SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS: CIVIL DIVISION - PART 23

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DAYRA GONZALEZ,

Plaintiffs,

-versus-

Index # 719084/2018

995 FIFTH AVENUE OWNERS CORP., & 995 FIFTH AVENUE, LLC,

Defendant(s)

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June 24, 2025
2510 Court Square West
Long Island City, New York 11101

B E F O R E : Honorable KARINA ALOMAR,
J U S T I C E

APPEARANCES:

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Senior Court Reporters

THE COURT: Good morning everyone. Before we get the jurors to come down, I believe that today you are going to start with the testimony of Dr. Ali Guy.

MR. SUBIN: Yes, your Honor.

THE COURT: And I believe there is a motion in limine with regard to Dr. Ali Guy; is that correct?

MR. BRODY: There has been a motion in limine your Honor, the issue --

THE COURT: Right, you sent another memo the other day with regards to a finding in federal court; is that correct?

MR. BRODY: I sent two supplemental memos. One of which was two decisions which came down recently. One by the first department --

THE COURT: Okay. Counsel, I'm addressing the issue of the finding.

MR. BRODY: Oh. So, separately, there is the issue of the federal court findings and the finding of Dr. Weiner.

THE COURT: Okay. I'm only addressing the federal court finding right now. The federal court finding, I read the decision. The decision is there is no finding against the doctor in that decision. The decision merely states that based on the evidence submitted, that there should be a temporary injunction because of the fact that in the

event that the evidence was sufficient, that the irreparable harm will be great on the defendants, but there was no actual finding that the defendant committed any actual fraud.

MR. BRODY: Judge, that would be relevant if that evidence was coming in. The only issue was whether or not these findings by this judge are sufficient to determine -- to question the reliability of his office records. That's the only issue here, and there is certainly --

THE COURT: But, counsel, there is no finding there. That's the issue that this Court has.

MR. BRODY: You have my exception.

THE COURT: Your exception is noted.

MR. BRODY: And before the jurors comes in, there is -- can we address one other issue, there is going to be some objections on the record, I want to get the wordage part of the objection now so I'm not doing it in front of the jurors.

THE COURT: Fair enough.

MR. BRODY: It is my anticipation that Mr. Subin is going to walk Dr. Guy through the surgeries that were performed by Dr. Gerling and Dr. McCulloch, and the reality is that while they have disclosed Dr. Guy as a treating physician, they disclosed Dr. Guy in their 3101(d) to come

in and testify as to the future care that is needed by Ms. Gonzalez and the issue of causation. They shouldn't be -- and there is no disclosure in this regard, that he's going to come in and explain how the doctor performed the procedures, walk these jurors through the procedure he didn't perform, he didn't attend, he didn't discuss with the doctors. The records say what they say and what he's doing, if he's allowed to testify about this, is simply bolstering records when an opportunity to cross-examine the very surgeons who performed these services is being deprived.

THE COURT: I'll hear you, Mr. Subin.

MR. SUBIN: Judge, I did belts and suspenders. Because Dr. Guy is a treating physician, under Frank versus the City of New York, and its progeny, he can give expert opinions without prior notice. To be belt and suspenders, I was advising the defendants that he opine as to all the medical records. He's permitted to do that. There is no exclusionary rule for that, and I would object.

THE COURT: So, the motion is denied. Your exception is noted. Let's call the jury and let's begin.

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Good morning. Please be seated. All right, Mr. Subin, you can call your first witness.

MR. SUBIN: Thank you. Good morning, everyone. At this time the plaintiff will call Dr. Ali Guy, please.

COURT CLERK: Please raise your right hand. Do you swear or affirm that the testimony you're about to give shall be the truth, the whole truth, and nothing but the truth.

THE WITNESS: I do.

COURT CLERK: Please state your name for the record.

THE WITNESS: Yes. My name is Dr. Ali Guy, office address is 7 Gramercy Park, New York, New York 10003.

COURT CLERK: Thank you. You may be seated.

THE WITNESS: Thank you.

MR. SUBIN: May I, Judge?

THE COURT: You may inquire, counsel.

MR. SUBIN: Thank you.

DIRECT EXAMINATION

BY MR. SUBIN:

Q Good morning, Dr. Guy.

A Good morning, sir.

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

A Yes, sir. I'm duly licensed to practice medicine and surgery in the State of New York.

Q Okay. I'd like to spend a few minutes talking about

your educational and medical backgrounds. Can you please tell us what your educational background is, starting from college.

A Yes. College, I went to Queens College, Flushing, New York. Then medical school I graduated from University of Northeast in the Dominican Republic in the June of 1981. Thereafter I did three separate residencies.

Q Doctor, can I cut you off for a second? I apologize.

A Sure.

Q What is a residency, first of all?

A It is a training program.

Q Now, is it traditional to do three separate residencies? What's the traditional method?

A It depends on what specialty you are pursuing. I wanted to become a doctor in physical medicine and rehabilitation, known as physiatry, not psychiatry, not podiatry, but physiatry. And, in order to do that, you need a prerequisite. You need at least one year of general surgery and-or one year of internal medicine. That was met as a prerequisite, the reason being this specialty crosses over into every other medical specialty. Orthopedics, neurology, neurosurgery, internal medicine, rheumatology, interpretations of x-rays, MRIs, CT scans, and disability, impairment evaluations, electrodiagnostics, pain management, both pharmacological and interventional such as epidurals, nerve blocks, etcetera. That's why I did those.

Q What was the third you said?

A Internal medicine, 18 months at Mount Sinai School of Medicine, Mount Sinai Medical Center. One year general surgery at Cabrini Medical Center in Manhattan. I completed a three-year residency training program in the field of physical medicine and rehabilitation at Mount Sinai School of Medicine, Mount Sinai Medical Center. Then, I went into private practice. I took my boards parts one, part two --

Q Okay. Let me stop you there. What boards did you take, and what are boards?

A I took the boards on American -- physical medicine and rehabilitation boards. When you take your boards and you become board certified, you become an expert as examined by the doctors that are already experts in this fields. Doctors that do research. Doctors that do write textbooks and papers. There is a part one that you take once you finish your residency training program. It is an eight-hour written examination. You get tested on orthopedic surgery, neurology, neurosurgery, internal medicine, interpretations of x-rays, MRIs, electrodiagnostic studies, disability, impairment evaluation and other principles of physical medicine, rehabilitation, pain management, both pharmacological and interventional, and rheumatological, cardiac and pulmonary rehabilitation.

Once you finish -- once you take that, which I did pass the first time, you have to be in private practice for minimum

of 18 months, gathering more knowledge, more information, then you take your boards part two, which is an oral examination, which is half a day. You fly to the Mayo Clinic in Minnesota where all the elite doctors that write textbooks, that do research, doctors considered experts in the field, they test you orally for half a day. Again, similar principles. And if you prove to them that your knowledge is up to par, they pass you and they give you the title of diplomate of physical medicine and rehabilitation. That was obtained in May of 1989, and up to this day it stands in good standing. And, once again, when you become board certified, they get all your credentials from college, from medical school, from residency, and if everything is up to par you are given that title, and you are considered as an expert in this specialty.

Q Now, I want to go back to residency. Are you familiar with the term chief resident?

A Yes, sir.

Q What's a chief resident?

A A chief resident is when you become a supervisor of all the residents in the program. You supervise their work, you teach and you discipline. If they step out of line, you take medical legal action against them as appropriate by the department.

Q Were you a chief resident?

A Yes, sir, I was. I was the chief resident of Mount

Sinai for a period of six months.

Q Now, you mentioned something about private practice. Can you tell us, first of all, how long have you been in private practice in physical medicine?

A Since approximately 1988, '89.

Q Before I go into that, have you worked -- describe your work in hospitals. What hospitals you worked in and what you've done?

A Yes. From 1997 to 2002, that's five years, I was the director of the department of rehab medicine at Maimonides Medical Center in Brooklyn, where my duties were to teach the orthopedic residents. Teach the surgical residents. Teach the internal medicine residents. Supervise and teach ten other doctors in my department, and to do consultations with other doctors in my hospital, these were orthopedic surgeons, oral surgeons, internal medicine doctors, and also to monitor the whole entire rehabilitation department.

Q Any other hospitals you were involved in or --

A Yes, I was the director of the neuromuscular equipment clinic and hospital joint diseases/NYU Medical Center. My duties were to take care of the patients. These were patients that were born with birth defects, spinal cord injuries, multiple traumatic injuries. My duties were to teach the residents and also take care of the patients and prepare those residents for the boards exams parts one and part two. And that

was done from 1990 until 2006. From 2006 I was promoted to clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU medical center, and that continued until about 2019. I got promoted again to assistant professor of physical medicine and rehabilitation at NYU school of medicine, NYU Medical Center. Where I, again, I teach doctors at NYU, and I also have them rotate through my offices whenever they choose to have an elective to go through doctors offices.

Q Are you familiar with something called the Rusk Institute?

A Yes, sir.

Q What is that and what is your affiliation?

A Rusk Institute is part of NYU. Dr. Howard Rusk was the founding doctor that founded this medical specialty shortly after World War Two. Initially, it was called orthopedic medicine and rehabilitation. Because of all the chaos and all the confusion between orthopedic surgery and orthopedic medicine, the name was changed to physical medicine and rehabilitation. So, the Rusk Institute of NYU is the first training center in the world for this medical specialty.

Q And, is that where you are a professor?

A Yes.

Q Are you also in any other way affiliated with Rusk?

A Well, Rusk and NYU are synonymous.

Q With regard to -- have you achieved any awards in the

field of medicine --

A Yes, I received an award from the president of Maimonides Medical Center as obtaining a center of excellence of physical medicine and rehabilitation when I was the director. Maimonides was the first hospital in all of Brooklyn to have a pool therapy for hydrotherapy, for pool rehabilitation. I was the one who started that. I was the one who started 4 to 6 outpatient rehabilitation centers, and they were all performing on an excellent fashion, so I got a special award. I got a special award from the New York State Pain Society for winning three out of four medical debates, and also for teaching other doctors how to do medical debates with 300 doctors participating.

And that's -- and also another recent award I got from the New York State Education Department Office of Professional Medical Conduct, known as OPMC. This is the facility where they issue doctors licenses, they suspend, they revocate. I'm an official medical mentor as of December of 2024. My duties are to go to doctors who have committed certain misdeeds that are not bad enough to have suspension or revocation. My job is to go in, review the records, correct their mistakes, teach them, and report to OPMC on a regular basis.

Q What are the requirements to be a mentor?

A Number one, you have to be board certified. You have to be in excellent medical standing, not good standing,

excellent medical stand. You cannot be under any investigation. You have to pass the rigorous evaluation. You have to know all the medical guidelines. You have to know all the medical indications for the treatments in your specialty, and once you pass the rigorous research and investigation process, they give you this title, and they stay in touch with you on a continuous basis to see if you are doing a proper job or not.

Q Were you involved with the National Guard?

A Yes.

Q Can you tell us?

A I was a captain with the New York National Guard for approximately four years. My duties were to take care of the solders that got hurt. Give them the routine medical examinations to make sure they are fit for duty. Once, I had a court marshall, an officer who forged documents on his healthcare application. And I received also two citations from the General for excellent performance.

Q Now, I want to go back to your private practice of medicine. Can you describe for us in some level of detail what it is that you've been doing with your career these last 40 years?

A Yes. I have a private practice in Gramercy Park and in Long Island Westbury, and I'm also the director of the department of rehab medicine at Med Alliance, which is an Article 28 facility in the Bronx. Article 28 is, like, a small

hospital. We have about 45 different doctors. We have four operating rooms. My job is to teach the house staff and to teach the doctors under my supervision. I'm also in charge of quality, morbidity and mortality, which means that any mistake that's made in that facility gets reported to me. I investigate and I teach and I correct and I discipline the doctors who dropped the ball and made those mistakes.

Q Any other surgical centers that you are involved in?

A Yes. I'm the director of the pain service at the North Queens Surgery Center. I supervise about 40 other doctors that do interventional pain management procedures, such as epidurals, neuro blocks, micro-discectomies of the spine. I review their works, I teach, and, unfortunately, I have to discipline. I don't like to do it, but I'm required to do so.

Q Have you written any similar articles in your field of specialty?

A Yes, I've published approximately 35 articles.

Q And with regard to your private practice, what types of patients do you treat, and what do you do for them?

A I treat anyone from the age six to age 100. Plus, I deal with referrals from all different doctors, orthopedic surgeons, neurologists, neurosurgeons, chiropractors from every walk of life. I do electrodiagnostics, that is a study to see if there is any muscle or nerve damage. I get referrals for interventional pain management procedures, like epidurals, nerve

blocks, micro-discectomies of the spine. I get patients referred to me for traumatic injuries, whether it is from a work related accident, a car accident, or slip and falls or sports injuries. And I also get a lot of referrals for electrodiagnostics from neurologists to see if there is any carpal tunnel syndrome, pinched nerve in the wrists, pinched nerves in the neck or the back and to treat. And also for disability and impairment evaluation, which means that I get referrals to evaluate to see if a patient is disabled, if it is a partial disability, or total disability, and what the future medical needs for that patient will be.

Q And are you familiar with the protocols for orthopedic surgery?

A I am.

Q Can you explain how?

A When I was doing my general surgery, I rotated through the orthopedic surgical department for approximately two months, when I covered the emergency room for approximately two months we had all kinds of multiple traumatic injuries, fractures, gunshot wounds, mixed. Again, a lot of orthopedic injuries, and from my training in physical medicine and rehabilitation, we have -- every two weeks we have orthopedic and rehabilitation rounds together. We discuss with a board certified orthopedic surgeon and a board certified physiatrist. The combination of the injuries, the pain she may have had such as fractures of the

hip, multiple traumatic injuries. We go over the cases with the two attendings. We discuss the case and they teach us the orthopedic version. The physiatrist teaches the physiatric version and the rehabilitation version. And also when I finished I used to work in orthopedic group. I used to work with Isaac Cohen and Sandy Farkas in Long Island for two years. My job was to take care of all the orthopedic patients for any rehabilitation, electrodiagnostics, and discussions of the patient's management of these two certified orthopedic surgeons.

Q As part of your practice, do you perform any invasive pain management procedures?

A I do. I do a lot of them. I do just about every interventional pain management procedures, including cervical lumbar epidural injections, medial branch block injections. Facet injections. Radiofrequency ablation procedures, micro-discectomies of the spine, and trigger point injections. Every intra-articular injection.

Q Is Dayra Gonzalez your patient?

A Yes.

Q And have you treated her neck and lower back?

A Yes, sir.

Q Before I get into the treatment, would it be helpful for you to give us a bit of an anatomy lesson of the spine? Have I shown you this model, Doctor?

A You said --

Q Have I shown you this model?

A Yes, you showed it to me. I'm familiar with that model.

Q Would this help you with the description of the anatomy?

A Yes.

Q And did you bring with you certain other models, would they assist you with your description of the anatomy?

A Yes, sir. I also brought a chart that would assist me as well.

MR. SUBIN: Judge, with the Court's permission, can Dr. Guy come down and describe the anatomy for us.

THE COURT: Yes, he may.

THE WITNESS: May I begin?

THE COURT: Yes, you may.

A So, in the human spine we have three segments to the spine. We have the neck, which is referred to as the cervical spine. There are seven vertebra. The first vertebra is called the atlas. It is completely flat. And between each vertebra we have a shock absorber called a disk. This is a disk. A disk has two parts. The outside portion is a fibrocartilage material called the an annulus fibrosis. And inside we have a gelatinous material called the nucleus pulposus. And the cervical spine has seven vertebra, mid-back is called a thoracic spine, the lower back has 5 vertebra, and the lower back ends with the

sacrum. The sacrum has 4 segments, and it ends with the coccyx. That is the last portion. So, all the nerves that go to the arms, they come off the branches of the nerve roots from the neck. Every portion of the nerve from the nerves from the neck has a number. If I say C5-C6, C means cervical. 5 means the fifth cervical vertebra. So, the nerve from the C5-C6 enervates the biceps. C6-C7 enervates the portions in the forearm. C7 through T1 enervates the medial or inner portion of the forearm, and also the fingers.

Q Can you explain what that word enervates mean?

A Enervates supplies sensory. It is the power supply that goes through the muscles. In order to make the muscle move you need muscle and you need a power supply. The power supply is the nerve. So, if the nerve is damaged, if the nerve is compressed, the power supply is diminished and you get shooting pain down the arm, with numbness, tingling, weakness, loss of sensation, lost of a reflex. They are all controlled by the nerve roots in the lower back again. They enervate the different portions of the muscles in the leg. Every muscle in the leg comes from a specific nerve root in the lower back. For example, your proximal thigh is enervated between the third and fourth lumbar vertebra. The calve is enervated from the S1 segment. And the word radiculopathy, radic means nerve root, opathy means damage to a nerve. So radiculopathy means damage to a nerve root. Damage to a nerve root can be caused by bone

compression. Disk compression.

Now, between each vertebra you have a disk. The best way to describe a disk, and I'm going to show you, this is a normal disk. There is no tears around it. This is a normal disk. Normal disk. Normal disk. Now, this is a disk protrusion. This is a disk herniation. A protrusion means the disk is torn, but the disk material does not pass the disk margin. If it does, it is called herniation. It is a herniation.

Q Doctor, can I ask the question, so what's inside the disk that could possibly come out?

A You beat me to the punch.

Q I'm sorry.

A You should be patient.

Q I'm sorry.

A So, this is a disk protrusion, this is a disk herniation. What's inside the disk is a gelatinous material. It is called nucleus pulposus. Is it is this gelatinous material that gives us the ability to bend forwards, bend backwards, rotate from side to side, and when we jump up, if we didn't have this disk, bone would hit bone and it would break. So, this is a very important substance, and I'm going to show you another chart. I will show you the bulges and protrusions, herniations better.

MR. BRODY: May I, Judge, for a moment, may we

approach.

THE COURT: Yes.

(Whereupon, a bench conference is held off the record.)

THE COURT: We are going to take a brief recess.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: It is the Court's understanding that counsel is objecting. Mr. Brody, counsel for the defendant, is objecting to the use of demonstrative chart. Is that accurate?

MR. BRODY: I'm objecting to the use of this demonstrative chart, actually as the record reflects. No objection to the use of the demonstrative evidence so far. This board, and it is a front and back document, is both a demonstrative evidence item, and an explanation of a variety of terms and conditions, none of which have ever been discussed as being relevant to this case. None of which is relevant to this doctor's care and treatment of the plaintiff because this doctor didn't begin to treat the plaintiff until seven and a half years after the accident, and five years after her spine surgery.

THE COURT: Okay. Counsel, I think you are going beyond the scope.

MR. BRODY: I will go right to what it says on

here. There are things on here such as chemicals reaching parts of her anatomy, chemical factors, compression. These chemical factors are not discussed in any of the treating doctors records and not discussed in his disclosure in any matter whatsoever. The same is true on the back. I have no problems to references to the anatomy parts, what was treated and what was done. But they are bringing in all kinds of things that no doctor has ever put in their record and has not been disclosed in the 3101(d) as an expert. Would be inappropriate, and these documents go way beyond what's been disclosed or what was contained in any of the treating doctors who actually treated the plaintiff, in their records.

THE COURT: Mr. Subin, I'll hear you.

MR. SUBIN: Judge, I will ask the questions to only discuss what's relevant to Ms. Gonzalez's treatment and condition by Dr. Guy, that should not be any potential prejudice.

THE COURT: All right. Let me ask you this, so, could the demonstrative evidence be redacted to take out the definitions?

MR. SUBIN: If we have to, Judge.

THE COURT: Would that work with you, Mr. Brody, as a compromise?

MR. BRODY: Yes, your Honor.

MR. SUBIN: I'm not offering it into evidence. We can just offer -- he wasn't going to read from it anyhow, as far as I know. I'll cover it if we have some stickies, that's all I need.

MR. BRODY: You have the other sheet, which doesn't have all that stuff on it. Why can't you use the other sheet. This is big and has all the words on it.

THE COURT: All right, but it is -- let's be fair, the jury can't read the wording right now from where they are sitting. Okay. He's really using the photo, the photographs, the diagrams.

MR. BRODY: Judge, if you just instruct the jury to pay attention to the photographs, at least to have some measure of curative, and I know we are not going to be getting into an argument of what was said and what was done.

MR. SUBIN: I have no objection to that.

THE COURT: I'll give them a curative instruction that they have to focus on the photos and not the definitions. And in the future they ask it to be published, we can address that then.

MR. SUBIN: I'm not going to offer it, Judge. That won't be an issue.

THE COURT: Okay. Wonderful. So let's take five minutes and then we'll be back.

(Whereupon, a recess was taken at this time.)

COURT OFFICER: All rise, jury entering.

THE COURT: Please be seated. Members of the jury, before we continue with Dr. Ali Guy's testimony, you are being shown a diagram. That diagram, you are only to focus on the physical diagram, not any of those words. Those words are not being used for today's purposes, or any purpose throughout the trial. Only focus on the testimony of Dr. Guy and the photos within the demonstrative diagram.

MR. SUBIN: May he continue, your Honor?

THE COURT: Yes, he may continue.

A So, as I was explaining, when you have a disk herniation, you have a complete tear of disk, and the water content inside the disk leaks out. So the disk begins to shrivel up. Look at the thickness of this disk. Look at the thickness of this disk herniation, and what happens is the body begins to produce osteophytes, which are bony projections. They try to stabilize the injured areas by forming these bony projections, and what happens, the disk space becomes narrow, and the nerve root becomes crowded and pinched. Once this happens, as the water content begins to leak out, this is what you have as an end stage disk disease. Normal end stage disk disease.

So, what happens with this disk is almost gone, and you have osteophytes all around both the vertebral body and inside

the neuroforaminal -- the nerve becomes more pinched. Once you have a disk herniation, there are certain chemicals inside the disk that leak out as well. There have been -- 100 chemicals have been described. These chemicals, once they leak out, they irritate the nerve root and the surrounding structures, the muscles, tendons and ligaments. That's why the disk herniation is considered permanent and progressive because fibrocartilage does not have the ability to repair itself once -- when it breaks. All you have to do is put the two pieces together. It heals with bone cement known as callus formation. And it becomes the strongest part of that body.

However, that does not happen with fibrocartilage, which is found in the disk and in the kneecap. And, now, to take you to what happens at a microscopic level. When you look at a disk, we look at it on a three-dimensional fashion. This is called the -- this is the sagittal view, the side view, like so. And this is, I call this the salami view, which you're looking at it like this. This is the spinous process. When you touch your neck, you are touching the spinous process. And this is the transverse process, these structures here, and this is the disk. So, once you have a disk herniation, without a tear in the disk, and the microscopic leak in the muscle fibers, and the disk, it becomes leaking out, compressing the root. That's how you get radiculopathy.

So, on the spaces below, what we are looking at, this

is a bulge. A bulge is a partial tear of a disk. Partial tear of the disk. Herniation is a complete tear of the disk. And, again, it is permanent and progressive. That's the anatomy.

Q Doctor, you talked about something called a radiculopathy. And I just want to -- when we hit our funny bone and you get that tingling, burning sensation, is that related at all to what radiculopathy is?

A If you hit your elbow, that's the ulnar nerve, which comes off the branch of the nerve root which goes into the brachial plexus, which is the Grand Central of all the nerves that cross each other and goes down the arm. When you have a pinched nerve on the neck, you have a tingling and burning sensation down the arm. And depending how much compression is on the nerve root, it determines whether you lose muscle, you lose reflex, etcetera.

Q Now, are you familiar with the body structure called the longitudinal ligaments?

A Yes.

Q And can you describe what that is and what its function is?

A Yes. We have anterior longitudinal ligament which covers the spine from the front to stabilize it, so the disk doesn't pop out. We have the posterior, posterior longitudinal ligament. Ligament attaches bone to bone. It stabilizes the disk from popping out. Anterior and posterior longitudinal

ligament, when the disk is herniated, is pushing on the posterior longitudinal ligament, which has a lot of sensory fibers, which causes a lot of pain.

Q I'm trying to understand this, does the longitudinal ligament go all the way around the --

A The posterior?

Q Yeah.

A The posterior, this goes -- occurs in the back. Here to here. Here to here.

Q And when we go forward and backwards, what's that called?

A Forward is flexion. Backward is extension.

Q And does the longitudinal ligament play any role in protecting us when we do that?

A Yes.

Q Can you explain that?

A It prevents the disk from popping out of place. It is a very important structure, holding the disk in its proper anatomic location.

Q What about the sides of the spine, are they covered by the longitudinal ligament?

A Partially. They have different ligaments, interspinous ligaments.

Q Is it different than for the spine when something is twisting versus something is going straight back and forth?

A Yes.

Q Can you explain how.

A When you go straight forward and backwards, you are putting pressure on the posterior longitudinal ligaments. And also you are putting into effect the anterior longitudinal ligament, and when you go from side to side or you rotate from side to side, you are affecting the interspinal ligaments here and here.

Q Anything else that you need to tell us about the anatomy?

A One more thing. So this is a side view. A sagittal view of the spine. This is the side view. This is the sacrum. This is the L5, this is L4, L3, L2 and so on and so forth. When you have a disk herniation between the fourth and the fifth, that's a herniation, complete tear of the disk, pinching the nerve. When you pinch the nerve, you get shooting pain down the leg with numbness, tingling and with weakness. Sometimes may not have lower back pain. You may just have numbness, tingling down the leg, or weakness. But the source is not here. The source is in the lower back because that's where the nerve roots come from. That's basically it.

Q I'm seeing these yellow things that are sort of coming out on the sides.

A Those are the nerve roots. These are the nerve roots.

Q And if this was more complete, where would, let's say,

the disk, their name based upon what?

A The anatomic location. When I say C5-C6, it means the disk space between the fifth and the sixth vertebra. When I say C4-C5, it means the space between the fourth and the fifth cervical vertebra.

Q And what are the vertebra made of?

A Vertebra is bone.

(Whereupon, Senior Reporter Nunez was relieved by Senior Reporter Jimenez-De Armas.)

DIRECT EXAMINATION

BY MR. SUBIN:

Q. And if these were to, let's say between 5 and 6, were to continue, if the model was more complete, where would that go?

A. C5 C6 goes all the way from the neck, down to the biceps and to the deltoid. This is controlled by the C5 C6 distribution, and the reflex is controlled by the C5 C6 nerve root.

MR. SUBIN: May he return to the stand, Judge?

THE COURT: Yes, please.

Q. Doctor, before getting to your treatment, would it help in your explanation to first go through the medical records that are in Evidence?

A. Yes.

MR. SUBIN: Judge, may I?

THE COURT: Yes, you may.

Q. Doctor, I'm going to be showing you -- may I move this out just a little, Judge, so that the text can be read?

THE COURT: Yes.

MR. BRODY: Just for the record, we have highlights and marks on there.

MR. SUBIN: That's demonstrative, I haven't obliterated it, Judge. It will greatly expedite the ability of the jury to understand and my witness's --

MR. BRODY: May we approach?

(Whereupon, a sidebar discussion was held at the Bench, out of the hearing of the jury.)

Q. Doctor, I'm showing you what's in Evidence as Plaintiff's Exhibit 14, can you see that from there?

A. No.

Q. No?

A. May I step down?

THE COURT: Yes, you may.

THE WITNESS: Thank you.

Q. And so this is, I want you to assume, Doctor, that this is Plaintiff's 14 in Evidence, and this is from an initial visit from plaintiff for her primary care doctor, Vishwanath Puttaswamy Gowda?

A. Yes.

Q. You're aware that what brings us to court is an incident that happened on June 20th, 2017?

A. Yes. Three months before this incident.

Q. And she was there for a routine physical, Doctor?

A. Yes.

Q. Can you explain the areas that are highlighted? Can you explain what they are and what they mean to you, medically?

A. Yes. So the musculoskeletal is the neck, the back, the hips, the joints. It says -- I'll stand over here. It says the patient denies any joint stiffness, denies any painful joints,

denies any swollen joints, and denies any weakness in the body. Denies any dizziness, denies any headaches, denies any depression, mood or suicidal/homicidal thoughts, denies any problem with sleeping.

Q. And can you go to the examination? Can you explain what that record means, what it says and what it means?

A. So, the doctor is examining the neck. The neck is supple, supple means able to move freely in each direction. Full range of motion. Full range of motion is range of motion of the neck is as follows, this is called forward flexion, this is extension, this is lateral bending.

THE COURT: Counsel, please approach.

(Whereupon, a sidebar discussion was held at the Bench, out of the hearing of the jury.)

Q. Doctor, there are certain red lines, and there will be certain highlighted areas, those were done by me, I haven't changed the record in any way, but it stands from the records that are in Evidence.

THE COURT: Okay. And these are the same records that are in Evidence as Number 14, correct?

MR. SUBIN: Yes.

THE WITNESS: Continue?

MR. SUBIN: Please. When the judge instructs you.

THE COURT: Continue.

A. So the neck, range of motion is fully normal. And then

the back is full range of motion, there is no tenderness. When you touch the area, it doesn't hurt. There is no muscle spasm. Spasm is defined as a long involuntary contraction of the muscle fiber. When you touch a normal muscle, it's soft. Once it gets injured, it goes into a reflex protective action, it becomes tight. The fiber is shortened, their range of motion is decreased.

The neurological exam is complete and normal, normal motor strength, upper and lower extremities. Sensory exam everything is intact, everything is completely normal.

Q. Are you familiar with the term baseline?

A. Yes.

Q. What is baseline?

A. Baseline is what is normal for you on a daily basis.

Q. Okay. Now three months before the traumatic event that brings us to court, what was Dayra's baseline?

A. Neck and back, no tenderness, full range of motion, muscle power normal, sensation normal, everything normal.

Q. Was not changed --

MR. SUBIN: Well, withdrawn.

Q. Moving to Plaintiff's 3 in Evidence, which is the emergency room records from Lennox Hill Hospital on June 20th of 2017.

A. Right.

Q. What's chief complaint, Doctor, at the very top?

A. What bothers of patient the most, the reason the patient is going to the emergency room.

Q. What does HPI stand for?

A. History of present illness, as to what's currently going on with the patient.

Q. And can you read what the objective statement says?

A. Yes. Patient has gone to the emergency department complaining of pain to the lower back, and the neck, and left knee after a slip and fall on a marble floor. And presenting symptoms, bruising, pain, stiffness, and tenderness.

Q. Going to another page from that record. Musculoskeletal, when you see that in the hospital record, what does that mean?

A. Musculoskeletal basically means the neck, the back, and the joints. So for the musculoskeletal there is complaints of back pain, joint pain, that's the knee, and also neck pain.

Q. Now, we see here presence of pain and pain rating. Can you explain to us what a pain rating is?

A. Yes. So pain is a subjective complaint, 0 means there is no pain, 10 means unbearable pain. 9 means excruciating pain, 8 means severe pain, 7 is moderate amount of pain, 6 is mild to moderate. 10 is the highest you can have, so the pain, as for the patient is 10 out of 10. That's severe pain.

Q. When you see rest versus activity, what does that mean?

A. When a patient is resting, the pain may vary. When you

became active, move the extremities, the pain may increase, but it still stays the same. 10 for both, rest and activity.

Q. Let's deal with that record. Continuing, now, it says neurological, what does that mean? What's the significance here?

A. So, when a patient gets injured and sometimes they may have hit their head or may not. So the physician wants to make sure they are alert, they know where they are, they are oriented, they know the time, the place, orientation is normal, as such was the case. There were no focal deficits, no motor or any sensory deficits. That's a good sign.

Q. Okay. What is that telling you about any condition that she would have had leading into this event?

A. If this condition was pre-existing, you would have had abnormalities noted in all of these areas. None was detected. When you get injured, the full impact of traumatic injury shows it's true picture several weeks later, it doesn't happen overnight or immediately.

In the medical field we have what is called incubation period. May I give two examples? The incubation for the common called is 48 to 72 hours. So if somebody sneezes on you, you don't get the symptoms right away, you get it two or three days later. For hepatitis type A incubation is 60 days, from the time of infection to the time of symptomology is 60 days. For traumatic injury it's several weeks, minimum four to six weeks,

nerve injuries minimum three to four weeks to begin. So there is nothing here, there is no abnormalities here.

Q. Oxycodone, can you tell us what that is, Doctor?

A. Oxycodone is a Class 2 narcotic medication for pain, very strong medication. One of the most highly abused drugs in the street. So this is the lowest dosage, 5 milligrams. When you give it with Acetaminophen, which is Tylenol, it potentiates the effect of the Oxycodone. It's a strong narcotic to treat severe pain.

Q. Even though she had the Oxycodone, she still was in excruciating pain?

A. She was.

Q. What's care initiated triage, C collar?

A. That's a cervical collar. So they give the patient a soft cervical collar, so they don't move the neck. The neck doesn't move around, to stabilize the injured neck. It gives them relief of pain and extra support.

Q. Okay. From all the, what's a CT Doctor?

A. CT stands for computerized cervical imaging. It is the best test to see if you have a subtle fracture in the bone. MRI checks the soft tissues, the disks. The CT checks the bony areas.

Q. When a priority says urgent, what does that mean to you?

A. Urgent means it should be done right away.

Q. And when they are transporting somebody by wheelchair, does that indicate anything to you?

A. Yes. The patient is not safe to walk on their own, so they are being transported by a wheelchair for safety reasons.

Q. Now, what's -- in a hospital, can an X-ray be done of the neck?

A. It can be done, yes.

Q. Is there a reason to do a CAT scan?

A. A CAT scan is much more accurate. If it's a big fracture, fracture means a break. If it's a big fracture, a routine X-ray would show it. A small fracture, X-ray will probably not show it. CT scan is the preferred choice of the diagnostic study.

Q. Can you please explain what is highlighted, Doctor?

A. Yes. The patient understands emergency department diagnosis is a preliminary diagnosis, often based on limited information, and that the patient must adhere to the follow-up plan as discussed.

The patient understands that if the symptoms worsen, or if the prescribed medications do not have the desired or planned effect, that the patient may return to the emergency room at any time for further evaluation and treatment.

Basically, what this is saying, when the patient goes to the emergency room is an initial evaluation. The full picture has not yet set in. The symptoms may worsen over time,

so the patient needs a follow-up by a primary private doctor. If that happens, they should seek the appropriate medical attention.

Q. I want to go to the next, Plaintiff's Exhibit Number 4, which is from the Rehab Focus Group, and what's the referring physician?

A. The doctor that referred the patient for the appropriate test, or procedure, or treatment like physical therapy.

Q. Is this the same doctor we saw earlier in Plaintiff's Exhibit 14, the primary care doctor?

A. Yes.

Q. What is the date of this exhibit?

A. 9/18/2017, approximately three months after the accident.

Q. Okay. In this case, what's the pain history here?

A. Cervical spine, 10 out of 10 currently. Worst 10 out of 10, her best day that she may have is still a 10 out of 10. That holds true for both the neck, the back, and the right knee.

Q. What is that telling you, just initially? If three months post trauma she still having excruciating, unbearable pain?

A. That is something severe, it needs to be investigated by the further appropriate diagnostic studies.

Q. Let's stay with this record. You can you read and

explain what the significance of the observations here are?

A. Yes. Patient has forward head position. I'm describing it, this is forward head position. And shoulder positioning in apparent pain distress, patient ambulates with a mild antalgic gait. Antalgic means a limp. There's decreased knee flexion. This is knee extension. This is knee flexion. Has decreased knee flexion and an insufficient heel strike.

So the normal gait pattern is as follows, first we have a double stance, push off, swing, heel strike, toe down. Swing heel strike, toe down, this is the normal gait pattern. When a patient is here, they have insufficient heel strike, they cannot do the heel strike. What they do, antalgic gait, that's some sort gait deviation to compensate for the amount of pain and dysfunction that they have, and the patient is without any assistive device. The patient's head remains in the forward position, with forward shoulder positioning.

Q. Why would somebody who has this kind of neck pain have this forward position?

A. They are trying to seek some relief. So if you keep your neck straight, and your neck is in severe spasm, you cannot do that. So by keeping it forward flexion, you get partial relief.

And, mild forward lumbar spine. This is mild forward lumbar spine with a gait pattern. Left lateral shift is present. Left lateral.

MR. BRODY: Let the record reflect the doctor was walking in the motion that the record reflects.

THE COURT: So noted.

Q. Continue Doctor, please.

A. Decreased cervical lordosis.

Q. What's cervical lordosis?

A. Normal curvature of the neck, depending which way you're looking at it. So the cervical and lumbar both have the same kind of curvature. The thoracic spine is the opposite. So the neck goes slightly, I'm describing it like a C, same with the lumbar spine. When the lordosis is lost, means there is severe muscle spasm and abnormal curvature that holds the body improperly. Anatomic location has been lost. There is indication of severe muscle spasm, both in the neck and in the lower back.

Q. So first of all, follow-up question. If you lying on something hard on your back and put on your hand under, on your neck in that space, what is that?

A. That's the normal lordosis, normal curvature of the neck.

Q. You said spasm, and I know you possibly said it earlier. Can you remind us what spasm is?

A. Defined as involuntary, which you have no control over. Involuntary prolonged contraction of the muscle fibers. So the muscles become tight, when the muscles become tight the fibers

shorten. When the fibers shorten, your ability to go through normal range of motion is decreased, and that's what happened here.

Q. What is spasm an indication of, Doctor?

A. Spasm is indication of a recent trauma.

Q. What does spasm mean for Dayra's physical condition?

A. Causes pain and stiffness.

Q. Go to the next page of the same note. Okay, first of all what's palpation?

A. Touching.

Q. Tell us what happened when she was palpated during this visit in September of 2017?

A. So there's tenderness during palpation of the cervical facet joints. These are the facet joints. The facet controls the movements; forward, backwards, sideways, each direction. So there was tenderness, meaning there is malfunction going on. There is also tenderness during the palpation of the spinous process, that's the spinous process right here. This is the spinous process. If you take your fingers, touch the back of your neck, you're touching the spinous process.

There is also tenderness over the transverse process of the cervical spine. This is the transverse process, if you touch the midline, go one finger over, you're touching the transverse process.

There is also tenderness in the palpation of the

lateral joint line, that's more or less near the transverse process. And there is tenderness during the palpation of the medial joint line, this is the medial joint line, where I'm touching.

And there is tenderness during palpation of the spinous process of the lumbar vertebra, that's right here. Tenderness during palpation of the lumbar paraspinal muscles, these are the paraspinal muscles. And there is tenderness during the palpation of the sacroiliac joint, when you touch your hip, you go all the way across, touch here, this is the sacroiliac joint. So there is tenderness throughout the entire neck and lower back area.

Q. What is that telling you?

A. That there could be consistent with an acute cervical lumbar radiculopathy due to disk bulge, protrusion, or herniation, which has to be tested by MRI and EMG studies.

Q. What's an assessment in the medical record, Doctor?

A. Assessment means clinical diagnosis.

Q. Okay. What was the assessment in this record?

A. The patient presents with signs and symptoms consistent with an acute lumbar and cervical disk herniation.

Q. So with regard to that, when it's the word acute, what does that mean in medicine?

A. Acute means recent. Anything less than three months is acute. Anything more than four to six months is considered

chronic.

Q. Okay. And what, up here, it says GASTROC/HAMS 3/5, what does that mean?

A. Gastrocnemius muscle, hamstring reflex -- sorry. Gastrocnemius hamstring muscle power. So 3/5 means you're basically only able to lift it against gravity. You cannot tolerate any stress to the area. It's four grades weaker than normal. The extensor hallucis longus is normal, 5/5. The quadriceps muscle, that's the muscle in the thigh, it is weak, that comes from L3 L4. The extensor hallucis in the peroneum in L5, gastrocnemius is S1 S2. All of these muscles are weak, except for the S1 S2 distribution, that's normal.

Q. Okay. Going forward now, you know that she got physical therapy at this facility?

A. Yes.

Q. Moving to the next record, which is Plaintiff's 4, which is from All Borough --

MR. BRODY: I'm going to object at this point, may we approach?

(Whereupon, a sidebar discussion was held at the Bench, out of the hearing of the jury.)

Q. Turning to Plaintiff's Exhibit 4 --

MR. BRODY: Objection.

THE COURT: What's the objection?

MR. BRODY: Same thing, highlighted records.

THE COURT: You have to wait until the question is asked. He's showing you Exhibit 4, these records are in Evidence. You may inquire.

MR. SUBIN: Okay.

Q. Doctor, what's an impression?

A. Impression is your initial working diagnosis.

Q. Okay. And did you review this record from January of '18?

A. I did.

Q. What was the impression?

A. Cervical spine versus cervical disk herniation. Internal derangement of the left shoulder. Lumbar spine versus lumbar disk herniation. Thoracic somatic dysfunction, internal derangement of the right knee.

Q. Okay. And have you treated all of these body parts, Doctor?

A. I have.

Q. And what is, it says to obtain an MRI. Briefly, what's an MRI?

A. Stands for magnetic resonance imaging study invented by doctor. Takes the bodies protons, transforms them to real life images. It is the study to check disk herniations in the spine.

Q. With regard to numbness and neck pain, with regard to --

MR. SUBIN: Withdrawn.

Q. I'm going to move forward to Plaintiff's Exhibit Number 6, New York Sports and Joints, March of '18. Did you review this record, Doctor?

A. I did.

Q. Okay. What is an orthopedic evaluation?

A. An orthopedic evaluation is a doctor that focuses on the joints, the shoulder, the knee. Then we have an orthopedic spine doctor that focuses on the spinal portions.

So here the doctor is focusing mostly on the knee and the shoulder.

Q. Earlier you mentioned something about traumatic injuries get worse over time. Patient states the knee has gotten worse since the initial injury. Explain how that happens.

A. So, every condition in the human body has an incubation period. Which means the time from exposure until the time of full symptomology, I gave you two examples, the common cold and another example.

So, for traumatic injuries the full picture is shown anywhere from several weeks to several months later, which is what's happening here.

MR. BRODY: Objection.

THE COURT: What's your objection?

MR. BRODY: Testimony says several weeks or several months later. This exhibit is from a year and a

half later.

THE COURT: From where?

MR. BRODY: Over a year later.

MR. SUBIN: It was a 2017 accident.

MR. BRODY: I apologize. I'll withdraw the objection.

Q. So now, states here the cervical spine, she has continued pain, headaches, and posterior cervical spine with intermittent numbness and tingling running down the right lower extremities to the right hand, what does this mean, Doctor?

A. These are the classic signs and symptoms of cervical radiculopathy, lumbar radiculopathy, due to a disk herniation.

Q. What's an assessment and plan?

A. Assessment is your diagnosis, plan is your plan of care, how you plan to treat the patient.

Q. And a 39-year, when it says traumatic right knee meniscal California tear. First of all, what's the significance that it says traumatic?

MR. BRODY: Objection. So far Counsel stated he's only, or the witness stated he treated her for neck and back, not knee. That's what the testimony was.

Q. Have you treated Ms. Gonzalez's right knee?

A. Yes. The neck, the back, the left shoulder, the right knee. I even gave an injection to the right knee.

Q. Okay. When you see traumatic in a medical record, why

is that significant?

A. Traumatic means it came from some sort of trauma; a fall, a hit, some sort of traumatic injury.

Q. The term here is meniscus. We haven't done this yet, but are you able to use this model to show what the meniscus is and what its function is?

A. Yes.

THE WITNESS: May I, Judge?

THE COURT: You may.

A. So just to orient everyone. This is a model of the knee, this is the end portion of the femur, the long bone. This is the fibula, the fibula is always on the outer portion of the leg, and this is the tibia. So the knee joint has different structures; this is the patella, the kneecap. This is the medial minis out, lateral minusc outer, this is the medial collateral ligament, this is the lateral collateral ligament. This is the lateral meniscus, this the medial meniscus. The meniscus has three basic functions. Number 1, separates the bones from each other so they don't hit each other. Number 2, attaches this bone to this bone. Number 3, the most important function, it takes the synovial fluid, swishes it around in the joint. It's like the oil and the oil pump of your knee joint. If your car has five quarts of oil and now it only has two quarts of oil inside, what happens to the pistons? There will be a lot of friction.

So, when a meniscus is torn, you have instability and pain in the knee. It does not lubricate the joint properly, so you will have very fast, rapid aging traumatic arthritis, which will set into the knee.

Q. After that it says for her cervical pathology recommending the patient obtain EMG for further evaluation.

Can you explain what an EMG is, and why this doctor would prescribe it?

A. It stands for electro myography, it's a test that is usually done by a neurologist, or a physiatrist. It checks to see if there is any muscle or nerve damage. The test has three portions; motor, steady, sensory steady, which checks the peripheral nerves in the hands, and the radiculopathy that are almost always normal.

Then comes the needle portion. You insert a sterile needle into the various muscles in the arms and neck. From anatomy you know which muscle is supplied by which nerve root, and you look for abnormal findings on a computer screen, and once you have the criteria for abnormality from the biceps muscle and the muscles in the neck, you are able to determine whether the radiculopathy is at which level.

Q. Okay. And why would the orthopedist prescribe this for Dayra?

A. Orthopedist orders an EMG to see if the problem is coming from the wrist or coming from the neck. Depending on the

result will determine how it should be treated.

For example, if you find mild carpal tunnel, which stenographers sooner or later will get. If it's mild, you wear a brace, severe you need surgical intervention. The surgeon wants to know if there is carpal tunnel. If it's severe, you have to go in and do the surgery right away. The longer you wait, the less benefit you have. If it's from the neck, cervical radiculopathy, if it's mild or moderate, you do physical therapy trigger point injections, epidural injections, pain medications. If it's severe, you need surgical intervention.

Q. Going through the rest of that note, knee surgery is recommended because the patient's history, MRI findings, and physical exam with failure to respond to conservative treatment over extended period of time. First of all, what's conservative treatment?

A. Conservative means non-surgical, physical therapy, anti-inflammatory pain medications is conservative, different types of injections are considered conservative. Surgery is not conservative, surgery is surgery.

Q. So, she tried these conservative measures, they didn't work, what's the next step?

A. Surgery, arthroscopic surgery,

Q. Going to the next record, which is May 24th of 2018. What's a postoperative diagnosis, Doctor?

A. When a doctor does surgery, you have his initial working diagnosis. After he goes in, after he looks inside with a scope, you go inside, you look around, that's when it's the post-surgical diagnosis. Usually they confirm each other. And sometimes the postoperative, you find more things when you go inside, as opposed to what the MRI will show you. An MRI is only an image, it is not the standard, the gold standard. The gold standard is the intraoperative findings.

So the postoperative diagnosis was he found a right medial meniscal tear, as well as lateral meniscal tear, synovitis, that's the inflammation of the structure that holds the knee and it found patellar maltracking.

So patellar maltracking is -- patella is this structure. The knee meniscus medially is torn, lateral is torn, the patella moves from its normal location, and you have abnormal grinding when you extend and flex the knee. That's patellar maltracking.

Q. General anesthesia, tell us what that is.

A. When you do a surgical procedure, there is many types of anesthesia. One is propofol, patient is half asleep, you don't feel pain. When you're going in and cutting deep structures, you want to put the patient complete sleep. You give them something by mouth, they are completely asleep.

Q. With regard to Dayra, what was done in the surgery? Can you show us?

A. Yes. Right knee arthroscopic partial medial and lateral meniscectomy. So, there is two types of surgeries that a physician can do. We can do open knee surgery, which the results are devastating, the healing part takes a long, long, time. Now, we have microscopic surgery, arthroscopy. Arthroscopy, the physician has a scope like this, at the end there is a blade, he pushes a button, water goes out. Pushes another button it has a blade. You can shave around the meniscus with the blade, then you suck out all the blood and debris inside, you wash it out again with water. You go in from the lateral portion, and the inner portion. Usually there are holes, and that's how the physician does the procedure.

So you are debriding, shaving -- you cannot cure a torn meniscus, cartilage does not have the ability to repair itself. So all they do is shave the jagged edges on both sides, and it goes smoothly, and the synovial, soft tissue that holds the knee in place, that is removed because it has become red and swollen and inflamed. And then he does a lateral release of the structures that were caught inside these condyles, here and here. And that's essentially it.

Q. What impact does having the medial and lateral meniscectomy do for the shock absorbing effect of the meniscus?

A. So you're losing two major functions of the knee. Losing the effect of the shock absorbancy, you're losing the effect of the lubrication to the knee, so the knee begins to

wear out fast. So when you hit fifty, your X-rays show the knee joint of a person that's like eighty or ninety years old.

Q. Going back to Exhibit Number 5, we had mentioned earlier that the orthopedist had prescribed an EMG?

A. Yes.

Q. When you see prolonged history of post-traumatic neck pain, what does that mean to you?

A. The neck pain has been lasting a long period of time.

Q. Going to -- what was the impression, Doctor?

A. Right sided C5 C6 cervical radiculopathy. The nerves that come between fifth and sixth cervical vertebra, which innervates mostly the biceps, and part of the deltoid.

Q. And was that consistent with the clinical picture that we have seen so far?

A. Yes.

Q. What does it mean, when I say clinical picture?

A. The patient's complaint of neck pain shooting down the arm with numbness and is tingling in the arm.

Q. Is there any way to, for Dayra to influence the outcome of this?

A. No, sir. It is not possible.

Q. Going, I'm going to go slightly out of order. This is Dr. Gondolo's records, in Evidence as Plaintiff's 13. I want you to assume Dr. Gondolo was a neurologist the plaintiff was treating with for unrelated conditions before this incident.

MR. BRODY: Objection. If he reviewed the records, he shouldn't have to assume. He should know the what's significant in the record and be able to testify about it.

THE COURT: Objection sustained.

Q. Okay. What's the date of this record?

A. January 28th, 2020.

Q. And what is the document?

A. EMG study performed by a neurologist.

Q. What were the findings on this EMG?

A. Evidence of a right C5 C6 radiculopathy.

Q. Was that the same findings?

A. Same findings.

Q. Back to the orthopaedic surgeons. Now, Doctor, the shoulder and the neck, are they related?

A. Yes, the shoulder and the neck, they serve and use a lot of muscles. For example, the shoulder, the biceps, the deltoid, and the trapezius are connected to the neck and the shoulder. Many times when a patient has shoulder pain, the actual source is coming from the neck and vice versa. So you have to make sure you know where the pain is coming from, is it one hundred percent from the neck, or one hundred percent from the shoulder, or sometimes both can cause it.

Q. We're looking at just a little over a year post trauma. What was going on here from the orthopedist, can you explain

what's happening here?

A. The patient has left shoulder signs and symptoms consistent with a rotator cuff tear, or biceps injury, that was incorrectly perceived to being part of the cervical symptoms, when these are separate and distinct, exactly what I just finished saying. We will obtain a high quality MRI to evaluate the left shoulder.

Q. Was she's getting the treatment she needed for her left shoulder pain the whole time?

MR. BRODY: Objection.

Q. Based on your review of the records?

MR. BRODY: Objection.

THE COURT: Counsel sustained. Rephrase your question.

MR. SUBIN: Sure.

Q. If there was no diagnosis of a -- in order to get physical therapy, do you need a prescription from a doctor?

A. Yes.

Q. And if she wasn't diagnosed with a left shoulder injury, could she have gotten a prescription from a doctor for left shoulder therapy?

A. No.

Q. Based on that, and based on your review of the records, was she not getting treatment for this condition in her left shoulder for the first year?

MR. BRODY: Objection.

THE COURT: Rephrase it.

MR. BRODY: There is no evidence of the injury, all this is alleged pain. There is no foundation for physical therapy, and they haven't identified an injury of the left shoulder, or the cause of the injury to the left shoulder.

MR. SUBIN: I'm getting there. I have to go through it first.

MR. BRODY: You can't get there by saying was she not getting treatment for something, identify what something is.

THE COURT: Counsel, rephrase the question.

Q. Was she getting any treatment for left shoulder for the first year?

A. No. There is a shoulder --

MR. BRODY: Objection, it was a yes or no question, the Doctor knows very well to give a yes or no answer to a yes or no question.

MR. SUBIN: He's not here to direct anybody. I object to that. He can make an objection.

THE COURT: The objection is sustained.

Q. Doctor, can you review of the note and let us know if there is anything indicating left shoulder injury?

A. Yes, there is.

Q. Can you explain what it is?

A. Left shoulder forward flexion is only to 120 degrees. Shoulder flexion goes from 0 to 180 degrees. 120 is two-thirds normal. External rotation normally is 90 degrees. This is external rotation, this is internal rotation. It's diminished.

And so there is positive Neer's sign, positive Hawkins sign, and positive O'Brien's testing. So positive Neer's is when you go past 150 degrees, you have impingement sign, it's abnormal internal abnormality of the shoulder. And once you turn your hand this way, and you give the patient some resistance and there is pain, that's another positive sign. So there is three abnormal positive signs to the shoulder, indicating there is pathology going on with the shoulder.

Q. Thank you, Doctor. Going back to Plaintiff's Exhibit 5, you talked about the lower back, do you know what this is, Doctor?

A. This is an EMG of the lower back and the legs performed on 7/9/18, approximately one year later.

Q. What were the pertinent findings?

A. Electrical evidence of a bilateral L5-S1 radiculopathy.

Q. What does that mean?

A. Damage to the nerve root. The last nerve root is L5 S1 damage to that nerve root.

Q. What does that mean for Dayra, a year later that she has this situation?

A. That the problem still persists and is ongoing.

Q. Now, your record, Plaintiff's Exhibit 7 in Evidence. November 2nd of '18. What was the history of present illness?

A. Thirty-nine-year old female who presents today was neck and low back complaints, with the pain in the neck being most severe. The symptoms began after the patient sustained an accident and are becoming progressively worse.

Q. Neck specific findings, what is the pain finding?

A. Ten out of ten.

Q. This is a year and a half post trauma?

A. Yes.

Q. The findings that the doctor made with regards to the radiating pain, what would that be consistent with?

A. When you have radiating pain to the right shoulder, right arm, right elbow, that's the C5 6 nerve root distribution.

Q. Clumsiness in the hands, what is the significance, if any, of that finding?

A. Numbness and tingling of the hand?

Q. Clumsiness?

A. So the motor power to the hand comes from the median nerve and/or the cervical spine, the C5 C6. So if you have clumsiness in the hand, C6 controls the first three fingers of the hand and the wrist. Controls the wrist extension, that's C5 C6.

Q. What does that mean for her ability to hold objects?

A. Means that there is damage to her nerve, if it's from the neck or from the hand. They need proof it's not the hand, they need to prove it's coming from the neck.

Q. What is the significance that she has spasm a year and a half later in her neck, Doctor?

A. The problem is continuing, is not alleviating, it's persisting.

Q. And same thing with the low back, that there was spasm in the low back?

A. That is correct.

Q. Okay. Romberg, what is that and what is the significance?

A. Romberg is a test you ask the patient to stand up straight, you put your hands in the front and the back, and you give the patient a little push. Sometimes they lose their balance. That comes from nerve root weakness or damage, or something coming from the brain. In this case it's coming from the nerve roots in the neck and the back.

Q. Did this Doctor also diagnose anything with regard to the left shoulder?

A. Yes. There is impingement of the of the left shoulder.

MR. BRODY: Objection, your Honor. To the, this doctor. Can we be more specific?

Q. The doctor in the record of the spine care?

MR. BRODY: Who is that?

MR. SUBIN: Judge, objection.

THE COURT: Step up, please.

Q. I'll go to that. I believe the doctor is, Dr. Michael Gerling.

Q. What's impingement, Doctor?

A. Impingement is when the supraspinatus tendon gets caught. The supraspinous tendon gets caught underneath the shoulder humeral head, in this space. Once you pass 150 degrees, a structure gets caught in this little hole. That's called impingement syndrome and the structure most commonly is the supraspinous tendon. Part of the rotator cuff.

Q. Is that something that would be painful to Dayra?

A. Yes, that would be painful.

Q. With regard to reflexes, why would a doctor who is a spine doctor test reflexes?

A. Because reflexes also shows the nerve roots. If you have muscle weakness, if you have sensory abnormality, if you have reflex abnormality, they all come from the nerve roots in the spine.

Q. Now, what would the, what would be a normal finding for reflex, Doctor?

A. Normal is 2 plus, 3 plus is increased, 4 plus is exaggerated, it's a sign of spinal cord compression.

Q. Now, we have been talking about radiculopathy. I believe you said it was pressure on the nerve roots. Is there

another condition in the spine that --

MR. Withdrawn. What would cause this hyper reflex.

A. A disk herniation compressing on the spinal cord. The spinal cord is right behind the disk. So if you have a disk herniation that's putting pressure on the spinal cord, in the neck you get brisk reflexes, and you would get weakness and sensory deficits.

Q. Is there a name for that condition, when the disk pushes on the spinal cord?

A. Yes, myelopathy.

Q. Okay. And is that -- what is the difference between myelopathy and radiculopathy?

A. Good question. Radiculopathy is when you have damage to the nerve root. Myelopathy is when you have a compression on the spinal cord.

Q. And is one more significant, is one more significant than the other?

A. Myelopathy is much more significant, because if you have continued, sustained compression of the spinal cord and you don't relieve it, it may become permanent, even when you do the surgical decompression.

Q. Now I want to go, still in the same record, the assessment, was that, did Dr. Gurling have the same assessment that you had?

A. Yes, with myelopathy. Very important, yes.

MR. BRODY: Objection.

THE COURT: What's the objection?

MR. BRODY: How can it be the same assessment he had, he didn't see the patient until seven years later.

THE COURT: Overruled.

Q. It says anterior --

MR. SUBIN: I'm going to skip that, withdrawn.

Q. The surgery in the neck, again. Decompression, where it says the primary goal is decompression, what's decompression

A. To remove the compression on the spinal cord.

Q. Okay. To relieve neurologic symptoms, what are the neurologic symptoms?

A. Shooting pain down your arm with weakness, reflex abnormality, sensory abnormality.

Q. And now Dr. Gurling says above anterior cervical discectomy and fusion at C5 C7, what level is the doctor referring to?

A. Anterior is going from the front. When you do surgery to the spine you want to go from the front, the back is much more dangerous. You have a lot of blood vessels and dangerous structure there, so you make an incision in the neck, you go and remove the structures. Discectomy means you're removing portions of the disk to get access to removing the disk and placing artificial disk in place. And with the cadaver bone,

you put bone and metal plates and screws in the front, so that the disk does not pop out of place.

Q. When it says C5 to C7, can you show us what level, Doctor, on this, based on this record?

A. 2, 3, 4, 5, to C7. From here to here.

Q. How many discs was he planning to operate on?

A. Three discs.

Q. Okay. And going now to, this is the NYU Langone record from March 28th of '19. HPI, can you tell us in the hospital what it said and what the significance is?

A. History of present illness. It says status post-traumatic injury to the neck with radiating paresthesias, with numbness and weakness, worse to the shoulders. Shoulders are, again, C5 C6 innervated nerve root structures. No relief from conservative measures, no changes since his last office note, ongoing difficulty with activities of daily living.

Q. What are activities of daily living?

A. Bathing, cooking, cleaning, combing your hair, brushing your teeth, putting your socks and shoes on, putting your clothes on.

Q. Same thing with the hospital record, can you read what's on the screen and tell us the significance?

A. Yes. So we have left wrist extension, that's C5 C6. Left interossei, this is the control of the interosseous, mostly C6. And then these are the lower extremities, right extensor

hallucis, the function brings the ankle up. And left extensor hallucis is 4/5, normal is 5/5.

Next is 5-/5, then comes 4+/5 then 4/5, so it's 3 grades weaker than normal.

Q. Are these the same weaknesses we saw when we saw the first physical therapy record?

A. Yes.

Q. What's the significance now, that what NYU found a year and nine months post trauma and Dayra still has weakness in the muscles?

A. The problem is continuous and is ongoing and slowly, gradually, progressively worsening.

Q. Are there any risks associated with this surgery?

A. There is always risks with every surgery; infection, paralysis, the problem may not alleviate the patients symptoms, and the other levels may get injured. These are the problems with surgery.

(Whereupon, Senior Court Reporter Melissa Jimenez-De Armas was replaced by Senior Court Reporter Robin Nuñez.)

Q So, says up here one of the risk is adjacent segment disease?

A Right.

Q Can you explain what that means?

A Yes, when you are operating on the neck, you are going from C4 all the way to C7. You are putting the pressure on the disks and the levels above them. It is called a domino effect. So, what happens, the other effect structures above and below will be doing more work because there is less flexibility to the areas that were operated, and the disks then become herniated and become dysfunctional.

Q Is that something that happens after surgery?

A Generally, yes. It doesn't happen right away. It happens after a few years depending on the patient's age and the overall condition.

Q Now, it also says the patient has the past medical history of anxiety which complicates her present condition. Can you explain that?

A Yes. When a patient has anxiety and pain, let's say you have this much anxiety and you have this much pain, it exponentially potentiates the patient's perception of pain. If you have only this much pain and this much anxiety, the patient's perception of pain becomes this high. Exponential increase.

Q Do you know why that is?

A That is the patient's perception of pain.

Q Doctor, what were we looking at here?

A We are looking at the surgery that was performed by Dr. Gerling at NYU on 3/28/2019.

Q And, again, the post-operative diagnosis you told us that was the gold standard, what was it?

A C4 through C7 disk herniation, there is three disk herniations.

Q Just for the purposes of this question, how many disks were operated on?

A Three levels. Three.

Q And when it says specimen is removed, what does it say and what does it mean? What's the significance?

A The disks were removed and sent to pathology.

Q It says headlights and loops were used and disk herniations were noted at all levels intraoperatively. What does that mean?

A So, these are the special surgical instruments and there was light placed into the intraoperative field to see the pathology a lot clearer, and some surgeons use magnifying glasses during the surgery so they can magnify the structure so they can see it much more readily.

Q Doctor, what is an indication in an operative report?

A The reason why the procedure is being performed.

Q And what was the indication?

A The patient has severe disk herniation after a traumatic injury to the cervical spine with severe neck pain, rated in upper extremities with numbness and weakness. There was weakness and examination, and an MRI demonstrated posterior disk herniation at the operative levels correlating with the patient's symptoms. The patient failed conservative management, including physical therapy, medications, and pain management trials.

Q The weakness on examination, MRI, demonstrated posterior desk herniations at the operative level correlating with the symptoms. What does that mean?

A Means everything is correlating. The patients symptoms, the patients MRI findings, the patient's examination findings, and the intraoperative findings. Everything correlates and confirms this suspected pathology.

Q I'm going to ask you in -- I've shown you this diagram?

A Yes, I'm familiar with this.

Q And would that assist you in describing the surgical procedure to us?

A Yes.

MR. SUBIN: Okay. And I've shown it to counsel. Judge, I'd like to display it with the Court's permission.

THE COURT: Any objection?

MR. BRODY: No, your Honor. I think we should mark it at some point, but I have no objection to its use.

Q One question before that, how long did the surgery take?

A Started 1102, that's 11:02 PM, and ended at 5:36 PM, approximately four and a half hours.

Q Now, so, can you orient us to what we are looking at here, Doctor?

A Yes. We are looking at the side view -- this is the front view. Front is called anterior lateral front. To get exposure to the disks, and what the doctor is doing is shaking out a portion of the vertebra to make room to place the artificial disk with metal plates and hardware. Is removing the disks, and he has a drill to shave the jagged edges, make proper room for the artificial disk to go into place, and he's removing -- he's sucking out all the debris, and here, with the shaver, he's making everything smooth. Upper and lower portion of a disk. Now, he's putting the artificial disk into place, and these are the screws and the plates to stabilize the area from the disk popping out.

MR. SUBIN: Judge, I'd like to show -- I have a screen shot from the films that are in evidence of the post-surgical films, Plaintiff's Exhibit 11.

THE COURT: Any objection?

MR. BRODY: If he's showing what's already in evidence, I have no objection.

MR. SUBIN: Okay.

Q Doctor, what are we looking at here?

A So, these are the artificial disk in place.

Q When we look at the front, the back, what are we looking at?

A This is the front.

Q And we talked about screws and things point out where the screws are, and what are the objects in the photograph?

A Screws, screws, screws, screws. That sounds terrible the way it comes out. And these are the plates and they are stabilizing plates. And these are the rods and plates.

Q And, Doctor, when we move our neck, does the disk play any function in the our ability to move?

A Yes. The function of the disk is to give us the ability to move normally in each direction, but once it is fused at the three levels, we lose that function. For every one level of fusion, you lose about 5 to 10 degrees. You have three levels, you lose about 15 to 30 degrees of range of motion in each direction, flexion, extension, left lateral, left lateral bending, right lateral, rotation.

Q What are we looking at here?

A This is the side view. View of where the surgery was done. This is the front portion. This is the back portion. And these are the facets. This is the spinous process, and this is the artificial disk here. Here, we have three levels. C4-C5, C5-C6, C6-C7. These are the screws to really drill into

the bony vertebra so that holds these plates so they don't pop out of place. And these are additional screws. These are part of the artificial disk.

Q Now, with regard to that, obviously, as a result of this, did the surgeon have to do a incision?

A Of course. To get exposure.

Q Where would --

A In the front.

Q And based on your treatment, does she have a scar from that incident?

A She has a one and a half inch scar.

Q Is that something you can show us here?

A Yes.

MR. SUBIN: With the Court's permission.

A This is the scar. Can everybody see it?

Q Thank you, Doctor.

That was in March of 2019. I'm going to fast forward a little to 2021. June 8th of 2021. What was going on with Dayra's neck on that day?

A So, she had the surgery on 3/28/19, and on this date she has unremitting neck pain with bilateral arm pain. Unremitting means doesn't go away. Not every surgery guarantees a success. Surgery is a lot of risk. One of the risks is it may not work. The use of a cervical spine soft collar was continued, and pain medications were given.

Q Now, causation, what did it say and what is the significance?

MR. BRODY: Objection.

THE COURT: What's your objection, counsel?

MR. BRODY: The doctor whose opinion that is not coming to court to testify.

THE COURT: Sustained.

Q Doctor, I want you to assume that in the medical records it says patient was asymptomatic on the cervical spine prior to injury. It is my professional opinion within a reasonable --

MR. BRODY: Objection, your Honor.

MR. SUBIN: It is in evidence, Judge. I can read it and ask a question about it.

MR. BRODY: These records were subject to redaction. He's trying get opinion evidence from a doctor he's not calling to this trial.

THE COURT: Overruled.

Q "The patient was asymptomatic on the cervical spine, it is my professional opinion within a reasonable degree of medical certainty that the injuries above, recommended treatments above, and resulted disability are directly related to the above stated accident."

And, Doctor, having reviewed the record, is that the accident of 6/20 of 2017?

A Yes, sir, it was.

MR. BRODY: Note my objection, your Honor.

THE COURT: Your exception is noted.

Q Fast forwarding again to April of '22. What was going on with Dayra's left shoulder -- her lower back and left shoulder?

A So, she's having sacroiliac joint injection because she has sacroiliac joint pain. She's also having left shoulder impingement plant. HEP means home exercise program for shoulder. Was recommended MRI of the left shoulder. Consult with a shoulder specialist.

Q Now, forwarding to May of '23, what is SP ACDF C4 to 7?

A Status post anterior cervical discectomy, with fusion from C4 to C7, and C3-C4 protrusion.

Q Now, this is -- now, this is about four years post surgery, Doctor?

A Yes, sir.

Q And when it says MRI CSP, what does that stand for?

A Cervical spine.

Q And what does that indicate to you that this is a summary of?

A Means that the surgical site from the C4 to C7 fusion remains intact and the hardware is intact. Sometimes the hardware loosens. That's not happening here based on the CT scans performed.

Q With regard to sensation, now, in four years after the surgery, it says decreased sensation, left C4 to T1 dermatomes. What does that mean?

MR. BRODY: Objection. Your Honor, it is the same objection. The highlighted parts is just leading the doctor.

THE COURT: These records are in evidence.

MR. SUBIN: Yes, Judge.

MR. BRODY: The records are in evidence. The highlights are not in evidence. I understand your Honor is going to let me show things later from this, but, you know this is -- it is leading at its best. Technologically.

THE COURT: Overruled. Continued.

A So, the dermatomes are the branches of the nerve roots as they come off the nerve roots in the neck, C4 is the deltoid, the C5-C6 is the biceps, C7, C6 are the structures in the forearm. C7-T1 are the structures in the finger. Here, the dorsal portion of the hand and the outer portion of the forearm.

Q So, what does that mean to you if she had the surgery about four years before this note, and now she's still having these new -- these symptoms, which are actually worse than the symptoms before?

A Very good question. Myopathy is gone. The compression on the spinal cord has been removed. That's a success. However, damage to the nerve roots are permanent. They still

persist despite removing the compression by removing the compression of the disk, you are not alleviating damage to the nerve roots. It still persists. This condition is permanent and progressive over time.

Q Now, is there a specific side these clinical slides we are on?

A Yes, initially on the right side, now they are on the left side.

Q So, going to back to the orthopedist, Dr. McCulloch, from November of '24. What did the doctor want to do for Dayra's left shoulder here?

A Yeah. He wants to obtain medical clearance from a neurologist to proceed with a possible Cortizone injection. If the patient is on a blood thinner we will hold on any injections. For now, we will continue with physical therapy, TENS unit, that stands and Transcutaneous Electrical Nerve Stimulation unit. It is used to block the stimulation of pain to the brain. It is clear, when no longer receiving blood thinners, she may be a candidate for platelet rich plasma to the shoulder. What that is is you take 20CCs of blood from the patient's arm in a sterile fashion, you spin it down from the centrifuge. You want to separate the red blood cells from the white cells. You get the white cells, which have a tremendous ability to repair damage structured and to heal damaged tissue. You inject it into the shoulder, and hopefully you get

significant relief.

Q Going to November of '24, Gerling Institute. What's happening with her spine, her cervical spine?

A She has limited range of motion, that's no surprise. She has a three level fusion. As I said, for each level you lose 5 to 10 percent. For every level, you are going to lose 15 to 30 percent. That's to be expected. With pain and tenderness to palpation and spasm noted in the midline of the cervical spine.

Q By the way, Doctor, does that mean this is going to be every minute of everyday for her?

A She's going to have good days and bad days depending on the weather, depending on what she's doing, depending on whether she's taking medications, physical therapy, epidural injections. So on and so forth.

Q Okay. This is still from November of 2024, and says rule out pseudoarthrosis and adjacent segment disease. Can you explain what that means?

A So, pseudoarthrosis means there was a -- the fusion site, artificially, has not fused properly. On x-ray it may show it has fused. That's what -- pseudo means false, false fusion. The doctor is trying to figure out why the patient still has so much pain. Is it coming from a false fusion, or is it coming from adjacent segmental disease. Is it coming from the herniations, pathologies above the operative side, or below

the operative side. Further investigation needs to be done by another MRI.

Q And can you read what it says there, and what it means?

A Next Gerling session with completed MRI of the lumbar spine for review of discectomy.

Q What is a discectomy?

A Discectomy is removing the portion of the disk to get exposure to the disk herniation.

Q Is the discectomy different from the fusion that Dayra had?

A In order to do the fusion first, you have to do the discectomy. Artificial disk then, you do the fusion.

Q Is he talking about doing the fusion in the low back?

A Not yet.

Q I'm going to be showing from Plaintiff's Exhibit 12 from -- Doctor, what are we looking at?

A We are looking at an MRI of the cervical spine.

Q What's the date here?

A Okay. I think it is May 4, 2023.

Q Okay. Can you sort of orient us on what we are looking at, Doctor?

A Yes. So, we are looking at the side view. This is the front portion. This is the back portion. This is the brain. This is the spinal cord. The spinal cord has the white matter all the way around it and the gray matter which sends messages

to the brain and down. And this is the artificial disk section from C4 through C7.

Q Now -- okay. And the area that's fused, can you point to that?

A C4, C5, C6, C7.

Q Now, generally, how does that MRI look as far as whether or not there are any protrusions or anything going on there?

A There is a protrusion at the C3-C4 level above the operative site, and the C6-C7, there is a little bone sticking out hitting the portion of the spinal cord. Just basically touching it. And the disks are completely obliterated from the normal fashion, they are all artificial right now. That's why you are seeing it like this. All black and wiggly structures. This is a normal vertebra. Normal vertebra. Normal disk, but you don't see it here.

Q Now, once you started seeing Dayra, did you send her in November of '24, a year and a half after this, for an MRI?

A I did.

MR. SUBIN: And that MRI is in evidence as 11, Judge.

Q Now, tell us again, tell us what we are looking at here?

A This is, again, an MRI of Dayra Gonzalez. November 21, 2024. This is the brain. This is the spinal cord. These are

the vertebras. These are the disks. This is C2-C3, this is C3-C4. There is a disk protrusion at C3-C4, and there is a little indentation from the artificial disk replacement from C6-C7 on the spinal cord right here. That's probably part of the bone that's sticking out touching the spinal cord.

Q What does that mean for Dayra now, that she has this condition?

A The compression, relieve the compression on the spinal cord. Now, she's having adjacent segmental disease a level above that C3-C4. There is a piece of the bone from the artificial disk replacement touching the spinal cord here.

Q What does that mean for her symptoms?

A Pain. Pain. This is why her pain has not been able to be completely eliminated.

Q And, Doctor, I'd like to show you a side-by-side view of the '23 and '24 MRIs and see if you can show us what the changes were. The left side is '23 and the right side is '24.

A So, '24 shows the C3-C4 pathology better, and at the C6-C7 it is essentially the same, but on this view there is more protrusion of the bony segments on the spinal cord.

Q So, now, what type of symptoms -- first of all, we had talked earlier about adjacent segment disease and things of that nature. What are we seeing here from '23 to '24?

A We are seeing classic adjacent segmental pathology at the C3-C4 level, which is what I was explaining earlier, and we

are seeing the effect of the disk replacement putting pressure on the spinal cord.

Q Does this adjacent segment disease, in your opinion with a reasonable degree of medical certainty, come from the original injury of June 20th, of 2017?

MR. BRODY: Objection.

THE COURT: What's your objection.

MR. BRODY: That's he's not competent to render that opinion.

THE COURT: On what basis?

MR. BRODY: He didn't see her for seven and a half years.

THE COURT: Do you want to comment, counsel?

MR. SUBIN: I don't, Judge. He's the treating doctor. It is in records. This is his MRI that he prescribed.

MR. BRODY: Judge, just note for the record we still don't have a mechanism of injuries in all of the hours of testimony that we have heard.

THE COURT: Overruled. Your exception is noted.

Q Doctor, if you can answer the question.

A So, once again, we are seeing adjacent segmental pathology setting in and there was a recent MRI of 2024, both at the C3-C4 level, and we are seeing the progression at the C6-C7 level, bony projection touching the spinal cord. This

indentation is coming from the bone sticking out. Otherwise, everything will be straight down, like here, straight down. Here is a little indentation. You all see that right here?

MR. BRODY: Objection. He shouldn't be asking the jurors questions. He knows that.

Q Okay.

THE COURT: Sustained.

Q Doctor, this is from Dr. Gouda's record from Plaintiff's, 2 of 20. An annual check up, recently had cervical spine surgery following an injury. What does that mean to you? How do you interpret that?

MR. BRODY: Objection.

THE COURT: What's your objection?

MR. BRODY: Doesn't require a medical opinion. It is plain English.

THE COURT: Overruled.

A Basically says that the patient had cervical spine surgery after an injury. She denies any weakness or numbness in the extremities. She's getting physical therapy. She's also having recurring dull abdominal pain.

Q Okay. Doctor, I want to show you what's in evidence as Plaintiff's Exhibit Number 1. This is an incident report from the accident. I want you to assume that it says she was crying in a lot of pain. Is that consistent with someone who sustained a traumatic injury.

A Yes.

Q And that they provided ice to relieve swelling, is that consistent with a traumatic injury?

A It is.

Q Doctor, I'd like to show -- and I have shown you video of this event?

A Yes, I've seen the video.

Q I'd like to show it to you with the Court's permission.

MR. BRODY: Your Honor, may we approach?

THE COURT: Yes, you may.

(Whereupon, a bench conference is held off the record.)

MR. SUBIN: Judge, with your permission, may I just show it once, then slow it down so the jury may see it.

THE COURT: Yes, you may, and your objection is noted, counsel for defendant.

MR. BRODY: Thank you, your Honor.

(Whereupon, video is shown in front of the jury.)

Q Doctor, I want to slow it down for a second here for the purpose of my next question.

MR. BRODY: Judge, I'm going to ask there be no leading during this line of questioning.

MR. SUBIN: Excuse me.

MR. BRODY: I would request there be no leading

during this line of question.

THE COURT: Counsel, remember, you are on direct.

Q I'm going to direct your attention for right now, her right knee. I'm going to ask you, if you watch it slowly, what the significance is?

A Okay. May I answer?

Q Yes, please.

A So, as you can see the left knee is hyperflexing all the weight is going on the right knee, and now you are getting a rotational force on the knee, although the picture doesn't show it because that's what's happening because her right leg is hyperextended and her knee is hyperflexed.

Q Let me go one more frame. Okay, now, do you see where her head -- can you describe where her head is turned?

A And her head is twisted. It is turned in an unnatural direction.

Q So, now, can you show us this model, and what happens to the knee when it gets twisted?

A So, once again the left knee is hyperflexed. I feel her pain already from this position. All the pressure that goes on the right knee, the right knee is hyperextended. This is a very unnatural position. A lot of weight goes on this structure, on this right knee.

Q And what happens now inside the knee?

A Well, you are going to get a tear of the medial

meniscus and the lateral meniscus.

Q And when the top -- what's the top one called here Doctor, this bone?

A This is the femur.

Q When it twists, what happens to the --

A You tear the lateral meniscus and the medial meniscus. It is called a rotational injury.

Q Now, what's happening with her spine in this position, Doctor?

A Right shoulder is going up like this. The neck is turning towards the right arm like so. It is twisted fashion.

Q Okay. Now, we talked earlier about the longitudinal ligament in the spine. Does that come into play when someone has this type of position?

A It does.

Q Can you explain how?

A From the rotational forces of the spine.

Q Okay. And versus going forward and backwards versus rotation, what's the significance?

A You are going to get an injury to the posterior longitudinal ligament, and other structures and neck, which will be the muscles and the disks.

Q And what happened to her left hand as in this picture, Doctor?

A Left hand is touching the floor to try to prevent any

further injury.

Q If you go down hard enough to get swelling in the knee, what pressure -- where does the pressure go when the left hand hits the ground?

A The pressure goes to the left hand and the forces -- the forces back up to the shoulder and to the cervical spine.

Q Were you aware that when she went to Lenox Hill later this day, that she didn't make any right knee complaints. She made left knee complaints?

A Correct, that's the left knee touching the ground initially, but the rotational forces also affected the right knee. The right knee come into effect later on.

Q Is the -- is what you've seen on this video consistent with the injuries to Dayra's neck, left shoulder, right knee and low back?

A Yes, sir, it is.

Q Is that an opinion with a reasonable degree of medical certainty?

A It is.

THE COURT: Counselors, please approach me.

(Whereupon, a bench conference is held off the record.)

Q So, I want to just now go back, Doctor, this was three months before the video we just saw, and the baseline I want you

to assume was normal.

A Okay.

Q I want you to assume that the video is a fair depiction of what happened to Dayra on March 20th of 2017. I want you to assume --

A You mean June of 2017.

Q June, thank you.

And I want you to assume that she was crying in pain according to the accident. I want you to assume that when she went to no Northwell Hospital, that her back and neck and knee were ten out of ten pain. I want you to assume that Dr. Wanda referred her to Rapid Focus Rehab, and she had the physical findings you've gone with, and she presented with signs and symptoms consistent with an acute lumbar and cervical herniated disk. I want you to assume that she went, on March 30th, '18, to an orthopedist who diagnosed her with a traumatic right knee meniscal tear and cervical herniation. I want you to assume that in July of '18, Dr. McCulloch diagnosed her with a left shoulder injury separate and distinct from the cervical injury. I want you to assume that at NYU it was indicated that she was status post traumatic injury to the neck. I want you to assume that in the operative report of the neck that the patient presented with cervical disk herniation after traumatic injury to the cervical spine.

Doctor, do you have an opinion with a reasonable degree

of medical certainty whether or not the herniated disks in Ms. Gonzalez were caused by the traumatic event of June 20th of 2017?

A The answer is yes for a variety of good reasons.

Q Can you tell us what the reasons were.

A Yes, we saw the initial note of March of 2017 from the primary care physicians. She had no neck pain. She had no back pain. Physical examination for the range of motion of the neck was normal. There was no numbness. There was no tingling. Everything was normal both for the neck and the lower back, and there was no muscular skeletal complaints. That is a very good guide to go by. No complaints. And then when she went to the emergency room, she had some complaints, but the full symptomology did not take place until several weeks and months after this traumatic event.

Q And I would ask you the same question with regard to an opinion with a reasonable degree of medical certainty whether or not the traumatic injury to her right knee was caused by the events of June 20th of 2017 within a reasonable degree of medical certainty?

A The answer is yes for the same reasons given earlier.

Q And I would ask you, with regard to her low back condition and the radiculopathy in her low back, do you have an opinion with a reasonable degree of medical certainty --

MR. BRODY: Objection.

THE COURT: Overruled.

Q Whether that condition was caused by the traumatic event that we saw on the video of June 20th of 2017?

A The answer is yes for the same reasons given earlier.

Q And, finally, for the left shoulder do you have an opinion with a reasonable degree of medical certainty whether or not the injuries from the left shoulder were caused by the traumatic event of June 20th of 2017?

MR. BRODY: Objection.

THE COURT: Overruled.

A The answer is yes for the same reasons given earlier.

Q Can I ask you to take the stand again, Doctor.

A Sit down? I am standing.

Q Yes, Doctor.

Now, Doctor, up until other than the -- when did you first start seeing Dayra?

A November 11, 2024.

Q And, Dr. Guy, do you know how she got to you?

A Yes, referred by your office.

Q And has my office referred other patients to you?

A Yes, sir, you have.

Q Have you testified for my office and for me in the past?

A Yes, sir, I have.

Q And with regard to that, has that happened recently?

A About 6 to 8 weeks ago if my memory serves me.

Q And do you end up, based on the type of doctor that you -- treatment that you give, do you end coming to court with some regularity?

A Yes, when you treat injuries and when there is accidents, treating physicians, experts has to come to court to give their explanations of the injuries.

Q So far, other than the one MRI you prescribed, of all the records we've gone through today, were those records before you got involved here?

A Were those records?

Q Before you became -- got involved?

A Correct.

Q And you got involved at the end of November of last year?

A Yes.

Q And the fact that I or my office referred Dayra to you, did that impact your treatment of her in any way, shape or form?

A No, sir. I'm not adding any new injuries. All the injuries that she's had are being confirmed by me and then some, and I've been treating here.

Q And let's talk about when she got to you, what was her condition the first time that she got to you?

A She told me that her neck pain radiates down both her upper extremities with numbness and tingling. She has lower

back pain which radiates to the right buttock area. She still has right knee pain. She still has left shoulder pain.

Q Okay. And, did you undertake, first of all, some way to try and diagnose her? What did you do with regard to her diagnosis?

A I sent her for new MRIs. New EMGs.

Q And the MRIs are in evidence, what were the findings of the MRIs, Doctor?

A Let me just refresh my memory. C3-C4 disk protrusion. And C4 to C7 anterior cervical discectomy with fusion.

Q Okay. How about with regard to the right knee?

A Medial and lateral meniscus status post right arthroscopic surgery with medial and lateral menisectomy and synovectomy.

Q And what's the condition now on the inside of her knee?

A She's missing part of the medial meniscus. She's missing part of the lateral meniscus. She has mild tracking. She has crepitation. She still has pain with intermittent swelling.

Q Crepitation, what is that?

A It is a grinding sensation when you flex and extend the knee. It comes from signs of traumatic arthritis.

Q Now, why would Dayra have a sign of traumatic arthritis?

A Because, as I explained earlier, when you have damage

to the medial lateral meniscus, you are no longer lubricating any joint properly. So, it begins to wear out a lot faster than normal.

Q And arthritis -- withdrawn.

Are you familiar with the term progressive?

A Yes.

Q Tell us what progressive means?

A Progressive means it slowly and normally gets worse over time.

Q Is arthritis progressive?

A We have many different types of arthritis. We have the normal, natural aging arthritis called osteoarthritis. We have Rheumatoid Arthritis which affects the fingers, causes different malformation of the fingers, affects the heart and the lungs. We have psoriatic arthritis, and we have traumatic arthritis, which is what she's getting.

Q What is the significance to Dayra that she has post traumatic arthritis in her right knee?

A This condition is permanent and progressive and she still has pain and dysfunction as a result of it. She'll have some good days and a lot of bad days.

Q What's the end stage of post traumatic arthritis?

MR. BRODY: Objection.

THE COURT: What's your objection?

MR. BRODY: Disclosure.

THE COURT: Approach.

(Whereupon, a bench conference is held off the record.)

THE COURT: Objection is overruled. Continue.

Q Do you recall the question I just asked?

A I do.

Q I'll ask it again.

What's the consequence, what is the end stage of post traumatic arthritis?

A The joint will slowly and gradually weaken and be completely narrowed and eventually the only treatment that will work is a knee replacement.

Q Before, I just want to ask you something. Are you familiar with something called a life care plan?

A Yes.

Q First of all, what is that?

A A life care plan is a special report that's provided by a board certified physiatrist like myself or certified life care planner. A certified life care planner, they take a two-week course, they pass an exam, they are called a certified life care planner. They cannot give medical opinions. They cannot order diagnostic studies. They cannot do any medical treatments. They usually get their reports and opinions off another treating doctors. But, as a board certified physiatrist, I treat, I order diagnostic studies, I can do minor surgeries of the spine.

I'm familiar with all the medical guidelines and all the medical indications in the traumatic field as approved by the New York State education department, office of professional medical conduct. I'm required to know all of these guidelines.

A life care plan is a combination of all these medical guidelines for a patient who has sustained a certain type of disabling injury, whether it is a partial or total disability. In this case, it is a partial severe disability, and you have a projection of what type of future treatments the patient will need, and you are required to know what the fees are for those treatments. Most of it is what I do myself, and the rest I'm familiar by reviewing thousands of medical records, and seeing the medical bills affiliated with those treatments, and also by asking other colleagues that come to the New York State Pain Society. Over 300 doctors come every year, and I usually ask them what they are charging in the area. It is usually about the same that I have opined for this patient.

MR. SUBIN: Judge, what time we are going to?

THE COURT: We are going to break right now.

MR. SUBIN: That's what I thought.

THE COURT: We are going to break for lunch. I'm going to ask everybody be back by 2:00. You have not heard all of the evidence. Please don't formulate any opinions, do not discuss this case with anyone, and do not do any type of research regarding any of the testimony you heard.

If you see any of the parties, the attorneys or the Court, and you are not acknowledged, please do not be offended. It is solely done to make sure you render an impartial decision. Have a nice lunch.

COURT OFFICER: Jury exiting.

THE COURT: All right. Doctor, you are still under oath. I remind you you are not to discuss this testimony with anyone.

THE WITNESS: Yes, your Honor.

THE COURT: Have a good lunch.

MR. BRODY: Judge, while we are still on the record, I think we should -- the display that counsel has used today with his highlights on it, it is printable, he's got a slide show of some type. I'd like it marked and I'd like a copy of it.

THE COURT: Fair enough.

MR. SUBIN: Sure, I'll print it for you.

THE COURT: Counsel, unfortunately I can't do that now because they have to go to lunch.

MR. BRODY: Can I get it right when we come back.

THE COURT: Yes.

MR. BRODY: And, Judge, can I take Exhibit 14 to lunch. Any objection. Denied. Okay.

THE COURT: How long are you going to need to go through those records?

MR. BRODY: I only need ten minutes.

THE COURT: So, Officer, did the jurors already leave.

COURT OFFICER: Yes.

MR. BRODY: Well, Judge, if they are not coming back --

THE COURT: 2:00, I was going to --

MR. BRODY: 2:15. No problem, Judge.

(Whereupon, there is a luncheon recess taken.)

(Whereupon, Senior Reporter Nunez was relieved by Senior Reporter Jimenez-De Armas.)

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated.

Counsel, you may continue with your direct examination.

MR. SUBIN: Good afternoon, Dr. Guy.

THE WITNESS: Good afternoon, sir.

CONTINUED DIRECT EXAMINATION

BY MR. SUBIN:

Q. You mentioned that you sent Dayra for some MRI of the body parts we have been talking about, why did you do that?

A. Because she had ongoing, persistent radicular neck pain, and ongoing persistent radicular back pain. On physical examination there was on lot of deficits in the range of motion in the cervical spine, lumbar spine, positive neurological deficits, I needed to know what was the current condition.

Q. And I think we looked earlier at the MRI of the lower back, I'm not positive that you told us what the findings were --

MR. SUBIN: Withdrawn.

Q. What were the findings with regard to the lower back on the MRI?

A. Three disk herniations in the lower back, L3 L4, L4 L5, L5 S1, and bulges from L1, L2 and L3.

Q. What does that mean for Dayra's condition?

A. That explains why she still has ongoing radicular back pain, and still has deficits in the cervical and lumbar spine. Still has positive neurological deficits, and I did an EMG, I found at two levels lumbar radiculopathy, and at two levels cervical radiculopathy, which has change since the first three images.

Q. Okay, I want to circle back. You used the word deficits when you talk about her. Can you define that for us?

A. Abnormal findings on examination.

Q. Now, you mentioned an EMG, which we saw earlier. Was there a reason why you performed this test?

A. I wanted to see if there was additional nerve damage, or any new finding, so that I knew how to treat it appropriately.

Q. Can you describe how you performed that test on Dayra?

A. Yes. An EMG has three parts, the motor nerve conduction study, the sensory nerve conduction study, that checks the nerve in the periphery. If you're doing the neck and the arm, checks the nerves in the hands and the feet. In the radiculopathy, those two tests are almost always normal. It's the needle EMG that shows the abnormality. The way the needle portion is, you have a machine which has a scope, you have a power line, you have a sterile needle you insert the needle in various muscles in the arms, various muscles in the neck. From anatomy you know what muscle is supplied by which nerve root,

and you look for abnormal findings on your screen where you record it, and make your conclusion both for the neck and the lower back.

Q. And when you perform that testing, does that then create a chart or anything?

A. Yes, it creates a printout image of those studies.

Q. Did you bring those with you today?

A. I did.

Q. And are those records that you make in the ordinary course of your business?

A. Yes, sir.

Q. And is it part of your treatment plan to perform that test on behalf of Dayra?

A. Yes, sir.

Q. And do you maintain them in the ordinary course of your medical practice?

A. I do.

Q. And can you take those out for us, please?

A. Yes.

THE COURT: Is this included with an exhibit that's been admitted?

MR. SUBIN: No, your Honor.

THE COURT: Are you seeking to admit?

MR. SUBIN: Yes, your Honor.

THE COURT: Is it being admitted by stipulation?

MR. SUBIN: It's been exchanged, so I don't know.

MR. BRODY: This is EMG report of his EMG he performed, then I do have them.

THE COURT: Are you going to be objecting to that them being admitted into Evidence?

MR. BRODY: I'm not, your Honor.

THE COURT: Why don't we have them marked and admitted?

MR. SUBIN: Who marks them in your courtroom? I apologize.

COURT OFFICER: The court reporter.

(Whereupon, the above-mentioned document was marked as Plaintiff's Exhibit 15 in Evidence.)

COURT OFFICER: Plaintiff's 15 has been marked in Evidence and being shown to the witness.

MR. SUBIN: Your Honor, it's rather small. Can he come down and show what the finding on the EMG was?

THE COURT: Yes, he may.

Q. Doctor, could you possibly come down and show us what the findings were and what the significance is?

THE WITNESS: May I?

THE COURT: Yes.

A. So this page shows the motor and sensory conduction studies to the arms and legs. It's normal, as expected.

The next page shows the abnormalities in a graph form,

and the next page shows the actual placement of each of those nerve responses.

So, you go to the nerve responses. So the first placement is the left biceps. These reflections are all abnormal, they should not be going down. They should be going up and straight back down. When they go down it's post called positive shock waves, these are all abnormal. I'm going to show you what they look like.

Q. Doctor, what's the significance to Dayra's condition that she has these abnormal findings?

A. It confirms that the condition is ongoing, the condition is progressive, and it has not resolved, it's ongoing. As I said, these injuries are permanent and progressive, means as time goes on, they continue to worsen over time, and the EMG and the MRI confirm that.

So to give you a summary of it, what these tests show is that she has a left sided C5 C6 C7 cervical radiculopathy and bilateral L4 L5, L5 S1 radiculopathy.

If you remember in the beginning it was only on the right side, C5 C6, after the surgery it got partially better. Now it's on the left side at two levels, that's new and is ongoing. Initially there was only one radiculopathy at the L5 S1 now, we have at two levels, bilateral L4 L5, L5 S1. The L4 L5 is new and due to a disk herniation at that level.

So these studies confirm the condition is permanent and

progressive.

Q. What does that mean as far as her symptoms, what --

A. She still has persistent radicular neck pain and radicular back pain, and there is still significant range of motion deficits in the neck and back. She still has a sensory deficit in her left biceps and right dorsal foot.

Q. Now, the fact that these conditions have existed for seven and a half years for Dayra, what does that mean for her?

A. So in the medical field anything that has persisted more than two years is considered permanent. No cure, you can just treat it. Is there any cure for arthritis, no, just treatments. Same thing for this condition, there is only treatment, there is no cure.

Q. Okay, thanks.

A. Want me to sit down?

Q. Please.

Q. Going back to Exhibit 14. Pointing out the very first visit from Dr. Gowda on March 13th. It indicates that a thirty-eight-year old lady with anxiety disorder here for routine physical, occasionally has complaints of low backache for long time. Denies any trauma or weakness in the extremities.

Doctor, did that backache, in your opinion, have anything to do with the injuries in this case?

A. No, for a variety of good reasons.

Q. Please explain.

A. Number 1, that back pain is localized, it's not radiating down the legs. There is no numbness, there is no tingling, there is no muscle weakness, there is no sensory loss, no reflex abnormality. There are many conditions that cause back pain that has nothing to do with the back. For example, if you have irritable bowel syndrome, that causes back problems.

MR. BRODY: Objection, your Honor.

THE COURT: Overruled.

A. If you have a liver condition, that can cause back pain. If you have a problem with the gallbladder, that can cause back pain. If you had an abdominal aortic aneurysm dissection, or swelling of the major aorta, that can cause back pain. Not everything that has back pain is specific to the lower back.

Q. We saw that she had no neurologic findings. I want to go to the record of, same record, but a different date. 11/29/17, which is after she went to the physical therapist, she went back to doctor Gowda, this is 11/29/17, and the findings were the same, okay, in this. Down here at the bottom it indicates EMR PM software. Do you know what EMR PM software is?

A. Yes. EMR stands for electronic medical records. It prints forward the last one that you had exactly the same. So whatever you had from the last one, the next one would be essentially the same.

Q. So with regard to this November 29, 2017, the fact that it is identical to the September -- sorry, to the March of 2017, do you know why that would be?

MR. BRODY: Objection.

THE COURT: What's your objection?

MR. BRODY: How can he know if the doctor examined the person or not? He was not there. He's guessing and speculating why she made the same findings before and after the accident. There is no way he can know that.

THE COURT: I think that you're missing a question, Counsel.

MR. SUBIN: Okay.

Q. Do you have experience in reviewing EMR, reading EMR?

A. I do.

Q. Can you explain how those findings would be identical?

MR. BRODY: Objection.

THE COURT: What's your objection?

MR. BRODY: Judge, he's claiming that the reason their findings are the same is because the software repeated it over and over again. He doesn't know whether the doctor examined the knee, the exact same nature and finding, he has no way of knowing that.

THE COURT: There is a question if he reviewed the medical record.

MR. BRODY: That is the medical record. He's

just, it's the same finding, so it must be a replay.

THE COURT: You're going to have the opportunity to question him.

MR. BRODY: Okay. You cannot permit --

THE COURT: Your objection is noted.

MR. BRODY: Okay. It's made up.

MR. SUBIN: Can we get objections with no comments?

Q. Doctor, can you explain it for us from the EMR perspective?

A. Yes.

Q. Would you, please?

A. Electronic medical records, when you, first -- when you do the first report and then you want to see the patient again, you hit a button, the whole things comes up again, and it's your physical exam. Everything is the same, it gives you the same exact printout as the last one.

Q. With regard to -- by the way, if you weren't here today, where would you have been if you were not here testifying?

A. At my office, taking care of my patients.

Q. Are you being compensated for your time here?

A. Yes.

Q. How much?

A. $5,000 for half a day.

Q. You're here for a full day.

A. Five times two equals ten.

Q. And with regard to it -- I want you to assume that if the defendants hired an orthopedist named Dr. Torielly and he examined Dayra and he came up with a diagnosis of dissolved cervical strain. Do you agree with that diagnosis?

A. Absolutely not. That is not a proper diagnosis.

Q. Okay. And can you explain why?

A. Because the patient had a three level cervical fusion. The patient had repeat MRIs showed the new C3 C4 disk protrusion, and shows currently there is no prior right C5 C6 cervical radiculopathy, prior L5 S1 radiculopathy, that doctors did not mention, those are big diagnoses that have been left out. And the new MRI shows the new pathology, and cervical sprain/strain, everybody knows that gets resolved. That's not the case here, it has not resolved. It has gotten worse.

Same thing for the lumbar spine, and doctor also has the right knee contusion. There is a major difference with the right knee contusion. Contusion means a below, a torn meniscus, medial, lateral is much greater than a right knee contusion. So those are all improper diagnoses.

Q. Doctor, did you reach a diagnosis on the patient --

MR. SUBIN: Sorry, withdrawn.

Q. Have you performed any invasive procedures on Dayra?

A. Yes, I have done two cervical epidurals, one left

shoulder intraarticular injection, and one lumbar steroid injection at the caudal level.

Q. Can you explain what those are and why you did them?

A. Yes. I have with me the diagrams, and if I can stand and show my chart, I can explain it best.

MR. SUBIN: With your permission, Judge.

THE COURT: Yes.

A. So when we do an epidural steroid injection, we're giving cortisone directly inside the spine. When you give cortisone directly inside the spine, it works a lot more powerful than if you take it by mouth. For example, 1 milligram of morphine inside the spine equals 100 milligrams of morphine by mouth.

If you give a patient 100 milligrams of morphine by mouth, you kill them. One milligram to the spine doesn't cause any death, it causes tremendous relief of pain and inflammation. Same with steroids, when used for pain and inflammation. So the way it's done is, this is a diagram of the patient's spine, this is my needle.

Right here is my needle, and this is the contrast dye from the spine, here, here, here and here, and this is the patient. So when you give an epidural, this is the kind of needle that is used, okay. Put it in the cervical spine, I put it in the spine, I have an X-ray machine that confirms exactly where the needle is going, and then I have a loss of resistance

syringe. If I lose resistance means I'm in the right place. If I don't lose resistance, I'm not in the right place. And I give a little contrast. The contrast flows freely, as you saw in that diagram, that confirms proper location, and it's usually given at the C7 T1 level, because that's the safest place. If you go too high, you can hit the spinal cord and cause paralysis.

So, I have done about thirty-five thousand of these injections. Success rate is about eighty percent, and some people get relief for a few weeks, some people get relief for a few months, every case is different. So that was for the cervical spine, she had two epidurals for the cervical spine, with trigger point injections to her upper back and lower back.

Q. What's a trigger point?

A. An area of muscle fibrosis, muscle scarring caused by trauma. You get a microscopic bleed inside the muscle fibers from the trauma, and the muscle becomes all knotted up. When you touch the muscle it feels like a knot, a marble inside the muscle. You inject it, break it up so the surrounding muscle has proper irrigation and blood supply to the area.

Q. What does trigger pain mean for Dayra?

A. Causes pain and spasm.

Q. And for the lower back?

A. The lower back, an epidural injection is what ladies have when they get pregnant. There's a few places you can put

them in. When a woman gets epidural during pregnancy, it goes to the center of the spine, that's the most dangerous. You can have leakage of the spinal fluid and have pounding headaches for life, and the patient will curse you for life. That's why I don't go there.

You can go two fingers away from the spine, you go underneath the transverse process, which is right above the nerve root, that's safe. But there is a lot of nerves in the area. I go through the tailbone, called the caudal epidural, it's the safest and most effective, why? Because there is no structures that are dangerous to hit. You put your needle at the tip of caudal entry, the medication goes up the spine. It gets rid of the redness and inflammation to the nerve roots on both sides. With one stick, kill two birds with one stick. Get the nerve root irritation on both sides.

She had two cervical epidurals with trigger points, and one lumbar epidural injection. Left shoulder intraarticular injection, and trigger points to the lower and upper back.

Q. Why did you give her an injection to left shoulder?

A. Because she still had pain in the left shoulder. She had a left shoulder rotator cuff tear with inflammation around the structure of the shoulder.

Q. Did you do anything for her right knee?

A. I gave her injection of lidocaine and cortisone into the right knee.

Q. Why did you do that?

A. Because she still had pain in the right knee and inflammation. That's it.

Q. Doctor, as a result of your review of Dayra's records and your own treatment, and your review of the radiological films and your complete records, were you able to formulate a diagnosis within a reasonable degree of medical certainty what injuries Dayra sustained on June 20th of 2017?

A. Yes, I have twelve different diagnoses.

Q. And they were?

MR. BRODY: Just note a running objection for this line, so I don't have to keep interrupting.

THE COURT: Noted. Objection is overruled.

A. Diagnosis Number 1, C4 through C7 disk herniations with cervical radiculopathy. Status post C4 through C7 anterior cervical disk discectomy and effusion, with permanent scarring with plates and screws. Right knee tear of the medial meniscus, lateral meniscus with synovitis, status post right knee medial and lateral meniscectomy and synovectomy. Permanent scarring to the right knee. Bilateral L4 to S1 radiculopathy. Left C5 through C7 cervical radiculopathy. L3 through S1 disk herniations, that's three disk herniations. L1 through L3 disk bulges, that's two disc bulges; remember, bulges are partial tears, herniation is a complete tear. And left shoulder partial rotator cuff tear with tendonitis. And permanent scarring to

the right knee.

Q. Doctor, did you also reach, within a reasonable degree of medical certainty, a prognosis for what the likely future holds for Dayra's injuries?

A. I have.

Q. Can you share them?

A. Yes.

MR. BRODY: Objection.

THE COURT: Overruled.

A. Prognosis, meaning a look into the future from a medical perspective. She's left with a permanent severe partial disability. Means that she's not totally disabled, she's partially disabled. She can still work, but partially, not completely.

She will need in the future, following services for the rest of her life, because her condition is permanent and progressive, as has been shown to be still progressive.

She will need to have the following services based on optimal level of care, based on proper medical guidelines, and this is going forward, not based on what she's had before in the past.

MR. BRODY: Your Honor, my objection, which you ruled on already with regards to the life care plan, I just renewed it.

Q. Doctor, at my request did you prepare a life care plan

for Dayra?

A. Yes.

Q. And can you tell us what your findings were, please?

A. My findings are that patient was left with a permanent severe partial disability. She's going to need the following services for the rest of her life, based on proper medical indications, proper medical guidelines, and they are as follows: Would you like me to list one by one?

Q. Yes.

A. She needs to see a spinal surgeon at least three times per year, to monitor the spinal injuries, look for adjacent segmental pathology, which we found already. Make sure there is no hardware failure. Make sure the plates and screws don't come out of place, sometimes they do. You want to be able to catch it early and treat it early, that's three times per year, for each visits is $300.

The patient needs to see a physiatrist, like myself, at least eight to ten times per year to monitor the patients overall musculoskeletal injuries, assess the need for physical therapy, MRI, EMG, and coordinate care with other health care professionals and other physiatric treatments, each costs $200.

The patient needs periodic MRIs of the cervical spine, lumbar spine, left shoulder, every two years to check if the condition is worsening. If I had not done the MRI in 2024, I would not have seen the condition is worsening. This is why you

need to go, to catch it early, treat it early. Of course, each MRI is $1,500, three every two years.

She's going to need EMGs of the upper and lower extremities every one to two years, to check the extent of damage to the nerve roots, and the cost for each EMG is $2,500.

The patient is going to need at least one comprehensive physical therapy session, a medical necessity to diminish pain, spasm, improve range of motion, improve muscle power weakness, and to prevent worsening of this condition. So if the patient has any one of these deficits, physical therapy is an absolute indicator, and she has all of these deficits, and, of course, each visit is $200.

Q. When you said one physical therapy, with what frequency?

A. Once per week. And she's going to need medications for pain, spasm, and inflammation, both orally and topically and the cost is --

MR. BRODY: Objection here, your Honor. There is no specificity as to what medications she needs in the life care plan of any type. So to put a cost on medicine that's not identified is speculation.

THE COURT: Sustained.

Q. Doctor, what medicine does she need?

A. She should have Celebrex, 200 milligrams once or twice a day, each pill is about $2.50. She should have Lyrica,

200 milligrams once per day, that's about $3 each.

Topical compounds which consist of capsaicin, lidocaine, menthol and Gabapentin to break up pain, spasm and inflammation, which has the least amount of side effects, that's about $5,000 per year.

Q. Total, what would be the total for all the medications you're recommending?

A. I put down $3,000 to $5,000, a very conservative number.

Q. That's per what?

A. Per year. And she's going to need the following interventional pain management procedures for the next five years. She should have three cervical epidural injections per year. Three lumbar epidural injections per year. Three cervical facet medial branch block injections per year. The cost for each epidural is $2,000, and the outpatient surgical procedure for each epidural is $3,000. The cost for each cervical facet is $3,000, and outpatient cervical procedure is $3,000. She's going to need two cervical radiofrequency ablation procedures for the neck, each one is $5,000, and the outpatient surgical facility fee $4,000. Two for the neck, two for the lower back every six months, one for each side. And she's going to need eight to ten trigger point injections per year, this is $400 per set. And as her lower back continues to worsen, as it is, she will need --

MR. BRODY: Objection. He's not talking about if things happen in the the future, that's speculation.

Q. Based on the conditions that you've seen, do you have an opinion with a reasonable degree of medical certainty if she's going to need lumbar surgery?

A. She's a candidate for lumbar surgery as of right now.

MR. BRODY: Objection.

THE COURT: Overruled.

Q. What's the cost?

A. The cost for the surgery is as follows: For a two level decompression surgery, the surgeon fee alone is about $75,000 to $100,000. The surgical team to help the surgeon during surgery is $10,000. One to two day hospital stay to give the surgeon the plates, screws and artificial disks and all of these expenses is about $200,000. Anesthesia fee is about $4,000. Neural monitoring fee, to monitor the spine during surgery, make sure no nerve gets damaged is $3,000. And after the surgery the patient will need post-surgical bracing to stabilize the area for about a month or so, that would be $1,000. And once the surgical site is healed, patient will need physical therapy three times a week, four to six months.

And the left shoulder also needs arthroscopic surgery, and, of course, that would be about $35,000 including the surgery fee, surgical assistant fee, anesthesia fee, outpatient surgical facility fee, and all of these other expenses.

Afterwards the patient will need additional physical therapy three times a week, four to six months.

Q. Dr. Guy, going forward, in light of what we've seen in her medical records and radiological films and the findings, what can Dayra expect as far as her level of function to be going forward?

A. Unfortunately, as time goes on her level of function will slowly, gradually diminish.

Q. And since she's been in pain now for over eight years, can she expect any long-term periods where she won't be in pain in the future?

A. No. The exact opposite. Unfortunately, she'll be expected to have more periods of pain and dysfunction, because the condition is permanent and progressive.

Q. I have nothing further.

THE COURT: Before we begin cross-examination, do any of jurors need a break? No, all right.

MR. BRODY: Your Honor, I'll reserve my opportunity to review his records for a little bit until we do take a break.

THE COURT: Would you like a short break?

MR. BRODY: No. I'd rather start and take a break in a little while, when the jurors are ready for a break.

THE COURT: All right.

CROSS EXAMINATION

BY MR. BRODY:

Q. Doctor, before I begin my regular cross, I want to get some clarity on a couple of things you just said. Did you say you've given thirty-five thousand injections?

A. I have, that's right. Probably more.

Q. And are those the cervical-type injections or lumbar-type of injections that you have been referring to?

A. Yes.

Q. And you charge $2,000.00 a piece, correct?

A. If there is no way to pay for it -- that is my fee that's correct.

Q. Where do you do that?

A. I did it in the North Queens Surgery Center, and the Avicenna Surgery Center in the Bronx.

Q. You don't do those at Gramercy itself?

A. No. You need anesthesia, you need a fluoroscopic machine. I don't have those at Gramercy Park.

Q. Okay. So at $2,000, thirty-five thousand injections to date would be $70 million, right?

A. Sometimes you get paid, sometimes you don't get paid for the procedures I do. If I get paid for everything at that rate, yes, your math would be correct.

Q. So, let's see. $70 million just to do the injections?

A. Over thirty years.

Q. Except that you probably weren't doing the injections

with the frequency as you are now, right?

A. I started doing them about eighteen, nineteen years ago.

Q. Okay. So that's, worse case scenario, 70 million over nineteen years, and that's just to do the injections?

A. That's if I get paid. No physician gets paid for all of them.

Q. In fact, how much have you been paid so far for your injections that you did for Dayra?

MR. SUBIN: Objection. You ruled on this.

MR. BRODY: He opened the door.

THE COURT: No, he didn't. Objection is sustained.

Q. Okay. Have you been paid?

MR. SUBIN: Objection, Judge. We have had rulings on this stuff.

THE COURT: Sustained.

Q. Have we paid for any of the treatment of Dayra?

MR. SUBIN: Objection. Can you ask him to move on, please?

THE COURT: Counsel, please move on, you have my prior ruling.

MR. BRODY: Judge, may we approach?

MR. SUBIN: Judge, please --

THE COURT: No, you may not.

Q. Doctor, did you take a an oath this morning when you came in?

A. Yes.

Q. And was that an oath to tell the truth, the whole truth and nothing but the truth, so help you God?

A. That is correct.

Q. One of the things that would mean is you shouldn't tell half truths, correct?

A. That is correct.

Q. And one of the things that counsel did with you this morning is you went over your educational background, right?

A. Yes.

Q. And you blew through it pretty quickly, told us where you went to college and medical school?

A. Right.

A. Yes.

Q. You only mentioned one medical school, but you went to two medical schools, right?

A. That's correct. I said I graduated from the University of Nordestana, that's correct. Whether I went to two, three medical schools is irrelevant.

Q. I didn't ask you what's relevant, Doctor. I'm going to ask you very specific questions, I ask that you give me very specific answers. If you can't, just tell me you can't, okay?

A. Okay.

Q. So you thought it was important to tell the Ladies and Gentlemen of the jury where you graduated medical school, but you forgot to mention that while you went to Queens College, you never graduated did you? Yes or no?

MR. SUBIN: Objection.

THE COURT: What's your objection?

MR. SUBIN: It's the phrasing of the question. You want to ask him just that question, you didn't graduate, that's fine, but the whole sort of, colloquy that leads up to it is not appropriate.

THE COURT: Sustained.

Q. And we agree, Doctor, that you never graduated college?

A. That is correct. I finished --

Q. That's all I asked.

A. The answer is yes with an explanation.

Q. I don't need an explanation. And if I need one, I'll ask you for one.

THE COURT: Doctor, answer the question yes or no.

A. Yes, your Honor.

Q. Part of the reason that you didn't graduate college was because you failed biology and organizational chemistry, isn't that correct?

A. That was the not reason.

Q. Did you fail those classes?

A. I did.

Q. And Doctor, you said earlier that it was a prerequisite that you take multiple different specialties of residencies to become board certified in physical medicine and rehabilitation. But that's not true. You can take a single residency in physical medicine and rehabilitation, can you not?

A. No, sir. You are incorrect.

Q. So, if I submit evidence to this jury that you can, that evidence would be false?

MR. SUBIN: Objection. That's not a question.

THE COURT: Sustained.

Q. Doctor, I'm going to look at the video with you later. When did you actually see the video for the first time?

A. A couple of days ago.

Q. So when you actually wrote all of your reports, you didn't have the availability of that video with you, did you?

A. That is correct.

Q. And when you wrote your reports, did you have any understanding as to how this accident happened?

A. Just based on the patient's history.

Q. And is that the history that you noted in your chart?

A. That is correct.

Q. And, by the way, is it important for a doctor to take an accurate history?

A. It is.

Q. And it's important for the doctor to take an accurate

history about all of the patient's medical conditions, not just the specific one you're treating, correct?

A. To a certain degree, that is correct.

Q. Okay. And in taking that history, it's also important to put that history in your chart, so that as you treat the patient over a period of time, you know what their history and medical conditions are, correct?

A. That question cannot be answered with a yes or no. It can be answered with an explanation.

Q. Go ahead, Doctor, I will give you room to explain this one.

A. Not everything, that the patient's history is relevant. It's my history. My history I extract what I feel is relevant. Irritable bowel syndrome is not relevant. If the patient has GYN problems it is not relevant to my history. If the patient has other non-traumatic injuries is not relevant to their history. And the records I reviewed corroborate the patient's history, the physical exam findings, the operative reports, et cetera. When I saw the patient in 2024, I had the ability to review all the pertinent diagnoses, and I knew what was going on and the patient's history, and physical exam confirmed all the prior medical records.

I am not giving any, a new diagnoses, I'm confirming the prior diagnosis, plus the recent additional injuries are consequential problems.

Q. Have you explained it?

A. I have.

Q. Okay. And is there anything else you want to add to that explanation before I move forward?

A. No.

Q. Okay. How do you know whether the history the patient is giving you is relevant, unless you first get all of the history?

A. I got the other history from the other medical records.

Q. Where did you get the medical records from?

A. I got them from Mr. Subin's office.

Q. So Mr. Subin's firm hired you in this case, is that right?

A. Referred the patient to me. The word hired, I am not for hire. I'm a physician, I do what I'm requested to do.

Q. They asked you --

MR. BRODY: Withdrawn.

Q. Doctor, did you receive a subpoena from my office to produce records in this case?

A. I don't know, I don't answer subpoenas. My office manager handles subpoenas.

Q. How do you make sure that your office manager responds with what the things are that are being asked for?

A. I trust her, she has been with me over twenty-five years. I trust that she is a good worker and she

does what she's supposed to.

Q. So if you fail to produce records that were requested in the subpoena, it's your office manager's fault and not your fault, correct?

MR. SUBIN: Objection.

MR. BRODY: Judge, I'm going to -- your ruling, he didn't follow what the subpoena asked for. There is no protective order motion. I'm entitled to have all the records I asked for --

MR. SUBIN: You're not entitled to make speeches here either.

THE COURT: Counsel, approach. Actually let's go in the back.

Madame court reporter, let's go in the back.

(Whereupon, an on-the-record discussion was held in Judge's chambers among the Court and counsel.)

MR. SUBIN: May I stay here?

THE COURT: Counsel, I believe you wanted to place something on the record.

MR. BRODY: Your Honor, very simply put, Plaintiff's counsel was given extremely wide latitude and has been throughout this litigation, to present what your Honor feels is appropriate material and relevant evidence, what your Honor believes is expert opinion as opposed to speculation with regards to the handling of this case.

However, any time the defendant has attempted to attack the bias or non bias of this particular witness, both with objections, and now with my questioning of him, specifically with regards to a subpoena that plaintiff's counsel had that did not move for a protective order on, that the witness had that did not move for protective order on. But I asked a question about complying with it and already I'm being shut down.

I want the record to be clear, that if we're going to make a record that's completely open to plaintiff's claims, it is necessary that we create a record that is completely open to defendant's claim. And to do anything else is unduly prejudicial to the jury.

I have to ask the questions in order to make that record clear. And I understand -- I don't mean to argue with your Honor, but if your Honor overrules, I'm going to move on to the next question, but I need to ask the question because I need the record to be clear.

THE COURT: Let the record be clear, you only have been asking questions for about ten minutes, and you are already assuming that everything that they are going to object to is going to be overruled, and you already are assuming that the Court is not giving you a fair chance. That's what you're trying to say on the record.

MR. BRODY: Judge, I just presented --

THE COURT: I want to be clear, you have been at this for ten minutes.

MR. BRODY: No, your Honor, the problem is Judge, is that the appellate division have both now agreed, with the appellate division first department coming down the other day, that the identical life care plan in a similarly pursued, Ali Guy, personal injury claim, was speculative and mandated a new trial. So...

THE COURT: Do you have a decision from the Second Department?

MR. BRODY: Yes. We submitted a Second Department decision earlier on --

THE COURT: No, you didn't. You did not submit a Second Department case that says that this life care plan was purely speculative. You have the right to cross-examine this witness, and you can argue that it's speculative, and that is something for the jury to decide.

MR. BRODY: So, I asked him a question about his records and producing in response to subpoena and I'm being shut down. It's hard to make a record when I don't get to show things such as, how he got the records in the first place.

THE COURT: Counsel, it's not meant for you to be argumentative with the witness. It's, ask a question, get an answer. Ask a question, get an answer. But what you're

doing out there is you're -- is you're trying to argue with the witness, and that's not going to be permitted. It's not going to be permitted for you, as well as for Mr. Subin.

MR. BRODY: That's fine.

THE COURT: Do you wish to go back and continue questioning your witness?

MR. BRODY: I don't really have an option, Judge, I'm not withdrawing my cross-examination of the witness.

THE COURT: Nobody asked you to. I'll see you outside.

MR. BRODY: Thank you, your Honor.

(Whereupon, Senior Court Reporter Melissa Jimenez-De Armas was replaced by Senior Court Reporter Robin Nuñez.)

THE COURT: Let's continue.

Q The subpoena that your office received in connection with producing records in this case, requested any e-mail exchanges or correspondence?

MR. SUBIN: Objection.

THE COURT: Excuse me.

MR. SUBIN: He's trying to say something that's out of Court. That's not in evidence. And he's saying what --

MR. BRODY: No problem. I'll mark it. I'll withdraw the question, Judge. I'd like to have this document marked as an exhibit.

THE COURT: Please show a copy to --

MR. BRODY: I have a copy for counsel.

COURT OFFICER: Defendant's Exhibit B marked for identification and being shown to the witness.

MR. BRODY: And, Officer, can I have that envelope that you had handed me earlier with the responses.

Q Doctor, you've been handed a subpoena which was served by your office and I will represent to you that I'm holding the response to that subpoena in my hand with a copy of the subpoena right on the front which acknowledges that your office received it.

A Okay.

Q As part of that subpoena, you were asked to provide all

e-mail exchanges and correspondences between your office and Mr. Subin. Did your office do that?

A I have no idea. I'm not aware of any correspondence or exchanges other than telephone calls.

Q Okay. Well, was it in a telephone call that you received all of the records?

A No, all of the records are right here in front of me. Every medical record that I have in my possession is right here for you.

Q Let's try to be direct question, direct answer. Did you receive those medical records through a phone call?

THE COURT: Counsel, let's not do the commentary.

MR. BRODY: I understand, Judge.

Q Did you receive them through a phone call?

A Received medical records, I don't handle these things. My office manager handles these things.

Q Did they come from an e-mail?

A I don't know.

Q Do you know whether or not you were being asked to appear as an expert witness or to treat the patient?

A In the beginning all I know is I was requested to do a life care plan and the patient chose to continue treating with me.

Q The patient chose to treat with you or that the Subin firm asked her to treat with you?

A No, the patient chose to treat with me.

Q Did you know that her treating doctors were not going to come to court?

A How would I know that.

Q You've testified recently for the Subin firm in other cases in which Doctors Gerling and McCulloch were the treating doctors?

MR. SUBIN: Objection.

THE COURT: What is your objection?

MR. SUBIN: What happens in other cases and asking him to assume things from other cases is --

THE COURT: Sustained.

Q Specifically, if you testified in other Subin cases where Dr. McCulloch or Dr. Gerling did not appear.

THE COURT: Counsel, I remind you of my prior rulings, okay. What happens in other cases is not an issue. Ask him about this case.

MR. BRODY: Okay.

Q Dr. Guy, in this case you were asked to do a life care plan; is that correct?

A Yes, sir, that's correct.

Q Have you done other life care plans for the Subin law firm?

A I have.

Q How many times?

A I have no idea. That's not something I can count on.
Q Okay. How many times have you testified for the Subin firm?
A To the best of my recollection, about a dozen times. It could be slightly less, it could be slightly more. I'm not exactly sure.
Q On January 10th, did you testify for the Subin firm in Ali versus Luis Rangel-Delgado?
A Yes.
Q Did you do a life care plan in that case?
A I did.
Q Did you testify on May 7th, 2025 for the Subin firm in Mendez Meza versus Dutch Vortex LLC?
A I don't know. I may have.
Q Did you testify for the Subin firm on behalf of your patient Haggerty in the case of Haggerty versus Seid?
A What was the patient's full name.
Q Michael Haggerty?
A I'm not sure.
Q How many times a year do you testify for Seth Harris?
MR. SUBIN: Objection, Judge. What does that have to do with anything.
THE COURT: I'll allow it.
A I have no idea.
Q Have you testified for him twice this year already?

A It is possible, yes.

Q Doctor, you said earlier that you get a lot of referrals from doctors. Isn't it a fact that you get the majority of your referrals from lawyers?

A I get my referrals from a mix of people. I get referrals from lawyers, from doctors, from former patients. I get referrals from NYU. I get referrals from all walks of life.

Q And what percentage of them do you get from lawyers?

A I can't tell you exactly.

Q How many times have you been asked that question?

A Whether I was asked ten times or more, same answer. I don't know. I don't keep track of it.

Q It is asked every time you come to court?

A I don't know about every single time.

Q Doctor, isn't it customary in the medical field that if you assume the care and treatment of a patient, that you contact their prior doctors to get their records?

A I have the records.

Q Is that what you believe, that you have their records?

A Well, I believe I have what I need to formulate my diagnosis and my treatment plan.

Q Okay. Doctor, I didn't ask you what you think you need. Isn't it custom and practice in the medical professional that when a patient goes to a new doctor, that that doctor gets their records from the previous doctors?

A Whatever is pertinent, yes.

Q Okay. And, for example, we know, and we are going to go over it in a few minutes, that the patient treated with Dr. Gouda; correct?

A Yes.

Q You never contacted Dr. Gouda's office to get Dr. Gouda complete file, did you?

A I did not.

Q In fact, if you look at your chart, you only have five pages of Dr. Gouda's records in that entire chart. If you want to challenge me please take a look.

A I'm not going to challenge you.

Q This, Doctor, it Dr. Gouda's chart, does it look like five pages?

A No.

Q How do you know if what is in here is pertinent to your care and treatment of Ms. Gonzalez if you didn't bother to get the rest of the chart?

A I have what I need, and Dr. Gouda was not a major treating physician for these traumatic injuries.

Q You decide what you need so that you can testify in this courtroom; correct?

A No, that's not how it works.

MR. SUBIN: Objection.

THE COURT: What's your objection, counsel?

MR. SUBIN: It is argumentative.

THE COURT: Sustained.

Q Okay. You can't possibly know, yes or no, can you possibly know if there is anything in here important to her care and treatment without looking at it, yes?

A No.

Q Doctor, do you know what part of Gouda's record that you actually have in your records?

A As you said, I have five pages out of the many pages.

Q And what do they say?

A Basically she had prior problems with low back, which we mentioned she had history of anxiety, which we mentioned. The physical examination for the neck and the back showed normal range of motion, normal muscle power, normal sensation, normal reflex etcetera.

Q Do you know whether or not Ms. Gonzalez considers Dr. Gouda to be a good doctor?

MR. SUBIN: Objection to that, Judge.

THE COURT: Sustained.

Q Do you know that Ms. Gonzalez continues to treat with Dr. Gouda today?

MR. SUBIN: Objection.

THE COURT: What is your objection?

MR. SUBIN: What is the relevance here to Ms. Gonzalez's injuries in this accident if she continues

to treat with an internal medicine doctor.

MR. BRODY: Her primary care doctor who is supposed to be --

THE COURT: She's -- he's not treating her for these injuries.

MR. BRODY: How do we know that?

THE COURT: Objection is sustained.

Q Doctor, is it your belief that a person who has a primary care doctor who sustains an injury doesn't discuss their injuries with that primary care doctor?

MR. SUBIN: Objection.

THE COURT: Sustained.

Q Didn't you say, Doctor, that her conditions, her injuries to her knee, her lower back, her neck, and her shoulder would take time to develop?

A Yes.

Q And aren't you claiming that Dr. Gouda referred Ms. Gonzalez for physical therapy related to the injuries she sustained to her back.

A She did. In patient, whatever.

Q And isn't it a fact, although it is not in your chart, that three days before or five days before this physical therapy visit, Dayra Gonzalez, on September 13th, of 2017, was in Dr. Gouda's office?

A Let's assume what you say is correct, so what.

Q Would it strike you odd that she didn't mention having an accident?

A I have no way of answering your question. I have no idea. That's not a question for me.

Q How would Dr. Gouda refer a person for a backache related to an accident that she didn't know the plaintiff had?

MR. SUBIN: Judge, objection to that question.

MR. BRODY: The record is in evidence, Judge.

MR. SUBIN: The record is in evidence, but the question is still not proper.

THE COURT: What's your basis for saying that?

MR. SUBIN: He's asking this witness to go get into the mind of somebody else. It is totally improper.

THE COURT: Sustained.

Q Did you review the record of Dr. Gouda from September 13th of 2018?

A I don't know if I have that record in front of me, maybe I did. I'm not sure. There is a lot of records in front of me.

Q You want to take a look?

A If you have it handy it might speed things up.

Q Here, let's do something different. Can we go to your highlighted outline which we have marked, your Honor, as Defendant's A. Let's start there.

MR. BRODY: Since we are not going to use the

screen, your Honor, since counsel has to take notes, may I walk in front of the jury so I can have my copy?

THE COURT: Okay.

Q Doctor, if you need to see anything, I'll walk up and hand you a copy too.

Let's start with, we went through the highlighted parts of these records, remember we are going to tell the whole truth, Doctor --

THE COURT: Counsel.

MR. BRODY: I apologize.

Q March 13, 2017, not highlighted, correct, where it says occasionally she complains of low back pain for long time, denies any trauma or weakness; correct?

A Yes.

Q Doctor, you've testified many times that women, beginning at or about age 30, can begin to have degenerative changes in their lumbar and cervical spine.

A Yes, sir, I have. You've been doing your reading.

Q And it gets worse over time; correct?

A It can, yes.

Q And I believe you used the term it can be permanent and progressive?

A What part, permanent and progressive? Disk herniation, yes.

Q Degenerative back conditions can be progressive over

time; correct?

A Yes, it can be slowly. Very, very slowly.

Q How about cervical spine conditions?

A Same thing.

Q The next record that counsel showed was of the examination of March 13, 2017, and you said this was the baseline; correct?

A Yes.

Q Was there anywhere that you knew from the five pages that you had in your chart whether or not this was the first visit by Ms. Gonzalez to Dr. Gouda?

A No.

Q And as you sit here today, you don't know, do you?

A I do not.

Q So, you don't know if the findings in this baseline exam are actual findings or taken from another report, do you?

A The way you phrased the question, the answer is no.

Q Now, the next record that was shown was from Northwell Health; is that correct?

A That's correct.

Q And that's highlighted, and in the highlighted part, you read patient to ED, complaining of pain to lower back and neck and left knee after slip and fall on marble floor. Do you remember reading that part?

A I do.

Q And it says right below it, symptoms, bruising pain, stiffness, tenderness. You read that, right?

A Yes.

Q But you didn't read the findings part, no abrasion, no bleeding, no confusion, which I'm going to assume meant contusion but you can disagree with me. No deformity. You didn't read that part, did you?

A I wasn't asked to read that.

Q But those things are important to determine the level of injury somebody sustained, didn't they?

A Yes and no.

Q And it says in that record that they did an exam of her; correct?

A Yes.

Q And it says in that record, again, not highlighted so you didn't read it to the jury, spine appears normal, range of motion is not limited. No muscle or joint tenderness. That's pretty important, isn't it, Doctor?

A It is.

Q Okay. So, now, you want this jury to believe --

MR. SUBIN: Judge, objection again. It is not an appropriate way to start the question, any question.

THE COURT: Sustained.

Q Doctor, it is your contention to the jury that Ms. Gonzalez herniated three cervical disks in her neck in the

motion that was shown in that video, and she went to the emergency room and they examined her neck and found absolutely nothing wrong with it; is that correct?

A The way you phrased the question cannot be answered with a yes or no. Requires an explanation.

Q But we can agree that according to the hospital record, because you were not there, there were no findings on examination of her neck or lower back; correct?

A That's what it states on the records, that's correct.

Q And then let me ask you this, Doctor, did they do tests at the hospital such as a CT scan?

A I'm not sure if they did.

Q Well, didn't you, from the highlighted outline that you testified from, didn't you look at the CT scan and explain to the ladies and gentlemen that a CT scan is better for bone but not really good for muscles and tissues. If it was muscles and tissue, you would do an MRI?

A That's correct.

Q And you did that looking at the CT scan from Lenox Hill Hospital on the date of the accident?

A I wasn't sure sitting here now when that was done, but I did say that. That's correct.

Q And the CT scan from Lenox Hill Hospital -- withdrawn.

I want to go back to something you said earlier. I'm sorry, a little far afield, you talked about osteophytes. What

are osteophytes?

A Bony projections.

Q And you said that they develop over a long period of time, right?

A They do.

Q So, if somebody were to fall right now and go to the emergency room and have an x-ray or CT scan done, if it showed an osteophyte, it wouldn't be from the fall, right?

A That's correct.

Q It would be from something that happened to the disk at that level sometime in the past and the body's reaction to whatever happened is the development of osteophytes; correct?

A The way you phrased the question cannot be answered with a yes or no. It can be answered with an explanation.

Q Can you explain it in three sentences or less?

A Yes, I can.

Q Please.

A So, osteophytes, small tiny osteophytes are formed with part of the normal natural aging process, and they don't appear around a disk herniation unless there was problems with a disk herniation before. That's my three-sentence explanation.

Q Thank you.

Did the CT scan at Lennox Hill Hospital show osteophytes?

A I don't recall.

Q Did it happen to show osteophytes at the same level that years later the EMGs showed positive findings?

A I just said I don't recall what it showed.

Q Now, Doctor, you knew you were coming here today to testify?

A I'm sorry.

Q You knew you were coming here today to testify, right?

A Yes.

Q And did you spend sometime with Mr. Subin talking about your testimony?

A Yes.

Q Did you go over the outline with the nice highlights the yellow and the red before you came here?

A I did.

Q And you didn't mark any of those things on there, Mr. Subin did, right?

A That is correct.

Q Reading from Plaintiff's Exhibit 3 in evidence, amongst other things, there is minimum anterior osteophytic lipping at C5-C6. That is the same level, is it not, where the EMG later on showed some disturbance with regards to the cervical spine and injury to the nerves of Ms. Gonzalez, yes or no?

A Before I can answer your question, can I see that report?

Q You may.

COURT OFFICER: Plaintiff's Exhibit 3 in evidence is being shown to the witness.

A Okay. Now, what is your question?

Q Is the osteophytic lipping identified on that film the exact same day of Ms. Gonzalez's accident at the same level that the EMGs found nerve irritation?

A If I answer that question with a yes or no, I would mislead everybody in the jury box. It requires an explanation.

Q I don't want your explanation. Just tell me you can't answer yes or no and I'll move on.

A It cannot be answered with a yes or no. It is a very important question.

Q That's good. I'm sure Mr. Subin will be very happy to ask you on redirect.

MR. SUBIN: Objection to all of these comments.

THE COURT: Counsel, please stop with the comments.

Q If, in fact, Ms. Gonzalez had sustained the injuries that you claim in the accident on June 20, 2017, she would have been symptomatic by September 13, 2017; is that correct?

A Every case is different. Every patient is different. What she was symptomatic from the very first date, she went to the hospital, she had complained of neck pain, back pain, knee pain, and I believe shoulder pain as well.

MR. BRODY: Officer, can I have Exhibit 14 again,

please. Thank you.

Q Doctor, I want you to look at Exhibit 14, the visit to Dr. Gouda that next took place on September 13, 2017. Do you see any mention of cervical pain in that note?

A No.

Q Do you see any mention of knee pain in that note?

A No.

Q Do you see any mention of shoulder pain in that note?

A No.

Q Do you see a mention of back pain in that note?

A I do.

Q Can you read what it says about the back pain?

A Chronic lower abdominal pain and back pain for long time, under reason for appointment number two.

Q Doesn't say anything about fell and hurt her back, does it?

A No.

Q Doesn't say anything about fell and aggravated her back, does it?

A Does not.

Q Doesn't say anything about radiculopathy into any of the lower extremities, does it?

A It says not associated with numbness or weakness in the lower extremities.

Q Which actually means that three months after the

accident, now, she still has simply localized back pain and no evidence of herniation or nerve root irritation; is that correct?

A That's on this report, that's correct.

Q That is the report of her primary care doctor that she still sees; correct?

A I don't know if she still sees.

Q That's right. I apologize. In fact, let me ask you this, Doctor, do you know who she does still see?

A I believe just myself.

Q When you took your history of Ms. Gonzalez, did you find out that she had other falls?

A No.

Q Were you aware that she was hospitalized twice since 2002?

MR. SUBIN: Objection, can we approach on this one, Judge.

THE COURT: Yes.

(Whereupon, a bench conference is held off the record.)

Q Doctor, were you aware of those?

A No.

Q I believe you said earlier that a person who has these injuries predispose to further injury when they have an event such as a fall; is that correct?

A It can be, yes, sir.

Q You see no records to indicate that someone who is in Ms. Gonzalez's condition who fell sustained further injury as a result of this fall; correct?

A That's correct.

Q Also, one of the things that's not in your record is that she suffers from blood clots and may had have had a neurologic event, including a stroke?

MR. SUBIN: Judge, objection. We are not making any claims to that.

MR. BRODY: There is something very relevant about it. I just need to ask 2 or 3 questions.

THE COURT: Have the jury step out for a moment.

COURT OFFICER: Jury exiting.

(Whereupon, the jury exits the courtroom.)

MR. BRODY: I need the witness outside the room too, your Honor.

THE COURT: Dr. Guy, would you please go outside.

THE WITNESS: Yes, your Honor.

(Whereupon, the witness exits the courtroom.)

MR. BRODY: In connection with the blood clots and or stroke or both that she had, she was placed on blood thinners. According to Dr. McCulloch, he wouldn't do an epidural injection of any kind until he confirmed with a neurologist that she wasn't on any type of blood thinner.

THE COURT: I can't hear you.

MR. BRODY: According to Dr. McCulloch's records, he would not do any type of treatment until he confirmed she was no longer on the blood thinners for a period of time. I questioned Ms. Gonzalez and her answers were not quite accurate because when she first went to Dr. Guy, it was three days before she went to Dr. McCulloch. When she went to Dr. McCulloch, she was still on blood thinners. It is perfectly relevant to ask him about that history. Whether or not he knew she was on blood thinners of any kind, and what he did to confirm that she was off of them before epidural steroid injections, which his own consent form says he must know about and must be disclosed. I don't know why that wouldn't be relevant here, his care and treatment, and how thorough he was in treating this patient.

MR. SUBIN: It doesn't at all go to -- even if it was true, Judge, it doesn't go to her injuries, which is what we are here about. Dr. Guy is not on trial for medical malpractice. We are here to find out what was wrong with Ms. Gonzalez. If he gave her an epidural -- and, by the way, Dr. McCulloch wasn't doing an epidural. He was doing a PRP injection, which could be different. We just -- we are here to find out about Ms. Gonzalez's, whatever injuries she had, not about whether Dr. Guy

committed any things that are a mistake, and I think we are getting far afield from the relevance of anything.

MR. BRODY: I mean, goes right to the credibility of his thoroughness and what his care and treatment was. Whether he was motivated by money, by the case, by anything else. He has a duty to be thorough. Asking a doctor whether or not he took a proper history --

THE COURT: Counsel, I don't think it is relevant to his motivation that he did it for money, etcetera.

MR. BRODY: You are not letting me ask that.

THE COURT: You don't know what my ruling is going to be. I'm really getting annoyed about the fact that you already made a decision. You went in there and you stated that you already knew how I was going to rule.

MR. BRODY: You wouldn't let me ask if he billed, Judge.

THE COURT: Counsel, let's take a break.

(Whereupon, a short recess was taken.)

MR. BRODY: The Court ruled on an issue with regards of who paid plaintiff's medical bills, and it was said it was issue for collateral source and not to be raised here. In this particular situation I'm looking to ask the witness a series of questions with regards to the fact that he hasn't been paid in this case, that he's taking this case fully on a lien. The Court has instructed

me that is covered by her prior ruling, so I'm not going to ask those questions. I simply asked to make the record.

THE COURT: Okay. Your record is made.

MR. BRODY: Can I have the last question read back?

(Whereupon, a portion of the testimony was read back.)

MR. BRODY: I'll rephrase the question, your Honor.

COURT OFFICER: Jury entering.

THE COURT: Please be seated. Counsel, you may continue.

Q Doctor, when Ms. Gonzalez came to your office for the first time, did you have her fill out any types of forms whereas she related to you what her medical history was?

A Yes.

Q You have that in your record?

A I do.

Q Can you hand that to me, please.

A Sure.

Q Is this the only document that you had Ms. Gonzalez filled out when she came to your office?

A Yes.

Q What are the notes on the back.

A That's my chicken handwriting.

Q What are the items, Doctor, that's checked off -- let me ask you this, let me show it to you, maybe you'll understand it. Doctor, one of the items asked was she injured while she was working essentially. You see that?

A I'm sorry, what was the question?

Q One of the items asks if she was injured while she was working. Do you see that?

A I do.

Q And yes is circled and no is underlined. What is the actual answer to your understanding?

A I don't know. My understanding is this is not an on the job injury.

Q It is important for a doctor to know whether or not a person that they are treating was injured in a work-related accident, is it not?

MR. SUBIN: Judge, objection.

THE COURT: Sustained.

Q Is it important for you in taking care of a patient to know whether or not an injury was sustained while they were on the job?

MR. SUBIN: Objection.

THE COURT: Sustained.

Q Doctor, there are certain types of medications that a person should not be on when you go to give an caudal injection; is that correct?

A Oral injection?
Q Caudal.
A Caudal. Three days before the procedure it should be stopped. Just three days.
Q Did you ever learn, at any time, that Ms. Gonzalez was on blood thinners?
A Only through Dr. McCulloch's records.
Q And Dr. McCulloch's records was after your initial visit; correct?
A I believe it was before my initial visit and after my initial visit as well.
Q The report that you referred to earlier was three days after your first visit; is that correct?
A I don't remember the exact date, but if it is, so be it.
Q And, at that time, she was on blood thinners; correct?
A That's what the report insinuated. I don't know if that was true or not true.
Q And you didn't ask anybody again?
A I did not.
Q So, how did you know she wasn't on them when you gave the initial injection?
A I ask. The nurses ask. The anesthesiologist ask. A whole group of people ask.
Q Do they ask when you last took them?

A Generally speaking, they do.
Q But you don't know if they asked in this case, do you?
A If the patient was taking any medications that interfered with an epidural, they would have asked, they would have brought it to my attention, the procedure would have been canceled.
MR. BRODY: Can I get Exhibit 13. I think it should have been right on top. I think I just pulled. Never mind, officer.
Q Doctor, what is a neurologist?
A A neurologist is a doctor that specializes in the nervous system. Deals with neurologic conditions.
Q And you referenced earlier a record by a Dr. Teresella Gondolo. Dr. Gondolo is a neurologist; is that correct?
A That is correct, yes.
Q And she's a neurologist who continues to treat Ms. Gonzalez to date; correct?
A That, I don't know.
Q Shortly before Ms. Gonzalez -- withdrawn.
Do you know how Ms. Gonzalez got to Dr. Gondolo?
A I do not know.
Q Do you know how Ms. Gonzalez got to Dr. Gouda?
A I do not know.
Q Do you know how Ms. Gonzalez got to Dr. Gerling?
A I do not know.

Q You know how she got to Dr. McCulloch?
A I do not know.
Q Have you ever testified in a case where Dr. Gondolo was a treating doctor before?
MR. SUBIN: Judge, objection.
THE COURT: Sustained.
Q Do you know who Dr. Gondolo is?
A I do not.
Q Were you aware that Ms. Gonzalez treated with her neurologist on July 19th, 2018?
A I don't know about the exact date, not sure.
Q But that's shortly before the August 2018 visit with Dr. McCulloch that you read from earlier; correct?
A I don't know the exact dates. We are talking about eight years from the time of the accident to the present.
Q What is the significance of the following statement, neck stiffness is not present?
A Who was that from and what's the date?
Q July 19, 2018, by Ms. Gonzalez's neurologist, and I will say to you that all of these next questions come from the same chart?
A I cannot speak for another physician.
Q What does "neck stiffness is not present" mean?
A Everybody knows what stiffness is, and it is not present. What would you like me to say.

Q Exactly that, Doctor.
A Okay.
THE COURT: Counsel, we are not doing a colloquy. It is question, answer.
Q Doctor, what does it mean, "paracervical and sternocleidomastoid are not tender"?
A Sternocleidomastoid is the muscle that I'm pointing to in front of my neck. And what was the other portion of the question?
Q Paracervical?
A Para means along the side of the neck.
Q And not tender means by to touch and pushing, there is no pain or other symptoms elicited from the patient?
A That's what it means, yes, sir.
Q And forward, backward, and side to side movements of the neck are not reduced. What does that mean?
A It is normal.
Q Cervical occiput is not tender, what does that mean.
A Cervical occiput is the upper portion of the neck, right below the cranium. I'm pointing to it with my finger, this is what it is.
Q So, if it says palpation of the cervical occiput does not precipitate radiating pain, what does that mean?
A It is a very non-specific comment.
Q But it means that by pushing in that area it didn't

cause any pain to either extremity; correct?

A Agreed.

Q Foraminal compression test is negative, what does that mean?

A When you push on the head, and when you tilt the persons head to the left and to the right, if you point, if there is shooting pain down the arm it is positive. If it doesn't happen, it is negative.

Q So, somebody with acute symptoms of three herniated disks in the neck, you would expect a foraminal compression test to be positive, wouldn't you?

A Sometimes it is. Sometimes it is not.

Q What is Tinel's sign?

A Tinel's sign is for the wrist. For carpal tunnel. Unrelated to this accident.

Q Examination of the lower back does not reveal tenderness in the lumbosacral and sacroiliac region in between the posterior superior iliac spine, and sacral areas. What does that mean?

A There is no pain or any malfunction in that area based on that physical examination.

Q There is no tenderness in the upper margins of both iliac bones, what does that mean?

A The iliac bone is the iliac crest that goes across your hips.

Q Denies joint pain, swelling, muscle cramp, stiffness and arthritis. What does that mean?

A There is no pain in the joints, in the shoulders and knees. The hips, there is no cramping, and there is no other abnormal findings with the joints.

Q So, if you recall in your testimony with Mr. Subin earlier, you took the report of Dr. Gouda of March 13, 2017, which was negative, and said this is the baseline, and then after the accident we find symptoms. Isn't that what you did earlier on your direct?

A I did. That's correct.

Q So, now, here is a report of Ms. Gonzalez's neurologist, who she continues to treat with today, and on July 19th, 2018, she has a full and complete negative exam. Why is that not her baseline?

A Can I see that report?

MR. SUBIN: Can he see the whole record, please.

MR. BRODY: Absolutely.

COURT OFFICER: Plaintiff's 13 in evidence being shown to the witness.

A Okay. What is the question?

Q Essentially, Doctor, the question was why isn't that her baseline?

A I don't know.

Q And, Doctor, we can agree that that exam is over a year

after her accident; correct?

A Yes.

Q And, by then, if the symptoms were to manifest themselves they should manifest themselves to some degree and in some amount when performed in an examination by a neurologist that the patient continues to treat with; correct?

A The answer is a yes and no.

(Whereupon, Senior Reporter Nunez was relieved by Senior Reporter Jimenez-De Armas.)

CONTINUED CROSS EXAMINATION

BY MR. BRODY:

A. The answer's yes and no.

Q. Doctor, did you review Ms. Gonzalez's original deposition testimony?

A. No, I only review medical records, I don't review depositions.

Q. Did you review her trial testimony?

A. It's not medical records, I don't touch them.

Q. Okay. Were you aware that Ms. Gonzalez's deposition testimony indicates that it's her right knee that went down and touched the ground, not her left knee?

PLAINTIFF'S COUNSEL: Objection, the significance as to what she said in her deposition, one way or the other.

THE COURT: Repeat the question again, Counsel.

Q. Were you aware that at her deposition Ms. Gonzalez testified that it was her right knee that went down and hit the ground, not the left knee?

A. I just said I don't read any depositions. How would I know that?

Q. Were you aware that Ms. Gonzalez believed it was her right hand that went down and touched the ground?

A. I saw from the video that's not the case.

Q. Actually you saw the video and it was her left hand

that went down and touched the ground?

A. That's correct.

Q. It was her left knee --

A. That is correct.

Q. -- that hit the ground, correct?

A. That is correct.

Q. And she claimed that the knee she injured in this accident was the knee that hit the ground, were you aware of that?

A. I just told you I'm not aware of that.

Q. But she went to the hospital that afternoon and she was there, she got there a couple of hours after the accident and left six and a half hours after the accident?

A. That's about right.

Q. While at the hospital she complained about knee pain, right?

A. That's correct.

Q. And she complained about knee pain to her left knee right, not right knee?

A. That is correct.

Q. And they took an X-ray of her left knee as well, correct?

A. Correct.

Q. But they examined both of her knees, correct?

A. That's correct.

Q. And they found nothing wrong with either knee, isn't that correct?

A. That is correct.

Q. So your claim is she tore her right knee meniscus, didn't feel any pain from it, they examined her, didn't notice any pain from it. But a year later when she had knee pain it was caused in this accident, correct?

A. Not about a year later. There is other doctors' treating records that indicates there was a problem with the knee. There was a problem with the neck and the back as well.

Q. Okay, isn't the only reference to knee pain a note in the Focus Physical Therapy record that says she experienced low back pain radiating to the knee.

A. That is correct.

Q. Doesn't talk about any joint issues with the knee, doesn't say the knee is unstable, doesn't say any of the things you would expect with a meniscal tear?

A. That is correct.

Q. It's also true when she went to her primary care doctor she didn't make any mention of limping, any problem with her knee, she didn't mention any of those things, did she?

A. She did. She complained of poor balance, unsteady gait. She did.

Q. Isn't it a fact that she complained of poor balance and unsteady gait to her neurologist during the same period of time?

A. She did.

Q. Because she was being treated for headaches, dizziness and lightheadedness that had nothing to do with this accident?

A. That is correct.

Q. Doctor can we agree --

MR. BRODY: Withdrawn.

Q. Can we agree that an emergency room, and I think you showed it to the jury, that's just an early examination of something that happens, right?

A. That is correct.

Q. Would you not also agree with me the tests they gave, the CT scan and the X-rays, those are objective tests, you can't fake this, right?

A. That is correct.

Q. You said earlier that Ms. Gonzalez had some anxiety issues which caused you to feel more pain than somebody else subjectively, correct?

A. You have it right partially, but not completely.

Q. Okay, you explain again how anxiety affects the person's reactions to the pain they are experiencing?

A. So anxiety, if a patient has underlying anxiety and they have pain, their perception of pain is exponentially increased, and I'll show with my fingers. If the patient has this much pain and this much anxiety, their perception of pain would be this much. Just to give an example.

Q. And so for Ms. Gonzalez, who slipped and fell in the lobby of the building where she worked, for her to be upset about it immediately after the accident would not be surprising, given her history of anxiety and depression, correct?

A. Would not be.

Q. But at some point objective signs of her injuries have to show up, correct?

A. And they have.

Q. What did Ms. Gonzalez do in the six, seven and eight months between the time of this slip and the time she started treating with Dr. Gerling and McCulloch?

A. I don't know.

Q. Do you know if she was going to the beach?

A. Beach?

Q. Yeah.

A. How would I know? I don't know.

Q. Do you take a history from your patient and say, what was the immediate post-accident situation like?

A. No. I did not ask that question. I didn't feel it was important to the diagnosis and treatment that I was proposing for the patient.

Q. Let me ask you a quick hypothetical. Suppose, hypothetically, Ms. Gonzalez was a professional soccer player and three months after this accident that you saw in the video, she was injured playing soccer.

If you didn't ask her the questions, you would have no way of knowing whether or not there was a subsequent injury or accident in connection with the condition, would you?

PLAINTIFF'S COUNSEL: Objection.

THE COURT: What's your objection?

PLAINTIFF'S COUNSEL: The most extenuating question you can think of, Judge.

THE COURT: Sustained.

Q. Okay. If she was capable to go to the beach and carry beach bags and beach chairs, would that be relevant?

A. At what stage?

Q. Two months, three months, five months after the accident.

A. Going to the beach and putting sand on your legs is therapeutic. Walking on the beach slowly is therapeutic. Carrying things if they are not heavy is also not too relevant, they can do that as well. Walking on the beach and exercising is therapeutic.

Q. But it also would be impacted by three herniated disks in her cervical spine, if, in fact, she had pain from the accident of June 2017?

A. If she has pain, nothing to do with the beach.

Q. Would it inhibit your ability to do things?

A. Not the neck. The back would, the knee would.

Q. The ligaments and the muscles in the disks in the

cervical spine, they are designed to withstand minimal levels of stretching, trauma, other things, correct?

A. Minimal, yes.

Q. Okay. People who play tackle football, they don't all have herniated disks in their necks, right?

A. Some do, some don't.

Q. Are you a sports fan of any kind?

PLAINTIFF'S COUNSEL: Objection.

THE COURT: Sustained.

Q. When a basketball player tears his --

PLAINTIFF'S COUNSEL: Judge, objection.

THE COURT: Sustained.

Q. Isn't it a fact, Doctor, that people who sustains a traumatic meniscal tear generally feel signs and symptoms of it within the first four hours?

A. No, sir, that is not correct.

Q. Isn't it also true, Doctor, that when a person tears a meniscus, within the first four hours the body reacts to that tear and that body part will become tender?

A. Absolutely incorrect.

Q. So a person who tears a meniscus will go to a doctor and the doctor will examine them, they will have no tenderness, no swelling, and they will experience no pain?

A. Every case is different. No two cases are exactly the same.

MR. BRODY: Your Honor, at this time I'm going to ask the video be shown.

THE COURT: Sure.

(Playing video)

Q. I ask, Doctor, on this run of the video I ask that you pay attention to her neck.

You can stop.

Did you see the motion that her neck made in that video?

A. I did.

Q. Were you aware that Ms. Gonzalez testified that she injured her neck because she saw this desk and she pulled her neck back, so that her teeth didn't hit the desk?

A. You are asking me if I'm aware she said that? I'm not aware of any such statement.

Q. Can you agree with me, Doctor, in this video that mechanism of injury didn't happen?

A. No. She's too far away from the desk.

Q. And her head stayed down the whole time?

A. Her head twisted as she fell to the ground, hitting her left knee to the ground.

Q. We agree it's the left knee that struck the ground?

A. Undisputed.

Q. If any knee felt the water that was there, it would have been the left knee?

A. Yes.

Q. It would have been her left hand, not her right hand that touched the ground, right?

A. That's what I saw.

Q. Doctor, let me ask you this. Is it at least possible, with your knowledge as a physical medicine and rehabilitation licensed physician in the State of New York, that a person could slip exactly the way Ms. Gonzalez did, have a minor bump, a minor bruise and nothing else?

A. Is it possible? Absolutely. Anything is possible.

MR. BRODY: Can we play that video one more time, please?

(Playing video)

MR. BRODY: Stop.

Q. We can agree, Doctor, the knee she went to grab for to check was her left knee, correct?

A. That is correct.

Q. Doctor, you gave a life care plan earlier?

A. That is correct.

Q. Let's start with the fact that you actually don't know if somebody is going to treat, get he the treatment on a life care plan, do you?

A. No. I render what is medically indicated, based on medical guidelines and accepted standards of care and practice.

Q. So, your life care plan is a recommendation for what

Ms. Gonzalez should do, is that correct?

A. Yes, that is correct.

Q. Bear with me one second. Sorry your Honor.

THE COURT: Counsel, how much more time?

MR. BRODY: I probably have about forty-five more minutes. Do we want to approach now, your Honor?

THE COURT: Yeah.

(Whereupon, a sidebar discussion was held at the Bench, out of the hearing of the jury.)

THE COURT: All right. It's 4:25, we're going to break right now. I'm going to ask that everybody be here at 9:30. Please remember you have not heard all of the testimony, all of the evidence, so please do not formulate any opinions, do not do any research on any of the topics or any of the individuals in this case, and do not discuss the case with anyone. Have a good evening. See everybody tomorrow.

COURT OFFICER: Jury exiting.

(Whereupon, the jury left the courtroom.)

THE COURT: All right, so it just makes sense to adjourn because you have -- it makes sense to adjourn at this point because based on the time, counsel needs another forty-five minutes, and I believe you're going to need time for redirect, is that correct?

MR. SUBIN: Yes, now, I will. Dr. Guy, are you

available tomorrow morning?

THE WITNESS: Yes, sir.

MR. SUBIN: So what I can do, Judge is --

THE COURT: Do you want this on the record?

MR. BRODY: I don't think we need it on the record.

THE COURT: Okay, so we can be off the record.

oOo

THE COURT: All right, so our court officer just notified me that Juror Number 3 has advised him that she has a plane to catch Friday morning. So the last day she can be here is Thursday. I do not --

MR. SUBIN: We asked, Judge.

THE COURT: Our court officer can ask her when she's planning on coming back, and then you can make your decision as to what to do. Why don't we do that first.

MR. SUBIN: We said, you have to be here 9:30 to 5:00.

MR. BRODY: All the way through Monday.

THE COURT: Counsel, I am not disputing that, I'm sure you did it.

MR. BRODY: He did it, and he was good at it.

COURT OFFICER: Sunday night.

THE COURT: Our court officer has advised us she will be back Sunday night. The question is, do you want to

go through until Thursday and then, whatever doesn't finish resumes on Monday, to keep the juror, or do you want to replace the juror with Alternate Number 1.

MR. BRODY: I never like to replace a juror. Can you give me until tomorrow, I have an expert on schedule for Friday.

MR. SUBIN: I mean --

MR. BRODY: I'm okay with that too.

THE COURT: Look, if you feel that you want to make, if you want to have an informed decision by speaking to your expert, I'll let you decide tomorrow, or, you know whatever you want. I'm not --

MR. BRODY: If we're on the record, I didn't want to be in the position to say replace. If counsel is okay with replacing, I'd rather not try to move the witness. I will agree to stipulate to replace the juror, as so we don't have to deal with the issue.

THE COURT: As long as you both agree.

MR. BRODY: No problem.

THE COURT: Are you agreeing to replace her with Alternate 1, or do you want the names to be pulled out of the box?

MR. BRODY: Your Honor, I leave that to whatever.

THE COURT: Oh, no, this isn't...

MR. BRODY: We didn't pick specifically that way,

so I don't really care.

MR. SUBIN: I agree. 1, 2, 3 is the same thing.

MR. BRODY: So let's pull from a hat, whoever we get, we get.

THE COURT: Madame Clerk, pull the three names.

COURT CLERK: Taraja M. Brown.

THE COURT: So, for the record, Juror Number 3 is excused on consent of both attorneys, and is being replaced with Alternate Number 2, who is name that has been pulled out of the box. Everybody in agreement with that, Counsel?

MR. SUBIN: Yes.

MR. BRODY: That's what we agreed, no issues.

THE COURT: Have a good day.

MR. BRODY: Thank you, your Honor.

(At this time, court was recessed to June 25, 2025, at 9:30 a.m.)

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REPORTER'S CERTIFICATION

Certified to be a true and accurate transcript of the original stenographic notes.

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MELISSA JIMENEZ-DE ARMAS
Senior Court Reporter

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ROBIN NUÑEZ
Senior Court Reporter

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