2006 WL 6644414 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Kings County

Lunel DESHOMMES and Nadille Petion, Plaintiffs,
v.
Momamed HUSSAIN and Rameshwar Ramdass, Defendants.

No. 2004-27378.
June 14, 2006.

Testimony of Plaintiffs' Expert Witness, Ali Guy, M.D.

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

Representing: Plaintiff

For the Plaintiffs: Ogen & Associates, P.C. by: Eitan Alexander Ogen, Esq. and Natalie Sedaghah, Esq.
76 Beaver Street, 2nd Floor New York, New York 10005.

For the Defendant Ramdass by: Zawacki, Everett, Gray & McIaughlin, Esqs. by: Claudia Lovas, Esq.
116 John Street New York, New York 10038.

Hon. Martin Schneier.

MR. OGEN: I call Dr. Ali Guy.

THE COURT: Stand up, please.

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

THE WITNESS: I do.

THE CLERK: Please be seated.

THE WITNESS: Thank you.

THE CLERK: State your name.

THE WITNESS: Dr. Ali. A-L-I. Last name G-U-Y.

THE CLERK: Please give us your office address.

THE WITNESS: 7 Grammercy Park, New York, New York, 10003.

THE COURT: Proceed.

Give Dr. Guy some water, please, when you have a chance.

Proceed, Counsel.

MR. OGEN: Thank you.

DIRECT EXAMINATION

BY MR. OGEN:

Q Good morning, Doctor.

A Good morning, sir.

Q Are you licensed to practice medicine in surgery in the State of New York?

A Yes, I am.

Q When did you receive your license?

A 1985.

Q Can you briefly go over your educational background?

A Yes. My undergraduate I went to Queens College in Flushing, New York. Medical school I graduated from University of Northeast. Dominican Republic in June of 1981. Thereafter I did three separate residences. I did my first residence in the field of internal medicine at Mount Sinai Medical Center for a period of 18 months. Then I did one year general surgery at Cabrini Medical Center. Then I completed a 3-year residency training program at Mount Sinai Medical Center. I was the director of the Department of Rehab Medicine at Maimonides Medical Center in Brooklyn from 199,7 to 2002, five years. My duties were to be involved and be in charge of all the inpatient and outpatient rehab services, provide teaching to the house staff, the internal medicine residence, surgical residence, orthopedic residence, physical speech and occupational therapist, provide occupation to other doctors in my hospital. I was in charge of quality insurance in my department. I was the director of neuromuscular equipment clinic at NYU Hospital for joint diseases from 1990 to December of 2005. That's 15 years, where I would see and treat patients with birth defects, with Polio, with cerebral palsy, with spinal cord injuries, and I would order whatever appropriate medical equipment that was medically indicated and I had residents assigned to me from NYU. My duties were to teach them and prepare them for the boards Part 1 and Part 2. Currently, I am the clinical instructor at NYU School of Medicine, NYU Medical Center where I work with the residents. Again, I prepare them for the boards Parts 1 and Parts 2.

THE COURT: Let's go toward.

Q Doctor, are you board certified?

A Yes, sir.

Q What area?

A Physical medicine and rehabilitation.

Q What does it mean to be board certified?

A The board certification is the highest recognition you can obtain in this particular specialty. In order to become board certified in my specialty, you have to have training in a field other than physical medicine and rehabilitation. Preferably internal medicine and/or general surgery, one year of each. That was met. You then have to complete a 3-year residency training program in physical medicine and rehabilitation. You have to pass the annual examination that is given by the department. You have to pass the monthly evaluations by your preceptors. Once you finish the training program, you sit and you take your boards Part 1, which is about an 8-hr r written examination. It covers orthopedics, neurology, basic surgery, internal medicine, muscle and nerve physiology, electro diagnosis and head trauma, other principles of physical medicine and rehabilitation. Interpretations of X-rays. CAT Scans, MRIs.

THE COURT: Let's go forward, Counsel, please.

Q Okay. What is exactly the field of physical medicine rehabilitation? How does it differ from neurology or orthopedics?

A It's medical specialty that was founded shortly after World War II by Dr. Howard Russ (phonetic). It deals with traumatic injuries to the body from head to toe. Deals with cardiac and pulmonary rehabilitation. Deals with slip and fall accidents on the job, car accidents, it deals with neurological orthopedic problems. And the difference between this specialty and orthopedic surgery is, we deal with nonsurgical orthopedics whereas the orthopedist deals with mostly surgical. Of course there are some nonsurgical as well. How it differs from neurology, neurologists concentrates more on central neurology. We concentrate more on peripheral. That is the nerve that comes off the spinal cord. The nerves to the arms and legs.

THE COURT: Let's go forward.

Q You deal with disability and impairment evaluations?

A Yes, sir.

Q Who do you do that for?

A My patients.

Q Have you ever been deemed as an expert in your specialty in any Supreme, Federal, or State courts?

A Many times.

Q Have you ever been denied status as an expert witness?

A In my specialty, never.

MR. OGEN: I offer Dr. Guy as an expert witness.

THE COURT: Any objection?

MS. LOVAS: No objection.

THE COURT: Let's go forward, Counsel, please.

Q Dr. Guy, are you here to render expert testimony regarding the treatment of one of your patients?

A Yes, sir.

Q Are you being compensated for your time?

A Yes, sir.

Q How much?

A My fee is 3,000 for half a day. 1,000 for pretrial preparation.

THE COURT: Total is $4,000?

THE WITNESS: Yes, Judge.

THE COURT: Doctor, is it true that Lunel Deshommes came under your care, correct?

THE WITNESS; Yes.

THE COURT: You have many patients, obviously.

THE WITNESS; Yes, your Honor.

THE COURT: You brought the file?

THE WITNESS: Yes, your Honor.

THE COURT: You may refer to your notes. Tell us the date, time, and place you first saw or examined, if you will, Mr. Lunel Deshommes. Sorry.

Tell us the first time of that examination. You may use your notes, obviously.

THE WITNESS: Yes, your Honor.

THE COURT; When was that?

THE WITNESS: The first time --

THE COURT: I am sorry.

THE WITNESS: The first time I saw him was November 30 --

THE COURT: November 30th?

THE WITNESS: Yes.

THE COURT: What year?

THE WITNESS: 2005.

THE COURT: Prior to that time you never saw him or examined him or anything?

THE WITNESS: No, your Honor.

THE COURT: Okay. We're on the same page. November 30, 2005. Okay.

Q Okay. At that time, did he give you a history?

A Yes, sir.

Q What was the history that he gave you?

A The history was that he was 42 years of age at the time. No prior problems with his neck, back. That on January 18th of 2004 when -- while he was driving his car, he became involved in a motor vehicle accident being hit with severe impact, hit from the front. He injured his head, neck, back. He loss consciousness temporarily. He was taken by ambulance to Jamaica Hospital where he was treated and released. He then came under the care of Dr. Rosner, chiropractor. When I saw.him first, he complained to me of neck pain shooting down both shoulders. He complained of the lower back pain shooting down the left lower extremity.

Q Did you review any records before coming here today?

A Yes, sir. The first time I reviewed the actual films and/or report of the CAT Scan of the lumbar spine that was done on 4/8/04, which revealed this disc herniation at L5 S1. Disc bulges, L3 and L4. And disc bulge at L4, L5 with spinal stenosis from L3 to S1 with central disc herniation at L5, S1 with nerve root compromise at the right S1.

Q Now, you mentioned you took the patient's history. Why is that important?

A 70 percent of a working diagnosis comes from history. 10 percent comes from physical exam -- that's 80 percent. Remaining 20 percent is confirmed by other diagnostic studies.

Q You mention patient had disc herniation. Can you tell us, first of all, what the discs are in the spine and what does it mean if they're herniated or bulging?

A I brought me some models and diagrams, which will assist me in explaining what they are.

MR. OGEN: Will the Court --

THE COURT: Yeah, sure.

A The diagrams are behind you.

THE COURT: I am sorry. Which one do you want, Doctor? Is that the one?

THE WITNESS: This one in conjunction with those two.

THE COURT: Okay.

Okay. Proceed, Doctor.

Q Doctor, please explain to us what the discs are in our spine and what it means if they're bulging or herniated?

THE COURT: Good question.

A I can do it from here or --

THE COURT: No. What?

THE WITNESS: Would you like me to do it from here?

THE COURT: Of course. You've been here before. You know that.

THE WITNESS: Okay.

A On the human spine we have three segments to the body; the neck is called the cervical spine. There, there are 7 vertebrae.

The mid back is known as thoracic spine, 12 vertebrae.

The lower back is lumbar spine, 5 vertebrae. The lower back -- the lower back ends with the tailbone which is called the sacrum, which is what we sit on.

And the cervical is abbreviated as C. So we are talking about C2, C3, C4, C5. The number 4 and 5 correlates to the fourth cervical vertebrae. C5 correlates to the fifth cervical vertebrae.

The lumbar is abbreviated L. Lumbar. So if I use the term L3, L4, it means the space between the third and fourth vertebrae. If I say L4, L5 disc, it means the disc between the fourth and fifth.

Now, in the back of the spine we have a structure called the spinous process. If you take your fingers and touch the back of your necks, this is what you're touching. This is the back portion. This is the front. Right behind. Inside the vertebrae is the spinal canal which runs from the brain all the way down to the lower back. It ends somewhere at the level of L2. It continues or branches of the nerve roots which looks like the tails of a horse. Then they are called the cauda equina. So every nerve root gives branches. All the nerves that go to your legs they originate from the nerve roots in the lower back. For example, the calf muscle is supplied by L4, L5. Some branches of S1. The nerves on top of the foot are mostly L5 and S1 nerve roots. The thigh is mostly L2, L3 and some L4, L5.

Any time you have shooting pain down the legs, it means the origin is coming from the lower back. And then we have three abnormal conditions to a disc. A normal disc looks like a jelly donut.

(Late juror enters and is seated.)

THE COURT: Have him sit over there. All right.

Now, you need the diagrams?

THE WITNESS: Yes.

THE COURT: Now, we are going to have some diagrams. We need an easel or somehow, something to hold it. What can we get to hold it? I think -- to hold it.

You can move anywhere you like. Okay.

THE WITNESS: Judge, do you have a pointer?

THE COURT: Now, we need something to point. What can we get to point? I don't know what we have to point. Okay. Very good.

A What we are looking at is a disc.

THE COURT: What. are you looking at?

A In this diagram, we are looking at a section of a disc from the side view. That's the side view. This is the sagittal view. I call it the salami or bologna view. Looking at it from top down.

A disc is analogous to jelly donuts. It has two segments. The outer portion -- the outer portion is called the annulus fibrosis. There are approximately 100 rings of this fibro cartilage material. Inside is a gelatinous material called nucleus pulposus. It is this structure that allows us to have range of motion. Bending forward. Bending backwards, Side to side. The disc functions as a shock absorber. The way it gets its nutriments and how it gets fed is by weight-bearing exercises, a pump that works inside the disc. Once the disc is torn, it's a permanent irreversible condition. You can't suture this tear back together. You cannot glue it back together. It's not like bone.

Bone, once it breaks, it heels with bone cement --

THE COURT: Doctor, is it true that the.tear in the disc is what you call a herniation?

THE WITNESS: If it's a complete tear, yes, it's called a herniation.

THE COURT: Or partial?

THE WITNESS: Would be a bulge. I was just going to get to that, Judge.

THE COURT: Okay. Go ahead.

A So, this is what a normal disc looks like. It's filled with water and it's filled with nuclear proteins inside the disc. so the first abnormal condition to a disc is called a disc bulge with a disc circumferential. The entire perimeter of a disc begins to stick out. When it sticks out, you have some tears of the fibers on the perimeter. Definition of a disc herniation is when you have a complete tear of a disc material and the disc material inside passes the boundaries of a disc. That is called a herniation.

THE COURT: When you have a herniation, Doctor, I want to review it; it's a permanent condition?

THE WITNESS: Yes, your Honor.

THE COURT: You made a good statement, you can't sew it back together.

THE WITNESS: You cannot. Not even with surgery.

THE COURT: Obviously, how will you sew it if you can't do surgery?

THE WITNESS: You can't do it.

THE COURT: You're the doctor. It's a permanent condition someone would have for the rest of his or her life?

THE WITNESS: Yes, your Honor.

THE COURT: Move forward.

A Once you have a disc herniation, this is what happens inside the disc. The outer -- the outer one third of a disc has nerve fibers called nociceptors. They come off the branch of the sinovertebral, S-I-N-O vertebral nerve which comes off a branch of this actual nerve root. When you have a tear in the outer perimeter of a disc, you interrupt its nerve fibers which causes pain. Once you have a complete tear or herniation, you have the release of these chemicals which are found inside the disc. Disc chemicals some -- most of the important ones are phosphatase A-2, nitric oxide, metalloproteinase and other inflammatory substances. So you don't always need direct compression of a nerve root for a disc herniation to cause radiculopathy, which means damage to a nerve root. Once these chemicals are released, they cause irritation to the nerve roots, tendons, the muscle, so on and so forth.

THE COURT: Irritation to the nerve root causes pain?

THE WITNESS: Yes, your Honor.

THE COURT: Go forward.

Q Doctor, you reviewed the CAT Scan films of the patient Mr. Deshommes?

A Yes.

Q And those are the same CAT Scan films that are in evidence here?

A Yes.

THE COURT: What did you reveal?

THE WITNESS: It showed a disc herniation at L5, S1. Central disc herniation causing impingement on the nerve root which is right behind it. That's what a disc herniation looks like from the side. It leaks out. What's behind it is the nerve root. You get shooting pain down the legs with pain and stiffness.

THE COURT: Go forward.

Q Did you also review, subsequently, MRI films of the patient?

A Yes, sir.

Q What were the findings of the MRI?

MS. LOVAS: Objection.

THE COURT: Objection sustained.

I am going to sustain it. We had the discussion. Sustaining it, sir. Okay.

Q Did the MRI findings confirm the CT findings?

MS. LOVAS: Objection.

THE COURT: Sustained.

Q Doctor, are you aware whether Mr. Deshommes had MRIs following his CAT Scans?

A Yes, sir.

Q Do you know why he had to have repeat MRIs?

A Yes, to see if surgery was indicated and, if so, at which level.

Q Did you review -- based on your clinical findings, which we're going to go through in a minute, based on your clinical findings and your review of records, you believe surgery is indicated for him?

A It is indicated at the present time.

Q What kind of surgery?

A Lumbar laminectomy.

Q What does at that mean?

A Lumbar means lower back. Laminectomy, they go in, they cut this portion, which is the lamina to get exposure to this disc herniation and they cut out this part that's sticking out compressing on the nerve root to decompress the pressure. There is no cure for this condition. Just taking the pressure off the nerve root so he has less pain, more function.

Q How much does this surgery cost?

MS. LOVAS: Objection.

THE COURT: Objection, please. Objection sustained. You can't tell us. Let's go forward.

MR. OGEN: Your Honor --

THE COURT: Sir, legal arguments outside the presence of the jury.

MR. OGEN: I just like to note my exception.

THE COURT: Of course. You have exception to every one of my adverse rulings. You have an automatic exception. Let's go forward.

Q What were your findings in your initial examination of Mr. Deshommes?

THE COURT: Good question.

A I examined the neck. There was diffuse tenderness. Diffuse means the whole area. It was moderate spasm.

Spasm is defined as prolong involuntary contraction of the muscle fiber. Normally when you touch, when you touch a muscle, it's soft to touch. When a muscle gets injured, it goes into a reflex protective posture to protect itself from recurring injury. That's what spasm is, it's a prolong involuntary contraction which means the patient has no control over. I also found multiple trigger points in the neck and range of motion from side to side bending was one half lateral flexion.

Definition of trigger point is an area of muscle, scarring muscle fibrosis. I brought a chart to show trigger point.

Q Would you like to use a demonstrative evidence to show that?

A Sure.

THE COURT: Just a second.

A This is a biopsy specimen of a trigger point taken from someone's human body from the microscope magnified 560 times.

What we are looking at, is normal muscle that is millions, millions of microscopic strands of muscle fibers. These black -- these black oval structures are called trigger points. They indicate muscle destruction. Muscle fibrosis. Muscle ischemia, which means lack of blood supply to the muscle fibers. Muscle is destroyed. The surrounding pain and spasm in the other areas that is what a trigger point is.

THE COURT: All right, let's move along.

Q Did you find trigger points?

A There were multiple trigger points in the neck. Then I examined the back. Again, there was tenderness. There was spasm. There was multiple trigger points in the back. Range of motion of the back in a different direction was one half normal. That's bending forward. Forward, backwards, left and right lateral bending. Left and right lateral rotation was one half normal. Straight-leg-raising was 75 degrees.

Q Before we go to that, Doctor, what causes trigger points?

A The most common cause of trigger point is trauma.

Q Go ahead, please. Continue.

A Straight-leg-raising was 75 degrees with bilateral lower back pain. Normally it's 0 to 90 degrees which is perpendicular to the floor. When it's abnormal, it indicates there is a problem in the lower back. Either from a disc herniation or from a pinch nerve or a combination of both. The way it's done, you lay the patient flat on the examining table. You grab his right foot. Your right -- your right hand goes behind the right ankle. Left goes behind his left hamstring or behind his left knee, with the knee straight, you bring it up. Once you feel resistance not just pain -- not just pain, you then stop and you record the abnormality which, in this case, was 75 degrees. Then I examined his range of motion in the lower extremities which are almost normal as expected, which was normal. Muscle power is normal. Sensation to pinprick and touch was decrease in the right biceps. This is supplied by the nerve root from the neck between the fifth and sixth vertebrae. Also the left calf, remember, left calf is mostly L4, L5 and S1 nerve root. This correlates to the problem in the lower back. Everything is correlating right now.

THE COURT: Go forward.

Q Did you examine him again?

THE COURT: When was the next time you saw him after November 30th?

A December 12, 2005.

Q What happened during that examination?

A He still had neck pain radiating to both arms, lower back, shooting down the left leg. I gave him trigger point injections.

Q What are trigger point injections?

A I draw up a syringe with 1 cc of 1 percent lidocaine, which is local anesthetic. When you go to the dentist, they give you novocaine with a 20-gauge needle. I break up the scar tissue. I go 12, three times. Three o'clock. Three times. Six o'clock. Three times. Nine o'clock, three times. I break up the scar tissue. Then by the sprouting, the neighboring muscle provides new corrective muscle fibers therefore you get rid of the pain in the surrounding spasm. That was done on that date.

Q How many trigger points on that date?

A Two. I typically give two.

THE COURT: When did you see him next time?

THE WITNESS: December 19, 2005 I gave him trigger point injections again to his back.

Q Are those painful, trigger points?

A Yes, painful.

Q Someone who doesn't have pain would want to go through that?

A No.

MS. LOVAS: Objection.

THE COURT: I will allow it.

It's a very painful procedure, isn't it?

THE WITNESS: Yes,

THE COURT: To the patient?

THE WITNESS: Yes.

THE COURT: When did you do it again?

THE WITNESS: I did it again --

THE COURT: January 18th.

THE WITNESS: January 18th. Then January 23rd.

THE COURT; I was there.

Q Please continue.

THE COURT: Doctor, is it true that it's your experience being a physician for so many years, it's a painful procedure? A patient not experiencing pain would not go through that painful procedure to go relieve such pain?

THE WITNESS: Unless they were crazy. Mr. Deshommes was not crazy.

THE COURT: When was the last time, Doctor.

THE WITNESS: 6/12/06.

THE COURT: Oh, two days ago?

THE WITNESS: Yes.

Q What happened on January 18th of '05?

A He got two more trigger point injections to his back. On January 23rd, he got two more injections to his back with Marcaine. Marcaine is a long lasting numbing agent which numbers the area for 72 hours. That's three days.

THE COURT: Okay.

Q What other treatment or testing did you do?

A I did an EMG on the patient.

Q What's an EMG, Doctor?

A EMG is a test done by a physician. It stands for electromyography. It's done to see if there is any muscle or nerve damage. The way it's done, if you're doing the back and lower extremities, you place electrodes over the different parts of the foot and ankle. You stimulate the nerve in the ankle and then you stimulate the nerve right behind the knee cap. You look for abnormal potentials. In a radiculopathy, which means damage to the nerve root in the lower back, the motor and sensory branch of EMG is almost always normal; as expected. As such was here. The needle, EMG is the test or part that checks the nerve roots. The way it's done is: I insert a long needle, this long. Sterile needle into various muscle in the legs and various muscle in the lower back. From anatomy, a physician knows what muscle is supplied by which nerve root in the lower back. In this case, when I checked his calf muscle on both sides and his lower back muscle at L5, S1, I found evidence of increase insertional activity, which means when I put the needle in, there was a lot of activity on my oscilloscope on my EMG machine and there was positive sharp waves which indicates damage to a nerve root at the LS, S1 on both sides.

THE COURT: Go forward.

Q What is the significance of those positive findings in the EMG?

A It shows disc herniation at L5, S1 is causing damage to the nerve roots on both sides.

Q By the way, the CAT Scan, is that an objective test?

A Yes, most definitely it's an objective test.

Q The board certified radiologist found radiation, does that have significance?

A Yes, it clinically correlates. It correlates with the physical -- it correlates with the physical examination findings and with the EMG findings.

Q Can you go through the findings of Dr. Freilich, the board certified radiologist who interpreted the CAT Scan?

A Yes.

Q Which you said you agreed with, correct?

A Yes. He found an exaggeration of the normal curvature of the lower back. It indicates muscle spasm.

Q What is the significance of having that two and a half months post accident?

A It indicates at that time there was still significant muscle spasm.

THE COURT: Let's go forward.

A It showed bulges at L3, L4. Bulges at L4, L5. And herniation at L5, S1. More towards the right and centrally indenting the thecal sac and the right L5 nerve root. The thecal sac is the covering of a nerve root as it comes off, begins from its actual origin. It showed us compression of the nerve root.

THE COURT: Let's go forward, Counsel, please.

Q Doctor, are you aware of whether Mr. Deshommes was evaluated by a neurosurgeon?

A Yes, sir, he was.

MS. LOVAS: Objection.

THE COURT: Overrule. I will allow it.

A Yes, he was seen by Dr. Richard Radner.

THE COURT: Just a second. You can't tell us what the doctor found. You cannot tell us what the doctor found.

Q Do you have an opinion as to whether Mr. Deshommes is going to need surgery?

A I said he is going to need surgery.

MS. LOVAS: Objection.

THE COURT: Overrule. I will allow it.

Let's move along.

Q Doctor, do you have -- first of all, is there anything else in the exam findings -- how many times did you see him?

A Approximately 12 times.

Q Okay. Any other pertinent exam findings?

A On my initial visit or subsequent visits?

Q Subsequent visits?

A Yes. I saw him on June 12th. He still has range of motion deficits. And backward bending and forward bending one half normal. Straight-leg-raising still 75 degrees. Prior to that I saw him June 7th of '06. Range of motion of his back was one half normal in each direction. Straight-leg-raising was still 75 degrees,

THE COURT: So the condition remains the same? Running about the same?

THE WITNESS: Yes.

THE COURT: Let's go forward.

Q Did you come up with a final diagnosis?

THE COURT: All right.

A Yes, sir. I did.

Q What is that?

A He has an L5, S1 disc herniation. L3, L4 disc bulge. L4, L5 disc bulge with stenosis, which means narrowing where the nerve roots exist from L3 all the way down to S1. He has bilateral L5, S1 -- bilateral L5, S1. Radiculopathy and traumatic myofacial pain syndrome, which is damage to the muscle. When you have two trigger points in two or more parts of the body, you meet the criteria for traumatic myofacial pain syndrome. It's damage to the muscle.

Q Doctor, did the patient need to have epidural injection?

A Yes. The patient had one epidural injection.

Q Why did he need one?

A Persistent pain. Radiating pain.

Q Tell us what an epidural injection is?

A Yes, it's a spinal injection. It's g??n by an anesthesiologist. You have a 6-inch long needle. You do a spinal tap. Right into the spinal canal. And you insert lidocaine and Cortizone directly into the canal to bathe the nerve roots to reduce the swelling and irritation at the nerve root level giving him some pain relief. Does it work on everybody, no.

Q What are the risks of epidural injections?

A Infection. Paralysis. And when you do a spinal tap, you tear a membrane that covers the nerve roots of the dura mater, the membrane that covers the nerve roots and the membrane that covers the spinal fluid. When you puncture it, you can get leakage of that spinal fluid that would cause severe headaches, especially when you try to stand. So if that occurs, the patient has to be on bed rest for several days until it heals.

THE COURT: Let's go forward.

Q And, Doctor, in your experience, does someone who doesn't have severe pain undergo epidural injections?

MS. LOVAS: Objection.

THE COURT: I will allow.

A No, unless they were crazy. This patient is not crazy.

Q What kind of surgery did the neurosurgeon recommend?

MS. LOVAS: Objection.

THE COURT: Sustained.

Q Dr. Guy, did you review the hospital records in 12. this matter?

A Yes, sir.

Q What did the hospital records show?

MS. LOVAS: Objection.

THE COURT: No.

MR. OGEN: I believe it's in evidence in the chiropractor's --

THE COURT: All right. From Jamaica Hospital emergency room record?

MR. OGEN: Yes, and ambulance.

THE COURT: All right. Sure.

MS. LOVAS: They are certified records?

THE COURT: It's in the records. Emergency room records is in evidence. All right.

Q Go ahead, Doctor.

A From the triage notes, the screening notes.

Q First of all, did he go by ambulance?

A Yes, sir. With a neck brace.

Q Was he immobilized?

A Yes, sir. The chief complaint was neck and hack problems when he went to the hospital. They examined him. They observed him for a little while. And once they found he was stable, they discharged him and told him to follow-up with his private medical doctor and they gave him medication; Motrin, which is painkiller. And he was discharged.

THE COURT: Let's go forward, please.

Q Okay. Doctor, do you have an opinion as to whether Mr. Deshommes' injuries are causally related to the accident of January 18th of 2004?

A Yes, sir.

Q With recent degree of medical certainty?

A Yes.

Q What is that opinion?

A They are caused by the accident of January 18th of 2004.

Q What do you base that opinion on that, Doctor?

A Based on the history. Physical exam findings. The multiple trigger points. The results of the EMG findings and reports of other doctors that have treated him. They all agree with the same opinion.

THE COURT: Anything else, Counsel? Move along.

MR. OGEN: I like the doctor to see the chiropractor's file.

THE COURT: Sure.

MS. LOVAS: Your Honor, I object to any portion of the file --

THE COURT: Just a second. Follow the Judge. Go around. Give it to him. Thank you, very much.

Q Doctor, did you review -- did the chiropractor perform any X-rays on Mr. Deshommes?

A Yes, sir.

Q Can you locate the X-ray report of the chiropractor, I believe, it's on when, you open the jacket of the folder it's right there.

A Oh, yes, it's right here. X-ray of the neck taken on January 24th of 2004 showed loss of the cervical lordosis, that is the curvature of the neck. If you look at the neck curvature it looks like a C. The fact the curvature is lost indicates there is severe muscle spasm.

THE COURT: Move along.

Q What is the significance of loss of curvature?

A The spasm. The tightness of the muscle fiber.

Q Does that indicate recent trauma --

A Yes, sir.

Q -- on the lumbar?

A It shows there was malposition at the L4, L5 level. One of the vertebrae was not properly aligned, also --

Q Is that also indicative of trauma?

A Yes, sir. Can be.

Q Did the chiropractor find any degeneration in the B spine?

A None.

Q In the X-rays?

A None.

Q Any degeneration found by you when you reviewed the CAT Scan films?

A None, whatsoever.

Q How about MRI films?

A None.

MS. LOVAS: Objection.

THE COURT: Objection sustained. That's stricken. Let's go forward.

Q Did the board certified radiologist who reviewed the CAT Scans find any degeneration in the lumbar spine of Mr. Deshommes?

A No, sir.

THE COURT: Let's go forward.

Q Did you see any osteophytes -- by the way, what are osteophytes?

A They are these bony spicules that are formed around the vertebral bodies and/or around the disc herniation. It presents -- it indicates the problem is old and long-standing. If it is not present, by opposite, it indicates the problem is probably recent and not old.

THE COURT: Go forward.

Q Was there any indication of any degenerative component to his spine?

A No, sir.

Q Would the radiologist -- board certified radiologist note that typically in a report if there was degenerative findings?

A Yes, sir.

Q Did you --- what is desiccation?

A Desiccation is shriveling up of a disc. This is normal disc. This is a shrivel up warn out disc. Once a disc tears or herniation, the water content slowly leaks out the disc begins to leak out like warn out shock absorbers.

Q Was there any evidence of desiccation in the non effected disc?

A No, sir.

Q What is the -- withdrawn.

What is the -- you told us about stenosis. What does that mean?

A It means narrowing. If you mention a word, canal -- spinal canal stenosis is the narrowing of the spinal canal. If you mention nerve root or foraminal stenosis, that's what a nerve root exists and if it's narrowed by a disc herniation, this is what it looks like.

Q What is the significance of having stenosis for him being a surgical candidate?

A Well, there is obviously a disc herniation compressing on a nerve root. That compression must be removed to give him relief of the compression of the nerve root and thereby relief of pain.

Q Doctor, do you have an opinion as to who's more qualified to render a diagnosis of a patient whether it's the doctor that has treated the patient or someone who has examined the patient one time briefly?

MS. LOVAS: Objection.

THE COURT: Objection sustained.

Q Doctor, do you have an opinion as to whether a radiologist, who's never seen a patient is more qualified to render a diagnosis than the treating doctor?

MS. LOVAS: Objection.

THE COURT: Wait a minute. Just a minute.

Is a radiologist, an expert in reading a film?

THE WITNESS: Yes.

THE COURT: Therefore, he can render an opinion based on what he sees or what she sees in reading the film.

THE WITNESS: Yes.

THE COURT: Based on your, all your years --

THE WITNESS: -- of training, yes.

THE COURT; Radiologist never sees patients?

THE WITNESS: That's correct.

Q Do different doctors differ about their opinion what is herniation and what is a bulge?

A Absolutely.

Q Has the American -- is it American Board of Radiologists --

A Right.

Q -- come up with a definition of bulges or herniation or protrusions?

A They still don't have a 100 percent concrete definition of what bulge protrusion herniation is. There is some uniform understanding what it is. That's where different radiologist differ. One call it bulge, one call it herniation. But what is important is clinical correlation what it's doing to the patient.

THE COURT: Please, let's finish up.

Q Do you have an opinion as to whether his herniation at L5, S1 is causally related to this accident?

A Yes, sir.

Q What is that opinion? What is it based on?

A Number 1, he never had prior problems with his lower back. If he did, he would not be able to sit and drive his long hours. Number 2, there was no osteophytes at the level of disc herniation. If he had disc herniation with radiculopathy, he would have known it and seek medical care and attention. He would have had MRIs and EMGs. He did not. History is very important. History, no prior problems in his back.

Q Are the injuries consistent with the mechanism of injury of high speed highway collision with a car spinning around, his head hitting the windshield, and temporary loss of consciousness?

THE WITNESS: Yes, sir.

MS. LOVAS: Objection.

THE COURT: Overruled. Let's finish up.

Q Doctor, based on your opinion --- medical opinion, is Mr. Deshommes able to do a job of driving around in a taxi for a full day or even part of a day?

MS. LOVAS: Objection.

THE WITNESS: No.

THE COURT: Overruled.

A He cannot. I know what the job involves. I drove a taxi when I was in college for three weeks. You sit 10, 12 hours, it starts to hurt. You may do it one day, half a day. You can't do it on a continuous basis.

THE COURT: Let's go forward.

Q If I told you that the radiologist hired by the defendants didn't find any degeneration in the lumbar CAT Scans either, would you agree with that?

A Of course. I also, I already said there was --

Q Is this injury permanent?

A This injury is permanent because a disc tear is permanent.

THE COURT: That's for the rest of his life?

THE WITNESS: For the rest of his life.

Q Doctor, are you familiar with the requirements for defendant doctor doing an IME or an independent exam?

A I am familiar, I done those exams myself, yes.

Q What is typically reported?

A When a doctor examines a patient independent medical basis, he has to take a history. He has to conduct physical exam. Review pertinent medical records. He then has to give diagnosis. He then has to give an opinion of the stability. Is it permanent? Partial? Or is it total? Whether or not this is causal relationship and whether or not that patient would need further treatments.

Q Why is the.diagnosis important?

A That's how you know what's wrong with the patient.

Q Okay.

THE COURT: Let's go forward, Counsel.

Q Doctor, if I were to tell you that the patient was not able to work for a period of 10 months or so, then work for a period for about a year, part time, light duty, and then again was unable to work, is that consistent with the type of injury that he had?

A Yes, sir.

Q Based on what do you say that?

A This condition is subject to good days, bad days. Medically it's called, this condition is subject to good days and bad days. That's remissions and exacerbations.

Q Based on his injuries, what kind of future treatment he is going to need?

A To be required to be seen by a doctor, which is myself, at least 12 times per year. Need at least 30 physical ??rapy sessions per year to prevent this from getting worse, to decrease his pain and spasm, and maintain his function and muscle tone.

Q You also indicated he needed the surgery?

A The back surgery, repeated EMG every two and three years.

Q Will he also need repeat diagnostic studies, MRIs CAT Scans?

A Yes. He will require repeat MRIs, lumbar spine CAT Scans every two to three years.

Q How much is an office visit?

MS. LOVAS: Objection.

THE COURT: Sustained.

Q Is Mr. Deshommes presently disabled from his occupation as a taxi driver?

A Yes, sir.

THE COURT: He said that, Counsel, come on. Now you're repeating, sir. Now you're being repetitious.

Q Are you aware whether Mr. Deshommes has training in any other field?

A He does not.

THE COURT: Let's go forward.

Q Doctor, are you aware any other doctors found him to be disabled?

MS. LOVAS: Objection.

THE COURT: Sustained. Don't answer it.

MR. OGEN: It's in evidence, your Honor.

THE COURT: The Court is going to redact that. Pull it out. It's not going to be in evidence. Let's go forward. Let's finish up.

Finish up, sir.

Q When a patient has this kind of back injury and they are aware of that injury, what is the patient tend to do or not to do?

A They are afraid or getting hurt. They always hold themselves in a tight protective reflex posture that makes more spasm.

THE COURT: Let's go forward.

Q Can Mr. Deshommes bend completely?

A He can do it, but he will pay the price.

THE COURT: Let's go forward.

MR. OGEN: I have nothing further.

THE COURT; Cross-examination.

CROSS-EXAMINATION

BY MS. LOVAS:

Q Good morning,

A Good morning, ma'am.

Q Dr. Guy, you indicated that your compensation is approximately $4,000 to testify here today, correct?

A Yes, ma'am.

Q And is that your standard fee?

A Yes, ma'am.

Q Okay. And in your professional career, how many times have you given testimony?

A I testify on the average about 10 to 12 times per year. Some years more, some years less.. I have been practicing my specialty since 1988. I say I probably testified about 150 times in my career slightly more, slightly less.

Q Have you previously been hired by plaintiff's firm to testify in these types of cases?

A I don't know what you mean by hired. Have I testified for my patients.

Q Have you testified --

THE COURT: Just a second. Have you ever testified before on behalf of patients who are represented by the plaintiff's firm?

THE WITNESS: Yes, I have.

THE COURT: How many times before, patients represented by plaintiff's, if you know?

THE WITNESS: If my memory serves me correctly about two or three times.

THE COURT: Okay. That's the question. Thank you.

Q Isn't it true that this firm has referred the plaintiff to your office?

A No, ma'am. I have a note the patient was referred by his wife.

Q Dr. Guy, upon your initial consultation and that was on November 30th of 2005, correct?

A Yes, ma'am.

Q You prepared a narrative report?

A I don't know what you mean by narrative; I call this my initial evaluation. It's not a narrative. My subsequent report is a narrative.

THE COURT: All right.

Q Is that report addressed to anyone?

A No.

Q Is it the normal course of your business not to address your reports to anybody?

A That's correct. This is my simple evaluation which I always present in this fashion. Typed up.

Q Do --

THE COURT: Let's go forward. I am sorry.

Q Do all of your subjective reports look like this?

A All of them.

Q Do they differ from your office notes?

A My office notes are handwritten.

THE COURT: Okay. Let's go forward.

Q I am just going to refer you to November 30, 2005, report?

A Okay.

MR. OGEN: Your Honor, is that report in evidence?

THE COURT: No, not in evidence.

MR. OGEN: I --

THE COURT: Are you offering that report in evidence?

MS. LOVAS: No, I am not.

MR. OGEN: I ask she not read from it.

MS. LOVAS: Just for the record, I am not reading from the report.

MR. OGEN: Your Honor, I move to introduce that into evidence.

THE COURT: Overruled.

Q Now Dr. Guy, how many times in total have you seen the patient?

A I believe I answered that question earlier about 12 times.

Q And on the date of your initial visit?

THE COURT: November 30th.

Q You testified that you conducted a thorough examination of the plaintiff, correct?

A. Yes, ma'am.

Q Upon your examination there was active range of motion for all of the extremities, correct?

A It was normal as expected. Yes, ma'am.

Q While we are talking -- when we are talking about extremities, we are talking about arms and legs; is that correct, Doctor?

A Yes, ma'am.

Q And how about muscle power testing, did you conduct that type of exam?

A Yes, ma'am.

Q What were your findings with that exam?

A It was normal.

Q How about with respect to the plaintiff's gait?

A It was normal.

Q Can you describe to the jury exactly what a normal gait is as opposed to abnormal gait?

A I think everybody knows what a normal gait is, the way you normally walk.

THE COURT: Okay.

Q Now Dr. Guy, isn't it true you did not prescribe any type of medication to Mr. Deshommes on this initial consultation?

A I give him injections. Those are medications not by mouth, but from the injection.

Q Did you prescribe any antiinflammatories?

A I did not.

Q Isn't it true that after this initial consultation you referred the plaintiff for rehabilitation therapy?

A I suggested that he should have a course of rehabilitation therapy, yes.

Q Did you know that Mr. Deshommes did not go for rehabilitation therapy?

A Yes, for a very good reason.

THE COURT: Please.

Q Now, you spoke about giving the plaintiff trigger point injections, correct?

A Yes, ma'am.

Q Isn't it true, Doctor, that the plaintiff actually expressed relief after these trigger point --

A Temporary relief as expected, yes.

Q The relief lasted at least two to three weeks; isn't that correct?

A Well, let me see. Sometimes less. Sometimes more. Typically a few days for the most part. Not weeks. A few days.

Q Now, Dr. Guy, you reviewed the notes of the chiropractor that have been admitted into evidence, correct?

A Yes, ma'am.

Q Now, isn't it true that Mr. Deshommes actually told his chiropractor that he experienced relief from these trigger point injections for two to three weeks?

A I didn't see that.

THE COURT: Assuming that's in there.

THE WITNESS: Okay.

THE COURT: The notes are the notes.

Q Dr. Guy, you have actually recommended surgery to the plaintiff, have you?

A One second. That was discussed when the EMG was done on January 4th of '06. All the diagnosis treatments different options were discussed with the patient.

Q Did you actually recommend surgery?

A That's one of the options.

Q Okay. Let me refer you to your examination of January 4th.

A Okay.

Q Isn't it true that actually you recommended surgery as a future plan should the plaintiff's injuries worsen?

A Or persist.

Q Or persist?

A Which they are.

Q But you actually haven't scheduled any type of surgery?

A I'm not the surgeon, I don't schedule.

THE COURT: Just a second.

Is it true that January 6th you told the patient that if the pains persists there's a possibility of future surgery?

THE WITNESS: Yes.

THE COURT: January 6th, at the present time any other time in your notes does it say anything about surgery in your notes?

THE WITNESS; No, your Honor.

THE COURT: See how easy.

THE WITNESS: Very easy.

THE COURT: Of course it is. It is what it is.

THE WITNESS: Yes, your Honor.

Q There are no present plans for surgery; isn't that correct?

A To my knowledge. No.

THE COURT: Thank you, very much.

Q Dr. Guy, you just testified and told the jury about the straight leg range of motion test that you conducted on the plaintiff?

A Yes.

Q Now, isn't it possible that this restriction of range o -notion could be caused by something other than trauma?

A To my knowledge no, because it's caused by the disc herniation and the pinch nerve which are caused by this trauma.

Q. Now, herniations, is there a possibility that herniation may be caused by something other than trauma?

A In this patient or other patients?

Q In general?

A In general, anything is possible.

MR. OGEN: Objection.

THE COURT: Overruled.

A Anything is possible.

Q Dr. Guy, isn't it true that the general population, about 40 percent of the general population within the age range of the plaintiff walk around with herniations that are asymptomatic?

A Absolutely not correct.

THE COURT: Okay.

Anything else?

MS. LOVAS: No.

THE COURT: Any redirect?

MR. OGEN: Yes.

THE COURT: Let's hurry up. Please. Don't be repetitious.

REDIRECT EXAMINATION

BY MR. OGEN:

Q Doctor, isn't it true that you come to court because often times your patients have been trauma victims and are engaged in law suits and you're called to court?

A Yes, sir.

Q What happens if you're called to come to testify to court and don't come?

A I could be punished by the medical boards.

Q So you have to come?

A You have to come, yes.

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

A To give their expert testimony as to their opinion of the injuries and their future prognosis and future medical needs.

Q Okay. Do you have an opinion as to why the patient didn't go to therapy after he saw you?

A Yes. Financial reasons.

THE COURT: Okay. That's an answer. Financial reasons.

Q Now, you stated earlier that if the pain persists, surgery would be indicated. Did his pain persist?

A Yes, sir, it did.

Q And did you also review the records of the neurosurgeon that also recommended surgery?

MS. LOVAS: Objection.

THE COURT: Sustained. Stricken.

Jury is instructed to disregard the statement. Statements by lawyers is not evidence, it's what the lawyer ask and plus the answer. Don't assume anything by the mere asking of a question. Objection sustained.

Q Doctor, did you recommend the patient go see a neurosurgeon?

A Yes, sir.

Q Did he, in fact, go see a neurosurgeon?

A Yes, sir.

THE COURT: Okay. Anything else, Counsel, finish up.

Q You mentioned earlier he might -- he would need a laminectomy?

A Yes, sir.

Q Is there another type of surgery that he could opt for?

A Yes, the new FDA approved prosthetic disc replacement.

Q How does that differ?

A Well, it's a procedure. It would change the whole entire disc. They give you an artificial disc.

Q Is that a more involved surgery?

A Yes.

Q Does it cost a lot more money?

A A lot more money, yes.

THE COURT: Anything else, Counsel, finish up.

Q Why did you recommend him to a neurosurgeon?

A Because his pain was not responding to continued conservative treatment.

Q Did you also show him home exercises?

A Yes, sir.

Q What kind of exercises?

A Exercises for his back. How to do, exercises to build up muscle power to his abdominals.

THE COURT: Counsel.

Q Do you have an opinion as to whether Mr. Deshommes needs the surgery now?

THE COURT: Objection sustained. Don't answer that question, sir.

Q What are --

THE COURT: Yes or no, Doctor, on your June 12th examination notes is there any where written regarding surgery on the June 12th notes?

THE WITNESS: No, your Honor.

THE COURT: Okay, let's finish up. I'm not going to allow anymore.

Q What are the risks of that FDA surgery?

A Well, there is paralysis. Infection. Failure and complications to disc above and below.

Q Are those the same risks with the laminectomy?

A *Yes,* but they're more.

THE COURT: Finish up.

Any questions? Thank you, very much for joining us. Okay.

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