2004 WL 5522731 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Kings County

LYNCH,
v.
CITY OF NEW YORK et al.

No. 9030/00.
May 10, 2004.

Civil Term Part 4

(Transcript of Ali Guy, M.D.)

Case Type: Vehicle Negligence >> Intersection
Case Type: Vehicle Negligence >> Motor Vehicle v. Motor Vehicle
Case Type: Vicarious Liability >> N/A
Jurisdiction: Kings County, New York
Name of Expert: Ali Guy, M.D.
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine

Representing: Unknown

Before: Honorable Vaughan, Justice.

ARANCES: (same as previously noted)

REPORTER: NANCY MARTIN

(Jury entering).

THE COURT: Good morning. I hope you had a pleasant weekend.

Counsel?

MR. FREEMAN: Yes. Plaintiff calls Doctor Ali Guy to the stand.

ALIGUY, MD, 7 Grammercy Park, New York, New York 10003, called as a witness by Plaintiff Prince, was duly sworn and testified as follows:

DIRECT EXAMINATION

BY MR. FREEMAN:

Q. Good morning, Doctor.

A. Good morning, sir.

Q. Before we even get started with reference to Mr. Prince, can you give the jury a sampling of your background and education and training?

A. Yes, sir. My undergraduate I went to Queens College. Medical college, I graduated University of North East in Dominican Republic, June of 1981.

Thereafter I did three residencies. My first residency was in the field of internal medicine at Mount Sinai School of Medicine, Mount Sinai Medical Center, for a period of eighteen months.

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

Then I completed a three-year residency training program at Mount Sinai School of Medicine, Mount Sinai Medical Center in the field of physical medicine and rehab, also known as physiatry; not podiatry or psychiatry, but physiatry.

I'm board certified in the field of physical medicine and rehabilitation. I was a director of the department of rehab medicine at Maimonides Medical Center in Brooklyn, New York, from 1997 to July 2002, five years, where my duties were to be in charge of all the inpatient and outpatient rehab services, to provide teaching to the orthopedic residents, prepare them for the boards with rehab section questions, to provide teaching to the internal medicine residents, provide teaching to the physical therapist, the occupational therapist, speech therapist and other doctors in my department.

I was also consultant to different doctors in my hospital doing consultations for them.

Also I'm director of a neuromuscular equipment clinic at NYU's Hospital for Joint Disease since 1992, the present time, where my duties are to see the patients that are assigned to me people that come in with birth defects, people that are paralyzed, in wheel chairs. My job is to see those patients, to treat them and also to train the residents from NYU assigned to the clinic; also to prepare them for the boards, part one and part two.

Q. And what is the relation of physiatry to orthopedics?

A. Physical medicine rehabilitation is a medical speciality that was founded shortly after World War II. It deals with traumatic injuries covering the whole body from head to toe.

How it's similar and different to orthopedics is as follows. Orthopedic surgeon concentrates on the surgical aspects of the bony and the musculoskeletal system.

We concentrate on the same thing but only nonsurgical. How it differences from neurology, a neurologist concentrates on central neurology. we concentrate on peripheral. Central neurological means diseases of the brain such as Lou Gehrig's disease, Parkinson's, muscle calendar sclerosis. We concentrate on peripheral neurology which is the nerves in the arms, legs and of the spinal cord.

And again there's a great deal of overlap between the two and we refer patients back and forth to one another in hospitals and outside the hospitals as well.

Q. Did there come a time when you examined Mr. Prince for the first time?

A. Yes, sir.

Q. And when was this?

A. May 15, 2000 at Maimonides Medical Center.

Q. And what were his complaints and history at that time?

A. His history was he was 59 years of age at the time. No history of any prior significant accident or injuries or problems to his neck, back and his knees.

That on 11/28/1999 he was a passenger on a bus which was hit by a police van and he sustained injuries to his head, his neck, his back, both knees. He fell out his seat, to the bus. He was taken by ambulance to Kings County Hospital Medical Center where he was kept there for observation for many hours.

X-rays were taken of his neck, his back, his knees; revealed no fractures. When he came to me he complained to me of neck pain shooting down both his arms with numbness and tingling in both arms.

He complained to me of lower back pain shooting down both of his legs with numbness and tingling. When I examined him, his neck showed severe tenderness, spasm.

Spasm is defined as a prolonged involuntary contraction of a muscle fiber which means when you touch a normal muscle it's soft to touch. Once you have an injury in the vicinity of the neck or the spine the body tries to protect itself, it goes into a reflex spasm which means that muscle fibers tighten up and become hard and the fibers shorten. As a result you lose range of motion.

You also get a microscopic bleed in muscle fibers and that bleeding heals with permanent scarring called trigger points. So I found spasm, trigger points. Neck range of motion was one-half of left and right lateral flexion.

The back revealed tenderness, spasm, trigger points and was one-half of backward extension. Straight leg raising was 75 degrees with bilateral low back pain. Normally it's 90 degrees without any lower back pain. So 75 degrees indicates abnormal finding; either there's a problem with the disks in the lower back, or there's a pinched nerve in lower back or combination of both.

And the rest of the exam was essentially unremarkable.

Q. Going through all this and I appreciate that, just so we understand this, with muscle spasm, how is that related to trauma?

A. Once you have an injury in the vicinity of a joint or vicinity of the spine, the body tries to protect itself from recurring injury; goes into spasm. The fibers shorten, the muscle fibers shorten and as a result you get tightness of the muscle. As a result you have -- lose range of motion and get pain and spasms cycle. Pain, spasm and cycle continues.

Q. And can you distinguish for the jury the difference between an objective and subjective finding?

A. Yes. Subjective is what a patient complains to a doctor about and the finding may be under the control of the patient.

Objective is what a doctor finds on his physical examination or by way of other diagnostic testing, where the patient has no control over those findings.

Q. Is muscle spasm objective or subjective?

A. It's absolutely objective because the patient cannot control it.

I define the word spasm for you. There are three criteria. It has to be prolonged, involuntary spasm where patient has no control over it. The patient cannot have any control over the spasm. In fact the spasm was confirmed by other diagnostic studies, not just physical exam studies.

Q. And let me ask you this. Is it significant that the muscle spasms existed seven months after accident?

A. Yes, very significant. It means that the injury is still persisting. The condition is still persisting and there's a good chance it may lead to permanency.

Q. And as far as trigger points is that objective or subjective?

A. That is most definitely objective. The definition of a trigger point is an area of muscle degeneration, an area of muscle scarring, with surrounding pain and spasm. It was caused by a microscopic bleed in the muscle fibers and then heals with permanent scarring.

Q. Where did you find those trigger points?

A. In the neck, upper neck, mid-neck, lower back, upper back, lower back.

Q. And were there any other -- you stated a straight leg raising?

A. Yes.

Q. Can you explain how that is done and significance?

A. The way it's done and this is why it's objective and not subjective, the doctor puts take the right hand, places on either of patient's ankle. The left hand goes underneath the patient's hamstring or knee. The knee is completely straight.

And you lift the patient's leg all the way up. Once you feel tightness or resistance that's when you stop. You don't stop when the patient says it hurts. You stop when you feel resistance and you can't push my more. That indicates nerve root irritation or a disk problem in the lower back. Anything less than 90 degrees is certainly abnormal.

Q. Let's go back to other than what you told us so far.

Were there any other objective findings based on your initial exam of the plaintiff? There was trigger points, spasm.

A. Range of motion deficits. And both the knees were tender with crepitation. Crepitation is grinding sensation when you flex and extend the knee.

Q. In reference to the lower back, you have straight leg raising trigger points?

A. And spasm and reduction of backward extension. Reduction of backward extension indicates a very high probability that this is a disk damage which is preventing the spine from bending backwards.

Q. And at the tire that you did that exam, did you have any other records in your file?

A. At that time, I did not.

Q. And did you reach a diagnosis based on your clinical findings and objective testing at that time?

A. Yes, sir.

Q. And can you tell the jury what your diagnosis was?

A. Yes. Multiple traumatic injuries, rule out cervical and/or lumbar disk bulge versus herniation.

Means that I wasn't sure if it was a disk bulge or herniation. I wanted to confirm it. Rule out cervical and/or lumbar radiculopathy to confirm that nerve root damage. And internal derangement, the both knees, rule out torn meniscus.

Q. At the time of your examination, let's say, start with the neck, it was just -- was it just a question whether it was a bulge or herniation?

A. That's what I was trying to rule out, if it was bulge or herniation.

Q. But it was one of the two?

A. Yes.

Q. And in reference to the lumbar, you wanted to find out whether it was a bulge or herniation?

A. Yes, sir.

Q. And as part of your -- at that time did you ask or recommend that you get the records?

A. Yes, I did.

Q. And did you subsequently get those records?

A. I did.

Q. And as part of those records did you get EMG test findings, not the results, but the actual EMG?

A. Yes, sir.

Q. And did you read those EMGs?

A. Yes, sir, I did.

Q. Can you share with the jury what your findings were?

MR. KOULISH: Objection. Someone else's test.

THE COURT: He can testify about that.

MR. KOULISH: He can testify to that?

THE COURT: About the EMG reports or tests.

MR. FREEMAN: Not reports. He has the actual EMGs so he read the EMGs with the --

MR. KOULISH: Same objection.

THE COURT: Did he do the -- did he do the tests?

MR. FREEMAN: It's not the other person's interpretation. It's his own interpretation.

THE COURT: No. Come up.

(Discussion off the record).

MR. FREEMAN: Note my objection.

THE COURT: Sure.

Q. Doctor, based upon your findings were you able to conclude whether the client had a cervical radiculopathy?

A. Yes, based on my own history, exam, findings, I made that diagnosis based on my own valuation of the patient on the first visit.

Q. Okay. And did you --

THE COURT: Tell the jury what that means?

THE WITNESS: Cervical radiculopathy means damage to a nerve root. The cervical means the neck.

The radiculopathy means damage to a nerve root. So cervical radiculopathy means damage to the nerve root in the neck.

Q. And did there come a time when you reviewed the EMG tests?

A. Yes, sir.

Q. And did the EMG test confirm your findings?

MR. KOULISH: Objection.

THE COURT: Sustained.

Q. Did there come a time when you reviewed -- is the EMG test a part your file?

A. Yes, sir.

Q. And were those records kept in the regular course of business?

A. Yes, sir.

Q. And did you obtain the MRI reports?

A. Yes, sir.

Q. And did the MRI reports confirm your --

MR. KOULISH: Objection, leading.

THE COURT: Sustained.

Q. Were the MRI reports made a part of your file?

A. Yes, sir.

Q. And at this time -- were those records kept in the regular course of business?

A. Yes, sir.

MR. FREEMAN: Okay. At this time I would like to offer Doctor Guy's office file into evidence.

MR. KOULISH: Object to the hearsay portions.

THE COURT: That's sustained.

MR. FREEMAN: I'll ask later on to argue that point but in any event.

Q. When you treated him on that first visit, did you subsequently see him?

A. Yes, sir.

Q. And when did you see him next?

A. I myself saw him a month later. He started -- I started him on physical therapy at Maimonides Medical Center. I saw him next on June 12, 2000.

Q. And what were his complaints of pain at that time?

A. He complained --

Q. And treatment?

A. Yes. He complained to me of neck pain, shooting down the right arm. Any time you have neck pain shooting down the arm or the leg it means there's a damage to the nerve root in the neck or lower back.

All the nerves in the arm originate from the nerves in the neck so if you have shooting pain down your arm, it's a very, very important piece of history. Indicates damage to nerve roots in the neck. So he had shooting pain down the arm, and he had lower back pain shooting down his right leg.

Then when I examined him I found similar findings as my initial examination plus the range of motion in his neck was now one-half normal.

And the back showed similar findings: Tenderness, spasm, it was trigger points. Range of motion of his back was one-half normal forward flexion. One half of backward extension. And the multiple testing for his right shoulder, deltoid and right hip extensor-flexor group was 4 plus over 5.

Deltoid is to bring the shoulder up like this and like so. And the hip muscles, the function of the hip muscles are to bring the hip joint up or backwards. Those were weaker than normal.

At that time he walked very -- walked very slowly. And with an antalgic gait which means a limp, and he required a straight cane to walk at that time. At that time I placed him on pain killers, Darvocet N 100, which is a narcotic medication for pain. One pill every 4 hours as needed. And to continue with physical therapy.

Q. Okay. Doctor can you explain the differences between a disk bulge and herniation?

A. Yes, I can. I brought with me charts and model which will assist me in my explanation.

THE COURT: -Go ahead.

MR. FREEMAN: Can we mark it for identification?

THE COURT: Deemed marked.

THE CLERK: Number 5.

THE WITNESS: Then my chart.

MR. MARTYNETZ: May we see that -- move over, please?

THE COURT: Yes. You can move over.

MR. KOULISH: Does each have a separate number or --

THE COURT: No.

THE CLERK: This is all one exhibit? The model and the chart as one?

THE COURT: Do it separately.

THE CLERK: Model is number 6 -- I'm sorry, everybody, 5 and the chart is number 6.

THE CLERK: ID, 5 and 6.

Q. Using the model, can you explain the difference between a -

A. May I step down?

THE COURT: Yes.

A. In the human spine, the neck, we have seven vertebra, seven vertebra. In the midback which is called the thoracic spine we have twelve vertebra. In the lower back which is called the lumbar vertebra, we have five vertebra, the lumbar spine ends with the tail bone called the sacrum. What we all sitting on is our tail bones, the sacrum.

Every vertebra is numbered and identified according to it's anatomic location. If I said the C4 -- “L” means lumbar. If I said the C4-C5 it means the space between the 4th and 5th vertebra, which is the disk.

Between each vertebra, we have a disk. A disk functions as a shock absorber like a jelly donut. Composed of two components, like a jelly donut outside is the donut portion, and this material is called the annulus fibrosis. It has approximately 100 rings.

And what you are looking at here, this is the disk, this is the axial view, looking at it from the top down, the side view, is the sagittal view:

So, the outer portion of a disk has 100 rings of a fibril cartilage here. Since a disk is consisting of fibril cartilage material, and once it tears, once it tears, it is a permanent, irreversible injury. This material cannot repair itself.

Bone when it breaks, it can repair itself. By bone commonly called callus, C A L L U S, formation. In fact once a bone breaks, the area that's broken becomes the smoothest part of that bone. So if you were to break the wrist again, the area that's broken will never break again. The area below it or above it slightly will break but not the same site. So bone has ability to repair itself. Muscle has ability to repair itself.

Q. Why wouldn't the fibrous --

A. Fibrous cartilage, I'm getting to that.

The composition of fibrous cartilage, it is the material is -- it's cartilage, soft cartilage. Soft cartilage does not have the ability to repair itself once it is torn. This is why it is a permanent, irreversible injury. Once you get injured it gets progressively worse, which I will get to.

Right behind the disk we have the spinal canal, where the spinal cord runs. The spinal cord runs from high up in the neck, from the brain, goes all the way down to the lower portion of your spine. It ends usually between the first and second lumbar vertebra.

It then continues with tiny branches of nerve roots which are called the Carta DeQuinae (phonetic). And the spine higher up in the neck, each nerve root gives a branch, right and left sides. And each root it bifurcates and gives more branches. Is that's how we get different nerves in the -- nerves in the arm and hands.

From anatomy a doctor knows what muscle is supplied by which nerve root. The deltoid is supplied by nerve root between the fourth and fifth vertebrae. The biceps is supplied by the C5-C6 vertebra. Most muscles have two nerves. Except for the triceps, it has four nerve fibers.

We have three abnormal conditions to a disk. The first abnormality is called a bulge. You see a partial tear on the outer perimeter and the disk between, to bulge. A disk bulge is a partial tear. Here you see more partial tears and the disk bulges out even further.

And on these models, what we see is a bulge as follows. Have normal disk. This is a disk bulge, shown a partial tear. This is a normal disk, this is a disk bulge showing a partial tear.

Now, as the pressure inside the disks continues to accumulate, the disk is like an -- analogous to a water damage, what is water behind the dam collecting. Once you have a little crack in the dam the pressure continues to build up and over time, days, weeks

to months, the material, annulus fibrosis material, this continues to tear more and more, the disk materials continue to leak out more until eventually it can lead to a full herniation which means complete tear.

A protrusion is a complete tear of this, but the disk material stopped right at the border of the disk margin. If the disk has the border disk margin it is called a full herniation. I'll show you examples. This is the normal disk.

MR. KOULISH: Could we have a question? There is no question.

Q. My question was explaining the difference between a bulge and herniation. That's the explanation. Please continue?

MR. MARTYNETZ: I object to having things marked for identification shown to the jury.

THE COURT: Then it's in evidence. Okay. Both of them.

THE CLERK: So marked.

A. So, this is a normal disk. This is a disk protrusion. There is complete tear of the disk but the disk stops at the margin.

Herniation is where the material ruptures around, passes the margin and hits the nerve root behind it. Normal disk, protrusion, herniation. Normal disk, protrusion, herniation.

So, herniated disk is a complete tear. Once a disk bulges, or gets injured the following things happen. The water content inside the disk begins to leak out. Once the water content inside, the leak begins to leak out, you get the disk that begins to shrivel up. This is a normal disk, the first one. Nice and thick and turgid.

As you see from the subsequent ones, the thickness of the disk begins to wear out and you have the rapid formation of these osteophytes which are bony spicules formed to stabilize the injured area, to prevent it from any further weakness to levels above it and below it.

One of these osteophytes form, which takes months to years to form, as they grow, they slowly begin to put pressure on the nerve which exits right on the sides, and causes more of a radiculopathy damage to a nerve root.

As this condition progresses, as you can see from the progression, this is normal, this is the abnormal. You see a lot of osteophytes and wear and tear. And the disk space is completely lost. One of the disk spaces is completely lost. You lose this shock absorbancy effect.

It's like having a car that has worn out shock absorbers, you feel every bump. As time goes on the height of the body decreases and the ability to absorb shock as you are walking or jumping will be diminished and you will have pain.

Furthermore, the outer perimeter, outer one-third of the disk has nerve fibers. Once you have a tear in the vicinity of the outer one-third of a nerve fiber, there is pain fibers that cause pain and irritation to the area and as a result get severe pain and spasm. This conditions is permanent, and progressive as you can see from the chronology of these disks.

Q. Doctor, what if anything causes the compression on the disk space?

A. Okay.

MR. KOULISH: Objection to a continued ongoing -- general discussion.

THE COURT: Ask him this case.

MR. KOULISH: Unless it applies.

THE COURT: I heard you.

Q. Doctor, based on your clinical findings, based on your office records, based upon the treatment and complaints, based upon the history of the van and the bus colliding, and I want you to assume that Mr. Prince was sitting right at the impact point, that he fell to the ground, banged his knees, that he was taken from the bus on a stretcher and cervical collar by ambulance to Kings County Hospital, I would like you to state if you can with a reasonable degree of medical certainty as to whether you have an opinion as to whether the cervical disk bulge was caused by the accident?

MR. KOULISH: Objection.

THE COURT: Overruled.

A. In my opinion, yes.

Q. And what is the basis?

A. Based on the history, based on the physical exam findings, at that time and currently, based on the fact that the spasm has persisted, still present. I saw him recently.

MR. MARTYNETZ: Objection.

THE COURT: Based on what?

MR. MARTYNETZ: He saw him recently.

THE COURT: Go ahead. Continue.

A. Based on the history, the physical exam findings initially and afterwards, in the medical field anything that lasts more than one to two years is considered permanent. His condition has lasted more than four years. It is most definitely permanent.

So, to answer your question based on the history, physical exam and the response to the physical therapy and the fact he had no prior problems with his neck and back, and third more, based on those x-rays that's right over there, those x-rays tell a lot of history.

Q. which I'll get to.

MR. KOULISH: Objection.

THE COURT: Sustained, x-rays.

A. Based on putting the whole picture together, history, exam, finding no prior problems with neck and back and the response to his first therapy, the significant residual deficits, put all together that's the basis of my opinion.

Q. And can you state with a reasonable degree of medical certainty whether the plaintiff suffered a lumbar bulge and whether that was related to the accident that I previously described?

MR. MARTYNETZ: Objection.

THE COURT: Overruled.

A. The patient suffered not one but three: L3-4, L4-5, L5-S1, which was in my opinion causally related to this accident for the same reason I've given.

Q. Let's get the x-rays of the hospital.

MR. FREEMAN: Do we have the shadow box?

THE CLERK: Yes, right here.

MR. FREEMAN: I ask these be moved into evidence. They are certified x-rays.

THE COURT: No problem. Collective exhibit then.

MR. FREEMAN: Consisting of three films. Kings County.

THE CLERK: Number 7.

Q. Doctor, you stated that the x-rays --

THE CLERK: Collective exhibit number 7.

Q. Doctor, you stated that the -- would these x-rays help in your explanation of the causation of injury?

A. Yes, they would.

Q. Can you explain how they help? Explain to the jury.

A. Yes. Step-by-step. First of all what we are looking at is this is the x-ray of Mr. Prince neck, cervical spine, taken at Kings County Hospital at the time of the accident. When we look at x-rays we're looking at bone.

What we look for is to see if the joint space is well maintained, that you have a little space between each vertebra.

If the join space is gone it indicates a strong possibility that there may have been a prior disk rupture or prior disk tear.

Second, when we look at the bone in the neck, look to see if the curvature of the neck is present. When you look at the x-rays of a neck, you will look for a C; normal curvature. The neck should be something like this, like a C.

Here it's completely straight. It indicates severe spasm. When you have that in the neck you lose the normal range of motion there. So we note right from the beginning there's a lot of spasm going on because the normal curvature of the neck is completely lost.

We did know that there's very minimal arthritic changes. Normal natural aging of arthritis for 59 year old person. The arthritic process begins in the female sex, 28 or 29. In the male it starts at age of 40, plus or minus a couple of years. So, 59 year old spine is certainly going to have some normal natural aging or the particular changes as expected here.

But the disk space is well maintained. Is well maintained You see a nice thick space between each vertebra and you don't see a lot of osteophytes like these, like these, to indicate that this was a prior preexisting problem.

The C4-C5 level, this is 2, 3, 4, 5. The 4-5 level, the disk space is well maintained. It is absolutely no problems with that disk space so this picture gives a lot of information. Spasm, normal -- abnormal range of motion. Disk space is well maintained, no osteophytes.

Next we go to the lower back. The lower back again, as you see the disk, this is the vertebra. Vertebra. The disk space is well maintained. You have nice thick space. This is your sacrum. This is L5. L4, L3. So, this is, these are the three levels that were bulging on the MRI. This space is well maintained. This space is well maintained and so is this space.

MR. KOULISH: Move to strike what's shown on the MRI since it's not in evidence.

THE COURT: Just testify about the x-rays.

A. On the x-rays we see all the joint spaces well maintained. There's no significant or any abnormal arthritic change. You see the normal sclerosis or the whitening, the top and bottom of the vertebrae which is part of a normal aging arthritis for 59-year old people. No abnormal osteophytes.

This is where the nerves exit, right here. No evidence of anything damaging the nerve roots. So this is an essentially normal x-ray of the lower back for 59-year old patient.

Q. Okay. When you say normal, saying of the bones?

A. Of the bones. Normal 59-year old x-ray for a 59-year old person.

Q. Perhaps the jury understood it and I didn't understand this but in terms of the disks, what would you expect to see if there had been a preexisting bulging or herniated disk?

A. The --

MR. MARTYNETZ: Objection.

THE COURT: Overruled.

A. The space between the two disks would be like so. Instead of being like so, it would be something like this. There would be a lot of osteophytes. The marked space narrowing and you don't see this on this x-ray.

Q. And is the x-ray -- and the x-ray is an objective finding?

A. Correct. It is most definitely an objective finding.

Q. And based on this, does this confirm or refute your prior opinion about his suffering bulging disk space on your clinical examination?

MR. KOULISH: Objection. You can't tell from x-ray.

THE COURT: Sustained.

Q. Okay, Doctor. Thank you.

Doctor, based on your examination, findings, review of records, can you conclude whether this was a significant and consequential injury?

A. Yes. I can conclude that this was a significant and a consequential injury.

Q. And what is that based on?

A. Based on the history, the physical exam, the response to his physical therapy and the significant residual deficits have lasted more than one to two years.

Q. Doctor, let's -- I want you to assume that the plaintiff has testified already and that he's testified that --

THE COURT: You can return to your seats, gentlemen.

MR. KOULISH: Fine.

Q. Assume that the plaintiff has testified that prior to date of accident he didn't have pain, that he was working three jobs as a maintenance man which involved sweeping, mopping, vacuuming, lifting heavy objects and then afterwards he had difficulty doing strenuous activities.

Do you have an opinion with a reasonable degree of medical certainty as to whether the accident was the competent cause of his limitations?

A. My opinion, the answer is yes.

Q. What is that based on?

A. For the reason I gave earlier based on the history, physical exam finding, fact he had no prior problems, the results of the x-rays that showed no significant preexisting problems, the response to his physical therapy, the effect that he required strong narcotic pain medications to alleviate pain and the recent physical exam findings to show that he still has deficits, his neck and back.

Q. And can you explain what activities to your knowledge that he would have limitations with?

A. Lifting, pulling, pushing things. He could lift things up to twenty to twenty-five pounds but no more. If -- because he's going to pay the price for it. You can lift up to twenty pounds but then you will feel the pain in your neck, upper back, lower back.

Prolonged sitting, prolonged standing will aggravate his condition. Stress, physical or emotional, causes muscle tightening that will aggravate his condition.

Laws of physics, extremes of temperature, cold weather, cold makes everything tight, contracted. Heat makes everything expanded. So in cold weather he'll feel more aches and pain and in warm weather slightly better.

In the rain and humidity, be more painful. That condition is subject to good days, bad days, known as remissions and exacerbations but the condition is progressive as I explained earlier.

Q. And I want you to assume that Mr. Prince testified that after the accident he went for a physical therapy for about three to four months at a different facility, took a few months off from the therapy before he came to you, and did home exercises but that he was still in pain before he came to you.

I want you to assume everything that you have testified to regarding your treatment of him for five to six weeks, three times a week, and that -- the home exercise.

Doctor, can you tell the jury your opinion as to whether this condition will continue and the need for treatment?

A. Yes, this condition is permanent. There is no cure for this condition as there's no cure for arthritis. As there's no cure ?? diabetes. There is only treatments.

So, when he's in pain he's going to need first therapy and pain medication, and this condition is subject to over time getting progressively worse.

I showed you from the chronology of what happens to the disks, the joint space between narrower and narrower and the nerve roots where they exit is call the neural foramina. They become smaller and smaller until the nerve roots become more and more pinched and eventually over time he'll have massive traumatic arthritis. And he will require a shaving for -- by that I mean to release the trapped nerves.

MR. KOULISH: Objection. There is nothing about that procedure anywhere.

Q. What is the interaction of the bulging disk with the nerves?

THE COURT: Overruled.

A. The bulging disks causes the joint space and the disk space to become narrow and narrow and you have osteophytes which will form around the bulging disks to stabilize the injured area.

As those osteophytes continue to grow over time, they are like the nails, nail beds on your finger nails; they continue to grow over time. As they grow, they stick out into where the nerve roots exit. They crowd the nerve root and over time they compress the nerve root and you get compression and then no function of the arm. You have to free that with a surgical procedure.

MR. KOULISH: Objection.

THE COURT: Sustained. Nothing in there about that.

MR. MARTYNETZ: Objection to all the things about the osteophytes.

MR. FREEMAN: Future consequences, Your Honor.

THE COURT: Finish.

Q. Can you describe what treatment Mr. -- would you recommend for Mr. Prince and the cost of those treatments?

A. He's going to need physical therapy as needed. The average cost for each session is $100 per session. He's going to need pain medications. The monthly cost of those pain medications, approximately $300 a month.

And he will need repeat x-rays, MRIs of his neck and back periodically to reassess the injured areas. He will need repeated EMGs of the neck and back every four or five years to reassess the damage. The actual cost is $1500 for each EMG. For each MRI is $900. Approximate costs for x-rays of the cervical lumbar spine are about $150.

Q. And how often would the tests --

MR. MARTYNETZ: Objection.

THE COURT: What is this?

Q. How often would you recommend the test be performed?

THE COURT: Go ahead.

A. EMGs every four to five years. The x-rays and the MRIs, every three to four years.

Q. How often would you recommend the physical therapy?

A. As needed. Ideally, twenty to thirty sessions per year.

MR. FREEMAN: At this time I have no further questions, Your Honor.

THE COURT: Counsel?

MR. KOULISH: Yes. One moment.

CROSS EXAMINATION

BY MR. KOULISH:

Q. Good morning, Doctor Guy.

A. Good morning.

Q. Who referred Mr. Prince to you?

A. Maimonides Medical Center. I have no idea who referred him. He came to the hospital. He was assigned to the doctor that was there at the date which was me. I saw him.

Q. Okay. Do you know, before seeing you, Mr. Prince was seen, am I correct, by a neurologist?

A. Yes, sir.

Q. At Maimonides?

A. At Maimonides, I don't believe it was at Maimonides.

Q. Kings County then?

A. It was a Doctor Kroninberg (phonetic).

Q. Doctor Kroninberg?

A. Yes.

Q. Now, before I get to that, you're being compensated for your time here today?

A. Yes, sir, I am.

Q. How much does that amount to?

A. My fee is 3,000 for half a day of testimony; 1,000 for pretrial preparation. All together 4,000.

Q. Okay. Now, in addition to that, you have a lien against this lawsuit, for Mr. Prince's medical treatment in other words?

MR. FREEMAN: Objection.

Q. You expect to be paid from -- if Mr. Prince wins the lawsuit?

A. That is not true. Absolutely incorrect. I have a bill to Mr. Prince. He owes me approximately $900 for the treatments that has been rendered to date and he owes that money regardless of the outcome of his case.

Q. Now, wasn't that bill assigned to the law firm representing him?

A. No, sir, a bill is not assigned to a law firm.

MR. KOULISH: May I see your file?

THE COURT: Is this necessary? Go ahead.

MR. KOULISH: Very briefly.

THE COURT: See the file then.

MR. FREEMAN: In terms of collecting bills?

Note my objection.

Q. Have you been paid your fee already, sir?

A. I've been paid most of my medical bills. Except $900.

Q. Okay. And that was by the -- who paid you?

A. I have no idea. I'm not in charge of billing. I take care the medical end.

Q. Wasn't it the law firm of Kenneth --

A. No, sir, no, they have not paid for my medical bills.

Q. Okay. Now, let's -- your -- your very erudite presentation about disk bulging and pressure on the nerves and ruptures, that's academic, is it not, Mr. Prince does not have herniated disks?

A. He does not have herniated disk as we sit here today and talk about it. He has bulges.

Q. Right.

A. But he has radiculopathy.

Q. So the thing you would talk about, about rupture and the fluid leaking out and the desiccation, drying out of disk space and the pressure on the nerves, that may apply to some patients but it doesn't apply at this stage to Mr. Prince?

A. It -- most levels do; if you were listening I said a bulge is a partial tear.

Q. I'm talking about herniation.

A. I'm talking about bulges. A bulge is a partial tear. It is a tear. Once you have a tear, the fluid inside the disk leaks out. The disk shrivels up. You have nerve root fibers in the outer one-third perimeter that become injured. They become inflamed. And the process does continue.

Osteophytes begins also at the disk level with -- where there are bulging as well.

Q. Isn't it a fact that bulge means just that, it's bulging but there's no leakage yet and once it's a tear it's classified as a herniation?

A. No, I suggest you reevaluate your definition. That's incorrect.

Q. Can you tell me of a single medical journal that describes a disk bulge as a leaking of material?

A. I just showed you pictures; that is one medical journal that I showed you, is the diagram that was taken from the Sieger -- illustration from a medical -- no such thing as authoritative. It is a medical source and it shows what a bulge is. And a bulge is a partial tear. Common sense you have a partial tear. The fluid inside the -- the disk begins to leak out.

Q. Well, there's no difference under that definition between a herniation where there's a tear and a bulge. You might as well call it a little herniation and a big herniation?

A. No, definition --

Q. Isn't a bulge just where say you're squeezing a balloon and the balloon bulges out. That's a disk bulge?

A. For a disk bulge to occur is a partial tear as well.

Q. Okay. We're arguing semantics. But isn't it a fact that the disk itself has no nerve roots or blood supply, that's why it can't heal itself?

A. The disk has no blood supply but it does have nerve fibers on the outer one-third perimeter.

Q. Right. And for a disk to be medically significant it has to impinge on the nerve fiber?

A. Wrong again. Wrong again.

Q. So the disk -- let me just -- so the disk can bulge and even if it doesn't touch the nerve fiber, you still have symptoms; is that your testimony?

A. Depends on a lot more factors than what you have portrayed. Depends on the clinical correlation. Every, every textbook will tell you disk bulge herniations in itself does not mean enough. It's what it is doing to the body itself.

Is there spasm, range of motion, is there radiculopathy present? So, if the clinical correlation indicates there is loss of range of motion, there's spasm, and/or trigger points, then it becomes significant whether it's a bulge, whether it's a protrusion or a herniation.

Q. Now, you would agree -- first of all, the reason you take an MRI is because x-rays don't show the injuries; you need the MRIs?

A. That's correct.

Q. The reason you take an MRI is to show whether -- in fact the condition of the disk and whether there's any nerve impingement?

A. Wrong. That's when we do an EMG. If the MRI could do that there would no, no reason for an EMG.

Q. In a -- in fact Mr. Prince's MRIs, the cervical MRI showed disk bulging with no disk space narrowing, no compromise of the thecal sac; is that correct?

A. That's correct.

Q. Now, that means in fact there was no nerve impingement?

A. No.

Q. Not true?

A. Nerve damage, you don't need nerve compression to cause nerve damage once you have an injury to the disk, once you have a tear partial tear or a complete tear, the material inside disk leaks out. What is inside the disk is also histamine, nitric oxide, bradykinin, all types inflammatory substances which leak out and cause irritation and damage to the nerve root.

Second, you can have a nerve root damage with no disk damage just as simple rotational forces that works on the spine that cause a stretching of the nerve roots. Once a nerve root gets stretched it becomes swollen. Once -- I'm not finished.

Once it becomes swollen, the nerve no longer functions properly. That causes a radiculopathy. So, radiculopathy can be caused by direct compression from a tumor or disk. It can be caused by the chemicals existing in the disk or third, just simply by the rotational forces that works on the spine and by the stretching a nerve root. You don't need --

THE COURT: All right, all right.

Q. But in Mr. Prince's case it's not caused by disk herniation or leaking of the disk material to the nerve?

A. I don't know what you say is correct. Once you have a partial tear which in a disk usually that material comes out.

Q. Can you --

A. Comes out and causes radiculopathy.

Q. Can you -- well, it's very convenient I think that you brought the x-rays but do you have the MRIs to show the jury what the disk actually consisted of other than theoretically, what Mr. Prince --

THE COURT: He doesn't have the MRIs; is that the question? Do you have them?

THE WITNESS: No.

Q. Any reason for that?

A. I don't have them. I didn't take them. I don't have them.

Q. Don't you agree it would have been important to illustrate in your point or the -- statements you are making?

THE COURT: Would it --

Q. To show the actual MRIs rather than a general model?

A. I have the reports. I don't have the films. Naturally the more films you have the more demonstrative aids you have. Of course it would help to understand it but in this case we don't have it and we have the report.

Q. The reports actually say no nerve impingement; don't they?

A. That is correct.

Q. And that's also true of the lower back?

A. That is correct.

Q. Now, you took -- when did you last see Mr. Prince?

A. 4/21/04.

Q. Did you take x-rays?

A. No, I did not take x-rays.

Q. Well, okay, so we have the x-rays of what is -- his neck looks like the day of the accident but not what it looks like five years after the accident, right?

A. That's correct.

Q. Don't you think since you bothered to show the original x-rays it might have been important to show the jury to reinforce your points what his neck liked like now?

A. There's very good reason. Who's going pay for it? You? Him? He doesn't have the money.

Q. Is any of the treatment you provided in the past contingent on who was paying for it?

A. No.

THE COURT: Anything else?

MR. KOULISH: Yes, just one more moment.

Q. So x-rays taken recently could show in fact whether there were osteophytes, whether there weren't any further osteophytes, correct?

An x-ray taken two weeks ago could show whether there was in fact any change from the x-rays that were taken the day of the accident?

A. The way you phrased question, the answer is yes.

MR. KOULISH: Nothing further.

THE COURT: Any questions?

MR. MARTYNETZ: Yes, Your Honor.

THE COURT: Don't cover the same stuff.

MR. MARTYNETZ: I'll try not to, Your Honor.

CROSS EXAMINATION

BY MR. MARTYNETZ:

Q. Good morning, Doctor Guy.

A. Good morning, sir.

Q. You've testified before in court, have you?

A. Yes, I have many times before.

Q. How many times have you testified approximately?

A. On the average I testify about twelve to fifteen times per year. Sometimes, some years less, some years more. I've been testifying for my patients about fifteen years.

Q. Fifteen years?

A. Yes.

Q. Are you familiar with the New York Jury Reporter Verdict Reporter?

A. Yes, I've been asked questions about that before, yes.

Q. And are you familiar with a jury verdict search tool that attorneys used?

A. Yes.

Q. That would tell an attorney how many cases you've testified in?

A. Yes.

Q. Let me show you what's been -- have this marked?

THE COURT: Just ask him questions. Ask him some questions. No reason to do that at this point.

MR. FREEMAN: Note my objection.

Q. Now, in view of these times that you testified, did you testify every single time for the plaintiff?

A. My patients, yes, except for ones -- I testified once for defense.

Q. Once out of all those times you testified you testified for the defense; all the rest for the plaintiff; is that correct?

A. Patients. You refer to them as plaintiffs. I refer to them as patients.

Q. In the courthouse they are referred to as plaintiffs; is that correct?

A. Obviously, yes.

Q. Now, during that testimony you always stated that you found a positive finding for your client?

A. That's correct because if I don't find a positive finding or give a report to that the case does not come to trial. Obviously gets dismissed or it gets resolved.

So, if I find nothing wrong I will not testify. Or I will tell the patient's attorney I have no findings. If you want to bring me in, fine, do so. I will testify about my findings and I have many patients that I have no positive findings.

Q. Sir, you testified that one of the first things you wanted to do is to obtain the history of the patient; is that correct?

A. One of the things, yes.

Q. Now, one of the first things, you have your plan, how you evaluate and treat Mr. Prince, was to obtain his prior history results, right, his records?

A. No -- prior records, yes.

Q. That is number one of what you have on your list to do, that's correct?

A. That's correct.

Q. Then you did obtain -- did you obtain the ambulance call report as part of the emergency room records from Kings County?

A. I don't have the ambulance call report. I have the emergency triage report which is -- should be the same.

Q. Don't you have -- ambulance -- flip further, I think. That's not what I'm referring to.

A. Okay.

Q. Your records are -- okay?

A. That's what I have in my records.

Q. Let me show you what's been brought into --

THE COURT: What's the question?

MR. MARTYNETZ: If he looked at the ambulance call report.

THE COURT: Have you seen it?

THE WITNESS: No, Judge.

THE COURT: He didn't see it.

Q. Let me show you what's been brought into this courthouse, subpoenaed to this courthouse as the record from Kings County Hospital.

Could you review this, please? Have you seen that entire record before you came here today?

A. (Perusing documents) I have most of it. A lot of it is redundant. I don't have.

Q. ?? the ambulance call report part of that record?

A. Yes, it is.

Q. Had you reviewed that before?

A. I have not.

Q. Would it have been significant in your review and in your taking of the history that --

THE COURT: Is this in evidence?

MR. MARTYNETZ: I'll put it in evidence. It's the hospital report.

THE COURT: Then it's in evidence. Subject to redaction.

THE CLERK: S, Judge.

THE COURT: Subject to redaction.

THE CLERK: S as in Sam. So marked.

Q. Did you know the finding of the ambulance personnel that said that Mr. Prince was found seated on the city bus when the ambulance personnel came to him, did you know that, sir?

A. That's what it states, yes.

Q. Did you make a note of the results of the x-rays taken at the hospital?

A. Yes, I did make a note of the x-rays. I can tell you what they show.

Q. Referring me to -- where you are referring to?

A. Lumbar.

THE COURT: What's the question? Ask him a question.

Q. What --

THE COURT: The juror can't see. You don't have to look over his shoulder.

Q. What portions of the body were the x-rays taken of?

A. The cervical spine, the thoracic spine, lumbar spine, and right knee joint.

Q. Were any fractures found?

A. No, sir.

Q. Was osteoporosis found in that gentleman's back?

A. Thoracic spine, yes, the midback, which is not injured in this accident.

Q. Take a look at the cervical spine?

A. Some mild degenerative change as I explained and as I showed on the x-rays.

Q. So you're telling us this gentleman had degenerative changes on x-ray when he got to the hospital; is that correct?

A. Told you that over five times.

Q. Did he have degenerative problems in his lower back?

MR. FREEMAN: Objection to the word “problems”.

Q. Did he have any degenerative changes in his lower back?

A. He had normal aging degenerative changes for his entire spine. Normal degenerative changes.

Q. Let's put this in perspective for the jury. You're familiar with various studies done of asymptomatic people?

A. They are not all authoritative studies.

Q. Let me finish the question.

Now, when you take them cumulatively you have some kind of--

MR. FREEMAN: Objection.

THE COURT: Sustained.

Q. You're familiar with studies done and reported in the New England School -- New England Journal of Medicine, are you not?

A. If you ask me, there's been many studies; even the author --

THE COURT: The answer is yes he is. Next question.

Q. Are you familiar with the fact that even asymptomatic people at age 60, age 60 if you were to do an MRI in their back, close to a hundred percent would have bulging disks, are you familiar with that study?

THE COURT: Is that true?

THE WITNESS: That's what that one study says but again it's not authoritative because that is the opinion of that one particular author.

Q. And that all those opinions is like a -- almost a hundred percent at age sixty?

A. No.

MR. FREEMAN: Objection.

THE COURT: Sustained.

Q. Are you familiar yourself with reviewing MRIs of people in the age of around sixty, and one of those MRIs almost always shows bulging disks?

A. The way you phrase the question, no, not almost always. That is not correct.

Q. What percentage would show bulging disks?

A. I cannot give you.

Q. Over eighty?

A. Every case is different.

Q. I'm asking for a percentage here?

A. I can't give you a percentage.

Q. Can you give me a range? Is it over eighty percent typically?

A. No, I would not say over eighty percent.

Q. Over ninety percent?

THE COURT: He said he can't give you a percentage.

Q. So I understand you correctly, Doctor, we're talking about disks, right?

A. Yes.

Q. The least severe problems with the disk is a bulge?

A. I would say yes.

Q. And the next severe is the protrusion?

A. That is correct.

Q. And then the worse is a herniation; is that correct?

A. That is correct.

Q. And this gentleman does not have a herniation?

A. That is correct.

Q. He does not have a protrusion?

A. That is correct.

Q. He has a herniation?

MR. FREEMAN: No.

Q. Excuse me. A bulge?

A. He has a bulge with a radiculopathy.

Q. He has a bulge.

A. Not just a bulge, a bulge with radiculopathy. It's a big difference between, difference between the two.

Q. Now, sir, as part of your plan you are trying to receive the medical records, right?

A. Yes.

Q. Did you receive the medical records from Doctor Kroninberg?

A. Yes.

Q. And you were aware that Doctor Kroninberg released this gentleman from his treatment, were you not?

A. So did I. I released him. I -- at least once from my care. He came back because his symptoms recurred.

Q. But you were aware that Doctor Kroninberg released him; that correct?

A. I wasn't aware he released him on a permanent basis.

Q. Did you get Doctor Patel's records by the way?

A. Doctor Patel, no, I don't have his records.

Q. Is there any reason why you didn't get Doctor Patel's records?

A. No, I don't -- I asked for all the records.

Q. You knew Doctor Patel treated him?

A. He treated him, yes.

Q. Now, when you saw him, you then obtained Doctor Kroninberg's tests results, right?

A. Yes.

Q. You didn't do your own test results, did you?

A. I did not.

Q. You didn't perform an EMG, did you?

A. No; for very good reason.

Q. And you didn't -- you haven't had, an EMG has not been performed on this gentleman since Doctor Kroninberg's EMG; is that correct?

A. That is correct and he's --

Q. Even though you are telling us that you should do it three or four or five times every three or four years, all right?

A. I said medically they are indicated to perform them. Who's going to pay for them? They don't costs two cents.

Q. Did you review Doctor Kroninberg's EMG from January 12, 2000?

A. Yes.

Q. And that January 12, 2000 EMG study, under the impression it says “This study reveals no evidence of radiculopathy of the L3, S1 segments”?

A. Of the lower back, yes.

Q. What does an EMG study measure?

A. Nerve damage. But it states that “If the patient's symptoms persist a repeat study would be indicated in future” reads the last.

Q. You did a repeat one?

A. And I told you the reason.

Q. So the only one we have here shows no damage at all to those lower limbs; is that correct?

A. That is correct.

Q. Are you familiar with what is known as an SSEP study?

A. Yes, that checks the sensory branch of the nerve whereas the EMG checks the motor branch.

Q. Now, did you review Doctor Kroninberg's SSEP study dated January 12, 2000?

A. Yes, it was normal for the lower back as was the --

Q. Absolutely normal; is that correct?

A. That is correct

Q. Doctor, when you measure on physical examination people raising their legs up, you are telling us that that is a --

THE COURT: Back up.

Q. You are telling us that that is an objective test rather than a subjective test?

A. Yes, it's not just me; it's the whole entire medical community as well as every teaching medical school.

Q. They find that persons can't just decide not to lift it up as high as he wants to?

A. As I explained earlier, the fact the patient doesn't lift it up, it's the doctor that lifts it up. It's the doctor that feels the tightness and resistance. You don't stop when the patient says it hurts. You go, you continue until you feel resistance, tightness. That's when you stop.

Q. That resistance can be given by the patient by pushing down?

A. No, if the patient gives resistance you pick it up right from the get go. SLR is an objective test.

Q. Before this visit in 2004, before -- for the purposes of trial testimony --

A. This was not --

Q. When was the last time you saw the patient?

A. 3/29/04 and then I saw him last -- 8/2703 and then 11/30/03.

Q. Before that when was the last time you saw him?

A. Last time was at Maimonides.

Q. That was when?

A. On 9/28/01 when I discharged him to home exercise program.

Q. Was that 9/21, what year?

A. '01.

Q. '01?

A. Yes.

THE COURT: Finish.

Q. And during all of those times you did not take an x-ray, you did not order an MRI, and you didn't do an EMG study; is that correct?

A. That's correct, for reasons I've given you.

Q. Thank you.

A. You're welcome.

MR. FREEMAN: I have a few questions, Your Honor.

THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MR. FREEMAN:

Q. Doctor, what were the results which were omitted by counsel of the cervical nerve conduction tests?

MR. MARTYNETZ: Objection.

THE COURT: Overruled. You opened the door.

MR. MARTYNETZ: Not on cervical.

THE COURT: You asked him about the report. I'll let him ask about it.

A. Showed two level radiculopathy on the neck. Two levels.

Q. And what levels -- was there a radiculopathy?

A. Yes, there was a radiculopathy.

Q. Where did the radiculopathy go?

A. From the neck, down the arm.

Q. Which arm is that?

A. I believe it was mostly the left side.

Q. Was that consistent with the clinical findings?

A. Yes.

Q. As far as the cervical MRI, sir, can you state what the rulings of t?? cervical MRI were?

A. Yes.

MR. MARTYNETZ: Objection.

THE COURT: Overruled.

A. It shows straightening of a normal cervical lordosis which is exactly what the x-ray showed indicating severe muscle spasm, indicated disk bulge at C4-C5.

Q. Did you have hospital x-rays in the file?

A. Right there.

Q. In your file. When you came to court today did you have them?

A. No.

Q. Are test results such as MRIs and nerve conduction tests the kind that is ordinarily accepted and relied upon by physicians in your field of practice?

MR. MARTYNETZ: Objection.

THE COURT: Overruled.

A. Yes.

Q. So that doctors might get reports from other doctors and use in their diagnosis; is that correct?

A. Yes, sir.

Q. And in your case you got these even after your first initial evaluation, correct?

A. Yes, sir.

Q. And did they confirm your evaluation?

A. Yes.

Q. Out of curiosity, Doctor, when is the first time that you and I met?

A. Today, this morning.

Q. Thank you. No further questions.

THE COURT: Okay.

MR. KOULISH: Just one.

RECROSS EXAMINATION

BY MR. KOULISH:

Q. Doctor, the cervical MRI also indicates, does it not, the thecal sac and the cord are normal in size and signal intensity?

A. Normal as expected yes.

Q. Signal intensity has to do with whether there's any nerve impingement, right?

A. Wrong, I correct.

Q. But they found -- when you have a problem with a herniated disk you -- what's happening is that the disk is impinging or pressing on the thecal sac, right?

A. Is that a question or telling me something?

Q. It's a question.

A. The way you phrased that --

Q. Are herniated disks, are the pulposis compressing the thecal sac, right?

A. Are you asking me the question?

Q. Yes.

A. You can have it both ways. You have disk herniation with compression of the thecal sac; also have a disk herniation with no compression on any structure.

Q. Right.

Q And if there is no compression then there's no effect. You can be completely asymptomatic if there's no nerve impingement; one can be asymptomatic?

A. You are completely incorrect in the way you explained that question or statement.

Q. Isn't it a fact that there are, whether -- we're dancing around. Talking 80, 90 percent, there's a large percentage, whether you want to call it 40, 50, whatever, percent of the population after say age 40 that have disk bulging?

A. With radiculopathy or without?

Q. with no symptoms at all?

A. I don't know of any study that's authoritative that explains that answer.

Q. You don't agree that the New England --

MR. FREEMAN: Objection.

THE COURT: Stop.

Q. Isn't that the -- isn't it common knowledge in the neurological/orthopedic field that many, many people have disk bulging without being aware of it at all?

MR. FREEMAN: Objection.

THE COURT: You can answer.

A. I won't say many. I will say there's some people that can have it without symptoms, yes. Every case is different.

Q. So that in fact if I have a disk bulging say, and say oh, I have pain in my neck, you have, without an MRI showing nerve impingement or pressure on the nerve, you have no way of knowing whether in fact my back hurts or doesn't; is that correct?

A. You just mixed up your neck with the back. Is it the neck or back?

Q. Either way, neck-neck or back-back?

A. Now, I would rely on much more information than you've given me. You have to put all the pieces of a cross word puzzle together to see the whole picture. You just give me a small little piece. I need the history, I need the physical exam finding, x-ray findings, MRI findings, then the injury --

THE COURT: All right, all right. Come on.

Q. Now, Mr. Prince is Medicare eligible at this time, isn't he?

A. I do not know.

Q. He's what, sixty-four or something?

A. To be eligible you have to be at least 65.

THE COURT: Next question.

Q. So these tests that you are talking about, we're wondering about who is going to pay for them. He'll be under Medicare pretty soon, right?

A. I don't know if that's the case.

Q. Nothing further.

THE COURT: Thank you.

(Doctor Guy leaves the stand).

MR. FREEMAN: I have no witness sitting outside.

MR. KOULISH: Could we approach and ask for an offer of proof as to what this witness --

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