2003 WL 25941062 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Kings County

James SANDERS,
v.
NEW YORK CITY TRANSIT AUTHORITY.

No. 340032003.
2003.

(Transcript of Dr. Ali Guy)

Case Type: Railroad >> Passenger Accident
Jurisdiction: Kings County, New York
Name of Expert: Dr. **Ali Guy**
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine

Representing: Plaintiff

the witness stand.)

THE COURT: Thank you.

(Whereupon, a lunch recess was held.)

AFTERNOON SESSION

COURT OFFICER: Are you ready for the jury?

THE COURT: Please.

COURT OFFICER: Please rise.

Jury entering.

(Whereupon, the Jury entered the courtroom.)

THE COURT: Please be seated.

As happened before, we're calling another witness out of turn.

Thank you.

MR. PILLERSDORF: I would like to call Dr. Ali Guy, please.

COURT OFFICER: Sir, please.

(Whereupon, Dr. Ali Guy took the witness stand.)

COURT OFFICER: Remain standing.

THE CLERK: Please stand, raise your right hand.

(Whereupon, Dr. Ali Guy was duly sworn by the Court Clerk.)

THE CLERK: You may be seated.

THE WITNESS: Thank you.

THE CLERK: In a loud, clear voice, please state your name and business address.

THE WITNESS: Yes. My name is Dr. Ali Guy.

A-L-I is the first name, G-U-Y is my last name. My office address is 7 Grammercy Park West, New York, New York 10003.

THE CLERK: Thank you.

THE COURT: You may inquire, counsel.

MR. PILLERSDORF: Thank you.

ALIGUY, called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PILLERSDORF:

Q Dr. Ali, first question: Are you a physician duly licensed to practice medicine in the State of New York?

A Yes, sir.

Q Let's get right down to this case as quickly as we can.

Could you tell the jury what your specialty is?

A Yes, physical medicine and rehabilitation.

Q Okay.

What is that, basically?

A It is a medical specialty that was founded shortly after World War II. It deals with traumatic injuries to the body, covering the body from head to toe. It deals with spinal cord injuries, below-the-knee amputations, nonsurgical orthopedic and neurosurgical

problems, patients that have cardiopulmonary problems, basically covers the whole body from head to toe, and traumatic injuries.

Q Now, Doctor, in as far as your hospital affiliations, could you tell us what hospitals you have been affiliated with?

A I'm a clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU Medical Center, where my duties are to teach the residents from NYU and prepare them for Boards one and part two.

Q Is the Rusk Institute at NYU?

A Yes, sir.

Q What is Rusk?

A The Rusk Institute was the first and premier training center in the world for this specialty.

Q Okay.

You also were affiliated with Maimonides Hospital here in Brooklyn?

A I was the director of the department of rehab medicine at Maimonides Medical Center in Brooklyn from 1995 to 2002, that is roughly five years, where my duties were to be involved and in charge of all the inpatient/outpatient rehab services, to provide teaching to the orthopedic residents, general surgical residents, internal medicine residents, and other doctors in my department. Also, provide teaching to other house staff members and to provide consultations to other doctors in my hospital.

Q Okay.

Following Maimonides, you were at the Hospital for Joint Disease, is that correct, Orthopedic Institute?

A I was at the NYU Hospital for Joint Diseases from 1990. I'm still there. But I was in charge of the neuromuscular equipment clinic from 1990 till December of 2005, that's 15 years.

Q Now, Doctor, in the field of medicine, there is, I guess, above being doctors, there are specialities and boards and Board Certification, is that right?

A Yes, sir.

Q To become Board certified in the field, what does that take?

A To become Board certified in my specialty you have to have the following prerequisites. You have to have training in a field other than physical medicine and rehabilitation, preferably one year of general surgery and one year of internal medicine. Then you have to take an accredited residency training program in the field of physical medicine and rehabilitation, it's a three-year program, and you have to pass the annual exams given by the department. You have to pass the monthly evaluations given by your doctors, your preceptors, and once you finish the training program, you have to sit and take your boards.

Part one, which is an eight-hour written examination, covers everything you learned from beginning to the end. You get tested on principles of orthopedics, neurology, neurosurgery, general surgery, muscle/nerve physiology, electrodiagnostics, interpretations of CAT scans, MRIs, EMGs, and other principles of physical medicine and rehabilitation.

Once you pass your Boards, part one, you have to be in private practice for at least 18 months to acquire additional knowledge and training, and then you fly to the Mayo Clinic in Minnesota, where all the elite physicians that write the textbooks, that do research, they examine you and you have to prove to those doctors that your knowledge is up to par. It's half a day examination. It's oral.

Again, they test you on principles of orthopedics, neurology, neurosurgery, general surgery, electrodiagnostics, muscle and nerve physiology, interpretation of X-rays, MRIs and CAT scans.

Q Okay.

So you passed these exams and you are, in fact, Board certified by the American Board of Physical Medicine Rehabilitation, is that correct?

A Yes, sir.

Q And you continue to be Board certified?

A Yes.

Q And along with that, you said you had training in internal medicine?

A Yes.

Q Which are organs of the body?

A Yes.

Q Where did you do that training?

A At Mount Sinai, for 18 months.

Q Okay.

Did you also work at the Veterans Administration Medical Center in the Bronx?

A Yes, I did. That is part of Mount Sinai.

Q Then you have special training in surgery, is that correct?

A Yes, I did.

Q Where did you do your surgical training?

A I did one year of general surgery at Cabrini Medical Center.

Q Okay.

That's internal medicine and surgery. And you did your training in physical medicine.

Now, in this particular case --

Dr. Guy, you have worked with my office on other cases, is that fair?

A Yes, sir.

Q We asked you to evaluate in your field -- First of all, your specialty deals with the treatment of amputees, is that a fair statement?

A Yes, sir.

Q And their rehabilitation and how far they can go?

A Yes, sir.

Q Have you also dealt with --

You have been certified or you work in neurology.

Have you also dealt with people who have ocular problems or loss of vision in the eye?

A Yes, sir.

Q And the disability and the training in that field?

A Yes, sir.

Q All right.

With the other injuries, we have facial maxillary fractures and various injuries. Have you had experience both surgical and through your rehab facilities in working with those?

A Yes, sir.

Q Now, the first thing we asked you to do is, we asked you to go through the records. We have offered into evidence the V.A. records, they are in this box. And these are voluminous. You have reviewed these at my request?

A Yes, I made my nice summary of them.

Q So you don't really need this, but you have them?

A Yes.

Q And we have the -- which has been marked 23 in evidence -- the actual post-trauma record, which is the Kings County Hospital record?

A Yes.

Q And you have had a chance to review that?

A Yes, sir.

Q All right.

Now, Doctor, so that we can run through this, what I'd like you to first do is tell us what injuries, based upon your review of the medical records, the patient has sustained. Take it that way.

A The injuries that he sustained were, first, he lost his right leg. He had a right below-the-knee traumatic amputation and he uses a prosthesis for that. He had-a closed fracture of the malleolar and maxillary bones. These are the part of the facial bones around the orbit. He had orbital-fractures. He had fractures of the facial bones, the bones in the face.

He had iron deficiency anemia secondary to blood loss. He lost a lot of blood.

He had a fracture of his mandible. He had a sixth nerve palsy, which controls vision on the right eye. That is why he is blind. The nerve to the eye has been damaged. And he had a laceration of his external ear. That had to be sutured back together.

He had a left great toe deformity. His left toe, the big toe, had to be cut down to the size almost of the left fifth toe.

And he also had traumatic myofascial pain, seizures, reactive depression. When you have lost your leg, you don't become happy, you become sad. That is called reactive depression.

Q That's a long list of injuries. I would like the jury to understand, and we brought in a couple of models. If we can start with the skeletal, we will take it from there, then the foot.

MR. PILLERSDORF: Can I borrow that chair again? We don't have a stand for it.

Q We discussed this and we brought in a full skeleton. It just makes it easier this way.

I'm going to sit the skeleton down only because I don't have a stand. All right.

First of all, Doctor, you have had an opportunity to look at the skeleton?

A Yes.

Q Is it fair and accurate?

A Yes, sir.

Q As a teaching tool, at any rate?

A Yes, sir.

Q Will it aid in your explanation to the jury?

A Yes.

Q All right.

Will he sit there and stay?

COURT OFFICER: He's sitting.

Q We also brought in, at your suggestion, we have a skull and we have a knee and we have a chart. Good enough.

What I'd like you to do --

And, Doctor, just without getting too technical, we'll sort of take it from --

I lost my head. I dropped it. I'm sorry. Okay. I am trying to rush.

MR. PILLERSDORF: We are trying to get out, Judge.

Q It's only good we can laugh about this sometimes.

I am giving you the skull. Why don't we start with whichever is easier for you to demonstrate the parts that we are talking about.

Two things, Doctor. From the hospital record it talks about the injury, all right, and where it is and then the function of what it does.

A Okay.

Q We will start from the top of the head.

He told us -- you were not here -- plaintiff testified, he called it a knot on whatever this part is up here (indicating) and this side, the opposite side?

A That's the parietal bone.

Q When a patient describes a knot in the parietal bone, what is he actually talking about?

A A contusion, a blow to the head.

I found a seven centimeter surgical scar on the top of his head.

When I first examined him, he had fractures of the following areas: He had fractures of the maxillary sinuses. These areas (indicating) were broken. The orbital area was broken. Okay. He had fractures'of the facial bones, here and here (indicating). He had a fracture of the mandible.

Q That is the jawbone?

A That is the jawbone.

And he had damage to the sixth cranial nerve, which is deep inside the brain, which controls vision. That is why he is blind in the right eye. So, essentially, these are all his injuries to the face and to the head.

Q Let me go one at a time now.

When you lose the sixth nerve --

A Yes.

Q There used to be an old limerick for what the sixth one was. What is the function of the sixth nerve?

A Sixth cranial nerve controls ocular movement from side to side. It also gives you vision. And because you're blind out of one eye, you lose depth perception, you lose peripheral vision, and it also affects your balance. So, as you're walking up and down steps or uneven terrain, you don't have good peripheral vision, so you have the risk of falling, tripping and causing more damage.

Q So, in the hospital record they confirm there was sixth cranial nerve severance or splitting?

A Yes.

Q Was that the cause of the blindness?

A Yes.

Q Just a normal question I am required to ask.

Doctor, is that permanent or will that nerve become reparable?

A No, sir, that's permanent.

Q We talked about the fracture of the maxillary sinus area?

A Yes.

Q Around the orbit of-the eye?

A Yes.

Q What is the function of those bones?

A The maxillary bones in the nose, they help warm the air, filter the air. So, when a maxillary sinus gets damaged, you run the risk of developing sinus infections, sinus inflammations, especially around the cold weather. So, that function is altered.

Q The mandible?

A Mandible controls the opening and closing of your mouth, chewing, especially hard food and/or meats, steaks, chewing gum. All those functions are affected. And the mandible affects the jawbone, the TMJ, the temporomandibular joint. So, you have a force that breaks this area (indicating), not only this area is affected, but the socket itself where the mouth opens and closes, that is called the TMJ bone, this area gets affected. With a lot of tension the mass of the muscle becomes tight, this area become inflamed, the mouth doesn't open and close normal.

Q Does it also cause teeth problem, the teeth -- tooth injury?

A It can cause malocclusion, cause uneven, malaligned teeth, they won't align properly because -- sorry, it's contagious.

So, the teeth will not align up properly, as a result your bite is off, as a result at nighttime you tend to clench down on your teeth, the mass of the muscle becomes very tight. That is how you develop TMJ syndrome, temporomandibular joint syndrome.

Q With regard to the facial bone, you are aware from the record -- why don't you tell the jury.

These were repaired, is that correct?

A Yes.

Q And the facial maxillary surgeon did all of that?

A That is correct.

Q Now, with regard to the -- we'll fix it later.

With regard to the -- When you examined him, he had at least a satisfactory recovery of the facial bones?

A For the best that can be.

Q Now, he told this jury that he has no feeling over the area. What would be causing that?

A That's the nerve, the trigeminal, and the facial nerves. There's nerves that run across the side of your face. The trigeminal is a sensory nerve. The facial is a motor nerve, motor, opening and closing the muscle, tightening, the trigeminal for sensation, feeling sensation on your face.

Q Again, these are permanent in nature?

A These are permanent.

Q Going down, moving down, we talked about -- so that the malleolar and maxillary bones you already described. What is the malleolar?

A This area (indicating).

Q The area under the eye?

A That's right.

Q All right.

The maxillary bones, you said there was status post closed fracture of the facial bones. What does closed fracture mean?

A We have two types of fractures. Fracture means a break in the bone. A closed fracture means that the two pieces did not cause the muscles to pierce through and stick out. That's a closed fracture. If the bone broke and pierced through the skin of the muscles, that would be an open fracture.

Q All right.

Now, if we can go from there to the leg injury.

A Yes.

Q Using the model or whatever is best, could you explain to us the below-the-knee amputation and how that works?

A Yes.

THE WITNESS: May I step down, Judge?

THE COURT: Sure.

(Whereupon, Dr. Ali Guy stepped down from the witness stand.)

A This patient had multiple fractures to his foot and his ankle and he had multiple damage to the tibia and fibula, the shin bones, and the damage was too far gone, they could not repair.

Q In other words, the train didn't sever the leg?

A Mangled it, almost severed. Multiple fractures. It was as good as severed.

So, the only way to salvage the leg was to cut off 12 centimeters or 14 centimeters below the knee joint. Anytime we want to maintain function, we want to cut as far away from the joint as possible because if you cut below the knee, the stress on the heart is 40 to 50 percent extra. If you cut above the knee, the stress on the heart is 60 percent If you cut the leg at the hip, the stress on the heart is about 70 to 80 percent. It's incremental, the amount of work that the heart muscle has to do to compensate for this area. And, also, when this area is cut, you need this bone for your prosthesis because you put the prosthesis on top of this area (indicating) for weightbearing.

So, 14 centimeters below the knee joint was cut and his stump was somewhere cut about this level (indicating). And the function of the knee joint is -- we have three different particles in here. We have the meniscus.

You have a diagram?

Q I have -- not the meniscus, the knee, but I have a leg.

There's an anatomy chart for the leg. Maybe if you can just draw where the amputation was, and because my question is -- if you can draw where the amputation?

A Approximately this level (indicating).

Q Okay.

A Now, when you do the amputation 14 centimeters below the knee, you cut a lot of muscles. Now, all these muscles have certain functions. These muscles are designed for -- to move your body, to control balance on the ground. So, when a muscle is cut in half, it doesn't have the full length of the muscle fibers for torque, to do work. So its ability to do work is diminished. So what happens, the other side has to compensate, do more work. The heart has to compensate and do a lot more work. So, you're basically taxing the other structures in the body, you're overloading the other parts of the body, the other systems.

So, also there's nerves that are being cut over here (indicating). As these nerves are cut, you can develop neuromas, which is an inflammation of the nerve endings and can cause different types of sensations, they cause pain, hyperirritability at the site of the stump.

Q He told us that to this day he'll feel cold in the foot that's not there, he'll feel pain in the foot that's not there, he feels -- he will wake up because he thinks he has to scratch an itch on the foot that's not there. But it's not there. We know it's not there. What's happening? What do they call that?

A This is what in the medical field we call phantom pain and phantom sensation.

When you've had your leg for so many years, your mind thinks it has still it. There is still a connection between the mind, the brain and the leg that was damaged. To this date we cannot fully explain this phenomena, but it does exist. In the same way we can't explain how acupuncture works, we know there's ample proof.

So, when these patients look at the leg, they think they still have it. They still have that psychological connection, they still feel it and they feel the pain. They have the sensation in the foot and sometimes they have noxious stimuli over the area that has been cut. They think that there's ants crawling, they sometimes feel that, as you said, it feels itchy, scratching. These kinds of sensations are very common with these types of amputations.

Q When you look at the leg, normally before it's amputated there will be nerves --

A Yes.

Q. -- that run all the way down the leg?

A. Right.

Q They have to get cut?

A They have all been cut. As a result, I said, once the nerve's cut, it contracts, pulls backward, upward. Once it pulls up, the nerve can be inflamed, you have no neuromas, which is inflammation of the nerve endings, it causes a lot of local pain.

Q The other thing he has told us is that he has already had several fittings of his prosthetic because of his shrinkage in the upper leg.

One would think it would get stronger because it's doing all that work. What actually happens?

A In the medical field we have this common saying, if you don't use it, you lose it. If you don't use your muscles to walk on, to stand up, the bulk shrinks. Once the muscle mass shrinks, it gets filled with water and fat, becomes weak, it shrinks.

As a result, you are constantly going to need different sizes with the prosthesis, as it goes up and down, so on, so forth.

Q It is a common phenomenon?

A Common phenomenon.

Q He does walk. He spent years at the V.A. We looked at the records. They have a good program? You trained there?

A They have one of the best.

But they walk, but with a great deal of difficulty, and it's not without stress to the stump and to the other muscles and fibers that still remain intact. So, those muscles, that sheering force on standing, on holding a prosthesis constantly, irritates these areas. It's just a matter of time. When these areas get irritated and eventually will be inflamed and infected, it's not unusual for the area in the near future to go up further. This area becomes overloaded and you'll need another level of amputation. Sometimes they have to go --

Q That is referred to as stump revisions?

A Yes.

Q That is a common phenomenon?

A It is a common phenomenon, yes.

Q You can take the stand. I guess we are done.

(Whereupon, Dr. Ali Guy resumed the witness stand.)

Q Going back to the record, Doctor, among the other findings you had was the iron deficiency anemia?

A Yes.

Q What are they talking about in the record with that? What is that?

A When you fracture bones, you get a tremendous amount of blood loss.

Q In the bone?

A In the bone, from the bone and from the blood vessels. The leg has blood vessels. So, when those blood vessels got cut from the train, he bled a lot. Rather than to transfuse him, run the risk of developing complications from blood transfusions, HIV, hepatitis, so on, so forth, doctors tend not to transfuse unless the blood level is not too, too low. So, the doctors give the patients iron and vitamin C to build up the blood level. But he had a lot of blood loss. He developed iron deficiency anemia.

Q What do need iron in the blood for? What does it do?

A Iron transports oxygen for breathing purpose and for energy.

Q Is that a permanent condition or did that go away after?

A It got better. But because he has other problems, it has not enabled him to be one hundred percent normal.

Q Okay.

Now, just as with each injury, I am not asking -- you told us the facial fractures are permanent?

A Yes.

Q Although they have been restored, the paralysis is permanent, the vision loss is permanent?

A Vision loss is permanent.

Q You told us the ear was put back on?

A Yes.

Q He has experienced a partial hearing loss in that ear?

A Yes.

Q Is that permanent?

A That is permanent.

Q Is that, again, a complication from this whole process?

A Yes.

Q All right.

Clearly the leg is not coming back?

A It doesn't grow back.

Q The iron deficiency anemia, can that be, hopefully, gotten rid of?

A It's a lot better than it was before. But, again, with the other problems that he has, it will not be -- has not been fully restored, in my opinion.

Q Now, going through the records, Doctor, both the Kings County Hospital record and the V.A. records, in fact the V.A. records work on the most. You note in your report that he had reactive depression and the record talks about traumatic amnesia?

A Yes.

Q Let's take traumatic amnesia. He's told this jury, all right that his recollection of what happened up until he fell off the platform is pretty much intact. He then has absolutely no recollection of being hit by the train. You have seen the ACR, ambulance report, no recollection of talking to ambulance crew. He has told us he has no recollection of the ambulance ride, no recollection of being interviewed and triaged at the hospital, no recollection of the amputation, no recollection of being intubated. He woke up with a catheter. In fact, his first recollection, according to the hospital record, were the 15th -- and I'm shortcutting this -- I'm asking you, is this your finding? You agree with that, from the hospital record?

A Yes.

Q Good enough.

Now, could you tell us why that happens, why there's this blank part of his memory?

A Yes.

When a patient has a traumatic episode, the body shuts down, they try to protect themselves from that shock, from that insult. So, we have what is called antegrade amnesia. What happens forward they don't remember, they block out psychologically, because you can imagine, reliving actually a train coming at you, hitting you, crushing your bones and breaking your bones and muscles, it's a very, very traumatic memory to live with. The body shuts down. It is a protective mechanism. As a result, it's very common, patients don't remember and they have antegrade amnesia from that moment.

Q The word antegrade, from the moment forward?

A Yes.

Q So it doesn't affect their brain per se? In other words, they can remember their name, their address, their wife, all that stuff?

A That's because memory, retrograde, old memory, is stored in so many different parts of the brain, not just one. That is the reason why, because they remember those things.

Q That was one of the findings you found in here?

A Yes.

Q Then we talk about reactive depression?

A Yes.

Q You have had a chance to review the records. The records are fairly extensive on that, correct?

A Yes, very extensive.

Q First of all, you've dealt with amputees?

A Yes.

Q You dealt with the victims of significant trauma, this type of thing?

A Yes.

Q In fact, in your profession that is who you deal with?

A Yes.

Q Now, in going through the record, could you just summarize to the jury what your findings have been?

A In reference to his reactive depression?

Q Yes.

A Depression or --

Q Depression or any problems with regard to that.

A Well, he has reactive depression. Reactive means as a result of an event.

I mean, it's common sense, when you lose your leg, you become upset, you become depressed because you lost a very important part of your body. Also, you were very active, now you have all these injuries and now your whole life has changed, it doesn't make you happy, it makes you sad. And you constantly have memories, you have phantom sensation, you keep remembering you have your leg, when you look down you don't have your leg, that makes you more sad. So, this is all reactive depression.

It develops anxiety, causes stress, causes depression, and all types of psychological problems that stems from it. Also, the fact that he has head trauma and posttraumatic seizures, that also adds insult to injury, that makes the depression more magnified.

Q Let's talk about the posttraumatic seizures, then we will get into the ultimate effect on him.

Those popped up, he was being treated for that almost immediately from the hospital, is that correct?

A Yes.

Q What do they treat him with?

A Depakote.

Q What is that?

A Depakote is an anti-seizure medication that affects the bone marrow, white cells and red blood cells. That is why I said, although his anemia has improved, but he's always at risk of developing further iron deficiency anemia because Depakote is one of them. He has to be monitored very carefully.

Q What causes a person to develop these post trauma or after trauma seizures?

A The sheer forces on the brain cells, the neuron. The brain is -- here's the picture of the cranium The brain is like jello, sits inside the cranium. When you get hit, the brain rocks forward and backwards, sideways. The brain cells, they get damaged. Once those neurons are damaged, they don't have the ability to repair themselves, it's permanent. As a result, the electrical activity from these brain cells is hyperactivated and that is what seizure is, increased electrical activity within the brain cells.

Q Now, they put him on medications such as Zantac. What does Zantac do?

A Zantac prevents stress ulcers. When you are under a tremendous amount of stress, the stomach produces increased gastric or hydrochloric acid, and that's something that can cause ulcers. To prevent an ulcer from happening, Zantac is given prophylactically to prevent it from occurring.

Q Now, we then switch, where he gets transferred from Kings County on January 6th to the V.A. Hospital in New York. And you reviewed those records, is that correct?

A Yes, sir.

Q Okay.

Again, I am looking now at the note on January 6th of '03. All right. He discusses what he recalls from the incident but goes blank from when he falls off the platform. All right. And as far as that's concerned, he expresses in the record all of these problems, then he can't remember it. Does the inability to remember things cause any effect on the patient itself?

A Yes. It causes further stress, further anxiety and further depression. It's a frustration. It is a constant frustration.

Q All right.

On the 8th there is a notation here that the patients says, nothing helps the pain. What pain is he talking about?

A He is talking about phantom pain in the limb, in the leg.

Q Are there medications that can help phantom pain?

A They can be tried. They are not always very helpful. Many different medications can be tried. We have Lyrica, we have neurontin, we have methadone, we have morphine, synthetic medications. There's so many. There's thousands of different medications.

Q But, obviously, the foot's not really itchy because the foot's not there?

A That is correct. That is correct.

Q For instance, Lyrica has approval as a pain drug, is that correct?

A Yes. It's used for neuralgia, neurogenic type of pain.

Q But it's really the thing's not there?

A That's correct.

Q But a medicine -- in other words, if someone had leg pain caused by a nerve impingement to the leg, Lyrica is a traditional drug?

A Yes.

Q For peripheral neuropathy?

A Yes.

Q RDS?

A In these cases usually no drugs work for that condition.

Q Do they switch drugs to sort of work with the patient?

A They do.

Q How does that work? In other words, almost fooling the patient into telling them there's a new drug?

A It's called a placebo effect. That is one mechanism. The patient is told they're getting something new and psychologically their brain gets tricked into thinking it's a new medication that might help. It's a lot of psychological issues involved.

Q On the 22nd, in the note they talk about depression, hopelessness, a lack of desire for rehab, and sleep varies with noise in the room and phantom limb pain. Is it common for phantom limb pain to wake people up?

A Yes.

Q Now, you are aware throughout the record that he had been on a two-year methadone program for drug addiction, is that right?

A Yes.

Q We know that he had had a serious drug problem before, addiction problem.

How does that fit into the ability to help him with these problems?

A People that have had addiction problems to drugs in the past, their body's opiates -- opiates is a natural painkiller. Their stores is depleted and as a result they don't have the ability to cope with pain the same way as a normal person would do. So, nothing works good on these patients. Most pain medications don't work on these patients, the amount per body's increased, as opposed to normal people who've never been addicted to different drugs.

Q Now, in his particular case the records indicate that he was heroin or drug free for even years before this particular incident and, obviously, he was heroin free all the time in the hospitals yet they continued him on methadone.

A Yes.

Q Now, he has told us like in the last couple of years he's been able to actually get off methadone with help from the V.A. You saw that in the records?

A Yes.

Q Once you get off the methadone, will this prior opiate level irregularity in your body allow you to get more relief from the pain pills?

A No.

Once the body's productions of endorphins have been affected and altered, it never comes back to a normal level. I mean, it gets better since you're off all these medications, all these drugs, but it never comes back to normal.

Q Okay.

Obviously there's an emotional status to this. Could you comment on what emotional status was found in him and how that -- in your experience whether this is the norm or it's an unusual occurrence?

A This is a usual occurrence. People that have lost their legs, they become depressed, they become withdrawn. They're -- they feel helpless, hopeless, they become pessimistic, negative, and this negative and pessimistic attitude can interfere with rehabilitation and their outlook for life changes.

They have sleep pattern differences. They don't sleep well. They cannot rest well. They are never fully rested when they wake up in the morning.

Q Doctor, on February 1st of '03, in the hospital record it notes, still have a lot of pain, then they talk about a pain level in the head and jaw of seven to eight over ten. What does that mean?

A In hospitals we measure pain on a scale of one to ten. Ten is the most severe, one, of course, the minimum. So, a pain level of seven to eight is pretty severe. He is describing pain in his jaw, in his face. This is part of the posttraumatic arthritis and healing of the multiple fracture condition that he sustained.

Q All right.

When he says the big toe is eight out of ten, that is also --

A It's still hurting, yes.

Q Are there medications that can help alleviate -- they use the word throbbing and alleviated by rest. How does that work?

A Well, when you have damage to the bones, muscles, tendons, if you move them, by moving them, they hurt. But then after, they get better. But when you have them at rest, you are not moving them, the pain becomes less, you are not aggravating the injured areas.

Q Doctor, in the V.A. they're seen by social workers, they are seen by chaplains, is that right?

A Yes.

Q There is a note on 2/3 in the hospital record, he does not desire to die cause he has a lot to live for.

A Right.

Q Is this the kind of thing that comes and goes? Is this how you --

A This is exactly the kind of thing. Patients have mixed emotions, one day they're positive, the next day they're negative. One day they want to live, one day they want to die. One day they are happy, one day they're sad. So, it's a very variable, mixed emotional picture.

Q On the next day it says he is reactive type depressing owing to traumatic injury. And then two days later he's all right. Are these common things that one finds?

A These are all common things.

Q All right.

Two days later they find he's very upset. What is the effect on the patient if they -- first of all, can they forget they don't have a leg?

A No, because they constantly look at it.

Q I understand.

A They're constantly feeling the prosthesis on the stump.

Q I am saying, when you're sleeping and wake up in the morning, this can be a problem?

A That could be a problem, yes.

Q All right.

There was a nurse's note on 2/6, all right, that when he tried to get out of the bed he didn't have a prosthetic and apparently fell and threw the walker in disgust. You have worked with people in rehab situations of this type?

A Yes.

Q In the V.A. Hospital as well?

A They can become frustrated because they're not walking properly when they put on the prosthesis and they start flipping plates, knives and forks at people. And sometimes we've had to take all utensils away from them.

Q All right.

On the 14th of '05, all the way to '05, going to the V.A. Hospital -- I am not doing too good.

Did you notice, in fact, on the lengthy reports, reports feeling increasingly depressed times few weeks, tearful, hopeless, and dysphoric throughout interview. What does “dysphoric” mean?

A His mood is very down.

Q Has become increasingly withdrawn and isolated. Denies suicidal ideation. What does that mean?

A He does not want to kill himself just yet.

Q But endures significant feelings of hopelessness?

A That's common.

Q And then a week later he seems to be in a better mood, all right.

Then we look at his discharge summary in '06, all right, and they go through histories and everything. They talk about the seizures and the TDs -- not TDs, I'm sorry -- the seizures and the blackouts.

What's been happening to him over -- you looked through that period in the box, is that correct?

A Yes.

Q What's been going on?

A He is having periods of spasms in his muscles. He has good days, he has bad days, he has mood swings. Sometimes when his seizure medication goes up too high and sometimes when they added Neurontin, Neurontin causes you to become more

obtundent, more down and more groggy, adds to confusion. So, when these medications are added on top of his prior preexisting condition, it only adds insult to injury in a negative context.

Q Now, Doctor, on 11/26/06, again I am skipping around, it was at the V.A. but it was in the psych or emergency department. Reading from the records, called to see patient for commenting of wanting to die.

Then it says he had passed out, then waking up to find his prosthetic leg missing and he was brought in by ambulance to Wards Island, one of the V.A. affiliates?

A Yes.

Q Where he was living at the shelter.

Unhappy living at the shelter, I'm tired -- I'm tired spending days going to meetings about recovery. All right.

This was a down time, is that correct?

A Yes.

Q All right.

And then in '07, the psych admit, I can't do a damn thing, I do not know what the F to do. He only gets 128 for monthly plus food stamps. Depression has finally set in with this patient?

A Yes.

Q How does that manifest itself?

A By being pessimistic, angry, withdrawn, having financial problems, social problems, living problems, he feels like the whole world is against him, the whole system is against him. That negative outlook continues on a decline fashion.

Q All right.

In a patient who's had a, let's say, an up and down past, all right, a patient who was in the process of recovering from heroin addiction, the process of recovering trying to get back into society, get back to work, all right, when this trauma hits at that point, I am going to ask you to assume, if you will, Doctor from a medical point of view, we know he went to high school, went to trade school, we know he went into the Army, that he was married, he had five kids, the marriage didn't work, all right, he was -- he got into a problems with drugs which ultimately led to his incarceration, which he told us was the best thing, it led to him being in a methadone program trying to clean up his act after spending time in jail. And he was now two years into a methadone program, living in a men's shelter, had just gotten an opportunity for a new job, was in fact through an ICD program, rehabilitation program, he was just going back -- going to be his first day part-time at Staples.

Assume with that history we then have this trauma, then the record is as it shows. Could you explain to the jury if there is a causal relationship or what is the causal relationship between this trauma and what's happened to him since then?

A Yes.

Again, we touched upon this earlier. He has mixed emotions. He has good days, he has bad days. Sometimes he's optimistic, sometimes he's pessimistic. These emotions will wax and wane, go up and down, they will not change. And sometimes when

something bad happens to him, his perception of that bad thing, he feels that's very exponentially increased. The fact that he mentions he lost his prosthetic leg, he couldn't -- that to him, he wanted to die, he wanted to paint the whole world red and he wanted to be more angry at everybody else. So, his ability to cope with frustration is very, very low. And he has good days, bad days over and over again.

Q But things like the phantom pain and obviously the disability and whatever this discomfort comes from walking from the prosthetic, that is a constant?

A That is a constant problem that he always has to deal with.

Q All right.

The history of this accident happening when he's actually on an upswing, almost done with methadone, he is almost about ready to start a job, according to the notes in the hospital record he had been Christmas shopping that morning. When a trauma hits you, for a guy who's had ups and downs, now jail behind him, hopefully the drug addiction behind him, you are on an upswing, what is the impact of a major trauma on that person as opposed to someone who's going along regularly?

A Well, he always has stored memory in his brain and also in his muscles, you have that stored memory of that shock, that insulting bad experience that stays with you and sometimes little events trigger and rekindle it.

Q All right.

Doctor, you indicated that these conditions, in his case, are permanent?

A These are all permanent.

Q You have had the opportunity to examine him. He is otherwise a healthy guy?

A Otherwise he's a health guy.

Q He looks big and strong and all of that.

Does that help or hurt the problem?

A Helps the problem slightly.

Q Why only slightly?

A Well, let me explain.

If -- if he was more deconditioned and not in good shape, he would not be able to tolerate and cope with these problems as he is right now, he'd probably be in a wheelchair. But the fact that he was in good shape, he strives to be in good shape, makes him more functional.

Q Just one at a time, the problems with the loss of vision, I think you indicated, so I have them all, it creates a peripheral vision, obviously?

A Alters peripheral vision and depth perception and he cannot read or watch programs on TV as long as -- because he is doing the function of two eyes with one eye.

Q Okay.

What about the stability of walking when you have a prosthetic?

A Also affects -- once you affect peripheral vision it also affects balance and equilibrium.

Q Walking with a prosthetic, what's the affect on stability? In other words, as a doctor, are they allowed -- would you advise him going out on a day when it's snowy or icy?

A No. His balance is significantly altered, so when the weather is bad he should not go out with the prosthesis.

Q All right.

One of the things I asked you to do, Doctor, if you could, in your field these are the patients that you get when they are in this position, is that right?

A Yes, sir.

Q They're after their surgery, they have had whatever medical care could be done, and now they come for you to make them as well as you can?

A Yes.

Q He is never going to get back to normal, that's a fair statement?

A That is a fair statement, yes.

Q I asked you to do is evaluate for us what medical needs, all right, he will need and continue to need in the future.

A Yes.

Q Could you start with -- and I have the report. The first item you talked about, what is that?

A He will need to see a physiatrist like myself to supervise his overall rehabilitation needs at least 12 times a year and it costs for each brief visit $100 per session.

Q That would be $1,200 per year, is a fair cost?

A Yes, sir.

Q That is your current rates?

A Yes, sir.

He would need to see a neurologist at least six times a year to control his seizures, to monitor his levels of his Depakote levels, so on, so forth. It costs for each visit $150 a session.

Q That would be $900 a year?

A Yes.

Q That's V.A. rates?

You worked in the V.A., is that right?

A Yes, sir. These are the standard medical rates.

Q In other words, $150 a visit for a neurologist, I am not getting “lord brain,” I am getting a doctor at the V.A.?

A These are the standard rates, yes. The V.A. charges the same rates, yes.

Q The third thing you put down was he'll need periodic retesting, CAT scans, MRI. What's that for?

A So that he doesn't develop hydrocephalus, water in the cavity inside his brain as a result of trauma, make sure he doesn't develop any complication as a result of the trauma, any unknown, unexplained collections of blood or abnormal tumors, masses in his brain. These should be done -- an MRI should be done once every two to three years. The cost is $2,000 per study.

Q Per year?

A Yes.

Q In other words, each year he should have different kinds of studies? Is this because of this trauma, the head trauma and the leg amputation?

A No, this is specifically because of the trauma he had, especially to the head and to the face.

Q Now, it has to be monitored because we know he had a nerve severed and everything else?

A That's right.

Q You put down, the next one was physical therapy. He seems to be using the leg great. Why does he need therapy?

A He needs to have physical therapy because of his altered gait. He is developing tightness in his lower back muscles, he is developing tightness in his hip muscles. He is overloading his left side. So, those areas need to be treated with physical therapy so he doesn't develop overuse syndromes, and to diminish the pain spasm in his lower back as well.

Q How often do you need that?

A Minimum, 30 to 40 sessions per year.

Q That's like one every other week, almost?

A That is.

Q Two every three weeks?

A Something like that.

At 150 per session.

Q So the math says that would be 52 -- 5,200?

A That is about right, yes.

Q More than about right. I got a calculator.

A Okay.

Q You talk about having bloodwork?

A Yes.

Q Why do you need bloodwork?

A As I indicated, Depakote is a toxic medication to the body, it affects the formation of red blood cells and white blood cells, you want to make sure the bone marrow is not being suppressed. Also, Depakote has -- the level has to be monitored because if the level is too high it causes toxic effects. If the level's too low, it's not doing anything. You have to constantly monitor the level. There are certain conditions, foods and other medications, that alters the level of this medication, so it has to be monitored very carefully. That's for the bloodwork and the monitoring of Depakote.

Q When you monitor, does that include making sure the iron levels are maintained?

A Yes.

Q So unlike the normal person, he needs a certain amount of additional bloodwork?

A Yes, sir.

Q Because of these problems and medications he's on --

A Yes.

Q -- as a result of the accident?

A That is right.

Q You put down $2,000 a year for that, correct?

A That is correct, yes.

Q Okay.

You put down orthopedic visits?

A Yes.

Q Who actually manages stump revisions, that type of thing?

A: Well, a physiatrist does, and sometimes an orthopedist. They both do. Especially damage to the joints, especially around the knee.

Q All right.

With the artificial leg is there extra pressure on the knee?

A. Yes. Tremendous increased pressure on the knee, on the hip, on the back, also on the heart and also on the other leg.

Q The jury was able to pick up and lift his prosthetic. You have seen his prosthetic. Are they all heavy?

A Some are heavier than others, yes.

Q His seems about average?

A Yes.

Q Does that weight affect the knee joint?

A It does.

Q For the orthopedist, how often should he visit?

A At least three to four times per year. The cost is $150 a session.

Q That would be $600 a year for orthopedic things?

A Yes.

Q Beyond other problems? In other words, if he tripped and broke an arm, I am not counting that.

A That's correct.

Q These are just specifically related to this accident?

A That is correct.

Q We talked about the prosthetic.

A Yes.

Q He's told us he's had a couple of them already. I guess in the beginning they get altered more often?

A Right.

Q How much do these things cost?

A The cheapest ones -- the cheaper one's about 7,000. We have other ones that are energy storing prosthesis, 15 to 20,000. The one he has is about 7,000.

Q How long should that last, assuming that once he is stable and everything?

A About five to seven years.

Q If we take seven years, we can take an average of $1,000 a year for the prosthetic?

A That would be a very low ball park estimate, yes.

Q Okay.

There is an item that you put down here in repair of prosthetic even. What do you mean by that?

A Well, the pylon insert sometimes shrinks, sometimes it tears, so they have repairs that go along with the prosthesis, and the approximate annual cost, rough low park number would be 500 to $700 a year.

Q I am going to put 600 as an average for repair.

I have something here listed as an Oxford.

A Shoes. We are talking about shoes. You have to have special shoes to fit into the prosthesis.

Q Can you buy regular shoes and --

A No.

Q stick one on the --

A No. Can't do that, no.

Q You put down $600 a year for that?

A Yes., sir.

Q You don't get sneakers or anything, these are special shoes?

A Yes. They have to be special shoes to give adequate support.

Q We then have -- you put down psychiatric visits?

A Yes.

Q Now, this deals with the depression?

A Yes.

Q He is getting -- he is seeing somebody, he is seeing social workers at the V.A. Hospital at the present time?

A Yes.

Q What's the difference between a social worker and psychiatrist, as far --

A We have two types of mental hygiene sessions. We have what is a psychiatrist, M.D., that prescribes medications, which is what he needs from time to time. Then we have the social worker or a psychologist, they are usually Ph.D., they are not an M.D., they cannot prescribe medications, they usually give psychotherapy. Psychotherapy is usually about 45 minutes a session, it's usually about $175 to $250 a session. And psychiatrist, M.D., he will need to see about ten to 12 times per year, his rate's about $150 per visit.

Q On your report for the psychiatrist you put down 1650?

A Yes.

Q For the depression, all the psychiatrists?

A That's right.

Q The talking him down off the wall?

A Psychotherapy.

Q That you have $4,375 a year?

A Correct.

Q If we just look at the medical expenses you have given us, I have done the math, it comes out to $20,175, that's per year?

A Also there is ADLs, that's household help.

Q I am going to get to that in a moment.

This is just a plain old fashioned medical attention that he needs, is that correct?

A This is the basic, basic requirements, the basic necessity.

Q What are ADLs?

A Activities of daily living, things -- he cannot shop for himself. He cannot always cook for himself. He can reheat food. He can't cook for himself. He cannot clean the house for himself. He cannot do heavy duty house chores. He needs somebody to do that for him so he doesn't get injured.

Q At the V.A. residence they don't provide that?

A They do not.

Q This would not be like luxuries here, but would this at least bring his lifestyle back to close to what it was?

A It will make it better. It will never be normal. It will try and bring it as close to normal as possible.

Q The ADLs, that is like a part-time worker that goes --

A Part-time worker.

Q Who provides that?

A They have different specialists that are trained for that. You have skilled nurses, you have a licensed practical nurse that can do that. They charge about 20 to $25 an hour.

Q How much of that would he need?

A About, minimum, four hours, five times a week.

Q That's 100 -- that is five, four -- $100 a day, five times a week, that is $500?

A A week.

Q A week times 52, that is almost $25,000 for that?

A That is correct, yes.

Q That's something that he gets partially from the V.A. now, actually partially from his ex-wife that goes --

A Yes.

Q To ensure that, that would be almost as much as the doctors is what you are saying?

A That's correct.

Q But that's four hours a day having someone with you?

A Right.

Q Doctor, in your opinion, are all of these directly related to the injuries in this accident?

A Yes, sir.

Q This is not because he had been a methadone addict -- a heroin addict who was then on methadone, this is just from this traumatic amputation, the head injury, the loss of vision, the toe crimping, all the other things?

A That is correct.

Q Doctor, one last thing I am required to ask-. I have given you the hypothetical. I told you that assume, if you will, a man standing on the platform of the train -- we won't get into this again -- he falls on the tracks and he is struck by a train. In your opinion, with a reasonable degree of medical certainty, is the train the competent and direct producing cause of all the injuries you seen in this chart?

A In this case yes, sir.

Q There is no question about that?

A. There is no question about that.

Q His prior medical conditions, have they impacted your decision, aside from the fact that he may need additional monitoring because he had some of them, this is not methadone treatment, this is not care, this is what he needs?

A That is correct, yes.

Q One last thing, Doctor. As a specialist in this field, I just want to put these in through you. You have seen the various bills. We have -- assume, if you will, that we have the certified copy of the Kings County Hospital records for the care and treatment rendered to him for those three weeks, that includes the multiple operations, the amputation, the whole thing, and that's $73,603.13.

MR. PILLERSDORF: Your Honor, I am going to offer this bill.

Q Doctor, is that the reasonable cost in 2002 for the care you saw in the hospital?

A It's very cheap.

Q Well --

A The surgical procedures alone would have cost close to that amount.

Q Good. He got a break.

THE COURT: Any objection?

MR. VERBESEY: I have no objection.

THE COURT: It is admitted.

Q The other thing I asked you to go through was Veterans affairs. We asked them to separate the bills as to those things directly related to this accident. You have had a chance to go through this --

A Yes.

Q -- when I brought it to your home.

And they have given us a bill, this is for care up and through October 6th of 2008?

A Right.

Q And they've charged -- you have had an opportunity to see all the therapy he's had?

A Yes.

Q Over those years they charged $183,674, again that is V.A. rates. You worked in the V.A. Hospital, is that appropriate, and was all that treatment needed and actually delivered according to the records you have seen?

A Yes.

MR. PILLERSDORF: I offer that.

THE COURT: Any objection, counsel?

MR. VERBESEY: No.

THE COURT: Plaintiff's 26 is admitted.

(Whereupon, the document was marked as Plaintiff's Exhibit 26 in evidence.)

Q There are two, Doctor, additional bills that I showed you. These were a Medicaid lien and SSI. What is SSI?

A Social Security disability income.

Q This is money that they have been giving him since December 28th.

MR. PILLERSDORF: I want to have these in evidence.

Q You looked at these? This was from December 28th, 2002 they started seeing him, a couple of weeks after he left the hospital, up until January 5th, $21,322, all right, and the Medicaid lien, which -- in the things not covered in those liens is $22,970, is that right?

A Right.

MR. PILLERSDORF: Your Honor, I am going to offer these.

THE COURT: Counsel?

MR. PILLERSDORF: Again, certified bills, your Honor. I will ask for the appropriate comments, for the Court to instruct the jury that these will all be taken care of in the collateral source hearing after, nobody gets doubled.

Q These are appropriate bills and the costs?

A Yes.

THE COURT: 27 and 28?

MR. VERBESEY: I have no objection.

THE COURT: Very good. Thank you.

(Whereupon, the documents were marked as Plaintiff's Exhibits 27 and 28 in evidence.)

Q With all of that, we know the bills -- we see the bills, we see what's been paid out by various services for this directly as a result of this injury.

Doctor, what's the human toll this kind of injury takes on a 41-year-old veteran who finally conquered a heroin addiction, all right, and he was good enough to tell us that it was jail that straightened him out, that once they got him on the right track after two years of living in the shelter, he was still on the methadone program to overcome, that he had been retrained, was ready to start a job. What is the human effect, forgetting the bills, what human affects, from a physiatrist's point of view, is impacted by this kind of multiple injuries?

MR. VERBESEY: Objection.

That is the question the jury is determining.

MR. PILLERSDORF: I am not asking for a number at all.

MR. VERBESEY: I am not talking about a number. The affect upon, that is, as a human being is exactly what this jury is going to be asked to do.

MR. PILLERSDORF: Let me withdraw that. Let me modify the question, your Honor.

Q What functional impact does it have on his life, what can he do or can't do?

A As a result of the below-the-knee amputation, he cannot run. He cannot do sports activities that he could do if he had his leg, such as soccer, such as football, such as martial arts, going to the beach with the prosthesis, you get stuck in the sand. If he did like walking on the beach, he can't do that now. He cannot walk in the rain. He should not. He cannot walk when it's snowing and he should not because if he does, he is going to run the risk of falling and causing other fractures. So, it's -- psychologically he is handicapped. Physically he is handicapped. He's handicapped both mentally and physically.

That adds anger inside, internally, and leads to frustration and more depression. It is a vicious cycle.

Q When you take that cycle and now throw in the loss of an eye, how does that add to it?

A Insult to injury.

The eye, he doesn't have good balance, he doesn't have good depth perception. When a patient is not functional, as much as they like to sit down and watch TV or read a book, he cannot do that for long periods of time because one eye gets tired a lot quicker than if you had two eyes so --

Q Now you throw in the last element, which was those seizures that he was on, that he's been on Depakote?

A Depakote.

Q Depakote.

A He has to be careful because stress, lack of sleep, loud music, noise, can trigger a seizure. So now these you have to watch out, it's a lot to overcome. It is a lot to deal with.

MR. PILLERSDORF: Doctor, thank you. I have no further questions.

THE COURT: Members of the jury, let's just stand in place for a moment, please.

Let the record reflect that 27 is a two-part exhibit, contains both of the liens referred to previously. There is no Plaintiff's 28.

THE COURT: Counsel.

MR. VERBESEY: Thank you.

CROSS-EXAMINATION

BY MR. VERBESEY:

Q Doctor, I suspect you have done this before?

A I'm sorry?

Q I say, I suspect you've done this before, come in and testified in court.

In an average year, in the last five years about how many times have you accepted referrals from attorneys for these kinds of evaluations?

A I have no idea. I cannot give you an exact numbet.

Q I certainly don't want an exact number, just gross, rough estimate.

A It would be a guess. I would be way off. It could be -- on an annual basis, is that what you are saying?

Q Yeah. On an annual basis it can be.

A It could be as little as 20, 30 patients to as much as 150 patients. It could be less, it could be more.

Q How do you average, in terms of court appearances a year for the last five years?

A On the average I testify about eight to ten times a year for my patients.

Q How about for people who are not your patients?

A Altogether, eight to ten.

Q How much do you get for your day or half day?

A For cancelling my patients my fee is 3,000 for half a day, 1,000 for pretrial preparation.

Q Okay.

Now, in this case were those the rates?

A Yes.

Q And the record was fairly extensive in this case?

A Yes. I would say so, yes.

Q Approximately how long did you spend reviewing the record at the initial time you got it, at the time your 3101-(d) was drawn and now?

A Maybe about three hours, could be more.

Q You digested or reviewed that entire record?

A I made summary notations for myself, yes.

Q I understand that, but you make notations based on having seen something?

A Yes.

Q So by digested, I didn't mean write out a digest, what I meant, that you review the entire record, take your notes?

A Right.

Q Confer with the attorney about drawing what we know as a 3101-(d), which is the general statement of what your findings are in this case, you issued a report?

A Right.

Q You conferred, I'm sure, at some point with counsel and that was all of three hours?

A I'd say, approximately, it could be more than three hours.

Q Now, you are not treating this patient, but you did examine him at one point in time?

A Yes, sir, that is correct.

Q Last November, I think?

A Yes. October.

Q I'm sorry, October. The report was November.

Now, obtaining an accurate patient history is something that is an important component to a doctor's working diagnosis, is that correct?

A To the best it could be obtained, yes, sir.

Q And, in fact, I think you have testified before that an M.D. derives about 70 percent of his working diagnosis from an accurate history?

A Yes, sir.

Q Just referring to your report dated October 1st of 2008, under past medical history you wrote “unremarkable.”

A That is correct.

Q Wouldn't someone who has multi years of being a heroin addict and multi years of high and excessive alcoholic intake, wouldn't that be something that's remarkable?

A Not -- when you have a broken arm, leg, not when you have lost your leg, not when you lost your eye, not when you have seizure activity. With reference to this accident, it's unremarkable.

Q How about with someone who's claiming a problem with brain function?

A The brain function is coming from the multiple trauma he had, from the multiple fractures he had around his eyes, his orbit, so on, so forth.

Q A person with a long history of heroin addiction and methadone and alcoholism can have that, that doesn't have a positive effect on brain function?

A I would say it does not have a positive effect, that is correct.

Q In fact, we all know many people with those long-term bad habits that have an adverse effect on their brain function?

A That's correct.

Q And yet with that history, even given these injuries that he had, you still don't mention them at all? You say it's -- that fact is unremarkable?

A Well, if you look at my notes, on page two, past medical history, this is what I obtained from the patient. Later, when I got records, then all that stuff was explained. But this is already just from what the patient told me.

Q So, when you spoke to him on October 1st or sometime there about and you were inquiring as to his health and he told you he didn't say anything about the fact that he had been a heroin addict, that he had been on methadone and that he had been a very serious problem drinker, you made no mention of that at all?

A To the best of my knowledge and my records, there is nothing mentioned to that effect, no.

Q Now, am I correct that on the morning of December 12th of 2002, as Mr. Sanders was walking down the station to the Winthrop platform, you didn't have a clue as to what the condition of his brain was with respect to how it may have been affected or permanently impaired by his long history of drug use and alcohol intake?

A The way you phrase the question it is correct.

Q And that's not to suggest that this accident didn't have an adverse impact on him, obviously, but you don't know what the condition of his brain was before this?

A That is correct.

Q Now, aren't there plenty of people who have, gees, have sympathy, this happened to me, they are in therapy, have addiction problems, who are depressed, who have anger issues, who have all the kinds of things that you have also described Mr. Sanders having, such as social living problems, anger issues, financial problems? Aren't there a lot of people who never fall in front of a train, get hit by a train, that have those issues as a result of excessive drinking and drug use?

A Both. It's possible.

Q It wouldn't be surprising that a person who was an excessive drug user and uses too much alcohol would have those problems and may even be under psychiatric care for them?

A That is also possible.

Q Are you aware of the fact that Mr. Sanders, before this accident, was undergoing some level of -- I won't use the word psychiatric treatment -- but some level of counseling through the methadone program?

A That was brought to my attention through Mr. Pillersdorf after we were preparing for the case.

Q And it doesn't surprise you that that wouldn't be the case, that is one of the things they do in methadone programs, is to help out with emotional issues and maybe mental problems that the people are having who they are caring for?

A Yes. But not as a skilled -- as a skilled Ph.D. and/or M.D. psychiatrist.

Q Okay.

Now, is there any reason --

There is no reason, is there, for you to believe, based on what you know about Mr. Sanders and what you know about his past, that if this accident had never happened, that today, six years later, he might not still be a drug addict, he might not still be drinking to excess, he may still have kind of problems in the average way of living? You have no way of knowing if this accident hadn't happened if those things would have continued?

A No, I have no way of knowing.

Q In just referring to -- well, I'll go into that later.

Continuing, in your report you mentioned that one of the risks and threats are that the stump, because of pressures and things, he can have breakdown of skin, there can become different kinds of, I think you described it as neuromas, bad things can happen?

A Yes.

Q. And that happens and it's not unusual?

A That's correct.

Q In this case, when you examined him six years after the event, the stump area, there was no skin breakdown of any kind, it was actually in very nice shape, wasn't it?

A On that date, yes, sir.

Q Okay.

Now, counsel took you through a list of kind of expenses that you were indicating were appropriate, a certain level of care and a certain cost associated with it.

Mr. Sanders right now is not receiving anything remotely close to the level of care that you're proposing, is he?

MR. PILLERSDORF: Objection, your Honor. There is no testimony to that effect.

In the V.A. records he is getting that now.

THE COURT: Overruled.

Let's hear the witness's response to the question.

Q You're describing or proposing a level of care under a whole different -- whole host of different types of doctors and care at a certain numbers of times. Right now he is not getting anything remotely near that level of care, is he?

A I don't know exactly what he is getting, what he is not getting. This is what he needs. This is what is medically indicated.

Q I am not arguing with you.

But now, you do know what he is getting now because you reviewed the records from the V.A.?

A He is not getting all of these things that I have recommended, that is correct.

Q Actually, it's not even anything close, is it?

A He is getting the benefits of all the things that he needs.

Q Is the V.A. practicing bad medicine on --

A I am not going to get into that. I am not commenting on that.

Q Final question. I got you out by 4:00.

You don't have a clue, the foggiest clue, as to what this Medicaid lien of $22,970 for the period of December 12th, 2002 to 2006, how it relates to his care, right? I mean, this is a sum of money that could be for flu shots and everything else that -- any kind of medical care that he's received in the last four years, isn't that right?

I mean, you didn't examine the records, you don't know what is in this Medicaid lien?

A If you are asking, me if I can give a breakdown, I do not know, no.

Q So you have no way of knowing what this $22,000 even --

A Exact breakdown, I do not know. I am assuming it's related to the injuries that he sustained and his overall health and condition.

Q Now, the Medicaid lien here begins on December 12th. He's in the hospital at that point, right? He was in the hospital for quite a long time after that?

A I am assuming Medicaid is picking up that bill for that hospitalization.

Q And through 2006 you're assuming that this is all related, that every single time he went to the hospital and it went on Medicaid or he went to a doctor, it went on Medicaid --

A I'm assuming -- no, sir.

Q -- that it was as a result of this accident?

A I'm assuming most or all of it was as a result of this accident, yes.

MR. VERBESEY: I have no further questions.

Thank you.

THE COURT: Counsel.

REDIRECT EXAMINATION

BY MR. PILLERSDORF:

Q Actually, the lien says it's related. That is what we asked for, the stuff related. I don't care about that bill.

Let me ask something of you. You have worked with people in rehab, you have worked with people in drug rehab, you have worked with veterans?

A Yes.

Q It's fair to say that some drug addicts go back and never get off the evil habit?

A Yes, sir.

Q It's fair to say that some, with the help of places like the V.A., get totally rehabilitated, is that correct?

A Yes, sir.

Q So, that is a question, we don't know what would have happened to James, he is absolutely right about that?

A That is correct.

Q Do you remember anybody saying the subway should be deputized to make the decision?

A No.

Q Now --

MR. VERBESEY: Objection.

Q With regard to his rehabilitation, all right, with regard to the numbers, and your numbers, for instance, at the V.A. he does see a physiatrist?

A He does.

Q He sees a neurologist. I don't know the number, but he gets periodic MRIs?

A He does.

Q Is that right?

A Yes.

Q He gets physical therapy?

A He does.

Q All right.

He has gorren new prosthetics?

A He has.

Q All right.

They gave him new shoes? He's gotten new shoes, all right, he's had the prosthetic repaired when necessary?

A Yes.

Q All right.

He's gotten --

You have seen the psychiatric records? He is seen by a psychiatrist?

A Yes.

Q We knows he's seen by psychologists?

A Yes.

Q To say that he gets none of this, all right, you told us medically, if this was a patient the amount of times he should be getting?

A This is what is medically indicated.

Q As far as we're concerned, during the times he was in the V.A. he was getting all of that, perhaps not in the same number but he was getting this, is that right?

A Yes.

Q And when you worked at the V.A., when a person, especially when they are a resident of the V.A. Hospital, it's no big deal, they get to see the physiatrist once a month or once a week, they come around?

A Most of the time they see residents, not attending doctors.

Q Understood. Understood.

Bu they change the cast as needed, the prosthetic as needed?

A Yes.

Q They change the shoes as needed?

A Yes.

Q All right.

So, to say he hasn't been getting care, that's not fair?

A That is not fair, no.

Q Are these numbers high, low, conservative, in your experience, whether it's V.A. -- you indicated privately it might cost a ton more, but $20,175 a year, is that a fair and accurate estimate of the current rates of the medical costs for a man who's lost his leg, can't see out of one eye, has had his entire face busted up, has part of his other toe, has a seizure problem, is that reasonable?

A It's a very, very, very conservative, reasonable number, yes.

MR. PILLERSDORF: Thank you.

I have nothing else.

RECROSS-EXAMINATION

BY MR. VERBESEY:

Q Okay.

If you add up the number of visits to physicians and medical personnel that you're proposing --

A Right.

Q -- it's over $100,000 per year. You are telling me Mr. Sanders has been to the V.A. an average of once every three days in the last four, five years?

A Sometimes.

Q Do you have any records that might reflect that?

A I am not saying how many times he's gone to the V.A. I am saying in my report this is what is medically indicated for him.

MR. VERBESEY: Thank you. I have no further questions.

THE COURT: Anything further, counsel?

REDIRECT EXAMINATION

BY MR. PILLERSDORF:

Q Just in fairness, when you go to the V.A., the physiatrist and the neurologist, the therapist, psychiatrist, the psychologist, they all see you the same day?

A Sometimes. Not all of them. Sometimes. Sometimes you see some on the same day.

Q You don't have to go 100 times to have that number of visits?

A That is correct.

MR. PILLERSDORF: I have nothing else.

Dr. Guy, thank you.

THE COURT: I am assuming you had nothing further, counsel.

MR. VERBESEY: No.

THE COURT: Very good.

Thank you very much, Doctor.

MR. PILLERSDORF: We got you done in time.

Thank you,- Judge.

(Whereupon, Dr. Guy stepped down from the witness stand and exited the courtroom.)

THE COURT: Members of the jury, we are going to adjourn for today and I will ask you to be back here tomorrow morning at -- I think we can make it 9:30.

MR. PILLERSDORF: Judge.

THE COURT: Let's make it 10:00. Let's make it 10:00.

Thank you. Have a good, safe evening.

See you in the morning. Let's try to be on time everyone, please.

Thank you very much.

(Whereupon, the Jury exited the courtroom.)

THE COURT: Gentlemen, we need your help with this charge.

Off the record.

(Discussion.held off the record.)

(Whereupon, the trial was adjourned to March 6, 2009.)

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