. I write down every life

[3]threatening situation in my pocket, and I make sure that

[4]the patient gets called back for follow-up, but if it is

[5]not a life threatening situation, I simply give them

[6]advice. They follow through with it, fine. If they don't

[7]follow through with it, I leave it alone.

[8]Q. You don't have any control over whether or not a

[9]patient returns to your office, Dr. Guy, do you?

[10]A. I have no control whatsoever.

[11]Q. You don't go to their house and drag them back

[0]
[12]into your office; do you, Dr. Guy?

[13]A. God forbid, no.

[14]Q. You don't -- you don't, you -- you are not

[15]getting paid for your treatment of Mrs. Iasello dependent

[16]on the outcome of this lawsuit; are you, doctor?

[17]A. Absolutely not. That's against the law. I
a

[18]would lose my license.

[19]Q. In other words, if you treat her and you are
W
d
? 20 entitled to get paid regardless of what happens here?

[21]A. Absolutely, that's the case. That's only a **[*127]**
s

[22]courtesy that I do that I wait for coompensation for my

[23]medical bills is something I do as a convenience for the

[24]patient as opposed to demanding it up front; where as many

[25]doctors do. They will not see you unless you pay them up

[2]front.

[3]Q. And as far as the payment that you received for

[4]testifying today, that had nothing whatsoever to do with

[5]Mrs. Iacello, did it?

[6]A. That's correct.

[7]Q. She was not obligated to compensate you for the

[8]$ 4, 000 that I paid you, right?

[9]A. That's correct. '

[10]THE COURT: You could lose your license if

[11]you had an arrangement where by your fee was

[0]
[12]dependent on the outcome of a case, is that

[13]correct?

[14]THE, WITNESS: That's absolutely right, Your

[15]Honor. And for $ 1, 200, no doctor would risk

[16]that.

[17]Q. Not even for $ 4, 000 right, doctor?

[18]A. Not even for 4, 000.

[19]Q. Not even for $ 4, 000, 000?
W
d
e 20 A. I wouldn't.

[21]MRS. FISHER: I have nothing further,

[22]doctor.

[23]RECROSS EXAMINATION

[24]BY MR. SCAHILL:

[25]Q. Just a few questions, doctor, if **[*128]** I may.

[2]When you saw Mrs. Iasello in December of 93 did

[3]you know at that point that she had a personal injury case

[4]pending?

[5]A. December 93?

[6]Q. Yes.

[7]A. I may have known. I don't know one way or the

[8]other.

[9]Q. Did you definitely when you saw her in January

[10]of 97 you knew that the case was pending, correct?

[11]A. I may have known. I don't recall. Maybe yes or

[0]
[12]maybe no. I am not sure when a patient comes to me I

[13]don't ask them are you here because you have a law suit.

[14]I ask them what is wrong with you. They give me the

[15]history and I examine them and I make my recommendations.

[16]That's it.

[17]Q. Did you ask Mrs. Iasello why she hadn't been to

[18]you in 3 years?

[19]A. She told me. She said she was treating with Dr.
? 20 Striano, and she's been ability lazy and she was afraid of

[21]getting the trigger point injections again and that is

[22]what I recommended to her the first time.

[23]Q. She didn't mention that the case was coming up

[24]for trial and she wanted to see you?

[25]A. Not to my knowledge. **[*129]**
[2]Q. Did you know at that point that you'd be

[3]testifying for her?

[4]A. January of 93 I did not know that the --

[5]Q. 97?

[6]A. At that point I did not know.

[7]Q. When did you realize you'd be testifying for

[8]her?

[9]A. When the attorney asked me my availability for

[10]court.

[11]Q. When was that?

[0]
[12]A. I believe about 2 weeks ago.

[13]Q. Thank you, doctor.

[14]Nothing further, Judge.

[15]MRS. FISHER: I have nothing further.

[16]THE COURT: Okay.

[17]Dr. Guy thank you.

[18]THE WITNESS: Thank you.

[19](Witness excused)

[20]THE COURT: Ladies and gentlemen of the

[21]jury, the attorneys can correct 4-me -if I -.am

[22]wrong, but I don't think we have-any-.other

[23]witnesses today.

[24]..J.. (Off the record discussion)

[25]THE COURT: Ladies and gentlemen of-the
r

[2]jury, at this point in time we will take our

[3]recess.

[4]I would request that you return here

[5]promptly 9:30 on Monday at which time the trial

[6]will resume.

[7]Have a good weekend.

[8](Jury leaving courtroom at 3:30 p.m.)

[9](Case adjourned) **[*130]**
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