SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM : PART 51

JUAN CARLOS BECERRA,

Plaintiff,

- against -

LEONCIO ALMONTE-&UPIA, NASSAU RENTAL & SUPPLY CORP., TOMASZ CZERSKI and TAMANG CHHOJARA,

Defendants.

Index Num. 27259/04

Testimony of Dr. Ali Guy

360 Adams Street
Brooklyn, New York
May 31, 2006

B E F O R E :

HONORABLE GERALD S. HELD,
Justice, and a jury

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THE COURT CLERK: Sir, kindly rise and raise jury right hand, please.

A L I G U Y , M.D., a witness called on behalf of the Plaintiff, after having first been duly sworn by the Court Clerk, was examined and testified as follows:

THE COURT CLERK: What is your name?

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

THE COURT CLERK: Thank you.

THE WITNESS: You are welcome.

THE COURT: You may proceed, Counselor.

DIRECT EXAMINATION

BY MR. OGEN:

Q Good afternoon, Dr. Guy?

A Good afternoon, sir.

Q Are you a doctor duly licensed to practice medicine in the State of New York?

A Yes, I am.

Q When did you receive your license?

A 1985.

Q And can you briefly go over your educational background?

A Yes. My undergraduate, I went to Queens College,

Flushing, New York. Medical school, I graduated from the University of the Northeast, Dominican Republic, June of 1981. Thereafter, I did three residencies. My first residency was in the field of internal medicine at Mount Sinai Medical Center for a period of 18 months. Then I did one year of general surgery at Cabrini Medical Center. Then I completed a three-year residency training program at Mount Sinai Medical Center in the field of physical medicine and rehabilitation.

I was the director of the Department of Rehab Medicine at Maimonides Medical Center in Brooklyn, New York. From 1997 till 2002, approximately five years, my duties were to be in charge of all the inpatient and outpatient rehab services, provide teaching to the house staff to the orthopedic residents, to teach them once a month and prepare them for the boards under the rehab section, and to provide training in internal medicine, surgical residents, physical therapists, occupational and speech therapists.

I was in charge of the quality issuance in my department, to make sure that the level of care which was given to the patient was up to the standard of medical care. And if any doctor violated those standards, they would be disciplined.

I was the director of the neuromuscular equipment clinic at NYU Hospital for Joint Diseases from 1990 till December of 2005, that's approximately 15 years, where my duties were to see the patients assigned to the clinic. These

are patients that are born with birth defects, with spinal cord injuries, with polio with cerebral palsy, to order appropriate equipment as medically indicated, and also to provide teaching to the NYU residents that were assigned to me. Also to prepare them for the boards, part one and part two.

Currently, I'm a clinical instructor at NYU Medical Center, NYU School of Medicine. My duties are to teach the residents from the Department of physical medicine rotation, and also to prepare them for the boards, part one and part two.

I have been board certified in my field since 1989.

Q What does that mean, to be board certified?

A To be board certified means that you have obtained the highest level of recognition and/or award in your 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 at least one year of each. That was met. You then have to satisfactorily complete a three-year residency training program in the field of physical medicine and rehabilitation. You have to pass the annual exams given by the department. Score at least 70 percent or higher. You have to pass the monthly evaluation given by your preceptors.

Once you do all that, you have to sit and take your boards, part one, which is a 78 to a ten-hour examination

covering topics in orthopedics, neurology, internal medicine, muscle and nerve physiology, electrodiagnostics. And once you pass that, you then have to be in private practice at least 18 months to acquire additional knowledge and experience, be sponsored by two board certified physiatrists, preferably your former teachers. You then fly to the Mayo Clinic in Minnesota where all the research and textbooks are written, and then you take your orals. That's part two, half a day, and test on interpretation of X-rays, MRI's, EMG's, muscle and nerve physiology, orthopedics, neurology, pulmonary and cardiac rehabilitation.

And if you prove to the doctors that are examining you that your knowledge is up to par, they pass you. They review all of your records from college, from medical school, from residency. After they find everything is up to par, they pass you and give you a title of diplomate of the American Board of Physical Medicine and Rehabilitation.

That was met in May of 1989.

Q You mentioned earlier you were a clinical instructor. What are the requirements to becoming a clinical instructor?

A You have to be board certified. You have to be in good medical standing. You have to prove to the medical committee, the credentials committee that your credentials are up to par, and you have the ability to teach.

Q And are you a member of any medical associations?

A Yes, sir.

Q Which ones?

A Diplomate of the American Board of Physical Medicine and Rehabilitation; members of the New York State and New York City Medical Societies.

Q Now, tell us, please, what is the field of physical medicine and rehabilitation?

A It is a medical specialty that was founded shortly after World War II by Dr. Howard Rusk, and namely the Rusk Institute at NYU is named after this. This field deals with traumatic injuries covering the whole body, head to toe. It deals with muscle and nerve physiology. It deals with orthopedics. It deals with neurosurgery. It deals with cardiac and pulmonary rotation.

It's probably the most holistic of all the medical specialties. We are experts in disability and impairments. We are trained to examine the pain to see if the patient is disabled. Is that disability total or partial, and what the future holds for the patient, along with the future medical needs.

Also, we train in orthopedics, neurology and electrodiagnostics. That's actually checking muscle and nerve problems.

The difference between orthopedic surgery and our specialty, which is called physiatry is orthopedic surgery

concentrates more on surgical aspects of the muscles and bones system. We concentrate more on the nonsurgical aspect. How it differs from neurology is we concentrate more on peripheral neurology. Neurologists concentrate on central neurology. Central neurology is diseases such as Parkinson's disease, Lou Gehric's disease, so on and so forth. The nervous system. The nerves that come off the spine, right behind the discs. The nerves that go to the arms and legs. There's a great deal of overlap between the two specialties, and we all cross refer patients one to another.

In most teaching hospitals, all nonsurgical neck and back problems are referred to our department for diagnosis, treatment and management.

Q You mentioned that you received training in neurology and orthopedic surgery. Did you also receive training in interpreting MRI's and EMG?

A Yes, sir.

Q Can you explain what an EMG is?

A EMG is electromyography, a study done either by a physiatrist or a neurologist. It's done to see if there are any muscle or nerve problems. EMG has three components. The first three components check peripheral nerves. That's the nerves in the arms and legs. The third portion is the actual needle. EMG's check the nerve roots from the neck to the arm, or from the lower back to the legs. The way it's done is, you

place electrodes over the patient's arms. You stimulate the nerve in the wrist here and in the arm here. You study the medial nerve, the ulnar nerve, the outer portion of the nerve and right behind the elbow. You study the distal latencies. That's the time from stimulation to the response. You study amplitude, the study of a nerve. You study the conduction velocity, the speed by which it travels from one side to the next.

Nerve root damage, the first two components are almost always normal as expected. the problem is not in the peripheral nerve. The problem is in the nerve root. That is tested by inserting a sterile needle into various muscles in the forearm, the neck, legs, and the back.

You check to see if there is increased abnormality when you insert the needle. Normally, it should be quiet and discreet. When there is a lot of activity, that is called insertional activity. If it is increased, that is one criteria for abnormality. Then you look and see if there's downward deflection that looks like a "V". They are called positive sharp waves. That's another indication for abnormality. Then you have other potential for abnormality called fibrillation potential and bizarre motor unit potential.

So from these abnormal findings, you know what is wrong with the patient in terms of motor problems. Each muscle is supplied by a specific nerve root of the neck. The cervical

spine nerve roots runs from C5, C6 in the neck. The lumbar spine nerve roots run from L4, L5. Later on, I have a model that I will go into to explain what these things are.

Q Obviously you have had that training and education. Have you conducted many EMG's in your practice?

A Tens of thousands, yes.

Q And as far as interpreting MRI films, do you have training and experience in that?

A Yes, as part of our boards, we are trained and we are tested on the interpretation of MRI's.

Q What is an MRI?

A MRI stands for magnetic resonance imaging. Invented by. Dr. Demadian in 1974 to check the body protons an transform them into real life images. You check to see the difference of nerve roots in the spinal cord and the other soft tissues.

Q Does your field deal with traumatic injury, and are you considered a trauma expert?

A Yes, sir.

Q Does your field also deal with disability and impairment evaluations?

A Yes, sir.

Q And do you do such evaluations for people?

A I do. In the hospital, or also in my private practice, I do these evaluations for other doctors that don't have this training.

Q Isn't it true, because you are a trauma expert and you deal with trauma, you are called to Court from time to time to testify?

A Yes, sir. That is correct.

Q And what happens if you are called to come to court and you don't come?

A If I treated the patient, medical ethics rules dictate that I do come in and answer the questions that are posed to me.

Q Do you have an opinion as to why doctors need to be called in to testify in court on behalf of their patients?

MS. BROOKS: Objection.

THE COURT: Overruled.

A When they have conflict of opinions as to what the injuries are, and they can't resolve the dispute amicably, experts are called upon and the jurors in the legal system are called upon to make that determination.

Q Have you ever been deemed an expert in your specialty in any supreme, federal or any other courts?

A Many times. Over 150 times in my 17 years' career as a physician.

Q Have you ever been turned down as an expert in any court?

A In my field, never.

MR. OGEN: Your Honor, I would like to introduce

this doctor as an expert witness in the field of physical medicine and rehabilitation.

THE COURT: Any objection, counsel.

MS. BROOKS: No.

THE COURT: So acknowledged.

Q Doctor, do you give lectures to various people?

A Yes. I have given lectures to medical students, to residents, I give lectures to nurses, to police officers. I give lectures to attorneys once a year. I give lectures at Mount Sinai School of Medicine, along with other doctors, to attorneys that attend the continuing CLE credits for their license renewal.

Q And do you get compensated for those?

A No, sir. We are considered honored and privileged to give these lectures. Nobody charges for these lectures.

Q When you come to court do you usually testify for the injured person, or for the other side?

A I usually testify for my patient. They are usually the injured ones, and the legal system refers to them as plaintiffs. Doctors calls them patients.

Q What percentage of your practice is devoted to treating patients?

A The vast majority. I'd say 95 percent, perhaps even more.

Q And do you do any consultations for other doctors?

A I do.

Q Are you here today to render testimony both for the treatment you rendered and also expert testimony on behalf of the plaintiff?

A Yes, sir.

Q Are you being compensated for your time to come to court today?

A Yes, sir.

Q How much?

A My fee for half a day of court testimony, to cancel my patients, is 3,000 for half a day; 1,000 for pretrial preparation.

Q And did you have to cancel any appointments or reschedule, move around your schedule, to come here today?

A Yes. I had to cancel all my patients from 1:00 p.m. to 7:00 p.m.

Q Did you also have to take time to review the file?

A Yes, sir. And also to undate it as to the medicals of the case.

Q Did there come a time when you examined Juan Carlos Becerra?

A Yes, sir.

Q Can you briefly go over the history that he gave you, and the physical exam.

First of all, when was that?

A The first time I saw him was January 18, 2006.

Q And what, what was the history and your examination findings at the time?

A That he was 38 years of age. The only prior significant medical history and problems he had is he had a prior motor vehicle accident in 1996, where he had a left knee injury which required, I believe, arthroscopic surgery.

And on 6/15/2004, he was a passenger in a car which became involved in a motor vehicle accident. He injured his neck, his back, both knees. He did not go to a hospital right away. The next day he went to a local chiropractic office. He saw a Dr. Kohansieh there.

THE COURT: Hold on, please.

(At which time, there was a brief pause in the proceedings).

THE COURT: I'm sorry for the interruption, Doctor.

A Yes. He was seen by a chiropractor, Dr. Kohansieh. X-rays of the injured parts were taken. The patient had MRI's of the cervical spine taken, and of his lumbar spine, as well as both his knees.

When he saw me, he complained of neck pain, shooting down both upper extremities. He complained of lower back pain, shooting down both lower extremities. He complained of bilateral knee pain and had been unable to work since this

accident.

Q Before you go into the examination, you talked about the history. Why is the history important?

A Seventy percent of a doctor's working diagnosis comes from the history. Ten percent comes from the physical exam. That's 80 percent. The remaining 20 percent is confirmed by other diagnostic studies such as X-rays, MRI's, EMG's.

To give you two quick examples why a history is so important, and how a doctor can make a diagnosis only on history, one example, if the patient complains of chest pain, he is a male, he's over the age of fifty, second criteria, he says the pain is stabbing or crushing, until proven otherwise, that's a heart attack happening or going to happen.

You deponent examine the patient, you admit the patient to the hospital and run some tests in the hospital to see if he's having a heart attack. Because if you miss it, the patient can die.

Second example, if a patient complains of abdominal pain. First criteria, it's the right lower quadrant; second criteria, if it has lasted more than four hours, you don't have to examine the patient, you admit the patient and prove there's acute appendicitis happening, or it's going to happen. Because if you miss it, the patient can die.

So history is very very important. So if a doctor does not take a history, he's missing 70 percent of the working

diagnosis.

In this case, Mr. Becerra's case, what is important is that he had no prior problems with his neck or his back. He was not involved in any other accident except the 1996 accident where he injured only his left knee. He is involved in this accident, he injures his neck, his back and both his knees, has neck pain, which shoots down both arms, the exact --

MS. BROOKS: Excuse me. Was a question asked?

THE COURT: Overruled.

MS. BROOKS: What's the question?

THE COURT: You will have to listen if you want to know the question, Counselor. Don't ask me what the question is. Ask yourself.

I'm sorry for the interruption, Doctor.

A Yes. If the neck pain shoots down your arms, it means the origin is coming from the discs and nerves roots in the neck. That's a very, very important piece of history.

The second history is lower back pain shooting down the legs. It means the problem is coming from the discs or the nerve roots. So the history points to a traumatic event, and the patient complains of shooting pain, which is very, very important.

And now you then begin to conduct your examination and put together all the little pieces. That is done by way of MRI's, EMG's and other studies that were done.

Q And what did your examination reveal?

A I examined him next. It was tender to touch. The whole area was painful to touch. There was severe spasm. Spasm is an objective finding. It means it is not under the control of the patient. Definition of a spasm is it's a prolonged involuntary contraction of a muscle fiber, which means that has lasted for a long time, more than two or three days, and the patient has no control over it.

Normally, when you touch a muscle, it's soft to the touch. Once a muscle gets injured, it become hard. Fibers shorten. It goes into reflex protective mechanism to prevent itself from injury. As a result, the fiber is shortened. You lose range of motion.

In this case, range of motion was one/half the normal range of motion in each direction. Then the neck and back have six different ranges of motion. Flexion forward, flexion, backward; extension. Left and right lateral flexion. Left and right lateral rotation. This was one/half. And also there were multiple trigger points present.

Q What are trigger points?

A Trigger points are defined as an injury of muscle pinpoint tenderness with a palpable nodule. It's caused by trauma. Once the muscle gets injured, you get a microscopic bleed inside the muscle fibers. This leads to permanent scarring. Permanent scarring is what the trigger point is.

Muscle degeneration. Usually most commonly caused by trauma.

So we have a history pointing to an accident. We have history showing shooting pain. Now we are going to the objective findings.

We find evidence of spasm, trigger point, reduction of range of motion. These are all abnormal objective findings, where the patient has no control over it. The reason why the neck range of motion is abnormal, that's objective, is because once the patient -- I ask the patient, turn your neck to the left and right, forward and backward. Once the patient can go no further, I push to see if I can push it above and beyond, whatever is abnormal is what I call it.

That is why it is objective and not subjective. Subjective means under the patient's control to some degree; objective means there is no patient control, or minimal patient control.

Then I examined the back. It showed diffuse tenderness. It's severe spasm. Multiple trigger points. Range of motion was one/half normal. Straight leg raising was abnormal. It was 75 degrees, with lower back pain and resistance. Normally, it's 90 degrees or better.

Why this test is objective is the way it is done. The patient is laid flat on the examining table. I start where his right leg first. I put my right hand behind his ankle. I put my left hand behind his knee. With the knee completely

straight, I try to bring it up. Once I feel resistance, I stop. Not when the patient tells me there is pain. That's why it is objective. It is not under the patient's control. It's a doctor's examination finding. So on both sides, it was 75 degrees, with bilateral lower back pain.

Then I check the muscle power for both legs. It was two grades, a weakened normal.

Sensation to pin prick and right biceps, right knee tab. The right biceps, the nerves that supply power and sensation come off the thighs, offer the fifth and sixth vertebrae. And the muscle and nerve roots that go to the calf muscle, they come from the lower back between the fourth, fifth and the first sacral nerve root.

So we had the history. We have the physical exam that points to a disc problem and a nerve root problem.

Q Did you also review records?

A Yes, I also reviewed records. I reviewed the actual MRI films of the cervical spine, the actual MRI's of the lumber spine. The cervical spine showed disc herniation at C3-C4, C4-C5.

THE COURT: I'm sorry, Doctor. A little too fast. Start again.

A C4-C3 was herniated. C4-C5 was herniated. C5-C6 bulge. C6-C7, bulge. L3, will three annual L5/S1 were herniated. L1 through L3 and L4-L5 were also bulging. And

there was a right knee torn medial and lateral meniscus.

There was a left knee torn medial and lateral meniscus with a partial tear of the anterior cruciate ligament. And there was arthroscopic surgery done to both knees by Dr. Bishow.

Q We are going to need an explanation for some of that terminology. Do you want to start with the neck and back?

A First I will start with the model of the spine to show what the normal anatomy is, and then the chart to show what a disc bulge and herniation is.

Q Would these models help to explain to the jury?

A Yes, along with the two charts.

MR. OGEN: Can I show it to the doctor for identification?

THE COURT: Show it to him. It's not in evidence. It's allowed in for demonstration purposes.

A COURT OFFICER: (Handing).

THE COURT: Proceed.

Doctor, answer the question.

A In the human spine, in a human spine, we have three segments to the human spine. The neck is called the cervical spine. You are going to hear terminology called "C", C1, C2, C3, C4. "C" means cervical. C3 means the third cervical vertebra. C4 means the fourth cervical vertebra.

So if I say C3/C4, it means the space between the

third and fourth cervical vertebrae. We are going to hear about L1, L2, L3, so on and so forth. "L" means lumbar. That's the lower back.

So in the human spine, the three segments are the cervical spine, there are seven vertebrae in your neck; the mid back is known as the thoracic spine. There are 12 vertebrae in the lower back. The lumber spine. There are five vertebra. The lumber spine ends with the sacrum. What we are all sitting on. We are sitting on our sacrum.

When I say L5/S1, it means the space between the fifth lumbar and the first sacral vertebra. That's basically the boney anatomy.

Right behind the vertebrae we have a space called the spinal canal or column, where the spinal cord runs from the brain, all the way down to the lower back. It ends between L1 and L2 in the lower back and continues with branches in the nerve root called the cauda equina, which means tale of a horse. That's how the nerve roots look.

The spinal cord gives rise to nerve roots on the right and left side. Each nerve root has two branches; one for motor for movement; one for sensation. So, if I say C5/C6, that means the nerve root which is existing off the spinal cord between the fifth and sixth vertebrae that supplies the biceps.

If I say L4/L5, that's a nerve root between the four an 35 vertebra, and it supplies your calf muscles. So,

therefore, we have two abnormal conditions to a disc. The mildest is a bulge; the most severe is a disc herniation, or an extrusion. And in between, you have what is called protrusion.

I have these charts to explain to you as to what they are.

Q Doctor, before you do that, what is the purpose of discs between the bones?

A Yes. I was going to explain by these charts.

THE WITNESS: May I step down, your Honor?

THE COURT: You may.

Position yourself so all the jurors can see.

A What we are looking at is a disc in two fashions. We are looking at the disc in the side view, which is called the sagittal view. That's this view.

Then we are looking at the disc in the axial view, which you call the salami view.

Looking at it from the top down, a disc is like a jelly donut. It has two components. The outer perimeter has 100 ranges of a fibrocartilage material called an annulus fibrosis. Inside, we have a gelatinous material, which is called the nucleus pulposus. This gelatinous material is filled with water and fibrocartilage and certain water and gelatinous products.

And the function of the disc is to serve as a shock absorbers, and also allow us to move our necks and backs in

different directions. The ability to bend my back forward and backwards is because of this gelatinous material inside. If we did not have this, I would not be able to move my neck and back properly.

So, the first abnormal condition to a disc is called a bulge. When a disc begins to bulge out, in laymen's terminology, or what a bulge is, is a partial tear of the outer perimeter of the disc.

Now, unfortunately, this material in the outer perimeter, this fibrocartilage material, does not have the ability to repair itself once it is torn. You can't go back and suture this together. You can't go back and surgically glue this back together. You can't go in surgically and do anything to correct these tears. It's permanent, and it's lifetime.

The same holds true for the meniscus because that is also fibrocartilage, or cartilage material. Once a disc tears, the gelatinous material begins to leak out. This pump action of a disc is lost. The disc begins to shrivel up. The disc begins to lose its function. And as the pressure builds up behind the disc, more and more fibers tear. So a bulge is a partial tear.

Let's go to the next model, the chart, rather. The outer one/third of the disc has nerve fibers. They are all nociceptors, which come off the branch of a nerve root, which

is right behind here. Therefore, any time you have a tear in the outer one/third perimeter, it will cause pain. The definition of a herniation is a complete tear of the disc, and the disc material leaks out, passes the boundary of the disc margin.

It may or may not compress on a nerve root. It may or may not compress on a spinal cord. But once the disc is torn, there are certain chemicals that are found inside the disc that are released. These chemicals cause further irritation to the surrounding muscles, tendons and ligaments. Some of these chemicals are phostolipase, nitric oxide prostaglandins, leukotriens, bradyquinines and so on and so forth.

There are hundreds and hundreds of these inflammatory substances found inside the disc. As long as the disc is torn these chemicals will be continuously released. Once this fibrocartilage material is torn, the condition becomes progressive and permanent because you cannot cure this hip, muscle, bone. Once a bone breaks, it heals with callous formation, which is bone cement. It will never break at the same site again. But unfortunately, fibrocartilage, once it is torn, you can never repair it. That's why it's a permanent condition.

The reason it's progressive is because as the water content leaks out, the discs become shriveled up. Once a disc

becomes injured, the body tries to protect and stabilize the area. You have rapid formation of osteophytes, which begin to form. Osteophytes are those bony spurs which will form to try to fuse this area together to prevent it from further herniation and further injury. Unfortunately, as those osteophytes grow, they grow inside the neuroforamina where the nerves exist. They cut into the nerve root area and cause further nerve root impingement or compression.

The condition, again, is continuous and progressive, and it's a painful condition. The pain doesn't occur right away. It can happen anywhere from as early as two to three days, or as late as three to four weeks later because trauma, the full picture of trauma takes three to four weeks to fully manifest itself. That's why when a patient get injured with multiple injuries, you don't have all the symptoms right away. It takes time.

You wants me to show the knee while I'm here?

Q Maybe we'll see the films first. Can you look at the MRI films of the cervical and lumbar spine of the patient? If we could start with the lumber.

A Okay.

THE COURT: The shadow box is right there. You can move it if you wish, Doctor.

THE WITNESS: I could put it right up here.

THE COURT: Okay.

Q Did you want the lumber first?

A Sure.

Q Doctor, first of all, do those films identify who they are of?

A Yes. The patient's name is right on top. Juan Becerra. The date the exam was taken, July 19, 2004.

Q So about a months after the accident?

A Right. And it has the patient's date of birth. 2/12/67.

Q And that sheet of images, what is that of?

A This is an MRI of the lower back, the lumber spine.

Let me orient you. What we are looking at is the spine in this fashion. This is the front part, this part. This is the back part. That's this part. This is the disc.

Q Those white areas are the discs?

A I'm sorry. These are the vertebra. These are the discs.

THE COURT: Jurors, if you have any difficulty seeing, you can stand up and move around to your convenience.

A The white objects are the discs; okay? This is the L5/S1 disc. This is the sacrum. This is the fifth lower back vertebra.

Q Can you tell us which image that is on that sheet? What number?

A This is the middle one. One row, second row from the bottom.

Q Okay.

A What we are looking at here is a disc herniation. This is the nerve root right here. This is a piece of disc that is herniated. It's sticking out and touching the nerve root. That's L5/S1. At L4/L5 is a little disc bulge slightly sticking out. And L4/L5 this is herniation. This black line that is sticking out does not belong there. That's an abnormal disc in an abnormal location above it slightly bulging.

How do we know this disc herniation is recent? First of all, there is no osteophyte around the area. Osteophytes are these little spicules. Had this been old, preexisting, that was present for many years, you would expect to see a lot of these osteophytes. You don't see a lot of those osteophytes. And the disc has normal color. Filled with water. Normal consistency.

If the disc was worn out and old and preexisting, this would be completely black. That's how you know this isn't an old preexisting disc. The fact that it is not completely black. The fact there are no osteophytes points to a recent herniation. The history points to a recent disc herniation. The physical exam points to a recent disc herniation. So on and so forth.

Now we are looking at the salami view.

Q This is still the lumber spine?

A Still the same lumber spine.

Q Same patient, same date?

A Same patient, same date. We are looking at the disc from the top down. This is the disc. This is the nerve root. The middle picture, second row from the top points to the L3/L4. How do I know it's L3/L4? The line cuts right through it. That's your reference point. Normally there should be -- the disc margin should be clearly delineated, and the nerve root should be clearly delineated. But here there is an eclipse, like an eclipse of the moon and the sun. There's an eclipse of the disc material with the nerve root.

You see these black dots spilling over? That's the disc rupture sticking out, hitting the nerve root. That's L3/L4.

As we go down, we get to L5/S1. At this level we see a tiny level of disc herniation right in the middle. That's sticking out. So, in order to see a disc herniation, we need to look at the it three dimensionally. We use the axial view. That's this view. And the sagittal view, that's the side view.

That was the lumber spine. Now we go to the cervical spine. That's the next one. Again, it has the patient's name, Juan Becerra. Has the date it was done, June 28, 2004.

Q That's about two weeks after the accident?

A Yes, sir it has the patient's date of birth.

This is the brain. There is the spinal cord going all the way down. These are the vertebra. These are the discs. Again, this is the second vertebrae. This is the third, the fourth, the fifth.

Between the third and the fourth, you see this black dot right here? That's disc material spilling over, hitting the spinal cord. And that's C4/C5. This is disc material spilling over, touching the spinal cord. Also the normal curvature of the neck looks like a C from this angle. It's completely straight, indicating severe Muscle spasm. The history, the physical exam, the MRI.

Q What's the significance of a cervical spine being so straight within two weeks of the accident?

A Indicating it's severe muscle spasm.

Q Does that indicate a recent trauma?

A Yes, sir. And, again, there are minimal normal natural aging arthritic findings here. There is nothing out of the ordinary. You don't see any significant osteophytes like this to indicated a longstanding abnormal condition. All you see is normal, natural aging conditions which a normal 38-year-old person would have.

So this was the sagittal or side view. I am now show you the axial view.

So what we are looking at, again to reorient you, the disc is here. That's the disc. This is the spinal cord. So

this is at the level of C2/C3, which is fortunately normal. You see the normal disc. You see the normal spinal cord. Nothing is going on here.

Now, once you go down to C3/C4, you see a little bit of a disc spillover coming out, pushing the spinal cord. That's at the C3/C4 level. At the level of the C4/C5, you see this material sticking out, ruptured, touching the spinal cord again at this level. At the other levels you have a bulge. C5/C6, C6/C7, those in my opinion are not that significant. The significance is C3/C4 and the C4/C5 levels.

Q Okay. Are we finish looking at the films at this time?

A Yes.

Q Thank you.

Now, you also talk about some abnormal findings with regards to the knees?

A Yes.

Q Do you have a model of the knee that will help you explain that?

A I do.

Q Can you please explain it.

A Yes. This is a model of the knee. What we are looking at, this the femur bone. That's the long bone that goes into your hip socket. This the tibia. That's your shin bone. This, that's the fibula. That's the little bone on the

outer portion of the leg. And of course this is a patella. When I say the word "medial", medial means inner. When I say "lateral", lateral means outer.

Basically, what we are looking at here now is my knee in this capacity, this inner, medial; this lateral, the outer. This is the medial meniscus. The function of the meniscus threefold. One is to serve as a shock absorber between this bone and this bone. Two, to attach this bone to this bone. And third, the meniscus takes the synovial fluid, that's the liquid inside the joints, takes it and pushes it, swishes it around the different components in the knee to lubricate it. It's like the oil pump of your car.

If it is torn or damaged, it doesn't do its job properly. It's analogous to having a car running, which needs to run on five quarts of oil, in fact running on two quarts of oil. So what happens is the engine has a lot of nicks, a lot of wear and tear. The same thing happens here.

Once the meniscus is torn, the patella begins to shift either outer or inner. When you have a torn lateral meniscus, as well, you have weakness. You have complete instability of the patella. Once the patella -- for it to work smoothly, that's the bending, extending and fully flexing, it has a very smooth bottom, it, it begins to wear and tear abnormally.

A good analogy is your patio door in its groove with

sand inside. You try closing your patio door, and it gets jammed. Same thing happens with the patella. When the meniscus is torn, the joint is not properly lubricated, and the patella begins to grind abnormally. That's called chondromalacia. It begins to wear and tear rapidly. And the patient is left with either a torn medial collateral ligament, that's the ligament which attaches one bone to the other, this was torn, as well, and also the anterior cruciate ligament was torn. That's the ligament which attaches the muscle in the patella to your quadriceps muscle right here. That was also torn.

Q So Mr. Becerra had tears in all those structures of the knee?

A Yes, sir.

Q Do you have an opinion as to whether those injuries were causally related to the accident of June 15, 2004?

A Yes, sir, they were.

Q What is your medical opinion?

A That it was causally related.

Q On what basis?

A Based on the MRI findings, based on the arthroscopic findings and the physical exam findings.

Q You mentioned arthroscopic findings.

MR. OGEN: Your Honor, I'd like to offer into evidence the hospital records.

MS. BROOKS: Objection.

THE COURT: Now you are offering in evidence the hospital record?

MR. OGEN: These are the records from the right knee arthroscopy and the left knee arthroscopy.

THE COURT: You have an objection to this, Counsel?

MS. BROOKS: Yes, sir.

THE COURT: Why.

MS. BROOKS: Because the reports are not in evidence. The doctor who performed the surgery did not come to court to testify. So that's the basis for my objection.

THE COURT: What hospital is that?

MR. OGEN: NYU Downtown Hospital.

THE COURT: Received in evidence and marked as Plaintiff's Number 2, the NYU Downtown Hospital records.

Counselor, these will be -- bring it over to him, please.

These will be subject to redaction. You will look through, both of you together, at a later time and see if there is any redactions to be made. If there are, you will either agree upon it, or bring it to my attention, at which time I will make a ruling.

Give the officer what you are offering in

evidence.

(At which time, the item previously referred to were received and marked as Plaintiff's Exhibit 2 in Evidence).

THE COURT: Jurors, these records are now in evidence. They may be read to you or displayed to you in this courtroom. Whether they are displayed to you or read to you in this courtroom or not, when you are deliberating you can call for their production. It's evidence. It's entitled to such weight as you choose to give to it.

Everybody understand?

Yes? Good.

Proceed, counselor.

Q Did you have the opportunity to review the operative reports of the surgeries conducted on Mr. Becerra's knees?

A Yes, sir, I did.

Q And what type of surgery did he have on his -- which surgery did he have first, first of all?

A One second.

I believe he had his right knee arthroscopy first on 8/28/84.

Q 8/28 or 8/27?

A 8/27. Sorry.

Q What does that mean? What kind of surgery is that?

A An arthroscopy is a procedure where a surgery

performed with a long piece of metal that has a scissor sharpened needle. You make two or three holes inside of the knee. You stick a scope inside. At the end it has a little scope you can look and see through. It has scissors, has a pump to suck out fluids and to pump fluids inside the knee.

You look around and find the injuries, the abnormality, and you try to correct it.

With a torn meniscus what the surgeon does is find the area of the tear, and they smooth out the area that is torn. They cannot completely rectify the tear because it's permanent. All they do is smooth it out. That's what was done in the right knee.

Q Can you tell whether, in the right knee operative report, whether the findings of the MRI's were confirmed by the surgeon looking at it himself?

A Okay. I'll tell you in a second.

The MRI finding in the right knee indicated a meniscal and incapsular tear of the lateral meniscus. That was confirmed. A partial tear of the anterior cruciate ligament was suspected on the MRI. It was not confirmed on surgery.

It showed a partial tear of the medial collateral ligament and fibula collateral ligament. That was not confirmed because simply the ligaments are on the outer portion of the knee joint. So that was not seen.

And the medial meniscus and lateral meniscus tears

were found and corrected by arthroscopic surgery and meniscectomies.

Q I call your attention to the bottom of page two of the operative report.

A Okay.

Q Can you read that, the surgeon's opinion? Dr. Bishow's opinion?

MS. BROOKS: Objection.

THE COURT: Overruled.

A "It is my opinion within a reasonable degree of medical certainty that the injuries visualized and treated at the time of the surgery are consistent with the patient's mechanism of injury, complaints and physical exam caused by his motor vehicle accident, and procedures performed were medically necessary."

Q And, Doctor, do you have an opinion with a medical, with a degree of medical certainty whether you agree with that opinion?

A I do. I do agree with that opinion.

Q And why?

A It's what I've been saying all along. The history, the physical exam, the MRI's, the arthroscopic findings and the findings after the surgery.

Q Okay. And the second surgery, can you locate the operative report for that?

A Yes. That was done on October 1, 2004. It showed a torn medial and lateral meniscus and a near complete tear of the anterior cruciate ligament.

The patient underwent left knee arthroscopic surgery with partial medial and lateral meniscectomy, which means they smoothed it out. They shaved the jagged edges of the meniscus. They never professed to repair the tear because it cannot be done.

Q So, in essence are they just minimizing the damage as opposed to repairing it?

A What they are doing is shaving the jagged edges of the meniscus so the knee joint is able to function smoother, and the meniscus is able to work better as opposed to fragments being torn and getting stuck inside the socket here.

Q Is the meniscus weaker?

A The meniscus is damaged so it has lost its three basic functions.

Q And was the anterior cruciate ligament repaired in that surgery?

A No, sir, it was not. That was not the purview of that procedure. It's very difficult to correct a complete near tear of the anterior cruciate ligament by way of arthroscopy. You have to open up the knee joint. That's not what the doctor did when he went in. He only repaired the medial and lateral meniscus.

Q Would that be a separate procedure that would be necessary?

A Yes, sir.

Q I call your attention to the bottom of page two, the operative report, where it has Dr. Bishow's opinion.

Can you read that, please?

A Yes.

MS. BROOKS: Objection again.

THE COURT: Overruled.

A "It is my opinion within a reasonable degree of medical certainty that the injuries visualized and treated at the time of this surgery are consistent with the patient's mechanism of injury, complaints and the physical exam caused by this motor vehicle accident. And the procedures performed were medically necessary.

Q And, Doctor, do you agree with that opinion?

A I do.

Q For what reasons?

A For the same reasons given earlier.

Q Doctor, did you see Mr. Becerra again after January 18, 2006?

A Yes, sir.

Q When did you see him again?

A I saw him again on February 8, 2006.

Q And what did you do for him on that occasion?

A I performed an examination and an EMG of his neck and upper extremities.

Q And what were your findings on the EMG of the neck?

A It showed right-sided C5/C6 cervical radiculopathy.

Q What does that mean?

A Damage to the nerve root between the fifth an sixth vertebrae on the right side.

Q And what is the significance of having a radiculopathy at this level?

A It means that this nerve root is damaged. It's causing pain shooting down the arm, with numbness deficit in the right biceps.

Q Is that a permanent injury?

A Yes, that's a permanent injury.

Q And do you causally relate that to the accident?

A Yes, I do.

Q On what basis?

A Especially since the patient never had any prior problems with his neck, the patient had a prior EMG done shortly after this accident. That was negative. The reason it was negative in my opinion is because it was done too soon. Nerve problems sometimes take weeks to months to manifest themselves. In the first EMG done, if it is normal, the doctor has to indicate in the report if the symptoms persist a repeat study should be done six to eight weeks later from the time of

the first procedure.

Q And did you examine him again on a later date?

A I did. I examined him again on February 22, 2006, and I conducted an EMG of his lower back and legs.

Q And what were the findings of the lower EMG?

A It showed bilateral L5/S1 radiculopathy. That's the last disc where he was herniated on the MRI findings.

Q What is the significance of that?

A That the disc herniation is causing permanent nerve root damage.

Q And does that cause pain?

A Yes, sir, it does.

Q And is that a permanent injury?

A Yes, it's a permanent injury for the reasons I explained earlier.

Q And did you -- by the way did Mr. Becerra also have therapy in your facility?

A Yes.

Q For what parts of his body?

A Neck, back and his knees. He had two visits. He stopped because it wasn't really helping him, and continued with his home exercises.

MS. BROOKS: Excuse me, Doctor, can you repeat that answer?

THE COURT: I can't hear what you are saying,

counselor.

MS. BROOKS: Judge, I would like that answer to be repeated. I didn't catch the last part.

THE COURT: I'll allow it, but I ask you once again to please listen more carefully.

Read back the testimony, please.

(At which time, the Court Reporter read back the requested portion of the testimony).

Q Did you examine him more recently before coming here today?

A Yes, sir, I did.

Q When was the last time you examined him?

A On May 17, 2006. Just a few days ago.

Q What were your findings then?

A He complained of persistent neck and back pain. The right knee pain was worse than the left. On physical exam, the neck showed moderate tenderness, multiple restrictions. Range of motion was one/half of normal. The back shows diffuse tenderness. The range of motion one/half normal motion. And the right knee was diffusely tender with crepitation.

Q What does that mean, crepitation?

A That's abnormal friction sounds from the kneecap beginning to be worn abnormally inside the socket. It's the undersurface of the kneecap wearing fast and wearing out.

Q Is that because of the damage to the other structures

of the knee?

A Yes, sir.

Q And -- Okay. Go ahead.

A The muscle power of the right leg was two grades weaker than normal. And his gait, the way he walked, was antalgic; meaning he walked with a limp, using a straight cane.

Q How do you test for crepitation?

A You hear it. And you put your hand on the knee joint as you flex, extend the knee. You hear it and you feel it.

Q Someone comes to you with the symptoms that Mr. Becerra had, would you test for crepitation?

A Absolutely.

Q Now, did you come to a final diagnosis of Mr. Becerra's condition?

A Yes, sir, I did.

Q And what was that?

A Left knee, torn medial and lateral meniscus with a complete tear of the -- near complete tear of the anterior cruciate ligament with arthroscopic surgery, with a partial medial and lateral meniscectomy. Right knee, torn medial and lateral meniscus with arthroscopic surgery with a partial and medial lateral meniscectomy. Disc herniation C3/C4. Disc herniation. C4/C5. Disc bulge at C5/C6 and C6/C7.

There's a herniation at L3/L4, L5/S1. Disc bulge at L1/L2, L2/L3, L3/L4. Bilateral L5/S/1 radiculopathy. Right

sided C5/C6 cervical radiculopathy. And traumatic myofascial pain syndrome. That means damage to the muscles around the neck, mid-back, low back.

Q Do you have an opinion with a a reasonable degree of medical certainty as to whether all these injuries are causally related to the accident of June 15, 2004?

A Yes, sir, I do have an opinion.

Q What is that opinion?

A The answer is yes. They were causally related to that accident.

Q And, is it based on the reasons you told us before?

A Based on the reasons I told you before and also based on the surgeon's opinion that agrees with my opinion.

Q Now, do you expect the patient to suffer any traumatic arthritis as a result of this accident?

A Absolutely. That's sine qua non. That's the condition that occurs typically after an injury in the vicinity of a disc and a joint. As I explained, once the discs are herniated, the water content leaks out, the disc shrivels up inside. Osteophytes begin to form. The nerve root where it exits becomes more and more crowded, and the knee joint, because of the torn medial lateral meniscus, begins to wear out a lot faster than normal and traumatic arthritis in the rapid formation of the arthritic condition, which would not have happened if there was no trauma, it happens a lot faster.

Q Do you have an opinion as to the permanence of the injury?

A Yes, I do.

Q What is the opinion?

A These conditions are permanent for the reasons I gave earlier.

Q Do you have an opinion as to whether the patient will require future treatment in the future?

A Yes. The patient will require it because the condition is permanent, since there is no cure for a disc herniation or a torn meniscus. The only treatment is the patient should be seen by a doctor like myself, a physiatrist a minimum of 12 times per year, an orthopedic surgeon a minimum of four to six times per year.

Even though the therapy did not cure or alleviate all the patient's pain, he still needs thirty physical therapy sessions a year at minimum to prevent further weakness, to prevent further deterioration of this condition.

Q What is the cost of a visit to see you or an orthopedist?

A It's $100 for a follow-up visit.

MS. BROOKS: Objection.

THE COURT: Overruled.

Q How about the physical therapy?

A It's $150 for three modalities.

Q What do you mean by modalities?

A Electrical stimulation, manipulation and therapeutic exercises. That's three modalities.

Q So fifty each, about?

A Yes, $50 for each.

Q Will the patient require any repeat diagnostic studies?

A Yes. The patient will require MRI's of the neck and back, both knees, on average of once every three years. And the cost is about $900 for each MRI.

Q So he would need four MRI's?

A Yes, sir.

Q What about EMG's?

A He requires repeat EMG every three years or so to reassess the condition of the nerve root damage. And the approximate cost for EMG's is 1,500 for each one.

Q Fifteen hundred for upper; 1500 for lower?

A Yes, sir.

Q And, based on the records, you also see the patient needing another surgery on his left knee?

A Yes, sir.

Q How much would that cost?

A Anterior cruciate ligament repair is about $10,000. And afterwards, the patient will need therapy three times a week for six months.

Q Do you see the patient requiring surgery to the cervical or lumber area, as well?

A Yes. If it continues to progress as it has been, he will need surgery to his neck. There are two types of surgery to the neck: Traditional anterior cervical discectomy. They cut an incision to the front. Get exposure to the disc herniation and remove the fragments.

That cost is $30,000. Then the patient needs therapy three times a week for four to six months. If the patient chooses that prosthetic disc replacement, that cost can go up to $100,000.

In the lower back, the patient can choose the traditional lumbar laminectomy, where they go in from the back and cut a portion of lamina and get exposure to the disc and remove the portion of disc that is herniated. That is $30,000. If the patient chooses the new FDA approved prosthetic disc replacement, that cost will go up to $100,000.

Q What does removing a portion of the disc do?

A The portion that's herniated, that's causing compression on the nerve root of his spinal cord, by removing that portion of disc, the compression on the nerve root is relieved, but the disc stays torn. Over time it can still leak out again and put further compression on the nerve root. It is not a cure. It's only palliative. It means that this gives the patient some relief and removes the compression on the

nerve root.

Q Do you expect the patient to experience pain in the affected areas?

A Yes. As he has been, which is almost two years later.

Q And are these conditions subject to remission and exacerbation?

A Yes, which means they will have good days and bad days. Weather affects it. Cold weather contracts everything. Makes everything more tense. Rain, humidity, snow makes it much more tense. When the barometric pressure plunges, the muscles become more dense. So when the weather is bad, it gets worse. When the weather is nice and dry, warm weather, the condition is slightly better. Whether the patient is getting therapy and home exercises, it will be getting a little better. If the patient stands a lot, walks a lot, it obviously gets worse.

Q Now, Doctor, do you have an opinion as to whether, if the patient didn't go to the hospital on the day of the accident, instead went to the doctor the next day, does that mean that he wasn't injured in that accident?

A Absolutely not. For very good reason.

Q Why is that?

A The full inflammatory response of an injury does not even begin until 48 to 72 hours. The full picture shows itself

three weeks later. Nerve damage takes typically minimally two to three weeks to begin to manifest themselves. So it's not unusual for a patient to get injured and have little or no symptoms. Symptoms begin the second, third, fourth day so on and so forth until the third week.

Q Is it possible for the patient to complain to the doctor about one knee more than the other, even though both are injured?

A Absolutely, by the gait theory of pain. Patients don't always feel all the body injuries that hurt. They may feel one area more than the other, and they may not feel the other area is important, or they may feel it less, so they may complain to the doctor about one, two, three areas, not all of them.

Q By the way, how did you communicate with Mr. Becerra?

A I speak fluent Spanish.

Q So if the doctor didn't speak fluent Spanish, they might have trouble communicating?

A Obviously.

Q Now, is it possible for some doctors' exams to differ from other doctors exams, or, you know, even the same doctors to differ on different days?

A Absolutely. It happens all the time.

Q Why is that?

A Because, depending on which doctor examines the

patient, a doctor may be -- if a doctor is an orthopedist surgeon, he may be paying more attention to the boney problems in the joint. If the doctor is a neurologist, he may be paying more attention to the nerves and not so much to the bones. If a doctor is a physiatrist like me, I pay more attention to muscles, bones, joint range of motion and function.

Q Do different doctors have different interpretations or definitions for what a disc bulge is, or what a disc herniation is?

A Yes, sir. As of today, to this date, 2006, the American Radiological Association still does not have a perfect definition of a bulge, protrusion or herniation. In the last two or three years, they have come to a better uniform consensus as to what a bulge is or isn't, but the definition is still not a hundred percent uniform among all of them.

For example, if you show the same MRI to ten radiologists, you might get more than two or three different opinions. Happens all the time.

Q How do you know who is right, then, if you have different opinions?

A Clinical relationship. You look at the full picture: The history, the physical exam, the surgical findings. MRI findings, EMG findings, and the physical exam on multiple occasions, not just one occasion.

Q Now, when a patient has sustained these types of

injuries to the spine, to the cervical or lumbar spine, or herniations, does the patient try to conduct themselves differently? Do they do something to compensate for that?

A Yes. When a patient knows they are injured, they try to hold themselves in reflex posture to prevent themselves from being reinjured. That reflex posture causes more stiffness in the neck and back and in the knees, as well.

Q Now, Doctor, have the bills of the patient been paid to date?

A No, sir.

Q Is there a time limit for no fault to pay a patient's bills?

A Yes, sir.

MS. BROOKS: Objection.

THE COURT: Overruled.

A Three years.

THE COURT: Did you submit your bill to the no fault carrier?

THE WITNESS: Yes, your Honor.

THE COURT: That's sufficient. Move on.

Q Does no fault sometimes cut you off before three years?

MS. BROOKS: Objection.

THE COURT: Remember I told you folks that you are entitled to reimbursement for out-of-pocket expenses,

all necessary out-of-pocket expenses? And if no fault contends that you have had enough, and you disagree, you can bring a proceeding to arbitrate it to bring it to a determination? As to whether or not that is necessary here, whether it has been done, that's not before us. It's not an item for you to consider.

Q Doctor, can a doctor examine a patient who has been injured in a trauma one time for a few minutes and make a complete determination about the status of the patient?

A Generally, one time is insufficient. He would need to see the patient on one or more occasions and hopefully and preferably different time periods. Once perhaps in the summer, once perhaps in the winter, to see what the different climate conditions will do to the patient's neck, back and his knees. So one time is not really sufficient.

Q Doctor, hypothetically speaking, if a doctor were to come in here, a doctor Who examined Mr. Becerra one time, were to come in here and say that Mr. Becerra doesn't require anymore treatment in the future, doesn't need anymore surgical help, doesn't need anymore medication, doesn't need anymore injections, doesn't need anymore treatment whatsoever, would you agree with that opinion?

A I would most definitely, most strongly, respectfully disagree with the opinion for the reasons I gave earlier. A disc herniation is a permanent injury. Torn meniscus? A

permanent injury. The patient is going to have good days and bad days. The pain is going to have a flair up. The patient is going to have future need for treatment. How could a person say that?

Q You are aware that Mr. Becerra is a house painter?

A Yes, sir.

Q With whatever physical necessity that job has, do you think that he could do his job the regular way that he would do it?

A If he had these injuries as preexisting you mean?

Q Well first preexisting. If he had these injuries before, would he be able to do that job?

A No way. Because as a painter, you have to go up and down ladders. If you have a torn meniscus, bones, torn ACL, you cannot go up a ladder. You have instability. It's dangerous. Your knee will give out. It's dangerous both to you and the people hiring you. That would not be medically possible. And if he has it, he should not do it.

MR. OGEN: One moment, your Honor, please.

(At which time, there was a brief pause in the proceedings).

Q Doctor, did you review any other medical records before coming here today?

A Yes, sir. I reviewed the MRI films and the reports. I reviewed records from a doctor Kohansieh. I reviewed records

from Dr. Bishow, the operative report. I reviewed reports of Dr. Arlen Caseman. I reviewed records from Dr. Mikelis, another physiatrist. I reviewed records from neurosurgeon Dr. Richard Radna. I reviewed records from Venezuela where Mr. Becerra received physical therapy while he was there.

Q Did you see anything on any of those records where any of his treating doctors said that his condition was not causally related to the accident?

A No, sir. It was the other way around. They all agree unanimously that they were all caused by the accident. Especially Dr. Bishow when he went in with the arthroscope.

Q What are the injections you are talking about?

A Epidural injections.

MS. BROOKS: Objection, your Honor.

THE COURT: Objection is overruled. The doctor is merely defining what an epidural infection is.

What is it?

A It's an injection given by a doctor that goes directly in the spine, into the epidural space where the nerve roots are. The patient is given an injection of lidocaine and cortisone. The needle is four to six inches long. It's painful and does have risks and side effects.

Q Would a doctor administer that injection if the patient didn't have a significant injury?

A No, sir.

Q Is it painful to get that injection?

THE COURT: He just answered that question.

MS. BROOKS: Objection.

THE COURT: He just answered it.

Q Okay. What is the reason for the injection?

A To diminish pain and inflammation to the nerve roots.

Q You were mentioning the risks of the injection.

A Yes. One of the risks is it can cause paralysis; number two, infection; number three, when you are going in with that sharp needle into the membrane of the epidural space, you can get a leakage of cerebral spinal fluid, the fluid that is inside the canal. That needle can tear the membrane cover, and that fluid can leak. Can you get pounding headaches. And if that happens, the patient has to be on bedrest for seven to ten days.

In some cases it heals; in some cases it doesn't. It leads to post-traumatic arachnoiditis.

MR. OGEN: Thank you, Doctor. I have nothing further.

THE COURT: Cross-examination.

MS. BROOKS: I would like to look at the doctor's notes and take a break of four or five minutes.

THE COURT: Hand up the notes, please.

THE WITNESS: (Complying).

We'll give you a short break. Five minutes.

Please return to your jury room.

A COURT OFFICER: Jury existing.

(At which time, the jury exits the courtroom, and there was brief recess taken).

* * * *

A COURT OFFICER: All rise. Jury entering.

(At which time, the jury enters the courtroom).

THE COURT: Okay. Cross-examination, please.

CROSS-EXAMINATION

BY MS. BROOKS:

Q So, Doctor, you have seen this patient three, four times in total?

A That's about right; yes, ma'am.

Q And you are now being paid for your services in total?

THE COURT: That's immaterial.

MS. BROOKS: He testified on direct. I'm trying --

THE COURT: In addition, if you would have objected to it, I would have sustained the objection.

Let's move on.

Q Doctor, you reviewed the four MRI's in this case; is that correct?

A Yes, sir.

Q And two surgical reports?

A That's correct.
Q None of them which you performed; correct?
A That's correct.
Q And this opinion that you've made a conclusion as to the plaintiff's condition and your conclusion is based on these four MRI's and two surgeries that you did not conduct?
A No, that is not correct.
Q You are not basing your opinion on those at all?
A In part, yes. If you were listening to my explanation --
Q Yes or no.
A It cannot be answered with a yes or no.
Q If it can't be answered yes or no, that's fine.
You conducted two EMG's in this case?
A That is correct.
Q And you also reviewed an EMG that was conducted before?
A That is correct.
Q And those EMG's were normal?
A That is correct.
Q And your explanation as to that is, well, nerve damage may take several months to develop; is that right?
A That is correct.
Q The MRI that you showed the members of the jury, that MRI was conducted June 28, 2004?

A That's correct.

Q And the MRI of the cervical spine, according to the radiologist, shows nerve damage; is that right?

A One second.

THE COURT: Counsel, are you going to refer to something which is not in evidence? If you are, you are opening a door for your adversary to introduce various reports that are not in evidence at the present time and will not get into evidence unless you lay the foundation for it right now.

MS. BROOKS: I'm not laying the foundation.

THE COURT: Be careful then. It's just fair notice.

MS. BROOKS: Plaintiff directed --

THE COURT: Ask your question, please.

Q Doctor, you showed the members of the jury an MRI film?

A That is correct.

Q And you showed them nerve damage on that film?

A That is correct.

Q And that MRI film was taken approximately two weeks after the accident?

A That is correct.

Q So, the nerve damage was already done, and it showed up in the MRI two weeks later; right?

A At the level of C3/C4 and C4/C5; that is correct.

Q Okay. The EMG that was done a month after the accident of the cervical and the lumber spine showed, came up normal; isn't that right?

A For the second time, yes.

Q Okay. So, Doctor, if the MRI film that was taken two weeks after the accident shows nerve root damage, what is wrong with the EMG test that was done a month later and shows no nerve root damage to the cervical or the lumber spine? What's wrong with that report?

A I gave you that explanation earlier. If you were paying attention, you would realize --

Q Thank you, Doctor. You gave it to me earlier. Thank you.

THE COURT: Just answer the question.

A The first EMG, four weeks was probably too soon. If he had repeated that test, you would have probably found the abnormal findings. That's why an EMG must be repeated if the first one is normal, in view of persistent symptomology.

Q But the MRI showed nerve root damage; isn't that right? Two weeks after, the MRI showed nerve root damage?

A Only two levels, C3/C4, C4/C5.

Q Okay, Doctor, you did an EMG a month -- a year and a half after the accident; is that right?

A That is correct. Yes.

Q And as you sit here today, you are telling the members of this jury that the findings of the EMG was positive and that it's a direct result of this accident; is that what you are saying?

A Yes. Yes, I am, for very good reason.

Q Doctor, that's what you are saying; right?

A Yes.

Q Now, you were not present when the accident occurred; right?

A No, I was not present.

Q And, from the time the accident occurred, to the date you conducted the EMG, you don't know what has happened to the plaintiff between that period; isn't that correct?

A In part, yes, that is correct.

Q And it's possible that plaintiff could have reinjured or injured his neck between that period; isn't that right?

MR. OGEN: Objection.

THE COURT: Sustained.

Q It's possible that plaintiff could have been engaged in activities --

THE COURT: Counselor, I already sustained the objection, and you are just rephrasing the same question. Let's try to avoid that if you can, please.

Q Doctor, let's take a look at your EMG report. When an EMG is conducted, are there slides that are taken or

produced on a computer or a machine afterwards?

A Right here.

Q Okay. And that slide, that's generated by computer?

A Yes. It's not a slide. It's a printout.

Q A printout of the different waves?

A That is correct.

Q And, Doctor, on that slide --

THE COURT: Counselor, he said it's a printout, not a slide.

Q Sorry. On the printout, does the computer print out the patient's name on that slide?

A No. I put the patient's name. I write it by hand and I put the date by hand. The computer, you could type it in, but for the past twenty years, I choose to write the patient's name down and put the date myself. That's how I was taught. This is how I teach it. This is how I do it.

Q The slide, the printout that you have, it has a heading called NCV?

A That's correct.

Q And at the bottom, is there a result of that NCV?

A The result is in the second page where it says "Conclusion".

Q And was the result based on the copy that was sent to the Court? I don't have the conclusion.

A It's right here. It says right C5/C6 cervical

radiculopathy on EMG of 2/8/06. And on the EMG of 2/22/06, it says bilateral L5/S1 radiculopathy. And the tracings are attached.

Q And the conclusions are written by you?

A And typed as well. There a two reports, a handwritten report by the worksheet, and a typed report. And the tracings are attached.

Q And, Doctor, you have another handwritten chart that -- is that something you fill out, also?

A Which one are you referring to? What date?

Q The EMG of the neck dated February 8, 2006.

A That is correct.

Q And that's -- you fill in the blanks on the chart; is that right?

A Yes. That is obtained from the computer printout. It's put in here in writing, and then it goes and gets typed.

Q Okay. Doctor, are there any machines or types of EMG reports where the findings are not handwritten, but they are -- it's computer generated?

A No such report is computer generated. The doctor has to type in the conclusion. The computer does not interpret the EMG results. An MD has to interpreter the conclusion.

Q And every report that gives the conclusions is typed by the doctor?

A That is correct, yes.

Q And the conclusion is typed by the doctor, but the doctor has to read the findings that's generated by the machine; right?

A In part. The doctor has to evaluate all the computer printouts, take the history, the physical exam, and then interpret everything and write his final conclusion. That could be written by handwriting or typed in.

Q I'm not talking about the written report, just the conclusion of the tests, itself.

A Yes.

Q After you read the printout, then you handwrite the conclusion?

A I handwrite the conclusion. I also have it dictated for typing.

Q I'm not talking about that. You just handwrite the conclusion; right?

MR. OGEN: Objection.

THE COURT: Overruled.

Q You handwrite the conclusion?

A Yes.

Q After you read the printout?

A That is correct.

Q Okay. Now, on the first visit in January 18, 2006, you examined the plaintiff?

A Yes, ma'am.

Q And you conducted certain tests?
A That is correct.
Q You did the straight leg test?
A Yes, ma'am.
Q And you testified earlier that that's an objective test?
A That is correct.
Q And it's in no way subjective?
A The way it is done, the way I described it, it is an objective test, yes.
Q Okay. So the way you conducted it, there is no way the patient can control the examination or control the result. Is that what you are saying?
A If the patient does that, I would know, and it would not be a valid test.
Q So, as you demonstrated, you will have the patient raise his leg?
A No. That's not what I said. I raise it.
Q You raise the leg?
A Yes.
Q And you have one hand on the leg that's raised? You hold --
A I have two hands on the same leg that is being raised in different areas.
Q Okay. And at some point you stop raising the leg;

correct?

A Once I feel resistance.

Q Yes or no? At some point you stop raising the leg?

A Yes. That is correct.

Q And you stop raising the leg when you feel resistance?

A That is correct.

Q So you are telling me that the plaintiff cannot control the resistance? Is that what you are saying?

A I'm saying if the patient does try to control the resistance, I would know. It would not be a valid test. I would have to repeat it.

Q Doctor, if you are raising the patient's leg, at some point you have to stop because it's causing pain; right?

A Again, I don't stop when it's causing pain. I stop when I feel resistance. That's why it's not in the patient's control.

Q And, if a patience wants to stop raising his leg and creates resistance, you are saying that's impossible?

A I have my hand on both large muscle groups. I would feel contracture. I would feel contracture. It would not be. a valid test.

Q Thank you very much, Doctor.

Now, you had many patients in and out of your office; correct?

A Yes, ma'am; that is correct.
Q And you've treated patients; correct?
A I have.
Q And in this particular case you did not see this patient to treat him.
A I did. I saw him. I treated him. I gave him medical advice, and I gave him two EMG's. That's treatment.
Q EMG's a test?
A And, and based on the --
Q Yes or no? EMG, is it a test?
A Yes, and based on --
Q Doctor, yes or no? EMG, is it a test?
A Yes, that is correct.
Q And you conducted a test on February 8 and February 22; is that right?
A That is correct.
Q Did you administer therapy treatment to the patient?
A Me, myself? No. It was done under my supervision in my office.
Q Okay. And, Doctor, would you consider seeing a patient four times as treating a patient?
A Yes.
Q Are you aware of the fact that the patient's chiropractor saw him 44 times? Is that consistent with treating a patient?

A It is. He has treated the patient.

Q Yes or no? Is that consistent with treating a patient?

A Yes. Yes, it is.

Q Now, Doctor, is it your testimony that as a result of this accident that occurred two years ago, the plaintiff is still experiencing radiating pain from the neck downwards?

A Yes. That is correct.

Q And that since the accident, this condition has not changed? As a matter of fact, it has gotten worse?

A Based on my examination on 5/17/06, it's very close and similar to my examination of January 18th, 2006. I don't see any significant worsening. It's essentially the same.

Q And it has been the same since the day of the accident, or the day after the accident when you, when he first went to a chiropractor?

A With some differences in between. That is correct.

Q But basically similar?

A Similar, yes.

Q Doctor, are you aware, in fact, that there were no damages to the vehicles that were involved in this accident?

MR. OGEN: Objection.

THE COURT: Objection sustained. The jury will disregard that completely. There has been no testimony with regard to damage, whether there was or there wasn't.

It's just not part of this case.

MS. BROOKS: The plaintiff testified as to the vehicle.

THE COURT: Counsel, don't argue my rulings. Next question, please.

Q Doctor, you have made your conclusions and your recommendations based on an MRI that was conducted almost two years ago; is that right?

A That is not correct.

Q Okay. You have not based any of your conclusions on that MRI that was conducted two years ago?

A I based my conclusion on numerous factors. That is one of the many factors.

Q And that's one of them?

A Yes.

Q And Doctor, MRI's are important; aren't they?

A I'm sorry?

Q MRI's are important?

A Are reported?

Q MRI's are important?

A They can be very important, yes.

Q And when a patient comes to you and complains of pain, you can't really see the pain; isn't that right?

A No, I can't see the pain, but the --

Q Can you see the pain?

A No.

Q And when the plaintiff complained that the neck or the back or the knee is hurting, you can't see inside of the neck, back or knee; isn't that right?

Can you see inside?

A Me personally? No. Me personally, no. I'm not Superman.

Q And so, in order to treat, you have to send the patient for a test, a different type of test other than just a physical examination?

A That is correct.

Q And so, the MRI that you have reviewed was instrumental in helping you to form your conclusion?

THE COURT: Asked and answered several times several different ways. Let's move on, please.

Q Isn't it a fact that you have not sent this patient for a second MRI? Yes or no?

A To this date, I have not.

Q And you don't know whether her -- his changes, whether his condition has changed based on what an MRI would tell you?

MR. OGEN: Objection.

THE COURT: Overruled.

A That question cannot be answered with a yes or no.

Q At the time when you evaluated the patient, you

didn't have his MRI films in front of you; is that right?

A That is correct.

Q You only had the reports?

A That is correct.

Q Now, you've concluded that the plaintiff has a disc bulge; right?

A That's one of the many things this patient has.

Q Just yes or no.

A It is one of the things. It's --

Q I didn't say the only one.

THE COURT: Counselor, please, a civil tongue, Take it easy. Take a deep breath and don't argue.

Q You've concluded that the plaintiff has a disc bulge; correct?

A That is correct.

Q And that the disc bulge was caused from this car accident?

A That is correct.

Q However, you have never seen the MRI of the plaintiff's neck before this accident.

A That is correct.

Q And it's possible that the patient could have had a disc bulge before this accident?

MR. OGEN: Objection.

THE COURT: Sustained.

Q Doctor, you knew that the plaintiff was a painter for 17 years; right?

A That's correct.

Q And he paints eight hours a day sometimes. His hands -- he's standing, he's looking up. Is it possible, Doctor, that from the wear and tear of painting for 17 years that one can get a disc bulge?

MR. OGEN: Objection.

THE COURT: Objection sustained as to the form of the question.

Q Doctor, can a patient get a disc bulge from anything other than a car accident?

A You are talking about any patient, or this patient?

Q Any patient.

A Anything is possible. Nothing is impossible.

Q So, is it possible that the plaintiff has been exaggerating his --

THE COURT: Counselor.

MR. OGEN: Objection.

THE COURT: Objection sustained.

Ms. Brooks, we will save a lot of time if you do not preface your questions with "is it possible". Ask a specific question, please, if you wish. It will save a lot of time if you avoid "is it possible" as an opening phrase. Because that's objectionable.

Q Doctor, can the plaintiff get a disc bulge from regular wear and tear on the body?

MR. OGEN: Objection.

THE COURT: Overruled.

A Is it possible? Yes. Did it happen in this case? In my opinion, no for a very important reason.

Q Doctor, just yes or no.

A I believe I answered you.

Q Can a plaintiff -- can a plaintiff get a herniated disc from something else, other than a car accident?

MR. OGEN: Objection.

THE COURT: Overruled.

A If he falls 15 feet off a ladder, that's possible. If he gets hit in the back in some accident, that is possible. If he has a significant injury, that is possible. But --

Q There's no "but", Doctor. I just wanted to know what's responsive.

Doctor, can a person have a disc bulge without feeling pain?

A It's possible.

Q Now, it is your conclusion that the plaintiff has suffered torn ligaments to both knees?

A Torn meniscus to both knees.

Q To both knees?

A Yes. Yes, ma'am.

Q As a direct result of this accident?
A Yes, ma'am.
Q And Doctor, is a torn -- when a meniscus is torn, isn't that a very painful process?
A In most cases there is no pain initially.
Q There is no pain at all when it happens?
A In most cases there is no pain initially.
Q If there are two torn meniscus to one knee, there's no pain?
A I said in most cases initially there is no pain. Subsequently, eventually, that pain will come into play.
Q Is to possible for one to feel pain after a torn meniscus?
MR. OGEN: Objection.
THE COURT: Sustained. I asked you to avoid that.
Q If a person feels pain from a torn meniscus --
A Yes.
MR. OGEN: Objection.
Q Okay. The plaintiff had two surgeries to his knees as a result of this accident --
A That is correct.
Q -- approximately two months after this accident; that's correct?
And after the first surgery to the right knee, before

the plaintiff left the hospital, a pathologist reviewed the fragments, or the tissues that were taken from that knee; isn't that right?

A That is correct.

Q And as to the right knee, the pathologist found the degenerative changes in the fragments that were taken from the knee; isn't that right?

A One second. Let me first find those reports before I answer you.

MR. OGEN: Can the doctor have the hospital records that are in evidence?

MS. BROOKS: Does he have a copy of it?

THE COURT: Do you have the records that are in evidence?

MS. BROOKS: Yes.

THE COURT: If the doctor needs it, we'll hand it up to him.

A Yes, I have the result. It says --

Q I didn't ask you what it says.

A Okay.

Q Isn't it a fact that degenerative changes was seen in that pathology report?

A Yes. Once a meniscus is torn --

Q Doctor, yes or no.

A The answer is yes.

Q Can you just tell the members of the jury what is degeneration?

A Wear and tear.

Q And in the second surgery of his left knee, am I correct, Doctor, in saying that the pathologist also found degenerative changes in his left knee?

A I don't have that pathology report, but I'm not surprised, because it is common to find degeneration.

Q Doctor, yes or no?

THE COURT: He said he doesn't have it in front of him.

Q Okay. Then I will give it to you.

THE COURT: You know, Counsel, if it's in evidence, you can read it right into the record.

MS. BROOKS: I just wanted him to see if he agrees with me.

A COURT OFFICER: (Handing).

A Okay. Would you like me to read it for you?

Q No thank you, Doctor.

So, Doctor, am I correct in saying that there were degenerative changes to that left knee after the surgery that was found? The fragment?

A It doesn't say degenerative changes. It says degenerative fibrocartilage. Big difference.

Q Thank you, Doctor.

And again, as you explained to the members of the jury, degenerative means wear and tear?

THE COURT: Asked and answered. Let's move on.

Q And so now, throughout all your reports that you've reviewed of the plaintiff, nowhere in any of those reports did any doctor recommend surgery of the back or the neck; isn't that right?

A At the present time, that is correct.

Q And there was an epidural injection that was done in May of 2006?

A That is correct.

Q And that was the only injection that was given?

A That is correct.

Q And, Doctor, you are aware that the plaintiff had a left knee surgery before this accident?

A Yes, ma'am. It's right in my report.

Q And, as you told the members of the jury earlier, when you get a tear in the knee, it never heals. It doesn't get better.

A Torn meniscus. That is correct.

Q And so the plaintiff suffered a torn meniscus ten year ago, and that was never healed?

A I'm not sure exactly what was the extent of the tear or the surgery. I don't have a record to review, so I'm not exactly sure what was done for him.

Q So then, you can't tell the members of this jury that the injury to that left knee, as it is today, is a direct result of this accident. You don't know that; isn't that right?

A The ACL tear --

Q Yes or no? Do you know that?

A I do know that for the reasons I'm about to give you.

Q Thank you. And that left knee injury that he had ten years ago, did you see that in the MRI --

A I did not.

Q -- that was conducted?

A I did not.

Q Is that something that you would see in the MRI if there was a tear of any kind ten years ago?

A The way you phrase the question, it cannot be answered.

Q Yes or no? Would you see it?

A It cannot be answered with a yes or no.

Q And you didn't show that to the members -- I'm sorry. You didn't show them the MRI of the knee.

THE COURT: Counsel, ask questions only. No comments, please.

Q Doctor, you are not a radiologist, are you?

A No, ma'am.

MS. BROOKS: I have no further questions.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. OGEN:

Q Doctor, you used the reports of other doctors as part of your diagnosis?

A Yes, sir.

Q What else went into your diagnosis?

A The operative findings of Dr. Bishow. The fact that he found a torn meniscus, a medial lateral meniscus and the ACL tear. And after he went in and he saw it with the disc scope, direct visualization, not MRI, which is only image, he saw pathology directly with his eye, and he found what he saw to be causally related.

And the fact that this patient had a prior left knee surgery, but he was functional, he was able to paint eight, ten hours a day and go up and down ladders, whatever it was couldn't have been that serious of a problem because he was working his normal duties.

The ACL tear and torn lateral meniscus, d based on the overall picture, I feel it is causally related.

Q The nerve damage that you see on the MRI, is that different than the nerve damage that you found in the EMG? Is it at a different point?

A Yes, sir, it is.

Q So, in your opinion, does it make sense that it may

not have manifested itself in that area of the cervical spine -- withdrawn.

Does it make sense that the positive findings of the EMG didn't manifest themselves within two weeks of the accident?

A No. Because as I explained earlier, nerve injuries take minimum, minimum two to three weeks to begin to manifest themselves. In most cases they take longer. That's why if you do an EMG too soon, you have to repeat it. This EMG was not repeated until I did it, and I found pathology at different levels other than C3/C4, C4/C5. I found it at C5/C6.

Q Doctor, how do you know if a patient is in pain?

A I look at if there is any muscle spasm. Muscle spasm is painful. That was confirmed on my physical exam. He had trigger points. Trigger points are painful. MRI showed loss of pneumolordosis. That is painful.

Disc herniation is painful because the outer one/third of the disc has nerve fibers. When those nerve fibers become inflamed, it causes pain. And also EMG showed there was nerve damage in the neck and low back. That is painful, as well.

Q Do you need to see pain in order to know there is pain?

A No.

Q You weren't permitted to continue your answer, but

can you tell us what the significance of degenerative fibrocartilage in the left knee is?

A Yes.

Q Does that mean that the injury was degenerative?

A No. Once you have a tear of fibrocartilaginous material, it automatically, automatically becomes degenerated. It becomes partially dead. So when you put in the pathology, they look at this under the microscope. Not knowing all the details, they report it is degenerating. It didn't say degenerative or degenerative condition. It said degenerative fibrocartilaginous material, which means it was partially worn out and damaged, which is what happens when the meniscus gets torn.

Q Was that true for both knees?

A Yes, sir.

Q Are there any other responses that you didn't get to finish that the attorney asked you?

A The fact that --

MS. BROOKS: Objection, your Honor.

THE COURT: Sustained.

MR. OGEN: I have nothing further, your Honor.

MS. BROOKS: Just one last question.

THE COURT: Okay. Recross?

MS. BROOKS: Yes.

THE COURT: All right.

RECROSS EXAMINATION

BY MS. BROOKS:

Q The surgical reports that you reviewed and testified to today, Doctor, isn't it a fact that when an arthroscopic surgery is done, there are different images and pictures that are taken?

A That is up at the discretion of the surgeon. Most cases there is no picture taken. In some cases, yes. It depends on the surgeon.

Q You don't know in this case whether pictures were taken?

A I do not know.

Q And arthroscopic surgery is a pretty, a modern type of surgery?

A Yes.

Q You don't have any pictures of that surgery to show the members of the jury; right?

MR. OGEN: Objection.

THE COURT: Sustained.

MS. BROOKS: No further questions.

THE COURT: Doctor, thank you for your time.

MR. OGEN: Doctor --

One more question, your Honor.

THE COURT: Re-redirect?

MR. OGEN: Yes.

THE COURT: Okay.

MR. OGEN: If a condition is degenerative, are you more susceptible to injury in that body part?

THE WITNESS: Obviously yes.

THE COURT: Once again, thank you, Doctor. You are excused.

THE WITNESS: Thank you.

* * * *

It is hereby certified that the foregoing is a true and accurate transcript of the stenographic record.

TAMMY AGUILERA,
Senior Court Reporter

(Not certified without original signature.)