2000 WL 35725226 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Marek SZPAKOWSKI and Agnes Szpakowski,
v.
SHELBY REALTY, LLC, et al.

No. 2000-123412.
2000.

(Transcript of Ali Guy, M.D.)

Case Type: Labor & Employment >> Work Place Injury
Jurisdiction: New York County, New York
Name of Expert: AliGuy, M.D.
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine
Area of Expertise: Health Care-Physicians & Health Professionals >> Internist

Representing: Plaintiff

A L I GUY, M. D., giving his business address as 7 Gramercy Park, New York, New York, 10007, called as a witness on behalf of the Plaintiff, having first been duly sworn, was examined and testified as follows:

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. KELNER:

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

A Yes, sir, I am.

Q Dr. Guy, could you trace your career for us and explain what you do and what you have done?

A Yes. My undergraduate, I went to Queens College, Flushing. New York. Medical Bchool, I graduated from University of Northeastern Dominican Republic, in Spanish is pronounced, Universidad North Estanda.

I started my first residency at Mt. Sinai School of Medicine in the field of internal medicine, for a period of 18 months. Then I did one year of general surgery at Cabrini Medical Center.

Then I completed a three-year residency training program at Mt. Sinai School of Medicine, Mt. Sinai Medical Center in the field of physical medicine and rehabilitation.

I'm board certified in the field of physical medicine and rehabilitation.

Q Just one second, what is physical medicine and rehabilitation?

Is that a specific specialty in medicine?

A Yes.

Q Tell us what -- is that also called physiatry?

A Yes, sir.

Q And tell us, what is that area of practice?

A It's a medical specialty that was founded shortly after World War Two by Dr. Howard Rusk, namely, the Rusk Insitute at NYU is named after Dr. Howard Rusk.

It deals with traumatic injury to the body, covering the whole body from head to toe. It deals with fractures, deals with neck problems, back problems, joint problems, orthopedic problems, neurological problems, cardiac problems, pulmonary, rehabilitation problems.

It deals with disability and impairment evaluations. It deals with vocational rehabilitation, which means a patient that is disabled to find --

Q There is some water up there, if you need it, Doctor.

A Thank you.

-- to determine the extent of the patient's disabilities, and to see if this patient can be a candidate to go back on the gainful work force, and if so, what capacity. That's called vocational rehabilitation.

It's very similar to orthopedics and neurology. The difference is a physiatrist concentrates on nonsurgical orthopedic problems, namely, problems that deal with the bones, the muscular, the nervous system, and we try to avoid surgery, if possible.

However, it differs, how it differs from neurology neurology concentrates on diseases of the central nervous system, such as Lou Gehrig's disease, multiple sclerosis, Parkinson's disease.

A physiatrist concentrates on the diseases of the spinal cord and the peripheral nervous system. And then there's a degree of overlap between the two specialties, and we refer -- cross-refer patients back and forth to another.

That's basically what a physiatrist is.

THE COURT: Where -- excuse me.

MR. KELNER: I'm sorry.

THE COURT: Would it be fair to say that a substantial portion of your practice is devoted to pain management?

THE WITNESS That's a portion of it. Not the whole entire thing, Judge, it's part of it.

A Yes, it also deals with pain management, as his Honor explained, yes.

Q Continue, please, Doctor, telling us what you've done in your career?

A After i finished my residency in the field of physical medicine rehabilitation, I started private practice, 1988. Thereafter I became the director of the department of rehab medicine at Maimonides Medical Center in Brooklyn, where I was there from 1997 to July of 2002 approximately five years.

Q When you say you were director of psychiatry at Maimonides, does that mean you were head of the department of physiatry at Maimonides Hcspital?

A Yes.

Q Okay. Continue, please?

A Where my duties were to be in charge of all the inpatient, outpatient rehab services. I had approximately 35 therapists altogether, about 31 other doctors in my specialty.

My job was to supervise their work, be in charge of quality assurance, make sure that they did the work according to the standard of medical care, and if they stepped out of line, to educate them and discipline where it was medically and clinically indicated.

Also, I rendered consultations to other doctors in my hospital, rehab consults, disability and impairment consultations.

Also taught the residents in the orthopedics department, preparing them for the boards under the rehab section questions.

I also gave lectures to the entire house staff, that is, the internal medicine.residents, the, again, surgical resident, the physical therapy students, the physician assistant students, so on and so forth.

Also, I've been the director of the neuromuscular clinic at NYU Hospital for Joint Disease since 1990, to the present. That's about 14 years. Where my duties are to see the patients assigned to the clinic. These are children that are born with birth defects, born with polio, with muscular dystrophy, born with congenital abnormalities, kind of spinal cord deformities.

My job is to see these patients, treat them, order whatever equipment that is medically indicated for them and teach the residents that are assigned on my clinic from NYU and to prepare them for the boards, part one and part two.

Q When you say teach the residents, do you mean NYU medical students are taught by you in this area? is that part your duty?

A Not medical students, doctors in residency training.

Q But they are connected with NYU Medical Center, in other words, they're doing their residency there and you are the person that is teaching them in this field?

A Yes, sir.

Q Okay. And have you also maintained a private practice, Doctor?

A Yes.

Q since, you sid, 1988?

A Yes.

Q And, Doctor, since 1988, have you seen a number of patients that have had spinal fractures?

A Yes, thousands.

Q Thousands?

A Yes.

Q And, Doctor, at some time did my wife, Gail Kelner, who --

MR. KELNER: Your Honor.

THE COURT: Yes, Plaintiff's co-counsel, as you may have noticed, is not here this morning, she's attending to family matters.

Q And so, did Gail Kelner, from Kelner and Kelner, refer Marek Szpakowski to you?

A Yes.

Q Were you told at the time he did not have a private doctor, that he was being treated at the clinic at Bellevue Hospital?

A Yes, that is correct.

Q Doctor, were you given the hospital records, excuse me, from Bellevue Hospital, for Marek Szpakowski?

A Yes, sir, I was.

Q What I would like you to do -- by the way, with regards to board certification, you indicated that you were board certified in psychiatry or physical medicine?

A Yes, sir.

Q Tell us what that means.

A To be -- to receive board certification in my specialty you have to complete the following prerequisites, you have to have training in a field other than physical medicine and rehabilitation, preferably internal medicine and/or general surgery. That was met.

You have to satisfactorily complete a three-year residency training program in physical medicine and rehabilitation. You have to pass the monthly examinations given by your preceptors. You have to pase the yearly exams given by the department.

And once you've finished all that and you graduate from your program, you then have to take your boards part one, which is about an 8 to a 10-hour written examination, which covers everything you learned from the beginning to the present, which covers principles of internal medicine, cardiac, pulmonary rehabilitation, orthopedic neurclogical rehabilitation, interpretations of x-rays, CAT scans, EMGs, and once you pass that, then you have to prepare for your boards, part two.

You have to be in private practice for at least 18 months before you can take your boards, part two. You have to be sponsored by two other doctors that are already board certified, preferably your former teachers who know completely about your work.

And once you are in private practice for 18 months or longer, you fly to the Mayo Clinic in Minnesota, where all the textbooks research is done by the elite doctors in this specialty, and you get tested on your boards part two.

It is an oral examination. It is approximately a half a day. You get tested on principles of orthopedics, neurology, again, interpretations of x-rays, CAT scans, MRIs, EMGs, and other principles of physical medicine and rehabilitation.

And if you prove to these doctors that your knowledge is up to par, they pass you and then the American Board of Physical Medicine, Rehabilitation reviews your credentials from college to medical school to residency, your boards part one, boards part two, they review everything, and if it meets the requirements, they give you the -- they pass you and give you a title of diplomate of the American Board of Physical Medicine and Rehabilitation.

That was achieved in May of 1989.

Q Thank you.

THE COURT: Did you say you take the test at the Mayo Clinic?

THE WITNESS: Yes, yes, your Honor.

THE COURT: Not the Rusk Institute?

THE WITNESS: No, Judge, not the Rusk Institute. No.

MR. KELNER: They export them, your Honor.

A Yes.

Q Did you review the hospital record of Marek Szpakowski, when he became your patient?

A Yes, sir, I did

Q And feel free to refer to any of the exhibits that you have up there and --

MR. KELNER: Your Honor, I think Dr. Guy also has marked his own copy of the hospital record, which is an exact copy.

Q With the Court's permission, if you'd like to look at that as well, to save time, please feel free to do so.

I want you to tell us what occurred with Marek Szpakowski in the hospital, to explain to the court and jury, exactly what happened to him.

A I can do it two ways.

Before I begin, they probably need a little bit of a review of anatomy, so when I mention some terminology, they would know what I'm talking about.

Q Okay.

A I can do it before or after.

Q Why don't you use the exhibits.

MR. KELNER: Your Honor, we have marked, in the interest of time, a skeleton, which I believe Dr. Guy will testify is a good model of a human skeleton.

THE COURT: Let's wait on him to testify.

MR. KELNER: Okay.

And some charts

THE COURT: Let's go through the exhibits for the record. What are they marked as?

MR. KELNER: The -- I believe that number -- Exhibit Number 11 were two charts.

THE OFFICER: 12A an 12B.

MR. KELNER: 12A and 12B were anatomical charts.

13 is a set of vertebrae, wich are present up with the doctor.

14 is the skeleton.

And 15 would be Dr. Guy's new films that were taken, which have not been marked in evidence, but have been marked for identification, which are films that we discussed with your Honor, which were taken this past summer.

THE COURT: So 12 through 14 are in evidence?

MR. KELNER: They are not in evidence.

THE COURT: They're all marked for identification?

MR. KELNER: They're all marked for identification.

Q Dr. Guy, when you feel free, and with the Court's permission to step off the witness stand, would you demonstrate to this jury and court the injuries to Marek Szpakowski?

THE WITNESS: May I, Judge?

THE COURT: Yes.

THE WITNESS: which may I begin, Judge?

THE COURT: Yes.

A This is a model of the human skeleton. We have the skull, we have the spine.

THE COURT: Whoa, whoa.

Just for identification you are marking it?

MR. KELNER: The answer is yes, your Honor, I have marked it for identification.

Q Doctor, is this I'11 use the word in quotes, an anatomically correct model of a human skeleton?

A Yes, sir, it is.

Q Would it facilitate your explanation to this Court and jury the anatomy that is involved in this case?

A Yes, sir, it would.

MR. KELNER: Your Honor, I offer this in evidence.

THE COURT: All right. We'1*l* mark it in evidence as Exhibit 14.

(Received and marked Plaintiffs' Exhibit 14 in evidence.)

Q Go ahead, Doctor.

A So, as I was explaining, we're going to be concentrating on the spine, since in this case most of the injuries are to the spine. This is a model of the spine. This spine will have three segments.

Next is called the cervical spine. There are 7 vertebra in the cervical spine. And then we have the thoracic spine. There are 12 vertebra in the thoracic spine. Then we have the lower back, which is called the lumbar spine.

The lumbar spine ends with a tailbone called the sacrum, what we are sitting on. We're sitting on our sacrurms.

Each vertebrae is numbered and named according to its unique location.

The words C for cervical, means the neck, suffice if I refer to the term C-6, 6 means the sixth cervical vertebra. If I refer to the term C-7, it means the seventh cervical vertebra. Therefore, if I refer to T12, T12 means the 12th thoracic vertebra. And if I say L-4, L means the lumbar, which is the fourth vertebra, so on and so forth.

Now, what we're looking at here, this is the back of the spine. This is the opinous process. If you take your fingers, touch the back of your neck, you're touching the spinous process. That is the back and this is the front.

Between each vertebra we have a disk. This is --

THE COURT: Counsel.

MR. KELNER; Let the record indicate that the doctor is using Exhibit 13 for identification.

MR. KELNER: Your Honor, would you prefer I mark these in evidence?

THE COURT: It's up to you. It's up to you.

MR. KELNER: All right, let's mark these into evidence.

THE COURT: Hearing no objection, we'll mark.

MR. KLEIN: I have an objection.

THE COURT: Oh. Well, so far, sustained.

Q Are those vertebra a fair and accurate representations of the human vertebra and will that assist you in your explanation of the anatomy to this jury?

A Yes, sir.

THE COURT: Are they anatomically correct?

THE WITNESS Yes, Judge.

THE COURT: Okay. Overruled.

Mark them in evidence.

(Received and marked Plaintiffs' Exhibit 13 in evidence.)

A May I begin?

Q Yes.

A This is a model of the human spine. These are the vertebra. This is the disk. A disk is analogous to a jelly donut. It has two portions. Outside we have the fibrous cartilage material called the annulus fibrosis.

There are approximately 100 rings of this fibrocartilage material, right in the center is a gelatinous water-filled component called the nucleus pulposus. This is analogous to the jelly portion of a jelly donut. And the outer ring is analogous to the doughy portion of a jelly donut.

Right inside the vertebra, right inside here, we have the spinal canal, where the spinal cord travels all the way from the brain all the way down to the lower back. It ends somreplace between the second lumbar vertebra, and it continues with branches of nerve roots called the corda eguina. And all the nerves that go down to our legs, they originate from the nerve roots in the lower back.

So, each nerve root behind each level corresponds to a specific portion of the leg. For example, the nerves that go to your calf, they come from the L-4, 4-5 nerve root or, again, they branch off.

Each nerve root has two branches. One is motor, for movement, one is for sensation, so you can feel.

There are three abnormal conditions to a disk.

Now, if I may be allowed to use these charts.

Q That is Number 11?

Are those charts anatomically correct charts portraying the human anatomy that would be involved?

THE COURT: Those are 12, aren't they?

MR. KELNER: I'm sorry, is that 12? My apologies.

THE COURT: A and B, right?

THE OFFICER: Right.

Q Are those anatomically correct charts of the appropriate anatomy we're dealing with and would that help you facilitate your explanation?

A Yes, sir.

MR. KLEIN: Your Honor, may we move around?

THE COURT: Yes, of course.

MR. KELNER: I offer them in evidence, your Honor.

THE COURT: Okay. Mark 12A and 12B in evidence.

(Received and marked Plaintiffs' Exhibits 12A and 12B in evidence.)

Q Would you like an easel?

A If you have one.

Q We do?

THE COURT: We have one.

MR. KELNER: This is a very well-equipped courtroom

THE OFFICER: This is State Supreme Court.

Q What we're looking at here is a portion of the disk in two views. This is called the axial view.

What we're looking at here is as follows. There is the disk, right here. This is the spinal canal, right here. This is the spinous process, right here. These are the transverse processes, right here.

This is the axial view. This is the sagittal view.

What you're looking at here is the side view, like so. Okay?

We have -- these are the disks, the jelly portion, the fibrous cartilage portion. There are approximately 100 rings of this fibrocartilage material.

There are three abnormal conditions on a disk. The first and mildest form is a bulge. Just what it says, it protrudes out, you have a partial tear of the annulus fibrosis and the disk begins to bulge out.

Once all these fibers are completely torn, we have a full herniation. Definition of a herniation is when you have a complete tear of the annulus fibrosis where the disk material leaks out and passes the boundaries of a disk, which is called a herniation.

To show you a model here, this is a normal, normal, normal. There's a bulge. It is a partial tear. It is a partial tear. Partial tear. Partial tear.

This is a herniation. Complete tear. Where the disk material has leaked out and passed the disk margin. That's the herniation. Normal herniation.

And once a disk completely tears or herniates, this is what happens inside of a disk. The outer one-third of a disk has nerve fibers called nociceptors. These nociceptors, they come off branches in the actual nerve root and they supply sensation to the outer one-third of a disk.

Once you have a complete tear of a disk or a disk herniation, you get a microscopic bleed in the perimeter. You irritate and inflame these nociceptors, these nerve fibers that are on the outer one-third of a disk.

Furthermore, once a disk completely tears, you have the release of certain chemicals which are found right inside the disk, which causes irritation and inflammation on the surrounding structures, specially the nerve roots, the muscles, the tendons and the ligaments.

Some of these chemicals are phospholipase, A2, prostaglandin, nitric oxid, metalloproteinases, you have bradykrenin, you have kalikrenin, so on and so forth.

So, once a disk herniates, the water contents leaks out. Once the water contents leaks out, the disk undergoes a rapid degeneration process.

The height of the disk, which is filled with water, drops, the disk becomes disintegrated, shriveled up or desiccated. Then you have the rapid formation of osteophvtes.

This is what an osteophyte is. The bony spurs that form around the vertebralis. These are osteophytes. These are osteophytes. These are osteophytes.

These osteophytes form to stabilize the injured area. As these osteophyte form, the condition is progressive.

There is no cure for disk herniation. Why? Fibrocartilage, once it tears, you can not suture this back together, you can not glue this back together, even with surgery, you can not plug this hole. All they do is, they remove the portion of the disk material which is sticking out, and the pressure on the nerve root is released and they hope that it works. Sometimes it does, sometimes it doesn't.

So, a disk herniation is a permanent condition and it's progressive and over time this is what happens to the disk, it becomes more and more shriveled up, and as the disk continues to become more desiccated, more oateophytes form until a disk portion is completely gone.

And remember, the function of a disk is to serve as a shock absorber. As we walk, as we fall from heights, the disk gives us the cushion so vertebra won't hit on each other and break.

And also, it is this water filled material inside the disk that gives us our abilities to move, to bend forward, backwards, flexion, backwards extension, left and right, lateral bending, left and right lateral rotation. If we didn't have this, we could not perform there range of motions.

So a disk is very important.

Now, in this patient, the patient had two types of fracture. We're going to be talking about compression practices. I'm going to be talking about a burst fracture.

First I'm going to define now what a compression fracture is. A compression fracture happens when the front portion of the vertebra is broken. Fracture means a break in the bone. So, the front portion of the vertebra is broken. It usually occurs from a drop in height and axial loadin. That's what a compression fracture is.

Then we have what is called a burst fracture. A burst fracture is one of the most devastating types of fractures in the skeleton, because the pieces burst, they fly all over the place. It's like an explosive. All the pieces move all over the place.

A great example is, picture a brown bag filled with air, you blow it up, close the top, make it explode, and it bursts. All the pieces go into different places. Why it's dangerous, because the pieces can also shoct backwards, hit the spinal cord or hit the nerve roots and can cause paralvsis, weakness, so on and so forth. That's why it is a very, very devastating type of an injury.

So, I've basically covered the anatomy, I'm ready to read from the medical records.

Q Okay, please feel free to resume your seat, Doctor, and explain to us what the medical records show.

A The first record I have ir. front of me in the operation record of the patient versus the preoperative diagnosis is an L-4 burst fracture. L-4 is the fourth lumbar vertebra and a burst fracture is exactly the way I just explained earlier, the pieces are all broken into spicules. And we have x-rays and CAT scans, which we'll show you later.

The patient was also found to have a small displaced C-7 fracture. C-7 is in the neck. So the seventh vertebra of the neck was broken.

Then we have --

Q What is displacement, by the way?

A The pieces moved. When you have a fracture, the fracture is either stable, the pieces stick together. Displaced mean the pieces move away form each other. So when the pieces move away from each other, it is more dangerous because a piece is sharp, bone is sharp, it can cut into the spinal cord and the neck, it can cut into a nerve root and cause neurological compromise.

Q So just this one fracture in the neck?

A Yes, that's correct.

Q Were there entries, by the way, that said either suspicious fracture or questionable fracture with regards to the neck?

A In some areas, yes, sir.

Q Okay.

A That's correct.

Q They characterized it. in various places in the hospital record, correct?

A That is correct.

Q Okay. Go ahead.

A Also, it says the patient's significant injury was the L-4, we had an 80 percent canal compromise.

Q Okay, Just was the most serious injury he had, by far, the burst fracture of L-4?

A Yes. And --

Q Tell us in detail what that meant, what you just indicated, Doctor?

A Can I have my models back again, please?

Q Sure.

THE OFFICER: I'11 get them. All the subpoenaed records were given to him?

MR. KELNER: Yes.

THE OFFICER: Do you want me to take this out of your way?

MR. KELNER: That would be fine.

A May I Continue?

Q Please.

A The L-4 vertebra -- this is L-5, this is L-4. This is the spinal canal where this yellow, the spinal cord, goes through.

So, he had an 80 percent compromise of the canal, and the pieces were retropulsed.

“Retropulsion means it shot backwards into the canal, and it occluded, blocked off BO percent of the canal.

Fifty percent of the canal blockage is bad enough. Tc have 80 percent of the canal is very bad, 90 percent, you have permanent irreversible neurological damage.

He came this close to causing a permanent irreversible neurological compromise.

Q When you say, “neurological compromise,” do you mean “paralysis”?

A Paralysis.

Q Ninety percent, thhe person is paralyzed?

A Yes.

Mr. Szpakowski had 80 percent. He was not paralyzed, but -- but he had a marked weakness in his right leg.

Q What was that from?

A From the L-4 compression shooting backwards, compromising the canal.

Q Okay.

A To continue, the patient also sustained spinal compression fractures at the L-1, L-2, L-4 vertebra.

We already mentioned what a compression fracture is.

The fourth one was a burst fracture.

The patient underwent L-4 vertebrectomy.

Q Just one second before we get to that.

Did he also have a fracture in the thoracic spine as well?

A Yes, T-12.

Q So, there was the fracture in the cervical spine - -

A T-12.

Q -- The fracture at T-12, and then three more fractures in the lumbar spine?

A L-1, L-2, L-4.

Q Thank you. Go ahead, Doctor.

A He underwent a medical term called “vertebrectomy,” which means part of the vertebra, and the fourth one, was removed.

The vertebra is a very, very sharp object. If it's broken, and the pieces are jagged or all over the place, you have to stabilize it.

If you can't stabilize it, you have to remove the piece that is the most dangerous, the one that is sharp and jagged.

So, approximately 30 percent of the vertebra was surgically removed, and then the spine was stabilized by long screws, metal plates and spinal fixators which attached the bone, the screws to the level above it and below it, for additional safety and stability.

Q Doctor, do you have some x-rays that would demonstrate that to the jury?

MR. KELNER: And I'd like the record to state all of these x-rays are in evidence.

A Yes, I do.

Q Could you please demonstrate -- we have a shadow box. I think the cord goes as far as it can.

MR. KELNER: So, your Honor, I would ask, if anybody can't see from their position in the jury, they be permitted to, but I ask that Dr. Guy be permitted to put these films on the shadow box and demonstrate, to the jury, what he has just stated.

THE COURT: Dr. Guy, you may put the films on the shadow box.

Anybody in the jury cannot see, step up.

But I think that this will be available for all jurors to see.

Tell us what exactly you are looking at.

THE WITNESS: 2B-5.

May I again?

THE COURT: Yes.

A Looking here, this is the sacrum, this is L-5, this is L-4, L-3, L-2, L-1.

L-5. Look at L-4. Look at the size of this vertebra as compared to the L-5. It's cut, broken into pieces here.

Here is the breakage, here is the breakage, here iB the breakage on top, and here is another breakage in this area.

Can you all see that?

Next there is L-4.

Then we go to L-2. As you can see, the height of the vertebra is decreased, That's what a compression fracture looks like from the side.

Here is L-1, another compression fracture, another compression fracture.

To continue showing you, on --

Q By the way, do you teach the residents how to read these films?

A Yes.

Q Is that part of your duty?

A Yes, x-rays, CAT scans, MRIs.

Q Thank you.

A Yes.

THE COURT: What is the exhibit number?

THE WITNESS: 2-B-4.

A What we are looking at here is the surgical procedure that was done to stabilize the broken vertebra.

This is the L-4, this is L-3, this is L-5.

You car.t put screws into a broken vertebra, common sense, you are going to break it even more, so obviously, you try to stabilize the area by screwing it into the area above and the area below.

So, we have a spinal fixator with two large screws going on the top, and two large screws going in the bottom to try and stabilize the area rigidly so the pieces don't shoot backwards or forwards.

That's what wa done.

Now --

THE COURT: Exhibit number?

THE WITNESS: This is 2-B-4.

A -- when this patient had the surgery performed, after he had the surgery performed, the very same date, when he went to the recovery room, he was found to have severe weakness in his leg, couldn't move his leg.

Q I want to stop you jus: one second, Doctor, please.

A Yes.

Q About how long was that first operation?

A Approximately 11 hours.

Q And was there -- what, if anything, happened with regard to hemorrhaging during that procedure?

A He lost -- the normal body has five liters of blood.

He lost approximately two liters.

Q In how long, Doctor, did he lose those two liters?

A In ten minutes.

And the danger of that is, you can go into shock and die.

If you lose:wo liters of blood slowly, the body might compensate if you give the patient a transfusion.

To lose half -- almost half of your body component of blood in ten minutes can lead to very quick shock.

So, that's what happened.

Whenever you do surgery around the vertebra, it is a very bloody procedure, you lose a lot of blood. He had to be transfused two units of packed red blood cells, two units of fresh frozen plasma to make sure the clotting factors are there.

To continue, after he had this procedure done, when he woke up in the recovery room, he couldn't move his leg.

They tried to find out why he couldn't move his leg. They repeated an x-ray. They found the crew was shot too far past the vertebra, as you can see. The screw was too long.

This was not the surgeon was careless, the surgeon was trying to be careful to try to stabilize this bad area as best that he could. If he used a short crew, it wouldn't hold. If he had to use as long a screw, possible to maintain good stability.

So, this was the size he thought, in his best medical judgment, was correct, and obviously, it was too long.

And, when they removed this screw back, and put a shorter one, his leg weakness improved, he was able to move his leg, hut -- not still fully normal, but it improved.

This is 2-B-3. Again, it shows the spine fixator from a different angle, that is shot of more from the side.

This shows it, where you have these little spaces where the screws go through and it's stabilized, and then you have a screw in the back you can tighten it with.

So this is the L-3, this is the L-5 to show where the screw went.

And, as you can see here, this view, went too far in the L-5. That had to be slightly adjusted as well.

Q Those look like very different films at this point.

A -- what are you showing us now, Doctor?

A Okay. These are the CAT scan films. This is number 2-B-1. Okay?

This shows the vertebra. As you can see, you see a crack right through the vertebra. That's a fracture.

You see this crack? Okay?

Right here.

Here is another crack right through the vertebra. Okay? That's the cracked vertebra.

We have much better film to show this to you.

That's -- this is --

THE OFFICER: Exhibit number?

THE WITNESS: This is number 2-B-2.

A This is the cervical vertebra. You see the fracture height here.

You all see that?

Right here.

Q Any doubt in your mind, by the way, because the hospital record had -- at one point, it said, “questionable fracture of the cervical vertebra”?

A No, no. When you see it, you can't miss it, it's right here.

Q Okay. Thank you.

A You're welcome.

Did you want me to use the other films, too?

Q Yes. If they will help -- help you to illustrate your explanation, please do, Doctor.

A I don't want to lose the order.

THE OFFICER: Thank you.

Q Now, are those the -- which films are those?

Are those the ones that are in evidence, or are the new films that were taken in 2004?

A No,

Q I have those over here, I guess?

A These are Bellevue Hospital films.

Q Those are Bellevue Hospital films?

A Yes. This is 2-A-1. What we're looking at here now is we're looking at - - from the front of the vertebra now, we're looking at this. This is the root we're looking at.

As you can see, this is a fracture line right through here, right through here, right through here, right through here. These are the compression fractures that were detected earlier on the x-rays.

This is the CAT scan with the bony window view.

The --

Q Identify the film, please?

A 2-A-2. This is the can CAT scan view.

What we1re looking at -- make believe this is not here -- we're looking at the bone, the vertebra, this is the spinous ?? right here.

This is the transverse process right here and here.

As you can clearly see -- you can't miss this -- that's a big crack right through the bone.

Can you all see this?

Here, here, here, here, here.

Again, this is a -- better views as we go down the list.

Next is 2-A-3. Again, this shows the front of the vertebra. Again, you see the crack here, here, here, here, here, here. You see a little piece here. Okay.

L-3, L-4.

THE COURT: What exhibit number?

THE WITNESS; I'm sorry.

2-A-4.

A This is the L-4 vertebra. This shows the burst fracture. Now, you can really appreciate what I was talking about when I said, “the burst fracture,” everything is exploded in pieces. You also see the breaks here, here, here, here.

These are all different breaks here, here, here, here, here, here, and here, here again. These are all different pieces.

This is the -- the superior portion. It's blown off the tip here. That's this piece. It's blown off the top.

You all see it?

There is another one, there is another one, there is another one, there is another one.

This is the burst fracture. You can see the crack here again, here, here, here, here, here, here.

Q What does the 80 percent compromise of the spinal canal mean?

And is this a film chat would help you to demonstrate that?

A This is the spinal canal.

To appreciate best, the spinal canal has to have all the space here free and void of any bone inside this canal.

Here, look at this canal. It's mostly filled with bony fragments. The entire right side is filled with bony fragments. The left side, you have a little bit left, but there is a piece of bone here, too.

So, 80 percent of it is occupied by bone as opposed to the left nerve root and other portions, branches of the spinal cord.

Q What does that do to the nerve?

A Nerve root compression. Nerve root compression causes severe pain, and causes weakness, and numbness, and tingling in the legs.

Q In your opinion, Doctor, with reasonable degree of medical certainty, has that caused permanent damage to his nerves?

A Absolutely.

Q Okay, please continue.

A Now, what we're looking at --

THE OFFICER: Number?

Q Exhibit?

A I'm sorry.

2-A-5.

What we're looking at here is the actual CAT scan view, the axial view. This is the screw that went through the vertebra and came out the other end.

You all see it?

And what's on the other side is a nerve root.

So, this ia putting pressure right on the nerve root. Had to be pulled back, replaced, repositioned.

Now, you can see the screw very well here. Look how far it is past the vertebral margin.

This is the screw, that is the screw.

Q So this portrays the films after operation 1, and before operation 2?

A Yes, sir.

This again -- this is 2-A-6. This again shows the screw going in -- this is the L4-5 level. You see parts of the fracture here, part of the screw going through.

Now, this ie the --

THE COURT: 2-A?

THE WITNESS; I'm sorry.

2-A-7

A This is the lower portion of the fixator, the L5-S1 level. Look, again, at L5-S1, the screw, again, went in too far, It is past the boundary of the disk -- the vertebra, rather.

This is the vertebra. It passed it too far. It is in too deep.

Over here is where nerve roots exit. This has to be repositioned as well.

And this is the fixator from a different view. This is the axial view.

That's, basically, the x-rays and the CAT scan.

Q Okay. Doctor, unless you need to, you can resume your seat.

First, fractures.

You said you had seen thousands of compression fractures?

A Yes, sir.

Q Are burst fractures common, or are they relatively rare?

A They're relatively uncommon, very uncommon, very devastating type of injuries, thank God, they're rare.

Q In your practice, how many burst fractures have you seen approximately?

A In my career as a physician, from 1982 to the present, over 22 years, I'd say, between a hundred to 200.

Q And is the level of compression of the spinal canal important in analyzing the amount of damage that will be caused to an individual that suffers a burst fracture?

A Yes, sir, it's very important.

Q Of the burst fractures that you've seen, could you give us an approximate percentage as to how much compromise of the spinal canal has occurred in the different types?

MR. KLEIN: Objection, your Honor.

THE COURT: Repeat the question.

MR. KELNER; I'11 withdraw the question and reask it in the interest of time.

Q Could you give us an approximation as to the level of compromise of the neural canal that you have seen in the burst fractures that you've observed?

MR. RCSENHECK: Objection, your Honor.

THE COURT: Overruled.

A The vast majority have been in the vicinity of 30 percent, 50 percent

I've seen less than a dozen this big, 80 percent or greater.

0 Now, you said at 90 percent, the person is permanently paralyzed?

A Yes, sir.

Q And do you have an opinion that you can express with reasonable medical certainty as to the level of disability that must occur as a result of an 80 percent compromise of the neural canal?

MR. ROSENHECK: Objection.

MR. KLEIN: Objection, your Honor.

THE COURT: Overruled.

A It is a serious permanent disability. Then you need other parameters to quantify that further. You just can't go by a -- one x-ray or that one CAT scan alone, you need the history, physical exam, EMGs, so on, so forth.

Q Okay. Doctor, with regard to the Bellevue Hospital record, at one point, it indicates the worst fracture is of L-4 with retropulsed bony fragments with 80 percent canal compromise.

What is a retropulsed bony fragment?

A “Retro” meana “backward,”“pulse” means “shot,” so it means the bony fragment shot backwards into the canal.

This is the back, this is the front, so, had the vertebra shot forward, it would not be as bad because there is muscles, cendons, ligaments in the front.

The back is bad because you have all the nerves in the back.

And, it shot backwards, right where the nerve root exits. That's why it is such a dangerous fracture.

Q When the vertebrectomy was done -- anything “ectomy” is “removal of”?

A Yes, sir

Q An appendectomy is removal of an appendix?

A Yes, sir, that's right.

Q When a vertebrectomy was done, a percentage of the vertebra had to be removed?

A Approximately 30 percent.

Q And was that significant to you when you first began to treat this patient?

A Yes. Thirty percent removal of the vertebra -- don't forget your L-4, L-5 are your -- the basis for your foundation.

Look at the spine. The spine --

THE WITNESS: May I step down again, Judge?

THE COURT: Yes, go ahead.

A The fracture was at the L-4 level. The L-5 -- L-5 is your last vertebra, L-4 is the one above it.

If you are building a tall skysraper, tall building, your foundation is broken or it's weak, what do you think is going to happen?

As you go higher and higher on your tall skyscraper, you're going to have instability, you're going to have weakness, a strong wind comes or a little push comes, then there will be more damage to here.

Unfortunately, in this patient, not only do you have problems at the L-4 level, you also have problems at L-2, L-1, T-12, and C-7. So, there is multiple problems here.

And also, because the spine is rigidly fixed in place from L-3 all the way down to L-5, the -- most of the motion in the lower lumbar spine is done at the L4-L5 and L5-S1 level.

If that area is made independently tight and affixed by spinal instruments, and metals, and screws, you can not normally bend forwards and backwards, you lose that range of motion, stiffness steps in, the flexibility is lost.

Once you have flexibility lost all the pressure is transferred to levels above it, so these are the other areas are now being asked to take additional work which they were not supposed to be doing.

This was supposed to be done by this le.

So, on these levels you are already injured, what happens over time is, you are going to have disk bulges, herniations here, as we already have at the L4-L5 level confirmed by the CAT scan that was recently done, and, as you go higher and higher, there will be more weakness, more instability at other levels, and traumatic arthritis will set in, and stiffness will set up in -- stiffnes will be progressive over time.

Q One quick question. In the second documented report, it says, “a small quality of CSF was noted when the rostral screw was removed”?

A It was, yes.

Q Is that cerebrospinal fluid?

A Yes.

Q Did that leak out after the second screw -- after the screw was removed in the second procedure?

A Yes, sir.

Q Was that significant?

A Yes, because once you have leakage of the cerebropinal fluid, it means one of the coverings, one of the membranes of the spinal cord or the nerve roots ia ripped.

You have three coverings, dura mater, arachnoid matter.

So, if these three coverings is -- one of them is ripped, that fluid leaks out, it can cause infection, and also, severe headaches.

When that leakage occurs, as you go from the supine position, the laying position, to the standing position, you get a massive headache because the cerebrospinal fluid pressure drops. As it drops, you get a massive headache.

Q Okay. Dr. Guy, have you basically explained -- further, when he was discharged from the hospital, there was significant weakness that was noted in his quadriceps?

A Right.

Q I quote, “Following surgery, the patient remained neurologically stable, with severe weakness in the right quadriceps, at best, 2/5”?

A Right.

Q What does that mean?

A Okay. Normal muscle power is graded as follows, perfectly normal is five over five, next, abnormal is five minus over five, next is four plus over five, next is four minus over five, next is four over five, next is three plus over five, next is three over five, next is two minus over five, so, if you grade it on a scale of one to ten, a two over five is 80 percent weaker than normal, it's this close to paralysis.

Q Okay. Doctor, have you basically told us what you think we should know about the hospital records and the films that are in evidence?

A No, I have not.

Q Please continue.

A The patient's hematocrit, which is the blood count, dropped to 27 and 29, normal hematocrit for a male of that age is between 43 and 51, so, when a hematocrit drops to 27, that's almost half your -- your blood count that was lost.

So, that was severely decreased and -- and he had to be transfused, and given iron supplementatation.

That, basically, concludes the important things we wanted to learn from the hospital records.

Q Okay, Doctor, could you tell us when you first saw Marek Szpakowski, and trace your treatment with him and your visit with him from the beginning up to the present?

A Yea. I saw him the first time on October 1, 2000.

Do you want me to briefly go over the history and the physical exam findings?

Q Yes.

A The history I obtained was that on April 27, 2000, he was 29 years old at the time, he was working on the dock doing construction work over a ladder/scaffold approximately 20, 30 feet high, he fell off the scaffold, he landed on his buttocks, landed on his right side, and he sustained all the fractures we mentioned.

There may have been loss of consciousnes, but the medical records were not clear.

When he came to me, he complained to me of severe lower back pain, severe right knee pain the lower back pain shooting down the right leg with weakness in his right leg.

He wore a TLSO brace, which stands for “thoracolumbosacral orthosis,” a big heavy jacket to support the spine.

When that was removed, I examined the skin. There was scarring over the left lower quadrant at the left flank area. He had bone grafting from the iliac crest.

Q We forgot to go into that.

A Yes.

Q I apologize.

Was there -- when this operation was done, did he require a bone graft to complete the operation?

A Yes.

Q Tell us what that means.

A May I step down again?

Q Please.

A Okay. This is the right, this is the left. This is the iliac crest. In this surgical procedure, whenever we want bone seal, we take bone from the iliac crest.

We clip away from here, and we take it, we grind it up, we smash it up, and we add it tc the area we want to plug the screws in the vertebra.

So, it acts as a bone cement, and what happens is, you have rapid formation of bone around the area, which takes -- begins in several days, takes several months to be completed, and it makes the area that was surgically corrected very strong, gets filled with bone cement. That's what that is.

Q Thank you, Doctor.

A Okay.

Q And that was done in this case correct?

A Yes, sir.

Q Okay, please continue.

A So, when I examined him, there was a scar on his left lower quadrant in the left flank measuring 24 centimeters in length. That was the surgery from the bone graft.

His right thigh, there was severe atrophy.

“Atrophy” means the size of the muscle was shrunk.

If you have nerve damage and you can't use your legs properly, you don't use it, you lose it.

So, he had severe atrophy.

The right thigh measured 46 centimeters, measured 15 centimeters above the superior portion of the kneecap compared to the left side, which was 48 centimeters, 53 centimeters different. That's about, roughly, one and a half inches.

The back was tender. There was severe spasm.

“Spasm” is defined as prolonged, involuntary contraction of the muscle fibers.

Q By the way, that one and a half inches atrophy, that is in what part of his body?

What part of his body is atrophied?

A His thigh.

Q His right thigh?

A That's right.

Q His right thigh is approximately an inch and a half less in diameter --

A Circumference.

Q -- circumference, I'm sorry -- than the left?

A That is correct.

Q And that is as a result of this accident and his injuries?

A Yes, sir.

Q Okay. Proceed, Doctor.

A So, the back revealed spasms which are defined as prolonged involuntary contractions.

Normally, when you touch a muscle that's normal, it's soft to touch.

Once a muscle gets injured, it becomes hard. That is the body's way of protecting itself from recurrent injury.

Then, the fibers shorten. Once the fibers shorten, you lose range of motion in each direction.

That' what I found. His range of motion forward and backward was one half of normal.

The range of motion for all four extremities, that's the shoulder, the hips, the knees, the ankles, was normal, as was expected.

The injury is not to the shoulder, or to the limbs, or to the knee, it's to the apine, so the other four areas was normal as expected.

Muscle power tested for his right lower extremity was four minus over five. That's approximately three grades weaker than normal.

The left lower extremity was four plus over five. That's approximately two grades weaker than normal.

Sensation to pin prick and touch, touching with a paper clip, was decreased on the right thigh, the medial, that's inner, and the lateral, that's the outer portion, that indicates nerve root damage, and his right knee jerk and the right ankle jerk, I was not able to elicit any response.

The right knee jerk is the L3-L4 nerve root, so it correlates to that level, an the ankle jerk correlates to the L5-S1 nerve root. That was probably damaged from the screws going in at that level.

So, even though you are moving the screw back, it doesn't mean that the damage is going to correct itself, may take some time, it -- it may never correct itself a hundred percent.

Q In this case, Doctor, has that corrected itself?

A A hundred percent?

No, sir.

Slightly?

Yes, it has.

Q Okay. Does he, in your opinion, with reasonable degree of medical certainty, have permanent damage to the nerve as result of that?

A Yes, sir, he does.

Q Go ahead, please.

A The gait, which is the way he walked, was antalgic -- “antalgic” means he walked with a limp -- using a straight cane.

Now he uses a straight came -- in the beginning, he used a straight cane most of the time, but later on, he uses a cane sometimes, and sometimes, he doesn't use a cane, so it depends on the days, sometimes he has good days, sometimes he has bad days.

MR. KLEIN: Objection, your Honor.

Is he testifying from knowing, or if he telling us a story?

THE COURT: I think he's doing both.

Q Do you know this patient having seen him many times, Doctor?

A I've been treating him for the past four, four and a half years, so I've seen him on a monthly basis. Sometimes he comes with a cane, sometimes he doesn't.

So, I'm giving you a summary of the pertinent information.

Q Okay.

A That concludes my history and physical exam.

Then you asked me to go over my notes.

Q Please.

A Okay. After -- the first time I saw him was October 6, 2000. I saw him next again --

MR. ROSENHECK: Your Honor, could we approach for one second, please?

THE COURT: Step up.

MR. ROSENHECK: Thanks.

(Conference held at the bench between the Court and counsel off the record.)

THE COURT: Counsel wants this area in the testimony marked because he wants to come back to it. I guess he wants to preserve it.

Okay.

Q Proceed, Doctor.

A I then saw him -- he was then seen again in the office on 11/27/2000. He still had complaints of back pain, and weakness in the leg, and at that time, he walked with a limp, but he did not use a cane.

Q When you say, “use a cane,” you mean in your presence, correct?

A Yes.

Q You don't know if he walked into the waiting room with a cane or not, you're talking about in your examination with him, correct?

A That's correct.

Q Okay, go ahead.

A He was then seen again on 12/18/2000. At that time, he had lower back pain shooting down the right leg with rumbnesB and tingling. He was coming for therapy. One time a week, I was helping him.

At that time, he still had weakness in his right leg. His gait, he walked with a limp, but at this time, he required a straight cane.

He was then seen again by me on 1/17/01. At that time, he had seen a neurosurgeon on 1/16/01. He says his lower back pain is a -- a bit better with therapy.

He still was not able to work.

His back, again, was tender, spasm, one half normal range of motion. Muscle-power testing of both lower extremities was weak. His gait was slow, but he did not use a cane.

01/29/01, he was seen again, similar complaints, lower back, right kne, similar findings.

At that time, his gait was slow, antalgic, with the use of a straight cane.

At that time, I gave hin medications for pain and inflammation, Celebrex, 200 millgramgrams twice a day.

He was then seen again on 2/28/01. Again, his lower back was a little bit better with the physical therapy. He had right knee pain. Physical exam was essentially the same.

At that time, his gait was slow, antalgic, with the ue of a straight cane.

He was then seen again on 3/28/2001. He has lower back pain shooting down the right leg with numbness and tingling, right knee pain, he's doing his home exercises.

At that time, his gait was slow, antalgic, with the use of a cane.

On 4/30/01, similar complaints, similar findings, his gait was slow, he did not use a cane in the office.

Next seen again on May 21, ‘01. He still had right knee pain, lower back pair, lower back was getting better with the therapy.

At that time, his gait, when walking slow was normal without the use of any cane.

Next, he wae seen on 7/18/01. He still was doing home exercises.

At that time, his gait was slow and antalgic, with the use of a straight cane.

Next, he was seen on 8/20/01, still is doing home exercises, still has lower back pain, right knee pain, his gait was slow with the use of a straight cane, gave him a prescription to go for physical therapy close to his house on June of 20C2.

He was then seen again on 9/19/01, again, unable to work, still has lower back pain, still shoots down the right leg with numbness and tingling, similar findings again. His gait was slow, antalgic, with the use of a straight cane.

Next, he was seen on 10/17/01. He still has lower back pain, still shoots down the right leg, similar findings on physical exam. His gait was slow, antalgic, with the use of a straight cane.

Next seen on 11/12/01. Still has lower back pain, right hip pain, he gets physical therapy close to his house, it's helping him, still remains unable to work.

At that time, his gait was normal in the office, no cane.

Next seen again on 12/12/01, still has lower back pain, his right hip is slightly better, but not a hundred percent.

Again, similar findings, the gait is antalgic, with the use of a straight cane.

The plan was continue with this physical therapy close to his house.

Q Doctor, you -- you do have dozens of those visits.

Just in the interest of time --

A About 25 visits.

Q -- okay -- can you just summarize, basically, or trace, just in the interest of time, to tell us, essentially, his progress during those several dozen visits?

A When he was getting physical therapy, he had less pain, he was able to walk better.

On some days, which were few, far in between, his gait -- he was able to walk in my office without the use of a straight cane, but moet time, he required a cane, and he walked with a limp.

That's, basically, the summary of it.

And he was most recently reexamined by me on 10/13/04. He still has lower back pain shooting down the right leg, he still has weakness in his right lower extremity. At that time, he walked with a cane.

And on May 26, 2004, he had EMGs of his back --

Q Okay, stop.

EMGs, tell us, please, what EMGs are.

A “EMG” stands for “electromyography.” It is test, that is done by a physician, that checks to see if there is any problems with muscles or nerves.

It has three parts. The first two parts checks the motor and the sensory component.

Q How does it work?

Tell us first how it works.

A You have a computer, you have an oscilloscope, a screen, you have a cable, an anifier box, and lots of electrodes.

The first two portions, you place surface electrodes over different muscles in the leg, you stimulate the nerve with a zapper, you zap the patient.

It's not the most comfortable test in the world, it's actually painful.

So, you stimulate the nerve, you shock the patient, and then you record the tracings on your

The tracings look something like this.

Q Are those his tracings by the way?

A Yes.

Q By the way, were you the physician that did the EMG?

A Yes, sir.

Q And do you teach EMGs to your studen:

A Yes, sir.

Q Okay, go ahead.

A So, the first portion, you record the motor, which is normal, as expected in a radiculopathy.

“Radiculopathy” means the problem is to the nerve roots, not to the peripheral nerves, not the nerves in the foot or the ankle, but nerve roots in the back.

Then you insert a sterile needle into various muscles in the legs and various muscles in the low back. When inserting the needle into the right L3-L4 level, I look and see if there is any abnormal findings. Normally, it should be straight like this.

When you see this “V,” like a “V,” they're called -- called positive shock waves.

Here, there is multiple downward deflections. There are called positive shock waves, indicates nerve root damage at the level of the right L3-L4.

At the level of the right L4-L5, again, you aee a lot of downward deflections. This indicatee nerve root damage to that area. And this it, again, the right L4-L5 level, indicating nerve root damage.

You see -- one, two, three, four, five, six, seven -- about eight downward deflections. They're called positive shock waves.

ThiS is the vastus medialis muscle. That's the muscle in your inner thigh that's supplied by the L3 nerve root, L2, L3 and L4. That shows abnormality.

Next, again, the right vastus medialis, and this is the right tibialis anterior muscle, which is the muscle right over your shin bone, and this shows two downward deflections, indicating damage to the nerve root, because all the nerves that go to the muscles in your legs originate, are from the nerves in the lower back, so, by anatomy, a physician knows what muscle is supplied by what nerve root, and, when you put it all together, he had damage to nerve roots from right L3 through L5, at two levels.

Q Doctor, do you have an opinion that you can express with reasonable medical certainty as to whether that nerve root damage was caused by this accident?

A Yee, sir. It's a -- the same exact thing that was found right in the hospital, where he had this weakness from the insertion of those screws.

And the problem has not corrected itself, it still continues.

This ia not from the, only, screw, it is also from the rotational forces that work on the spine, and also, it's coming from damage to the disks and/or the nerve roots in the area, not just from the screw.

Q Okay.

THE COURT: I think it's time for a break.

We'll take about 10 minutes.

THE OFFICER: All rise.

(Whereupon, the jury leaves the courtroom.)

MR. KLEIN: I'd like to renew the defendants' application to strike certain testirmony of Dr. Guy that was contained in the second supplemental bill of particulars,

Dr. Guy has testified that the L4-L5 herniation was visible on the Bellevue films, which means that it was known to the plaintiffs' attorneys at the beginning of this lawsuit.

It was not contained in any bill of particulars until recently.

MR. KELNER: I don't think he said that.

THE WITNESS: I didn't say that.

MR. KLEIN: You said you saw a fracture of the L4-L5.

THE WITNESS: I did not say that at all, I said there was a disk herniation at L4-L5, and the radiculopathy is not coming from the screws going into a level, it's coming from multiple causes.

MR. KLEIN: Right. But you saw the herniation.

THE WITNESS: I repeat, I did not see a herniation at L4-L5 in the Bellevue CAT scan films, I did not.

MR. KLEIN: When did you first discover them?

THE WITESESS Based on the CAT scan that was done on -- just recently, June of 2004.

MR. KELNER: Which is exactly what we've been discussing, your Honor.

And do let the jury -- let the record indicate that the jury has not been present for this application.

MR. KLEIN: Right.

Well, I still say my notes say what they say, Judge.

THE COURT: Well --

MR. KELNER: I'll be happy -- if there is confusion, I'll clear that up.

THE COURT: The record stands for itself.

MR. KELNER: All right.

Ten minutes, you said, your Honor?

THE COURT: Yes.

(After the recess:)

MR. ROSENHECK: Your Honor, I would ask all the records, Dr. Guy's records and the EMGs, be kept here, not be taken with him.

THE COURT: You mean the stuff not in evidence?

MR. ROSENHECK: Also the stuff aren't in evidence, everything, his notes and everything, everything be left here.

MR. KELNER: I object to that.

MR. ROSENHECK: Why?

THE COURT: You can look at his notes, but, I mean, there is nc reason to keep them here.

MR. ROSENHECK: It is not I who has to look at the notes, it is cur doctor who is going to come in and testify who eventually, has to look at the notes.

THE COURT: I'll keep everything that is n evidence. I won't keep anything that is not in evidence.

MR, ROSENHECK: Okay.

THE OFFICER: All rise, jury entering.

THE COURT: Be seated.

Q Dr. Guy, you have been seeing this patient approximately once a month for the last couple of -- number of years, correct?

A Yes, that is correct.

Q And did you render more --a more recent report dated May 26, 2004, June 7, 2004?

A Yes, sir.

Q Tell us what you did, and what you found back in May and June of this year.

A May 26, 2004, the patient was reexamined by me. He still had lower back pain shooting down his right leg, he told me that sometimes, he has to walk with a Cane and sometimes he can walk short distance without a cane, sometimes, he walks better than other times.

I examined him, checked his back, which showed moderate tenderness, moderate spasm. Multiple trigger points were present.

Trigger points are areas of fibrotic tissue with pinpoint tenderness, indicates muscle scarring.

Range of motion for extension was one-third normal, for flexion, it was zero to 60 degrees, it was approximately two-thirds normal, right and left lateral flexion was approximately one half, there was pinpoint tendernese over the L-3, L-4 and L-5 spinous processes in the back.

Straight-leg raising was 70 degrees on the right, 80 degrees on the left, indicating -• indicating abnormality on the right.

Right thigh, there was visible atrophy or loss of muscle bulk for the entire right thigh. The right thigh measured 52 centimeters, that's 20 centimeters above the border of the patella, the left thigh measured 55 centimeters, indicating a three-centimeter discrepancy, which is roughly about an inch and a half.

Both calfa were, essentially, symmetrical.

Range of motion was normal for all four extremities, as expected, except for the lumbar spine, that was diminished.

Muscle-power testing for the entire right lower extremity was four minus over five, sensation waa diminished to pin prick and touch right anterior and lateral thigh.

The right knee jerk was trace.

Q What does that mean?

A The -- it means -- my first visits, there was no knee jerk, now it is trace. It's still abnormal. Normal is 12 plus. “Trace” means you barely get a response, means there is still evidence of nerve root damage.

The left knee jerk on the other side was two plus.

Right ankle jerk was one plus, the left ankle jerk was two plus, indicating there was still some abnormalities on the reflex on the right.

The EMG studies was performed to rule out any nerve damage. it confirmed electrical evidence of the right L3 through a right L5 radiculopathy.

Patient was sent for x-rays of the thoracic and the lumbar spine to see if there is any arthritic changes occurring.

Q You referred the patient for x-rays?

A Yes.

Q Ckay. And do you have -- do you have those x-rays with you?

A Yes, I do.

Q What other tests did you refer him to?

A The patient was sent for a CT scan of the lumbar and the C spine.

Q Is that alsoo called a CAT scan?

A Yes, sir.

Q Do you have those films with you?

A Yes, I do.

Q What else, Doctor?

A And then I formulated a treatment plan, and I gave my opinion as to his prognosis, and that he was still totally disabled, and that his condition was progressively worsening, and now, clinically and radiologically, traumatic arthritis had clearly set in.

Q Doctor, do you have the films that were taken back in, I guesa it was May of this year, for Marek Szpakowski?

A I have them.

MR. KELNER: Could we mark those, your Honor?

THE COURT: Mark them, yeah.

Tell me what you want them to be marked as.

MR. KELNER: I want to mark them into evidence

THE COURT: Well, what is the exhibit number?

MR. KELNER: I'm sorry.

Exhibit 15.

THE COURT: Fifteen and 16?

There is two of them?

MR. KELNER: One would be --

THE COURT: Three of them?

MR. KELNER: The first --

THE COURT: How many?

THE OFFICER: Two, three, four, five -- six x-rays total.

THE COURT: Okay. Let's mark them 15 through -- that is 16, 17, 18, 19, 20. Twenty.

Any objection to marking them in evidence?

MR. ROSENHECK: Just what we discussed,your Honor, before.

THE COURT: Nothing about foundation or anything like that?

MR. ROSENHECK: No foundation problems, your Honor.

THE COURT: Okay, mark them in evidence.

Marked 15, 1 through 6.

(Received and marked Plaintiffs' Exhibits 15-1 through 15-6 in evidence.)

THE OFFICER: The exhibits, so marked.

Q By the way, did you receive a report of the radiologist that you asked to take the film, Thomas Cole?

A Yes sir, I did.

Q Okay. And, when you saw the firm, they came with the radiology report, correct?

A Yes, sir, that's correct.

Q Did you look at the films?

A I did.

Q Did you agree with everything that was in Dr. Cole's report?

A Yes, sir.

Q Okay. Could you put, on the shadow box, an example or examples of those films to demontrate the findings of -- the radiological findings in this situation?

A Yes, sir.

THE COURT: Go ahead.

A 15-1.

These are the films that were taken on 5/28/04.

What we're looking at is Marek Szpakowski' x-I / of the spine. We see again the spine fixator, this is, again, L-5 level, L-4, L-3 shown showing the screws the proper location, the screws in proper location.

There is nothing out of the usual. The screws are not protruding out to where they were before, they're back in their normal place.

This is the L-5.

This is 15-2.

This is, again, the spine fixator, this is the L-5, this is the -- where you can still see fragments of the shattered bone, okay?

This is L-3, L-2.

Here is the conpression fracture again, still noticeable at L-2.

This is L-1, still noticeable, and this is T-12, and here, you start seeing evidence of arthritic changes by way -- your sclerosis around the pedicles here, here, here.

This is what a -- spicules, the osteophytes, will begin to come outside from, here, here.

So, there is evidence of traumatic arthritis setting in.

Q And when you say, traumatic arthritis has been setting in, is that actually similar to the model of the vertebrae that you showed to us with the -- I think there were four different vertebrae, right?

A Right.

Q Is that what you're seeing in an x-ray?

A I'm seeing something between this and this, not quite this yet. It takes several years to get on this level

Once he reaches over 55, he -- it may start to come to something like this. Has not happened yet.

Q So he is something -- rather than vertebrae number 1, he is something in between vertebrae 2 and vertebra 3 --

A That's correct.

Q -- In terms of the arthritis that has set in?

A Yea, sir.

Q Okay. What else does --do the films show, if anything, that is significant?

A On the x-rays, or on the CAT scan?

Which one are you talking about?

Q Have you shown us what you think we should see with regard to the x-rays?

A Yes.

Q Okay.

A Furthermore, the neural foramina, the nerve root -- this space here is celled the neural canal. Look how big it is here. Look how it is at the L-4 left. It's almost completely blocked, you barely see it. This big, the other level, this small at the level of L-4.

Q What is the significance of that?

A Evidence of nerve root compression at that level.

Q Thank you.

A Okay.

Next, I'm going to show what's marked 15-3.

What we see here is the patient's CT scan, has the patient's name on top, has the day it was taken, on 5/28/04, and this, basically, shows the screws again going through the L-5 level. You see the fracture here, the screw, the screw going through, again, the screw,

This is 15-4. This is the L-4 vertebra showing the burst fracture. Again, you can see -- see these lines have been -- have not been united.

That's the screw, end of the screw here.

This is the L4-L5 level, part of the screw going through.

Next, I'm going to show 15-5. What we're looking at here, this is the L4-L5 disk level, there is the disk, this is the nerve root.

As you can see, there is an eclipse overlapping.

This is the herniation right here.

Q So, you see a herniated disk at a level at this time?

A Yes.

Q Did you see that in -- was that present in the -- the films that were taken at Bellevue Hospital?

A No, sir, it was not. This is the --

Q What is the significance of that?

A This is the progression of what I was explaining to you before earlier, once you have injury at one level, the pressure is put on all the other disks and all the other vertebra, as times goes on, pressure increases on the other areas that have not yet been injured,

It will cause problems to the disks, it will cause problems to the bone, it will cause problems to the articular facets where the disk glides forward and backward.

You have facet hypertrophy.

Where you already have facet hypotrophy, which comes from wear and tear of the articular surface, evidence of traumatic arthritis.

Q Doctor, you indicated that there is a disk herniation at the L4-L5 level, correct?

A Correct.

Q Does that impinge directly on the thecal sac?

A Yes.

Q Does that mean -- by the way, what is the thecal sac?

A The thecal sac is the covering of the membrane of the nerve root as it exits the spinal cord. This is the thecal sac right here.

If he has compression on the thecal sac, you have compreassion on a nerve root.

If you have a compression on a nerve root, you're going to get shooting pain, you're going to get pain, spasm and muscle weakness, sensory deficit and range-of-motion deficit.

Q Okay. Does that also involve the left-sided neural foramen?

A It does, yes, sir.

Q Show us what that is.

A This is the right side. It's labeled. This is the left side. It's labeled.

This is the neural foramen, this little dot right here. It is crowded, and narrowed, too, and compromised.

Q What is the significance of that, Doctor?

A Causes nerve root compression.

Q Okay. And is the exiting left-sided nerve root directly involved by that compression?

A Yes, sir, it is.

Q What is the significance of that?

A Nerve compression causes pain, spasm, loss of reflex -- possible loss of reflex, and range-of-motioa deficits.

Q Okay. Is there anything else in the CAT scans that you think we should know about?

A I have one more in my hand to show. This is --

THE OFFICER: The number:

THE WITNESS: I'm sorry.

This is number 15-6.

Q This looks different from some of the others?

A Yes. This is your guide. The numbers here tell you, when you look at the subsequent films, what you're looking at.

104, 55, correlates on the numbers here. This way, you can appreciate what level you are studying.

Thirty-three, 35, 37, 49 correlates to the L4-L5 level, which would be right arouid here.

That's your reference mark.

Q Doctor, with regard to the films, the -- what is the effect on - -

MR. KELNER: Withdrawn.

Q What is facet hypertrophy, Doctor?

A Facet -- I showed that on the films. The facets, the articular facets, are these facets right here, right here, which allows the vertebra to glide forward and backward.

These are the articular facets. If they hypertrophy -- mean they get big -- that means the facets will now no longer be able to glide a smooth as possible, you have friction with normal gliding forward and backward, and to the side.

That's one of the signs of early traumatic arthritis in this type of a setting.

Q Thank you, Doctor.

A Okay.

Q Doctor, based on the films and your examination, do you have an opinion that you can express with reasonable medical certainty as to whether Marek is getting better, staying the same, or getting worse?

A He's slowly and progressively getting worse over time for the reasons I explained earlier.

Q Okay. you said that traumatic arthritis has now set in.

A Yes.

Q He was 29 years old at the time of this incident, and he's now, I believe, 34?

A Right.

Q Doctor, do you have an opinion that you can express with reasonable medical certainty as to what he's going to be like when he's 54 or 74?

A Well, the models of the spine right in front of the board best describes it. They say a picture is worth a thousand words.

As time goes on, the rapid formation of osteophytes will begin to form. Osteophytes will begin to form.

THE WITNESS: Judge, may I step down?

THE COURT: Yes.

A As osteophytes begin to form rapidly over time, these osteophytes, they will cause crowding into the neural canal, which is already crowded at L-4, which is 80 percent blocked, and you only have 20 percent left, it doesn't take much of an osteophyte to cause further blockage to that nerve root.

And, is these osteophytes continue to grow, they will continue to stick out, and dig in, and make this neural canal even more narrow. As a result, nerve roots will become pinched and compressed.

As time goes on, you need a procedure to go in and shave this area to relieve the compression on the nerve root. This is a surgical procedure called a foraminectomy, where a surgeon goes in with a drill and they shave the area to make the space bigger, to make it no longer compressed.

This will be required every several years -- depends on the patient -- every five to seven years once it becomes significantly narrowed.

Q Doctor, do you have an opinion you can express with reasonable medical certainty as to whether he's going to need these procedures, these foraminectomies, done to him?

MR. ROSENHECK: objection, your Honor.

THE COURT: Overruled.

A The answer is, yes, at the L-4 level sooner than later.

As we - - also, right from the get-go, he was already 80 percent narrowed. Now, it is much more narrowed. Now, you have the arthritis setting in, and the spicules setting in.

I would say, in about another three to five years, he will need a procedure for that to be rectified.

The other levels will take a much longer time to set in, with a reasonable degree of medical certainty, I'd say, between 10 to 12 more years from now for the other levels.

The L-4, I'd say, between five years from today, three to five years from today.

Q Doctor, with regard to the way he walks -- I think I added 20 years and 40 years -- when he's 54, do you have an opinion, with reasonable medical certainty, as to how he's going to walk and function?

A First of all, he'll have a tremendous limitation of range of motion.

May I show that?

THE WITNESS; May I step down, Judge?

THE COURT: Go ahead.

A As 20 years goes by, with all these problems he has, with the metal fixators, and the traumatic arthritie setting in, when he wants to pick something up. he can't do this, he has to bend at his knee.

When he bends at his knees, he still has his back compressed, so he has to squat.

Unfortunately, arthritis affects the whole body.

He will already have arthritis at the knee, he will not be able to bend at the knee also, so he's going to have to find a way to bend.

That's going to be a challenge for him.

Also, as time goes on and that traumatic arthritis get progressively worse over time, he'll be walking with a big limp, and he will need the use of what is called a narrow-based quad cane a four-pronged cane.

Right now, he walks with a single-prong cane.

The four-prong cane delivers the base and distributes the weight easier.

First he'll go from a straight cane to a narrow-based quad cane, then he'll go to a wide-based quad cane.

The -- after that, the next is a walker.

Q Doctor, you said before that he came to your office and he used a cane at certain times, and not at other times.

Tell us what his situation on the cane is right now.

A I said -- I meant when he was examined for the purpose of his gait analysis. I did not say he didn't have a cane, I said, just for the portion of evaluating, examining his gait.

Some days, it required a cane to walk for that analysis, and sometimes, he did not use the cane, but he always -- as far as I remember, he always came with a cane.

Q When you say, to your office to your office?

A That's correct.

Q But he would walk without the cane, at various times, for you --

A Yes.

Q -- for your testing?

A That is correct.

Q Doctor, do you have an opinion that you can express with reasonable medical certainty as to whether all of the problems and injuries that you've described all came from the accident of August -- of April 27, 2001?

A That is, in my opinion, all these problems came from that unfortunate accident.

Q And, Doctor, with regard to Marek's ability to work, do you have an opinion, as a physiatrist, that you can express with reasonable medical certainty, as to what his prognosis is for working in the future?

A Yes. Right now, ho's left with a total and -- permanent total disability for any type of job that requires construction work, heavy lifting, pulling or pushing for the following reasons.

A patient with this type of an injury, with multiple fractures in his spine, that is still broken, you cannot -- no doctor in their right, sane or insane mind would comprehend putting him through the possibility of giving him construction work to do because he's going to get reinjured, the going to reinjure the areas that are broken before, and new levels.

Also, his gait is not steady. He doesn't have proper proprioception.

“Proprioception” means you feel the ground normally.

As he walks, he has a nerve damage in his lower back, two levels, which controls how he feels the ground when he walks.

If you walk on uneven terrain and you don't have normal proprioception, and the ground is uneven, you're going to twist your foot, ankle, and possibly fall and reinjure your foot, ankle, leg, and your lower back, so construction is definitely out of the question.

Now, jobs are given either sitting or standing.

This man cannot stand, on a continuous basis, for more than a half hour to one hour.

He can sit for under four hours, on some occasions. He'll pay the price. He can do it. He can probably do it maybe one day, two days, three days, four days, maybe slightly more.

Can he do it on a continuous, sustained basis?

Back to work with had weather, with the snow and the rain, that's where it comes a medical uncertainty, improbability.

He should not.

He should not be allowed to work in that setting because, if he falls -- this is not, like, a normal person -- if he falls, he will have major, devastating injuries, limb fractures, knee fracture, so on, so forth, and other spinal injuries, and possible paralysis next time he breaks that L-4 vertebra.

It doesn't take much co break it. It. It's already broken.

The canal is already 80 percent compromised. All we need is a little bit more compromised, and he will be paralyzed.

So, we have to -- have to prevent him from being at risk to recurrent injury, and prolongd sitting can make that worse.

Q So, Doctor, do you have an opinion -- let's assume he wanted to work in an office where he would work eight hours a day, five days a week, sitting at a computer.

If he were able to master the computer, could he, like, you know, a normal worker, go to work 48 to 50 weeks a year sitting at a desk, working a typical eight-hour day?

Do you have an opinion as to whether he can do that?

A In my opinion, absolutely not. In fact, he should not be allowed to do that.

Q Why?

A Because he will injure his spine further, more.

Q Okay. Doctor, you have projected the cost of some of his care.

I don't want to talk first about operations, I just want to talk about what he will need, leaving operations out.

Have you performed an analysis for us on that?

A Yes, I have.

Q And could you tell us what you found, please?

A Since his injuries are permanent in nature, he will need to be seeing a doctor, such as a physiatrist, to supervise his overall condition to.see if it is getting better, it's getting worse, to order the appropriate therapy sessions, the appropriate medications, and whatever his needs might be, and also, to assess for physical therapy.

He will need to be seen by a physiatrist at least, minimum, 12 times per year and he'll need physical therapy sessions, on an as-needed basis, for the rest of his life, to diminish his pain, diminish his spasm, improve his flexibility, prevent his condition from getting worse.

Physical therapy is not designed to cure this condition because there is no cure for a disk herniation, there is no cure for radiculopathy as there is no cure for diabetes and arthritis, there is only treatments.

When you get the treatments, you have less pain, less stiffness.

So, he will need physical therapy on and off as needed, minimum, 30 to 40 sessions per year.

He will need repeat EMGs.

Q Tell us the cost of each of these services, please.

A Each office visit is approximately $100.

Each physical therapy session is probably $100.

He will need an EMG of his back every two to three years to reassess the nerves to see how bad they're damaged.

If the damage gets worse, an immediate referral to a neurosurgeon must be made to correct the compression of the nerve roots.

An EMG every two or three years costs approximately $1500, and a CT scan of his lumbar spine should be done every two to three years to reassess all the levels that were studied to see if they are getting better, worse or/and whether the levels are becoming injured.

And the cost of a CAT scan without contrast is about $500, with contrast is $650.

Contrast allows you to see the area much clearer.

0 How long will he need these?

A Every two to three years.

And he should be seen by a spinal surgeon at least three times per year to make sure there is no other problems with his spine, and the approximate cost for follow-up visits is $100.

Usually, spinal surgeons order x-rays of different views, and CAT scans.

He can't have an MRI because he has metal plates in his spine.

Q Okay. And what about surgery, Doctor, in your opinion, will he need surgical procedures in the future?

A Yes. As I explained earlier, as time goes on, the neural foramen will get more and more compressed, will get more and more narrow. He will need a procedure to relieve the compression and the narrowing of the foramen and nerve exits. This is called foraminectomy.

And the approximate cost is between 10 to $20,000, and -- and after the surgery is finished, the patient will need physical therapy aggressively three times a week for four to six months.

Q And the coat of this surgery again?

A Between 10 to $20,000.

Q How about the hospitalization?

A The hospitalization is about $800 a day. Usually, they're kept in the hospital between three to four days.

THE COURT: This foraminotomy.

THE WITNESS: Foraminotomy.

THE COURT: How many times?

THE WITNESSi The foraminotomy at the level of L-4 will be required sooner or later, I'd say, between three to five years. It lasts, on the average, between seven to ten years.

It is like the nail on your fingernails, they keep growing. As they grow longer and longer, you have to cut them.

Same thing here, if you don't cut them, you go into the nerve roots, then you have excruciating pain, and loss of muscle and reflex power.

Q Okay. So, let me just go through this to be sure I understand.

The -- the physiatrist, you said, on an approximately once-a-month basis, which would be 12 times a year, times a hundred dollars per session?

A Yes.

Q The physical therapy, you are estimating at a cost of a hundred dollars per session, did you say?

A Yes.

Q And that is how many times per year?

A Thirty to 40 sessions on an as-needed basis. Some years, it will be less, some years, more, hut the average is between 30 to 40 per year.

Q The EMG studies?

A Yes, that's $1500. That will be required every two to three years.

Q Okay. And the CT scarn films, how often did you say that should be done?

A Every two to three years.

Q Okay. And the cost of -- of that was?

A Five hundred dollars if it is without contrast, 650 if it is with contrast.

Q And just the visit to a spinal surgeon, I'm not talking about surgery, how much would that be?

A For follow-up visit, not the initial visit, I -- the follow-up visit is $100 per session. That's not including x-rays or CAT scans.

Q And you have also given us the figures for the hospitalizations and the surgeries chat he will require.

A Yes, sir.

Q Okay. Doctor, do you have an opinion that you can express with reasonable medical certainty as to whether all of the conditions that you previously have described are permanent in nature and character?

A Yes, they are permanent in nature, and progressive in natur.

Q “Progressive” meaning they will get worse?

A Yes, sir.

MR. KELNER: Thank you, Doctor.

THE WITNESS; You're welcome.

THE COURT: This is a good time to break for lunch, I guess, and we'll come back at 2 o'clock.

(The witnesses leaves.)

THE COURT: You have another witness this afternoon?

MR. KELNER: I had planned to call both of my clients this afternoon.

Hopefully, your Honor.

And that's the end of my proof.

I hope we can get them all in.

THE COURT: Do you have the juror?

MR. ROSENHECK: Thursday.

THE COURT: You're not bringing that, it's not your witness?

MR. KELNER: Definitely not.

Proceedings

THE COURT: That's right, it's your witness.

I'm getting confused.

All right, 2 o'clock.

(Luncheon recess.)

Proceedings

AFTERNOON SESSION.

MR. KELNER: Let the record indicate we are out of the presence of the jury.

I was not certain as to whether -- whether the envelope marked 15, which are the recent films of plaintiff from 2004, the CAT Bcans and the regular x-rays, were marked in evidence.

We have discussed it out of the presence of the jury, and all of those x-rays are in evidence, marked Exhibit 15.

THE COURT: Correct.

MR. KELNER: Thank you.

MR. ROSENHECK: Just so your Hnor -- at the time -- this was aleady done before because I objected to it -- the Court asked me, doing it on what basis.

I said, we already discussed it.

You said, on the technical basis, the foundation?

I said, no, I have no foundation problema with the x-rays, but I had other objections which we alieady diacussed.

THE COURT: I think the confusion was that we marked the file, but we didn't mark the exhibits.

Marking the file is enough, and, as the individual exhibits were introduced into evidence, I marked them in my -- as a matter of fact, from 15-1 to 15-6 are all indicated, in my list, as in evidence.

MR. ROSENHECK: Yes, they were.

THE COURT: Okay.

MR. ROSENHECK: Over our objections, but they were.

THE COURT: Right.

(Whereupon, the jurors entered the courtroom and took their respective seats in the jury box.)

THE COURT: Okay, be seated.

Lee's continue.

Cross-examination.

MR. ROSENHECK: Thank you, your Honor. CROSS-EXAMINATION

BY MR. ROSENHECK:

0 Good afternoon, Dr. Guy.

A Goods afternoon, sir

Q How are you doing?

A Good.

Q I have questioned you before on this particular case, correct?

A Yea, you have.

Q And that was, what, May 19, I believe?

A That's about right.

Q Okay. Did you speak tc Mr. Kelner with respect to anything about this case since the last time you testified?

A Yes, sir.

Q And did you discuss the fact that the plaintiff, at his prior trial, had testified, on my questioning, that he was unable to walk outside, even take one or two steps, without the use of a cane?

Did Mr. Kelner tell you that?

MR. KELNER: Objection, your Honor.

THE COURT: Well, I'll allow it.

If it's miacharacterizing the evidence --

MR. KELNER: I do.

THE COURT: -- The -- I'm not the judge of that, the jury is.

MR. KELNER: I feel it is a mischaracterization.

MR. KELNER: Thank you.

THE COURT: Go ahead.

A No, that was not discussed in that capacity. All that was discussed was, shortly after I testified, Mr. Kelner called me back a few day later, he said that we have to retry this case because there was a discrepancy with -- ne of the jurors saw Mr. --

THE COURT: Okay, that's enough.

Q So Mr. Kelner did discuss with you the fact that a juror had been Mr. Szpakowski walking outside, correct?

A Yes.

0 Okay. And Mr. Kelner, during that conversation with you, told you that this juror, potentially, was going to testify in a manner that contradicted the way Mr. Szpakowski walked in court, correct?

A That --in that capacity, it was not discussed, it was just discussed chat Mr. Szpakowski had his cane on his arm, he went across the street to buy a frankfurter and something to drink, he had his cane on his forearm, that's all that was discussed.

Q And that he walked with the cane on his other arm without using the cane, correct?

A That's correct, yes, sir.

Q And Mr. Kelner, of course, told you that the juror had seen him doing that, correct?

A Yes.

Q Okay. And Mr. Kelner, of course, also told you that Mr. Szpakowski denied walking without the use of a cane?

MR. KELNER: No.

I object to that, your Honor.

Your --.

MR. ROSENHECK: Your Honor, it goes --

MR. KELNER: I object to that.

THE COURT: What Mr. Kelner said?

I mean, he can testify.

What ia the basis for your objection?

Let's not have a long conversation.

MR. KELNER: MiBcharacterization.

THE COURT; Okay.

Let the jury -- well, we don't Know what you told him, to tell you the truth.

MR. KELNER: That's correct, your Honor.

THE COURT: It's up to the witness to say, that's all.

Q Did Mr. Kelner tell you that?

A All he told me was what I said earlier, that a juror law him walking with his cane on his forearm, he had a hot dog and I think a soda in the other hand, that's all that was discussed.

Q Did Mr. Kelner ever tell you that I questioned Mr. Szpakcwski and asked him yesterday, at any time, anywhere, while you were outside, not in your home, outside in the public, did you ever take more than two steps without your cane?

Answer, to my knowledge, no.

Did Mr. Kelner ever tell you Mr. Szpakowski testified that way?

A No, sir.

Q Would you agree with me that a person who walks at least 40 feet without the use of a cane is taking more than one or two steps?

A Obviously.

Q Obviously.

Now, sir, you have, to a certain extent, a business relationship with the Kelners, am I correct?

A When you say, “a business relationship,” meaning, what, that they have referred cases to me before in the past?

Q Yes.

A Yes, that is correct.

Q And you have testified for them in the past?

A Yes.

Q And you, of course, are being compensated for your time today?

A Yes, sir.

Q And you are also, of course, being compensated by the patient who they refer you to for their medical treatment for them?

A That's usually covered by a third party, yes.

0 So you're being compensated?

A Yes.

Q Paid?

A Yes.

Q And how much are you beg paid for your time today?

A 3,000 for half a day of testimony, 1,000 for pretrial preparation.

0 Okay. You said for half a day?

A Yes, sir.

Q Today is a full day?

A Depends how long you keep me. If you keep me part of a half a day, I will prorate it.

Q Okay. What is a half a day?

Isn't chat the morning?

A Half a day is morning until when?

Now, if you keep me here until 3:30, one hour, obviously, I'm not going to charge the full fee for half a day. I'll prorate that amount.

Q You'll prorate the 3,000 or you'll prorate something higher than 3,000?

A Let me make it simpler for you.

Q Please.

A If you keep me here until 3:30, by the time I get back to my office, it will be about 4 o'clock. I'll probably charge another extra thousand dollars in addition to the 3,000.

Q Okay. And there was preparation time for today?

A Yes, sir.

Q And there was preparation time for the last trial?

A Yes.

Q And you testified at the last trial?

A Yes.

Q So, we're talking about a fee anywhere from 8 to $10,000?

A No, sir.

Q Okay.

A Let me do the math.

I'm sorry.

You're correct, yes.

Q Okay. And you've testified on many occasions in the past, correct?

A Yes, sir, I have.

Q Approximately how many?

A To date, I'd probably say, about 180 times, give or take two or three.

0 And those are always on behalf of your patients, correct?

A That's correct.

Q Not -- plaintiffs?

A Yes, sir.

Q And you have, in the past, testified in conjunction with a Dr. Barenson, correct?

A Yes, sir, I have.

Q Now, approximately how many times, on average, have you testified on behalf of Mr. Kelner's office?

A I can't give you an exact number. Probably between six to seven times. It could be slightly leas, slightly more.

Q When did Mr. Szpakowski first come to you?

A October 6, 2000.

Q And when, for the first time, did you see his medical records?

A I'm not sure. It was shortly around the same time I saw him the first time, because, when I examined him, i had the past medical records.

So, I would say, from what they provided to me beforehand, or certainly at the same time.

Q And who gave you those records?

A I believe Mr. Kelner's office.

Q And did Mr. Kelner speak to you before you examined Mr. Szpakowski?

A To my knowledge and recollection, no, sir.

Q Okay. Would you make a notation in your file if you had spoken to him?

A No, sir.

Q So you're recalling now, over four years ago, whether or not you spoke to Mr. Kelner?

A I'm saying to you I don't have any independent recollection. I'm not sure.

Q Okay. You could have, and, on the other hand, you might not have, fair enough?

A That's correct, sir.

Q And when, for the first time, the first time, did you ever look at any actual x-rays?

A The last case we had together, May of -- May 19, 2004.

Q May 19?

A Yes.

Q So we're talking about approximately three and a half years after you started treating Mr. Szpakowski is the first time you actually saw any x-rays?

A I had the record, but the actual x-rays, that was the time, yes.

Q That's what I'm asking.

A Yes, that's correct.

Q And the same with CAT scans, rignt?

A Yes, sir.

Q In the case of the -- the first time you looked, physically, you, at the film, as the treating physician, ever looked at the actual CAT scans, was approximately three and a half years after you started to treat Mr. Szpakowski?

A That is correct.

Q Okay. Can Mr. Szpakowski work?

A Did he work?

Q No, can he work.

A Right now?

Q Right now.

A No, sir, in my opinion, no.

Q He can do nothing?

A That'a correct, no type of gainful occupation that's either part-time sedentary or above and beyond that.

Q So it's your testimony that he could net, for even one hour for the entire year, work as a translator, correct?

A If you told me --

Q I'm sorry.

A One hour?

Q Is that your testimony?

MR. KELNER: Your Honor, he's trying to answer the quest ion.

I think we should let him answer the question.

A If you ask me, can he work one hour --

Q Yes.

A -- absolutely.

Q Okay.

A Can he work two hours?

Absolutely.

Can he work more than three to four hours on a continuous basis, on a daily basis?

No.

Can he work sporadically?

Yes, he can.

But depending on how much work he does, what he does, how much sitting he does, he will pay the price depending on the amount of work he does.

Q Okay. So let's just slow this down.

Can he work one hour a day?

A Every day?

Q Every day.

A Some days yes, some days, no.

Q Okay. You have people who work in your office?

A I do.

Q You give them sick days?

A Sick -- six sick days a year.

Q Six?

A Yes.

Q You would agree with me not everybody works every single day, correct?

Is that a “yes,” or “no”?

A That question cannot be answered with a ‘yes,” “o” because everybody is different.

Q Okay.

A Everybody's medical condition differs a well.

Q Okay. But people get sick days?

A They get sick days, yes.

Q They get to use those sick days?

A That is correct.

Q So I'll go back.

Can Mr. Szpakowski work one hour a day?

A Again, I answered your question, and again, I repeat it, can he do it on some days?

Absolutely, yes.

Can he do it every single day out of 365 days a year?

??

Q How many people you know work 365 days a year?

Do you work every day?

A I work every day, seven days a week.

Q You're a good man.

A Thank you.

Q Other than yourself, is there anyone else you know that works 365 days a year?

A I don't know.

Q Do your employees work 365 days a year?

A My employees?

No.

If I fcrce them, they'll quit on me. They would not work those hours.

Q Your statement that he can't work 365 days a year was a rhetorical statement, you didn't mean it in real life, because nobody works those kind of hours except, of course, yourself?

A There is other people that -- other doctors that work those hours, yes, they do.

Q Okay. Can he work two hours a day?

A He can work two hours a day, he can work three hours a day, he can work four hours a day, five hours a day, six hours a day.

Again, if you ask me, on an annual basis, can he work those hours, absolutely, yes.

The question is, can he do it every single day.

The answer is, no.

He's going to have good days, he's going to have bad days.

Can he work, in one week, five days a week, can he work two days a week, one and two hours a day?

Absolutely.

Can he do it every single week?

Absolutely not.

Q Would you agree with me that being able to work one, two, or three hours a day as -- is considered part-time?

A Part-time, in my understanding, is less than four hours a day, less than ten hours a week.

Q So, he can work part-time, correct?

A Again, limited hours yes. He can work limited hours doing light sedentary work. Again, he'll have good days and bad days. He will not be able to do it on a continuous, sustained basis for the reasons I gave.

Q Okay. And, at the last trial, you were asked the question, can he work part-ime, and in fact, today, you were asked, can he work part-time, and you said, no, correct?

A Again, on a regular basis?

Q Correct.

A I have to explain my answer. On a regular, sustained basis, no. For the reord, no, on a regular, sustained basis.

If you ask me, can he work sporadically, the answer is, yes.

Q Did you ever tell Mr. Szpakowski that be could work sporadically?

A I told him -

Q No. I'm asking you, did you -- did you ever him -- tell him, jo work soradically?

A No. I -- I did tell him --

Q I didn't ask you that. You'll have an opportunity. If I don't get to it, Mr. Kelner will.

You've testified, you said, 1B0 times, correct?

A That is correct

Q You know the procedure, at time of trial, that as best as you can, you should respond to my questions, correct?

A If it can be answered.

Q If it can be answered?

A If it cannot, I simply cannot answer it.

Q You'll say, right?

A That is fine.

Q Of course, the attorney who brought you in to testify always has the opportunity to ask you further questions, fair enough?

A Fair enough.

Q Okay. Then Mr. -- did Mr. Szpakowski ever ask you whether he could go back to work?

A That was never discussed.

Q So he never asked you?

A No, for a very good reason.

Q I didn't ask you that.

A There is a reason.

Q And Mr. Kelner, I'm sure, will get into it.

But by all means, tell me, what was the reason what Mr. Szpakowski never asked you whether he could work part-time?

A May I answer?

Q Yes.

A Because I told him right now, he should not work for the reasons I gave earlier this morning.

If you like, I can repeat them all over again.

Q You've already told us that.

A Okay.

Q So he shouldn't. do anything which would endanger him, correct?

A Endanger him, cause increased pain, cause increased damage, cause increased irritation to the muscles, tendons, nerve rcots, and disks, that is correct.

Q And does that include going up and down staircases?

A He can go up and down staircases, a limited capacity.

Q What is “a limited capacity”?

A Everyone has their own tolerance. On some days, he can go up and down more, on some days, he can go up and down, stairs less, he can go up and down, perhaps, 40 steps on some days, some days, he cannot, it depends on how he feels.

Q And he can walk outside during the winter months?

A Some days he can, some days, he should not.

If it's snowy, and slippery, and icy, he should not.

Q Did he ever go to your office when it was snowing outside?

A I don't recall if it was snowing and he came, I don't recall. He did come see me in winter months, yes.

Q And rainy days also, correct?

A I don't know. I don't have the weather almanac in my possession to answer your question.

Q Now, Mr. Szpakowski can carry weight, right?

A He can.

Q How much?

A Occasionally, on some occasions, no more than ten pounds.

Q And he can stand for a period of time, correct?

A On a continuous basis, no more than one hour.

Q And how about sitting?

A On a continuous basis, no more than three to four hours.

MR. ROSENHECK: Your Honor, this had been -- previously marked it as a defendants' exhibit.

THE OFFICER: Marked in evidence?

MR. ROSENHECK: I will be seeking that to be marked in evidence.

Right now, I need to identify it.

THE COURT: What's the exhibit number?

MR. ROSENHECK: Defendants' A.

Q Do you see the document I just gave you?

A That's correct.

Q Okay. And that's your signature, correct?

A There is two of these documents, one is dated 2/20/02, this is dated 7/24/02.

Which one are you referring to, this one (indicating)?

Q The one I gave you.

A But there are two of these documents, exact duplicate documents, different dates.

THE COURT: He wants you to identify just the one he gave you.

THE WITNESS Yes, okay.

Q That's your signature?

A That is correct.

Q I'm sorry.

That date is July 24, ‘02?

A That is correct.

Q Okay.

MR. ROSENHECK: Your Honor, I'd like to have that marked in evidence, please.

MR. KELNER: May I see, your Honor?

May we approach the bench?

MR. ROSENHECK: You know what?

I'11 ask the question, I won't look to put it into evidence.

Q Doctor, would you agree with me the document in front of you, under number 2, says --

THE COURT: How can you do that if it's not in evidence?

Q Doctor, in your notes, do you have a document that reflects that the plaintiff can stand or walk up to two hours per day?

A I do.

Q Do you also have a document in your file that reflects that he can sit less than six hours per day?

A I do.

Q And, in that same document, there is also a marking which says, “sit less than two hours per day”?

A That is correct.

Q So, would it be fair to say your marking that he can sit less than six hours per day means he can sit between two and six hours?

A That's correct.

Q Okay. Does it also indicate, with respect to lifting and carrying, that the maximum number of pounds that can be lifted and carried, from one-third to two-thirds of the workday, is two to three pounds?

A That's correct.

Q And does it also say that he can carry, up to one-third of the workday, five pounds?

A I think you have -- I think you have it backwards.

Q I don't.

A Maybe I misunderstood.

Frequently is two to three pounds, occasionally one-third of the workday is five pounds.

Q Okay. And now you also testified today he can, in fact, carry up to ten pounds, fair enough?

A Occasionally, yes.

Q Okay. Thank you.

A You're welcome.

THE OFFICER: Do you want that document?

MR. ROSENHECK: It's his document. Oh.

THE OFFICER: The one you just gave me.

MR. KELNER: May I?

Q You prepared three reports for this case, correct?

A One second.

Two narratives, one initial typed report.

Q Okay. The initial typed report, was that for litigation purposes?

A No, that was sent to the carrier for obtaining appropriate physical therapy, EMG, and CAT scan approvals.

Q And the second report?

A The second and third were narrative reports done at the request of Mr. Kelner's office.

Q Okay. Is his name on any of those records?

A No.

Q Why not?

A I don't put attorneys' names on my reports.

Q He requested them?

A So?

Q You prepared it for him?

A So?

Q You senc it to him?

A I don't put an attorney's name on my narrative reports. It's just not done that way by my office.

Q Why?

A Because I feel not to do it that way.

Q Do you have a cover letter to Mr. Kelner where you forwarded those records?

A No.

Q How did you send it to him?

A By mail. By mail and/or fax. I'm not sure. It was sent to him either by mail, or by way of fax.

Q And when you sent it by mail, did you just put the report in an envelope and send it to him without any cover letter?

A I do not do that, I have an office manager that handles that. Typically, the way it is done, they put the report in an envelope, and they address it to the attorney of that case.

Q Okay. Were you paid for those reports?

A The first report yes the second report no.

Q How much were you paid for the first report?

A $300.

Q So that's another fee associated with this case that you received?

A. That's correct

Q Thank you.

A You're welcome.

BY MR. KLEIN:

Q Good afternoon, Doctor.

A Good afternoon, sir.

Q Now, Doctor, there is treatment, is there not, for disk herniations?

A Treatments, yes.

Q Do you have the EMG films?

A No such thing exists.

EMG tracings.

No such thing as EMG films.

Q The tracings, you have?

A I do.

MR. KLEIN: Can we have those marked aid put ir. evidence, please?

MR. KELNER: Objection.

MR. KLEIN: They're his films, I mean, his EMG.

MR. ROSENHECK: We move to strike his testimony with respect to the EMGs, your Honor.

THE COURT: It's a little late.

What is the basis for the objection?

MR. KELNER: Your Honor, I think he's already testified to it. I don't think it has to go into evidence at this time, and we haven't had the doctor specifically interpret or mark, on each of the films, his exact testimony.

So, I think that it just should not be in evidence.

THE COURT: I don't understand.

We have not had the document --

MR. KELNER: May I approach the bench?

THE COURT: Yes.

(Conference held at the bench between the Court and counsel off the record.)

MR. KELNER: You know, Judge, I'll withdraw the objection.

MR. KLEIN: Okay. That will be Exhibit B.

THE COURT: What exhibit is this?

MR. KLEIN: B.

MR. ROSENHECK; A was for identification.

THE COURT: Let's mark it.

MR. ROSENHECK: B is in evidence.

THE COURT: What is this?

THE OFFICER: B -- Defendants' B for identification.

THE COURT: Okay.

Now we're marking it in evidence?

THE OFFICER: In evidence.

MR KLEIN. In evidence

(Received and marked Defendant Exhibit B in evidence.)

THE OFFICER: Would you like it shown to the witness?

MR. KLEIN: Yes.

Q Those are the EMG studies?

A Yes, these are the tracingss

Q And those tracings were done by you?

A Yes, sir. They were produced by the computer.

Q Right. And you reviewed them, correct?

A Yes, sir.

Q And part of your testimony this morning was based on that?

A Yes, sir.

Q Now, you're associated with the Rusk Institute at NYU Medical Center?

A Through Hospital for Joint Diseases, yes, sir.

Q Okay. And do you recall at the last trial, I asked you if you knew a person by the name of Dr. Joyce Mesch-Spinello, and you said you didn't?

Correct?

A That is correct.

Q Do you know her now, as of this date?

A Other than what you've told me just now, I don't know her personally.

Q Have you ever heard the name?

A Other than what you said, no. I don't know of her outside this case.

Q Outside me just asking you, do you know the person by that name?

You never heard her nam before, correct?

A That's correct.

Q And you never saw it anyplace at the Rusk Institute, correct?

A I have not.

Q Now, you're also paid certain monies in preparation of your testimony here today?

A Yes, sir.

Q How much is that?

A I said already, it's 1,000.

Q You also paid 1,000 back in May for your preparation?

A Yes, sir.

(Transcript continued on the next page.)

Q And presently Mr. Szpakowski can sit for three to four hours at a time?

A Yes, sir.

Q Did any one from Mr. Kelner's office speak to you when Mr. Szpakowski was first referred to you, anyone at all from his office?

A I'm trying to think. Either Gail Kelner or Mr. Kelner himself. One of them spoke to me some time.

Q And before I believe you were testifying that you don't recall Mr. Kelner speaking to you correct?

A I'm saying one of them spoke to me. I don't know which one.

Q And what did Gail Kelner tell you?

A Shortly before trial that she was asking me about my availability and if I had time to go over the medical aspects of the case with her and that was basically what was discussed.

Q All right I'r talking about the first visit, the initial referral to you?

A No, I don't recall speaking to anyone before my first initial visit.

Q Did you ask Mr. Szpakowski who referred him to you?

A Oh, I knew. I knew. When he came, he told me Mr. Kelner's office referred.

Q So, you didn't -- you knew once Mr. Szpakowski told you, right?

A That's correct.

Q You didn't know before?

A Right.

Q Have you discussed with anybody at the Rusk Institute Mr. Szpakowski's ability to be employed?

A No, sir.

MR. KLEIN: Thank you.

THE COURT: You're welcome.

REDIRECT EXAMINATION

BY MR. KELNER:

Q Just a few questions. Dr. Guy, tell us what that document is please?

A This is a pnysical capacity evaluation for the purpose of Social Security disability.

Q Okay. When was that prepared?

A 7/24/02.

Q So, that would be your opinion as to his conditior on 7/24/02?

A That's correct.

Q And how much -- why don't you go through the document and tell us what you found at that time?

A There were three questions. The first question is lift and carry. Is there limitation or no limitation. Obviously, there is limitation. At that time the limitation was occasionally he could carry up to 5 pounds and frequently the most he could carry was 2 to 3 pounds. Second question was his ability to stand or walk. There was limitation. He could stand and/or walk to a total of two hours per day. A day is 24 hours. Sit. Is there limitations or no limitations. The limitations I checked off was less than six hours per day. Again, a day is 24 hours. He can sit intermittently up to six hours a day.

MR. KELNER: Okay. I'd like to offer that into evidence now, your Honor.

MR. ROSENHECK: Okay.

THE COURT: What is the exhibit number?

KR. KELNER: I think we're on 16 now. Does that sound right?

THE COURT: Yes. Okay.

(Plaintiff's Exhibit 16 marked in evidence)

Q You said that -- by the way, Doctor, how long have you and I known each other about?

A Gosh. Twelve years, perhaps more.

Q And about how many patients do I ask you o see per year on average?

A Very small amount. To the best of my recollection, about two per year. They are usually big, big injuries.

Q And the people that I have you see, are they people that do not have their own private doctor or need someone within your specialty?

MR. ROSENHECK: Objection, your Honor.

THE COURT: Sustained.

Q Did Marek Szpakowski have a private doctor at the time that he was referred to you?

A No, sir.

Q And you've been treating him ever since and seeing him at least once a month or approximately once a month for examinations, correct?

A Yes, sir. That's correct, along with the therapy that he received, yes.

Q Now, Mr. Rosenheck asked you as to whether it was your opinion that Marek could work and you said -- and then you got into six sick days per year is what people in your office have.

If Marek were given 26 sick days per year, do you have an opinion that you can express with reasonable medical certainty as to whether he could be there enough to keep a job?

A I do have an opinion.

MR. ROSENHECK: Objection, your Honor.

THE COURT: Sustained.

MR. KELNER: Is that on form, your Honor, or substance? Just so I know what I'm doing wrong.

THE COURT: To tell you the truth, he's not a vocational expert.

MR. KELNER: Your Honor, he is a vocational expert.

Q Doctor, did you testify before that --

MR. ROSENHECK: Your Honor, can we approach please.

(Discussion held at the Bench)

Q Doctor, as a physiatrist, is the issue of vocational rehabilitation exactly within your field of specialty?

A Absolutely yes. We get tested.

Q Did you say that before, Doctor, to refresh my recollection?

A I did.

Q Was that part of your testimony earlier?

A Yes, sir.

Q Do you have an opinion that if someone gave Marek Szpakowski five times the sick days that Mr. Rosenheck mentioned of 30 sick days per year, could Mr. Szpakowski in your opinion with reasonable medical certainty hold down a job?

MR. KLEIN: Objection, your Honor.

THE COURT: Sir, I have a question. Have you made any kind of survey the availability of jobs and the requirements for them?

THE WITNESS: Not in those exact words, Judge, but I am familiar with the requirements of different jobs. The vocational rehabilitation experts follow physiatrists preparings as to diagnosis, disability, impairment. Then they make that calculation based on those guidelines. If the guidelines indicate he cannot do a certain type --

THE COURT: What guidelines are they?

THE WITNESS: I just finished explaining the guidelines of diagnosis, disability, impairment, how long they can sit, how long they can stand, how much they can pull, push or carry. Then they base that on that information as given to them.

THE COURT: I understand that but do you have a specific knowledge based on your interaction with vocational experts on what the substance of those guidelines are, what they say?

THE WITNESS: I don't understand your question, sir. what the substance of the guidelines?

THE COURT: Yeah, what's in the guidelines. How are you going to testify as to his availability if you can't refer to some criteria.

THE WITNESS Judge, the vocational rehabilitation experts follow a physiatrist guidelines, is he employable yes or no, can he do X, Y, Z. They cannot force a patient to work if he doesn't have medical clearance. The reason is if he gets hurt on the job.

THE COURT: I understand but do you have a knowledge of what's out there for people to be --

THE WITNESS: Oh, I do.

THE COURT: -- equipped for?

THE WITNESS: I do, Judge. I don't have a knowledge of every single job but I have a general knowledge, what types of jobs are available. For example, sedentary jobs, security, sitting watching a monitor from a distance. There are jobs such as answering telephones with a headset. These are some of the jobs that are available.

THE COURT: How did you acquire that knowledge?

THE WITNESS: Part of my training at Mt. Sinai when I was doing my residency. We had a rotation in vocational rehabilitation.

THE COURT: Okay. I'll allow it. I'll allow him to testify.

MR. KELNER: Thank you.

Q Could you answer that question?

Let's say we give him five times the six sick days Thirty sick days per year. If there were such a job that had that, do you have an opinion that you can express with reasonable medical certainty?

THE COURT: I think it's vocation in this case.

Q Reasonable medical certainty as to whether he physically could do that?

A I do have an opinion and the answer is no, he would not be able to do that.

Q Because he's going to have numerous days when his back would bother him, can he sit on one day?

A As I explained, yes. Can he sit on two days? Yes. Can he sit for two, three hours? Start to add that all up. As you sit on a continuous basis, the pressure on the disks and the nerve roots starts to exponentially increase once you go over two, three, hours. Once you have that on a continuous basis is the way it becomes a physical impossibility with these types of injuries.

Q Have you seen Mr. Szpakowski on both good days and bad days?

A I have.

0 In the dozens of times that you've seen him?

A I've seen him more than a dozen?

Q Dozens.

A Sorry, dozens, yes.

Q In those dozens of times that you have seen him, describe him on a good day and describe him on a really bad day?

A When he was gettina his therapv --

MR. KLEIN: Objection your Honor.

Can we have a timeframe as to when this occurred.

THE COURT: If you can, give us a timeframe.

THE WITNESS: I'll give you past and recent. In the beginning when he was getting physical therapy, he would be better. He would have less pain but he still had pain, discomfort and loss of range of motion and abnormal gait. When he was taking his medications, the weather was warm, he was getting his physical therapy, that's when he would be at his best. When the weather would be cold, lack of therapy, lack of pain medications, that would be his worse.

Q And when ne was having a bad day, could he function in any kind of job?

A No, sir.

Q Why?

A When you have pain, you cannot concentrate properly. You cannot sit properly. You try to move from side to side to find a comfortable position. Your mind will not be on your job. Your mind will be on finding a way to relieve your pain.

THE COURT: Okay. Now, you said he could lift 10 pounds. He could lift 10 pounds in a job continually up and down.

A No, sir, I said that is the most he could ever lift. On a continuous basis and not even on a repeated basis.

Q What would happen if he tried to lift 10 pounds over just one four hour period? What would that do to his condition?

A It will tremendously reinjure his lower back.

Q Now, you were asked by counsel when you first saw the films of Mr. Szpakowski, when a film is taken, does a radiologist write a radiology report giving his interpretation and an analysis of the particular film?

A Yes, sir.

Q And would that be so for either a CAT scan, an MRI or a regular x-ray.

A Yes, sir.

Q And did you read all of those radiology reports?

A Yes, sir

Q For Mr. Szpakowski in the course of your treatment?

A Yes, sir. It's right in my first report.

Q Okay. How many patients do you see in a year?

A Can't give you an exact number but thousands.

Q Thousands?

A Yes.

Q So, you've said you've testified something like 180 times for your patients?

A That'a right.

Q How many years is that?

A 16 years.

Q So, that would be something in the range of 12 per year, 11 to 12 per year. Once a month you may testify for a patient?

A Some months more, some months none at all.

Q Herniated disks. Mr. Klein asked you about treatment for herniated disks. What's the treatment for a herniatad disk?

A There is treatment for disk herniations but there is no cure for disk herniation as I explained earlier. Like arthritis and diabetes, there is no cure, there is only treatment. One treatment, it's called conservative. It's physical therapy, exercise, anti-inflammatory medications, hot packs, so on and so forth.

Q Does that always work?

A No. When you get it, you get a temporary relief. It's called palliative. You get a temporary relief. It's better to get it than not to get it because if you don't get it you might get progressively worse. It's better to do it than not to do it. Other treatments are nerve blocks, epidurals which have a lot of side affects, complications which in this patient you don't want to take a chance.

Q Is that a needle into the spine?

A Yes,sir.

Q You don't recommend given the fractures that he's had not to do that?

A Also the altered anatomy with all the screws and pedicles and hardware present. I would not recommend.

Q But you give patients these needles into their spine when they are appropriate for them, correct, Doctor?

A I do, yes sir.

0 What other treatment is there for herniated disks?

A Last resort is surgery.

Q That was the foraminotomy that you prescribed before?

A There is two types of surgery. The first type is a laminectomy, foraminotomy and now as of last week the FDA has approved prosthetic disk replaement. Again an artificial disk inside your spine.

Q Can you jut give us a little more detail about each of those two procedures?

A The disk replacement?

Q Yes.

A You have an artificial disk which has a Teflon coating with titanium. Inside is a gelatinous material to basically simulte a normal disk. You will take out the old disk. You replace it with a new disk.

In this case at the L4, L5 level you cannot do that because the L4 is fractured still. If you take that disk out, the whole thing, the whole building is going to collapse. So, I don't want to do that.

So, the most you can do is foraminotomy, shave the foramen to allow there to be more room and space for the nerve root as it is exiting but again you have to be so careful because if you overdo it you can make the broken fragments worse.

Q Now, you said that he might be able to sit three or four hours at a time as I recall. Is that on a sustained basis for a job?

A No, sir. That is on an unsustained basis, only occasionally and he will pay the price for it.

MR. KELNER: Thank you.

MR. ROSENHECK: Before I start my recross, can we approach for a moment, your Honor?

THE COURT: Step up.

(Discussion held at the Bench)

THE COURT; We'll take a break.

(Jury excused)

MR. KELNER: Judge, may I put this on the record?

Mr. Rosenheck has requested off the record that he be permitted to inquire as to the plaintiff's application for Social Security disability. There is a form here. I don't know whether Dr. Guy mentioned social security or did not mention social security. didn't happen to hear that but whether he did or he didn't, that is not grounds to open up the issue of social security disability where I would have to call five witnesses in to explain a social security disability process. It is a completely separate proceeding.

THE COURT: Has he been denied social security disability?

MR. KELNER; I believe he has not gotten social security disability and I believe, Judge, I need to speak to someone in my office on this, that he didn't have enough quarters in. You know, in other words, the timeframe. I don't think that this is anything to do -- and I don't even know whether the process is over yet. It's something that I would have to find out about but it's a totally separate proceeding.

THE COURT: You opened the door. Yes, it's a totally separate proceeding but if you mentioned it you leave the jury with the impression that he's getting social security disability.

Let's hear what the testimony was.

MR. KELNER: Judge, well then could I then ask for your Honor to give whatever curative instruction you would want to give with regard to this? This clearly is a completely collateral proceeding and has nothing to do with this case even more than a person can put in a Workers' Compensation form?

THE COURT: Well, I understand what it has to do with this case.

MR. KELNER: No, your Honor, I would like to state that a Workers' Compensation form under certain circumstances may go into evidence and that doesn't open up the whole comp issue.

THE COURT: But that is always redacted. So as far as there is nothing on this document that says anything about social security, all I want to know is whether there was testimony that he applied for social security disability and then you can put in whatever evidence you have contrary to that but I can't help it if the door was opened. I didn't open it.

So, let's hear the testimony.

(Whereupon, the testimony was read back by the Reporter)

MR. KELNER: Let the record indicate we are out of the presence of the jury.

The doctor happened to mention that this was a form that was prepared for a social security disability form. The entire social security proceeding I've been advised by my client is an open issue at this point. This is not something where I should be required to have this entire issue brought out. It is a totally collateral proceeding. I should not -- this should not be something that should come up before the jury. The jury could conceivably in its own mind either add or deduct figures because of this.

This is very prejudicial to the plaintiff to have this issue come up. I think that nothing further should be done with regard to this but if your Honor feels that a curative statement from your Honor should be made, I certainly would not object to that but this certainly does not open up a whole separate pruceeding. where I now have to learn all about social security disability, call witnesses with regard to this. It's terribly prejudicial.

This certainly does not open the door to going into an entirely separate proceeding. It will only cause prejudice for no reason and this -- at this point is such a non-sinister situation.

I would ask that your Honor not permit further inquiry on this issue.

THE COURT: Well, you're perfectly right it is collateral and it shouldn't have been mentioned. It shouldn't be mentioned but it was.

Therefore, in order to set the record straight, if defendant wishes to, I'm going to allow him to ask the question.

It doesn't stop you on rebuttal from saying that the application has not been -- he has not received a response to the application and that should end it. I don't see what the prejudice is and I don't see that it's so terrible. I do see that it leaves an impression on the minds of the jury that he may be getting social security at this time and that would be prejudice to you by the way.

I don't see how it's prejudice to you to have this question asked because at this time the jurors may be thinking that he's getting social security disability.

MR. KELNER: But your Honor it's like Workers' Compensation. It is something that is -- it patently is not allowed during a trial.

THE COURT: That's correct but if it is, it has to be addressed. It should not have been mentioned and it was. So, counsel has a right to inquire about it.

I don't see why you have to get into the question of what is social security and how is it distributed and what are the requirements and to bring in six witnesses. I don't see why you have to do anything more than say he's not getting it yet. Period. What is so wrong about applying for it?

MR. KELNER: It's a totally collateral issue.

THE COURT: It is. I agree with you.

MR. KELNER: Are you going to permit then inquiry -- in other words, you're permitting him tc ask the question of the doctor. Then are they permitted to ask questions of Mr. and Mrs. Szpakowski as well on this issue, Judge, or is that the end of it?

THE COURT: Well, if there is rebuttal, they have the right to cross-examine, don't they?

All I'm going to allow since social security is not supposed to be a part of this proceeding is for them to inquire whether he's getting it period, whether he is getting social security disability.

I don't even know how the doctor can answer that and if there is an issue about it, I will allow you to put your client on in rebuttal. I really don't see the prejudice.

MR. KELNER: Your Honor, I would respectfully except. There is tremendous prejudice. Just as with Workers' Compensation, they assume that someone is get money from another source and that they don't need to comensate the person in this forum.

THE COURT: Well, can't that issue be allayed by your client saying that they haven't responded to his application yet?

MR. KELNER: Your Honor, I would need time to speak to my client to find out exactly how the procedure works, what has been done, what hasn't been done. I'm not certain that Mr. Szpakowski who is not a -- who may not know all the ramifications of this and I think that this is just improper.

I would ask that you just give a curative instruction.

THE COURT: Because the issue is in your eyes harmful to the plaintiff is not a basis for saying that it is inadmissible. It shouldn”t have been -- well, I don't know how to cure the instruction except by causing more confusion in the jury's mind.

MR. KELNER: Just simple, your Honor. All you have to state is that anything that Dr. Guy may have said about the issue of social security should not be in their mind and please disregard it which is what Judges do with regard to issues that don't belong in a case many times. This is clearly an issue that your Honor stated does not belong in this case.

When there are -- when a witness accidentally blurts out the word insurance which happens in many cases involving automobile accidents, what Judges always will do in that is to state that that is not to be something within the jury's consideration. It is blurted out. It is not something that is the subject properly of inquiry in the particular case.

This is identical to a situation where someone mentions insurance in an automobile accident case.

This is clearly, as your Honor stated, this is not something that belongs in the case.

The fact that the word was stated probably has gone completely passed most of the jurors and in any event since we have an issue that doesr't belong in the case, came up completely inadvertently by the doctor in this case, will require a complete collateral analysis of a matter that we all know doesn't belong in the case.

I would ask your Honor not to permit this totally collateral issue to come in.

MR. ROSENHECK: Your Honor, you've already ruled on this. We've gone on off the record and on the record. Mr. Kelner is revisiting your ruling now for the fourth time. The bottom line is he opened the door. He introduced the document. He asked the doctor about the document and the doctor said that it was prepared for social security.

He opened the door. I came to the Court and said that I had all intention of inquiring with respect to social security because it's appropriate and I still feel it's appropriate.

MR. KELNER: By the way, if a document is prepared for social security, that doesn't mean that you open up the whole issue to tell the jury X, Y and Z has happened with social security. They allow this; they didn't allow that.

This would be the subject, your Honor, of something for collateral source purposes perhaps but that would not be for the jury. That would be for you after the trial is over.

THE COURT: I know it's a collateral source issue.

MR. KELNER: But it's not for this -- it is clearly not something for the jury. And based on the fact that it would, A, in a collateral source hearing would be for your Honor only; B, it was blurted out inadvertently by Dr. Guy; C, it is not something as we've all realized that would normally and properly be part of a trial such as this This should not be in the case.

And if necessary, if you feel a curative instruction is necessary, fire. Then I have no problem with that but my view is that even if there is a document, if someone says, gee, this is a Workers' Compensation document, that doesn't mean you open up a whole Workers' Comensation issue. That is a collateral source issue for the Judge only.

THE COURT: Okay, my ruling is that the inadvertence of the doctor should not be allowed to open the door to this issue. It was mentioned in passing. I didn't, myself remember it If anybody wishes, and I think counsel is right, it opens up an issue that should not be before the jury, and I don't think that I would give a curative instruction now, because it would draw their attention to it.

:If anyone wishes me to give a curative instruction as part of my final instructions to the jury, I will do so. But I'm convinced now that we didn't go into the details, it was just mentioned in passing. The document does not, does not mention social security, so it won't go into evidence as a social security document, and therefore I agree that the matter of social security should be addressed in a collateral hearing before the Court.

MR. ROSENHECK: Your Honor, you previously ruled we could bring it in.

THE COURT: I could change my mind. You know, you ever hear of a motion to reargue?

MR. ROSENHECK: But plaintiff's counsel is the one who asked the question about the document.

THE COURT: He didn't ask about social security

MR. ROSENHECK: He said, why was the document prepared.

THE COURT: So he's allowed to get this in. Now, we have another issue, all I heard was this was prepared for social security, I didn't hear him ask why was the document prepared.

MR. ROSENHECK: You ruled first, your Honor. I mean, revisiting this thing adnauseam by the plaintiff's attorney, you already ruled.

THE COURT: I undersand, but I'm entitled to change my mind.

MR. ROSENHECK: Then listen to the full thing about how it got in and how he introduced it into evidence. How he questioned the doctor about that particular point, and how the doctor who has testified 180 times.

THE COURT; I think the only thing we heard was that the doctor mentioned this was a document prepared for social security, period.

MR. ROSENHECK: Listen to the questions beforehand, your Honor.

THE COURT: Why didn't you have me do that when she first read them?

MR. ROSENHECK: Because you already ruled for us, your Honor.

THE COURT: But I was, I was, trying, I hadn't actually ruled for you, I said let me hear what the testimony is before I rule.

MR. ROSENHECK: And then you ruled for us, then you allowed him to continue the argument.

THE COURT: I ruled. Well, okay, I'm entitled to change my mind.

MR. ROSENHECK; But then at least listen to the other testimony.

THE COURT: I don't want to go through it. We wasted enough time, it's time for our break.

MR. RQSENHECK: Your Honor it's not a waste of time for us.

THE COURT: You have your objection.

(After the recess.)

THE OFFICER: All rise, jury entering.

THE COURT: Be seated.

Cross examination.

MR. ROSENHECK: Thank you, your Honor,

RECROSS EXAMINATION

BY MR. ROSENHECK:

Q Dr. Guy, when you took over the treatment of Mr. Szpakowski, were you under the impression that he had no doctors?

A He didn't have a regular primary physician, he had treatments at Bellvue.

0 So, he had no doctor who was treating him as one would call a family physician?

A A primary care doctor, he did not have one. When you go to Bellvue you have a different doctor each time, you don't have a regular, set doctor.

Q Okay. Now, forgetting Bellvue for a second.

A Uh huh.

Q To your knowledge, did he have a family physician?

A I don't know.

Q What do you mean, you don't know?

A. You --

Q You didn't ask him when he first came to you?

A No. It's not pertinent to the case. He did not not have a regular doctor taking care of him for this particular case.

C How do you know?

A He told me he didn't have one, he wao going to Bellvue.

Q So he was going to the clinic?

A That's correct.

Q And the clinic is Bellvue where they performed his surgery?

A Yes, sir, that's correct.

Q And seeing the physician who did the surgery is not a good idea?

A I don't think they see the same doctor each time. I'm familiar with how the clinic at Bellvue wcrks, they have different residents that see him each time. The surgeon that did the procedure does not see him every single time.

Q If he had seen the surgeon, if he had seen the physician who did the surgery, would that have been a good thing?

A Every single time?

Q Yeah.

A Yes and no. He would require to see him, someone else besides him as well, such as a physiatrist.

Q So, he did't come to you solely because he wasn't being treated by soemone, he went to you because you were a physiatrist?

A For a number of reasons. He didn't have a regular primary care physician that was taking care if his overall treatment with this case. The spinal surgeon only deals with the spinal surgery, the orthopedic surgeon only deals with orthopedic issues. The physiatrist takes care of the whole patient, A to Z.

Q Do you know who Dr. Ewa Wierzba is?

A No.

Q Well, do you know that she is his family phvsician?

A I do not know.

Q By the way, you can't force anyone to work, right?

A No.

Q You're not allowed to?

A That's correct.

Q And you also can't force somebody to work who doesn't want to work? Fair enough?

A Fair enough.

Q Thank you.

RECROSS EXAMINATION

BY MR. KLEIN:

Q Doctor, have you exaggerated any of your answers to any of the questions on cross examination here today?

A To the best my knowledge, no. If you have a specific question you want to ask me again, I'd be happy to reevaluate it.

Q Have you been a hundred percent accurate in your answers to the questions on cross examination?

A Again, to the best of my knowledge and recollection, the answer is yes. If you have a specific area that you want me to readdress, I'd be happen happy to do so.

Q I notice there is a wedding ring on your left hand?

A Yes, that's correct.

Q How long have you been married?

A Whatt does that have to do with this case?

MR. KELNER: Your Honor, this is improper.

THE COURT: Sustained.

MR. KELNER; This is recross.

THE COURT: Yeah.

Q Do you recall testifying that you worked 3G5 days a year?

MR. KELNER: Oh your Honor, this is improper.

THE COURT: Well , it is impeachment

MR. KLEIN: Goes to credibility.

THE COURT: I said, it is impeachment.

A Yes, I ??. years, I've taken no vacation. Some years on some occasion 1 do take a vacation, but I work seven days a week.

Q Okay. Do you have any children?

A I do.

year being a married and with children; is that correct?

A 1 do, that's correct.

Q Okay.

THE COURT: What is this, re-redirect?

MR. KELNER: No, this is redirect.

THE COURT; It is?

MR. KELNER: I'm sorry. This is --

THE COURT: Re-re.

MR. KELNER: This is just on the point he just raised, your Honor.

THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MR. KELNER

Q Dr. Guy, are you happily married with your family?

A Yes, sir, I am.

MR. KLEIN: Objection, ycur Honor.

THE COURT: Let's not go into this.

MR. KELNER: He went into this.

THE COURT: I know. So what?

Q Do you work 12 hours a day, seven days a week or do you put part time in on certain days?

A On Sundays I work part time, I don't work full time. Saturday days I work part time. Monday through Friday I work full time.

Q Thank you. Thank you. And Dr. Ewa ierzba, to your knowledge is a general practitioner that would deal with colds or the flu or something like that? Would that be the type of person that would deal with treatment of these injuries in this particular case?

A No, sir.

Q Thank you.

THE COURT: I doubt that you have any more questions.

MR. ROSENHECK: No.

THE COURT: You're excused.

THE WITNESS: Thank you, Judge.

(Transcript continued on the next page.)

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