TRIAL EXCERPT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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WINSTON HOYTE,

Plaintiff, New York, N.Y.

v. 04 Civ. 5297 (GEL)

NATIONAL RAILROAD PASSENGER CORP.,

Defendant.

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May 23, 2006
2:07 p.m.

Before:

HON. GERARD E. LYNCH,

District Judge

APPEARANCES

MONSOUR, WINN, KURLAND & WARNER LLP
Attorneys for Plaintiff
BY: STEPHEN G. WINN

LANDMAN CORSI BALLAINE & FORD PC
Attorneys for Defendant
BY: RONALD JOSEPH

TRIAL EXCERPT

A F T E R N O O N S E S S I O N

2:07 p.m.

(Jury present)

THE COURT: All right. Good afternoon, folks.

Mr. Winn.

MR. WINN: Dr. Guy.

THE WITNESS: Yes, sir.

THE CLERK: Will the witness please rise.

Raise your right hand, sir.

ALI GUY,

called as a witness by the plaintiff,

having been duly sworn, testified as follows:

THE CLERK: Please be seated.

Please state your name and spell your last name slowly for the record.

THE WITNESS: Yes. My name is Dr. Ali Guy. The first name is A-L-I, last name is G-U-Y. Office address is 15 Jericho Turnpike, Jericho, New York 11753.

THE COURT: Good afternoon, Dr. Guy.

THE WITNESS: Good afternoon, sir.

THE COURT: Mr. Winn, whenever you are ready.

DIRECT EXAMINATION

BY MR. WINN:

Q. Doctor, first, how old are you?

A. You want to knows my age?

Q. Yes, I just want to --

A. I'm 50.

Q. Tell us about your education and training that led you up to becoming a medical doctor.

A. Yes, sir. I went to Bayside High School. My grades were very good in Bayside High School. I went to Queens College from 1974 until about December of '77. My grades were not that good in college. I applied to only one medical school; that was in Dominican Republic. I was accepted and I went basically because my grades weren't up to par to getting into a U.S. medical school, and I wanted to get into medical school very badly so I applied to one school. They accepted me, I went. From there on in, my grades were very good all during medical school, during residency and afterwards.

After I finished medical school from The University of Northeast in the Dominican Republic June of 1981, after I graduated, I took my boards, the ECFMG exam, which is to test your credentials and the training when you study overseas, and I passed it the first time.

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

Mt. Sinai Medical Center.

I was the director of the Neuromuscular Equipment Clinic at NYU's Hospital for Joint Disease from 1990 to December of 2005, when my duties were to see the patients that were scheduled in the clinics, patients with wheelchair needs, patients that had equipment needs, patients that had paralysis from the neck down or from the waist down, patients that were born with birth defects, patients that have polio, cerebral palsy. In addition to my duties, I had to teach the residents from NYU that were rotating through that clinic and also to prepare them for the boards part one and part two.

Q. What boards?

A. Physical medicine and rehabilitation boards.

Q. Keep going.

A. Yes. Also I was the director of the Department of Rehab Medicine at Maimonides Medical Center in Brooklyn, New York, from 1997 to July of 2002, that is about five years, where my duties were to be in charge of all the inpatient and outpatient rehab services, provide teaching to the house staff, including the orthopedic residents. My duties were to teach them once a month and prepare them for the questions under their boards for the rehab section.

I had trained the physical therapy students, the speech pathologists, occupational therapists, physician assistants, and I was in charge of quality assurance in my

department. My duties were to review all the mistakes that were made by the doctors in my department, to teach them the right way, and to punish them if they did something really terrible.

I finished my contract with Maimonides for five years, I left on good terms, and currently am the clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU Medical Center and Rusk Institute, and also am on staff at NYU's Hospital for Joint Diseases and Cabrini Medical Center. I am Board certified in the filed of physical medicine and rehabilitation since 1989.

Q. What does "Board certified" mean?

A. Board certification is the highest recognition which you can obtain in your level of training and specialty. In order to become Board certified in my specialty, you have to have the following prerequisites: You have to have training in the field of internal medicine and/or general surgery, one year of each. That was met.

You then have to satisfactorily complete a three-year residency training program, passed a monthly examination that is given by your preceptors. You have to then take the annual exam given by the department. You have to score at least 70 percent or higher. And once you finish their three-year program, you sit and you take your boards Part I, which is an approximately eight- to a ten-hour examination. It covers

everything you learn from the beginning to the end. You get tested on orthopedics, neurology, internal medicine, muscle and nerve physiology, cardiac rehabilitation, pulmonary rehabilitation and other principles of physical medicine rehabilitation, including reviewing and interpreting x-rays and MRIs.

Once you sit and you take your boards, which I had passed the first time, you then have to be in private practice for at least 18 months, be sponsored by two other doctors that are already Board certified, preferably your former teachers. You then fly to the Mayo Clinic in Minnesota, where all the research and textbooks are written. You then take your boards part two, which is an oral examination. It is approximately a half a day long.

You get tested on interpretations of x-rays, CAT scans, MRIs, EMGs, neurology, orthopedic surgery, muscle and nerve physiology, disability and impairment evaluation and other principles of physical medicine and rehabilitation. If you prove to these doctors that your knowledge is up to par and you are in good medical standing, you then -- they review all of your credentials from medical school, college, residency and once they review everything and everything is up to par, they pass you and they give you a title of Diplomate of the American Board of Physical Medicine and Rehabilitation.

That was met May of 1989.

Q. What is the field of physical-- physical medicine and rehabilitation?

A. Yes.

Q. Tell us what it is.

A. Yes, it is a medical specialty that was founded shortly after World War II by Dr. Rusk, namely the Rusk Institute is named after him. It deals with traumatic injuries covering the whole body from head to toe. It deals with orthopedic issue, neurological issues, neurosurgical issues, surgical issues, internal medicine issues, cardiac and pulmonary rehabilitation issues. It deals with disability and impairment evaluations, which means you examine the patient and see if this patient is disabled. If they are disabled, is it mild, is it moderate or severe, or is it total; there is a certain criteria.

And there is a great deal of overlap between orthopedic surgery, neurology and our specialty, which is also known as physiatry, not psychiatry or podiatry but physiatry. The difference between orthopedic surgery is the orthopedic surgeon concentrates primarily on the surgical aspects of the musculoskeletal system and the bony system. We concentrate on the nonsurgical aspects.

How it differs from neurology is a neurologist concentrates primarily on diseases of the central nervous system, such as Parkinson's Disease, multiple sclerosis, Lou Gehrig's disease, so on and so forth. We concentrate on

disorders of the spinal cord, the nerve roots, the discs, the peripheral nerves, the nerves in the arms and legs, the joints, so on and so forth. And, again, there is a great deal of overlap between these specialties.

Q. Do you maintain an office besides the one you told us about in Long Island?

A. Yes.

Q. Where is it?

A. I have an office in Manhattan at Gramercy Park. I also have an office in Yonkers where I go there once a month, and also at I see three patients at Hospital for Joint Disease and I teach at NYU.

Q. For Maimonides, in addition to being the director of their physical medicine and rehab department, did you have any other duties and, if so, what were they?

A. Yes. I also did consultations to other doctors in the hospital. Also, we have three outpatient sites. I would also see patients at the outpatient sites and supervise the quality of the physical therapy that was going on at the outpatient centers.

Q. Back in April of 2004, did Winston Hoyte become your patient?

A. Yes, sir.

Q. And you brought your chart with you?

A. Yes, sir.

Q. And you displayed your chart to Mr. Joseph before you got on the stand?
A. Yes, sir.
Q. OK. When is the first time -- and by "chart," what is a chart? What is a doctor's chart?
A. The medical records that I obtained in treating Mr. Hoyte, including other diagnostic studies which I sent out for and other consultants' reports which I refer the patient to, physical therapy records, EMG records and some billing records.
Q. You said "EMG records," so I might as well ask you now: What is an EMG, and, first, were EMG tests done on Mr. Hoyte?
A. Yes, sir.
Q. OK. Now tell us what an EMG test is.
A. An EMG stands for electromyography. It is a test that is done by a physician, usually a neurologist or a physiatrist like myself. The purpose of this test is to find if there is muscle or nerve damage.

The indications are if a patient complains of neck pain, shooting pain down the arms with or without numbness or tingling, that is one indication. You want to find out what the cause of that is. Or if the patient has lower back pain that shoots down the legs with or without numbness and tingling, that is another indication. You want to see if that problem is coming from the nerve roots in the neck or the lower back, or the peripheral nerves in the arms and/or a combination

of both.

The only way to make this distinct evaluation is by an EMG. Now, an EMG has three different components. The first component is the motor conduction study. The second component is the sensory conduction study. The third component is the actual needle EMG. The first two components --

Q. Doctor, slow down just a touch. We have a court reporter who I know is trying to keep up with you, but I can't hear that fast.

A. Yes. The motor conduction study and the sensory conduction study checks the peripheral nerves. That's the nerves in the arms or the nerves in the legs. The way this test is done is the physician places surface electrodes over the muscles in the hand. We take the median nerve and the ulna nerve most commonly. We place the electrodes. We stimulate distally and proximally. Measure the distance from the two points, and figure out the conduction velocity, which is the speed by which it travels from one point to the other. If a nerve is pinched in the peripheral nervous system, the conduction velocity will be slowed. If the amplitude, which is the size of the nerve impulses, if it is low, that is another indication that a nerve is damaged in the peripheral area.

Once this is done, we record the abnormal findings or normal findings. Then we go into the third part, which is the actual needle EMG. The actual needle EMG checks the nerve

roots. The way this is done is you have a long needle about one-and-a-half to two-inches long. It is a sterile needle with a Teflon coating so it doesn't hurt all that much when it enters the skin; it does hurt somewhat. You insert the needle into various muscles in the arms, both sides, and in the neck.

You then look and see if there is any abnormal findings. You look for increased activity when you insert the needle, that is called insertional activity. If that is increased, that is the first criteria for abnormality.

Then we look for positive sharp waves that look like a downward deflection, like a V. If that is present --

Q. It looks like a V where? Where are you seeing this?

A. On the screen. The electrodes are attached to a needle. The needle is attached to an amplifier box, which is attached to a computer and there is a screen. You see all the activity on the screen. And you look to see what abnormalities you find.

So as I explained, the first abnormality is increased insertional activity, which means there is a lot of activity when you insert the needle. Normal muscle, when you insert the needle, it is quiet. If it is increased, that is one abnormality. Second is positive sharp waves that looks like a V. Third is fibrillation potentials. They look like little dips first going down and then going back up. And normal motor unit first goes up and then spikes downwards and goes baseline.

So if you have positive sharp waves and with increased insertional activity, you meet the hard-core criteria for radiculopathy, which means damage to a nerve root. It could be from a pinched nerve, from a desk herniation, from a tumor or from the chemicals that are released from a disc once the disc becomes ruptured. So this is basically what it is, and then you record the abnormal findings, and whatever is abnormal, you push the computer printer to print out the abnormal findings and you keep it as part of your chart.

Q. When you first saw Mr. Hoyte, did you obtain a history from him about what brought him to see you?

A. Yes, sir.

Q. And what were you told?

A. That he was well until April 24, 2004. No history of any significant past medical problems or any significant prior injuries. He had the usual sprains and strains that we all get.

That on 4/19/04, he was a passenger on the Long Island Railroad sitting in the back of the train, and while the train was pulling into the station, coming to a stop, the train got hit by another train, the Amtrak, plowed into the rear. He was thrown forwards and backwards in his seat. His body was jerked in a twisted position. He injured his neck, his back, both arms, both legs. He did not hit his head, as far as he remembered. He did not lose consciousness, as far as he

remembered.

When he saw me the first time, he complained of headaches, neck pain radiating down both arms, and bilateral shoulder pain, lower back pain shooting down both legs, and every day he was feeling the pain was getting progressively worse and he complained of feeling pain all over his body.

And his past medical history was unremarkable. No history of any prior significant medical problems or injuries.

Q. Did you examine him?

A. Yes, sir, I did.

Q. And that's in addition to listening to what he had to tell you?

A. Yes, sir.

Q. What did your examination show you about what was cooking with Mr. Hoyte?

A. Well --

MR. JOSEPH: Objection as to form, your Honor.

Q. What did your examination reveal?

A. I took his vital signs, his blood pressure, his pulse. I wanted to check his blood pressure because he was complaining of headaches. I wanted to make sure that his blood pressure was not exceedingly high or exceedingly low. That was normal.

I examined his heart. I examined his extremities. I examined his lungs.

When I examined his neck, it was diffusely tender.

"Diffuse" means the whole area. There was severe spasm. "Spasm" is defined as a prolonged involuntary contraction of a muscle fiber. "Involuntary" means the patient has no control over it. It is an objective finding in the sense that there is no control by the patient. And there were multiple trigger points.

Q. Let me just stop you at "spasm."

How do you tell there is spasm on Mr. Hoyte?

A. By palpation. Normally when you touch a normal muscle, it is soft to touch. When a muscle gets injured, the fibers shorten. That is the body's way of protecting itself, it is called a reflex mechanism. As a result, the muscles go into spasm, they become hard. When you touch it, you feel the muscles are very, very hard.

Once you have been something like this for 17, 18 years, your fingers become computer probes; you very easily feel the spasm. And once the muscles go into spasm, the fibers shorten. Once the fibers shorten, you lose range of motion such as bending your neck forward, backward, left and right lateral flexion, left and right lateral rotation both in the neck and in the back.

The trigger point is defined as a area of pinpoint tenderness with a palpable nodule most commonly caused by trauma.

What happens is when a muscle gets injured, you have a

microscopic bleed inside the muscle fibers. It then heals with permanent scarring. That scarring is what a trigger point is. It causes pain with surrounding muscle inflammation and spasm.

The range of motion of the neck was one half normal in each direction. As I mentioned, that is forward flexion, backward extension, left and right lateral flexion, left and right lateral rotation.

And I examined his back. Again, the same thing. There was diffuse tenderness. There was severe spasm. There were multiple trigger points. Range of motion was one half normal.

Then I did a straight leg raising test. The way that test is done is, first of all, it is done to check and see if there is any nerve root damage in the lower back or any disc herniation or a combination of both. You lay the patient flat on the examining table with the patient facing up. First I started with right leg. I grabbed the right leg, put it into my right hand with the knee completely straight, I put my left hand behind the patient's hamstring, I bring it up.

Once I feel resistance, not pain, I record the abnormality. Normally it is 90 degrees or greater. In this case it was 60 degrees on both sides, and that is abnormal because it indicates there is either a nerve root compression in the lower back or a disc herniation or a combination of both.

Q. We will come to those things as we go on.

Keep going on.

A. Then I proceeded to do a range of motion of the four extremities, the shoulders, the elbows, wrists, hips, knees and foot and ankle. That was normal, as expected.

The muscle power testing for both shoulders and both legs was weak. It was four minus over five. Normally it is five over five. Next is five minus over five. Next is four plus over five. Next is four over five. Next is four minus over five.

Q. What do these numbers mean, four plus five?

A. This is the manual method of testing muscle strength, comparing the good side with the bad side and against normal resistance.

Q. OK.

A. Sensation was diminished to pinprick and touch for the right biceps, the right third digit and the right calve. This is a very important finding because the muscles -- the sensation that goes to the biceps is supplied by the nerve root from the neck, C5-C6. The third digit is supplied by the median nerve, or the C6 nerve roots from the neck. The right calve is supplied by the nerve root in the lower back that comes from L4, L5 and S1, these three nerves.

Q. These letters and numbers you are using, what are they?

A. There is a model of the spine. If I may be allowed to use

the spinal model, I can explain this to you as I am going.

Q. OK.

THE COURT: We will call it Plaintiff's 6, for identification.

Q. (Handing to the witness)

Go ahead, Doctor.

A. OK. This is a model -- judge, may I stand?

THE COURT: Yes, sure.

A. This is a model of the spine. This is the front portion. This is the back portion. This is the spinous process. If you take your fingers, touch the back of your necks, you are touching the spinous process.

This is the lateral process.

Between each vertebrae we have a structure that is called a disc which serves as a shock absorber between each vertebra. A disc is analogous to a jelly doughnut. It has two parts. The inside material is a gelatinous material called the nucleus pulposus. The outer perimeter is a fibrocartilage material called the anulus fibrosus. That is the doughy portion of the jelly doughnut. There are approximately 100 rings on the outer perimeter, and it is that gelatinous-filled cavity that allows us to have our range of motion bending forwards and backwards and sideways.

Right inside the spinal canal is the spinal cord, which runs from the brain all the way down to the lower back.

It ends someplace between the first and second lumbar vertebra in the lower back, and it continues with the branches of nerve roots called the quarter equina. Those are like the tails of a horse. They look almost exactly the same.

As the spinal cord runs through, it gives rise to nerve roots on the right and left sides. These nerve roots in turn give you branches.

Q. Are those nerve roots the yellow things sticking out of the sides?

A. Yes, sir. These come off on both sides. There are two branches. One is for motor, for movement. The other is for sensation so you can feel.

Every nerve root from the neck gives you branches to different muscles in the arms. For example, the biceps comes off the nerve root between the fifth and sixth vertebra in the neck. The muscles in the forearm come between the nerve roots from the sixth and seventh cervical vertebra. So every nerve root or every disc is numbered according to its anatomic location. If I say C5-C6, the word "C" stands for cervical. "L" stands for lumbar.

The spine has three segments: The neck, which is the cervical; there are seven vertebra. The mid-back is known as thoracic spine, there are twelve vertebra. The lower back is called the lumbar spine; there are five vertebrae.

The lumbar spine ends with the tailbone, called the

sacrum. What we are all sitting on, we are sitting on our sacrums. And each of these nerve roots gives further branches. The muscles that go into the calve come from the L4-L5, and there is some S1-5 but mostly L4 and L5.

Then the neck has a curvature. The body is held together with the curvature of the neck, the mid-back and the lower back, along with muscles, tendons and ligaments. So when a muscle gets injured, that normal curvature of the neck can become completely straight. It can happen for the neck. It can happen for the lower back.

Q. Why does that happen? Why does it get straight?

A. The body tries to protect itself with that reflex mechanism I mentioned, that spasm. Once the muscles go into spasm, the normal curvature becomes straight or becomes reversed. That is the body's mechanism for trying to protect itself from recurring injury. That is basically anatomy.

So when I was saying that the nerve roots, whenever you have shooting pain that goes down your arm, it comes from the nerve roots in the neck, and whenever you have shooting pain down the legs, it comes from the nerve roots in the lower back. If there is loss of sensation in the biceps, it could be coming from the nerve root, and if you have loss of sensation in the third finger, it could be coming from t
the neck, C6 or C7, or the median nerve, and t
is L4-L5 with some S1 fiber, mostly L4 or 5.

Q. After those nerve roots come out of the spine, where do they go?

A. Once these nerve roots exit from the neck, they come down to the armpit. It is the big Grand Central Station. It is called the brachial plexus. All the nerves crisscross. And they go down the arm and they form different branches and trunks that go down and supply power and sensation to different muscles in the legs.

In the lower back, the sciatic nerve is formed from the nerve roots of L4, L5 and S1. These three nerve roots combine together to form the sciatic nerve, which goes down the back of the leg.

Q. By the way -- let me backtrack a moment -- did you find out if Mr. Hoyte had been seen in any hospital?

A. Yes, sir. Once he got injured, he was treated at St. Luke's-Roosevelt Hospital. He was taken there. X-rays of his neck only were taken. It revealed no fractures. He was treated and released.

Q. So now that you've seen him, you've examined him, did you form an impression or an opinion as to what ailed him?

A. Yes. I diagnosed him initially as having multiple traumatic injuries. Rule out cervical or lumbar disc bulge versus herniation.

The world "rule out" means to prove he has it or he doesn't have it. The way that is done is by way of an MRI.

My next diagnosis was rule out cervical and/or lumbar radiculopathy. Radiculopathy means damage to a nerve root. Again, "rule out" means to prove either he has it or he doesn't have it. The way that is proven is by way of an EMG.

Also, I diagnosed him as having a traumatic mild fascial pain syndrome. That means whenever you have two trigger points in two or more body parts, you meet the criteria for traumatic myofascial pain syndrome.

That was met by the fact that he had trigger points in his upper neck, mid-neck, lower neck, upper back, lower back. That is multiple areas.

Q. That's it?

A. That's my initial working diagnosis.

Q. OK. Did you give him any advice?

A. Yes. I proceeded to get a release for him to sign and obtain the medical records from the hospital. I told him to abstain from work until he is better. I gave him a prescription for Bextra.

At that time Bextra was not yet taken off the market. Now it is. Therefore that was stopped.

I started him on a course of physical therapy and I told him I would reexamine him in about two weeks to see how he's doing and then we'll proceed with appropriate testing as indicated. And I sent him for an MRI of his spine to see if there is any herniations.

Q. Did the MRIs -- I'm sorry, Doctor, forgive me. I was reading a note I had just been given.

Did I ask you if you made any recommendations as to how he was to act until those tests were done?

A. Yes. I said to abstain from work.

Q. OK.

A. And to get physical --

Q. OK, if you said it, you said it, and forgive me for not listening.

You then arranged for these -- at least some of these tests to be done, the MRIs?

A. Yes, sir.

Q. And those are already in evidence, and I am going to show you -- have you ever seen the films of the MRIs?

A. Yes, sir, I have.

Q. And do the reports of the MRIs reside in your chart?

A. Yes, sir.

Q. I am going to hand you the reports of the MRIs -- those are a part of what is now Exhibit 4 in evidence -- and tell us what the results of the MRI of his neck was, of the cervical spine, as it impacts on Mr. Hoyte and his symptoms.

A. First of all, he had a lot of normal natural aging arthritic problems, which is found normally in a 48-year-old patient. The arthritic process in the males starts at the age of 40. In the females, it starts at the age of 26. Different

hormones protect different sexes from different diseases.

For example, a woman, until she reaches menopause, usually almost never gets a heart attack; males do, as early as in their 30s. Males don't get arthritic problems until after the age of 40, women start as early as 26.

So for a 48-year-old man, this is a normal, natural aging spine which had no symptoms, had no pain whatsoever, and then it became symptomatic as a result of this accident.

It also showed that there was abnormal increased signal activity at the vicinity of the C3 and C4 vertebral bodies, which is consistent with mild compression fracture.

A compression fracture means when you have an injury to the vertebra, you lose part of a normal height of the vertebra. It breaks loose and you have a break in the vertebra. That is a compression fracture.

And the radiologist pinpointed it as being subacute, which means it happened within six weeks of a traumatic event. When you take -- that was done on May 12, 2004. The accident was on 4/19/04. It correlates within that timeframe.

The next --

Q. In addition to the compression fracture, didn't the radiologist see some other alternative diagnosis there?

A. Yes. Mild subacute compression fracture versus a contusion, which is a blow to the vertebra. That is usually a sprain and a strain of a muscle, tendon or ligament.

Q. And as far as what the patient felt in terms of the compression fracture versus the contusion, to the patient's perception, what difference is there?
A. Nothing. The patient is going to have pain and reduction of range of motion.
Q. OK. What did the radiologist find with respect to the lumbar or lower back on the films that you requested?
A. Well, I am going to go in order. First is the neck, then there is the thoracic spine and then there is the lumbar spine.
Q. You didn't order the thoracic spine, did you, Doctor?
A. No.
Q. Then just tell us what you ordered because --
A. Fair enough. The MRI of the lumbar spine was performed on May 12, 2004, which showed a small central desk herniation at L5-S1; a bulge at L4 or 5; flattening of the fecal sac. That is the nerve root sac where the nerve roots exit. It showed a mild anterior wedging compression fracture of the L4 vertebral body.

"Anterior" means the front. The L4 vertebra is the fourth vertebra in the lower back. That would be this one. Wedging means a part of it is wedged off. Like a slice of cheesecake, you take a wedge off out of it. That was partially broken at the fourth vertebra.

And there was a disc bulge and a disc herniation.

A disc herniation is defined as a complete tear of the

outer portion of a disc.

I brought some models with me. If I may show them, I can explain to the jurors exactly what I'm talking about.

Q. Sure. I will hand you these models, and can we mark these as number 7A, B, C and D or just 7?

THE COURT: Make them 7A, B, C and D, why not.

Q. Here we go, Doctor. Sorry for the delay.

A. OK. Would you like me to show them from here or step down?

MR. WINN: Could the doctor approach the jury?

THE COURT: Sure. If it will be more helpful to you to step down, you can certainly do that.

THE WITNESS: Yes. Thank you, Judge.

(By the jury rail)

A. May I begin? This is a normal disc, as you could see. This is the vertebra. This is the disc. These are the nerve roots that exit behind it on the right and left sides.

A normal disc is turgent, it is filled with water and gelatinous substance, and the outer perimeter has approximately 100 rings of this fibril cartilage material called the nucleus pulposus. Inside this is this gelatinous material called the nucleus pulposus. This is the anulus fibrosus.

We have three abnormal conditions to a disc. The myelous form is a bulge, which means a partial tear. This has no tears. This was a partial tear. This is a normal disc. This is a partial tear. That is how a bulge begins. A partial

tear. A normal disc.

Q. Slow it down, Doctor. I can see the jurors trying to follow you and you are going too fast for them.

A. Yes, I will slow down.

The next abnormal finding that we have is called a disc protrusion and the third one is herniation.

A disc protrusion is when the outer perimeter of a disc completely tears, the disc material leaks but it stops right at the boundary and the border of a disc. This is normal. That is a disc protrusion. There is a complete tear but it hasn't leaked past the disc margin. That is the protrusion. Normal disc protrusion.

Next abnormal finding is what we call herniation, which means a complete rupture of a disc where disc material leaks out and passes the disc margin.

So this is a normal. That's disc protrusion. That is the herniation.

Normal. Protrusion. Herniation.

Normal. Protrusion. Herniation.

Now, when a disc herniates, what happens to a disc? The outer one third of this fibril cartilage material has nerve fibers. They are called nociceptors, N-O-C-I-C-E-P-T-O-R-S They come from a branch of the nerve root they called the sinuvertebral nerve. So whenever you have a tear in the outer perimeter, it causes pain.

Once a disc herniates, it is a permanent progressive condition because the water content leaks out, the fibrocartilage material does not have the ability to repair itself once it is torn. In fact, when bone breaks, it has a tremendous amount of ability to repair itself unless the two pieces are broken far apart from each other. A bone breaks, a fracture heals with callus formation, and in fact it becomes the strongest part of the area so if you were to break that same bone again, you would not break it at the level that it was broken before. It breaks at the level below or slightly above it.

So fibrocartilage, once it is torn, is a permanent condition. Once the water content in a disc leaks out, the disc becomes shriveled up. This is a normal disc. Stage one. Stage two, and stage disc. This is a really advanced disc degeneration that has been damaged and shriveled up. As you could see, the disc space is completely gone. This osteophyte formation -- "osteophyte" is defined as these bony projections from the edges of the vertebra, they come out.

Q. Doctor, let me stop you at that last demonstration at that point.

Has Mr. Hoyte reached stage four?

A. No, sir.

Q. Do you have an opinion as to whether Mr. Hoyte will, with reasonable certainty, reach stage four?

A. Yes, it will take several years.
Q. OK. Then you can keep going.
A. Yes. So right now in his neck he has some normal natural ageing osteophytes, which is normal for his age, but once a disc becomes damaged by way of a bulge, protrusion or herniation, the body again tries to repair that area. The way it does it is by forming these osteophytes around the vertebral bodies so after many years the disc shrivels up, the herniation level starts to go inside, but it still remains permanent because once you tear it, it is permanent. It can be treated but not cured. And the disc eventually becomes like so, where the disc space is completely gone and all these osteophytes overlap, the bone becomes fused, and the nerve root where it exits the neural foramina becomes narrowed and becomes compressed by these bony osteophytes.

That is when eventually you need to get in here by surgery and shave out these areas and make the nerve root have more room so it breathes better and functions better.

So that is what a disc bulge protrusion herniation is, and the condition is permanent and progressive.

(The witness resumed the stand)

Q. And based on the findings, Doctor, of that MRI report, he had how many of those conditions discovered in his back?
A. In his lower back, the last disc, the L5-S1, which is the foundation of the spine, is broken. So when the foundation of

his spine is broken, it is like building a skyscraper, as you go higher and higher, the loading on that one area becomes more and more, the disc herniation becomes more pronounced, and more of the work gets transferred to the discs above it and eventually those discs, by the domino effect, will have to bear more weight and do more work and they will become compensated, but the L4 already has a compression fracture and the L4-L5 already has a bulge, which is a partial tear, so those areas have a higher predisposition to becoming more pronounced and more damaged.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty whether the injuries you have just described to us at least as far as the MRI findings in that time span were caused by the accident that Mr. Hoyte was in?

A. Yes, sir, I do have an opinion.

Q. And what is your opinion?

A. That it was most definitely caused by the accident of 4/19/04 for a variety of good reasons.

Q. Do you want to tell us what the reasons are?

A. Yes. 70 percent of a doctor's working diagnosis comes from history. 10 percent comes from the physical exam. That is 80 percent. The remainder, 20 percent, comes by or are confirmed by other diagnostic studies.

The history points that this man never had any prior problems with his neck and back. He worked as a computer

technician for Morgan Chase doing a lot of sitting and highly diligent and hard work that required sitting and required you to be fully alert.

He then gets involved with this accident. The force from a train coming from the rear is very, very hard. The MRI of the neck showed that he has got a subacute mild compression fracture versus a contusion, and that in itself did not -- was not there from before, it was recent.

The MRI of the lumbar spine points to wedging compression fracture of the L4 vertebral body with a disc herniation with an annular tear of the bulge at L4-L5. I showed what an annular tear is, that tear of the fibrocartilage material. And the physical exam points to a lot of spasms, trigger points, range of motion deficits, loss of sensation. This is not a normal finding; this is abnormal.

And then when the EMG was done --

Q. When was that done? We will get to that?

A. Yes. The EMG was done -- I'll tell you in a second. EMG of the lower back was done on June 18, 2004. It did not reveal any polyphasic potentials. These are multiple dips. If those were present, it would indicate this condition was over nine to twelve months. So the fact that there was no polyphasic potentials, this indicates to a recent injury.

Again, the EMG on the neck was done on June 11, 2004. It showed a C4-C5 radiculopathy on both sides. Again, there

was no polyphasic potentials, which indicate that was also recent.

When you put all the pieces together, you arrive at the full picture of a big crossword puzzle. If you take one piece of it out and only look at one part of the puzzle, you could say was this possible or not possible. Anything could be possible or not possible. When you put all the pieces together, you see the full picture.

Q. And the full picture is?

A. That it was traumatically induced from the episode of 4/19/04.

Q. Did you treat Mr. Hoyte?

A. Yes, sir, I did. He had over 100 physical therapy sessions. He had many follow-up examinations with me. He was seen by multiple different doctors.

Q. What is the purpose of physical therapy as far as Mr. Hoyte is concerned?

A. The purpose of physical therapy is not to cure his problem because there is no cure for his condition. There is no cure for disc herniation. You can't take that broken piece, suture it back together by surgery, you can't glue it back together. All you can do is treat it. As diabetes and arthritis, there is no cure for these conditions, only treatment. When you treat the patient, the symptoms are under control. When you don't give the patient the treatments, they become more pain,

more spasm.

So the purpose of physical therapy is to decrease pain; decrease spasm; improve range of motion deficits, if there are any; restore any muscle weakness, if there is any; restore any abnormal gait pattern, if there is any; and to prevent further deterioration. These are the functions of physical therapy.

Q. And that has gone on, has it -- how successful has the physical therapy been in terms of eliminating his problems?

A. Well, as far as his muscle weakness is concerned, it was improved tremendously. His muscle power is now normal.

As far as his pain was concerned, it was significantly reduced. That was successful.

As his range of motion was concerned, some days he had good days, some days he had bad days, made worse by rain, snow, humidity.

So for the most part, it helped him. Even if it was palliative rather than restorative. That means he got temporary relief from it. It was never designed to cure the problem.

Q. Did he ever make complaints to you of anything related to his thought process?

A. Yes. The first day he complained of headaches, which I attributed to his neck tightness. Then as I continued to examine him, I continued to follow him, on June 18, 2004, he

complained to me of having difficulty with concentration.

MR. JOSEPH: I'm sorry, I didn't get that date.

THE WITNESS: June 18, 2004.

MR. JOSEPH: I'm sorry, your Honor. I didn't mean to interrupt.

THE COURT: OK.

A. He complained of having difficulty sleeping, being unable to concentrate, being unable to work at all, and that's the first time I had that, that complaint.

Q. To what did you attribute those complaints, the -- let's take them one at a time -- the difficulty sleeping?

A. To his pain.

Q. Would you consider that, Doctor, a sleep disorder?

A. No.

Q. What would you consider it?

A. I would consider that a consequence of a painful condition.

Q. Next, the next complaint was in that list?

A. Difficulty concentrating and having headaches.

Q. What did you attribute the difficulty in concentrating to at that point in time?

A. The Tylenol with codeine medication that I was giving him for his pain.

Q. And how about the headaches?

A. I attributed the headaches coming from the tight muscles in the neck that go all the way up to the back of the head.

Q. And he was on pain medications from your answer, I take it?
A. Yes, sir.
Q. And with what frequency do you know he was taking or did you prescribe?
A. I prescribed Tylenol with codeine, one tablet every four hours, as needed. In the beginning, Bextra for mild pain, and later on I gave him medications for spasm, as well, such as Flexeril, F-L-E-X-E-R-I-L, 10 milligrams three times a day.
Q. Did you ever refer him to a Dr. Nadler, Nadler?
A. Yes, sir.
Q. And who is he and what was the purpose of that referral?
A. Dr. Nadler is a psychologist who deals with patients with traumatic injuries and pain problems, anxiety disorders, problems with concentration, so on and so forth.
Q. Where was Dr. Nadler's office located at first?
A. In my office, in Long Island, in Jericho. It is a 6,000 square foot facility.
Q. And in addition to Dr. Nadler -- what was your purpose in referring him to Dr. Nadler?
A. For the management and treatment and further probing into problem with his concentration, the problem with his headaches, the problem with his sleep and his pain process, to evaluate him for biofeedback, which is a treatment where you have electrodes placed on the neck, back muscles and lower back muscles, and by the actions on the screen they show you what

happens when the muscles tense up, there are spikes all over on the machine, and what happens when you do meditation and listen to nice soothing music or special relaxation tapes, the muscle tension drops. It teaches the patient how to reduce their pain and spasm, that is called biofeedback, and also for psychotherapy.

Q. In addition to Dr. Nadler, did there ever come a time when you referred Mr. Hoyte for other treatment?

A. Yes. I referred the patient to Dr. Rafiy, an orthopedics surgeon, for the evaluation of his spinal fractures. I also referred the patient to NYU, to Dr. Sherr, S-H-E-R-R, for cognitive evaluation, neuropsychological testing and treatment.

His symptoms started to get more pronounced. He started to have thought process disorder, speech disorder, mentation disorder. Then I knew this was not just headaches or concentration problems from the medication, this was something more pronounced and it required a further look and probing.

Q. And at what point did you decide to send him out to Dr. Sherr?

A. April 8, '05, almost a year later.

Q. What was it about a year later that had you decide to send him to her as opposed to what had been going on before?

A. Well, his symptoms were becoming more pronounced and he was having more and more problems with his cognitive functions, trouble remembering things, trouble with concentration, with

his thought process, word-finding ability.

Q. And these are the -- and he first told you about these when?

A. The full picture didn't come out until around April of 2005.

Q. And how about the first reports of this, when did they come out?

A. The first report --

Q. I think you told me but I forgot.

A. June of 2004, when I first referred him to Dr. Nadler for simple psychological evaluation and treatment.

Q. What is his pain tolerance these days?

A. He has good days. He has bad days. Stress makes the muscles more tight. Therapy, medication, relaxation makes the muscles less tight. Extremes of temperature, cold, rain, humidity, snow makes the condition worse.

Q. Can he walk?

A. He can walk, absolutely.

Q. Can he bend?

A. He can bend but not too much. He could bend occasionally, not repeatedly.

Q. And I want you to assume that while Mr. Hoyte was on the witness stand, several times in each session he would ask for a break and make facial expressions, hold his neck.

How does that fit into his picture, if it does?

A. Well, sometimes the muscles tighten up from stress. You try to find relief. Some patients crack their own necks. Myself, I do that, too. My wife doesn't like it but it gives me temporary relief. That is from stress.

And also by simply getting up and stretching, walking, that also relaxes the muscles. So different patients, different people find different ways that the body becomes adjusted to for finding ways to relieve their stress, their tightness and their spasm.

Q. Do you believe -- do you have an opinion as to whether Mr. Hoyte could return to the type of work he did before this accident?

A. No, sir, for a variety of reasons.

Q. Tell us the reasons.

A. He has a traumatic brain injury with cognitive involvement, with speech involvement, with mentation disorder.

Q. Let me stop you right there.

A. Yes.

Q. I thought you told us right in the beginning that he didn't tell you that he hit his head and he didn't remember whether he hit his head.

A. Right.

Q. How does he get this traumatic brain injury if you don't have a history of him hitting his head?

A. Very good question, very good answer.

The brain sits in the cranium, in the skull. It is filled with water around the brain. So it is like in a water environment. The same force that made his neck and back swing forwards and backwards also jolted his brain forwards and backwards. That is enough to hit the frontal lobe, the occipital lobes and the other parts of the brain, which cause a bizarre variety of different symptoms.

If you have an open head injury, if you have a skull fracture, the pressure is released. In a closed head injury, the pressure is not released; it gets transferred to all of the different parts of the brain. The frontal lobe controls memory, concentration and mood. The occipital lobe controls balance, coordination and vision. The temporal lobes controls hearing and other higher intellect. So all the different lobes of the brain was affected by the shearing forces working on the brain.

So you don't need a direct blow to the head to have these symptoms. The same force that hit you from the back, lunged you forwards and backward is sufficient to cause these symptoms.

Q. It doesn't happen all the time?

A. It doesn't happen all the time, no.

Q. Do you have an opinion whether it happened in this fellow's case?

A. Yes, based on the persistence of the symptomatology and

based on neuropsychological testing that was done at NYU and based on Dr. Sherr's report and testing, yes, it is -- it did happen in this case and has become permanent in this case.

Q. How about the physical injuries, how do they play on his ability to return to work?

A. Well, he has a condition, his lower back, he has a disc herniation, a disc bulge with a annual tear and a wedging compression fracture. That prevents him from sitting or standing on a long period of time. He cannot sit or stand on a continuous basis for more than an hour. He has to change and find ways to relieve his problem. There might be days he could do it, but he cannot do it every single day 360 days a year. As a result, he will not be able to do that work.

Second, because of his head trauma, he can't concentrate. There is no job that I know that requires you to work without being able to concentrate. Who would hire you? I wouldn't hire anybody that can't concentrate. What if you make mistakes?

Q. Are these conditions permanent, Doctor?

A. Yes, these conditions are permanent. A fracture is permanent. A disc herniation is permanent. The radiculopathy that was found on the EMGs to his neck and back are permanent. This traumatic brain injury that has lasted for more than one year and is still persisting is permanent.

Q. Do you know -- where I'm still just a touch lost is how

does an injury -- I want you to assume that Mr. Hoyte has told us that he has pain in his back that goes down the back of his legs and at least on one side into the sole of his foot --

A. Mm-hmm.

MR. JOSEPH: Objection.

THE COURT: Well, ladies and gentlemen, I take it we are having a hypothetical question where the lawyer is asking the doctor to assume that certain symptoms were reported, and now I guess he is going to ask something like how do you explain that.

MR. WINN: Yes.

THE COURT: So of course, it is your recollection of what Mr. Hoyte actually testified to that controls, and if in your view the hypothetical question doesn't actually correspond to the testimony or, for that matter if you recall the testimony being given but don't accept the testimony, then the answer to the question won't make much difference to you.

But for now, I am going to allow the question, and it will be up to you to decide whether the conditions on which this hypothetical question are based actually exist or not.

Go ahead.

BY MR. WINN:

Q. So the question is, Doctor, assuming that he has described those symptoms, you have used the term "radiculopathy" a couple of times?

A. Yes, sir.
Q. How do those symptoms match up with that term?
A. Well, the criteria for diagnosis for radiculopathy is whenever you have shooting pain down the extremity. If the neck is involved, you get shooting pain down the arms. If the lower back is involved, you get shooting pain down the legs or in the buttocks or a combination of both. So any time you have shooting pain in a history, until proven otherwise, the nerve roots are damaged.
Q. One of these diagrams here that we have looked at earlier, and we have shown it to Mr. Joseph, shows the nerves in the leg.
A. Mm-hmm.
Q. Could you use that diagram to help demonstrate what you just are talking about?
A. Yes, sir.
Q. I will hand it to you. I've got to put another sticker on it.

MR. WINN: It is going to be 8.

THE COURT: Plaintiff's 8, for identification.

Q. Using this diagram, just explain to us all what it is that you are talking about.
A. OK. This is a diagram that shows how the sciatic nerve is made. The sciatic nerve comes out of the buttock area. It is formed by the combination of the L4, the L5 and the S1 nerve

roots. They all unite and they form the sciatic nerve.

This nerve runs all the way down the legs and it gives branches to different parts of the legs as it goes down the leg. When it hits the back of the knee, it branches off into the tibial nerve and the peroneal nerves. Thee continuously supply power to the different portions of the legs.

Q. And the injury to the back --

A. So the injury affects the L4-L5 and the L5-S1. So, therefore, these three nerve roots are damaged. As a result, you get shooting pain down the legs.

Q. I want you also, Doctor, to assume that Mr. Hoyte has told us that, oh, 15 years or so ago he experienced some pain in his left buttock after shoveling snow or something like that that flared up periodically every couple of years and he took medication and it went away. Does that enter into or change your opinion in any way?

A. No, sir, that was a simple sprain and strain of a muscle fiber. He may have irritated the sciatic nerve temporarily, but it comes back unless there is a compression at high levels.

Q. And that polyphasic activity business that you told us about with the EMG, does that exclude an old injury?

A. Yes, sir, it does.

Q. OK. There was, in addition to the MRIs that you ordered, Doctor Rafiy ordered some other MRIs to his mid-back, correct?

A. Yes, sir.

Q. And the results of those, do you want to tell us about?
A. Yes. It found some normal natural aging arthritic problems, as we mentioned he has. It also found some small focal lateral disc herniations at the T7-T8. That is the thoracic spine in the middle of the mid-back. T8-T9, T9-T10, with encroachment on the neuroforamina at T9-T10.

T9-T10 is one, two, three, four, five, six, seven; one, two, three, four, five, six, seven. So there was a disc herniation between T7 and T8, between T8 and T9 and between T9 and T10, and the level between T9 and T10, the disc herniation was compressing the nerve roots on both sides, so you get referred pain to your chest and upper abdominal area.

And also, it showed a tiny herniation at the T2, T3 and T4 levels higher up in the thoracic spine.

Q. Now, assuming that he was in that train accident that you have been told he was in, do you have an opinion as to whether those conditions that you just read were caused in that train accident?
A. Yes, for the reasons I gave earlier.
Q. Which are, very briefly, what?
A. There was no prior history of any disc herniations to his body. There was no problems with him working on a continuous basis sitting for long hours of doing his computer work, the fact that the EMGs did not show any polyphasic potentials, the fact that he had spasm, he had trigger points -- trigger points

most commonly come from an accident -- and the fact that he had loss of sensation and initial muscle power weakness, it all points to a big traumatic event that caused this many herniations and the two fractures.

Q. Doctor, the value of the services that have been rendered from your office to Mr. Hoyte from day one to now, the reasonable value of those services -- to begin with, my question deals with that, but do you do the billing?

A. No, sir.

Q. Who does the billing?

A. I have billing people in my office that do the billing, they are medical billers.

Q. And they billed pursuant to what kind of schedule?

A. The normal prevailing customary rates.

Q. And what is the total of the services rendered?

A. To date, approximately 36,000.

Q. And how does that break down?

A. Some is for physical therapy. Some are for office visits. Some are for the EMGs. An EMG is about $1,500 each. He had two, neck and back. Each physical therapy session is $50 per modality. He got three modalities. That is $150 for each section.

Q. What is a modality?

A. Electrical stimulation is one modality, massage is another modality, and therapeutic exercise is another modality.

Q. OK. And can you tell us what the future is going to hold for this man?

A. He is left with a permanent injury. He is permanently and totally disabled. As a result in the medical field, when you have a permanent total disability, you are required to be seen by a doctor once a month for assessment of medications and physical therapy.

You cannot give physical therapy unless you examine the patient once a month to monitor his condition to see if his condition has worsened, improved, what works, what doesn't work.

To prescribe narcotic medications requires examinations, reevaluations and periodic assessments to see if he needs any other services. So he needs to be seen by a doctor, such as myself, about a minimum of 12 times per year. He needs approximately 30 to 40 physical therapy sessions per year, at the minimum.

Q. Why?

A. To maintain what he has, so he doesn't get worse.

He needs repeat EMGs of his neck and back to see, make sure the nerve damage has not gotten worse. If that progressive condition happens, the nerve root becomes compressed. You want to pick it up early so you can do something about it early, otherwise there will be no benefit from him having surgery because it will not relieve the

compression once it is longstanding.

So the EMGs are required approximately every three years. Each EMG is about $1,500.

He will need MRIs of his neck, thoracic, lumbar spine to monitor those injuries, to make sure it hasn't gotten worse. That will be required also every three years. Approximate cost for an MRI is about $950 for each MRI.

He will need to see an orthopedic surgeon, someone like Dr. Rafiy, periodically three to four times per year to make sure those fractures have not gotten worse. Follow-up visit from orthopedic surgeon is about $125 for a follow-up visit.

He will need periodic x-rays, a set every two years or so. A complete set of his spine is about $300.

And he would need medications for pain, for spasm and inflammation. The approximate annual cost for the medication will vary from between 2,000 to 5,000 per year, and if nothing works, eventually he will need evaluation for surgical intervention for his disc herniation.

Q. The hope is some of this works and he doesn't need the surgery?

A. Right.

Also, he will need continued evaluation by a neuropsychologist and psychological --

MR. JOSEPH: Objection.

THE COURT: Overruled.

A. He will need continued psychological treatments by a psychologist for anxiety, depression and pain management, as well. And a session for psychotherapy is about $150 for about a 45-minute session, and he would need periodic psychotherapy -- neuropsychological testings every two to three years. Those tests are very expensive. They are between 2 to $3,000 for each test.

Q. And that's what's done by Dr. Sherr and her department up at Rusk?

A. Yes, sir.

Q. That is done on an outpatient basis up at NYU, correct?

A. Yes, sir.

Q. And do you know whether he is undergoing any present treatment at Rusk?

A. Yes, sir.

Q. What is he undergoing, what kind of treatment?

A. Cognitive therapy.

Q. Do you know about speech?

A. That's part of the therapy. They are giving him speech therapy, cognitive therapy. They are working with his speech, his motor skills, all his deficits that they found on the tests.

MR. WINN: Thank you, Doctor. I have no further questions.

THE COURT: OK. This feels like a perfect opportunity for the afternoon recess so as not to interrupt the cross-examination.

So, ladies and gentlemen, let's take ten minutes and then we will be back in business.

Don't discuss the case while you are gone.

THE CLERK: All rise.

(Jury not present)

THE COURT: All right. We will see you in ten minutes.

(Recess)

(Jury present)

THE COURT: Before we begin, first, I have been watching and I noticed a lot of you are wearing coats and things. The way this room and most of the courtrooms seem to be designed, the jury box is right under the air-conditioning vents, and so there is not much we can do for you short of roasting the rest of us.

But I noticed there are a lot of pretty heavy coats on. So I am going to ask Mr. Lopez to see if he can get the AC turned down a little bit to warm it up over there. But there is a limit to what we can do, and, you know, if you are uncomfortable, just speak to him at one of the breaks and he will try and do the climate control. But unless you want the judge and lawyers falling asleep on you, there is not -- there

is a limit to what we can do because you are just right under it and it is a design flaw and there is not that much we can do about it.

OK, Mr. Joseph, you may examine.

MR. JOSEPH: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. JOSEPH:

Q. Good afternoon, Dr. Guy.

A. Good afternoon, sir.

Q. Dr. Guy, you have testified before, is that correct?

A. Yes, sir, many times.

Q. So would it be fair to say that you know how to answer a yes or no question?

A. To the point that it could be answered with a yes or no.

Q. Well, if it comes to a point or to a question where you cannot answer a yes or no question yes or no, would you please tell us that before answering the question?

A. Fair enough, yes, sir.

Q. OK. Doctor, you reviewed the records from St. Luke's-Roosevelt Hospital, is that correct?

A. Yes, sir.

MR. JOSEPH: And, Judge, there is a housekeeping matter. Do you want me to use numbers or letters on defendant's exhibits?

THE COURT: Whatever you want, whatever is more

convenient.

MR. JOSEPH: We are going to mark Defendant's Exhibit 1 in evidence. It has been -- counsel have conferred.

THE COURT: OK.

BY MR. JOSEPH:

Q. Doctor, you have reviewed those records, right?

A. Yes, sir.

Q. The St. Luke's-Roosevelt records include the ambulance report, is that correct?

A. Yes, sir.

Q. And they include the Emergency Room record, is that correct?

A. Yes, sir.

THE COURT: Just for the record, so we are clear, Defendant's Exhibit 1 is the St. Luke's-Roosevelt records?

MR. JOSEPH: St. Luke's-Roosevelt record which includes both the ER and ambulance records, your Honor.

MR. WINN: I think it is A. Is it A or 1?

MR. JOSEPH: It is 1.

MR. WINN: OK.

THE COURT: And those are admitted into evidence.

MR. JOSEPH: Thank you, your Honor.

(Defendant's Exhibit 1 received in evidence)

BY MR. JOSEPH:

Q. Doctor, do you have those records in your chart?

A. I do. Just give me a minute.
Q. I'm sorry.
A. Yes. It is right here in front of me.
Q. Could you turn to what's called the NYC 911 System Provider Ambulance Call Report.
A. All I have is these three pages.
MR. JOSEPH: OK. Judge, I am going to approach the witness to give him my --
THE COURT: Sure.
Q. Doctor, can I see what three pages you were given? OK.
What you were given, just to match, is you were given a copy of Plaintiff's Exhibit 5, is that right? Does that look right?
A. Yes, sir.
Q. Three-page document?
A. Yes, sir.
Q. So, Doctor, you never actually examined the Emergency Room report?
A. I thought this was it.
Q. Well, that's just -- that exhibit is the instructions to Mr. Hoyte when he was released from the hospital, is that right?
A. That's all I have, sir.
Q. You were not -- so, in other words, you didn't examine the treatment records from the St. Luke's-Roosevelt Hospital or the

ambulance, is that right?

A. That is correct, yes, sir.

Q. OK. I am going to hand you what's Exhibit 1, and for your convenience, so that you don't have to keep flipping through it, I have turned to the first document that we are going to refer to in this exhibit, which is the NYC 911 System Provider Ambulance Call Report. Do you see that page?

A. Yes, sir.

Q. Now let me just get back to what the court calls the lectern, and, Doctor, it would be fair to say that that document, which you have in front of you, that is what is called, in layperson's terms, an ambulance report, is that right?

A. Yes, sir.

Q. OK. And could you go almost halfway down the page, under the heading "Trauma," do you see that?

A. Yes, sir.

Q. All right. And do you see that it has got a bunch of boxes that can be checked off, is that right?

A. Yes, sir.

Q. And one of those boxes is "Head trauma," is that correct?

A. Yes, sir.

Q. And that box is not checked, is that correct, sir?

A. That is correct.

Q. Which means that they didn't see any -- at that time did

not see any evidence of head trauma, is that correct?
A. Yes, sir, that is correct.
Q. OK. Now, Doctor, when you told us today on direct examination that it was your interpretation that notwithstanding that Mr. Hoyte had not struck his head on any object, that his brain slid forward and backward inside the skull, that's what people normally call a concussion, isn't that correct, Doctor, yes or no?
A. In part, yes.
Q. OK. And, Doctor, I would like you to go a little farther down the page, and do you see where it says "Time" and it says 9:50 and 9:59?
A. Yes, sir.
Q. OK. Go almost to the end of the page, where it says "pupils," do you see that, Doctor, or do you want me to approach and show you where I am talking about?
A. Pupils?
Q. Would you like me to help you?
A. Please.
Q. OK.
(Pause)
A. Oh, OK.
Q. OK?
A. "Pupils are normal."
Q. OK. And those pupils were tested twice, is that right,

Doctor?

A. Yes, sir.

Q. And they were tested both times, once at 9:50 and once at 9:59, and they were normal, is that right?

A. Yes, sir.

Q. And one of the things that they are looking for is to make sure that the pupils are not dilated, which might be indicative of a concussion or serious brain injury; is that right, Doctor, yes or no?

A. The first one no, the second one yes.

Q. So it might be indicative of a serious brain injury?

A. If his pupils were dilated, yes, sir.

Q. And, Doctor, let's go farther to the left on that page.

A. OK.

Q. All right. Still in that same range, do you see where it says "GCS"?

A. Yes, sir.

Q. "GCS" is an abbreviation, is that right?

A. Yes, sir, for Glasgow Coma Scale.

Q. Glasgow Coma Scale.

And, Doctor, you are familiar with the Glasgow Coma Scale, aren't you?

A. Yes, sir.

Q. The Glasgow Coma Scale is used by doctors and EMTs to assess a person's possible brain injury; is that correct, yes

or no?
A. Yes, sir.
Q. I am going to show you Defendant's Exhibit 2, for identification, and ask you if you recognize what this is, without getting into any elaboration because the jury at this point, this is not in evidence at this time.
A. Yes, sir.
Q. What is that?
A. This is how you determine the numbers for the Glasgow Coma Scale, what is normal what is abnormal.
Q. So this is a copy of the Glasgow Coma Scale?
A. Yes, sir.
MR. JOSEPH: I move Exhibit 2 into evidence, your Honor.
MR. WINN: No objection.
THE COURT: OK, Defendant's 2 is received.
(Defendant's Exhibit 2 received in evidence)
BY MR. JOSEPH:
Q. Doctor, I'm not trying to be unfair to you. Can you see that from where you are?
A. Yes, sir.
Q. Because I have tried to set this up in a position where the jury could also see it, OK?
A. Yes.
MR. JOSEPH: Judge, is this OK?

THE COURT: That is fine, and if Dr. Guy needs to come down and look at it, that will be fine, too.

Q. All right. Now, Mr. Hoyte was tested twice on the Glasgow Coma Scale by the emergency medical technician, is that right?

A. Yes, sir.

Q. And a perfect score on the Glasgow Coma Scale is 15, is that correct?

A. Yes, sir.

Q. On each of those occasions that the EMTs tested Mr. Hoyte, he tested at a perfect 15, is that correct?

A. Yes, sir.

Q. And 15 means his eyes were open spontaneously so he got a four, is that right?

A. Yes, sir.

Q. It means that his verbal responses, he was oriented and conversed so he got a five, is that correct?

A. Yes, sir.

Q. And he obeyed all his motor responses, is that right?

A. Yes, sir.

Q. And he got a six?

A. That is correct.

Q. So he got a total score of 15?

A. Yes, sir.

Q. That is a good sign, isn't that correct, yes or no?

A. It is normal, yes, sir.

Q. Now, in the narrative where it says "Treatment/response" on that ambulance call report, do you see that, Doctor, further down that page?

A. Above "Comments"?

Q. Do you see what I am talking about?

MR. JOSEPH: May I approach you?

A. This section?

Q. Let me just show you, it is easier.

A. OK.

Q. Doctor, that narrative, that written narrative by the EMTs indicates, "Patient" -- it has the words "PT was A & O X 3."

You see that, right, Doctor?

A. Yes.

Q. All right. "PT" means patient, is that right?

A. That is correct.

Q. "Was," we know what the word "was" was, right? That is not a medical term, right?

A. Yes.

Q. "A" means alert, is that right?

A. That is correct.

Q. "O" means oriented, is that right?

A. Yes, sir.

Q. X3 means in three spheres, is that right.

A. It means to time, place and person.

Q. Right. Three spheres?

A. Yes.

Q. So he was alert and oriented as to time, place and person, correct?

A. Yes, sir.

Q. Which means he knew approximately the time of day?

A. Mm-hmm.

Q. He knew where he was, is that correct?

A. Yes, sir, that's correct.

Q. And he knew who he was?

A. That is correct.

Q. And those are all things that you -- that's something you want to know about if you want to know whether the patient has suffered some sort of head or brain injury, isn't that correct, Doctor?

A. A serious injury, yes.

Q. And so he tested normal on that test, is that correct?

A. That is correct.

Q. And it indicates in that same narrative that the patient was complaining of cervical, back pain and left arm pain, patient had no other obvious injuries, is that correct?

A. That is correct.

Q. All right. It also indicates "HEENT intact," is that correct?

A. Yes, sir.

Q. "H" is head, is that correct?

A. Yes, sir, that is right.
Q. The first "E" is eyes?
A. That's correct.
Q. The second "E" is ears?
A. Yes, sir.
Q. The "N" is nose?
A. Correct.
Q. The "T" is throat?
A. That is correct.
Q. Head, eyes, ears, nose and throat are intact?
A. That is correct.
Q. That is a good sign if you are checking for a head injury, isn't that right, Doctor?
A. That is correct.
Q. Now, Doctor, can you turn to the Roosevelt Hospital -- St. Luke's-Roosevelt Hospital was kind enough to actually when they prepared this give us I guess a computerized readout of their treatments and assessments. Do you see that?
A. Yes, sir, I do.
Q. OK. At 10:33, while he was in the ER, they found that he was alert and oriented as to time, place and person, is that right?
A. Yes, sir, that's correct.
Q. And, Doctor, there is no indication of any dizziness -- withdrawn.

On this, it says that he denied dizziness at that time, is that correct?
A. That is correct.
Q. Doctor, that is a good sign when you are looking for a head injury, isn't that right?
A. That is correct.
Q. And by the way, Doctor, that ambulance report, there is no indication of dizziness, is there?
A. That is correct.
Q. Now, in the ER, at that 10:33, it indicates that his chief complaint was his left shoulder pain, is that correct?
A. At 10:33?
Q. Yes, sir.
A. Yes, sir, correct.
Q. It also indicated that Mr. Hoyte denied loss of consciousness, is that right?
A. That is correct.
Q. All right. And when you are looking to see if somebody had a head injury, you would like to know if they had lost consciousness, isn't that right?
A. Yes, sir.
Q. And if you are looking for a major brain injury, you need to know whether they have lost consciousness, isn't that right, that is one of the things you would want to know?
A. Yes, sir.

Q. There is no indication in the ER or in the ambulance report that he ever lost consciousness, is that right?

A. Yes, sir.

Q. In fact, it indicates that he did not lose consciousness, isn't that correct?

A. Yes, sir.

Q. That same notation indicates that in the ER he denies dizziness, isn't that right?

A. That is correct, sir.

Q. It also indicates that he denies fainting, is that right?

A. Yes, sir.

Q. That is because one of the reasons you might want to know about that when you are assessing somebody who might have a head injury is because a patient might not know the difference between fainting and losing consciousness, is that right?

A. That is one possibility, yes, sir.

Q. But he didn't faint, is that right?

A. That is correct.

Q. And it also indicates that he denied being nauseous, is that right?

A. Yes, sir.

Q. And one of the reasons you want, when you are assessing a possible brain injury, you want to know if the person is nauseous, because nausea could be an indication that the person had a concussion, is that right?

A. One of the signs and symptoms, yes, sir.

Q. OK. Now, Doctor at 12:38 in the afternoon that day, do you see that?

A. Yes, sir, I do.

Q. All right. It indicates that Mr. Hoyte may return to work without restrictions, do you see that?

(Pause)

Q. Would you like me to show it to you?

A. At 12:38?

Q. 12:38. Yes, 12:38.

A. Yes, please do.

Yes, I see it. "You may return to work without restrictions," yes, sir, I do.

Q. So those doctors found that he can return to work without restrictions, is that right?

A. Yes, sir.

Q. Now, Doctor, you first saw Mr. Hoyte five days later, on April 24th, is that right?

A. Yes, sir.

Q. And you wrote a report based upon that visit, is that right?

A. Yes, sir.

Q. By the way, is that typed document, is that considered a report, or am I using the wrong vernacular?

A. Well, there are many types of reports. That is a report --

Q. It is a report?
A. Yes, sir.
Q. I just wanted to make sure that you were comfortable with that term.
A. Yes, sir.
Q. OK. You indicated in that report that Mr. Hoyte had no head trauma, is that right, yes or no?
A. Yes, sir.
Q. You indicated that Mr. Hoyte never lost conscious, isn't that correct, yes or no?
A. Yes, sir.
Q. You indicated in that same report that he had no complaints of dizziness, is that correct?
A. Yes, sir.
Q. On the bottom of the first page of your report, you wrote "HEENT, normal cephalic, atraumatic," do you see that?
A. Yes, sir.
Q. "HEENT" we know is head, eyes, ears, nose and throat, is that right?
A. Yes, sir.
Q. "Normal cephalic" means that the skull is normal?
A. Yes, sir.
Q. "Atraumatic" means that those -- that the head, eyes, ears, nose and throat, they were not subjected to any trauma, is that right?

A. Yes, sir.

Q. And you also saw him on June 11 and June 18, is that right?

A. Yes, sir.

Q. And on those visits, Mr. Hoyte had no complaints of dizziness, isn't that right?

A. Yes, sir.

Q. He did not indicate to you that he had suffered a head injury, isn't that correct?

A. Yes, sir.

Q. He had no complaints concerning concentration or inability to focus at that time, isn't that correct, yes or no?

A. No, that is not correct.

Q. On June 11 and June 18?

A. Yes, sir, he did complain of difficulty with sleeping and concentrating. It is on page 3 of that report, second paragraph from the bottom.

Q. Second paragraph from the bottom on the third page?

A. If you like, I can show it to you from my report.

Q. I will approach and you can show it to me.

(Pause)

OK. At that time you did not refer Mr. Hoyte to a neurologist for an assessment of a head injury, is that right?

A. That is correct, yes, sir.

Q. And in fact, you've never referred Mr. Hoyte to a neurologist, isn't that correct?

A. That is correct.
Q. Mr. Hoyte has never had an MRI of the brain, is that right?
A. That is correct.
Q. And a brain MRI can show, amongst other things, what's going on with soft tissues, isn't that right?
A. The way you phrase the question, it cannot be answered with a yes or no.
Q. OK. Can a brain MRI show things such as swelling of the brain?
A. Yes, sir.
Q. Can a brain MRI show things such as contusions?
A. No, sir.
Q. It cannot show a contusion -- it wouldn't show bleeding or a contusion of the brain?
A. A bleed, yes; a contusion, no. It differs.
Q. It can show bleeding?
A. Yes, sir.
Q. It could show certain types of brain damage, is that correct?
A. Swelling, bleeding, subdural hematoma; that is about it, though.
Q. You've never sent him for any of that, have you?
A. No, sir.
Q. You also never sent him for what's called a CAT scan, is that correct?

A. No, sir.
Q. A CAT scan is a computerized tomography, is that right?
A. Yes, sir.
Q. And a CAT scan can also show certain types of brain damage, isn't that right?
A. Similar to MRI.
Q. And you never sent him, referred him to a neurologist or any other practitioner for what's known as an EEG or electroencephalogram, isn't that right?
A. That is correct.
Q. The electroencephalogram, in layperson's terms, measures electrical activity concerning the brain, is that right?
A. Yes, sir, that is correct.
Q. You did refer Mr. Hoyte to Dr. Nadler, is that right?
A. Yes, sir.
Q. Dr. Nadler is a psychologist, is that right?
A. Yes, sir.
Q. At the time Dr. Nadler was practicing at 15 Jericho Turnpike, isn't that right?
A. I don't know if he was or if he wasn't. He might have been, I'm not sure.
Q. Well, would it surprise you if Mr. Hoyte said that in the beginning, when he saw Dr. Nadler, it was at 15 Jericho Turnpike?
A. That could be about right. He moved on or about that time.

Q. All right. And 15 Jericho Turnpike, that's where you have your office?

A. Yes, sir.

Q. In fact, you own the building, isn't that right?

A. Yes, sir.

Q. Have you seen Dr. Nadler's office records?

A. No, sir.

Q. Do you have access to them?

A. No, sir.

Q. Have you received reports from Dr. Nadler?

A. I don't believe so.

Q. Did you receive Dr. Nadler's report dated April 18, 2005?

A. I have not seen -- received or seen any reports from Dr. Nadler.

Q. Did you ask him for a report?

A. I asked him as a routine every time he sees one of my patients to please send me a report. He doesn't always do that.

Q. How many people have you referred Dr. Nadler -- let me withdraw that.

How many people have you referred to Dr. Nadler over the years?

A. Hundreds.

Q. Hundreds?

A. Yes, sir.

Q. Did you discuss Mr. Hoyte with Dr. Nadler?
A. Yes, sir, I did.
Q. Dr. Nadler never found any traumatic brain injury, did he?
A. I have no idea what he found. I don't have his records.
Q. But you discussed it with him?
A. Yes, sir.
Q. And he never found that, isn't that right?
A. That was not part of the discussion.
Q. You never discussed whether he had traumatic brain injury?
A. I don't recall that.
Q. Dr. Nadler felt that Mr. Hoyte suffers from depression and anxiety, isn't that right?
A. Yes, posttraumatic.
Q. And he found that his anxiety symptoms exacerbated his pain, isn't that right?
A. Yes, sir, that is correct.
Q. He found that Mr. Hoyte's depression also exacerbated his pain, is that right?
A. They go together, yes, sir.
Q. He found that Mr. Hoyte was suffering from severe emotional distress, is that right?
A. Yes, sir.
Q. And anxiety -- let me withdraw that.

Pain can be influenced by -- he said that his pain is influenced by his anxiety and somatization, isn't that right?

A. I don't remember those exact words but anxiety can affect pain and pain can affect anxiety, that is correct.

Q. And somatization is what, doctor?

A. To bring into reality, to form an organic fashion, to find cause.

Q. And emotional distress can contribute to cognitive and pain symptoms, isn't that what he said?

A. I don't remember those exact words.

Q. But they can, can't they?

A. They can, yes, sir.

MR. WINN: Is that what Dr. Nadler said? I am losing it.

MR. JOSEPH: Objection, your Honor.

THE COURT: I think this is what the witness said, as I understood that question.

BY MR. JOSEPH:

Q. Doctor, would you agree that depression is a treatable illness?

A. To some extent, yes, sir.

Q. Would you agree that anxiety is treatable?

A. To some extent, yes, sir.

Q. Emotional distress is treatable?

A. To some extent, yes, sir.

Q. Dr. Nadler recommended that Mr. Hoyte undergo biofeedback, is that right?

A. Yes, sir, that is correct.
Q. And he recommended that he undergo biofeedback in lieu of medication, is that right?
A. Initially, yes, sir, that's correct.
Q. Now, Doctor, you told us earlier today that you attended Northeastern Medical School in the Dominican Republic, is that right?
A. Yes, sir, that is where I graduated from, that is correct.
Q. And you told us that the reason that you -- well, let me withdraw that.

The reason that you did not go to medical school in the United States is because your grades weren't high enough in Queens College, is that right?
A. That is correct.
Q. And you majored in premed at Queens College, is that right?
A. I had three majors. I had premed, I had accounting, I had English, just in case one of them didn't work out for me.
Q. In fact, you didn't graduate from Queens College, did you?
A. No, sir, I did not.
Q. And, sir, would you agree that general biology is something that a student should understand in order to get into medical school?

MR. WINN: Objection. That is not his opinion.

THE COURT: No, overruled.

A. It's one of the required courses, yes, sir.

Q. And would you -- and the first time you took general biology, you withdrew from the course, is that right?

A. I believe that's correct, yes, sir.

Q. And the second time you took general biology, you received a D, is that right?

MR. WINN: Objection.

THE COURT: Overruled.

A. I believe that's correct, yes, sir.

Q. And you took it a third time?

A. I don't remember a third time, no, sir. There are two semesters of biology.

Q. Were you also required to take a math course called calculus?

A. Yes, sir.

Q. That was for your biology -- for your premed as well?

A. It is one of the preferred courses, yes, sir.

Q. And you failed that course, is that right?

A. Calculus?

Q. Yes, sir.

A. I don't believe so.

Q. Sir, do you recognize Defendant's Exhibit 3, for identification?

A. I do.

Q. Is that a copy of your college transcript from Queens College?

A. Wow, this is --

MR. WINN: Objection.

THE COURT: Well, either it is or it isn't. Overruled.

A. Wow, yeah, this is from 30 years ago. Yes, it is.

That's what it says. I didn't even remember I failed calculus but that's what it states, yes.

Q. OK. And you were required to take physics as a premed as well?

A. Yes, sir.

Q. And you received a D in that?

A. That is correct.

Q. And you are required to take organic chemistry?

A. Yes, sir.

Q. And that is an important part of your premedical education?

A. That is correct.

Q. And you failed that course?

A. I failed one semester, yes.

Q. And then you got a D the second semester?

A. That is correct.

Q. And you left Queens College with a 2.226 cumulative average, is that right?

MR. WINN: Objection.

THE COURT: Overruled.

A. That sounds about right, yes, sir.

Q. And, sir, you previously testified in this very courthouse in front of Judge Denny Chin in the case of Dominic Respente v. National Railroad Passenger Corporation, also known as Amtrak, is that right?

A. If you say it is. I don't remember the case, but if you say it is, probably correct.

Q. I am handing you what has been marked for identification as Exhibit 4.

A. OK.

MR. JOSEPH: Judge, do you need a copy?

(Handing to the Court)

Q. Does that refresh your recollection as to whether you testified in this courthouse?

A. Yes, sir, I did.

Q. You did, is that right?

A. That is correct.

Q. And, sir, in the Respente case, you gave the following testimony about Queens College and your application to medical school.

MR. JOSEPH: Your honor, beginning on page 48, at line 6.

MR. WINN: Judge, not knowing what is coming, I am objecting to it as totally collateral to any issue in this case.

THE COURT: Well, I am guessing there is going to be

something that is contended to be a prior inconsistent statement.

MR. JOSEPH: That is correct, your Honor.

THE COURT: At what lines?

MR. JOSEPH: 48, line 6 to line 19.

THE COURT: OK. Go ahead.

BY MR. JOSEPH:

Q. Doctor, did you give the following testimony? I am going to ask if you were asked the following questions and gave the following answers, beginning on page 48, line 6:

"Q Doctor, you went to two different medical schools?

"A That's right.

"Q The second medical school you had much higher ability in doing your clinical rotations in New York. What is the reason that you didn't go to medical school in the United States?

"A I never applied. 1977 was during the time I was applying -- was the toughest time to get into schools in medical history. Friends of mine with much higher scores, 3.8, 3.9. I did not have 5,000 to $15,000 to lose in applications.

"Q Did you have a 3.8 or 9?

"A No, but slightly below that."

Doctor, did you give that testimony in the Respente case, yes or no?

A. I did, yes.

Q. And, Doctor, you've also given testimony in the case of

Zadra -- Z-A-D-R-A -- v. Metro North Commuter Railroad, isn't that right?

A. Yes, sir, that is correct.

Q. OK. Doctor, just forgive me. What exhibit is that that you have in front of you? 4, OK.

I am going to show you Defendant's Exhibit 5, for identification.

A. OK.

MR. JOSEPH: Judge, would you like a copy?

THE COURT: Sure.

BY MR. JOSEPH:

Q. And that testimony was in Supreme Court, Bronx County, is that right?

A. Yes, sir, that is correct.

Q. And --

MR. WINN: Your Honor, I am going to move to strike the last deposition use. I don't see that there was any inconsistency, and I don't think it should have been read.

THE COURT: Yes. Overruled. Denied.

BY MR. JOSEPH:

Q. Sir, in the Zadra case, which was before Judge Suarez in Bronx County, you also gave testimony concerning your cum at Queens College and your applications to medical school, is that right?

A. Yes, sir.

Q. Your Honor, beginning on page 75, line 21.

Doctor, let me know when you have gotten there.

A. OK.

Q. On page 75, line 21, were you asked these questions, did you give these answers?

"Q Why didn't you go to a United States medical school?

"A I never applied. I came from a very poor family. My mother was working two jobs. My father was working two jobs. They were putting my brother through medical school. I didn't have $75 in application to apply. I did not have a perfect 4.0 index.

"Q In fact, Doctor, your grades were pretty good, weren't they?

"A They weren't 4.0.

"Q How close were they?

"A 3.1, 3.2."

Were you asked those questions, did you give those answers, Doctor?

A. Yes, sir, that's what I believed to be my GP index but obviously they were lower.

Q. Doctor, you are being paid to appear in court today?

You can put that transcript down.

A. I'm sorry.

Q. Let me start the question again. You can put that down.

A. Yes, sir.

Q. You are being paid to testify in court today?
A. I am being compensated for my time for canceling my patients and being here, yes, sir, I am.
Q. What is your rate of compensation for appearing here today?
A. 3,000 for half a day of testimony, 1,000 for pretrial preparation, altogether 4,000.
Q. And, Doctor, how many times a year do you testify in court?
A. Currently, on the average currently about a dozen times, slightly more, slightly less.
Q. A dozen times a year?
A. Approximately a dozen times recently.
Q. And you have been in practice since approximately 1985?
A. I was doing my residency in 1985.
Q. OK. When did you go into private practice?
A. 1988 or '89.
Q. And since that time, have you had an active -- let me withdraw that.

Since that time, have you been testifying in court?
A. In '88, '89, very rarely. 1990, a little bit more. On the average, I testify about 10 to 12 times per year; some years more, some years less.
Q. That is for the past 15 or 16 years?
A. Yes, sir.
Q. Would it fair to say that you have testified, my math could be wrong, approximately 180 times in court, yes or no?

A. Plus or minus.
Q. Plus or minus.
And, Doctor, that is at $4,000 for each testimony and each preparation?
A. Yes, sir.
Q. So over the years, you have earned approximately $720,000 to testify in court, is that right?
A. Yes, sir.
Q. You also testify in things called Workers' Compensation hearings, is that right?
A. Yes, sir.
Q. And how many times a year do you testify for Workers' Compensation hearings?
A. Currently maybe two, three times.
Q. Per year?
A. Yes, sir.
Q. At one point in your career was it more?
A. Yes, sir.
Q. At one point in your career it was approximately eight to ten times?
A. It's possible, yes, sir.
Q. When did it curtail down to two to three times?
A. I would say in the last few years, maybe the last four, five years.
Q. So it would be fair to say that have testified in those

types of hearings approximately 120 times?
A. If the math is correct, that is what it is.
Q. Are you more comfortable with 100?
A. It doesn't matter, whatever the math is.
Q. OK. How much do you get paid for those?
A. You get paid 400. You lose almost 2, $3,000. It is a losing proposition.
Q. So it would be fair to say you've earned approximately $40,000 for those types of hearings?
A. That is about right.
Q. And you've also testified in what's called no fault hearings, is that right?
A. Yes, sir.
Q. How many times a year do you testify doing that?
A. Currently I would say about the same as the Workmen's Comp.
Q. Prior to that --
A. It was more. I would say about eight to ten times per year, plus or minus.
Q. So would it be fair to say that you've testified in at least 100 of those types of hearings?
A. I would say approximately right. It could be slightly less or slightly more.
Q. How much do you get paid for no fault?
A. It depends on the location, it depends on the time, anywhere from 1,500 to 2,000.

Q. So someplace in the ballpark of $175,000 ove your career for testifying at no fault?
A. If the math is correct, that's what it is.
Q. You've also testified in depositions over the course of your career, is that right?
A. Very, very, very few, yes, that's correct.
Q. How many?
A. I can't give you an exact number. Very, very few.
Q. Less than ten?
A. I would say less than ten.
Q. For the ones that you charged for, how much did you charge for those?
A. It depends on how much time. Typically 500 an hour for those cases. They were usually in my office.
Q. So usually about $2,000 each?
A. No, they are usually about two hours.
Q. $1,000 each?
A. And some of them I never got paid; they were done under subpoena.
Q. So about $8,000, you would say?
A. I don't know. I'm guessing.
Q. All right. I don't want you to guess.

So I just want to make sure we have this right. In total, you have testified approximately 380 times, is that right, not including depositions?

A. If the math is correct, that's what it is.

Q. And from testifying, not including depositions, you have earned almost $900,000, is that right?

A. I also lost similar, if not greater, from not seeing the patients that were canceled for those days.

Q. So you would agree with that number, 900,000, give or take?

A. If the math is correct, that is what it is.

Q. Do you disagree with the math?

A. I am not sitting here with a calculator in my brains to figure that out.

MR. WINN: He flunked calculus.

THE COURT: He didn't flunk arithmetic, but either way, it is what it is. So let's move on.

MR. JOSEPH: Thank you, your Honor.

Q. Doctor, you also give lectures to lawyers to teach them how to prove their cases, isn't that right?

A. I give lectures on anatomy and physiology. In fact, I just gave one last week at Mt. Sinai School of Medicine.

Q. You also give lectures to lawyers on how to help prove their cases, isn't that right?

A. The way you phrase the question, it is not right. I give lectures, that was one of the topics, but I've given lectures in the past about 10, 12 years ago. I talk about the medical aspects of the injury. I prove and I teach attorneys to understand the medicine because most attorneys don't understand

the medicine.

Q. Doctor, did you ever give a speech or a lecture entitled:

"Every Attorney Must attend!

"How to prove bulging and degenerative discs as serious injuries"?

A. I gave a lecture on that topic as one of the guest speakers. I spoke about 15 minutes and --

Q. Doctor, that was a yes or no.

A. Yes, I gave you the answer. Yes.

Q. And I'm going to show you what has been marked Defendant's Exhibit 6, for identification.

Do you recognize this document?

A. Wow. That is about 12, 13 years ago. How did you get this?

Q. Doctor, do you recognize --

THE COURT: The question is do you recognize this?

THE WITNESS: Yes, I recognize this.

THE COURT: Excuse me. We are going to go a lot faster if you just answer the questions and don't editorialize, let alone question the attorney about where he got something.

A. Yes, I recognize this, yes.

Q. Doctor, is this an invitation to a lecture, in which you participated, to lawyers?

A. Yes, sir, it is.

MR. JOSEPH: I move it into evidence.

MR. WINN: Can I have a voir dire, Judge?

THE COURT: Sure.

VOIR DIRE EXAMINATION

BY MR. WINN:

Q. Whatever this is, this is --

MR. JOSEPH: Exhibit 6.

Q. Exhibit 6, is this something you made?

A. No, sir.

Q. Do you know who made it?

A. Yes, sir, Dr. Bernstein.

Q. Did you have anything to do with the making of it?

A. No, sir.

Q. So somebody else made this and sent it out?

A. Yes, sir.

MR. WINN: Objection.

THE COURT: Yes, I will sustain the objection.

CROSS-EXAMINATION (Resumed)

BY MR. JOSEPH:

Q. Doctor, was Exhibit 6 an invitation to a lecture that you participated in?

A. Yes, sir.

Q. And at that lecture, you were the first billed -- the first billed doctor, isn't that right?

MR. WINN: Objection. Judge, if we have objected and it is excluded, we shouldn't be --

THE COURT: We are not going to be reading from it, but, Dr. Guy, at the time that this lecture went on, had you seen the advertising materials for it?

THE WITNESS: No, sir. No, your Honor.

THE COURT: So you weren't even aware of how it was being advertised?

THE WITNESS: No, sir.

THE COURT: The objection is sustained. Let's go on.

BY MR. JOSEPH:

Q. Doctor, did they serve hors d'oeuvres and drinks to these lawyers?

A. Yes, they were served. It was at one of these hotels, yes.

Q. And you were lecturing them on how to prove that a bulging and degenerative disc was a serious injury, isn't that correct?

A. No, sir. My topic was how to explain what a bulge protrusion herniation is and why it can be a serious injury. Not every budge is a serious injury but some can be.

Q. Now, Doctor, you told us that Mr. Hoyte suffered neck and back injuries, is that right?

A. Yes, sir.

Q. And you referred him to Dr. Rafiy, isn't that right, Doctor?

A. Yes, sir.

Q. And Dr. Rafiy is a spinal surgeon, is that right?

A. Yes, sir.

Q. Dr. Rafiy did not recommend that plaintiff have sp surgery, isn't that correct?
A. That is correct, yes, sir.
Q. And you would agree, Doctor, that pain is a subjective complaint, isn't that right?
A. To some degree, yes, sir.
Q. It is something that cannot be quantified by some sort of computer or machine, isn't that right?
A. That is correct.
Q. And, Doctor, would you agree that there is a difference between a degenerative condition and a traumatic condition?
A. Yes, sir.
Q. A traumatic condition is something which is caused by a trauma, is that right?
A. Yes, sir.
Q. And in many cases an accident can be a trauma, is that right?
A. Yes, sir.
Q. A degenerative condition is, in comparison to that, something that occurs to the body over a course of time, is that right?
A. Yes, sir.
Q. And if something is degenerative, it doesn't mean that there was trauma inducing it, isn't that right?
A. That is correct, although sometimes degenerative changes

can be caused by trauma, as you saw with the discs. Once a disc herniates from trauma, the process becomes rapidly degenerative.

Q. Doctor, that was your on model you are talking about?

A. I am talking about generally.

Q. Now, Doctor, you told us earlier today that you did not have an opportunity to review Mr. Hoyte's actual films -- excuse me, actual records from the Emergency Room, is that right?

A. Yes, sir.

Q. But now you have had an opportunity to do that?

A. Yes, sir.

Q. And in fact, they took x-rays of his neck, is that right?

A. Yes, sir.

Q. They found no fractures, is that right?

A. Yes, sir, that is correct.

Q. Now, Doctor, you told us that you and Dr. Rafiy, between the two of you, referred Mr. Hoyte for three MRIs, is that right?

A. I referred him for two. Dr. Rafiy referred him for the thoracic spine, yes, sir, that is correct.

Q. You are the person that referred him for the MRI of the cervical spine, is that correct?

A. Yes, sir.

Q. And, Doctor, the MRI of the cervical spine was taken on

May 12, 2004, is that correct?

A. Yes, sir.

Q. That is approximately, give or take, three weeks after the accident, is that right?

A. Yes, sir.

Q. And that MRI revealed that at the C3-C4 vertebra, there was broad-based posterior osteophytic ridging completely effacing the ventral portion of the thecal sac and minimally impinging upon the ventral surface of the spinal cord, is that correct?

A. Yes, sir.

Q. And let's talk about osteophytic ridging.

Osteophytic ridging means that there are osteophytes, is that right?

A. Yes, sir.

Q. What that means, Doctor, is that there are bones growing or ridges growing at the bones where they aren't normally, isn't that right?

A. That is part of the normal natural aging process.

Q. Just yes or no?

A. Yes.

Q. Doctor, would you agree that that ridging, those bony spurs, do not occur overnight, it takes a period of time for those to grow, is that right?

A. Yes, sir, that is right.

Q. And you would agree, Doctor, wouldn't you, that the three

weeks between the time of Mr. Hoyte's accident on April 19, 2004, and the May 12, 2004 MRI is not enough time for osteophytic ridging to occur?

A. That is correct.

Q. That is clearly a degenerative condition, isn't that right?

A. Yes, sir, that is correct.

Q. OK. In fact, it takes years for that to develop, isn't that right?

A. Yes, sir.

Q. And that same MRI, that cervical spine MRI of May 12th, there is indication that at C4-5, so that is the next set of vertebrae, is that right?

A. Yes, sir.

Q. At C4-5, there is a prominent broad-based osteophyte most prominent in the left paramedian location?

A. Yes, sir.

Q. Was that a finding on that MRI?

A. That is correct.

Q. Did I pronounce those words right?

A. You sure did.

Q. OK. Again, that osteophyte at C4 and C5 is something that took years to occur, is that right?

A. Yes, sir.

Q. That is not something that occurred between the accident of -- the time of the accident on April 19 and the MRI of

May 12th?

A. That is correct.

Q. OK. And, Doctor, that same MRI found that bilateral neural foraminal narrowing was present, isn't that right?

A. That is correct, yes, sir.

Q. Did I pronounce those words right?

A. You sure did.

Q. OK. Would you agree, Doctor, that bilateral neuroforaminal narrowing is also a degenerative condition?

A. It can be, yes.

Q. And that it takes more than three weeks for that condition to occur?

A. Yes, sir.

Q. OK. So that is also a degenerative condition that Mr. Hoyte had prior to the accident of April 19th, isn't that right, yes or no?

A. Yes, sir, that is correct.

Q. And, Doctor, you mentioned that the cervical MRI indicated a subacute mild compression fracture versus a contusion?

A. Yes, sir.

Q. When it says "versus a contusion," what that means is that the neuroradiologist who read the film couldn't tell whether it was a fracture or a contusion, isn't that right?

A. That is correct.

Q. And just so we understand, a contusion is a bruise, is that

right?

A. It is a blow.

Q. It is a bruise?

A. It is more than a bruise.

Q. It is not a fracture?

A. It is not a fracture.

Q. All right. And a neuroradiologist -- by the way, you referred Mr. Hoyte to that neuroradiologist, is that right?

A. I referred him to the facility, yes.

Q. Because you trusted their judgment?

A. Yes.

Q. OK. And this neuroradiologist is a specialist in reading spinal films, isn't that right?

A. Yes, sir.

Q. And he, Dr. Dorfman, didn't say that it was a fracture, he said he couldn't tell, isn't that right?

A. That's correct.

Q. And, Doctor, would it be fair to say that there is no indication on this MRI report of any marrow edema at C3 or C4, isn't that correct?

A. That is correct, yes, sir.

Q. So there is no marrow edema where this possible compression fracture is, isn't that right?

A. That is correct.

Q. And marrow edema is swelling of the marrow, is that right?

A. Yes, sir.

Q. And marrow is what is inside your bone, isn't that right?

A. That is right. That is correct.

Q. And normally, Doctor, when you have a fracture, you expect to see marrow edema if it is a fresh fracture, isn't that correct, yes or no?

A. Not always; sometimes yes, sometimes no.

Q. There is no marrow edema here, is there?

A. There is no marrow edema here.

Q. At that time, Doctor, Dr. Rafiy did not recommend doing surgery to do any sort of repair of that what you think might be a compression fracture, did he?

A. That is correct.

Q. Yes or no?

A. That is correct.

Q. In fact, there was no treatment done specifically to treat this alleged fracture, isn't that correct?

A. Yes, it is the conservative treatment, yes.

MR. WINN: I'm not sure I understand the answer.

MR. JOSEPH: Objection, your Honor.

THE COURT: Well, I take it there was an objection coming, but let's just go on.

MR. JOSEPH: Thank you.

BY MR. JOSEPH:

Q. Doctor, have you looked at the films from St.

Luke's-Roosevelt?

A. The x-rays?

Q. Yes.

A. No, sir.

Q. But the reports indicate that there were no fractures, isn't that right?

A. That is correct, yes, sir.

Q. And that was the cervical spine, isn't that right?

A. That is correct.

Q. So the x-rays reflect no fracture, is that right?

A. The x-rays, that is correct, yes, sir.

Q. And the MRIs -- and when an x-ray is taken, if it was taken well, it will show fractures of bony materials, is that right?

A. If it is not a mild compression fracture, if it is not a hairline fracture, if it is a real cortex through-and-through fracture, yes, it will show up on x-ray.

Q. Are you telling us, are you telling the jury that you cannot see a hairline fracture on an x-ray?

A. No, sir, not every single hairline fracture can be seen on x-ray. That is why we do bone scans and/or MRIs and/or CAT scans with bone windows.

Q. And, Doctor, since this May 12, 2004 MRI of the cervical spine, you have not prescribed any further x-rays of Mr. Hoyte's cervical spine, have you?

A. Yes, sir, that is correct?

Q. You have not prescribed any further MRIs of the cervical spine, isn't that right?

A. That is correct.

Q. If there had been a follow-up MRI, you might be able to tell whether that was a fracture or a contusion, isn't that right?

A. Maybe yes, maybe no.

Q. There might be nothing reflected on it at this point?

A. That is correct.

Q. You have no reason to believe that there would be anything on an MRI on that right now?

A. The treatment would be the same. There is no reason for me to repeat an MRI at this time.

Q. It could be completely healed at this time, isn't that right?

A. That is also possible.

Q. Let's talk about the MRI of the lumbar spine.

First, Doctor, the neuroradiologist Dr. Dorfman, indicated, close to the top of his report, that there were no old studies available for comparison, isn't that right?

A. Yes, sir.

Q. What he is indicating there is that it would be nice -- but, of course, none of us go for MRIs as a matter of routine course -- it would be nice to see what a prior MRI might have shown, isn't that right?

A. Yes, sir.
Q. He actually indicated that also on his report of the MRI of the cervical spine, isn't that right; fourth line from the top on page 1?
A. Yes, sir, that's correct.
Q. OK. Now, Doctor, on the lumbar spine MRI report, Dr. Dorfman indicated that the intervertebral discs demonstrate diminished signal intensity at L4-5 and L5-1 consistent with degenerative change, is that right?
A. That's correct, yes, sir.
Q. So what he is saying is that the discs at those levels, L4-5 -- can you show it to us on that spine?
A. The last two discs.
Q. All right.
A. That's L5-S1. This is L4-5.
Q. Those discs had degenerative problems at the time of the MRI on May 12, is that right?
A. Not problems.
MR. WINN: Objection to the use -- never mind, I will withdraw it.
Q. That they had degenerative changes?
A. Normal aging process degenerative changes.
Q. Yes or no, Doctor?
A. The answer is yes, based on what I said.
Q. That is on May 12?

A. Yes, sir.

Q. And those degenerative changes did not occur over the course of three weeks, between April 19 and May 12, is that right?

A. That is right.

Q. Those degenerative changes were there prior to the accident of April 19?

A. Yes, sir.

Q. And he also found that -- show us where the L1 and 2, L2 and 3 and L3 and 4 levels are.

A. This is L5-S1, L4, L3, L2, L1.

Q. He found mild posterior facet joint arthritic changes to be present, is that right?

A. Yes, sir.

Q. At all those levels?

A. Yes, sir.

Q. That all existed prior to this incident, is that right?

A. Yes, sir.

Q. He also found that there was mild facet joint arthritic changes present at L4-5, is that right?

A. Yes, sir, that is correct.

Q. And, Doctor, he found -- you talked about a herniation, a small -- what he called a small herniation at L5-S1, is that right?

A. Yes, sir, that is correct.

Q. And it was not associated with any central canal stenosis or a neural foraminal narrowing, isn't that right?
A. Yes, sir, that is correct.
Q. That is a good sign, isn't that right?
A. That's a good sign.
Q. And, again, you said that there was a mild anterior wedging compression fracture at L4, is that right?
A. Yes, sir.
Q. Again, Doctor, Dr. Dorfman doesn't mention any marrow edema at that level, does he?
A. He does not.
Q. OK. And Dr. Rafiy didn't suggest any surgery for that, did he?
A. No, sir.
Q. He didn't suggest anything other than physical therapy for that, is that right?
A. Yes, sir, that's correct.
Q. And we have no -- you've not prescribed any follow-up x-rays or MRIs of that level, is that right?
A. That is correct, no, sir, I have not.
Q. So we don't -- there is nothing indicating that there is not healing at that level at this time, isn't that correct?
A. The way you phrased the question, it cannot be answered with a yes or mow.
Q. There is no film indicating that that has not healed, is

there?

A. No film has been done so how can that question be answered?

Q. Is that correct, you have not taken any film --

A. That is correct.

Q. OK. Dr. Rafiy had the thoracic spinal MRI, is that right?

A. Yes, sir.

Q. That also showed degenerative changes throughout, isn't that right?

A. Yes, sir.

Q. That MRI showed that there are degenerative changes at the articulation of the ribs with the vertebral bodies, greater on the right than the left in the mid-thoracic region, is that right?

A. Yes, sir, that is correct.

Q. You also told us that there were tiny disc herniations at T2-3 and T3-4, is that right?

A. Yes, sir.

Q. Did you tell us that they were tiny or that is just what Dr. Dorfman told us -- actually, it is Dr. Ohlig.

A. I don't remember if I said tiny or didn't say tiny, but there are herniations at those two levels.

Q. And the neuroradiologist who specializes in reading these films called them tiny, is that right?

A. Yes, sir, he did.

Q. Actually, I think it is a she.

Is Dr. Ohlig a woman?

A. I don't know this doctor, I am not sure.

Q. And Dr. Ohlig didn't say that they were -- actually, that they were tiny disc herniations but there was a suggestion that they might be tiny disc herniations, isn't that right?

A. Yes, sir, that is correct.

Q. OK. And she said also that there was no encroachment on the neuroforamina, is that right?

A. Yes, sir, that is correct.

Q. Which means that even if there are these tiny herniations present, they are not causing a neurological deficit, isn't that right, yes or no?

A. Based on the report and the film, yes, that is correct.

Q. And she also indicated that the spinal cord maintains normal sign and signal characteristics, isn't that right?

(Pause)

On the bottom of page 1, Doctor.

A. Yes, sir.

Q. That is a good sign, right?

A. Yes.

Q. It means that there is no damage to the spinal cord at that location, doesn't it, Doctor?

MR. WINN: I can't hear the question. I'm sorry.

Q. It means that there is no damage to the spinal cord at that location, doesn't it, Doctor?

A. At that location, yes, but other locations there is.

Q. All right. Well, in her impression, Dr. Ohlig said that there are no compression deformities or marrow edema, isn't that right?

A. That is correct.

Q. She indicated that the disease at T4-T5 -- and she used the word "disease" -- was degenerative, isn't that right?

A. Degenerative disc disease is the same entity. It is not a disease. It is part of the same entity. It means --

Q. Is that a yes, Doctor?

A. I forgot your question.

Q. Doctor, she found that there was degenerative disc disease at T4-5?

A. That is correct, yes.

Q. She found that there was no cord impingement at T9-10 and T7 and 8.

A. There is encroachment at T9-T10 on the neuroforamina.

Q. Not on the cord?

A. That is correct, not on the cord, but there is one on the neuroforamina.

Q. That is a good sign when it is not on the cord, isn't that right, Doctor?

A. Yes and no, it depends.

Q. And T2-3 and T3-4, there is no cord impingement, is there?

A. That is correct.

Q. And she found that degenerative changes of the spine in the mid-thoracic region at the level of the articulation with the ribs, greater on the right than the left?
A. That is correct.
Q. And, Doctor, I believe earlier today you told us that you completed part of your postgraduate education at Mt. Sinai School of Medicine?
A. Yes, sir.
MR. JOSEPH: Your Honor, I believe we are up to 7.
THE COURT: Yes.
Q. And you did that training in 1985 through 1987?
A. That is physical medicine rehabilitation, yes, sir.
Q. Take a look at Exhibit 7, for identification, Doctor.
A. OK.
Q. Doctor, would it surprise you if the Legal Department of Mt. Sinai --
MR. WINN: Objection. Objection.
THE COURT: Yes, sustained.
Q. Doctor, Mt. Sinai has no record --
MR. WINN: Objection.
THE COURT: Sustained.
Q. Doctor, is there a record of you completing that physiatric training at Mt. Sinai?
A. If you look at the Mt. Sinai Medical Center, you will see I have. I have all the diplomas. In fact, you have them; you

subpoenaed them six years ago. You have all of that information. They are hanging in my office. If you do the right search, you will find the right search, and if you want, I will be happy to show you the diplomas.

Q. Does Mt. Sinai have a record of you attending there?

A. You apply to Mt. Sinai School of Medicine, not to Mt. Sinai Medical Center. The postgraduate training is done at Mt. Sinai Medical Center, not Mt. Sinai School of medicine. That is undergraduate. That is medical school.

You applied to the wrong entity. So obviously you got the wrong information.

THE COURT: We don't know that he has anything at all.

The question is you have said there is an appropriate record of that, and now we are going to move on to the next question.

MR. JOSEPH: Would you give me a moment, your Honor, please.

THE COURT: Yes.

(Pause)

Q. Doctor, is Mr. Hoyte's blood pressure taken every time he presents to your facility?

A. No, sir.

Q. Is it taken when he has physical therapy there?

A. No, sir.

Q. Is it taken on each of your examinations?

A. Blood pressure? No, sir. There is no reason for every single time.
Q. Did he ever advise you that he has actually been diagnosed with hypertension?
A. According to my records, no, sir.
Q. Would you have wanted to know that?
A. My blood pressure was normal. I had no history of hypertension. I'm not his primary physician; I don't need that information.
Q. Would you have wanted to know that he had been diagnosed with hypertension?
A. It has no relevance to this case.
Q. Well, Doctor, didn't you tell us earlier that severe headaches can be caused by hypertension?
A. They can be, yes, sir.
Q. And severe headaches can also be caused by neck spasms, isn't that right?
A. That is right, yes, sir.
Q. And were you aware that before this accident he had been diagnosed with suffering from tension headaches?
A. I do not know.
Q. Is that something you would have wanted to know?
A. Maybe yes, maybe no, but it still has no relevance to the overall picture of this case.
Q. Doctor, are you familiar with who his primary care

physician or physicians were at the time of your treatment?
A. If I was aware, no, sir, I was not.
Q. Have you ever conferred with Dr. William Johnson or Dr. Coads concerning Mr. Hoyte?
A. No, sir, because there was no need.
Q. Well, Doctor, yes or no, you did not rule out other possible medical causes for what you believe to be his cognitive problems, isn't that correct, yes or no?
A. The way you phrased the question, it cannot be answered with a yes or no.
Q. Doctor, did you refer him to a neurologist to rule out other possible causes, yes or no?
A. No, sir.
Q. Did you refer him to his internist or another internist to rule out other possible causes, yes or no?
A. No, sir.
Q. Doctor, you told us that on your first visit you tested Mr. Hoyte's strength, is that right?
A. Yes, sir.
Q. And I believe you said that it was a four minus out of five?
A. Yes, sir.
Q. Did I write that correctly?
A. Yes, sir, that's correct.
Q. And I believe you said that was bilateral?

A. Yes, sir, both shoulders and both lower extremities.
Q. Just so when we say "bilateral," that means both sides?
A. Yes, sir.
Q. Right and left?
A. Correct.
Q. OK. And so when you tested his right side, the only thing you could compare it to was the left side?
A. That is correct.
Q. And when you tested -- and that was for the shoulders and the lower extremities?
A. Yes, sir.
Q. OK. And did you test the individual muscles in the shoulder and upper arms?
A. Yes, sir.
Q. Did you reflect that, or did you just say upper arms and shoulders four minus over five?
A. The upper extremity, everything was normal except for both shoulders, and the entire lower extremity was four minus over five.
Q. You didn't delineate between all the muscles in the lower extremities, did you?
A. They were all four minus over five.
Q. Does it say that or does it just say lower extremities?
A. That's what it means when it says both lower extremities.
Q. Do you normally delineate between the muscles?

A. I do, and if there is any exceptions, I write it the way I wrote it in the first one. Muscle power testing was within normal limits except for both shoulders and both lower extremities.

Q. Did you use some sort of scale with weights or other device to measure his muscle strength in his shoulders?

A. To do that you don't use weights or any device other than the manual system.

Q. So you can't tell by, let's say, pounds or meters or liters what the strength is, right; this is all based upon your impression, is that correct?

A. My manual muscle power testing, yes, sir.

Q. And that's for both the upper and the lower?

A. Both shoulders and both lower extremities, yes, sir.

Q. And in part, when you do that portion of the examination, you need the full cooperation of the patient, is that right?

A. Yes.

Q. If he or she doesn't give you their best effort, you are not going to get an accurate reading, is that right?

A. The way you phrased the question, that is correct.

MR. JOSEPH: Thank you, Doctor. I have no further questions.

THE WITNESS: OK.

THE COURT: Any redirect?

MR. WINN: Yes.

REDIRECT EXAMINATION

BY MR. WINN:

Q. So if I understand the last question you were asked correctly, Doctor, it's possible that the patient could fake his strength?

A. That's the way the question was phrased, but there are ways to confirming whether he is faking it or not.

Q. Did you do it?

A. I did it and got a good response and it was still reduced. It was confirmed by MRIs and EMGs.

Q. Can he fake the results of an EMG?

A. No, sir.

Q. Can he fake the results of an MRI?

A. No, sir.

Q. Can he fake having a fracture in the lower back?

A. No, sir.

Q. Can he fake having what the doctors weren't sure was a bone contusion or a mild or small compression fracture in the neck, can he fake that?

A. No, sir.

Q. You were asked, Doctor -- if you go to the record of the hospital?

A. Yes, sir.

Q. Do you still have it in front of you?

A. I do, yes, sir.

Q. And if you go to that page with all of the computerized entries?

A. Yes, sir.

Q. You were asked whether his presenting -- I'm sorry, whether his chief complaint at 10:33 in the morning on April 19th, what they wrote down for his chief complaint, and you said what?

A. Left shoulder pain was the chief.

Q. Go down two lines and tell us what it says there.

A. "Presenting complaints: Shoulder pain, back pain, neck pain, left."

Q. You were read a note at 12:38, if you look on the right-hand side of the page?

A. Yes, sir, I see it.

Q. And at 12:38, "Return disposition," what does it say they were advising Mr. Hoyte at 12:38 in the afternoon?

A. May return to work without restrictions.

Q. What does it say at 13:09 in the afternoon, a half hour later?

A. "Medication administered, Diazepam 5 milligrams PO."

Q. Go down one more.

A. "Medication, Diazepam. Response to medication. Medication, ibuprofen. Response to treatment, feels worse."

Q. A half hour after they say he should go back to work, he felt worse; is that what they wrote down?

A. Yes, sir.

Q. Can I see the records that you actually have there, Doctor?

At the very end of this record you were asked to look at, just tell us what it says at the bottom of that page. There are a couple of boxes for checks, are there?

A. Yes. "Unable to sign. Due to possible body injury, patient unable to move."

Q. That's when they let him go?

A. That's what it states.

Q. Did the grades you had, or tell us, what did the grades you had when you were in college have to do with the injury that Mr. Hoyte had in the train wreck?

A. None whatsoever. It is a smokescreen.

THE COURT: The last remark is stricken. You will disregard it.

Q. In the --

THE COURT: I take it, Doctor -- excuse me -- that in your opinion, one's undergraduate record, would you say, does that have any reflection on one's skill as a physician?

THE WITNESS: At this point, after what I have accomplished, no, your Honor. No one asks me about my college grades and my residency.

THE COURT: I'm not asking you about anybody asking you about it, I am asking whether in your opinion undergraduate grades are reflective of skill as a physician.

THE WITNESS: In my opinion, with this type of

accomplishment, no.

THE COURT: OK.

THE WITNESS: It depends on the individual.

THE COURT: OK.

BY MR. WINN:

Q. In your opinion, Doctor, where is the top place in the New York area for evaluation of mild traumatic brain injury?

MR. JOSEPH: Objection, beyond the scope of cross.

THE COURT: No, I think I see where it is going. I will allow it.

A. NYU, Rusk Institute.

MR. WINN: That is all.

THE COURT: OK.

MR. JOSEPH: We are going to wrap up before 5.

THE COURT: Well, he only asked about four questions. There can't be a whole lot of recross based on that.

MR. JOSEPH: I think it is two issues, Judge.

THE COURT: Fair enough. Do what you can do.

MR. JOSEPH: OK.

THE COURT: I am just saying, I am confident that we will be done by 5.

RECROSS-EXAMINATION

BY MR. JOSEPH:

Q. Doctor, do you have the St. Luke's-Roosevelt ER records in front of you?

A. Yes, sir, I do.
Q. OK. You have that entire computerized triage initial assessment in front of you, is that right?
A. Yes, sir, I do.
Q. And you were asked about other complaints he had in addition to the chief complaint, is that right?
A. Yes, sir.
Q. There is no complaint indicating loss of consciousness --
MR. WINN: Objection.
Q. -- dizziness?
THE COURT: No. Overruled.
A. No, sir.
Q. All right. There is no complaint indicating lack of concentration, lack of ability to focus, is there?
A. No, sir.
Q. There is no complaint concerning any cognitive dysfunction, is there?
A. No, sir.
Q. Doctor, you were asked about what happened later in the day or later in the afternoon after I asked you about the return disposition and said may return to work without restrictions, and you were asked about how he was feeling.
And, Doctor, go to the bottom of that first page -- of that second page.
A. OK.

Q. Do you see where it says "Pain at discharge"?
A. Yes, sir.
Q. It says, "pain decreasing," isn't that right, yes or no?
A. Yes, sir.
Q. OK. And, Doctor, above that it indicates: "The patient voiced understanding of instructions. Patient reviewed written discharge instructions. Patient reviewed follow up plan of care." Is that right?
A. Yes, sir.
Q. No indication that he didn't understand any of that, is there?
A. No, sir.
Q. No indication that he expressed an inability to understand what they were talking about, is there?
A. No, sir.

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

THE COURT: OK. Dr. Guy, thank you very much. You are excused.

(Witness excused)

THE COURT: Ladies and gentlemen, that brings us to the end of the trial day. So we'll begin again tomorrow morning 9:30 a.m., the same as we did today. I appreciate your punctuality today. We'll see you tomorrow at 9:30.

Don't discuss the case among yourselves or with others overnight. I will see you tomorrow. Have a good evening.

THE CLERK: All rise.

(Jury not present)

MR. JOSEPH: 9:30, Judge?

THE COURT: 9:30 tomorrow morning.

OK. Thank you very much. Have a good evening.

(Adjourned to 9:30 a.m., Wednesday, May 24, 2006)