DIRECT ONLY

Index No. 17688/90

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX : TRIAL TERM PART 6

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HOWARD McNICHOL and DUANE GOODE,

Plaintiffs,

-against-

NYC TRANSIT AUTHORITY, MABSTOA and JAMES SMITH,

Defendants.

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TRIAL
DIRECT EXAMINATION
DR. ALI GUY

851 Grand Concourse
Bronx, New York 10451
November 6, 1997

Before:

HONORABLE HOWARD R. SILVER,

J.S.C.

Appearances:

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Blase J. Spinozzi,
Sr. Court Reporter

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November 6, 1997

E X C E R P T

(The trial continued. All counsel and Jury present.)

THE COURT: Good afternoon, ladies and gentlemen of the jury.

First, I want to apologize for the delay. What happened was there were certain issues of law presented to the Court today and I had to do that first before we could have any further testimony.

And there was long discussions and arguments and testimony which was taken.

But that has now been resolved and we can continue with the trial.

Also, you remember in my opening charge to you, I said that sometimes we take witnesses out of turn in order to accommodate that witness. This will be one of those times.

You may call your witness.

MR. SAMUELS: Thank you, your Honor.

Plaintiffs call Dr. Ali Guy to the stand.

DR. A L I G U Y, having been called as a witness by and on behalf of the Plaintiffs, having been first duly sworn, testified as follows:

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THE CLERK: Please state your name and business address for the record.

THE WITNESS: My name is Dr. Ali Guy, A L I, G U Y.

My office address is 7 Gramacy Park, New York, New York, 10003.

THE COURT: You may proceed.

MR. SAMUELS: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. SAMUELS:

Q. Good afternoon, Dr. Guy?

A. Good afternoon.

Q. Are you duly licensed to practice medicine?

A. Yes, I am.

Q. When did you receive your medical license?

A. 1985.

Q. Would you briefly tell the Court and jury your medical educational background?

A. My undergraduate training I attended at Queens College; medical school, I went to Dominican Republic. I graduated in June of 1981.

Then I attended three separate residencies. My first residency being in the field of internal medicine at Mount Sinai School of Medicine, Mount Sinai Medical

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Center for a period of eighteen months. Then I did one year of general surgery at Cabrini Medical Center.

Then I did three years of physical medicine and rehabilitation at Mount Sinai School of Medicine, Mount Sinai Medical Center.

I am board certified in the field of physical medicine rehabilitation. Clinical instructor to the residents at Hospital for Joint Diseases, Orthopedic Institute. I teach the residents from NYU Medical Center.

Also the director of the Neuromuscular Equipment Clinic at that hospital. Director of rehab medicine at Maimonides. Also on the staff at Cabrini Medical Center.

Q. Doctor, what does it mean to be board certified?

A. Board certification is the highest degree which you can retain in your level of specialty, the equivalent of a Ph.D. to a non-medical person.

In order to become board certified in my specialty, you have to fulfill the following prerequisites. You have to have at least one to two years of training in a field other than physical medicine and rehabilitation. You must then satisfactorily completed your three-year training program, scored at least 70 percent or higher on the yearly examinations given by the Board.

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Then, once you finished, you must sit and pass an 8-hour written examination.

You must then be in private practice for a period of no less than eighteen months, be sponsored by two other doctors that know your work closely, and they have to vouch that they know your work, and your ethical background. You then fly to the Mayo Clinic in Minnesota where all the research is done, where all the textbooks are written. You then get tested orally by a group of doctors. It is a half day examination. They test you in the field of orthopedics, neurology, interpretations of CAT Scans, MRI's, EMG'S, which stands for electromyography.

They test you on other principles of physical medicine and rehabilitation. If you prove to them that your knowledge is up to par, they pass you and you are given a title of a Diplomate and a fellow of the American Board of Physical Medicine and Rehabilitation.

Q. And did you pass your board certification?

A. Yes, I did.

Q. Were you ever a chief resident during your residency training?

A. Yes, I was.

Q. Would you tell the jury about that?

A. I was the chief resident at one of the rotating

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hospitals affiliated with Mount Sinai Elmhurst Hospital for a period of six months.

Q. Now, are you a clinical instructor at any major teaching hospital?

A. All the hospitals I am affiliated with, they are all teaching hospitals. And in order to be on staff, you have to give time and teach the residents and the house staff.

More specifically, Hospital for Joint Diseases, where I personally teach and train the residents from NYU Medical Center. I help prepare them for the board examinations. I run the neuromuscular equipment clinic with the residents.

We see pediatric patients and adults as well. All kinds of problems, birth defects, spinal cord injuries, polio, cerebral palsy, multiple sclerosis, all kinds of problems that come into our field.

Q. What are the requirements to become a clinical instructor and teach other doctors?

A. One, you have to be board certified; second, the superiors at the hospital, the medical ethics credentials committee have to certify that your knowledge is up to par based on your performance, letters of recommendation, and prior performance in your prior residency.

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Q. Doctor, are you a member of any medical organizations?

A. Yes, I am.

Q. Would you tell the jury what they are?

A. The New York County Medical Society, New York State Medical Society.

Q. Doctor, would you briefly tell us what the field of physical medicine and rehabilitation is all about?

A. It's a medical specialty that was started shortly after World War II by Dr. Howard Rusk, and this field deals with traumatic injuries.

It's similar to orthopedic surgery but yet different. It is similar to neurology but a little bit different.

Q. How does it differ from neurology and orthopedic surgery, doctor?

A. Another good name for my specialty physical medicine rehabilitation is known as physiatry. Not psychiatry. Not psychiatry. But physiatry.

It is nonsurgical orthopedics, or simply orthopedic medicine.

The field deals with muscle problems, nerve problems, boney problems, problems from head to toe, head trauma, neck pain, back pain, arm problems, nerve problems,

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disc herniations, bulges, all kinds of traumatic injuries.

Our job is to restore the patient to optimal level of function prior to their injuries. We use different principles in internal medicine, surgery, orthopedics, neurology, kinesiology--the study of motion--electromyography, and principles to restore function to the optimal level of care prior to their injury.

Q. Doctor, as part of your training, do you receive any formal training in neurology and orthopedics and internal medicine and EMG's as you stated?

A. Yes.

Q. Would you tell us about that?

A. In the field of internal medicine at Mount Sinai, we had a formal rotation through the neurology department for a period of two, two and a half months, and many of the patients that we admitted to the internal medicine department had neurological problems, such as you had patients that were admitted for myocardial infarctions with a stroke, because once you have a heart attack the blood doesn't get pumped properly to the brain, you get a stroke.

So a lot of problems are superimposed.

Also, when I was doing my residency in general surgery we had a lot of trauma, and when you have gunshot wounds and multiple falls, head traumas, falling

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from fifty-foot heights, the whole body gets injured. So neurology again comes into the picture.

The field of physical medicine rehabilitation is a combination of those three.

Q. Does your field of medicine deal with traumatic injuries?

A. Yes, extensively so.

Q. And does your field of medicine, that being physical medicine and rehabilitation, deal with disability and patient evaluations?

A. In fact we are considered the experts in that.

Q. Doctor, are you engaged in the private practice of medicine?

A. I am.

Q. Would you tell the jury what type of practice you currently engage in?

A. Physical medicine and physical rehabilitation, known as physiatry.

Q. Could you define the term of physiatry?

A. Medical specialist that concentrates in the field of specialty of physical medicine and rehabilitation.

Q. Does your common practice in physiatry deal with the area of traumatic injuries?

A. Yes, it does.

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Q. Does your practice treat patients who have had trauma to their neck?

A. Yes.

Q. Does your practice also include the treatment of patients who have had trauma to their back?

A. Yes.

Q. Could you tell the jury, please, approximately how many such patients you have treated in the past?

A. Thousands.

Q. What percentage of your practice is devoted to treating patients?

A. The majority. The majority is devoted to teaching and treating patients.

Q. Did you ever treat patients who have herniated discs in their lower back?

MR. FERGUSON: Objection.

THE COURT: Sustained.

Q. Doctor, are you being compensated today for your time in court?

A. Yes.

Q. And would you tell us how much you are being compensated?

A. For cancelling my patients and my other obligations, I charge three thousand for half a day of

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testimony.

And I also charge a thousand for pre-trial preparation and consultation.

So altogether four thousand.

Q. Doctor, have you ever testified in court before?

A. Yes, many times.

Q. And, doctor, have you ever testified for my law firm before?

A. Yes, I have.

Q. And would you tell the jury when was the last time you testified for my law firm?

A. Two days ago.

Q. Primarily, doctor, who do you testify for?

A. For my patients.

Q. Now, doctor, did there come a time when you became acquainted with Duane Goode?

A. Yes.

Q. And did there come a time, doctor, that you became acquainted with Howard McNichol?

A. Yes.

MR. SAMUELS: And, with the Court's permission, your Honor, may Dr. Guy refer to his notes for the remaining part of his testimony?

THE COURT: Yes, you may refer to your notes

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to refresh your recollection, but don't read from them per se.

THE WITNESS: Yes, your Honor.

MR. SAMUELS: Thank you, your Honor.

THE COURT: Go ahead.

MR. SAMUELS: And just to make the testimony a little clearer, your Honor, I would like to elicit testimony first with regard to Mr. Goode, and then with regard to Mr. McNichol, so it is clear.

THE COURT: Okay.

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

Q. First, doctor, when did you first become acquainted with Mr. Goode and Mr. McNichol?

A. December 19th, 1989.

Q. Who referred them to you?

A. Mr. Rubenstein, the patients' attorney.

Q. Now, when you first saw Duane Goode, did you obtain a history from him?

A. I did.

Q. First, tell me what is the significance of a history to a physician.

A. A history is what guides you as to which path to

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take.

If the patient comes to you complaining to you of abdominal symptoms, you are going to ask a lot about their digestive tract. You are not going to ask about head problems, or neurological symptoms, and vice versa.

So a history guides you as to what systems of the body are involved so you can zoom in, focus and ask additional questions to concentrate and elaborate further as to what happened to the patient with that particular body system.

Q. What was Duane's history when you took it?

A. He was twenty-seven years of age at the time, worked as a plumber, no prior history of any problems to his neck and back.

He was well until 12/16/1989. That's three years prior to coming to see me.

He was the driver of a vehicle. He became involved in a motor vehicle accident.

THE COURT: Three years before?

THE WITNESS: Three days.

THE COURT: I thought you said three years.

THE WITNESS: I'm sorry, three days.

A. (Cont'g) He was the driver of a vehicle. He became involved in a motor vehicle accident. He sustained

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injuries to his neck, his back and his mouth, as well as his anterior chest.

He was treated at Jacobi hospital. X-rays of the injured parts were taken, revealed no fractures.

He then came to see me. He complained to me of neck pain, lower back pain, anterior chest pain. He complained to me of lower back pain radiating down into the buttock area.

MR. FERGUSON: Objection if the doctor is reading from his notes.

THE WITNESS: No, I am referring to my notes.

THE COURT: Just refresh your recollection and then testify.

A. He complained of lower back pain radiating down the lower extremities with numbness, tingling and a burning sensation in his leg.

He also complained of neck pain radiating to his left shoulder, but with no complaint of numbness or tingling in the extremities, and that the pain was made worse by any kind of movement.

MR. SAMUELS: Your Honor, at this time I would like to introduce into evidence as Plaintiff's Exhibits 5 and 6, respectively, your Honor, the certified hospital records from Jacobi

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Hospital for Duane Goode--that's Plaintiff's Exhibit 5. And the certified hospital records from Jacobi Hospital for plaintiff Howard McNichol as Exhibit 6?

THE COURT: Show them to counsel.

MR. FERGUSON: No, objection, your Honor.

I would just like a read back of the last answer that the doctor gave.

THE COURT: Okay, go ahead, read it back.

(The court reporter read back the last question and answer as directed.)

MR. FERGUSON: Thank you, your Honor.

THE WITNESS: Can I make a correction, your Honor?

MR. FERGUSON: Objection.

THE COURT: There is no question on the floor, so you can't make any correction.

Please mark the Jacobi Hospital record for Duane Goode as Plaintiff's 5 in Evidence, and the Jacobi Hospital record for Howard McNichol as Plaintiff's 6 in Evidence.

(The aforesaid documents were respectively marked as Plaintiff's Exhibits 5 and 6 in Evidence.)

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MR. SAMUELS: Your Honor, can those documents be given to the doctor?

THE COURT: Yes.

(Handed to the witness)

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

Q. Doctor, did you want to make a correction after hearing the read back of your testimony?

A. Yes.

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. The patient complained of low back pain radiating down the left lower extremity with numbness and tingling in the leg.

The neck pain traveled to the anterior chest, with no complaint of numbness and tingling in the arms.

Q. Doctor, did Duane Goode come to you three days or three years after the accident for the first time?

A. Three days, 12/16/89.

Q. Thanks, doctor.

Doctor, did you also have his hospital records, which are now in evidence?

A. Yes.

Q. And did you have occasion at that time to examine

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Duane?

A. Yes.

Q. And Duane made subjective complaints to you?

A. Yes, he did.

Q. Would you tell the jury what subjective complaints are?

A. Subjective is what the patient tells a physician.

Q. What is the significance of that?

A. It guides you to what system to go into.

If the patient says my neck hurts, the next question would be, does it travel down the arms, is there any numbness and tingling, because all the nerve roots that go down the arms come off the nerve roots in the neck. So that's the significance of it.

And what makes the pain better, what makes the pain worse. That's additionally further important.

If X-rays were done, what they show, et cetera.

Q. Doctor, tell us what your pertinent examination findings and what they mean in connection with your examination of Duane?

A. My pertinent physical exam findings as of 12/19/1989, that patient appeared in moderate distress from pain and spasm from the expressions on his face.

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His anterior chest revealed minimal diffused tenderness.

MR. FERGUSON: Objection to the doctor reading from his notes.

THE COURT: Yes, read it to yourself to refresh your recollection, then put it down and then testify.

THE WITNESS: Yes, your Honor. I don't want to make a mistake because he will be the first one to crucify me.

MR. FERGUSON: Objection to that statement, your Honor.

THE COURT: Sustained.

MR. FERGUSON: Crucify.

THE COURT: Sustained.

THE WITNESS: Okay.

A. His neck revealed diffused tenderness. There was diffuse spasm. Range of motion was diminished by one third normal range of motion.

His lower back revealed diffused tenderness, diffused severe spasm. Multiple trigger points were present. Range of motion was one half normal range of motion.

Straight leg raising was 65 degrees on the

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left side, 90 degrees on the right side, with complaints of lower back pain.

That indicates nerve root irritation.

Active range of motion and manual muscle power testing was normal for all four extremities.

Sensation was diminished to pinprick and touch in the left calf.

The significance of that is that the left calf is supplied by the nerve roots of the L5 and S1 distribution.

His gait was slow and antalgic.

That means he walked with a limp.

Q. Doctor, what is a spasm?

A. Spasm is defined as a prolonged involuntary contraction of a muscle fiber, which means the patient has absolutely no control over it.

When you touch a normal muscle, it is soft to touch. When a muscle is in spasm, it is hard. Depending on how much spasm there is, it could be as hard as this board when you touch it.

When a muscle goes into spasm, the fibers shorten. You lose the ability to go through full range of motion.

For instance, the neck forward flex, backward

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extension, lateral flexion to the left, to the right, lateral rotation to the left and to the right, and the lower back has the same range of motion, forward, backward, to the side, turning to the left, turning to the right.

If the muscles are in spasm, the fibers shorten and you lose that range of motion.

Q. Is a patient able to fake a spasm?

A. No. That's why it is called an objective test.

Q. You mention trigger point. What is a trigger point?

A. Trigger point is defined as an area of pinpoint tenderness with a palpable nodule.

It indicates scaring within the muscle fibers, and when you touch it feels like there is a little marble inside. And if you take a biopsy, specimen of a trigger point, under a microscope you see evidence of destruction, necrosis and fibrosis, those specific muscle fibers.

Q. Doctor, you are throwing a lot of medical words. What is necrosis and fibrosis?

A. Necrosis means destruction. Fibrosis is when a muscle becomes sloughed off, becomes traumatized it heals with permanent scaring to the muscle fibers, and the end result is a palpable nodule which is called a trigger point.

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Q. And you found trigger points in Duane?

A. Yes.

Q. And you found spasms in Duane when you first examined him?

A. Yes.

Q. You also mentioned straight-leg-raising. What is that?

A. Straight-leg-raising is done as follows.

You put the patient on a table, you hold his foot and ankle in your hands and you try to bring it all the way up as high as possible.

Normally, for a 27 year old healthy individual, it would be at least 90 to 110 degrees.

If the patient cannot go to at least 90 to 110 degrees, it indicates a nerve root problem, because all the nerve roots that go down, all the nerves that go to the legs come off the nerve roots in the lower back.

If I give a little demonstration of anatomy, perhaps people can understand me better.

Q. Doctor, is there anything that would aid you in discussing the anatomy for the jury?

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. I have a model.

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I also have some exhibits there that shows the anatomy of the spine.

Q. Are these exhibits anatomically correct?

A. Yes, they are.

Q. Would they aid you in explaining your findings, your diagnosis, the anatomy and all the medical terminology to the jury?

A. They would.

MR. SAMUELS: Your Honor, can I have these marked for identification purposes?

THE COURT: Yes.

How many do you have?

MR. SAMUELS: I have four charts and one model.

THE COURT: Okay, we will mark the charts Plaintiff's 7, 8, 9, and 10 for Identification, and the model, Plaintiff's 11 for Identification.

MR. SAMUELS: Thank you, Judge.

(The aforesaid exhibits were respectively marked Plaintiff's Exhibits 7, 8, 9, 10 and 11 for Identification.)

THE COURT: You may proceed.

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

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Q. Doctor, is there any particular diagram or model you wish to use first in your explanation to the jury?

A. This one.

Q. Now, doctor, what is a disc?

A. If I can explain it myself, first I will cover the disc and the basic anatomy, if I may, with the Court's permission.

In the spine we have three parts. We have the neck, known as the cervical spine; we have we have the mid back, known as the thoracic spine; the lower back is called the lumbar spine.

The cervical spine has seven vertebrae, the thoracic spine has twelve vertebrae, the lower back has five vertebra. It ends with the tail bone known has the sacrum.

In the cervical spine each level is numbered, C-1 meaning the first cervical vertebra, C-2 meaning the second, C-3 the third, and so an and so fourth.

"T" means thoracic. If I say T-11, T-12 means the space between the 11th and 12th thoracic vertebra.

If I say L-4 L-5, that means the space between the fourth and the fifth lumbar vertebra. If I say L-5 S-1, that means the last vertebra and the first sacral division, the tail bone.

Now, in this spine between each vertebra we

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have a disc which functions as a shock absorber. A disc has two parts.

Outside is a cartilage material called the annulus fibrosus. Inside we have a gelatinous material called a nucleus pulposus, analogous to a jelly doughnut. Outside is cartilage, analogous to the doughy part of the doughnut. Inside a gelatinous material analogous to the jelly part of the material.

In the spine we have three abnormal conditions relating to a disc. The mildest form is a bulge, simply means that the disc is slightly pushed out of it's place. It is not ruptured, it is not broken, may or may not be hitting a major structure behind it.

What's behind it is the spinal cord, the nerve roots on the right and left sides.

In the neck, all the nerves that go down your arms come off from the nerve roots in the neck. The biceps is C-5, C-6, comes from the fibers between the fifth and 6th cervical vertebrae. The forearm, C-6 C-7, and C-7 T-1. The calf is L-5 S-1, so on and so forth.

So if there is lack of sensation in this part of the arm, from anatomy a physician knows what it correlates to, namely, C-6 C-7 distribution. If it is in the biceps area, it is C-5 C-6. Calf area, L-5, S-1, so on

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and so forth.

Now, a second abnormality in a disc is a protrusion. A protrusion is in between a bulge and herniation.

The word herniation means an actual rupture of a disc. The gelatinous material leaks out, it may hit a nerve root, or the spinal cord, which is right behind it. At that time you get shooting pain down the arm, or down the leg, depending where it is. If it is in your neck, it goes down the arm. If it is in the lower back, it goes down the leg, with or without sensory loss, with or without reflex loss.

The fact that you have radiating pain is sufficient enough to indicate a problem at the level of the nerve roots.

Now, when you do a straight-leg-raising test, you stress the nerve roots in your lower back by bringing it all the way up. When these nerve roots get stressed, if they have a disc herniation, naturally the patient cannot go to a full 90 degrees or better. The patient has pain and resistance in ability to go to full range of motion.

Now, I would like to refer to my other diagrams to show the bulge, the protrusion, and the herniation.

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MR. FERGUSON: Objection.

THE COURT: Well, let's talk about this case rather than to give a general picture of the overall anatomy.

THE WITNESS: I'm trying to refer this --

THE COURT: Well, you haven't testified to what you found was the injury caused in this case.

THE WITNESS: First, I'm trying to explain the anatomy, then I am going to go into what I found.

THE COURT: Do it my way.

THE WITNESS: Sure, absolutely.

MR. SAMUELS: Thank you, your Honor.

THE COURT: As Frank Sinatra would say.

THE WITNESS: Sure.

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

Q. Can trauma cause a disc herniation?

A. Trauma is the most common cause of disc herniation in a young healthy individual.

Q. Can trauma, such as a bus hitting a van that is stopped, cause a disc herniation?

A. Absolutely.

MR. FERGUSON: Objection.

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THE COURT: Sustained.

MR. FERGUSON: Move to strike.

THE COURT: What happened in this case, you tell us.

THE WITNESS: In Mr. Duane Goode?

THE COURT: Yes.

Q. Before we get to that, did you yourself perform any diagnostic tests on Duane?

A. Yes, I did.

Q. What type of tests did you perform on Duane?

A. I performed an EMG study of the patient's neck on 1/11/1990, which was normal. I then performed another test of the patient's lower back on 1/4/1990, which was abnormal, indicate a nerve root damage to the left L-5 level.

Q. And, just for the record, what type of test did you perform to Duane's lower back?

A. Electromyography, EMG.

Q. And what exactly are you testing in an EMG?

A. You test to see if there is any muscle or nerve damage.

Q. Tell us what were the results of the EMG to Duane's lower back.

MR. FERGUSON: Objection.

THE COURT: Overruled.

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A. A left sided L-5 radiculopathy.

Q. What is a radiculopathy?

A. The word "radic" comes from the Latin word which means nerve root.

Opothy means any kind of a pathologic condition related to a nerve root. And in this case, an L-5 radiculopathy means nerve root damage at the level of L-5.

Q. Is that painful?

A. Very painful.

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. Yes, it is very painful.

Q. Can you tell the jury why is medical history so important?

MR. FERGUSON: Objection. Asked and answered.

THE COURT: Sustained.

Q. What percentage of your diagnosis is derived from a history?

A. The majority, at least 70 percent.

Q. And tell me what percentage of your diagnosis is derived from your physical examination?

A. Approximately an additional 10 percent.

Q. What percentage of your diagnosis is derived from

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diagnostic testing?

A. The other 20 percent. And that confirms your working history, and your physical exam findings.

Q. On the basis of your history, and your examination, and your diagnostic testing, EMG's that you performed, did you make a tentative diagnosis of what injuries, if any, Duane sustained as a result of his motor vehicle incident of December 16th, 1989?

MR. FERGUSON: Objection as to form.

THE COURT: Overruled.

A. Yes, I did.

Q. Would you tell the jury what was your diagnosis?

A. I found that he has a left sided L-5 radiculopathy, clinically, caused by a disc herniation at that level.

MR. FERGUSON: Objection.

THE COURT: Overruled.

Q. I'm sorry, could you repeat that?

A. Caused by a disc herniation at that level.

And if I could use my diagrams, I can explain better why?

MR. SAMUELS: With the Court's permission?

THE COURT: Yes.

THE WITNESS: May I step down, your Honor?

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THE COURT: Yes, you may.

Q. By the way, doctor, while you are stepping down, can L-5 S-1 radiculopathy caused by a disc herniation be caused by a trauma?

A. The most common cause is by trauma.

Q. Can that L-5 S-1 radiculopathy caused by a disc herniation be the result of an automobile accident where a bus hit a van that was stopped?

A. Yes.

MR. FERGUSON: Objection.

THE COURT: Sustained.

Q. Doctor, you were going to show us something on your diagrams?

A. Yes.

THE COURT: Before you do that, these charts were only for I.D.

MR. SAMUELS: Yes, your Honor.

THE COURT: He hasn't I.D'd them yet, and he can't show it to the jury until it is moved into evidence.

MR. SAMUELS: Would you turn them around, doctor.

Can we approach, Judge?

THE COURT: Yes.

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(There was an off-the-record discussion at the bench among the Court and Counsel at this time.)

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

Q. Doctor, the model you were referring to earlier, is that anatomically correct?

A. Yes, it is.

MR. SAMUELS: Your Honor, I move that model into evidence.

THE COURT: Any objection?

MR. FERGUSON: No objection to the model, your Honor.

THE COURT: All right, please mark the model as Plaintiff's 11 in Evidence.

(Model of the spine marked Plaintiff's Exhibit 11 in Evidence.)

THE COURT: Go ahead, you may proceed.

BY MR. SAMUELS:

Q. Doctor, are those four diagrams that you brought to aid in your explanation to the jury anatomically correct, also?

A. Yes.

Q. Each and every one?

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A. Each and every one.

Q. Was there a particular one that you were going to use at this very moment to aid in your discussion to the jury?

A. Yes.

Q. And just tell me the number is, without showing it to the jury.

A. Number 9.

MR. FERGUSON: Objection, your Honor.

THE COURT: Step up.

What's the objection?

(There was an off-the-record discussion at the bench among the Court and Counsel at this time.)

THE COURT: Overruled.

MR. SAMUELS: Your Honor, I move that into evidence.

THE COURT: Yes, please mark the chart as Plaintiff's 9 in Evidence.

(Diagram marked Plaintiff's Exhibit 9 in Evidence).

A. May I begin?

Q. With the Court's permission.

MR. FERGUSON: Is there a question?

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I didn't hear a question.

THE COURT: Please read the last question.

(The court reporter read back as directed.)

THE COURT: Well, you have to ask a question, then he can refer to the chart.

DIRECT EXAMINATION (Cont'd)

BY MR. SAMUELS:

Q. Could you explain to the jury, using that chart, what a herniated disc is?

A. Yes. In the lower back, right in the spine, between each vertebra we have a disc.

A disc is viewed axially from the side, or axially from the top looking down.

Now I am looking at it axially. This is the spino process. This is what we touch back in the back of my neck or lower back. And if you were to remove this bone, you would see the disc.

This is exactly what you see from an axial view.

Okay, this is the disc. As I indicated to you earlier, a disc outside is cartilage, inside is gelatinous material. The outer fibers is cartilage known as the annulus fibrosus.

So, we have the condition where from pressure

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building up, pressure increasing, it bursts the first few layers of the annulus. A bulge starts this way, and you could see here a bulge beginning to start. Starts to stick out. Progresses. Goes to a protrusion. You see more tears on the outside. You see this inside material sticking out further.

Then you see a complete tear and a full herniation.

Once you have a herniation of this material, there is release of toxins inside the disc, nitric oxide, histamine, and other toxins.

These toxins irritate the surrounding structures. When it is released, what are the structured nerve roots, tendons, ligaments and muscles, that causes pain. Once the nerve root gets involved, injured, you get shooting pain down the legs.

When you have a herniation, it is a permanent injury.

Why?

Because cartilage does not have the ability to repair itself. Muscle does. Bone does. Nerve does, to a degree, but not cartilage. Once it is torn, it is a permanent irreversible damage, and that's why it is a permanent injury.

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MR. FERGUSON: Objection, your Honor.

Move to strike.

THE COURT: Overruled.

A. So that is what a herniation looks like from the side.

May I show another model?

THE COURT: No, that has not been marked.

Q. What number is that, if you need to use it?

A. Number 8.

Q. Is number 8 anatomically correct?

A. Yes, it is.

Q. Will that assist you in further explaining a herniated disc to the jury?

A. Yes.

MR. SAMUELS: Your Honor, I move Plaintiff's Exhibit 8 into Evidence.

MR. FERGUSON: Objection, your Honor.

THE COURT: Overruled. Please mark this chart as Plaintiff's 8 in Evidence.

(Plaintiff's Exhibit 8 marked in Evidence.)

A. Once a disc herniates, it ruptures, the water content filled inside comes out. When the water content comes out, the disc shrivels up like so.

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This is a normal disc and this is a shriveled up disc. Once it herniates, the water comes out, it shrivels, becomes smaller.

Q. What is the medical term for that?

A. Degeneration or desiccation.

This is a disc herniation seen at another view like so. This is the nerve root.

When a disc herniates, what is right behind it is the nerve roots which exit, it hits it, compresses it, and damages it. And once this nerve root gets damaged, what happens you get shooting pain down the legs.

Also, the outer one-third of these annulus fibroses has nerve endings. Once it is stretched, once it is torn, the nerve endings send an impulse to the spinal cord causing a vicious cycle of pain, spasm, pain, spasm, irritation, and that's why it is very painful.

So this is basically herniation.

Q. You analogize that to a jelly doughnut?

A. Yes.

Q. Can you put the jelly back in the doughnut?

A. No.

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. Once the gelatinous material comes out, it sticks

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to the different parts of the spinal cord and the nerve roots. It is a very sticky material. Once it sticks, you can't just remove it. Even by surgery, you could only remove part of it, but you cannot repair a disc completely because it is an open sac, and it remains an open sac unless you do a permanent plugging with a bone graft. And the problem with that is you lose flexibility, and the cure then becomes worse than the actual disease itself.

MR. FERGUSON: Objection, your Honor.

THE COURT: Sustained.

MR. FERGUSON: Move to strike the last portion of that testimony.

THE COURT: Yes, the later portion is stricken.

Q. What about a bulging disc, doctor?

A. Bulging disc.

What would you like to know about a bulging disc?

Q. Can it be repaired or unbulged?

MR. FERGUSON: Objection.

THE COURT: Sustained.

MR. SAMUELS: All right, nothing further on the exhibits at this point.

THE COURT: Put that down.

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Q. Doctor, with regard to Duane, as a result of your diagnosis of an L-5 S-1 radiculopathy caused by a herniated disc --

A. L-5 radiculopathy.

Q. Caused by a herniated disc at L-5 S-1.

A. Yes, or at L-4, L-5.

The nerve root at the L-5 level is damaged.

You can have a disc herniation at L-4 L-5, or L-5 S-1, because the L-5 nerve root is common to both those levels.

Q. Did you prescribe a course of treatment to Duane as a result of your diagnosis?

A. Yes, I did.

Q. What did the treatment consist of?

A. Physical therapy, consisting of hot packs, electrical stimulation, manual message, myofacial release techniques and exercises.

Q. What is myofacial release techniques?

A. A form of a massage technique where you massage the areas where there is scaring and trigger points to try and break up the spasm, to try and break up the trigger points, and to bring back the flexibility to the muscle fibers.

Q. In the beginning, how often did you prescribe

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treatment in the form of physical therapy as you just described to Duane?

A. Mr. Duane Goode had approximately 50 visits in my office from beginning to the end, most of which were for physical therapy.

Q. When did Duane's 50th or last visit to your office commence?

A. His last visit to my office was 8/20/1990.

Q. Did Duane's condition change at all during the course of his physical therapy to your knowledge?

A. Got better, got worse. He would get temporary relief from the therapy, and when the therapy would be stopped, the pain would come back.

That's the natural course of this problem.

Q. Are you familiar with the term exacerbation and remission?

A. Yes.

Q. Can you explain that to the jury?

A. Remissions and exacerbations means it gets better, it gets worse.

When you have a permanent condition like arthritis, you can't cure it, you can treat it. What makes it better? Medication, rest. What makes it worse? Cold weather, stiffness, activity, exposure to humid weather, air

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conditioning. Anything that stresses the joints makes it worse.

Q. By the way, doctor, in your opinion, with a reasonable degree of medical certainty, who is in a better position to comment on Duane's over all condition? You, his treating physician, or a examining physician who just saw him once?

MR. FERGUSON: Objection.

THE COURT: Sustained.

Q. Well, doctor, can you as a physician get a complete picture of Duane's condition from just reviewing one diagnostic study such as an EMG?

MR. FERGUSON: Objection.

THE COURT: Sustained.

Q. After treating Duane for approximately 50 treatments over the course from December through August, did you come to a final diagnosis of Duane's condition?

A. Yes.

Q. Can you tell the jury what was your final diagnosis?

A. Internal derangement of the cervical and lumbar spine, traumatic myofacial pain syndrome, a left L-5 radiculopathy, and a clinical disc herniation at the level of L-5.

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Q. What is internal derangement?

A. When you have spasm and you have malalignment of the structures of that area, whether it is from spasm, whether it is from vertebra moving away from another, whether it is from a disc going out of place or combination of all of the above.

Q. What is traumatic myofacial pain syndrome?

A. Traumatic is a traumatically induced condition from trauma where you have two or more trigger points in two or more areas of the body.

This patient had it in his upper back, middle back and lower back, meeting the criteria for traumatic myofibrositis.

It is a very painful condition, and when you have that the muscles surrounding the neck, upper back and lower back, that whole support to the vertebra, the muscles go into spasm.

They become weakened. When they become weakened, they don't fulfill their job in holding the spine erect. It puts more stress on the other structures, tendons, ligaments and the discs, adding insult to injury.

Q. After you came to your final diagnosis after treating Duane for 50 treatments over the course of that eight months, was there any indication that Duane would need

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further treatment?

A. I'm sorry?

Q. Was there any indication that Duane would need further treatment?

A. Absolutely. He has a permanent condition.

Q. What type of treatment did you deem necessary for Duane?

A. To continue with periodic medical supervision and periodic physical therapy on as needed basis, periodic medication as needed, and if nothing worked, at the end, finally surgery is the last resort.

MR. FERGUSON: Objection. Move to strike.

THE COURT: Sustained as to surgery.

MR. SAMUELS: May we approach, Judge?

THE COURT: Yes.

(There was an off-the-record discussion at the bench among the Court and Counsel at this time.)

THE COURT: Sustained.

MR. SAMUELS: Thank you, Judge.

BY MR. SAMUELS:

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that Duane sustained in the motor vehicle incident of December 16

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-- withdrawn.

Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that Duane sustained were causally related to his motor vehicle incident of December 16th, 1989?

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. Yes, I do have an opinion.

Q. And what is your opinion?

A. It was caused by the accident of 12/16/1989, for a very good reason.

Q. What is that reason, doctor?

A. Based on the EMG findings, the EMG not only diagnosticates--gives you a diagnosis--also, tells you how long that pathological condition was present.

There was no fibrillation potentials found on the patient's --

MR. FERGUSON: Objection.

THE COURT: Don't show that. That is not in evidence.

A. There was no fibrillation found on the abnormality.

If there were, that means that the condition was present for at least one year or longer, and that would

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increase polyphasics to thirty percent or more.

MR. FERGUSON: Objection.

Move to strike. Speculative.

THE COURT: I will allow it. Go ahead.

A. Polyphasics are certain abnormalities you find in your EMG testing. Indicates there is a lot of dips and valleys on your tracings.

If there is increase the abnormality, along with fibrillation potentials, it means the problems was present for one year or longer.

There was none detected. That means the condition was an acute or recent injury.

When you put the whole condition together, it indicates to a disc herniation caused of a recent origin, less than one year.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that Duane sustained in that motor vehicle incident of December 16th, 1989 are permanent?

A. Yes, they are permanent.

Q. And what is the basis for your opinion?

A. As I indicated to you earlier, as I indicated earlier a disc herniation is cartilage on the outside. Cartilage does not have the ability to repair itself. Once

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it is torn, that's it, it can't repair itself.

So as a result, the disc starts to shrivel up. As a result you have osteophytes, or spuring that start to form, causing rapid traumatic arthritis, adding insult to injury.

And it is a permanent progressive condition. It will never get better. That pain --

MR. FERGUSON: Objection. Move to strike.

THE COURT: Overruled.

A. The pain may get better, but the condition itself is permanent.

It is analogous to arthritis. The pain has good days, bad days. The condition is permanent, no one professes they cure arthritis. You can treat it.

Same with a herniated disc. You can treat it, but you can't cure it.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injury that Duane sustained in that motor vehicle incident of December 16th, 1989 are capable of causing him pain?

A. Yes, it is a very painful condition, because you have a nerve root damage.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that

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Duane sustained in that motor vehicle incident of December 16th, 1989, caused him any limitation of movement?

A. Yes, they do.

Q. And would you explain the basis for your opinion?

A. When you have a disc herniation sticking out in the spine like so, you are hitting a nerve root. When you bend backwards, this interferes with the normal flexibility of the spine.

When you go backwards, as the condition by which you put the most stress on the disc and the nerve roots, so backward extension causes increased pain and symptoms, as well as the straight-leg-raising test.

And, also, any kind of prolonged sitting, or standing, or lifting any heavy weights aggravates that disc condition.

Q. Doctor, I would like you to assume there was testimony by Duane that he was not employed on December 16th, 1989. That he was -- that he did testify he was employed in November of 1989, and had been employed for some period before as a plumber.

And what I would like to ask you, doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that Duane sustained in this motor vehicle incident of December 16th, 1989,

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prevented him from performing his usual activities as a plumber?

A. Yes.

MR. FERGUSON: Objection.

THE COURT: Overruled.

Q. And what is the basis for your opinion?

A. Well, I personally told him he should not go back to doing any kind of heavy-duty work, especially plumbing.

I have done plumbing myself. My father is a plumber --

MR. FERGUSON: Objection. Move to strike.

THE COURT: Sustained as to what your father is, or what you do as a plumber.

A. Any kind of heavy lifting aggravates a spinal condition such as this.

So you have to avoid heavy lifting, prolonged standing, pushing or pulling any heavy objects.

Q. Now, doctor, I would like to direct your attention to Howard McNichol.

A. You left me these things here. What should I do with these?

THE COURT: Just leave them there. We will take care of them.

You may proceed.

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Q. Did you take a history from Howard?

A. Yes, I did.

Q. And what was Howard's history?

A. Thirty-eight years of age. No significant past medical problems or injuries.

Was a passenger on 12/16/89 when he became involved in a motor vehicle accident. Sustained injuries to his neck and back.

Also was treated at Jacobi Hospital. He complained of neck pain with radiation to his left shoulder, and to his head. He complained of lower back pain with radiation to the bilateral buttock area, L-5 S-1 distribution.

Had no complaint of numbness or tingling in the extremities.

Q. Did you examine Howard at that time?

A. Yes, I did.

Q. Did Howard make any complaints to you?

A. I just told you the complaints he made to me.

Q. I'm sorry.

Late in the day, I apologize.

Tell us what your pertinent examination and findings with regard to Howard were at that time?

A. His neck revealed diffused tenderness, severe

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spasm.

Range of motion was only two-thirds normal. His lower back, upper back, tender with diffused spasm. Multiple trigger points present.

Range of motion was one-half normal extension--that's backward bending.

Straight-leg-raising was 75 degrees with bilateral lower back pain. Sensation was diminished to pinprick and touch left forearm.

Reflexes were normal.

His gait was slow and antalgic.

Antalgic means a limp.

Q. Did you perform any diagnostic tests on Howard?

A. I did.

Q. Would you tell us, doctor, which tests, if any, you performed on Howard?

A. On 1/14/1990, EMG studies of the lower extremities were performed. They were normal.

MR. FERGUSON: Objection.

Is he reading from a document?

THE COURT: Yes, please, just read it to yourself, refresh your recollection, put it down, and then testify.

A. On 1/11/90 he had EMG studies of the upper

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extremities and neck, abnormal, suggestive of a left C-5 C-6 cervical radiculopathy.

Q. Now, doctor, on the basis of your history and examination of Howard, and the EMG study performed on Howard that revealed a C-5 C-6 radiculopathy, did you make a tentative diagnosis of what injuries, if any, Howard sustained in this incident of December 16, 1989?

MR. FERGUSON: Objection as to form.

THE COURT: Rephrase the question.

Q. Doctor, did you make a tentative diagnosis of what injuries, if any, Howard sustained in this motor vehicle incident of December 16th, 1989 as a result of the history you obtained, the examination you performed, and the diagnostic tests that you performed?

MR. FERGUSON: Same objection, your Honor.

THE COURT: Overruled.

A. Yes.

Internal derangement of the cervical lumbar spine, cervical radiculopathy, rule out cervical and/or lumbar disc herniations.

Q. Did you then, doctor, prescribe any course of treatment for Howard as a result of your tentative diagnosis?

A. Yes. Same therapy, same modalities.

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Q. What is a modality?

A. Heat, electrical stimulation, therapeutic exercise.

Q. And would you tell the jury how many times you treated Howard as a result of this incident?

A. Approximately 25 times.

Q. Did Howard's condition change during this time, if at all?

MR. FERGUSON: Objection.

THE COURT: Overruled.

A. Yes, his condition improved while he was getting the therapy temporarily. And when he stopped this therapy, it would get worse.

He would have remissions and exacerbations, as the other patient.

Q. Doctor, do your records reflect the last date that you treated Howard for the injuries he sustained in the December 16th, 1989 incident?

A. 5/7/1990.

Q. After treating Howard approximately 25 times from December up until May, did you then come to a final diagnosis of Howard's condition?

A. Yes.

Q. And would you tell the jury what was your final

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diagnosis?

A. A clinical lumbar disc herniation, cervical radiculopathy, traumatic fibromyositis, internal derangement of the cervical and lumbar spine.

Q. What was the basis of the final diagnosis?

A. Which one?

Q. All of them.

A. All of them, based on the history, the physical exam findings, and the cervical spine, based on the EMG findings.

Q. Was there any indication that Howard needed further treatment after you last saw him in May of 1990?

A. Yes.

Q. And what was that?

A. He still needed continued periodic medical supervision and still required periodic physical therapy on an "as needed" basis.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether the injuries sustained by Howard are causally related to the motor vehicle incident of December 16th, 1989?

A. Yes.

Q. What is the basis of that opinion?

A. Yes, they are.

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Q. What is the basis of the opinion?

A. Based on the history, the response to the rehabilitation treatment program, based on the deficits found before therapy started and after therapy was given, and based on the EMG findings performed on 1/11/1990.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries sustained by Howard in this motor vehicle incident of December 16, 1989 are permanent?

A. Yes. My opinion is that they are permanent.

Q. What is your opinion based on?

A. Based on the history, the clinical exam findings, and the EMG abnormalities.

Q. Do you have an opinion, doctor, with a reasonable degree of medical certainty as to whether the injuries that Howard sustained in this motor vehicle incident are capable of causing him pain?

A. Yes.

Q. Would you tell us your opinion?

A. Muscle spasm and trigger points and nerve damage definitely cause pain, and he has all of them, as well as clinical disc herniation.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether the injuries that

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Howard sustained in the December 16th, 1989 incident are capable of causing him any limitation of movement?

A. Yes.

Q. And what is your opinion?

A. Yes, they do cause limitation of movement.

Q. And what is that based on?

A. Based again on the history, the clinical findings, the EMG findings, my clinical impression of a herniated disc in the lumbar region.

Q. Doctor, do you have a prognosis with regard to Howard?

A. Yes.

Q. And what is your prognosis?

A. Prognosis, meaning future outcome, he is left with a permanent injury. He is going to have good days and bad days. He can work, very light duty work, cannot do any heavy lifting work.

Q. Doctor, do you have a prognosis as you sit here today with regard to Duane?

A. Same prognosis.

Q. What is that?

A. He has a permanent injury.

He is going to have good and bad days, and he is left also with a permanent injury.

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MR. SAMUELS: Thank you, doctor.

I have nothing further.

THE COURT: Step up.

(There was an off-the-record discussion at the bench among the Court and Counsel at this time.)

THE COURT: Okay, you may cross examine.

END OF THE EXCERPT

THIS IS TO CERTIFY THAT THE FOREGOING IS A TRUE AND ACCURATE TRANSCRIPTION OF THE ORIGINAL STENOGRAPHIC NOTES.

BLASE J. SPINOZZI
Senior Court Reporter

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