SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM: PART 66

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NATHALIE GONZALEZ and PATRICIA RUIZ,

Plaintiffs,

-v-

Index No.
500161/2015

SCHOOL BUS BY SUPERIOR INC. and NORMAN BREWER,

-TRIAL-
(Excerpt)

Defendants.

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360 Adams Street
Brooklyn, New York

May 29, 2018

B E F O R E:

HON. RICHARD VELASQUEZ, Justice of the Supreme Court
Kings County

A P P E A R A N C E S:

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ALSO PRESENT: Nicole Brown (paralegal)

JEAN DEBIASE, RPR
SENIOR COURT REPORTER

- Proceedings -

THE COURT: Before we proceed, I understand we have a couple more motions on the floor today.

MR. WHALEN: I submitted one more, Your Honor.

THE COURT: Let's begin.

Did you submit a motion as well, Counsel?

MR. FORDE: Yes, Judge. We received, I think, Thursday night, we got in an economist report and I had emailed a motion in limine with regard to the economist report.

THE COURT: Why don't we start with that.

Begin.

MR. FORDE: Yes. I believe his name is Freifelder. We received Thursday, basically, a 3101(d) just identifying an economist, Dr. Freifelder. There was nothing attached to it other than the 3101(d). There was no analysis or report or anything other than a statement that he was going to be testifying, I suppose, in opposition to life care plans that we submitted but nothing more than that.

THE COURT: And when did you receive the 3101(d) report?

MR. FORDE: We received the 3101(d) by email Thursday at about 6:00 after we finished with the first day of testimony.

- Proceedings -

THE COURT: Counselor.

MR. WHALEN: Judge, we're submitting Dr. Freifelder. He's contemplated if they call an economist and what he testifies to.

THE COURT: All right.

Anything further, Counselor?

MR. FORDE: No, Judge.

THE COURT: What's the next motion on the floor?

MR. WHALEN: I know we have a few pending, Judge, but --

THE COURT: Anything new?

MR. WHALEN: The new one is to preclude testimony and it's kind of identical to the one on Dr. Ali Guy, Dr. Struhl from testifying to a number of things and this would apply to Dr. Ali Guy which is pending also. Dr. Struhl, in his report, reports that he had reviewed, specifically, x-ray and CAT scan narratives, and if he's not reviewed the films himself, he should not be allowed to rely on the radiologist's narratives in accordance with Wagman. The narrative is of the radiologist and he can't be reciting that narrative that's in opposition to the Wagman case. I say the same applies for Dr. Ali Guy. If he's reviewed the film and he wants to render an opinion about what he sees, he is a doctor, and if he qualifies

himself that he's capable of reading CAT scans, x-rays and MRI's, then I understand that but he can't recite the narrative of somebody else, so I would move in advance to preclude both Dr. Ali Guy and Dr. Struhl from testifying about somebody else's narrative.

THE COURT: All right.

MR. WHALEN: Also, there's another point. In each of Dr. Ali Guy's motion pending, the new one you just got about Struhl discussing gynecological and OB/GYN issues with regard to the plaintiff, Nathalie Gonzalez. It's not in his field of expertise. He's a pain management doctor and Dr. Struhl is an orthopedist as to the risks in a vaginal childbirth in the future. It's also, most importantly, for Dr. Ali Guy and Dr. Struhl, not in any of the four bills of particulars.

THE COURT: Counselor.

MR. FORDE: Okay. All right. Well, first of all, with regard to the motion in limine with Dr. Struhl, I believe that Dr. Struhl did mention that he reviewed films himself, personally, but in any event, as an expert, as a disclosed expert, he would be entitled to discuss any medicals that are properly marked into evidence during the trial, so whether that constitutes a report or hospital record or anything to that effect, he would be entitled to

do that, but I believe he did say, specifically, that he reviewed films himself in his report dated August 23rd of 2016.

With regard to the issue of the, again, we discussed this with regard to Dr. Guy with the childbirth problems, I mean, we don't purport to have either one of these doctors who don't have a specialty in OB/GYN. It's not an OB/GYN question. It's an orthopedic question with regard to whether the injuries to the pelvis would cause any kind of complication or difficulty. That's about the extent of Dr. Guy's testimony that would be on that point and also Dr. Struhl, as well.

THE COURT: Anything further?

MR. FORDE: No.

MR. WHALEN: No.

THE COURT: All right. We'll address each one. Give us five minutes. We'll address each motion and we're ready to proceed.

Who do we have ready to testify?

MR. FORDE: We have Dr. Guy is here this morning. I'm just checking trying to organize the records, Judge.

(Whereupon, a brief recess is taken.)

THE COURT: Very well. We're going to address

each motion on the floor.

We'll begin with one we already made a ruling on at the bench, but plaintiff's motion regarding potential questioning of the plaintiff concerning her treatment and psychiatric evaluation and depression prior to the accident is hereby granted. The probative value of such questioning is far outweighed by the potential prejudice that could result.

Plaintiffs' motion to preclude BalaCare Solutions registered nurses is hereby granted. The opinions are not based upon any degree of medical or nursing certainty in any field.

Plaintiffs' motion to preclude defendant's economic expert is hereby granted. The 3101(d) exchange is not only late but it fails to include a report which the expert's opinion is based upon.

Defendant's motion to preclude plaintiff's computer-generated photographs is granted to the extent that the computer-generated photograph depicting the bus crushing the plaintiff will not be permitted as there has been no testimony by any expert regarding the data such generation was based upon. All other photographs will be allowed.

Defendant's motion to preclude Dr. Ali Guy from

testifying regarding future medical expenses and future child-bearing issues is hereby denied. He is, in fact, the plaintiff's treating doctor. Moreover, this expert is subject to cross examination regarding his expert opinions.

Defendant's motion to preclude Dr. Les Seplaki is hereby denied. This expert was disclosed on time and, again, is subject to cross examination regarding his expert opinions.

And, finally, defendant's motion to preclude Dr. Struhl is also denied. This expert was disclosed on time and, again, is subject to cross examination regarding his expert opinions. That is the ruling of the Court.

Ready to proceed, Counselors?

MR. FORDE: Yes. I just need a few minutes to organize the stuff.

THE COURT: I thought that's what I did when I went out the first time.

MR. FORDE: We were working on it.

THE COURT: All right. Very good. Five-minute recess and then we'll get the jurors.

(Whereupon, a brief recess was taken.)

THE COURT: Please approach.

(Whereupon, a bench conference takes place.)

note.

THE COURT: Good morning. Just for the record, note your appearance here just who you are.

MS. BROWN: Nicole Brown.

THE COURT: Let's get the jurors, please.

THE COURT OFFICER: Yes, Your Honor.

All rise. Jury entering.

(Jury enters courtroom.)

THE COURT: Please be seated.

Good morning, jurors, and welcome back. We are going to be getting going right away.

Counsel, please call your next witness.

MR. FORDE: Plaintiff calls Dr. Ali Guy.

THE COURT OFFICER: Just follow me, sir. Just watch your step, sir.

Sir, please proceed straight, head and up the stairs and remain standing.

(Witness takes the witness stand.)

THE COURT OFFICER: Please raise your right hand.

D R. A L I G U Y, was solemnly sworn and testified as follows:

THE COURT CLERK: Please be seated.

State your name and address for the record.

Spell your name.

THE WITNESS: First name is A-L-I. Last name is Guy, G-U-Y.

THE COURT CLERK: Address.

THE WITNESS: Main office address is 7 Grammercy Park, New York, New York 10003.

THE COURT: Good morning, Doctor.

THE WITNESS: Good morning, Your Honor.

THE COURT: Counsel, you may inquire.

MR. FORDE: Thank you, Judge.

DIRECT EXAMINATION

BY MR. FORDE:

Q. Good morning, Dr. Guy.

A. Good morning, sir.

Q. Have we ever met before today?

A. Never.

Q. Okay. Dr. Guy, are you duly licensed to practice medicine and surgery in The State of New York?

A. Yes, sir. I am.

Q. And when did you receive your license?

A. 1985.

Q. Okay. And could you just, if you would, could you give us your educational background.

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

Flushing New York. Medical School, I graduated from University of Northeast Dominican Republic June of '81. Thereafter, I did three separate residencies. I did 18 months of internal medicine at Mount Sinai School of Medicine, Mount Sinai Medical Center. I did one year of general surgery at Cabrini Medical Center in Manhattan. I completed a three-year residency training program in the field of physical medicine and rehabilitation and was Board certified in the field of physical medicine and rehabilitation. I was in charge of NYU's Hospital for Joint Diseases Neuromuscular Equipment Clinic from 1990 till 2005. That would be about 15 years. My duties were to see the patients assigned to the clinic, teach the residents rotating through the clinic, and from 1997 till 2002 I was the director of the Department of Rehab Medicine at Maimonides Medical Center, Brooklyn, New York. My duties were to teach the house staff -- that would be the orthopedic surgical residents, the surgical residents, internal medicine residents, other doctors in my department to render consultations to other doctors in my hospital, and, currently, from January of 2006 to the present, I'm the clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU Medical Center. My duties are to work with the residents to teach them, prepare them for the Boards, part one and part two, and currently I'm also in charge of the physical medicine

rehabilitation and pain management program at Med Alliance. It's an Article 28 facility in the Bronx. Article 28 is like a small mini-hospital. I take care of the patients. I do epidurals, nerve blocks, facet injections, et cetera, and I'm also captain with the New York National Guard. My duties are to take care of the officers, the soldiers. I'm also on standby 24 times seven for riots and disasters and I also hold private practice offices in Manhattan and Long Island.

Q. Doctor, you mentioned Board certification.

What does Board certification mean?

A. Board certification is the highest degree which you can obtain in your level of specialty. In order to become Board certified in my specialty, you have to have the following prerequisites: You have to have training in a field other than physical medicine rehabilitation, preferably one year of internal medicine and/or one year of general surgery. You then have to complete a three-year accredited program, pass the monthly evaluations given by your preceptors, pass the annual exams given by the department, and once you do that, you have to sit and take your Boards, part one, which is an eight-hour written examination. You get tested on principles of orthopedic surgery, neurosurgery, neurology, muscle and nerve physiology, cardiac and pulmonary rehabilitation, internal medicine, general surgery, electrodiagnostics, interpretations

of x-rays, CAT scans, MRI's, and once you pass that Boards part one, you have to be in private practice at least 18 months to acquire additional knowledge and then you fly to the Mayo Clinic in Minnesota where all the top doctors that do research and write text-books, they test you orally for half a day on standard principles and principles of physical medicine rehabilitation. Once you prove to these doctors that your knowledge is up to par, all your credentials from college, residency get sent to the American Board of Physical Medicine and Rehabilitation, and if everything is up to par, they pass you and you get a title of Diplomate of the American Board of Physical Medicine and Rehabilitation. That was obtained in May of 1989 and remains in good standing to date.

Q. Now, were you ever a chief resident in any of the training programs that you were involved in?

A. Yes. I was chief resident in my training in physical medicine and rehabilitation at Mount Sinai Medical Center.

Q. Are you a member of any medical organizations, Doctor?

A. Yes. I'm a member of the New York State Pain Society.

Q. Now, Doctor, the field of Physical Medicine and Rehabilitation, can you tell us what that is, what that specialty is.

A. Yes. The specialty is called physiatry. Not psychiatry or podiatry but physiatry. This specialty was founded shortly after World War II by Dr. Howard Rusk. That's why the Rusk Institute was named after him. The specialty was originally called "orthopedic medicine and rehabilitation" but because of all the chaos and all the confusion between the orthopedic surgery, the name was changed to "Physical Medicine and Rehabilitation." It deals with non-surgical orthopedic problems and it deals with post-surgical orthopedic neurosurgical conditions that the patient needs to be rehabilitated for. Our job is to restore function to an injured patient or a patient who has had significant surgeries, such as brain surgery, spinal surgery, hip replacement, knee replacement, et cetera. We work with all the other medical specialists. We are trained in pain management both pharmacological and intervention pain management, which is epidurals, facet injections, nerve blocks, radio frequency ablation procedures, and we have extensive training in disability and impairment evaluation, which means that we have training to evaluate a patient, review pertinent medical records, examine the patient, arrive and see if that patient is disabled, whether that disability is permanent, total or partial and what the future medical needs and expenses for that patient would be. That is called a life care plan.

Q. Now, in the field of physical medicine and rehab, did you also receive any formal training in neurology and orthopedics and other disciplines?

A. Yes, we did. As part of our training in internal medicine we had formal rotations in neurology. We would admit patients every third night and most of the patients had neurological problems and conditions and we would present the case to our teachers. We would be taught on the neurological conditions by our preceptors as well as the neurological grounds and rotations we had. That was also the case in physical medicine and rehabilitation.

Q. So in the course of your practice do you, in your field, do you deal with traumatic injuries that people had, like accidents like this one?

A. Yes, sir. We do. I do, yes.

Q. And do you provide evaluations with regard to disability and impairment?

A. I do, yes.

Q. Now, who do you typically do those kinds of evaluations for?

A. For my patients and other doctors.

Q. Now, you're here to testify today. In the course of your practice, because of your evaluations, are you called upon to come to court to testify?

A. Yes, sir.

Q. Have there been occasions where you've been asked to testify on behalf of a patient where you have refused to do so?

A. Oh, I have never refused. There is severe punishments by the Office of Professional Medical Discipline if you refuse to do so.

Q. And have you been qualified as an expert in your field --

A. Yes.

Q. -- in the courts and state and Federal courts in New York State?

A. Every single court. Never been turned down.

Q. Now, have you also provided any type of lectures or instructions to the legal profession --

A. I have.

Q. -- with regard to your specialty?

A. Yes.

Q. Can you describe that?

A. I love to teach. I teach students, doctors and also lawyers. In fact, once a year at Mount Sinai School of Medicine we have this special seminar called Medical School for Attorneys. Through these lectures they get continuing CLE credits toward their license. I've been asked to talk to different topics on physical medicine rehabilitation.

Sometimes on electrodiagnostics, EMG. Sometimes hand injuries, sometimes, spinal injuries. I, myself, along with six other professors, we cover different topics and then the attorneys give lectures and they do their thing and we walk away.

Q. Are you compensated when you give those lectures?

A. No, sir.

Q. You're not.

Now, when you give those lectures, you said, to attorneys, are they plaintiff's attorneys or are they also defense attorneys?

A. Both plaintiff and defense. And sometimes there's doctors in the audience there, as well.

Q. What percentage of your current practice is devoted to actual treating patients, treating and evaluating patients?

A. I would say 95 percent. Plus I work sometimes six days a week, sometimes seven days a week, and sometimes I have residents from NYU, other programs rotating through my offices. As I see patients I'm required to teach them, as well. So I would say the vast majority is dedicated to taking care of patients.

Q. Are you here today to give testimony on behalf of your patient, Nathalie Gonzalez?

A. Yes, sir.

Q. And are you being compensated for your time to

prepare and also to appear to testify?

A. Yes, for canceling my patients. The answer is yes.

Q. And how much are you being compensated to do that in total?

A. My fee is 4,000 for half Day and One thousand for pretrial preparation, so for a whole day is 9,000.

Q. And you said you have to cancel other appointments in order to do that, to testify?

A. Yes. You told me to be here the whole day so I cancelled my whole entire day.

Q. Now, how was it Nathalie Gonzalez was referred to you?

A. I believe she was referred by your law firm. They called my office and asked if I would be interested in treating a patient. She has no health coverage. She has no financial means to pay for the services, and once I heard the injuries, I said, Sure. I'll be happy to take care of her.

Q. When was that, that she first was referred to your office for care and treatment?

A. The first time I saw her was August 3, 2015.

Q. Now, Dr. Guy, did you bring your chart here today to --

A. Yes.

Q. -- assist you in testifying?

A. Yes, sir.

Q. And, at times, would it be necessary for you to refer to your chart?

A. Yes, sir.

Q. Okay. Can you describe for the record what your chart consists of.

A. Yes. My chart consists of my history, my physical examinations, my physical therapy treatments, three epidural injections, one select nerve block injection, various EMG studies, various office notes, follow-up notes and records from Elmhurst Hospital, the two operative procedures, MRI reports, records from Blythedale Children's Hospital. I believe, that's essentially it. There's various different diagnostic studies from Elmhurst Hospital; CT scans of the abdomen and pelvis, various x-ray reports.

Q. Now, were there diagnostic studies that you actually reviewed yourself?

A. Yes. I have with me, which I reviewed, x-rays of the hip and pelvis, CAT scan of the abdomen and pelvis, CT of cervical spine, thoracic spine, lumbar spine and, I believe, I covered, yes.

Q. And the actual CD's are part of your chart?

A. Yes. I have the actual CD's, yes.

Q. Now, when Ms. Gonzalez came to you, did she give you

a medical history?

A. She did.

Q. And what was the history that she gave you?

A. Well, she was crossing the street, hit by a school bus, dragged several feet and the left rear tire of the school bus ran over her body. She was taken to Elmhurst Hospital, admitted for approximately three weeks and then she was sent to Blythedale Children's Hospital for continued outpatient rehabilitation for about another four months. She had two surgical procedures done. She lost a lot of blood at the hospital. She had to be transfused and she had a lot of x-rays, CT scans of the abdomen, pelvis, cervical spine, thoracic and lumbar spine. She had multiple fractures and she complained of lower back pain with stiffness in the groin with tightness in the pelvic area. Sometimes, the lower back would shoot down the right leg more than the left with numbness and tingling. This was, essentially, the history.

Q. Now, why is the medical history from the patient important in your initial evaluation?

A. Seventy percent of a doctor's diagnosis comes from a good pertinent history and the other ten percent comes from physical examination. The 20 percent is confirmed by other diagnostic studies such as x-rays, operative reports, CT scans MRI reports, et cetera.

Q. Okay. All right.

Now, based upon your review of the records, when Nathalie went to the hospital, were there x-rays taken of her pelvis?

A. Yes.

Q. And did you have an opportunity to review those x-rays?

A. I did.

MR. FORDE: Judge, if I could, just for a minute.

(Mr. Forde looks through his documents.)

(Whereupon, a bench conference takes place.)

THE COURT: So we're going to mark this into evidence.

MR. FORDE: Yes.

THE COURT OFFICER: This is going to be Plaintiffs' 6 in evidence.

MR. FORDE: Thank you.

(Mr. Forde sets up projector.)

Q. Now, Dr. Guy, you had an opportunity to review the x-ray films that were taken before Nathalie had her surgery. Is that correct?

A. Yes, sir.

Q. Okay. And what we have up as Plaintiffs' 6, which is

marked into evidence, we have a CD of the x-ray films and diagnostic tests from Elmhurst that have been marked in evidence. On the screen right now there are a couple of images. Can you explain for the jury what those images are.

A. Yes.

THE WITNESS: Judge, would you like me to step down?

THE COURT: If you would like to step down, yes.

(The witness steps down to view screen.)

MR. WHALEN: If we could, Judge, I know there's multiple images on this CD. If we can identify the particular image we're dealing with.

THE WITNESS: It's a little blurry. Could you make it (indicating).

MR. FORDE: If I move it closer, it'll get sharp.

(Mr. Forde moves screen for clarity.)

THE WITNESS: I can show you this one. The one to the left, we have a fracture here at the symphisis pubic area, superior ramus (indicating). There's another fracture, inferior ramus. Trying to see what else we could see. There's another fracture site over here (indicating).

MR. WHALEN: Dr. Guy, sorry to interrupt. I

know in the CAT scan there's thousands of pictures taken.

Can you identify the number on the one on the right you're discussing. Sorry, Judge.

THE COURT: No, no. Sure.

THE WITNESS: The numbers are very blurry here. They're not clear.

MR. FORDE: I'm trying to get a sharper image.

I don't see a numbered image. I see a timestamp.

THE WITNESS: It would be here (indicating).

MR. FORDE: Maybe you can look here doctor. Just take a look.

(Witness looks at laptop.)

THE WITNESS: Oh, yes. That's much clearer.

Okay. This is sequence three/three.

MR. WHALEN: Thank you. And the one on the left is --

THE WITNESS: Sequence one/three.

MR. WHALEN: Thank you very much.

THE WITNESS: Okay. So the x-ray to my left shows the fractures better. This is the -- Once again, a fracture means a break in a bone. We have many types of fractures. We have what is called a displaced fracture where the two pieces move away from each other. We have a

comminuted fracture, which also means the pieces move away from each other. So this is a displaced or a comminuted fracture where the two fragments have moved away from each other. That's the superior pubic ramus. This is the inferior pubic ramus.

I have, if I could show a diagram of what the pelvic looks like so they can understand better.

MR. FORDE: For demonstrative purposes, Your Honor, if we could --

MR. WHALEN: I have no trouble just marking it as an exhibit for demonstrative.

THE COURT: Mark it in.

THE COURT OFFICER: This is going to be Plaintiffs' 7.

THE WITNESS: (Indicating).

MR. FORDE: She's going to put a little sticker on it.

THE WITNESS: Um-hmm.

(Court Officer marks exhibit.)

THE WITNESS: All right. So this is a diagram of what the pelvis looks like. This is the pelvic rim. It's a cervical area. This is the iliac crest. You take your fingers. You touch up here. You're touching the superior and here the iliac spine. This is the front

portion. This is the back portion. This is your sacrum, your tail bone, and this is the symphisis pubis. This is the superior pubic ramus. This is the inferior pubic ramus. This is the ischial tuberosity, what we're sitting on in a chair, the ischial tuberosity is touching the chair. This is the acetabulum. The head of the femur gets inserted here. This is the sacrum. The sacrum has three segments. Nerves come out of here. So in Nathalie we had a break, also, in the sacrum going through the midline of the neural foramen. We have what is called a Denis type II fracture. It's the classification of fractures of the sacrum by Dr. Denis. If the fracture line is away from the neural foramen, it's known as type one. If it involvements the neural foramen, it's called Denis type II. If it involves the spinal canal, it's a Denis type III fracture. So because she had a Denis type II fracture, the nerve root is involved. The nerve root comes out of this hole.

Q. Okay. Hold on. Let me stop you for a second.

Can you explain what you mean by "nerve root."

A. Yes. I have brought with me some -- There you go (indicating).

MR. FORDE: If you could use this. Maybe we could mark this as a demonstrative.

THE COURT OFFICER: Plaintiffs' Number 8.

A. Okay. So this is a model of the spine. The spine has three segments. The neck is referred to as the cervical spine. There are seven vertebra. The mid back is referred to as the thoracic spine. There are 12 vertebra. The lower back is called the lumbar spine. There are five vertebra. Each vertebra has a disc in between to serve as a shock absorber. A disc is analogous to a jelly doughnut.

Could I provide the other diagram over there?

MR. FORDE: This?

MR. WHALEN: Yes.

MR. FORDE: What number are we up to?

THE COURT OFFICER: Do you have something else? This will be nine. This is for demonstrative?

MR. FORDE: Yes.

THE COURT OFFICER: This is Plaintiffs' 9 for demonstrative purposes.

MR. FORDE: Thank you.

A. A disc has two parts. Inside you have a gelatinous material called the nucleus pulposus. It's filled with water and a gelatinous substance. It's because of this structure that gives us our ability to bend forward, backwards, rotate from side to side. It is this structure that prevents bone from hitting bone and breaking bone. When we jump up and down,

it's like a jelly cushion area. Now, it has two portions. The outer portion has approximately 100 rings of a fibrocartilage material called the annulus fibrosis. There's nerve endings on the outer portion, so right behind the discs, the nerve roots exit from the spinal cord. The spinal cord runs from the brain all the way down to the lower back. It ends somewhere between the first and second lumbar vertebra and then it continues with a whole bunch of nerve root branches that resemble a horse's tail called a caudae equinae, and every one of these nerve roots has two branches; one for motor, one movement, one for sensation, and they continue all the way down into the sacral area, and we have nerve roots that exit the sacral area, S1, S2, S3 (indicating). Every area is labeled according to its anatomic location. If I say "S1," it means the first sacral nerve root. If I say L4-L5 space, it means the space between the fourth and fifth. If I said the L4-L5 disc it would be here. If I said nerve root, it would be between these two vertebra. So this was a brief anatomy of the spine and the pelvis and the discs.

Q. Okay. So now, Dr. Guy, as far as the various fractures that you described to the pelvic ring, how many fractures were there in the ring?

A. Well, we have superior, inferior, both sides, one, two, three, four. We had the fracture of the sacrum, S2 level.

That would be three. We have fracture of the symphisis pubis. That would be five. We had approximately -- There were several fractures. I didn't count them one by one but there were several fractures.

Q. Have you also seen the images and the model of a pelvis that has the fracture sites marked on it?

A. Yes.

Q. -- based upon that x-ray?

A. Yes.

MR. FORDE: This is the next for demonstrative.

THE COURT OFFICER: Something new?

MR. FORDE: Ten.

THE COURT OFFICER: This is a different one?

MR. FORDE: Different one.

THE COURT OFFICER: Plaintiffs' 10.

MR. FORDE: Ten, yes.

THE COURT OFFICER: For demonstrative purposes?

MR. FORDE: Yes.

THE COURT OFFICER: This is Plaintiffs' 10 for demonstrative purposes.

Q. So in using this model, can you basically show the jury --

A. Yes.

Q. -- based upon the x-rays that are there, what the

landmarks are on that model of the pelvis.

A. So this is the front portion of the pelvis. This is the back portion (indicating). That's the iliac crest, both sides (indicating). This is the sacroiliac joint. This is the sacrum. So there was fractures of the symphisis pubis on both sides, fractures of the superior pubic rings, fracture of the inferior pubic rings here, here and here. And so now I can count better; one, two, three, four, five, six, seven, eight. There was also a fracture of the second sacral ala (indicating). There was also a fracture of the sacral ala. That would be this area here. There's a special nerve that sits there. It's called the L5-S1, medial facet branch. And, I believe, I covered all the fractures.

Q. All right. You just mentioned that L5-S1 medial facet branch. What is that?

A. It's a sensory nerve that transmits messages of pain from the lower portion of the spine to the brain.

Q. And a fracture in that particular area of the pelvis, of what clinical significance is it as far as that L5-S1 medial facet branch?

A. Okay. There's a nerve root that exits the second sacral neural foramen area. There's also a nerve that is found right over the sacral ala over here where I have my pointer so there's nerves here and here. So when you have a fracture in

the vicinity of a nerve, this area gets injured. The nerve also gets injured, and the nerve problems are detected by a test called EMG, electrodiagnostics.

Q. All right.

A. One thing I left out. She had a fracture of the symphisis pubis. There was a lot of bleeding inside the vaginal canal so she had to have ice packing there for several days until the bleeding and swelling stopped and came down.

Q. Now, you mentioned that she needed to have transfusions performed?

A. Yes. Five units of red blood cells and one unit of fresh frozen plasma. Fresh frozen plasma has the clotting factors, so if you transfuse a patient more than three to four units of packed blood cells, you need to add the clotting factors that is found in fresh frozen plasma.

Q. Why did she need to have the transfusions?

A. When you have bone fractures, you bleed a lot. And also during surgery, you also bleed, as well, so because of the fractures and the surgery, there was a lot of blood loss.

Q. She, obviously, she had x-rays done at Elmhurst Hospital.

Was there surgery performed?

A. Yes, two surgeries. External fixators to hold these broken pieces together from moving and trying to heal. It

never healed with bone cement. It healed with fibrous tissue so this area is not as strong as if it healed with bone on bone, so when you have a break in bone, if you bring the two pieces together (indicating,) the bone heels with what is called callus formation. It's bone cement. Becomes very strong. If the two pieces are not brought completely together and it heals with fibrous tissues, and that is not as strong as bone, so the area healed not as strong as with bone.

Q. Now, in your chart, did you have a copy of the operative report?

A. I did.

Q. If you could refer to your chart --

A. Yes.

Q. -- for a moment and then I'm going to switch the image.

A. Okay. I have the one from December 23, 2014.

Q. All right. Now, what was the type of surgery that Nathalie had done?

THE COURT: Can you lower the screen.

(Ms. Brown lowers screen.)

A. The answer is she had application of external fixators to the pelvis due to pelvis fractures with a sacral Denis type II fracture and fracture of the bilateral superior and inferior pubic rami.

Q. So --

MR. WHALEN: Judge, just for the record, he's reading from a record. We've agreed to put that record into evidence. Let's mark it into evidence.

THE COURT: Why don't we do that.

MR. FORDE: Yeah. I mean, if you want. It's part of his chart, as well. You can mark his whole chart if you want.

MR. WHALEN: I would rather just mark the Elmhurst Hospital records.

THE COURT: Why don't we mark the records.

MR. WHALEN: That's in evidence, Judge.

THE COURT OFFICER: So it will be Plaintiffs' 11.

MR. FORDE: In evidence.

MR. WHALEN: I don't know if he has those records. Those are his records.

THE WITNESS: They're from Elmhurst Hospital.

MR. WHALEN: This isn't all evidence. Is it? You want all of them? I don't mind him having an excerpt, Judge, from Elmhurst, and reading from it, but let's mark the Elmhurst record, the disk. Don't you have a disk?

MR. FORDE: No.

MR. WHALEN: Judge, I've consented to the

Elmhurst Hospital records going into evidence.

THE COURT: Right.

MR. WHALEN: So we'll deem them marked at this point?

THE COURT: They're deemed marked.

MR. WHALEN: Okay. Good. I don't have a problem. Just trying to create the record.

THE COURT OFFICER: So that would be Plaintiffs' 11.

MR. FORDE: Yes.

THE COURT OFFICER: Give the witness back the records?

MR. WHALEN: Yes.

MR. FORDE: Yes.

(Court officer hands back to witness.)

Q. Okay. All right. Doctor, perhaps, if you used Plaintiffs' Exhibit 10.

THE COURT OFFICER: The witness is being shown Plaintiffs' 10 for demonstrative purposes (handing).

Q. If you could, referring to the operative report that you have in your chart, could you describe what the nature of the surgery was that was done. How was the surgery performed?

A. Yes. When you have these types of fractures, it's very difficult to cut the patient open to get inside to all

these fractures because the surgery, the postoperative phase would be a devastating postoperative course, so you place external fixators which are long long prongs, needles. You put them right through the two areas that were broken and you hope to stabilize the broken pieces. You see when I move the two pieces apart, you see the jagged pieces? So the external fixators go in this direction to push it close to this way and they go this way (indicating). So they look something like this (indicating). Several long prongs going in different directions; one here, one here, one this way, this way, one this way, one this way. I think you have a diagram of it.

Q. Yes. Let me just, if we could, did you also see a postoperative x-ray after she had the surgery?

A. May I step down?

Q. Yes.

THE WITNESS: Judge, may I?

THE COURT: You may.

(Witness steps down to projector.)

THE WITNESS: There we go.

Q. Okay.

A. So these are the external fixators. I see one, two on this side, one, two on this side. There's other two on the lower portion. There's one, two, again, on the lower portion, so there's several long external fixators. They come from the

outside to the inside to stabilize the fracture sites.

MR. WHALEN: Can you refer to what x-ray slide or CAT scan slide we're referring to. I don't know if it's x-ray or CAT scan.

THE WITNESS: This is x-ray.

MR. FORDE: This is a post-op x-ray sequence one of one --

MR. WHALEN: Thank you.

MR. FORDE: -- on this particular study.

Q. Now, doctor, have you seen an illustration of this image with an illustration showing the way the surgery was performed?

A. Yes, sir.

Q. Okay.

MR. FORDE: I think I'm going to need the easel for this, Judge.

What number are we up to for demonstrative?

THE COURT OFFICER: We're up to 12. This is going to be Plaintiffs' 12 for demonstrative purposes.

MR. FORDE: Yes.

THE WITNESS: So just to orient everyone, this is the front portion. This is the front portion. Pins placed. These are the external fixators placed into the iliac crest. That is here and here, on both sides. Here

is additional external fixators here, here, here, here, here (indicating). Interlocking screws to make these two probes more stable. This is to stabilize the fractures at the superior pubic ramus and the inferior pubic ramus on both sides (indicating).

Q. Okay. And as far as the placement of the external fixators, the brown rods with the knobs on the outside --

A. Right.

Q. -- what's the purpose of the apparatus that's outside of the body?

A. It is to bring in, move these pieces close together or apart from each other to tighten them up so that the fracture site can be confirmed by x-ray to make sure the two pieces come as close to each other as possible.

Q. And was this also used to control the bleeding?

A. Yes. Once the fracture site becomes in close proximity, the bleeding slows down and stops.

Q. And how long did Nathalie have to remain in this apparatus before the second surgery?

A. Approximately two to three weeks.

Q. So she was still in this when she went to Blythedale?

A. She went to Blythedale after Elmhurst Hospital I believe. Yes, I believe, she was.

Q. So she was obviously in this apparatus the whole time

she was in the hospital?

A. Yes. Oh, yes.

Q. Okay. Also, doctor, while you're here, did you also have an opportunity to review the x-ray image, preoperative x-ray image with an illustration of where the fracture sites were?

A. Yes.

MR. FORDE: This is number --

THE COURT OFFICER: Going to be Plaintiffs' 13. Is this for demonstrative purposes, as well?

MR. FORDE: Yes.

Q. So if you could, with the help of the illustration that you have there, can you just explain to the jury the various fracture sites and what the significance of those sites are.

A. Right. So this is the superior pubic ramus; bone here, here and here (indicating). This is the inferior pubic ramus broken on this side, this side, two places (indicating). Here is another fracture (indicating). As you can see, they're all displaced, comminuted. Two pieces have moved from each other. If all the pieces were together, it would be called a non-displaced fracture. A displaced or comminuted fracture has a more devastating sequelae than a non-displaced fracture.

Q. Why is that?

A. Because you have a lot of bleeding. The bone is completely interrupted. It takes a lot more effort to make it heal properly if, in fact, it ever does heal properly. In this case it never healed properly with a bone cement. It healed with fibrous banding. That's fibrous tissues. And here is the Denis type II fracture. This is the foramen line. If the fracture is away from the foramen line, it's called a Denis type one. If it involves the neuro foramen it's called a Denis type II. If it goes further over here and affects the spinal column, it becomes a Denis type III. Because a Denis type II is in the vicinity of a nerve -- nerves are over here -- it causes nerve dysfunction. And there's also a fracture of the sacral ala. Sacral ala is here. I don't see it here on your diagram. There was also a fracture of, I believe, the right sacral ala.

Q. Okay.

A. And this is the sacral iliac joint. That was also broken. It was fractured here, as well (indicating).

Q. So as far as the fracture sites that you just were describing there, what does that have to do with any kind of symptomology with regard to back pain?

A. Well, the sacral ala is right near the L5 vertebra. The S1 nerve root is here. The S2 nerve root is here. So you have the S1 and the S2 nerve roots involved. S1 nerve root

gives you shooting pain into the buttock, gives you shooting pain into the calf muscles. The calf muscles are supplied by S1 and S2 nerve roots. S2 is here. S1 is here (indicating,) and initial presentation she had lower back pain when she came to see me shooting into the groin area, the buttock area and down the leg with numbness tingling in the calf.

Q. Would that be consistent with an injury sustained in the area of those fractures?

A. Yes, sir. And so you want me to count the number of fractures. Here you can see them beautifully; one, two, three, four, five, six, seven, eight. Eight fractures, approximately.

Q. All right. Now, as far as the fracture that's on the right of that diagram, the one that's near the hip joint.

A. Right (indicating).

Q. On the right side.

A. This is the left; this is right.

Q. So that's the left hip (indicating)?

A. Left hip (indicating).

Q. What significance is there, if any, is the fact that fracture being near the area of the hip joint?

A. Causes referred pain to the hip. Causes stiffness to the hip. Also causes referred pain to the proximal thigh muscles (indicating).

Q. And are there any long-term implications as far as

the fracture in that specific type area?

A. Yes. Any time you have a fracture in the vicinity of a joint or in the vicinity of a nerve, there's long-term sequela. You cannot say this is going to heal perfectly and the patient is never going to have any future problems. Whoever says that, I respectfully and most vehemently disagree because traumatic arthritis begins to form around the fracture site area. We have many different types of arthritis. We have the normal arthritis called osteoarthritis, degenerative arthritis. We have rheumatoid arthritis which affects the joints, heart and lungs. We have psoriatic arthritis; psoriasis of the skin and also arthritis. We have tuberculous arthritis and you have traumatic arthritis, which usually comes after a traumatic event, fractures in the vicinity of a joint. Here, this is a joint. That's a joint (indicating). These joints play a function in an area I'm not allowed to go into.

Q. Can a patient also develop arthritis in the areas where the sacral fractures were?

A. Yes. Wherever there's a joint. We have the sacral iliac which is a joint. That's a joint. This is a joint. This is a joint (indicating) and the sacral ala is also a joint.

Q. What is facet arthropathy?

A. Means arthritis of the facets.

I'll borrow this model (indicating).

Facet is a joint between the two articular facet. Facet helps to move the spine forward, backward, right and left. It's with the help of the facet and the help of the disc. So this is a facet. It is a joint. So a facet arthropathy means arthritis of the facet joint.

Q. Is that the kind of finding, facet arthropathy, that you would typically find in a 19- or 20-year-old girl?

A. You would not expect to find any facet arthropathy; except that's one of the signs of traumatic arthritis, which Nathalie has.

MR. FORDE: Okay. I think we're done with this portion of the demonstrative, Judge.

THE COURT: Why don't we take a three-minute recess and then we'll continue so we can stretch.

(Whereupon, a brief recess was taken.)

THE COURT OFFICER: All rise. Jurors exiting.

(Jury exits courtroom.)

(Whereupon, a brief recess is taken.)

THE COURT OFFICER: All rise. Court is back in session.

MR. FORDE: Judge, I just want to see if the doctor can pull out an image.

(Witness looking at laptop.)

THE WITNESS: Okay. This is the image we want ST4.50.

MR. WHALEN: It's a sagittal MRI.

THE COURT: Jurors had a hard time looking at the screen as the two of you are by the screen, having a hard time seeing.

MR. FORDE: Okay.

THE COURT: Jurors, please.

THE COURT OFFICER: All rise.

Jury entering.

(Jury enters courtroom.)

THE COURT: Please be seated.

You may continue.

MR. FORDE: Thank you.

What was my last question?

(Whereupon, the requested portion was read back by the court reporter.)

Q. Okay. Now, Dr. Guy, does your chart reflect what her course of care was at Elmhurst Hospital after she had the surgery? What was being done for her?

A. Yes. She was getting bedside range of motion. She had the external fixators in place. She was given transfusion of packed red blood cells and fresh frozen plasma. She was being given pain medications. She was being given Ferrous

Sulfate to replenish her red blood cells because she became very anemic when she lost all that blood, and multivitamins to help with the absorption of the iron pills, and that was essentially it.

Q. And as far as your chart is concerned, when did she leave Elmhurst?

A. Let me look in my chart to refresh my memory.

I believe, approximately, three weeks after she was admitted there.

According to Elmhurst Hospital, she was stabilized. She had the external fixators in place. She was given Morphine for pain and other medications for pain. Initially, she was hypotensive. That means the blood pressure --

MR. WHALEN: Objection to this testimony. He was asked what the discharge date was.

THE WITNESS: Oh, discharge date.

THE COURT: Objection sustained.

Last portion is stricken from the record.

Focus on the question, please, doctor.

THE WITNESS: Yes.

MR. WHALEN: Judge, I'll stipulate that it was January 8.

MR. FORDE: Okay.

THE COURT: So stipulated.

Q. So, doctor, you don't need to actually find the date there in the chart.

So she stayed at Elmhurst Hospital until January 8 of 2015, correct?

A. Correct.

Q. And then after January 8th, where did she go for further care?

A. Blythedale Children's Hospital.

Q. And what was your course of care at Blythedale Children's Hospital?

A. Okay.

MR. WHALEN: Judge, I hate to be a stickler, but I agreed the Blythedale records should be in evidence. I just want to, before he starts reading from it, make sure they're in evidence so we have a proper record. That's all. I'll stipulate.

MR. FORDE: Yes, we do. Do you want to mark them now?

MR. WHALEN: No, we could deem them marked now. I just want to make sure if he's going to read from them --

THE COURT: They are deemed marked and they are in evidence.

MR. WHALEN: Thank you, Judge.

THE WITNESS: She was basically stabilized. She was being given treatments for her coagulation problem.

Q. Coagulation?

A. Coagulation, bleeding. She was treated for her constipation, insomnia, for pain. The external fixators were in place until April 6 of 15. They were then removed at Elmhurst Hospital. She had continuous orthopedic follow-up. She had developed fluid in her right thigh. There was a needle aspiration to remove the fluid and check if there was any infection in place. She developed a Vitamin D insufficiency. She was given Vitamin D supplementation.

Q. Just backing up a moment, the fluid in the thigh, what was that about? Do you know what the cause of that was?

A. That was the trauma. When you have a fracture of the symphisis pubis and the superior inferior pubic ramus in the vicinity of the joint, that hip joint, it will also affect the area below it so there was a contusion. So there was a contusion to the area. There was a hematoma. There was blood in her right thigh.

Q. And what was done to address that issue?

A. They removed part of it to make sure it's not infected and then they allowed it to be accumulated slowly -- be absorbed by the body slowly by itself.

Q. All right. And as far as any type of physical

therapy or anything like that, that was administered at Blythedale, what type of treatment was she getting?

A. She had physical therapy two to three times per week and she had gait training, the way she walks. She had ADL training, Activities of Daily Living training. She had occupational therapy given to her, as well.

Q. So ADL training, what is that?

A. ADL means Activities of Daily Living; grooming, bathing, combing your hair, dressing, putting your pants on, your undergarments, your shirt, et cetera, all part of ADL training.

Q. And occupational therapy, what is that?

A. Occupational therapy works with the upper extremities. Helps you to transfer from one area to the another, transfer from the hospital bed to a wheelchair or from an assistive device or to get up from the hospital bed, begin to stand a little bit.

Q. So what period of time was she non-weight bearing up until?

A. I would say, at least, until April, until the external fixators came out. She remained non-weight bearing until April 6, 2015.

Q. Prior to that period of time, were there any occasions that she had any problems with any of the discs in

her lower back?

A. I don't believe any MRI was done because she had metal in her body. You can't do the MRI with metal.

Q. So once she was released from Blythedale Children's Hospital, did she start a course of physical therapy someplace else?

A. She started a course of therapy at home and then she came to see me August 3, 2015 and then I started with the physical therapy.

Q. Before she started with you, do you have an indication that she went to Restore Physical Therapy in Queens?

A. No, I don't have that in my records.

Q. Okay. So the first time she saw you was in August of?

A. August 3, 2015.

Q. And you told us that she gave you the history that you talked about before?

A. Yes, sir. That's correct.

Q. What were your physical findings at that point?

A. I examined the neck and the back. The reason why I examined the neck was because I want to make sure there was nothing going on with the neck. The neck showed tenderness, spasm. It showed slightly decreased range of motion. The back showed tenderness, spasm. Multiple trigger points present.

Back with extension, going backward, was one half normal. It was 15 degrees out of 30. Forward flexion was 60 degrees out of 90. Bilateral flexion, lateral rotation, bending to the side, and rotating to the side, it was one half normal. It was 15 degrees out of 30. Straight leg raising was 75 degrees out of 90. That is to check to see if there is any disc problem in the lower back or any nerve problem in the lower back. Range of motion was normal for all four extremities; except for both hips was two-thirds normal. Muscle power testing for both legs was two grades weaker than normal. It was four plus over five. Normally, it's five over five. Next is five minus over five. Next is four plus over five. Sensation was diminished to pin prick or touch, left dorsal foot, right dorsal foot and right medial calf. So the dorsal foot comes from the L5 and the medial calf comes from the S1 S2 nerve root branches. Reflexes were normal. Gait, the way she walked, was slow and antalgic.

Q. And at that point in time, did she give you any indication that she was in pain or discomfort as a result of any of these findings that you had?

A. Well, she told me she still has back pain.

Q. So your course of treatment was what at that point? What did you decide to do?

A. Initially, it was physical therapy. I sent her for an MRI of her lower back. I did EMG's of her lower back and

then I did epidural injections and then select nerve block injection.

Q. All right. Let's start with the MRI of the lower back.

When did you send her for an MRI to the lower back?

A. She had the MRI of the lower back on 11-22-15.

Q. And where did she have that done?

A. At Standup MRI of Manhattan.

Q. And did you have an opportunity to review those MRI results?

A. Yes, sir.

Q. What were the results of that MRI?

A. It showed an L5-S1 disc herniation impinging on the nerve root and L4-L5 annular tear and L3-L4 bulge.

MR. FORDE: This is Plaintiffs' in evidence, Standup MRI.

THE COURT OFFICER: This is 15 in evidence.

MR. WHALEN: Do you want to approach.

MR. FORDE: Yes.

15, is that what we said?

THE COURT OFFICER: Fifteen.

(Whereupon, a bench conference takes place.)

Q. Dr. Guy, up on the screen we have Plaintiffs' number 15 in evidence.

Your Honor, may the doctor step down?

THE COURT: You may.

(Witness steps down to projector.)

Q. All right. So, doctor, on the screen here, can you tell us what we're looking at here as far as what portion of the body and what the perspective is?

A. Yes. So when we look at an MRI of the patient's lower back --

THE COURT OFFICER: I'm sorry, doctor. The jurors can't see.

THE WITNESS: Where should I stand?

THE JUROR: That's better.

THE COURT: At any time if you can't see something here, let us know. We'll make arrangements.

THE JUROR: Thank you.

A. So MRI stands for Magnetic Resonance Imaging. It picks up, depending on the area you're studying. Here we're looking at the discs. It takes the body's protons and transforms them into real-life images. So when we look at an MRI of the patient's low back, we look at it in two views; the side view is called the sagittal view. The axial view would be this view (indicating,) so we look at it in two different views to be able to see it in a three-dimensional capacity. What we're looking at here, these are the nerve roots. These are

the vertebra, and these are the discs (indicating,) okay. So the L5-S1 is the last disc. It is herniated. It is sticking out. It's touching the nerve root over here (indicating). The L4-L5 has a tear in it. The L3-L4 has a bulge touching the nerve root. Now, to see it better, we go to the axial view. I'll show you the axial view. May I borrow my --

MR. WHALEN: I'm going to object to this exhibit. I think we have enough exhibits that we don't need to refer to another one.

THE COURT: Which exhibit are we talking about?

MR. WHALEN: The one in counsel's hand. I think we have enough exhibits.

THE COURT: Why don't we use the exhibits we have, please.

THE WITNESS: It won't show it as good as the one I have. Mine will show it a lot better.

THE COURT: That's fine. We'll use the ones we have already.

A. So the axial view, what we're looking at, this is the vertebra (indicating). That's vertebra. This is the spinal canal and this is the part of the herniation over here sticking out (indicating). So that's what a herniated disc looks like on an MRI.

Q. Okay. And, again, this type of finding at this point

the patient would have been 18 years old?

A. Yes.

Q. Would this be considered a normal finding for an 18-year-old?

A. No, sir. It would be considered an abnormal finding.

Q. And of what significance is the presence of any kind of findings on an MRI like this -- Withdrawn.

What is the purpose of doing the MRI?

A. To see what is causing the patient's lower back pain, to see if there is any disc problems, if there's any other nerve root problems. Nerve root problems are tested and confirmed by a test called an EMG, electromyography. So this is suggestive of a nerve root impingement, something touching the nerve root. When you have a disc herniation, a disc sticks out, hits the nerve root right behind it (indicating).

Q. Okay. Doctor, I think we're done with this. You can take the stand now.

A. Okay.

(Witness resumes the witness stand.)

Q. Dr. Guy, in addition to the MRI, you mentioned a test called an EMG?

A. Yes.

Q. What is that, exactly?

A. An EMG stands for electromyography. It is a test

done by a physiatrist like myself or a neurologist. It checks to see if there is any muscle or nerve problems.

Q. Did you have those tests performed?

A. Yes.

Q. And when were those tests performed?

A. On August 22, 2015.

Q. What were the results of those tests?

A. Showed a right L5 lumbar radiculopathy.

Q. "Radiculopathy," that's a very long word.

A. Yes.

Q. Can you explain what that is.

A. Yes. Means damage to a nerve root.

Q. What is its cause? I mean, if you have damage or radiculopathy, what type of symptoms does that cause?

A. You get shooting pain from the back into the buttocks down the legs. You get numbness and tingling in the legs. On physical examination you can find weakness. You can find loss of sensation in the dermatomes that comes off the nerve root from the lower back. As I explained, loss of sensation on the top of the foot comes from the L5 nerve root so you have calf muscle comes from S1 and S2.

Q. So you did the EMG's in August of 2015 and then the MRI you did in November of 2015, correct?

A. That's correct.

Q. So what was the purpose of doing the MRI after you had done the EMG?

A. I did the EMG first. I found there was nerve damage. Now I wanted to find the cause of nerve damage. There are three causes of nerve damage; one is a disc problem, two is a fracture, something with a bone hitting the nerve root. Number three, the rotation forces that work on the spine that pull the nerve. The nerve becomes swollen and inflamed. It begins to malfunction, causes radiculopathy.

Q. So once you had the EMG and MRI results, did that change your treatment or the way you approached the patient?

A. I gave her other treatment options, such as epidural injections that were discussed. When you give a patient epidural they want to go home and think about it because it does have risks; danger of hitting a nerve causing paralysis, infection and side effects from the steroid causing a whole battery of side effects. So she went home and thought about it and then finally wanted to have the first one done.

Q. So to back up a little bit, when you talked about epidural injection, what is actually injected? What is it that is actually injected into the body?

A. Lidocaine and cortisone.

When you give medication like cortisone intrathecally -- means inside the epidural space -- it is much

more powerful than orally. For example, Morphine is a painkiller. One milligram of intrathecal Morphine equals 100 milligrams by mouth, so it's a lot more effective and it goes directly to where the problem is, and the cortisone serves as a painkiller and also as a strong antiinflammatory medication. It reduces the swelling, the inflammation around the nerve roots.

Q. So the Lidocaine -- correct me if I'm wrong -- the Lidocaine is like an anesthetic.

A. Yes. Numbs the nerve, breaks up the pain, spasm; pain, spasm, the irritative cycle, so they both work in this fashion together.

Q. And cortisone has both effects of an anesthetic and --

A. No. Lidocaine is an anesthetic. Numbs the area for about four to six hours.

Q. All right.

A. Reduces nerve hyperexcitability, irritation. Cortisone is a painkiller and strong antiinflammatory, breaks up inflammation.

Q. And cortisone is a steroid?

A. It's a steroid, yes.

Q. Now, that type of treatment, does that type of treatment give long-term relief or long-term results?

A. Every case is different. It is basically designed for short-term relief not for long-term relief.

Q. And how often can that type of treatment be repeated, let's say, on an annual basis?

A. Epidurals are done safely three times per year. Facet injections, three times per year. Sometimes you need both to work together and sometimes sacroiliac joint injections, as well.

Q. So now, a facet injection, is that different from an epidural injection?

A. Yes.

Q. So the epidural injections she had when?

A. Okay. She had the first one on 3-26-16.

Q. Can you describe how that is done, what the procedure is.

A. Yes. I have pictures of it if I can show (indicating).

Q. Is it in your chart?

A. Yes.

MR. WHALEN: Is it of her epidural?

THE WITNESS: Yes.

THE COURT: Any objection?

MR. WHALEN: No objection.

THE COURT: You may.

THE WITNESS: May I step down, Your Honor?

THE COURT: Why don't you formulate some questions.

Q. Sure. Just so we know what we're going to be looking at, can you describe what the procedure is that you're performing and maybe you can use the images to help illustrate.

A. So based on the clinical findings and the MRI findings and the EMG findings, I do know that the L4-L5 and L5-S1 was involved and the patient's pain was mostly on the right side shooting down the right leg and right buttock area. So using fluoroscopy, which is like an x-ray, helps me guide my needle exactly where to put the needle and I use that and I give the medication to the area where the nerve roots are supposed to be, and I give a little contrast to confirm I'm in the right spot, that I'm not in a blood vessel, then I give the medication to the appropriate level.

MR. FORDE: So, Your Honor, may Dr. Guy show the images to the jury?

THE COURT: You may.

MR. WHALEN: Are they marked as an exhibit? Deem them marked?

THE COURT: Sure.

MR. FORDE: We can.

THE COURT: Officer, please.

MR. WHALEN: For demonstrative purposes?

MR. FORDE: Yes.

MR. WHALEN: Okay.

(Court officer marks exhibits.)

THE COURT OFFICER: This is Plaintiffs' 16 for demonstrative purposes.

THE COURT: Do you want to step down, doctor?

THE WITNESS: Yes.

(Doctor publishes to jury.)

THE WITNESS: May I begin?

THE COURT: You may.

THE WITNESS: So this is a fluoroscopy evaluation of the patient. These are the vertebra. This is the fourth lumbar vertebra. This is the L5 vertebra. I'm going to come there (indicating). This is my needle going in where the nerve root is, and here, this is the contrast dye showing the configuration of the nerve, here and here, and then once I know I'm in the right spot, I know I'm not in a blood vessel, I give 40 milligrams of Kenalog, which is a long-acting cortisone medication and Lidocaine. I give medications to this level and this level (indicating).

Q. All right. So the first series of injections you did in March of 2016?

A. The first one was on March 26, '16. It gave her 75 percent relief lasting a few weeks. The second one was done on 5-6-16 at the same levels. That gave her 85 percent relief lasting for several weeks. The third one was done on 7-8-16. The third one did not give her much relief.

Q. The ones in July?

A. July 8, 2016. So when it doesn't give her much relief, it means the pain is coming from a different origin, is no longer coming from a nerve root. The first two injections got rid of the nerve root problem, so that means the pain is coming from a different area so we have to investigate where. The answer is the facet.

Q. So after July 8 of 2016, what did you do next as far as investigating the source of this pain and discomfort?

A. The patient was referred to a spinal surgeon, Dr. deMoura, and he sent the patient for another MRI, which was done on 9-9-16. It showed L5-S1 joint arthropathy, did not show the bulge or herniations for a very good reason.

Q. Why would that be?

A. Once you have a disc herniation, the water content leaks out. The disc no longer sticks out, out of its shell it normally would. It's like a turtle sticking its head inside its shell. It's no longer sticking out, so it begins through the degenerative process and it was no longer sticking out.

Doesn't mean the tear has disappeared and it's gone. It just means it's no longer showing itself on the MRI.

Now, the facet at the right L5-S1 is showing that's where the sacral fracture was, the sacral ala fracture. That's the sign of traumatic arthritis which I was mentioning.

Q. And what, if anything, could be done about the development of that facet arthropathy that showed up in the September 9, 2016 MRI?

A. What can be done about it?

Q. Yes.

A. Facet injections and physical therapy and stretching exercises, home exercise.

Q. So after that consult with Dr. deMoura, did she come back to you and continue with care?

A. Yes. Dr. deMoura sent her back to me to do a select nerve block in the lumbar spine to see exactly where the pain is coming from, so then I did that select nerve block injection.

Q. So when did you do the select nerve block injection?

A. July 28, 2017.

Q. Now, can you describe what that process is like.

A. Yes. So that nerve block was done at three different levels in the lumbar spine; the L3-L4 and L4-L5. It's similar to this (indicating). At the fluoroscopy, put the needle

between the third and fourth, the fourth and the fifth and the fifth and the sixth to see which one would give her relief of pain. Each time I would do the injection, I would then ask the patient, "So did you have any relief from this procedure," right after the procedure was done. The answer was yes, so that means it was coming from that particular nerve root.

Q. So in this case, you were injecting higher up on the lumbar spine; L3-L4?

A. I'll tell you exactly what I did. Two levels were injected. It was also L4-L5 and L5-S1. I did not do L3.

Q. You did not?

A. No.

Q. Okay. So L4-5 and L5-S1?

A. Yes, and I felt that it was mostly coming from the L5.

Q. Now, other than the select nerve block, to address this issue of the facet arthropathy, is there anything else that can be done to control or manage those symptoms and pain?

A. We have facet injections. When the facet gets involved, the sacroiliac joint goes with it as well, especially since there were fractures in that vicinity. That can be tried. Antiinflammatory medications could be tried. Physical therapy was being done continuously. Home stretching exercises was done, and when the facet arthropathy gets very severe, you

need another surgical procedure.

Q. What type of procedure?

A. Facetectomy. You cut out the part of the bone around the facet which is interfering with normal flexibility and range of motion.

Q. So after she had the select nerving blocks in July of 2017, what was your course of treatment after that?

A. We continued with physical therapy. Physical therapy was helping her tremendously so we just continued with the physical therapy.

Q. And is she still treating with you up until the present?

A. Oh, yes. She got her last physical therapy this month. May, I believe. Some time in May.

Q. Now, during the period of time -- Let's just talk about her activities from the time that she first started treating with you in August of 2015. Was she working? Was she going to school? What were her activities?

A. Initially, she was working -- I'm sorry. Initially, she was going to school. She was trying to study music and something else. As of 9-25-17 she was working part time at a CVS as a cashier, and currently she's working in a clothing store.

Q. So as far as her current limitations from work or

physical daily activities, what type of restrictions does she have now?

A. No running, no contact sports. She has to avoid prolonged standing. Anything that would stress the hip, pelvic area and the spine.

Q. For what period of time would you say she would be able to stand if she were working, for example?

A. She could stand as tolerated, but -- she can do it but she's going to pay the price. The hip, the spine and the buttock areas are going to become inflamed.

Q. Is she currently under any kind of medications?

A. She takes over-the-counter medications; Advil, Aleve.

Q. Now, with regard to her future care with regard to the hips -- I know we have been talking about the discs and the back for a little while now -- what is her current status as far as the damage to the pelvic ring and the fracture that she had?

A. Well, the right sacral ala fracture and the right S2 fracture, Denis type II fracture, throughout all my examinations, the range of motion of the hip has been intermittently abnormal decrepitation that is indicative of arthritis in the hips so down the road she will be a candidate for total hip replacement.

Q. When would you say that she would be a candidate for

something like that, as far as her current age? She's 20 now.

A. Not yet. She's too young. That will be determined by the orthopedic surgeon who's going to do the procedure. That's why she needs to see different doctors. Each doctor has a different plan and a different area of specialty to pursue, so the orthopedic surgeon would be concentrating on the joints; especially, the knee and hip, and the spinal surgeon would concentrate on the spine, so she needs to see, I believe, she's seeing an orthopedic surgeon for that, Dr. Struhl.

Q. Now, with regard to -- Obviously, she's 20 years old and of child-bearing age at that point.

From a point of view of the pelvis from an orthopedic standpoint, are there any complications that you're aware of that a trauma like this would have to childbirth?

A. Yes.

MR. WHALEN: Objection, Your Honor.

THE COURT: I'm going to overrule it. I'm going to allow it.

You may answer.

A. From normal childbirth, certain bones have to open up. The symphisis pubic has to open up. The sacroiliac joint has to open up to allow the child to come down the pelvic ring and for normal delivery, so when traumatic arthritis sets in and when this area is not going to be able to open up properly,

there will be complications.

Q. Now, as far as the condition that she has with regard to the hip fractures, were there any areas where the fractures did not heal completely?

A. The superior inferior pubic rami did not heal properly. The symphisis pubic area did not heal properly. The sacroiliac joint did not heal properly. The right sacral ala over here did not here properly (indicating). The S2 Denis type II did not heal properly. So most of them did not heal properly because there were comminuted displaced fractures.

Q. And is there anything that can be done at this point to correct that type of healing?

A. At this point, no. All they can do is prevent any further damage.

Q. And what would be involved in preventing further damage?

A. Proper physical therapy, proper exercise regimen. Keep the muscles around the pelvic rim strong, improve your core muscles. If your core muscles, your abdominal muscles are strong, hopefully, less force goes on the pelvic area and on the spine. So this is what can be done. Periodic pain management procedures. Combination of everything. Do everything together.

Q. So is that something that would be in the nature of a

life care plan as to what she would need to do going forward?

A. Yes, sir.

Q. And for Nathalie, did you actually provide such an analysis as to what her future needs might be to address these issues?

A. I did.

THE COURT: Time to break for lunch at this time.

MR. FORDE: I think so.

THE COURT: All right. Jurors, we are going to break for lunch at this time. Please be back at 2:15 and we'll continue with the examination.

THE COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

THE COURT: Doctor, you may step down.

(The witness steps down.)

THE COURT: See you back this afternoon at 2:15.

THE WITNESS: Yes.

MR. FORDE: 2:15. Thank you, Judge.

(Whereupon, a lunch recess was taken.)

THE COURT OFFICER: All rise.

THE COURT: Please be seated.

THE COURT OFFICER: Ready for the jury, Your Honor?

THE COURT: Yes.

(Witness takes the witness stand.)

THE COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom.)

THE COURT: Please be seated.

Good afternoon. Counsel, you may continue your examination.

MR. FORDE: Thank you, Your Honor.

THE COURT OFFICER: Doctor, you are reminded that you're still under oath.

THE WITNESS: Yes.

Q. Dr. Guy, before we broke for lunch we were talking about a life care plan.

Can you explain what that life care plan is, please.

A. Yes. A life care plan takes into account the patient's history, the various physical examination findings, all the various different reports. Comes out to an analysis, whether the patient is disabled partially or totally and what future medical needs and frequency she will need and what the cost for each of those services will be.

Q. Okay. And can you describe based upon all of those factors with regard to Nathalie, what you determined her future needs would be as far as life care?

A. Do you want the cost also?

Q. I'm sorry?

A. The cost also?

Q. Yes.

A. Yes. So because she has a permanent condition and this condition is progressive, especially with traumatic arthritis setting in, especially since the second MRI showed a facet arthritis at L5-S1, confirming the beginning of traumatic arthritis, she will need to have an MRI of the lumbar spine on both hips at least once every one to two years, and the cost for each MRI is 1,000. The patient needs to have EMG's of her lower back and extremities once per year. The cost is about $2,000. She would need to see an orthopedic surgeon four to six times per year to assess the fractures to see if there is any complications setting in and to be able to catch the problem early rather than late four to six times per year. The cost for each visit is $150. The patient should be seen by a physiatrist like myself, ideally, once per month to supervise her overall musculoskeletal condition to assess the need for referral to other specialists to assess the need for referral for MRI's, EMG's, medications, different types of injections. The cost for each visit is $150. She needs to have on the average one physical therapy session per week, 40 or 50 per year, on average, to diminish pain and spasm, to prevent this condition from getting progressively worse and the cost for

each visit is $150. In the future the patient will need medications for pain and inflammation. Depending on what medication and what dose and frequency, the cost will be between 3- to $5,000. That's a very low conservative number. And as the patient continues to get older and as traumatic arthritis sets in, she will need 12 sets of trigger-point injections per year. The cost is $300 per set. She would need three lumbar epidural injections or three lumbar facet injections or both. The cost for each is 1,500 and the outpatient surgical facility for each is $3,000. That's for anesthesia, the recuperation from anesthesia and the post-anesthesia care, and that's essentially it.

Q. So this life care plan and these procedures and the various costs that you're telling us about, if she were not to have that done, what would be the prognosis for her in the future as far as her level of recovery without having this done?

A. She would suffer. She would have more pain, more stiffness and more bad days than more good days.

Q. Also, on the converse of that, if she has all of this, does this mean that she would make a full and complete recovery?

A. No. Her condition is permanent. A disc herniation is permanent and progressive. Traumatic arthritis is permanent

and progressive, and all these are done to treat these conditions not to cure them. There is no cure for arthritis.

Q. Now, during the period of time that she was under your care, how were her medical bills being paid as far as your facility?

A. She had no third-party coverage. She had no means to pay for it. I took it under a lien. The lien means if and when she's able to pay for them, she will pay for them, or when the case over if she's able to pay for them, she will pay for them that way.

Q. So, currently, what is the amount of the medical lien that you have for services that you have provided since August of 2015?

A. Approximately $30,000.

Q. And she is continuing to treat with you on an ongoing basis?

A. Yes.

Q. Now, during the period of time that Nathalie has been your patient, have you taken a history from her?

A. Yes.

Q. About her complaints on an ongoing basis?

A. Yes.

Q. What kind of historian is she with regard to her own medical treatment?

A. She is very shy. She is very timid. She is very introverted. You have to extract information from her. She doesn't really volunteer everything. She is very very shy.

Q. Did you also have an opportunity to review any examinations that were done on behalf of the defendants with regard to this?

A. Yes.

Q. And do you recall which specialties they had --

A. I reviewed the radiological report from Dr. Rigney confirming the fractures, confirming the fact that there were comminuted displaced fractures and the contradicted reports from Dr. Grelsamer and Dr. Elkin that they were not displaced fractures. They were displaced fractures, but they said they were not displaced fractures.

Q. Any other medical reports that you reviewed on behalf of the defendant?

A. Yes. I saw two life care plans prepared by two --

Q. I'm talking about the medical experts, the life care plan.

A. I covered Dr. Elkin. I covered Dr. Struhl, also. I reviewed his report.

Q. I'm talking about now the exam on behalf of the defendants.

A. Dr. Elkin, Dr. Grelsamer, Dr. Rigney. I don't

remember any others.

Q. To the extent that a conclusion would be drawn, I'm going to give you a hypothetical doctor.

Would you say there would be no residuals to Nathalie at this point based on the injuries that she sustained? Do you have an opinion with regard to that?

A. I would most vehemently disagree for a number of good reasons.

Q. So what are those reasons?

A. I conducted an EMG on her in December of 2017. We went from the one level, one side of radiculopathy on the right L5 and that EMG showed a bilateral L4 through S1 radiculopathy, two level on both sides. Condition is worsening. The first MRI did not show facet arthritis at the right L5-S1. The second one done in September of 2016 did show that facet arthritis so traumatic arthritis is beginning to set in and it's going to slowly progressively worsen over time, and they were displaced fractures which we saw the pictures today that both those doctors said there were no displaced fractures.

Q. Now, with regard to the pelvic injuries, do you have an opinion with a reasonable degree of certainty as to whether or not those injuries were related to this accident?

A. Undoubtedly, yes.

Q. Do you have an opinion as to whether or not these

injuries are going to result in permanent residuals to Nathalie?

A. Yes. Especially, all the fractures in the vicinity of a joint, which I indicated earlier, the symphisis pubis, the superior pubic ramus. It's right near the inferior pubic ramus, is also another joint. The biliteral sacroiliac fractures, the right sacral joints, the Denis type II fracture, the sacral. These are all in the vicinity of a joint or a nerve or in the vicinity of nerve root exits.

Q. Okay. And your description right now, that's with regard to the injuries to the pelvis and the sacral area affecting the nerve roots?

A. Yes.

Q. Now, Dr. Guy, the life care plan that you itemized and the amounts of services that you placed into the life care plan, what do you base that on? Where did you draw those numbers from?

A. Most of those services I perform myself. The other services that are performed by other doctors, orthopedic surgeons, I'm familiar with what they charge. The numbers I've given is a very low number. Many orthopedic surgeons charge a lot more than 150. They charge 200, 250. I'm familiar with MRI's. I send my patients for MRI's. I see the bills coming back. I've spoken to different MRI facilities as to what they

charge for different areas, and the rest I do myself. I'm familiar with my own fee schedule.

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

THE WITNESS: Okay.

THE COURT: Counsel, you may examine the witness.

MR. WHALEN: Thank you.

CROSS EXAMINATION

BY MR. WHALEN:

Q. Good afternoon, Dr. Guy.

A. Good afternoon, sir.

Q. You may not remember, but you and I have actually met a couple of times.

A. I don't recall, but if you say so.

Q. You testify in court quite frequently. Is that fair to say?

A. What do you mean by "quite frequently"?

Q. Fifteen times a year?

A. No. Right now, on the average, eight to ten times per year.

Q. In the past it was more?

A. Yes.

Q. So now you've cut down on the testimony.

You told us you have two principal offices, correct?

A. Yes, sir.

Q. And you split your time between those two offices. Is that fair to say?

A. Yes, sir.

Q. You also have a couple of satellite offices, also?

A. One satellite office in Queens, I just do epidural injections, and at Meadowlands I'm an employee of that facility.

Q. No other satellite offices because your website indicated two satellite offices? Would that be incorrect?

A. Bronx, Manhattan, Long Island and Queens.

Q. So four offices in total?

A. Right. But not all of them are mine.

Q. You're not there at the same time, at all four of them. Right?

A. No.

Q. I assumed that, okay.

You also have patients?

A. That's correct.

Q. How many patients do you see in a day?

A. Varies from day-to-day. Some days more; some days less.

Q. Forty, 50 patients in a day?

A. Twenty to 35, average.

Q. At times you have testified, principally testifying on behalf of Plaintiffs.

A. Yes, sir.

Q. About 98 percent of your testimony is for Plaintiffs, correct?

A. Yes, sir. That's correct.

Q. But you do do independent medical exams, correct?

A. I do, yes.

Q. What is an independent medical exam?

A. When a third-party asks you to review records, examine the patient, render your opinion regarding that diagnosis, disability, et cetera.

Q. And you render your opinion in those exams fairly and honestly. Would that be fair to say?

A. Yes.

Q. Okay. And you get compensated, of course, for those exams also, correct?

A. Yes, sir.

Q. And you get compensated if you have to write a report, for writing a report also, correct?

A. Generally, you have to write a report, yes.

Q. In this case you wrote several reports, correct?

A. When you say a "report," the initial report is just

my initial evaluation of the patient then there's reports on EMG's that is typed up, so you call them reports but they're not reports that you charge a fee for.

Q. Okay. Well, you have a couple of reports in your file that have life care plans in them. Right?

A. Yes.

Q. And you certainly charged for figuring out a life care plan, correct?

A. Yes.

Q. And writing a report, correct?

A. Yes, that's correct.

Q. How much did you charge for that?

A. Life care plan is $1,500 each.

Q. And how about the report? You sent a report at a point in time to Plaintiffs' office regarding your findings and what they represented with regard to Nathalie.

A. There is no fee for those reports.

Q. No fee for those reports?

A. No.

Q. You told us you were compensated today it's a full day. It's $9000 for your testimony, correct?

A. Yes, sir. Correct.

Q. Okay. And you do this, you told us, eight to ten times a year at this point in your career.

A. That's correct.

Q. And for the last year or two it's only been for Plaintiff's attorneys, correct?

A. That's correct.

Q. Okay. So about anywhere from $72,000 to $90,000 for your testimony in court, correct?

A. Most cases are half day. Eight, ten times a year times 4,000 is 40,000 so how do you get 72-?

Q. Because you said it was $9000 today --

A. If it goes --

Q. Let me finish.

If we start at 10:00. We have breaks 12:30. We don't resume at 2:30. We get a lot of full days. Is it fair to say?

A. Not all cases are this severe. They're very short. They're usually half days and whatever you get you lose from your office.

Q. You have worked with the Plaintiffs' office, Omrani and Taub, correct?

A. I have, yes.

Q. Many many occasions, correct?

A. What do you mean by "many many occasions"?

Q. Ten, 15 occasions?

A. In the 30-year-period I can't give you an exact

number. If I would have to take a guess, I would say under a dozen times.

Q. Okay. And you know that Nathalie was referred to your offices, you knew at the time by Omrani and Taub, correct?

A. Yes. Of course.

Q. At the time she was referred to your offices, your understanding was that there was no medical insurance, correct?

A. Yes.

Q. Did you know at the time that Nathalie was under the medical insurance of her mother?

A. I did not know.

Q. Did you ever make any inquiries as to Omrani and Taub, "You know, I don't want to be on the hook for this. Can you check with the mother since she's only 18 years old, 17 years old at the time, see if there's any insurance?"

A. I don't get involved with insurance. My office handles all that stuff. I just handle the medical. I have a full office that handles the insurance part.

Q. But you're not working for free. Right?

A. No. Hopefully, not.

Q. Okay. And you said that to counsel just in the end there, you think that the lien is about -- or the amount for your services -- and when you say your services, does that include all the people in your offices, because there's

physical therapists and nurses, I assume, and other people in the office?

A. We don't charge for ancillary staff, just for the professional staff; physical therapy, medical, EMG's, epidurals, et cetera.

Q. Okay. So you're doing EMG's, correct?

A. Right.

Q. You're doing the epidurals, correct?

A. Right.

Q. You're doing the trigger-point injections, correct?

A. Yes.

Q. Physical therapists are doing the physical therapy that's administered --

A. Correct.

Q. -- to Nathalie, correct?

A. Yes.

Q. Any other professionals that are --

A. Massage therapists, also.

Q. You know that Nathalie, when she goes to your offices, gets massage therapy --

A. Yes.

Q. -- correct, that lasts about ten minutes?

A. Yes.

Q. She gets TENS treatment?

A. It's not TENS; it's electrical stimulation.

Q. Electric stimulation treatment.

And that takes ten to 20 minutes, somewhere in that frame, fair to say?

A. Fifteen, 20 minutes.

Q. Fair enough.

So she gets electrical stimulation, massage and stretching from the physical therapist?

A. Yes, correct.

Q. So those are the three exercises -- that's the wrong way to say it -- three modalities she gets each time she attends the physical therapy center?

A. That's correct.

Q. You don't do the physical therapy. You're not involved?

A. I do not.

Q. And you told us that for any services that have gone on since 2015, your offices are owed about $30,000. Right?

A. That's correct.

Q. Did you bring any bills?

A. I'm sorry?

Q. A bill.

A. Did I bring a bill?

Q. Yes.

A. Yes, it's in my file.

Q. And that bill, can I see the bill that reflects $30,000?

A. Yes. Sure.

(The witness hands to the court officer and the court officer hands to Mr. Whalen.)

Q. So you handed me two bills, doctor. Neither -- or both of them have zero balances on them, then you wrote in some numbers on them. Is that correct?

A. I did no such thing. My office calculated the last page is here (indicating). She went to two --

Q. I apologize. I didn't know whose writing it was.

A. Right.

Q. There is a zero zero for the balance owed on that until the handwriting part is in. Is that correct?

A. No. There's a computer number here (indicating) written on the bottom. Says 27,159 plus 3,412. Total 30,587.24.

Q. Now, are there people in your office that take care of this for you? You don't do it. Right?

A. That's correct.

Q. Okay. Would they put that through insurance? Wouldn't you ask them to do that? That's $27,000. That's a lot of money. You've been working for free?

A. If there's no health insurance, they can't.

Q. So somebody from either Omrani and Taub or Nathalie's mother told you that there was no -- or Nathalie told you there was no health insurance?

A. Once again, I don't take care of -- probably told my office there was no health insurance.

Q. You do a lot of work with a lot of other claims firms also, correct?

A. I do.

Q. And you also do that work on the same basis you're doing it here for Nathalie, Nathalie Gonzalez that you wait to get paid at the end of it.

A. Yes. On a case-by-case basis, yes.

Q. So when Nathalie was in Blythedale Children's Hospital, you know she made -- once the external fixator was taken off, you know she made significant progress, correct?

A. What do you mean by "significant progress"?

Q. I'm pretty much quoting from what they say she made, actually, "rapid" is the word they used, rapid progress in ambulating --

A. Yes, I saw that.

Q. -- in dealing with her daily activities of living, correct?

A. Yes.

Q. Okay. Walking longer and longer distances, correct?

A. Yes.

Q. Without complaints of pain, correct?

A. I don't remember seeing "without complaints of pain."

Q. On discharge, she wasn't taking any medications, I think; except you said occasional Advil. I think in the record they say Motrin. Same thing though. Right?

A. Correct. Yes.

Q. Okay. And I want you to assume Nathalie in her deposition testified she takes Tylenol once or twice a week. That's all she takes.

A. My records say she has taken Advil or Aleve occasionally.

Q. Six of one; half dozen of another, Tylenol, Advil. I know one is a pain reliever and one is an antiinflammatory?

A. They're both pain relievers, Advil and Aleve, is an antiinflammatory. Tylenol is not.

Q. But that's consistent with what you noted with Nathalie.

A. Yes.

Q. At a point in time while she was at Blythedale Hospital, obviously, at the beginning, the surgery, couple of weeks after it she's on some significant medications, correct?

A. She's off significant medications.

Q. She came off significant medications some time in February, correct?

A. That is correct, yes.

Q. Then she got to the point and place where she was when she left Blythedale only taking Ibuprofen, correct?

A. Correct.

Q. Okay. She doesn't pick up with you until October. Is that right?

A. August 3, 2015.

Q. I'm sorry. I was thinking August and I said October. I apologize.

A. That's okay.

Q. August of 2015, correct?

A. Yes. Correct.

Q. And at that time she reported to your office, I believe, it was the Grammercy Park office?

A. I forget which office. She went to both offices.

Q. Now, at that point in time, you examined her, correct?

A. Yes.

Q. Took the history you talked to us about.

Did you ever get in touch, since you were a treating physician for her, with her surgeon, Dr. David Joseph?

A. No.

Q. You didn't think that was important to talk to him about what he did and how he did it --

A. No.

Q. -- and what his findings were?

A. No.

Q. Would you agree he did an excellent job with Nathalie, Dr. David Joseph?

A. Yes.

Q. And the staff at Elmhurst Hospital also did an excellent job with regard to Nathalie Gonzalez' care and health?

A. To the best that could be done, yes.

Q. Did you speak to anybody at Elmhurst Hospital besides Dr. Joseph about Nathalie Gonzalez' health and care when she left there?

A. Excuse me. You try to speak with someone at Elmhurst Hospital. It's almost impossible. I work there. I know.

Q. So maybe you have an in. You can get through.

A. No.

Q. Did you speak to anybody at Blythedale?

A. Did not.

Q. Would you agree that the doctors at Blythedale, the doctors, nurses, therapists did an excellent job in getting Nathalie back to being able to handle her daily activities of

living when she left?

A. To the best that could be done, yes.

Q. And you're not aware of any physical therapy until your physical therapy started. Is that correct?

A. No, that is wrong. She went to Restore before she came to me, a local place in Queens. She had about 30 sessions of therapy there before she came to see me, and then she ran out of coverage.

Q. When did you find out about that? This morning you said you weren't aware of that.

A. I didn't have the records but I was aware that she went --

Q. So when we had a break, counsel provided you with some records?

A. Last night when I was speaking to counsel, he told me the chronology of A to Z that was reviewed.

Q. This morning you testified you weren't familiar with Restore.

A. I did not know the name of the facility. I did not have the records. I said I don't have the records and I did not recall the name.

Q. Would that have been important for you to have the records when you first saw Nathalie to see what they were doing for their occasions of physical therapy?

A. No. For very good reason.

Would you like to know why?

Q. No.

A. Okay.

Q. Let me ask you this: You have a pain scale as a physiatrist of people that complain of pain, correct?

A. Yes.

Q. Zero, no pain at all?

A. Correct.

Q. And ten, the most pain you can have, correct?

A. Yes.

Q. And that's important. You keep track of that also in the course of your business, the pain scale that the patient reports. Isn't it?

A. Generally, yes.

Q. That's part of the history. You want to know if they're in pain so you can treat them. Right?

A. That's correct, generally speaking, yes.

Q. Do you know that when Nathalie attended Restore Physical Therapy after leaving Blythedale Hospital, that she explained that her pain was only on a scale of four out of ten which is aggravated by physical therapy or action, motion.

Did you know that?

A. I did not.

Q. Did you know that when Nathalie left Restore Physical Therapy after those 20 or 30 visits, that she reported zero pain?

A. Mr. Forde told me that last night.

Q. How long did you speak to Mr. Forde last night?

A. Oh, I've been speaking to him for a few days now; one hour here, half hour there, one hour there.

Q. Okay. You want to make sure you got all the testimony correct. Right?

A. The pertinent stuff, yes.

Q. Anybody else from Omrani and Taub you were speaking to?

A. No, just Mr. Forde.

Q. Did you speak to Nathalie at all?

A. About general stuff; how are you doing, what are you doing lately, that the kind of stuff.

Q. So she's out of Blythedale, she goes to Restore -- She's referred to Restore.

Did you know how she got to Restore?

A. No.

Q. Okay. She was referred by Blythedale Hospital.

Did you see that in the records?

A. I'll take a look.

(Witness refers to documents.)

It just says she will be discharged with medical providers in the community.

Q. Okay. There's another record in there. These are voluminous records --

A. Um-hmm.

Q. -- doctor, but it gives her a choice of three facilities, one of them being Restore.

A. Okay.

Q. And the choice in giving her those three facilities, which was to her mother, which is expected since Nathalie was only 17 at the time, was that these three facilities in the Blythedale records take your insurance.

A. Okay.

Q. Okay. But you didn't see those records before you started treating her. Right?

A. I did not.

Q. When she came to you, your understanding, when she's referred to you by Omrani and Taub was that she has no insurance.

A. That's correct.

Q. Despite the fact that at Restore there was insurance and it took care of her physical therapy?

A. But she exhausted it.

Q. She exhausted it?

A. Yes.

Q. I thought you didn't know about it?

A. All this stuff was discussed last night, and for the record, I did not know the name of the facility. I did know the details.

Q. So she finishes at Restore. You say you know the details, but you didn't know she was reporting zero out of ten pain.

By the way, did Nathalie have a pediatrician or an internist as her day-to-day doctor?

A. I'm not sure.

Q. Okay. Do you know if she had an OB/GYN doctor, somebody of that nature to take care of her female needs?

A. I believe she was seen by the OB/GYN department at the hospital, but afterwards I have no idea.

Q. Okay. Did you contact her, ask her all the times you treated her, Do you have a doctor, a primary care physician? Do you have an OB/GYN doctor that I can discuss your situation with, because if I'm going to come into court and give some opinions about childbirth and what the future is and how she's doing?

A. The answer is no, for a very good reason.

Q. Did you review either of Nathalie's two depositions?

A. I did not.

Q. You know what a deposition is, correct?

A. I do.

Q. And you know that in a deposition you discuss or can discuss all your complaints and your problems and your issues that are the subject matters of the case?

A. I don't read depositions. I just read medical records.

Q. Did you know or did you see in the Blythedale Children's Hospital medical records that the low back and pelvic pain had resolved?

A. At the time, yes.

Q. The pain had resolved and she was not referred to surgery. Did you see that too?

A. I did.

Q. Did you know also that she was able to ambulate up and down stairs before she left?

A. Yes, that's one of the requirements before discharge.

Q. Do you know that she was referred to a primary care physician or an orthopedist because she was cleared to return to high school, but to return to gym class she needed further clearance?

A. You're asking me if I knew she was referred to an orthopedic surgeon?

Q. Did you see that in the Blythedale Hospital notes?

A. All I saw was what I said, that she was referred to different providers in the community.

Q. Okay. You reviewed the x-rays and the CAT scans yourself, correct?

A. Yes, sir.

Q. You also saw the narratives from the various radiologists that did that, correct?

A. Yes, sir. I did.

Q. Would it be fair to say that, although you were -- you got some experience in reading films, correct?

A. Yes.

Q. And you got that experience not only in your profession now as a physiatrist where you had a rotation somewhere in medical school or in residency or internship.

A. All of the above.

Q. All of the above, okay.

Would it be fair to say, though, you deferred to a radiologist as to his opinion like a Board certified like yourself, radiologist?

A. Generally speaking, yes, but sometimes there may be disagreements so then I have to ask the radiologist to reread it or ask a different radiologist for another opinion. It happens. It happens. Things are missed.

Q. But these are just like yourself, gone through all

the testing, exams to become a Board certified radiologist, correct?

A. That's right. But --

Q. In general, would it be fair to say you defer to their opinion, in general?

A. In general, yes.

Q. Okay. Fair enough.

I guess I gather you also know how to review MRI's, correct?

A. Yes, sir.

Q. You reviewed the MRI's.

There were how many MRI's taken of Nathalie?

A. Lumbar spine, two.

Q. Lumbar spine, two.

The first one which showed the radiologist found what he believed to be a herniation and an annular tear, in sum and substance, correct?

A. Yes.

Q. Okay. And then the second MRI taken in September of 2016 didn't show that that was a normal MRI, correct?

A. Correct. Except for right L5-S1 facet arthropathy.

Q. It said examination of the intervertebral disc spaces shows no evidence -- I'll wait for you to get it out.

A. I have it.

Q. No evidence of disc bulge, disc protrusion or extrusion. Right?

A. Correct.

Q. The disc is right where it was supposed to be, correct?

A. That's what the report says, yes.

Q. It's not going in any directions. It's not puffing out, it's not pushing out. Right?

A. That's what it says.

Q. I think you used the analogy of the jelly doughnut this morning when you were describing it. Could have been early afternoon but when you were describing the makeup of the disc, correct?

A. Yes.

Q. And you had talked about the nucleus pulposus which is the center and really a lot of you doctors use this as your analogy, the jelly of the jelly doughnut, correct?

A. That's correct.

Q. And there's pushing on that jelly doughnut then the end of the annulus pulposus is perforated the surrounding structure and or bulged out, correct?

A. You mixed me up with a lot of --

Q. It's not easy to do for a lawyer to get a doctor.

A. You have it partially correct; you have a lot of it

incorrect that's why it got all mixed up.

Q. So we push down on the jelly. It goes out the jelly hole, okay --

A. That's a full herniation.

Q. There we go.

A. Complete tear of the annulus.

Q. Correct.

A. Complete release of the disc, the nucleus pulposus past the disc margin. That is a definition of a disc herniation.

Q. Okay. Not present September 9, 2016.

A. No.

Q. It goes on to say that the facet joints appear otherwise unremarkable, but there is -- I read it the wrong way. Let me correct, "right L5-S1 facet joint arthropathy is present."

A. Correct.

Q. That's what you're saying is the onset of the arthritis, correct?

A. That is correct.

Q. Okay. And the word "arthropathy" is, really, it's definition is an abnormality. Right?

A. Arthropathy means a pathologic condition to the joint. It's synonomous to arthritis.

Q. And abnormality.
A. And abnormality.
Q. The facet joints appear otherwise unremarkable.
A. The other ones, that is correct.
Q. So all the other facet joints pictured in this particular MRI are fine. Right?
A. That is correct.
Q. There is no exit foraminal stenosis. There's not a shrinking of the canal or anything like that. Right?
A. That's not what "stenosis" means.
Q. What does it mean?
A. Narrowing of the canal.
Q. So I said shrinking. Narrowing of the canal, that's not present. Right?
A. No.
Q. And that's a finding of arthritis, correct? Can be.
A. Narrowing of the canal happens in people age 50 and above not in a 19-, 20-year-old girl.
Q. And it wasn't here.
A. It was not there.
Q. So she's fine for a 19-, 20-year-old girl, correct?
A. No. She has right L5-S1 facet arthritis.
Q. With regard to the stenosis.
A. She has no stenosis.

Q. The conus medullaris and the cauda equina, "horse's tail."

A. Yes.

Q. Just a big Latin word. Right?

A. That's correct.

Q. -- appear within normal limits, also.

A. Correct.

Q. So everything is looking good with regard to those two things.

A. Correct.

Q. The vertebral body height alignment and marrow signal are within normal limits, so it looks normal --

A. Correct.

Q. -- for Nathalie Gonzalez. Right?

A. Correct.

Q. For her age and things like that.

A. For that time, that is correct. Yes.

Q. No gross para-spinal masses are seen, correct?

A. Correct.

Q. So you're treating Nathalie with physical therapy for the couple of years that you're doing this, correct?

A. Correct.

Q. Okay. Plus the epidural injections that you discussed with us also, correct?

A. Correct.

Q. And you know that Nathalie completed high school.

A. Correct.

Q. Okay. Went to college the next year, correct? You knew that?

A. I don't know if she finished college. She went to college, yes.

Q. We're talking about went to college in September.

A. Right.

Q. Did her first year of college. You knew that?

A. Right.

Q. Because you were treating her.

A. Right.

Q. You knew some of this history.

This is important history because it's showing she's getting into college, going into college like 17-, 18-year-olds would be doing, correct?

A. Correct.

Q. That she finished her first year and went back to college for her second year. You knew that. Right?

A. Yes.

Q. Finished her second year, correct? You knew that?

A. I stopped knowing after the second year. I don't know if she finished or not.

Q. Was it because you were not seeing her or you don't know or it wasn't an important part of her history that she was going about her normal activities of daily living?

A. She was going about her normal activities of daily living, no question about that, but with some difficulty here and there.

Q. And you also know that she finished that second year. Right?

A. I'm not sure if she finished it, but if you say so.

Q. Do you know what she's doing now?

A. Yes.

Q. What is she doing now?

A. She's working in a clothing store.

Q. Do you know what she's doing at the clothing store?

A. Sales, cashier.

Q. Is that what she told you or you're just guessing?

A. I'm guessing.

Q. You mentioned that you had reviewed reports from Dr. Rigney, a doctor I hired to look at the films, correct?

A. Yes.

Q. You said you looked at a report from Dr. Grelsamer, a doctor I hired, correct?

A. Yes. I know both of them very well, yes.

Q. And Dr. Elkin.

A. Him, I don't know.

Q. Either do I.

He might not be one of my doctors.

A. Okay.

Q. Does Nathalie have any scheduled appointments with you?

A. Yes.

Q. When is the next appointment?

A. I don't know. My office has the next appointment.

Q. Would that be a physical therapy appointment?

A. A physical therapy appointment and one to probably see me again for reevaluation.

Q. And do you know when her last physical therapy appointment or appointments was?

A. Yes, May 15 of this year.

Q. How about the one before that?

A. I have it right here. May 15, 2018. Before that was 4/17/18. Before that was 4-10-18.

Q. And were those physical therapy appointments?

A. Physical therapy, yes.

Q. Not appointments with you?

A. No. Physical therapy.

Q. Where they had the heat and massage and the electrical stipulation?

A. And exercises, yes.
Q. And the exercises.
She's doing home exercises also --
A. Yes.
Q. -- as part of her recovery?
A. Yes.
Q. The life care plan, when were you asked to do that?
A. On or about February 1, 2016.
Q. Okay. Was it revised ever?
A. Yes. Tell you when the first one was done. The first one was done without the MRI findings. The first one was done November 7, 2015. Did not have the MRI findings because the MRI's were done after that report. They were done on 11-22-15.
Q. And despite the MRI of 2016 that was normal, you still think it's appropriate that Nathalie has an MRI every year. Is that what you're opining?
A. Yes, for a variety of good reasons.
Would you like to know what they are?
Q. No.
A. Okay.
Q. And EMG's also every year?
A. Yes. She had one in September of 2017. It showed a worsening of a radiculopathy.

Q. But that was your interpretation. Right?

A. There's only one interpretation. You have the abnormality. You have the tracings and you have the findings and you have the conclusion.

Q. To revise the life care plan were you paid an additional amount of money?

A. I believe a smaller amount not the full amount. I believe it was half the amount.

MR. WHALEN: No further questions.

Thank you.

THE COURT: Anything further of this witness, Counsel?

MR. FORDE: Yes, just a few things.

REDIRECT EXAMINATION

BY MR. FORDE:

Q. Okay. Dr. Guy, when Mr. Whalen was asking you about why it would not be necessary for you to have the records from Restore Physical Therapy, you said that there were very good reasons for that?

A. Yes.

Q. What were those reasons?

A. Physical therapy is standard. There is no magical way to change physical therapy. It's standard. It's hot packs, electrical stim and therapeutic exercise. I don't need

to know what was done because I have my own evaluations and I'm going to do my own physical therapy, so if it was an examination by a surgeon, a procedure, an MRI, an EMG or another x-ray, yes, I would like to have that to be seen, but physical therapy at another facility? No. It's just repetitious.

Q. I see.

Now, with regard to the September 9 of 2016 MRI that was done after Dr. deMoura --

A. Right.

Q. -- saw Nathalie, would you consider that to be a normal MRI?

A. It's not a completely normal MRI, no.

Q. And in what way was it abnormal?

A. The right L5-S1 facet joint arthropathy is not present on the prior MRI of 11-22-15 and, by the way, that's where the sacral ala fracture was on the right side near that area. Sacral ala right over here (indicating). That's where the fracture was so it's not unusual to have arthritis at the level of a prior fracture, which is what I've been saying all morning long.

Q. Now, but with regard to the fact that -- and Mr. Whalen was pointing out to you or asking you about the bulges, protrusions being not present, so how do you account

for that as far as the September 9, 2016 as opposed to the MRI that you had taken earlier November 22nd of 2015?

A. Right. When you have a herniation of a disc, the water content leaks out. The disc begins to shrivel up and once the disc shrivels up, when you do another MRI one year, two years later, it may not show up again, so it the doesn't mean that the disc is not herniated. It just means it's not showing up. I use the analogy of a turtle sticking out its neck underneath it's shell. With the herniation the head of the turtle goes back underneath the shell. You don't see the head or the neck. Doesn't mean the turtle doesn't have a head or a neck. You just can't see it.

Q. So MRI's, as a general premise, can you have varying results from one MRI from one year to another MRI from another year?

A. It happened right here (indicating). That's why you need to repeat it periodically to see what's going on.

Q. And the purpose of an MRI like those two as a diagnostic tool --

A. Right.

Q. -- is that meant to be a definitive determination based upon what's in the MRI report --

A. No.

Q. Or is it --

MR. WHALEN: Objection.

Beyond the scope.

THE COURT: Sustained.

Q. Doctor, are you familiar with the term "malingering"?

A. Yes.

Q. What is the term malingering?

MR. WHALEN: Objection.

Beyond the scope.

THE COURT: I'll allow it.

You may answer.

A. A malingerer is a person that doesn't have a bonafide injury. They're trying to milk the system and fabricate something when they have nothing. A person that has multiple fractures is not a malingerer. A person that had epidural injections is not a malingerer. These things hurt and these things have dangers and side effects. A patient that's a malingerer doesn't continue medical treatments. They go once or twice and stop. This is not a case of a malingerer.

THE COURT: Anything further?

MR. WHALEN: One more thing.

Thanks, Judge.

RECROSS EXAMINATION

BY MR. WHALEN:

Q. Doctor, you said with regard to that second MRI that

sometimes because the herniation is out and it dissipates or whatever you used, that the vertebrale heights diminish.

A. Never said that.

Q. What did you say?

A. I said that the water content leaks out. The disc begins to shrivel up. I didn't say the disc height drops.

Q. So if the disc shrivels up and there's water in the space, and shriveling up doesn't mean shrinking in your vocabulary. Is that correct?

A. It has levels, has stages; stage one, stage two. Those diagrams that you took away from the desk shows the pathology.

Q. But this is normal. Right?

A. That is normal --

Q. (Continuing,) Normal height.

Yes or no, doctor, normal height?

A. Yes, it's normal height.

MR. WHALEN: That's all. Thanks.

THE COURT: You may step down. Thank you.

Counsels, step up.

(Whereupon, a bench conference takes place.)

THE COURT: All right. Counsel, ready to call your next witness?

MR. FORDE: Yes. Plaintiff calls Dr. Steven

Struhl.

MR. WHALEN: Can we approach for a second?

MR. FORDE: Sure.

(Whereupon, a bench conference takes place.)

THE COURT OFFICER: Follow me, sir.

(Witness takes the stand.)

THE COURT OFFICER: Please proceed straight ahead and up the stairs and remain standing.

THE COURT CLERK: Please raise your right hand.

D R. S T E V E N S T R U H L, was solemnly sworn and testified as follows:

THE COURT CLERK: Please be seated.

State your name and address for the record. Spell your name.

THE WITNESS: Steven Struhl, S-T-R-U-H-L.

THE COURT CLERK: Address.

THE WITNESS: Business address is 136 East 57th Street, New York, New York.

THE COURT: Good afternoon.

THE WITNESS: Good afternoon, Your Honor.

THE COURT: Counsel, you may inquire.

MR. FORDE: Thank you, Judge.

DIRECT EXAMINATION

BY MR. FORDE:

Q. Good afternoon, Dr. Struhl.

A. Good afternoon.

Q. Dr. Struhl, have we ever met before today?

A. No.

Q. All right. And are you a physician licensed to practice medicine in The State of New York?

A. Yes.

Q. When were you so licensed?

A. 1986.

Q. Could you just state your educational background.

A. I went to college at MIT. I went to medical school at University of California in San Francisco. I did an internship in surgery at University of Michigan, residency in orthopedic surgery at Montefiore Medical Center in Einstein and I did a fellowship in sports medicine in Penn State.

Q. Are you board certified?

A. Yes, and recertified.

Q. Board certified and recertified?

A. You have to recertify every ten years. I've been recertified twice.

Q. Do you have a medical specialty as far as orthopedics?

A. Arthroscopy and sports medicine.

Q. And you are an orthopedic surgeon.

A. Yes.

Q. What is the field of orthopedic surgery?

A. Basically, it comprises the part of medicine dealing with the musculoskeletal systems; specifically, the bones, joints, ligaments.

Q. Okay. Now, in the course of your practice, do you deal with trauma patients who have been injured in accidents?

A. Yes.

Q. And have you testified before on behalf of claimants, people making claims for personal injuries?

A. Yes.

Q. Approximately how many times have you done that in the past?

A. It seems like I go maybe twice a year, so times 15 years, we'll say 25 times.

Q. The people you testify for, are they typically your patients?

A. Almost always.

Q. Are you being compensated for your time today?

A. Yes.

Q. What are you being compensated?

A. $7,500 for the afternoon.

Q. Now, were you asked to evaluate Nathalie Gonzalez with regard to this accident?

A. Yes.
Q. And when were you asked to provide an evaluation?
A. August 23, 2016.
Q. Before then had you ever seen her before?
A. No.
Q. And how did that come about? How were asked to conduct your evaluation?
A. The law firm of Omrani and Taub, that was their client, and they sent her to the me to do what they call a narrative summary.
Q. Narrative summary?
A. Yeah.
Q. And in order to prepare that narrative summary what types of records did you review?
A. I reviewed the records they sent me. I don't know if I recorded all of them but the pertinent things are the hospital records and surgical records.
Q. Did you have a file with regard to this patient?
A. Yes.
Q. Did you bring it with you today?
A. Yes.
Q. And what --
A. I'm not hundred percent sure that there wasn't more documents than are in this file because sometimes when I'm

asked by a lawyer to review files, they send me three inches of records and I filter through them and find out what I want. So I don't recall whether they sent me what I brought today or they sent me this plus other stuff that I filtered out.

Q. I see.

So with regard to what you have with you today, could you give us an idea of what your file consists of.

A. Yes. There is a surgical note from her surgery -- looks like that's a duplicate (indicating) -- an MRI report from September 9, 2016, some photographs, some at the time of injury, some after the surgery. An artist's drawing, a rendering, and I admit these are printouts from my office because we are fully electronic so we don't keep. We just scan and print the originals and the color printer wasn't working today but these are high quality images. I brought, of course, the narrative summary from Omrani and Taub. There's a discharge summary from Elmhurst Hospital and there's a discharge summary from Blythedale Children's Hospital, and I think that's pretty much it -- I take that back -- an MRI of the pelvis from July of 2016 and an MRI of the lumbar spine that was done earlier on November 23, 2015 and then we always ask the patient to fill out what we call an intake sheet, so she just fills out some basic information like anybody else that comes to the office.

Q. All right. So when you saw Nathalie to do your evaluation, did you take a history from her?

A. Yes.

Q. What was here that you got from her?

A. The history was at the age of 18 she was a pedestrian hit by a school bus and my understanding is she was not only hit but the back tire ran over her body.

Q. And as far as your examination, when you met with her, what were her complaints?

A. She, basically, said she had posterolateral pain in her back so, in my view, she was pointing somewhere in the junction of her sacrum and pelvis, the low back area, and it was a moderate degree. I always ask patients to give me their pain score, which is a crude way of determining somebody's subjective experience, and she said, it was five on a zero to ten analogue pain score.

Q. Now, did you also, when you reviewed the medical records, did you make a medical chronology as to what her course of treatment was from the time she had the accident up until the time she saw you?

A. Yes.

Q. What was that chronology?

A. That she was taken to the hospital and evaluated in the emergency room. She had x-ray studies done. They

determined she was losing blood. The discharge summary from the hospital says there were multiple episodes of hypotension, which means low blood pressure, which means bleeding. Since there was no obvious source of bleeding, they found a pelvic fracture. It's well known that pelvic fractures can cause internal bleeding or the fancy word is "retroperitoneal" bleeding, and because the pelvis is a large space, you can bleed -- essentially, you can bleed out without ever looking like you have any blood loss externally. So she had multiple episodes of hypotension. She got multiple units of blood. She still had hypotension, so within a short period of time, I think 12 hours or less, she was taken into the operating room where they put on a device called an external fixator. The simple purpose of that is to, shall we say, close the pelvic ring to reduce bleeding. That's the primary purpose of the procedure she had. So they put the fixator on and she stabilized.

Q. The primary purpose is to stop her from bleeding?

A. Correct.

Q. And, secondarily, is there an orthopedic element?

A. To some extent. I mean, you can't really align the bones with pins that are four inches away from the fracture site, so its primarily to close the pelvic space to stop the bleeding. You may get some orthopedic benefit. Really nothing

on the front. Probably not a lot on the back. Its primary purpose is potentially to save her life so she doesn't bleed to death.

Q. To save her life?

A. So she doesn't bleed to death. That's right.

MR. FORDE: Let me see if I can get this working.

Just for the record, the image on the screen is from Plaintiffs' 6 which has been marked into evidence and this is from the Elmhurst Hospital radiologist studies performed.

Judge, can the doctor step down?

THE COURT: You may step down, doctor.

(Doctor approaches the projector.)

Q. Dr. Struhl, if you could try to get close to the screen so that the jurors can see what it is that you're pointing out here.

THE WITNESS: Could you make that bigger?

MR. FORDE: I don't know that I can do that. If there is a way to do that, I don't know what it is. I can make it bigger by pushing this away.

THE WITNESS: Okay.

THE COURT: Can all the members of the jury see?

(The jurors indicate they can see.)

Q. Okay. So looking at this image from the preop, can you identify fracture sites in that x-ray?

A. Yes. You can see there is a crack here on the superior pubic ramus. You can see a crack here in the inferior pubic ramus. It appears that there's a comminuted fracture of the pubic ramus over here and another one over here (indicating) and the technical term "comminuted fracture" means it's not two simple pieces. It's a fracture that has three or four fragments. It's more smashed, if you will.

Q. So the fractures that you were pointing out there that you referenced comminuted, these are not like clean breaks.

A. Some are. This is definitely not and this probably is not (indicating).

Q. Okay. What is the difference, clinically, as far as a comminuted fracture from one that would be a clean break?

A. Usually, comminuted fractures are more unstable. The bones tend to move around because there's less stability.

Q. And in the left side of the fracture, is there an area near the left hip joint where there is a fracture site?

A. Well, I know from other things there is, but I know it's around here but you really can't see it on that film.

MR. FORDE: Maybe if we can have the easel put up, Judge, I can finish with this.

(Court officer puts up easel.)

Q. Doctor, we have what has been marked for demonstrative purposes as Plaintiffs' --

THE COURT OFFICER: That's 13.

MR. FORDE: Thirteen. Okay.

Q. Would this help you to illustrate a little better to the jury the x-ray that we're looking at using the diagram as far as the various fracture sites?

A. Much better. It's three dimensional.

THE COURT OFFICER: He can't see.

(The witness backs up for juror to see.)

Q. If you could, could you explain the different fractures that are shown in that.

(Court officer hands pointer to witness.)

THE WITNESS: Thank you.

A. I point at a fracture over here, here, here and here on the regular x-rays, but what this shows is, actually, each one of them is comminuted so all four fracture sites. That's a break but there's what we call butterfly fragment here (indicating). There's a break here. See one, two, three, four, five fragments. So that's comminuted. Here is just, it's actually pulverized all throughout here, and this fracture you see an extra fracture so it's crushed here, here, here and here (indicating.) And that's just the front. There's a crack

here at the top of the pubic ramus and that crack goes into the hip joint, and that's all on the front side. Pelvic fractures usually always have a front side component and a back side component, so the back side is here and you can see the sacrum is cracked all the way through here. There's another fracture here and, by the way, these little black spots, those are called neural foramen, so the sacral nerves come out of these holes and supply different parts of the body. So this one is right where the neural foramen is, and this bone is called the coccyx bone, so there is a fracture right through here (indicating.)

Q. So the fact that the fracture sites run along the neural foramen, of what clinical significance is that?

A. It might give rise to neurological symptoms. This is S3. It's probably going to affect something more in sensation than motor.

Q. What about here, L5-S1?

A. This is L5-S1. The neural foramen would be up here so there's nothing going on up there on the bone. And that's kind of an important issue here which is, you know, we focus on what we can see here. We see bones, but when you see this amount of comminution that's pretty high energy, and any time you have a high energy injury, there's going to be tremendous amount of soft tissue and damage. As doctors we tend to under

estimate that because we zone in on what we can see forgetting there's a ton of other soft tissue that gets disrupted. So just because you can't see it here, that doesn't mean there's not a lot of other damage in a lot of other places, and that all then creates scar tissue (indicating).

Q. So the kind of soft tissues that you're talking about that surround the pelvic ring, the hip joint and things like that, what kind of connective tissues and soft tissues are they?

A. Well, just for instance, here on the pubic ramus, you have all your abdominal muscles attached. Here you actually have tendons, ligaments. Here are the hamstring muscles. So the bone is the site of a lot of muscle and tendon attachments and when you crush this, those things are going to get affected too (indicating).

Q. Okay. So now, the surgical procedure that was done, you said that there was external fixation, correct, doctor?

A. Yes.

Q. This has been marked as Plaintiffs' number 16, I think.

THE COURT OFFICER: It should be 12.

MR. FORDE: Twelve.

Upside down it's 16.

Q. Now, in the upper right-hand corner there's an image

there.

Can you explain what that image is in the upper right.

A. Basically, it's the same image you saw before except you will see two pins in each part of the upper pelvis and then as you see on the pictures here, they're connected by a little Erector set, shall I say, or external fixator, and what that does, it provides stability to the pelvis, because when you have on the other x-ray when it's cracked there and there (indicating) the pelvis naturally expands a little bit, and as I said before, the primary purpose of this is to put the pelvis back to its original volume so the patient stops bleeding (indicating.) And you can't really see it well here, but if you look, this is the worst fracture site, the left pubic fixator. As you see, this left fixator doesn't do anything for the fractures. It's there to reduce pelvic volume as its primary purpose.

Q. Doctor, you can take the stand now.

Doctor, I'm going to show you what has been marked as Plaintiffs' 10 for demonstrative purposes.

(Court Officer hands to the witness.)

Q. Okay. Now, that model, have you ever seen that model or an image of it?

A. I believe I have.

Q. And do you know if you made any markings on either that model or an image to create it?

A. An image to create it?

Q. Yes. Did you make any markings on the image to create it?

A. I believe so. When I first saw her two years ago.

Q. When you saw her two years ago.

A. Yes.

Q. What did you do as far as the image that you took to create that model?

A. Well, I basically try to see where the fracture lines were and note where they were at this part on the various parts of the pelvis, but as you can see, this doesn't tell the whole story because as you saw from the 3D image, there's a lot of comminution and they can't make lines. I'm not much of an artist.

Q. It's a road map of where the fractures were?

A. It really doesn't do justice to the amount of energy that went into those fractures.

Q. And that wouldn't show, obviously, any of the soft tissues or connective tissue or anything like that?

A. No.

Q. It would not, okay.

So based upon the examination you conducted, doctor,

what were your physical findings with regard to Nathalie at that time?

A. The primary abnormality that I saw -- there were a few -- is that she had a loss of motion on her left hip on external rotation, so there was an asymmetry on right versus left and she had areas of tenderness over where the fracture sites were. Looks like a little bit more on the right side than the left side.

Q. And did you also --

A. (Continuing,) Obviously, I noticed the scars from the fixator. The external fixator, because when the pins stay in there they're in there for like three months and there's always like a low grade infection that always has to be cleaned up so there's like scars not like surgical scars. They're kind of holes and there's four of them.

Q. All right. Doctor, what is pseudarthrosis?

A. Pseudarthrosis is, essentially, a nonunion. Nonunion is an orthopedic term. If the process doesn't happen, you take an x-ray. It looks like it's still fractured but a pseudarthrosis is a situation where there's scar tissue on both sides of the fracture. You still see the fracture line, so it almost looks like a joint where there's no joint. That's why pseudarthrosis, "arth-" is the joint, like pseudo joint. So essentially, that's a nonunion. It's a descriptive way of

calling something a nonunion.

Q. Did you have a chance to look at an MRI of the pelvis from July of 2016?

A. Yes.

Q. And you looked at the films yourself?

A. Yes.

Q. Okay. Doctor, this is an MRI film from July 19 of 2016 from NS Radiology?

A. Okay.

Q. Is that the date of MRI?

A. Yes.

MR. FORDE: I would like to mark this in evidence.

(Mr. Forde shows Mr. Whalen.)

MR. WHALEN: No problem.

No problem with the disc.

MR. FORDE: Yes. What's attached you can take off.

THE COURT OFFICER: Plaintiffs' 17.

MR. FORDE: So, Your Honor, maybe it would be better if the doctor navigated this.

MR. WHALEN: I have no problem with that.

THE COURT: You may step down, doctor.

(Witness steps over to projector.)

Q. If you can, doctor, what I would like you to do is, I know you said you reviewed this MRI with regard to potential pseudarthrosis of the pubic and left Ischial fractures. Maybe you can navigate this.

(Witness finds on computer.)

A. This doesn't show it great, but this is a frontal view of the pelvis and you can see here all this black signal here --

THE COURT: I don't believe the jurors on the right can see.

(Witness moves over so jurors can see.)

A. There's a lot of black signal here where there should be bone, so that's the scar tissue that formed on the left side which was heavily damaged, okay, right in there (indicating).

MR. WHALEN: Could you tell us what sequence in the MRI you're looking at.

THE WITNESS: When you say "sequence" --

MR. WHALEN: I know there's a hundred quick little pictures. I just have to know which one you're looking at.

THE WITNESS: That's the axial FS80 and it looks like -- it's here somewhere.

MR. WHALEN: I see study ID dot on the screen with 16863 --

THE WITNESS: That's probably just a study. Usually, it says image number --

MR. WHALEN: It says image nine.

THE WITNESS: It says nine over 60 here.

MR. FORDE: Oh, nine out of 60.

MR. WHALEN: Thank you.

THE WITNESS: I'm more used to looking at CT scans and MRI's for bones. It's not the best thing for bones.

THE COURT: This is the beauty and the curse of modern technology.

How are we doing, doctor?

THE WITNESS: That's the best I could do so far.

THE COURT: All right. Let's continue.

THE WITNESS: I guess, I'm used to seeing CT more than MRI.

Q. All right. So, doctor, based upon your review of the MRI after you examined Nathalie, you felt that there was nonunion of the pelvic ring fracture?

A. Yes, I mean, basically, when you look at that original x-ray and you look at the post-op one with the fixator, especially the anterior bones, they're are going to look the same because the only way to realign all those bones is to open up and put a plate on it so however it looked at the

fracture, it's going to look the same when it's healed. Some of the cracks will heal but the comminuted areas are not going to fill with bone.

Q. Does that cause a problem for the patient in the future as far as their physical activities or function in any way?

A. Well, you have a lot of scar in the pelvis and, again, there was a posterior element fracture, as well, so any time you have a lot of scar tissue, you have the potential for chronic pain.

Q. The patient was 17 years old at the time.

Would you expect a patient like that to have permanent residuals as a result of such a trauma?

MR. WHALEN: Objection.

THE COURT: Sustained.

Rephrase.

Q. Okay. Did you form an opinion with regard to her future prognosis?

A. I did.

Q. And what was that opinion?

A. First of all, we didn't talk a lot about the crack in the bone that went into the hip joint, so any time you traumatize what's called the "articular surface" and you get scar tissue there, it has the potential to develop into what's

caused traumatic arthritis. Arthritis is normally a degenerative condition that affects some people as they get older, but if you traumatize the cartilage, especially young in life, that can break down over time. So I said there was more than even likelihood that she would require hip replacement at some point in the future.

Q. Okay.

A. And I also said that she was at increased risk of not being able to have a vaginal childbirth, that she would be more likely to require or be advised to get a cesarean section whenever she gets pregnant.

Q. So with regard to the injuries and the residuals to the pelvic ring and those things, do you have an opinion with a reasonable degree of certainty as to whether or not her condition is permanent as of the time you examined her?

A. Yes. I think, if I'm not mistaken, I saw her roughly two years after the original injury -- not quite but close -- and my opinion, is once, for almost any orthopedic condition, once you get two years out, you pretty much got what you got.

Q. So as far as any increase in her condition to the future, would you anticipate that there would be any appreciable improvement in her complaints?

A. No, I wouldn't expect any improvement, and in some areas I would expect some deterioration.

Q. Deterioration.

And would she require any type of further care into the future in order to give her a better chance?

A. Well, as I said, there's some chance of more than an even chance of needing a total hip replacement. I'm not a spine surgeon, but I know that there was signs of arthritis at the L5-S1 level. It's really something unusual in a 19-year-old so if you see it at that age, there's a reasonable chance it's going to progress requiring spine surgery. I can't tell you what because it's not what I do, but I do know you shouldn't see those changes on a 19-year-old girl.

MR. FORDE: Thank you, doctor.

I have nothing further.

THE COURT: Counsel, you may examine the witness.

MR. WHALEN: Thank you.

CROSS EXAMINATION

BY MR. WHALEN:

Q. Good afternoon, doctor.

A. Good afternoon.

Q. We never met before. Right?

A. No.

Q. Did you review any of the reports prepared by the defendant's doctors before coming in here to testify?

A. No.

Q. Do you know a Dr. Rigney, a Board certified radiologist?

A. Heard of him.

Q. Dr. Grelsamer.

A. Ron Grelsamer?

Q. Yes.

A. Yes, I know him.

Q. How do you know him?

A. Well, I worked at NYU Hospital for Joint Disease. In the late nineties he was there too. I saw him in the locker room all the time. I got to know him. I haven't seen him in the 15 years but I got to know him.

Q. Fair enough.

You were asked to see Nathalie Gonzalez on August 23rd of 2016, correct?

A. Correct.

Q. And that request came through the law office of Omrani and Taub. Right?

A. Yes.

Q. Have you worked with them before?

A. Yes.

Q. How many times?

A. You have to define what you mean by "work with them"

before.

Q. Have you examined plaintiffs that they've sent to your offices for physical examinations and rendered an opinion?

A. Yes.

Q. How many times?

A. Over the last ten or 15 years, 50, maybe. It's a guess. More than ten. Less than a hundred.

Q. Fair enough.

And on those times you've also been asked to prepare a report in examining the plaintiff, in this case Nathalie Gonzalez, correct?

A. Always.

Q. And you're compensated, obviously, for your time to review the records, conduct the examination and prepare that report, correct?

A. Yes.

Q. And, presently, what is your rate of compensation?

A. $850.

Q. And did you have to do any revisions to the report in this case?

A. I don't recall.

Q. You were asked, though, in preparing that report to opine as to the future needs for hip replacement. Is that correct?

A. Yes.

Q. In looking at that MRI of July 20, 2016 -- You read MRI's, by the way, as a part of your profession, correct?

A. It's part of my job, but I'm not as expertise as the people that do it for a living.

Q. You would defer to a Board certified radiologist's findings, would that be fair to say, with regard to the MRI?

A. I wouldn't say "defer to." That wouldn't be inaccurate.

Q. What would be accurate?

A. I'd read it myself, come to my own conclusions. I see what they said. I try to see if I agree with what they said. Not pertaining to this case, not infrequently, I may call a radiologist up and say, Hey you read this but I see this and say, Can you take another look. Sometimes they change their opinion, but it's a piece of information not gospel.

Q. When you examined Nathalie Gonzalez in this case, it was approximately 18 months after the original accident, correct? Accident happened December 23, 2016.

A. Twenty months, yeah.

Q. Twenty months.

And you were not examining her as a treating physician, correct?

A. Correct.

Q. What's the difference?

She's not your patient, correct?

A. I'm not expected to render care. I'm only expected to render a medical opinion.

Q. In your report on Page 2 where you start to summarize it, you talk about the healing of the numerous fractures that she sustained to her pelvis, correct?

A. You want to tell me what line you're looking at.

Q. Last paragraph "in summary."

A. Yes I see "in summary," yes.

Q. And you say, "She was stabilized and ultimately recovered in terms of her walking status," correct?

A. Yes.

Q. And you say also, next line down, "The assessment at this time is that the patient has a healed fracture of the pelvic ring," correct?

A. Yes.

Q. And then you opine as you did here on direct examination about some of the increased risks that she may have from a medical point of view with regard to birth, correct?

A. Giving birth, yes.

Q. And development of arthritis, the increased risk, correct?

A. Correct.

Q. Okay. Now, when you were looking at those x-rays, you told us that there was a fracture into the acetabulum.

Did it show on any of those x-rays that you were looking at here?

A. No, need a CT scan to see that.

Q. You did review the MRI done July 20, 2016, correct?

A. Yes.

Q. Okay. And there were certain findings in that MRI.

Let me ask you if you agree with these findings: There is a healed fracture of the right ischium?

A. Yes.

Q. Okay. There is possible pseudarthrosis of the right superior pubic fracture, correct? Did you see that?

A. Yes.

Q. So it's possible that that was healed but it's also possible it was pseudarthrosis. Is that right?

A. It was not clear which.

Q. Okay. Same with your findings? Not clear which?

A. Correct.

Q. Okay. Same thing with the left pubic fracture, correct?

A. No, I didn't put the word "possible" in front of that.

Q. Okay. It also notes, did you agree with these

findings that both hips are in good alignment?

A. Alignment?

Q. I'm using the words of the radiologist asking if you agree with that.

It would be under "findings" the second paragraph where it starts "both hips."

A. Yes.

Q. What does that mean?

A. Alignment is a very strange term to be seen in that kind of report, but to me all it means is the hip is in the socket. It's not half out of the socket. It's not dislocated. It's in the socket.

Q. Would you agree there was no articular cartilage thinning seen?

A. Yes.

Q. That there was no osteochondral defect or loose body?

A. Correct.

Q. There was no labrale tear, correct?

A. Correct.

Q. You never saw Nathalie Gonzalez again after this exam, correct?

A. Till today.

Q. Fair enough.

Did you ever have a chance to look at any of her

physical therapy records?

A. No, other than what was in the Blythedale Hospital discharge summary.

Q. She was discharged from Blythedale and the pelvic external fixator had been removed. You know that. Right?

A. Yes.

Q. It was removed on April 6th, a couple of weeks after that, approximately. I think on April 18 she was discharged from Blythedale.

A. Sounds right. Yes.

Q. And she was making rapid progress with her ability to ambulate and walk at that point in time that she left Blythedale.

A. Yes.

Q. Makes sense. Right?

A. Yes.

Q. When you examined her, you didn't make any notation of any walking problems, correct?

A. No comments on gait.

Q. So her "gait," meaning, how she walked, it was okay when you saw her, correct?

A. Correct.

MR. WHALEN: I have nothing further.

Thank you, doctor.

THE COURT: Any follow up, Counselor?

MR. FORDE: Just a couple of things.

REDIRECT EXAMINATION

BY MR. FORDE:

Q. I just want to clarify, doctor.

Now, as far as your reading of the July 19 of 2016 MRI of the pelvis, you said there was possible pseudarthrosis of the right superior pubic ramus fracture, and where would that be on the model?

A. So this is the pelvis. This is the right side. This is the left side. The right. So this is the superior. This is the inferior. So it's the right superior right up here. Left superior here, so the right superior is this one (indicating).

Q. Okay. So you said that that was where you thought that there was a possible pseudarthrosis, but then you said that there was a pseudarthrosis of both the left pubic ramus and the left ischial fractures. Where would that be?

A. That's this area here. This was the most crushed area on the drawing and the x-rays, this was folded in (indicating).

Q. So in that area on the left side, is it your opinion that there was a definite pseudarthrosis on the left ramus and left ischial fracture?

A. There was no bony union. That's right.
Q. No union. So the bones never really healed.
A. Correct.
Q. Thank you.
THE COURT: You may step down, doctor.
(Witness steps down.)
THE WITNESS: Leave this (indicating)?
THE COURT: The officer will take care of it.
Approach.
(Whereupon, a bench conference takes place.)
THE COURT: Okay. We're going to break for the day. We'll continue with the examination of the witnesses tomorrow morning. Please be here tomorrow morning at 11 a.m.
Again, I remind you, please do not discuss this case among yourselves just yet. When we conclude, you'll have every opportunity to deliberate downstairs.
I know you had a question for my officer. She will be responding to your questions, as well.
Have a good evening. I'll see you tomorrow morning.
THE COURT OFFICER: All rise. Jury exiting.
(Jury exits courtroom.)
Counsels, please approach.

- Proceedings -

(Whereupon, a bench conference takes place.)

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C-E-R-T-I-F-I-C-A-T-E

I, JEAN DeBIASE, a Registered Professional Reporter and Senior Court Reporter for and within the State of New York, hereby certify that the foregoing is a true and accurate representation of my stenographic notes.

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JEAN DeBIASE, RPR
SENIOR COURT REPORTER

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