SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX : CIVIL TERM : PART IA-4

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RAMONA ROSADO,

INDEX NUMBER:
25005/2014E

-against- Plaintiff

271 ZACKO LLC
FINKLESTEIN-TIMBERGER, LLC
LGLS BRONX PORTFOLIO, LLC

Defendants

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851 Grand Concourse
Bronx, New York 10451
October 1, 2025

Testimony of Dr. Ali Guy

B E F O R E:

HONORABLE ANDREW COHEN,
Justice of the Supreme Court

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

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Senior Court Reporter

MR. BURBAGE: Good morning, Your Honor.

THE COURT: Good morning.

MR. BURBAGE: It's in our understanding the Plaintiff is going to call Dr. Guy to testify today, and Dr. Guy intends to use, if the Court allows, demonstrative presentations to assist his testimony to the jury.

We've had the testimony of Dr. Cordiale, Plaintiffs spinal surgeon, he testified without any demonstrative aids.

We've had the testimony of Dr. Dassa, the orthopedic surgeon who operated on her knees twice and on her right shoulder; he testified without any demonstrative aids.

Dr. Guy is not a surgeon, he is a physiatrist. He's treated her a few times we believe that allowing him to use these demonstrative aids when Plaintiff's actual surgeons declined for whatever reason to use those aids would simply allow Dr. Guy to bolster testimony that the jury has already heard. And we would object to his use of these demonstrative aids.

MR. PETTUS: Before the Court rules, Dr. Guy is still in the audience. Can we ask him to step out for a moment?

THE COURT: Sure.

Dr. Guy, would you mind stepping out in the Hallway.

MR. POLLACK: It's so technical that you need him to step out?

MR. PETTUS: Yes.

MR. POLLACK: May I, Your Honor?

THE COURT: Yes. It might have been more useful to have the witness understand what the ruling is, but go ahead, please, Mr. Pollack.

MR. POLLACK: Your Honor, Dr. Guy is an expert in Physical Medicine and Rehabilitation. He deals with the parts of body we're talking about. I'm not going to intend, as Your Honor has already instructed us, to bring out any cumulative testimony; however, we have some demonstrable exhibits here, he's just going to spend a few minutes just showing it and describing it, he's familiar with it, and that's about all we're gonna use it for.

THE COURT: Mr. Pollack, it is my understanding that he's essentially going to testify about future care?

MR. POLLACK: That is correct, Your Honor. With respect to the shoulder, the back, and the knee, and he has examined her, and she's treated with him as well.

THE COURT: Is it your intent to elicit testimony regarding his treatment?

MR. POLLACK: Well, that he treated her, yes, and that based on his treatment and the hypotheticals I'm gonna give him with respect to causation when Dr. Cordiale and

Dr. Dassa, do you have opinion as to what treatment she shall need in the future? And he's gonna, of course, say yes, and then we are gonna get into that.

THE COURT: Mr. Burbage, anything further?

MR. BURBAGE: No, Your Honor.

THE COURT: There is nothing facially inadmissible even though we are not admitted them into evidence for the use of demonstrative evidence in this trial. If you hear an objectionable question, if you hear a question that is bolstering, that is cumulative, you object and I rule on a question by question basis. Okay.

MR. BURBAGE: Thank you, Your Honor.

MR. POLLACK: Thank you.

THE COURT: Okay. I don't know how many jurors we have. Yes, we are all set. Call the jury in.

Ladies and gentlemen in the gallery, if you are here on anything other the trial, if you need to talk to your adversary, if you could go out in the hall, we are going to start the trial momentarily.

THE COURT: Let's bring them in.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seats.)

THE COURT: Everyone, please be seated.

Good morning, members of the jury.

JURY PANEL: Good morning.

THE COURT: Okay.

Mr. Pollack, do you have a witness?

MR. POLLACK: I do, Your Honor.

At this time the Plaintiff calls Dr. Ali Guy to testify.

COURT OFFICER: Please raise your right hand.

Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth under penalty of perjury?

THE WITNESS: I do.

COURT OFFICER: You may be seated.

THE WITNESS: Thank you.

COURT OFFICER: Please state your full name and business for the record.

THE WITNESS: Yes. My name is Ali Guy, A-L-I. Last name is G-U-Y, MD. Office address is 7 Grandson Park, West New York, New York 10003.

COURT OFFICER: Your Honor, the witness have been sworn.

THE COURT: Excellent.

Mr. Pollack.

A L I G U Y, a witness, called on behalf of the Plaintiff, after having been first duly sworn, took the witness stand and testified as follows:

DIRECT EXAMINATION

By MR. POLLACK:

Q Good morning, Dr. Guy.

A Good morning, sir.

Q What is your profession, sir?

A I am licensed to practice medicine and surgery in the State of New York. I am a physician.

Q What is your educational background?

A Undergraduate, I went to Queens College, Flushing, New York. Medical school, I graduated from university -- medical school, I graduated from the University of North East in the Dominican Republic in June of 1981. Thereafter, I did three separate residencies.

I did 18 months of internal medicine at Mount Sinai School of Medicine, Mount Sinai Medical Center. I did one year of general surgery at Cabrini Medical Center in New York City. I completed a 3-year residency training program in the field of Physical Medicine and Rehabilitation at Mount Sinai School of Medicine, Mount Sinai Medical Center.

I'm board certified in the field of Physical Medicine and Rehabilitation, and my specialty is physiatry, which is physical medicine rehabilitation.

Q Can you tell the jury what physical medicine rehabilitation is, and are you an expert or specialist in physical medicine and rehabilitation?

A Yes. So the field of Physical Medicine and Rehabilitation is a medical specialty that was founded shortly after World War 11, that's why we have the Rusk Institute at NYU named after Dr. Howard Rusk, R-U-S-K. He's the first doctor that started this specialty in the world.

This specialty overlaps and covers almost every medical specialty. It covers orthopedics, neurosurgery, neurology, muscle/nerve physiology, disability, impairment evaluations, life care planning, and electrodiagnostics, pain management both pharmacological and interventional, and carries pulmonary and cardiac rehabilitation as well.

Q You mentioned board certification, what exactly is board certification?

A To become board certified in a specialty means that you have been designated as an expert in the specialty by all the elite doctors. And to qualify for this, number one, you have to have finished a three-year accredited residency training program in the specialty, which was done. You have to pass all the monthly examinations given by your teachers. You have to pass the annual examinations written and passed by -- given by the hospital.

You then sit and take your boards part one after you finish your 3-year residency training program, and the board part one is an 8-hour written examination. You get tested on orthopedic surgery, spinal surgery, neurosurgery, neurology,

muscle and nerve physiology, disability impairment evaluation, electrodiagnostics, interpretations of X-rays, MRIs, CT-Scans, and other diagnostic studies, and other physical medicine and rehabilitation topics.

Once you do that, which was passed the first time around, you have to be in private practice at least 18 months, be sponsored by two other board certified doctors that know you closely.

You then fly to the male clinic in Minnesota, where all the elite doctors that do research, write textbooks, they test you orally for half a day on similar topics, and once you pass the oral examination all your credentials from college, medical school, residency, is sent to the American Board of Physical Medicine and Rehabilitation, and if everything is up-to-par they pass you. They give you a title of a Diplomate of Physical Medicine and Rehabilitation that was obtained in May of 1989, and to this date it stands in good standing.

Q Doctor, what does your practice consist of today?

A My practice consists of taking care of patients from age 6 to age a hundred, all types of trauma cases from head to toe, deals with pain management both interventional and pharmacological. Interventional means I do microsurgeries of the spine.

I do epidurals, nerve blocks, facet injections, radio frequency ablation procedures, trigger point injections, joint

injections, all types of nerve blocks, and electrodiagnostics, disability and impairment evaluations, and that's basically it.

Q Okay. Now, at some point you have seen Ramona Rosado as a patient, correct?

A Yes, sir.

Q You also were asked to prepare what's called a life care plan by her attorneys, correct?

A Yes, sir.

Q Now, before we get to that specifically from your testimony you're familiar with the spine, correct?

A Yes, sir.

Q Are you also familiar with the shoulder?

A Yes, sir.

Q Are you also familiar with the knee?

A Yes, sir.

Q And how is that you are familiar with those parts of the body?

A I treat tens -- I have treated tens of thousands of patients with these types of injuries, and I have hundreds of patients with these types of injuries still under my care.

Q Now, Doctor, we had Dr. Cordiale come in and testify, and he described the spine, specifically the cervical and lumbar spine. And then we had Dr. Dassa who came in and discuss the shoulders and the knees.

Is there something that you have here today that will

help describe the shoulder, the knee, and the spine in a little bit more -- to a little bit more extent than just telling people?

A Yes, sir. I have a chart front and back, I have models of the spine, I have a model of the shoulder and the knee.

MR. POLLACK: Your Honor, with your permission I would just like the doctor -- I will bring it to the doctor or an officer to use this as demonstrable evidence on issues of the spine.

Q Doctor, I know you have taught in the past, correct?

A I am sorry.

Q You have taught medicine in the past?

A I still do.

Q You still do, okay. So I know you may have your teaching hat on right now, but we are trying to move this along, because we've already had testimony.

A Yes.

Q So if you could just give us the basic anatomy on that chart with respect to the spine that will be appreciated?

A Yes. May I use the easel?

Q Of course, you can.

THE WITNESS: May I step down, Your Honor?

THE COURT: You may. We just need you to speak into the microphone.

THE WITNESS: Yes, Your Honor.

THE COURT: Gentlemen, if you need to see you can sit anywhere other than the jury box.

THE WITNESS: May I use those models to correlate with the chart?

THE COURT: Sure.

Q And these are models -- we have models of the spine right here, correct?

A Yes, sir.

Q We don't need this for that.

THE COURT: Mr. Pollack, at some point these should be marked as demonstrable exhibits.

MR. POLLACK: We will mark as demonstrable evidence Plaintiff's --

THE COURT: Whatever.

MR. POLLACK: The chart is Plaintiff's 24 for identification, and it's not going into evidence. And we will mark the models of the spine as Plaintiff's 25 for identification. I think that's where we are.

THE COURT: You may proceed.

MR. POLLACK: All right.

Q Go ahead, Doctor, if you can just explain?

A So in the human spine we have three segments, and that is referred to as the cervical spine and there are seven vertebrae. In the midback it is referred to as the thoracic spine, and we have 12 vertebrae. The lower back is referred to

as the lumbar spine, and we have five vertebrae. Each area is numbered and named according to its anatomic position. If I say C5-C6 it means the space between the 5th and 6th cervical vertebrae, C means Cervical.

If I say L4-L5, it means the space between the 4th and the 5th lumbar vertebrae.

Now, we have three pathological conditions to a disc. The function of a disc is two-fold: One, is to serve as a shock absorber between the two vertebrae, so when we move, when we jump, bone doesn't hit, bone doesn't break. And, also, inside the disc we have a gelatinous material called the nucleus, N-U-C-L-E-U-S, 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 it is this structure that prevents us when we jump bone doesn't hit bone and break.

Now, right behind the disc we have the nerve root. The nerve root innovates or gives power and sensation to the muscles in the arm that comes from the neck. The muscles in the legs are supplied by the nerve roots from the lower back.

So this is a normal disc. This is a bulging disc with a partial tear. This is a bulging disc, partial tear.

How you see it on this diagram this is what we are looking at, this is the axial view, this is called the sagittal or the side view. A bulge in layman's term is a partial tear of

a disc, partial tear of a disc, partial tear of a disc.

Herniation is a complete tear of a disc when the disc material passes the disc margin. Let me show you a disc herniation: Disc herniation, disc herniation, disc herniation, disc herniation.

Now, what happens to this once it herniates? The water content begins to leak out and the disc begins to become degenerated and form bony projections called osteophytes. These osteophytes begin to form to stabilize the injured vertebrae. Normal disc, a worn out disc.

Now, when you look at a disc at a microscopic level, a disc herniation is a complete tear of the annulus, A-N-N-U-L-U-S fibrous F-I-B-R-O-S-U-S. The disc has two parts, inside is the gelatinous material, outside is the fibrocartilage material. Once this structure is torn it does not, does not have the ability to repair itself, that's why a disc herniation is considered a permanent injury.

Once you have a disc herniation the outer one-third of a disc has nerve fibers. The nerve fibers come off a nerve root, and they supply sensation to the outer one-third of the disc. So once a disc herniates you have a release of over five hundred chemicals. These chemicals irritate the nerve root, the tendons, and the ligaments around it.

If I were to list all of them I will put everybody here to sleep, I won't to do that. I'll just mention a couple of

them: Prostaglandins P-R-O-S-T-A-G-L-A-N-D-I-N-S, bradykinin B-R-A-D-Y-K-I-N-I-N and nitric N-I-T-R-I-C, oxide O-X-I-D-E.

So these chemicals will continuously irritate the nerve root, and when we have a disc herniation this is the lumbar region, this is L5-L4, L3-L2-L1, so on, and so forth. This is a normal disc, that's a disc herniation.

Okay. The nerve root is right behind it. So when you have a disc herniation causing impingement or a pinch nerve you get shooting pain into the hip, the buttocks, the legs, depending on where the disc herniation is.

So L4-L5 usually correlates to this portion. L5-S1 covers the posterior portion of the legs and the front of the shank and the foot. The foot is mostly L5 and some S1 nerve fibers. So that's basically the disc anatomy.

Q Okay. Now, the jury has heard the term also "bulging disc".

A Bulging disc, I showed everybody.

Q All right. And can a bulging disc turn into a herniated disc?

A Absolutely, because a bulging disc is a partial tear. Picture a dam, a dam have a partial crack. The water collects behind it, the pressure builds up, what happens when the pressure builds up? It cracks it open, it becomes a full crack in advance same thing with a disc. So when you have a bulge and you have another trauma on top of it you were already partially

damaged, and then it doesn't take much to push the bulge into a full herniation.

Q Can someone with a degeneration of the spine have an accident and that accident aggravated the degeneration even if the degeneration is either mildly symptomatic or asymptomatic?

A Yes, sir. So if a person has a preexisting condition, would this --

THE COURT: Doctor, I am going to remind you, and I appreciate your effort to speak to the jury, but we need you to use the mic.

THE WITNESS: Okay.

Q If you want you can sit back down, Doctor?

A Okay.

Q Thank you, officer.

Doctor, can you answer that question or you need me to repeat it?

A No, no, I heard your question, I can repeat it. So if a person already has disc degeneration in the spine, it means the spine is slightly weakened already. It doesn't take much to make that area to go from no symptoms to become fully symptomatic and become aggravated.

We call it the eggshell theory. So if you have an egg, it's partially cracked, comes another accident or trauma, what's it going to do to the egg? It's going to crack it open, and that's the analogy that I use.

Q Doctor, I am going to show you another model specifically for the shoulder, would a shoulder model help you in demonstrating what the anatomy is of the shoulder?

A Yes.

MR. POLLACK: Your Honor, this is Plaintiff's 26 for identification for demonstrative purposes only.

A I can do it from here.

Q Yes, absolutely. Make sure you speak into the mic, remember.

A So the shoulder is the most complicated joint in the body. Why? Because we have three articulations at the same point. We have the clavicle, we have the humerus, and we have the scapula, the shoulder blade. They all unite and articulate at the same level.

Now, the shoulder is the only joint in the body that loves to lock up and freeze itself and be called frozen shoulder or adhesive capsulitis. The shoulder has six ranges of motion: We have shoulder flexion, which goes from zero to 180 degrees; we have shoulder extension, which goes from zero to 90 degrees; we have shoulder adduction A-D-D-U-C-T-I-O-N, which goes from zero to 60 degrees; we have shoulder abduction, which goes from zero to 90 degrees; we have external rotation and internal rotation, which goes from zero to 90 degrees.

When you have an injury to the shoulder, the first muscle, the first structure that gets injured most commonly is

the supraspinatus tendon, which is inserted someplace back here, here, and here. So once again this is the humerus, the shoulder bone, this is the joint. Then we have what is called the labrum, L-A-B-R-U-M. The labrum is like a shock absorber inside the shoulder. If it gets torn you begin to lose range of motion and muscle power.

And we have what is called the rotator cuff muscles, there are four muscles that hold the shoulder in place. We call them the SITS muscles, S-I-T-S. S, Supraspinatus, Infraspinatus, Teres Minor, and Subscapularis. That's basically the anatomy of the shoulder.

Q Okay. Doctor, with respect to the shoulder, can a shoulder prior to a traumatic event have degeneration?

A Absolutely, depending on the patient's age.

Q And could it have pain and as a result of the trauma become worst?

A Absolutely.

Q Doctor, the last one I want to talk you you about -- which I just broke your knee.

A I have to sue you.

Q There you go. Is the knee, and I appreciate the manner in which you are doing this quickly, if you could tell us how the knee works?

A Yes. So the knee, this is a model of the right knee. How do I know it's a model of the right knee? Because the

fibula always sits on the outside. This is called the lateral portion outside, this is called the medial portion or the inner side. This is the patella, the kneecap, and this is the lateral meniscus, this is the medial meniscus.

Now, the function of the meniscus is three-fold: Number one, it separates bone from bone, bone from bone. And number two, it serves as a shock absorber. Remember, the meniscus is also fibrocartilage material, so once fibrocartilage material tears it does not have the ability to repair itself. The third function of the meniscus is to take the fluid inside the knee called the synovial fluid. It takes it and switches around the joint to lubricate the joint.

So the meniscus is analogous to the oil pump of your car. If your car runs on five quarts of oil and now your oil pump is damaged, you are not lubricating the parts, what you think is gonna happen? A lot of wear and tear as time goes on, leads to early traumatic arthritis, and it leads to a lot of pain and dysfunction inside the joint.

Q Thank you, Doctor. Now, Doctor, the good news is we've already had Dr. Cordiale and Dr. Dassa testified, and I want you to assume that Dr. Cordiale with respect to the cervical lumbar spine discussed certain surgeries that Ms. Rosado had.

You're familiar with the surgeries she's had, correct?

A Yes, sir.

Q Okay. Dr. Dassa testified with respect to some knee

surgeries and a shoulder surgery that he performed, you're familiar with that, correct?

A I am, yes, sir.

Q I want you to assume that they testified that as a result of the accidents of July 11th and/or July 14th those injuries were sustained. And you are familiar with this accident and with respect to the claims, correct?

A Yes, sir.

Q I want you to assume that in December of 2003 Ms. Rosado had a MRI of her lumbar spine as a result she had -- as a result of an accident she had while working, and that was a normally MRI of her lumbar spine?

A Yes, sir.

Q I want you to assume that on the date of the accident she had testified that periodically she would have pain to her back. Are you aware of what I just mentioned to you?

A Yes, sir.

Q All right, very good. I want to talk about now the right knee, and I want you to assume that prior to the accident July of 2014, she had an X-ray of her right knee, which was a negative examination, and that was on March 9, 2010. Are you familiar with that report?

A Yes, I am.

Q And I want you to assume that the testimony of Dr. Dassa was that as a result of this accident she injured her

right knee. You are aware of that, correct?

A Yes, sir.

Q With respect to her right shoulder I want you to assume that she had an X-ray prior to July of '14, on April 3, 2008, of her right shoulder, which it was a negative examination.

A Yes, I am aware of it.

Q And I want you to assume that she's testified periodically with respect to her neck, shoulder, both knees and her spine she would have pain periodically, but as a result of this accident increased. You are aware of that?

A Yes.

Q Is it of significance to you with respect to the two X-rays and the MRI just mentioned as having a negative examination?

A No, it only tells me that she had some prior preexisting problems. The problems to her lower back were localized, they were not radiating. If the pain is radiating it means that there is a disc problem and/or a pinched nerve. If the pain is localized the most common area is the muscles or the bones from a -- for the condition. So it tells us, it tells me there were some preexisting subtle conditions, nothing of any major nature. And then can these two accidents which exacerbated the underlying degenerative condition made her symptomatic and necessitated MRIs, EMGs and surgical intervention.

Q It's the same thing with respect to her right shoulder and her right knee?

A Yes, sir.

Q Okay. Now, Doctor, you personally examined Ms. Rosado on a number of occasions, correct?

A Yes, sir.

Q Okay. Are you -- as part of your practice are you familiar with the term Medalliance?

A Yes, that is a facility where I am the Chief of the Department of Rehab Medicine. I am in charge of morbidity and mortality, which means that any problems happens it gets reported to me, I investigate and I teach the house staff so it doesn't get repeated again.

Q Okay. And we are not going to go into specific accounts, Counsel may ask you, but we have some if not all the records from Medalliance, and Ms. Rosado did treat with Medalliance for some period of time, correct?

A Yes, sir.

Q And you examined her a couple period of time, correct?

A Yes, sir.

Q Now, as part of this case the law firm asked you to do what's called a life care plan, correct?

A Yes, sir.

Q And you don't do that for free, do you?

A I do not.

Q Okay. You are not coming to court for free either, are you?

A No, because I lose from my practice, I've got to be compensated.

Q Well, that was my next question. How much are you being compensated for being here today?

A The fee is $5,000 for half a day.

Q And with respect to preparing the reports, how much were you compensated, you remember?

A Back in 2018 and 2022 the fee was $3,000 for a life care report.

Q Okay. And you prepared two life care reports as time has passed, you did one in 2018 and one in 2022, correct?

A That's correct.

Q Now based on your -- can you tell the jury what a life care report is?

A So a life care report is a special report that is provided by only two experts, a board certified physiatrist like myself or a certified life care planner. A certified life care planner is not a doctor.

MR. BURBAGE: Objection, Your Honor.

Beyond the scope of the question.

THE COURT: The objection is overruled.

A So, a certified life care planner is not a medical doctor, not a doctor. They only have a two-week training

program and they take an examination, once they pass the examination they are called a certified life care planner.

They don't have credentials or ability to order diagnostic studies, they don't have the ability to order tests or refer patients to any other specialists or do any surgical procedures. They take the evaluations of other doctors.

So if the other doctors evaluations or opinions are correct that report may be correct; if it's wrong it will be incorrect. However, a life care plan provided by a board certified physiatrist they have the ability to order tests, they have the ability to do certain surgical procedures, they have the ability to do all of the things that they said, and most importantly they have to know the medical indications for every procedure that is done, and they have to know the standard of care, which is medical necessity.

Now, I didn't mention this, but I am an officially designated physician mentor by the State Education Department Office of Professional Medical Discipline.

THE COURT: Dr. Guy, it is going to be helpful if you just answer the question that's actually asked.

THE WITNESS: Yes.

Q Let me ask you this way then: Are you -- obviously you are licensed as a doctor in the State of New York, correct?

A Yes, sir.

Q And I am doing this quickly, but you've been published

and you teach, correct?

A Yes, sir.

Q Have you also been appointed in some capacity with the State of New York in the area of basically looking at the doctors and the way they practice?

A Yes.

Q And what is that?

A So I have been designated by the State Education Department, this is the institution that issues licenses, revokes them, suspends them, and takes them away. They have chosen me based on my credentials and my training to be an official doctor to go into other doctors offices that have committed certain misdeeds to teach them, bring them up-to-par to teach them the standards of care so they practice safely and properly. And to do that I have to know all the medical indications and the standard of care.

Q Doctor, now I want you to assume that the medical records, which you've seen most of the medical records, and there are a lot of pages, correct?

A Yes, a lot of pages.

Q The patient has been diagnosed with carpal tunnel syndrome, fibromyalgia, and depression. Does that affect your opinion at all with respect to the life care plan?

A No, sir. Unrelated.

Q And how is it unrelated?

A Well, fibromyalgia does not cause disc herniations. Fibromyalgia is -- the best way to determine it in layman's terms is called muscle rheumatism. It does not cause radiating pain, it does not cause numbness and tingling, does not cause disc herniations, does not need surgery. Carpal tunnel is a problem with a pinch nerve in the wrist, has nothing to do with the neck.

Q Okay. And you are certainly aware that she's been disabled for depression prior to this accident?

A Major depression, yes, sir.

Q Is that something that would affect the injury she sustained as a result of the accident and the treatment she needs in the future as you are about to talk about?

A The answer, no, a major depression does not cause disc herniations, does not cause disc pathology or nerve damage. However, if a person does have major depression their ability to perceive pain is exponentially increased. So let's say an average 10 person have no depression they perceive this much pain, now they have major depression the way they perceive the pain is at this level, exponentially increased.

Q That's not talking about -- and we are not talking psychiatric problems, we are talking about some may become more susceptible, correct?

A Yes, sir.

Q All right. And, Doctor, you prepared a life care plan,

correct?

A I did.

Q And what did you put into and what did you determine and what did you look at in order to prepare a life care plan?

A I reviewed all the pertinent medical records, I conduct my own examination, my own findings, and I apply what is medically indicated based on optimal level of care going forward.

So in the medical field we believe that an injured person is entitled to best medical care, not sub-optimal level of care. They need good care so they don't get worst, they get better. So I put in the medical indications for future physical therapy, diagnostic studies, MRIs, EMGs, X-rays, future surgeries, future medications and their costs, and whatever the patient may need going into the future from the day that I conduct that evaluation.

Q Is this done to a reasonable degree of medical certainty?

A Yes, sir, it is.

Q And, certainly, you said optimal, a patient may not need that or could need more, but to your opinion to a reasonable degree of certainty this is what would be optimal. Fair statement?

A Yes, sir.

Q All right. So with respect to Ms. Rosado, there are

certain categories in which you made determination as to what she needs. And I want you to assume that she's got approximately 32 years of life expectancy. Is that something you take into consideration when you do a life care plan?

A Yes, sir, that is correct.

Q Why is that?

A Because the life care plan is based on future, going forward, if a person's injuries are permanent and progressive as such is the case here, so as a physician giving the life care plan, I would be predicting future medical needs for the rest of her life, because this condition is permanent, and it continues it doesn't stop as such been the case.

Q So, for example, I can ask you specifically on these categories that you have in your report unless you prefer to tell me -- you tell me if you wanna go item by item or you want me to ask you. What's best for you?

A Whatever is easy for you.

Q Let me ask you this: Orthopedic surgeon, how often should miss -- do you have to a reasonable degree of medical certainty that Ms. Rosado should see an orthopedic surgeon per year?

A At least six to eight times per year to monitor the orthopedic injuries, the shoulder and knees, to make sure there's no future indication for imminent surgery, for example, the knees the patient has had multiple arthroscopic surgeries

already, and future arthroscopic surgeries is not going to help, the next will be a total knee replacement. So the orthopedic surgeon needs to monitor her on a regular basis to make a determination when that should be done.

Q And what's the costs of each one of those appointments, approximately?

A $200 per visit.

Q How did you get that number?

A I have been doing this for over 37 years, and I have reviewed over tens of thousands of medical records and medical bills. When I review records the medical bills comes with the records. I'm familiar.

I'm also the director of The Department Of Rehab Medicine at Medalliance. We have -- I'm also the Director of The Department of Rehab Medicine at Medalliance, which is an Article 28 Facility, which is like a small hospital. We have about 35 doctors, we have several surgeons. I see all the bills.

MR. BURBAGE: Objection, Your Honor.

MR. POLLACK: I'll go on. I will move on, Your Honor.

Q So you are familiar with the billing, of course?

A Yes.

Q Okay. The second item we have is a neurological -- a neurologist, how many times a year should Ms. Rosado see a

neurologist?

A Six to eight times per year to monitor the neurological injuries. And, of course, there's again the $200 per visit.

Q And the neurological injuries you are talking about which injuries, specifically?

A To the head, the radiculopathy, the neuropathy, et cetera.

Q Okay. Well, we're not gonna deal with the head at this point. So you're talking about the neck and the back and the knee, radiating pain and things along those lines?

A Yes, sir. That's called radiculopathy.

Q Okay. Thank you. The third one we have is a spinal surgeon, and I want you to assume that Dr. Cordiale, who's the spinal surgeon, says it could be anywhere from one to two times a year depending on as she needs it.

Do you have an opinion to a reasonable degree of medical certainty how often she should see a spinal surgeon?

A Ideally -- one to two is the minimal. Ideally three to four times because you wanna catch things early. If you catch things early, you can have a good success in alleviating that problem. If you catch it late, one to two times means every six months, if a problem happens before that you don't catch it early, it could have problems down the road.

Q How much is the neurological appointment?

A It's about $300 per visit.

Q Okay. Thank you. We then have doctor -- a physiatrist. You've already talked to us a little bit about a physiatrist, but why would a patient, if -- later we are going to talk about physical therapy. Why should a patient see a physiatrist? And how many times a year should Ms. Rosado see a physiatrist?

A So a physiatrist is the primary care physician in traumatic injuries. The function of the physiatrist is to manage the patient's overall muscular skeletal condition from head to toe, not just the shoulder, not just the knee, not just the neck, not just the back, the whole thing. To assess the need for physical therapy, assess the need for pain medications, assess the need for injections or surgical referrals or a combination of all of the above. So ideally it should be once per month and the cost is $200 per visit.

Q Doctor, then we have physical therapy. I want you to assume that Ms. Rosado continues to date with physical therapy. Is that something that she should continue?

A Yes, because in the medical field we have a slogan, if you don't use it, you lose it. So you have to exercise each joint. You have to exercise each joint at least ten times each direction, otherwise it will lock up on you. So the purpose of physical therapy is not to cure the problem, it's to decrease pain, decrease spasm, improve function, improve range of motion, improve muscle power, improve gait, and most importantly to

prevent this condition from getting progressively worse.

So if a patient has any one of these deficits the patient deserves to have physical therapy, and she has all of them. So she needs to have physical therapy at least one to two times per week. And the cost for comprehensive -- for modality physical therapy session is $200 per session.

Q Doctor, with respect to physical therapy, somebody whose got an acute injury, meaning it happened recently, sometimes they see more therapy than one or two times per week, correct?

A Absolutely, yes.

Q But with respect to Ms. Rosado, because she is trying to maintain, one to two times a week is reasonable to a reasonable degree of medical certainty?

A Yes, sir.

Q Okay. Doctor then we have MRIs. Now, with respect to Ms. Rosado we have records and we know she's had multiple MRIs to her shoulder, her back, her neck, and her knees. Is this something that she should continue into the future?

A Yes, sir.

Q Why and how often?

A To monitor the injuries to make sure that if they're getting progressively worse you catch them early. If you catch things early you can be very successful in rectifying the problem. So the MRIs of the neck, the back, right shoulder,

both knees should be done every two to three years, and the cost is $1500 for each.

Q And, again, that's the optimal?

A That's the optimal, yes, sir.

Q All right. With -- and that's to a reasonable degree of medical certainty with respect to Ms. Rosado as a result of her problems from this accident, correct?

A Yes, sir.

Q With respect to injections, you've already mentioned facet injections and epidural injections. Can you tell the jury, generally, what they are and whether you perform them and why the injections should be given?

A Yes. So I do them. I do these epidural injections. I also teach them the -- there's three types of injections that we usually do in patients of this kind. We do epidural injections. We do facet injections. We do radiofrequency ablations, and we do muscle injections called trigger point injections. If you hand me the spinal -- it's over here.

MR. POLLACK: Judge, may I approach?

THE COURT: Yes.

A Thank you. So if I may demonstrate what an epidural is?

Q Sure.

A So epidural injection is an injection that goes into the spine. When you inject medication directly into the spine,

it is much, much more powerful than if you take it by mouth. To give an example, morphine one milligram into the spine equals 100 milligrams by mouth. If you give a patient morphine a hundred milligrams by mouth, you will kill him. One milligram here, gives adequate relief, equals to one hundred milligrams by mouth.

So whenever you give medication into the epidural space, which is directly into that -- inside the spine, it works much more effectively than by mouth.

So epidural into the spine is usually a steroid medication long acting or short acting, and the neck we give saline, because we can't give lidocaine it will cause respiratory suppression, but in the lower back we do give lidocaine and cortisone, it works much better together.

So if the patient has radiating pain that's radiculopathy, they get three epidurals per year. If they have arthritis with facet arthropathy, this is the facet right here, the facet controls movement from side to side, forwards, and backwards, three facets per year. And radiofrequency, there's a nerve that comes from the facet to the transfers process, it's called the medial branch, we burn it. We put a special needle probe inside, we heat it up to 150 degrees Fahrenheit, and we keep it there for about 75 seconds, we burn that nerve. It grows back after six months, so the patient has no pain for six months.

And then the muscle pain is the trigger point injections that goes into the muscle, those are done about 10 to 12 per year. The costs for each epidural is $2000 and the outpatient surgical facility to monitor is $3,000. The facet, each one is $3,000, and the outpatient surgical facility is $3,000. Radio frequency is $5,000, and the outpatient surgical facility for each is $4000, and the trigger point injection for each per set is $400.

Q So, Doctor, let's clear this up. With respect to the epidural injections for the cervical spine, how many should she have per year?

A Three per year.

Q Okay. And they are $2,000 each, and then the facility is another $3,000 each?

A Yes, sir.

Q With respect to the lumbar, how many should she have per year?

A Same, three.

Q With respect to the facet injections, how many should she have a year?

A Three to the neck. Three to the lower back.

Q And that's $3,000 and $3,000, correct?

A Yes, sir.

Q For the radiofrequency ablation, how many should she have of that a year?

A Two for the neck, one to each side, and the same for the lower back.

Q Okay. When you say the same for one on each side, is that additional cost or it's the same cost for both?

A No, it's separate cost.

Q Okay. So how much --

A You don't do both -- you don't do both at the same time, you do them on different times.

Q All right. So she should have four. She should have two a year for the neck on one side, two a year for the neck on the other side?

A No, sir. The neck in one year, two; one for each side.

Q Okay. So two total?

A Correct.

Q And that's 5000 and $4,000?

A Yes, sir.

Q And for the back for the same radial, same thing?

A Yes, sir.

Q So two total, both sides five and four. And you mentioned the trigger point injections. What is -- how often should she have a trigger point injection?

A Ideally, at least once per month.

Q And is that both for the cervical and the lumbar spine?

A Yes, sir.

Q Now, Doctor, this is a lot of injections. This is what

we're talking about lumbar, optimal to the -- to a reasonable degree of medical certainty, correct?

A This is for the next three to five years, not forever.

Q So all these injections that we just mentioned are for three to five years?

A Yes, sir, that is correct.

Q And would you agree that if she's got extra -- if she's got good relief for a couple of them it means she can skip a couple if necessary?

A Yes, sir.

Q Okay. So this is just optimal assuming she doesn't have continued relief from any of these injections?

A That is correct.

Q All right. Great. Now, Doctor, in addition I want you to assume that Ms. Rosado testified that her right shoulder is feeling better, but she still has pain to the shoulder. And Dr. Dassa says she may need surgery in the future. If she does need surgery in the future to a reasonable degree of medical certainty, what would be the cost of a surgery to the future? And let's make it an arthroscopic surgery, not a shoulder replacement, just an arthroscopic surgery.

A Yes. The fee will be approximately $35,000, this will include the surgeon's fee, surgical assistant fee, anesthesia, and the facility fee. And afterwards she would need additional physical therapy three times a week for four to six months.

Q And that's what we were talking about before, because when you have surgery it's kind of -- that's almost a traumatic event, so at that point you would bump up the physical therapy. Fair statement?

A Yes, sir.

Q Okay. And why would you do that?

A Because to help the shoulder to recover appropriately and expeditiously.

Q Okay. Let's talk about the right knee. I want you to assume that Dr. Dassa also testified that the right knee, which Ms. Rosado said is getting better, and has been better. But if she needs a surgery or a knee replacement to her right knee what would that require?

A Well, the cost would be as follows: $30,000 for the surgeon's fee, $30,000 for the prosthetic knee replacement parts, anesthesia fee $3,000, one to two day hospital stay about $75,000. After the surgery the patient will need post-surgical bracing, which will be $1,000. And then the patient would need physical therapy three times per week for four to six additional months.

Q Let me just make sure I got this right. So if it was a knee replacement to the right knee, $30,000 for the procedure for the doctor?

A Correct.

Q $30,000 for the facility fee?

A No.
Q $30,000 for the --
A The knee replacement, the prosthetic knee replacement part.
Q Okay. And there is $75,000 for the facility, correct?
A For the hospital, one to two day hospital fee, yes.
Q And then there again she needs three times a week for four to six weeks or months for physical therapy?
A Four to six months.
Q Okay. Now, let's assume she just needs -- they decided to do an orthoscopic surgery, an orthoscopic surgery to the right knee as opposed to a knee replacement, what would that involve?
A First of all, I would not recommend it. It's not going to work.
Q Then let's skip it. Let's skip it. And I want you to assume that Dr. Dassa testified yesterday that he performed two surgeries on the left knee, and then Dr. Allen performed two surgeries on the left knee, and his testimony was the second two surgeries he would not have done either. Is that something you would agree with?
A A hundred percent, yes.
Q And why is that?
A Once you do one arthroscopic surgery, to do another one all you're doing is with arthroscopic surgery to the knee, all

you're doing is you're shaving the jagged edges of the meniscus that is torn. You're not replacing the meniscus. You're doing nothing to replace the torn meniscus, it remains torn. So you're putting Band-Aid over an open wound. It's not gonna work, and as you can see it today, it has not.

Q Okay. And with respect to the left knee, I want you to assume that she had the two surgeries, and let's forget about the other two surgeries for the time being, and that Dr. Dassa said she does need a knee replacement at this point.

Do you agree with that to a reasonable degree of medical certainty?

A Absolutely.

MR. BURBAGE: Objection, Your Honor.

THE COURT: You can approach.

MR. POLLACK: I'll move on, Your Honor. I'll move on, it's not necessary.

THE COURT: I don't think that -- you got to approach.

I am going to sustained the objection. I am going to strike the last answer. We're gonna give the jurors a short break, so we will take ten minutes.

MR. POLLACK: Thank you.

THE COURT: Ten minutes, everybody.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: Everyone, please be seated.

Mr. Pollack.

MR. POLLACK: Thank you.

Q Doctor, let's do it this way: You talked about what the cost for the right knee, whether it be an arthroscopic surgery or a replacement would cost, correct?

A Yes, sir.

Q Would it be the same thing for the left knee?

A Yes, sir.

Q Okay. And that's to a reasonable degree of medical certainty?

A Yes, sir.

Q Okay. Doctor, let's talk about the cervical and lumbar spine. I want you to assume that Dr. Cordiale testified that with respect to both the cervical and lumbar spine there's often lower or higher discs become affected from a fusion. Are you familiar with that?

A Yes, it's called adjacent segmental pathology.

Q Okay. And given the plaintiff's age of 39, do you have an opinion as to whether or not she'll need a cervical and/or lumbar fusion in the future at another area, another disc?

A Yes, sir, she --

MR. BURBAGE: Objection, Your Honor.

THE COURT: I think the objection is sustained Mr. Pollack. You could rephrase.

MR. POLLACK: All right.

Q Let's do it this way: The Doctor testified she -- to a reasonable degree of medical certainty she will need another fusion to her cervical and lumbar spine. Tell us about the cost for a cervical fusion and a lumbar -- and a lumbar fusion if they're the same doing?

A So for two level fusion and the cervical spine the cost for the surgeon's fee would be between 100,000 to 150,000. Surgical assistant fee would be about $5,000 to $10,000. One to two day hospital stay would be about $150,000 to $200,000 that will include the very expensive artificial disc spaces with the metal plates and screws, which are very expensive. Anesthesia fee would be about $4,000. Neuromonitoring fee would be about $3,000 to monitor the spine during surgery. And postsurgical bracing would be about $1,000.

Q Postsurgical what?

A Bracing.

Q Bracing?

A Yes. After the surgery the patient would need additional physical therapy sessions three times a week for four to six months.

Now, if the same surgery is done by advanced robotic

surgery at NYU, the cost would be in --

MR. BURBAGE: Objection, Your Honor.

THE COURT: The objection is sustained.

Q What type of surgery is it you just mentioned?

A The typically standard discectomy, foraminotomy, and disc space replacement.

Q Okay. Now, we didn't talk about it in the report about the robotics, so I'm not gonna talk to you about it.

A It's in my report.

Q It's in your report, robotic?

A Yes, it's in my report.

MR. BURBAGE: Objection, Your Honor.

THE COURT: Approach.

Q Doctor, you are correct, it is in your report. So I apologize I didn't see it, but we're gonna leave it with the standard way that you testified as to how it's done pretty much most of the time, correct?

A Yes, sir.

Q Okay. Obviously things are gonna improve over time, but for now reasonable degree of medical certainty the way it would be done is the way in which you discussed it, correct?

A Yes, sir.

Q Okay. Great. Now, you mentioned that's the cervical spine. How would the lumbar spine be different or it would be the same thing and the same cost?

A Essentially, the same cost.

Q All right. Doctor, the last couple of questions I have for you, if I could find my notes, I certainly can. Now, you've testified in Court before, correct?

A Many times, yes, sir.

Q Who do you usually testify for?

A For my patients. The legal system calls them plaintiffs, I call them patients.

Q All right. And have you been qualified as an expert in courts?

A Every single time I've testified in courts, Supreme Court, Federal Court, yes, sir, never turned down.

Q All right. And everything you will told us today is that your opinion to a reasonable degree of medical certainty?

A Yes, sir.

Q Okay. And is it your opinion to a reasonable degree of medical certainty that the treatment you discussed today was necessitate by the accident that Ms. Rosado had on July 11th of 2014 and July 14, 2014?

A Yes, sir.

MR. POLLACK: I have nothing further. Thank you.

THE COURT: Mr. Burbage.

MR. BURBAGE: Yes, Your Honor.

CROSS EXAMINATION

BY: MR. BURBAGE:

Q Good morning, Doctor.

A Good morning, sir.

Q Would it be fair to say that all those times when you in trial and you testified on behalf of your patients, plaintiffs, sometimes the jury accepts your analysis and your costs and sometimes they reject them. True?

A That I don't know. After I'm done, I have no idea what happens after I'm done.

Q You don't speak to any of the attorneys regularly as to the outcome of a case?

A Sometimes they tell me. Sometimes -- I've never heard them tell me the jurors didn't accept my opinions.

Q Okay. Now, can we agree if you're gonna testify as an expert in a court you should be knowledgeable, correct?

A Yes.

Q You should be thorough?

A Yes.

Q You should be accurate?

A Yes.

Q And you also --

A To the best you can. To the best you can.

Q Yes. And you're familiar with 3101 exchange?

A That's what the lawyers do.

Q Right.

A Yes.

Q Have you seen it?
A In the past on occasions, yes. On this case, no.
Q You've never seen it?
A I said in the past I have. On this case I have not seen it.
Q So they never sent you the 3101 disclosure?
A No, sir.
Q So you have no idea why they said you are gonna testify about a motor vehicle accident?
A Motor vehicle accident?
Q I'm telling you what's in the 3101.
A I have never seen it.
Q So you have no idea why that's there?
A That is correct.
Q Okay. Now, in this case you were retained by the Yankowitz Law Office, correct?
A Yes, sir.
Q And you were retained in part to prepare a life care plan, yes?
A Yes, sir.
Q And the Yankowitz Law Firm provided you with medical records, correct?
A Yes, sir.
Q Did you believe that they provided you with all the medical records?

A My goodness, they sent me over a thousand, over a thousand pages, I hope that should be enough. And I believe I had enough medical records to formulate my opinions.

Q Are you aware of other medical records that you did not have?

A For example?

Q Dr. Averbach records for the four years he treated the plaintiff's cervical spine?

A I saw some of his records.

Q Tell me where in your report you referenced Dr. Averbach's record review?

A Oh, it's not in my report. It's --

Q Thank you, Doctor. You said you reviewed the records from Montefiore Medical Center?

A Yes.

Q I assume those are the two Emergency Room visits?

A One was Montefiore, and one was North Central Bronx.

Q Did you review the North Central record?

A I did, yes.

Q And can we agree that neither of those records refer to --

THE COURT: Mr. Burbage, hold on one second.

MR. BURBAGE: Sure thing.

THE COURT: Okay.

Q Can we agree that neither of those emergency room

records make any reference to her lower back or to her knees?

A That is correct.

Q Now, you were shown MRIs from Doshi Diagnostic Imaging, correct?

A Yes.

Q Do you know how many MRIs films you were shown?

A Cervical spine, lumbar spine, right knee, left knee.

Q And you know what dates they were taken?

A I don't recall. This goes back 11 years.

Q Understood. Do you recall seeing the MRI report from Doshi Diagnostic dated February 17, 2007, for the cervical spine?

A Yes. It showed bulging disc.

Q Do you recall that the reason the cervical MRI was ordered was because Ms. Rosado showed up complaining of neck pain and numbness in both hands?

A Okay.

Q And she's making those same complaints now 14 years later?

A It's little bit worst than it was 14 years --

Q It's the same complaint. We are not talking degree, we are just talking about the same complaint, numbness and pain?

A I don't believe in the old predating this accident there was radiating pain, there was numbness and tingling. She had carpal tunnel syndrome.

Q Have you reviewed Dr. Merchant's medical records for his treatment of Ms. Rosado?

A That I have not.

Q So when you say you don't believe on the basis of what don't you believe if you didn't?

A I saw some records. There's a lot of records here.

Q You see Dr. Merchant's records referenced anywhere in your report?

A No, it's not in my report.

Q Isn't that part of being thorough listing the records you review?

A I have on my e-mail over a thousand pages of records.

Q I understand that, Doctor, but you're here testifying as an expert about all this future care the Plaintiff needs.

A Right.

Q And you're telling the jury that you don't know what you saw because you only have certain records listed and not other records.

A Whether it says that which you say or not, she still needs the future care that I'm saying that she needs.

Q That's not what I'm asking. I understand what you're saying. That's not what I'm asking. I am asking, there's no reference in your report to seeing Dr. Merchant's records of his treatment of Ms. Rosado back in 2007?

A That is correct.

Q Thank you. Now, I don't see in your list of records Dr. Cordiale's records?

A It does not say. I got them shortly before I --

Q Is it in your report, Doctor?

A I'm sorry?

Q Is it in your report -- we're testifying on the report you --

A No, it's not.

Q And I don't see any reference to New York Spine and Pain records?

A That is correct.

Q Now, can you tell the jury what a comorbidity is?

A Yes.

Q Tell the jury, please.

A Comorbidity is another medical condition that overlaps with that particular condition. If you like I can give an example.

Q No, we don't need an example.

A Okay.

Q You indicated that the Plaintiff has fibromyalgia?

A Yes.

Q And fibromyalgia can cause pain in the body, yes?

A Yes.

Q And fibromyalgia can also cause numbness and pins and needles sensations.

A Highly unlikely, it is rear, not common.
Q But it can cause it?
A It can, yes.
Q And it can cause this pain and these conditions in the upper body and the lower body?
A It can, yes.
Q And it's a chronic disease?
A It's a chronic condition, yes.
Q Which means it's not gonna be cured?
A No, sir.
Q It's gonna go on forever?
A That's right. There's levels of it.
Q Have you seen any of the treatment records for Ms. Rosado's fibromyalgia from any doctor?
A In some of the records I did see it was listed.
Q As a -- but were they treatment records or just history records, if you know?
A Based on what I remember, it was history.
Q Okay.
A I did not see any treatment records.
Q And the history also talks about corporal tunnel syndrome, correct?
A Yes, sir, that is correct.
Q And that can cause numbness and pain in the affected hand, correct?

A It can.
Q Okay. And Ms. Rosado does complain about numbness and pain in her hand, correct?
A Yes, but --
Q No.
A The answer is yes, with an explanation.
Q Thank you. I don't want the explanation, that's Mr. Pollack's job.
A Okay.
Q Now, in your history of Ms. Rosado you list depression?
A Yes.
Q You don't reference fibromyalgia, no?
A No.
Q And you don't reference corporal tunnel syndrome?
A No, because I --
Q You don't reference them, yes or no, Doctor?
A The answer is no for very --
Q Doctor, it's a yes or no for very -- doctor. Now, you reviewed the Vista Medical records, correct?
A Yes.
Q And you reviewed Dr. Bernard's initial evaluation of the Plaintiff from July 29, 2014? It's part of the Vista record?
A Yes.
Q And we assume you reviewed it?

A Yes.
Q And she identifies fibromyalgia and carpal tunnel syndrome as past medical history?
A That is correct.
Q And they don't appear anywhere in your report?
A They do not for very good reason.
Q Thank you, Doctor. In the course of your evaluation of the Plaintiff in an effort to be thorough, you don't indicate in your report that you reviewed from Stand-Up MRI?
A I don't think anybody has them. No, I did not.
Q And you didn't indicate that you reviewed the MRI from Third Avenue Imaging?
A I don't think anybody has them.
Q Okay. Now, I want you to assume that last week Dr. Cordiale, the Plaintiff's spinal surgeon, testified and during his testimony we went through a series of MRI reports from Stand-Up MRI. These MRI reports were from 2007 through 2021, and up until 2021 every MRI report indicated that she had a bulging disc at C5-C6.
A Right.
Q Okay. Dr. Kolb in 2021 is the first doctor to indicate that that was a herniation?
A That is correct.
Q Now, we've agreed that discs do degenerate naturally?
A Discs can degenerate naturally and/or traumatically.

Q Okay. If she injured her back in 2014, how is it that there's no herniation until seven years later, isn't that rather unusual?

A That answer cannot be -- that question cannot be answered with a yes or no --

Q Thank you, doctor.

A -- it requires an explanation.

Q Thank you, Doctor. Now, when you were talking about your life care plan, you kept telling the jury that it outlines optimal care?

A Yes, sir.

Q Are you suggesting that the doctors who have treated her since 2014 have not provided her with optimal care?

A I have no comment on other treating doctors treatments or lack of treatments. This is my professional opinion going forward, this is what is medically indicated.

Q Okay. Now, in 2022 she was a patient at Medalliance, she was a patient of yours, correct?

A Yes, and I did an EMG on her.

Q Understood. And in your report you just told the jury that she needed six cervical epidural injections, six lumbar epidural injections?

A You are wrong, sir, I did not say that. Three, three cervical epidurals, three for the cervical spine and three for the lumbar spine.

Q Okay. So we have three cervical and three lumbar?
A Yes, sir.
Q That's six?
A That is correct.
Q Then we have three cervical facet and three lumbar facet.
A Facet.
Q That's six more, that's 12?
A That's correct.
Q And then we have two radio ablations?
A That is correct.
Q Now we are at 14. And then we have 12 trigger point injections per year?
A That is correct.
Q That takes us to 26?
A That is correct.
Q Do you have a record to show that in 2022 when you were treating Ms. Rosado you prescribed, authorized, or actually performed 26 injections?
A No, sir, I said --
Q Do you have a record for 2023 that you performed or injected her 26 times in accordance with your plan?
A If you let me finish.
Q Doctor, I'm just asking the question. Did you injection her 26 times in 2023?

A The answer is no for very good reason --

Q Thank you, Doctor. In 2024 did you in fulfillment of your plan ensure that she had 26 injections?

A I don't believe she was under my care in 2024.

Q Thank you, Doctor. In 2025 in September -- October 1, we're 10 months into the year, how many injections she have this year?

A I have no idea.

Q Thank you, Doctor. Now, when you talk about these expenses, this, that, whatever it is they cost, you're working on the assumption that Ms. Rosado is going to have to make these payments out of her pocket, correct?

A I'm giving the price of the standard prevailing rates in the tri-state area. I have no idea how she's gonna pay or not pay, but this is what is indicated and these are the reasonable costs in the tri-state area.

Q Now, Doctor, again going back to the optimal medical care, all doctors take the hippocratic oath?

A They're supposed to.

Q Did you take it?

A Yes.

Q There you go. And you do no harm, correct?

A Yes.

Q So you provide the best possible treatment you can, that's the theory.

A That is correct.
Q In all the records you reviewed is there any basis that you can tell us that she now needs to see an orthopedic surgeon six to eight times a year?
A The way you phrased the question it cannot be answered with a yes or no.
Q Okay, then I'll ask it simpler. Have you ever spoken to Dr. Dassa about how often he wants to see her?
A No.
Q He's the orthopedic surgeon in this case?
A And for very good reason.
Q I'm not answering -- I'm just asking you if you ever spoke to him, the answer is no, correct?
A The answer is no for a very good reason.
Q Have you ever spoken to Dr. Cordiale?
A No, for the same reason.
Q Thank you. Have you ever spoken to Dr. Brian Haftel?
A No, sir.
Q Now, you indicated in your report that she should see a physiatrist at least once a month, 12 times a year approximately, correct?
A That is correct.
Q And you are a physiatrist?
A I am.
Q Okay. I believe your testimony was that she should see

a physiatrist so the physiatrist can assess her situation determine additional medical care, injections, things of that nature, right?

A In part, yes, sir.

Q Well, what are her other doctors doing if they're not doing the same thing?

A Every doctor has a different specialty, and the role is different.

Q Well, you're talking about injecting her cervical spine or her lumbar spine, isn't that something Dr. Cordiale would be interested in since he is her treating orthopedic surgeon?

A I have no idea --

Q Thank you, Doctor.

A -- what he is interested in, I am just making opinion --

Q I understand that, Doctor, we all understand that it's an opinion. It's an opinion you've been paid for, correct?

A The way you phrased the question, I'm not gonna --

Q You are being paid -- you were paid to prepare this report, right?

A I was compensated for giving --

Q You were compensated. We will use the word "compensated". It's the report you were compensated for, correct?

A That is correct.

Q Thank you. And the compensation came from the Yankowitz Law Firm?

A That is correct.

Q And the medical records came from the Yankowitz Law Firm?

A In part, not all. Medalliance --

Q Let's go back to your review of the following medical records.

A Mm-hmm.

Q Didn't those records come from doctor Yankowitz -- the Yankowitz Law Office?

A Vast majority, yes. Medalliance, I'm part of Medalliance, I have those records myself.

Q Yes. So down there what comes from Medalliance besides Dr. Zeren's records?

A Medalliance are the physician, treatments from my physician assistant, Ruben Guy, no relations to me, from the physical --

Q Doctor, where is that listed here? All I see is records from our chiropractic doctor, Dr. Mitchell Zeren. He works for you or with you?

A No, does not.

Q You referred to him as "our chiropractic doctor"?

A If you read the first sentence in my report you would see it says that I've been treating the patient at the

Medallaince Health Facility since May 17, 2017, it's right there.

Q So you've been treating her since 2017, so let's ask this other question: After you prepared your optimal life care plan with 26 injections per year, did you go back to your records from 2017 to see if she's ever had 26 injections in any particular year?

A She did not.

Q Thank you.

A She was never under my regular --

Q Thank you.

A Okay.

Q Have you ever spoken to any of her other treating doctors?

A I have not.

Q Thank you. In your report -- well, scratch that.

Mr. Pollack asked you about adjacent segmental surgery possibilities.

A Adjacent segmental pathology.

Q Yes.

A Yes.

Q And she had a lumbar surgery at L5-S1?

A Yes.

Q In your report you write: "She will need another full open laminectomy, discectomy, and foraminotomy with fusion at

L2L3."

A At two levels, two lumbar levels.

Q Doctor it says at L2-L3 levels. Can you show this jury what MRI that you reviewed when you wrote this report indicates that the L2-L3 requires surgery or even suggests it requires surgery?

A That is a typo. It's L2 to 3 lumbar level --

Q Doctor, you've answered the question. Thank you.

Now, you planned for her to see an orthopedic surgeon six to eight times a year, and to see a spinal surgeon three to four times a year, so that's 12 visits. And a physiatrist 12 times a year, so that's 24 visits. And a neurologist, I think the neurologist was six to eight times as well?

A That's correct.

Q That's 32 visits a year. In those 32 visits presumably the Plaintiff would make complaints if she had them, yes?

A Yes.

Q And on the basis of those complaints doctors would or would not order additional testing, correct?

A Whatever is medically indicated should be ordered. This is, again, optimal plan.

Q Understood. So the orthopedic surgeon, Dr. Dassa, who sees her six to eight times a year or Dr. Allen, whoever it may be, would see her, ask her how she's doing, ask her what her complaints are. And if she had a new complaint then they would

possibly order a diagnostic test, an MRI or an X-ray, correct?

A I cannot answer or speak for another doctor.

Q Thank you.

A I answer and speak for myself.

Q You're not treating her -- you're not her orthopedic surgeon, right?

A I am not.

Q Thank you. When she goes to see Dr. Cordiale three to four times, presumably, he will ask her how she feels, and she'll tell him how she feels, right, that's the way it's supposed to work?

A Yes, that's correct.

Q And if her status is unchanged, that's the way it is, correct?

A Again, again, I cannot speak for another doctor.

Q Okay. Well, if you have a patient who comes into you in January and says this is how I feel, then they come back in February and say I feel the same way, come back in March and say I feel the same way, come back in April and say I feel the same way; then they come back in May and say, oh, something is different, that's when you would order a medical test, right?

A Wrong again, sir.

Q Okay. Why am I wrong?

A Because you need to correlate clinical findings. You need to examine the patient. The patient tells you I have pain,

I have stiffness in my joint, then you examine the joint, you look for crepitation, you look for swelling, you look for McMurray's test, you look for other signs of dysfunction. Let's say if you're talking about the knee, we're talking about the knee.

Q Right.

A If you're talking about the spine then you do range of motion, you look for muscle power testing, you look for trigger points, you look for sensory loss, you look for reflex loss, you look for all the other correlated conditions, not just subjective. You need to have subjective and objective findings.

Q And if the patient tells you that the pain is getting better or the pain is not that bad, I feel the same way I felt last month where you wrote down the same thing or a month later where you wrote down the same thing, you wouldn't just order a diagnostic MRI, would you?

A You left out -- you left out --

Q Educate me.

A -- the physical examination portion, what about that portion? That's the most important portion.

Q I've looked at a lot of medical records in this case, I don't see a lot of physical examinations that are different from one month to the next.

MR. POLLACK: Objection, Your Honor.

THE COURT: The objection is sustained.

Q Now, if a patient comes to you and has no complaint, I feel fine, Dr. Guy, I feel better. You don't order invasive procedures, do you?

A If that is the case why did the Plaintiff come to me in the first place?

Q Because you think she should see you 12 times a year.

A No. If the patient has no problems the patient will not come to see me. Patients are smart too.

Q And if the patients have no problem a spinal surgeon or an orthopedic surgeon they're not gonna order tests just to order tests. They need -- they need it based on something, correct?

A If the patient says I have nothing wrong with me, and the physical exam shows no area of dysfunction, no test will be ordered.

Q Thank you. Going forward, your belief that she's going to need all this testing is based on what, she's gonna make complaints?

A It's based on a lot of different factors.

Q Okay.

A If you like, I can give them.

Q No, I don't want them. I just wanna know what it's based on. You told me different factors.

And some of those factors are orthopedic, but you don't talk to Dr. Dassa, correct?

A I don't have to.
Q Some of those factors are spinal, but you don't talk to Dr. Cordiale?
A I don't have to.
Q Some of those doctors -- some of those factors are how she's perceiving pain or anything like that, but you don't talk to Dr. Haftel, right, you don't have to?
A That's correct.
Q Okay.
A Would you like to know why?
Q No.
A Okay.
Q Would you agree that Ms. Rosado over the course of her 14 years of treatment, 11 years of treatment has seen a variety of doctors?
A Yes, sir.
Q A host of doctors?
A Absolutely.
Q She's gone to different facilities?
A Absolutely.
Q Different physical therapy facilities?
A Yes.
Q And are you aware that at the physical therapy facilities, generally, the notes indicate that her pain level was six to eight consistently?

A I've seen that, yes.
Q Okay. And are you aware she told doctor Averback that before this incident her pain level was at a five, around a five?
A I saw that and it makes no sense. I don't know he means by that.
Q Well, five out of ten, correct? Isn't that the scale, one to ten?
A I said I saw that in his report. The way he wrote it is not clear if he's talking before, currently, but then he writes after that eight out of ten.
Q Well, that's based on her complaint, right?
A If you pull the record I can show it to you.
Q You go to a doctor's office, and a lot of them have that chart hanging on the wall, right, pain chart, number one happy smiling face, number ten very depressed face. They have that?
A Some do. Many don't.
Q And on their intake forms, right, there's usually a question about what kind of pain you have, correct?
A Yes.
Q And what's the level of your pain?
A Correct.
Q And they fill it in?
A Correct.

Q Now, at one point in your report I believe you indicated in 2022 her pain level was eight out of ten?

A That is correct.

Q When a pain level is eight out of ten, what's the manifestation?

A It's the patient's subjective complaint of pain. The way you phrased your question makes no sense in the medical context.

Q The patient comes to and says my pain is eight out of ten and you write down eight out of ten, that came from the patient, correct?

A Go back to your original question.

Q I'm asking you this question: You wrote down eight out of ten, correct?

A Then you asked me what does it mean.

Q Well, what -- how -- when a person has ten out of ten, are they up wandering around, dancing, smoking, drinking, hanging out, going to movies, or are they bedridden?

A They will be going, hopefully, to a medical provider for help.

Q Right. And you know at times pain has been identified it's like ten out of ten?

A I've seen it on some occasions, yes.

Q Okay. So ten out of ten is the worst?

A The worst, correct.

Q Nine is a bit better?
A Nine is still severe pain, yes.
Q So what is eight, what kind of pain is eight?
A Eight is moderate to severe pain.
Q Moderate to severe?
A Yes, sir.
Q Now, you indicated earlier when you testified that people who have depression they experience pain differently.
A Perception is -- exactly, it increased.
Q Right. And the perception is subjective?
A Yes.
Q It's based on how they're feeling?
A Yes.
Q Is there an objective test for pain?
A The MRI results, EMG results, physical examination findings, trigger point findings, muscle spasms --
Q They give you issues, problems, but if she has all these complaints would you expect her pain to be bit more consistent along the time instead of going from like six to eight, six to ten, ten to ten, five to ten?
A Pain varies from time to time.
Q And being depressed can alter the perception of that pain?
A That is correct.
Q Thank you, doctor.

MR. POLLACK: Just a few questions, Your Honor.

THE COURT: Please, Mr. Pollack.

REDIRECT EXAMINATION

BY: MR. POLLACK:

Q Doctor, let's clear up a few things that Counsel didn't let you.

MR. BURBAGE: Objection, Your Honor.

THE COURT: Mr. Pollack, you have questions for this witness?

MR. POLLACK: Yes, I do, Your Honor.

Q With respect to your report why wasn't carpal tunnel syndrome or fibromyalgia discussed?

A Because I did an EMG on the patient on February 10, '22. I found no evidence of carpal tunnel, I found evidence of persistent bilateral C5 through C6 cervical radiculopathy. So the numbness and tingling in her hands is coming from her neck not from the carpal tunnel syndrome. And I found no evidence of fibromyalgia in my evaluations.

Q And an EMG does what?

A EMG checks for muscles and nerves.

Q Okay. With respect to Counsel talk to -- asked you about a bulge being found in 2007 and in 2014.

A '14.

Q And then seven years later with Dr. Kolb it was an herniation. And I want you to assume Dr. Cordiale testified

that when he did the surgery in the cervical spine he saw a herniation. Can you explain the progression of the bulge to the herniation?

A Yes. We spoke about that earlier this morning. A bulge is a partial tear and over time that partial tear can become a complete tear, as it happened here. It doesn't happen immediately, it doesn't happen overnight, it's a slow, gradual progress, and that's what happened.

Q Now, in your report, it doesn't mention Dr. Averbach, and it doesn't mention some other doctors. Is there a reason why?

A I did not need them to formulate my formal diagnosis and my opinions.

Q And why is that?

A Because I had sufficient information. I had -- the other doctors records that I had were sufficient, and I'm not required to speak to a doctor about getting my opinions.

Q Well, that was the next question. Why don't you talk to the doctors?

A First of all, they have no independent recollection of injuries and treatments from 11 years ago, they refer to the medical records, which is what I did. And in my field I'm not required to call doctor, hey, what do you think? Hey, what do you think? I have my own opinion. He/she may agree with my opinion or may disagree with my opinion, but this is my opinion.

Q And your opinion with respect to life care plan isn't blind, meaning you've examined the patient and looked at the records from Medalliance and other facilities, correct?

A Yes, sir.

Q Doctor, counsel asked you about a report where it said L2-L3, and you said it's a typo, can you explain to the jury what happens sometimes?

A Yes. Sometimes I am dictating, the typist makes mistakes. Nobody is infallible. And L2-L3 I meant two to three lumbar vertebrae.

MR. BURBAGE: Objection, Your Honor.

THE COURT: The objection is overruled.

Q I mean, we've got tons of records here and there's often misspellings and mistakes in records, correct?

A Hundred percent.

Q Okay. Counsel talk to you about 26 injections a year, what do you mean about 26 injections a year?

A I'm saying is -- this is what is medically indicated. Now, the trigger points can be done when a patient is getting an epidural, when a patient is being sedated, you can take advantage and give the trigger points at the same time. So there are different injections for different problems and different procedures.

Q Okay. And I want to make it very clear that if the patient is having low level pain let's say a one or a two versus

an eight or nine --

A You don't do it.

Q -- you don't do it, correct?

A Absolutely.

Q 'Cause we're talking about optimal care, and that was my next question. Can you explain to the jury what -- and I already asked you what optimal care is, but in a perfect world this is what they would get, correct?

A Yes, sir.

Q We don't live in a perfect world, do we?

A We do not.

Q Okay. So you're not suggesting to this jury that optimal care is the only care that she should ever get?

A No. I'm not saying that.

Q Last question: Counsel asked you about being compensated to provide your report, correct?

A Yes.

Q Now, you weren't compensated by the attorneys to treat Ms. Rosado, correct?

A No, sir.

Q Okay. And when you're compensated to provide a report that's something that all doctors are compensated for when they write a report for an attorney, correct?

A Yes, sir.

Q Is that what basically happens in this industry?

A That is correct.

Q And with respect to making determinations as to causes, it's not necessarily something a doctor does, 'cause what does a doctor -- what is the purpose of a doctor seeing a patient, generally?

A Take a history, examine the patient, formulate a diagnosis, a treatment plan.

Q So we bring you into court doing things that really isn't part of treating the patient, correct?

A That's correct.

Q Okay.

MR. POLLACK: Nothing further. Thank you.

THE COURT: Can I have the attorneys in the back, please.

Dr. Guy, you are excused.

THE WITNESS: Thank you, Your Honor.

THE COURT: Members of the jury, you have heard all the testimony for today. Tomorrow I will be observing a holiday. I will not be here tomorrow. Friday we have two witnesses lined up, if you are here at 10 o'clock hopefully we will get a bright and early start, and we will start at 10 o'clock.

So see you at 10 o'clock on Friday morning. You are off tomorrow, Friday morning, okay.

Have a good day off.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

(Whereupon, the trial was adjourned until October 3, 2025, at 10:00 a.m.)

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