SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU: TRIAL TERM PART 43
INDEX NO. 601870/2018

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MARTA FAVIOLA ROSADO-ROCA,

Plaintiff,

-against-

DALE WESTREICH,

Defendant.

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EXCERPT

CONTINUED
JURY TRIAL

100 Supreme Court Drive
Mineola, New York
January 28, 2025

B E F O R E : HONORABLE LISA A. CAIRO
Justice of the Supreme Court

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

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Kelly Culen
Official Court Reporter

(Plaintiff's Exhibit 19, binder of Southside Hospital ER records, 10/29/17 and 10/31/17, marked into evidence.)

(Plaintiff's Exhibit 20, Perry Physical medicine and rehabilitation records, marked in to evidence.)

(Plaintiff's Exhibit 21, Dr. Kohane's records, marked into evidence.)

(Plaintiff's Exhibit 22, Southshore University Hospital ER 12/13/23, marked into evidence.)

(Defendant's Exhibit F, Dr. Winick's records, marked into evidence.)

THE COURT CLERK: Nassau Supreme Court Part 22 now in session. The Honorable Judge Lisa A. Cairo presiding. On the calendar 601870 of 2018, Marta Faviola Rosado-Roca against Dale Westreich.

Counselors, please state your appearance for the record.

MR. SPANO: Yes, for the plaintiff, Marta Faviola Rosado-Roca, Sal Spano, Edelman Krasin & Jaye, 7001 Brush Hollow Road.

MR. MURTAGH: Good morning, your Honor, Kevin Murtagh, from the firm Ahmuty, Demers & McManus, 200 I.U. Willets Road, Albertson, New York.

Good morning, your Honor.

THE COURT: Good morning. You can be seated.

Just before I forget, Mr. Murtagh, in terms of Friday, do you know whether you're going to have one or two witnesses yet?

MR. MURTAGH: Your Honor, I do know that I can have two.

THE COURT: Okay. So we'll figure that Friday will be a full day.

MR. MURTAGH: Yes, your Honor, and the only other thing I have after that I've got that vocational rehab. We probably have to get that in on Monday morning.

THE COURT: Okay, let's talk about it at the break.

MR. MURTAGH: Yes, your Honor.

THE COURT: So you guys did that yesterday afternoon?

MR. SPANO: Today.

MR. MURTAGH: We're doing it today, your Honor.

THE COURT: We'll talk about it at the break.

Is there anything else we need to discuss.

MR. SPANO: I was told to have the charges and the verdict sheet.

THE COURT: If you guys can have them in

tomorrow morning, and then we'll have our conference Thursday at 11 subject to any changes based upon testimony afterwards. I mean, I understand that, okay?

We're ready for the jury, thank you.

THE COURT OFFICER: Ready, Judge?

THE COURT: Yes, thank you.

THE COURT OFFICER: Jury entering.

THE COURT: Good morning, you can be seated, thank you.

Mr. Spano, your next witness, please.

MR. SPANO: Yes, Judge. Plaintiff calls to the stand Dr. Ali Guy.

THE COURT: If Dr. Guy can please step up.

(Whereupon, ALI GUY, called as a witness, was duly sworn by the Clerk of the Court.)

THE COURT CLERK: Please state your full name and spell it for the record.

THE WITNESS: Yes. My name is Dr. Ali Guy, A-L-I. Last name is G-U-Y, M.D.

THE COURT CLERK: And your address, please?

THE WITNESS: 400 Post Avenue, Westbury, New York 11590.

THE COURT CLERK: Perfect. You can have a seat.

THE COURT: Please just wait until they finish

the question before your answer. The attorneys will be asking you some questions. We're being recorded and we need to make sure that everything is recorded properly so only one of us can speak at a time.

If there's an objection to a question, allow me a chance to make a ruling. If I overrule the objection, it's okay for you to answer. If I sustain the objection, you should stop answering, all right?

THE WITNESS: Yes, your Honor.

THE COURT: Thank you.

THE WITNESS: You're welcome.

THE COURT: Whenever you're ready.

MR. SPANO: Thank you, Judge.

DIRECT EXAMINATION

BY MR. SPANO:

Q Good morning, Dr. Guy.

A Good morning, sir.

Q I need to ask you some basic questions so we can talk about your qualifications.

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

A Yes, sir, I'm licensed to practice medicine and surgery in the State of New York since 1985.

Q And what is your current area of medical specialty?

A I'm an expert in physical medicine rehabilitation

known as physiatry and interventional pain management.

Q Could you just describe to the jury your educational background, your medical training and experience in those fields?

A Yes.

Medical school -- undergraduate I went to Queens College. Medical school I graduated from University of Northeast Dominican Republic, 1981. Thereafter, I did three separate residents.

I did 18 months of internal medicine at Mount Sinai School of Medicine Mount Sinai Medical Center. I did one year of general surgery at Cabrini Medical Center in Manhattan. I completed a three-year residency training program in the field of physical medicine and rehabilitation.

I'm board certified in the specialty since 1989, and my board certification remains in good standing. And from 1990 -- sorry, from 1997 till 2002, I was the director of the department of rehab medicine at Maimonides Medical Center in Brooklyn New York where my duties were to teach the orthopedic residents, teach them about pain management, how to treat nonsurgical low back pain, spinal cases, and I was also able to do consultations to other doctors in my hospital.

This hospital is the largest single operating

hospital in the United States. We have 400 residency in training.

My duties were to teach the residents both in orthopedic surgery, general surgery, internal medicine, to teach ten other doctors assigned to my department and, also, teach the physical therapists, speech therapists and physicians assistant.

And from 1990 to 2006 I was the director of NYU's Hospital for Joint Diseases Neuromuscular Equipment Clinic. My duties were to take care of the patients that were assigned to this clinic. This would be patients with multiple traumatic injuries, orthopedic injuries, fractures, spinal cord injuries, so on and so forth, was to take care of the patients and teach the residents from NYU rotating through this clinic, and I would have to prepare them for their boards parts one and part two, and from 2006 till 2019, I was a clinical instructor of physical medicine and rehabilitation at NYU School of Medicine, NYU Medical Center, again, to teach the residents, prepare them for the boards parts one, part two, and from 2019 to the present, I was promoted to assistant professor of physical medicine and rehabilitation at NYU School of Medicine, again, teaching and doing workshops with the residents.

And I'm also a captain with the New York National Guard from 2019 till 2023 where my duties were to be on

standby twenty-four times seven, take care of emergencies, and when we had annual meetings with the different forces, the Navy and other paramilitary forces at Kemp Smith to take care of the soldiers, take care of their orthopedic problems/injuries they may have, and I'm also the director of the department of rehab medicine at Medalliance, which is an Article 28 facility in the Bronx.

Article 28 facility is like a small hospital. We have about fifty doctors. We have four operating rooms.

My duties are to teach the house staff and, also, I'm the director of quality assurance. That means I do chart reviews, catch mistakes and go to whoever made the mistake to teach them and correct it so they don't make the same mistakes.

I'm also the director of the pain service at the North Queens Surgery Center in Bayside. My duties are to supervise the work of fifty other doctors that do interventional pain management procedures and microsurgeries of the spine, review their work, make sure they're doing it correctly and to teach, and, recently, I was chosen by the Office of Professional Medical Conduct the State Education Department to be a physician mentor for this department.

This is the department that gives doctors their licenses and take them away to go and teach doctors that are on probation. These are doctors that have committed certain

misdeeds but not bad enough to have their license suspended order revoked.

My duties are to go into their office, check make sure they're doing their work properly, supervise them, teach them and report to the OPMC as needed, and I also have an office in Westbury and in Manhattan.

Q I don't know if you want me to mention this, but did I see you on the cover of U.S. World News and Health not too long ago?

A Yes.

I was chosen by U.S. World News and Report as one of the best doctors in the country. I had a five out of five ratings. Five star out of five star rating.

Q Okay.

What fields are you board certified?

A Physical medicine and rehabilitation.

Q What is the medical specialty of physical medicine rehabilitation as opposed to we heard from an orthopedist in this case, maybe other orthopedists will testify, but can you kind of just distinguish your specialty among the others?

A Yes. This is a medical specialty that was founded shortly after World War II by Dr. Howard Rusk. That's why the Rusk Institute at NYU is named after him.

NYU was the first training program in the world in

this specialty. This specialty covers the whole body from head to toe. We have training in neurosurgery, neurology, orthopedic surgery, internal medicine, general surgery, rheumatology, interpretations of X-rays, MRIs, CT scans and rheumatology and disability and impairment evaluation, which means that we have training to evaluate a patient to see if that patient is disabled partially or totally and what the future medical needs for that patient would be.

And in order to become a physiatrist, first you have training in a field other than physical medicine and rehabilitation. One year of internal medicine, one year of general surgery. I have both, and that's because this field covers all the medical specialties, and in our boards we get tested in all these areas both written and oral.

Q And to what extent does your field deal with traumatic injuries?

A Extensively so.

Um, what is trauma? There's disability, there's injuries and those patients need rehabilitation, pain management, both pharmacological and interventional. I do both pharmacological pain management and interventional. I've done about, I'd say, over 35,000 different interventional pain management procedures such as epidurals, facet injections, radiofrequency ablation procedures, select nerve blocks, et cetera.

Q In your years of training and experience, to what extent do you encounter patients postoperatively, post-op spinal surgery who are still suffering some pain and limitation?

A Well, during my training in general surgery, I was on call every other night. We had a lot of orthopedic injuries. We had multiple traumatic injuries, car accidents, gunshot wounds, skiing accidents. So we had orthopedic injuries on a daily basis. We had teaching by board certified orthopedic surgeons teaching us, going over the X-rays, radiological films, and, also, I assisted in numerous orthopedic surgical cases during my orthopedic surgery. During my residency training in the field of physical medicine rehabilitation we had weekly orthopedic surgical rounds with physical medicine rounds. We would discuss different patient's cases and their X-rays, MRIs, CT scans, et cetera, and we would have weekly radiological rounds with board certified radiologists. We'd go over again interpretations of X-rays, CT scans, MRIs, et cetera, and after I finished my residency training program, for two years, I worked with a group of orthopedic surgeons in Rockville Centre, Dr. Sandy Farkus and Dr. Eisen Cohen. Again, we would share patients. We'd go over orthopedic injuries, how to manage these cases, electrodiagnostic studies, which I would do, and rehabilitation management of

these patients, and in New York City, for two years, I would work with a board certified radiologist, Dr. Leonard Bellok, B-E-L-L-O-K, and a neurosurgeon Dr. Robert Holtzman. We would go, again, over these neurosurgical cases, neurological cases, discuss their diagnosis and management.

So that was a lot of training in these areas.

Q Doctor, is it fair to say you that are familiar with, in your experience, education and training with the indications for spinal surgery, when and why a patient might need it?

A I do spinal surgeries myself. I do minimally invasive discectomies of the spine. The indications for surgery are known to every physiatrist, every neurologist, every surgeon that does surgery, so it's not a secret.

The indications are when conservative treatments have failed and physical therapy for more than six weeks in duration, pain medications for more than six weeks in duration, a couple of epidural injections have failed, next comes surgery.

Q What is a life care plan?

A Life care plan is prepared by two experts. One is a physiatrist like myself with twelve years plus experience. I've been in practice almost forty years. The other one is prepared by a certified life care planner, who is not a doctor. They have a hundred twenty hours training online.

They take an exam. If they pass, they become a certified life care planner, but they cannot give predictions about what future medical needs a patient may have. They cannot it do procedures themselves. They cannot write prescriptions. They cannot order diagnostic studies and so on and so forth.

So, in my opinion, a person that's not an M.D. and is going to give medical opinions is not in the right position. They have to be an M.D., Preferably someone who does these procedures themself.

MR. SPANO: Judge, at this time I would like to offer Dr. Guy as an expert in the fields of physical medicine rehab, pain intervention and life care planning.

MR. MURTAGH: No objection, your Honor.

THE COURT: All right. So the doctor will be accepted as an expert in physical medicine, rehab, pain intervention and life care planning.

MR. SPANO: Thank you, your Honor.

Q Now, to be clear, you're not a physician in this case who's actually treated Ms. Rosado-Roca; is that correct?

A Yes, sir, that is correct.

Q And full disclosure, I retained you to consult on this case and offer your expert opinions on Ms. Rosado-Roca?

A Yes, sir, for disability, impairment and a life care plan.

Q Right.

And what are some of the things you did initially in taking on Favi's case? What is some of the steps you did?

A I obtained all the pertinent past medical records. I took a history. I conducted a physical examination, and I arrived at my own diagnosis, prognosis and future medical needs.

Q And when did you first meet her?

A June 21, '22.

Q Did you generate a report as a result of that?

A Yes, sir, I did.

MR. SPANO: Can we just mark it for I.D., at this point, Judge, in case he needs to refer to it?

THE COURT: Yes.

MR. SPANO: So this will be Plaintiff's 23 for identification.

THE COURT: Do you want to hand it up?

MR. SPANO: I have my own copy.

(Plaintiff's Exhibit 23, Dr. Guy's report, marked for identification.)

Q So what records did you review? Up to date, what have you reviewed in this case?

A I reviewed the three operative reports performed by Dr. Joseph Weinstein. I reviewed the records from the Lennox Hill Radiology. I reviewed various MRIs of the cervical spine, lumbar spine, right shoulder, X-rays of right shoulder, neck and back, CT scans of the lumbar spine. I reviewed records from Dr. Kohane, Daniel Kohane who performed approximately twelve to thirteen different types of interventional pain management procedures. I reviewed records from Northwell Health Physicians, report of Dr. Daniel Cohen, C-O-H-E-N, records from Dr. Perry from Perry Physical Medicine Rehabilitation, records from Dr. Visram, V-I-S-R-A-M, and records from orthopedic surgeon Dr. Barry Katzman and, also, records from neurologist Daniel Winick.

Q And as part of your making and forming your opinion, review of the records, to get an understanding of all of that, you met with Ms. Rosado-Roca on June 21, 2022?

A Yes, sir, I did.

Q What is -- did she give you a medical history?

A She did.

Q What is a medical history in the context of arriving at a medical opinion?

A A pertinent medical history gives a physician approximately 70 percent of a working diagnosis. The other 10 percent, 20 percent comes from the physical examination.

That's about 80 percent, and the remaining percentage comes from other diagnostic studies such as X-rays, MRIs, EMG, operative reports, et cetera.

So may I give two quick examples of --

MR. MURTAGH: Objection, your Honor.

THE COURT: Okay. Just wait for the next question, Doctor.

Q Did you want to give an example of why a history is important?

A Yes.

Q Is it important for the jury to understand this?

A Yes.

Q Well, then, go ahead.

THE COURT: You can answer.

A So if a physician takes a good medical history, he can make a diagnosis just from a history alone.

To give two quick examples, if a patient is a male 55 years of age or older, complains of chest pain, the physician asked describe your chest pain, is it stabbing or is it crushing, if he says yes, that's a heart attack happening. You admit the patient to a hospital, you do cardiac enzymes, you do EKGs, and you admit the patient through the coronary care unit and modify -- monitor the patient and make sure the patient doesn't go into a full myocardial infarction.

So that's diagnosis made just from the history alone.

Second example, if a patient comes to a physician complains of abdominal pain, a physician asks how long have you had it? If it's six hours or longer, next question, is it the right lower quadrant or what part of the abdomen it is. If it's the right lower quadrant and associated with nausea or vomiting, that's an acute appendicitis happening. You don't even have to examine the patient. You admit the patient, take them to the OR and do exploratory laparotomy and check for the appendix. If it's inflamed, you remove it. If you miss it, the patient can die.

So that was just two quick examples of how important a patient history is.

Q Did Ms. Rosado-Roca relay to you her history of what occurred on October 29, 2017?

A Yes.

MR. SPANO: Do you know what? I just realized something. Can we just approach real quick on something?

THE COURT: Yes.

MR. SPANO: I think it's important. Excuse me, one second.

(Whereupon, an off-the-record Bench conference was had outside the presence of the witness and the

jury.)

Q Okay, so you were going to tell us the history that Favi related to you. I'm just going to qualify that question and just omit any reference to any legal matters in the history that she gave you.

A Okay.

Q Okay, just what did she tell you happened to her?

A Yes, she told me she was working on a job on 10/29/2017 as a housekeeper. She was assaulted by the lady owner of the house. I believe her name was Dale, and she started to walk away, run away from her.

MR. MURTAGH: Objection, your Honor.

THE COURT: Okay. So what is the objection?

MR. MURTAGH: The objection is, your Honor, going to legal matters other than -- that shouldn't be in front of the jury now. I think the history should be the medical history that's given.

THE COURT: Okay. So limit your answer to medical history provided by the plaintiff. Thank you.

Q Did she describe trauma to her body?

A Yes.

Q What traumas did she describe?

A She informed me of trauma to her head, neck, back and later the shoulder became manifest. Initially, she was taken to the hospital. She was treated and released.

X-rays of the injured parts were taken, revealed no fractures. She had a hematoma in the right buttock area.

When she came to see me, she already told me she had the three surgeries. Each surgery gave her some partial relief, but the pain was coming back. She complained to me of neck pain which radiated down the right upper extremity with numbness and tingling, lower back pain with radiation down the right lower extremity with numbness and tingling. Right shoulder pain with difficulty with range of motion.

Q Now, did she relate to you --

Describe her affect and her demeanor when she related this to you.

A She was tearful and crying throughout the whole entire examination evaluation. She appeared anxious and depressed.

Q What did you do next? Did you perform a physical exam?

A Yes.

Q What was --

A I proceeded to do a physical examination of the chief complained areas -- that's the right shoulder, the neck back, range of motion, muscle power and neurological exam and her gait pattern.

Q I forgot to ask you, also, as far as did she state to you whether or not she had ever injured these parts of

her body before?

A No prior injuries to these injured body parts, no.

Q So please describe what your physical exams were on that day and what your findings were.

A Yes.

Her pain level on that day was seven to eight out of ten. Ten being the most severe pain, zero being no pain. Right shoulder was diffusely tender. There were three well-healed arthroscopic surgical scars on the front of the shoulder, side of the shoulder, back of the shoulder.

The shoulder is the most complicated joint in the body because there's three complicated articulations. You have the shoulder, you have the clavicle and you have the scapula.

The shoulder has six ranges of motion.

MR. MURTAGH: Objection, your Honor.

THE COURT: Okay.

MR. SPANO: What's wrong?

THE COURT: What's the objection?

MR. MURTAGH: Your Honor, I think he was describing the pain, not describing the shoulder.

THE COURT: So the objection is overruled.

Q Doctor, I'm going to ask you -- I have some models. We'll do some anatomy discussion subsequent.

Right now what were the results of your

examination?

A So her shoulder flexion was 160 out of 180.

Shoulder flexion is going from zero to this. [Indicating.] This is shoulder flexion 180. [Indicating.]

It was 160 out of 180.

Her internal rotation and external rotation --

That's external rotation [indicating.] This is internal rotation [indicating.]

-- was 75 degrees out of 90.

Extension going back was 60 degrees out of 90. There was a positive Hawkin's and positive of Neer signs. These are signs of partial rotator cuff tear. The rotator cuff is what holds the muscles in the shoulder in place.

Q So these differences -- when you say that she was 160 out of 180, are you stating that 180 would be normal?

A Yes.

Q And she was only able to go to 160?

A That is correct.

Q What would make a person stop and not go to 180?

A When they're developing adhesive capsulitis. In laymen's terms, frozen shoulder. After you have surgery, you have scar tissue, that forms. You have traumatic arthritis that forms. So that's one of the reasons why you have decreased range of motion. Also, if you have cervical radiculopathy, you get referred pain to the shoulder.

Most people, even doctors, get confused whether it's coming from the shoulder or it's coming from the neck. That's why you have to do certain tests to confirm that.

Q Okay.

A So this is some of the examples of that decreased range of motion.

Q All right. And did you perform a physical exam of her neck?

A I did.

Q Okay. Please describe what you performed, what your findings were and what they mean.

A The neck showed diffuse moderate tenderness, moderate amount of spasm, multiple trigger points.

Range of motion for lateral flexion, which is bending from side to side, was 30 degrees out of 45 degrees.

Lateral rotation, which is rotating from side to side, was 40 degrees out of 80. That's half.

And forward flexion and backward extension was 45 out of 60.

Those are 4.5 centimeter anterior cervical discectomy surgical scar. Four point five is about two inches plus or minus.

Back showed, again, tenderness, spasm, multiple trigger points present.

There was eleven centimeter surgical scar. That's

about, roughly, four inches plus or minus.

Range of motion for backward extension was 15 degrees out of 30.

Forward flexion was 60 degrees out of 90.

Bending from side to side, that's called lateral rotation, that was 20 degrees out of 30.

Shoulder -- active range of motion of all muscle groups, joints, was normal except for the right shoulder. Muscle power for the right shoulder and both lower extremities was four out of five.

Normally, it's five over five. Next is five minus over five. Next comes four plus out of five. Next comes four out of five. So it was four grades weaker than normal.

Sensation was diminished to pinprick and touch right biceps and right medial calf. The biceps comes from the nerve root from the fifth and six vertebra. The calf is S1/S2 nerve roots from the lower back.

So I already know just from the physical exam what her problems are, and then the diagnostic studies and op reports confirms my diagnostic studies, and her gait was slow, antalgic with the use of a --

Q When you say gait, what is the gait for the jury?

A The way she's walking.

Antalgic means she walked with a limp with a narrow based quad cane.

So we have a straight cane. A quad cane has four prongs for extra balance, extra stability.

Q Now, there's been a term tossed around -- there's been a word used in court, essentially, implying that there is something called maybe secondary gain or a sense of malingering.

A Right.

Q Let me put it in plain English. Do you come across patients who are trying to put you on, trying to fake you? Have you ever --

A I've been doing this for a long time. It's hard to fool me, but I've been fooled. I've been fooled.

But a malingerer is a person that does not have any bona fide injuries. They refuse to undergo certain dangerous procedures like surgery. So a malingerer person is not a person who submitted themselves to a shoulder surgery, to a neck surgery, to a back surgery because you could die during these procedures from many different causes. You can become paralyzed from these procedures.

She underwent more than thirteen different types of interventional pain procedures -- several cervical epidural injections, several lumbar epidural injections, several cervical facet injections, several lumbar facet injections. This is not a malingerer.

Q The other term that I -- more specifically, might

come up is called symptom magnification.

A Yes.

Q Are you aware of that term?

A I am.

And when a person has anxiety and has posttraumatic stress syndrome, they're afraid of getting hurt again. When you touch the areas that have been hurt, of course, they're gonna show certain grimaces by the face and certain movements to prevent themselves from getting injured. So to a non-treating physician, that they may call symptom magnification.

So a patient has these injuries, there's no symptom magnification. They're hurt. They have pain. They have decreased range of motion, positive neurological deficits, gait disturbance. Their whole life has changed, so, of course, they don't want to get reinjured again.

Q Now, you began defining before the anatomy of the shoulder. I have a model here and would it assist you to maybe use a model instead of your own shoulder to the jury to explain the anatomy of the shoulder?

A Yes.

Q It is an oldy but goody.

MR. SPANO: Can the witness be handed --

THE COURT: Yes.

MR. SPANO: Are we going to mark it?

THE COURT: No.

MR. SPANO: There's no need to mark it. I'll ask you questions about it.

Q What are you holding in your hand?

A This is a model of the shoulder joint.

Q And does that -- is that an anatomically accurate model of a shoulder joint?

A Yes.

Q And would it assist you in describing to the jury how the shoulder works and what, if anything -- how if anyway that relates to the condition Ms. Rosado-Roca?

A May I stand there?

THE COURT: No. You can stay right there, thank you.

THE WITNESS: From sitting or standing, Judge?

THE COURT: It would help you to stand?

THE WITNESS: Yes, your Honor.

THE COURT: You can stand.

THE WITNESS: Okay.

THE COURT: Just be careful.

A So what we're looking at is a model of the shoulder. This is pertaining to the left side. [Indicating.] This is the humerus. [Indicating.] This is the head of the humerus. [Indicating.] This is the scapula. [Indicating.] This is the clavicle, the

collarbone. [Indicating.]

So the shoulder is the most complicated joint in the body because it has very difficult and complicated ranges of motion. It has six ranges of motion. We have shoulder flexion, zero to 180; shoulder extension, zero to 90. We have shoulder abduction, zero to 90; we have shoulder adduction zero to 60; shoulder external rotation, zero to 90; internal rotation, zero to 90.

Now, the rotator cuff covers the shoulder area. There are four muscles -- supraspinatus, infraspinatus, teres minor, subscapular. They control moving the shoulder up and down in different directions.

Then we have the labrum, which covers the shoulder joint. It's a ring around the shoulder joint. It's like a cushion. It serves as a shock absorber.

So as it pertains to this patient, she had a partial tear of the rotator cuff muscles, most importantly, the infraspinatus, and she had a tear of the labrum, the ring around the shoulder.

Q And you've read the operative report of Dr. Weinstein --

A Yes, I did.

Q -- who addressed the issues in her shoulder?

A Yes.

Q And was this a medically indicated surgery?

A Absolutely.

Q And do you have an opinion, to a reasonable degree of medical certainty, as to whether or not the need for that surgery was precipitated by the October 29, 2017, event?

A Yes, I do have an opinion.

Q What is your opinion?

A It was causally related to this incident. For many reasons.

Q Explain the many religious.

A Number 1, the patient never had any prior problems with the shoulder.

Number 2, in the beginning, she didn't have shoulder complaints because she was having neck pain radiating to the shoulders. She thought it was coming from the neck, but later on, after the neck surgery, the brain picks up the one or two areas that hurts the most.

She had the neck surgery; the neck pain got better, so now the shoulder, the right shoulder became manifest. So the shoulder surgery became manifest after her neck surgery, and then it failed conservative treatments. It failed medications, Percocet. It failed different types of injections. The next thing to do is the surgery because of failed conservative treatments.

Q Okay. In evidence or --

MR. SPANO: Withdrawn.

Q Yes.

In evidence as Exhibit 20 -- you've read the records from Perry Physical Medicine and Rehab?

A I did.

Q And in those records, does it reference --

MR. SPANO: Withdrawn.

Q And these are records from within a month after the incident, November 2nd, 2017 through March 22, 2018, true?

A True, yes.

Q And among her first visits to Dr. Perry, are there reference to the shoulders?

A Neck pain radiating to both shoulders.

Q If, hypothetically, a doctor would come into a courtroom later this week and say the only time the shoulder came up was three years, four years after the incident, accurate or inaccurate?

A Not accurate.

Q Spinal cord, I would like to discuss with you. Did you read the MRIs regarding the spinal cord post October 29th, 2017?

A Yes, sir.

Q And what was the most recent MRI after that incident?

A Okay. 2023 and --

Q Let me --

Okay.

A -- and March 5, 2024.

MR. SPANO: Can I have this marked for I.D.?

MR. MURTAGH: What is that?

MR. SPANO: Can I just mark it for I.D.?

THE COURT: So this is 24 for I.D.

(Plaintiff's Exhibit 24, Diagnostic Imaging of Rockville Centre report, marked for identification.)

MR SPANO: Keep that as I.D. I'm going do show the witness exhibit -- the Perry Physical Medicine and Rehab exhibit.

Can this please be shown to the witness. I'll take that back I.D., if that's okay with everybody.

Sorry for the confusion.

Q So you're looking at Exhibit 20 in evidence. That's the first medical facility she sought after the incident, we've established that, right?

A That's correct.

Q And did the doctors do a workup?

A Yes.

Q And among the workups that they did, did they recommend radiology?

A Yes. MRI of the cervical spine performed on December 12th, 2017.

Q Two months after the incident, yes?

A Yes.

Q And was there an impression in that MRI?

A Yes.

Showed four disk bulges, one disk herniation at C4/C5 and the two levels above it from bulging, and the two levels below it were also bulging.

Q There's been a bunch --

Well, there's been other MRIs subsequent over the years, Doctor?

A Several, yes.

Q Several.

You've seen some of them, if not most of them?

A Yes, sir.

Q Are they mainly, and just to summarize, consistent with what we're seeing here as far as the cervical spine?

A Yes, sir.

Q You're familiar with the idea of what's called a pathology of a cervical disk herniation?

A Yes.

Q And are you familiar with the concepts of disk degeneration and the relation between the pain syndromes?

A Yes, sir.

Q If I brought out some exhibits -- if I brought out, rather, a model, would it assist you in educating the jury on those points?

A Yes, sir.

Q Do you want to use the big ones or the small ones?

A I'm going to use all four of them.

MR. SPANO: Okay, so I'm handing the witness four items that he'll describe what they are.

Q First, just tell us what they are and just in general terms what are those things?

A These are models of the spine showing -- showing the anatomy of the disk, the vertebra, the surrounding structures.

Q Each one of those items appears to be, maybe, three to four inches big, yes?

A Yes.

MR. SPANO: With the Court's permission, I'd like the witness to maybe step down from the stand. I see some of the jurors are putting their glasses on before, sort of craning their necks. Can he please come down and use those models to describe what they are?

MR. MURTAGH: I didn't know that they were straining their necks, your Honor. I don't know that that's necessary.

THE COURT: It's fine. You can step down.

(Whereupon, the witness is testifying from the well.)

THE COURT: Doctor, when you're speaking, the reporter needs to see you --

THE WITNESS: Yes, your Honor.

THE COURT: --so please face this way.

Q So now my question to you is -- I'm gonna ask you to please describe to the jury the anatomy of the vertebrae and the spinal processes, the disks and, if you could state how it relates to the case of Mrs. Rosado-Roca.

A Yes.

So in the human spine we have three segments. The cervical spine is referred to as cervical spine. There's seven vertebra. The mid-back is referred to as the thoracic spine. There are twelve vertebra. The lower back is referred to as the lumbar spine. There are five vertebra. The lumbar spine ends with the tailbone, the sacrum and the coccyx.

Now, in the cervical spine, each level is labeled according to its anatomic location. If I say C5/C6, that means the space between the fifth and the sixth cervical vertebra.

So we have a disk. The function of a disk is to serve as a shock absorber. It is the disk that gives us the spaces between our vertebra and the material inside called the nucleolus pulposus, P-U-L-P-O-S-U-S. It is this structure that gives us our ability to bend forwards, bend

backwards, rotate from side to side, and if we did not have the this structure, every time we jumped up, bone would hit bone and it would break, so it's a very important structure.

Now, right behind the disks, we have the nerve roots which exit from the spinal cord. The spinal cord goes from the brain all the way down to the lower back and somewhere between the first and second lumbar vertebra, and it continues with branches of nerve roots.

So the facet are these structures. The function of the facet is to give us range of motion to bend backward, bend from side to side, rotate from side to side. That's a facet.

If a patient has localized back pain, it doesn't radiate and is made worse with back extension and turning from side toe side, that is a facet syndrome, and we have different treatments for that, and we have different pathological conditions to a disk.

This is a normal disk. [Indicating.] This is a bulge, a partial tear. [Indicating.] Normal, a bulge, partial tear. Normal, partial tear.

A protrusion is defined as a complete tear of the disk, but the disk material doesn't pass its disk margin. If it does like here, that's called a herniation.

I'm gonna show it. Disk protrusion, disk herniation. Disk protrusion, disk herniation. Protrusion,

herniation. Protrusion, herniation.

So a disk protrusion, in laymen's terms, is defined as a complete tear of a disk where the disk material does not pass the disk margin. A disk herniation is defined as a complete tear of a disk where the disk material passes its disk margin and it crowds the nerve root.

This is the neuroforamen where a nerve root exits right here. So when you have a disk herniation, sometimes it causes crowding of the nerve root.

Now, once we have trauma to the spine, the body reacts by protecting that part from a recurrent injury.

Spasm is when the fibers shorten and muscles become tight. That's one way of the body's mechanism trying to prevent the body from a recurring injury.

Then the body begins to form these bony projections called osteophytes. These are osteophytes. [Indicating.] This is a normal disk. [Indicating.] This is a degenerative disk with a disk space that has shriveled up. [Indicating.] The water content has leaked out, and you have formation of these bony projections called osteophytes, and this is an example of an end stage disk disease. When a disk has been completely damaged, there's almost no disk space. It's like a truck -- an old truck with old shock absorbers going over through the streets in downtown Manhattan. You feel every bone.

So that's degeneration. That's facet hypertrophy, and this is an example of disk herniation causing radiculopathy. Radic means nerve root. Opathy means damage to a nerve root.

Q Doctor, if a surgeon came into this case and said that Ms. Rosado-Roca was suffering from --

Did the surgery, opened it up, saw the disk herniations, and that she was also complaining of radiating radicular pain, which one of those would most accurately fit Ms. Rosado-Roca?

A This one. [Indicating.]

Q Okay, a herniated disk.

Now, you picked one with some degeneration, I noticed.

A Right.

Q Is that an abnormal finding or a normal finding?

A This is a normal finding in a 44-year-old female.

So degenerative process in the male starts later than females. Different hormones protect different sexes from different ailments. So the degenerative process in the female starts at the age of 30, plus or minus two years. In the male it starts at the age of 40 plus or minus two years.

Q Okay.

And so if there were some degenerative process on the MRIs of Ms. Rosado-Roca over the years or even in the

beginning and over the years, a normal finding?

A It's a normal finding, yes.

Q Now, can somebody have -- be 40 years old, female and have degenerative process in the spine and be asymptomatic and not have a problem?

A In most cases, it is asymptomatic. I see some of the people here, any females over the age of --

THE COURT: Okay, Doctor, we're not here to ask the jury questions.

MR. MURTAGH: Objection.

THE COURT: Are you done with the --

MR. SPANO: I'm done with the bones.

THE COURT: You can step back to the stand, thank you.

Q So do you have an opinion to a reasonable degree of medical certainty as to whether a degenerative process can be activated into a painful permanent back pain?

A Yes, I do have an opinion, and the answer is yes.

Q And what do you base that on?

A Based on many, many years of experience and many, many years of reviewing diagnostic studies before and after certain injuries.

Q So is it your opinion that Ms. Rosado-Roca could have lived her life expectancy without any neck or back pain based upon -- well, yes or no --

MR. SPANO: Withdrawn.

Q But for the October 29, 2017 beating that she took, could she have lived a pain-free life?

A Absolutely. As she did up until this incident.

Q And I'm gonna ask you to assume --

MR. SPANO: I'm hearing some voices back there.

THE COURT: Please don't speak in the back.

Go ahead, Mr. Spano.

Q I'm going to ask you to assume, as she's testified in this courtroom to this jury, that she was thrown to the ground and that she, on her back, was beaten and pounded with fists, that she tried to get away, and when she did, she was grabbed by her hair, and the evidence in this case shows she was then pulled back to the ground and dragged, that Ms. Rosado-Roca fought back and tried to get away and was pushed over a half wall, and that the defendant in this case had a cell phone and was pounding on the back of her head and her neck, but she was able to push away and run away and scream, given that assumption that that did occur and if that is true, do you have an opinion as to whether that conduct, that incident was a competent-producing factor of the back, of the neck, shoulder and spinal injuries she suffered?

A Absolutely.

Common sense question, common sense answer.

MR. MURTAGH: Objection, your Honor.

THE COURT: Sustained.

MR. SPANO: Do I have to rephrase that whole question?

THE COURT: The answer will be stricken.

Q Do you have an opinion to a reasonable degree of medical certainty, assuming that what I have just described was testified and is accurate, and based upon your examination and based upon your review of all of these records and your training and experience in trauma, do you have an opinion, to a reasonable degree of medical certainty, as to whether or not the beating that Dale Westreich did to Favi Rosado-Roca caused the need -- caused the injuries to her neck, to her back and to her shoulder?

A Yes.

Q What is your opinion?

A That it was causally related to the this incident.

Q You mentioned before --

Well, have you read records in this case of a Dr. Kohane?

A Yes.

Q And Dr. Kohane is what type of doctor?

A Pain management doctor.

MR. SPANO: I'm gonna show the witness what's

been marked into evidence as Exhibit 21.

THE COURT: Are you finished with 20, Mr. Spano?

MR. SPANO: Yes.

Q You've had a chance to review those records?

A Yes, sir.

Q When did that treatment begin with Dr. Kohane?

A April 20, 2018.

Q Okay, April 20, 2018, and just not yet even a year after the incident?

A Correct.

Q So about six or seven months after the incident she saw Dr. Kohane?

A Yes, sir.

Q There's a lot of records. You've read them. Can you just summarize --

A Yes.

Q -- what Dr. Kohane's plan of action was?

A Yes.

The doctor gave her multiple cervical interlaminar epidural injections, multiple lumbar epidural injections, multiple cervical facet medial branch block injections to the cervical spine, multiple lumbar medial branch block facet injections to the lumbar spine, and, I believe, also, let me just -- radiofrequency.

Let me make sure he did radiofrequency also. Give me a minute.

I don't see the radiofrequency, so I'm just gonna stick with the --

Q But he did do epidurals?

A Yes, he did.

Q Have you done epidurals?

A Over 35,000.

Q In plain terms what is an epidural injection?

A Okay, where did my models go? I was gonna show it.

THE COURT: Just answer the question, please, thank you.

Q Would using a model help you?

A Tremendously.

Q Where are they? Would these little ones help you or do you want the big one?

A The little ones.

MR. SPANO: For the record, I'm handing the doctor the four vertebrae exhibits.

A So --

Q Please continue.

THE WITNESS: May I continue, Judge?

THE COURT: Yes.

A So when you give an injection to a patient in the epidural space, the medication that goes into -- next to the

spine has much more power than if you give it by mouth orally.

One example is Morphine. One milligram of Morphine in the spine equals 100 milligrams by mouth. If you give a patient 100 milligrams of Morphine by mouth, you'll kill 'em. One milligram does nothing to diminish the pain.

So we deliver epidural injections, usually, if it's in the neck, we don't give lidocaine, we give normal saline with a strong powerful steroid.

Steroid reduces pain and inflammation.

May I use the needle to show how it's done?

Q Do you -- when you use a needle --

Did you bring a needle?

A I did.

MR. MURTAGH: Objection. The witness is responding to things that are not asked.

THE COURT: Just answer the question, but don't answer the question with a question, all right?

MR. SPANO: Okay.

THE COURT: Do you have another question, Mr. Spano?

MR. SPANO: I do, your Honor.

Q Did you happen to bring a sample epidural needle with you today?

A Yes.

Q Okay. Can you please take it out? I'd like it show it to counsel.

For what purpose did you bring it?

A To show for demonstrative purposes.

Q Okay.

MR. SPANO: May I show it to --

THE COURT: Hold on.

Mr. Murtagh, do you have any objection to the witness using the needle for demonstrative purposes?

MR. MURTAGH: No, your Honor.

THE COURT: Okay.

Q Would it assist you in explaining to the jury how that epidural would work using the needle and the vertebrae that you're holding?

A Yes.

THE COURT: Go ahead.

Q Please stand up, please.

THE WITNESS: May I stand?

THE COURT: Yes.

A So when you give epidural needle into the spine, the needle looks like this [indicating], and we have a fluoroscopy machine, which is like an X-ray, to make sure we are going into the right direction. So if we --

If you're gonna be doing an epidural in the neck, we usually go between the sixth and seventh vertebra. That

is the safest place to give the injection. The medication will go above and below the level.

So we put the needle inside in the middle of the spine, and we have the fluoroscopy that will confirm where it's going. We're going deep enough until we reach the targeted area, and then we have a loss of resistance syringe where -- when the resistance of the syringe is lost, it means we're in the right spot. We give usually 40 to 80 milligrams of a milky steroid medication which lasts for long time as opposed to a clear liquid which lasts for very short time, and we see the results.

If the patient has a decent result of 60 percent improvement or more, we do another one when the pain comes back, and we do another one. Usually three per year. The standard of care for epidural is three per year for the cervical spine, three per year for the lumbar spine.

So that was the cervical epidural.

Q Okay. Thank you.

And, so, when a cervical epidural is done to a patient who is experiencing radicular pain and trouble with rotation, what is the hoped-for outcome?

A The purpose of the epidural is to reduce the pain, reduce the inflammation.

Not to cure. There is no cure for disk herniation. Because the fibers on the outside, once they tear, there's

no way they can repair themselves. Fiber cartilage does not have the ability to repair itself as opposed to bone.

So, again, the purpose is to decrease the pain, decrease the inflammation, improve range of motion.

THE COURT: We're going to take a short break.

Members of the jury, just as a reminder, no discussing the case, no research. I'll see you in about ten minutes.

You can step down.

Mr. Spano, just in the future, don't start setting up the screen while you're asking a witness questions.

MR. SPANO: I'm just trying to segue.

THE COURT: We'll take a break so that you can get whatever you need right away, okay?

I'll see you in ten minutes.

(A short recess was taken.)

THE COURT CLERK: Remain seated, come to order.

THE COURT: Doctor, you can return to the stand, please. Thank you.

THE COURT OFFICER: Are you ready?

THE COURT: We're ready, thank you.

THE COURT OFFICER: Jury entering.

THE COURT: You can be seated, thank you.

Mr. Spano, whenever you're ready.

MR. SPANO: Thank you.

Q You've described the performance of a cervical epidural, yes?

A Yes, sir.

Q And Ms. Rosado-Roca also had a series over time of the lumbar, is that so?

A Yes, sir.

Q Is that something you do in your practice?

A Yes, sir.

Q I have -- as part of exhibit -- of Dr. Kohane's records, which is Exhibit 21 in evidence, I brought up just a sample operative report of a lumbar epidural. You've seen this before?

A Yes, sir.

Q And I know it speaks for itself, but this was done on what date, doc?

A I can't see from here.

JUROR NO. 1: It's highlighted.

THE COURT: Mr. Spano, this is part of Exhibit 21?

MR. SPANO: This is part of Exhibit 21.

THE COURT: So why don't we just give the doctor Exhibit 21 if you want him looking at the same document.

MR. SPANO: He has it, your Honor.

THE COURT: He has it?

MR. SPANO: It's enormous, so I was just going to pull out what is up on the screen just to move things along.

THE COURT: Okay.

Q I'm showing the doctor a report that is contained within Exhibit 21. Just please, what are you looking at?

A This is the operative procedure for the lumbar epidural injection that was performed.

Q Is that what is up on the screen here?

A Yes.

Q So what is the pre-op diagnosis?

A Lumbosacral radiculitis.

Q Which is what?

A Damage to a nerve root.

Q And the operation that Dr. Kohane performed is what?

A A lumbar transforaminal epidural steroid injection with contrast using Benadryl for her allergy and transforaminal and fluoroscopic acquisition of rootograms.

Q Plain English, what does that mean?

A Can I use my models?

THE COURT: Yes.

MR. SPANO: Yes? Great.

A So when we do epidural injection in the lower back, it can be done in three places:

In the center of the spine, which is called interlaminar. It's dangerous because you can have leakage of the spinal fluid.

Transforaminal is usually two fingers away from midline. This is a transforaminal epidural injection, and we give contrast to make sure we are outlining the nerve root. That's called either a discogram or a -- he calls it a rootogram, an outline of the nerve roots.

And the other way you can do the epidural is through a tailbone called a caudal epidural injection.

He chose to do the transforaminal because the pain on that date was only on the right side.

Q Okay.

And the location of the -- this particular epidural was where on the spine?

A Between the L4/L5 and the L5/S1, the last two levels in the lumbar spine.

Q We've used a model, this model before. I'm gonna -- can you point out to the jury using this model where that spot of the epidural was?

Yes, can you do it?

A With the judge's permission.

Q First, can you do it?

A Yes.

Q Will this model assist you in making it very clear to the jury where the epidural lumbar as shown in that operative report is?

A Yes.

MR. SPANO: With the Court's permission, can the witness step down and maybe we'll put this in a safe place and just have the witness demonstrate for the jury where that was?

THE COURT: Yes.

THE WITNESS: May I step down, your Honor?

THE COURT: Yes.

Q Please go ahead.

A So may I begin?

Q Please do.

A So epidurals are done from the back of the spine.

This is the front of the spine. [Indicating.] This is the back of the spine. [Indicating.]

The last vertebra in the low back is L5. This is L4, L3, L2, L1. [Indicating.]

So between L4/5, between fourth, fifth vertebra, the transforaminal you go right underneath this transverse, this structure right here, so needle going here between L5/S1. The needle would go down here. [Indicating.]

Q Okay. And is this done under -- is the patient

awake when this is going on?

A Generally, the patient can get a local anesthesia or they can get sedation with propofol.

Q This here says IV conscious sedation?

A That's with propofol.

Q So she's kind of --

A Half awake, half asleep.

MR. MURTAGH: Objection, your Honor. Can he complete the question before the witness answers?

THE COURT: Just let Mr. Spano complete the question before you answer, Doctor.

Q She was kind of between --

Describe what the state she was in with this sort of anesthesia?

A So with the IV sedation, the patient is half awake, half asleep, but they don't feel the pain.

Q And you can resume the stand, please.

This was done, according to the records, on January 18th, 2023, yes?

A Yes, sir.

Q And that is roughly six -- six, maybe a little bit more, six years, six to seven years after this incident?

A Yes, sir.

Q Does that have any significance to you?

A It does.

Q What does that mean?

A It shows that the patient's condition is permanent, progressive as it is.

When you have a disk herniation, it is a permanent condition. It has no cure. It has treatments. The treatments are physical therapy, medications, different types of injections, epidurals, facets, surgery.

After the surgery, you have traumatic arthritis that sets in, and you have what is called adjacent segmental pathology that sets in, which means the pressure is gonna be transferred to the disks, the disks above or below where the surgery was.

The surgery was at L5/S1, so now the pressure is going to the disks above. They become injured, they become inflamed and become symptomatic.

So this condition is progressive as is being shown by the clinical picture and the need for further treatments.

Q Based upon the whole picture that you have, all of the records, all of the op reports, physical exam, your training, did you arrive at a diagnosis for Ms. Rosado-Roca?

A Yes.

Q What diagnosis did you arrive at?

A So I'm going from head to toe status post multiple traumatic injuries, head trauma with postconcussion syndrome, reactive anxiety and depression with posttraumatic

stress syndrome, C6/C7 disk bulge, C4/C5, C5/C6 disk herniations, C2/C3, C3/C4 disk bulges, cervical and lumbar radiculopathy, right gluteal hematoma with a right hamstring tendonitis, L5/S1 disk protrusion with herniation and nerve root impingement, L3 to L4 disk bulges, right shoulder arthroscopic surgery due to a partial rotator cuff and a slap tear and a labral tear, gait disturbance status post cervical and lumbar surgeries.

Q And do you have an opinion to a reasonable degree of medical certainty as to whether those diagnoses you just recited were a result of the October 29, 2017 assault?

A Yes, sir.

Q What is your opinion?

A That they're causally related to this accident.

Q Knowing that Ms. Rosado-Roca --

Well, she's testified in court that she's led a very active life prior to this; are you aware of that?

A Yes.

Q Knowing that she has led a very active work life and has never had a neck, back or shoulder complaint before October 29th, 2017, do you have an opinion, to a reasonable degree of medical certainty, as to whether the injuries you diagnosed have fully or partially disabled Mrs. Rosado-Roca from working?

A I feel that they have totally disabled her from any

current or any future work.

Q I have also asked you to give an opinion as to future medical records, rather, a life care plan. I asked you to do a life care plan, yes?

A Yes, sir.

Q Do you have an opinion as to what the future needs, medical needs of Ms. Rosado-Roca will be?

A Yes, sir.

Q December 2023, even after the epidural we just saw, she had a car accident?

A Yes, sir.

Q You're aware of that?

A Yes, sir.

Q In fact, I sent her to you to update, yes?

A Yes, sir.

Q Okay.

Did you have a chance to examine Ms. Rosado-Roca after the December 2023 car accident?

A Yes, sir, I did.

Q Did it change your opinion in any way as to what was caused by this assault?

A No, sir.

Q What effect, if any, can you tell us did the car accident have in the context of the injuries from her assault?

A Yes. It exacerbated her neck and back condition.

Q Okay.

A But no new injuries.

Q Now, is it your testimony here in court today that she was permanently disabled prior to this car accident?

A Totally and permanently disabled prior to this car accident, yes, sir.

Q So the life care plan, do you have it in front of you?

A Yes, sir, I do.

Q How do you arrive at a life care plan?

A Based on the medical indications and the prognosis for future medical needs and treatments and knowing the fee schedule for those medical treatments.

Q Okay.

And --

MR. SPANO: Excuse me, your Honor.

Q Based upon the history, clinical findings, your review of the medical records, in your professional opinion of all of the diagnoses above, what is your opinion as to what the proper medical needs for this patient going forward are and the relative costs of those medications?

And if you can take them one at a time, I'd appreciate it.

A Yes.

MR. MURTAGH: Are we putting something up on the screen?

MR. SPANO: I'm going to put up on the screen a little Power Point of what he's gonna say.

THE COURT: So let's just give you a minute to do that.

Q How many points are you gonna reference?

A Eleven.

Q What is the first one?

A The patient will need to see a neurologist at least six to eight times per year to monitor the neurological injuries, and the cost for each visit is $200.

Q And that's based upon everything you've read? That's based upon your examinations, that's based upon costs that you know, medical costs are?

A Yes, sir.

Q Next, is there another cost?

A The patient should be seen by a spinal surgeon at least three times per year to monitor the spinal injuries, look for adjacent segmental pathology, traumatic arthritis, hardware loosening, metal screws, plates loosening and/or becoming dysfunctional. So that will be three times per year, and the cost is between 300 to $400 for each visit depending on the amount of time the surgeon spends with the patient.

Q So when you talk about segmental adjacent pathology, those are big words. I don't know what they mean. Explain to the jury.

A May I use a model?

THE COURT: Yes.

A So when you have a disk herniation, let's say, at C5/C6, that's where the surgery was, the pressure of the spine goes to the level above and the level below. So when that disk or those disks are asked to do more work than they're supposed to, they become dysfunctional, they become bulging, protruding or herniated. That is referred to, in the medical terminology, as adjacent segmental pathology, next to the level where the surgery was.

And then we have traumatic arthritis. This is an example of traumatic arthritis, where the disk space narrows faster than usual. Bone projections called osteophytes begin to form faster than usual. This is an example of traumatic arthritis which follows trauma.

Q It's your opinion that, as far as prognosis --

Well, what is your opinion as far as prognosis?

A She's left with a permanent total disability. The condition is permanent and progressive, which means that over time it would slowly progressively worsen as I showed with these models.

Q Okay.

Next.

A Okay. The patient should be seen by a physiatrist, someone like myself with training and interventional pain management, at least twelve times per year to monitor the patient's overall musculoskeletal condition, assess the need for physical therapy, pain medications, referral to other medical specialists, assess the need for medications and possible interventional pain management procedures. The cost for each visit is $200.

Q Okay. Is that twelve times a year, is that excessive in any way?

A No. It's once per month. That's the minimum --

Q Okay.

A -- because to assess -- prescribing medications, you want to assess how the patient is doing without medication at monthly intervals, not at annual intervals where a patient may develop side effects and you don't catch it early.

Q Okay.

A So that's the minimum monthly as per standard of care.

Q Please continue.

A The patient should have one physical therapy session at the least per week to diminish pain and spasm, restore range of motion deficits and to prevent this

condition from getting progressively worse. The cost for each comprehensive physical therapy session is $200.

Q Is that excessive?

A It is not excessive.

Q Next.

A The patient should have EMGs of the upper and lower extremities now and every one to two years to assess the extent of nerve damage, and the cost for each EMG is about $2,000.

Q Is what is an EMG?

A Electromyography is a test that is done by a physiatrist, like myself, or a neurologist. It is done to check the nerve roots or the peripheral nerves to see if there's any nerve damage.

Q In your review of the records, did Mrs. Rosado-Roca undergo EMGs?

A Yes. She had the first one with Dr. Cohen in 2019 which did not show any cervical radiculopathy. It showed bilateral carpal tunnel syndrome. That's a pinched nerve in the wrist, however, in 2021 there was a repeat EMG done by Dr. Winick, and his EMG showed radiculopathy at the C5/C6 level.

Q How can that be explained?

A Many times when you do an EMG, whoever does an EMG, if it comes back as normal, you must put down in your

report. A repeat study is indicated in six to eight weeks if the symptoms percents.

Because when you do an EMG, it's like finding a needle in a haystack. You got to go in different directions so many times, and sometimes it's painful. You have a needle going into the muscle in different directions. Patient may not be comfortable in allowing to full needle sampling, and you may miss an area, and the condition may be progressive, so you have to catch it if the radicular symptoms persists, as such was the case here.

Q Was there anything else in your life care plan?

A Oh, yes.

The patient should have periodic MRIs of the brain, cervical spine, lumbar spine, right shoulder every two to three years to check for extent of injuries and progression of the injuries, and the cost for each MRI is 1,500.

A good example was the shoulder. It was not being manifest in the beginning. It became manifest after the neck surgery, so it was done approximately three years afterwards. That's a perfect example of that.

Q Have you seen that in your experience somebody has cervical spine surgery, and they're complaining now the shoulder is worse or it's activated in some way?

A Yes. For many reasons.

Q Why?

A The neck and the shoulder muscles, they share similar muscles, and they're both in the same vicinity, and the neck symptoms radiate to the shoulder and sometimes the shoulder radiates to the neck. So it becomes a little confusing in the beginning, that's why we do different diagnostic studies to confirm where the pain is coming from.

Q Please continue. Anything further in your life care plan?

A Yeah.

So the cost for each MRI is 1,500, and, next, the patient would need periodic medications for pain, spasm and inflammation and the approximate annual cost is anywhere from 3,000 to $5,000.

We have different medications. Celebrex can cost anywhere from four dollars to six dollars a pill. If you take just one a day, sometimes twice a day, you can do the math, eight dollars to twelve dollars a day multiply by 365 days, and then we have Lyrica, L-Y-R-I-C-A, a hundred milligrams, which is about three to four dollars a pill. That's for neuropathic pain for the radicular pain, and when you add it up, it's -- I have a very conservative number, 3,000 to $5,000.

Q For the next five years, what is your recommendation for the patient as far as interventional pain management?

A For the next five years, according to the standards of medical care and practice, the patient is entitled to three cervical epidural injections per year, if each one works. Three lumbar epidural injections per year, if each one works. Three cervical facet medial branch block injections and the same for the lumbar spine, three for each, and then the patient will need radiofrequency ablation procedures and two for the neck, two for the low back. The cost for each epidural is $2,000 to be done at a surgical facility with anesthesia, with recovery, with nurses, with fluoroscopy and the medications. The medical cost for the surgeon to do the procedure is 2,000. The outpatient surgical facility for each procedure is about 3,000. The cervical facet injections, the cost for the surgeon is 3,000. Outpatient surgical facility for each is $3,000. Radiofrequency ablation is $5,000.

Q Hold on a second. I think we're getting -- I'm trying to keep up with you.

So No. 8, the patient will need three facet injections and three lumbar facet injections per year. This is the cost of 300?

A 3,000. It's not 300. It's 3,000.

Q I'm sorry I typed this very late last night, 3,000, and the outpatient surgical facility is about what?

A It's 3,000 for each procedure.

Q Okay, please continue, No. 9.

A And then the patient will need to have two cervical radiofrequency ablation procedures per year and two lumbar radiofrequency ablation procedures per year.

Q Do you do those?

A I do those, yes, sir.

Q What is, in plain English, what is a radiofrequency ablation?

A With heat energy, we have -- place a needle right to the facet where the medial branch comes at with a heat energy, a hundred sixty degrees Fahrenheit. We burn the sensory nerve. It grows back after six to nine months, and that is radiofrequency. It's done for facet syndrome conditions.

Q Okay.

A And the cost for that is 5,000, and the outpatient surgical facility for that for each is $4,000.

Q All right.

And you mentioned further that, optimally, she would need twelve sets of trigger point injections per year for muscle pain?

A Yes, sir, that's correct.

Q And that cost 400 per set?

A Yes, sir, that is correct.

Q Number 10, please.

A Number 10.

Q Slowly.

A So as future adjacent segmental pathology and traumatic arthritis to the cervical and lumbar spine gradually sets in, and the typical longevity of these procedures is about five to seven years, plus or minus two years, therefore, for the future the patient would need a two to a three level cervical -- anterior cervical discectomy with fusion as well as a two- to a three-level lumbar interbody fusion with a prosthetic disk replacement for each cervical and lumbar spine, and the cost for each surgery is as follows:

Surgeon's fee for each surgery is about 40,000 to $60,000; surgical assistant fee for each surgery is about $10,000; one to two day hospital stay for each surgery is anywhere from 100,000 to $200,000; anesthesia fee is $3,000; intraoperative evoke potential studies to monitor the spine and the nerve roots during surgery is about $3,000. And after the surgery, patient would need post surgical bracing for each surgery. That would be $1,000. After each surgery, the patient would need additional physical therapy sessions three times a week for four to six months.

Number 11, if the patient chooses to go to and have the state-of-the-art robotic spinal surgery which is done at NYU Medical Center, the cost is anywhere from 400,000 to

$800,000, only for robotic surgery.

Q So is it fair to say what you've listed here as a life care plan would be, if I can put it in plain terms, you know, optimal?

A Yes.

Q You know, top of the line, optimal care, right?

A Yes, sir.

Q Because she has not had a lot of these things?

A She has not.

Q All right. I'm going to turn off the TV. A couple of more questions.

Have you read a report or reports from a Dr. Jeffrey Richmond?

A Yes, sir, I have.

Q And you understand that --

Well, do you understand that the defense has no burden of proof in this case, do you know that?

A Yes.

Q He may call Dr. Jeffrey Richmond to the witness stand. I have been given the report and I gave it to you. Do you understand that?

A Yes, sir.

Q Have you read it?

A Yes, sir.

Q Do doctors always agree?

A No, sir.

Q And is it somewhat common that doctors will have the same thing and see it differently and view it differently and have diverging opinions?

A Happens all the time.

Q Okay.

Dr. Richmond had some concerns and thoughts about your life care plan, you're aware of that, you read them?

A I read them, yes, sir.

Q Do you agree or disagree with his concerns?

A I most respectfully and most vehemently disagree with many of his opinions.

Q Could you be specific?

A Yes.

For example, Dr. Jeffrey Richmond mischaracterizes my report. He says the cost for the spinal surgery is 400,000 to 800,000. He doesn't say what I said. It's about 40,000 to 60,000. He quotes the higher amount for the robotic surgery which is done at NYU. He doesn't mention the first cost that I said.

Q Okay.

A And No. 2, the doctor says that the patient has a completely -- essentially -- he doesn't say completely -- he says essentially normal neurological exam.

I did not find a normal neurological exam. I find

an abnormal neurological exam, and you could still have a serious injury even if you have a normal neurological exam.

And, third, the doctor disagrees with the interventional pain management procedures that I said are indicated only for five years. He says Dr. Guy says for life. I never said that. I just read the report. So that is another one, and he mischaracterizes and says that these -- my suggestions deviate from the standards of medical care and practice.

I teach the standards of medical care and practice. The State Education Department has chosen me to be the expert in this area to go into other doctors and check for standards of medical care.

So he, basically, um, defamed me by these false statements.

Q Okay. Your position is clear.

You're taking time away from your office, and you're here in court to testify and you charge a court fee?

A Yes, sir.

Q You and I have worked together before on other cases, doc?

A A few. Not many.

Q What is your standard fee for a day of testimony?

A For canceling my patients and being here is $5,000 for half a day. That includes reviewing all the patient's

medical records and discussing the case with -- the medical aspects of the case with you before coming here.

Q Okay.

MR. SPANO: I have no further questions for the witness.

THE COURT: Mr. Murtagh.

MR. MURTAGH: Thank you, Judge.

CROSS-EXAMINATION

BY MR. MURTAGH:

Q Good morning, Dr. Guy.

A Good morning, sir.

Q Sir, we have not met before, I don't believe?

A I don't believe so.

Q I don't believe so either.

So can you tell me, coming here today, approximately, how many times have you testified in court?

A On the average, eight to ten times per year, except for the COVID period.

Q And, approximately, how many times since you began testifying, how many times have you done it?

A Under 300 times, slightly less, could be slightly more.

Q So 300 times, under 300 or slightly less, slightly more, and each time you charge the fee like what you've just described?

A In the beginning was much less.
Q How much less?
A In the beginning, 1990, 3,000 for half a day.
Q When did it become 5,000 for half a day?
A I'd say the last five years, plus or minus.
Q All right.
And you also do reviews for attorneys, and you don't testify in court and collect fees for that; is that correct?
A Yes, I charge a fee for my time and effort, yes, sir.
Q How much do you charge for review of the case?
A Depends. If they ask me just for a simple narrative report, I charge 1,500. If they ask me for life care plan and review of records, it's 3,000.
Q And can you tell me, sir, approximately how many you've done over the course of your career?
A I cannot tell you.
Q Hundreds?
A It could be.
Q Could be hundreds, could be more, could be a couple of thousand?
A No, not thousands.
Q Okay.
A Okay. I'd say, I'm guessing, don't quote me on it.

Q I want to quote you on it.
A Hundred, plus or minus a few.
Q Plus or minus?
A A few.
Q Okay.
Doctor, in fact, when you testified concerning your education background, you went to Queens College?
A Yes, sir.
Q You didn't graduate from Queens College?
A I didn't have it. I went right to medical school.
Q I didn't ask you that. What I said was you did not graduate from Queens College.
A I have not.
Q You do not have an undergrad degree?
A I do not.
Q Went to medical school, I believe, in the Dominican Republic?
A That is correct.
Q You actually went to two medical schools?
A That is correct.
Q What is the first one called?
A It's ten semesters. The first four semesters I went to UCE. The UNE was a much better program. They let you do the clinical rotations in the United States. So I did my clinical rotations in the U.S.

Q Where did you do that?

A Lincoln Hospital, Cabrini Medical Center and there was another hospital in Harlem. I forget the name. It's closed right now. I don't remember the name.

Q In terms of clinical programs, do you do clinical programs, Doctor?

A Yes.

Q Where do you do them?

A I just told you.

Q No. Now.

A Oh, right now?

Q Yes, sir.

A What do you mean if I do clinical programs.

Q Do you teach any clinics?

A Ah, I teach, yes, I teach at NYU. I teach at Medalliance in the Bronx. I teach at North Queens Surgery Center, and a lot of times, international medical students rotate through my offices, I teach them while they're rotating through my offices.

Q Do you have privileges at NYU?

A Yes, sir, I do.

Q And you have admitting privileges there?

A I do, yes, sir.

Q When is the last time you admitted a patient?

A I don't admit patients. Most of my work -- all of

my work is outpatient.

Q So you have never admitted anybody into NYU?

A I have not.

Q Can you tell me, sir, in your practice now, approximately how many patients do you have?

A I have a lot of patients.

Q Okay.

A I can't give you an exact number. It's a lot of patients.

Q Okay.

And you treat in different specialties. You treat orthopedic patients, you said?

A I do.

Q What percentage of your practice is the treatment of orthopedic patients?

A It's a mixed bag. The same orthopedic patients have neurological conditions. They have musculoskeletal conditions. They have interventional pain management conditions, so it's a mixed bag.

Q Sir, when you were reviewing the records here, you had certainly reviewed the 10/29/17 records of Southside Hospital, correct?

A Yes, sir.

Q You have this in front of you. I don't know what exhibit it was marked. I think it's 19, sir. If you want

to look at it.

MR. SPANO: It's 19. He may not have it in front of him.

A I don't have it in front of me.

THE COURT: Let's hand Exhibit 19 to the witness, please. Thank you.

Q Doctor, if you could, open up that, Exhibit 19, and I think you'll see there was some radiologic studies done on the admission of 10/29/17, the date of the incident. Do you see that, sir?

A Yes, I do.

Q Actually, there was a cervical spine CT done and CT of the brain, correct?

A Yes, sir.

Q You have those records in front of you, sir?

A Let me find them. CT of the brain, yes, it was normal.

Q Okay. That was gonna be my next question, Doctor.

Can you tell me what the result of the CT scan of the brain was?

A Normal.

Q Okay.

Does it say no evidence of acute intracranial pathology?

A Yes, sir, that is correct.

Q There's also a result of the CT scan of the cervical spine, is there not?

A Yes, sir.

Q What are the findings, if you can read those, Doctor?

A Unremarkable exam.

Q Okay.

A Normal.

Q Right, sir, but can you read the findings, that starts with the bones are? If you would read those for me, please.

A Yes, sir.

The bones are normally mineralized and in normal alignment. There is no evidence of any fracture or dislocation. There is no abnormal soft tissue swelling seen. The disk spaces are well maintained. Facet joints and spinous processes are unremarkable.

Q And that was the date of the incident, correct, sir?

A Yes, sir.

Q Now, sir, also, I'd like to go, if you could, sir, to the Perry Hospital records -- I'm sorry, Perry Physical Therapy records.

A Are they in this folder?

MR. SPANO: Exhibit 20.

Q Exhibit 20, sir, I'm sorry.

THE COURT: Can you please give the witness Exhibit 20, if he does not have it up there. Thank you.

A Okay.

Q Now, sir, the Perry Physical Therapy records, you discussed them before with Mr. Spano, correct?

A Yes, sir.

Q And you'll note that there was some records done by a Dr. Nizarali Visram, correct?

A Yes, sir.

Q He also has a fellowship in interventional pain management and anesthesia, correct?

A I do believe that's correct.

Q As a matter of fact, he treated from -- I think, the first one was sometime around November 9, 2017, is that correct, the first time Perry Physical Therapy?

A November 2nd --

Q November 9, I'm sorry, sir.

A November 2nd.

Q November 9, 2017.

A Okay.

Q And actually, I'm sorry, sir, I misspoke, it is November 2nd, excuse me, sir.

November 2nd was the first date that you have in

front of you?

A Yes, sir.

Q And I believe, sir, they go up to March of 2018; is that correct, sir?

A I believe that's correct.

Q And, sir, in March 22nd of 2018, Dr. Visram had a note that said followup evaluation; is that right, sir?

A Give me a second to find that note.

Q Sure.

A I'm sorry, what was the date on that?

Q Yes, sir, March 22nd of 2018.

MR. SPANO: The last page.

Q Could very well be the last page, sir. It is the last date of treatment.

A Okay, I have it.

Q You have it in front of you, sir?

A I do.

Q That's a note that's entitled followup evaluation, correct, sir, on the very top?

A Whoa, I thought my handwriting was bad. I can't read it.

MR. SPANO: I don't think that's it.

Q That's not what I'm referring to, sir. I'm referring to the note. If you want, I can pass it up to you sir.

A Please. That would save time.

THE COURT: Pass it up.

MR. MURTAGH: May I, your Honor?

THE COURT: Yes. This is part of Exhibit 20, Mr. Murtagh?

MR. MURTAGH: It is, your Honor.

THE COURT: All right, go ahead.

A Thank you.

Okay, yes, I see it.

Q Do you have that in front of you?

A Yes, sir.

Q Did you review that record that you have in front of you before you testified here today?

A I don't recall seeing this note, no.

Q Could you read the very first paragraph in that note, please?

A Yes.

Date of exam, March 22, 2018. History of chief complaints. This 40-year-old female presents today for followup visits and states that she continues to have headaches and residual neck stiffness. She takes Motrin as necessary and continues to followup with Dr. Liguori, L-I-G-U-O-I-R, for headaches and concussion. She was recommended to return to work as a nanny, however, she does not have any other employment. Currently she's unemployed.

She does perform home exercises.

Q Now, sir, that's Dr. Visram stating in March of 2018 there was a recommendation to return to work, correct?

A Yes, sir.

Q All right.

May I have that back, sir?

A Yes, sir.

Q Thank you.

Now, this is a doctor that has been treating this particular patient from November 2nd of 2017 up through March 22nd of 2018; is that correct?

A Yes, sir.

Q All right. And I think you referred to records of Dr. -- was it Dr. Kohane as well?

A Yes.

Q I know they're rather large, sir.

A Yes.

Q I don't know what number they are, sir. If I may.

Do you have the records in front of you of Dr. Kohane?

A Yes, I do.

Q It is a rather large book.

A It is a large portion, yes.

MR. SPANO: 21.

MR. MURTAGH: Thank you, Mr. Spano.

Q Now, Dr. Kohane is someone who is treating the patient for what, Doctor?

A Interventional pain management specialist.

Q Exactly.

He treated her over a period of time as well, right? From, let's say, April of '18 up through sometime in July or August of 2019, would that be about right?

A No. From 4/20/18 through July 29, '24.

Q In other words, there was records up until July something 2024?

A Yes, sir.

Q Now, sir, I'm going to ask you to take a look at, and I guess it's gonna be the same thing.

MR. MURTAGH: If I may, your Honor, I'm gonna ask if I can hand up a portion of the record to save time rather than have the doctor go through things.

THE COURT: Yes, that would be fine.

MR. MURTAGH: Is that okay, Mr. Spano? Your Honor said okay.

MR. SPANO: Yes.

Q Sir, I'm referring to two pages from that record, sir. I tell you that's what they're from, rather than have you search through them, sir.

A Okay.

Q Now, what is the date on those, sir?

A This is dated March 11, 2019.

Q And one of the conditions there that the plaintiff suffers from cervical spondylosis?

A Yes, sir.

Q What is the definition of cervical spondylosis?

A Arthritis of the spine.

Q So, in other words, that would be part of the degenerative condition that we've been talking about, correct?

A Yes, sir.

Q So she certainly was suffering from spinal -- I'm sorry, cervical spondylosis, correct?

A Cervical and lumbar undisputed.

Q Undisputed.

Now, sir, there's a reference there to a Dr. Brandenstein; do you see it?

A I do.

Q Do you know who Dr. Brandenstein is?

A I do not.

Q What does Dr. Kohane's records say about what Dr. Brandenstein recommended, if any, at that time?

A It says patient was evaluated by Dr. Brandenstein, no surgical intervention indicated. For conservative management, recommend physical therapy. Continue the use of cervical therapy collar to be worn one to two hours daily as

needed. Medication management same for now.

Q And that's approximately a year and a half after the incident, correct, sir?

A Yes, sir.

Q If I may, I'll take that back.

I have it marked as Exhibit F in evidence a portion of the hospital record from Southside Hospital on 12/19/18 which, again, is approximately a year and two months after the incident, correct, sir?

A Yes, sir.

Q I'll bring up this exhibit to you, sir.

MR. SPANO: Is that Exhibit F?

MR. MURTAGH: Yes, it says F.

MR. SPANO: I thought F was the video.

MR. MURTAGH: I think we're going to have to remark it.

THE COURT: So Mr. Murtagh, is this the actual exhibit?

MR. MURTAGH: It is, your Honor. This is the actual exhibit, your Honor. May I give it to the witness?

THE COURT: Yes.

MR. MURTAGH: I want to read it before I give it to him.

Q So that discusses, in part, the fact that the

patient has been diagnosed with this cervical spondylosis, right, sir?

A Yes, sir, undisputed.

Q All right.

You also, sir, stated that your subsequent record, the subsequent report that you did in May of 2024, was done as a result of the patient's car accident in December of 2023, correct?

A Yes, sir.

Q And so Mr. Spano asked you to look at the plaintiff again after that car accident; is that right?

A Yes, sir.

Q And do you have those records in front of you?

A I do.

Q They have been marked as Exhibit A in evidence?

A My records or your records?

Q No, no. The records of Central Suffolk Spine and Sports Chiropractic, do you have those? If not, I have them here. Exhibit A.

THE COURT: Just give me a minute.

(WHEREUPON, THERE WAS A FIRE DRILL AND A RECESS WAS TAKEN.)

A F T E R N O O N S E S S I O N

THE COURT OFFICER: Jury entering.

THE COURT: You can be seated, thank you. So

we had a fire alarm. We're all here and good. So thank you for coming back.

Mr. Murtagh, whenever you're ready.

MR. MURTAGH: Thank you, Judge.

CONTINUED CROSS-EXAMINATION

BY MR. MURTAGH:

Q Sir, I think I was about to show you what has been marked in evidence as Defendant's Exhibit A, which is the Central Suffolk Spine and Sports Chiropractic records, okay, and this would be for after the automobile accident of December 2023. You reviewed those records, sir?

A Yes.

Q And, sir, those are chiropractic records, correct?

A It's mixed. Some is chiropractic, some is nurse practitioner. It's mostly chiropractic.

Q Right. And is it Dr. Levi, L-E-V-I?

A Yes, yes.

Q And when did he first see the patient? And I think that was the very first --

A 12/19/23.

Q I'm sorry, sir?

A 12/19/23, six days after the accident.

Q That was my next question, six days after the accident.

Now under the complaints of subjective, can you

read for me what it says there, sir?

A Yes.

Patient presents with severe cervical spine pain, onset acute. Cause of symptoms motor vehicle accident. Prior neck pain. Patient underwent a cervical spine fusion surgery, C4 to C6 June of 2020. Affected side bilateral. Pain, achy, sharp. Level, 8 out of 10. Pain is constant. Pain radiates to the posterior head, right trapezius, right shoulder. Headaches are occipital in region, throbbing sensation, daily episodes rated seven to eight out of ten on a visual analog scale.

Q This essentially runs through May of 2020, the ones that are marked there; is that right, sir?

A That is correct, yes.

Q And the last record -- the last entry that is there, sir, does it talk about the cervical pain?

A It does.

Q What does it say there, sir?

A You're talking about May 21, '24?

Q I am, sir.

A Okay.

Patient presents with severe cervical spine pain, prior neck pain. The patient underwent a cervical spinal fusion surgery from C4 to C6 in June of 2020.

That's wrong. It should be C5/C6.

Pain is achy sharp level, eight out of ten. Pain is constant. Pain radiates to posterior head, right trapezius, right shoulder. Headaches are occipital in region. They're throbbing in sensation. They're daily, rated seven to eight out of ten on a visual analog scale.

Q And, sir, what does acute to you mean, sir?

A Acute, recent, meaning less than one month.

Q Can you tell me, sir, you have testified in response to some questions by Mr. Spano about a patient history. Seventy percent of -- you can make a diagnosis based on 70 percent of the history given to you by the person?

A Pertinent history, yes, pertinent.

Q Pertinent history. Meaning that the history that is given to you you're relying upon that?

A Yes.

Q So you're hoping, certainly, that the patient is going to be giving you an accurate history?

A Yes, sir.

Q And, of course, that's subjective sir, correct?

A Yes.

Q You can only react to what the patient is telling you?

A Yes, but there are objective ways to confirm it.

Q I understand that, sir, but, also, as I said, 70

percent is by history, you said, correct?

A Yes, that is correct.

Q Sir, with regards to -- with regards to this particular case, had there been any recommendation for surgery before the patient was seen by Dr. Weinstein?

A Based on the records I reviewed, I did not see any.

Q And Dr. Weinstein's first surgery was done when, sir?

A 6/23/20, C5/C6.

Q So that's, approximately, almost three years after the occurrence, correct?

A Yes, that's correct.

Q As a matter of fact, no one had recommended shoulder surgery prior to Dr. Weinstein; is that correct?

A That's correct. For very good reason.

Q Okay, but my question was was there anybody other than Dr. Weinstein that recommended surgery?

A I answered your question. No, sir.

Q Right.

Okay. Now, with regards to -- you have done orthopedic surgery, sir?

A I have assisted on many orthopedic surgeries, yes, sir.

Q You have?

A Yes.

Q And what do you do when you assist on these surgeries?

A When you're doing your residency, you do part of the case. You hold the retractors, um, you close the wound and you follow the patient up after the surgery.

Q Are you familiar with the American Academy of Orthopedic Surgeons?

A I am.

Q You are.

And how are you familiar with that, sir?

A It's one of the medical boards that exist.

Q And you're familiar with the standards of the American Association of Orthopedic Surgeons?

A The basic standards?

Q Yes.

A The basic, yes.

Q Now, sir, when you have testified on some 300 occasions, have you ever in your career, when you testify as an expert, ever accept a fee contingent upon the -- contingent upon the success of the lawsuit?

A No, sir.

Q You haven't done that?

A I have not done that, no.

Q Can you tell me why is that?

A Has nothing to do -- one has nothing to do with the

other.

Q Exactly, but is that a violation of any standard of the American Academy of Orthopedic Surgeons?

A It could be.

Q It could be?

A Yes.

Q Well, you've seen the standards, sir?

A I have not seen them, but it's unethical. It's not that it's illegal. It's unethical.

Q I understand that, sir, so if someone were to come here, and testify that their fee, the fee for --

I'm sorry.

That their medical bills were going to be paid out of the recovery of the lawsuit, that would be unethical, correct?

A Depends how it was phrased. If it was phrased that he's waiting for his bills to be paid based on when the patient has the ability to pay the bills, that's one way. If the patient is able to have the ability to pay his bills after the resolution of the case, that's another way. So it all depends how it was phrased.

Q I'm asking about whether or not there's a lien on the recovery, okay. So in other words, you're giving expert testimony, okay, you're giving expert testimony on behalf of a party, okay, you understand that? And you're saying that

there's a lien against the recovery, so that would be out of the proceeds of the lawsuit. Is that ethical to do?

A I believe I answered your question. It depends -- it depends how you phrase your answer.

If you say only you're only gonna get your money if the patient wins, it could be. No not that it is. It could be.

If you say that I'm waiting to get paid once the patient is able to pay, there's nothing wrong with that.

Q No.

In other words, if the patient is able to pay, not necessarily out of the proceeds of the lawsuit, correct, that wouldn't be a problem?

A Yes, that's correct.

Q But if it's out of the proceeds of the lawsuit, that would be unethical, correct?

A I don't want to comment on that.

Q You don't want to comment?

A I don't want to comment.

Q Have you ever seen the standards I was just referring to, sir?

A I have not seen the standards, no.

Q But you're familiar with that there are standards?

A The medical standards. Not the medicolegal standards, no, that I'm not familiar with.

Q You're not?
A I am not.
Q Okay.
With regards to the -- with regards to the --
I just want to see if I went over this before our break?
You talked about the patient having an antalgic gait.
A Yes.
Q Can you tell the jury what an antalgic gait is?
A A limp, walks with a limp.
Q And if one were to have -- someone like -- if someone like Ms. Faviola Rosado-Roca would have an antalgic gait, you would expect her to have that constantly, correct?
A No, absolutely not.
Q No? Why is that, sir?
A If the patient is getting treatments like an epidural injection, you would expect that antalgic gait to be much improved.
Q I see.
A If the patient is getting treatments, if they're getting physical therapy, if they're getting pain medications, you have a nice warm weather, you would hope that would be much better, not necessarily antalgic.
Antalgic is not constant.

Q No, okay.

Have you seen any video of the plaintiff?

A I have not.

Q Were you told about it by Mr. Spano or anybody else?

A Very briefly.

Q Well, what were you told?

A That there was an antalgic gait.

I'm sorry. That they have a video of her showing her gait. That's all he told me about it.

Q That's it?

A That's it.

Q And you didn't look at it?

A No.

Q Okay. All right.

With regards to the life care plan that Mr. Spano had you testify to, sir, you didn't bring any data with you to substantiate those claims of what the expenses were, did you?

A I did. Myself.

Q So, in other words, we are to expect to believe you with regards to this?

A And I gave the reasons why. I gave the reasons why.

Q You did?

A I did.

Q I heard you, sir, and the reasons that you gave were basically that you know what they are and, therefore, you testified to them, correct?

A I gave you my professional opinion based on 40 years of treating tens of thousands of patients like this.

There is no such textbook to say you need X, Y, Z. There is no such textbook that says you must absolutely only do X, Y, Z. It goes from case to case based on a doctor's medical expertise.

Q Right.

A And the jurors have the right to whether -- to believe whether that is credible or not credible.

MR. MURTAGH: Judge.

THE COURT: So just focus on the question, thank you, doctor.

MR. MURTAGH: Move to strike that portion of the answer not related to the question, not to what the jurors think.

THE COURT: The portion related to what the jurors think will be stricken.

Q I'm talking about, now, you gave figures with regard to each of those treatments, you gave monetary figures with regards to each of those treatments, correct?

A Yes, sir.

Q Those are figures that came from you?

A That is correct.

Q Is there data to support the figures that were given by you?

A A lot of those things I do myself. I'm familiar with the fee schedules because I do those procedures myself, and before putting my fee schedule, I checked around to see what other board certified physicians in my area charge for those services. That's how I placed my fee schedule. Some charge more than that. Some charge less than that.

Q Sure. But the only things that we have as evidence in this courtroom are the figures that you testified to, correct?

MR. SPANO: Objection.

THE COURT: Overruled.

MR. SPANO: There are a lot more than that.

MR. MURTAGH: Judge.

MR. SPANO: Objection.

THE COURT: You just say objection, Mr. Spano.

If I want the basis, I'll ask, thank you.

A In fact, if you want, I have with me my briefcase some of the fee schedules for some of those spinal surgeries.

Q Sir, what I'm asking you is that the evidence that's in this case that you testified to you didn't provide

us with any data concerning what those fees were, correct?

A If you want, I can give it to you now. I have it in my briefcase, but I don't have to. I'm giving you my professional opinion.

Q This is only your professional opinion?

A That is correct.

Q Okay. All right.

Now, you talked about a robotic surgery costing between 400 and $800,000?

A Yes, sir.

Q Do you have any figures with regards to that?

A I do. It's in my briefcase. I can show it to you.

Q But you didn't testify to them with regards to Mr. Spano's questions?

A I answered whatever question he asked me.

Q Okay.

A And I mention it, that NYU, they charge between 400 to $800,000. I've seen the bills. I'm on the faculty on NYU, and I'm familiar with the fee schedule.

Q Has anybody ever said that the patient needs that surgery?

A Yes.

Q Oh, really, the robotic surgery?

A This particular patient?

Q The robotic surgery?

A This particular patient, no.

Q Yeah, that's what I'm asking.

A No, no.

Q So in other words, that's something that you think may be needed at some point in time?

A If the patient wants the best treatment, robotic surgery is the best surgery for this because there's absolutely no mistakes when you do robotic surgery under supervision of a board certified spinal surgeon like Dr. Jason Galina.

Q And can you tell me, sir, with regards to this -- these surgeries, did Dr. Weinstein --

Did you read Dr. Weinstein's testimony?

A I did.

Q You did.

And can you tell me, sir, whether or not Dr. Weinstein has ever recommended this surgery?

A He has not.

Q He has not, and did he recommend any future surgeries at this time?

A He remained open to future surgeries.

Q But he hasn't said that the patient needs future surgery?

A Not right this minute, no, and I also said the same not just this minute. In the future, yes.

Q It is now some almost six, seven years after this particular incident.

A I said in my report these typical surgeries last five to seven years, plus or minus two. That will be -- plus or minus two will be up to nine years after the surgery.

Q I see, but Dr. Weinstein didn't mention that, did he?

A He did mention about segmental adjacent pathology.

Q Right. In other words, if that happened?

A It's something that would inevitably happen. It is just a matter of time.

Q Oh.

A It's not a matter of if it will happen. It's a matter of time and when.

Q I see.

Can you tell me, Doctor, what would you recommend with regards to the patient --

She has to undergo future physical therapy; is that right?

A She's getting it now, and she's getting the injections also now.

Q Can you tell me, Doctor, the things that you recommended in your life care plan, how many of these has she undergone at this point?

A She's had some of them, but not all of them. She's still getting injections.

Q Which ones, Doctor?

A In fact, she's scheduled to have a recent one coming up in the next day or two.

Q What is that again?

A Cervical epidural.

THE COURT: Okay, don't speak over one another, please.

MR. MURTAGH: Sorry, your Honor.

THE COURT: That's okay. Ask your question.

Q Of the eleven items you have in your life care plan, how many has she gone through?

A Okay.

She has not seen a neurologist.

When she saw Dr. Daniel Winick, I don't know. I'm not sure if she has seen a doctor recently or not.

She has not seen a spinal surgeon recently.

She has had physical therapy at least once per week.

She still is getting epidural injections.

She still is getting facet injections.

She still is getting medications for pain and inflammation.

She has not had recent EMGs. The last EMG was in

2021 by the neurologist which she found radiculopathy.

And so these are based on optimal level of care. She has not had optimal level of care.

Q Meaning that if she needs it, that's what she would have to get, correct?

A Not necessarily.

Q Okay, not necessarily?

A Right.

Q But, again, she hasn't had the items that you just talked about?

A For very good reason, yes.

Q And can you tell me, sir, you have said that this particular plaintiff, this particular Ms. Rosado-Roca --

Let me see how I can phrase this.

Oh, I know what I wanted to ask you:

Were you aware that Dr. Weinstein asked her to come back for future visits but that she didn't?

A I saw that in the records, yes.

Q You would recommend that if a patient is told to come back by her treating doctor, especially one who has done three operations of her, to come back when the doctor expects her to come back, correct?

A I would, but I would ask the patient why didn't come back. If a patient is depressed, that may be one reason.

Q But you don't know that, right?
A I know she's depressed.
Q No, no, no, you don't know why she didn't come back?
A I do not know.
Q You're speculating as to why she might not have come back, correct?
A I don't know.
Q Sir, I'm just going to show you what's been marked in evidence as Exhibit G in evidence which are some records from Dr. Winick, which this is a visit of 2/13/19, sir, and I've marked it because I don't want you to have to go through all the different pages. All right, sir?
A Okay.
Q And if you can refer to the page that I have marked there as 2/13/19, do you see that, sir?
A I do, I see it.
Q Sir, it refers to some -- is it some MRIs or CAT scans that were done?
A Yes.
Q And what were they, MRIs or CAT scans?
A It says MRI of the brain was done on 5/18/19 was unremarkable. MRI of the cervical spine performed on 12/12/17 in Rockville Centre. This study demonstrated mild degenerative changes and disk bulges at multiple levels.

Lumbar spine MRI performed on 4/25/18 at Zwanger Pesiri Radiology. The study demonstrated degenerative changes and disk bulges. There was no significant spinal stenosis.

Q And, sir, those are both MRIs scans, correct?

A That's correct.

Q Which are more diagnostic of spinal conditions, an MRI or a CT scan?

A CT is better for bone. MRI is better for disks.

Q MRI is better for disks?

A Yes, and intraoperative findings are the best.

Q I see. Let me take that back, Doctor, thank you.

In a patient such as Ms. Favi Rosado-Roca, can you tell me, sir, whether or not walking on sand is contraindicated or shouldn't be done?

A No. In fact, it is beneficial because --

Q Oh.

A -- the cushion on the sand helps you, and it also helps to strengthen you, and if you fall on sand, you won't get hurt terribly as opposed to hard concrete.

Q Oh, I see, okay.

MR. MURTAGH: All right, Doctor, I have nothing further. Thank you very much.

THE COURT: Mr. Spano?

MR. SPANO: I have nothing further for the witness, Judge.

Thank you, Doctor.

THE COURT: Thank you, you can step down.

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