

1 SUPREME COURT OF THE STATE OF NEW YORK  
2 COUNTY OF QUEENS: CIVIL DIVISION - PART 23  
3

4 DAYRA GONZALEZ,  
5

6 Plaintiffs,  
7

8 -versus-  
9

10 Index # 719084/2018  
11

12 995 FIFTH AVENUE OWNERS CORP., & 995 FIFTH AVENUE, LLC,  
13

14 Defendant(s)  
15

16 June 24, 2025  
17 2510 Court Square West  
18 Long Island City, New York 11101  
19

20 B E F O R E : Honorable KARINA ALOMAR,  
21 J U S T I C E  
22

23 APPEARANCES:

24 SUBIN ASSOCIATES, LLP  
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28 535 Eighth Avenue, 15th Floor  
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29 BY: SCOTT BRODY, ESQ.

30 Robin Nunez  
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32 Melissa Jimenez De-Armas  
33

34 Senior Court Reporters  
35

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

4 MR. SUBIN: Yes, your Honor.

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

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

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

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

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

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

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

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

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

13                  MR. BRODY: You have my exception.

14                  THE COURT: Your exception is noted.

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

20                  THE COURT: Fair enough.

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

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

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

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

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

22                   COURT OFFICER: All rise, jury entering.

23                   (Whereupon, the jury enters the courtroom.)

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

1 MR. SUBIN: Thank you. Good morning, everyone.

2 At this time the plaintiff will call Dr. Ali Guy, please.

7 THE WITNESS: I do.

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

12 COURT CLERK: Thank you. You may be seated.

13 THE WITNESS: Thank you.

14 MR. SUBIN: May I, Judge?

15 THE COURT: You may inquire, counsel.

16 MR. SUBIN: Thank you.

17 || DIRECT EXAMINATION

18 || BY MR. SUBIN:

19 Q Good morning, Dr. Guy.

20 A Good morning, sir.

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

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

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

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

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

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

8 A Sure.

9 Q What is a residency, first of all?

10 A It is a training program.

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

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

1           Q     What was the third you said?

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

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

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

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

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

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

17 A Yes, sir.

18 Q What's a chief resident?

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

24 Q Were you a chief resident?

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

1      Sinai for a period of six months.

2 Q Now, you mentioned something about private practice.

3 Can you tell us, first of all, how long have you been in private  
4 practice in physical medicine?

5 A Since approximately 1988, '89.

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

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

18 Q Any other hospitals you were involved in or --

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

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

9 Q Are you familiar with something called the Rusk  
10 Institute?

11 A Yes, sir.

12 Q What is that and what is your affiliation?

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

21 Q And, is that where you are a professor?

22 A Yes.

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

24 A Well, Rusk and NYU are synonymous.

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

1 field of medicine --

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

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

23 Q What are the requirements to be a mentor?

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

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

8 Q Were you involved with the National Guard?

9 A Yes.

10 Q Can you tell us?

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

18 Q Now, I want to go back to your private practice of  
19 medicine. Can you describe for us in some level of detail what  
20 it is that you've been doing with your career these last  
21 40 years?

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

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

8 Q Any other surgical centers that you are involved in?

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

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

17 A Yes, I've published approximately 35 articles.

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

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

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

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

14 A I am.

15 Q Can you explain how?

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

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

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

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

18       Q       Is Dayra Gonzalez your patient?

19       A       Yes.

20       Q       And have you treated her neck and lower back?

21       A       Yes, sir.

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

25       A       You said --

1 Q Have I shown you this model?

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

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

6 A Yes.

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

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

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

13 THE COURT: Yes, he may.

14 THE WITNESS: May I begin?

15 THE COURT: Yes, you may.

16 A So, in the human spine we have

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

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

10 Q Can you explain what that word *enervates* mean?

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

1 compression. Disk compression.

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

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

12 A You beat me to the punch.

13 Q I'm sorry.

14 A You should be patient.

15 Q I'm sorry.

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

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

1 approach.

2 THE COURT: Yes.

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

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

6 COURT OFFICER: All rise, jury exiting.

7 (Whereupon, the jury exits the courtroom.)

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

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

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

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

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

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

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

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

22 MR. SUBIN: If we have to, Judge.

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

25 MR. BRODY: Yes, your Honor.

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

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

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

17 MR. SUBIN: I have no objection to that.

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

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

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

2 COURT OFFICER: All rise, jury entering.

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

10 MR. SUBIN: May he continue, your Honor?

11 THE COURT: Yes, he may continue.

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

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

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

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

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

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

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

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

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

18 A Yes.

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

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

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

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

6           A     The posterior?

7           Q     Yeah.

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

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

12          A     Forward is flexion. Backward is extension.

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

15          A     Yes.

16          Q     Can you explain that?

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

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

22          A     Partially. They have different ligaments, interspinous  
23       ligaments.

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

1       A     Yes.

2       Q     Can you explain how.

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

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

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

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

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

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

1 the disk, their name based upon what?

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

6 Q And what are the vertebra made of?

7 A Vertebra is bone.

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

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1 DIRECT EXAMINATION

2 BY MR. SUBIN:

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

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

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

11 THE COURT: Yes, please.

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

15 A. Yes.

16 MR. SUBIN: Judge, may I?

17 THE COURT: Yes, you may.

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

20 THE COURT: Yes.

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

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

1 MR. BRODY: May we approach?

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

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

6 A. No.

7 Q. No?

8 A. May I step down?

9 THE COURT: Yes, you may.

10 THE WITNESS: Thank you.

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

15 A. Yes.

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

18 A. Yes. Three months before this incident.

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

20 A. Yes.

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

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

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

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

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

12               THE COURT: Counsel, please approach.

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

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

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

21               MR. SUBIN: Yes.

22               THE WITNESS: Continue?

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

24               THE COURT: Continue.

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

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

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

11 Q. Are you familiar with the term baseline?

12 A. Yes.

13 Q. What is baseline?

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

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

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

19 Q. Was not changed --

20 MR. SUBIN: Well, withdrawn.

21 Q. Moving to Plaintiff's 3 in Evidence, which is the  
22 emergency room records from Lennox Hill Hospital on June 20th of  
23 2017.

24 A. Right.

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

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

3           Q.    What does HPI stand for?

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

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

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

11          Q.    Going to another page from that record.

12          Musculoskeletal, when you see that in the hospital record, what  
13 does that mean?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 A. She was.

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

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

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

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

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

25 A. Urgent means it should be done right away.

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

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

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

7           A.    It can be done, yes.

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

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

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

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

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

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

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

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

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

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

12 A. Yes.

13 Q. What is the date of this exhibit?

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

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

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

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

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

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

1 explain what the significance of the observations here are?

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

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

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

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

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

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

3 THE COURT: So noted.

4 Q. Continue Doctor, please.

5 A. Decreased cervical lordosis.

6 Q. What's cervical lordosis?

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

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

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

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

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

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

4 Q. What is spasm an indication of, Doctor?

5 A. Spasm is indication of a recent trauma.

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

7 A. Causes pain and stiffness.

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

10 A. Touching.

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

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

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

25 There is also tenderness in the palpation of the

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

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

13 Q. What is that telling you?

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

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

18 A. Assessment means clinical diagnosis.

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

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

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

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

1       chronic.

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

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

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

15       A.     Yes.

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

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

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

22       Q.     Turning to Plaintiff's Exhibit 4 --

23                    MR. BRODY: Objection.

24                    THE COURT: What's the objection?

25                    MR. BRODY: Same thing, highlighted records.

4 MR. SUBIN: Okay.

5 Q. Doctor, what's an impression?

6 A. Impression is your initial working diagnosis.

7 Q. Okay. And did you review this record from January of  
8 '18?

9 A. I did.

10 Q. What was the impression?

#### A. Cervical spine versus cervical disk herniation.

12 Internal derangement of the left shoulder. Lumbar spine versus  
13 lumbar disk herniation. Thoracic somatic dysfunction, internal  
14 derangement of the right knee.

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

17 A. I have.

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

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

23 Q with regard to numbness and neck pain, with regard to

24

25 || MR. SUBIN: Withdrawn.

1 Q. I'm going to move forward to Plaintiff's Exhibit Number  
2 6, New York Sports and Joints, March of '18. Did you review  
3 this record, Doctor?

4                   A.       I did.

5 Q. Okay. What is an orthopedic evaluation?

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

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

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

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

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

22 MR. BRODY: Objection.

23 THE COURT: What's your objection?

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

1 half later.

2 THE COURT: From where?

3 MR. BRODY: Over a year later.

4 MR. SUBIN: It was a 2017 accident.

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

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

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

13 Q. What's an assessment and plan?

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

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

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

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

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

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

1 is that significant?

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

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

7 A. Yes.

8 THE WITNESS: May I, Judge?

9 THE COURT: You may.

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

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

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

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

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

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

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

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

1 result will determine how it should be treated.

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

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

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

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

23 A. Surgery, arthroscopic surgery,

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

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

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

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

18           Q. General anesthesia, tell us what that is.

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

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

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

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

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

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

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

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

5 A. Yes.

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

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

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

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

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

15 A. Yes.

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

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

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

21 A. No, sir. It is not possible.

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

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

5 THE COURT: Objection sustained.

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

7 A. January 28th, 2020.

8 Q. And what is the document?

9 A. EMG study performed by a neurologist.

10 Q. What were the findings on this EMG?

11 A. Evidence of a right C5 C6 radiculopathy.

12 Q. Was that the same findings?

### 13 A. Same findings.

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

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

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

1 what's happening here?

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

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

10                   MR. BRODY: Objection.

11                   Q. Based on your review of the records?

12                   MR. BRODY: Objection.

13                   THE COURT: Counsel sustained. Rephrase your  
14 question.

15                   MR. SUBIN: Sure.

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

18                   A. Yes.

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

22                   A. No.

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

1 MR. BRODY: Objection.

2 THE COURT: Rephrase it.

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

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

13 THE COURT: Counsel, rephrase the question.

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

16 A. No. There is a shoulder --

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

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

22 THE COURT: The objection is sustained.

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

25      A. Yes, there is.

1           Q.    Can you explain what it is?

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

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

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

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

19           Q.    What were the pertinent findings?

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

21           Q.    What does that mean?

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

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

1           A.    That the problem still persists and is ongoing.

2           Q.    Now, your record, Plaintiff's Exhibit 7 in Evidence.

3           November 2nd of '18. What was the history of present illness?

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

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

9           A.    Ten out of ten.

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

11           A.    Yes.

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

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

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

18           A.    Numbness and tingling of the hand?

19           Q.    Clumsiness?

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

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

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

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

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

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

10          A.    That is correct.

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

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

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

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

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

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

25                    MR. BRODY: Who is that?

1 MR. SUBIN: Judge, objection.

2 THE COURT: Step up, please.

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

5 Q. What's impingement, Doctor?

6       A.     Impingement is when the supraspinatus tendon gets  
7     caught.   The supraspinous tendon gets caught underneath the  
8     shoulder humeral head, in this space.   Once you pass  
9     150 degrees, a structure gets caught in this little hole.  
10    That's called impingement syndrome and the structure most  
11    commonly is the supraspinous tendon.   Part of the rotator cuff.

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

13 A. Yes, that would be painful.

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

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

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

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

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

1 another condition in the spine that --

2 MR. Withdrawn. What would cause this hyper  
3 reflex.

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

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

11 A. Yes, myelopathy.

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

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

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

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

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

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

2           MR. BRODY:  Objection.

3           THE COURT:  What's the objection?

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

6           THE COURT:  Overruled.

7           Q.    It says anterior --

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

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

11          A.    To remove the compression on the spinal cord.

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

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

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

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

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

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

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

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

7 A. Three discs.

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

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

17 Q. What are activities of daily living?

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

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

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

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

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

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

7       A.     Yes.

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

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

13      Q.     Are there any risks associated with this surgery?

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

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

21

22

23

24

25

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

3           A     Right.

4           Q     Can you explain what that means?

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

12          Q     Is that something that happens after surgery?

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

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

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

25          Q     Do you know why that is?

1       A    That is the patient's perception of pain.

2       Q    Doctor, what were we looking at here?

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

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

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

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

11      A    Three levels. Three.

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

14      A    The disks were removed and sent to pathology.

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

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

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

24      A    The reason why the procedure is being performed.

25      Q    And what was the indication?

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

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

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

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

17      A     Yes, I'm familiar with this.

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

20      A     Yes.

21                    MR. SUBIN: Okay. And I've shown it to counsel.

22                    Judge, I'd like to display it with the Court's permission.

23                    THE COURT: Any objection?

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

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

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

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

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

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

22 THE COURT: Any objection?

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

25 MR. SUBIN: Okay.

1           Q     Doctor, what are we looking at here?

2           A     So, these are the artificial disk in place.

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

5           A     This is the front.

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

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

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

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

20          Q     What are we looking at here?

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

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

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

6 A Of course. To get exposure.

7 Q Where would --

8 A In the front.

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

11 A She has a one and a half inch scar.

12 Q Is that something you can show us here?

13 A Yes.

14 MR. SUBIN: With the Court's permission.

15 A This is the scar. Can everybody see it?

16 Q Thank you, Doctor.

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

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

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

3           MR. BRODY: Objection.

4           THE COURT: What's your objection, counsel?

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

7           THE COURT: Sustained.

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

12           MR. BRODY: Objection, your Honor.

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

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

18           THE COURT: Overruled.

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

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

1           A     Yes, sir, it was.

2                   MR. BRODY: Note my objection, your Honor.

3                   THE COURT: Your exception is noted.

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

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

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

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

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

17          A     Yes, sir.

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

19          A     Cervical spine.

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

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

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

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

7                   THE COURT: These records are in evidence.

8                   MR. SUBIN: Yes, Judge.

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

13                   THE COURT: Overruled. Continued.

14           A     So, the dermatomes are the branches of the nerve roots  
15 as they come off the nerve roots in the neck, C4 is the deltoid,  
16 the C5-C6 is the biceps, C7, C8 are the structures in the  
17 forearm. C7-T1 are the structures in the finger. Here, the  
18 dorsal portion of the hand and the outer portion of the forearm.

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

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

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

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

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

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

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

1 significant relief.

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

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

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

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

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

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

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

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

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

6 Q What is a discectomy?

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

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

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

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

14 A Not yet.

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

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

18 Q What's the date here?

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

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

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

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

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

5 A C4, C5, C6, C7.

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

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

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

19 A I did.

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

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

24 A This is, again, an MRI of Dayra Gonzalez. November 21,  
25 2024. This is the brain. This is the spinal cord. These are

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

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

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

12 Q What does that mean for her symptoms?

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

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

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

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

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

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

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

6 MR. BRODY: Objection.

7 THE COURT: What's your objection.

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

10 THE COURT: On what basis?

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

13 THE COURT: Do you want to comment, counsel?

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

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

20 THE COURT: Overruled. Your exception is noted.

21 Q Doctor, if you can answer the question.

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

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

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

6 Q Okay.

7 THE COURT: Sustained.

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

12 MR. BRODY: Objection.

13 THE COURT: What's your objection?

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

16 THE COURT: Overruled.

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

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

1           A    Yes.

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

4           A    It is.

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

7           A    Yes, I've seen the video.

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

9                    MR. BRODY: Your Honor, may we approach?

10                  THE COURT: Yes, you may.

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

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

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

18                  MR. BRODY: Thank you, your Honor.

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

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

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

24                  MR. SUBIN: Excuse me.

25                  MR. BRODY: I would request there be no leading

1 during this line of question.

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

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

6 A Okay. May I answer?

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

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

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

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

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

24 Q And what happens now inside the knee?

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

1 meniscus and the lateral meniscus.

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

4 A This is the femur.

5 Q When it twists, what happens to the --

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

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

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

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

15 A It does.

16 Q Can you explain how?

17 A From the rotational forces of the spine.

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

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

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

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

1 further injury.

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

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

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

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

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

17 A Yes, sir, it is.

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

20 A It is.

21 THE COURT: Counselors, please approach me.

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

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

1 to assume was normal.

2 A Okay.

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

6 A You mean June of 2017.

7 Q June, thank you.

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

25 Doctor, do you have an opinion with a reasonable degree

1 of medical certainty whether or not the herniated disks in  
2 Ms. Gonzalez were caused by the traumatic event of June 20th of  
3 2017?

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

5 Q Can you tell us what the reasons were.

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

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

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

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

25 MR. BRODY: Objection.

1 THE COURT: Overruled.

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

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

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

9 MR. BRODY: Objection.

10 THE COURT: Overruled.

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

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

13 A Sit down? I am standing.

14 Q Yes, Doctor.

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

17 A November 11, 2024.

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

19 A Yes, referred by your office.

20 Q And has my office referred other patients to you?

21 A Yes, sir, you have.

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

24 A Yes, sir, I have.

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

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

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

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

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

11      A     Were those records?

12      Q     Before you became -- got involved?

13      A     Correct.

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

16      A     Yes.

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

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

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

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

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

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

6 A I sent her for new MRIs. New EMGs.

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

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

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

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

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

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

20 Q Crepitation, what is that?

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

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

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

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

4 Q And arthritis -- withdrawn.

5 A Are you familiar with the term progressive?

6 Q Yes.

7 Q Tell us what progressive means?

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

10 Q Is arthritis progressive?

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

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

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

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

23 A MR. BRODY: Objection.

24 A THE COURT: What's your objection?

25 A MR. BRODY: Disclosure.

1 THE COURT: Approach.

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

4 THE COURT: Objection is overruled. Continue.

5 Q Do you recall the question I just asked?

6 A I do.

7 Q I'll ask it again.

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

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

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

15 A Yes.

16 Q First of all, what is that?

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

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

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

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

19 THE COURT: We are going to break right now.

20 MR. SUBIN: That's what I thought.

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

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

5 COURT OFFICER: Jury exiting.

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

9 THE WITNESS: Yes, your Honor.

10 THE COURT: Have a good lunch.

16 THE COURT: Fair enough.

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

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

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

21 THE COURT: Yes.

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

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

1                   MR. BRODY: I only need ten minutes.

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

4                   COURT OFFICER: Yes.

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

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

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

9                   (Whereupon, there is a luncheon recess taken.)

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

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2 (Whereupon, the jury entered the courtroom.)

3 THE COURT: Please be seated.

4 Counsel, you may continue with your direct  
5 examination.

6 MR. SUBIN: Good afternoon, Dr. Guy.

7 THE WITNESS: Good afternoon, sir.

8 || CONTINUED DIRECT EXAMINATION

9 BY MR. SUBIN:

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

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

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

19 || =

20 MB SUBIN: Withdrawn

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

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

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

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

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

9           A.    Abnormal findings on examination.

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

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

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

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

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

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

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

7 Q. Did you bring those with you today?

8 A. I did.

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

11 A. Yes, sir.

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

14 A. Yes, sir.

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

17 A. I do.

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

19 A. Yes.

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

22 MR. SUBIN: No, your Honor.

23 THE COURT: Are you seeking to admit?

24 MR. SUBIN: Yes, your Honor.

25 THE COURT: Is it being admitted by stipulation?

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

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

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

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

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

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

11                  COURT OFFICER: The court reporter.

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

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

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

18                  THE COURT: Yes, he may.

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

21                  THE WITNESS: May I?

22                  THE COURT: Yes.

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

25                  The next page shows the abnormalities in a graph form,

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

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

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

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

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

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

25 So these studies confirm the condition is permanent and

1 progressive.

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

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

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

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

14 Q. Okay, thanks.

15 A. Want me to sit down?

16 Q. Please.

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

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

25 A. No, for a variety of good reasons.

1           Q. Please explain.

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

8           MR. BRODY: Objection, your Honor.

9           THE COURT: Overruled.

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

16          Q. We saw that she had no neurologic findings. I want to  
17 go to the record of, same record, but a different date.  
18 11/29/17, which is after she went to the physical therapist, she  
19 went back to doctor Gowda, this is 11/29/17, and the findings  
20 were the same, okay, in this. Down here at the bottom it  
21 indicates EMR PM software. Do you know what EMR PM software is?

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

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

4           MR. BRODY: Objection.

5           THE COURT: What's your objection?

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

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

12           MR. SUBIN: Okay.

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

14           A.    I do.

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

16           MR. BRODY: Objection.

17           THE COURT: What's your objection?

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

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

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

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

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

4 MR. BRODY: Okay. You cannot permit --

5 THE COURT: Your objection is noted.

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

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

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

11 A. Yes.

12 Q. Would you, please?

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

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

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

22 Q. Are you being compensated for your time here?

23 A. Yes.

24 Q. How much?

25 A. \$5,000 for half a day.

1           Q.    You're here for a full day.

2           A.    Five times two equals ten.

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

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

8           Q.    Okay. And can you explain why?

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

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

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

23                            MR. SUBIN: Sorry, withdrawn.

24           Q.    Have you performed any invasive procedures on Dayra?

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

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

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

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

6 MR. SUBIN: With your permission, Judge.

7 THE COURT: Yes.

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

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

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

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

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

14 Q. What's a trigger point?

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

21 Q. What does trigger pain mean for Dayra?

22 A. Causes pain and spasm.

23 Q. And for the lower back?

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

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

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

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

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

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

23 Q. Did you do anything for her right knee?

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

1 Q. Why did you do that?

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

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

9 A. Yes, I have twelve different diagnoses.

10 Q. And they were?

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

13 THE COURT: Noted. Objection is overruled.

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

1 the right knee.

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

5 A. I have.

6 Q. Can you share them?

7 A. Yes.

8 MR. BRODY: Objection.

9 THE COURT: Overruled.

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

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

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

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

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

1 for Dayra?

2 A. Yes.

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

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

9 Q. Yes.

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

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

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

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

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

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

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

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

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

22 THE COURT: Sustained.

23 Q. Doctor, what medicine does she need?

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

1 200 milligrams once per day, that's about \$3 each.

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

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

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

10 Q. That's per what?

11 A. Per year. And she's going to need the following  
12 interventional pain management procedures for the next  
13 five years. She should have three cervical epidural injections  
14 per year. Three lumbar epidural injections per year. Three  
15 cervical facet medial branch block injections per year. The  
16 cost for each epidural is \$2,000, and the outpatient surgical  
17 procedure for each epidural is \$3,000. The cost for each  
18 cervical facet is \$3,000, and outpatient cervical procedure is  
19 \$3,000. She's going to need two cervical radiofrequency  
20 ablation procedures for the neck, each one is \$5,000, and the  
21 outpatient surgical facility fee \$4,000. Two for the neck, two  
22 for the lower back every six months, one for each side. And  
23 she's going to need eight to ten trigger point injections per  
24 year, this is \$400 per set. And as her lower back continues to  
25 worsen, as it is, she will need --

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

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

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

7 MR. BRODY: Objection.

8 THE COURT: Overruled.

9 Q. What's the cost?

10       A. The cost for the surgery is as follows: For a two  
11       level decompression surgery, the surgeon fee alone is about  
12       \$75,000 to \$100,000. The surgical team to help the surgeon  
13       during surgery is \$10,000. One to two day hospital stay to give  
14       the surgeon the plates, screws and artificial disks and all of  
15       these expenses is about \$200,000. Anesthesia fee is about  
16       \$4,000. Neural monitoring fee, to monitor the spine during  
17       surgery, make sure no nerve gets damaged is \$3,000. And after  
18       the surgery the patient will need post-surgical bracing to  
19       stabilize the area for about a month or so, that would be  
20       \$1,000. And once the surgical site is healed, patient will need  
21       physical therapy three times a week, four to six months.

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

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

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

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

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

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

15 Q. I have nothing further.

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

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

21 THE COURT: Would you like a short break?

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

24 THE COURT: All right.

25 CROSS EXAMINATION

1 BY MR. BRODY:

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

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

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

8 A. Yes.

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

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

12 Q. Where do you do that?

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

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

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

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

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

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

24 A. Over thirty years.

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

1 with the frequency as you are now, right?

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

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

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

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

10 MR. SUBIN: Objection. You ruled on this.

11 MR. BRODY: He opened the door.

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

14 Q. Okay. Have you been paid?

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

17 THE COURT: Sustained.

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

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

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

23 MR. BRODY: Judge, may we approach?

24 MR. SUBIN: Judge, please --

25 THE COURT: No, you may not.

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

3           A. Yes.

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

6           A. That is correct.

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

9           A. That is correct.

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

12          A. Yes.

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

15          A. Right.

16          A. Yes.

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

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

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

25          A. Okay.

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

5           MR. SUBIN:  Objection.

6           THE COURT:  What's your objection?

7           MR. SUBIN:  It's the phrasing of the question.

8           You want to ask him just that question, you didn't  
9 graduate, that's fine, but the whole sort of, colloquy that  
10 leads up to it is not appropriate.

11           THE COURT:  Sustained.

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

13           A.    That is correct.  I finished --

14           Q.    That's all I asked.

15           A.    The answer is yes with an explanation.

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

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

19           A.    Yes, your Honor.

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

23           A.    That was the not reason.

24           Q.    Did you fail those classes?

25           A.    I did.

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

6 A. No, sir. You are incorrect.

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

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

10 THE COURT: Sustained.

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

13 A. A couple of days ago.

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

16 A. That is correct.

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

19 A. Just based on the patient's history.

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

21 A. That is correct.

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

24 A. It is.

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

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

3 A. To a certain degree, that is correct.

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

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

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

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

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

1 Q. Have you explained it?

2 A. I have.

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

5 A. No.

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

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

10 Q. Where did you get the medical records from?

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

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

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

16 Q. They asked you --

17 MR. BRODY: Withdrawn.

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

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

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

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

1 does what she's supposed to.

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

5 MR. SUBIN: Objection.

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

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

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

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

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

17 MR. SUBIN: May I stay here?

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

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

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

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

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

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

25                   MR. BRODY: Judge, I just presented --

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

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

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

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

5                   MR. BRODY: That's fine.

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

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

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

12                  MR. BRODY: Thank you, your Honor.

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

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1 THE COURT: Let's continue.

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

5 MR. SUBIN: Objection.

6 THE COURT: Excuse me.

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

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

13 THE COURT: Please show a copy to --

14 MR. BRODY: I have a copy for counsel.

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

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

24 A Okay.

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

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

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

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

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

10 Q Let's try to be direct question, direct answer. Did  
11 you receive those medical records through a phone call?

12 THE COURT: Counsel, let's not do the commentary.

13 MR. BRODY: I understand, Judge.

14 Q Did you receive them through a phone call?

15 A Received medical records, I don't handle these things.  
16 My office manager handles these things.

17 Q Did they come from an e-mail?

18 A I don't know.

19 Q Do you know whether or not you were being asked to  
20 appear as an expert witness or to treat the patient?

21 A In the beginning all I know is I was requested to do a  
22 life care plan and the patient chose to continue treating with  
23 me.

24 Q The patient chose to treat with you or that the Subin  
25 firm asked her to treat with you?

1           A     No, the patient chose to treat with me.

2           Q     Did you know that her treating doctors were not going  
3 to come to court?

4           A     How would I know that.

5           Q     You've testified recently for the Subin firm in other  
6 cases in which Doctors Gerling and McCulloch were the treating  
7 doctors?

8                            MR. SUBIN: Objection.

9                            THE COURT: What is your objection?

10                  MR. SUBIN: What happens in other cases and asking  
11 him to assume things from other cases is --

12                  THE COURT: Sustained.

13                  Q     Specifically, if you testified in other Subin cases  
14 where Dr. McCulloch or Dr. Gerling did not appear.

15                  THE COURT: Counsel, I remind you of my prior  
16 rulings, okay. What happens in other cases is not an  
17 issue. Ask him about this case.

18                            MR. BRODY: Okay.

19                  Q     Dr. Guy, in this case you were asked to do a life care  
20 plan; is that correct?

21                  A     Yes, sir, that's correct.

22                  Q     Have you done other life care plans for the Subin law  
23 firm?

24                  A     I have.

25                  Q     How many times?

1 A I have no idea. That's not something I can count on.

2 Q Okay. How many times have you testified for the Subin  
3 firm?

4 A To the best of my recollection, about a dozen times.

5 It could be slightly less, it could be slightly more. I'm not  
6 exactly sure.

7 Q On January 10th, did you testify for the Subin firm in  
8 Ali versus Luis Rangel-Delgado?

9 A Yes.

10 Q Did you do a life care plan in that case?

11 A I did.

12 Q Did you testify on May 7th, 2025 for the Subin firm in  
13 Mendez Meza versus Dutch Vortex LLC?

14 A I don't know. I may have.

15 Q Did you testify for the Subin firm on behalf of your  
16 patient Haggerty in the case of Haggerty versus Seid?

17 A What was the patient's full name.

18 Q Michael Haggerty?

19 A I'm not sure.

20 Q How many times a year do you testify for Seth Harris?

21 MR. SUBIN: Objection, Judge. What does that have  
22 to do with anything.

23 THE COURT: I'll allow it.

24 A I have no idea.

25 Q Have you testified for him twice this year already?

1           A    It is possible, yes.

2           Q    Doctor, you said earlier that you get a lot of  
3   referrals from doctors. Isn't it a fact that you get the  
4   majority of your referrals from lawyers?

5           A    I get my referrals from a mix of people. I get  
6   referrals from lawyers, from doctors, from former patients. I  
7   get referrals from NYU. I get referrals from all walks of life.

8           Q    And what percentage of them do you get from lawyers?

9           A    I can't tell you exactly.

10          Q    How many times have you been asked that question?

11          A    Whether I was asked ten times or more, same answer. I  
12   don't know. I don't keep track of it.

13          Q    It is asked every time you come to court?

14          A    I don't know about every single time.

15          Q    Doctor, isn't it customary in the medical field that if  
16   you assume the care and treatment of a patient, that you contact  
17   their prior doctors to get their records?

18          A    I have the records.

19          Q    Is that what you believe, that you have their records?

20          A    Well, I believe I have what I need to formulate my  
21   diagnosis and my treatment plan.

22          Q    Okay. Doctor, I didn't ask you what you think you  
23   need. Isn't it custom and practice in the medical professional  
24   that when a patient goes to a new doctor, that that doctor gets  
25   their records from the previous doctors?

1       A    Whatever is pertinent, yes.

2       Q    Okay. And, for example, we know, and we are going to  
3 go over it in a few minutes, that the patient treated with  
4 Dr. Gouda; correct?

5       A    Yes.

6       Q    You never contacted Dr. Gouda's office to get Dr. Gouda  
7 complete file, did you?

8       A    I did not.

9       Q    In fact, if you look at your chart, you only have five  
10 pages of Dr. Gouda's records in that entire chart. If you want  
11 to challenge me please take a look.

12      A    I'm not going to challenge you.

13      Q    This, Doctor, is Dr. Gouda's chart, does it look like  
14 five pages?

15      A    No.

16      Q    How do you know if what is in here is pertinent to your  
17 care and treatment of Ms. Gonzalez if you didn't bother to get  
18 the rest of the chart?

19      A    I have what I need, and Dr. Gouda was not a major  
20 treating physician for these traumatic injuries.

21      Q    You decide what you need so that you can testify in  
22 this courtroom; correct?

23      A    No, that's not how it works.

24                    MR. SUBIN: Objection.

25                    THE COURT: What's your objection, counsel?

1                   MR. SUBIN: It is argumentative.

2                   THE COURT: Sustained.

3           Q     Okay. You can't possibly know, yes or no, can you  
4 possibly know if there is anything in here important to her care  
5 and treatment without looking at it, yes?

6           A     No.

7           Q     Doctor, do you know what part of Gouda's record that  
8 you actually have in your records?

9           A     As you said, I have five pages out of the many pages.

10          Q     And what do they say?

11          A     Basically she had prior problems with low back, which  
12 we mentioned she had history of anxiety, which we mentioned.  
13 The physical examination for the neck and the back showed normal  
14 range of motion, normal muscle power, normal sensation, normal  
15 reflex etcetera.

16          Q     Do you know whether or not Ms. Gonzalez considers  
17 Dr. Gouda to be a good doctor?

18                   MR. SUBIN: Objection to that, Judge.

19                   THE COURT: Sustained.

20          Q     Do you know that Ms. Gonzalez continues to treat with  
21 Dr. Gouda today?

22                   MR. SUBIN: Objection.

23                   THE COURT: What is your objection?

24                   MR. SUBIN: What is the relevance here to  
25 Ms. Gonzalez's injuries in this accident if she continues

1 to treat with an internal medicine doctor.

2 MR. BRODY: Her primary care doctor who is  
3 supposed to be --

4 THE COURT: She's -- he's not treating her for  
5 these injuries.

6 MR. BRODY: How do we know that?

7 THE COURT: Objection is sustained.

8 Q Doctor, is it your belief that a person who has a  
9 primary care doctor who sustains an injury doesn't discuss their  
10 injuries with that primary care doctor?

11 MR. SUBIN: Objection.

12 THE COURT: Sustained.

13 Q Didn't you say, Doctor, that her conditions, her  
14 injuries to her knee, her lower back, her neck, and her shoulder  
15 would take time to develop?

16 A Yes.

17 Q And aren't you claiming that Dr. Gouda referred  
18 Ms. Gonzalez for physical therapy related to the injuries she  
19 sustained to her back.

20 A She did. In patient, whatever.

21 Q And isn't it a fact, although it is not in your chart,  
22 that three days before or five days before this physical therapy  
23 visit, Dayra Gonzalez, on September 13th, of 2017, was in  
24 Dr. Gouda's office?

25 A Let's assume what you say is correct, so what.

1           Q     Would it strike you odd that she didn't mention having  
2 an accident?

3           A     I have no way of answering your question. I have no  
4 idea. That's not a question for me.

5           Q     How would Dr. Gouda refer a person for a backache  
6 related to an accident that she didn't know the plaintiff had?

7                    MR. SUBIN: Judge, objection to that question.

8                    MR. BRODY: The record is in evidence, Judge.

9                    MR. SUBIN: The record is in evidence, but the  
10 question is still not proper.

11                  THE COURT: What's your basis for saying that?

12                  MR. SUBIN: He's asking this witness to go get  
13 into the mind of somebody else. It is totally improper.

14                  THE COURT: Sustained.

15           Q     Did you review the record of Dr. Gouda from  
16 September 13th of 2018?

17           A     I don't know if I have that record in front of me,  
18 maybe I did. I'm not sure. There is a lot of records in front  
19 of me.

20           Q     You want to take a look?

21           A     If you have it handy it might speed things up.

22           Q     Here, let's do something different. Can we go to your  
23 highlighted outline which we have marked, your Honor, as  
24 Defendant's A. Let's start there.

25                    MR. BRODY: Since we are not going to use the

1                   screen, your Honor, since counsel has to take notes, may I  
2                   walk in front of the jury so I can have my copy?

3                   THE COURT: Okay.

4                   Q     Doctor, if you need to see anything, I'll walk up and  
5                   hand you a copy too.

6                   Let's start with, we went through the highlighted parts  
7                   of these records, remember we are going to tell the whole truth,  
8                   Doctor --

9                   THE COURT: Counsel.

10                  MR. BRODY: I apologize.

11                  Q     March 13, 2017, not highlighted, correct, where it says  
12                  occasionally she complains of low back pain for long time,  
13                  denies any trauma or weakness; correct?

14                  A     Yes.

15                  Q     Doctor, you've testified many times that women,  
16                  beginning at or about age 30, can begin to have degenerative  
17                  changes in their lumbar and cervical spine.

18                  A     Yes, sir, I have. You've been doing your reading.

19                  Q     And it gets worse over time; correct?

20                  A     It can, yes.

21                  Q     And I believe you used the term it can be permanent and  
22                  progressive?

23                  A     What part, permanent and progressive? Disk herniation,  
24                  yes.

25                  Q     Degenerative back conditions can be progressive over

1 time; correct?

2 A Yes, it can be slowly. Very, very slowly.

3 Q How about cervical spine conditions?

4 A Same thing.

5 Q The next record that counsel showed was of the  
6 examination of March 13, 2017, and you said this was the  
7 baseline; correct?

8 A Yes.

9 Q Was there anywhere that you knew from the five pages  
10 that you had in your chart whether or not this was the first  
11 visit by Ms. Gonzalez to Dr. Gouda?

12 A No.

13 Q And as you sit here today, you don't know, do you?

14 A I do not.

15 Q So, you don't know if the findings in this baseline  
16 exam are actual findings or taken from another report, do you?

17 A The way you phrased the question, the answer is no.

18 Q Now, the next record that was shown was from Northwell  
19 Health; is that correct?

20 A That's correct.

21 Q And that's highlighted, and in the highlighted part,  
22 you read patient to ED, complaining of pain to lower back and  
23 neck and left knee after slip and fall on marble floor. Do you  
24 remember reading that part?

25 A I do.

1           Q     And it says right below it, symptoms, bruising pain,  
2 stiffness, tenderness. You read that, right?

3           A     Yes.

4           Q     But you didn't read the findings part, no abrasion, no  
5 bleeding, no confusion, which I'm going to assume meant  
6 contusion but you can disagree with me. No deformity. You  
7 didn't read that part, did you?

8           A     I wasn't asked to read that.

9           Q     But those things are important to determine the level  
10 of injury somebody sustained, didn't they?

11          A     Yes and no.

12          Q     And it says in that record that they did an exam of  
13 her; correct?

14          A     Yes.

15          Q     And it says in that record, again, not highlighted so  
16 you didn't read it to the jury, spine appears normal, range of  
17 motion is not limited. No muscle or joint tenderness. That's  
18 pretty important, isn't it, Doctor?

19          A     It is.

20          Q     Okay. So, now, you want this jury to believe --

21                    MR. SUBIN: Judge, objection again. It is not an  
22 appropriate way to start the question, any question.

23                    THE COURT: Sustained.

24          Q     Doctor, it is your contention to the jury that  
25 Ms. Gonzalez herniated three cervical disks in her neck in the

1 motion that was shown in that video, and she went to the  
2 emergency room and they examined her neck and found absolutely  
3 nothing wrong with it; is that correct?

4 A The way you phrased the question cannot be answered  
5 with a yes or no. Requires an explanation.

6 Q But we can agree that according to the hospital record,  
7 because you were not there, there were no findings on  
8 examination of her neck or lower back; correct?

9 A That's what it states on the records, that's correct.

10 Q And then let me ask you this, Doctor, did they do tests  
11 at the hospital such as a CT scan?

12 A I'm not sure if they did.

13 Q Well, didn't you, from the highlighted outline that you  
14 testified from, didn't you look at the CT scan and explain to  
15 the ladies and gentlemen that a CT scan is better for bone but  
16 not really good for muscles and tissues. If it was muscles and  
17 tissue, you would do an MRI?

18 A That's correct.

19 Q And you did that looking at the CT scan from Lenox Hill  
20 Hospital on the date of the accident?

21 A I wasn't sure sitting here now when that was done, but  
22 I did say that. That's correct.

23 Q And the CT scan from Lenox Hill Hospital -- withdrawn.

24 I want to go back to something you said earlier. I'm  
25 sorry, a little far afield, you talked about osteophytes. What

1 are osteophytes?

2 A Bony projections.

3 Q And you said that they develop over a long period of  
4 time, right?

5 A They do.

6 Q So, if somebody were to fall right now and go to the  
7 emergency room and have an x-ray or CT scan done, if it showed  
8 an osteophyte, it wouldn't be from the fall, right?

9 A That's correct.

10 Q It would be from something that happened to the disk at  
11 that level sometime in the past and the body's reaction to  
12 whatever happened is the development of osteophytes; correct?

13 A The way you phrased the question cannot be answered  
14 with a yes or no. It can be answered with an explanation.

15 Q Can you explain it in three sentences or less?

16 A Yes, I can.

17 Q Please.

18 A So, osteophytes, small tiny osteophytes are formed with  
19 part of the normal natural aging process, and they don't appear  
20 around a disk herniation unless there was problems with a disk  
21 herniation before. That's my three-sentence explanation.

22 Q Thank you.

23 Did the CT scan at Lennox Hill Hospital show  
24 osteophytes?

25 A I don't recall.

1           Q     Did it happen to show osteophytes at the same level  
2 that years later the EMGs showed positive findings?

3           A     I just said I don't recall what it showed.

4           Q     Now, Doctor, you knew you were coming here today to  
5 testify?

6           A     I'm sorry.

7           Q     You knew you were coming here today to testify, right?

8           A     Yes.

9           Q     And did you spend sometime with Mr. Subin talking about  
10 your testimony?

11          A     Yes.

12          Q     Did you go over the outline with the nice highlights  
13 the yellow and the red before you came here?

14          A     I did.

15          Q     And you didn't mark any of those things on there,  
16 Mr. Subin did, right?

17          A     That is correct.

18          Q     Reading from Plaintiff's Exhibit 3 in evidence, amongst  
19 other things, there is minimum anterior osteophytic lipping at  
20 C5-C6. That is the same level, is it not, where the EMG later  
21 on showed some disturbance with regards to the cervical spine  
22 and injury to the nerves of Ms. Gonzalez, yes or no?

23          A     Before I can answer your question, can I see that  
24 report?

25          Q     You may.

3 A Okay. Now, what is your question?

4 Q Is the osteophytic lipping identified on that film the  
5 exact same day of Ms. Gonzalez's accident at the same level that  
6 the EMGs found nerve irritation?

7       A     If I answer that question with a yes or no, I would  
8     mislead everybody in the jury box. It requires an explanation.

9 Q I don't want your explanation. Just tell me you can't  
10 answer yes or no and I'll move on.

11           A     It cannot be answered with a yes or no. It is a very  
12 important question.

13 Q That's good. I'm sure Mr. Subin will be very happy to  
14 ask you on redirect.

15 MR. SUBIN: Objection to all of these comments.

16 THE COURT: Counsel, please stop with the  
17 comments.

18 Q If, in fact, Ms. Gonzalez had sustained the injuries  
19 that you claim in the accident on June 20, 2017, she would have  
20 been symptomatic by September 13, 2017; is that correct?

21 A Every case is different. Every patient is different.  
22 What she was symptomatic from the very first date, she went to  
23 the hospital, she had complained of neck pain, back pain, knee  
24 pain, and I believe shoulder pain as well.

25 || MR. BRODY: Officer, can I have Exhibit 14 again,

1           please. Thank you.

2           Q     Doctor, I want you to look at Exhibit 14, the visit to  
3     Dr. Gouda that next took place on September 13, 2017. Do you  
4     see any mention of cervical pain in that note?

5           A     No.

6           Q     Do you see any mention of knee pain in that note?

7           A     No.

8           Q     Do you see any mention of shoulder pain in that note?

9           A     No.

10          Q     Do you see a mention of back pain in that note?

11          A     I do.

12          Q     Can you read what it says about the back pain?

13          A     Chronic lower abdominal pain and back pain for long  
14     time, under reason for appointment number two.

15          Q     Doesn't say anything about fell and hurt her back, does  
16     it?

17          A     No.

18          Q     Doesn't say anything about fell and aggravated her  
19     back, does it?

20          A     Does not.

21          Q     Doesn't say anything about radiculopathy into any of  
22     the lower extremities, does it?

23          A     It says not associated with numbness or weakness in the  
24     lower extremities.

25          Q     Which actually means that three months after the

1 accident, now, she still has simply localized back pain and no  
2 evidence of herniation or nerve root irritation; is that  
3 correct?

4 A That's on this report, that's correct.

5 Q That is the report of her primary care doctor that she  
6 still sees; correct?

7 A I don't know if she still sees.

8 Q That's right. I apologize. In fact, let me ask you  
9 this, Doctor, do you know who she does still see?

10 A I believe just myself.

11 Q When you took your history of Ms. Gonzalez, did you  
12 find out that she had other falls?

13 A No.

14 Q Were you aware that she was hospitalized twice since  
15 2002?

16 MR. SUBIN: Objection, can we approach on this  
17 one, Judge.

18 THE COURT: Yes.

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

21 Q Doctor, were you aware of those?

22 A No.

23 Q I believe you said earlier that a person who has these  
24 injuries predispose to further injury when they have an event  
25 such as a fall; is that correct?

1           A    It can be, yes, sir.

2           Q    You see no records to indicate that someone who is in  
3    Ms. Gonzalez's condition who fell sustained further injury as a  
4    result of this fall; correct?

5           A    That's correct.

6           Q    Also, one of the things that's not in your record is  
7    that she suffers from blood clots and may have had a  
8    neurologic event, including a stroke?

9                    MR. SUBIN: Judge, objection. We are not making  
10                 any claims to that.

11                  MR. BRODY: There is something very relevant about  
12                 it. I just need to ask 2 or 3 questions.

13                  THE COURT: Have the jury step out for a moment.

14                  COURT OFFICER: Jury exiting.

15                   (Whereupon, the jury exits the courtroom.)

16                  MR. BRODY: I need the witness outside the room  
17                 too, your Honor.

18                  THE COURT: Dr. Guy, would you please go outside.

19                  THE WITNESS: Yes, your Honor.

20                   (Whereupon, the witness exits the courtroom.)

21                  MR. BRODY: In connection with the blood clots and  
22                 or stroke or both that she had, she was placed on blood  
23                 thinners. According to Dr. McCulloch, he wouldn't do an  
24                 epidural injection of any kind until he confirmed with a  
25                 neurologist that she wasn't on any type of blood thinner.

THE COURT: I can't hear you.

2 MR. BRODY: According to Dr. McCulloch's records,  
3 he would not do any type of treatment until he confirmed  
4 she was no longer on the blood thinners for a period of  
5 time. I questioned Ms. Gonzalez and her answers were not  
6 quite accurate because when she first went to Dr. Guy, it  
7 was three days before she went to Dr. McCulloch. When she  
8 went to Dr. McCulloch, she was still on blood thinners. It  
9 is perfectly relevant to ask him about that history.  
10 Whether or not he knew she was on blood thinners of any  
11 kind, and what he did to confirm that she was off of them  
12 before epidural steroid injections, which his own consent  
13 form says he must know about and must be disclosed. I  
14 don't know why that wouldn't be relevant here, his care and  
15 treatment, and how thorough he was in treating this  
16 patient.

17 MR. SUBIN: It doesn't at all go to -- even if it  
18 was true, Judge, it doesn't go to her injuries, which is  
19 what we are here about. Dr. Guy is not on trial for  
20 medical malpractice. We are here to find out what was  
21 wrong with Ms. Gonzalez. If he gave her an epidural --  
22 and, by the way, Dr. McCulloch wasn't doing an epidural.  
23 He was doing a PRP injection, which could be different. We  
24 just -- we are here to find out about Ms. Gonzalez's,  
25 whatever injuries she had, not about whether Dr. Guy

1 committed any things that are a mistake, and I think we are  
2 getting far afield from the relevance of anything.

3 MR. BRODY: I mean, goes right to the credibility  
4 of his thoroughness and what his care and treatment was.  
5 Whether he was motivated by money, by the case, by anything  
6 else. He has a duty to be thorough. Asking a doctor  
7 whether or not he took a proper history --

8 THE COURT: Counsel, I don't think it is relevant  
9 to his motivation that he did it for money, etcetera.

10 MR. BRODY: You are not letting me ask that.

11 THE COURT: You don't know what my ruling is going  
12 to be. I'm really getting annoyed about the fact that you  
13 already made a decision. You went in there and you stated  
14 that you already knew how I was going to rule.

15 MR. BRODY: You wouldn't let me ask if he billed,  
16 Judge.

17 THE COURT: Counsel, let's take a break.

18 (Whereupon, a short recess was taken.)

19 MR. BRODY: The Court ruled on an issue with  
20 regards of who paid plaintiff's medical bills, and it was  
21 said it was issue for collateral source and not to be  
22 raised here. In this particular situation I'm looking to  
23 ask the witness a series of questions with regards to the  
24 fact that he hasn't been paid in this case, that he's  
25 taking this case fully on a lien. The Court has instructed

1                   me that is covered by her prior ruling, so I'm not going to  
2                   ask those questions. I simply asked to make the record.

3                   THE COURT: Okay. Your record is made.

4                   MR. BRODY: Can I have the last question read  
5                   back?

6                   (Whereupon, a portion of the testimony was read  
7                   back.)

8                   MR. BRODY: I'll rephrase the question, your  
9                   Honor.

10                  COURT OFFICER: Jury entering.

11                  THE COURT: Please be seated. Counsel, you may  
12                  continue.

13                  Q     Doctor, when Ms. Gonzalez came to your office for the  
14                  first time, did you have her fill out any types of forms whereas  
15                  she related to you what her medical history was?

16                  A     Yes.

17                  Q     You have that in your record?

18                  A     I do.

19                  Q     Can you hand that to me, please.

20                  A     Sure.

21                  Q     Is this the only document that you had Ms. Gonzalez  
22                  filled out when she came to your office?

23                  A     Yes.

24                  Q     What are the notes on the back.

25                  A     That's my chicken handwriting.

1           Q     What are the items, Doctor, that's checked off -- let  
2 me ask you this, let me show it to you, maybe you'll understand  
3 it. Doctor, one of the items asked was she injured while she  
4 was working essentially. You see that?

5           A     I'm sorry, what was the question?

6           Q     One of the items asks if she was injured while she was  
7 working. Do you see that?

8           A     I do.

9           Q     And yes is circled and no is underlined. What is the  
10 actual answer to your understanding?

11          A     I don't know. My understanding is this is not an on  
12 the job injury.

13          Q     It is important for a doctor to know whether or not a  
14 person that they are treating was injured in a work-related  
15 accident, is it not?

16                    MR. SUBIN: Judge, objection.

17                    THE COURT: Sustained.

18          Q     Is it important for you in taking care of a patient to  
19 know whether or not an injury was sustained while they were on  
20 the job?

21                    MR. SUBIN: Objection.

22                    THE COURT: Sustained.

23          Q     Doctor, there are certain types of medications that a  
24 person should not be on when you go to give an caudal injection;  
25 is that correct?

1       A    Oral injection?

2       Q    Caudal.

3       A    Caudal. Three days before the procedure it should be  
4 stopped. Just three days.

5       Q    Did you ever learn, at any time, that Ms. Gonzalez was  
6 on blood thinners?

7       A    Only through Dr. McCulloch's records.

8       Q    And Dr. McCulloch's records was after your initial  
9 visit; correct?

10      A    I believe it was before my initial visit and after my  
11 initial visit as well.

12      Q    The report that you referred to earlier was three days  
13 after your first visit; is that correct?

14      A    I don't remember the exact date, but if it is, so be  
15 it.

16      Q    And, at that time, she was on blood thinners; correct?

17      A    That's what the report insinuated. I don't know if  
18 that was true or not true.

19      Q    And you didn't ask anybody again?

20      A    I did not.

21      Q    So, how did you know she wasn't on them when you gave  
22 the initial injection?

23      A    I ask. The nurses ask. The anesthesiologist ask. A  
24 whole group of people ask.

25      Q    Do they ask when you last took them?

1       A    Generally speaking, they do.

2       Q    But you don't know if they asked in this case, do you?

3       A    If the patient was taking any medications that  
4       interfered with an epidural, they would have asked, they would  
5       have brought it to my attention, the procedure would have been  
6       canceled.

7                    MR. BRODY: Can I get Exhibit 13. I think it  
8       should have been right on top. I think I just pulled.

9       Never mind, officer.

10      Q    Doctor, what is a neurologist?

11      A    A neurologist is a doctor that specializes in the  
12       nervous system. Deals with neurologic conditions.

13      Q    And you referenced earlier a record by a Dr. Teresella  
14       Gondolo. Dr. Gondolo is a neurologist; is that correct?

15      A    That is correct, yes.

16      Q    And she's a neurologist who continues to treat  
17       Ms. Gonzalez to date; correct?

18      A    That, I don't know.

19      Q    Shortly before Ms. Gonzalez -- withdrawn.

20                    Do you know how Ms. Gonzalez got to Dr. Gondolo?

21      A    I do not know.

22      Q    Do you know how Ms. Gonzalez got to Dr. Gouda?

23      A    I do not know.

24      Q    Do you know how Ms. Gonzalez got to Dr. Gerling?

25      A    I do not know.

1 Q You know how she got to Dr. McCulloch?

2 A I do not know.

3 Q Have you ever testified in a case where Dr. Gondolo was  
4 a treating doctor before?

5 MR. SUBIN: Judge, objection.

6 THE COURT: Sustained.

7 Q Do you know who Dr. Gondolo is?

8 A I do not.

9 Q Were you aware that Ms. Gonzalez treated with her  
10 neurologist on July 19th, 2018?

11 A I don't know about the exact date, not sure.

12 Q But that's shortly before the August 2018 visit with  
13 Dr. McCulloch that you read from earlier; correct?

14 A I don't know the exact dates. We are talking about  
15 eight years from the time of the accident to the present.

16 Q What is the significance of the following statement,  
17 neck stiffness is not present?

18 A Who was that from and what's the date?

19 Q July 19, 2018, by Ms. Gonzalez's neurologist, and I  
20 will say to you that all of these next questions come from the  
21 same chart?

22 A I cannot speak for another physician.

23 Q What does "neck stiffness is not present" mean?

24 A Everybody knows what stiffness is, and it is not  
25 present. What would you like me to say.

1 Q Exactly that, Doctor.

2 A Okay.

3 THE COURT: Counsel, we are not doing a colloquy.

4 It is question, answer.

5 Q Doctor, what does it mean, "paracervical and  
6 sternocleidomastoid are not tender"?

7 A Sternocleidomastoid is the muscle that I'm pointing to  
8 in front of my neck. And what was the other portion of the  
9 question?

10 Q Paracervical?

11 A Para means along the side of the neck.

12 Q And not tender means by to touch and pushing, there is  
13 no pain or other symptoms elicited from the patient?

14 A That's what it means, yes, sir.

15 Q And forward, backward, and side to side movements of  
16 the neck are not reduced. What does that mean?

17 A It is normal.

18 Q Cervical occiput is not tender, what does that mean.

19 A Cervical occiput is the upper portion of the neck,  
20 right below the cranium. I'm pointing to it with my finger,  
21 this is what it is.

22 Q So, if it says palpation of the cervical occiput does  
23 not precipitate radiating pain, what does that mean?

24 A It is a very non-specific comment.

25 Q But it means that by pushing in that area it didn't

1 cause any pain to either extremity; correct?

2 A Agreed.

3 Q Foraminal compression test is negative, what does that  
4 mean?

5 A When you push on the head, and when you tilt the  
6 persons head to the left and to the right, if you point, if  
7 there is shooting pain down the arm it is positive. If it  
8 doesn't happen, it is negative.

9 Q So, somebody with acute symptoms of three herniated  
10 disks in the neck, you would expect a foraminal compression test  
11 to be positive, wouldn't you?

12 A Sometimes it is. Sometimes it is not.

13 Q What is Tinel's sign?

14 A Tinel's sign is for the wrist. For carpal tunnel.  
15 Unrelated to this accident.

16 Q Examination of the lower back does not reveal  
17 tenderness in the lumbosacral and sacroiliac region in between  
18 the posterior superior iliac spine, and sacral areas. What does  
19 that mean?

20 A There is no pain or any malfunction in that area based  
21 on that physical examination.

22 Q There is no tenderness in the upper margins of both  
23 iliac bones, what does that mean?

24 A The iliac bone is the iliac crest that goes across your  
25 hips.

1           Q     Denies joint pain, swelling, muscle cramp, stiffness  
2 and arthritis. What does that mean?

3           A     There is no pain in the joints, in the shoulders and  
4 knees. The hips, there is no cramping, and there is no other  
5 abnormal findings with the joints.

6           Q     So, if you recall in your testimony with Mr. Subin  
7 earlier, you took the report of Dr. Gouda of March 13, 2017,  
8 which was negative, and said this is the baseline, and then  
9 after the accident we find symptoms. Isn't that what you did  
10 earlier on your direct?

11          A     I did. That's correct.

12          Q     So, now, here is a report of Ms. Gonzalez's  
13 neurologist, who she continues to treat with today, and on  
14 July 19th, 2018, she has a full and complete negative exam. Why  
15 is that not her baseline?

16          A     Can I see that report?

17                    MR. SUBIN: Can he see the whole record, please.

18                    MR. BRODY: Absolutely.

19                   COURT OFFICER: Plaintiff's 13 in evidence being  
20 shown to the witness.

21          A     Okay. What is the question?

22          Q     Essentially, Doctor, the question was why isn't that  
23 her baseline?

24          A     I don't know.

25          Q     And, Doctor, we can agree that that exam is over a year

1 after her accident; correct?

2 A Yes.

3 Q And, by then, if the symptoms were to manifest  
4 themselves they should manifest themselves to some degree and in  
5 some amount when performed in an examination by a neurologist  
6 that the patient continues to treat with; correct?

7 A The answer is a yes and no.

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

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1 CONTINUED CROSS EXAMINATION

2 BY MR. BRODY:

3 A. The answer's yes and no.

4 Q. Doctor, did you review Ms. Gonzalez's original  
5 deposition testimony?

6 A. No, I only review medical records, I don't review  
7 depositions.

8 Q. Did you review her trial testimony?

9 A. It's not medical records, I don't touch them.

10 Q. Okay. Were you aware that Ms. Gonzalez's deposition  
11 testimony indicates that it's her right knee that went down and  
12 touched the ground, not her left knee?

13 PLAINTIFF'S COUNSEL: Objection, the significance  
14 as to what she said in her deposition, one way or the  
15 other.

16 THE COURT: Repeat the question again, Counsel.

17 Q. Were you aware that at her deposition Ms. Gonzalez  
18 testified that it was her right knee that went down and hit the  
19 ground, not the left knee?

20 A. I just said I don't read any depositions. How would I  
21 know that?

22 Q. Were you aware that Ms. Gonzalez believed it was her  
23 right hand that went down and touched the ground?

24 A. I saw from the video that's not the case.

25 Q. Actually you saw the video and it was her left hand

1 that went down and touched the ground?

2 A. That's correct.

3 Q. It was her left knee --

4 A. That is correct.

5 Q. -- that hit the ground, correct?

6 A. That is correct.

7 Q. And she claimed that the knee she injured in this  
8 accident was the knee that hit the ground, were you aware of  
9 that?

10 A. I just told you I'm not aware of that.

11 Q. But she went to the hospital that afternoon and she was  
12 there, she got there a couple of hours after the accident and  
13 left six and a half hours after the accident?

14 A. That's about right.

15 Q. While at the hospital she complained about knee pain,  
16 right?

17 A. That's correct.

18 Q. And she complained about knee pain to her left knee  
19 right, not right knee?

20 A. That is correct.

21 Q. And they took an X-ray of her left knee as well,  
22 correct?

23 A. Correct.

24 Q. But they examined both of her knees, correct?

25 A. That's correct.

1           Q.    And they found nothing wrong with either knee, isn't  
2 that correct?

3           A.    That is correct.

4           Q.    So your claim is she tore her right knee meniscus,  
5 didn't feel any pain from it, they examined her, didn't notice  
6 any pain from it. But a year later when she had knee pain it  
7 was caused in this accident, correct?

8           A.    Not about a year later. There is other doctors'  
9 treating records that indicates there was a problem with the  
10 knee. There was a problem with the neck and the back as well.

11          Q.    Okay, isn't the only reference to knee pain a note in  
12 the Focus Physical Therapy record that says she experienced low  
13 back pain radiating to the knee.

14          A.    That is correct.

15          Q.    Doesn't talk about any joint issues with the knee,  
16 doesn't say the knee is unstable, doesn't say any of the things  
17 you would expect with a meniscal tear?

18          A.    That is correct.

19          Q.    It's also true when she went to her primary care doctor  
20 she didn't make any mention of limping, any problem with her  
21 knee, she didn't mention any of those things, did she?

22          A.    She did. She complained of poor balance, unsteady  
23 gait. She did.

24          Q.    Isn't it a fact that she complained of poor balance and  
25 unsteady gait to her neurologist during the same period of time?

1                   A.     She did.

2 Q. Because she was being treated for headaches, dizziness  
3 and lightheadedness that had nothing to do with this accident?

4 A. That is correct.

5 Q. Doctor can we agree --

6 MR. BRODY: Withdrawn.

7 Q. Can we agree that an emergency room, and I think you  
8 showed it to the jury, that's just an early examination of  
9 something that happens, right?

10 A. That is correct.

11 Q. Would you not also agree with me the tests they gave,  
12 the CT scan and the X-rays, those are objective tests, you can't  
13 fake this, right?

14 A. That is correct.

15 Q. You said earlier that Ms. Gonzalez had some anxiety  
16 issues which caused you to feel more pain than somebody else  
17 subjectively, correct?

18 A. You have it right partially, but not completely.

19 Q. Okay, you explain again how anxiety affects the  
20 person's reactions to the pain they are experiencing?

21       A.    So anxiety, if a patient has underlying anxiety and  
22 they have pain, their perception of pain is exponentially  
23 increased, and I'll show with my fingers.  If the patient has  
24 this much pain and this much anxiety, their perception of pain  
25 would be this much.  Just to give an example.

1           Q.    And so for Ms. Gonzalez, who slipped and fell in the  
2 lobby of the building where she worked, for her to be upset  
3 about it immediately after the accident would not be surprising,  
4 given her history of anxiety and depression, correct?

5           A.    Would not be.

6           Q.    But at some point objective signs of her injuries have  
7 to show up, correct?

8           A.    And they have.

9           Q.    What did Ms. Gonzalez do in the six, seven and  
10            eight months between the time of this slip and the time she  
11            started treating with Dr. Gerling and McCulloch?

12          A.    I don't know.

13          Q.    Do you know if she was going to the beach?

14          A.    Beach?

15          Q.    Yeah.

16          A.    How would I know? I don't know.

17          Q.    Do you take a history from your patient and say, what  
18            was the immediate post-accident situation like?

19          A.    No. I did not ask that question. I didn't feel it was  
20            important to the diagnosis and treatment that I was proposing  
21            for the patient.

22          Q.    Let me ask you a quick hypothetical. Suppose,  
23            hypothetically, Ms. Gonzalez was a professional soccer player  
24            and three months after this accident that you saw in the video,  
25            she was injured playing soccer.

1           If you didn't ask her the questions, you would have no  
2 way of knowing whether or not there was a subsequent injury or  
3 accident in connection with the condition, would you?

4           PLAINTIFF'S COUNSEL: Objection.

5           THE COURT: What's your objection?

6           PLAINTIFF'S COUNSEL: The most extenuating  
7 question you can think of, Judge.

8           THE COURT: Sustained.

9           Q. Okay. If she was capable to go to the beach and carry  
10 beach bags and beach chairs, would that be relevant?

11          A. At what stage?

12          Q. Two months, three months, five months after the  
13 accident.

14          A. Going to the beach and putting sand on your legs is  
15 therapeutic. Walking on the beach slowly is therapeutic.  
16 Carrying things if they are not heavy is also not too relevant,  
17 they can do that as well. Walking on the beach and exercising  
18 is therapeutic.

19          Q. But it also would be impacted by three herniated disks  
20 in her cervical spine, if, in fact, she had pain from the  
21 accident of June 2017?

22          A. If she has pain, nothing to do with the beach.

23          Q. Would it inhibit your ability to do things?

24          A. Not the neck. The back would, the knee would.

25          Q. The ligaments and the muscles in the disks in the

1 cervical spine, they are designed to withstand minimal levels of  
2 stretching, trauma, other things, correct?

3 A. Minimal, yes.

4 Q. Okay. People who play tackle football, they don't all  
5 have herniated disks in their necks, right?

6 A. Some do, some don't.

7 Q. Are you a sports fan of any kind?

8 PLAINTIFF'S COUNSEL: Objection.

9 THE COURT: Sustained.

10 Q. When a basketball player tears his --

11 PLAINTIFF'S COUNSEL: Judge, objection.

12 THE COURT: Sustained.

13 Q. Isn't it a fact, Doctor, that people who sustains a  
14 traumatic meniscal tear generally feel signs and symptoms of it  
15 within the first four hours?

16 A. No, sir, that is not correct.

17 Q. Isn't it also true, Doctor, that when a person tears a  
18 meniscus, within the first four hours the body reacts to that  
19 tear and that body part will become tender?

20 A. Absolutely incorrect.

21 Q. So a person who tears a meniscus will go to a doctor  
22 and the doctor will examine them, they will have no tenderness,  
23 no swelling, and they will experience no pain?

24 A. Every case is different. No two cases are exactly the  
25 same.

1 MR. BRODY: Your Honor, at this time I'm going to  
2 ask the video be shown.

3 THE COURT: Sure.

4 (Playing video)

5 Q. I ask, Doctor, on this run of the video I ask that you  
6 pay attention to her neck.

7 You can stop.

8 Did you see the motion that her neck made in that  
9 video?

10 A. I did.

11 Q. Were you aware that Ms. Gonzalez testified that she  
12 injured her neck because she saw this desk and she pulled her  
13 neck back, so that her teeth didn't hit the desk?

14 A. You are asking me if I'm aware she said that? I'm not  
15 aware of any such statement.

16 Q. Can you agree with me, Doctor, in this video that  
17 mechanism of injury didn't happen?

18 A. No. She's too far away from the desk.

Q. And her head stayed down the whole time?

20 A. Her head twisted as she fell to the ground, hitting her  
21 left knee to the ground.

22 O. We agree it's the left knee that struck the ground?

23 A. Undisputed.

24 Q. If any knee felt the water that was there, it would  
25 have been the left knee?

1 || A. Yes.

2 Q. It would have been her left hand, not her right hand  
3 that touched the ground, right?

4 A. That's what I saw.

5 Q. Doctor, let me ask you this. Is it at least possible,  
6 with your knowledge as a physical medicine and rehabilitation  
7 licensed physician in the State of New York, that a person could  
8 slip exactly the way Ms. Gonzalez did, have a minor bump, a  
9 minor bruise and nothing else?

10 A. Is it possible? Absolutely. Anything is possible.

11 MR. BRODY: Can we play that video one more time,  
12 please?

13 (Playing video)

14 MR. BRODY: Stop.

15 Q. We can agree, Doctor, the knee she went to grab for to  
16 check was her left knee, correct?

17 A. That is correct.

18 Q. Doctor, you gave a life care plan earlier?

19 A. That is correct.

20 Q. Let's start with the fact that you actually don't know  
21 if somebody is going to treat, get he the treatment on a life  
22 care plan, do you?

23 A. No. I render what is medically indicated, based on  
24 medical guidelines and accepted standards of care and practice.

25 Q. So, your life care plan is a recommendation for what

1 Ms. Gonzalez should do, is that correct?

2 A. Yes, that is correct.

3 Q. Bear with me one second. Sorry your Honor.

4 THE COURT: Counsel, how much more time?

5 MR. BRODY: I probably have about forty-five more  
6 minutes. Do we want to approach now, your Honor?

7 THE COURT: Yeah.

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

10 THE COURT: All right. It's 4:25, we're going to  
11 break right now. I'm going to ask that everybody be here  
12 at 9:30. Please remember you have not heard all of the  
13 testimony, all of the evidence, so please do not formulate  
14 any opinions, do not do any research on any of the topics  
15 or any of the individuals in this case, and do not discuss  
16 the case with anyone. Have a good evening. See everybody  
17 tomorrow.

18 COURT OFFICER: Jury exiting.

19 (Whereupon, the jury left the courtroom.)

20 THE COURT: All right, so it just makes sense to  
21 adjourn because you have -- it makes sense to adjourn at  
22 this point because based on the time, counsel needs another  
23 forty-five minutes, and I believe you're going to need time  
24 for redirect, is that correct?

25 MR. SUBIN: Yes, now, I will. Dr. Guy, are you

1 available tomorrow morning?

2 THE WITNESS: Yes, sir.

3 MR. SUBIN: So what I can do, Judge is --

4 THE COURT: Do you want this on the record?

5 MR. BRODY: I don't think we need it on the  
6 record.

7 THE COURT: Okay, so we can be off the record.

8 oOo

9 THE COURT: All right, so our court officer just  
10 notified me that Juror Number 3 has advised him that she  
11 has a plane to catch Friday morning. So the last day she  
12 can be here is Thursday. I do not --

13 MR. SUBIN: We asked, Judge.

14 THE COURT: Our court officer can ask her when  
15 she's planning on coming back, and then you can make your  
16 decision as to what to do. Why don't we do that first.

17 MR. SUBIN: We said, you have to be here 9:30 to  
18 5:00.

19 MR. BRODY: All the way through Monday.

20 THE COURT: Counsel, I am not disputing that, I'm  
21 sure you did it.

22 MR. BRODY: He did it, and he was good at it.

23 COURT OFFICER: Sunday night.

24 THE COURT: Our court officer has advised us she  
25 will be back Sunday night. The question is, do you want to

1 go through until Thursday and then, whatever doesn't finish  
2 resumes on Monday, to keep the juror, or do you want to  
3 replace the juror with Alternate Number 1.

4 MR. BRODY: I never like to replace a juror. Can  
5 you give me until tomorrow, I have an expert on schedule  
6 for Friday.

7 MR. SUBIN: I mean --

8 MR. BRODY: I'm okay with that too.

9 THE COURT: Look, if you feel that you want to  
10 make, if you want to have an informed decision by speaking  
11 to your expert, I'll let you decide tomorrow, or, you know  
12 whatever you want. I'm not --

13 MR. BRODY: If we're on the record, I didn't want  
14 to be in the position to say replace. If counsel is okay  
15 with replacing, I'd rather not try to move the witness. I  
16 will agree to stipulate to replace the juror, as so we  
17 don't have to deal with the issue.

18 THE COURT: As long as you both agree.

19 MR. BRODY: No problem.

20 THE COURT: Are you agreeing to replace her with  
21 Alternate 1, or do you want the names to be pulled out of  
22 the box?

23 MR. BRODY: Your Honor, I leave that to whatever.

24 THE COURT: Oh, no, this isn't...

25 MR. BRODY: We didn't pick specifically that way,

1 so I don't really care.

2 MR. SUBIN: I agree. 1, 2, 3 is the same thing.

3 MR. BRODY: So let's pull from a hat, whoever we  
4 get, we get.

5 THE COURT: Madame Clerk, pull the three names.

6 COURT CLERK: Taraja M. Brown.

7 THE COURT: So, for the record, Juror Number 3 is  
8 excused on consent of both attorneys, and is being replaced  
9 with Alternate Number 2, who is name that has been pulled  
10 out of the box. Everybody in agreement with that, Counsel?

11 MR. SUBIN: Yes.

12 MR. BRODY: That's what we agreed, no issues.

13 THE COURT: Have a good day.

14 MR. BRODY: Thank you, your Honor.

15 (At this time, court was recessed to June 25, 2025, at

16 9:30 a.m.)

17 \* \* \* \* \*  
18 REPORTER'S CERTIFICATION

19 Certified to be a true and accurate transcript of the original  
20 stenographic notes.

21 

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MELISSA JIMENEZ-DE ARMAS  
22 Senior Court Reporter

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ROBIN NUÑEZ  
24 Senior Court Reporter

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