2006 WL 6650336 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Westchester County

Jonathan A. KORN, M.D., Plaintiff,
v.
FIRST UNUM LIFE INSURANCE COMPANY, Defendant.

No. 2001-05958.
January 11, 2006.

Testimony of Plaintiffs' Expert Witness, Dr. Ali Guy

Case Type: Insurance >> Disability
Case Type: Insurance >> Life
Jurisdiction: Westchester County, New York
Name of Expert: Dr. Ali Guy
Area of Expertise: Health Care-Physicians & Health Professionals >>Physiatrist/Rehabilitation Medicine

Representing: Plaintiff

For the Plaintiff: Quadrino Schwartz by: Richard Quadrino, Esq., William J. O'Mahony, Esq. and Michael Sepe, Esq.
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By: Patrick W. Begos, Esq. and Evan L. Gordon, Esq.
150 East 58th Street - Suite 2310 New York, N.Y. 10155.

Hon. Nicholas A. Colabella.

MR. SEPE: Plaintiff calls Dr. Ali Guy.

ALI GUY, MD, Having been called as a witness, having been first duly sworn, was examined and testified as follows:

MR. SEPE: May I have a moment to give Mr. Begos copies of some exhibits to save time?

THE COURT: Please be seated, doctor. Get close to the microphone. Make yourself comfortable. Speaking into the microphone, speaking through the microphone to your attorney -- to the attorney, give us your full name, spell your last name and your occupation.

THE WITNESS: My name is Dr. Ali Guy, A-L-I is my first name, last name is G-U-Y. My office address is 7 Gramercy Park West, New York, New York 10003.

THE COURT: Your occupation.

THE WITNESS: I'm a physician.

THE COURT: Thank you.

THE WITNESS: You're welcome.

MR. SEPE: May I inquire, your Honor?

THE COURT: Yes.

DIRECT EXAMINATION

BY MR. SEPE:

Q. Good afternoon, Dr. Guy.

A. Good afternoon, sir.

Q. Dr. Guy, what is your field of specialty?

A. Physical medicine and rehabilitation.

Q. What is the term physiatry?

A. Physiatry is a medical doctor that has specialized in the field of physical medicine and rehabilitation. It's a medical field that was founded shortly after World War II by Dr. Howard Rusk. It deals with traumatic injuries covering the whole body from the head to toe. It deals with nonsurgical orthopedic problems, it deals with neurological problems, it deals with muscle and nerve physiology, disability and impairment evaluations, which means you evaluate an injured patient and see if he's disabled, if it's partial, moderate, total and what the future and the prognosis holds for the patient.

It also deals with electro-diagnostics, the performance of a test to see if there's any muscle and nerve problem.

Q. And do you hold any board certifications?

A. Yes, sir. I'm board certified in the field of physical medicine and rehabilitation.

Q. And are you licensed to practice medicine?

A. Yes, sir, I am.

Q. Is that in New York State?

A. New York State and Pennsylvania.

Q. Can you please tell the jury what your educational background is?

A. Yes, sir. My undergraduate, I went to Queens College. Medical school I graduated from University of Northeast Dominican Republic in June of 1981.

Thereafter I did three separate residencies. My first residency was in the field of internal medicine at Mount Sinai School of Medicine, Mount Sinai Medical Center, for eighteen months. Then I did one year of general surgery at Cabrini Medical Center. Then I completed a three-year residency training program in the field of physical medicine and rehabilitation at Mount Sinai Medical Center.

I was the director of the department of rehab medicine at Maimonides Medical Center in Brooklyn, New York from 1997 to July of 2002 where my duties were to be in charge of all the inpatient, outpatient rehab services, provide teaching to the medical residents, the house staff, the orthopedic residents. My duties were to prepare the orthopedic residents for the boards under the rehab section questions.

I was in charge of the quality assurance in my department, my hospital.

I did consultations to other doctors in the hospital.

I have been the director of the neuromuscular equipment clinic at NYU's Hospital For Joint Disease from 1990 to December of 2005.

I've been a clinical instructor to the residents at NYU from 1990 to the present, where my duties are to teach the NYU residents, prepare them for the boards parts one and part two.

Q. And how does the field of physiatry or physical rehabilitation in medicine relate to the fields of neurology and orthopedics?

A. Physical medicine --

Q. If at all.

A. Also known as physiatry, not psychiatry, how it differs from neurology is neurology concentrates primarily on diseases of the central nervous system, diseases such as Lou Gehrig's Disease, Parkinson's Disease, Multiple Sclerosis.

As a physiatrist, we concentrate primarily on diseases of the peripheral nervous system, problems with the nerves in the upper extremities, the legs, coming off the nerve roots, the lower backs.

We are considered the experts on nonsurgical problems with discs and the spinal areas. Neurologists do electro-diagnostics on some occasions, but physiatrists must do EMGs, electro-diagnostics on all the patients that are medically indicated.

So the basic difference is one concentrates on central neurology, we concentrate on peripheral neurology and there's a great deal of overlap between the two specialties and we cross refer patients back and forth to one another.

Q. Have you also received training in the interpretations of MRIs and x-rays?

A. Extensively, sir, yes, sir.

Q. And how about EMGs?

A. Yes, sir, as well.

Q. Are you a member of any medical organizations?

A. Yes, I'm a diplomate of the American Board of Physical Medicine and Rehabilitation. I'm a member of the New York County and the New York State Medical Societies.

Q. And do you have any current hospital affiliations?

A. Yes.

Q. What are those?

A. NYU's Hospital For Joint Diseases and Cabrini Medical Center.

Q. And in your career, have you treated patients with neurological symptoms resulting from traumatic injury?

A. Tens of thousands, yes, sir.

Q. About a minute ago, Dr. Guy, you mentioned you had done a year rotation in general surgery.

A. Yes, sir.

Q. Approximately how many surgeries have you performed?

A. Well, I assisted on numerous surgical cases, hundreds, perhaps thousands.

Q. What types of surgeries?

A. All types, orthopedic surgeries, arthroscopies, joint replacements, gallbladder surgeries, gunshot wounds, trauma. Just about every type of surgery.

Q. And have you previously given lectures in the area of physiatry?

A. Yes, sir, I have and I still do.

Q. Approximately how many have you given?

A. Hundreds.

Q. Have you previously been qualified as an expert witness in the state or federal courts of New York?

A. Yes, sir. In my 17-year career as a physician, I have testified many times in just about every single court there is in New York, and I have been deemed as an expert in my field every single time.

MR. SEPE: Your Honor, I offer Dr. Guy as an expert in the field of physiatry and ask that he be questioned as such.

MR. BEGOS: No objection.

THE COURT: Yes, he's so certified.

MR. SEPE: Thank you.

Q. Dr. Guy, do you know the plaintiff in this case, Dr. Jonathan Korn?

A. Yes, sir, I do.

Q. How do you know him?

A. When I was doing my surgical residency at Cabrini Medical Center, he was one of my teachers. He was an attending. I would scrub in on some of his cases and I would take care of a lot of his cases and he would teach us and supervise the cases that were his patients. And I also worked in his office after I finished my residency, I worked in his office for several months. I performed EMG studies for his office.

Q. And what time period was that?

A. Shortly after my graduation from residency from rehab, I'd say 1988, '89.

Q. Did you ever socialize with Dr. Korn?

A. In the past when I used to work in his office, we went out to dinner once or twice.

Q. What year was that, if you know?

A. In '88, '89.

Q. And since the time when you formed your own practice, have you referred patients to Dr. Korn?

A. Yes, I have referred many patients to him. I referred my own mother to him, my own father to him.

Q. And has he referred patients to you?

A. Yes, sir, he has.

Q. Are you being compensated for your time appearing in court today?

A. Yes, sir, I am.

Q. And what is your compensation?

A. My fee is $3,000 for half a day of court testimony, $1,000 for pretrial preparation.

Q. And how does that compare to -- withdrawn.

Do you have an ordinary fee that you charge?

A. That is my ordinary fee.

Q. And how does it -- okay, thank you.

Doctor, did there come a time in or about December of 1994 that you began to treat Dr. Korn?

A. Yes, sir.

Q. And specifically did there come a time December 12th, 1994 that you met with, examined and treated Dr. Korn?

A. Yes, sir, I did.

Q. And could you please tell us what if any observations you made of his physical condition at the time you met with him on that day?

A. After taking a history, I examined the areas of chief complaint which were mostly the left upper extremity. The chief complaint was weakness, paraesthesias which means numbness and tingling in the left upper extremity, left shoulder, left shoulder pain, left shoulder weakness, left arm weakness.

The left shoulder, there was tenderness over the acromio-clavicular joint, also the mid portion of the clavicle. There was a lot of spasm in the shoulder girdle region area. The range of motion of the shoulder was diminished; it was two thirds normal range of motion.

The shoulder is a very complicated joint; it has six ranges of motion. You have shoulder flexion which is zero to 90 degrees. We have shoulder abduction -- shoulder flexion abduction is to 180. Abduction is to 90. We have internal rotation which is zero to 90 degrees. External rotation is zero to 90 degrees and we have adduction which is zero to 30 degrees.

The range of motion was diminished by one third and the muscle power was four plus over five, it was approximately two grades weaker than normal and there was loss of sensation in his forearm and his left hand, the last two fingers.

Q. Did there come a time during that exam you examined Dr. Korn's left AC joint.

A. Yes.

Q. What is an AC joint?

A. Acromio-clavicular joint. That's the joint right over here. And it was tender to touch and range of motion to the shoulder was diminished.

Q. We've previously marked into evidence an exhibit I believe it is 147. Could you please show the jury where the AC joint is?

A. Yes. This is the clavicle, the acromio-clavicular joint is right about here, held together with ligaments.

Q. Thank you.

A. You're welcome.

Q. Doctor, I'm showing you what's been marked as Plaintiff's Exhibit 163 for identification.

MR. SEPE: Your Honor, for the record this is an excerpt from an exhibit already in evidence under Bates stamp numbers 0195 through 0197 and I've given it to Mr. Begos already. I'd offer it in evidence at this time.

MR. BEGOS: It's already in, no objection.

Q. Do you recognize that document, Dr. Guy?

A. Yes, sir. This is typed report that I produced after my first visit with Dr. Korn on December 12, 1994.

MR. SEPE: Your Honor, may I publish it to the jury?

THE COURT: Yes.

Q. Doctor, does this report accurately reflect the history given to you by Dr. Korn as well as your observations of him on that date?

A. Yes, sir, that is correct.

Q. What is a grade four AC separation?

A. That is the maximum type of separation. Mild is a grade one, moderate is a grade two to a grade three. Grade four is the maximum amount of separation.

Q. And in the context of that diagram that you previously discussed with the jury, could you explain what it means and demonstrate what it means?

A. The separation?

Q. Yes.

A. The normal space between the AC is approximately one to two millimeters. A grade four is a significant separation. When you put your finger over the patient's shoulder joint area you can actually feel the separation and a protrusion and the abnormality. Once you have a separation, a whole complex of different symptomatology occurs, such as when you have a separation the clavicle is no longer in its proper anatomic location, it's anatomic alignment has been altered.

Right underneath the clavicle, the middle to approximately one third we have the brachial plexus which is the Grand Central of nerve roots which criss-cross from the neck all the way down from the armpit down through the arm. It puts pressure on the brachial plexus and it causes weakness, numbness, tingling to the different muscles in the arms and hands and fingers and as a result you lose range of motion to the shoulder and the shoulder can pop out of place frequently.

Q. When you say pop out of place, what do you mean?

A. Dislocates.

Q. At which point?

A. AC joint.

Q. And what was the condition --

A. And over here as well.

Q. And what was the condition of Dr. Korn's AC joint when you examined him on that day?

A. It was tender, there was crepitation. Range of motion was diminished. The muscle power for the entire left shoulder was decreased.

Q. And were you able to visually observe the separation?

A. Based on my notes, based on palpation was able to be felt.

Q. When you say palpation, what does that mean?

A. By me touching and feeling around.

Q. Could you explain how it is that from touch you can tell that the AC joint is separated?

A. When you touch the shoulder and you follow the clavicle, you have to feel no protruding, abnormal protrusions. After you examine many patients your feel becomes like computer sensors and you know when there's an abnormal deformity and separation.

If there's a significant separation you can put your finger right through that area and you feel pain, you feel tenderness and all also you feel a little separation, you feel the space.

Q. Doctor, in this report you used the term traumatic myositis. Can you tell the jury what that is please?

A. Yes. Traumatic myositis and sinovitus of the shoulder is when the muscles in the shoulder, after they've been injured by any capacity, the muscles go into a reflex spasm, they tighten up. When they tighten up you lose range of motion and the whole area becomes very sore to touch. So myositis means inflammation of the muscles.

Q. And what is traumatic sinovitus?

A. Sinovitus, the synovium are the membranes that cover the joint inside the joint. When a joint gets injured, many structures get injured, the muscles, the underlying structures and the membranes that cover the actual shoulder capsule. That's the synovium. They get inflamed as well, they become swollen.

Q. Doctor, with regard to 163 in evidence, in the second paragraph you had noted that Dr. Korn had stated he was experiencing weakness in his left shoulder and left hand, with numbness and tingling in his left forearm and left hand.

A. Yes, sir, that's correct.

Q. And that was reported in your report?

A. Yes, sir.

Q. Did you come to a diagnosis at the conclusion of that examination?

A. Yes, sir. After I took my history, after I conducted a physical exam and after I conducted an EMG, I arrived that the patient has a grade four AC separation. The patient has left partial brachial plexus injury and left shoulder traumatic myositis and sinovitus.

Q. Doctor, what is an EMG?

A. An EMG stand for electromyography. It is a test conducted by a physician, either a physiatrist or a neurologist. It checks to see if there's any muscle or nerve problems. An EMG has three separate parts. The first part is the motor conduction, second is the sensory conduction, third is the needle EMG.

The first two components checks the motor and sensory branch of a nerve, and the third component, the EMG checks to see if there's any nerve root problems or any abnormal nerve responses to the actual muscles caused by either the brachial plexus or the nerve roots in the neck.

Q. And did you conduct an EMG test on Dr. Korn on that date?

A. Yes, sir, I did.

Q. Doctor, I'm showing you what's been previously marked as 164 for identification.

MR. SEPE: Your Honor, for the record this is not already in evidence.

Q. Do you recognize that?

A. Yes, sir. This is the EMG that I performed on Dr. Korn on December 12, 1994.

Q. Is it signed?

A. Yes, sir, it's signed by me.

Q. And is it the ordinary course of your business to generate records such as these?

A. Yes, sir.

Q. And has that record been maintained in the ordinary course of business of your practice?

A. Yes, sir, it has.

Q. Has it been maintained by your practice since the time of the test itself?

A. Yes, sir.

Q. And was the report generated at or about the time that the test was conducted?

A. Yes, sir.

MR. SEPE: Your Honor, I would offer plaintiff's 164 in evidence at this time.

MR. BEGOS: No objection.

THE COURT: Mark it in.

(Plaintiff's Exhibit 164 for identification, document, received in evidence.)

MR. SEPE: Thank you.

Q. Doctor, do you have that report in front of you?

A. Yes, sir, I do.

Q. Can you please explain with regard to Dr. Korn how that test was conducted on that day?

A. If we turn to the page 2 of the report, which is the nerve conduction portion, the nerve conduction portion is performed as follows: I have surface electrodes. I place them on different muscles of the patient's hand and I stimulate the nerve in the wrist. The median nerve is stimulated right here with a little two prong stimulator.

Once I stimulate the nerve, I look to see what type of a response I guess. I look for the size of the amplitude, the height of the response, by normal variances I know what nerve has what amplitude. So in this case the amplitude was 16 millivolts, that's normal. Anything more than 10 is normal.

I then checked the left median distal ANC, which means the time from stimulation to time of response was 2.5 milliseconds, that's normal. Anything under 4.0 is normal.

I did the same thing for the right and left median and ulnar nerve which is on the outer portion of the wrist. I checked the proximal and the distal, and then I checked the speed by which it traveled from one point to the other.

Q. When you say it, what do you mean?

A. Checked the conduction velocity.

Q. Conduction of what?

A. Of the two nerves, the median nerve. The median nerve response from proximal to distal. That was 80 meters per second, that's normal. Anything over 45 is normal.

Then I conducted the sensory portion. The sensory portion for the left median was prolonged, it was 4.1 milliseconds and the amplitude was 15. Now I compare it to the other side. If the other side, the peak difference is greater -- oh, I have it right there. This is the left median peak is 4.1. This is the right, right there, 3.4, amplitude was 60, here is 15. Big difference between 60 to 15.

If a difference between the peak from this, this is the right median, this the left median, if the peak is greater than 0.6 it is significant, it indicates nerve problems along the path of the median nerve which is a branch of the C5-C6 brachial plexus division.

So, then I turn to the first page. This is the actual needle EMG.

Q. Just one second, doctor. Please continue.

A. The way the needle EMG is performed is I insert a sterile needle into various muscles in the arms and neck. I look and see if there's any increased insertional activity. Increased insertional activity normally should be quiet. For the left biceps it was increased, for the left flexor carpal radialis was increased, left flexor carpii ulnaris was increased.

There were some beginning abnormalities occurring at the C6-C7 nerve roots in the neck but not enough abnormalities on the other parameters to call it a radiculopathy.

Then I looked for fibrillation potentials. These are abnormal findings. The way you look for these findings is the normal response goes up and down. Fibrillation first goes down and then back up to normal. There was no fibrillation potentials.

However, positive sharp waves which are abnormal findings was present at the left biceps, left flexor carpii radialis, left flexor carpii ulnaris.

However, there was none present on the paracervical muscles. So there was not enough evidence of abnormal findings to call a radiculopathy in the neck.

And then the voluntary motor unit potentials were normal. The way that is done is while the needle was inside the patient's arm I asked the patient to fully flex the arm. I resist. The screen gets filled with a lot of motor activities. That is normal. If the screen did not get filled with those motor activities that would be another example of a different problem, such as myopathy, damage to the muscles, not to the nerves and nerve roots.

So, we have something occurring on the left side that's affecting the biceps which is C5-C6 nerve root, flexor carpii radialis, which is C6-C7 nerve root distribution and it comes off part of the upper and middle trunk of the brachial plexus.

Then flexor carpii ulnaris which is also a division of the middle trunk of the brachial plexus, there was abnormal findings in all these levels, indicates there was something happening mostly at the upper trunk with some findings in the middle trunk of the brachial plexus.

Q. Thank you.

A. You're welcome.

Q. Doctor, based upon your EMG test of Dr. Korn that day as well as the history you took and the physical examination that you performed, did you reach a diagnosis?

A. Yes, sir.

Q. Going back to 163 in evidence, first of all I'm using the word diagnosis, same word as impression?

A. Yes, sir.

Q. What was your impression from your exam and testing of that day?

A. That he had a grade four AC separation of the left shoulder. He had a left partial brachial plexus injury. He had traumatic myositis and sinovitus of the left shoulder.

Q. Thank you.

A. Your welcome.

Q. And what was that diagnosis based upon?

A. Based on the history, the physical exam and the performance of the EMG.

Q. Doctor --

MR. SEPE: Your Honor, may I?

Q. With regard to your prior testimony as to the visual observations of the separated AC joint?

A. Yes, sir.

Q. Assuming a grade four separation, would the clavicle itself, the bone, be mobile or moving?

A. Yes, sir.

Q. Would it be possible for that clavicle to move against what you describe as the brachial plexus?

A. Absolutely. In fact, that's what has been happening, so that's what is preventing from the brachial plexus injury to continue to improve.

Q. So hypothetically, doctor, on a given day, if a clavicle that was mobile, meaning separated from its natural socket or joint and moved around to the point it impacted or touched or rubbed against the brachial plexus, what would the effect of that be?

A. It would be continued weakness in the left shoulder, arm and hand with numbness and tingling.

Q. These nerves at the brachial plexus that you described, where do these nerves run to anatomically?

A. I will show you. The brachial plexus is formed by the union of the nerve roots from the neck, C5-C6 forms the upper trunk, C7 forms the middle trunk, C8 and Tl forms the lower trunk.

C5-C6 goes in the vicinity of the approximate shoulder. The C6 fibers partially run along the medial inner forearm, all the way down to here and also C6 fibers supply some innervation to the thumb and then the C6-7 fibers provide innervation to the fingers, the first, second and third and then we have C7, C8 and some T1 fibers that begin to provide sensory and motor to the last two fingers of the hand.

So it's a mixture, a mixture of different nerves in the arm and hand but mostly C5-C6 is in the upper arm or shoulder area.

Q. Doctor, assuming an impact of the clavicle on the brachial plexus, what type of symptoms would that produce in an ordinary patient?

A. The usual symptoms of brachial plexus are weakness in the upper extremity, the shoulder area, the hand area depending what branches are affected. Also you get numbness and tingling.

Q. And during your exam of December 1, 1994 did Dr. Korn report numbness and tingling in his left hand?

A. Yes, sir, he did.

Q. Doctor, did there come another point in time you examined Dr. Korn on March 6, 1995?

A. Yes, sir.

THE COURT: Okay, we're going to have to stop. I have naturalization between 1:00 and 1:30, so we will come back at 2:00, folks, 2:00 o'clock.

(The Jury departed the courtroom.)

(Luncheon recess.)

AFTERNOON SESSION

(In open court; without jury.)

THE COURT: In respect to the waiver matter, I've determined as a matter of law there is no waiver.

You have an exception.

MR. SEPE: Thank you, your Honor.

MR. BEGOS: Thank you.

Are we interrupting the doctor to take someone else?

MR. QUADRINO: I think we're finishing the doctor and then picking up with Ms. Keeley; is that the plan?

MR. SEPE: I believe so.

COURT OFFICER: Jury entering.

(The jury entered the courtroom.)

MR. SEPE: Your Honor, the plaintiff re-calls Dr. Guy.

ALI GUY, MD, RESUMED, Having been previously duly sworn, was examined and testified further, as follows:

MR. SEPE: Your Honor, may I inquire?

THE COURT: Yes.

DIRECT EXAMINATION

BY MR. SEPE: (Continued)

Q. Good afternoon, Dr. Guy.

A. Good afternoon, sir.

Q. Dr. Guy, we had left off right after your first examination of Dr. Korn in December of 1994.

A. Yes.

Q. Did there come times that you examined and treated Dr. Korn after that date?

A. Yes, sir.

Q. Specifically, did you examine Dr. Korn on March 6, '95?

A. Yes, I did.

Q. Did you also examine him on April 24th, '95?

A. Yes, sir, I did.

Q. Did you also examine him on April 15, 1996?

A. Yes, sir.

Q. And December 18, 1996?

A. Yes, sir.

Q. And February 20, 1997?

A. Yes, sir.

Q. May 14, 1997?

A. Yes, sir.

Q. February 10, 1999?

A. Yes, sir.

Q. February 18, 2000?

A. Yes, sir.

Q. September 28, 2000?

A. Yes, sir.

Q. And then finally on March 3rd, 2004?

A. March 3rd, 2004, yes.

Q. And finally on July 7, 2005?

A. Yes.

Q. And in each of those examinations did you take a history from Dr. Korn?

A. Yes, I did.

Q. And he reported to you the symptoms he was experiencing at the time?

A. Yes, sir.

Q. And did you also do independent examination of Dr. Korn to test for those symptoms during those exams?

A. Yes, sir.

Q. And on some of those visits did you perform further EMG studies?

A. Yes, sir, that's correct.

Q. Doctor, I'd like to show you what's been previously marked as Plaintiff's Exhibits 165 through 174, covering a time period of March of 1995 until July of 2005. Please take a look at these.

A. I think you asked me if I saw him on February 18, 2000, did you ask me that question?

Q. I don't recall, I'll check.

A. Because it was September 28, 2000.

Q. Okay. Thank you.

A. Yes, I recognize these as my reports.

Q. And were those reports generated either on the date of the exam or shortly after with regard to each exam?

A. Yes, sir.

Q. And have they been maintained during the course of your practice since the time that each report was generated?

A. Yes, sir.

Q. Is it your ordinary course of business to maintain reports such as those for patients that you examine or treat?

A. Yes, sir.

Q. And have they been maintained by your office since the time each of those reports were generated?

A. Yes, sir.

MR. SEPE: Your Honor, at this time I would offer the previously referenced exhibits into evidence. I would note, your Honor, that some of them are excerpts from the claim file that have Bates stamp numbers and thus are already in evidence but some are not. Mr. Begos has been given copies ahead of time. It's my understanding that we agreed to have them put into evidence.

MR. BEGOS: Correct.

THE COURT: Okay, Mark will mark them in at his leisure.

(Plaintiff's previously referenced exhibits for identification, document, received in evidence.)

Q. With regard to your examination of Dr. Korn on March 6, 1995, what were your observations as to his physical condition on that day?

A. His left shoulder remained diffusely tender. Diffuse means the whole surrounding area. Range of motion remained two thirds normal range of motion. Muscle power remained weak. It was four minus over five.

The left elbow muscle power was four plus over five. Sensation was diminished to pin prick and touch left lateral forearm and left medial forearm.

MR. SEPE: Your Honor, may I publish to the jury?

THE COURT: Yes.

Q. Dr. Guy, can you go to page 1 of the March 6 -- excuse me, of April 24, 1995.

A. Yes, sir.

Q. Did you examine Dr. Korn on that date?

A. Yes, sir.

Q. Does that report also encompass the examination from April 24, 1995?

A. Yes, sir.

Q. It's a little bit difficult to read on the presenter. With regard to the paragraph beginning April 24, 1995, could you read that please?

A. Yes, sir. Patient returns for follow-up examination on 4/24/95. He states that he is using a home TENS unit. TENS stands for transcutaneous electrical nerve stimulator. It's a device used for pain. And does home exercises. He also exercises in a gym. He still has numbness and tingling in his left upper arm, which has now somewhat improved in the upper arm, but has now spread to the dorsal aspect of the distal arm. He states that he still has weakness in his left hand in dorsiflexion. He has pain in the left shoulder in the acromio-clavicular joint.

Q. Let me stop you there. Going up to the top line of this page, is this a reason you emphasized portion of the sentence that's underlined?

A. Yes, sir. It shows that the problem is now beginning to spread, progress.

Q. Was that consistent with the history or the symptoms reported to you by Dr. Korn in April of 1995?

A. Yes, sir.

Q. That same page, Dr. Guy, if you go to the end of that first paragraph.

A. Yes, sir.

Q. Read the second to last sentence.

A. He gets severe headaches with flashing light sensation. He has difficulty controlling his right hand but not his left hand. He gets a foul taste in his mouth.

Q. Dr. Guy you previously testified from your report in evidence that Dr. Korn had a left brachial plexus injury; is that correct?

A. Yes.

Q. Does your report correctly relate what he said to you about having difficulty controlling his right hand?

A. Yes, sir.

Q. And did you reach a diagnosis with regard to that reported symptom and the results of your examination of Dr. Korn starting in December 94 through April of 1995?

A. The right hand symptoms along with the flashing light sensation and with a foul taste in his mouth is coming from some sort of head trauma symptomatology. So now he has evidence of upper motor neuron lesion, lesion inside the brain.

Q. Dr. Guy, what is atrophy?

A. Loss of muscle tone, loss of size of a muscle.

Q. And what if any effects does that cause in a typical patient?

A. Weakness and ability to be able to use the joint through full range of motion, which requires add mat muscle power.

Q. During the years that you examined and treated Dr. Korn, did there come a time or times that you observed atrophy in Dr. Korn's left shoulder?

A. Yes, sir.

Q. And do you have an opinion, with a reasonable degree of medical certainty, as to the cause of that atrophy in Dr. Korn's left shoulder?

A. Combination of the brachial plexus injury and the C5-C6 cervical radiculopathy which was later detected on a subsequently EMG study.

Q. What is cervical radiculopathy?

A. The word cervical means the neck, the word radio means nerve root, opathy means damage to a nerve root, so cervical radiculopathy means damages to a nerve root in the neck region.

Q. Doctor, with regard to the last report in evidence, there is a reference to pin prick, what is that?

A. Pin prick is a way you check for sensation.

Q. And how is that physically done?

A. You have a sharp object, the tip of a paper clip, you ask the patient to close his eyes. I touch different parts of the body to see if he has normal sensation. I compare let's say the biceps on the left with the right. If he feels the right I ask if he felt both sides, the answer is yes. Which did you feel more, which did you feel less. Whichever one he feels less that's the one I record.

Q. Is it fair to say then that pin prick test results rather relies on the accuracy of the patient and reporting what he feels?

A. To some degrees, but there's ways to confirm it.

Q. We will get to that. Is that what's known as a subjective test?

A. Actually, it is classified as an objective test with some subjective components.

Q. The subjective components being what?

A. That the patient can be truthful or not so truthful with the pin prick test.

Q. And what if any are the objective components of a pin prick test?

A. The fact that you're checking for different parts in the anatomical distribution. For example, if the patient says that the pin prick is diminished in every part of the arm, that has a lot of explanations need to be made after that. If the pin prick is in the anatomic distribution where the anatomy is, where the pathology is then it makes sense. If it's confirmed by muscle power testing then it continues to make sense. If it is further confirmed by EMG, then it is hundred percent confirmed.

Q. Thank you.

A. You're welcome.

Q. Did there come a time you examined Dr. Korn on April 15, 1996?

A. Yes, sir.

Q. Was an EMG test performed on that date?

A. Yes, sir.

Q. Was the result of that EMG test before you as exhibit 167 in evidence?

A. Yes. It indicates improving left brachial plexus injury and the left C5-C6 nerve root dysfunction.

Q. When you say improving, what do you mean by that?

A. That the brachial plexus injury itself was improving based on the EMG studies.

Q. With regard to that report in evidence, 166, from April of 1996, did you reach any conclusions on that date?

A. Yes, sir, that the brachial plexus injury was improving. He now has a new problem, a left sided C5-C6 cervical radiculopathy.

Q. What led to you that conclusion?

A. Based on the EMG findings.

Q. How exactly?

A. If you would like to put into the projector, I can explain my answers best.

Q. Okay. Showing you what's been marked as 167, April 15, 1996 EMG report.

A. Okay.

Q. I would ask on behalf of everyone including the jury that we not go through exactly what an EMG is again since you've explained that before.

My question is and what I'm trying to direct you to is what about the EMG result led you to the conclusion that there was a superimposed nerve root dysfunction at C5-C6?

A. First of all, the first thing we see that was abnormal in the first EMG was the left median sensory, the first test it was a 4.1, now it is a 2.7 and this is well within normal.

If you remember what I said before, if the difference between the sensory from one nerve to the other is less than 0.6 it's normal. 2.7 from 3.2 is .5, it's absolutely normal. That improved.

And if you would turn to the second page, the actual needle EMG, if you remember from the first needle EMG the left flexor carpii ulnaris was increased with positive sharp waves here, now it is normalized. That shows improvement. The first one is positive sharp waves here at the left flexor carpii radialis, now you only see occasional positive sharp waves. However, before there was no increased insertional activities at C5-C6. There were increased at C6-7, but not at C5-C6 there why no positive sharp waves on the left C5-C6 paracervical muscles, now we see them here. This indicates badge damage to the nerve root at the left C5-C6.

Q. Doctor, did there come a time you examined Dr. Korn on December 18, 1996?

A. Yes, sir.

Q. If I may, do you have a copy of that report?

A. Yes, sir.

(Handing to Mr. Sepe.)

Q. Do you recall the circumstances under which you saw Dr. Korn on that date?

A. Yes, sir.

Q. And what were they?

A. He came to see me as an emergency basis. He stated that his left scapula had locked up completely.

Q. And did you observe that?

A. Yes, sir. I had to free it myself manually.

Q. What is a locked left scapula in layman's terms?

A. The scapula is the shoulder blade. This is the front portion. Actually the scapula is right here. This is the scapula, this bone here, the wing bone as we call it. And that was stuck to the patient's rib cage from the severe contraction of the muscle fibers. The muscles were so tense it was tightened, it was pushing it stuck against the rib cage.

Q. And how if at all did you treat it?

A. I massaged the muscles around the area. I loosened some of the muscles and I manually pulled the scapula upwards. I mobilized it and I manually gave him range of motion with stabilizing the clavicle.

Q. And do you have an opinion, with a reasonable degree of medical certainty, as to the cause of that condition on that day?

A. Yes, the cervical radiculopathy and the brachial plexopathy causing severe tightness, spasm and trigger points.

Q. Did there come a point in time you treated Dr. Korn on February 20, 1997?

A. Yes, sir.

Q. And what, if anything, were your observations as to his physical condition that day?

A. His neck was tender, it was painful to touch. There was moderate spasm. Spasm is defined as a prolonged involuntary contraction of a muscle fiber. When you touch a normal muscle it's soft to touch. A muscle that's in spasm becomes hard, the fibers shorten and as a result you lose significant range of motion.

His range of motion in his neck was one half normal. His upper back was tender, there was spasm. The muscle power testing for his left wrist extensor group was four minus over five. That's about three grades weaker. The left shoulder was four minus over five.

Q. Did Dr. Korn give you a history that day?

A. Yes, sir.

Q. And was there any discussion as to pain experienced from water skiing?

A. Yes, sir.

Q. What, if anything, did you discuss with regard to that topic?

A. He told me that he tried to water ski in Florida. He felt excruciating pain in his left shoulder over the acromial area, that's where the AC separation is, and with severe neck pain radiating down the left arm.

Any time you have radiating pain down the left arm it means the origin is probably coming from the nerve roots in the neck. That's what a cervical radiculopathy that we found.

He also complained to me of weakness in his left wrist extension with visual flashing beginning a day after his water skiing. He complained of twitching of the left side of his face. He takes a drug called Depakote for the tremors in his hand. He's followed by a neurologist, Dr. Arthur Weiss.

Q. Did you observe the twitching in his face during the exam if you recall?

A. It's not indicated in my notes and I have no independent recollection of it.

Q. What is Depakote?

A. It's a drug used for seizures, it's a drug used for chronic pain, it's a drug used for tremors of the hands.

Q. And what are the known side effects, if any?

A. Causes drowsiness, causes loss of cognitive function, causes loss of abstract thinking, sedates. It can cause heart rhythm abnormalities, it can cause hematologic problems, it can cause electrolyte balances, it can cause upset stomach.

Q. Prior to this point in time, in your various examinations of Dr. Korn, had you discussed physical therapy with him?

A. Yes, sir.

Q. And did you specifically recommend that he attempt to give therapy to or build up the muscles in the left shoulder?

A. Yes, sir.

Q. If you recall to the best of your recollection, what did you advise him to do?

A. I told him if he wants he can come to my office, I'd be happy to give him therapy. He says no, I'm an orthopedist, I know how to give therapy.

I prescribed for him a TENS unit which is a machine that contracts the muscle fibers. Those forceful contractions gives the muscle re-education, prevents atrophy, massages the areas, and I also reviewed with him some basic exercises, stretching and strengthening most of which he knew already.

Q. What sort of strengthening exercises?

A. Isometrics and some mild weight lifting.

Q. And what is the benefit of isometrics or mild weight lifting on an injury like Dr. Korn's?

A. Isometric means muscle against muscle. You pull your muscles against your own muscles. The advantage of isometrics, you don't do damage to the joints, as opposed to isotonic exercise, isotonic exercises are weight lifting. We have isometric, isotonic and isokinetic exercises which means the extremity is always on some moving object that moves you.

So the isotonic exercises which are weight lifting can have some dangers if the person does not know how to properly lift the weights, so both were discussed with the patient.

Q. Assuming the patient did properly engage in the physical therapy regardless of what type, the weight lifting or isometrics, what would be the benefit of that for an injury like this?

A. The purpose of physical therapy and exercise is, one, to maintain whatever range of motion you have. The shoulder is the most complicated joint in the body. It has a high predisposition to becoming frozen, therefore developing adhesive capsulitis or a frozen shoulder. The reason for that is because we have three articulations.

THE COURT: Doctor, a little slower, doctor.

A. Yes. The reason for that is because we have three articulations. We have the clavicle, we have the scapula and we have the humerus. We have three very complicated joints all working at play at the same level.

So if you don't move the joint through full range of motion at the minimum of ten times per day, there's a high tendency for this area to become locked up, then you lose more range of motion.

Furthermore, the joint gets the nourishment by range of motion.

Third, strengthening exercises prevents weakness, prevents further atrophy. If you don't strengthen the area, you already have atrophy, you're going to have insult on top of injury, more and more progressive atrophy. It would be a domino effect if you did no exercise.

So these are some of the basic advantages and principles of exercise.

Q. So, doctor, as of this date were you aware that Dr. Korn was lifting weights and doing physical exercises for his shoulder?

A. Yes, sir.

Q. And was that consistent with your recommended treatment for his injury?

A. Yes, sir.

Q. Did you advise him to water ski?

A. No, I did not do that.

Q. What is crepitus?

A. Crepitus means grinding. It's something you feel. In order to feel crepitus you have to have normal sensation in your hand or fingers, you place the hand over the extremity that's involved, if it's the knee or if it's the shoulder joint. And when you touch it, when a person is moving the shoulder joint through full range of motion you feel a grinding-like sensation.

A good example would be if you have a patio door, you have some dirt in the patio door as you open and close it you get that grinding sensation. It's extra friction.

Q. Doctor, did there come a time that you -- withdrawn.

You testified that you examined and treated Dr. Korn on May 14, 1997, correct?

A. Yes, sir.

Q. And as of that date what were your observations as to his physical condition? That's 169?

A. I got it. The left shoulder was still diffusely tender. Internal and external rotation was zero to sixty degrees actively, normal zero to 90 so there was 30 percent decrease.

Muscle power testing was four over five, normal is five over five, next is five minus over five, next is four plus over five, so four over five would be about three grades weaker than normal.

The shoulder was tender with pinpoint tenderness over the biceps tendon. That's in the vicinity of the AC joint. The neck was tender, with spasm. Range of motion was within functional limits.

Upper back was diffusely tender with spasm, and multiple trigger points. Trigger points are defined as areas of pinpoint tenderness with a palpable nodule. It indicates muscle fibrosis, muscle scarring, muscle damage.

Sensation was decreased to pin trick and touch over the left deltoid area, the left hand, first two fingers and the rest of the range of motion was normal except for the shoulder as indicated.

Q. Let me stop you there, doctor. With regard to the condition of Dr. Korn's shoulder on that date, was his AC joint still dislocated at that time?

A. Yes, sir.

THE COURT: Side-bar, please.

(Discussion off the record at the side-bar.)

BY MR. SEPE:

Q. Dr. Guy with regard to your exam on May 14, 1997, did you perform an EMG on that day?

A. Yes, sir, I did.

Q. And based upon that EMG, was the brachial plexopathy you previously described still present?

A. Yes, sir, it was.

Q. How did it compare to the previous level of brachial plexopathy?

A. It showed no significant improvement nor worsening when compared to the prior study of 4/15/96.

Q. Doctor, moving ahead to February 1999, specifically February 10th, did there come a point in time when you saw Dr. Korn on an emergency basis?

A. Yes, sir.

Q. What did you observe about his condition at that time with regard to his left shoulder?

A. The left shoulder was severely tender. It appears to be dislocated.

Q. When you say dislocated, what did you mean?

A. It was out of place.

Q. Which joint specifically?

A. The left shoulder.

Q. The AC joint?

A. AC joint. And also the shoulder, the shoulder and the AC both were out of place.

Q. Thank you. When you say out of place, what do you mean with regard to the AC joint?

A. It was dislocated. Dislocated means out of place.

Q. Do you recall what position it was in?

A. No. I don't recall.

Q. Fair to say it was out of the AC socket or joint?

A. Yes, sir.

Q. September 28, 2000, doctor, do you recall treating Dr. Korn and examining him on that date?

A. Yes, sir.

Q. And was a history given to you at that time?

A. Yes, sir.

Q. And specifically was history given to you of Dr. Korn's allegations of injury from a car accident from February 18 of 2000?

A. Yes, sir.

Q. And what, if anything, did you observe about his physical condition after that accident at that time?

A. After I took accurate, pertinent history, I examined him. Both shoulders were now diffusely tender to touch. Range of motion was full but the muscle power testing of both shoulders was four over five. Neck was tender. There was spasm. Range of motion was normal except for lateral flexion which was one half. Lateral flexion is bending from side to side.

Q. Doctor, if I can interrupt you for one second. Your report makes reference to a Hil-Sach's fracture?

A. Yes, sir.

Q. What is that?

A. Hil-Sach's fracture is, a good analogous would be the humeral head gets slapped against the borders of the glenoid and you get a fracture or a dimple fracture right in the area, and that happens from trauma.

Q. Thank you.

A. You're welcome.

Q. The report also indicates that Dr. Korn reported diminished right arm and right hand sensation in the first four fingers. Was that confirmed by you in any manner?

A. Yes, sir.

Q. How was that done?

A. Had an EMG done and also physical examination.

Q. With regard to the result of that EMG, did that confirm -- withdrawn. Was that consistent with your diagnosis and Dr. Korn's complaints of diminished sensation in his right hand?

A. Yes, sir.

Q. Specifically the first four fingers of his right hand?

A. Yes, sir.

Q. March 3rd, 2004, did you examine Dr. Korn on that date?

A. Yes, sir.

Q. And what was his physical condition at that time?

A. His neck showed moderate tenderness with some spasm and multiple trigger points present. Range of motion was one half of lateral flexion, bending from side to side and one half of lateral rotation, turning his neck from side to side. Upper back was tender. There was spasm. There were clusters of trigger points present.

Range of motion was normal at this time. Muscle power testing for the right shoulder was four minus over five. The left shoulder was four plus over five.

Now it appears that the right shoulder is getting worse than the left shoulder.

Q. And your report from that date, exhibit 173 indicates C6-C7 cervical radiculopathy?

A. Yes, sir.

Q. How was that verified?

A. By the EMGs performed by me.

Q. Thank you.

A. You're welcome.

Q. Prior to that exam, doctor, your report indicates that you reviewed a prior MRI report from April of '01 showing a C4-C5 herniation --

A. I just want to add one thing. It didn't just show bilateral C6-7 cervical radiculopathy, it showed evidence of bilateral brachial plexopathy.

Q. When you say bilateral you mean both sides?

A. Both sides, yes, sir.

Q. Your report indicates that you had when writing the report referred to an April 16, 2001 MRI report showing a worsened C5-C6 herniation?

A. Yes, sir.

Q. Was that part of basis of your diagnosis from this exam?

A. Yes, sir.

Q. And then finally on July 7, 2005, did you examine Dr. Korn that day?

A. Yes, sir.

Q. What did you observe about his condition then?

A. His right biceps measured 31 centimeters in circumference, and it should be mentioned that the patient is right-handed. His left biceps measured 32 centimeters. That's significant. It's not just a one centimeter difference. If a person is right-handed, their right dominant arm is typically one to three centimeters bigger than the other side. So a one centimeter difference is really two to a four centimeter difference from side to side, indicating there was significant difference on his right-hand dominant side.

His neck was tender, there was spasm. Range of motion was one half of lateral flexion and one half of lateral rotation.

Upper back was tender. There were spasm, multiple trigger points present.

Active range of motion was normal for all four extremities including his shoulders.

Muscle power testing was weak on the right shoulder, was four minus over five. The left side was four plus over five.

Q. Doctor, let me stop you there. As a result of that exam, did you reach a diagnosis on that date?

A. Yes, sir, I did.

Q. What was your diagnosis?

A. That the patient had a C4 through C6 disc herniations, bilateral brachial plexopathy right side worse than left. Bilateral C6-C7 cervical radiculopathy and myofacial pain syndrome.

Q. And was that report based in part upon the MRI report that you had reviewed?

A. Yes, sir.

Q. And was that confirmed by any testing or your observations?

A. Yes, sir, it was confirmed by my physical exam findings and my EMG findings.

Q. As of that EMG from July 7, 2005 what is the condition of Dr. Korn's right and left shoulder in the terms of the EMG?

A. He has problems with the shoulder joints on both sides, has problems with the muscles, with the nerves, with the brachial plexus and the nerve roots in the neck which contribute to the shoulder stability.

Q. And the nerve roots in the neck at the levels that you've been describing, C5-C6 and C4, C5, where do those nerves go through in the body?

A. C4-C5 goes to the deltoid and the upper trapezius, C5-C6 predominantly goes to the biceps, upper arm. C6-C7 predominantly goes into the forearm.

Q. Doctor, hypothetically speaking, taking the hypothetical patient with the exact injuries that you've observed Dr. Korn to have, what symptoms would be consistent with the injuries you've observed of Dr. Korn over the roughly eleven years that you've treated him?

A. As of my July 7, 2005 examination?

Q. Yes.

A. The symptoms would be neck pain, decreased range of motion, shoulder pain, upper arm pain, bilateral upper arm weakness with numbness, tingling, decreased hand dexterity, decreased ability to sense and feel things.

Q. Decreased ability to sense and feel things where?

A. In his hands.

Q. When you say decreased dexterity, what do you mean by that?

A. Dexterity, fine manipulation, such as doing fine motor movements such as surgical procedures, such as trying to remove sutures from a patient. To remove a suture you need completely still hands. Patient has sutures, if you remove them, your hands shake you're going to cause a lot of pain.

Q. Doctor, one of your reports made reference to something called Babinski sign, what is that?

A. Babinski is a test for upper motor neuron lesion. The way it is done, the patient is laid flat, you get a pen or some sort of object, you tickle the bottom of the patient's foot in the direction of the big toe. If the big toe goes up, that's abnormal. That indicates a positive Babinski. It's found in head trauma cases, upper motor neuron lesions. If it's normal means there's no upper motor neuron lesion.

Q. Doctor, from the time that you first examined Dr. Korn in December of 1994 until your last exam with him in July of 2005, during that eleven-year period, how did Dr. Korn's condition at the end of that period compare to his condition at the beginning?

A. Obviously as you can see from the records, it got progressively worse.

Q. With regard to which body part?

A. The left shoulder and the right shoulder. The right shoulder, the worsening superseded the left side.

Q. During your treatment of Dr. Korn did you discuss any medications he was taking?

A. Yes.

Q. And are you yourself authorized to describe medications as a doctor?

A. Yes, sir.

Q. What is topomax?

A. Topomax is a drug used for many different things. It's a drug used for stopping seizures, it is used for chronic pain. It can be used for causalgia, burning pain, burning sensation as in reflex sympathetic dystrophy. It has a lot of side effects.

Q. Prednisone?

A. Prednisone is a drug used to diminish inflammation, swelling and also pain. That also has a lot of side effects and it can only be used for short period of time.

Q. What are the side effects of Prednisone?

A. The most common side effect is upset stomach, bleeding inside the stomach, weight gain, fluid retention, electrolyte imbalance, causing stretch marks in the arms called striae, S-T-R-I-A-E. It can call ulcers, can cause dementia, it can cause mental status confusion, it can cause delirium. It can change your cognitive function. It can give you nightmares. It can cause nystagmus, which is rapid twitching of the eye in a horizontal fashion.

Q. And what about Decadron?

A. Decadron is the potent form of Prednisone. It's much stronger than Prednisone, much more concentrated.

MR. SEPE: Nothing further, your Honor.

CROSS EXAMINATION

BY MR. BEGOS:

Q. Dr. Guy, over the lunch break did you talk to anybody about your testimony?

A. My testimony, not about my testimony. I did speak with Mr. Sepe about some anatomical questions he had. I addressed his questions.

Q. Just talked about anatomical questions?

A. Yes, sir.

Q. You said on direct examination that you've testified many times.

A. Yes, sir.

Q. As an expert I'm assuming?

A. As an expert, as a treating physician.

Q. Can you tell me how many times a year on average you testified as an expert?

A. On the average, about twelve to fourteen times per year, some years more, some years less.

Q. And your rate you said is $3,000 for half day?

A. Yes, sir.

Q. And you determine that based on the value of your time?

A. That's my fee.

Q. So you just pick a fee and say that's it?

A. That includes travel time to, back and forth. That involves where you burn my brain after all the questions you do. I can't really do much afterwards. That's what I charge.

Q. And do you get a lot of your -- your clients get referred to you by other doctors, correct?

A. My patients come from many different sources, doctors is one of them.

Q. Do most of your patients come from other doctors?

A. It's mixed. It's very mixed. Come from other patients, come from word of mouth. For example, in my office in Long Island it's a freestanding building, I get a lot of walkins. They go up and down Jericho Turnpike, I'm right across the street from Home Depot. Get a lot of walk-ins. It's a mixture.

Q. Would you say more than half your patients come from lawyers?

A. No, I would not say that. I have no way of knowing for sure but not half. Half is way too much.

Q. Way too much to expect to have lawyers refer more than half your patients?

A. That is correct, yes.

Q. In various of your examinations you had made some statements beginning in 2000. Mr. Sepe didn't ask you about them, but you made some statements about what in your view Dr. Korn could and couldn't do. You said that he couldn't perform surgery, correct?

A. Yes, sir.

Q. And you said that he couldn't do something that required him to use both of his arms, correct?

A. Dexterity, fine motor movements and also he has decreased ability to concentrate from the medications that he's on.

Q. When you wrote in your reports, and I'm looking at exhibits 172 and 173 and 174, what you said was, you referred to physical problems, that he couldn't perform surgical work, couldn't perform work that required the use of both arms, that's what you wrote in your reports, correct?

A. More or less, yes, sir.

Q. Testifying at trial, that doesn't require the use of both your upper arms, does it?

A. No, but it requires your mental, cognitive function.

Q. And your report --

A. I'm not finished. It requires you to be lucid, to be able to understand the questions, to be able to last for two, three, four hour trial, to be able to recollect certain details, to be able to lucidly answer certain questions, to remember certain facts, dosage of medications and also not to fall asleep upon testifying, because the medications you're on causes drowsiness.

Q. And if Dr. Korn is able to do that, he's able to testify, correct?

A. If he's able to do that he's able to testify?

Q. Yes.

A. I'm saying he can probably do it for short period of time, but not on a continuous basis, not for continued trial.

Q. Are you aware of the frequency with which he has testified in recent years?

A. The exact frequency, no, sir, I am not.

Q. You have testified on various occasions in the same cases as Dr. Korn, correct?

A. Yes, sir, I have.

Q. He's referred patients to you?

A. And I have referred patients to him, yes, sir.

Q. Nothing further.

MR. SEPE: No questions.

THE COURT: Thank you, doctor.

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