

1 IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT
2 OF THE STATE OF FLORIDA, IN AND FOR HILLSBOROUGH COUNTY
3 GENERAL CIVIL DIVISION

3

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6 MADELINE M. GASTER,

7 Plaintiff,

8

9 VS

CASE NO: 05-08140

DIVISION: J

10 WILLIAM D. GRABLE, and
11 ULTRA VISION SE INC, a
12 Florida Corporation

12

Defendants.

13

14

15

16 EXCERPTS OF TESTIMONY DAY 3 AND DAY 4
17 TRIAL PROCEEDINGS BEFORE THE HONORABLE JAMES D. ARNOLD

17

18

DATE: JANUARY 21, 2010
JANUARY 22, 2010

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TIME: 8:30 AM - 6:10 PM
8:30 AM - 4:45 PM

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LOCATION: GEORGE EDGECOMB COURTHOUSE
800 E. Twiggs Street
Courtroom 501
Tampa, Florida

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Randy Biddle
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1 (BEGINNING OF EXCERPTED TESTIMONY OF DR. VANDERPLOEG)

2 THE COURT: You may proceed, counsel.

3 MR. IGOU: Thank you, Judge.

4 CROSS EXAMINATION

5 BY MR. IGOU:

6 Q. Good afternoon, sir.

7 A. Good afternoon.

8 Q. You talked about the concept called mild

9 traumatic brain injury to the jury earlier.

10 A. Yes.

11 Q. And if I heard you correctly, you said that mild

Page 3

GASTER excerpts

12 traumatic brain injuries in a non-sports context resolve
13 within seven days.

14 A. Typically -- No. In a non-sports context within
15 30 days.

16 Q. Within 30 days. And are you aware as to whether
17 or not something called diffuse axonal injury can occur in
18 the context of a mild traumatic brain injury?

19 A. Yes.

20 Q. Can it?

21 A. Yes.

22 Q. Does it?

23 A. It can.

24 Q. Diffuse axonal injury, Doctor, is when the brain
25 axons and cells get stretched and some of them die; is that

5

1 correct?

2 A. The concept is they get stretched and they may
3 die. They may not die.

4 Q. So that would be biologic organic brain injury;
5 would it not?

6 A. Yes, it would.

7 Q. And that would last more than seven days,
8 correct?

9 A. (No response).

10 Q. More than 30 days, correct, if it happened,
11 correct?

12 A. If it happened, those cells would be dead. What
13 gets better in seven or 30 days are the symptoms and the
14 cognitive difficulties that result from the mild traumatic
15 brain injury, including mild axonal injury.

16 Q. Would you agree with me that seven to 33% of the
17 persons who suffer mild traumatic injury do not recover and
18 have persistent symptoms?

19 A. No. I would say that it tends to be more between
20 seven and 15%.

21 Q. Well, let's take a look at this overhead.

22 MR. JONES: May we approach the bench.

23 THE COURT: Yes, sir.

24 (Bench conference).

25 Q. Let me show you a published article. It's

6

1 published in Neuropsychiatry Clinic and Neuroscience.

2 (Tendering). Have you seen this.

3 These are all in what I gave you earlier, sir.

4 This is an article entitled Recent Neuroimaging Techniques
5 and Mild Traumatic Brain Injury.

6 Were you one of the co-authors of that?

7 A. Yes, I was.

8 Q. Do you mind if we go through it.

9 A. (Indicating). Okay.

10 Q. You were the co-author, sir. Let me show you
11 your name up there. You are Rodney Vanderploeg.

12 A. That is I.

13 Q. It says "most patients recover fully from mild
14 TBI, but seven to 33% have persistent problems".

15 Is that different from what you just told the
16 jury, sir?

17 A. What I told the jury is what I believe it's
18 between seven and 15%. The reference, there is one
19 reference which goes to as high as 33%.

20 Q. Well, without reading the footnotes, what you're
Page 5

GASTER excerpts

21 telling the medical community is seven to 33% in this
22 paper, is it not?

23 A. No. What I'm telling the medical community is
24 that those references, 9, 10, 11 have studies which suggest
25 that it's between seven and 33%. That's what I'm telling

7

1 them.

2 Q. Do you think that mild traumatic brain injury is
3 a significant health problem in the United States?

4 A. I think it can be, yes, particularly as it's
5 misunderstood.

6 Q. You sound like you're not sure. Do you think or
7 do you not think that mild traumatic brain injury is a
8 major health problem in the United States?

9 A. It's not a simple yes or no answer.

10 Q. If you can't answer it, we'll move on. Do you
11 think that mild traumatic brain injury costs, medical cost
12 in this country of over \$20 billion a year?

13 A. The ongoing evaluation and treatment of
14 individuals who sustain a mild traumatic brain injury is a
15 significant problem and results in huge costs, yes.

16 Q. In your paper it says 44% of \$56 billion. That
17 would be about \$20 billion a year, sir; is that correct?

18 A. I'll take your word for it.

19 Q. No, I'll take your word for it. You wrote the
20 article. I'm sorry.

21 A. Yeah.

22 Q. So if everybody or almost everybody who gets a
23 mild traumatic brain injury is fine after seven or 30 days,
24 why is it costing this country \$20 billion a year; is

25 everybody crazy, are they all faking it, what is it?

8

1 A. I'll be happy to explain it to you, and that's
2 where it's not a simple yes or no answer. Individuals who
3 have preexisting psychological problems --

4 Q. Like Mrs. Gaster.

5 A. Like Mrs. Gaster -- individuals who are
6 unemployed or who have poor support social systems, social
7 support systems, have poor outcomes.

8 The symptoms that began at the time of the mild
9 traumatic brain injury in these individuals tend to
10 continue, and in the research that I have done, as well as
11 others have done, what accounts for that continuing is not
12 the fact that they had a mild traumatic brain injury; it is
13 those co-existing psychiatric difficulties, poor social
14 supports, other medical factors that are accounting for the
15 sustaining ongoing nature of the symptoms.

16 However, to answer your question, they're being
17 conceptualized and treated within the United States and
18 within the healthcare system as if everything is due to a
19 mild traumatic brain injury.

20 Q. Well, that's not how you put it in your own
21 paper, is it, Doctor?

22 You simply said -- and this is for public
23 consumption, is it not -- "increasingly mild traumatic
24 brain injury, TBI, has been recognized as a major public
25 health concern, with annual worldwide incidents ranging

9

1 from so and so -- "the economic impact is substantial
2 accounting for", and then you list billions of dollars.

GASTER excerpts

3 A. Right.

4 Q. Now, instead of the complicated matter that you
5 have talked about earlier, isn't this one of the problems
6 in mild traumatic brain injury?

7 "Certainly microscopic diffuse axonal injury
8 reported as present in autopsy studies of mild TBI is
9 largely undetectable using traditional neuroimaging
10 techniques".

11 Now, explain that for the jury. I believe what
12 happens is someone sustains a mild traumatic brain injury,
13 they weren't knocked out or if they were, it was very
14 short, they died later of a heart attack and they opened
15 them up and autopsied their brain. Correct? Am I right so
16 far?

17 A. Yes.

18 Q. And when they looked at their brain under a
19 microscope, they found to their surprise, that there was
20 cellular damage to the brain neurons, correct?

21 A. Correct.

22 Q. Now, 20 years ago when you were in college you
23 would have never thought that was going to be possible,
24 would you?

25 A. I actually don't know. I didn't think about it

10

1 in college 20 years ago.

2 Q. That's probably because no one ever thought --
3 come on, Doctor. You know that 20 years ago this would
4 never have been thought about.

5 MR. JONES: Objection. Argumentative.

6 THE COURT: Sustained.

7 Q. Are you saying that you didn't know about diffuse
8 axonal injury in your --

9 A. In college, that's correct. In college -- no.
10 In graduate school the answer is also no. I didn't know
11 about it. I learned about it in post-doctoral training and
12 in my subsequent work.

13 Q. Wouldn't you agree with me, Doctor, that 20 years
14 ago, even 15 years ago, the concept of diffuse axonal
15 injury from trauma in the human brain was largely thought
16 to be in the context of severe brain injury and maybe
17 moderate brain injury, not thought to be present in mild
18 traumatic brain injury?

19 A. It's not thought that there were permanent
20 injuries that could be documented on autopsy following mild
21 traumatic brain injury, that is correct.

22 Q. Doctor, you have done good work with veterans
23 coming back from the Iraq war.

24 wouldn't you agree with me that there has been an
25 evolution and a much better understanding of mild traumatic

11

1 brain injury in the past five to seven years than there has
2 been in the last 30; a lot of progress has been done,
3 correct?

4 A. Correct.

5 Q. And what we're learning, as the detection gets
6 more fine as we are able to look at the brain in a finer
7 and finer degree and as our medicine becomes more and more
8 powerful, is that these things that can hurt the brain
9 cellularly are more prevalent than we thought, and your
10 doing studies on the veterans confirms that, doesn't it?

11 A. Doesn't confirm this because that's not my work.
Page 9

GASTER excerpts

12 This is simply my review of the literature along with other
13 co-authors.

14 Q. But you rely on this in the treatment of
15 veterans?

16 A. Yes.

17 Q. Don't you have veterans who were kind of thrown
18 in the waste-can because they either weren't knocked out or
19 didn't complain of their problems in a timely manner in the
20 Veterans Administration who you are now saying they are
21 really hurt; isn't that part of what you're doing?

22 A. Part of what we're doing is screening to
23 determine whether or not somebody may have sustained
24 traumatic brain injury and then doing a careful evaluation
25 to determine whether they did; and if they did, then

12

1 treating them as a result of that, yes.

2 Q. And many of those veterans, just keeping on that
3 subject, might have been around a blast, may not have been
4 knocked out, were not told or thought they had a mild
5 traumatic brain injury, come home, have terrible problems
6 and you, among other doctors, have now said son, you
7 sustained a mild traumatic brain injury in Iraq.

8 MR. JONES: Objection. Relevance.

9 THE COURT: Sustained.

10 Q. Doctor, do you treat soldiers who have had the
11 same thing as Michelle Gaster that have been in an accident
12 where they weren't knocked out and then they complained of
13 a mild traumatic brain injury later in time?

14 A. I've evaluated soldiers who've come back who have
15 been screened by the system that I described, who I then

16 evaluate to determine whether or not they sustained a
17 traumatic brain injury.

18 The crucial thing is whether or not they
19 sustained a traumatic brain injury, and that, in this
20 research as well as in what I do clinically with veterans,
21 has to do was there an event in time in which there was a
22 physiological dysfunction of brain functioning resulting in
23 a period where they were not able to function normally,
24 such that they were confused, disoriented, or later really
25 can't remember exactly what happened in the event.

13

1 So what I do with veterans is what I did with
2 Mrs. Gaster and what we watched on that videotape is do a
3 very careful interview about those events to determine
4 whether or not they had a traumatic brain injury.

5 Now, to completely answer your question if I may,
6 many of those individuals have Post-Traumatic Stress
7 Disorder, and the symptoms that have been attributed by
8 them, as well as other healthcare providers, are really due
9 to Post-Traumatic Stress Disorder.

10 With this evaluation that I and others do, we
11 make that differentiation and we refer them to PTSD
12 programs, or if we determine that they do have a mild TBI,
13 we refer them to cognitive therapists or cognitive therapy
14 and compensatory strategies to deal with the issues of
15 attention and concentration that truly are due to TBI and
16 not due to PTSD.

17 Q. Doctor, someone does not have to be knocked out
18 to suffer mild traumatic brain injury, correct?

19 A. Someone has to have evidence of having a
20 physiological disruption of brain functioning.

GASTER excerpts

21 Q. How long does that disruption have to last?

22 A. It can last for a few seconds to eternity.

23 Q. Can it be a moment?

24 A. It can be a -- well, what's a moment? It can be
25 for a few seconds. There has to be evidence that that

14

1 individual's brain is not functioning, and the only
2 evidence of that is either one is knocked out, or there is
3 evidence on imaging, or there's a period of time where one
4 is dazed, confused, disoriented and not able to function.

5 Or in sports, for example, you can have a
6 concussion and actually continue to play, but later you
7 talk to your buddy and you don't remember three, four,
8 five, six, seven plays after that concussion.

9 Q. Doctor, if you can continue to play football, you
10 can continue to drive a car, correct?

11 A. I wouldn't make that assumption.

12 Q. Well, if somebody goes back in the game and plays
13 quarterback in the NFL with a concussion, which is harder;
14 driving a car down the highway or taking the snap and being
15 the quarterback in the NFL?

16 MR. JONES: Objection.

17 THE COURT: Sustained. Improper hypothetical.

18 Q. Is a moment too little time to have a disruption?

19 A. I don't know what a moment is.

20 Q. Did you write this paper called Assessment and
21 Diagnosis of Mild Traumatic Brain Injury, Post-Traumatic
22 Stress Disorder and Other Polytrauma Conditions?

23 A. I co-authored that with --

24 Q. Do you mind if we just put it up.

25 A. That's fine.

15

1 Q. (Overhead). Well, if you don't know what a
2 moment means, Doctor, but that's what's in your paper.
3 Okay.

4 A. I'm sorry to hear that.

5 Q. Yeah.

6 THE COURT: All right. Let's keep our comments
7 to ourselves. You ask questions, and Doctor, if you
8 would be kind enough to just answer them.

9 A. Yes, sir.

10 Q. Doctor, this was published by the Department of
11 Defense and Veterans Affairs, correct?

12 A. Yes.

13 Q. You put it in your paper, correct?

14 A. Yes.

15 Q. And it's talking about the criteria for mild,
16 moderate and severe brain injury, correct?

17 A. Yes.

18 Q. You have noted here "structural imaging in mild
19 traumatic brain injury is usually normal", correct?

20 A. Yes.

21 Q. And so you would not expect in the case of Mrs.
22 Gaster for her MRI or CT to be abnormal, would you, if it's
23 a mild traumatic brain injury?

24 A. Correct.

25 Q. "Loss of consciousness, 0 to 30 minutes". Zero

16

1 meaning the person did not lose consciousness or lost it
2 for 30 minutes, correct?

GASTER excerpts

3 A. Yes.

4 Q. "Alteration of consciousness/mental state, a
5 moment up to 24 hours".

6 Okay. Do you know what a moment means now?

7 A. No, because I didn't write that. What a
8 moment -- what that means to me is several seconds up to
9 24 hours. That's what that means to me. But I didn't
10 write that. That's something that was written by a group
11 of individuals and it was a consensus definition and that's
12 what they chose to use that word.

13 If I were the sole author of that, I would have
14 said something other than a moment because I don't know
15 what a moment is.

16 Q. There's a definition of alteration of mental
17 state. It says "confusion, difficulty thinking clearly, or
18 responding appropriately to mental status questions",
19 which we don't have here, "but does not require amnesia",
20 does it, Doctor?

21 A. No, it doesn't require amnesia. Amnesia in the
22 example I --

23 Q. I'm just asking, does it require amnesia?

24 THE COURT: Excuse me.

25 MR. JONES: Objection, Your Honor.

17

1 MR. IGOU: You can answer.

2 THE COURT: First answer the question and then
3 you can explain your answer.

4 A. Actually I forgot what the question was. I'm
5 sorry.

6 THE COURT: I can't remember.

7 Q. This definition doesn't require amnesia, correct?

8 A. Right.

9 Q. And it also doesn't say that if you're dazed, you
10 must not be able to think. It says you have difficulty
11 thinking, correct?

12 A. Yes.

13 Q. And that's why a quarterback can receive a
14 concussion and go back in the game, because it's a learned
15 behavior and it doesn't maybe require a lot of thinking
16 about new things, agreed?

17 A. Well, that's why quarterbacks used to be able to
18 go back in the game following a concussion, yes.

19 Q. Yes. Doctor, in regards to football players, are
20 you aware of The Legacy Foundation?

21 A. No, I'm not.

22 Q. Are you aware of work similar to what we talked
23 about with the autopsy now being done on ex-professional
24 football players?

25 A. Yes, I am.

18

1 Q. Are you aware that in many of the brains donated
2 by these individuals who have gotten mid-aged or early
3 senility, when they're autopsied, their brains are tangled,
4 abnormal and look like they're 80 years old?

5 MR. JONES: Objection. Lack of predicate.

6 Improper hypothetical. Lack of foundation.

7 THE COURT: Overruled.

8 A. Yes, I'm aware of that.

9 Q. That is also something that you weren't aware of
10 20 years ago, and even 10 years ago, correct?

11 A. Correct.

GASTER excerpts

12 Q. And that is an evolution towards us having a
13 fuller understanding of what it is to have a mild traumatic
14 brain injury, correct?

15 A. Actually that's a better understanding of what it
16 means to have multiple concussions over the course of a
17 long football career, not sustaining a single mild
18 traumatic brain injury or concussion.

19 Q. Okay. Several blows to the head then, several
20 concussions could do that?

21 A. Yes.

22 Q. How many concussions has -- never mind. While we
23 are on this paper, Doctor, your paper says "in addition
24 preexisting or co-morbid psychiatric difficulties have been
25 shown to be important moderators of persistent concussive

19

1 symptoms", correct?

2 A. Yes.

3 Q. That would mean that given two people that have
4 the same blow to the head, someone who may have anxiety and
5 depression, although manageable in their life, might have a
6 worse outcome than a person who doesn't have those things,
7 correct?

8 A. Correct.

9 Q. There's also a finding that "mild TBI increased
10 the risk for developing subsequent psychiatric conditions".

11 So, in other words, someone gets a mild TBI, they
12 have an increased vulnerability and increased rate of
13 developing psychiatric problems after the incident occurs,
14 correct?

15 A. That can happen, yes.

16 Q. Do we or do we not see an increase in psychiatric
17 symptoms in Mrs. Gaster after October '03 as before October
18 '03?

19 A. I believe we do, yes.

20 Q. Those things complicate treatment and recovery,
21 don't they?

22 A. What things?

23 Q. Well, two things. Having previous blows to the
24 head, worse outcome, correct?

25 A. It can result in worse outcome, yes.

20

1 Q. And psychiatric, some psychiatric things in your
2 past also complicate, correct?

3 A. It can, yes.

4 Q. Those individually complicate and when they're
5 together, it's doubly complicated, isn't it?

6 A. Actually we don't have the research to know
7 whether it's doubly complicated or not.

8 Q. More complicated. Let me rephrase that.

9 All of the things being equal, somebody with both
10 of those things has a worse outcome than somebody with one
11 of them?

12 A. It's reasonable to hypothesize that. I don't --
13 I'm not aware of any research that actually demonstrates
14 that.

15 Q. Doctor, the first paper that we talked about, you
16 also cite a study conducted. It says "studies conducted
17 with more chronic mild TBI in patients, i.e., six months or
18 more post-injury, also reveal hyperperfusion on SPECT".

19 This is in the paper that you wrote, correct?

20 A. Yes.

GASTER excerpts

21 Q. So you're citing a study that's studying the
22 brains of people who have had mild traumatic brain injury
23 symptoms for more than six months, correct?

24 A. Yes.

25 Q. And the scans are abnormal in some of them,

21

1 correct?

2 A. In some of them, yes. And these kinds of scans
3 basically are looking at blood flow.

4 Q. Abnormal blood flow to the brain?

5 A. Unusual patterns of blood flow.

6 Q. Many studies have shown a connection between a
7 traumatic injury and decrease in the blood flow in that
8 part of the brain on a SPECT scan, correct? That's why you
9 cited it.

10 A. No, not in these studies.

11 Q. Some studies?

12 A. Some studies.

13 Q. So you told the jury that people get better in
14 seven to 30 days, but yet this whole group is being studied
15 for more than six months, with mild TBI, correct?

16 A. That's correct.

17 Q. Now, Doctor, we talked a little bit about the
18 school records and I want to ask you something. Were you
19 given a budget or did the defense attorneys tell you look,
20 you can only spend 24 hours as you bill on this case?

21 A. I had no budget. I was given no limitations.

22 Q. And you have these two boxes over here, correct?

23 A. Yes.

24 Q. In this case, and in front of this jury, you're

25 asserting, you're the only person in her life so far to do

22

1 so, that she has a histrionic personality disorder.

2 MR. JONES: Objection, Your Honor. Argumentative
3 and lack of predicate.

4 MR. IGOU: It's in his report.

5 THE COURT: Excuse me. I'll sustain the
6 objection as to argumentative. State your question.

7 Q. Doctor, did you diagnose her with a histrionic
8 personality disorder?

9 A. Yes, I did.

10 Q. Are you aware of the DSM IV, Doctor?

11 A. Yes.

12 Q. Is it not the Bible of psychology that gives you
13 the ability to diagnose, the criteria to diagnose, the
14 number to bill for, almost -- is it the Bible of
15 psychology, would you agree?

16 A. Well, it's actually primarily used by
17 psychiatrists. Psychology also uses it. It's published by
18 the American Psychiatric Association.

19 Q. And you use it?

20 A. Yes.

21 Q. And you used it in this case to diagnose Mrs.
22 Gaster, correct?

23 A. Yes.

24 Q. Because you put a number on the diagnosis that's
25 in this book, correct?

23

1 A. Yes.

2 Q. Now, you would agree with me that a personality
Page 19

GASTER excerpts

3 disorder is different than a personality trait, correct?

4 A. Yes, I would.

5 Q. Personality trait is that someone can be a little
6 funny or a little bit sad or a little bit outgoing, right?

7 A. Yes.

8 Q. The difference is, when you say histrionic
9 personality disorder, the word disorder must mean that that
10 personality trait results in a significant impairment of
11 their social life and their occupation, correct?

12 A. At least at times, yes.

13 Q. And that also means that they had this disorder
14 beginning after adolescence, correct?

15 A. They can have it throughout their life. Yes, it
16 starts in adulthood, but it can be carrying over
17 personality characteristics from childhood, but it's
18 typically not diagnosed at that point in time because
19 sometimes individuals change over time.

20 Q. I'm not saying when it's diagnosed. I'm saying
21 according to the DSM that person who is diagnosed at age 44
22 with a histrionic personality disorder, you're saying they
23 have had it since they were 12-years old or so, correct?

24 A. No.

25 Q. No?

24

1 A. No.

2 Q. Are you saying that it can emerge out of the
3 clear blue at age 44?

4 A. No, I'm not saying that at all. But what I'm
5 saying is you can't diagnose personality disorders in
6 childhood because personalities are not stable in

7 childhood. So the DSM basically says it needs to be
8 diagnosed in adulthood and it needs to be an established
9 set of behavioral patterns for years in adulthood, and it
10 can't be diagnosed before adulthood for the reasons that I
11 just cited.

12 Q. Now, when you're looking for a personality
13 disorder that as you said results in significant disruption
14 of social and vocational parts of a person's life, it's
15 important to you as the person making the diagnosis to know
16 whether or not there was disruption of the person's
17 vocation, correct?

18 A. Correct -- excuse me. Disruption of some aspects
19 of functioning. Vocation would be one. Relationships
20 would be another. It doesn't have to be vocation.

21 Q. Now, you told the jury, you talked about
22 significant others in relation to this personality
23 disorder, correct?

24 A. Yes.

25 Q. But in the DSM it doesn't say only significant

25

1 others. It says people out in the world, friends,
2 co-workers and neighbors are affected by this, correct?

3 A. Yes.

4 Q. It's not just a one-on-one love thing. It is
5 your presentation to the world is flawed. Isn't that
6 correct in these respects?

7 A. Not necessarily. Not necessarily.

8 Q. And you diagnosed her in part with this
9 personality disorder based upon school records, correct?

10 A. Well, no, that was one factor which again --

11 Q. I said in part. Would you agree, in part.

GASTER excerpts

12 A. That was one factor which went into my
13 understanding of this, yes.

14 Q. And one of the things that you noted were
15 comments made by teachers when she was in elementary
16 school, correct?

17 A. Yes.

18 Q. Now, if we assume you're assuming that those are
19 accurate observations and that these are good teachers,
20 correct?

21 A. I'm assuming that, yes.

22 Q. And you don't have any problem with diagnosing
23 her in part based upon little squibs of information back in
24 the sixties, but Doctor, did you take the time to read what
25 her friends, neighbors, and co-workers said she was like in

26

1 the last 10 to 15 to 20 years?

2 A. Yes.

3 Q. Did you put that analysis in your report?

4 A. No.

5 Q. Did you make any reference to it whatsoever,
6 positive or false, other than calling it a pack of
7 testimonials?

8 A. I don't believe I did, no.

9 Q. Did you mention it in Direct Examination at all?

10 A. No.

11 Q. Do you think it's important, Doctor, to see if
12 there is significant disruption of vocational or social
13 skills in a person who you're diagnosing the life-long
14 disorder by talking to the people that interacted with her
15 in the last 15 to 20 years; do you think that's important?

GASTER excerpts

16 A. I don't think it's essential. I think it can be
17 important and necessary. I don't put much stock into
18 testimonials. I do put stock into actually interviewing
19 people and questioning them carefully.

20 Q. Did you ask to interview any of these people?

21 A. No, I did not.

22 Q. Did you ask to interview any family members?

23 A. I did not.

24 Q. Did you ask to interview her partner Cliff
25 Froggatt?

27

1 A. No.

2 Q. Did you ask to interview her significant others
3 in the past 15 years?

4 A. No.

5 Q. Did ask to interview her neighbor Robin Bennett?

6 A. I didn't ask to interview anybody else.

7 Q. And does not the DSM tell you that in diagnosing
8 a somatoform disorder especially that it is helpful to do
9 such interviews?

10 A. It can be, yes.

11 Q. And yet you chose these remote words on a page
12 rather than these living people; is that what you did in
13 this case?

14 A. No.

15 Q. Doctor, having read these testimonials as you
16 called them, do you find any evidence of any disruption,
17 significant disruption of her vocational history or work
18 history?

19 A. In those testimonials?

20 Q. Yes.

GASTER excerpts

21 A. No.

22 Q. Do you have any evidence anywhere in those boxes
23 or anywhere in this courtroom of vocational disruption in
24 the past 20 years?

25 A. No.

28

1 Q. Do you have in those boxes or anywhere in this
2 courtroom any evidence of social disruption that you would
3 expect to find in a person with histrionic personality
4 disorder in the past 20 years?

5 A. Yes.

6 Q. So you're going to rely on Olga? Who are you
7 relying on for that?

8 A. I'm relying on the notes from the therapist that
9 had worked with her and described issues, and relying on
10 the comments that Cheryl made in those notes.

11 I'm relying on things that Mrs. Gaster told me on
12 the clinical interview.

13 Q. And I asked questions of some of these people who
14 testified specifically regarding the diagnosis of
15 histrionic personality disorder. One of the criteria, is
16 it not, Doctor, that they are often inappropriately
17 sexually provocative or seductive?

18 A. That's one of the criteria, yes.

19 Q. Do you have any evidence that she ever had that?

20 A. Yes.

21 Q. You think she was flirty with you in the exam?

22 A. I do.

23 Q. Any other evidence?

24 A. That's enough evidence.

25 Q. It showed that?

29

1 THE COURT: Excuse me. Approach the bench.
2 (Bench conference).

3 Q. Doctor, another criteria, Criteria 4 for
4 histrionic personality disorder is that the person
5 diagnosed is "overly concerned with impressing others by
6 their appearance and spending an excessive amount of time
7 and energy and money on clothes and grooming"; is that
8 correct?

9 A. That is a potential criteria, yes.

10 Q. Do you have any evidence of that?

11 A. No.

12 Q. Another feature is that they can "often take the
13 role of a princess or a victim", correct?

14 A. Yes.

15 Q. Do you have any evidence of either of those?

16 A. Yes.

17 Q. What?

18 A. Victim.

19 Q. Prior to this accident?

20 A. Yes. And again, in the therapy notes in terms of
21 relationships.

22 Q. Do you have any idea that she's easily influenced
23 by others, any evidence of that?

24 A. I would say the answer is yes, and it basically
25 comes from the eight hours that we spent together and our

30

1 own relationship during that period of time.

2 Q. Now, Doctor, you also talked about part of what
Page 25

GASTER excerpts

3 went into your diagnosis was that you said she was a sickly
4 child.

5 A. That is part of what I was looking at in terms of
6 somatoform disorder, yes.

7 Q. And you also stated that she had a high number of
8 absences from school.

9 A. Right.

10 Q. Did you ever ask her why she had absences from
11 school?

12 A. I asked her about her perception of her health as
13 a child and adolescent and she said it was excellent.

14 Q. Did you ever ask her what was causing her to be
15 out of school?

16 A. No, because I hadn't reviewed those files at the
17 time I had done my interview.

18 Q. And one of the usual things with somatoform
19 disorder, especially when it is undifferentiated, was that
20 your diagnosis with her?

21 A. Yes, it was.

22 Q. Doctor, under 300.82 Undifferentiated Somatoform
23 Disorder isn't it true that the frequent complaint of
24 persons with this diagnosis are one, chronic fatigue?

25 A. Yes.

31

1 Q. Do you have any note of that anywhere in your
2 boxes?

3 A. I have notes of that from her interview with me
4 that basically she talks about being fatigued a lot and
5 spending a lot of time isolating and not having much
6 energy.

7 Q. Any of that evidence prior to this accident in
8 her lifetime?

9 A. Not that I'm aware of offhand.

10 Q. Gastrointestinal or genitourinary symptoms,
11 correct?

12 A. Uh-hum(affirmative).

13 Q. That's one of the four. Any evidence of any of
14 that?

15 A. I believe that in the previous records she
16 reported being nauseous at various times, particularly
17 after the previous accidents in which she was involved.

18 Q. Chronic loss of appetite, do you have any long-
19 running proof of that?

20 A. I didn't ask and so no, I don't have proof of
21 that.

22 Q. Doctor, with a conversion disorder would you
23 agree with me that DSM suggests "supplementing a person's
24 self-report -- which is what you got from her -- with
25 additional sources of information from associates and

32

1 records and that may be helpful"?

2 A. Yes. But conversion disorder, I didn't diagnose
3 her with conversion disorder.

4 Q. Would it also be something that you could have
5 done in this case?

6 A. That I could have asked her about conversion
7 disorder?

8 Q. No, that you could have interviewed, talked to,
9 gotten information from co-workers and friends in her life
10 in the past 20 years.

11 A. If it was a clinical evaluation, I would say yes.

GASTER excerpts

12 My experience in doing forensic evaluations is that I'm
13 never allowed to talk to anybody other than the claimant.

14 Q. On Page 2 of your report, Doctor, you made this
15 statement.

16 "In terms of social interpersonal characteristics
17 Mrs. Gaster was rated below average in dependability,
18 industriousness, and initiative in the 3rd, 4th, 9th and
19 10th grade"; is that correct?

20 A. Yes.

21 Q. Do you want to be fair to Mrs. Gaster in your
22 dealings with her today?

23 A. Yes.

24 Q. If we look at the chart that you were relying on
25 in the medical records, 3 being average, 2 being above

33

1 average, 1 being superior, 4 being below average, isn't it
2 true, Doctor, that you left out rows and rows of "average"
3 or "above average" conduct on her part?

4 A. I focused -- yes, I mean, I focused on what was
5 salient to me in terms of trying to understand what she was
6 like as a child. Average doesn't mean a whole lot. If I
7 see anything that is below average, that is concerning to
8 me and that's what I tend to focus on.

9 Q. What about above average, in 11th grade when she
10 was above average in every category and was superior in one
11 category; did you note that in your report?

12 A. No.

13 Q. Self control, is that important?

14 A. Yes.

15 Q. Do you note anything below average there?

16 A. It looks to me like 12th grade is below average.

17 Q. I think both grades is above average. That's a
18 2.

19 A. Okay.

20 Q. So self control improved from 1st to 12th grade,
21 did it not?

22 A. That's what that suggestion says.

23 Q. Do you think you were fair to her in the way that
24 you put this on your report?

25 A. Yes, because again, what I focused on is things

34

1 that are concerning, things that are abnormal.

2 I mean, typically what you see in the records is
3 everything is average. If you see anything that is less
4 than average, that is concerning.

5 Q. Doctor, are you saying that these few 4s in here
6 are concerning to you in the midst of all the average and
7 above average assessments?

8 A. Yes.

9 Q. You also put all of these comments about her in
10 your report. These are yearly comments from her teachers,
11 are they not?

12 A. They are.

13 Q. And you would be concerned about a patient who
14 had an evolving problem, correct? In other words, if these
15 records showed her getting worse in school as she gets up
16 to the higher grades, that would be concerning to you?

17 A. Yes, it would.

18 Q. But in fact, Doctor, isn't it harder for somebody
19 with a personality disorder to get along and get along well
20 in high school than it is in perhaps elementary school;

GASTER excerpts

21 life is more complex, there's cliques, there's boys, all
22 that, correct?

23 A. I don't know that I would agree with that.

24 Q. Well, you didn't put this in your report, did
25 you, Doctor? That says "seems well adjusted and attentive

35

1 in 11th grade".

2 A. No, I didn't.

3 Q. What does that mean to you?

4 A. That means that in the 11th grade she seemed well
5 adjusted and attentive. However, well, I would need to
6 look at it in careful review again, but there's other
7 comments in there that suggest ongoing relationships, not
8 applying herself as much -- I need to look in my notes.

9 Q. I agree those are there earlier, Doctor, if that
10 would help.

11 A. Okay.

12 Q. In 12th grade what was the comment, Doctor?

13 A. Well, the one that I wrote down here is "very
14 sports minded".

15 Q. That's correct. Doctor, if I were to tell you
16 that Mrs. Gaster suffered from asthma and a sinus condition
17 in school and that's why she had the absences, would that
18 be consistent or inconsistent with your diagnosis?

19 A. It would not be inconsistent.

20 Q. If I told you that she had surgery on her
21 adenoids to cure that problem, and that in 11th grade, the
22 year of the surgery, she was out 33 days and in 12th grade
23 after the surgery her absences went down to 15, would that
24 be consistent or inconsistent with your sickly childhood?

25 A. I think it would be consistent. I think three

36

1 weeks of absence in any year of school is significant.

2 Q. Doctor, you know that she suffered from Graves
3 Disease, correct?

4 A. Yes.

5 Q. And are you aware that Graves Disease has
6 numerous symptoms?

7 A. Yes.

8 Q. And are you aware that people don't just wake up
9 one morning and say I've got Graves Disease, that in fact,
10 it sneaks up on people, they suffer the symptoms until it's
11 detected and remedied?

12 A. Right.

13 Q. So some people can go through a year or two or
14 three of cold/hot sweats, palpitations, panic attacks,
15 concentration problems until they finally get to a doctor
16 and they say oh, it's your thyroid and boom, they fix it,
17 right?

18 A. Correct.

19 Q. And you would agree that the symptoms that I just
20 listed are ones commonly people suffer from undiagnosed or
21 recently treated Graves Disease?

22 A. Correct.

23 Q. And you would agree with me that in 2000, 2001,
24 2002 that part of the complaints that she had were
25 consistent with this?

37

1 A. Yes.

2 Q. And that that problem is eventually taken care of

GASTER excerpts

3 by taking Synthroid which she is on, correct?

4 A. Yes.

5 Q. Doctor, in your report you put a great deal of
6 weight on the fact that -- we'll flip through that page up
7 there. Page 10. That is a self-report of the injury from
8 Mrs. Gaster.

9 Indicates no traumatic brain injury. Then you
10 said the symptoms. Dr. Olafsson's notes beginning two
11 weeks after are not the kind of symptoms associated with
12 brain injury, correct?

13 A. Yes.

14 Q. Now, if a patient walked into your office without
15 a history and said I've got depression, anxiety,
16 irritability, agitation, poor motivation, somatic concerns,
17 sleep disturbance, dizziness, confusion, social withdrawal
18 and interpersonal difficulties --

19 MR. JONES: Objection. May we approach the
20 bench.

21 THE COURT: Yes, sir.

22 (Bench conference).

23 THE COURT: (Perusing document). Let's move on.

24 Q. If someone came to you with all these symptoms,
25 what would be your first diagnosis?

38

1 A. I wouldn't offer a diagnosis based on just a
2 report of symptoms.

3 Q. Let me rephrase that. Are those symptoms
4 consistent with mild traumatic brain injury and/or post-
5 concussive syndrome?

6 A. They are consistent with a lot of things. They

7 are consistent with post-concussive symptoms.

8 They are consistent with depression.

9 They are consistent with anxiety disorder.

10 They are consistent with somatoform disorder.

11 And that's why I wouldn't offer a diagnosis

12 because they're consistent with lots of potential

13 diagnoses.

14 Q. Doctor, in one of the papers we have gone over
15 earlier you in fact have that list of symptoms as relating
16 to post-concussive syndrome, correct?

17 A. Yes.

18 Q. And are those or are those not symptoms reported
19 and experienced by Mrs. Gaster?

20 A. Yes.

21 Q. Now, you also said to the jury that mild
22 traumatic brain injury and post-concussive syndrome get
23 better over time, right?

24 A. Yes.

25 Q. In your paper here?

1 A. In most individuals.

2 Q. In most individuals. Because you say here, "some
3 studies report that post-traumatic symptoms increase with
4 time post-injury". Correct?

5 A. Yes.

6 Q. So, the fact that Mrs. Gaster may in part report
7 an increase of symptoms over time is not necessarily
8 inconsistent with a mild traumatic brain injury, is it?

9 A. Those studies basically show that the increase of
10 symptoms over time is due to co-morbid conditions such as
11 depression and anxiety or stress or other kinds of things,

GASTER excerpts

12 not due to post-concussion syndrome per se.

13 Q. Isn't it common for post-concussive syndrome to
14 give rise to depression?

15 A. No.

16 Q. No?

17 A. No, not as a diagnosis. It's common for
18 depressive symptoms, depressive experience to be a symptom
19 of post-concussion disorder.

20 Q. Exactly. So a large percentage of people with
21 post-concussive syndrome suffer depressive symptoms?

22 A. Yes.

23 Q. A large number of people who have mild traumatic
24 brain injury suffer anxiety symptoms, correct?

25 A. Yes.

40

1 Q. Somebody who has a mild traumatic brain injury
2 and has manageable anxiety and depression can often have
3 those things be magnified into a serious problem; is that
4 correct?

5 A. That can happen, yes.

6 Q. Would you agree with me, Doctor, that preexisting
7 psychiatric disorders of mood, anxiety and conduct uniquely
8 place individuals at significantly increased risk for
9 sustaining a TBI, traumatic brain injury, later in life?

10 A. Individuals with depression have, and some of
11 those other conditions, yes, tend to have concentration
12 problems resulting in a somewhat more likely incident if
13 they would sustain an accident which would result in a
14 traumatic brain injury, yes.

15 Q. Doctor, this is a page from your report, Page 14.

16 It's got the whole Vocational Background. You've got her
17 whole history there, correct?

18 A. Yes.

19 Q. From year to year. Let me move that down.
20 (Indicating on overhead). Now, in that history, Doctor, on
21 that page, do you have anything that shows a significant
22 disruption of her vocational ability due to a personality
23 disorder or somatization disorder?

24 A. Well, what that history suggested to me is that
25 she moved around.

41

1 Q. It's a yes or no question.

2 A. I'm trying to answer it.

3 MR. JONES: Objection, Your Honor. Let him
4 answer the question.

5 THE COURT: Let him answer.

6 Q. Go ahead.

7 A. What that history suggests to me is that she
8 moved around a lot which could be due to difficulty in the
9 position with bosses or other kinds of things. In one of
10 those positions she did talk about having a bad boss, which
11 again, could be, it could be a bad boss, it could be her
12 relationship. Could be lots of things.

13 But when I see people moving around a lot in
14 jobs, that suggests vocational instability to me, which is
15 part of, again, the relationship issues and the stability
16 issues associated with a hysteric personality.

17 So, yes, I look at that and I say this is
18 consistent with my diagnosis.

19 Q. You used the word "could be" three times.

20 A. Uh-hum(affirmative).

GASTER excerpts

21 Q. You're guessing about some of that, aren't you?
22 You're guessing about the bad boss, aren't you, you don't
23 know?

24 A. No, I'm not guessing about the bad boss. Those
25 are her words.

42

1 Q. You don't know that any more than you've written
2 there, do you? Have you talked to anyone that she's worked
3 with?

4 A. No. This is what Mrs. Gaster told me.

5 Q. Do you think that job instability existed at her
6 private detective company that she's been with since 1994?

7 A. I don't know. No, I'm not aware of any.

8 Q. Aren't you aware that she's had the same company,
9 in the same position, done the same work with the same
10 person Cliff Froggatt since 1994 up until 2003, or '4;
11 aren't you aware of that?

12 A. Yes.

13 Q. Does that suggest job instability, Doctor?

14 A. No.

15 Q. We have heard the testimony of Ben Hayes who
16 worked with her closely on high level investigations of
17 Major League Baseball for a number of years.

18 He said she's an excellent employee, he trusted
19 her, she did a good job.

20 Have you talked to Ben Hayes?

21 A. No.

22 Q. Have you read his deposition?

23 A. No.

24 Q. Does that suggest job or vocational instability

25 to you?

43

1 THE COURT: Approach the bench.

2 (Bench conference).

3 THE COURT: Okay.

4 Q. Page 16 of your report. It's the section called
5 Report of Current Symptoms.

6 A. (Overhead). (Perusing document). Report of
7 Current Function.

8 Q. Current Function. Now, these are things she
9 reported to you, correct?

10 A. Yes.

11 Q. Is short term memory a symptom of mild traumatic
12 brain injury?

13 A. It can be.

14 Q. Can impaired gait be?

15 A. It can be.

16 Q. Can peripheral vision problems be?

17 A. Not in one eye only, no.

18 Q. Can headaches?

19 A. It can be.

20 Q. Coordination dysfunction?

21 A. It can be.

22 Q. Can the need to do things methodically?

23 A. It can be.

24 Q. Can being less social and fear to leave the house
25 be consistent?

44

1 A. It could be. It's typically not associated with
2 that.

GASTER excerpts

3 Q. What about inability or fear of driving after an
4 accident?

5 A. Well, not necessarily due to traumatic brain
6 injury, no, but due to being in an accident or a potential
7 accident.

8 Q. Getting angry quickly, irritability is common in
9 someone with mild traumatic brain injury?

10 A. It can be.

11 Q. Insomnia is a common complaint in mild traumatic
12 brain injury patients?

13 A. Can be.

14 Q. Anxiousness?

15 A. Can be.

16 Q. Now, you said up above here "there is no
17 indication of traumatic brain injury in the history or
18 objective measures such as neuroimaging. The symptoms she
19 reports got worse over time".

20 And you had a problem with her reporting her
21 symptoms got worse over time, correct?

22 A. I had a problem with there's no evidence she ever
23 sustained a traumatic brain injury and that her symptoms
24 got worse over time.

25 Q. You've also raised questions about the fact that

45

1 she wasn't reporting symptoms immediately after the
2 accident, isn't that correct, in your report?

3 A. Yes.

4 Q. But in fact, she has reported and she did report
5 those symptoms immediately after the accident, didn't she?

6 A. Not that I'm aware of. She's saying now that she

7 had those symptoms immediately after the accident, but the
8 first medical records that we have available are 40 days
9 after the accident, and they clearly state she's had
10 headaches for the last five days.

11 Q. Are you clear about that?

12 A. Yes, sir.

13 Q. Here's Dr. Cosma's records that you were
14 referring to, Doctor. Let's take a look at that.

15 A. (Perusing document).

16 Q. Now, the sentence says "reports 5-day history of
17 headaches with increasing severity".

18 Can that not be read as a report of "in the last
19 five days I've had an increase in the severity of my
20 headaches"?

21 MR. JONES: Objection, Your Honor. It calls for
22 speculation.

23 THE COURT: Sustained. The document speaks for
24 itself.

25 Q. Did you read that to suggest that her headaches

46

1 started five days before this report?

2 A. Yes.

3 Q. Can it be read another way?

4 MR. JONES: Same objection, Your Honor.

5 THE COURT: Approach the bench and give me the
6 document.

7 (Bench conference).

8 THE COURT: Okay.

9 MR. IGOU: Back to this record, Doctor.

10 Q. It says "unable to focus", correct?

11 A. Yes.

GASTER excerpts

12 Q. Is there a time frame on that?

13 A. No.

14 Q. It says "reports photophobia and nausea". Is
15 there a time, starting time on that?

16 A. No.

17 Q. And if Mrs. Gaster has reported these symptoms
18 started shortly after the accident, within an hour or two
19 and continued up to the time she went to Dr. Cosma, is that
20 consistent or inconsistent with the symptoms of mild
21 traumatic brain injury and the proper time of the
22 emergence?

23 A. It's inconsistent with the course. This is
24 40 days or so after the accident or the incident in which
25 she did not sustain a traumatic brain injury, because there

47

1 was no alteration of consciousness, there is no loss of
2 consciousness, there is no daze and confusion.

3 She was able to be purposeful, planful
4 immediately at the time and drive, apparently on two
5 wheels, which would be impossible to do; impossible to do
6 if she had even a momentary alteration of consciousness.

7 So all of these symptoms are inconsistent with
8 the history because there is no history of traumatic brain
9 injury.

10 Q. Do you know whether she had a memory of hitting
11 her head with Cliff's head?

12 A. Yes.

13 Q. Do you think she does?

14 A. She told me she does.

15 Q. And if someone says that they saw the Star

16 Spangled Banner or saw stars, is that consistent or
17 inconsistent with being dazed?

18 A. It's not consistent or inconsistent with
19 anything.

20 Q. Isn't that commonly the way people describe being
21 dazed, Doctor, yes or no?

22 A. It is something that individuals who sustain a
23 traumatic brain injury will say they saw stars, yes. But
24 you can see stars and not have a traumatic brain injury.

25 You can't have a traumatic brain injury and not

48

1 experience being confused, disoriented, and not being able
2 for your brain to function in the moment when you're
3 driving and in a planful way.

4 Q. Doctor, it would matter if it's a learned or
5 over-learned activity, when the quarterback goes in and
6 performs, it's overlearned, correct?

7 A. I'm not aware of anybody having an overlearned
8 ability to drive on two wheels on an Interstate.

9 Q. Do you know how long she was up on two wheels?

10 A. I don't know that she was. I only know that she
11 told me she was.

12 Q. Are you assuming that she was up on two wheels
13 for seconds or minutes?

14 A. I'm not assuming anything.

15 Q. If she's not up on two wheels, isn't driving an
16 overlearned process that could be done rather
17 automatically?

18 A. Not after you hit your head supposedly three
19 times, no.

20 Q. You did what we call a Motivational Validity Test

GASTER excerpts

21 on Mrs. Gaster, correct?

22 A. Yes.

23 Q. And you do these tests to determine if somebody
24 is malingering, correct?

25 A. No.

49

1 Q. You do it to test their motivation?

2 A. I do it to test their cooperation and
3 participation in the testing procedure.

4 Q. And aren't these types of tests that are
5 specifically designed for motivation also commonly looking
6 for someone who may be malingering on the test?

7 A. That is a potential interpretation of a poor
8 performance.

9 Q. Malingering means someone who is purposely faking
10 bad or acting like they have an injury when they don't?

11 A. Correct.

12 Q. And you say she has somatization disorder, which
13 is doing poorly without consciously doing it.

14 A. I say she had somatoform disorder which is not
15 the same thing as somatization disorder, although they are
16 similar.

17 Q. But you're saying if there's any decrease in
18 performance, it's not purposeful, it's subconscious?

19 A. That is my understanding of this case, that's
20 what I believe, yes.

21 Q. And it's true, isn't it, Doctor, that Dr.
22 Olafsson gave her malingering motivational tests and she
23 passed them, correct?

24 A. That is my understanding, yes.

25 Q. And you gave her yet a different test. He gave

50

1 her a Computer Assessment Bias and the Rey-15. Those are
2 commonly used motivational malingering tests, correct?

3 A. Yes.

4 Q. She passed those, correct?

5 A. That's what he reported, yes.

6 Q. And you gave her another very commonly well-
7 tested test called the TOMM, T O M M, correct?

8 A. Yes.

9 Q. Test of Memory and Malingering, correct?

10 A. Yes, sir.

11 Q. If she had gotten a score below 45, then you
12 would have put in this report that the neuropsychological
13 testing was invalid because she had motivational or
14 malingering problems, correct?

15 A. No.

16 Q. No?

17 A. No.

18 Q. Have you ever done a report where someone failed
19 the TOMM test and you wrote that the person had a
20 motivational problem in taking the test?

21 A. No.

22 Q. No?

23 A. Not like that, no. I mean, this is assessing --
24 it's a relatively easy test that looks like it's a
25 difficult test. So most people get -- there's 50 items and

51

1 you give two learning trials and then you give a delayed
2 recall.

GASTER excerpts

3 If people do poorly, basically it suggests that
4 they're not giving their best effort, but there's lots of
5 reasons for not giving the best effort. So I wouldn't say
6 anything about any particular score taken in and of itself.

7 I would look at the behaviors that I see at the
8 interview. I would look at the personality testing. I
9 would look to see what they do across all the rest of the
10 testing before I would determine what really that one
11 single score means.

12 And no, I would never say what you suggested
13 based on any score on any test.

14 Q. Well, speaking of that, on the working Memory
15 Test you have noted that the "test score was at a level
16 between good and questionable effort".

17 A. Yes.

18 Q. Do you see that?

19 A. Yes.

20 Q. Now, does that mean on that particular test,
21 Doctor, that she showed questionable effort or not?

22 A. This is the test that we talked about a little
23 while ago where Digit Span and she did well on Digit Span
24 forward. She did very poorly on Digit Span backwards. And
25 she did well on Digit Span sequencing.

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1 We talked about that, at least I suggested to
2 you, that that was a psychological factor which was coming
3 into play because it was a brain function factor.

4 She should show a deteriorating performance as
5 the test got more difficult, and instead we see a V-shaped
6 performance where it's poor on the moderately difficult but

7 fine on the easy and the most difficult.

8 So that overall pattern, and then the overall
9 score suggests that there's some effort or participation
10 issues on that test that came into play, and that's what I
11 say here.

12 Q. But the actual score does not say she did
13 questionable effort; is that correct?

14 A. I think I answered the question --

15 Q. Is there -- I'm sorry. Is there a cutoff,
16 Doctor?

17 A. Yes. It's called Reliable Digit Span and there
18 is a cutoff.

19 Q. And was she on the side of the cutoff that said
20 questionable effort or was she on the side that said good?

21 A. I think -- well, I don't remember. I think she
22 had a score of 7 which is the score. So it depends where
23 you believe the cutoff to be.

24 Q. Doctor, in your Test Summary you said that her IQ
25 testing that you did turned out to be fairly low in the

53

1 80s; is that correct?

2 A. I don't think I gave a score. I said it was ten
3 points lower than I expected it to be.

4 Her verbal IQ -- that's not mine. (Perusing
5 document).

6 Her performance, her IQ, full scale IQ was 80.

7 Then there is four scores that go into that which
8 range in her case from 79 to 89.

9 Q. What was her performance IQ?

10 A. On the WAIS 4, which is the current version, we
11 don't have a performance IQ any more. We have a perceptual

GASTER excerpts

12 reasoning score and we have a processing speed score, which
13 on earlier versions together would make up the full scale
14 IQ score -- I mean the performance IQ score. Excuse me.

15 Q. Doctor, would you agree with me that a
16 performance IQ score years later after an injury is the
17 significant, the most significant predictor of return to
18 work or school?

19 A. No, I don't think I would.

20 Q. Were you the lead author of this study?

21 A. (Perusing document). Yes.

22 Q. Was it published in the Journal of Head Trauma
23 Rehabilitation in 2003?

24 A. Yes.

25 Q. It states "approximately four years post-injury

54

1 performance IQ at time of acute rehabilitation was the most
2 significant predictor of return to school or work more so
3 than socioeconomic variables, injury severity, or physical
4 impairment".

5 A. Correct.

6 Q. So you stand corrected on what you said earlier?

7 A. No. I didn't do that study. You asked what I
8 would agree to. That one study showed that. That wasn't a
9 study that I did.

10 Q. But you put it in your study.

11 A. Yes.

12 Q. Did you put it in there because you disagreed
13 with it or because you agreed with it?

14 A. I put it in there because I do think that
15 performance IQ is an important predictor of ability to

16 return to work, but it's not, when you look at the broader
17 literature, the most important predictor.

18 Q. Doctor, her IQ in school we know was above 100,
19 correct?

20 A. I was not aware of that.

21 Q. Well, the school records that we have been
22 talking about forever, don't they have an IQ score in them?

23 A. If they do, I don't recall seeing that and I'm
24 happy to have you point it out to me.

25 Q. Isn't that something that you generally look for?

55

1 A. Yes.

2 Q. Do you see it here, Doctor.

3 A. No.

4 Q. Do you see it over at the end, it says IQ 104.
5 Here. I can show it to you in case you can't read it.
6 (Tendering).

7 A. (Perusing document). It looks like it says 104,
8 yes.

9 Q. Was that something that you would have liked to
10 have known?

11 A. Looking at that I don't have any idea what that
12 means. It doesn't tell me what test was used and so I have
13 no idea what that means.

14 Q. Well, I think it does say Weschler, doesn't it?

15 A. It does? That's not what it looks like to me.
16 Does not look like anything I can read.

17 Q. Well, it does say IQ 104.

18 A. Yes.

19 Q. And you tested her IQ and it was in the low 80s?

20 A. 80, yes.

GASTER excerpts

21 Q. That would also include a low performance IQ,
22 correct?

23 A. Again --

24 Q. I'm sorry. Let me rephrase that. That would
25 also include a performance IQ in the low 80s, close to 80,

56

1 correct?

2 A. Again, on the WAIS 4 Performance IQ it is no
3 longer an IQ score that's obtained from the WAIS 4 which is
4 the test that I gave.

5 Q. But the IQ score that you came up with was 24
6 points lower than the one she had in this school record;
7 would that be correct?

8 A. Yes.

9 Q. Now, Doctor, you said that it was odd that Mrs.
10 Gaster did better and became more interactive with you as
11 the testing went forward, correct?

12 A. I said that that was inconsistent with what you
13 expect with brain injury.

14 Q. So if a person, generally speaking or I mean,
15 it's your opinion that a person taking the neuropsych
16 battery will wear down instead of getting friendlier and
17 more involved in the testing as the day goes on?

18 A. No. What they will do is they will get more
19 fatigued and generally you'll see the fatigue on their
20 face. You'll see it in the energy level. And you'll tend
21 to see lower scores on testing unless you take appropriate
22 breaks.

23 Q. Is it possible that motivation can increase
24 during the testing day rather than decrease?

25 A. Motivation typically varies across testing

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1 depending upon one's, the person who is taking the test
2 sort of belief about the test.

3 I mean, some individuals for example say I can't
4 do math. So if you give them a math test, even though they
5 can do it, their head is saying they can't do it and their
6 motivation decreases.

7 So motivation varies throughout the day.

8 Q. Can motivation increase during the session owing
9 to building rapport with the test-giver?

10 A. Definitely.

11 Q. That's in your book, right?

12 A. Yes.

13 Q. That could have happened here with Mrs. Gaster,
14 correct?

15 A. It could have. I think it probably did.

16 Q. So is that an unusual scenario given that you put
17 that in your book as something that can happen?

18 A. But we're talking about fatigue, not motivation.
19 We are talking about rapport. Not fatigue.

20 Q. Do you know whether or not Mrs. Gaster drank Red
21 Bulls during the day of the test?

22 A. I'm pretty sure she didn't. I'm not aware that
23 she did.

24 Q. If she did, would that help against fatigue?

25 A. It could help temporarily.

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1 Q. Doctor, we have been here a while. I'll try to
2 wrap it up.

GASTER excerpts

3 You talked about and relied upon a test called
4 the Personality Assessment Inventory; is that correct?

5 A. I talked about it as being invalid because of the
6 high elevation on the Negative Impression Management score
7 which is NIM up there on the screen.

8 Q. Are there other validity scores in there, Doctor?

9 A. Yes.

10 Q. Which ones are they?

11 A. The first one which is inconsistency.

12 The second one is infrequency.

13 Then NIM, Negative Impression Management.

14 Then we have Positive Impression Management, PIM.

15 All those together are scales that we look at to
16 determine whether or not we can really interpret the other
17 scores as being a valid reflection of a person's
18 symptomatology.

19 Q. Now, Doctor, which used to be called Rogers?

20 A. I'm sorry.

21 Q. Wasn't there a Rogers Index on this test?

22 A. Not that I'm aware of.

23 Q. Was there one called MAL?

24 A. Not that I'm aware of.

25 Q. ICN she passed, correct?

□

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1 A. That's considered borderline elevated. The
2 computer interpretation based on that score suggested that
3 there was more inconsistency across items and therefore the
4 interpretation should be judged with concern, and then when
5 it got to the NIM, in terms of computer interpretation, it
6 basically said it's invalid and they weren't going to offer

7 any additional computer interpretations after that.

8 So my answer to your question, that's what the
9 computer interpretation says. My interpretation would be
10 consistent with that.

11 Q. Doctor, you're aware, aren't you, of studies
12 which have been published in the same places that you're
13 published that have critiqued the NIM as a valid instrument
14 for talking about somebody having motivational or feigning
15 issues, correct?

16 A. I'm aware that there is some literature. I'm not
17 completely up on all that literature.

18 Q. Who developed the PAI, Personality Assessment
19 Inventory?

20 A. Les Morey.

21 Q. And does Mr. Morey say that this test should be
22 used as a malingering test per se, or not?

23 A. I doubt it.

24 Q. He said it's not a malingering test per se; you
25 would agree with that?

□

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1 A. Yes.

2 Q. And are you aware of cautionary studies talking
3 about the use of the PAI?

4 A. No, I'm not familiar with that article.

5 Q. Are you familiar with an article authored by
6 Samuel Hawes and Marcus Boccaccini from Sam Houston State
7 University?

8 A. No.

9 Q. If they stated that "the future research with the
10 PAI validity measure that is high in ecological validity is
11 needed", would you agree?

GASTER excerpts

12 A. I don't think I would agree or disagree. I would
13 say I don't have enough information to make a reasonable
14 comment.

15 Q. "Ecological validity", Doctor, that's a concept
16 that has evolved more recently, correct?

17 A. Ecological validity usually refers more to
18 neuropsychology than to personality testing. It refers to
19 an ecological measure of memory. For example would be how
20 a person remembers a person's name, let's say, in a social
21 situation as opposed to how they perform on a list-learning
22 test that they get in testing with me.

23 So ecological validity refers to whatever we're
24 measuring, what it's really like in the real world, as
25 opposed to what it's like in a structured one-on-one

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1 testing situation.

2 Q. Doctor, you would agree with me that the concept
3 of ecological validity in the last 10 years has gained in
4 importance?

5 A. It's talked about a lot. It's difficult to
6 accomplish. And it's extremely difficult to assess.

7 Q. And the concept of ecological validity would also
8 say that neuropsychological test batteries and their
9 interpretation "should try to", "should try to be
10 consistent with what's going on with the patient in the
11 outside world although that's difficult". would that be
12 fair?

13 A. I don't think that the field in general would
14 agree with that and I would not agree with that. what we
15 are doing in the psychological assessment, as I talked

16 about before, is trying to see what the brain is capable of
17 doing. There's many reasons for people to perform
18 differently than the brain is capable of in the real world,
19 for again psychological reasons, for fatigue reasons, for
20 medication reasons, and so on and so forth.

21 In a neuropsychological assessment one of the key
22 goals is what can the brain do and is it impaired.

23 That's a very different question than what is
24 this person generally functioning like in the real world,
25 where literally thousands of things can impact that.

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1 Q. We'll move on. You're aware of the records of
2 Dr. Libreros from 11/24/03, correct?

3 A. I recall reading that in the past. I don't
4 remember the details.

5 Q. I'm reading that marked paragraph. Does that
6 indicate a history of symptoms consistent with mild
7 traumatic brain injury, onset occurring at the time of the
8 accident?

9 A. Not necessarily.

10 Q. Does it say "since the accident"?

11 A. It says "since the accident", but that would be
12 self-report and I'm not sure when this was in relationship
13 to the accident --

14 Q. Doctor, I'm sorry. I don't want to interrupt.

15 A. -- so when anybody remembers things that happened
16 months or even years earlier, it's hard to know with
17 accuracy that a statement like this "I have had headaches
18 ever since the accident", it's really hard to know what
19 that means.

20 Does that mean at the moment the accident started

GASTER excerpts

21 or in general since the accident "I've had headaches".

22 So this statement could mean a whole bunch of
23 different things and the kind of questioning that would be
24 necessary to figure it out, well, did it ever go away,
25 exactly when did you have the first headache, and do you

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1 have the same kind of headaches right now that you had
2 then, is it better or worse, what's been the course, and so
3 forth.

4 You need to ask all of those kinds of questions
5 and document that to be able to answer your question, sir.

6 Q. Doctor, you said this self-report was done years
7 later. This self-report for this particular doctor was
8 done less than two months after the accident, correct?

9 A. My memory at this point is I'm not sure.

10 Q. 10/7/03.

11 A. This is --

12 Q. 11/24?

13 A. D O V?

14 Q. Date of Visit.

15 A. Date of Visit. That would suggest the answer is
16 yes.

17 Q. This is not an ancient recollection. It's a
18 fresh recollection.

19 A. It's a fresh recollection, but what I said, which
20 still holds, which I don't know what that means and without
21 asking those kinds of detailed questions, "since the
22 accident" could mean very different things.

23 Q. Didn't Mrs. Gaster tell you on the video that we
24 watched that her symptoms, that these types of symptoms

25 started immediately and continued?

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1 A. She did tell me on the video that she had a
2 headache immediately afterwards, and I would expect her to
3 have a headache because she hit her head on the left side
4 against a window and on the right side against another
5 person, so I would expect her to have a headache from that,
6 yes.

7 Q. And are you skeptical or are you discounting the
8 report of immediate symptoms from Mrs. Gaster?

9 A. Can you clarify your question.

10 Q. In the first five weeks Mrs. Gaster said she had
11 a number of problems; sound bothered her, light bothered
12 her, she had headaches, she had memory problems, she had
13 balance problems, she had speech problems.

14 Are you suggesting that that self-report is false
15 or incorrect?

16 A. What concerns me about that self-report is the
17 first time it's reported to a physician is 40 days after
18 the accident. If those symptoms are going on from the
19 outset, I would think that a person would go for treatment
20 earlier than that, or when they went for treatment, the
21 note that the doctor wrote wouldn't say "for the last five
22 days the headaches have been getting worse".

23 They would have said "from the time of the
24 accident there has been headaches and they have gotten
25 worse, gotten better", whatever.

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1 Q. Would it be helpful to know that her business
2 partner Cliff Froggatt noticed these types of symptoms from

GASTER excerpts

3 the time of the accident until the first visit?

4 A. If I could do an interview with Cliff Froggatt,
5 it would be helpful to me, yes.

6 Q. If Cheryl Dininno, the woman who was her best
7 friend at the time, reported a continuation of those
8 symptoms in that time period, would that be helpful to you?

9 A. No. It would be helpful if I could do a clinical
10 interview and ask questions in detail the way I'm
11 describing. That would be helpful.

12 Q. Doctor, Mrs. Gaster has also been diagnosed in
13 this case with a malingering psychiatric illness. That is
14 not consistent with your findings, is it?

15 MR. JONES: Objection, Your Honor. Is this an
16 exhibit?

17 MR. IGOU: It's Forman's report.

18 MR. JONES: It hasn't been identified.

19 Q. Let me identify this. This is the diagnosis page
20 of an IME done by Dr. Arthur Forman who is a psychiatrist
21 who examined Mrs. Gaster.

22 I'm sorry. Now I have explained to you his
23 diagnosis under Axis I was malingering psychiatric illness.

24 Is that consistent or inconsistent with your
25 diagnosis after examining Mrs. Gaster?

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1 A. Neither. And the reason I say that is because as
2 we talked about I'm saying that NIM, that Negative
3 Management Scale, she is exaggerating symptoms. Whether or
4 not that is malingering is whether those are conscious and
5 deliberate for secondary gain, in other words, for example,
6 to win this lawsuit.

GASTER excerpts

7 So it's neither consistent nor inconsistent.
8 It's a judgment call that I made that my diagnosis suggests
9 that it's an unconscious process consistent with a
10 personality disorder and somatoform.

11 It's this person judgment that that same kind of
12 exaggeration is conscious.

13 One can malingering with one doctor and not malingering
14 with another doctor. So it's entirely possible that Mrs.
15 Gaster did malingering with Dr. Forman and didn't malingering
16 with me.

17 Q. She didn't malingering because she passed the test,
18 correct, the TOMM, among other things?

19 A. Well, again, the Negative Impression Management
20 suggests significant exaggeration. That could be conscious
21 and unconscious. It's my interpretation that I believe
22 it's unconscious, not conscious, and therefore I don't give
23 a diagnosis of malingering.

24 Q. Fair to say, Doctor, on Axis I you and Dr. Forman
25 had different --

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1 THE COURT: Approach the bench.

2 (Bench conference)

3 MR. IGOU: That's all I have, sir.

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GASTER excerpts

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1 (BEGINNING OF EXCERPTED TESTIMONY OF DR. MELLMAN)

2 CROSS EXAMINATION

3 BY MR. IGOU:

4 Q. Dr. Mellman, you primarily do work, as you said,
5 for the defense, correct?

6 A. The majority of my work is done for defense,
7 that's correct.

8 Q. And 82% of your earnings comes from defense?

9 A. Yes, sir, as of that time when I calculated it a
10 few weeks ago.

11 Q. How much an hour are you charging to be here?

12 A. \$600 an hour.

13 Q. How much did you charge per hour for seeing her,
14 the same amount?

15 A. No, sir. The charge for the Independent Medical

16 Evaluation is \$300 an hour for reviewing of the records,
17 then depending on how long that takes.

18 And then the Independent Medical Evaluation
19 itself is a flat fee of \$1,000.

20 And then if there is a Court Reporter, as there
21 was in this case, that's an additional \$250.

22 Q. Doctor, since you were in medical school in 1966
23 been a lot of changes in the field of brain injury, haven't
24 there?

25 A. Well, there have been changes in the --

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1 Q. In the field of neurology?

2 A. Well, there's been changes sort of in the
3 treatment and the way we do it and how we operate and how
4 we do it and things like that. Head injury hasn't changed
5 that much.

6 Q. For example, when you graduated from medical
7 school, there was no MRI of the brain, correct?

8 A. No. When I graduated there was no CAT scan.

9 Q. No CAT scan, no field of neuropsychology. We
10 have had neuropsychology testimony here. That didn't
11 exist?

12 A. I'll take your word for it.

13 Q. Doctor, would you agree with me that the
14 evolution of finding out about brain injury, treating brain
15 injury, and the biological basis of brain injury has
16 evolved tremendously in the last 20 years?

17 A. Yes.

18 Q. And Doctor, another example of something in the
19 old days, as I'll call it, nothing personal, but 20 or
20 30 years ago, doctors like yourself were trained to say if

GASTER excerpts

21 you weren't knocked out in an accident, you couldn't have
22 brain injury, right?

23 A. No. Not at all.

24 Q. So 30 years ago wasn't the primary idea that you
25 had to be knocked out?

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1 A. No. We understood back then that you could get
2 bonked and see stars, you had problems like that, but I
3 mean back then -- you all don't remember this -- but there
4 were no -- there were no headrests. No seat belts.

5 In your rear-end collisions people were actually
6 looking -- see, if you go forward, your chin hits here.
7 (Indicating). If you go backwards, there's nothing to stop
8 you.

9 And people were looking -- they were hitting the
10 rear of the car and they were looking out the back window.
11 You try that.

12 Those people had severe neck and they had severe
13 personality changes. The reason they had severe
14 personality change is because their frontal -- without
15 going into an anatomy lesson -- their frontal lobes and
16 their temporal lobes sit on very hard and pinnacled and
17 sharp pieces of skull inside, and they actually had
18 personality changes because their brain was damaged.

19 When we were doing psychological tests back
20 then -- I don't know much about the field of
21 neuropsychology -- but the point is back in the sixties and
22 seventies we knew that.

23 Q. So, Doctor, Mrs. Gaster did not have the benefit
24 of seat belts helping her or a headrest helping her,

25 correct, this was side to side?

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1 A. I'm sorry. Are you saying her seat belt and
2 headrest were in place?

3 Q. Right, but since she is side to side motion, they
4 weren't effective.

5 A. Okay, I see what you mean. Correct. Well, they
6 helped her because they kept her from having more torsion,
7 that's twisting problems, and she would have been worse off
8 with that if she had not been wearing her seat belt. I
9 don't know much about the headrest. But I know the seat
10 belts hold you in place.

11 I don't know if hers grabbed or not, but the
12 potential is there that it helped her.

13 Q. Doctor, in a person who hits her head and sees
14 stars you'd expect more symptoms and perhaps hypothetically
15 more injuries with something like that than what Mrs.
16 Gaster had?

17 A. No, I mean, we've all hit our heads -- I don't
18 know about everybody -- but certainly I have and a lot of
19 people I know have hit their heads and seen stars. You say
20 oh, man, you're working in kitchen and you come up against
21 a cabinet or something. And oh. (Indicating verbally).

22 But you're fine, you know, within a couple of
23 minutes. You may have a sore head for a while, but that's
24 about it.

25 Q. Are there known predispositions, in other words,

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1 isn't it true, Doctor, someone who had a previous blow to
2 the head is more susceptible to a worse outcome in a

GASTER excerpts

3 subsequent blow to the head than somebody who didn't have
4 that history, would you agree?

5 A. No, I don't agree because we're not talking
6 about, I mean, like a fight physician. They get blows to
7 the head and more susceptible or suspect. But if you get
8 somebody like Mohammed Ali who 20 and 30 years down the
9 road has Parkinson's because his brain was damaged from
10 boxing, there was a lot of issue with boxing.

11 Or where you get football players where the
12 linemen, in particular professional football, get
13 Alzheimer's early and die. They have severe brain
14 problems, as opposed to the running backs and the
15 quarterbacks.

16 So there is a thing about head injuries being
17 more prone to problems, but on an acute basis, in terms of
18 her head injuries, there's not that cumulative effect.

19 Q. Do you feel that someone who has a preexisting
20 history of psychiatric disorder such as anxiety or
21 depression is more susceptible to a worse outcome than
22 someone without those premorbid conditions?

23 A. You mean with a head injury?

24 Q. Yes.

25 A. The answer is a qualified answer of yes. When

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1 people such as what he described have premorbid conditions,
2 psychiatric conditions, and they have a head injury that
3 severe, they're in a coma, unconscious, you see on the CAT
4 scan there is brain damage, this, that and the other, they
5 can be worse.

6 The only person I saw was a kid, 16-year old

7 decided to shoot himself and he put a gun in his mouth and
8 he did a bifrontal lobotomy on himself. We saved his life.
9 He did well. His mother called me two years later he was
10 in college, doing well. He had basically done his own
11 bifrontal lobotomy. That is rare.

12 But as you say, if you're severely emotionally
13 disturbed before and you have a severe head injury, yes,
14 you can get emotionally worse.

15 Q. Doctor, would you agree that 7 to 33% of persons
16 who suffer mild traumatic brain injury can have persistent
17 symptoms?

18 A. Well, you're going to have to define a mild
19 traumatic brain injury. But Mrs. Gaster did not have a
20 mild traumatic brain injury. So the answer is that however
21 you define it, that can be so.

22 Q. Doctor, are you aware of a definition of mild
23 traumatic brain injury which includes "structure normal
24 MRI, loss of consciousness from 0 to 30 minutes, alteration
25 of consciousness from a moment up to 24 hours".

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1 Are you aware of that definition of mild
2 traumatic brain injury?

3 A. There are various definitions and I don't know if
4 you are quoting Rogers or not. But in any event, that is
5 okay. Okay.

6 Q. Would you agree that is a definition?

7 A. That sounds like -- there are many definitions.
8 This is a controversial field and anybody can write, is
9 writing about it. But for the sake of where we are, okay.

10 Q. So if someone has a short alteration of
11 consciousness, they can be diagnosed with a mild traumatic

GASTER excerpts

12 brain injury?

13 A. If somebody -- say that again -- if they have a
14 what?

15 Q. Under this definition, which is widespread,
16 someone could have a blow to the head, have a momentary
17 alteration of consciousness and a normal MRI and be
18 diagnosed with a mild traumatic brain injury and have
19 symptoms?

20 A. Yes, yes.

21 Q. Those symptoms include photophobia?

22 A. Right.

23 Q. Light.

24 A. Light bothers you.

25 Q. Phonophobia?

□

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1 A. Sound bothers you.

2 Q. Headaches?

3 A. Headaches.

4 Q. Dizziness?

5 A. Dizziness.

6 Q. Incoordination?

7 A. Uncoordination.

8 Q. Short term memory problems?

9 A. It varies, yeah.

10 Q. Irritability?

11 A. Yeah.

12 Q. Those are all common after a blow to the head?

13 A. No. See, now you're going from a blow to the
14 head from minimal brain damage.

15 Q. I misspoke. Let me rephrase. That is common in

16 the case of a diagnosis of mild traumatic brain injury?

17 A. It's not necessarily common. If I remember, you
18 said 33% which is one-third, which is however you define
19 common, but in any event, I'll accept what you said.

20 Q. There's also something associated with mild
21 traumatic brain injury, this is where it gets a little bit
22 murky, called post-concussive syndrome.

23 A. Murky all along, but yes, there is such a thing
24 called post-concussion syndrome, which is what I was
25 talking about before.

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1 Q. And we know, even though it's controversial, that
2 some persons who get this blow to the head that I just
3 described that you agreed with, have emerging and
4 continuing symptoms for years from that blow to the head.

5 A. Yes.

6 Q. Certain subsets, correct?

7 A. Correct.

8 Q. And that certain subset includes people who go
9 into the blow to the head with preexisting anxiety or
10 depression, for example.

11 A. Okay.

12 Q. Right?

13 A. Right.

14 Q. And you're aware of the research that indicates
15 that this section can continue to, you know, spiral and
16 have all sorts of psychiatric and funny symptoms?

17 A. I don't know about spiral, which means they are
18 getting worse and worse and out of control, but they can be
19 made worse.

20 Q. And if Michelle Gaster, in these three blows to

GASTER excerpts

21 the head from a car going up on two wheels, gives a history
22 of seeing stars and having been dazed and then having all
23 of the symptoms that I described, and now continuing
24 seven years later to have significant psychiatric and
25 behavior problems, is that consistent with, possibly

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1 consistent with that minority of people?

2 A. If you would totally ignore the head injuries she
3 had before that accident, which were still relatively minor
4 but worse than this particular accident, and she didn't
5 have any of those things, so, you know, you're correct up
6 to a point.

7 But it falls apart when one understands her
8 history. If she had never had any head injury or done
9 anything in the past and she had this thing, but she did,
10 she had all those things, it's just no.

11 Q. Why does your treatment of Michelle Gaster change
12 adversely only because she has a history of several blows
13 to the head prior?

14 A. What I'm saying is the prior history of head
15 injuries negates this accident being a problem. If you
16 didn't have those things, then this would be the first
17 person out of thousands of people I have seen with head
18 injuries, but just say the few hundred I've seen with minor
19 head injuries who they were acting like this, there would
20 be sort of something you could -- you know, I would be on
21 less firm ground. There's no question about it.

22 But the fact that she had these other things and
23 didn't have problems from it, to me she's just transferring
24 these issues that she had emotionally to this particular

25 accident. She could have transferred them to the mission

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1 bench. She could have transferred them to the airliner
2 when she bonked her head.

3 She could have -- so, anyway, I don't know if I'm
4 making myself clear, but that's my thought.

5 Q. Let me see if I can clarify this. From a
6 forensic point of view, you're right, one of your
7 assignments is to look backwards from the incident and to
8 look forward and to make sense out of it. That's what
9 you're talking about, correct?

10 A. I think so, yes.

11 Q. So one way of saying whether or not the prior
12 blows to the head were significant and caused significant
13 problems or any problems in her life, compared to this one,
14 is forensically for you to hypothetically interview people
15 in the family, friends and relatives, co-workers, correct?

16 A. The answer is no. And I know about these letters
17 before and after and people supporting her. That's all
18 taken into my opinion.

19 And, you know, I'm just dealing with like I said
20 my 30 some years of experience and thousands of people I
21 have taken care of and the various things I have done with
22 head injury and continue to do, because I have run into
23 this thing with people that have been tortured, is it real,
24 is it not real. Things like that.

25 Q. Well, Doctor, I mean, you told the jury a little

79

1 while ago that all of the problems that she's having now,
2 including being Baker-Acted twice, correct?

GASTER excerpts

3 A. Okay.

4 Q. Being arrested twice.

5 A. Okay.

6 Q. Not being able to work.

7 A. Okay.

8 Q. Acting pretty crazy with you, right?

9 A. She didn't act crazy with me.

10 Q. She didn't? She acted normal?

11 A. Yes. She denied things that were in the records,
12 but she didn't have bizarre behavior with me.

13 Q. But assuming that all of these things are
14 happening since the accident, do you have any equivalent
15 data to suggest dysfunction at the workplace, socially in
16 the neighborhood, in jail, and Baker Acting at any time
17 prior to this accident?

18 A. I think she got what we call a red herring.
19 whatever that means. But it's something that sort of it
20 was there, had nothing to do with the ongoing things. So I
21 think it's pretty well documented that she's worse now than
22 she used to be years ago. She's getting progressively
23 worse and whatever.

24 But the accident, if that's indeed true, the
25 accident that we're here about had nothing, nothing,

□

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1 nothing to do with it.

2 Q. Is it just coincidence that Mrs. Gaster began to
3 complain of symptoms consistent with mild traumatic brain
4 injury or post-concussive syndrome immediately after this
5 accident and continues to do so seven years later?

6 A. You mean after her rage reaction, she cried and

7 had a headache or something?

8 Q. No. I'm talking about her -- Doctor, you read, I
9 mean, part of your review is to review all the records in
10 this case. I think. And you had the ability to look at
11 all of these records that you listed on Page 2, correct?

12 A. Yes, sir.

13 Q. Now, correct me if I'm wrong, but Dr. Libreros
14 and Dr. Figueroa, medical doctors, took her history and
15 diagnosed her with post-concussive syndrome, correct?

16 A. Yes.

17 Q. Dr. Herrero did the same thing, correct, he's a
18 psychiatrist?

19 A. Yes.

20 Q. Dr. Harrison documented psychiatric problems and
21 possible post-concussive syndrome as well. He's a
22 neurologist.

23 A. Correct.

24 Q. Are you saying that there's no emergent history
25 of symptoms and problems that are related to these doctors,

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1 and that their diagnoses don't mean anything to you?

2 A. They mean something to me; they're wrong. She
3 doesn't have it. She didn't have it. And she doesn't have
4 it now. And they are wrong.

5 Q. So likewise, all of these letters that you read
6 from attorneys, insurance adjusters, the kind of people
7 that hire you 80% of the time, they in their professional
8 opinion saw an acute decline in this lady that they had
9 never ever seen prior to October 7, 2003; isn't that what
10 they all say?

11 A. Right.

GASTER excerpts

12 Q. Are they all wrong too?

13 A. It's a true/true/unrelated. Let's just say it's
14 true, everything they say, she was getting worse. Let's
15 say it's true she had this particular motor vehicle
16 accident. Yes. But they're unrelated.

17 Q. And you also have to say another truth. True
18 that she didn't have these problems before the car
19 accident. They are not describing anything, nor do you
20 have anything in your file to suggest ongoing vocational
21 and societal disability of any kind, do you?

22 A. I think she got worse. I mean, she had emotional
23 problems before the accident.

24 Q. Were they affecting her job?

25 A. That, I really don't, you know -- actually, I

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1 wonder, because I read her partner's deposition and they
2 might have been. So the answer is I'm not sure, but they
3 might have been.

4 Q. Take hypothetically that there is no suggestion
5 from these people, or people who testified in this matter
6 about significant disruption or failure at the vocational
7 world prior to October 7, 2003.

8 Okay.

9 A. Okay.

10 Q. Do you have evidence to show that this problem
11 that she's got now was interfering with her work before?

12 A. That, I don't know the answer to that. I have
13 not reviewed these things recently, but I'm willing to
14 accept, if you're saying they didn't and these people were
15 listening to what the other people are saying, if that's

16 what everybody heard, then fine. I don't have a problem
17 with it.

18 It's just, what I'm just saying is her head
19 injury did not, her bonking of her head did not cause any
20 psychiatric increase -- increase in psychiatric or
21 emotional problems.

22 Q. Do you have a hypothesis as to what all of these
23 people are seeing?

24 MR. JONES: Objection. Speculation.

25 THE COURT: Approach the bench. I want to see

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1 the report.

2 MR. IGOU: (Tendering).

3 (Bench conference).

4 THE COURT: Okay. Please move on.

5 Q. Along with your other opinions that these doctors
6 are wrong, is Mrs. Gaster wrong about her describing to you
7 the acute adverse changes following October 7, 2003?

8 A. I'm accepting -- basically I'm not calling
9 anybody a liar. I'm not. I'm calling the physicians wrong
10 in saying that she had a post-concussion syndrome and she
11 had brain injury from the accident. That, I am saying.
12 That's what I did and do for a living.

13 what I'm saying, okay, she had it and it's
14 basically a true/true/unrelated type thing. I don't know
15 if I'm making myself clear, but I'm really not calling into
16 question anything other than the physicians' diagnoses.

17 Q. Let me go back for a minute to Dr. Figueroa who
18 you talked about a little bit earlier. Now, he did some
19 testing. You're not an expert in the eye testing field,
20 are you?

GASTER excerpts

21 A. Well, I used to order it on patients and I had to
22 understand it and things like that. Go ahead.

23 Q. Assuming Dr. Figueroa has testified that he
24 doesn't feel that the drugs she was on caused the
25 abnormalities that you saw in those records, would that

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1 change your opinion at all?

2 A. Absolutely not. I would be shocked if he said
3 that. I would really be surprised that a neurologist would
4 say psychotropic medication had no potential to change the
5 findings on that particular test, because she didn't have
6 anything clinical to go along with it. He just ordered
7 that test. So I would be surprised. But I'm not sure that
8 answered your question.

9 Q. Doctor, you're aware of the concept of diffuse
10 axonal injury?

11 A. Absolutely.

12 Q. Would it be fair to say that 20, 25, 30 years ago
13 it was thought by doctors and experts that diffuse axonal
14 injury could only occur in the context after moderate or
15 severe brain injury?

16 A. I'm afraid you're going to go into that diffuse
17 axonal injury can occur in a mild head injury.

18 Q. Yes.

19 A. You're going there?

20 Q. Yes.

21 A. Diffuse axonal injury, the axons, you have nerve
22 cells and they talk to each other because there's wires
23 that go along. The wires are called axons. The axons are
24 covered with something called myelin. It's a fatty tissue.

25 It's just like the telephone lines.

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1 And this fatty tissue allows the signals to go
2 fast. That's why when I want to do this, I do it, because
3 all these axons send signals to allow me to do it.
4 (Demonstrating).

5 Diffuse means all over your brain. Axonal means
6 those axons are injured. And what you see on a brain,
7 normally, normally to about age 60 or 65 you have a size 10
8 head and a size 10 brain, they fit. It's like wearing a
9 shoe. As you get older your brain shrinks. That's normal.

10 Diffuse axonal injury, when you lose this fatty
11 material, your brain shrinks, you go from a size 10 head to
12 a size 8 brain or size 9 brain, whatever it is, it shrinks
13 and you can see it on MRI scans and CAT scans. Your brain
14 gets smaller. That's a serious head injury because you've
15 lost brain.

16 Your signals can't go around, get there fast
17 enough. You're not as smart as you used to be. You
18 can't -- you're confused. Depends on where it is. But
19 it's diffuse.

20 I'm sorry. If you're going to go that mild head
21 injury causes diffuse axonal injury, I'd have to know your
22 source.

23 Q. Well, Doctor, are you aware of studies by Adams
24 JH, et al, published in 1989, Mittal LRH, et al, published
25 in 1994, and Erin Bigler published three years ago in which

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1 persons who had suffered a mild traumatic brain injury and
2 died later of an unrelated cause were autopsied and the

GASTER excerpts

3 brains were inspected microscopically?

4 MR. JONES: Objection.

5 THE COURT: Sustained.

6 Q. Are you aware of that literature?

7 THE COURT: I sustained the objection. Do you
8 wish to be heard?

9 MR. IGOU: Yes.

10 (Bench conference).

11 Q. Doctor, are you familiar with studies like I just
12 described?

13 A. The answer is no, but what you said proves my
14 point.

15 Q. Go ahead.

16 A. The reason your brain gets smaller is because
17 there's little bleeding in the brain and the blood cells
18 come in and white cells and they chew up this myelon,
19 because the myelon breaks up and your brain goes around and
20 the myelon tears and so forth. It's a coating over the
21 wires. It tears. So the myelon, the little white cells
22 eat it and take it away and your brain gets smaller.

23 what the gentleman has just said is people who
24 have minor head injuries and then years later when they
25 die -- who knows what happened in between that and what was

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1 going on -- they then take the brain out and they let it
2 sit for a couple of weeks, because you have to fix it, you
3 let it sit, they cut it up and they look at it
4 microscopically, and they see signs of it. Okay, so they
5 did.

6 My point is what I was saying, diffuse axonal

7 injury is on CAT scans and myelograms, when you see the
8 size 10 head with a size 8 brain, and if you have to take
9 the brain out and cut it up and look at it under a
10 microscope, you know, that's more than I'm willing to say.

11 So the answer to his question is no, I'm not
12 aware of those studies. I'm not aware of the limitations
13 of what those studies involved.

14 Q. If those studies existed, would you want to talk
15 about them?

16 MR. JONES: Objection.

17 THE COURT: Sustain the objection.

18 Q. Doctor, as a neurosurgeon, would it be fair to
19 say that when you were doing operations 10 years ago plus,
20 you were dealing with people who had severe brain injuries
21 that you had to get involved with?

22 A. I was dealing with all sorts. I mean, I had
23 people with very minor head injuries and people who died
24 from their head injuries.

25 Q. Would it be fair to say when a person you

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1 interacted with in the hospital with a minor head injury,
2 you would send them off to a specialist or a
3 neuropsychologist, and you wouldn't deal with them any
4 longer?

5 A. Well, I don't know whether or not I dealt with
6 them any longer. Depends on whatever else was going on.
7 But usually if they did have problems, yes, I would ask for
8 a neuropsychologist that I knew and trusted to evaluate the
9 patient. Those tests are very subjective.

10 Q. (Conferring). You have talked about progression
11 of her -- what are you calling it? what exactly is wrong

GASTER excerpts

12 with her now, do you know?

13 A. I'm not willing to put a psychiatric disorder on
14 her. I don't know. I don't know exactly what her
15 emotional problems are. You talked about a progression. I
16 said I'm willing to accept it. I'm not going to sit here
17 and dispute it.

18 Q. But as you sit here today, as a physician, having
19 read all of her records, you must -- you either think there
20 is something wrong with her or there's not something wrong
21 with her. What if anything do you think is wrong with her
22 causing all the problems we're dealing with in this trial?

23 A. You're talking about the emotional problems?

24 Q. I don't know. I didn't see a diagnosis in your
25 report.

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1 A. Right. She doesn't have a -- she didn't have a
2 significant head injury. I mean, there was a diagnosis. I
3 mean, it was a minor closed head injury. Whatever I said
4 there.

5 what I said "motor vehicle accident sequelae".
6 She basically had a very minor closed head injury. By
7 closed, it means there was no cuts, where there's openings
8 in the scalp. And minor means there it was very minimal.

9 Q. But Doctor, you may not have an answer to this,
10 so bear with me, because you have mentioned psychiatric,
11 possible psychiatric treatment on the last page, do you or
12 are you saying that that might be what's happening with
13 her, or do you not even think that she's suffering a
14 psychiatric condition?

15 A. Well, that's why I wanted an independent

16 psychiatric opinion. I wasn't sure how real her
17 psychiatric problems were. I knew that people thought she
18 had real ones and that was fine. I'm not debating that. I
19 thought a second psychiatric opinion was in order.

20 Q. So as to the existence or non-existence of
21 psychiatric difficulties, diagnosis, or symptoms, are you
22 deferring to a psychiatrist or some other specialist?

23 A. Psychiatrist.

24 Q. Doctor, when someone comes to the ER and they are
25 checked out by a triage nurse and there's a checklist as to

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1 neurological, gastrological, are you familiar with that
2 form?

3 MR. JONES: Objection. Relevance.

4 A. Yes.

5 THE COURT: Overruled at this time.

6 Q. Is that what you call a gross exam by a nurse?

7 A. Well, sometimes it's just asking questions. I
8 mean, it's triage. That's what you said, right?

9 Q. Right.

10 A. Triage is just sorting patients out to see the
11 most extreme, who's going to live, who's going to die. But
12 when you come into an Emergency Room, you need to be seen
13 right away or can you wait. That's what a triage person
14 does.

15 Q. This is a piece of paper that's from the Palms of
16 Pasadena Hospital. This is on Michelle Gaster.

17 I want to ask you general questions about it. Is
18 this something that you as a neurosurgeon would look to to
19 base your diagnosis, or is it a gross screening?

20 A. Well, the answer is it depends. If that has

GASTER excerpts

21 something to do -- I mean, I don't know the date of that,
22 but if that has something to do with this accident or this
23 problem, you know, it would mean -- until I had a chance to
24 analyze it and figure it out, it might or might not mean
25 something to me.

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1 Q. So you have no opinion on where Mrs. Gaster is
2 going to go in the future as far as her level of complaints
3 or psychiatric difficulties?

4 A. That's a fair statement, yes.

5 MR. IGOU: That's all I have.

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1 (BEGINNING OF EXCERPTED TESTIMONY OF DR. FORMAN)

2 CROSS EXAMINATION

3 BY MR. IGOU:

4 Q. One moment, Your Honor. We're having technical
5 problems.

6 Good morning, Doctor.

7 A. Good morning.

8 Q. As I understand your testimony, you were
9 suggesting that Mrs. Gaster has on Axis II a personality
10 disorder not otherwise specified; is that correct?

11 A. Yes.

12 Q. Doctor, that would mean that you are telling the
13 jury that she has had this disorder since, or just after
14 adolescence; isn't that true?

15 A. That's the way a personality disorder is defined
16 in terms of longevity.

17 Q. Now, Doctor, you talked about the DSM. Is this
18 the same book you were talking about?

19 A. It's the same book. This is a -- this is the
20 Reader's Digest version, I guess, but it's the same book.

21 Q. Do you mind if we go through it a little bit.

22 A. Sure.

23 Q. This is the DSM IV. This is what you use to
24 diagnose your clients, correct?

25 A. Yes.

1 Q. It's what everybody uses in psychiatry?

2 A. What everybody uses now essentially.

GASTER excerpts

3 Q. If you don't follow this, for example, a doctor
4 may not get paid for a diagnosis or get paid his
5 reimbursement?

6 A. Not true. Not true.

7 Q. You usually use this when you diagnose?

8 A. I usually use it, but that's not true.

9 Q. Now, this page on the Diagnostic Features of a
10 Personality Disorder, we are over here, see, the next page.
11 Let's go through that a little bit.

12 A. (Perusing document).

13 Q. It says that "personality traits --

14 A. Let me find it.

15 Q. I can't tell you the page.

16 A. It would be a different page obviously.

17 (Perusing document). Okay. Go ahead.

18 Q. "The difference between a personality trait and a
19 disorder is that a trait can be flexible and come and go.
20 A personality disorder, as it says, is inflexible and
21 maladaptive", right?

22 A. Right.

23 Q. That would cause -- it has to cause, for purposes
24 of your diagnosis, significant functional impairment,
25 right?

1 A. Yes.

2 Q. And one of the most important things we look at
3 in that regard is what effect the personality disorder
4 negligibly had on someone's vocation, correct?

5 A. That's one of them.

6 Q. Usually -- I've got some of your earlier

7 testimony there -- you would agree with me that the usual
8 case is that such a diagnosis as you've given Mrs. Gaster
9 will have a negative impact upon their vocation, correct?

10 A. That's true.

11 Q. These people usually can't hold down a job,
12 right?

13 A. That's true.

14 Q. They go from job to job?

15 A. Yes, frequently.

16 Q. And they frequently get fired?

17 A. They can.

18 Q. Now, you know that Mrs. Gaster has had steady
19 employment that has been highly praised by a number of
20 people that we've had in this proceeding. Are you aware of
21 any vocational problem, disruption, complaint or anything
22 else adverse in regards to her vocation in the last
23 20 years?

24 A. I didn't detect any from the history.

25 Q. Is that consistent or inconsistent so far with

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1 your diagnosis?

2 A. There are characteristics. It might be one of
3 them. I'm not exactly sure that she had a 20-year history
4 of one specific job that was stable.

5 Q. She's had this investigative firm since 1993.

6 A. I know she's had it for a few years. She had it
7 from, I guess from '93, if that's the case, and I don't
8 recall specifically, but that would mean she had it in
9 excess of 10 years.

10 Q. Doctor, you've got to collect the data to make a
11 diagnosis, correct?

GASTER excerpts

12 A. I try and collect the data as much as possible.

13 Q. You have not collected any data to suggest that

14 that was a problem; is that correct?

15 MR. JONES: Objection. Asked and answered.

16 A. Not from her --

17 THE COURT: Excuse me.

18 A. Not from her --

19 THE COURT: Excuse me. Overruled. You may

20 proceed.

21 A. Not according to what she claims.

22 Q. And you haven't gone and found any outside data

23 to support that either, have you?

24 A. That's correct.

25 Q. Nothing in all these boxes and notebooks that you

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1 rely on in that, correct?

2 A. I don't know if I know exactly what's in there,
3 but from the materials which I was supplied, I don't think
4 that was one of the criteria.

5 Q. Now, it said Criteria B, "this problem leads to
6 clinically significant distress or impairment in social,
7 occupational or other important areas of functioning",
8 correct?

9 A. Yes.

10 Q. Criteria B, we have just talked about
11 occupational.

12 Socially, do you know whether the people that we
13 talked about knowing her in this trial, and the other
14 before and after witnesses which were given to you, talked
15 about social dysfunction out in the real world?

16 A. I read most of their letters and they praised
17 her.

18 Q. A person who's interacting with lawyers,
19 insurance companies, the legal system, you know, you're
20 familiar with that, correct?

21 A. Yes, I am.

22 Q. She might have worked with --

23 A. Especially doctors.

24 Q. She might have worked with you on a patient?

25 A. She never worked with me. I never saw her

97

1 before.

2 Q. I don't know. But that kind of work, Doctor, you
3 would agree with me requires a stable personality to get
4 through.

5 A. It would require a stable -- it would require
6 someone who is able to do that, but I don't think you
7 necessarily have to be stable. Let's say, let's say stable
8 enough to do that.

9 Q. Do you have any neighborhood, social proof of
10 significant impairment or functioning?

11 A. Concerning what, concerning before she was
12 injured or after?

13 Q. Before she was injured.

14 A. Before?

15 Q. Yes.

16 A. She had a lot of relationships were disturbed.
17 She had a history of psychiatric problems from at least
18 high school.

19 Q. Excuse me, Doctor. You said psychiatric
20 problems. Does that mean she had seen a psychiatrist?

GASTER excerpts

21 A. She's seen counselors and psychiatrists in the
22 past.

23 Q. Do you have any proof or any name or anything at
24 all to suggest she saw psychiatrists at any time prior to
25 2003?

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1 A. I think Dr. Herrero specifically says she had a
2 20-year history of psychiatric difficulties.

3 Q. Does that mean she saw a counselor or
4 psychiatrist, Doctor? Isn't there a difference.

5 A. Well, there's definitely a difference, but she
6 saw counselors and she was taking psychotropic medication
7 before she was injured which would be consistent with
8 somebody who has a psychiatric illness. You don't usually
9 treat somebody with four or five drugs who does not.

10 Q. Was she on four or five drugs before this
11 accident?

12 A. I believe she was at least on Effexor which is an
13 anti-depressant.

14 Q. That's one.

15 A. Yes.

16 Q. You said four or five.

17 A. Let me finish.

18 Q. Okay.

19 A. And Ativan. Afterwards she was treated, I
20 believe inappropriately she was treated with Depakote and
21 another anti-convulsant drug called Lamictal for bipolar
22 disease. So I don't agree that she had the treatment that
23 she should have had, and considering that some physicians
24 thought --

25 MR. IGOU: Your Honor, it's non-responsive to the
99

1 question, Your Honor. I asked about the number of
2 drugs.

3 A. Okay. She was taking two before and five
4 afterwards that we know about, and two of them for sure
5 weren't appropriate and one of them --

6 Q. I'm not interested in after the accident, Doctor.
7 what we are talking about is -- I'm talking about before
8 October 7.

9 A. Before the accident she was taking two
10 psychotropic drugs.

11 Q. Doctor, aren't there a lot of people in the real
12 world who go to their general practitioner and get
13 occasional medication for anxiety?

14 MR. JONES: Objection, Your Honor. Relevance.

15 THE COURT: Pardon me.

16 MR. JONES: Relevance.

17 THE COURT: Overruled.

18 A. Some people do. Most don't. Most have a
19 clinical psychiatric illness that requires those drugs.

20 Q. Is it unusual for someone to go to counseling or
21 get anxiety medication after the divorce of their parents;
22 do you think that's odd?

23 A. They were married 48 years. She was an adult and
24 she was -- is it unusual? It's not. It's been done. It's
25 done by persons who are having those problems sometimes.

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1 Q. And aren't there lots of people that you have
2 treated in your life and out there who have occasional

GASTER excerpts

3 anxiety and depression and may get medicated for it that
4 live full normal lives and have good jobs and stay
5 employed?

6 A. I try and help them do that. But if they didn't
7 have the appropriate medication, they probably wouldn't be
8 able to, and many of the people I treat, even with those
9 types of drugs, have difficulty functioning.

10 Q. Now, let's talk about the rest of the page, still
11 talking about your duties in diagnosing a personality
12 disorder.

13 It says "a clinician should assess the stability
14 of the personality traits over time and across different
15 situations. Although a single interview with a person is
16 sometimes sufficient for making a diagnosis, it is often
17 necessary to conduct more than one interview and to space
18 these over time". Is that correct?

19 A. That's what it says.

20 Q. Okay. So although you are allowed to see a
21 patient once and make this diagnosis, the DSM doesn't
22 suggest that, does it?

23 A. It says "that although a single interview can --

24 Q. -- is sometimes sufficient.

25 A. -- is sometimes sufficient, it is often

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1 necessary". I didn't feel it was often necessary.

2 I felt the history that I took, with the piles
3 and piles of information available to me, that I could make
4 this diagnosis.

5 Q. It says "an assessment can also be complicated by
6 the fact that characteristics that define a personality

7 disorder may not be considered problematic by the
8 individual".

9 A. Often it is, that most of these people with
10 personality disorders think they're functioning very well
11 and their perception of how they're functioning is at odds
12 with the way they are functioning.

13 Q. Exactly my point, Doctor. So when you're talking
14 to someone who you think might have a personality disorder,
15 you may not get all the information that you need from them
16 because they are -- they are relating history to you about
17 how they get along in the outside world, maybe they might
18 say everything is fine, right?

19 A. They might say that everything is fine.

20 Q. Then this is the last part "to help overcome this
21 difficulty, supplementary information from other informants
22 may be helpful"; is that correct?

23 A. Yes. I had so much supplementary information
24 that -- well, not by that itself, but I had a great deal of
25 supplementary information.

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1 Q. Did you interview or talk to any other live
2 person about Mrs. Gaster?

3 A. No, I did not.

4 Q. Did you take into consideration the pile of
5 before and after letters that were given to you?

6 A. I read them.

7 Q. Did you take them into consideration?

8 A. Let's put it this way; it's not hard to get
9 recommendations like that.

10 Q. It's not?

11 A. No, it's not.

GASTER excerpts

- 12 Q. From lawyers, from insurance adjusters?
13 A. From any human being in the whole world.
14 Q. Do you give out recommendations like that?
15 A. Yes, I do.
16 Q. Do you lie about it?
17 A. No, I don't. I sometimes -- I wouldn't say I lie
18 about it, but I try to put the best possible light on
19 somebody who I think deserves praise. I don't lie.
20 Q. Is that ethical for you to do that?
21 A. I don't think that I do anything unethical in
22 terms of writing recommendations for persons.
23 Q. Do you tell the truth?
24 A. Yes, I do.
25 Q. Do you have any reason to think that the letters

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- 1 that she wrote from defense attorneys, from adjusters and
2 insurance adjusters are untrue?
3 A. I don't know whether they are or not.
4 Q. Assuming they are true, Doctor, do they suggest
5 anything consistent with a personality disorder going on
6 with Mrs. Gaster prior to this accident?
7 MR. JONES: Objection. Asked and answered.
8 MR. IGOU: No, I haven't asked that.
9 THE COURT: Overruled.
10 A. Well, first of all, a personality disorder starts
11 early on in one's life, and I can't read what you've just
12 read completely.
13 Q. "To help overcome this difficulty supplementary
14 information from other informant may be helpful". It says
15 informants. Not other doctors. Other informants.

16 (Indicating).

17 A. Generally speaking it says that, but I was
18 satisfied by reading, for example, the depositions of
19 friends of hers that she wasn't doing that well.

20 Q. Who were those?

21 A. I think somebody named Cheryl and somebody named
22 Cliff, who I think was her partner.

23 Q. I would agree with you that those depositions say
24 she's not doing very well, but do either of those people
25 suggest any difficulty prior to October 7, 2003?

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1 A. I think that they're indicative of some problems
2 she was experiencing.

3 Q. Like what?

4 A. I don't have the depositions in front of me even
5 though I went through them. I don't have them in front of
6 me.

7 Q. Don't Cliff Froggatt and Cheryl Dininno both
8 point out extreme acute decline of Michelle Gaster
9 following October 7, 2003?

10 A. They say that. That's true.

11 Q. And is that consistent or inconsistent with your
12 earlier statement to the jury that she had the same number
13 of complaints before and after the accident? That's what
14 you said on Direct Examination.

15 A. Well, that's not exactly true. She had several
16 serious head injuries as opposed to this one.

17 Q. They were serious?

18 A. Well, they are serious enough that she went to
19 seek medical care and she waited 40 days before she thought
20 it was necessary to seek medical care this time. She was

GASTER excerpts

21 able to drive home right after the accident.

22 Q. Doctor, I'm not questioning you on that. I
23 mean --

24 A. Well, I think they were serious, certainly more
25 serious than this. She complained of concentration

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1 problems. She complained of memory problems. She
2 complained about other problems which were more severe than
3 problems that she said she had right after this episode.

4 Q. Doctor, was she ever sent to a neurologist for
5 any of those prior blows to the head?

6 A. I think she probably was. I don't recall
7 specifically.

8 Q. If I told you there is no such proof, would you
9 agree with me?

10 A. I don't recall that there was. Perhaps she
11 should have.

12 Q. Was she ever sent to a psychiatrist after bumping
13 her head prior to this accident?

14 A. I don't know.

15 Q. Are you suggesting somehow that those prior
16 injuries have something to do with her psychiatric
17 difficulties?

18 A. I think that they did, yes.

19 Q. So when she bumped her head before this accident,
20 those could affect her psychiatrically, but here it doesn't
21 affect her psychiatrically?

22 A. I think one of the reasons was because there was
23 not litigation connected to the earlier ones.

24 Q. So if there's litigation, then you don't have

25 psychiatric problems. And if there isn't litigation, you

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1 do?

2 I mean, what's that.

3 A. Well, you certainly could, but someone might be
4 amplifying complaints or upping complaints afterwards,
5 after the accident if they're aware of the fact that there
6 is potential secondary gain which you talked about earlier.

7 Q. Doctor, you're suggesting that Mrs. Gaster is
8 faking psychiatric difficulties; is that correct?

9 A. I think she's faking a lot of the organic
10 psychiatric difficulties that she's complaining of.

11 Q. Do you think when she was Baker-Acted that she
12 was faking that?

13 A. No, I don't think that's true.

14 Q. Do you think when she was Baker-Acted the second
15 time she was faking that?

16 A. I don't think so, but she was having significant
17 relationship problems at the time and it strikes me that
18 those were probably more likely to cause her
19 hospitalization.

20 Q. Do you know that she broke through a window and
21 got arrested for burglary?

22 A. I was aware of that.

23 Q. So, Doctor, you've said that Axis I she has
24 malingering psychiatric illness.

25 A. Yes, I did.

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1 Q. Are you aware that -- you said you relied on
2 these other doctors. Are you aware then that Dr. Olafsson

GASTER excerpts

3 gave her malingering tests?

4 A. He gave her malingering tests, at least that's
5 what he said.

6 Q. Let's assume he actually did because he came and
7 testified about it.

8 A. We'll assume he did.

9 Q. You've had interactions with neuropsychologists
10 before?

11 A. Yes, I have.

12 Q. And you have sent patients to neuropsychologists
13 before?

14 A. Yes.

15 Q. You have actually had patients who have been sent
16 to a neuropsychologist and were given the malingering tests
17 and failed them, correct?

18 A. Yes.

19 Q. And in those cases the neuropsychologist and you
20 perhaps would say that patient is malingering, correct?

21 A. I don't see where that is necessarily true, and
22 also a lot of these tests that neuropsychologists give also
23 can be interpreted incorrectly or dishonestly.

24 Q. By the doctor or by the patient?

25 A. By the doctor.

□

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1 Q. Are you saying that was done in this case?

2 A. I'm not saying it was done in this case.

3 Q. Bear with me then. Assume that a malingering
4 test such as the TOMM -- you know that test, don't you?

5 A. No, I don't.

6 Q. Test of Memory Malingering.

7 A. I'm not familiar with that test.

8 Q. Assume she was given three malingering tests as
9 part of her neuropsychological workup.

10 A. By whom?

11 Q. Two by Dr. Olafsson, one by Dr. Vanderploeg, and
12 one by the defense's neuropsychologist, two by her
13 treating. She passed all three.

14 A. She passed all three. There was evidence, at
15 least in reading the reports, that she was exaggerating her
16 symptoms based on some of the other psychological tests.

17 Q. By Dr. Vanderploeg, but not by Dr. Olafsson?

18 A. I believe that to be the case, yes.

19 Q. You also said that she had a borderline
20 personality, correct?

21 A. Yes.

22 Q. Let's go back to the DSM if we could. Now, part
23 of this diagnosis, Doctor, is that a person, as it says
24 here, "displays impulsivity in at least two areas that are
25 potentially self-damaging", correct?

□

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1 A. Yes.

2 Q. It lists gambling. Do you know anything about
3 her gambling?

4 A. No, I don't.

5 Q. Do you know anything about her spending money
6 irresponsibly?

7 A. Those are examples. There's a lot of other
8 characteristics that you can point out that are equivalent
9 to unstable behavior such as gambling or substance abuse.

10 Q. The DSM chose to pick these and put them in the
11 book, correct, so they must be?

GASTER excerpts

12 A. They said they were examples. They didn't say --

13 Q. Let's go through it. I mean, substance abuse,
14 any evidence of substance abuse?

15 A. She denies it.

16 Q. Any engaging in unsafe sex?

17 A. I don't know for certain. People usually don't
18 disclose that.

19 Q. Driving recklessly, we know she did that at least
20 once?

21 A. Yes.

22 Q. Self-mutilation?

23 A. She didn't say she had done so. Why don't you
24 read some of the others.

25 Q. Well, there are others. Suicide attempts. She

110

1 did that.

2 A. She did that when she was a teenager.

3 Q. What else? I don't see any others there, but
4 please read the rest out.

5 A. "Recurrent suicidal threats or self mutilation.

6 Affect, which means emotional instability, due to
7 marked reactivity of mood such as intense episodic
8 dysphoria", which means that somebody is sometimes
9 depressed and sometimes not depressed, or they become
10 hyperactive.

11 "Irritability and anxiety lasting a few hours or
12 rarely more than a few days".

13 "Chronic feelings of emptiness".

14 Her relationship is certainly consistent with
15 somebody who feels that way. She needs a lot of support by

16 somebody else. I don't remember her name. But we
17 discussed it in the Direct Examination.

18 Q. Are relationship problems rare or common?

19 A. They are common, yes.

20 Q. Wouldn't the two most common things that people
21 come to a psychiatrist about arise from personal
22 relationships or family problems?

23 A. I wouldn't say the most, but certainly a large
24 number do.

25 Q. Doctor, let's go to the school records. You have

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1 said in your Direct Examination that she displayed behavior
2 in high school that was consistent with a personality
3 disorder, correct?

4 A. Yes.

5 Q. Now, this is an Evaluation of Social and Personal
6 Assets.

7 A. Why don't you show the whole thing. I think
8 you're excluding. Why don't you show them all the comments
9 that the teachers made.

10 Q. We're going to get to that.

11 A. Okay.

12 Q. We'll get to that. I don't want to be unfair to
13 you.

14 Now, self control, that's important, isn't it?

15 A. Self control is important.

16 Q. Do you see anywhere, 1st through 12th grade that
17 she had anything other than average self control.

18 A. Well, I don't know what 2, 3 is.

19 Q. 2 means above average. So she got above average
20 in 11th and 12th grade, didn't she?

GASTER excerpts

21 A. In the 11th and 12th grade she got 2s and 3s.
22 Somebody gave her a 1.

23 Q. So in 11th and 12th grade, high school as you
24 described it, she received average and above average on
25 every single social and personal asset, didn't she?

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1 A. That's what at least one teacher did in each
2 grade.

3 Q. And that includes cooperation, courtesy,
4 dependability, industriousness, initiative, leadership,
5 emotional maturity and personal appearance, correct?

6 A. Yes.

7 Q. That covers a lot of ground, doesn't it?

8 A. Yes.

9 Q. Would a person with a personality disorder get
10 above average in all of those things, an average in all of
11 those things in high school?

12 A. It's the opinion of one teacher in each one of
13 those aspects.

14 Q. Well, here's some more teachers. This is what
15 you want to get to, right.

16 A. I can't read them.

17 Q. Do you have copies of this, Doctor.

18 A. I have them in my -- I don't have them with me.

19 Q. Well, this is the list of personal comments made
20 by teachers from 1965 to 1976. You have a copy of this as
21 well, and this is what you wanted to talk about.

22 My question is, in the 11th and 12th grade what
23 were the comments made by these teachers.

24 A. Well, one of them says "needs to develop more

25 self control". If I had the actual --

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1 Q. Here. (Tendering).

2 A. (Perusing document).

3 Q. I'm talking about her last two grades, 11th and
4 12th grade.

5 A. why don't you talk about the other grades.

6 Q. We can, sure.

7 A. "Craves attention and recognition". Somebody who
8 needs that is usually quite manic.

9 Q. Have you ever diagnosed somebody with a
10 personality disorder based upon five or six words of one
11 teacher, as you said, in an elementary transcript?

12 A. Not specifically one, but here's another one
13 "needs to develop more self control".

14 "Tends to be moody".

15 "Needs study skills".

16 "Very talkative".

17 Q. Are elementary school kids often talkative?

18 A. well, apparently it was enough to impress whoever
19 was writing these things that it was worth pointing this
20 out.

21 Q. Are you more impressed with those teachers than
22 these teachers?

23 A. well, I don't know either one, any of them, so I
24 don't know who --

25 Q. That's a fair point.

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1 A. "Doesn't try to do her best work".

2 "Doesn't take time in her work".

GASTER excerpts

3 I can't read the rest.

4 Q. How about 11th grade, the last two lines.

5 A. "Seems well adjusted and attentive" and it says
6 "in homeroom acts appropriately" I assume. And then the
7 other one is "very sports minded".

8 Q. So in the 11th and 12th grade, is there any
9 suggestion -- that's all right. We're done.

10 MR. BROCK: (Tendering). Okay.

11 Q. Doctor, do you diagnose someone with a
12 personality disorder based on this?

13 A. No. I mean, tell me about the 11th grade. One
14 says she's "sports minded" and the other one said "in the
15 homeroom she acts appropriately".

16 Q. Then she gets all of these.

17 A. Well, there's a conflict -- but there's a
18 conflict. I can't argue with that. There is obviously a
19 conflict in opinions.

20 Q. Doctor, you've done over 500 evaluations for the
21 defense?

22 A. Probably, yes, over 30 years. Maybe more than
23 30 years.

24 Q. This is from your report Page 3. "I might add
25 that it's very important for physicians to know about one's

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1 past medical history of head injury, especially when they
2 are evaluated for a new head injury". Correct?

3 A. (Perusing document on the overhead). Yes, I
4 believe that.

5 Q. You also mentioned Graves Disease. Doctor, are
6 you familiar with some of the side effects of undiagnosed

7 and untreated Graves Disease?

8 A. Well, let me tell you one thing. I'm aware of
9 them if someone is hypothyroid, they are likely to be
10 lacking energy. If one is hyperthyroid, they are likely to
11 perhaps be too energetic. But I looked at her laboratory
12 workup when Dr. Herrero examined her, and those laboratory
13 values for the thyroid were within normal limits.

14 So whether she has thyroid disease or not, at the
15 time she had the injury, her thyroid values were normal.

16 Q. I'm not suggesting that. What I said was
17 undiagnosed and untreated back in 2000, you know, how that
18 usually occurs is somebody has symptoms. They don't know
19 what's going on in their life and they go and oh, your
20 thyroid is overactive and you need to have it taken care of
21 is how it works, isn't it?

22 A. Well, a physician -- among the workup for most
23 anybody is a thyroid profile if you send somebody for a
24 general physical condition, general physical examination.

25 Q. I don't want to spend time on it. But her

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1 history is she had night sweats, couldn't sleep, had
2 problems concentrating, was finally diagnosed with a
3 hypothyroid condition, got it treated back in 2000, 2001,
4 and has been on Synthroid ever since.

5 I'm not suggesting any problems since then. I'm
6 saying before the person finds out and gets their thyroid
7 taken care of, they are suffering from Graves Disease, and
8 you can have some wild symptoms, fair?

9 A. I don't like the word wild.

10 Q. I don't either. Sorry.

11 A. Why did you use it?

GASTER excerpts

12 Q. I made a mistake.

13 A. Okay.

14 Q. Interesting number of symptoms, heart beating,
15 panic attacks, concentration, night sweats. All those
16 kinds of things.

17 A. That is true.

18 Q. Now, I want to talk to you about the difference
19 between amnesia and memory loss or having memory problems.

20 Amnesia is when someone is knocked out or in a
21 coma and has no recollection of anything, right?

22 A. Knocked out in a coma is not -- someone who is
23 knocked out in a coma, generally they have a long term
24 amnesic problems and they don't remember the accident.
25 And after the coma, after they awake, they have no

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1 recollection when you talk to them, let's say.

2 Q. It's like there's a blank, like in the Nixon
3 tapes there's a blank.

4 A. Of 18 minutes.

5 Q. An 18-minute blank before --

6 A. But we know in her case there is no 18-minute
7 blank.

8 Q. I'm just trying to define the term.

9 A. And that's not amnesic. I won't go through
10 those tapes, but it's not important.

11 Q. Amnesia is a blank space around the time of the
12 trauma. Memory problems are not the same thing. Would
13 that be fair?

14 A. I think they're close to being the same thing and
15 I'm not certain they're not.

16 Q. Because you've made the statement on Page 4 of
17 your supplementary report, "although one might say her
18 failure to inform all of these physicians concerning other
19 head injuries due to her memory problems, she does not
20 appear to have had any pre-traumatic amnesia problems or
21 post-traumatic amnesia problems with respect to the October
22 7, 2003 incident".

23 A. Nobody said she did, and none of the physicians
24 said. She didn't tell any of the physicians that she had
25 those difficulties, and that would, that would go to the

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1 heart of the fact that she wanted to appear, just to make
2 this appear it was an isolated problem.

3 Q. Did she tell Dr. Herrero that she had a 20-year
4 history of psychiatric treatment?

5 A. She denies that later on in her report that I
6 generated, and Dr. Herrero said that she denied it, that
7 she told Dr. Herrero that, but somewhere along the line
8 from the history he took he said that she did and that she
9 told him.

10 Q. Now, Doctor, you're aware of medical studies, we
11 have gone through some of these in the prior witnesses,
12 that suffering a mild traumatic brain injury can aggravate
13 or intensify preexisting premorbid psychological
14 difficulties?

15 A. That is true.

16 Q. So if somebody has anxiety or depression and is
17 going to their GP and functioning and working, they get a
18 mild traumatic brain injury, that can decrease their
19 function, can't it, by increasing those problems?

20 A. It could.

GASTER excerpts

21 Q. And a mild traumatic brain injury doesn't require
22 the loss of consciousness, does it?

23 A. I wouldn't use the word traumatic, and this is
24 not really a medical term, but a mild bump on the head does
25 not constitute a traumatic brain injury.

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1 There are three -- there are three coverings of
2 the brain plus the skull. There is something called
3 cerebral spinal fluid, and to get a real traumatic brain
4 injury you would have to have a significant -- you would
5 have to have a very significant blow. You would have to
6 have studies that were consistent with some sort of injury.

7 Q. Are you suggesting that in order to have symptoms
8 from a mild traumatic brain injury you have to have an
9 abnormal CT or MRI; you're not saying that?

10 A. No, I'm not saying that.

11 Q. Doctor, you're aware of what happened to Natasha
12 Richardson, correct?

13 MR. JONES: Objection. Irrelevant.

14 A. Natasha Richardson? It seems to me --

15 THE COURT: Approach the bench. Excuse me. If
16 you have an objection, approach.

17 (Bench conference)

18 THE COURT: Sustain the objection.

19 Q. You did not diagnose Mrs. Gaster with a
20 histrionic personality disorder; is that correct?

21 A. Not histrionic. I said there were
22 characteristics of it.

23 Q. You did not diagnose her with a somatoform
24 disorder; is that correct?

25 A. No, I did not. But I did -- histrionic, I did

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1 say that she had traits of that.

2 Q. Now, one thing that you looked at is whether the
3 symptoms that you're describing are consistent with the
4 injury that we're talking about, correct?

5 A. That's true, but you can't just go by what the
6 patient tells you.

7 Q. Sure. You can also go by what people say out in
8 the real world, correct?

9 A. You have to have reliable physicians and perhaps
10 reliable psychologists, and I suppose people who observe a
11 person's work and their relationship with friends and
12 co-workers.

13 Q. And so that should be given some weight?

14 A. It should be given some weight.

15 Q. And some weight should be given at least to all
16 of these doctors who have diagnosed her having
17 post-concussion syndrome and mild traumatic brain injury,
18 shouldn't they?

19 A. I would say that you have to consider everything
20 that you're provided with in terms of medical history and
21 depositions and various other aspects of one's life and
22 behavior.

23 Q. Dr. Herrero is a psychiatrist. He says she's had
24 a downfall since this accident, correct?

25 A. Yes, he has.

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1 Q. Dr. Harrison said she has post-concussive
2 syndrome and had some aggravation or creation of

GASTER excerpts

3 psychiatric conditions, correct?

4 A. He said at the end in his last evaluation that he
5 thought that the problems were primarily emotional. Even
6 if he said at first when he was working her up that the
7 problems were, that she had --

8 Q. He said "I think her psychological problems are
9 secondary to injury and aggravation associated with it. I
10 agree with your current treatment program". Isn't that
11 what you put in your report?

12 A. I quoted it, but the point is that Dr. Harrison
13 didn't take the history from her. In fact, I looked at it
14 last night and he didn't do anything about past medical
15 injuries or past neurological injuries. So I don't think
16 he had a full picture of what had happened to her prior to
17 this.

18 Q. Why would he -- you know, everybody keeps talking
19 about these other injuries. If she didn't go to
20 specialists, if she didn't have a disruption in her career,
21 which you agreed with, her social life, which you agreed
22 with, why the heck is it so important to you?

23 A. Well, it's important to me that she neglected to
24 tell all of these examiners -- I'm not saying everyone --
25 her family physician she did tell -- but her family

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1 physician was her doctor both before and after the
2 accident. Even before that she disclosed that she had
3 these problems.

4 If you go to three neurologists and you don't
5 tell them look, I had this injury where I had a blow on my
6 head before and not only that, within the last year or so,

7 and you're in litigation, it would seem to me somebody is
8 being very selective in the history that they give about
9 their preexisting past medical history.

10 And when all three of these doctors had listed
11 what the past medical history was, at least from what
12 history they took, there was no mention of these other head
13 injuries.

14 Q. There is no evidence she was still having
15 problems from those injuries up until the time of this
16 accident, is there?

17 A. She didn't tell -- she wasn't honest in the
18 history that she gave.

19 Q. Okay. Now, assuming she --

20 A. Not only that, she told other persons from that
21 first accident, the first accident that she had many of the
22 same complaints, concentration problems and memory problems
23 and other problems. I could dig them out for you.

24 Q. She also had Graves Disease at the time, didn't
25 she?

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1 A. I don't know when the Graves Disease came under
2 control, but I don't think -- I don't think -- we're
3 talking about the fact that she didn't give it. You don't
4 see the exact same findings --

5 Q. Well, I was --

6 A. Wait, wait. Let me talk for a moment. You don't
7 see the exact same findings from a head injury that you see
8 from Graves Disease, and also she still failed to disclose
9 this information to at least three neurologists who
10 examined her.

11 Q. Doctor, assume that Cheryl who was her companion
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GASTER excerpts

12 at the time was an attorney working for an insurance
13 company. Assume that what you know about Mrs. Gaster is
14 that she worked as an investigator in association with
15 insurance companies and adjusters and defense attorneys.

16 You would agree with me that the two of them knew
17 their way around this system, correct?

18 MR. JONES: Objection, Your Honor. Approach the
19 bench.

20 A. I would say --

21 THE COURT: Excuse me.

22 A. I would say -- Oh, I'm sorry.

23 THE COURT: Excuse me.

24 (Bench conference)

25 THE COURT: Overruled.

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1 Q. You answered my question yes, that it would
2 appear the two of them from their jobs have known more than
3 the average person about injuries and litigation and all of
4 this.

5 A. It's also true if that's the case, that they know
6 what kind of symptoms people would feign in order that
7 their litigation be more strong on their side. It goes
8 both ways.

9 Q. It does. And wouldn't you think, Doctor, with
10 the knowledge and what you just said that it would have
11 been very easy and consistent for them to tell the doctors
12 about those things?

13 A. About what?

14 Q. About the prior things. I mean, wouldn't you
15 admit, having read that huge pile of medical records, that

16 Mrs. Gaster and/or Cheryl Dininno made a huge inconsistent
17 mess out of the medical records. That's part of what
18 you're relying on.

19 A. No. What I'm saying is that there was a failure
20 to disclose information which is very significant when
21 somebody has a head injury, past head injuries and she
22 consistently did not tell doctors who are very important in
23 diagnosing and treating persons who have these problems.

24 Q. Don't you think that she would have known, if
25 this was a setup, to rush to the doctors, to get

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1 documentation, to go to the doctor and not wait 40 days?

2 MR. JONES: Objection. Speculation.

3 THE COURT: Sustained.

4 Q. Doctor, wouldn't you agree with me that a person
5 with an advanced degree, say a doctor or Ph.D., could add
6 two numbers together to make 100?

7 MR. JONES: Objection. Speculation. Relevance.

8 THE COURT: Sustained.

9 A. I would agree that you don't have to have a Ph.D.
10 to know that 93 and 7 are 100.

11 MR. IGOU: Can we approach the bench.

12 (Bench conference).

13 Q. I'll ask it again. Wouldn't you agree with me
14 that a person with an advanced degree, either a physician
15 or Ph.D., should be able to add up two numbers to equal
16 100?

17 A. I would agree, yes.

18 Q. So Dr. Mellman was here yesterday and told the
19 jury that 82 and 28 equals 100, that's not correct, is it?

20 A. No, it's not.

GASTER excerpts

21 Q. So it's not hard to make mistakes with math, is
22 it?

23 A. It's not hard for some people to make mistakes in
24 math. I do it myself sometimes. Well, what does Dr.
25 Mellman have to do with all this stuff?

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1 Q. You made some comments about Mrs. Gaster --

2 THE COURT: Excuse me. That is not a question.
3 You get asked questions and you get to answer
4 questions. Let's ask the next question and move on.

5 MR. IGOU: Let's not get into that. You're
6 right.

7 Q. Doctor, you have testified that in the past that
8 you do longitudinal evaluations?

9 A. Excuse me.

10 Q. Longitudinal evaluations.

11 A. I do one to two evaluations a week now, yes.

12 Q. No. I mean, what is a longitudinal evaluation,
13 what does that mean?

14 A. Well, I try and get a live history from the
15 patient to see, because it's very important to get a
16 biographical history because it would help here, it's a
17 predictor of how somebody's behavior would be in the
18 future.

19 Q. Doctor, without arguing about what or why or when
20 Mrs. Gaster was hurt or not or how much, you have said by
21 your diagnosis that Axis II personality disorder, "she has
22 an ongoing significant impairment in her vocation and
23 social life as of the time you examined her"; is that
24 correct?

25 A. Yes.

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1 Q. And that would make someone's life difficult,
2 wouldn't it?

3 A. It would make someone's life difficult, yes.

4 Q. It would affect their ability to work, correct?

5 A. It might affect their ability to work, yes.

6 Q. And a person like that may have to go to
7 counseling or to a specialist on a regular basis, correct?

8 A. Yes.

9 Q. A person like that is going to have to continue
10 to take medication, correct?

11 A. It depends on what type of disorder they have
12 above and beyond that, but yes, frequently they need
13 medication to help them function.

14 Q. And that is your opinion today, right?

15 A. Yes.

16 MR. IGOU: Thank you. That is all I have.

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18 (END OF EXCERPTED TESTIMONY)

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CERTIFICATE OF REPORTER

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GASTER excerpts

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I, Cynthia A. Cianciolo, Court Reporter, Notary Public for the State of Florida at large, do hereby certify I stenographically reported the entire proceedings at the time and place so indicated and that my notes were hereinafter reduced to a computer-generated excerpted transcript.

I further certify that I am not an employee or relative of any of the parties and am not an employee or relative of either counsel, and further certify that I am not financially interested in the outcome of this litigation.

I hereby affix my signature this _____ day of _____ 2010, in Tampa, Hillsborough County, Florida.

CYNTHIA A. CIANCIOLO
Court Reporter